Contact Officer: Liam Archer
Telephone: 01785 276817
Email: StaffsHWBB@staffordshire.gov.uk

Staffordshire Health and Wellbeing Board

Thursday 7 December 2023
14:00 - 16:00
Oak Room, County Buildings, Stafford

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all - it will be a good place. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of a strong, safe and supportive community".

We will achieve this vision through

"Strategic leadership, influence, leverage, pooling of our collective resources and joint working where it matters most, we will lead together to make a real difference in outcomes for the people of Staffordshire".

Agenda

Chair: **Cllr Mark Sutton, Cabinet Member for Children and Young People**
Vice-Chair: **Cllr Julia Jessel, Cabinet Member for Health and Care**

The meeting will be webcast live and archived for 12 months. It can be viewed at the following link: https://staffordshire.public-i.tv/core/portal/home

No	Time	Item	Presenter(s)	Page(s)
1.	2:00pm	**Welcome and Routine Items** a) Apologies b) Declarations of Interest c) Minutes of Previous Meeting d) Questions from the Public	Chair	1 - 12
2.	2:05pm	**Good Mental Health Priority Progress Update**	Jan Cartman-Frost Karen Coker Nicola Bromage	13 - 28

3.	2:30pm	**Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/23**	Helen Jones John Wood Ruth Martin	29 - 84
4.	2:45pm	**Joint Strategic Needs Assessment Update**	Emma Sandbach	85 - 86
5.	2:55pm	**Staffordshire Health and Wellbeing Board Audit Report and Review of the Terms of Reference**	Jon Topham	87 - 96
6.	3:05pm	**ICB Joint Forward Plan**	Chris Bird	97 - 110
7.	3:15pm	**Right Care, Right Person**	Lisa Cope	111 - 122
8.	3:30pm	**Forward Plan**	Jon Topham	123 - 126

Date of Next Meeting

Thursday 7 March 2024 at 2:00pm in the Oak Room, County Buildings, Stafford

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Draft 2024 – 2025 Dates for the Health and Wellbeing Board:

- Wednesday 12th June 2024 – 2:00pm
- Wednesday 11th September 2024 – 2:00pm
- Wednesday 11th December 2024 – 2:00pm
- Wednesday 12th March 2025 - 2:00pm

Exclusion of the Public

The Chairman to move:

"That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs of Part 1 of Schedule 12A of the Local Government Act 1972 (as amended), indicated below".

Part Two
(All reports in this section are exempt)

Nil.

Membership	
Mark Sutton (Chair)	Staffordshire County Council (Cabinet Member for Children and Young People)

Julia Jessel (Vice-Chair)	Staffordshire County Council (Cabinet Member for Health and Care)
Dr Richard Harling MBE	Staffordshire County Council (Director for Health and Care)
Neelam Bhardwaja	Staffordshire County Council (Director for Children and Families)
Chris Bird	Staffordshire and Stoke-on-Trent Integrated Care Board
Dr Rachel Gallyot	Staffordshire and Stoke-on-Trent Integrated Care Board
Phil Pusey	Staffordshire Council of Voluntary Youth Services
Garry Jones	Support Staffordshire
Gill Heesom	District/Borough Council Representative
Rita Heseltine	District/Borough Council Representative
Tim Clegg	District/Borough Council CEO Representative
Baz Tameez	Healthwatch Staffordshire
Ian Read	Staffordshire Fire and Rescue Service
Emily McCormick	Staffordshire Police

Notes for Members of the Press and Public

Filming of Meetings

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Recording by Press and Public

Recording (including by the use of social media) by the Press and Public is permitted from the public seating area provided it does not, in the opinion of the chairman, disrupt the meeting.

Minutes of the Staffordshire Health and Wellbeing Board Meeting held on 7 September 2023

Present: Mark Sutton (Chair)

Attendance	
Julia Jessel (Vice-Chair)	Garry Jones
Dr Richard Harling	Tim Clegg
Neelam Bhardwaja	Baz Tameez
Dr Rachel Gallyot	Carmel Warren (Substitute)
Phil Pusey	Nicola Bromage (Substitute)

Presenters: Natasha Moody, Amanda Stringer, Emma Sandbach

Apologies: Elliott Sharrard-Williams and Claire McIver

Part One

9. Welcome and Routine Items

a. Minutes of Previous Meeting

Resolved – that the minutes of the meeting held on the 8th June 2023 be agreed and signed by the Chair.

b. Declarations of Interest

There were no declarations of interest on this occasion.

c. Questions from the Public

None received.

10. Health in Early Life Priority Progress Update

The Board received a report and presentation from Natasha Moody and Nicola Bromage on the Health in Early Life Priority Progress Update.

The HWBB strategy had a priority for 'Health in Early Life' which sought to improve health in pregnancy and infancy with a focus on reducing infant mortality.

The presentation noted the local picture of Infant Mortality, both at Staffordshire, Stoke-on-Trent and the West Midlands. It was noted that Stoke-on-Trent had the highest infant mortality rate in England, whilst Staffordshire was rated 25th highest. Neonatal and Post-Natal mortality

rates were shown to the Board.

The slides further showed the rates across the districts and boroughs within Staffordshire. The Board were informed that whilst there is a lag in the published data, the latest available being from 2021, the 2023 provisional data was promising in a reduction in rates of Infant Mortality.

The Board were shown modifiable factors which would impact on infant mortality cases in Staffordshire. This included:

- Smoking during pregnancy
- Poor nutrition
- Pre-term and low birth weight of babies
- Access to support from GPs, Midwives, Health Visitors and other key workers

Smoking in pregnancy was highlighted as the top risk factor in infant mortality. The County Council had commissioned a stop smoking in pregnancy service for several years which offered a 12 week behavioural support and NRT therapy to pregnant women who smoke, post-natal support for up to six months and a preventative offer to support Staffordshire Schools.

In a step to overcome infant mortality, a parent education programme, called ICON helped to aim prevent abusive head trauma and help people who care for babies cope with crying. ICON served to show that:

- Infant crying is normal
- Comforting methods can help
- It's OK to walk away
- Never, ever shake a baby.

A co-ordinated whole system approach Staffordshire and Stoke-on-Trent was also in place to support breastfeeding. An infant feeding survey aimed at families was carried out to understand experiences and help inform future planning. A total of 752 responses were received. An action plan was in development following the analysis of the survey which had three key priorities:

- Improve the awareness of and benefits of breastfeeding within the community and for parents
- Increase the support to breastfeed particularly the first 10 days following birth
- Embed infant feeding pathway so more people know and access timely help and support.

The Board were further informed of a whole family support system, called

the Families' Health and Wellbeing Service (0-19). This offered holistic support to the entire family with a number of mandated checks.

The Strengthening Families Team work with pregnant and post-natal people and provided more targeted support for children known to services. They provide a named health worker for each eligible family and focus on achieving high quality outcomes.

It was noted by the Board that whilst there was significant work underway to address varying modifying factors of infant mortality, the approach was somewhat fragmented and lacked clear overall ownership. It was demonstrated that there were approximately 16 strategic and partnership/working groups who had reducing infant mortality as a priority focus. Moving forward, one system wide group had been established which would drive forward improvement, currently reporting into the SSCB and HWBB.

Garry Jones queried whether circumstances of the birth itself were included in the modifiable factors, and whether evidence of inequalities were linked to protected characteristics. Natasha responded to say that evidence and research suggested that certain cohorts of people were more likely to experience infant mortality. Nicola Bromage would take away the first point regarding modifiable factors.

Councillor Sutton questioned the age of data available and asked why there was such a lag, and whether there was any way of getting more up to date data. Natasha was not able to confirm why there was a lag in the data from the ONS, however, comparable data from Child Death Overview Panel showed similarities in the data between the two sources. Richard Harling highlighted that a local system could be established for the overall data, but with a deeper dive into the causes.

Natasha also highlighted the Child Death Overview Panel which runs across Staffordshire and Stoke-on-Trent and discusses deaths of every single child. This panel is used to inform the work that is then undertaken.

Baz Tameez informed the Board of higher rates of infant mortality across BAME communities, and offered to bring data and deep dive findings back to a future meeting.

Tim Clegg observed that similar cohorts of people exhibiting similar health concerns are becoming apparent with each priority update to the Board and commented on the need to co-ordinate interventions across the system.

Councillor Jessel noted that the Board did not want to lose focus on infant mortality and questioned the prevalence of smoking and whether alcohol

and drug use was an emerging factor. In response, Natasha confirmed that the data wasn't showing drug and alcohol use as a major factor currently and would also consider the points raised by Tim and include more data sets where appropriate.

Councillor Sutton highlighted the governance surrounding the work on infant mortality and stressed the importance of all Boards having the same information presented to them, and co-ordination between what each Panel/Board are doing.

Resolved – that the Board (a) note the progress being made by partners in Staffordshire regarding Healthy Start in Life;

(b) Support the widening of the focus on children and young people beyond infant mortality to encompass the work we are doing on the wider determinants of health to improve outcomes for Children and Young People;

(c) Endorse the CYP Framework which has been developed by the Programme Board delivering on behalf of the Integrated Care System;

(d) Endorse the Co-Production Promise as a critical way in which we plan to work with CYP&F and consideration of its use across the broader partnership;

(e) Acknowledge the planned work across the partnership and continue to support the development of these programme of work over the coming year; and

(f) Work towards enhanced and timely data of infant mortality and more joined up working between the various governance structures.

11. Healthwatch Staffordshire Progress and Update on 3 Deep Dives

The Board received a report and presentation from Baz Tameez on progress within Healthwatch Staffordshire and in particular an update on the three deep dives undertaken:

- Root causes of good and poor teenage mental wellbeing and health outcomes when you've been in care as a child
- Access to primary care
- Seldom heard groups

Healthwatch Staffordshire had been working with Healthwatch England to use a theory of change model to focus resources in areas in the deep dives where it was most needed. This sought to increase chances of successful outcomes, identify what was working and what wasn't, so the

approach could be adjusted and resources targeted.

The theory of change model also sought to measure and communicate the effectiveness of the work undertaken and evidence the outcomes achieved.

The methodology for the deep dives was presented to the Board, which included:

- Face to face events
- Surveys and questionnaires
- Focus groups
- Case studies
- Social media
- Desktop research; and
- Partnership working

The slides further demonstrated the root causes of good and poor teenage mental wellbeing and health outcomes when you've been in care as a child. Healthwatch had been working with the County Council and the ICS to co-ordinate and contribute to the development of a new 'Staffordshire Joint Mental Health Strategy'. This seeks to address and help improve the mental health and mental wellbeing of young people and uses six key outcomes identified from engagement activities.

Early key themes and recommendations showed that primarily young people prefer to have face to face appointments with the flexibility of other means to engage, the transition from Child Adolescent Mental Health Services into Adult Mental Health Services needed to be smoother, reducing the risk of vulnerable people slipping through the net and reducing waiting times by utilising more referrals to other providers. The Access to Primary Care deep dive showed that 92% of NHS consultation took place at the GP and this was where Healthwatch was receiving the most feedback, along with dentistry. Feedback showed that one patient made over 210 calls over two days before they got through, but did get the treatment they needed once booked in.

Healthwatch had been supporting the ICS with their Primary Care Access Campaign in line with the new delivery plan, by promoting the Additional Roles Reimbursement Scheme (ARRS).

Early key themes emerging from patient feedback included:

- Neurodiversity – reasonable adjustment was required for patients with communication needs
- Cost of living was making it difficult to afford prescriptions and travel to appointments

- Telephone access remained an issue for patients and found waiting times frustrating
- Patient registration which were specific to Burntwood and East Staffordshire
- Digital communication challenges including the use of the NHS App
- Mixed views on patient experiences with NHS 111

The Board were informed of next steps on this deep dive which included the potential role of PPGs, supporting changes in local practices, the continuation of the work with ICB primary care managers to understand countywide implementation of the Primary Care Improvement Plan, development of a simple guide to secure the best out of Primary Care and consideration of an event and looking at patient feedback in early 2024 on effects of changes on patients.

The final deep dive focused on 3 seldom heard groups:

- Transgender community (LGBTQIA+)
- People with Neurodiverse Conditions (co-occurring needs)
- Those in Rural Areas (rurality)

Feedback showed that patients felt that GPs were generally unsure how to support them when they wanted to transition, and that transitions were taking longer than the initial promised timescales.
Surveys were formulated which gathered feedback around wanting professionals to have more of an understanding on co-occurring needs which would improve access to services.

Survey feedback on the rurality strand showed that people had concerns around time and money for travelling to GP appointments, opticians, pharmacists and health centres along with wishes that services were available closer to home. In addition, the survey highlighted feedback around the lack of public transport to get to appointments.

Councillor Jessel provided comments around self-diagnosis of young people's mental health conditions and whether feedback was based on professional diagnoses or self-diagnoses. In response, Baz highlighted that feedback was mixed between self-diagnoses and formal diagnosis with a health professional. The latest data showed that 12 in 100 young people had a diagnosable mental health condition.

Tim Clegg highlighted the points raised around digital communication and the excessive amount of phone calls to get an appointment, considering the use of a digital triage system. Baz further commented on the barriers in place affecting peoples use of digital options, however stated that those who are supported to use digital do use it.

Garry Jones reminded the Board that the role of Healthwatch was to shine a light on things that were most important to the public and patients, which may not always be the same things that are important to service providers. As this was the first year under new arrangements for Healthwatch, learning from the deep dives shows that collaboration was good but future deep dives would be even more focused and therefore may reduce the breadth.

Resolved – that the Board consider and comment on the progress made by Healthwatch Staffordshire service on the three deep dives.

12. CQC Single Assessment Framework

The Board received a presentation from Amanda Stringer on the Care Quality Commission Single Assessment Framework.

The presentation demonstrated the following areas of interest:

- Providers
- Integrated Care Systems
- Local Authorities

CQC were suggesting that an assessment of a local authority would take around 20 weeks, with notice given to collate evidence including a self-assessment. Evidence would be primarily reviewed off site, with the on-site assessment taking two days and one day spent in virtual meetings. There would be an opportunity to review the report before it was published.

The self-assessment to date included assessing needs, supporting people to live healthier lives, equity in experiences and outcomes, care provision integration and continuity, partnerships and communities, safe systems pathways and transitions, safeguarding, governance management and sustainability, learning improvement and innovation, with strengths and areas to work on identified against each assessment criteria.

Garry Jones queried whether an overall rating would be provided, similar to that of OFSTED, despite recent learning from inspections at schools. Amanda confirmed that an overall rating would be provided but a full report would identify how this position had been reached.
Richard Harling asked a question to the Board, what help and support would be needed to make an informed representation.

Councillor Jessel supported the comments made by Garry and noted the impact that a rating would have on staff, confidence of service users and the ability to recruit.

Councillor Sutton queried if a self-assessment would be completed and shared beforehand to demonstrate awareness of any issues present. Amanda confirmed this was in place and regularly updated and tested with partners.

Resolved – that the presentation be noted.

13. JSNA Development

The Board received a report and demonstration from Emma Sandbach on the development of the Joint Strategic Needs Assessment for Staffordshire.

Since the last report, a JSNA steering group had been established to oversee the development of the assessment. The group had representatives from key local organisations including the County Council, ICB, District and Borough Councils, MPFT and Stoke-on-Trent City Council.

A working group that met on a more regular basis had also been established, which supported the development of the content of the JSNA chapters. The initial chapters would follow a life course approach, including an initial focus on population demographics, starting well, living well and ageing well. Due to the complexity of the piece of work, it would be necessary to complete the JSNA in phases, and it would become an iterative process to be continually updated and augmented as data sources evolved.

To date, detailed mapping had been undertaken on the data requirements for the population demographics chapter. This included collating all requirements for data indicators, sources, dates, geography, etc. A detailed mapping for the Ageing Well section had also been started.

The working group would be asked to scrutinise the various datasets and indicators to be included in each chapter which would ensure that members of the group with expertise in data or in the subject would be confident that the right information is included.

The first draft of the demographics chapter would be available to view in October 2023, and a further update report would be brought to the Board in December 2023.

Resolved – that the Board support the development of the Joint Strategic Needs Assessment 2023 and note the timescale for its development.

14. Staffordshire Better Care Fund

The Board received a report from Rose Cororan on the Staffordshire Better Care Fund.

The 2023-25 BCF Policy Framework required the submission of BCF Plans by the 28th June 2024, to include a narrative plan and an expenditure template, capacity and demand, as well as ambitions and delivery plans for BCF metrics. Plans were expected to be assured by the 8th September 2023.

Staffordshire's plans had been completed and were approved by the Health and Wellbeing Board Chair on the 27th June, under delegated authority. Plans were subsequently submitted.

The total ICB ASC Discharge Grant allocation for 2023/24 was £5.148m, and £9.837m for 2024/25. The current proportion split used in the submission to each HWB area was 72% Staffordshire and 28% Stoke-on-Trent, which was not consistent with the adult population of the Integrated Care System which was 78% Staffordshire and 22% Stoke on Trent. This meant that of the £5,148m and £9,837m allocated in 2023/24 and 2024/25 respectively Staffordshire would receive only £3,706,560 and £7,082,640 compared to our fair shares of £4,015,440 and £7,672,860, a shortfall of £899,100 over two years. The Council had requested that the apportionment of the ICB's ASC grant allocation in 2024/25 was reviewed to redress this imbalance.

Resolved – that the Board (a) note that the 2023-25 BCF Policy Framework was published in April 2023 which required the submission of BCF Plans by 28th June 2023;

(b) Note that the Staffordshire 2023-25 BCF Plans had been submitted, including a narrative plan, expenditure template, capacity and demand and ambitions and delivery plans for BCF metrics;

(c) Note that the expenditure plans for the 2023/24 and 2024/25 SCC and ICB Adult Social Care Discharge Grants had been agreed, and were detailed in tables 2 and 3 of the report; and

(d) Note that the current proportion split of the ICB ASC discharge grant to each Health and Wellbeing Board area was not consistent with the adult population of the Integrated Care System, and that the Council had requested that the apportionment of the ICB's ASC grant allocation in 2024/25 was reviewed to redress this imbalance.

15. Health and Wellbeing Board Strategy - Comparative Health Metrics and Performance Indicators Update

The Board received a report for information on the comparative health metrics and performance indicators update on the Health and Wellbeing Board Strategy.

At the Board meeting in March 2023, to support the monitoring of the strategy, baseline data was provided. For each of the four priority areas, a priority lead was assigned with agreement that each priority area would be the focus for discussion in more depth at a different quarterly meeting, including discussion of the associated metrics/indicators. The lead officer for the Good Mental Health priority had suggested that further metrics ma be added to their area.

Since the March meeting, discussions had taken place and one further metric was added: 'New referrals to secondary mental health services for those under 18 years of age'.

Resolved – that the Board note the contents of the report.

16. Right Care, Right Person

Due to the non-attendance of the Staffordshire Police representative for the meeting, this item was not considered, but assurance had been given to the Chair that an appropriate representative would be sent to the December meeting to provide an update.

The Board held a discussion on the item and what Right Care, Right Person meant, and sought to clarify engagement events that had taken place with various partners.

Councillor Jessel asked that the Board request that partners are kept fully informed and provided with a demonstration on how the system would work before the initial go-live in February.

17. Forward Plan

The Board noted the following items for consideration at their December meeting:

- Good Mental Health Priority Progress Update
- Staffordshire and Stoke-on-Trent Adult Safeguarding Board Annual Report
- JSNA Update
- Right Care, Right Person

Resolved – that the Forward Plan be received.

18. Date of Next Meeting

Resolved – that the date, time and venue of the next meeting (Thursday 7th December 2023 at 2:00pm in the Oak Room, County Buildings, Stafford), be noted.

19. Exclusion of the Public

Resolved - That the public be excluded from the meeting for the following items of business which involves the likely disclosure of exempt information as defined in the paragraph of Part 1 of Schedule 12A (as amended) of the Local Government Act 1972 as indicated below.

Chair

Staffordshire Health and Wellbeing Board – 07 December 2023

Good Mental Health Priority Progress Update

Recommendations

The Board is asked to:

a. Approve the Action Plan for the Good Mental Health Strategy 2023-28.
b. Note the Staffordshire and Stoke-on-Trent Children and Young People's Local Transformation plan.
c. Note the wider activity across the health and care system to support good mental health.

Background

1. Good mental health is one of the priorities of Staffordshire's Health and Well-being Strategy. As a result, Staffordshire County Council and the Staffordshire and Stoke on Trent Integrated Care Board (ICB) produced a Good Mental Health in Staffordshire Strategy, which was approved by the Health and Well-being Board in December 2022.

2. This Strategy has six main outcomes:

   a. Everyone can look after their own mental well-being and find support in their communities when they need it.
   b. People have access to services when needed.
   c. A timely response to crises.
   d. There is equal access to support to improve mental well-being and services to manage mental health problems.
   e. People with severe mental health problems are supported to live in the community and have good quality, integrated care.
   f. More integrated, good quality services for young people that focus on achieving independence in adulthood.

3. An Action Plan has been developed to achieve the outcomes set out in the Strategy and is included at Appendix 1. The Action Plan was co-produced by the Council and ICB working with people affected by mental health conditions as well as frontline professionals. A wide range of partners including the Council, ICB, NHS Trusts, district and borough councils, voluntary sector organisations, care providers as well as people with mental health conditions will be involved in implementing the actions. The Action Plan will be reviewed annually as actions are complete and new actions are required to achieve the outcomes.

4. The primary focus of the Strategy is adults in Staffordshire. However, as it was recognised that there are opportunities in people's early lives to positively influence their future mental health and well-being, the Strategy also references children and young people. The action plan therefore includes some actions for children and young people but is not inclusive of the full programme of work across Staffordshire. Other work is ongoing as part of the Staffordshire and Stoke on Trent Integrated Care System Children and Young People's Mental Health Local Transformation Plan and will be considered as part of the Health in Early Life priority in September 2024.

5. Note that there is also wider activity across the health and care system to support good mental health through a range of strategies and programmes including:

    a. NHS Long Term Plan
    b. Community Mental Health Transformation
    c. Mental Health Practitioners in Primary Care Networks (PCNs)
    d. Crisis Alternatives including:
        i. Crisis Café,
        ii. Safe Hands,
        iii. Out of Hours Home Sitting Service,
        iv. Crisis House,
        v. Core24 Service
        vi. Mental Health Ambulances and
        vii. NHS 111 option 2
    e. Investment in Peri-natal Mental Health
    f. Mental Health Support Teams for Children and Young People -(MHSTs)
    g. Staffordshire Emotional Health and Wellbeing Services
    h. Staffordshire and Stoke-on-Trent Suicide Prevention Partnership

6. Progress to achieve the Strategy will be measured using the following metrics as well as tracking completion of the actions set out in the Action Plan.

    a. Everyone can look after their own mental well-being and find support in their communities when they need it. Metrics include:
        i. Number of support organisations and number of care navigators attending Network meetings.
        ii. Number of people accessing the revised SCC IAG pages.
        iii. Number of workplaces and number of individuals receiving workplace mental health training.
        iv. Increased numbers of Adults and Older Adults accessing Talking Therapies whilst maintaining waiting time and treatment standards.
        v. Activity data from digital solutions such as websites and apps, Referral data from providers where available and Customer feedback.

vi. Increase in number of schools reporting that they are implementing a Whole School Approach to Mental Health.
vii. Expand Mental Health Support Teams in schools; enabling all schools in all districts to have access to support.

b. People have access to services when needed. Metrics include:

i. Increase the numbers of children and young people accessing mental health support (at least one contact) in line with annual trajectories.
ii. Publish the CYP Mental Health Transformation Plan.
iii. Increased numbers of people accessing perinatal mental health services and Maternal Mental Health services (MMHS).

c. A timely response to crises. Metrics include:

i. Reduction in suicide rates
ii. Improve the speed of access to mental health crisis services for all ages through the expansion of services.
iii. Reduced avoidable long lengths of stay in adult acute mental health inpatient settings, so that people are not staying in hospital any longer than necessary, including people with a learning disability and autistic people in mental health inpatient settings.

d. There is equal access to support to improve mental well-being and services to manage mental health problems. Metrics include:

i. Numbers of people with lived experience involved in the co-production of actions in 22/23 and refresh of the action plan for 24/25.
ii. Increased numbers of adults with SMI receiving physical health checks (PHC).

e. People with severe mental health problems are supported to live in the community and have good quality, integrated care. Metrics include:

i. Increased numbers of adults with SMI accessing Individual Placement and Support services by 2023/24.
ii. Increase in the number of people with SMI accessing transformed models of integrated primary and community care (at least two contacts) in line with annual trajectories.
iii. Fewer people with mental health problems living in nursing accommodation.
iv. More people will receive care and support from a CQC 'Good' or 'Outstanding' provider.
v. Feedback from people's reviews on individual outcomes.
vi. Increasing the numbers of adults who are in contact with secondary mental health services living in their own homes.

f. More integrated, good quality services for young people that focus on achieving independence in adulthood. Metrics include:

i. Higher % of more appropriate psychological assessments for C&YP where these are directed / ordered by the courts.
ii. Reduction in placement breakdowns linked to unmet mental health & emotional wellbeing needs.

List of Background Documents/Appendices:

Appendix 1: Good Mental Health Strategy Action Plan 2023-2028

Contact Details

Board Sponsor: Neelam Bhardwaja, Director for Children and Families
Richard Harling, Director for Health and Care

Report Author: Jan Cartman-Frost, Senior Commissioning Manager
Telephone No: 01785 276851
Email Address: jan.frost@staffordshire.gov.uk

Good Mental Health Strategy 2023 – 2028: Action Plan

	Outcome	Measured by:	Actions	Who will do this:	By when:	Also links to outcomes:
1	**Everyone can look after their own mental well-being and find support in their communities when they need it.**	Number of support organisations and number of care navigators attending Network meetings.	• Identify opportunities to improve the ability of people to find suitable support in their communities by establishing a regular, local network for sharing up to date news and activities by grassroots organisations supporting mental health and wellbeing with care navigators.	SCC Chris Stanley	First network meeting by End of October '23	2
		Number of people accessing the revised IAG pages.	• Actively Promote the "Five Ways to Wellbeing" through improved IAG, campaign and promotion through "Let's Talk about Wellbeing" Shobnall project.	SCC Chris Stanley	By Dec '23	5,6
		Number of workplaces and number of individuals receiving workplace mental health training.	• Commission programme of training around mental wellbeing and resilience targeted at SMEs to tackle poor mental wellbeing in the workplace.	SCC Chris Stanley	By Oct '23	6
		Increased numbers of Adults and Older Adults accessing Talking Therapies whilst maintaining waiting time and treatment standards.	• Promoting IAPT (Increasing Access to Psychological Therapies) to populations that will benefit from IAPT interventions, including those who are currently under-represented. • Updating the IAPT brand to ensure the public understand and can benefit.	Mental Health Programme Board ICB Lead - Nicky Bromage ICS Lead - Sarah Watts (MPFT)	Mar-24	2,4

			• Developing a trusted assessor model for referral to Talking Therapies. • Increased integration with physical health pathways to deliver on Talking Therapies Long Term Conditions commitment.			
		Activity data from digital solutions such as websites and apps Referral data from providers where available Customer feedback.	• Co-produce an approach that allows people that are seeking support to know what's available and how to access it, establishing the best methods of communicating the mental health support offer for adults and for children and young people.	SCC Chris Stanley and Jan Cartman-Frost ICS CYP MH System Improvement Board Service Delivery Working Group - SCC Karen Coker	Apr- 25	2,3,4,5,6
		Increase in schools reporting that they are implementing a Whole School Approach to Mental Health.	• Action plan to be developed in response to the Emotional Wellbeing survey carried with staff in all schools across Staffordshire in Autumn 2022 to improve workplace mental wellbeing in schools and support implementation of Whole School Approach to Mental Health. • Implementation of Action Plan responding to findings of schools Emotional Wellbeing survey during academic year 23 / 24.	SCC Sandra Webb SCC Sandra Webb	October 2023 July 2024	1, 6

		Expand Mental Health Support Teams in schools; enabling all schools in all districts to have access to support.	• September implementation in Lichfield. • January implement additional capacity in Cannock, Stafford, and South Staffs.	Pan-Staffordshire MHST Steering Group ICB Lead - Kevin Day ICS Lead - Deb Hargreaves (NSCHT) Sarb O'Brien (MPFT)	Sept- 23 January -24	6
2	**People have access to services when needed.**	Increase the numbers of children and young people accessing mental health support (at least one contact) in line with annual trajectories.	• Promote self-referral processes via a digital front door improving accessibility, responsiveness, and choice. • Grow the CAMHS workforce to respond to more CYP's and provide timely access; monitoring waiting times for CYPs to ensure access is timely. • Increase numbers of children and young people accessing emotional resilience programmes in schools through Mental Health Support Team's (MHST).	Mental Health Programme Board ICB Lead - Nicky Bromage ICS Lead - Josey Gaitley (NSCHT) ICB Lead - Nicky Bromage ICS Lead - Josey Gaitley (NSCHT)	Mar-24	5,6
		Publish the CYP Mental Health Transformation Plan.	• Refresh / update the annual CYP Mental Health Transformation Plan; aligned with those for children and young people with learning disability, autism, special educational needs, and disability (SEND), children and young people's services, and health and justice. • Publish the updated version on the ICB website. • Development of joint agency plans; an opportunity to be transparent about and	Mental Health Programme Board ICB Lead Nicola Bromage	Oct-23	4,5,6

			accountable for improvement plans that are embedded into and/or align with wider strategic documents and core governance.			
		Increased numbers of people accessing perinatal mental health services and Maternal Mental Health services (MMHS).	• Recruitment in line with indicative 2023/24 workforce profile, including clinical, VSCE roles and peer roles. • Increase in psychological professions staffing, delivering evidence-based psychological interventions, including: o Parent-infant work. o Couples & family work. • Understanding and improving equalities of access and care provided.	Mental Health Programme Board ICB Lead - Nicky Bromage ICS Lead - Jo Heaney (MPFT)	Mar-24	6
3	**A timely response to crises.**	Reduction in suicide rates	• Review structure and governance of Staffordshire and Stoke on Trent Partnership to ensure activity driven by evidence from Real Time Suspected Suicide Surveillance.	SCC Chris Stanley	Nov-23	
			• Establish a working group to consider the development a system wide approach to consistent person-centred risk assessment/safety planning	SCC Chris Stanley	Nov-23	
			• Commission and launch Postvention (Suicide Bereavement) Service across Staffordshire and Stoke on Trent (NHS funded)	SCC Chris Stanley	Service launched by Nov '23	
			• Adaptation of existing online commissioned Suicide Prevention Awareness Training to target people working with young people	SCC Sarah Tunnicliffe	Nov-23	6

			• Revise or recreate suicide prevention awareness training to be made suitable for Gypsy Roma Traveller Communities.	SCC Chris Stanley	Mar-24	4
		Improve the speed of access to mental health crisis services for all ages through the expansion of services.	• Establish a single point of access including through 111 to crisis support, advice, and triage. • Crisis assessment available within the emergency department and in community settings. • 24/7 crisis provision for CYP which combines crisis assessment, brief response, and intensive home treatment functions. • Ambulance Response - Increase the provision of alternatives to A&E and admission & improve the ambulance MH response. • Increase options for alternative forms of provision for those in crisis such as crisis houses, safe havens, and crisis cafes.	Mental Health Programme Board ICB Lead - Nicky Bromage ICS Leads - Josey Gaitley (NSCHT) Lyse Edwards (MPFT)	Mar-24	5,6

		Reduced avoidable long lengths of stay in adult acute mental health inpatient settings, so that people are not staying in hospital any longer than necessary, including people with a learning disability and autistic people in mental health inpatient settings.	• Improved therapeutic offer from inpatient mental health services by enhancing access to therapeutic interventions and activities. • Increase the level and mix of staff on acute mental health inpatient wards, including improving access to peer support workers, psychologists, occupational therapists, social workers, housing experts and other relevant professionals during admission.	Mental Health Programme Board ICB Lead - Cath Marsland ICS Lead - Lisa Agell (MPFT) Rachael Birks (NSCHT)	Mar-24	2,4,5
4	**There is equal access to support to improve mental well-being and services to manage mental health problems.**	Numbers of people with lived experience involved in the co-production of actions in 22/23 and refresh of the action plan for 24/25.	• Promote involvement of people with lived experience in the design of support and services associated with the GMH strategy. • Establish joint opportunities with NHS and other partners for people with lived experience to regularly contribute to the design of tools, pathways, and services. • Ensure report from Healthwatch deep dive on mental health of care experienced young people informs action plan 24/25. • Adapt GMH strategy action plan considering what people with lived experience have told us.	SCC Jan Cartman-Frost	Mar-24	1,2,3,5,6

		Increased numbers of adults with SMI receiving physical health checks (PHC).	• Incentivising full Physical Health Checks (PHC). • Increased investment in to Outreach. Using core20Plus5 community connectors and tech pilots to deliver PHC remotely. • Increase access & making every contact count (MECC). • Improve the quality and emphasis of follow up interventions.	Mental Health Programme Board ICB Leads – Waheed Abbasi/Murray Campbell	Mar-24	1,2,5
5	**People with severe mental health problems are supported to live in the community and have good quality, integrated care.**	Increased numbers of adults with SMI accessing Individual Placement and Support services by 2023/24.	• Increase the number of employment specialists in line with increased trajectory. Embed IPS into the Community Mental Health Transformation. • Mental Health Services Data Set review.	Mental Health Programme Board ICB Lead - Kevin Day ICS Lead - Gavin Hicks (NSCHT)	Mar-24	1,4,6
		Increase in the number of people with SMI accessing transformed models of integrated primary and community care (at least two contacts) in line with annual trajectories.	• Full PCN coverage of care model including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis). • Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.	Mental Health Programme Board ICB Lead - Nicky Bromage ICS Lead - Angie Upton (MPFT)	Mar-24	2

		Less people with mental health problems living in nursing accommodation. More people will receive care and support from a CQC 'Good' or 'Outstanding' provider. Feedback from people's reviews on individual outcomes.	• Ensure that the needs of people with mental health problems are reflected in the specification for recommissioned residential and nursing care arrangements, so that people with complex needs can be supported through recovery and maintain living within the homes. • Specification for accommodation-based care is strength based with a focus on enablement. • Feedback from people with lived experience are incorporated into the recommissioning of residential and nursing care.	SCC Deborah Cooper	Apr 25	1,2,6
		Increasing the numbers of adults who are in contact with secondary mental health services living in their own homes.	• Work with housing and care providers to ensure peoples supported living arrangements are appropriately funded and the rent costs can be met.	SCC Jan Cartman-Frost/Sarah Taylor	Oct-24	1,2,6
			• Work with health, district and borough councils and other relevant partners to ensure appropriate housing is offered to people on discharge from hospital to support recovery. • There is adequate support for people to maintain their tenancies wherever possible.	SCC Jan Cartman-Frost	Oct-24	1,2,6
			• Ensure the Housing with Care strategy for working aged people with disabilities reflects the needs of people with mental health problems.	SCC Chidi Okeke	Dec-23	1,2,6
			• Consider potential options for moving groups of people who wish to remain living together from residential and nursing care to alternative independent living arrangements.	SCC Jan Cartman-Frost	Jun-24	1,2

			• Feedback from people with lived experience are incorporated in to, and the needs of people with mental health problems are reflected in, the specifications and tendering of recommissioned supported living arrangements. • Supported living services tailored to meet the needs of people with mental health problems is implemented. • People will be supported to move to the new supported living arrangements.	SCC Kate Harrold/H&C Supported Living Programme	Aug 23 April 24 July 24 - Oct 24	1,2,6
6	**More integrated, good quality services for young people that focus on achieving independence in adulthood.**	Higher % of more appropriate psychological assessments for C&YP where these are directed / ordered by the courts.	• Implement utilisation of regional framework to procure court ordered psychological therapies, ensuring the right actions for children and young people.	SCC Becky Murphy	Jul-24	2
		Reduction in placement breakdowns linked to unmet mental health & emotional wellbeing needs.	• Develop a Risk Register of children and young people where their placement breakdown is caused by unmet mental health needs. • Agree a process with partners to agree / provide support to mitigate against placement breakdowns due to CYP's unmet mental health needs.	SCC Eddie Birch	Jul-24	1,2,3,4

Good Mental Health Strategy 2023 – 2028: Future Actions

	Outcome	Area of activity	Outline Actions	Who will do this:	By when:	Also links to outcomes:
1	**Everyone can look after their own mental well-being and find support in their communities when they need it.**	Establishment of revised Supportive Communities Programme.	• Align Public Mental Health and Wellbeing planned activities with the evolving iterative action plan from the review of the Supportive Communities Programme	SCC Chris Stanley/Tilly Flanagan	TBC	
		Self-reported Loneliness/Social isolation.	• Deliver actions identified within Staffordshire Loneliness & Social Isolation Reduction Plan 2022 -2027	SCC Vicky Rowley	TBC	4
		Partnership CYP Mental Health - Prevention Action Plan.	• Develop partnership CYP Mental Health - Prevention Action Plan with the aim of improving community resilience, empowering communities to be environments where children, young people and their families can thrive, achieve, and maintain good emotional wellbeing and mental health. Action Plan will link to activity around early help and Family Hubs and include a focus on developing community resilience. • Implement partnership CYP Mental Health - Prevention Action Plan (in line with 23 / 24 Mental Health Transformation Plan).	ICS CYP MH System Improvement Board, Prevention Working Group SCC Becky Murphy	Oct 23 Oct 24	1,6

2	**People have access to services when needed.**					
3	**A timely response to crises.**					
4	**There is equal access to support to improve mental well-being and services to manage mental health problems.**	Mental health and mental wellbeing of carers.	• Consider the mental wellbeing needs of carers and young carers in the development of the SCC and ICB joint all age carers strategy 2024-29. • Incorporate the lived experience of carers and young carers in the development of strategies and services.	SCC Jackie Averill	Apr-24	1,2,6
5	**People with severe mental health problems are supported to live in the community and have good quality, integrated care.**	Implementation of Right Care, Right Person (RCRP) national partnership agreement following publication of guidance. (Metrics for this scheme are still to be confirmed / published).	• Assess readiness for implementing Right Care, Right Person (RCRP) national partnership agreement; this includes existing practices and approaches which aim to reduce or improve police involvement in mental health incidents. • Review data currently collected which could inform monitoring of approach.	Mental Health Programme Board ICB Lead - Nicola Bromage	Mar-24	2,3
6	**More integrated, good quality services for young people that focus on achieving**	Preparing For Adulthood (PFA).	• Programme currently being developed. Project deliverables and actions expected to support delivery of the GMH strategy.	SCC Christine Wheeler/PFA Programme	TBC	1,2,4,5

	independence in adulthood.	Improve the mental health outcomes of care experienced children and young people.	• Identify gaps and barriers in mental health support using findings from professionals and those with lived experience. • Mapping activity completed, findings reported to strategic partners and actions identified to address gaps. • Develop partnership approach for addressing these, including commissioning additional services where required.	SCC Becky Murphy / Karen Coker	Jul-24	1,2,4,6
		A targeted prevention offer which meets the needs of children and young people who may be more vulnerable / have higher risk of experiencing mental health difficulties.	• Develop partnership CYP Mental Health - Prevention action plan which includes focus on targeted prevention. • Implement partnership CYP Mental Health - Prevention Action Plan (in line with 23 / 24 Mental Health Transformation Plan).	ICS CYP MH System Improvement Board Prevention Group SCC Becky Murphy	October 2023 October 2024	1

Staffordshire Health and Wellbeing Board – 07 December 2023

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/23

Recommendations

The Board is asked to:

a. Receive and consider the SSASPB Annual Report 2022/23 in accordance with the requirements of the Care Act 2014; and

b. Provide feedback as to how the HWBB can enhance contributions to safeguarding of adults with care and support needs at risk of abuse or neglect.

Background

1. Safeguarding Adult Boards (SABs) became statutory under the Care Act 2014 which states that the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

   a. Have needs for care and support
   b. Are experiencing or at risk of abuse and neglect; and
   c. As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse and neglect.

2. The SAB has a strategic role to oversee and lead adult safeguarding and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. SAB partners also have a role in challenging each other and other organisations where there is cause for concern that actions or inactions are increasing the risk of abuse or neglect.

3. The SAB has 3 core duties:

   a. To publish a strategic plan
   b. To publish an Annual Report
   c. To undertake Safeguarding Adult Reviews in accordance with criteria

4. This Annual Report of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) covers the period 1st April 2021 to March 31st, 2020/22. Mr John Wood was the Independent Chair of the Board throughout the period. The report provides an overview of the work of the Board and its sub-groups and illustrated with case studies as to how the focus on Making Safeguarding Personal is making a positive difference to ensuring that adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse.

Adult Safeguarding Data: Staffordshire headlines for the reporting period 1st April 2022 to 31st March 2023:

5. The safeguarding partners have established and widely publicised the procedures for reporting concerns that an adult with care and support needs may be experiencing or is at risk of abuse or neglect and unable to protect themselves. Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014, if the duty of enquiry requirements are met.

    a. Concerns reported: There have been 15,680 occasions when concerns have been reported that adults with care and support needs may be experiencing or at risk of abuse and neglect. This number has increased by 2,543 from 2021/22 which was reported as 13,227. Following initial assessment it was determined that the duty of enquiry requirement was met in 17% of those reported concerns, a decrease of 4% from 2021/22 reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21.

        i. Safeguarding concerns range from the very serious to the relatively trivial. The number of people who meet the threshold for a Safeguarding enquiry under Section 42 is broadly unchanged. It is the increase in the total number of concerns that has contributed to the reducing conversion rate.

        ii. The information gathered from audits indicates that the variance could be related to the type of concerns raised, for example, there are a significant number of concerns arising through quality or assessment processes.

        iii. Audits indicate that some concerns are found to be low level incidents which have led to no harm to the individual. Concerns such as these are triaged early and, when no other actions are needed, they will be closed. Examples include concerns regarding medication errors, service user incidents, missed and late care calls. In other situations, appropriate actions have been taken by others to reduce the risk and therefore a Section 42 enquiry is not required.

iv. Arising from the increasing number of reported concerns there are discussions currently amongst safeguarding partners to develop a mutual understanding of what constitutes a safeguarding concern and to ensure that referring thresholds are understood with the aim of ensuring proportionate ongoing management to protect resources to deal with the more serious cases.

b. Age: Of the people subject of a Section 42 enquiry, those aged 75 to 84 years (26.9%) represent the largest cohort followed by 85 to 94 years (25.1%). Last year these age groups were reversed with 85 to 94 being the most prevalent at 25.2% compared to 24.9% for 75 to 84 years.

   i. When drawing comparison with the population statistics of Staffordshire it is evident that adults in the 75yrs+ age groupings are disproportionally over-represented for Section 42 enquiries. Around 12% of the adult population in Staffordshire are aged 75 and over, however, 56.8% of safeguarding enquiries are related to this age group.

c. Gender: Females represent the majority of adults subject of a Section 42 enquiries with 63% over the year. This is disproportionately above the population average for females in Staffordshire which is 50.3%. Females over the age of 75 years are consistently found to be most at risk of abuse or neglect.

d. Ethnicity: Most adults involved in a Section 42 enquiry are white – 91.9%, an increase from 87.8% last year. The percentage of the population of Staffordshire who self-identified as white is 90.2%. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.

e. Primary Support Reason (PSR): Physical support continues to be the most common PSR in Staffordshire at 48% the same percentage as last year. This is followed by mental health support at 20% reflecting a 6% increase from last year. It is of note that there is a significant decrease in the category of 'not recorded' which is down to 0% from 17% last year.

f. Type of Abuse: Neglect and Acts of Omission continues to be the most prevalent type of abuse at 37% and is the same figure as last year. Financial Abuse remains similar at 20% compared to 19% last year. Physical Harm has reduced to 13% from 17% last year.

g. Location of Abuse: The most reported location of abuse in Staffordshire was the adults' own home at 70% compared to 62% in 2021/22. The

next most prevalent locations were nursing home 17% a slight increase from 16% last year and independent residential home 12% a slight increase from 11% last year. Put into context the adult may consider their care/residential or nursing home as their 'own home'.

h. Expressed Outcomes met: In Staffordshire 67% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry had been met in full, partially met or not met. A total of 97% adults of those responding stated that their desired outcomes were fully met or partially met. This is the same figure as last year.

   i. The reasons why the adults' desired outcomes have not been met have been explored. Amongst the reasons are situations where the outcomes set by the adult are not always achievable. By way of example, in financial abuse cases the adult may want their property/money returned but it cannot be recovered. In some instances, the adult may want staff members disciplined or sacked etc. and again this is not possible. In some situations, it is because the adult wants to either move away from or stay with the family, but the risks are too high and there is a need for appropriate proportionate action to reduce the risks.

6. SSASPB Strategic Priorities: During the reporting period the SSASPB Strategic Priorities were:

   a. Ensuring Effective Practice. This is a new priority arising from a revision of the SSASPB Strategic Plan and in response to five themes of significant importance and recurring concern arising from a combination of learning events. Pages 18 – 32 of the Annual Report provide a comprehensive overview of the collective activities of safeguarding partners that evidences the changes in practice in response to learning experiences.

   b. Improving engagement with adults with care and support needs, their families, carers, members of the public, professionals and volunteers. Pages 32 – 33 of the Annual Report set out the range of methods that have been utilised to raise awareness, including commissioning Rockspur working with adults with autism or a learning disability to produce a more accessible version of the Annual Report.

7. Learning from experience: The SSASPB's approach to learning from experience is outlined in pages 11-16. As required by the Care Act 2014, a summary of the Safeguarding Adult Reviews (SAR) undertaken in 22/23 is presented. A total of five referrals were received. Following assessment, two met the criteria for a SAR, two did not meet the criteria and one is being considered as a Domestic Homicide Review.

8. Arising from the learning from the SAR of Andrew, the SSASPB has facilitated extensive training for practitioners to help in responding to self-neglect and in trauma informed practice collectively attended by around 1,200 practitioners during the past year. This section of the report concludes with a summary of the other work that is being done through the SSASPB to support strategic priorities.

List of Background Documents/Appendices:

Appendix 1: The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) Annual Report 2022/23

Contact Details

Board Sponsor: Dr Richard Harling MBE, Director for Health and Care

Report Author: Mr John Wood, Independent Chair (SSASPB)
Telephone No: via 07887 822003 (SSASPB Business Manager)
Email Address: john.wood1@staffordshire.gov.uk / ssaspb.admin@staffordshire.gov.uk

Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board
Abuse must stop

Annual Report 2022 to 2023

CONTENTS

'If you suspect that an adult with care and support needs is being abused or neglected, don't wait for someone else to do something about it'.

Adult living in Stoke on Trent: Telephone 0800 561 0015

Adult living in Staffordshire: Telephone 0345 604 2719

Further information about the Safeguarding Adult Board and its partners can be found at:

www.ssaspb.org.uk

1. Independent Chair Foreword

This Annual Report is longer than previously for good reason. Once again it illustrates the enormous amount and range of safeguarding activity done in partnership, much of which builds on learning from good practice as well as where things have gone wrong. The constant challenge – it is a big one - is to demonstrate and evidence that the necessary changes in practice needed in response to the learning have been implemented by safeguarding partners to mitigate the potential for future recurrences.

Accordingly, the SSASPB has adapted its approaches to seeking assurances and these are reflected in the revisions to the Strategic Plan to include a new strategic priority of Effective Practice. As you will read there are five themes to Effective Practice and the updates of actions and, where available, their positive impacts have lengthened this report. A key element in responding to the challenge of breaking the cycle of recurring themes and issues is to continuously raise awareness of the learning points from adults who have had adverse experiences.

A significant theme has been identified in relation to adults who self-neglect and the practical difficulties that this sometimes presents for practitioners. This was illustrated with the 'Andrew' SAR in last year's Annual Report. Over a period of 18 months Andrew was seen on 308 occasions by 11 organisations but sadly died at the age of 37 years. This was a 'watershed' moment for safeguarding partners locally and in the last 12 months a total of 1,193 practitioners have attended training or learning events emanating from the learning from 'Andrew'.

The case studies in this report illustrate the positive differences being made and what can and is being achieved by reflective practice and determination to go the extra mile. What is still missing, however, is a greater sense of safeguarding partners being able to better evidence what local communities and people who have experiences of using the multi agency safeguarding services say.

I again take this opportunity to acknowledge the commitment and enthusiasm of all our partners and supporters including the statutory, independent, and voluntary community sector who consistently demonstrate a strong clear focus on doing their best for those adults we are here to protect. Through the extension of an inclusive approach to safeguarding I extend a welcome to new partners who have recently joined the Board and bring a particular focus and a wider perspective to the work on recurring themes.

As always, I am immensely grateful to all who chair the Board Sub-Groups as well as the Board Manager Helen Jones who works so hard behind the scenes to ensure that our business programme works efficiently. On behalf of the Board, I record here thanks and good wishes to Rosie Simpson who, after 4 years, left her valuable role of Board Administrator in November 2022 to re-locate to another area. We look forward to working with Lorraine Hudson in the Administrator role.

John Wood QPM

2. About the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board

The Care Act 2014[1] provides the statutory requirements for adult safeguarding. It places a duty on each local authority to establish a Safeguarding Adult Board (SAB) and specifies the responsibilities of the local authority and connected partners with whom they work, to protect adults at risk of abuse or neglect.

The main objective of a Safeguarding Adult Board, in this case the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB), is to help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does. The Board's role is to assure itself that safeguarding partners act to help and protect adults who:

- have needs for care and support;
- are experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

A Safeguarding Adult Board has three primary functions:

1. It must publish a Strategic Plan that sets out its objectives and how these will be achieved.
2. It must publish an Annual Report detailing what the Board has done during the year to achieve its objectives and what each member has done to implement the strategy.
3. It must conduct a Safeguarding Adult Review where the threshold criteria have been met and share the detailed findings and on-going reviews within the annual report.

Composition of the Board

The Board has a broad membership of partners in Staffordshire and Stoke on Trent and is chaired by an Independent Chair appointed by Staffordshire County Council and Stoke on Trent City Council in conjunction with Board members. The Board membership can be found here.

The Board is dependent on the performance of agencies with a safeguarding remit for meeting its objectives. The strategic partnerships with which the Board is required to agree responsibilities and reporting relationships to ensure collaborative action are shown in the Governance Structure and can be found here.

Safeguarding Adults – A description of what it is

The statutory guidance[2] for the Care Act 2014 describes adult safeguarding as:

"*Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time, making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances".*

Abuse and neglect can take many forms. The various categories as described in the Care Act are shown here. The Board has taken account of the statutory guidance in determining the following vision:

Vision for Safeguarding in Staffordshire and Stoke on Trent

"Adults with care and support needs are supported to make choices in how they will live their lives in a place where they feel safe, secure and free from abuse and neglect"

Our vision recognises that safeguarding adults is about the development of a culture that promotes good practice and continuous improvement within services, raises public awareness that safeguarding is everyone's responsibility, responds effectively and swiftly when abuse or neglect has been alleged or occurs, seeks to learn when things have gone wrong, is sensitive to the issues of cultural diversity and puts the person at the center of planning to meet support needs to ensure they are safe in their homes and communities.

[1] Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents

[2] Care and support statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and- support-statutory-guidance

3. Safeguarding Principles

The Department of Health 2011 (DoH) set out the Government's statement of principles for developing and assessing the effectiveness of their local adult safeguarding arrangements and in broad terms, the desired outcomes for adult safeguarding for both individuals and agencies.

These principles are used by the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements.

The principles can be found on page 5 of the SSASPB Adult Safeguarding Enquiry Procedures.

4. What have we done?

This section outlines the work done in partnership during the year to help and protect adults at risk of abuse and neglect in our area. It also highlights some of the key challenges that have been encountered and consequent actions.

The Board

Independent Chair:	John Wood
Vice Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

The Board oversees and leads adult safeguarding across our area and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in the local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders.

At every quarterly Board meeting the Chair reminds Board members of their statutory responsibility to seek assurances that there are effective arrangements in place to protect adults with care and support needs who are at risk of abuse and neglect and unable to protect themselves and assurances that agencies are working together effectively. The Chair goes on to say that constructive challenge, as always, is welcomed and encouraged.

During 2022/23 the Board has:

- Approved the 2022/2025 SSASPB Strategic Plan with Effective Practice, focusing on 5 key themes, and Engagement as its two Strategic Priorities.
- Held a Development Day Workshop in June 2022 at which pledges were made by Board partner organisations in support of the 5 themes within the Effective Practice Strategic Priority. The Board has received reports on the progress of priorities at each of its quarterly meetings.

- Approved Safeguarding Adult Reviews 'Heather' (April 2023) and 'Frank & Elsie' (January 2023), Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

- Received a presentation from the chair of the Staffordshire and Stoke-on-Trent Quality, Safeguarding and Information Sharing Meeting. QSISM examines quality and safeguarding matters in care settings and aims to support providers through challenges aiming to prevent escalation. Themes and trends from the meetings in 2022/23 were discussed. The Board sought assurances on recurring themes and reaffirmed alignment on mutually relevant work.

- Examined annual assurance reports regarding Large Scale Enquiries and constructively challenging reasons for recurring themes.

- Examined annual assurance reports regarding Deprivation of Liberty Safeguards including reasons for and responses to the increasing number of DoLS applied for.

- Received a presentation on the refocus of the LeDeR (Life and Death Mortality Review) programme noting the changes to the programme which now includes 'autistic people' in its remit. The presentation included the main themes and trends outlined in the LeDeR Annual Report. Reaffirmed alignment on work on mutually relevant themes.

- Continued to contribute to the review of the arrangements and working of the Multi-Agency Safeguarding Hub (MASH) and received updates on the review.

- Received a presentation by Dr Laura Pritchard-Jones, Keele University, on the key findings from the Insight research into the impact of COVID on Adult Safeguarding. One area of focus was the reduction of Mental Capacity Assessments undertaken during the pandemic. The SSASPB hosted a learning event presented by Dr Laura Pritchard-Jones, covering Mental Capacity and Adult Safeguarding in response to this.

- Received an update on the progress of the Stoke-on-Trent City Council Multi-agency Resolution Group (MaRG) and the Changing Futures programme. The chair of the MaRG, a lead officer from Changing Futures, and one of the Expert Citizens attended the Board meeting to discuss strategic and operational links on matters of mutual relevance and the key contribution of Expert Citizens. The discussions helped to further strengthen the links between the work of the Changing Futures programme and the SSASPB Effective Practice priority.

- Received a presentation from the Staffordshire County Council lead officer for the Integrated Co-occurring Needs (ICON) project. The project is about the response to adults with vulnerabilities and multiple needs whose personal circumstances don't meet the eligibility criteria for support through the Care Act 2014 or other eligibility. The plan is for the project work to result in a forum similar to the MaRG in Stoke-on-Trent but bespoke to the needs of a multi-tiered Local Authority.

- Promoted and supported the Ann Craft Safeguarding Adult week, hosting multi-agency awareness raising and learning events and encouraging partners to run events within their own organisation. One example was the 'Safeguarding's Got Talent' event arranged by the Integrated Care Board. Several connected partners showcased multi-agency adult safeguarding work. Congratulations to North Staffordshire Combined Healthcare Trust for receiving the highest scores in a very closely contested event. The practitioner networking was also appreciated by those attending.

- Received and considered the publication of a report 'Addressing Violence against Older Women; Learning from practice' sponsored by Comic Relief. Staffordshire Women's Aid were one of 7 areas contributing to the research. An update on actions arising was received from the Chief Executive, Stafford Women's Aid.

- Considered the impact that the 'Cost of Living crisis' and other winter pressures was having on Adult Safeguarding and sought and received assurances that risks were being mitigated as far as possible and that partners were ready to respond to increases in demands upon resources.

- Contributed to the funding and supported the Alcohol Change led research into 'Cognitive Impairment in Dependent Drinkers'. One of the key reasons for participation in this research was as a response to the findings of the Safeguarding Adult Review of 'Andrew'.

- Discussed the impact of the increase of 'quality' concerns currently being reported into Safeguarding and actions needed to help practitioners to identify which process should be used.

- A standing agenda item on matters arising from links with others partnership boards and fora enables visibility and alignment on matters of safeguarding relevance.

- Cross partnership working is being strengthened through the development of a protocol with Safeguarding Children Board, Health and Wellbeing Board, Integrated Care Board and the Police and Crime Commissioner.

- A standing agenda item for inspection, organisational review and peer review updates from partners that facilitates constructive discussion about areas of good practice and offers of support to meet organisational challenges. Subjects have included CQC readiness assessments in preparation for the forthcoming Adult Social Care inspections, this included participation in a peer assessment of Staffordshire County Council and focus groups (both tactical and strategic) with Stoke-on-Trent City Council.

Internal Audit of the SSASPB

In August 2022 Staffordshire County Council and Stoke-on-Trent City Council jointly commissioned an internal audit of the SSASPB to seek assurance that the Board was fulfilling its role as outlined in the Care Act 2014.

The aim of the audit was to provide assurance on the governance and performance of the SSASPB to ensure that the Adults Safeguarding Partnership Board continues to operate in accordance with its terms of reference and statutory requirements of the Care Act 2014 including roles and responsibilities of the Board and representation by partner organisations.

The terms of reference for the audit were to ensure that:

- adequate governance arrangements are in place, which are robust and effective;

- a performance management framework has been established, against which performance is reviewed and reported routinely;

- SSASPB members are trained appropriately to ensure that they can carry out their membership duties;

- financial support is provided to assist with achieving the aims and objectives of adult safeguarding and to ensure that strategic risks have been identified and are being monitored periodically.

The auditors spoke to the Independent Chair and Board Manager and scrutinised key SSASPB documents. The overall findings were that Internal Auditors were able to offer adequate assurance as most areas reviewed were found to be adequately controlled.

The following control weaknesses were identified with 3 medium risks and 1 low risk resulting in associated recommendations:

Medium priority

1. Officers should ensure that Terms of Reference and business plans are approved/ratified within the required timescales.

2. Budget information should include complete information to show a clear picture of the account of the Board.

3. The SSASPB should produce a statement to record the Board's new approach in respect of how risk is going to be managed.

Low priority

1. The Board should ensure that sub-group meetings are held in accordance with their frequency stipulated within their corresponding Terms of Reference.

Actions in response

All recommendations were completed and finalised by Internal Audit by 31 July 2023.

Executive Sub-Group

Chair:	Lisa Bates, Designated Nurse for Adult Safeguarding, Staffordshire and Stoke-on-Trent Clinical Commissioning Groups August 2020 to present.
Vice Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust.

The Executive sub- group has responsibility for monitoring the progress of all sub-groups as well as its own work-streams. The core work of the Executive sub-group includes:

- receiving and considering regular updates of activity and progress from sub-groups against their Business Plans;
- ensuring that the core functions of the Board's Constitution are undertaken and that the Strategic Priorities of the Board are delivered.

The Executive membership is made up of the Chairs of the sub-groups, Officers to the Board, the

Board Manager and the Board Independent Chair. Organisations represented include the Statutory Partners (which are Stoke-on-Trent City Council, Staffordshire County Council, Staffordshire Police and the local Integrated Care Board); the Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

During 2023/23 the sub-group has:

- Co-ordinated the work undertaken to review the strategic priorities in preparation for the Board approval of the 2022/2025 Strategic Plan. Monitored progress against the SSASPB strategic priorities (Engagement and Effective Practice).

- Monitored the progress of all Safeguarding Adult Reviews raising constructive challenges around practice where appropriate. Used several of the challenges to inform the new Strategic Plan 2022/25 – these have formed the basis of the Effective Practice Strategic Priority.

- Heard a case study of Predatory Marriage and as a consequence sought and received assurances that Registrars in Stoke-on-Trent and Staffordshire receive adult safeguarding training.

- Received a presentation on the main themes arising from the Learning from Lives and Deaths Programme (LeDeR).

- Examined assurance updates from both Local Authorities regarding Large Scale Enquiries (LSEs) and Deprivation of Liberty Safeguards (DoLS) authorisation backlogs, linked to Effective Practice Theme 2.

- Discussed the work of the Stoke-on-Trent Multi-Agency Resolution Group which is a multi-agency forum to discuss adults who have multiple needs and at risk of abuse or neglect, particularly self- neglect linked to Effective Practice Themes 3 and 5.

- Received an update on the work which is looking at the response to 'vulnerable adults with multiple, complex and co-occurring needs' in Staffordshire. In particular, those who are not in safeguarding processes. This has links with Theme 5 of the Effective Practice Strategic Priority.

- Received the feedback from the Joint Local Authority Internal Audit of the SSASPB and initiated actions to respond to the 4 recommendations.

- In response to challenge raised at SSASPB meeting received assurance from SCC that there were no instances of safeguarding concerns connected to prison releases (medication prescription).

- Agreed support for the National Ann Craft Adult Safeguarding week. The SSASPB hosted 3 learning events covering Mental Capacity, Adult Safeguarding Awareness and the Role of Advocacy in Adult Safeguarding. From the subsequent local evaluation acknowledged the excellent work done by many partners to support the awareness raising initiative.

- Considered several Board membership requests in accordance with the SSASPB Board membership procedure.

- Continued to strengthen alignment of working on mutually relevant themes working with leads/chairs of Safeguarding Children Boards and Health and Wellbeing Boards in accordance with the Staffordshire Strategic Partnership Protocol.

- Confirmed that links with the MAPPA governance and procedure were in place. Several Board members sit on both MAPPA and SSASPB meetings and can share learning from reviews through standing agenda item on links with other fora.

- Made links to two new Independent Domestic Violence Advocate roles specialising in Older People and Disability facilitating information sharing on matters of relevance.

- Considered the Whorlton Hall findings (SAR) the seeking of assurances locally.

- Received assurances from partners that there had been individual agency activity in response to the SAR Andrew action plan.

- Tasked the Audit and Assurance sub-group to consider Discriminatory Abuse as a theme for a Tier 3 audit arising from the finding of extremely low numbers in the annual data capture (it was noted that this finding was replicated nationally).

- Received updates from Regional and National Adult Safeguarding fora through membership at various meetings.

- Sought assurances that any safeguarding issues from the welcoming of Ukrainians to the Stoke-on- Trent and Staffordshire area are recognised and addressed.

- Received updates from the links with the Domestic Abuse Commissioning Board with shared partners reporting matters of relevance to each Board.

Safeguarding Adult Review Sub-Group

Chairs:	Staffordshire Police Superintendents Nicky Furlong to March 2023. Victoria Lee from March 2023.
Vice Chair:	Lisa Bates, Designated Nurse Adult Safeguarding Stoke-on-Trent and Staffordshire Integrated Care Board (ICB).

The Safeguarding Adult Reviews (SAR) sub-group has responsibility for management of SAR referrals from the point of receipt to the approval of the final report and delivery of the improvements action plan. The sub-group also has responsibility for identifying and cascading the lessons learned from any reviews conducted by other SABs.

During 2022/23 a total of five SAR referrals were received. Following assessment, two met the criteria for a SAR, two did not meet the criteria and one is being considered as a Domestic Homicide Review. Information is provided on the referrals meeting the criteria.

'Frank and Elsie': A SAR conducted under Section 44(1) Care Act 2014 – Mandatory Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received in July 2022 and involved a white British male (81yrs) and a white British female 72yrs, neither of whom had capacity and resided in a nursing home in Staffordshire. The names Frank and Elsie are not their actual names have been used to protect their identities.

There were concerns that there was insufficient focus and multi-agency working with regards to the risks presented by Frank to Elsie and others. There were numerous incidents of both physical and sexual violence to other residents and physical assaults/sexualised behavior to staff. There were concerns about the lack of clarity on the funding for the extra supervision of Elsie via one-to-one support. Frank was a Stoke on Trent resident (initially funded by Stoke) who then was assessed as having eligibility for NHS funded care (Funded Nursing Care). Staffordshire County Council were involved in a Section 42 safeguarding enquiry into one of the sexual assaults and it is believed that a more proactive stance to prevent re-occurrence may have been required.

This SAR was conducted by an Independent Reviewer supervised by the Social Care Institute for Excellence (SCIE) using their Review in Rapid Time model. The review commenced on 25 October 2022 and the final draft was presented to the SSASPB where it was approved on 26 January 2023. This model focuses on systems findings and seeks to identify the key barriers and/or enablers that make it harder/easier for good practice to flourish and that need to be tackled to see improvements.

Systems Finding 1:
Staffordshire safeguarding policies and procedures recognise sexual abuse as a category however there is no local policy or procedure about how sexual safety can be maintained specifically in residential care settings, including how to respond to incidents, assess and manage risk. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common. This leaves disparate and sometimes contradictory efforts by different agencies to support the individual and protect others, with no effective multi-agency working or effective oversight of risk management within a home, or of placement decision making, whether routine or in emergencies following evictions.

Systems Finding 2:
Staff in residential care are not adequately equipped to distinguish consensual sexual activity from sexual assault, based on an assessment of an individual's capacity to consent. This is reflected in unclear language to describe sexual activities and increases the chances of downplaying both the risks an individual may pose, and the needs of others for protection.

What the SSASPB has done in response to the findings

The Board responded by developing an action plan to address the above findings. It was agreed that a practical toolkit or resource pack would be produced making use of guidance and help available from National bodies including the Local Government Association (LGA), SCIE and the Care Quality Commission (CQC).

In response to Finding 2 the SSASPB will be facilitating a learning event 'Mental Capacity and Sexual Safety' with a presentation and workshop to be delivered by Doctor Laura Pritchard-Jones, Senior Law Lecturer, Keele University, timed to contribute to associated learning events during the Ann Craft Adult Safeguarding Week.

Clive Treacey: A SAR conducted under Section 44(4) Care Act 2014 – Discretionary Review (Staffordshire)

Brief overview of the circumstances and how the criteria for a SAR was met:

A referral was received on 8 November 2022 about Clive Treacey a 47-year-old white British man

from Staffordshire who died in January2017. Ordinarily, the identity of a person subject of a review would be anonymised but his family wish the circumstances of his lived experiences to be widely known and communicated.

Clive had a learning disability and diagnosis of autism and epilepsy. He grew up within a loving and supportive family. At the age of 18 years he attended a residential college and went on to reside in a variety of residential settings as an adult. It was alleged by Clive that he was sexually abused whilst in one of the placements in Cheshire. It is then reported that the source of risk followed Clive into subsequent placements.

Clive had been detained under the Mental Health Act 2005 (MHA) for a decade. He gained an unwarranted reputation for being complex and challenging, and someone for whom a community setting was only properly considered during the later years of his life. A LeDeR (Learning from Life and Death review - formerly known as a Learning Disability and Mortality Review) was conducted on behalf of NHS England which identified that there were financial and systemic barriers that thwarted Clive residing in community settings and remained in settings that were poorly equipped to meet his needs.

Concerns have been raised that the safeguarding alerts that Clive's family and professionals raised over the course of his life through community and specialist hospital settings were not adequately responded to. It has been raised that these were missed opportunities to intervene and had these matters been responded to more effectively, this may have altered the course of events that followed.

Clive was not kept safe from harm, and it is believed that he experienced sexual abuse whilst in the care of some providers. Questions have been raised regarding the effectiveness of his safeguarding and the police response to this. The reviews by NHS England and LeDeR were not able to ascertain what safeguarding and police actions followed these serious incidents.

It was decided that a Safeguarding Adult Review would be conducted jointly by Staffordshire County Council and Cheshire East Council. The focus of the SAR is to be how policies, procedures and practice have changed since the early 1990s when the abuse is alleged to have taken place and to seek assurances that future risks for others can be mitigated. The review is ongoing at the time of writing and will be authored by Professor Michael Preston-Shoot. An update will be provided in the 2023/24 Annual Report.

Update on the 'Andrew' SAR from the 2021/22 Annual Report

The SSASPB approved the final report of 'Andrew' in April 2022. Briefly, the SAR was about the learning from the death of a 37 years old white British man who was living in social housing in Stoke-on-Trent. Andrew had multiple needs arising from mental ill health, substance misuse, grief following the death of his mother, poor health generally and indifference to whether he lived or died and fluctuating engagement with service providers.

Over the last 18 months of his life Andrew was seen on 307 occasions by 11 service providers. Andrew died from gastrointestinal bleeding with self-neglect as one of the key contributory factors. There were concerns as to how agencies worked together.

The published report can be accessed from the link to the SSASPB website Safeguarding Adult Reviews (SARs) (ssaspb.org.uk).

What the SSASPB has done in response to the findings

The Andrew SAR has provided significant and extensive learning that is continuing. The findings and lessons learned are a regular focus of discussion.

During the review of the SSASPB Strategic Plan 2022-25 the themes from the SAR of self-neglect and adults with multiple needs who don't meet the eligibility criteria under the Care Act 2014 were specifically included within the themes of a new strategic priority to seek assurances of Effective Practice.

The SSASPB has initiated and facilitated several events focusing on themes from the learning attended by a total of 659 practitioners. These include:

- Three interactive learning events (facilitated through Microsoft Teams) presented by the Independent Reviewer, Patrick Hopkinson, which focused on the findings from the review attended by 336 practitioners and supervisors/managers.

- An interactive learning event presented by Patrick Hopkinson on the theme 'Trauma Informed Practice'. A total of 169 practitioners attended this event which was open to anyone whose work includes engagement with adults with needs for care and support.

- An interactive learning event presented by the Prevention and Engagement sub-group on 'Self Neglect'. This was attended by 134 practitioners.

- A learning event to focus on 'Mental Capacity and Self-Neglect' has been planned to take place in the autumn of 2023.

The SSASPB contributed to the funding of a national project undertaken by Alcohol Change on the theme of 'Identifying and Addressing Cognitive Impairment in Dependent Drinkers'. The project included research using local case studies and a focus group with practitioners who work with dependent drinkers. The findings of the project were communicated through a multi-agency training event led by the clinical researchers which was offered to practitioners from the Board member organisations to whom the theme was relevant. Key learning points from the training and key messages for practitioners were subsequently included in the SSASPB Newsletter which prompted positive feedback.

The SSASPB has reviewed its representation and invited Humankind to become a member to meet a need for a perspective on substance misuse by adults with care and support needs to be better recognised.

Audits have been conducted to examine reported safeguarding concerns that were not considered to have met the requirement for a Section 42 enquiry. The audit in Stoke-on-Trent identified that two referrals should have been categorised as Section 42 enquiries because a significant amount of protective work was described in both. Three cases were closed without the person referred being seen in person and the inherent risks of managers agreeing closure without the referee being seen were followed up with managers by the auditors. In two cases seen, there appeared to be an absence of clear descriptions of actions undertaken and the rationale for closure. Auditors concluded that overall the adult had been seen, protective factors had been put in place and risks mitigated.

The SSASPB has actively promoted the benefits of the appointment of a Lead Professional for multi-agency responses, recognising that Andrew had been in contact with 11 different services but there was no effective co-ordination of intervention or support. Messages have been conveyed through a combination of Newsletter articles, Social Media messages, learning presentations as well as amendments to the Section 42 multi-agency procedures.

The SSASPB has received a presentation from the Independent Chair of the Multi Agency Resolution Group (MARG) in Stoke-on-Trent and the programme lead for Changing Futures to seek assurances on the effectiveness of the partnership work to help adults with multiple needs typically including homelessness, drug and alcohol misuse and self-neglect.

The Board has encouraged preventative work, especially with those adults who don't meet the Care Act 2014 criteria for 'care and support' and received a presentation from Staffordshire to seek assurances on the response to inadequate care for people with co-occurring needs (ICON).

Other SAR Sub-Group Activity

In addition to the management of SAR processes the sub-group has:

- Engaged with the Safeguarding Adult Board Managers National and Regional Networks to share good practice developed by other SABs.
- Reviewed the SAR protocol to ensure continuous improvement and consistency with Regional SAR procedures.
- Incorporated the National SAR Quality Markers into the local SAR Guidance.
- Promoted the Olive Branch training made available by Staffordshire Fire and Rescue Service, to support fire risk reduction at home.
- Engaged with Community Safety Partnerships that are managing Domestic Homicide Reviews (where they involve adults with care and support needs).
- Promoted the use of advocacy services in SARs to support the adult involved (where appropriate).
- Tasked the Audit and Assurance sub-group with auditing how lessons are being embedded in organisational practice from the recurring findings in SARs.
- Provided detailed assurance against the 29 improvements recommended by Professor Michael Preston-Shoot in his academic analysis of SARs nationally (2020)
- Continued to actively raise awareness amongst practitioners of the previously identified recurring lessons to learn from SARs, which are:
    - Better recording of the rationale for decision-making to be made in case files.
    - Use of the SSASPB escalation policy as early as possible to resolve professional disagreements.

- Appointment of a lead professional to drive multi-agency resolution in complex cases.
- The need for better understanding of the application of the Mental Capacity Act 2005 particularly in relation to self-neglect.

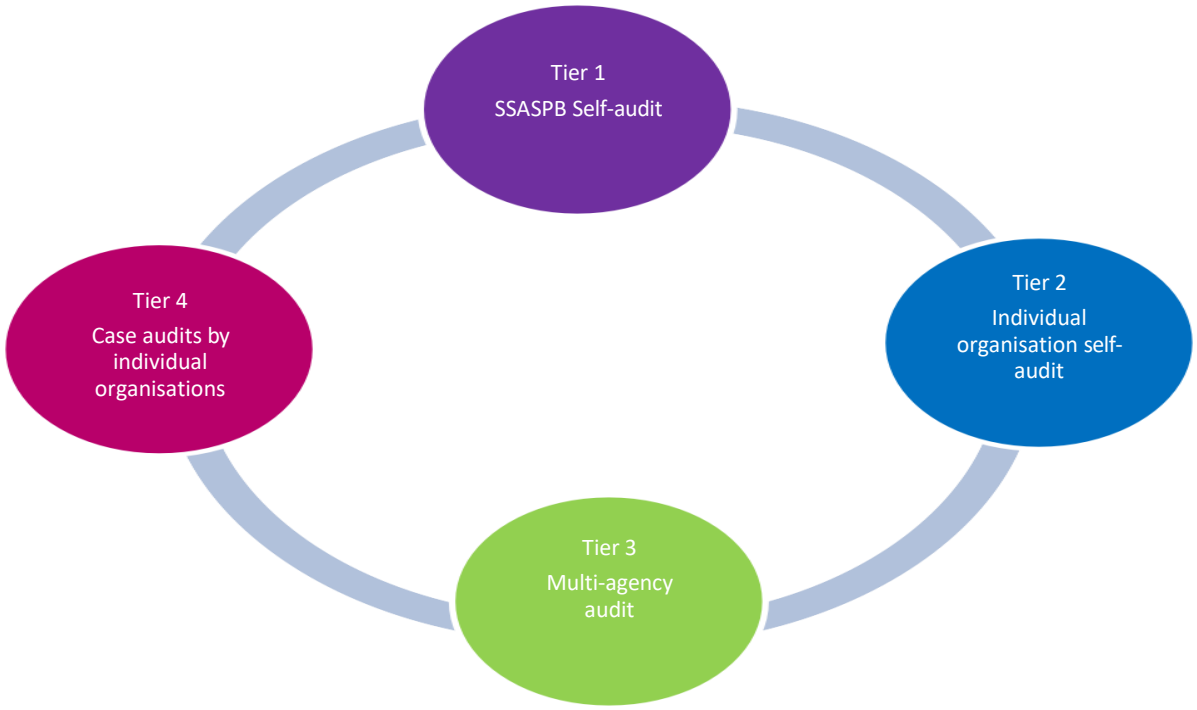
➢ Promoted to practitioners' webinars made available nationally that are relevant to SARs.

Audit and Assurance Sub-Group:

Chair:	Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership Foundation Trust
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust

The SSASPB 4-tiered audit framework:

Overleaf is an illustration of the audit framework which is referred to in the sub-group activity below



Tier 1 SSASPB self-audit is an annual self-assessment against the SSASPB constitution.

Tier 2 Individual Organisational audit: in year 1 each organisation completes a self-assessment against a set of agreed standards, in year 2 there is a peer review of evidence put forward against specific standards.

Tier 3 Multi-Agency Audits are themed multi-agency audits, the themes come from questions raised following receipt of the annual data report.

Tier 4 Individual Agency audits which can be requested by the Board or one of the sub-groups with the purpose of seeking more detailed information about a trend or theme which becomes apparent.

During this year the Audit and Assurance sub-group has:

- Completed the annual Tier 1 audit. This helps the Board to understand where its challenges are and where it can evidence that it is meeting the requirements set out in the Board's Constitution.

- Selected specific standards from the Tier 2 audit data capture to request further assurances and evidence to support the self-awarded RAG (Red, Amber, Green) ratings. The standards chosen were bespoke to each partner's submission to provide detailed assurance on their Workforce Development section of the audit (Training).

- Conducted Tier 3 (Multi-agency) audit on the subject of 'Appointment of Lead Professionals in multi-agency responses to safeguarding activity'. Key findings and actions were:

  - There was evidence in some cases that a lead professional had been appointed but there were more cases where this would have been beneficial; there was often a perception that the appointment of a lead professional would impact on that person's capacity.

  - It was agreed that the benefits of appointment of a Lead Professional should be further promoted through the SSASPB Newsletter and Practitioner Forum.

- Conducted Tier 3 (Multi-agency) audit on the theme of Discriminatory Abuse. Key findings and actions were:

  - Where Discriminatory Abuse is recorded this was an accurate assessment of the abuse presented.

  - Limitations on recording systems mean that Discriminatory Abuse may be recorded as other categories of abuse leading to under representation in data; the Police often record discriminatory abuse as a Hate Crime and this type of crime is a rich source for further research (understanding that Care and Support needs is often difficult for Police to categorise separately); two partners who expected to find Discriminatory Abuse referrals had none recorded, a further check is to be done following this audit to examine if there is an increase.

  - Awareness of discriminatory abuse was included in the SSASPB newsletter and learning presentations.

- Conducted Tier 3 (Multi-agency) audit on the subject of online abuse. Key findings and actions from the Online Abuse Tier 3 audit: This audit was conducted following a query by Staffordshire County Council's Overview and Scrutiny of the SSASPB Annual Report 2021/22. This type of abuse isn't one of those identified in the Care Act 2014, consequently the research had to identify cases through free-text research where that was possible.

  The lack of a facility to identify the online abuse of adults with needs for care and support is a barrier to understanding this type of abuse; this type of abuse mostly affects adults under 60 years of age who have a learning disability or mental ill- health, most adults affected by online abuse don't have care and support needs as identified by the Care Act 2014; there was evidence of good awareness of this type of abuse and positive action to prevent impact, seen especially by banks when unusual activity on an account was identified; there were many links

to so-called 'romance-fraud' i.e. people from oversees approaching others using dating apps requesting money; many did not believe that they were being exploited and gave the money willingly.

Following the audit contact was made with both Local Authorities' Trading Standards teams and an article written for the SSASPB Newsletter which included links to more information and help available.

Prevention and Engagement

Interim Chair:	Helen Jones, SSASPB Business Manager.
Vice chair:	Laura Collins, Named Nurse for Safeguarding, North Staffordshire Combined Healthcare NHS Trust.

This sub-group was formed to drive the work of the Engagement Strategic Priority. For an update on progress please see the Strategic Priority section on page 32 of this report.

5. Performance against 2022/2025 Strategic Priorities

Strategic Priority 1: Effective Practice

This is a new priority arising from a revision of the SSASPB Strategic Plan. It was developed with the engagement of the Board and sub-groups in response to five themes of significant importance and recurring concern arising from a combination of learning events. At the SSASPB Development Day in June 2022 Board partners made a series of pledges and commitments to action. The updates are summarised below.

Theme 1:
That Making Safeguarding Personal (MSP) is meaningfully implemented and embedded in practice by all partners, (other than in exceptional circumstances when it may be less appropriate) and that its effectiveness is measured to give confidence.

The Board has sought assurances that adults are supported to make choices that balance risks with positive choice and control in their lives.

Stoke-on-Trent City Council

- Case file audits in relation to 57 safeguarding cases were undertaken during October and November 2022. Findings were that overall, there was good social work practice, however, the rationale for decision making was not always clear and therefore MSP is not always visible. Arising from the findings a series of workshops were convened with all qualified Social Workers, Senior Social Workers, Team Managers and Senior Managers to provide feedback and to improve recording and practice in line with MSP.

- Case note practice guidance was issued to staff to support person centered and consistent case note recording following the above audit and workshop.

- A new training package for practitioners has been developed which includes legal duties under the Care Act 2014 and responsibilities in relation to Making Safeguarding Personal.

- A new feedback loop is under development. Each month safeguarding assistants contact people who have been involved in a Section 42 enquiry and seek information on their experiences, this helps to inform practice and development of communication/feedback methods.

- In complex cases where high risk individuals cannot access all mainstream services there is access to support and representation through Expert Citizens to enable the person's thoughts, feelings, goals, and strengths to be articulated at the meeting.

Staffordshire County Council

- Quality audits generally demonstrate that safeguarding is person centred and Making Safeguarding Personal can be demonstrated. The quality audit on safeguarding found that 69% of people subject of the enquiry agreed that it had been completed in a timely way and the good practice timelines had been met.
- Staff responses identified variances in terms of approach, but there was agreement about keeping the person at the centre through practice, personalisation, proportionality, and with sensitivity. One team identified this as one of their services strengths by supporting people to balance risk with positive choice and control.
- It is recognised that there is a need to further improve to ensure that MSP is consistently embedded in practice. The safeguarding training has been redesigned and with the principles of MSP at the centre of it.
- A feedback form has been produced for adults who have been subject to a safeguarding enquiry completed by the Adult Safeguarding Enquiry Team (ASET). A feedback form has also been produced for carers and providers. At the time of this Annual Report the arrangements are subject to an evaluation.

- A process to seek feedback from adults where a concern may not have progressed to a Section 42 enquiry is being developed.

- Health and Social Care are committed to co-production and have a co-production network to support colleagues with information and resources about doing it well.

Midlands Partnership Foundation Trust (MPFT)

- Produced a Making Safeguarding Personal information leaflet that is available to all staff and patients through MPFT intranet.

- Produced a seven-point briefing on MSP that is of helpful practical relevance during safeguarding supervision discussions.

- An audit to examine compliance with MSP guidance was completed. This will be repeated to take account of the updated guidance issued to practitioners.

Staffordshire Fire and Rescue Service (SFRS)

- A quarterly safeguarding report is produced that provides details on the number of staff who have completed mandatory training. In the report for the period January to March 2023, Adult Safeguarding Awareness Level 1 – 92% completed (7% increase from previous quarter).
- Different levels of safeguarding training commensurate with roles and responsibilities have been developed and are being rolled out across the service.
- Information is produced in the quarterly Safeguarding Report and shared at SFRS Safeguard Board and SFRS Prevent and Protect Board.

Trent and Dove Housing

- There is a reflective practice approach used in the supervision of staff involved in safeguarding settings.
- Enhanced reporting of relevant information to the quarterly meeting of Safeguarding Forum.

Healthwatch

- Healthwatch has reviewed the use of its approach to 'Enter and View' with partners to be more effective. Enter and View is now consistent with Making Safeguarding Personal. All staff have a focus on Safeguarding in their work. All safeguarding concerns are raised with relevant parties to ensure good practice.

Theme 2:

The assessment and reviews of mental capacity and Deprivation of Liberties Safeguards (DoLS) are of a good standard and includes the perspective of service users/carers, with appropriately skilled advocacy accessed where appropriate.

Stoke-on-Trent City Council

- The Advocacy contract has been renewed to support adults needing representation. Management information on Deprivation of Liberties Safeguards and safeguarding data is produced monthly. Team Managers and senior social workers meet to scrutinise it and respond to issues arising.
- Audit cycle to check quality of assessments is overseen by quality assurance officer.
- Group supervision is on a bi-monthly cycle to discuss new case law and any relevant cases that may require peer support.
- Work has been commissioned to tackle the backlog of assessments. At the time of this Annual Report working with three separate providers to complete assessments and quality assurance work.

- Options being examined to identify longer term plans to sustainably address the assessment backlog.
- DoLS authoriser training completed via 'Edge Legal' with four more training places on Best Interest.
- Assessor course being offered to current workforce to increase assessment capacity.
- Transitions team in discussions to have a multi-agency approach to assessing capacity where appropriate involving Adults, Children and Health services (at the time of this report going through governance processes).

Staffordshire County Council

- Monthly audits examine how the person's voice is heard and this includes the use of advocacy. It is recognised that this is an area that needs more attention. Strength based training will cover aspects of this.
- In practice it is not easy to distinguish between when independent advocacy has been used or when family members have been involved. This is currently being reviewed by performance and systems teams so that the data can be more easily collected.
- There is a need to develop a specific audit in relation to the application of the Mental Capacity Act that will better capture the use of advocacy. This will be done once the updated statutory guidance which is awaited has been produced.
- Practitioners have been provided with training in relation to advanced mental capacity as well as the overview of mental capacity that has been available previously. These resources are now part of the role related training programme.
- Part of the preparation for CQC assessment has included how adults are supported when they experience transitions/moves between settings. Guidance is being produced and will include the use of advocacy when a person lacks capacity.

MPFT

- MPFT has worked with the Trust's Mental Health Law Team to produce learning materials and prompts to help practitioners to adhere to the requirements of the Mental Capacity Act.
- Completed a safeguarding confidence and competency survey across the Trust with responses from over 700 practitioners.
- Plan is to include Mental Capacity Act considerations in the next Trust wide safeguarding survey of staff.

SFRS

- SFRS was a partner in the Fireside Study Project lead by Keele University resulting in the production of a paper: Optimising Fire and Rescue Service "Safe & Well" visits to support detection and signposting for mental health problems in older adults. This report was submitted to the National Institute for Health and Care Research.

- Further project work is to be carried out to develop this area further primarily researching if, by providing more training in this area, it will help staff to recognise the signs of early mental health concerns and equip the staff with the knowledge and understanding of how to access help and advice.

- As partnership working continues to expand, there is further work required regarding signposting to relevant partners regarding Mental Capacity and DoLS. It is expected that awareness will be raised through the work of the Fireside Project and the wider work in this area that is being conducted by the National Fire Chiefs Council.

Healthwatch

- Staff are being trained around DoLS to be actively looking out for patients and resident feedback on their experiences.

Theme 3:

Safeguarding partners commit to improve our response to self-neglect, including that we will explore what experiences led, and sustain, a person to live in this way rather than judge self-neglect and substance use to be a lifestyle choice and we will consider wider social, physical and mental health factors rather than over rely on substance use to explain a person's circumstances. We will recognise the impact of trauma, substance use, and the coercive and controlling effects of addiction, on a person's mental capacity to make decisions about their self-neglect and substance use.

Stoke-on-Trent County Council

- Changing Futures and Public Health have co-commissioned the enhancement of the services of the Multiple Disadvantage Team which is delivered by North Staffordshire Combined Healthcare Trust. The aim is to understand and address underlying trauma, whilst individuals may still be in active substance addiction. The approach of the service is to be flexible with outcomes that evidence the impact of addressing co-occurring needs.

- The Changing Futures programme is currently funded until 2025.

- Attendance at Trauma Informed training and Safeguarding training is mandatory for all social care practitioners who are engaged with making assessments. The training input is co-produced with Insight Academy and people with lived experiences.

- Safeguarding audits where self-neglect has been identified are scrutinised. Examples of trauma informed approaches being used in practice have been found in case file audits.

- Making Safeguarding Personal feedback arrangements are being developed to add value and understanding of people with lived experience.

- People with lived experience are increasingly engaged to inform commissioning strategies. Current engagement includes Learning Disability and Autism Panel and Direct Payments.

- Principal Social Worker, Adult Social Care practitioners and Expert Citizens are actively engaged in the Multi Agency Resolution Group where the circumstances of adults with multiple needs are examined with the aim of improving outcomes.

- Research into a practice model for self-neglect is being conducted from an academic and practitioner perspective in partnership with Keele University.

Staffordshire County Council

- The Integrated Co-Occurring Needs (ICON) and Bullseye projects are in place. The projects are a multi-agency approach currently involving Public Health, Commissioners, Midlands Partnership Foundation Trust and Humankind/STARS. There is an ongoing expansion of the projects to include Adult Social Care and Housing. The aim and approach is to provide: one team for people with drug/alcohol and mental health needs; preventing 'bounce' between services and long waits for trauma therapy; focusing on the client not their 'conditions' in isolation supported by psychologists and overcoming significant data-sharing and governance hurdles.
- The ICON and Bullseye projects have been independently reviewed with a positive endorsement of the approaches.
- Training in Trauma Informed Practice has been introduced and provided to practitioners conducting assessments. More training is to be provided in Autumn 2023.
- Training to respond to and help adults in situations of self-neglect has been provided as well as forums to support staff.
- It is recognised that there is a need to review the self-neglect pathways from a multi-agency perspective and arrangements are being made for this be done.

MPFT

- Safeguarding practitioners recognise the challenges when dealing with adults who self-neglect. A self-neglect tool kit is being produced to provide staff with practical support.
- Ambition is to recruit a self-neglect navigator who can support staff with complex cases and ensure that multi agency actions are overseen and completed.
- Training in Trauma Informed Practice is available for staff. This is not currently mandatory training.
- An audit into the practical application of the Mental Capacity Act has been undertaken. It had not been published at the time of this Annual Report.

Integrated Care Board (ICB)

- All ICB safeguarding staff completed the training arising from learning from 'Andrew' SAR.
- There is a plan to work on shared understanding of risk across partner agencies especially in relation to self-neglect.
- Work is underway on the Safeguarding Collaborative approach across the health system.
- Further work to done across the health system and with SSASPB partners to review the self-neglect pathway.

SFRS

- Improved the Olive Branch offer, making it more accessible, and users can do the training at a time that suits them. Olive Branch Training is aimed at people who visit vulnerable members of communities in their own homes within Staffordshire. It helps them to identify potential fire hazards, including self-neglect (hoarding) and other risks in the home. It will also advise how to refer vulnerable people for a Safe and Well Visit.

- The number of referrals that are made regarding self-neglect are recorded and examined to identify the outcomes arising from the referral. The number of referrals received from partners following Olive Branch training are also recorded to identify outcomes.

- SFRS Prevent Teams attend relevant meetings to discuss concerns raised by partners and our teams as required.

- Learning events are regularly shared with relevant staff who are encouraged to attend to help to enhance understanding.

Healthwatch

- Working with commissioners around Drug and Alcohol contract designs to reflect the impact these are having on the users of the services. Constructive feedback provided that, from experience of users of services perspective, drug services need to be more person centred and not so data driven.

Case Study 1: North Staffordshire Combined Healthcare NHS Trust

A female patient 'Sarah' (name anonymised) was referred to North Staffordshire Combined Healthcare NHS Trust following repeated attendances at University Hospital of North Midlands Accident and Emergency Department related to alcohol misuse.

Sarah has been known to misuse alcohol since she was a child and lives with her elderly mother who also has care and support needs. The relationship between Sarah and her mother appears to be dysfunctional. Staff at the University Hospital of North Midlands experienced difficulties when trying to follow up the Sarah's non-attendance at outpatient appointments. Sarah's mother would inform staff that her daughter did not need services and that she did not need any follow-up care. It appeared that the mother was preventing her daughter from accessing services.

There were concerns for both the mother and daughter as they both had their own vulnerabilities and they lived at home together. North Staffordshire Combined Healthcare NHS Trust High Volume Users Team made a referral to the Olive Branch due to the risks presented around alcohol and smoking. Arising from a professionals meeting Sarah was referred to the Community Mental Health Team within North Staffordshire Combined Healthcare NHS Trust (NSCHT).

As there was a high risk for both women, who both appeared to be avoiding or unable to access support, further meetings of professionals were arranged by the High Volume Users Team to engage Staffordshire Police, University Hospital of North Midlands and NSCHT Safeguarding

Team to establish what additional help could be offered. A social worker was allocated to the case and a joint visit of partner agencies arranged.

This is an illustration of effective multi-agency working. Meetings were arranged quickly, with appropriate information sharing, safeguarding referrals and risk mitigation with all relevant agencies involved.

Case Study 2: Stoke-on-Trent City Council Adult Social Care

'Ken' is a 56-year-old white British man. He has had a variety of physical health issues and suspected cognitive impairment.

Ken was self-neglecting. He was not looking after his personal care; not meeting his nutritional needs; not taking prescribed medications; not maintaining his home environment and was experiencing significant deterioration in his physical and mental health. Adult Social Care was contacted arising from concerns that he was being subjected to physical and financial abuse, was alcohol dependent and was 'rough sleeping'.

Continuous communications between the Rough Sleepers Team and Adult Social Care resulted, after several attempts, a meeting between all relevant agencies which was the start of Ken receiving the support that he needed.

A Section 42 Safeguarding Enquiry was commenced in response to concerns for self-neglect. There were difficulties in engaging with Ken and his living environment was not conducive to completing an accurate assessment of need. A series of Multi-Disciplinary Team Meetings were convened to involve the relevant services including Housing, Health Services, Occupational Therapy, Memory Clinic, Police, Drug and Alcohol Services, Changing Futures and support workers through charities including Reaching North Staffordshire.

Ken's circumstances presented challenges to the safeguarding partners particularly in relation to the differences in value bases between professionals. Service gaps were also a challenge - the most notable of these between housing and the limited services that are willing to work with adults who are actively misusing alcohol.

The processes included completing mental capacity assessments, risk assessments and regular reviews of Ken's needs. A key aspect was managing the co-ordination of relevant services to address each specific area of need. These included completing health checks, supporting Ken to make, remember and attend appointments. Supported living was eventually sourced and implemented with an appropriate care package that promoted Ken's independence and sustains his safety. Police supported Ken to examine previous incidents of abuse through the appropriate channels. The Community Drugs and Alcohol Service (CDAS) completed ongoing work around Ken's misuse of alcohol and the trauma-based factors underlying this.

Six months after the referral to Adult Social Care Ken has stability in his life. He is thriving in supported accommodation; engaging well with support services for his mental health and alcohol dependence; receiving proportionate daily support; building social networks; establishing new relationships and is no longer self-neglecting.

Case Study 3: Staffordshire County Council, Adult Safeguarding Enquiry Team (ASET)

"Violet" is an 82 years old woman with a number of physical health needs. She lives in her own home with a care package in place. Violet is known to use alcohol to excess which resulted in recurrent falls.

Several safeguarding concerns about the risk of self-neglect were raised by Violet's domiciliary care provider and social worker. It was noted that Violet was choosing not to engage with the recommendations from professionals and it was considered that Violet was at high risk of harm due to self-neglect. It was agreed that a Multi-Agency Planning Meeting (MAPM) would be convened under the self-neglect protocol and chaired by one of the Practice Leads from the Adult Safeguarding Enquiry Team (ASET).

A MAPM was arranged with all involved agencies which included Violet's Social Worker, District Nursing Team, GP, Domiciliary Care Provider, Day Care Provider and the Fire and Rescue Service. Although Alcohol Services were not involved at the start of the process, and Violet had initially declined their support, it was recognised that their involvement was required in terms of sharing knowledge and they were invited to meetings. The meetings enabled consideration of the measures that could be put in place to reduce the risks.

Violet had clearly identified that she wanted to remain in her own home, but it was noted that her family felt that she would be safer in a residential setting. Given the differences of opinion it was agreed that a referral to advocacy services would be made to help Violet express her views and wishes throughout the process. Violet attended safeguarding meetings supported by her advocate.

A safeguarding plan was developed with input from all involved agencies and agreed by Violet. Following a hospital admission Violet returned to her home address with a new package of care in place. Violet continued to attend the day centre which she appeared to gain significant benefit from. Violet had also agreed to measures to reduce the risk of falls at home such as an additional handrail on her stairs and the removal of a rug identified as a trip hazard. Violet had also agreed to the gas cooker being disconnected and had purchased an electric hob.

Violet was involved with her needs and wishes being heard throughout this process. It was recognised that it would not be possible to remove all risks, but professionals were able to work with each other and Violet to reduce the risks. Violet was able to remain living in her own home in accordance with her wishes. At the time of writing the safeguarding plan remained in place and was being monitored by the local area team.

Theme 4:

There is awareness and understanding that there can be an increased risks in relation to safeguarding when a person moves between services, such as when a person is discharged from hospital to their home or other community settings

Stoke-on-Trent County Council

- Adults with Multiple Disadvantages are identified and provided with case co-ordination, aware that many self-neglect, with an approach to enable services to identify gaps and work effectively. Weekly Multiple Disadvantages Team meetings to review progress and address service barriers, so individuals do not 'slip through the net'.

- Social Care staff are based at the Acute Hospital to support discharge planning. Daily calls are undertaken with all partners across the system to facilitate safe planning. If required, a personal budget may be provided for quick solutions to mitigate risks following hospital discharge.
- Homeless Healthcare Service in the community enables treatment to continue post discharge (co- commissioned by Changing Futures and Housing Department in LA).
- Feedback from young people transitioning to adulthood and their carers/advocates is that transitioning requires further attention and resourcing capacity.

Staffordshire County Council

- Pathways have been reviewed and there is working towards a 'One Adult Social Care' approach.
- Training to staff around effective recording has been provided with guidance updated. The focus is on ensuring that a person's records are reflective of their current circumstances including where they live, if they are at a temporary address or in hospital.
- There is an ongoing project in relation to Preparation for Adulthood. This is focusing on meeting the needs of young people where multiple agencies are involved to ensure that agencies work better together at an early stage to prepare for the transition from children's services to adult services. It has been recognised that adult safeguarding had not been considered as part of this but is now to be included.
- Guidance to staff in relation to how to approach transitions between services and teams is being reviewed. This includes how people transfer between settings, such as leaving prison or hospital.

Integrated Care Board (ICB)

- The Safeguarding Team has contributed to the pan health digital design group and worked with IT providers to support the visibility of patient information pertinent to safeguarding and risk.
- Collaborative work will continue to promote the value, and use of, the Integrated Care Record (One Health and Care) across Health and Social Care.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

MPFT

- One Health and Care record is now available across Staffordshire and Stoke-on-Trent and accessible by all NHS Trust primary care and social care staff. This innovation allows all those who have a legitimate purpose to access the information to have sight of a person's health journey, including discharge from hospital and community support.

UHNM

- The vulnerable patient team has been invited to become a member of the Trust's Patient Experience Group. This will provide a direct source of feedback from patients and carers experiences at the acute trust. Any learning pertaining to safeguarding will be then shared via the Safeguarding Working Group.

- The Head of Patient Experience and the Corporate Governance Team are now members of the Trust's Safeguarding Working Group and the Vulnerable Patient Steering Group. This will enable the team to triangulate information, reviewing themes and trends.

- Work has commenced on developing and implementing a carers strategy which the vulnerable patient team support and cross reference to safeguarding.

- The audit programme will identify good areas of practice and areas of learning in relation to discharge arrangements where there was an identified safeguarding concern.

Healthwatch

- Is involved in Integrated Care Board meetings to ensure processes are being followed with a focus on ensuring that the patient voice is being heard.

- Through attendance at meetings of the Health and Wellbeing Board reported the concerns around delays in hospital discharges and the impact of safeguarding when moving people at a later stage than is beneficial to the person which is leading on occasions to a greater need for care.

SFRS

- Arrangements have been agreed with the Hospital Discharge Teams throughout Stoke-on-Trent and Staffordshire to ensure there is a robust pathway in place for clinicians to sign post for a Home Fire Safety Visit for patients that pose a fire risk. This is on-going work and will be shared with the relevant Prevent Leads.

Trent & Dove Housing

- Person centred risk assessment is an operational focus for new applicants for social housing and where existing customers with an identified need wish to move to alternative accommodation.

Theme 5:

That amongst connected partners professionals and leaders are alert to the sources of risk of abuse and neglect for adults with care and support need in communities and residential settings particularly the hidden voices and people 'falling between the eligibility gaps'.

Stoke-on-Trent County Council

- Changing Futures programme provides a prevention strategy and practical support to people with multiple disadvantages.

- There are 15 Community Lounges in Stoke-on-Trent that provide a 'Front Door' to offer early help to prevent further need. These facilities are well used.

- Two new posts for Locality Connectors are at the recruitment stage. One of these is for hospital discharge planning based in Accident and Emergency and the other is to meet need for Ukraine/Asylum seekers working across the City at Community Lounges.

- Insight Academy is providing training on Care Act, Safeguarding and Trauma Informed Care.

- Case Managers provide bespoke support to social care staff. Multi-Disciplinary Team meetings are convened to provide bespoke solutions to prevent escalation to full care package requirements.
- Work is ongoing to upskill the workforce to professionally challenge and respond when people are deemed to be 'falling through the gap'.
- Social Worker in post to work with people on the Homes4Ukraine Scheme and other people seeking Asylum in Stoke-on-Trent.

Staffordshire County Council

- The developing work of the Multi Agency Risk Collaboration group will seek to address those who currently fall between the gaps of support services. There is a working group examining how to work differently and more effectively with people with multiple needs and complex personal circumstances. This work is still in its early stages but over the next 12 months will make progress.
- There is improved support from an administrative perspective in relation to our approach to People in Position of Trust risk so that we can monitor individuals and risk assess. This approach is being reviewed to seek further improvements.

MPFT

- The term professional curiosity has been used in relation to safeguarding for some time, however, the meaning and purpose of it does not seem generally to be well understood. MPFT safeguarding service has developed guidance on professional curiosity and this is included in staff briefings and forms part of the safeguarding supervision offer. Encouraging staff to think beyond the care and treatment being offered provides an opportunity to intervene and prevent adults at risk from falling between the gaps of service eligibility.

Integrated Care Board (ICB)

- The Safeguarding Team continuously monitor to ensure statutory reviews are completed.
- Plan to work on shared understanding of risk across partner agencies especially in relation to self- neglect.
- Multi-Disciplinary Team (MDT) risk assessment is completed before complex discharges from hospital/care setting.

Healthwatch

- Working more closely with Adult Social Care and ICB to discuss eligibility gaps and to ensure the voices of those who would otherwise be missed is being heard at all levels.

SFRS

- Through its activities within communities SFRS staff fulfil a valuable role as the 'eyes and ears' in identifying neglect and abuse. The Service has developed many single referral pathways with partners across the Stoke-on-Trent and Staffordshire.
- The SFRS safeguarding report provides a record of actions and outcomes. Referrals into Mental Health services is an area for further development and improvement.

Staffordshire Humankind

- Using links with the safeguarding board to identify shared learning and disseminate this learning across our Staffordshire services.
- We will ensure that all staff are trained to recognise and respond to abuse and will support this by developing safeguarding champions who will lead on a rolling programme of training which includes identifying risk factors for self-neglect and financial abuse.
- We will roll out a new programme to upskill staff to work in a trauma informed way from first point of contact.

Trent & Dove Housing

- Has completed a review of its approach to safeguarding and introduced a safeguarding forum that meets quarterly. From this an assurance statement is provided to Executive Management Team.
- Safeguarding is a mandatory training requirement for all staff.
- Safeguarding referenced in Strategic Risk Register.

VAST/Support Staffordshire

- Has disseminated safeguarding information through bulletins, social media and website in line with the pledge made by Support Staffordshire.
- Has supported its members by providing awareness events:

    - 4 Adult Safeguarding awareness training courses attended by 37 VCSE organisations.
    - 3 Bitesize Supportive Communities training sessions attended by 29 community-based staff/volunteers.
    - 1 - 1 information, advice and guidance on Adult Safeguarding policy and practice to 15 VCSE organisations.

Case Study 4: North Staffordshire Combined Healthcare NHS Trust

This case concerns 'Matthew' (name anonymised) a male who was referred to North Staffordshire Combined Healthcare NHS Trust Early Intervention Team with first episode psychosis. The approach of the team was to engage with and treat Matthew using the least restrictive approach in the community.

At the beginning Matthew was engaging well and his partner was fully involved and supportive. Over time Matthew developed and expressed fixed beliefs about his partner and he made persistent accusations about her which were unfounded. The couple separated and Matthew left the family home, but he continued to contact his ex-partner which became distressing. His ex-partner reported the matter to the Police.

Police concluded Matthew's illness was the reason behind his persistent harassment of his ex-partner. The ex-partner had contacted a range of services for advice and support and had been told by each organisation there was nothing that any of them could offer to help her. The situation was getting worse and risks to her were increasing.

The Early Intervention Team concluded that the risks to the ex-partner could not be ignored. Mental illness could not be an excuse for Matthew's behaviour. The Early Intervention Team escalated their concerns and contacted North Staffordshire Combined Healthcare NHS Trust Safeguarding Team for advice.

The Safeguarding Team arranged a meeting with the Stalking and Harassment Lead Officer for Staffordshire Police and the case was reviewed. Arising from the review Police confirmed that the case did meet the threshold for a Stalking Protection Order and the appropriate steps were taken to safeguard the ex-partner.

This case highlights the importance of escalation and professional challenge particularly in situations when people are adjudged not to meet the threshold for support services.

Case Study 5: Stoke-on-Trent City Council Adult Social Care

'Isaac' is a black man of Afro Caribbean heritage aged around 60 years. Adult Social Care was contacted by Isaac's tenancy support officer due to concerns about his deteriorating personal health and the increasing risks of physical, psychological and financial abuse that he was experiencing from 'cuckooing' at his home.

A Changing Futures worker and the local Police Community Support Officer (PCSO) would visit daily due to the significant risks identified with the aim of dispersing the people who were cuckooing Isaacs property. A deep clean was completed at his home but within a week it was back to the condition it was before the clean. At that time Isaac wanted to remain at his home to decorate and to make it a safe and nice environment to live but his living situation deteriorated and the risks to him escalated. A Section 42 safeguarding enquiry was subsequently commenced.

Changing Futures worked closely with the Police and the Local Authority Anti-Social Behaviour Officer. A warning marker was put on Isaac's home address, ensuring that in the event of any calls to the Police relating to him or his property a Police Officer would attend as a matter of urgency.

One day Isaac was assaulted whilst walking in the street near his home. Arising from this Isaac agreed that he was no longer safe and he wished to move home. However, none of the housing providers locally would rehouse Isaac. This was due to his previous criminal convictions and his reputation. All involved in offering support considered that he was being unjustly disadvantaged and this became a major difficulty.

Arising from the persistent approach of the Changing Futures team, the consistent approach of the local PCSO and a housing provider being prepared to give Isaac a chance where no one else would he moved into a supported tenancy.

The safeguarding risks to Isaac have been significantly reduced. He has maintained contact with his support team. He is happy, able to communicate effectively with his key worker and feels safe, eating regular meals and has plans to pursue his hobbies which include art and music. He now has access to benefits, he is registered with a GP, is engaging with Community Drug and Alcohol Service (CDAS) and attending appointments and his drug use has significantly reduced.

Case Study 6: Stoke-on-Trent Adult Social Care

Steven is a 35-year-old white British man living in council tenancy.

Adult Social Care was contacted due to concerns about significant self-neglect and substance misuse accompanied by Schizophrenia. His associates were financially and emotionally exploiting him, selling him substances at inflated rates, threatening violence to intimidate him and cuckooing his flat.

Following a Care Act Assessment, a Section 42 safeguarding process engaged agencies in developing a safeguarding strategy. Many attempts were made through multi-agency approached to support and engage Steven including providing regular food parcels, contacting utility providers as his services had been disconnected, frequent visits from Police Community Support Officers, support from the Community Mental Health Team and Housing Officers to alleviate the risks he was known to be subjected to. Steven did not sustain his engagement with services which diluted the impact of the support offered. During this time Steven had to move out of his home.

However, the allocated Changing Futures worker was able to offer the consistency of contact and approach that is the unique added value of Changing Futures workers. Through the repeat visits, perseverance and dedication of the Changing Futures worker, Steven began to engage.

Changing Futures was able to utilise a budget to safeguard Steven in bed and breakfast accommodation until a Social Worker eventually sourced a supported living flat. Steven began to access and sustain community support for his substance misuse addiction and remains substance free. He has been provided with new clothes and has regular meals. His relationships with his family have healed.

The willingness to 'go the extra mile' in multi-agency working coupled with Changing Futures working intensively beyond the usual challenging time constraints of Social Workers has helped Steven to work to his potential and shine. He is engaged with Expert Citizens and developing a peer mentor role for himself and currently working towards becoming a volunteer as a peer member with lived experience.

Strategic Priority 2: Engagement

Lead: Helen Jones, SSASPB Business Manager

The activity around this priority is managed and co-ordinated by the Prevention and Engagement sub- group which meets bi-monthly and is chaired by Laura Collins (North Staffordshire Combined Healthcare Trust). This is a sub-group with a broad membership and attended by partners with a good knowledge and insight into operational practice.

For the purposes of the work of the Board during 2022/23 engagement refers to raising awareness of adult abuse and neglect and how to respond with several key groups of people including:

- Adults with care and support needs

- Carers and advocates
- Professionals and Volunteers
- Members of the public

The following activities have been completed through the sub-group:

- Hosted 3 events for the Independent Reviewer of the Safeguarding Adult Review of 'Andrew' to present the findings and learning. The three events were attended by 336 practitioners.

- Hosted a Trauma Informed Practice learning event in support of the findings of SAR 'Andrew' attended by 169 practitioners.

- Hosted Practitioner Forum events to discuss topics arising from audit findings, SARs, or at the request of practitioners. Topics have included cuckooing; hoarding; self-neglect; Advocacy in Adult Safeguarding and Mental Capacity.

- Supported the Ann Craft Trust National Safeguarding Adults Week in November 2023.

- Hosted a learning event covering Adult Safeguarding Awareness pitched at practitioners including District and Borough councils and housing groups for whom adult safeguarding is part of their work but not a full-time element.

- Supported the inclusion of Advocacy services and Drug and Alcohol Services to the SSASPB membership in recognition of the findings from SARs locally and nationally.

- Produced the autumn newsletter which was distributed widely. Topics included: contributions in support of the Adult Safeguarding Week; the work of the Board partner Asist who provide advocacy services; how to raise a safeguarding concern; key messages to practitioners from SARs and audits and introduction to new Strategic Priority 'Effective Practice.'

- Enhanced awareness raising of Adult Safeguarding Week by promoting partner organisations to host their own organisational events.

- Provided a variety of online learning events that were attended by a total of 1193 practitioners in 2022/23.

- Commissioned Board partner Rockspur to produce a more accessible version of the 2021/22 Annual Report. This was produced by adults with autism or a learning disability. It is the second to be produced and reflects the positive feedback from the report produced for 2020/21.

- Facilitated the gathering of information for a refresh of the SSASPB website that is accessed on a monthly average of more than 3,000 occasions.

- Produced a power point presentation for partner organisations to use on the subject of 'Learning Lessons from SARs'. The presentation highlights the recurring themes and encourages effective practice.

- The Board has decided to continue with Engagement as a Strategic Priority for 2023/25 and will continue to focus on how to better engage with care and support needs who have experienced abuse or neglect.

6. Staffordshire and Stoke-on-Trent 2022/23 Performance Report Overview

Number of safeguarding concerns received by the

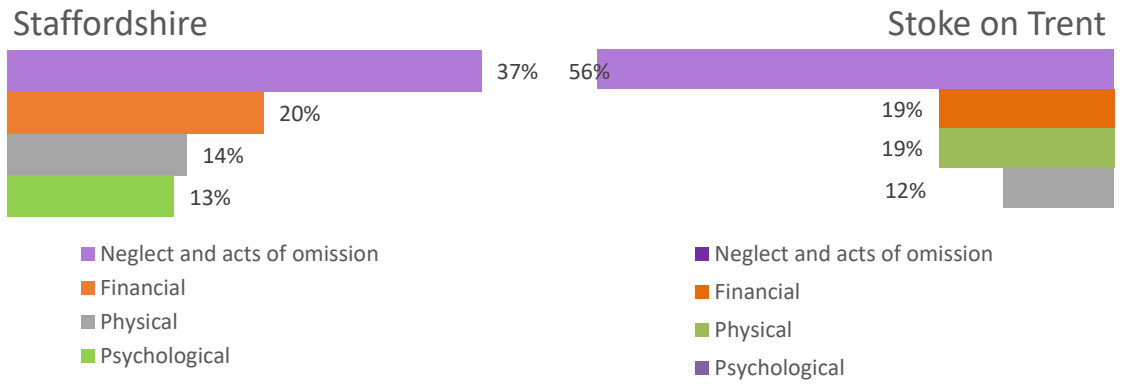
Staffordshire	Stoke-on-Trent
15,680	5,226

Staffordshire 57%

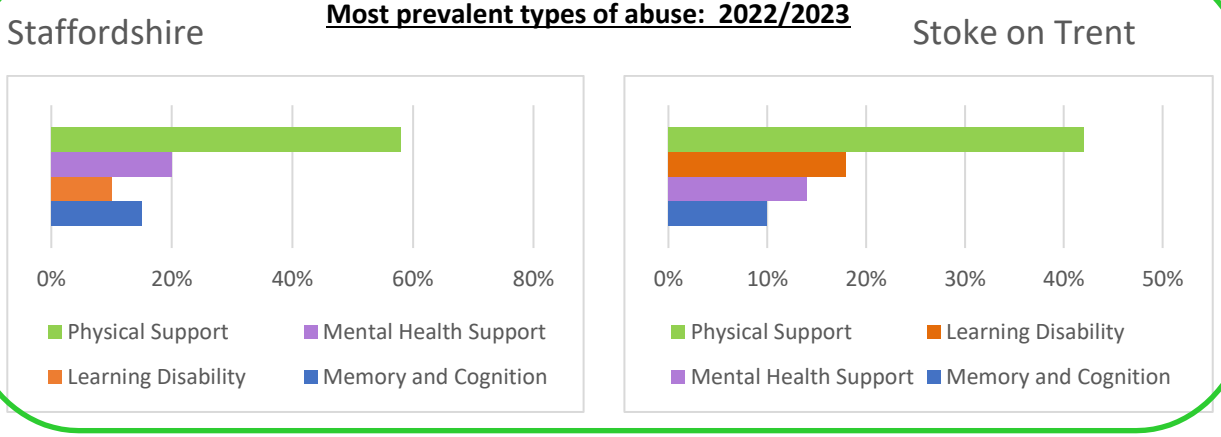
Stoke-on-Trent 42%

Of safeguarding enquiries are regarding adults who are 75 or over.

Most prevalent primary care and support need for the adult



Most prevalent types of abuse: 2022/2023



Top 4 Locations of Abuse

	Own Home	Residential Home	Nursing Home	Hospital
Staffordshire	70%	17%	12%	1%
Stoke on Trent	37%	22%	15%	4%

7. Analysis of Adult Safeguarding Performance Data

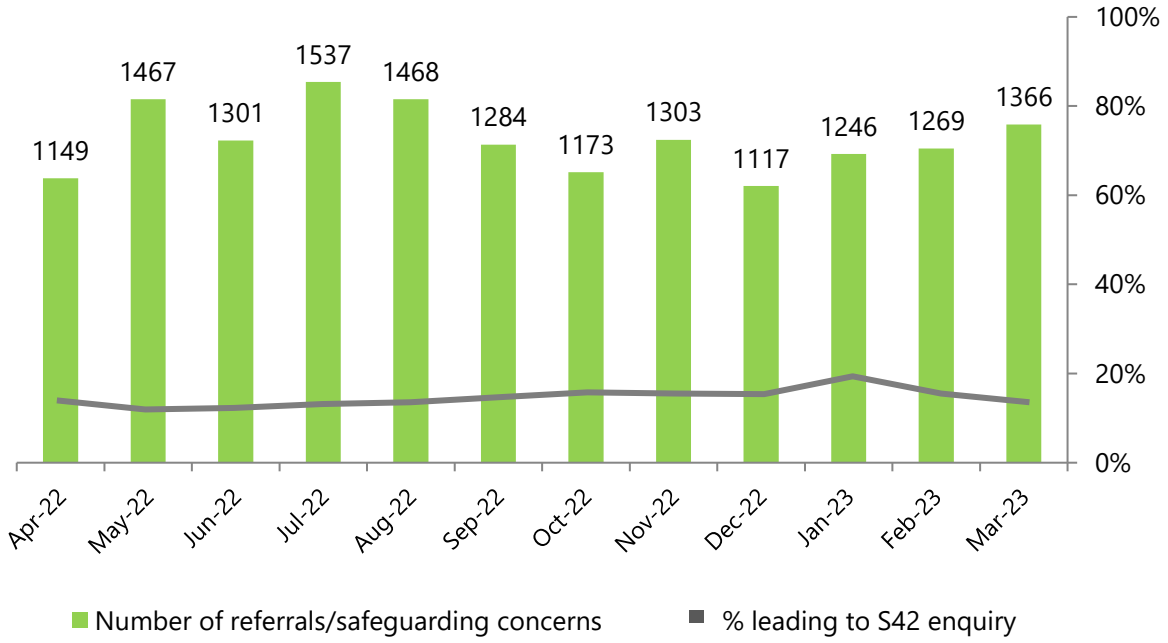
This section provides commentary and analysis of safeguarding data from Stoke on Trent and Staffordshire. Please note that in many sections the percentage has been rounded to the nearest whole number and therefore not all percentages will add up to 100%.

Number and Proportion of Referrals/Safeguarding Concerns:

The safeguarding partners in Staffordshire and Stoke on Trent have established and widely publicised the procedures for reporting concerns that an adult with care and support needs may be experiencing or is at risk of abuse or neglect.

Reported concerns can progress to a formal enquiry under Section 42 of the Care Act 2014 if the criteria for the duty of enquiry requirement is met. It should be noted that there is a difference between how both LAs capture and report this data. In cases where a statutory response is not required the SSASPB continues to seek assurances that local arrangements ensure signposting and engagement as necessary with appropriate support services.

Fig.1 - Staffordshire: number and proportion of referrals/safeguarding concerns

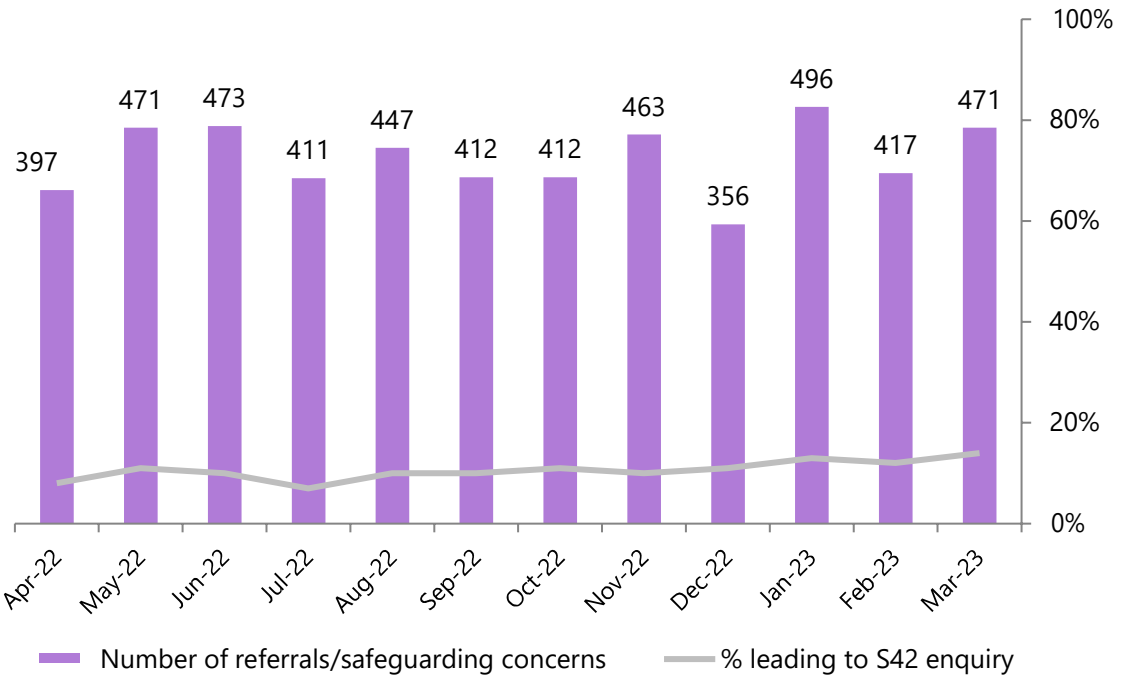


During 2022/23 in Staffordshire there have been 15,680 occasions when concerns have been reported that adults with care and support needs may be at risk of or are experiencing abuse or neglect. The total figure has increased by 2,543 occasions from 13,227 in 2021/22 which is an increase of 19.2%.

This year the duty of enquiry requirement was met in 17% of reported concerns, a decrease of 4% from 2021/22 (21%) reflecting a downward trend, a further 4% fewer than the figure of 25% in 2020/21. The reasons for the percentage decrease in concerns meeting the duty of enquiry threshold have been explored. The number of people who meet the threshold for a Section 42 enquiry is broadly unchanged. It is the increase in the total number of reported concerns that

has contributed to the reducing conversion rate. The information gathered from audits, indicates that the variance could be related to the type of concerns raised, for example, there are a significant number of concerns arising through quality or assessment processes. Audits indicate that there is rarely 'no activity' following the submission of a concern and whilst a formal enquiry may not commence there is a benefit to the person subject of concern. Staffordshire has been examining the reported concerns and is working with referring partners to ensure that thresholds are understood.

Fig.2 - Stoke-on-Trent: number and proportion of referrals/safeguarding concerns



In Stoke on Trent there were 5226 reported safeguarding concerns in relation to adults with care and support needs during 2022/23. This is an increase of 636 (13.8%) from 4590 during 2021/22.

In Stoke on Trent the first contact workers carry out fact finding/information gathering on each safeguarding concern prior to being passed on to a manager who then makes the decision on whether or not the concern is moved onto a Section 42 enquiry or takes an alternative route. Therefore, a lot of work is done at first contact stage which may be viewed as an enquiry albeit a telephone call or further discussions with the provider and or adult at risk in accordance with Making Safeguarding Personal. Following initial assessment, it was determined that the duty of enquiry requirement was met in 11% of occasions when a concern was raised. This is an increase from 9% in 2021/22.

Stoke-on-Trent has been conducting audits to explore the outcomes for adults whose safeguarding concern does not progress to a Section 42 enquiry. This is part of a quality assurance process with the aim to examine decision making and rationale for the actions taken. Referrals made to the local authority are subjected to a scrutiny process to ensure that these meet threshold criteria. The findings of the audits provide assurances that it is rare that no action at all is taken following receipt of a safeguarding concern.

The Board has asked for an explanation from the local authorities about the different methods of gathering and interpreting information in relation to safeguarding concerns. The responses are summarised below:

- Both authorities review information on the initial safeguarding referral form.
- Both make a decision at this point to determine if the three stage criteria is met:

  a) *does the adult have care and support needs?*

  b) *are they at risk or experiencing abuse?*

  c) *and as a result of their care needs, are they unable to protect themselves?*

- If the three-stage test is met, then a decision is made by both authorities to gather further information (called a planning discussion).
- The planning discussion will involve information gathering from various sources, both professional and family and friends and the adults view where they have capacity to be involved.
- Following this information gathering both authorities make a decision if further enquiries and exploration of safeguards for the adult is required.
- If the decision is for no further enquiries, it is at this stage that Staffordshire and Stoke on Trent make a different recording decision:

  - Stoke on Trent record this decision as – no Section 42 required (but also record what other actions either care assessment request, review etc. as a non-statutory Section 42).
  - Staffordshire record this decision as – Section 42 enquiry completed (either no ongoing risk, closed at adult's request, concerns substantiated or unsubstantiated).

At the request of the SSASPB both local authorities have re-examined their approaches to seek better alignment in recording practices. This review has illustrated that both authorities are following the same procedures to ensure adults are safe and risks minimised and both comply with the recording guidelines. In essence the preferred recording systems is an internal decision for each authority.

The following pages provide an analysis of the findings under various headings from the concerns that have resulted in a formal Section 42 enquiry.

About the Person

To give a picture of the personal circumstances of those at risk of abuse or neglect information is collected on the age, gender, ethnic origin, and primary reason for adults needing care and support and this information is provided below.

Fig. 3 Staffordshire Age Breakdown of the County

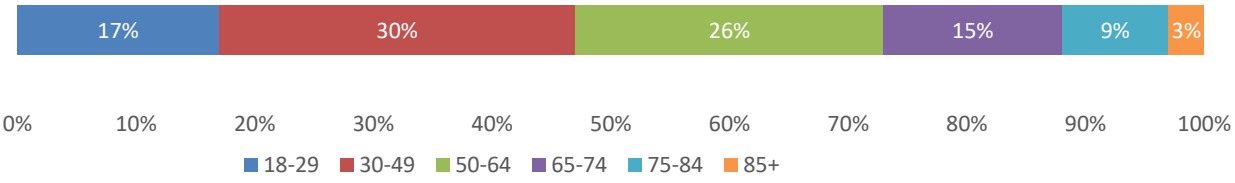
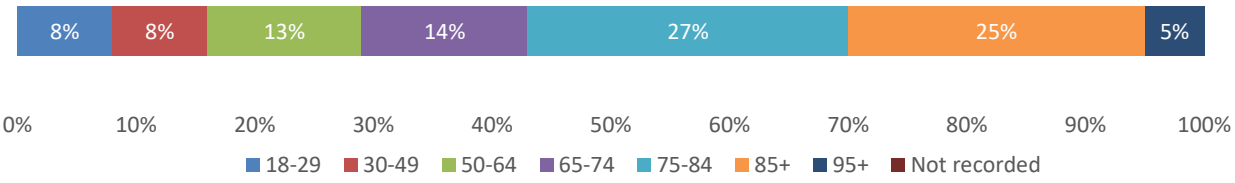


Fig. 4 Staffordshire Age Breakdown (Section 42)



Staffordshire:

Of the adults who have been the subject of a Section 42 enquiry, those aged 75–84 (26.9%) represent the largest cohort followed by 85-94 (25.1%). Last year, 2021/22, these age groups were reversed with 85–94 being the most prevalent at 25.2% compared to 24.9% for 75-84yrs.

When comparing the age breakdown with general Staffordshire population statistics, it is evident that people in the 75+ age groupings are disproportionally overrepresented for Section 42 enquiries. Around 12% of the adult population in Staffordshire are aged 75 or over, however, 56.8% of safeguarding enquiries relate to this age group.

The average life expectancy for a man living in Staffordshire is 79.7 years and for a woman 83.5 which may explain why there are more enquiries for women than for men as there is an increased need as a population grows older for care and support. This seems consistent with the national picture over the last few years.

Note: the age bands given by the Office of National Statistics conclude at 85+ and do not match the age- related Section 42 enquiries above.

Fig. 5 Stoke-on-Trent Age Breakdown (Section 42)

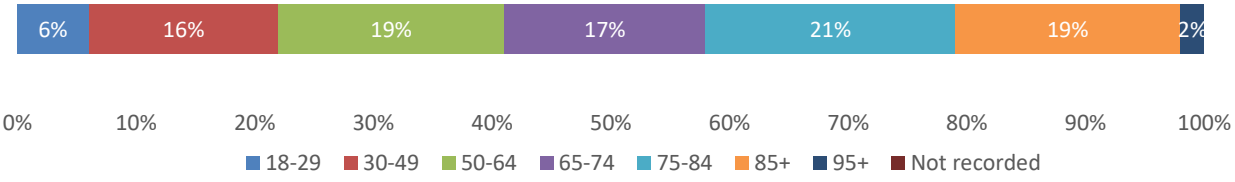
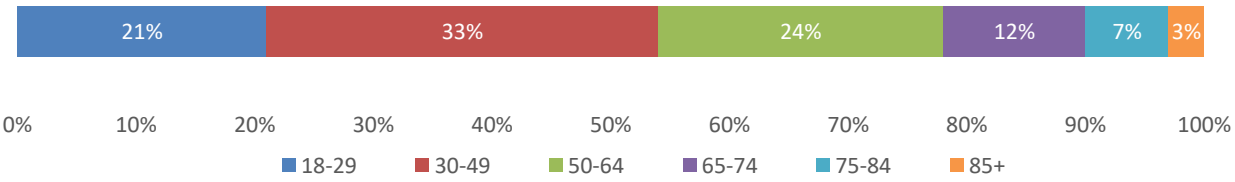


Fig. 6 Stoke-on-Trent Age Breakdown of the City



Stoke-on-Trent:

For Stoke-on-Trent there is a fairly even spread of ages of adults who have been involved in a Section 42 Enquiry. The largest cohort is adults aged 75-84 years (21%) an increase of 1% from last year. The second largest cohorts both represented 19% of Section 42 enquiries. These adults aged 85-94, a reduction of 8% compared to 27% in 2021/22 and adults aged 50-64 years. For the younger cohort this is an increase of 5% from last year. There was a decrease from 27% to 19% for those adults aged 85 to 94. Due to the relatively small number of Section 42 enquiries small changes in numbers can significantly change the percentages.

When comparing the age breakdown with the general Stoke on Trent population figures, it is apparent that people over 65 are disproportionally overrepresented for Section 42 enquiries, 22% of the population are over 65 but 59% of adults subject of a Section 42 enquiry are in this age category.

Men in Stoke on Trent have a life expectancy of 76.5 years and for women 80.2 years. There are again more concerns raised for women this year which may be because there are more women who are older and the older the population the greater the need they may have for care and support.

Gender

Fig. 7 Staffordshire: Gender Breakdown (Section 42)

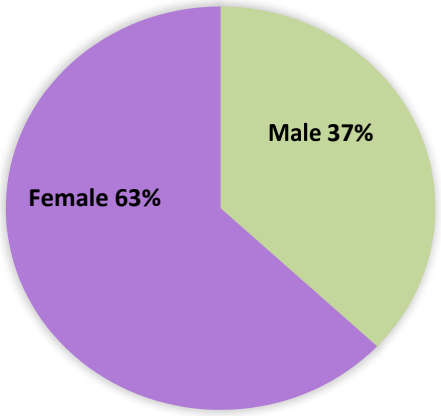
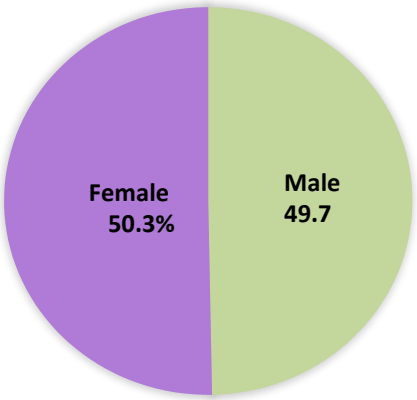


Fig. 8 Staffordshire: Gender Breakdown of the County



Staffordshire:

Females represent the majority of adults subject of a Section 42 enquiry with 63% over the year. This is in very similar proportions to those seen in previous years.

Fig. 9 - Stoke-on-Trent: Gender Breakdown (Section 42)

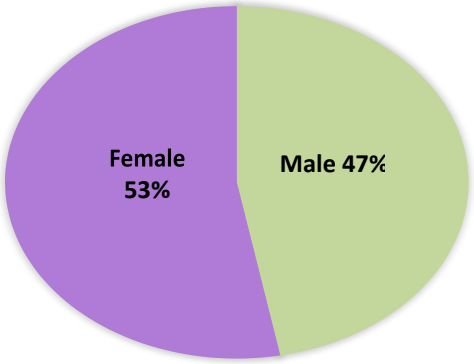
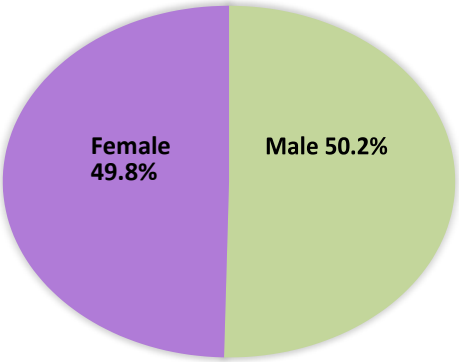


Fig. 10 - Stoke-on-Trent: Gender Breakdown of the City



Stoke on Trent:

Stoke on Trent has broadly remained the same for the number of males and female who were subject of the Section 42 enquiry process (last year females accounted for 55%). It is of note that women have a higher average life expectancy 3.7 years more than men and as a population is more elderly and accordingly may have more needs for care and support.

Note: Recording systems are currently unable to break down data further to reflect broader gender categories to be fully inclusive. This has been raised with Local Authorities with a request that there is a range of gender options to reflect the local communities.

Ethnicity

Ethnicity	Stoke on Trent Section 42 enquiries	Stoke on Trent overall population	Staffordshire S42 enquiries	Staffordshire overall population
White British	87.9	78.5	91.9	90.2
Not Recorded	4.5	-	2.2	-
Pakistani	1.9	6.0	0.4	1.3
Any other mixed background	1.6	1.5	0.2	0.0
Black Caribbean	1.0	0.4	0.5	0.3
Not Stated	1.0	-	2.3	-
Other White	0.6	4.5	0.8	2.9
Any other ethnic group	0.6	1.8	0.3	1.4
Any other Asian Background	0.3	1.8	0.4	0.8
Indian	0.3	1.1	0.3	1.1
Mixed White/Caribbean	0.3	0.8	0.2	0.8
Black African	0.0	2.0	0.1	0.4
Bangladeshi	0.0	0.6	0.0	0.1
Any other Black Background	0.0	0.4	0.0	0.1
Arabic	0.0	0.3	0.0	0.1
Gypsy /Roma	0.0	0.3	0.0	0.1
White Irish	0.0	0.2	0.4	0.4

Stoke-on-Trent:

The majority of individuals subject to a Section 42 enquiry are recorded as 'White British' at 87.9%, an increase from 83.1 % last year. There has been an improvement of 'Not Recorded' which has been reduced to 4.5% from 9.8% in 2021/22.

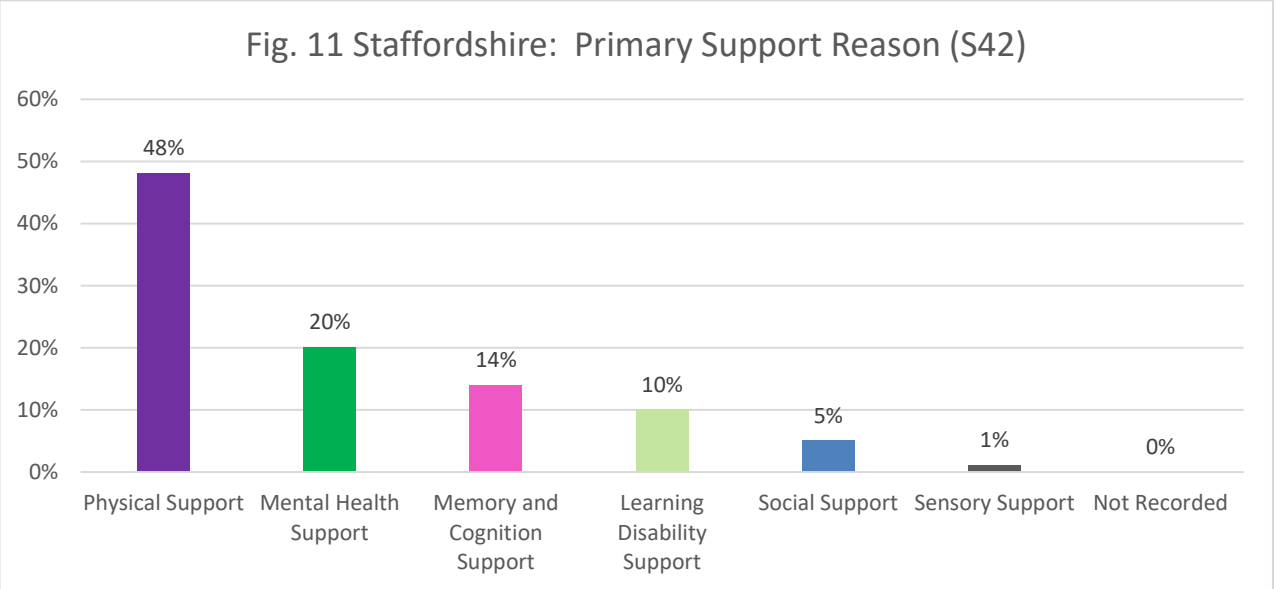
Staffordshire:

The pattern is similar in Staffordshire with the majority of declared ethnicities as 'White British' 91.9%, an increase from 87.8% last year. There has been an improvement of 'Not Recorded' reduced to 2.2% from 6.2% last year.

Note: The Board has promoted the importance of accurate ethnicity recording in 2022/23 through its Practitioner Forums, learning events and Newsletter. This coincides with the more accurate recording reflected in this years' data and the progress is acknowledged.

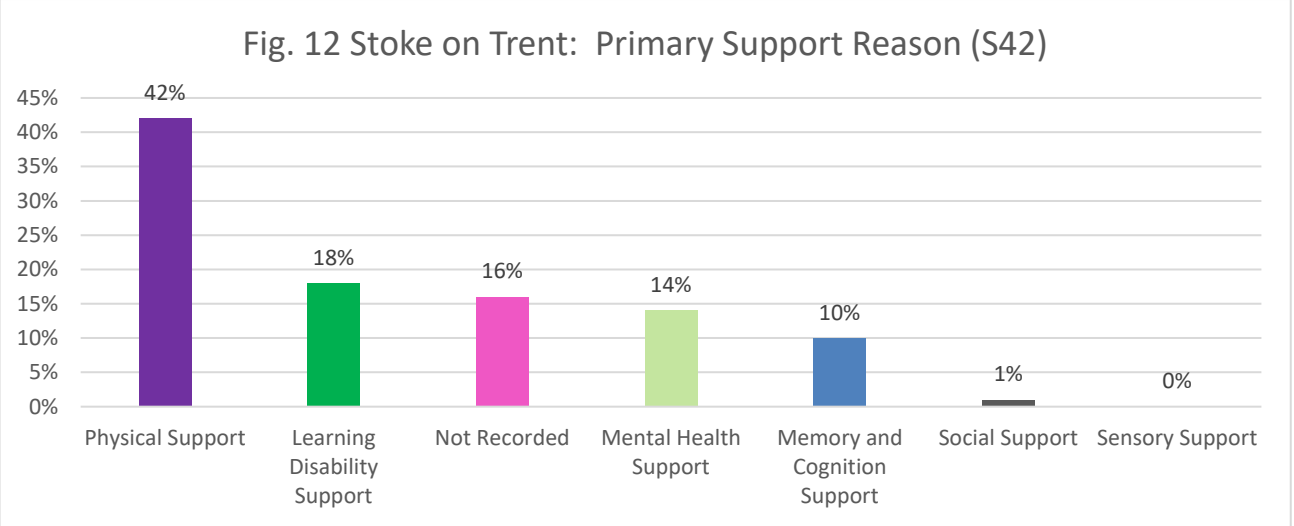
Primary Support Reason

The bar charts below illustrate the type of care and support need of the adult subject of abuse or neglect.



Staffordshire:

Physical support continues to be the most common primary support reason in Staffordshire in 2022/23 (48%) exactly the same percentage as reported last year. The second most prevalent primary support reason is Mental Health Support at 20% reflecting a 6% increase on last year. It is to be noted that there has been a significant decrease in the category of 'not recorded', which is down to 0% compared to 17% in 2021/22.



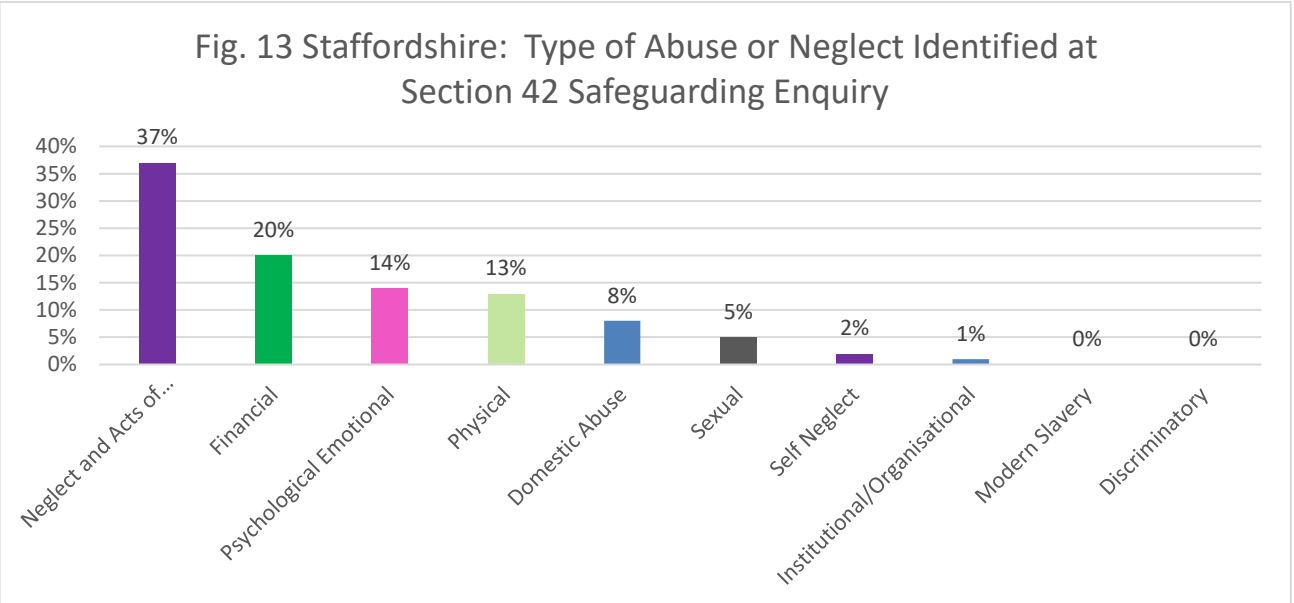
Stoke on Trent:

Physical Support similarly represents the largest proportion of primary support reasons recorded in Stoke on Trent at 42%, an increase from 39% last year, followed by learning disability support with 18% which is a reduction from 24% compared to last year.

The 16% shown as not recorded in the chart above is better explained as 'not known at the point of recording' as the adults were not known to Adult Social Care and, at that time, their needs not assessed. There are plans to move the recording of this information to later in the safeguarding process.

Types of Harm or Abuse identified at Section 42 Safeguarding Enquiry

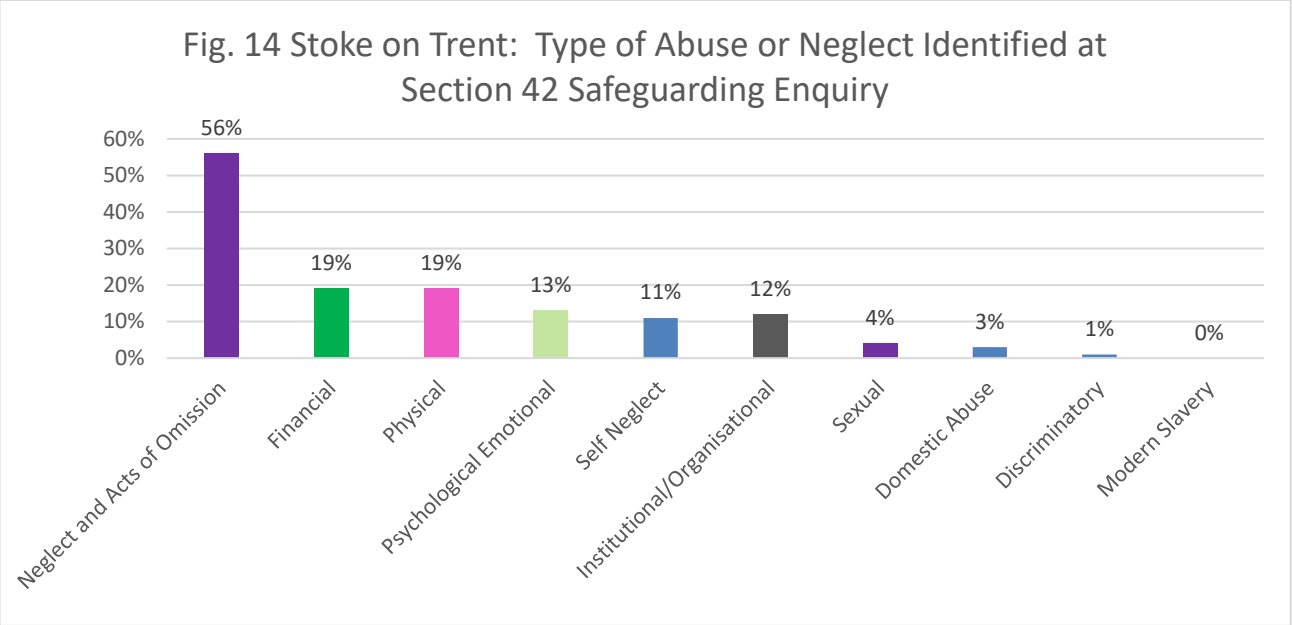
The below information shows the types of abuse and neglect reported in comparative proportions:



Staffordshire:

There are no significant changes to the percentages reported in 2021/22. Neglect and acts of omission continues to be the most prevalent type of abuse at 37% and is the same as the figure reported in 2021/22. Financial abuse remains similar at 20% compared to 19% last year. Physical abuse has reduced to 13% from 17% last year.

It is believed that organisational abuse remains under-reported at 1%. This is believed to be owing to there being only one type of abuse that can be recorded in Staffordshire case management systems and other categories are selected at the point of recording to describe the abuse e.g. physical abuse.



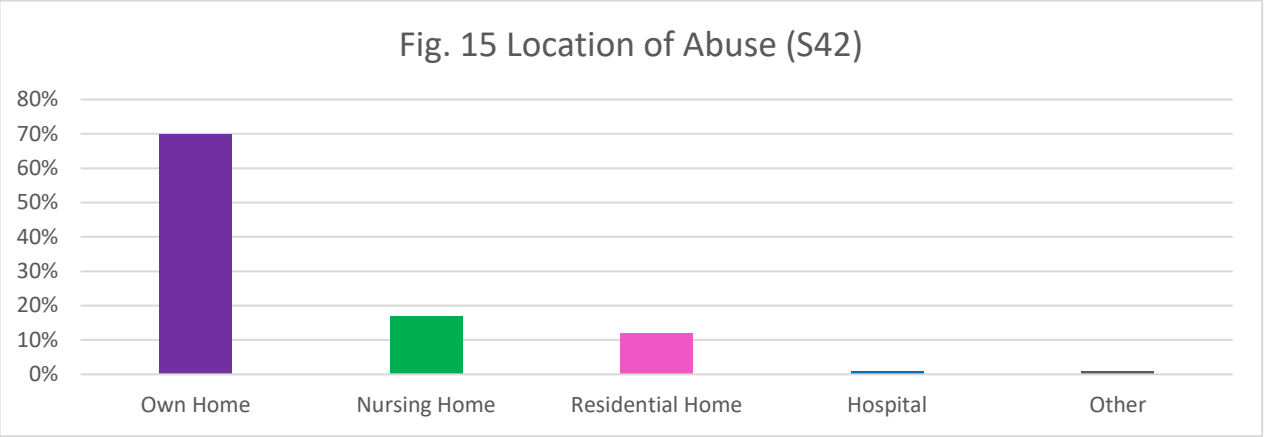
Stoke-on-Trent:

The percentage of neglect and acts of omission cases has decreased to 58% from 61% last year. Financial abuse has increased to 19% from 12% last year. Self-neglect concerns continue to increase to 11% this year. This compares to 7% last year and 2% in 2020/21. It is believed that this may be attributable to the awareness raising of self-neglect as a category of abuse following the well-attended learning events that followed the Safeguarding Adult Review of 'Andrew'. The increase in practitioner recognition of self- neglect should be seen as a positive development.

Organisational abuse, where more than one category of abuse can be recorded, is better reported in Stoke-on-Trent than Staffordshire where the recording arrangements are different.

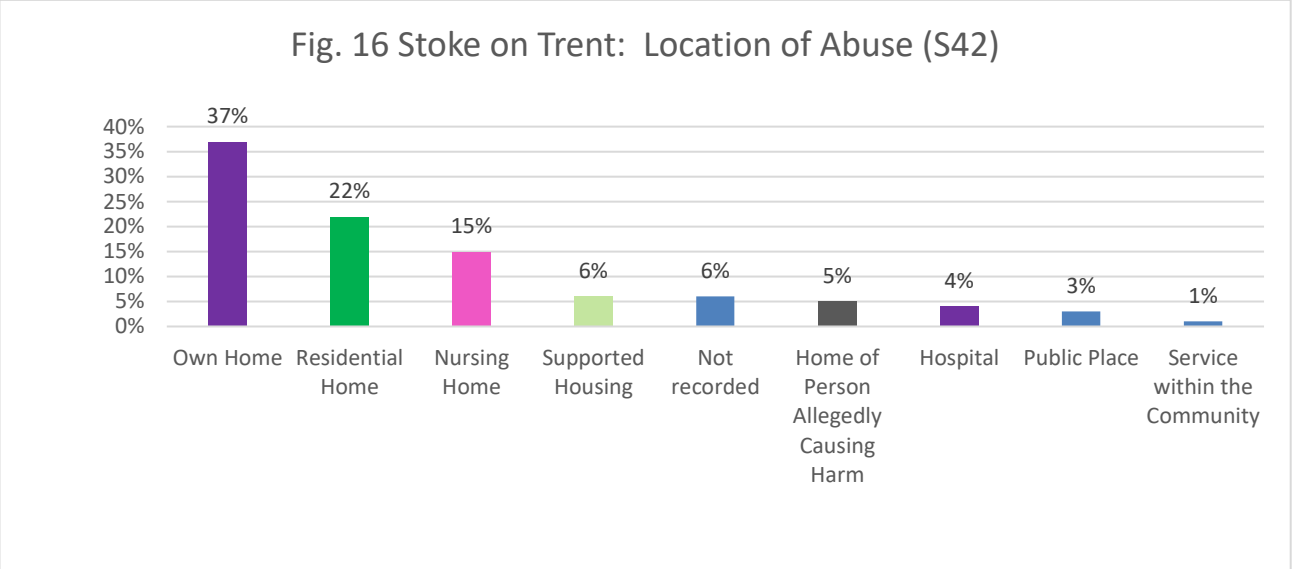
It should be noted that there can be relatively small numbers of adults in types of abuse which can cause a percentage change to appear more pronounced. In Stoke on Trent more than one type of abuse may be reported for a single case, as illustrated above in relation to organisational abuse. The total cases therefore total more than 100%.

Location of Abuse



Staffordshire:

Of those people subject of Section 42 enquiries, the most common location of abuse or neglect was the person's own home (70%) compared to 62% in 2021/22. The next most common locations in Staffordshire were Independent nursing home at 17% a slight increase from 16% last year and residential home at 12%, an increase from 11% last year.



Stoke on Trent:

The most prevalent location of abuse in Stoke on Trent is in the person's own home 37% an increase from 26% the previous year. This was followed by 22% in an independent residential home and 15% nursing home. Stoke-on-Trent's recording system allows for a broad type of location, for example, public place, supported housing etc.

Through audit it has been identified that some practitioners record a care home as a person's own home. Work continues to improve consistency in recording standards. For this report "own home" also includes the categories of supported accommodation whilst hospital also includes those locations recorded as mental health inpatient setting or community hospital that are recorded separately on the Stoke on Trent local authority recording system.

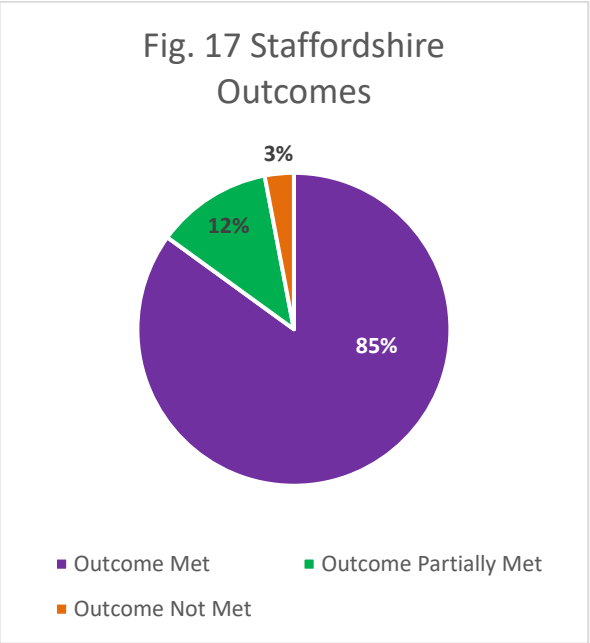
Findings of Concern Enquiries

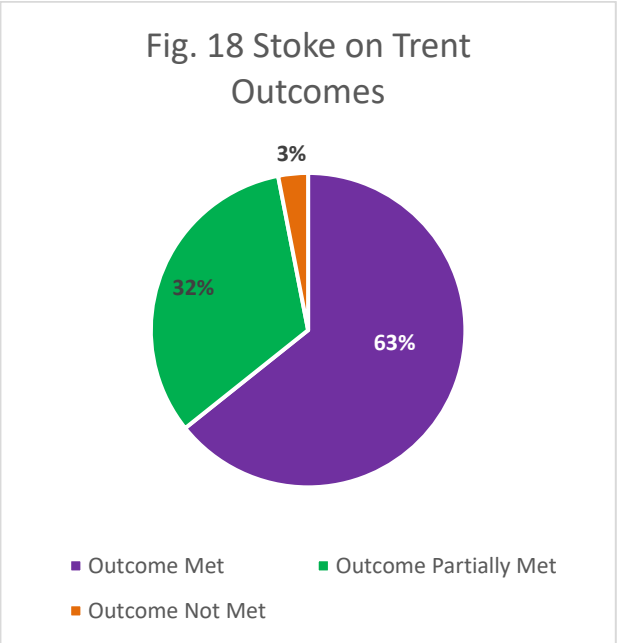
The following section provides an overview of the findings of Section 42 enquires showing what is happening to referrals with a comparison to previous years.

Staffordshire**:** 17% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This compares to 19% in the previous year.

Stoke-on-Trent: 11% of adults involved in a Section 42 Enquiry had previously been involved in an enquiry in the past 12 months. This is an increase compared to 4% last year.

Number and proportion of people who were involved in a Section 42 Enquiry whose expressed outcomes were met





Staffordshire**:**

The data is collected by the enquiry worker at the close of the case who will discuss with the adult or their representative their opinion on whether the case has met, partially met, or not met their preferred outcome.

In Staffordshire 67% of adults subject of a Section 42 enquiry provided a response to the question of whether their desired outcomes from the enquiry were either met in full, partially met or were not met. A total of 97% of adults responding stated that their desired outcomes were fully met or partially met. This is the same figure as reported last year.

Stoke on Trent:

The data is collected by a social worker who has been working with the adult and able to obtain the adults opinion.

In Stoke on Trent 54% of adults subject of a Section 42 enquiry provided a response, an increase from 44% in 2021/22. 95% of these stated that desired outcomes were fully met or partially met. This is a slight decrease from 96% last year.

There is a continuous focus on accurate data capture of adults expressed desired outcomes and whether these have been met. Quality assurance audits explore the relevance and accuracy of information recorded within the Section 42 enquiries focusing on whether the outcomes identified by adults adhere to the principles of Making Safeguarding Personal.

Report from Staffordshire Police and Adult Safeguarding Enquiry Team

The Adult Safeguarding Enquiry Team (ASET) is a multi-agency team comprising Police Detectives and Adult Social Care with a remit to undertake investigations into reports of abuse and neglect of adults with care and support needs and associated investigations into persons in positions of trust. The remit includes proactive visits to care homes that may be on the verge of going into Large Scale Enquiry (LSE), proactive investigations on behalf of the Coroner and problem solving at repeat locations.

Whilst many investigations involve a potential criminal act the team is also engaged in multi-agency investigations and early intervention in care settings that do not reach criminal thresholds, for the purpose of preventing harm to vulnerable adults. This approach can achieve better outcomes for adults than a response after harm has occurred. The team has wider links to safeguarding partners, the Care Quality Commission (CQC) and Her Majesty's Coroner.

The table overleaf lists the types of incidents the Team has investigated (1 April 2022 to 31 March 2023).

Offence Type	
Non Crime or Blank	44
Care worker ill-treat/willfully neglect an individual	25
Assault occasioning actual bodily harm	30
Common assault and battery	15
Theft if not classified elsewhere	12
Rape of a female aged 16 or over	10
Sexual assault on a female 13 and over	10
Care provider breach duty of care resulting in ill treatment/neglect of individual	11
Action Fraud	5
Sexual assault on a male 13 and over	4
Sending letters etc. with intent to cause distress or anxiety	3
Theft in a dwelling other than from automatic machine or meter	3
Temporary Code – Third party report – waiting for victim confirmation	2
Wounding with intent to do grievous bodily harm	2
Engage in controlling/coercive behavior in an intimate/family relationship	2
Assault on a female 13 and over by penetration	2
Other criminal damage to other residential building £500 - £5000	2
Malicious Wounding: wounding or inflicting grievous bodily harm	1
Stalking involving serious alarm/distress	1
Non-fatal strangulation and suffocation	1
Rape of a male aged 16 or over	1
Rape of a male aged 16 or over – multiple undefined offenders	1
Burglary – Residential	1
Care workers: sexual activity with a person with a mental disorder – male person	1
Care workers: causing or inciting sexual activity (person with mental disorder) no penetration	1
Care workers: sexual activity in the present of a person with a mental disorder	1
Cause of incite the sexual exploration of a child – child 13 – 17	1
Take/make/distribute indecent photographs of a pseudo- photographs of children	1
Exposure	1
Ill treatment or neglect of a person lacking capacity by anyone responsible for that persons care	1
Fear or provocation of violence	1
Harassment	1
Total	**187**

Examples of investigations include:

- Carer convicted of ill-treatment of care home resident

  An investigation was commenced following a report was made to police that a carer had been witnessed assaulting a 78-year-old male resident at a care home. The witness reported that the carer has pushed the resident onto the bed banging his head against a wall before punching and slapping him several times around his head causing cuts and bruising. The carer then forcibly removed the resident's shirt causing him further distress.

  A joint investigation was conducted by police and adult social care as the resident lacked capacity. The carer was interviewed and denied ill-treating the resident. Following the

investigation which was challenging due to the resident not having mental capacity the Crown Prosecution Service brought criminal charges against the carer for ill- treating the resident. Following a trial at Stoke-on-Trent Crown Court in March 2023 the carer was found guilty of ill treatment and sentenced to eight months in prison. On sentencing the carer the Judge commented:

"The Court of Appeal has made it clear that cases such as this almost always require custodial sentences…….not only did you maintain your innocence but you accused at least two of your colleagues of lying…….you were in a trusted, responsible position working with vulnerable people and you lost your temper."

This is an example of effective team working between police and safeguarding partners to protect adults with care and support needs from abuse by people in positions of trust.

➢ <u>Responding to Modern Day Slavery</u>

The care co-ordinator for 'Paul' contacted the Safeguarding Team at North Staffordshire Combined Healthcare Trust with concerns that Paul wasn't fully engaging but was accepting his medication. The care co-ordinator reported not being able to see Paul but, family members with whom he was living temporarily had concerns about his welfare and requested a visit.

When Paul was seen he disclosed that over the previous four weeks he had been kept hostage at an unknown address and had been made to complete tasks in return for drugs. The care co-ordinator observed that Paul's hands were injured and dirty.

An adult safeguarding referral was made to Adult Social Care and a report to Staffordshire Police. An investigation was commenced and several arrests were made on charges of assault occasioning Grievous Bodily Harm and Modern Day Slavery with the outcome that the source of harm to Paul was removed.

The case illustrates the effectiveness of the multi-agency working to respond to abuse that is often hidden.

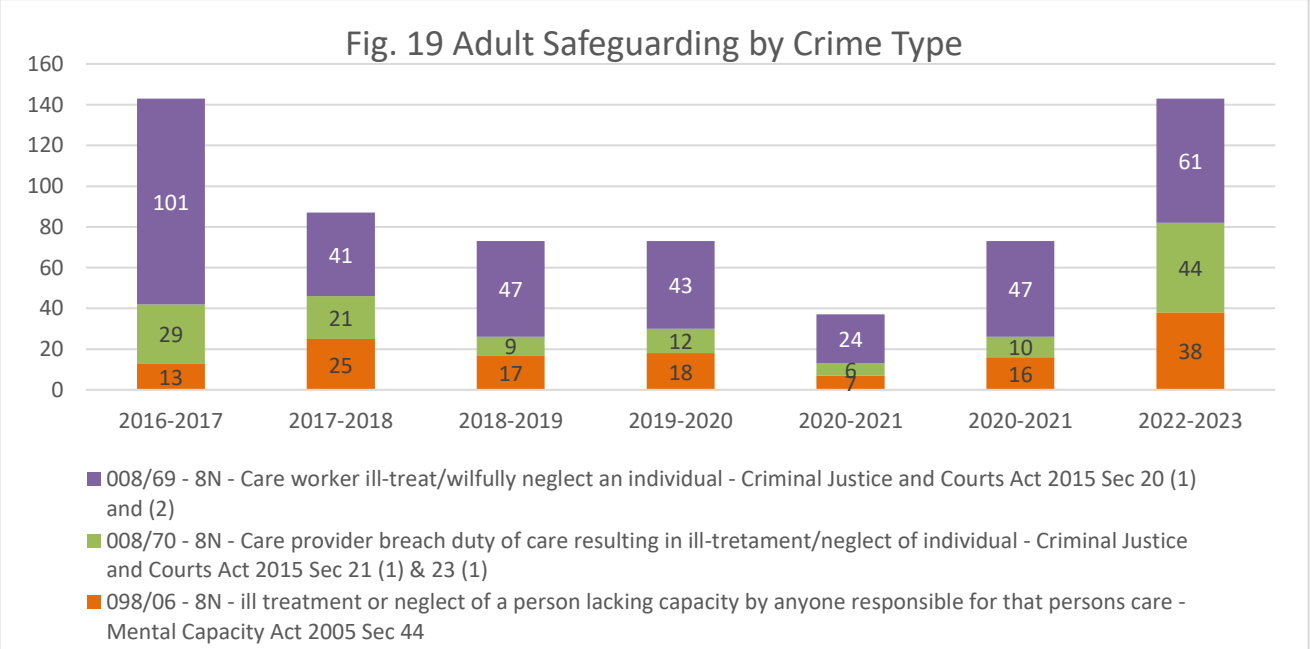
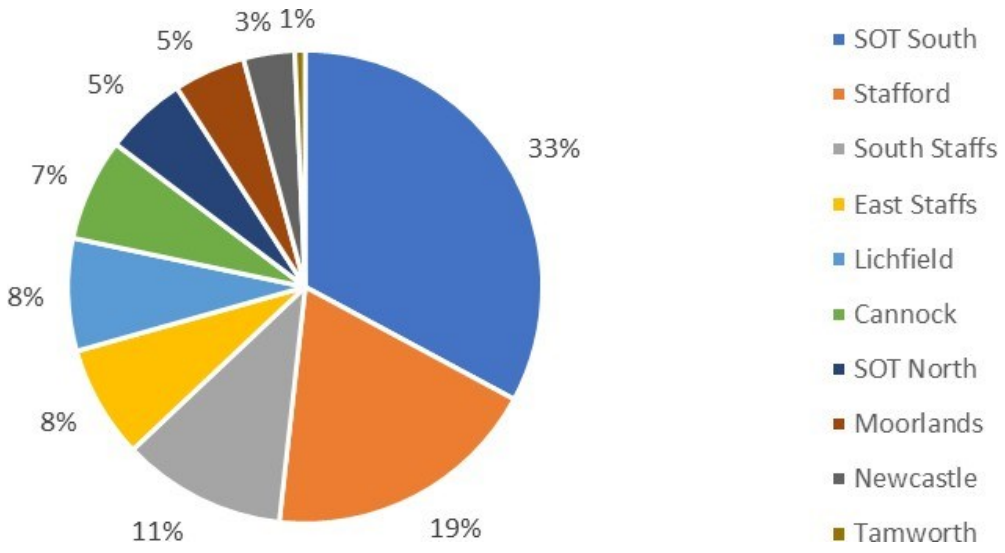


Figure 19 illustrates that there were a total of 143 offences reported for criminal investigation in the 12 months to 31 March 2023. The year is contrasted with previous years to indicate reporting rates over time. From analysis of 2022/23 reports:

- Of the Neglect offences, there are 9 repeat victims in the last 12-months period; none had been a victim in the previous 5 years.
- 1 victim has 3 associated occurrences
- 8 victims have 2 associated occurrences
- 5 out of the 9 victims had all offences occur at the same address.
- There are 6 repeat suspects in the last 12-month period, none had been a suspect/offender in the previous 5 years.
- 2 repeat offenders are linked to the same 3 crimes.
- There are 17 repeat locations in the last 12-month period. Of these 14 are care homes with 3 residential addresses.

The analysis is used operationally in conjunction with safeguarding partners to target preventative actions. The location of the crime types are illustrated below.

Fig. 20 Location of neglect type crime by Local Policing Team Area 2022/23



8. Finance Report (Draft)

The Board is supported by a part-time Independent Chair, a full-time Board Manager and a full-time Administrator. There was a period of 9 weeks when there was no administrator and so employment costs were slightly less than anticipated.

Income: This was year 1 of a 3-year budget agreement which was approved by the statutory partners in July 2022.

Partner:	Stoke-on-Trent City Council	£16,875
	Staffordshire County Council	£50,625
	Integrated Care Board	£67,500
	Staffordshire Police	£15,000
	TOTAL	**£150,000**

Spend:	Staffing/Employee costs	£121,369 *note (i)*
	Consultant fees	£3,738 (SAR costs)
	Training resources/catering	£252
	Website costs	£2,500
	Insurances	£2,102
	TOTAL:	**£129,961**

Note (i) all staffing costs including employment costs, mobile phone, printing and travelling.

Staffordshire Health and Wellbeing Board – 07 December 2023

JSNA Development

Recommendations

The Board is asked to:

a. Support the development of the Joint Strategic Needs Assessment 2023 and note the timescale for its development.

Background

1. The Joint Strategic Needs Assessment (JSNA) is a statutory requirement for all Upper Tier Local Authorities and Integrated Care Boards. It provides an overview of the health and well-being needs of the population and can be used to identify areas of greatest need, monitor trends, target intervention and evaluate impact. The JSNA informs the Health and Well-being Strategy as well as the Integrated Care Partnership Strategy.

2. This report builds on the update that was presented at the September Health and Wellbeing Board.

New JSNA tool development

3. Since September a JSNA steering group has been meeting on a monthly basis to oversee its development. The group has representatives from key local organisations including Staffordshire County Council, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), District and Borough Councils, Midlands Partnership University NHS Foundation Trust (MPUFT) and Stoke-on-Trent City Council.

4. Sub working groups have also been formed and these have been meeting bi-monthly. These groups have overseen the development of the demographics chapter and the older adults chapter. These groups will continue to support the development of the content of all the JSNA chapters to ensure they are relevant and responsive to the needs of local partners.

5. The first chapter on population demographics has now been completed and work is underway on finishing the chapter on ageing well.

6. The next phase of this work will be to complete the ageing well chapter, living well chapter, starting well and growing well chapter and wider

determinants chapter. It will then become an iterative process which will be continually updated and augmented as data sources/needs evolve.

7. Detailed mapping of the data requirements has been completed of the ageing well chapter and is being finalised for the living well chapter. Also, much of it has been completed for the starting well and growing well chapters.

Chapter	**Timescale for completion**
Ageing well	End of November
Living well	End of December
Starting and growing well	End of January
Wider determinants	End of February

8. The working groups have been scrutinising the mapping of the various datasets / indicators to be included in each chapter. This will ensure that members of the group with expertise in data or in the subject are confident the right information is included.

9. Once the remaining work has been completed on the life course and wider determinants, the working group and other stakeholders will meet to decide on the scope of further developments. These can be focused on key priorities across partnerships/local systems or be a more in-depth analysis on a specific topic or population. A systematic approach needs to be adopted for deciding on focus and content of future development. This is to ensure the validity and integrity of data included within the end product. Therefore, the steering group will agree some basic criteria against which to review proposals for further chapters or deep-dives (to ensure an objective approach).

List of Background Documents/Appendices:

N/A

Contact Details

Board Sponsor: Richard Harling / Paul Edmondson-Jones

Report Author: Emma Sandbach
Telephone No: 07970670995
Email Address: emma.sandbach@staffordshire.gov.uk

Staffordshire Health and Wellbeing Board – 07 December 2023

Staffordshire Health and Wellbeing Board Audit Report and Review of the Terms of Reference

Recommendations

The Board is asked to:

a. Note the findings from the Audit Report; and
b. Discuss and agree the revised Terms of Reference for the Board.
c. Consider the discussion points below

Background

1. Internal Audit were asked to provide assurance that the Health & Wellbeing Board were operating in accordance with clearly defined Terms of Reference which align with the requirements of the Health and Care Act 2022.

2. The audit report made several recommendations which focused on updating the Terms of Reference and making minor changes to the Board Administration.

Summary of Audit Findings

3. The following recommendations were made in the Audit report:

Rec Ref	Risk Rating	Summary of Weakness	Action
4558	Medium Priority	The Health and Wellbeing Board Terms of Reference had not been analysed against the Health and Wellbeing Board guidance (November 2022) to identify gaps. Testing carried out during the audit highlighted areas of guidance that were not reflected in the Board's Terms of Reference.	Draft Terms of Reference for the Board has been added to the December 2023 meeting agenda, & take account of the 2022 Guidance
4560	Low Priority	A date for the Health and Wellbeing Board to receive the Partnership Protocol following planned updates by the Integrated Care Board has not been programmed into the Forward Plan for 2023/24.	Date to be confirmed, but added to the Forward Plan (point 23 in Terms of Reference)
4552	Medium Priority	Not all individual purposes of the Board were clearly defined or supported by appropriate evidence to provide assurance of	Purposes and Functions revised and simplified in Terms of Reference to meet the 2022 Guidance.

		achievement, and one purpose included an out of date reference to the Sustainability and Transformation Partnership (STP).	(Points 2 and 3 in Terms of Reference)
4553	Medium Priority	Processes in place did not ensure that an annual review of the Board's Terms of Reference was undertaken on a timely basis or that an annual review of the Boards effectiveness is undertaken to inform the review process.	Annual Review identified for December Board meetings in Forward Plan (Point 23 in Terms of Reference)
4580	Low Priority	A process to link the development of the Board Forward Plan with the annual review of the Board Terms of Reference was not in place.	Forward Plan is now included in the Terms of Reference (Point 23 in Terms oof Reference)
4590	Medium Priority	Not all Statutory Functions of the Board were supported by clear evidence to provide assurance that confirmed that expected duties or oversight were being met.	Statutory Functions have been adapted to meet new guidance and the Forward Plan will include an agenda item to assure the Board that functions are being met. (Points 2 and 3 in Terms of Reference)
4591	Low Priority	There is no expected minimum level of attendance for Members of the Board and formal processes are not in place to nominate a Deputy as stated in the Terms of Reference or maintain a record of formally nominated deputies.	Set at 50% with an attendance register published annually in December. (Point 14 in Terms of Reference)
4593	Low Priority	There is no process in place to demonstrate that appropriate papers have been seen by Board sub-groups prior to being presented to the Board.	There are no formal subgroups, but reporting comes in via a number of different groups. (Points 15 in Terms of Reference)
4594	Low Priority	Terms of Reference do not include standing agenda items and there was a lack of clarity over arrangements for some standard agenda items (statutory items).	Statutory Items and standing terms detailed in the Forward Plan detailed in the Terms of Reference and include all HWBB Priorities and Statutory requirements. (Point 23 in Terms oof Reference)
4629	Medium Priority	The Board Terms of Reference did not clearly define the methodology for assessing quoracy and the arrangements to be applied if quoracy is not met.	Quoracy is Terms of Reference is fully defined. (Point 13 in Terms of Reference)
4631	Low Priority	Meeting arrangements, relating to the publishing of agendas and the circulation of draft minutes, were not being operated in accordance with the terms of reference.	Clarified in the Terms of Reference (Point 25)

4632	Low Priority	The arrangements for supporting and maintaining strong working relationships with four defined partnership bodies were out of date and not operating in full in respect of the Staffordshire and Stoke on Trent Local Enterprise Partnership.	The Board may want to consider whether it seeks a relationship with the LEP and OPCC (Point 30)

4. The revised Terms of Reference attached to this report reflect and cover all the points raised.

5. A copy of the full report can be made available to any member of the Board.

Key Changes to the Terms of Reference

6. Streamlining and updating of the Purpose & Functions. (2&3)

7. The principles have been changed to reflect the principles in the 2022 guidance (4).

8. Membership has been updated to remove reference to CCGs and to reflect changes to Elected member representation. NHSE added to the membership of the Board (5).

9. Substitute arrangements expanded to include reference to a register of substitute members (6)

10. Removal of the Board member Job Description (see previous Terms of Reference (Terms of reference - Staffordshire County Council)

11. Quoracy details have been updated and made clearer (11)

12. All reference to formal subgroups of the Board have been removed, and replaced with groups that may report to the Board (13). The Terms of Reference do allow the Board to create subgroups if required.

13. Removal of reference to a "Committee in Common", with Stoke City Health & Wellbeing Board, has been replaced with a statement about enabling greater alignment with the priorities of Stoke (14).

14. Reference to lead officers managing agenda items rather than subgroups (20)

15. The standard forward plan and agenda items have been included. (21).

16. Reference to maintaining strong working relationship with the STP, LEP and Safeguarding Boards have been removed.

Discussion Points & Actions

17. The Terms of Reference have been updated to reflect the November 2022 Guidance, especially Purpose, Function and Principles do we;

    a. want to add to them?
    b. think that the Board is set up to achieve the purpose and function.

18. Leadership for place is mentioned in the Guidance and the Case Studies from other areas. Does the Board want to see a greater emphasis on Place in the Terms of Reference and subsequent action of the Board?

19. We have never formalised a system of sub-groups, this was picked up as part of the audit. The Terms of Reference have been updated to explicitly state that groups reporting to the HWBB are not sub-groups. Does the Board support this approach?

20. Is the Board happy with the membership arrangements & are there other organisations that should be invited?

21. Is the Board happy to "consider" alignment with the Stoke HWBB priorities?

22. We need to tighten membership arrangements, all Board Members are requested to update details about membership and substitute arrangements.

23. Is the Board happy with:

    a. Quoracy?
    b. Attendance and Register?

24. Do we continue support the Forward Plan as a basis for future agendas?

List of Background Documents/Appendices:

Appendix 1: Revised Terms of Reference

Contact Details

Board Sponsor: Dr Richard Harling MBE, Director for Health and Care

Report Author: Jon Topham, Senior Commissioning Manager
Telephone No: 07794 997621 / 01785 854628
Email Address: jonathan.topham@staffordshire.gov.uk

Staffordshire Health and Wellbeing Board Terms of Reference

1. These Terms of Reference take account of the latest guidance, published in November 2022[i].

2. The Purpose of the Staffordshire Health and Wellbeing Board, as described in the latest guidance, is to provide a forum where political, clinical, professional and community leaders from across the health and care system come together to:

   a. lead improvement of health and well-being and
   b. reduce health inequalities.

3. The statutory Functions of Staffordshire Health and Wellbeing Board are described in section 195 and 196 of the Health and Social Care Act 2012[ii]. These emphasise a "Duty to encourage integrated working".

4. The Staffordshire Health and Wellbeing Board, has some practical functions, which it must continue to discharge, these are:

   - assessing the health and wellbeing needs of the Staffordshire population, and publishing a joint strategic needs assessment (JSNA)
   - publishing a joint local health and wellbeing strategy (JLHWS), which sets out the priorities for improving the health and wellbeing in Staffordshire and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA
   - The JLHWS should directly inform the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006) in the place and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans
   - Develop a Pharmaceutical Needs Assessment which is separate to, but can be annexed to, the JSNA.

5. There are also several updated expectations with respect to NHS partners. These are as follows:

   - The Integrated Care Board (ICB) and partner NHS Trusts and NHS Foundation Trusts must outline the steps they will take to support the implementation of the Health and Wellbeing Strategy
   - The Health and Wellbeing Board must be involved in the development and subsequent refresh of the ICB Joint Forward Plans (JFP).
   - The Health and Wellbeing Board must ensure that the JFP takes proper account of the Health and Wellbeing Strategy.

- The Health and Wellbeing Board must provide a statement to the ICB to confirm that the Health and Wellbeing Strategy has been properly taken account of within the JFP.
- The ICB Annual Report must review steps taken to implement the Health and Wellbeing Strategy.
- The ICB must consult the Health and Wellbeing Board as it prepares the annual report.
- As part of an annual performance assessment of ICBs, NHS England must consult relevant Health and Wellbeing Boards to receive views on how the ICB has contributed to the delivery of the Health and Wellbeing Strategy.
- Health and Wellbeing Boards are expected to work with the Integrated Care Partnership and Integrated Care Board "to determine the integrated approach that will best deliver holistic care and prevention activities, including action on wider determinants in their communities."
- A Care Quality Commission (CQC) review of Integrated Care Systems (NHS Care, Public Health and Adult Social Care) will include an assessment of how the system functions as a whole.
- ICBs and their partner NHS trusts and NHS foundation trusts are required to share their joint capital resource use plan and any revisions with each relevant HWB.

6. The Key Principles that are expected of the Health and Wellbeing Board and partners are:

   a. Building from the bottom up & being informed by people in our local communities.
   b. Decision making that is made as close as possible to local communities (subsidiarity).
   c. Having clear governance, with clarity on which statutory duties are being discharged.
   d. Ensuring that leadership is collaborative.
   e. Avoiding duplication of existing governance mechanisms
   f. A focus on population health and health inequalities

Membership

7. The following are constituent organisations and members of the Board.

Staffordshire County Council (x4)

- Cabinet Member for Children & Young People
- Cabinet Member for Health & Care
- Director of Health and Care (statutory member – DASS / DPH)
- Director of Children's Services (statutory member)

Integrated Care Board (statutory member) (x2)
- Chair or Non-Executive
- Chief Executive or Director

Healthwatch (statutory member) (x1)
- Lead Officer

Voluntary Sector representatives (x2)
- Chief Executive of SCYVS
- Chief Executive of Support Staffordshire

District and Borough Council representatives (x3)
- Elected Member x2
- Chief Executive x1

Police representative (x1)
- Chief Constable or nominee

Fire representative (x1)
- Chief Fire Officer or nominee

NHS England
- To be confirmed

8. Members will be asked to nominate one substitute who is able to attend meetings in the event they are not available. A register of substitute members will be provided on the Health and Wellbeing Board website.

9. The Board is a Committee of Staffordshire County Council and is to be treated as if it were a committee appointed by that authority under Section 102 of the Local Government Act 1972.

10. Decisions will be made by consensus. The Board does not have the power to direct any of the statutory organisations. However, where the Board has agreed a course of action is will expect the statutory agencies to ensure that this is enacted.

11. Board members will come to meetings with the authority to take decisions on behalf of their organisations or will secure this where necessary through their own governing bodies.

12. Board members are expected to feedback the deliberations and decisions of the Board to their respective organisations.

13. The **quorum** for a meeting shall be a quarter of the membership rounded up to a whole number (e.g. if the Board has 18 members, quoracy will be 18/4 rounded up = 5). To be quorate, Board Members must attend in

person. The Board must have at least one elected member from Staffordshire County Council and one member from the NHS.

14. Board Members are expected to have a minimum 50% attendance and a summary of attendance will be published prior to each December meeting.

15. **Reporting Structure:** The following groups may report to the Board but are not subgroups of the Health and Wellbeing Board:

    Families Strategic Partnership
    - Health in Early Life
    - Childrens Safeguarding

    Health & Care Social Care
    - Better Care Fund
    - Adult Safeguarding
    - Mental Health
    - Better Health Staffordshire steering group
    - Healthy Ageing
    - JSNA

    ICB
    - Health Inequalities Group
    - ICB Prevention Group

16. The Board will consider an approach to enabling greater alignment with the priorities of Stoke-on-Trent Health and Wellbeing Board.

17. Formal subgroups may be formed and at the discretion of the Board.

18. **Administrative support** will be provided by the County Council.

19. Constituent organisations are responsible for meeting the expenses of their own members.

Meeting Arrangements

20. Meetings will be held in public except where there are items that need to be considered in public due to protect the confidentiality of individuals or commercial confidences.

21. Meetings will be held at a frequency and intervals to be determined by the Board and there will be at least 4 meetings a year, currently held quarterly as follows:

    - March

- June
- September
- December

22. The expectation is that items will be managed by respective lead officers.

23. The Board Forward Plan will provide the outline for each Agenda, as follows:

Meeting	Agenda Items	Other items
Standard Agenda Items	• Welcome to the meeting • Apologies • Declarations of Interest • Questions from the Public • Matters Arising • Action Tracker	
March	• Healthy Ageing & Frailty Progress Update • Staffordshire Better Care Fund • Public Engagement - Healthwatch • ICB JRF / Annual Report	• Pharmaceutical Needs Assessment (every 3 years) • ICB Joint Capital Resource Use Plan • Director for Public Health Report • Ad-hoc strategies e.g. Mental Health • Specific items raised by Partners • Partnership Protocol
June	• Healthy Weight Priority Progress Update • Joint Strategic Needs Assessment Review • Staffordshire Better Care Fund • Children's Safeguarding • ICB JRF / Annual Report Sign Off	
September	• Health in Early Life Priority Progress Update • Public Engagement - Healthwatch • Staffordshire Better Care Fund • JLHWS General Review	
December	• Good Mental Health Priority Progress Update • Adult Safeguarding Board Annual Report • Staffordshire Better Care Fund • Joint Strategic Needs Assessment Update • ICB JRF / Annual Report Process	

24. The forward plan for the next meeting, will be reviewed at each meeting to ensure it remains appropriate.

25. Agendas for each Board meeting will be published at least 5 clear working days in advance of a meeting. Draft minutes will be circulated to the Chairs for comment at the preview meeting for the subsequent Board meeting. Final minutes and actions will be published after they have been ratified by the Board.

26. Any report due for the Health and Wellbeing Board will be discussed at an Officers' Briefing Meeting and subsequently a draft version presented to a Chairs' Preview Meeting, approximately two weeks before they are published. Reports are therefore expected to be received in line with

these meetings and a final version submitted to the County Council's Member and Democratic Services Team no later than 7 working days in advance of the Board meeting.

Code of Conduct

27. Members of the Board and their substitutes are required to abide by a Code of Conduct based on the 7 Nolan Principles of Public Life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership).

28. Board members must complete a register of interests (Disclosable Pecuniary Interests - DPIs). DPIs cover matters such as sponsorship, contracts tenancies and securities. This will be reviewed annually.

29. Where a Board member feels they have a DPI in relation to a decision being taken by the Board then they are required to declare this at the start of the meeting and the Chair will take a view on whether it is appropriate for them to speak or vote on the matter.

Review

30. These terms of reference will be reviewed annually.

[i] Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)
[ii] Health and Social Care Act 2012 (legislation.gov.uk)

Staffordshire Health and Wellbeing Board – 07 December 2023

ICB Joint Forward Plan

Recommendations

The Board is asked to:

a. Note that the JFP was published on the 30th June 2023 following on from the draft JFP being presented at the Staffordshire Health and Wellbeing Board on the 8th June 2023.

b. To formally approve the decision, to delegate to the Chair the sign off, of the JFP for the Health and Wellbeing Board.

c. Receive the final Joint Forward Plan published on 30th June 2023.

d. Note that the JFP will require refreshing in line with any new guidance and feedback from ongoing engagement work.

e. Endorse the approach for the refresh.

f. Agree to the refresh JFP being presented to the H&WB on the 7th March 2024.

Background

1. All Integrated Care Systems (ICS) were expected to produce three key outputs in 2023:

   a. Integrated Care Partnership Strategy
   b. Operational Plan for 2023/24
   c. Joint Forward Plan for 2023/24-2028/29

Joint Forward Plan – National Guidance and Local Principles

2. The JFP is a five-year plan, set within a statutory framework. In line with the Health and Care Act 2022, the Integrated Care Board (ICB) must develop a JFP which sets out the vision for the next 5 years.

3. It will be updated on an annual basis in collaboration with local Health and Wellbeing Boards (HWB).

4. It should not duplicate supporting strategic plans but refer to them where relevant.

5. It should be a delivery mechanism for the initial Integrated Care Partnership Strategy and national priorities as defined by NHS planning guidance.

6. Be co-ordinated through the ICB and co-produced with partners, providers, stakeholders and the systems delivery and enabling portfolios.

Overview of Content

7. The JFP outlines how the ICB will support the delivery of the ambitions articulated in the ICP Strategy. The document structure aims to reflect:

   a. Introduction, outlining who we are and our vision and aims.
   b. Why we need a Joint Forward Plan, outlining some of the key challenges we face.
   c. How will we work differently to achieve our priorities, outlining our operating model, leadership and governance frameworks.
   d. Our Portfolios and Priorities. This section outlines commitments, ambitions and priorities against aligned to the ICB 7 Portfolios and 8 key focus areas covering:
      i. Improving Population Health
      ii. Planned care
      iii. Children & Young People and Maternity
      iv. Urgent and Emergency Care
      v. End of Life, Long-Term Conditions and Frailty
      vi. Primary Care
      vii. Mental Health, Learning Disabilities and Autism
   e. Our Finance strategy and the challenges across the Health and Care Sector.
   f. Our enablers to success, which covers a wider range of functions that are integral to the delivery of our priorities eg our workforce, digital and estates.
   g. Ways of working / cross cutting themes, covering areas such as the Greener Plan, Personalised Care, Continuing Healthcare and our approach to Working in Partnership with People and Communities.
   h. Wider Strategic System Development, focusing particularly on the ongoing development of the ICB.

JFP Refresh

8. All systems are required to undertake an annual refresh of the JFP. This is intended to include any new guidance and the outputs of public and stakeholder feedback, such as the JFP survey which concluded in August 2023.

9. The refresh should be developed with Health and Wellbeing Boards.

Next Steps

10. Opportunity for feedback from the HWB about the current JFP.

11. System task and finish groups re-established and meeting fortnightly.

12. Work across portfolios to refresh the JFP.

13. National guidance expected shortly.

14. Refresh JFP to be presented to Health and Wellbeing Board on the 7th March 2024.

List of Background Documents:

Guidance on Developing the Joint Forward Plan, published 23.12.22.
https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

Full copy of the Staffordshire and Stoke-on-Trent Joint Forward Plan published 30.06.23.
https://staffsstoke.icb.nhs.uk/staffordshire-and-stoke-on-trent-joint-forward-plan-2023-2028/#:~:text=Staffordshire%20and%20Stoke%2Don%2DTrent%20ICS%20are%20pleased%20to%20publish,over%20the%20next%20five%20years.

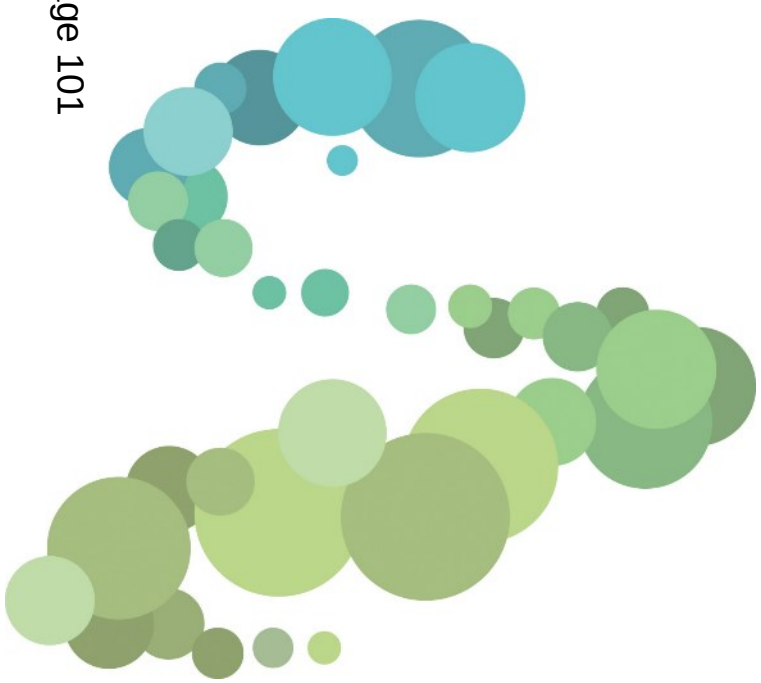
Summary of the Staffordshire and Stoke-on-Trent Joint Forward Plan.
https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/plans-and-strategies/acge-13613-ssot-ics-jfp-summary-v3-ac/?layout=default

Contact Details

Report Author: Debbie Danher, Senior Planning and Assurance Manager
Email Address: Debbie.danher@staffsstoke.icb.nhs.uk

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Joint Forward Plan 2023-2028



Chris Bird
Chief Transformation Officer
Staffordshire and Stoke-on-Trent ICB
07.12.23

Background

- All systems were expected to develop and publish a Joint Forward Plan. This was in addition to the annual publication of the Operational Plan.
- The draft JFP was presented to the H&W Board on the 8th June 2023 for feedback and agreement for statement of opinion being included.
- JFP was published on the 30th June 2023.
- Annual refresh of the JFP is a requirement for all systems with Health and Wellbeing Boards.

The guidance

National expectations and policy

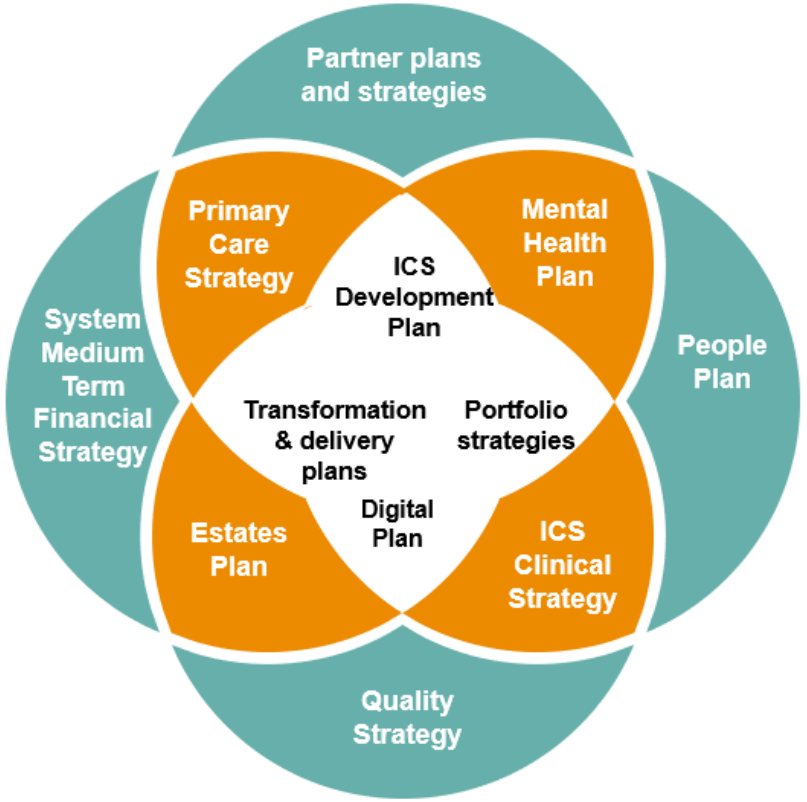
ICP Strategy
- *How the assessed health, care and wellbeing needs of the local population are to be met by the ICB, LAs and System Partners.*

Joint Forward Plan (5 years)
- *How the ICB will contribute to meeting the health needs of its local population.*
- *Reflect local priorities and address the four core purposes of ICSs*

One year Operational Plan
- *Set out the details of our plans for the year covering key areas of delivery, activity, workforce and finance.*
- *A technical set of templates relating to activity, workforce and finance.*

Supports and supported by a set of enabling delivery plans and strategies

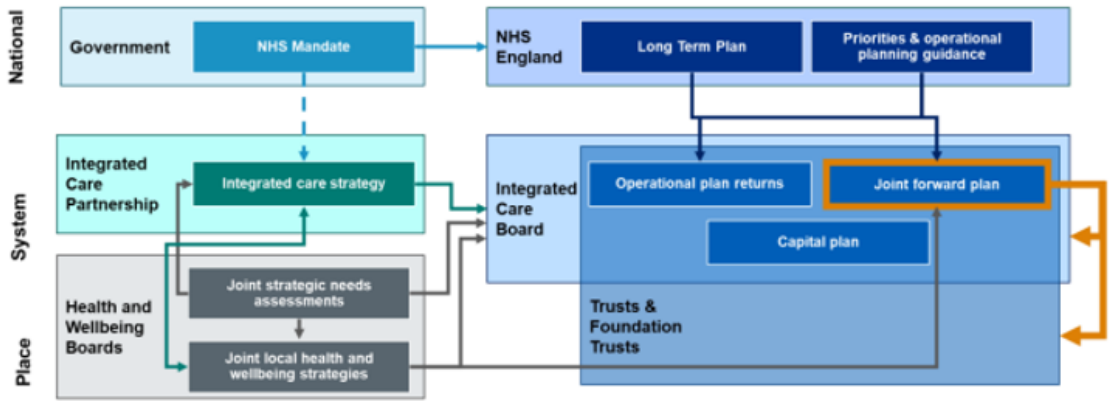
Local system plans and strategies



STAFFORDSHIRE HEALTH AND WELLBEING BOARD

What is a JFP?

- The JFP is a five year plan, set within a statutory framework.
- It will be updated on an annual basis in collaboration with the Integrated Care Partnership and local Health and Wellbeing Boards (HWBs).
- The JFP is a five-year plan covering 2023 to 2028.
- It outlines how the ICB will support the delivery of the ambitions articulated in the Integrated Care Partnership Strategy (as presented initially to the HWB in March 2023))



- It has a focus around
  - Joint priorities across the Integrated Care System (ICS)
  - Ongoing National Long Term Plan commitments as set out in 2019
  - Feedback from our population
  - The need to restore access to services to at least pre-Covid levels
  - Our locally determined actions to address system priorities
  - Other national guidance and frameworks
  - How the ICB is exercising its key functions and discharging its statutory duties in an effective way.

Stoke-on-Trent City Council Health & Well Being strategy priorities

- Getting the most healthy start in life
- Developing well into adulthood
- Promoting good physical health
- Promoting good mental health
- Supporting people to maintain independence
- Living well into old age
- Providing the best end of life care
- Building strong communities
- Living in a healthy home and environment
- Supporting sustainable employment, skills and local economy

Staffordshire County Council Health & Well Being strategy priorities

- Health in early life - Improving health in pregnancy and infancy with a priority focus on reducing infant mortality.
- Good mental health - Building strong and resilient communities and individuals who are in control of their own mental wellbeing
- Healthy weight - creating the conditions to help people to make healthy choices that will help adults and children reach a healthy weight.
- Healthy ageing - promoting well-being and enabling independence for older people.

Integrated Care Partnership Strategy priorities

- Give infants and children the best start to life
- Enable children to thrive into adulthood, supporting physical, mental and social development
- Enable adults to take ownership of health and wellbeing and achieve their potential
- Enable people to remain independent, active and connected in their communities with a plan for later life
- Maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed

Existing shared priorities across the Integrated Care Partnership

Improving health in pregnancy and infancy • Mental health • Learning disability and autism • Reducing drug and alcohol harm • Addressing obesity across the life course • Prevention and early intervention – long-term conditions (LTCs) and cancer • Improved prevention and management of LTCs • Reducing health inequalities • Healthy ageing • Personalised care • Improved employment • Digital transformation.

8 ICS PRIORITIES

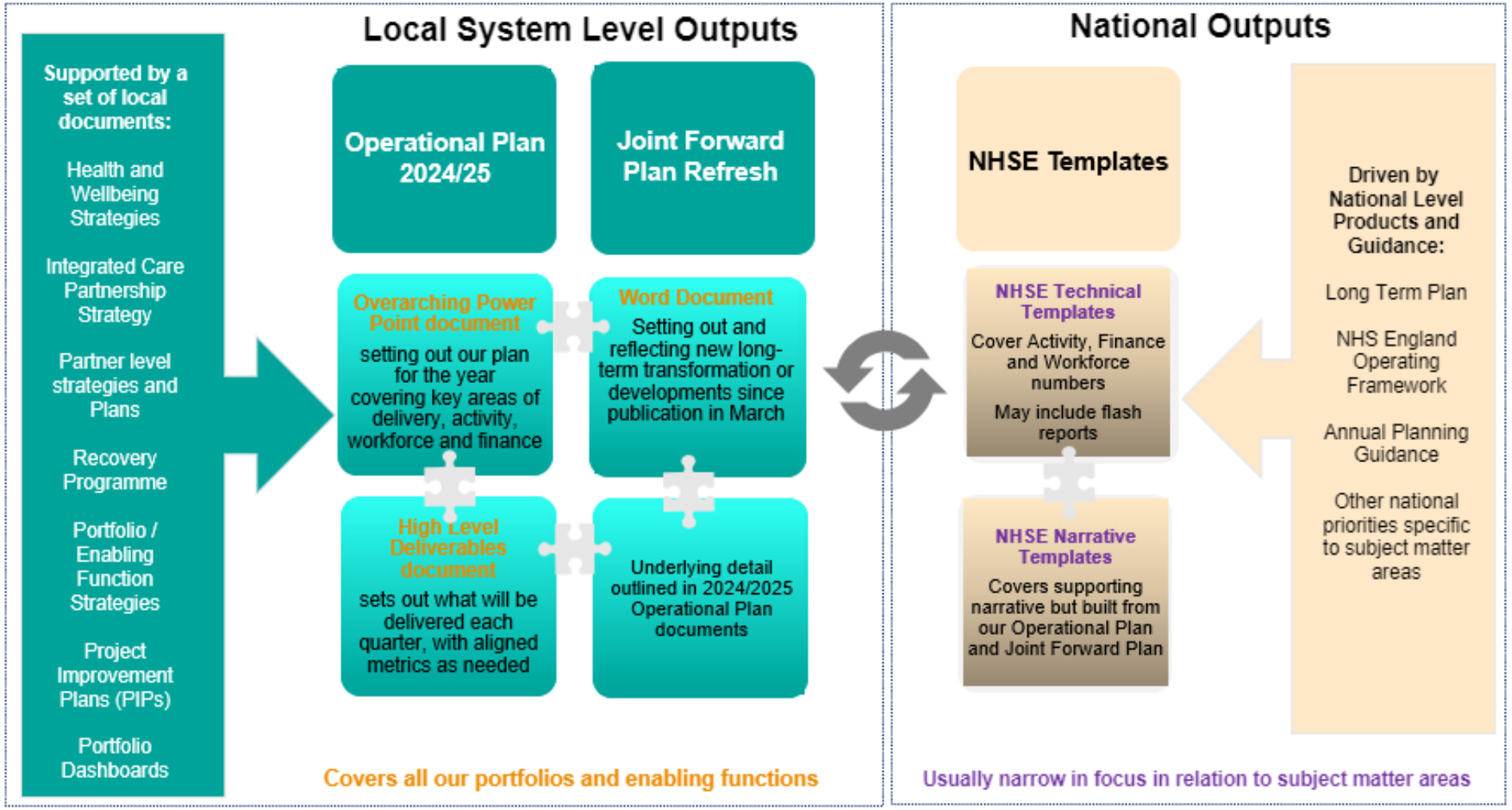
1. Improving outcomes in population health and health inequality
2. Improving delivery of Elective Care services
3. Improving Cancer services and outcomes in Cancer care
4. Delivering improvements in CYP services and maternity care
5. Improving UEC and delivering more care at home
6. Promoting healthy ageing and managing frailty
7. Delivering more services through Primary Care to support system transformation
8. Growing and improving mental health and learning disability & autism services

How we will work together; Our wider enablers, cross cutting themes and strategic development

Provider Plans and Strategies

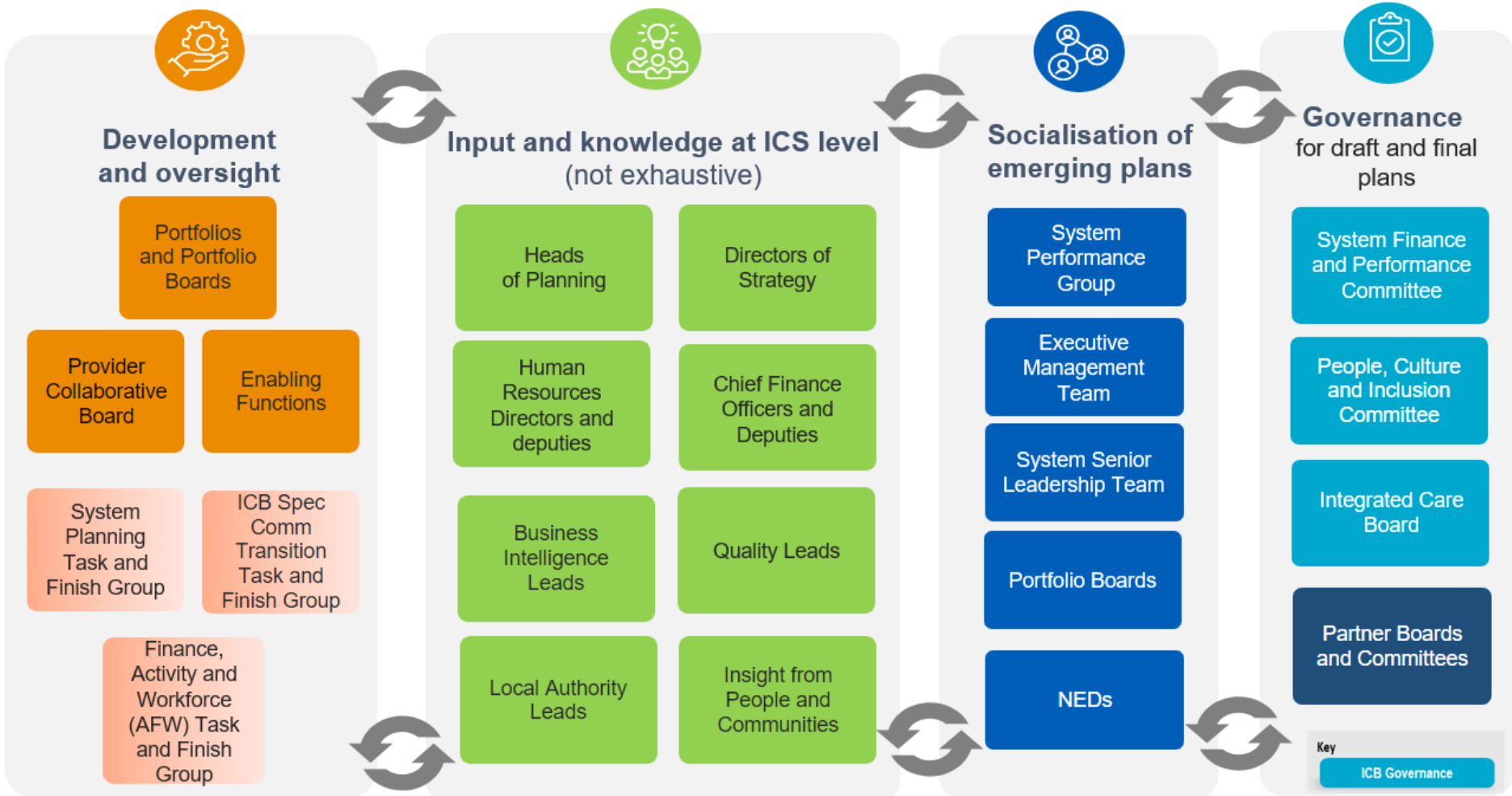
STAFFORDSHIRE HEALTH AND WELLBEING BOARD

Approach to the refresh



STAFFORDSHIRE HEALTH AND WELLBEING BOARD

Approach to refresh



Health and Wellbeing Boards

JFP Suggested areas for refresh

- Reflecting any changes to local authority priorities.
- Reflecting any changes to provider priorities and plans.
- Add Ongoing Recovery and over 75 population piece.
- How we have used ongoing engagement to refresh the plan.
- Long term Finance strategy and recovery.
- Legacy Long Term Plan elements not covered in current version e.g. Stroke.
- Portfolios to reflect any new areas of focus i.e. Single Delivery Plan for Maternity and Neonates.
- Enablers to reflect any new areas of focus i.e. national people plan.
- Cross-cutting themes to reflect any new areas of focus.
- Impact of ICS wide strategies published since June.
- Wider strategic system development to reflect any new areas of focus (Neighbourhood and place development)
- Clinical and Professional Leadership focus.
- Specialised commissioning delegation ongoing and specialised commissioning priorities/planning

Have we missed anything?

Next Steps

- First System Task and Finish Group – 23rd November 2023
- Work has commenced across portfolios to support refresh
- Guidance expected shortly
- Updates and refresh of JFP requested to be presented to the Staffordshire Health and Wellbeing Board on the 7 March 2024

STAFFORDSHIRE POLICE

Right Care Right Person

Right Care Right Person (RCRP) Staffordshire Approach

Lisa Cope RCRP Business Lead Staffordshire Police

STAFFORDSHIRE POLICE

Right Care Right Person

The overarching principle of the RCRP model is to ensure we can better protect vulnerable members of our communities and provide them with the specialist help they need.

- Phase 1 of RCRP in Staffordshire will be launched in Feb 24 and will focus on reports relating to concerns for welfare and walk-outs of health care facilities
- Phase 2 of RCRP will launch in May 24 and will focus on AWOL and walk out of MH facilities.
- Phase 3 will launch in August 24 and will focus on transportation.
- Phase 4 will launch in November 24 and will focus on S.136/management of mental health incidents.

The Police will continue to respond to all incidents where there is an immediate, real and substantial threat to life or risk of significant and serious harm. All incidents will be reviewed on a case by case basis to assess risk, threat and harm and determine if it is right for the RCRP principles to be applied.

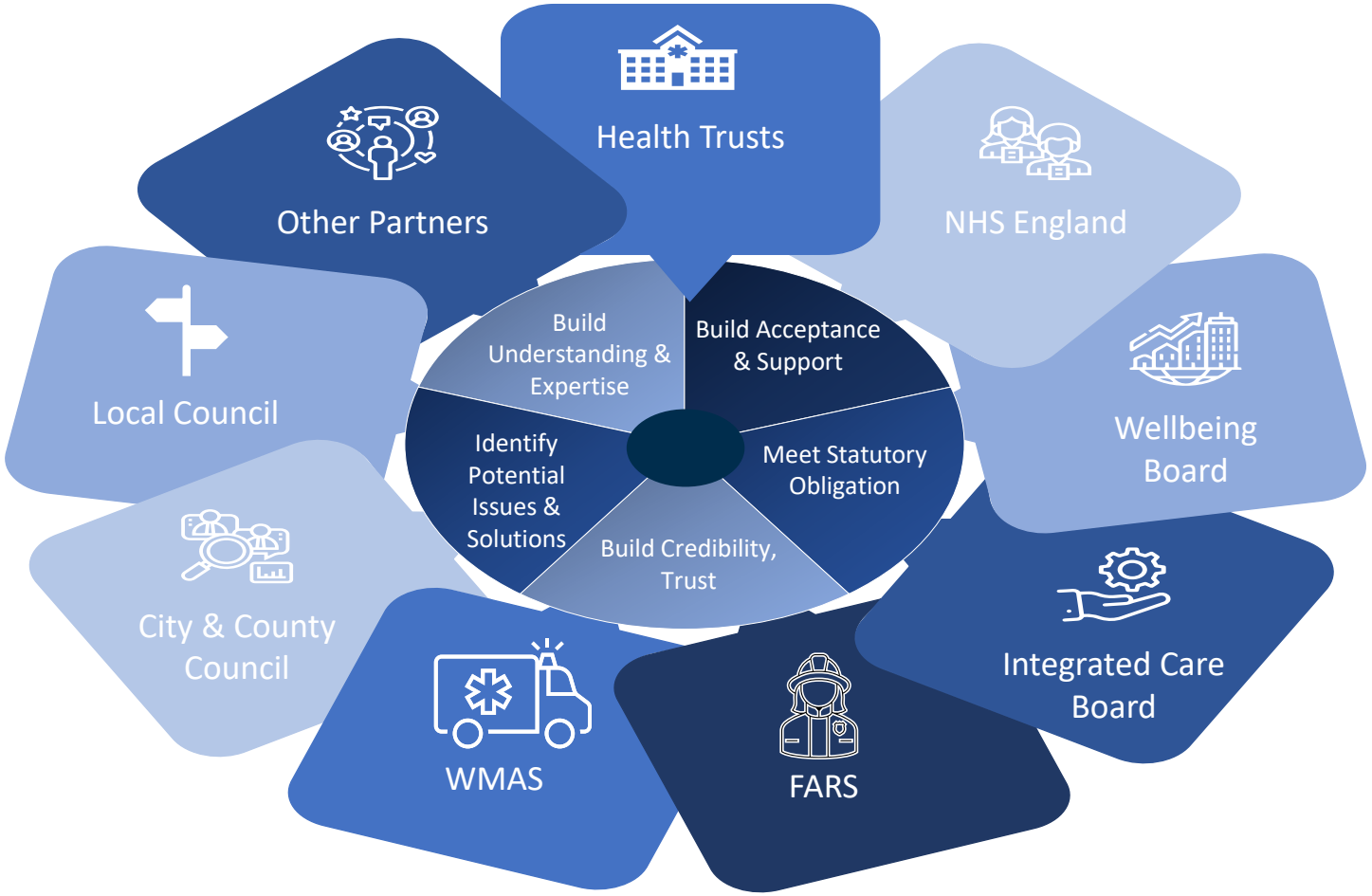
Home Office | Department of Health & Social Care | NPCC | NHS England | Association of Police and Crime Commissioners | College of Policing

- SP launched the implementation of RCRP in July 23 through a number of multi-stakeholder engagement events, noting that implementation will be phased and in partnership with system colleagues. These events were well attended by Local Authority, health and social care partners from across the ICF as well as third sector organisations.
- SP have and will continue to attend numerous partnership meetings across the ICF to update on RCRP including, the MHLDA portfolio day on the 6th October where community MH transformation and portfolio strategic plans were discussed.
- SP have established a multi-agency partnership group with representatives from across local authorities, health, social care, VCSE etc. to work through the implications of the implementation and share learning.
- SP have also established a single point of contact for stakeholders to communicate issues or concerns regarding RCRP.
- The tactical group is multi-agency, meeting monthly and enables communication between partner agencies to better inform policies, procedures and practices at a tactical and operational level. The group will also undertake proportionate 'lessons learnt' exercises to review and improve the quality of service and address cases or concerns that system partners have experienced. This learning will then be fed back into the force control room and into other partner agencies as required.
- The SP SRO has oversight of the work of the tactical group and will focus on ensuring that all partners have a robust and effective understanding of RCRP, its potential impact and aiding in informing the planning process of the further role out.

STAFFORDSHIRE POLICE

RCRP Partnership landscape

Right Care Right Person



STAFFORDSHIRE POLICE

Key Actions for Mental Health

Right Care Right Person

The National Partnership Agreement, published in July 2023, sets out the following actions for RCRP and Mental Health:

1. Agreeing a joint multi-agency governance structure for developing, implementing, and monitoring the RCRP approach locally. People with lived experience of the urgent mental health pathway, including those from ethnic minorities, should form part of the governance structure and be actively engaged in considering how RCRP is implemented. In addition, from a health system perspective, Integrated Care Boards will play a key role in coordinating the approach to supporting the implementation of RCRP.

2. Reaching a shared understanding of the aims of implementing RCRP locally and the roles and responsibilities of each agency in responding to people with mental health needs. Given that 'mental health needs' covers people with a broad spectrum of needs, this should include agreeing what is the remit of health services (primary care and secondary mental health services), local authority services (including social care and substance misuse services), and voluntary, community and social enterprise organisations.

3. Enabling universal access to 24/7 advice, assessment, and treatment from mental health professionals for the public (via the NHS111 mental health option), as well as access to advice for multi-agency professionals, including the police, which can help to determine the appropriate response for people with mental health needs. Plans should be put in place to communicate the availability of this advice to the public and other organisations/professionals locally, who may otherwise call the police as their first point of contact.

4. Putting in place arrangements to work towards ending police involvement in the following situations, where the RCRP threshold is not met:
   - initial response to people experiencing mental health crisis.
   - responding to concerns for welfare of people with mental health needs (i.e., undertaking welfare checks), where the person is already in contact with a mental health service or other service commissioned to provide mental health support.
   - instances of missing persons from mental health facilities, and walkouts of people with mental health needs from other health facilities (e.g., the Emergency Department).
   - conveyance in police vehicles.

… continued

5. Embedding multi-agency ways of working that can support decision-making about which service or services are most appropriate to respond to an incident reported to the emergency services (e.g., whether it is police, ambulance, or mental health services, or a joint agency response). For example, health-led, integrated multi-agency triage of 999 calls that enables shared decision-making has been shown to be effective in reducing avoidable police deployment, use of section 136 MHA and police conveyance.

6. Ensuring arrangements are in place to minimise delays to handovers of care between the police and mental health services. Currently, there can be significant delays in accessing appropriate mental health expertise and facilities, particularly at evenings and weekends, and when someone is detained under section 135 or 136 of the MHA. These delays are detrimental to the person with urgent mental health needs and the family or friends supporting them and impacts on police capacity to fulfil wider duties. Systems should look to reduce these delays as far as is safe to do so, working towards a timeframe of one hour as specified in local plans (unless mutually agreed in relation to a particular incident on a case-by-case basis).

7. Developing an approach for police and health systems to work together to quickly and efficiently identify the best place to take a person detained under section 136 of the MHA, to reduce time spent on conveyance.

… continued

8. Developing local escalation protocols for situations including: significant system delays that result in people being inappropriately under the care of the police when they should be accessing mental health support; detentions in custody (all areas should be ending the practice of detaining people with mental health needs in police cells); and reoccurring situations where health partners feel the RCRP threshold is met but a police response is not provided. Protocols should include information on how to escalate urgent issues that cannot be resolved locally and processes for identifying reoccurring issues that indicate a system change is required.

9. Establishing effective mechanisms to support data collection and sharing across agencies, to inform the development and implementation of RCRP, including any changes required to ways of working and wider-system resourcing. The data should enable an understanding of local urgent and emergency mental health need, current levels of police involvement in mental health related pathways, and the impact of the changes introduced under RCRP, both operationally and in terms of the experiences and outcomes of people requiring urgent mental health support. This includes monitoring the impact for people from ethnic minorities, and other groups with specific needs, such as children and young people, and autistic people, and taking action where inequitable impact is identified.

10. Developing multi-agency training to support decision making and understanding of roles and responsibilities in relation to RCRP, as well as the Mental Health Act.

Next Steps
Staffordshire Temperature Check Responsibilities Matrix

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Right Care Right Person

It is important that we understand, from local authorities, health and social care partners, the current likelihood of being able to meet the 10 recommendations so this can be discussed in partnership ahead of, and throughout the phased approach of the initiative going live.

To help the system understand the current position of health and social care partners against the 10 recommendations we will requesting a temperature check exercise is undertaken asking organisations to rate themselves using a Red, Amber, Green (RAG) assessment - Red meaning: Actions routinely not in place, Amber meaning: Actions in place some but not all of the time and Green meaning: Action in place.

Colleagues will be asked to provide commentary, where possible, to support their rating.
The temperature check will be shared with colleagues in each place, acute provider, mental health provider, primary care and local authority to ensure a rounded view of readiness is obtained.

Why a Responsibility Matrix

- Improve understanding across Integrated Care Systems of RCRP
- Improve understanding of potential impact of changes to policing
- Identifies – what's happening now, what will change, is there a gap?
- Escalation to Executive Officers across partnerships – solutions
- Transparency of roles and responsibilities v 4 phases of RCRP
- Enables difficult conversations using a tool as a guide
- Identification of service gaps/changes required to existing services
- Identification of risks and mitigation

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Lessons learnt so far

Right Care Right Person

Getting the right representation at RCRP meetings - Ensuring all organisations are represented at the right level at the Partnership Tactical Meetings is critical for positively moving forwards.

Making use of the briefing documentation provided – Make sure to use agreed briefing documentation to ensure consistent messaging/understanding from the top to the front line.

Have a single point of contact for RCRP – SP have established an RCRP email address to manage communications/concerns/queries, this provides consistency.

Get the messaging right - Reassure people that RCRP is not the Police withdrawing from protecting vulnerable people. It is a national programme supported by the College of Policing Home Office, NPCC and Policing Minister and the Department of Health and Social Care (DHSC).

Create a feedback loop – Collect information and then share the learning from this.

Foster a learning and sharing culture – The SP Tactical Group is established to share specific examples where partners may feel the wrong decision has been made, for these to be reviewed and learning shared - this initiative is a learning process and we want to get it right.

Invest in mental health services and lobby for further funding – Ensure the system focusses on delivery of the NHS Long Term Plan ambitions and meets the Mental Health Investment Standard, plus additional growth, and lobby jointly with partners (i.e. SP) for additional investment.

STAFFORDSHIRE POLICE

Key Contacts

Right Care Right Person

Staffordshire Police

Executive Lead/SRO

ACC Stuart Ellison

stuart.ellison@staffordshire.police.uk

Strategic Leads

Chief Superintendent Paul Talbot
paul.talbot@staffordshire.police.uk

Mrs Lisa Cope
lisa.cope@staffordshire.police.uk

Project Manager
Mrs Danielle Hassall
danielle.hassall@staffordshire.police.uk

RCRP email- rcrp@Staffordshire.police.uk

STAFFORDSHIRE HEALTH AND WELLBEING BOARD FORWARD PLAN 2023/2024

This document sets out the Forward Plan for the Staffordshire Health and Wellbeing Board.

Health and Wellbeing Boards were established through the Health and Social Care Act 2012. They were set up to bring together key partners across the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch to lead the agenda for health and wellbeing within an area. The Board has a duty to assess the needs of the area through a Joint Strategic Needs Assessment and from that develop a clear strategy for addressing those needs – a Joint Health and Wellbeing Strategy. The Board met in shadow form before taking on its formal status from April 2013.

The Forward Plan is a working document and if an issue of importance is identified at any point throughout the year that should be discussed as a priority this item will be included.

Councillor Mark Sutton – Cabinet Member for Children and Young People, Chair
Councillor Julia Jessel – Cabinet Member for Health and Care, Vice-Chair

If you would like to know more about our work programme, please get in touch with Jon Topham on 07794 997621 or jonathan.topham@staffordshire.gov.uk

	Meeting Date:	Venue:
Board Meetings:	8 June 2023	Oak Room, County Buildings, Stafford
	7 September 2023	Oak Room, County Buildings, Stafford
	7 December 2023	Oak Room, County Buildings, Stafford
	7 March 2024	Oak Room, County Buildings, Stafford

Date of Meeting	Item Name	Report Author
8 June 2023	Healthy Weight Priority Progress Update	Tony Bullock / Natasha Moody
	ICS Joint Forward Plan (JFP)	Chris Bird
	Co-production: Healthwatch Update	Baz Tameez
	Children's Safeguarding Board Annual Report	Ian Vinall
	JSNA Review	Emma Sandbach
	Healthy Ageing Follow Up	Tilly Flanagan
7 September 2023	Health in Early Life Priority Progress Update	Karen Coker / Natasha Moody
	Right Care, Right Person	Staffordshire Police
	Better Care Fund	Rosanne Cororan
	CQC Single Assessment Framework	Amanda Stringer
	Co-production: Healthwatch Update	Baz Tameez
	JSNA Update	Emma Sandbach
	HWBB Strategy: Comparative Health Metrics and Performance Indicators Update	Louise Goodwin
7 December 2023	Good Mental Health Priority Progress Update	Karen Coker / Chris Stanley / Jan Cartman-Frost
	Staffordshire and Stoke-on-Trent Adult Safeguarding Board Annual Report	Helen Jones / John Wood
	JSNA Update	Emma Sandbach
	Audit Report and Review of the Terms of Reference	Jon Topham

Date of Meeting	Item Name	Report Author
	Right Care, Right Person	Staffordshire Police
	ICB Joint Forward Plan	Chris Bird
7 March 2024	Healthy Ageing Priority Progress Update	John Rouse / Zafar Iqbal / Tilly Flanagan
	Carers Strategy	Jackie Averill
	Staffordshire Better Care Fund	Rosanne Cororan
	Children's Safeguarding Board Annual Report	Lynne Milligan
	ICB JRF / Annual Report Sign-off	TBC