NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Via MS Teams

Thursday 19th December 2024
1.00pm – 3.00pm

[A = Approval / R = Ratification / S = Assurance / D = Discussion / I = Information]

	Agenda Item	Lead(s)	Enc	A/R/ S/D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	1.00pm	
2.	Leadership Compact	Chair	Enc 01	A		3
3.	Conflicts of Interest	Chair	Enc 02	---		4-5
4.	Minutes of meeting held on 21st November 2024	Chair	Enc 03	A		6-20
5.	Action Log - progress update on actions	Chair	Enc 04	D		21
6.	Questions submitted by members of the public in advance of the meting	Chair	---	D	1.05pm	
Strategic and System Development						
7.	ICB Chair and Chief Executive Update	DP/PA	Enc 05	I	1.15pm	22-30
8.	Specialised Commissioning Delegation	ED	Enc 06	S	1.25pm	31-37
9.	Medium Term Plan	PB/ED	Enc 07	R/S	1.40pm	38-59
System Governance and Performance						
10.	Quality and Safety Report	HJ	Enc 08	S	1.55pm	60-63
11.	Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report	PEJ	Enc 09	I/S	2.05pm	64-66
12.	ICS Finance and Performance Report	PB/PS	Enc 10	I/S	2.10pm	67-91
	Finance and Performance Committee AAA Chairs Report	MN	Enc 11	I/S	2.20pm	92-98
13.	People, Culture and Inclusion Committee AAA Report – Part 1&2 November	SL/MI	Enc 12	I/S	2.25pm	99-102
	People, Culture and Inclusion Committee AAA Report – Part 1&2 December	SL/MI	Enc 13	I/S	2.30pm	103-105
	People, Culture and Inclusion Committee AAA Report – Part B December	SL/MI	Enc 14	I/S	2.35pm	106-107
14.	Staffordshire and Stoke on Trent ICB Remuneration Committee Summary and Escalation Report	SL	Enc 15	I/S	2.40pm	108

Any Other Business						
15.	Items notified in advance to the Chair	All	---	D	2.45pm	
16.	Questions from the floor relating to the discussions at the meeting	Chair	---		2.50pm	
17.	Meeting Effectiveness	Chair	---			
18.	Close	Chair	---		3.00pm	
19.	**Date and Time of Next Meeting** 16th January 2015 at 12.30pm held in Public, via MS Teams					

ICS Partnership leadership compact

Trust

- We will be **dependable**: we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency**, working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be **open to changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness and honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respect

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to understand others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness and compassion

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion**.

System first

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire and Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking forward

- We will **focus on what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution**.

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2024-2025
INTEGRATED CARE BOARD (ICB)
AS AT 10 DECEMBER 2024

Key

Declaration completed for financial year 2024/2025

Declaration for financial year 2024/2025 to be submitted

Note: **Key relates to date of declaration**

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
20th September 2024	Dr	Buki	Adeyemo	Chief Executive Officer	North Staffordshire Combined Healthcare Trust (NSCHT)	Nothing to declare	1. Board of Governors University of Wolverhampton (ongoing) 2. Mental Health Network, NHS Confederation, NHS CEO Representative (ongoing)	Nothing to declare	Nothing to declare	(h) interest recorded on the Conflicts Register
15th July 2024	Mr	Nadeem Tony	Ahmed	ICB Participatory (non-voting) member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director of Dentaire Ltd and TT Partners Ltd, Principal dentist at Dentaire Dental Care (ongoing)	1. Chair of Local Dental network - Shropshire and Staffordshire (ongoing)	Nothing to declare	1. Brother is an ENT surgeon and head of department at QE Hospital Birmingham (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) interest recorded on the Conflicts Register.
11th July 2024	Ms	Helen	Ashley	Acting CEO	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	Nothing to declare	1. Member of Derbyshire Community Health Services FT (2014 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
25th June 2024	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u13 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
23rd July 2024	Mr	Peter	Axon	CEO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st July 2024	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014- March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018) 3. Non-executive director of The Care Kingdoms, an investment consortium with the aim to build a company initially focussing on the Home Care market. The company does not currently have any trading activities and I do not have any shares in it, but at some point I might be offered equity in the company, should it be able to attract investment and move to a trading status. (June	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
12th September 2024	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing) 4. Visiting Professor - Wagner College, New York (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
simon	Mr	Simon	Constable	Chief Executive	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	1. Visiting Professor, University of Chester (2015 - ongoing) 2. General Medical Council Responsible Officer and Designated Body is Dr Eileen Marks and Liverpool University Hospitals NHS Foundation Trust (2019 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
13th September 2024	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
8th Nobember 2024	Ms	Elizabeth	Disney	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Brother is Clinical Lead and Consultant at UHNM (1st September 2024 to date). 2. Brother's partner is owner-operator of Nature and Nurture Psychology, a child and family psychology service based in Staffordshire (November 2024 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on the conflicts register.
10th April 2024	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employed session a week (0.1 wte) by MPFT as Head of SSoT PH Alliance (as a locum public health consultant) (June 2024 - ongoing)	1. Fellow of the Faculty of Public Health (FFPH) and registered with the GMC (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
10th July 2024	Mrs	Lisa	Ellis	Executive Support Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
25th June 2024	Mrs	Julie	Houlder	Non-Executive Director Chair of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner of Elevate Coaching (October 2016 - ongoing)	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) (Non-Executive since October 2018) 2. Non-Executive George Eliot NHS Trust (May 2016 - ongoing) 3. Director Windsor Academy Trust (January 2019 - ongoing) 4. Associate Charis Consultants Ltd (January 2019 - ongoing)	1. Owner Craftykin Limited (July 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register
24th July 2024	Mr	Chris	Ibell	Chief Digital and Information Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
12th September 2024	Ms	Mish	Irvine	Chief People Officer (Interim)	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	1. Trustee (NED) of the YMCA, North Staffordshire (July 2023 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
25th April 2024	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Daughter-in-law volunteers as a Maternity Champion as part of the SSOT maternity transformation programme (2021 - ongoing) 4. Brother-in-law works for occupational health at UHNM (ongoing) 5. Step-sister employed by MPFT as Staff Nurse (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
25th July 2024	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Member of the Black Country Integrated Care Partnership through day job at Sandwell Council (ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
17th April 2024	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Renumeration Committee (September 2022 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register
8th April 2024	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Chair Land based College linked with Chester University (2018- 31st March 2024 retired)	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing)	(h) recorded on conflicts register.
11th April 2024	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. I sometimes do shifts for MPFT that I am not paid for (ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - March 2024) (Declaration to be removed from register September 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance Service (WMAS) (February 2021 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
9th April 2024	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
17th April 2024	Mrs	Josie	Spencer	Independent Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing) 2. Non-Executive Director for Coventry and Rugby GP Alliance (December - 31/05/2024 (To be removed from register November 2024)	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - 31/05/2024) (To be removed from register November 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
4th August 2024	Mr	Baz	Tameez	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
9th April 2024	Mr	Paul	Winter	Associate Director of Corporate Governance and DPO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

ANY CONFLICT DECLARED THAT HAS CEASED WILL REMAIN ON THE REGISTER FOR SIX MONTHS AFTER THE CONFLICT HAS EXPIRED

1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the ICB)*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child etc) close friend or business partner*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the ICB role with which the interest conflicts (e.g. membership of an ICB commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any ICB decision)
(b) Not to appoint to an ICB role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the ICB believes the conflict cannot be effectively managed
(d) All staff with an involvement in ICB business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key ICB decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other members (but only for immaterial conflicts)
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the ICB Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board

HELD IN PUBLIC

Staffordshire County Council, Council Chamber, County Buildings, Martin Street, Stafford, ST16 2DH
Thursday 21st November 2024
12.30pm – 2.30pm

Members:	Quoracy	18/04/24	16/05/24	20/06/24	18/07/24	26/09/24	17/10/24	21/11/24	19/12/24	16/01/25	20/02/25	20/03/25
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	✓	✓	✓	✓	✓	✓	✓				
Peter Axon (PA) Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	✖	✓	✓	✓	✓	✓				
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	A	✓				
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	A				
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	A				
Elizabeth Disney (ED), Chief Transformation Officer						A	✓	✓				
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✓				
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓				
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓				
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	✓				
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	A	A	A	✓	✓	A				
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council		✓	A	✓	A	A	✓	✓				
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	A	✓	✓	A				
Dr Simon Constable (SC) Chief Executive Officer, University Hospitals of North Midlands NHS Trust						✓	✓	✓				
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	A	✓	✓	A	A	A				
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓	✓	✓	A	✓	✓				
Participant Members:												
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓	✓	A				
Baz Tameez (BT), Healthwatch Support Staffordshire		✓	A	✓	✓	✓	✓	A				
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		A	✓	A	✓	✓	✓	✓				
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		A	✓	✓	✓	A	✓	✓				
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓				

Mish Irvine (MI), Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓				
Dr N Tony Ahmed (TA), Dental Participant Board Member					✓	✓	✓	✓				
Lynn Tolley (LT), Assistant Chief Nursing & Therapies Officer, Staffordshire & Stoke-on-Trent ICB – representing Heather Johnstone								✓				
Rachel Gallyot, (RG), Deputy Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB – representing Dr Paul Edmondson-Jones							✓	✓				
Lisa Ellis, Executive Support Officer, Staffordshire & Stoke on Trent ICB						✓	A	✓				

In attendance:												
Louise Stockdale (LS), Head of Transformation and Sustainability, UHNM							✓					
Fiona Miller (FM), Chief Executive Officer, Beat the Cold							✓					
Helen Slater (HS), Associate Director of Transformation, Staffordshire & Stoke on Trent ICB							✓					
Sarah Jeffery (SJ), Portfolio Director, Planed Care, Staffordshire & Stoke on Trent ICB							✓					
Hayley Allison (HA), Portfolio Director, Planned Care, Staffordshire & Stoke on Trent ICB							✓					
Tom Bailey (TB), Delivery and Improvement Lead, Urgent Care, Staffordshire & Stoke on Trent ICB							✓					

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting and advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. The meeting is being recorded and will be available on the ICB website after the meeting. DP reminded members of the importance of the Leadership Compact document which was used in all the meetings transacted by the ICB and guides the way business is conducted.	
	Apologies	
	Apologies were received from: Heather Johnstone — Chief Nursing and Therapies Officer, represented by Lynn Tolley Paul Edmondson-Jones — Chief Medical Officer, represented by Dr Rachel Gallyot Dr Jack Aw — Primary Care Partner Member Neil Carr — Chief Executive, MPFT Jon Rouse — Chief Executive, Stoke on Trent City Council Baz Tameez — Healthwatch Support Staffordshire Simon Fogall — Stoke on Trent Healthwatch	
2.	**Confirm Quoracy**	
	DP confirmed that the meeting was quorate.	
3.	**Leadership Compact**	
	Received and noted.	
4.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	

5.	**Minutes of the Meeting held on 17th October 2024**	
	TS stated that it was reported at the last meeting that the ICB is in "NOF 4" but confirmed that the ICB is in "NHS England Finance Level 4" and confirmed that this has been amended on the website and amended in all minutes and papers. The minutes of the meeting held on 17th October 2024 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
6.	**Action log**	
	Action log reviewed and updated accordingly.	
8.	**Questions submitted by members of the public in advance of the meting**	
	Question one – submitted by Garry Jones & Lisa Healings - Chair and Vice Chair, VCSE Healthy Communities Alliance As the Board will be aware the Chancellor has recently increased Employer NI contributions (eNICs). This will affect charities as they are not exempt. For example: • Support Staffordshire will see a net impact of £58,000, or £81,000 when the Living Wage is factored in. • VAST will see a net impact of £20,000, or £40,000 when the Living Wage is factored in. These sudden, unexpected increases will need to be funded, or we will need to make savings against them. As I am sure you will appreciate, unlike private businesses, we have no profit buffer against which to lean. Can the ICB please set out: a. Its approach to uplifting existing grant funding of not-for-profit VCSEs where the eNICs will have a material impact. Or how it will reduce output requirements accordingly? b. Whether the ICB funding of Primary Care ARRS social prescribers, delivered by third parties (in Staffordshire these are Support Staffordshire, Burton Albion Community Trust and Community Together CIC), will maintain the existing 100% reimbursement of salary and on-costs including the new eNICs? Without this commitment, providers may need to consider if their service is sustainable. Please note that that the national GP DES guidance was not published in 2024 until Easter Sunday, leaving zero working days for implementation – this will not be viable in 2025 and decisions will need to be made in the new year. **Response provided by Paul Brown** The NHS expects the National Insurance increase to be neutral, with funding adjustments anticipated. However, the financial outlook remains challenging, and while the ICB is committed to supporting the voluntary sector and primary care services, no guarantees can be made at this time. DP added that the Government is considering certain exemptions and the VCSE alliance is encouraged to contact relevant offices to lodge their concerns.	

Question two – submitted by Ben Oliver- Area Operations Manager and Regional Professional Lead, Bestway Healthcare

Context, a local surgery is moving the vast majority of patients onto 56-day scripts, as a cost saving measure - are there currently any plans from the NHS to move to 56-day prescribing for patients? If so, has the impact on community pharmacy been considered?

Response provided by Dr Rachel Gallyot

There is no formal policy on the optimal duration for repeat prescribing cycles. The ICB traditionally promotes a 28-day prescribing cycle, but some practices may use a 28 or 56-day cycle depending on clinical situations. The impact on community pharmacy, stock levels, and medicine wastage has been considered and there is no formal move to a 56-day cycle.

Question three – submitted by Ian Syme

UEC and Ambulance Handover delays at UHNM:

Today's CEO/Chairmans Report agenda item 6 para 4.0 points to a significant deterioration in timely Ambulance handover delays October 2024 at Royal Stoke and County Hospitals with the October situation being very significantly above plan.

Winter Surge Plan efficacy will also be reliant on Ambulance Handover Delays being minimised and frankly dramatically improved.

I have previously queried the ICB around the protracted Ambulance Handover delays situation at Royal Stoke.

I have also over several years put questions (plural) to UHNM Board re Ambulance handover delays and on one occasion asked if UHNM is normalising such which the UHNM board at that time strongly refuted.

There is now a 45 min MAXIMUM standard for Ambulance handovers.

Data in WMAS Board Papers October 2024 and for comparison WMAS October 2023 show LESS ambulance conveyance for that 6months this year April to September inclusive to Royal Stoke 2024.
2023:conveyance = 25497
2024:conveyance = 25343
154 LESS conveyance 2024

However, despite less Ambulance Conveyance to Royal Stoke ambulance handover delays in excess of 60 min have substantially increased. 2024 Royal Stoke 7579 whereas 2023 5765 i.e. 1814 more 60mins + handover delays a 31% increase.

Further in the 6months April to September this year (WMAS public data). Royal Stoke 9241 ambulance handovers exceeded the 45 minutes standard. County same metric is YTD 517.

There have been significant resources and public monies invested to improve UEC performance, that investment being from an increasingly strained financial envelope available to the ICS/ICB. These investments include Virtual Wards; Call before Convey; Front of House GPs: CRIS: Same Day Emergency Care Unit which opened August 2024.

Whilst UEC Performance is a "whole system issue" requiring 'whole system ownership' to ensure improvement there is much that remains the remit of a provider to assist service improvement. There's evidence from an Association of Ambulance Chief Officers review that very busy EDs in Tertiary Centre Acute Hospitals Trust have significantly swifter Ambulance Handovers than does UHNM. Further those very same trusts which do have swifter handovers also have zero tolerance of Corridor Care and Boarding.

Using the back of an ambulance as a surrogate for a ward bed is certainly unacceptable. It is an awful experience for any patient its demoralising for the ambulance crew and demoralising for ED staff who know it inhibits their ability to provide care input to patients.

What assurances have there been given to the ICS/ICB that the deterioration in ambulance handovers delays at both EDs within UHNM will be minimised and dramatically improved so that Ambulances will be swiftly released to do their job of responding and attending to Emergencies elsewhere in the community instead of being stuck outside an ED waiting to offload their vulnerable patient?

Response provided by Phil Smith

The position we are in and the impact on the patient is unacceptable, it is a joint responsibility. Ambulance is a route in and patients also present themselves at A&E. From a UHNM perspective, colleagues are in regular contact and support the actions that the Trust is taking and we are the first system in the region to go live to track and support, ensuring ambulance handover is within 45 minutes. Action in the following areas will be taken:

Transformation
Process
Capacity

Question four – submitted by Ian Syme

UEC and Ambulance Handover delays for ICB/ICS patients who do not use UHNM EDs:

Using the same WMAS public reported data set and comparison i.e. April -September 2024 and same 6 months 2023 as per one above.
There has been significant deterioration at two EDs where Southern Staffordshire patients may be conveyed by Emergency Ambulance.

Queens Hospital Burton: A slight increase in Ambulance Conveyance (around 2%) but a significant increase in Ambulance holds exceeding 60 minutes (651 in 2023 but 1126 in 2024 an increase year to year of 475)

Good Hope Hospital: Significantly LESS ambulance conveyance yet a very large increase in Handovers exceeding 60 minutes (up from 2679 in 2023 to 4477 in 2024)

New Cross the situation is more or less on a par in 2024 with that in 2023.

Walsall Manor has seen a significant INCREASE in ambulance conveyance yet a significant DECREASE in handover delays exceeding 60 mins (down from 627 2023 to 236 2024) Walsall consistently outperforms all West Midlands EDs in ambulance turnaround.

Re Queens Burton and Good Hope Hospitals:
Has the ICS/ICB had any assurance from either units or their respective ICS/ICB that the handover performance at those units will significantly improve and how would such be monitored?

Response provided by Phil Smith

As an ICB we have responsibility for the whole population the ambulance response time covers the whole population. Queens hospital is overseen by the System Control Centre. The ICB participates in Regional forums to share intelligence and review performance across providers and there is a daily call with NHS England. The ICB is committed to improving handover performance and will continue to monitor and support these efforts.

7	**Community Story - Keep warm, keep well community energy scheme – transforming health and the environment**	
	Louise Stockdale, Head of Transformation and Sustainability, UHNM and Fiona Miller, Chief Executive Officer, Beat the Cold were welcomed to the meeting. LS presented the community story, which focuses on the "Keep Warm, Keep Well" community energy scheme, and is a collaborative initiative aimed at addressing fuel poverty and improving health outcomes in Staffordshire and Stoke-on-Trent. The scheme involves generating solar energy from vacant roof spaces at UHNM and using the income generated to support community health initiatives. The scheme started in 2016 and was an innovation with Combined Healthcare NHS Trust and works closely with Moorcroft Medial Centre, as they are the first primary care provider to use “one health, one care”, which is used to refer patients to identify and target patients who are at high risk of deprivation and have a chronic condition. The scheme involves generating clean, resilient power through solar panels installed on hospital roofs. The power generated is used within the hospital, and the income from the government feed-in tariff is ring-fenced for community health improvements. The scheme has provided significant benefits, including cheaper energy tariffs for the hospital and funding for community health initiatives. The scheme has been recognised as an ICS estate's priority and is being expanded to include more roof spaces and support more patients. The goal is to scale up the initiative to benefit more people in the community. Fuel poverty is high and Stoke on Trent has been named as the fuel poverty capital. The scheme is cost neutral to organisations and if colleagues work together to establish vacant roof space, this can increase the reach of this scheme for people of Stoke on Trent and Staffordshire. FM shared a case study of a patient named Matthew, a 14-year-old with asthma, whose family benefited from the scheme. The support included home visits, fuel vouchers, and practical advice on improving home conditions to manage asthma better. FM advised that one of the initiatives was launched in May this year and focuses on childhood asthma and funding has been secured from national energy. It is anticipated that an additional 1,000 patients will be targeted as from December and will focus on the over 65s and those with vulnerable conditions. DP welcomed the presentation, which is a fantastic initiative and suggested that this is presented to the Integrated Care Partnership meeting, which is attended by broader system partners. JH stated that this is a great example of working together and asked what the timescales are. FM stated that colleagues are looking at how we make this scalable across the City and are aiming to roll out the initiative over the next 18 months. MN was delighted that it has been presented at today’s meeting, as she is the nominated Non-Executive Member lead for green initiatives for the ICB and offered assistant if there anything else we can do as a system to accelerate this. PA welcomed the presentation and fully supporting the initiative and advised that this links with the medium-term plan and stated if we can do anything to quantify these types of schemes. SL stressed the importance of addressing the wider determinants of health and interface with schools, general practice and primary care and referred to a recently published article where it was stated that parents cannot afford personal hygiene and scaling up is a great example of this. DP thanked, FM, LS and HS and requested that this is brought back for an update following the Integrated Care Partnership discussion.	

	The ICB Board: • **Acknowledged the contents of the report and presentation and recognises the significance of the Keep Warm, Keep Well scheme, both nationally and locally.** • **Noted the proposed expansion of the scheme, thereby reducing the population need for primary and secondary health services.**	
8.	**ICB Chair and Chief Executive Update**	
	DP presented that report and highlighted various initiatives in Primary Care and emphasised the positive impact of Black History Month initiatives across the area. PA was pleased to report the progress been made on the development of the medium-term plan, which sets outs ambitions and expectations over the next five years and is being developed with all system partners. PA provided an update on the ongoing Investigation and Implementation process and advised that Deloitte's and Kingsgate commenced their work a couple of weeks ago, which focuses on both the current year's financial position and the long-term financial plan and advised that a detailed report is being produced and will be presented at the next meeting. He emphasised the importance of financial resilience and sustainability, with a focus on redistributing resources and added that the work being undertaken by Deloitte's and Kingsgate aims to address both immediate financial challenges and long-term strategic approach. JH referred to the work being conducted by Deloitte's and Kingsgate and how this will feed into 2025/2026 and referred to the longer term in terms of the medium-term plan. She referred to the number of Community engagement initiatives and stated it would be beneficial to understand the impacts of these and how it is going to feed into the wider Community transformation programme. JS referred to section 3.1 within the report, elective wait summary table, which was presented at a recent Finance and Performance Committee and noted that the out of system number is unvalidated and asked when will colleagues receive the validated figures. PS advised that an October position has been received for providers, which states: 78 week waits -19 patients - 12 at UHNM and 4 at Burton 65 week waits - 265 patients - 118 UHNM and 82 at UHDB PS confirmed that going forward final validated position will be included in the report. **The ICB Board:** • **Received the report.** • **Were assured that the leadership are working on each topic as raised.**	**PB/ED** **ED**
9.	**System Level Access Improvement Plan**	
	DP welcomed Sarah Jeffery Portfolio Director to the meeting. SJ presented the report and stated that the first draft was published in November 2023, following which it was presented to the ICB Board in May this year for comments and today a revised version is being presented, as the final submission in due in December. She advised that the plan focuses on improving access to healthcare services across the region and involves several key initiatives aimed at reducing waiting time, improving patient flow and enhancing the overall patient experience.	

	It was noted that over the past year appointments in general practice have increased, 100 % of patient have access to their medical records if they so wish. There has been a decrease nationally in the number of general practitioners, however this is not the case in Staffordshire and Stoke on Trent, as there has been significant increase. It was report that: 76.3% of patients reported that their experience was good 90% of patients reported that their needs were met 88.9% of patients reported an overall good pharmacy experience SJ advised that across the system we have 25 primary care network estates plans and are in the process of developing a framework, which will focus on the prioritisation of the plans. She added that cloud-based telephony has been signed up to by all our practices and there will be 100% cover by March 2025. It was highlighted that across the system we have 229 pharmacies delivering pharmacy first scheme and we are one of the highest referral rates in West Midlands SJ reported that, digital technology is more enhanced, access to records making more informed decisions, number of appointments have increased, more pharmacists, patient satisfaction rates on the rise. DP welcomed the report and stated that there is lot of information contained in the report that should share with the local population. MN asked if there is any variation across the patch. SJ stated that there is variation across the patch and added that there is a quality dashboard, which will highlight if there are any practices that are struggling and colleagues will them provide the necessary assistance. JS referred to the health and wellbeing of staff and asked what the uptake on the "app". SJ will look into this and come back to JS. FM referred to the data set and asked where the information comes from. SJ advised that it is a national survey developed by NHS England and is sent out to a selection of households. CI commended UHNM and MPFT for the huge amount of work over the past number of years for embracing the patient engagement platform to enable patients to access their medical records. **The Board is asked to note the contents of the plan and discuss any amendments required.**	**SJ**
10.	**System Surge Plan for Winter**	
	PS introduced Hayley Allison (HA), Portfolio Director, Urgent and Planned Care, Staffordshire & Stoke on Trent ICB and Tom Bailey (TB), Delivery and Improvement Lead, Urgent Care, Staffordshire & Stoke on Trent ICB. PS presented the report and advised that it has being presented to the relevant governance processes throughout the system and has been subject to NHS England visit. He added that there has been a great deal of change in terms of how partners come together to plan, deliver and learn and provided assurance that all colleagues from across the system have complete focus on patient safety and outcomes. He added that the challenges are significant and stated that it is essential that the system works together to ensure we deliver value for money out of all the investments made in winter. TB advised that the plan replicates the approach taken over the past few years and has a three faceted approach to the development of the system surge plan and advised that the system capacity plan is underpinned by the system capacity and bed modelling.	

	TB stated that the system escalation plan is designed to facilitate risk management and aligns system pressures and also aligns to the NHS England Opal Framework and system workforce plan and colleagues have sought to make the plan as resilient as possible and have worked with UK Health Surveillance to build in resilience. He highlighted that weekly MDT surge meetings take place and has representatives from all system partners. HA advised that colleagues go through a process to understand the potential capacity gap, along with focusing on the transformation aspect and work collaboratively across the system to develop a plan that will be fit for propose and constantly reviewed. She added that some of the mobilisation additional capacity schemes have been brought forward to ensure we maintain flow across the emergency system. HA emphasised that all system partners are working incredibly hard, with a limited amount of investment. She added that as a system the System Co-ordination Centre was established, which operates seven days a week and the model aims to provide the co-ordination of all our urgent care pathways, ensuring that we are operating as efficiently as we can. She was pleased to report that the System Co-ordination Centre was commended recently as exemplar across the Midlands by the NHS England Assurance process. SL stated that the plan was considered at the last People Culture and Inclusion Committee and welcomed the reference regarding the system workforce plan and in particular the range of lessons that have been learnt especially in relation to recruitment, which provided a greater level of assurance regarding how workforce will be managed. DP noted that plan has been through the appropriate governance processes and the resilience of the plan will be tested as we go into winter. PF welcomed the report and asked if colleagues have an understanding of the impact and are we on track, as we have not reached the peak of winter, as the urgent care system is already under significant pressure and referred to the early mobilisation of some of the schemes. HA advised that the system has been challenged and a number of schemes have been mobilised and stated that these are monitored at a weekly multi-agency forum. PS added that the plan balances the more traditional and transformation elements, ensuring we get the best return on investment and if required investment will be relocated where required. MN referred to the early mobilisation of schemes and stated that as a system we are not where we want to be and asked have we got the right things in the plan, given we are already in November. PS stated that demand across the system has been higher earlier, hence why some schemes have been brought forward and stated that in conjunction with partners we are working together to ensure patient flow through services is efficient as it can be. DP concluded and stated that going forward the plan is flexible and will be subject to checks in terms of resilience and requested that the plan is subject to further governance processes when escalation when necessary. PS agreed and stated that the Surge Group meets on a weekly basis and has representatives from all partners from across the system and produces a highlight report which is shared across the system and an update will also be provided at the monthly Finance and Performance Committee **The Board were requested to ratify the decision of the Finance and Performance Committee and confirm approval of the System Surge Plan for 2024/25.**	
11.	**Medium Term Plan**	
	ED presented that report and advised as a system we have an opportunity to articulate our ambition over the next five years, ensuring that as a system we are fit for purpose for our population and ensuring we improve our performance ensuring we retain quality and safety. She added that colleagues are currently in the modelling phase, which is being undertaken as a whole system plan, which will be built to together and lead together.	

	ED advised that the unmitigated model has been completed, which looks at how our population will change and if nothing changes, we will have demand that we will not be able to cope with as a system. She added that by 2036 our population of over 70 will have increased by 20% and this will present significant challenge. PB stated that last year's planning process was extremely difficult, therefore this year's planning process commenced in July to build the longer-term horizon. He advised that we have a £90 million deficit plan, however it is reported that the deficit is £156 million and £280 million deficit as a system and emphasised that we need to avoid the unmitigated solution. He added that colleagues are working on the plan, which includes our clinical community and is focusing on reducing the volume of healthcare and the data has identified that this can be achieved and would result in less patients in hospital beds, which would mean more demand in different parts of the health system in terms of primary care and community care, which is being worked through and would create better outcomes for patients, ensuring we have the best models of care and creating a significant financial opportunity. ED advised that a proposal would come to a future meeting in the new year, as colleagues continue developing the plan and agree how it would be delivered as from April 2025. RG stated that she is pleased that there is clinical input and the whole system is driving this together and there is has visibility through the Clinical Senate and will be clinically driven. PF welcomed the update and energy from colleagues, he referred to the current demand across the system and financial challenges and asked if colleagues will be allowed the space nationally to focus on this, taking into account the environmental aspects. PA stated that discussion will be held with NHS England and highlighted that the report will be based on evidence and will have full support from all system partners. DP concluded and assured the Board that the plan will go through the appropriate governance processes prior to being presented in the new year. **The Board received the report and were assured on the progress made to date and the next steps outlined.**	**ED**
12.	**Quality and Safety Report**	
	LT presented the report and referred to the community nursing section and stated that demand is increasing within the community services and an update has been received from MPFT where colleagues from local authority have offered support to community nurses offering upskill care providers. It was noted that there is significant demand on the paediatric dietetics service and a review will be undertaken. Improvement has been made with regard to the waiting time for the wheelchair service, however, there continues to be some issues and there is a visit planned next week to get the patients perspective, with assistance from Healthwatch. LT referred to "Rowans Rule" and advised that at a recent Local Maternity and Neonatal System Partnership Board a mother presented a story regarding the tragic death of her seven-day year old son and she is now working with us to promote a video about infant CPR, which will be presented to the Infant Mortality Group LT advised that a letter has been received from the National NHS England Executive Team requesting assurance and outlining actions required to maintain focus on our oversight and quality within our urgent care services. She reported that an unannounced visits to the urgent emergency care services at both UHNM and UHDB took place in July and feedback was very positive in regard to both our services, patients were spoken to and colleagues were reviewed against six key areas, which were presented to the Quality and Safety Committee and our Urgent and Emergency Care Boards and requested ratification from the Board.	

	TS referred the new system "Insights" and requested that this is aligned to the freedom to speak up information, our complaints and intelligence, so assurance can be provided that triangulation will occur and any themes will be identified. **Members of the Board :** • **Receive the report.** • **Were assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System** • **Ratified the decision of the Quality and Safety Committee with regards to:** *** Assurance that the ICS are working in partnership to maintaining focus and oversight on quality of care and experience in pressurised service**	
	System Quality and Safety Committee AAA Chairs Escalation Report To receive and note	
	JS presented that report and advised this is the new format using the AAA format (alert/advise/assure) and thanked members of the Governance Team for assisting with the compilation of the report. She advised that there is one alert, which relates to quality impacts assessments and provided assurance that colleagues are working to ensure this is realigned. JS stated that there are a number of advisories and referred to the intensive and assertive community mental health care review and advised that there is a lot of work that still needs to take place, however, good progress is being made. She referred to Looked after health children's assessments and advised that progress is being made to readdress the issues previous highlighted to the Board and stated that work continues. JS referred to Gorden Street Surgery Quality Report and advised that colleagues have welcomed the improvements which have been made to ensure that the patients within the practice are receiving an improved service and thanks all colleagues involved. DP welcomed the quality impact assessments that had been undertaken as these help to provide assurance that the ICB are continuing with the assurance processes as we move forward, ensuring services remain safe and we manage the financial challenges. LT stated that there are a couple of retrospective quality impact assessment which need to be undertaken and provided assurance that all colleagues are fully engaged. DP requested, if necessary, escalation for any quality impact assessments regarding quality impact on patients. **The Board received and noted the report.**	
	Staffordshire and Stoke on Trent Health and Care Senate Summary and Escalation Report	
	RG presented the report and advised that there are no alerts She requested ratification from the Board for a policy in relation to Vitamin D testing which has come through the clinical values collaborative and is to support the use of guidance for appropriate use of Vitamin D testing, which we currently benchmark over 10% of our peers. RG advised that the Health and Care Senate approved the Integrated Medicines Group decisions regarding migraine medications, freestyle libre 3 and anaesthetic gases. She added that the Senate clinically approved the adult asthma improvement project and clinical approved the system surge plan. RG referred to the clinical approval of the liver phase one and lower GI diagnostic pathways supporting the planned care work and stated that there was also clinical approval for the development of a business case for a 24/7 advise line. DP welcomed the report, which provides an insight into the work being undertaken by the Health and Care Senate and welcomed the visibility at the Board meeting.	

	TS referred to palliative care and the valuable work being carried out, especially with our voluntary sector and asked how we bring all the elements of the palliative care together and highlighted the discussions will be taking place at the next Integrated Care Partnership meeting. **The ICB Board:** • **Received and noted the report.** • **Ratified the Vitamin F testing and prescribing guidelines.**	
13.	**ICS Finance and Performance Report**	
	PB provided an update in relation to the month 6 financial situation and advised that a month 6 there is a £30 million variance from the plan. He reminded colleagues that the plan was set as a deficit of £90 million and stated that £90 million has been received as support but is repayable. He advised that the ICB has a break-even plan and at month 4 it was predicated a deficit of £104 million against the plan, but due to the recovery plan the predicated deficit is £56 million against the plan, with a number of elements being high risk, for example the absence of dental contracts. PB reported that the financial situation is serious and we have been instructed to reach breakeven and stated that the Investigation and Intervention process has commenced and their report is expected in due course. The ICB is required to report a break-even position to NHS England, which it is adhering to and colleagues continue to implement the medium-term plan. PS provided an update in relation to the performance element and advised that in terms of urgent care the NHS had its busiest October with an increase of 6% from last year and locally there was a 7% increase compared to the same period last year. PS advised that there has been a deterioration in the category performance in terms of ambulance response times, which has exceeded the target of 30 minutes with the average wait time being 38 minutes, which has also had an impact on the A&E performance. PS sated that work across the system continues to ensure that only patients who need acute care are admitted to hospital. He added that the single point of access for care professionals is well embedded and received over 100 calls a day, with 53% being diverted to alternative pathways and colleagues are looking to identify further opportunities to manage escalation in alternative ways. PS referred to UHNM and stated that there is focus to consistently apply the application of processes within the Trust, including, 45-minute handover protocol, internal professional standards, ward standards, your next patient or home care is best care. He added that there has been significant focus from a discharge perspective, ensuring patient flow and stated that a Multi-Disciplinary System Team has been established and visits UHNM every Wednesday to support identification of discharges from hospital, which has been effective and also added that NHS England visit last week to look at the discharge process where they felt that process was exemplar and other organisation could emulate. PS referred to urgent emergency care and provided assurance that there are robust escalation processes in place, both within our organisation and across the system PS highlighted waits time and it was noted: Planned care – UHNM have been de-escalated from national tier one escalation for elective cancer and diagnostic, reflective of the significant progress that has been made and work continues. NHS has set a target of eliminating 65 week waits by the end of September, however national data indicated that there are 22,903 patients national who remain waiting at the end of September	

	and it has been identified that were have 333 of those patients and have decreased to under 300 in October. Activity levels remain strong and against the cost weighted activity metric are at 109% and will continue with the recovery plan and linking to the medium-term plan and identifying how we need to delivery activity and pathways in a different way. Diagnostic activity – strong progress has been made, previously reported that non-obstetric ultrasound has been a significant challenge and it was reported that additional capacity and support has been identified. Cancer waiting time are overall, progressing well against the standard and trajectories. SC stated as a system the urgent care situation is not acceptable and as a system this will be managed differently going into winter. He reported that progress is being made with regard to the ambulance handover, acknowledging further work is required. In addition, UHNM have experienced some challenging IT system issues, which colleagues are working through. **The Board:** • **Acknowledge the high-level performance against the five priorities.** • **Acknowledge the high-level key programme deliverables update.** • **Acknowledge the financial position.**	
14.	**Finance and Performance Committee Assurance Report**	
	MN presented the report and advised that the Finance and Performance Committee continue to focus on the key performance challenges, especially around emergency care. She added that a clear reporting process regarding the recovery programme has been established through the Recovery Director, which will also include reports from the Investigation and Intervention process. MN referred to the alert section of the report, and particularly the capital plan, which is compliant for 2024/2025, however there is some potential slippage on national programmes and mitigations are currently being developed. MN referred to the “advise” section of the report and advised that a deep dive into continuing healthcare took place at the November meeting and was pleased to report that renewed pace and grip has been taken forward by the collaborative. She also to the VSCE report which was presented at the meeting and highlighted the positive feedback regarding the development of the alliance, together with the ongoing review on grants, in particular highlighted the length of time the process takes and assurance was provided that the six month notice period would be honoured and the Committee also acknowledged the critical role they play in developing healthy, strong communities. MN advised that there are two issues to be escalated, firstly ratification is required in relation to the home oxygen contract extension and secondly the ICB Board were required to note that the Committee provided approval for new prescribing cost improvement plan and colleagues will work closely with the LMC. PF welcomed the report and referred to the workforce, which is almost 25,000, which is 400 above plan, which is controllable and possibly something we should be tackling. He requested clarification regarding dentistry and acknowledged that colleagues are working significantly hard and stated when there is pressure to come in on balance, but you are not allowed to use any additional funding, what is the challenge the ICB is working to. PB stated referred to the workforce and confirmed that we are above plan and colleagues are working on. He advised that there are significant constraints and stated that dentistry is a significant issue.	

	The Board received and noted the report.	
15.	**People Culture and Inclusion Assurance Report**	
	DP took the opportunity to congratulate MI on her substantive appointment as Chief People Officer for the ICB. MI presented the report and referred to the workforce and confirmed we are currently 400 over plan and colleagues are working Deloitte's and the relevant organisation to identify if any reductions can be made whilst maintain safe staffing. MI advised that we are 2.6% in terms of agency spend, which is lower that the cap of 3.2%, which is positive. She added that turnover is 8.7 % and the vacancy rate is 9% and continue to decrease. It was noted that sickness levels are increasing and colleagues will continue to monitor sickness across the system from a wellbeing perspective. **The Board:** • **Noted the workforce position, operating plan, risks and mitigations in place.**	
16.	**People, Culture and Inclusion Committee AAA Report**	
	SL presented the report and advised that there are no additional escalations, apart from the increase in sickness levels, as referred to in the previous agenda item. **The Board received and noted the report**	
17.	**Staffordshire and Stoke- on -Trent ICB Remuneration Committee Summary and Escalation Report**	
	SL presented the report and advised that Remuneration Committee approved the commencement of the recruitment process for the vacant post of Non-Executive member and added that the Committee also approved the VSM pay increase of 5% with effect from the 1st April 2024. **The Board received and noted.**	
18.	**Items notified in advance to the Chair**	
	No items were notified to the Chair and no other items of business were raised.	
19.	**Questions from the floor relating to the discussions at the meeting**	
	Ian Syme welcomed the presentation from Beat the Cold, which shows from a small amount of investment a huge return can be made and highlighted significant levels of deprivation in the City, which affect many cohorts of people, not just the elderly. Ian Syme requested clarification regarding the system level access improvement plan and referred to the 30 whole time equivalent increase in GPs and as a Stoke resident stated it is difficult to recruit GPs to practices in Stoke on Trent. He added 2746 patients registered to one fully qualified GP in Stoke on Trent and in Staffordshire it is less, at 2700 patients, which is higher than the national average and asked where these additional GPs are being placed. RG agreed to check the detail where the GPs are being deployed and provide the context and get back to him. Ian Syme referred to the Quality and Safety, in particularly looked after children healthcare assessments and noted that improvements are being made and asked if improvements are being made in one Local Authority area or both and added that a large number of children receive care outside of the area, and the Local Authorities have responsibility for these children and asked who	**RG**

	has the responsibility for monitoring and performance. LT thanked Ian Syme for his question and advised that the position is improving and the trajectory focuses on the whole of Staffordshire and Stoke on Trent, will look at the workforce and identify any areas where improvements can be made. She added that the ICB has the responsibility for monitoring children who receive out of area care, ensuring they receive their health assessments. A member of the public present stated he was pleased to hear the link between the medium-term efficient plan and transformation strategy and referred to having the capacity to undertake this and exploring the opportunities about partnership and collaborations and stated that he works for NHS Supply Chain, who are also transforming in the same way and would be keen to ensure that they have capacity and capacity to support ICBs to enable local transformation, shifting care closer to home and welcomed the opportunity to work in collaboration.	
20.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the Leadership Compact.	
21.	**Close**	
	There being no further business, the Chair closed the meeting.	
22.	**Date and time of Next Meeting**	
	19th December 2024 at 100pm held in Public, via MS Teams	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent ICB Board Meeting
HELD IN PUBLIC

Open Actions

Agenda item	Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
8	**21/11/2025**	ICB Chair and CEO Update	JH referred to the work being conducted by Deloitte's and Kingsgate and how this will feed into 2025/2026 and referred to the longer term in terms of the medium-term plan. She referred to the number of Community engagement initiatives and stated it would be beneficial to understand the impacts of these and how it is going to feed into the wider Community transformation programme.	19/12/2024	Elizabeth Disney	A critical first step of the community transformation work will be to take stock of learning and strategy development to date to ensure the programme is fully sighted and informed by work that has gone before. This includes outputs from work such as that being completed by Deloitte and also information and insight gathered from previous community engagement events.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**19 December 2024**					
Title:	Chair and Chief Executive Officer Report					
Presenting Officer:	David Pearson, Chair, and Peter Axon, CEO					
Author(s):	David Pearson, Chair, and Peter Axon, CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent system that are not reported elsewhere on the agenda.

Specifically, the paper details a high-level summary of the following areas:

1. System and General Update
2. Finance
3. Planned Care
4. Urgent Care
5. Key figures from our population
6. Quality and safety

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
N/A	Click or tap to enter a date.

(3) Implications:

Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	N/A for the report

Workforce or Training	N/A – no specific training implications; workforce matters are inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☒
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

To receive the report and be assured the leadership are working on each topic as raised.

1.0 System and general update

1.1 Medium-Term Plan (MTP)

The Task and Finish Group has now concluded, and the mitigated modelling and opportunities were approved by the System Finance and Performance Committee on 3 December. This work will be taken forward into the detailed build of the MTP, translating these ambitions into a phased, actionable plan, focused on clinical optimisation and value, productivity and system transformation. The development of these plans including delivery design, implementation, and transformation and will require a significant change in the way workforce and leaders currently operate. Engagement and involvement of the workforce and leaders across the system will be a priority, including a robust Organisational Development and change management programme spanning five years and beyond.

1.2 National Operational Planning Round and Guidance

NHS England and the Department of Health and Social Care (DHSC) have indicated that national operational planning guidance may be published before Christmas, though no firm deadline has been set. Staffordshire and Stoke-on-Trent submissions, both technical, activity, finance and workforce, and supporting narrative, will be co-ordinated through the ICB, and co-produced with partners. The governance approach will utilise existing structures, such as the ICB Board and System Finance and Performance Committee, for submission sign-off. A time-limited Activity, Finance, and Workforce (AFW) task and finish group will oversee the development of technical submissions, fostering collaboration and information-sharing across the system and will take advice from the group developing the MTP to ensure alignment between the submission and the MTP. A summary of the national planning guidance once published will be shared with the board.

1.3 Megan Nurse appointed Chair of Mid Cheshire Hospitals NHS Foundation Trust

Megan Nurse has been appointed Chair of Mid Cheshire Hospitals NHS Foundation Trust. As a result, Megan will be stepping down from her position as Non-Executive Member and from her role as Chair of the Finance and Performance Committee, leaving Staffordshire and Stoke-on-Trent ICB from March 2025. We would like to acknowledge the significant contributions Megan has made to both our organisation and the wider health system as a Non-Executive Member and Chair of the Finance and Performance Committee. We wish Megan every success for the future.

1.4 Primary care

1.4.1 The Staffordshire Training Hub Practice Managers Conference

The Staffordshire Training Hub Practice Managers Conference is held annually in two locations, Uttoxeter Racecourse and Bet365, to ensure all Practice and Primary Care Network (PCN) Leads receive the latest updates, learn about new ways of working and build relationships. The programme includes keynote speakers from leading health and care professionals on Care Quality Commission, HR and Employment Law, General Practice Finance, NHS Pensions and Health and Safety. A total of 142 Practice and Primary Care Network leads attended this year's face-to-face event. The event ensures that this cohort of people, who are often isolated, receive the opportunity to share their experiences, develop skills, increase their knowledge and network with their peers.

1.4.2 Living Well Event

The Living Well event, held on 5 December by Cannock North and Cannock Villages Primary Care Networks, along with several stakeholders, saw over 230 attendees and was an opportunity to talk to experts and professionals about memory, diabetes, keeping active, staying healthy and managing health concerns, with NHS stall holders gaining many referrals as an outcome.

1.4.3 Association of Business Psychology (ABP) Award for Excellence in Behavioural Interventions

Caja Ltd has won the Association of Business Psychology (ABP) Award for Excellence in Behavioural Interventions. This recognition highlights their work in Primary Care and specifically the innovative efforts with Staffordshire and Stoke-on-Trent ICB.

Enhancing access to primary care is a national challenge. Using behavioural science, Caja developed a working theory to appropriately optimise the use of full range primary care professionals, nudging patient behaviour to appropriately route demand, whilst maintaining customer satisfaction levels. Commissioned by the ICB, Caja deployed a layered suite of behavioural nudges including improved telephone messaging, care navigation scripts, short message service reminders, website optimisation and staff training. Trial results demonstrate positive changes in patient behaviour, appointment wastage (did not attends) has significantly diminished, and teams are making ongoing efforts to refine and implement strategies for better access using behavioural science.

Work is continuing with additional practices and Primary Care Networks from December 2024.

1.5 People team

1.5.1 People and workforce health, wellbeing and morale

An area of particular concern addressed by the People, Culture and Inclusion (PCI) Committee is the deteriorating sickness absence position, with various impacting factors on employee experience and health and wellbeing, including operational and financial pressures. Additionally, burnout, morale, and culture were highlighted as a key risk area, which the committee will continue to monitor as pressure increases, particularly as we head into the winter months.

Focused discussions took place following a deep dive undertaken by the Employee Experience, Health and Wellbeing Sub-Committee into increased sickness rates, with emphasis on stress, anxiety and depression as reasons for absence. It was noted that these are the top reasons for absence, alongside cold, cough, flu and musculoskeletal in NHS Trusts, with a similar picture anecdotally reported across primary care and social care. The broader impact of sickness that has been highlighted recognises the importance of focusing on improving health and wellbeing, rather than achieving targets.

Further deep dives into reasons for sickness and data are planned, alongside targeted programme activity to address the top sickness reasons via service offers, such as the Staff Psychological Wellbeing Hub, internal services, Occupational Health and staff vaccination promotion. Furthermore, system-wide resources are being collated to support overall improvement of experience, health and wellbeing,

1.5.2 Disability History Month

During December, Staffordshire and Stoke-on-Trent Integrated Care System (ICS) partners will be marking Disability History Month in various ways through engagement and networking events, sharing resources and recognising disability within our workforce. A system-wide event with take place on 17 December, with key speakers planned to share important information, updates and stories for our workforce.

1.5.3 Workforce Investigation and Intervention regime

Extensive discussions have taken place at the PCI Committee regarding the engagement undertaken with Deliotte and Kingsgate, throughout the Investigation and Intervention stage. Chief People Officers have been meeting internally with Kingsgate and system leads regarding additional workforce measures. Further discussions are taking place to design approaches and processes to enhance controls.

2.0 Finance

Following the guidance to release non-recurrent funding, equivalent to the deficit agreed on the 12 June 2024, this has now been transacted. The system is reporting a year-to-date adverse position of £33.7m against a revised year-to-date £4.3m surplus plan. The main drivers for the aggregate year-to-date position are efficiency slippage (£19.2m) and binding conciliation (£13.5m) with adverse impacts in Continuing Health Care (CHC) (£9.4m) and medical staffing (£5.7m). These are partially offset by other non-recurrent mitigations (£14.5m) and dental underspend (£3.0m). Within the £33.7m, there is a phasing mis-alignment between NHS England's plan and UHNM's, which equates to £3.9m at Month 7. This will reduce monthly to no impact by year-end.

Whilst we continue to work to secure as much recovery as possible, we note that between month 6 and 7 two issues out of our control have been flagged. Firstly, the delegated dental underspend (estimated as £6m within the recovery plan) is now highly likely to be drawn back to the centre with a resulting direct impact to the systems financial position. Secondly, a cost pressure in relation to ambulance delays is being flagged by West Midlands Ambulance Service which if passed out, is estimated to cost Staffordshire and Stoke-on-Trent £1.5m. However, in the light of the formal commencement of Deloitte, our Investigation and Intervention (I&I) partner on 4 November, our Chief Finance Officers have collectively made the decision to maintain the net risk as reported at month 6 of £56m, Risk Adjusted Forecast Out Turn (RAFOT) of £146m, but would note that to deliver this, we need to identify a further £7.5m efficiencies not currently identified in the recovery plan. This also assumes that Deloitte identify sufficient savings to cover their fee.

Work is underway to refresh the medium-term financial model where the focus on addressing the underlying financial pressure of c£200m through clinical models, productivity and demand management is being developed.

2.1 System Finance Event

A system finance event was held on 23 October with 140 finance colleagues in attendance from the ICB, UHNM, Midlands Partnership Foundation Trust (MPFT), North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Stoke-on-Trent City Council. Colleagues joined together to network and build on the relationships that already exist across organisations, and the great work teams are already doing, enabling us to achieve a sustainable balanced financial position and the best outcomes for patients.

The event was sponsored by Healthcare Financial Management Association (HFMA), covering the cost of the event being held at Stoke City Football Club. Attendees had the opportunity to ask Chief Finance Officer's questions, with a panel of clinicians discussing clinical issues and how to work effectively between the financial and clinical community to improve the lives of the population and patients, along with sessions on the System Financial Recovery Plan, wellbeing and staff development.

The event was a great success in bringing all the finance teams together in person, to understand the current environment and how we can work collaboratively to make ourselves professionally fit for future challenges.

3.0 Planned Care

University Hospitals North Midlands (UHNM) and University Hospital of Derby and Burton (UHDB) continue to be in Tier 2 elective oversight.

3.1 Elective Waits (104, 78 and 65 week waits)

Appendix 1: Summary table of breaches

	October - Number of patients waiting		
	104+ weeks	78+ weeks	65+ weeks
University Hospitals of North staffordshire	0	12	130
Nuffield North Staffordshire	0	0	1
Ramsay	0	2	3
Medefer	0	1	1
System Providers Total	0	15	135
Out of System Providers	0	5	121

The table in appendix 1 shows the 104, 78 and 65 week waits for October. The October month-end Referral to Treatment submission has provided the October position for both providers outside of the system and within the system.

The October month end Referral to Treatment submission has provided the October position for providers, this is latest published data available.

The numbers for providers within the Staffordshire and Stoke-on-Trent system are for all patients waiting, not just Staffordshire and Stoke-on-Trent patients. To note, Medefer reported one patient breaching 65 weeks, Ramsay reported three patients breaching 65 weeks and Nuffield reported one patient breaching 65 weeks. All three providers have confirmed that these are data quality issues and there were no breaches. The ICB are working closely with the providers to ensure accurate future submissions.

The numbers for providers outside of the Staffordshire and Stoke-on-Trent system, are for Staffordshire and Stoke-on-Trent patients only.

3.2 Cancer Performance

The statements below are not solely for Staffordshire and Stoke-on-Trent patients, but for the provider position as a whole.

UHNM's September position for 28-day Faster Diagnosis was 70.9% against a trajectory of 76%. UHDB's September position is 72.7% against a trajectory of 75.5%

UHNM's September position for 31-day target was 93.3%, with UHDB's position being 90.4% against a trajectory of 86.5%.

UHNM's September position for 62-day combined standard was 65.9% against a trajectory of 65.5%.

UHDB's September position for 62-day combined standard was 71.6% against a trajectory of 64%.

Further and ongoing actions include:

Continued focus on clearance of the 78ww cohort and 65ww cohort.

Planning for reduction and clearance of 52ww cohort.

Continued discussion with Derbyshire ICB and providers in relation to achievement of the operational planning ambitions.

4.0 Urgent and Emergency Care (UEC)

The latest Category 2 Response Time for last week has risen above the hour mark for the first time since 24 February, increasing from 59 minutes and 49 seconds, to 1 hour, 3 minutes and 17 seconds. This was almost 30 minutes above plan and 16 minutes above the same period last year, placing the system 29th nationally and 7th regionally. The latest 4-week average of 48 minutes and 57 seconds placed the system 27th out of 42 nationally, and 7th out of 11 regionally.

November's average handover time at UHNM remained challenged, shifting minimally from the 1 hour and 40 minutes reported in October, to 1 hour and 42 minutes for the latest month. Whilst overall time lost due to handover delays reduced by 1.7%, it remained 45% above plan for November. Work towards compliance with the Ambulance Handover Trajectory saw West Midlands Ambulance Service (WMAS) complete 57% of Handovers at UHNM within 45 minutes, up from 54.3% in October. This remained below the target of 60% as defined in the new trajectory plan.

'All types' of attendance at UHNM fell by 5.3%, which is the equivalent of 43 fewer patients each day throughout the month, with decreases reported across all Type 1 and Type 3 locations. Overall, there was a further increase of 0.3 percentage points in patients being assessed within 15 minutes, from 61.6% to 61.9%, whilst the number of Type 1 attendances seen within the first hour fell by 1.5%, resulting in less than one out of every four patients being seen within that time. Emergency admissions via the Emergency Department increased by 2% during November but remained 6.8% below the same period last year.

Four-hour performance during November fell to 64.8%, a shortfall of 5.8 percentage points against plan, a drop of 4.4 percentage points below September and 0.5 percentage points below October. Type 1 locations reported improved performance during this period, reaching 45%, up from 43.7% the previous month, whilst Type 3 locations saw a reduction of 2.3 percentage points from 98.8% to 96.5%.

Unvalidated 12-hour performance saw a 0.4 percentage point improvement from 11.3% to 10.9%, which was helped in some way by the drop in Accident and Emergency attendances at UHNM during November. The November position was 0.8 percentage points below the regional average for the month but 1.5 percentage points above the same month last year.

Bed Occupancy for November for both adult general and acute beds, and adult and paediatric general and acute beds, reduced as COVID-19 numbers fell, but remained significantly above plan. The continuing Infection Prevention and Control (IPC) issues around the new diarrhoea and vomiting strain and emerging flu closed beds, resulted in both occupancy metrics remaining above 92%. The shorter 7+ Long Stay Patient cohort saw an overall reduction in numbers whilst the longer 14+ and 21+ days remained stable.

The discharge profile for up to and including the 18 November showed UHNM discharge 75.06% of patients on Pathway 0, which is 3.3 percentage points below plan (78.4%) and a reduction of 1.8 percentage points in October. Discharges to Pathway 3 at 0.5% remain below plan (0.8%) for the fifth month, whilst Pathways 1 and 2 both saw increases with acuity of patients being admitted requiring more complex care and needs. Due to changes in reporting, monthly data is only currently available after the second Thursday of each month, so the position reported above will likely change.

Virtual Wards occupancy remained stable through the month with the latest Sitrep submission, as of 21 November, reporting that 72.7% of the capacity of 293 beds were occupied. Sector based breakdowns have yet to be received from the service, however, with the overall position shifting minimally there is little difference expected from the figures reported for the first submission of the month, which were 70% for the North, 90% for the South-East, and 49% for the South-West.

During the last week of November, the whole system went into a System Critical incident, with a number of strategic and tactical actions taken to de-escalate. This has now been achieved and a full review of the critical illness (CI) will be presented at appropriate forums asap.

5.0 Key figures from our population

	Last 4 months in current financial year				Comparator month		Change on same month previous year		
	Jul-24	Aug-24	Sep-24	Oct-24	Sep-23	Oct-23	No.	%	Direction
111 calls received	28,415	27,073	25,879	28,587					
Percentage of 111 calls abandoned	3.1%	2.7%	2.1%	2.2%					
A&E and Walk in Centre attendances (UHNM)	21,793	20,079	20,891	22,519		21,864	655	3.0%	↑
A&E and Walk in Centre attendances (other providers)	19,757	18,007	18,089	19,232		19,200	32	0.2%	↑
Non elective admissions (UHNM)	8,278	7,746	7,875	8,495		7,940	555	7.0%	↑
Non elective admissions (other providers)	6,923	6,305	6,183	6,958		6,354	604	9.5%	↑
Elective and Day Case spells (UHNM)	8,299	8,612	8,714	9,696		7,137	2,559	35.9%	↑
Elective and Day Case spells (other providers)	8,944	8,263	8,504	9,265		8,432	833	9.9%	↑
Outpatient procedures (UHNM)	8,808	7,327	7,684	8,680		7,179	1,501	20.9%	↑
Outpatient procedures (other providers)	13,496	12,319	13,064	14,002		12,514	1,488	11.9%	↑
GP appointments (all)	552,045	485,982	537,554	706,063		621,388	84,675	13.6%	↑
Physical Health Community contacts (attended)	159,690	145,185	148,255	160,575		140,975	19,600	13.9%	↑
Mental Health Community contacts (attended)	45,190	39,530	42,100		42,225		-125	-0.3%	↓

*** NHS 111 - following the switchover to DHU in April 2024, published data is no longer available. Data is available through a local solution from June 2024 onwards. Please note due to the change in methodology it is not currently advisable to compare to the same month last year.**

Most datasets are subject to change upon refresh.

** Physical and mental health contacts - are sometimes one month behind other datasets depending upon publication timing.

The comparison with the same month the previous year is the same month for most measures, apart from when measures lag one month behind (e.g. Mental Health contacts).

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays). The increase in GP appointments in October 2024 is largely due to the additional activity generated from Flu/Covid vaccinations, which started later this year, with the main cohorts commencing early October rather than September. The large increase in elective activity at UHNM is believed to be driven by elective recovery activities alongside industrial action suppressing activity last October.

6.0 Quality and safety

6.1 Quality and Safety strategy

Work continues to deliver the year one actions agreed within the ICB Quality Strategy with over 65% of the plan now delivered. Assurance has been given to the Quality and Safety Committee that there is an expectation that all actions will be completed by the end of quarter four. Discussions are taking place to develop the delivery plan for next year which looks to focus upon the national patient safety improvement programme aligned to the ICB priorities.

6.2 Nursing Times Awards

UHNM received the 2024 Nursing Times Award for the Care of Older People with the introduction of a Diversional Therapist initiative, tackling an increase in falls among older patients by engaging patients in mobility-promoting activities. The judges praised the project as an excellent example of a nurse-led,

patient-centred innovation, noting its introduction of a unique role and meaningful activities for older patients. The judges were impressed by the commitment and passion shown by the team to improve outcomes for older people in acute wards, empowering patients and staff to be creative, confident, valued and engaged, positively impacting care and experience for patients. Supported by UHNM and other systems, a project is now underway to pilot the programme in a small number of care homes.

David Pearson, ICB Chair
Peter Axon, ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

Report to:	**Integrated Care Board**					
Date:	**19 December 2024**					
Title:	**Specialised Commissioning Delegation – phase 2**					
Presenting Officer:	Elizabeth Disney, Chief Transformation Officer					
Author(s):	Kirsten Owen, Associate Director – Special Projects					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* ICB financial allocation will increase to reflect additional commissioning responsibilities. Financial allocations agreed with ICB Chief Financial				
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	SSOT ICB Briefing, NHSE Briefing Paper					

(1) Purpose of the Paper:

This briefing paper describes the next phase of specialised commissioning 'Spec Com' services delegation to ICBs which is to be undertaken by April 2025, this will include details regarding the commissioning resource and the aligned staffing resource, along with the contracting options

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**

(3) Implications:	
Legal / Regulatory	NHS England will retain legal accountability for all specialised services – the ICB will become operationally responsibility for the commissioning and performance of the services
CQC / Patient Safety	A Quality Assurance Framework has been established to support ICB oversight of the new services
Financial (CFO-assured)	ICB financial allocations will increase to reflect additional commissioning responsibilities.
Sustainability	None arising directly from this report

Workforce / Training	None arising directly from this report
Equality & Diversity	The delegation of these services will improve integration and support equality of access across services in Staffordshire and Stoke-on-Trent
Due Regard: Inequalities	None arising directly from this report
Due Regard: wider effect	None arising directly from this report

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why This process is managed by NHSE, who will undertake the necessary DPIA assessment* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	*This process is managed by NHSE, who will undertake the necessary EIA assessment*
	QIA	☐	☐	☒	*If N, why This process is managed by NHSE, who will undertake the necessary QIA assessment* *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Delegation of specialised services is part of national policy as set out in the NHS Long Term Plan

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☒
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

Since April 2023, the Midlands Integrated Care Boards (ICBs) and NHS England have worked under statutory joint arrangements to commission specific specialized services. In April 2024, all 11 Midlands ICBs formally supported the delegation of 59 services as part of phase one of this process. Phase two of this delegation will begin in 2025/26, followed by phase three in 2026/27.

The delegation of specialised commissioning does not change the accountability for these services as this remains with NHS England, however the services become the responsibility of the 11 Midlands ICBs, which is delivered by BSOL on behalf of the West Midlands ICBs and NHS England remains a partner in this process and is responsible for the commissioning of retained specialised services.

Next Phase of Specialist Commissioning Delegation from 2025/26 includes the following:
i. An additional number of acute specialised services
ii. Mental health Learning Disability and Autism (MHLDA) specialised services

A new delegation agreement will be required to include the additional service responsibilities and any agreed developmental arrangements from April 2025, and it is expected that the agreement will be presented to the ICB Board for approval in early 2025

The current Specialised Commissioning programme infrastructure oversees the delegation process, this has relevant representation from the 11 ICB's and is managed through 6 key workstreams: - Governance, BI, Workforce and People, Finance & Contracting, Quality and Comms & Engagement

Specialised commissioning updates regarding quality and finance are shared with the System Quality and Safety committee or Finance and Performance committee respectively.

It is proposed that going forward once the Strategic Commissioning and Transformation Committee has been established that this committee will act as the coordinating committee for Specialised Commissioning Arrangements, receiving regular updates from the six key workstreams and monitoring the value proposition that delegating specialised commissioning was expected to deliver and reporting to the ICB Board.

The NHSE briefing paper provides information in relation to the contracting arrangements for the Mental Health and Learning Disabilities and Autism services, and the eight Midlands NHS Lead Provider Collaboratives (LPC) delivering against the NHSE contract.

The options are currently being considered by ICBs, and will be developed through November/ December to propose the most appropriate model for hosting the contracts to ensure the risks effectively managed and maximise the opportunities. The final decision will be made by the East Midlands Joint Committees and West Midlands Joint committees in January 25.

The ICB will continue to keep the Board updated on the progress of these discussions, final outcome, along with providing assurance to the Board in January and February regarding the Quality reporting and clinical safety of these services as part of this next Phase of Specialised Commissioning Delegation.

The new delegation agreement will be presented to the March 2025 Board for agreement.

(7) Recommendations to Board / Committee:

The ICB Board are asked to:

- Be assured that the task and finish group members are actively involved with the Regional workstreams established to oversee the delivery against the delegation agreement
- To be advised that Staffordshire and Stoke-on-Trent ICB have expressed an interest in option three for the contracting arrangements with regards to the management of the NHS Lead Provider Collaboratives
- To agree that the regional specialised commissioning reports are presented to the Strategic Commissioning and Transformation Committee once this has been established.

BRIEFING PAPER

DATE: December 2024

PAPER TITLE: Mental Health, Learning Disability and Autism specialised services host ICB commissioner and contract model

PURPOSE: INFORMATION ☒

EXECUTIVE SUMMARY: This paper provides a summary of the considerations for contracting models for Specialised Mental Health, Learning Disability and Autism (MHLDA) services Provider Collaborative contracts which will be taken to the East and West Midlands Joint Committees.

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1. INTRODUCTION AND PURPOSE OF THE PAPER

1.1 The purpose of this paper is to update Boards on Specialised Mental Health Learning Disability and Autism Provider Collaborative Contracts prior to a decision that will be taken at the East and West Midlands Joint Committees on the ICB host contract leads once the Provider Collaborative Contracts are delegated to ICB in April 2025.

1.2 NHSE Midlands will cease to have commissioner responsibility for the services delegated to ICBs in the Midlands subject to final Board agreements. ICBs will be the responsible commissioners from 1 April 2025. However, the National NHSE will remain accountable for all specialised MHLDA services regardless of whether services have been delegated to ICBs or retained services that NHSE regions continue to be responsible commissioners for.

1.3 NHS Led Provider Collaboratives PC have the operational and day to day delivery responsibility of the delegated services on behalf of NHSE (ICBs post delegation).

1.4 There are 8 NHS Led Provider Collaboratives in the Midlands. There is a Lead Provider Contract (LPC) in place with each NHS trust who coordinate a set of mental health provider organisations (NHS and Independent sector) working together as a provider collaborative bound by a legal Partnership Agreement and a risk and gain share agreement (in some case). Pre and post delegation, each PC will continue to:

- Coordinate planning/ service transformation activities.
- Coordinate and lead annual contract negotiations with sub-contractors (NHS and ISP) within their PC footprint (circa 18 subcontractors that cover 39 different sub-contracts).
- Hold quarterly contract meetings with sub-contractors.
- coordinate and submit quarterly LPC contract review reports to NHSE Midlands (ICBs post delegation).
- Coordinate and identify population needs, gaps e.g. capacity and bed planning, Natural Clinical Flow with the LPC footprint/ services lines (NB: beds cannot be ring fenced just for East/ West or Midlands patients)

- Have financial oversight and management (payments, investments, expenditure) on a sub-population basis with sub-contractors.
- Ensure quality engagement and involvement of EbE in all activities.
- Undertake procurement activities/ PSR regime 2015 where required e.g. sub-contracting arrangements, new market entrants.
- Have quality and patient safety oversight of providers including annual quality service site reviews, quality improvement oversight.
- Coordinate and submit national/regional returns as requested related to LPC service lines.
- Be part of national LPC network and take part on national/regional working groups e.g. service transformation work, interface with other LPCs in other regions re cross border patient flows/ clinical pathway interdependencies.

1.5 The new 2-year LPCs have been issued and signed from 1 April 2024 with an option to extend for one additional year from 1 April 2026. The decision to extend the additional one year will be via ICBs post delegation as the new responsible commissioner from 1 April 2025.

2.Post Delegation

2.1 All 11 Midlands ICBs will have commissioning responsibility for the following specialised MHLDA delegated services:

- Adult secure services (incudes low secure, medium secure)
- Adult eating disorder services
- Perinatal (Mother Baby Units)
- Tier 4 CYPMH services (includes General Adolescent Unit, Eating Disorder, Low Secure, Psychiatric Intensive Care Units and community forensic CAMHS)

2.2 These delegated services align to the 8 Midlands NHS Led Provider Collaborative operating model/ arrangements (across 40 subcontracts) on a sub-regional footprint (East/West Midlands).

Table 1 – Midlands LPCs.

Specialised MHLDA services	**Live as at**	**East Midlands NHS Lead Provider and no: of subcontracts within footprint**	**Live as at**	**West Midlands NHS Lead Provider and no: of subcontracts within footprint**
Adult Low & Medium Secure (includes MI, PD and LDA)	1 Oct 2020 (Fast Track)	Nottinghamshire Healthcare NHS Foundation Trust 8 subcontracts	1 Oct 2021	Birmingham and Solihull Mental Health NHS Foundation Trust 7 subcontracts

Specialised MHLDA services	Live as at	East Midlands NHS Lead Provider and no: of subcontracts within footprint	Live as at	West Midlands NHS Lead Provider and no: of subcontracts within footprint
Tier 4 CYMHS services (GAU, PICU, ED, LSU)	1 April 2021	Northamptonshire Healthcare NHS Foundation Trust 6 subcontracts	1 Oct 2022	Birmingham Women's and Children NHS Foundation Trust 7 subcontracts
Adult Eating Disorders (AED)	1 April 2021	Leicester Partnership NHS Trust 5 subcontracts	1 April 2021	Midland Partnership NHS Foundation Trust 5 subcontracts
Perinatal (Inpatient MBU)	1 Oct 2023	Derbyshire healthcare NSH Trust 1 subcontract	1 Oct 2023	Midland Partnership NHS Foundation Trust 1 subcontract

A small number of acute and MHLDA specialised services will remain commissioned through NHSE.

2.3 From 1 April 2025, NHSE Midlands will cease to have commissioner responsibility.

2.4 The Commissioning Team that will transfer to the host ICB will continue to provide the commissioning expertise to include the following

- Leadership/ coordination and assurance role re retain Midland's view across the 8 LPCs e.g. service transformation across LPC in the Midlands.
- Provide expertise and support to NHS Led Provider Collaboratives (LPC) to achieve strategic ambitions.
- Support LPCs to develop and deliver their transformation programme across specialised MHLDA delegated service lines.
- Coordinate learning, risks, and issues within the local systems and LPCs to inform learning and action at a national, regional and system level.
- Ensure LPCs complete consolidated annual PAMs for all delegated specialised MHDLA service lines by provider.
- Hold quarterly LPC contract review meetings with the respective 8 Midlands Lead Provider Collaboratives.
- Director level representation to each LPC programme boards.
- Interface with national NHSE and networks that include all LPCs across the country and NHSE regions (retained NHSE service lines).

- Coordinate, facilitate, de-escalate matters raised by LPCs and other regions/ ICBs.
- Coordinate/respond to FOI, complaints, and legal proceedings with respective LPCs and relevant partners.

2.5 The ICB host holding the contract would be expected to be:

- 3-way signatory to all NHS Led Provider Collaborative Direct Agreements with subcontractors to enable 'step in rights' should a LPC declare they no longer wish to be a Lead Provider or ICB decision to disband the NHS Led Provider Collaborative operating model.
- Step in rights mean, the responsible commissioner is required to take back direct operational responsibility for these services and to directly manage the subcontracts and all the associate actions that the LPC would have undertaken.

2.6 The management capacity and leadership of all processes will be provided by the expertise in the specialised commissioning team (who will be hosted by BSOL) but working on behalf of the East And West Midlands joint committees.

2.7 In the unlikely evet of any requirement to take back direct operational responsibility the specialised commissioning team would undertake this function working closely with the host ICB holding the contract. This would be articulated in the delegation agreement.

3. NEXT STEPS

3.1 Options are being developed through November and December 24 through the working groups to develop a consensus view of the most appropriate model for hosting the contracts which manages risk effectively and whilst maximising the opportunities.

3.2 These options will need support from the ICB host designate before going to the East Midlands Joint Committees and West Midlands Joint committees in January 25

3.3 The agreed position will then be incorporated in the delegation agreements for ICB board approval before the end of March 2025

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07

Report to:	**ICB Board**						
Date:	**19th December 2024**						
Title:	**Medium Term Plan – Mitigated Modelling**						
Presenting Officer:	Paul Brown, Chief Finance Officer Elizabeth Disney, Chief Transformation Officer						
Author(s):	Co-produced with members of the Base Model (MTP) - Task and Finish Group						
Document Type:	Report						
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒	
	Approval (A)	☐	**Ratification (R)**	☒	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	Medium Term Plan (MTP) Mitigated Model						

(1) Purpose of the Paper:
The purpose of this paper is to provide the board with an update on the mitigated model developed to support the Medium Term Plan (MTP).

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Finance and Performance Committee (A)	03/12/2024
System Performance Group (D)	27/11/2024

(3) Implications:	
Legal or Regulatory	N/A
CQC or Patient Safety	N/A
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	N/A
Equality & Diversity	N/A

Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

Our shared endeavour over the five-year period of our Medium-Term Plan is to create a values-based healthcare system which improves outcomes through optimised care and support. This will also pave the way for a future that is a better place to work and be both operationally & financially sustainable.

The mitigated model

The purpose of the mitigated modelling is to scope a set of evidence-based opportunities that could address the impacts of demographic growth and health inequalities.

The Challenge Ahead
Without action it is projected at a high level that we will see a 2.9% increase in Type 1 Accident and Emergency activity, 2.7% increase in daycase and elective and 2.7% increase in outpatients. Demand for community services increase by 6%, Mental Health services will see a 2.7% increase and Primary Care 7% increase in demand. We have an underlying deficit of £280m at present. This would grow were we to increase costs to cover the impact of our ageing population. We have assessed that we need to achieve recurrent savings of £602m by 2029/30 to eliminate this gap.

Approach to the model and opportunities
A structured data driven approach has been taken to identifying opportunities aimed at supporting decisions to address our key clinical challenges and financial gap. Opportunities have been identified across Model Health System pathways (elective - cancer and MSK, non-elective - gastrointestinal, genitourinary, respiratory, outpatients and medicines management), our system collaborative programmes, productivity, provider efficiency and innovation. We have had early discussions with the Clinical and Professional Leads to share and explore the opportunities identified and gather their professional insight from the outset.

We have adopted a set of modelling assumptions to deliver breakeven over a 5-year period, produced in the absence of the long-term allocations, planning assumptions and national efficiency ask. To have a breakeven recurrent underlying position within 5 years a 4.8% efficiency of influenceable expenditure is

required, which equates to 3% of the total cost base. This is on average £113m a year of recurrent savings across the system. The model indicates that achieving balance is possible, but it would require the full five years to do so.

The modelling and opportunities were presented to the System Performance Group who were supportive of the model as the intended approach and a commitment to pursue the opportunities collectively. System Finance and Performance Committee approved the model and opportunities on 3rd December.

Next Steps

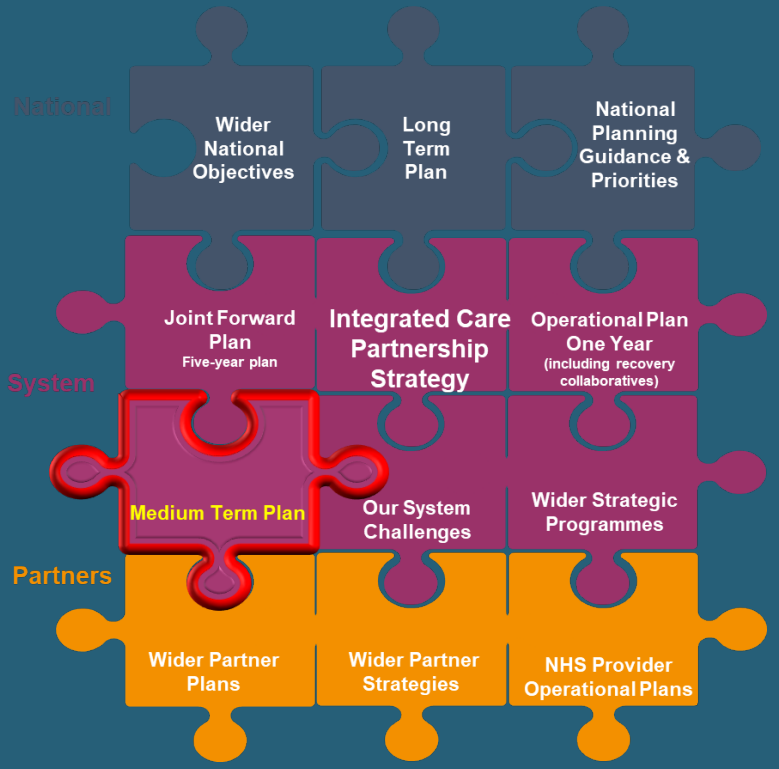
- *December onwards* - the detailed build translating our ambitions into a phased, actionable plan focused on clinical optimisation and value, productivity and system transformation including
  1. Defining clinical optimisation priorities with transformation overseen by the Health and Care Senate
  2. Defining a structured approach to productivity through the work of provider collaboration and individual organisational plans
  3. A focus on community transformation through the Strategic Transformation Group
  4. Agreeing our financial principles for cost reduction and investment
- *December to February* - talk to NHS England about the need for a multi-year agreement to return to financial balance and deficit reduction plan.
- *End of March* - Agree an operational plan – reprofiled activity, workforce and finance and assurance on quality/safety – based on agreed MTP priorities being delivered
- *Ongoing* - the development of our plans including delivery design, implementation, and transformation will require a significant change in the way our workforce and leaders currently operate. The transformation required will be significantly influenced by culture and the requirements to work differently. Engagement and involvement of the workforce and leaders across the system will be a priority including a robust OD and change management programme spanning 5 years and beyond.

(7) Recommendations to Board / Committee:

1. Be assured on the work undertaken to finalise the MTP mitigated model and the next steps outlined.
2. Ratify the approval decision of the System Finance and Performance Committee.

Staffordshire and Stoke-on-Trent Integrated Care System

Medium Term Plan (MTP)



Mitigated Model
November 2024

Executive Summary

Our shared endeavour over the five-year period of our Medium-Term Plan is to create a values-based healthcare system which improves outcomes through optimised care and support. This will also pave the way for a future that is a better place to work, and both operationally & financially sustainable.

- We have a material bed gap, long waiting times and a large underlying deficit. Base modelling indicates that without further action this will result in a bigger bed gap, even longer waits and a bigger deficit.
- We will see an increase in population of 3.9% by 2036 with the population aged over 70 increasing by 20.8%. Services which treat older patients are likely to see the biggest increase in demand. The total burden of ill-health will increase, with more people living with long-term conditions. We have an underlying deficit of £280m at present. This would grow were we to increase costs to cover the impact of our ageing population. We have assessed that we need to achieve recurrent savings of £602m by 2029/30 to eliminate this gap.
- A structured data driven approach has been taken to identifying opportunities aimed at supporting decisions to address our key clinical challenges and financial gap.
- We will need to maximise all opportunities available to the system to address our gap, improve outcomes and optimise care. We have identified opportunities sitting across Model Health System pathways (elective - cancer and MSK, non-elective - gastrointestinal, genitourinary, respiratory, outpatients and medicines management), our system collaborative programmes, productivity, provider efficiency and innovation.
- We have adopted a set of modelling assumptions to deliver breakeven over a 5-year period, produced in the absence of the long-term allocations, planning assumptions and national efficiency ask. These assumptions are built off a reasonable set of expectations based on past levels of efficiency, the reductions in NHS productivity and a not unreasonable assumption of a flat cash settlement once pay awards and other known pressures are addressed.
- To have a breakeven recurrent underlying position within 5 years a 4.8% efficiency of influenceable expenditure is required, which equates to 3% of the total cost base. This is on average £113m a year of recurrent savings across the system. The model indicates that achieving balance is possible, but it would require the full five years to do so.
- In summary, while the challenge is substantial, success is dependent on unified effort and commitment from across the system.

Introduction: Our future success

Critical to our success will be ensuring that for the future we have

- Developed and delivered system transformation with optimised care for our population and shifted care closer to home
- Provided a significantly improved experience and outcomes for both those who use our services and those who work within it
- Addressed areas where we are outliers from established benchmarking
- Harnessed the power of prevention and proactive care recognising that interventions that protect health tend to be far less costly than dealing with the consequences of illness
- Adapted to emerging treatments
- Unlocked productivity using Technology and Digital
- Aligned Workforce Strategy with Future Policy Needs recognising that successful transformation and change is dependent on an engaged and healthy workforce
- Achieved Financial Sustainability through defining where and how our allocation is best utilised

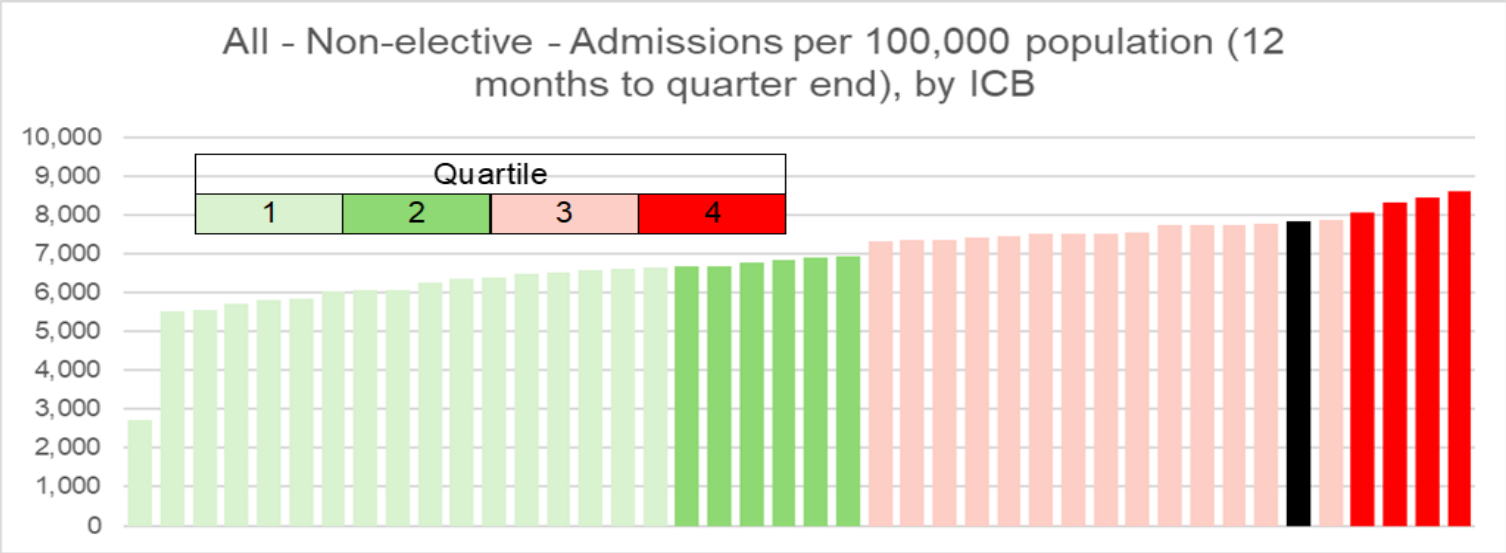
Our Approach

- The size of the deficit is far too large now to tackle in one year. We need a multi-year strategy.
- We set out to achieve optimal levels of acute activity for our population. Currently we over-hospitalise, relative to our peers. If we can reduce the rates of hospitalisation, we would save money, and it would be beneficial in terms of outcomes.
- Over the course of this strategic period, we would also need to deliver improved productivity and efficiency. We will need to provide current levels of care for less money.
- As part of this transformation, we will need to reduce levels of CHC spend to be in line with our peers.
- We set out to create a model to show the impact of applying this best practice. We sought to establish whether applying best practice would be sufficient to eliminate the underlying deficit. This paper summarises the work done to this point – the development of a theoretical but evidence-based model.
- As shown in the following slides, the model does show that best practice would enable the system to achieve recurrent financial sustainability. However this is theoretical at this point, so the work now needs to move into the next phase, which is to:
    - Consider the sequence of the transformation plans
    - Look at the annual impact and the way that double running costs during transformation would be factored in
    - Seek approval of regulators to this multi-year approach

Data, intelligence and evidence informed approach

- We have used a structured data driven approach to identifying opportunities aimed at supporting decisions to address our key challenges.
- We have looked at the opportunities to
    - understand at a condition/pathway level the variation for our population compared with the most similar systems (Source Model Health System)
    - understand the drivers of this variation by understanding how our population accesses healthcare (eg the high levels of over 65 admissions, High Intensity Users, Continuing Health Care, growth in mental health demand particularly in children and young people)
    - understand where our costs of delivering healthcare vary from our most similar systems.
- We have had early discussions with the Clinical and Professional Leads to share and explore the opportunities identified and gather their professional insight from the outset.
- We are building a model based on both the allocative efficiency (transformation) and technical efficiency (productivity).
- Within Model Health System the ICB does not have access to the benchmarking for our main out of system providers. To address this, we have set out leading metrics eg conversion of A&E attendances to admissions, day case procedures v inpatient procedures; UEC length of stay, which the regional analytical team will work through to inform the more detailed work around the opportunities identified to date for our population.

One Example from Model Health System Opportunity



Non Elective Inpatients

Opportunity	Metric	SSOT Status	ICB rate per population		ICB Numerator			Sub ICB Rate						In System	Out of System
			Peer	SSOT	Peer	SSOT	Var	CC	ES	NS	SES	SAS	SOT		
All Non Elective	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	7,723	7,827	91,987	99,272	7,285	7,687	7,604	7,553	7,521	6,941	9,039	5,578	1,707
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	54,915	53,682	681,776	707,198	25,422	57,513	54,673	49,075	56,281	45,691	58,377	8,691	16,731
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£270k	£285k	£301m	£368m	£67m	£300,885	£297,665	£256,934	£294,486	£246,093	£309,993	£29,247,484	£37,752,516
Problems of the Gastro-intestinal system	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	973	1,026	10,693	12,990	2,297	995	906	1,081	919	884	1,233	2,145	152
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	6,185	6,862	71,722	89,197	17,475	8,019	5,570	6,795	6,129	6,397	7,973	12,582	4,893
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£32k	£38k	£36m	£49m	£13m	£40,375	£34,615	£37,984	£33,942	£34,177	£44,327	£8,899,316	£4,100,684
Problems of the Genitourinary system	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	540	627	5,267	8,100	2,833	594	544	650	551	565	775	2,275	558
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 4	3,646	4,195	39,410	56,122	16,712	4,266	3,441	4,104	4,048	3,841	5,058	11,789	4,923
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£17k	£20k	£17m	£26m	£9m	£21,155	£17,104	£19,292	£18,491	£18,343	£23,374	£4,827,431	£4,172,569
Problems of the Respiratory System	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	1,185	1,221	12,818	15,929	3,111	1,324	1,087	1,184	1,171	1,010	1,446	2,152	959
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	8,420	8,705	94,500	116,493	21,993	9,335	8,193	8,341	8,489	6,924	10,406	13,764	8,229
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£38k	£41k	£42m	£55m	£13m	£45,072	£38,782	£39,906	£39,831	£33,837	£48,945	£5,572,320	£3,427,680
Endocrine, Nutritional and Metabolic Disorders	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	223	208	2,637	2,881	244	233	209	202	228	198	256	142	102
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	1,613	1,624	20,015	21,463	1,448	1,727	1,744	1,342	1,643	1,486	1,847	615	833
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£6.9k	£7.6k	£8.5m	£10m	£0.2m	£7,782	£7,035	£6,758	£7,413	£6,937	£9,224	£130,614	£69,386

- The graphs show variation for our population compared with the most similar systems i.e. taking account of the demographics by ICB. The black bar is our ICB.
- On this graph in their modelling, NHSE indicates that red is negative while green is positive ones.
- For Non-Elective admissions, the ICB has a rate of 7.8k admissions per 100k population, at the very top end of quartile 3.
- Opportunities for improvement' are then drilled down by pathway eg gastro- intestinal.
- The table shows opportunities where we have a higher rate of admissions per population than our peers in the Midlands split by ICB/sub ICB then in system and out of system activity.
- Further detail on all the opportunities identified are available in the supporting information around quartile, activity, spend, to sub-ICB level to identify specific locations where variation is higher.
- MHS, along with additional data sources such as Finger Tips and the Shared Care Record, provides extensive supporting analysis. These resources will be leveraged to develop more detailed plans aimed at addressing the identified variations.

Model Health System – Themes and Opportunities Identified

- To mitigate our position, we have identified opportunities in specific areas, themed around pathways where there is the highest level of variation for our population compared with the most similar systems i.e. taking account of the demographics (Source Model Health System).
- Total bed reduction across all acute providers (in and out of system) has been calculated locally to provide an indicative daily average. NHSE modelling removes zero-length of stay non-elective admissions due to data quality issues relating to the coding of activity from Same-Day Emergency Care Units
- Although the opportunities are derived from acute activity, it is crucial to begin identifying potential interventions earlier in the pathway (addressing failure demand & focusing on the primary/secondary prevention offer) to improve outcomes, reduce activity going into secondary care and provide optimised care.

Theme	Comments	Activity Reduction	Beds Reduction (average daily)
MSK Elective	• Rates of activity highest in Cannock where 53% at RWT, and 20% to Rowley Hall. • Procedures of Hand, Spine, Hip and Knees. Hand procedures all at Royal Wolverhampton Trust. • High rates in Stafford, with 55% at Rowley/Beacon Park	6.6k per year	26
Cancer Elective	• Inpatient Elective admissions. • With exception of Cannock Chase all localities have admission rates in quartile 4.	22.4k per year	38
Gastrointestinal Non-Elective	• Rates of activity highest in North Staffs and Stoke with majority at UHNM. • Main conditions include gastroenteritis and colitis, constipation, gastritis. 20% of admissions are children	2.3k per year	48
Genitourinary Non-Elective	• All localities (apart from East Staffs) are in Quartile 4. Third of admissions are UTIs. Acute Renal Failure and Retention of Urine also high levels. • Levels of activity at all providers match proportions across localities.	2.8k per year	46
Respiratory Non-Elective	• Highest rates in Stoke on Trent. • COPD and Pneumonia.	3.1k per year	83
Outpatients (all specialties)	• Higher rates per population in Cannock Chase and Stafford, particularly in MSK services, reflecting the level of MSK elective admissions (see above)	394k attends per year	-
Primary Care Prescribing (all drugs)	• In quartile 3 for items prescribed per population. Stoke-on-Trent has the 3rd highest rate of prescribing for respiratory conditions in England	3.1m items prescribed per year	-

The Size of the Financial Challenge Over the 5 years

2024.25 Financial position

- Outturn deficit likely to be £146m
- That is underpinned by £124m of non-recurrent support

Underlying Deficit closing 2024.25

- £280m

Impact on the Underlying Deficit of the further activity growth due to demographics

- £318m

Estimated annual cost of cost pressures, inflation, OOA tariff deflator

- Average £57m a year

Savings required over 5 years to achieve recurrent break-even

- £318m + (£57m x 5) = £602m

Approach

- We have adopted a set of modelling assumptions to deliver breakeven over a 5-year period, produced in the absence of the long-term allocations, planning assumptions and national efficiency ask. These assumptions are built off a reasonable set of expectations based on past levels of efficiency, the reductions in NHS productivity and a not unreasonable assumption of a flat cash settlement once pay awards and other known pressures are addressed.

- These opportunities are categorised as follows:

	Rationale	Basis of Assessment
Model Health System	Opportunity to right size the activity as benchmarking suggests areas of over hospitalising our population. Supported by interventions including 'Optum 12'	Calculated at 75% of PbR to reflect fixed costs of running the service will not be saved, These opportunities have not been through provider costing models. Where these specialties are a large user of independent sector activity the saving will be full cost
Collaborative	The existing system collaboratives have several schemes running with associated financial impacts to overlay into the MTP (includes CHC, prescribing, clinical values)	CHC opportunity is based on national benchmarking, Demand management focus of mitigating the growth modelled. Contracts, clinical values and medicine have stretched targets applied to existing programmes. Enabling function opportunity is using Deloitte. Included in the MTP is an investment reserve of 0.5% to reflect the costs of transforming services
Productivity	As part of the national agenda to improve productivity	Calculated by 2% of pay costs for treating the same number of patients more productively (transformation will have removed any growth). This does not return the system to pre covid productivity as per the NHSE calculation
Provider Efficiency	As part of national efficiency ask. Provider efficiency will be supported by I&I Deloitte interventions	A 2% efficiency is modelled based on past levels of recurrent efficiency delivered and is in line with 2024/25
Innovation	To ensure we capture all opportunities and in line with Lord Darzi report adapting to technologies	Included Digital and estates where innovation for invest to save business cases are anticipated over the MTP period

Mitigated Modelling

- Based on the information the opportunities equate to £631m over 5 years
- Each segment requires working up further over the coming weeks and developing into clinical models which would also remove any potential double count in pathways
- The programme opportunity is purposely larger than required in order to create an investment reserve to help deliver transformation, there is also £10m built into the base model
- The opportunities are split between allocative efficiency with different resource inputs are combined to produce different outputs and technical efficiency by achieving maximum outputs with the least cost
- The phasing is linear across the 5-year period, this will require refining as the clinical models are developed

	Efficiency Type	Area	Year 2025/26	2026/27	2027/28	2028/29	2029/30	Total
			£m	£m	£m	£m	£m	£m
Allocative	Model Health System	MSK Electives	4	4	4	4	4	20
		Gastrointestinal NEL	2	2	2	2	2	10
		Genitourinary NEL	1	1	1	1	1	7
		Respiratory NEL	2	2	2	2	2	10
		Cancer	2	2	2	2	2	8
		Other	4	4	4	4	4	20
	Model Health System Opportunity		**15**	**15**	**15**	**15**	**15**	**75**
	Collaboratives	Continuing healthcare	13	13	13	13	13	65
		Demand management	10	10	10	10	10	50
		Contracts	3	3	3	3	3	15
		Clinical value & Medicines	3	3	3	3	3	15
		Enabling functions	3	3	3	3	3	13
	Total Collaboratives		**32**	**32**	**32**	**32**	**32**	**158**
	Innovation	Digital	2	2	2	2	2	10
		Estates	1	1	1	1	1	5
	Total Innovation		**3**	**3**	**3**	**3**	**3**	**15**
	Sub Total Allocative		**49**	**49**	**49**	**49**	**49**	**247**

	Efficiency Type	Area	Year 2025/26	2026/27	2027/28	2028/29	2029/30	Total
Technical	Productivity	Productivity (2% pay wte)	26	26	26	26	26	132
		OOA Contracts	7	7	7	7	7	34
		Independent sector	2	2	2	2	2	10
	Total Productivity		**35**	**35**	**35**	**35**	**35**	**176**
	Provider Efficiency	2% of cost base	**42**	**42**	**42**	**42**	**42**	**209**
	Sub Total Technical		**77**	**77**	**77**	**77**	**77**	**384**
	Grand Total		**126**	**126**	**126**	**126**	**126**	**631**

Next Steps: from a model to defining our plans

- We will continue to co-produce and co-develop the opportunities outlined, enabling us to co-deliver and co-own a transformed future for both those who use our services and those who work within them.
- December onwards - the detailed build translating our ambitions into a phased, actionable plan focused on clinical optimisation and value, productivity and system transformation including
    1. Defining clinical optimisation priorities with transformation overseen by the Health and Care Senate
    2. Defining a structured approach to productivity through the work of provider collaboration and individual organisational plans
    3. A focus on community transformation through the Strategic Transformation Group
    4. Agreeing our financial principles for cost reduction and investment
- December to February talk to NHS England about the need for a multi-year agreement to return to financial balance and deficit reduction plan.
- Agree an operational plan by end March 2025 – reprofiled activity, workforce and finance and assurance on quality/safety – based on agreed MTP priorities being delivered
- Ongoing - the development of our plans including delivery design, implementation, and transformation will require a significant change in the way our workforce and leaders currently operate. The transformation required will be significantly influenced by culture and the requirements to work differently. Engagement and involvement of the workforce and leaders across the system will be a priority including a robust OD and change management programme spanning 5 years and beyond.

Conclusion

- There is considerable potential to reduce activity by addressing the current over-hospitalisation of the population.
- It should be acknowledged that many of these opportunities have been recognised for some time and realising them now will demand a fundamentally different approach.
- Achieving this would require a comprehensive system transformation programme.
- The requirement to deliver 2% efficiency and 2% productivity improvements presents a significant challenge, though it is not entirely unprecedented compared to expectations placed on organisations in the past.
- Given the scale of the task, a collective effort will be essential, as it cannot be accomplished by individual organisations working in isolation.
- The model indicates that achieving balance is possible, but it would require the full five years to do so.
- Efforts should focus on persuading regulators to grant this timeframe, as extending beyond five years is unlikely to be approved. Even with the full five years, the task remains highly demanding.
- In summary, while the challenge is substantial, success is dependent on unified effort and commitment from all parties involved.

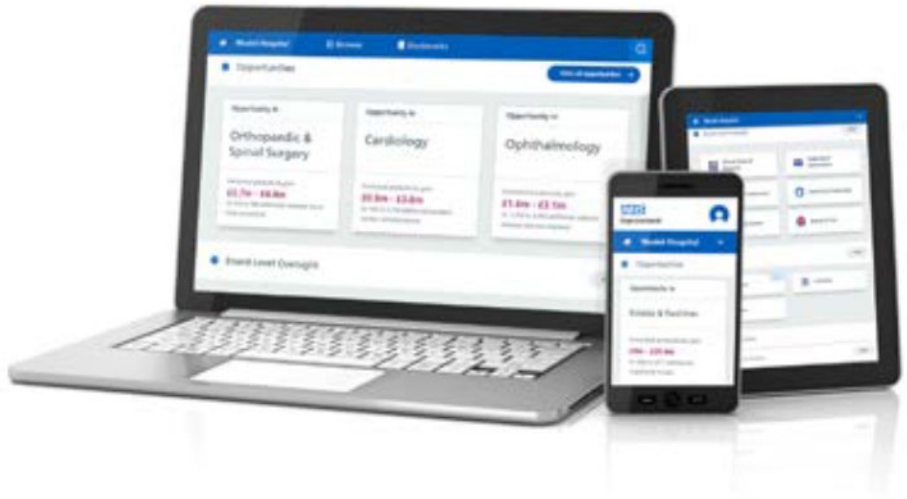
Supporting Information on Opportunities from Model Health System

What is the Model Health System?

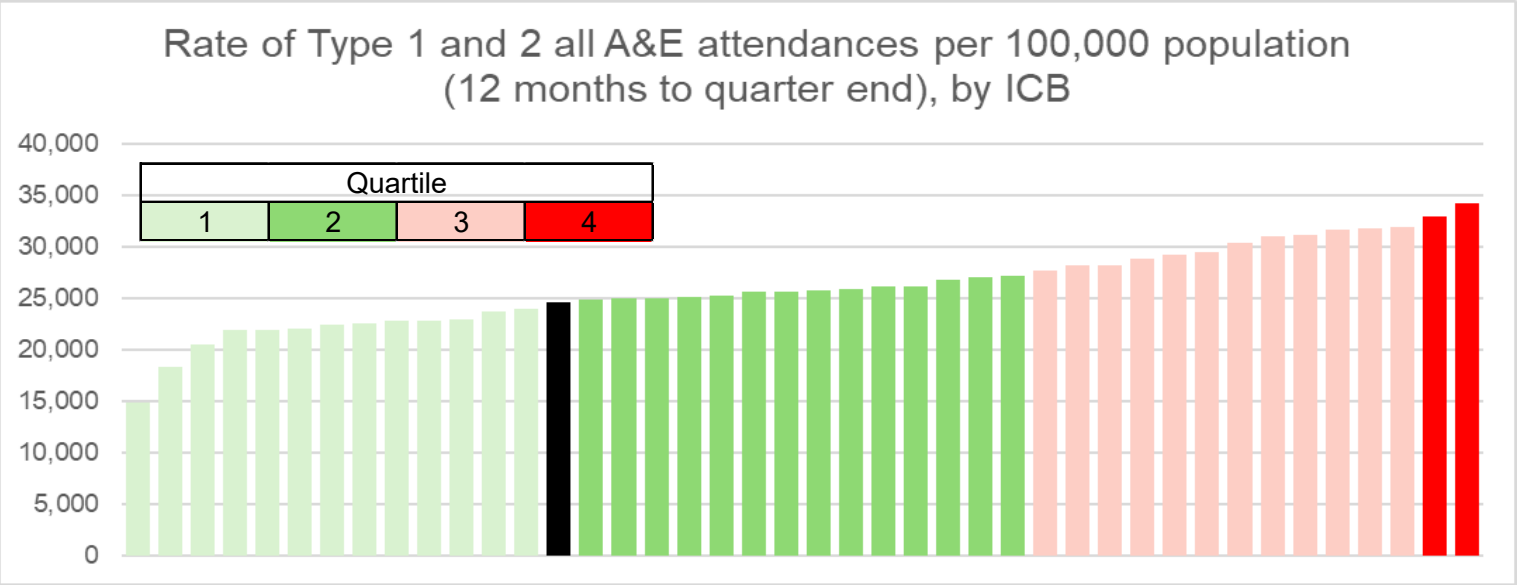
- The Model Health System is a data-driven tool that supports improving patient outcomes and population health.
- It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement.

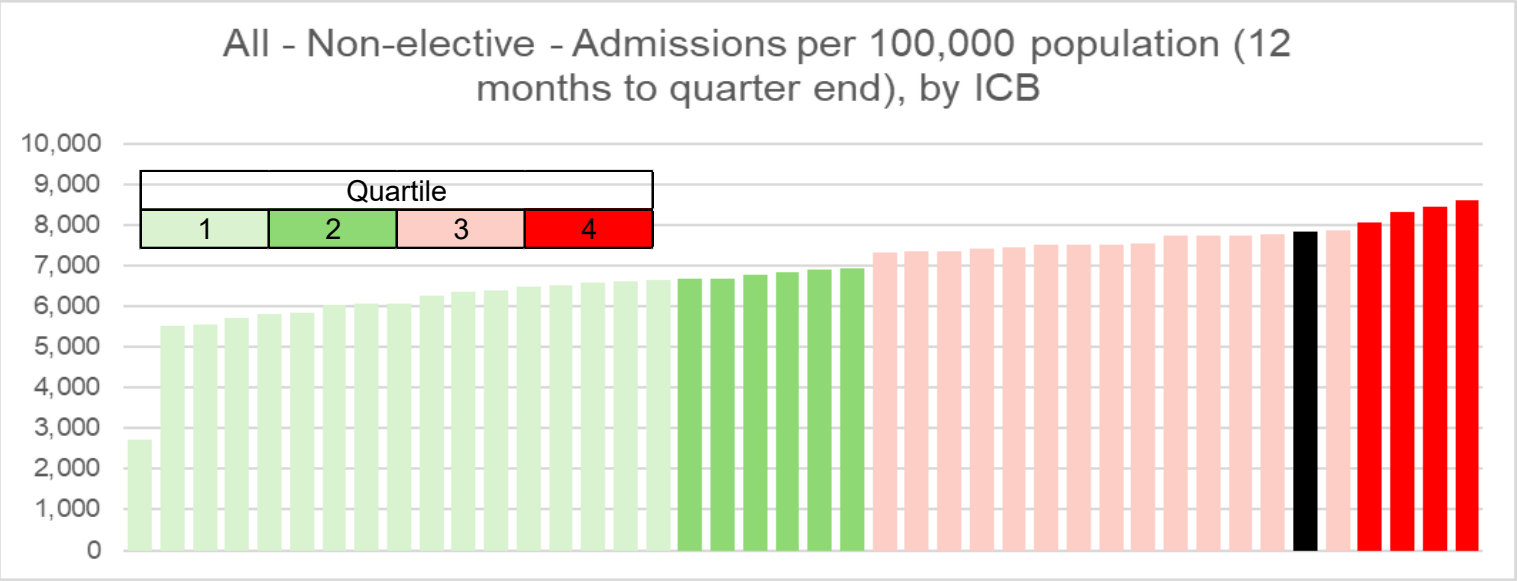
Benchmarked data across specialties, providers and systems is available to all systems within the Model Health System

- Clinical improvement data, reflecting the **GIRFT** and **RightCare programmes** are all provided with the Model Health System and routinely updated.
- **'Opportunities for improvement'** are highlighted at ICB/sub-ICB provider level, in addition to **highlighted metrics and measures**
- Activity data, theatre productivity, diagnostics, workforce and medicines optimisation info are all provided
- The data produced by the Model Health System provides an indicator.
- The important thing is that it helps the multi-disciplinary team to identifying opportunities and to drill down into the key issues.



Model Health System Opportunity - A&E and Non-Elective Admissions





- The charts show A&E attendances (Type 1 and 2) and Non-Elective Admissions per 100,000 population, indirectly standardised to take account of the differing age structure of populations across England. Data is for a 12-month period ending June 2024.
- Charts show the activity rate for all 42 ICBs in England. **The ICB** is the black bar. The rate is calculated from registered practice population of the ICB and is activity at all providers.
  - For **A&E Activity**, the ICB has a rate of 24.6k attendances per 100k population and in **Quartile 2**. This metric excludes activity at Type 3 units (e.g. Sir Robert Peel, Haywood, Samuel Johnson)
  - For **Non-Elective admissions**, the ICB has a rate of 7.8k admissions per 100k population and in **Quartile 3**. Zero-length of stay non-elective admissions have been removed due to data quality issues relating to the coding of activity from Same-Day Emergency Care Units.
  - Further work will be needed to understand the implications of lower rate of A&E activity and higher rate of Non-elective admissions. For example, analysis in conversion rates by provider and conditions may need to be carried out.

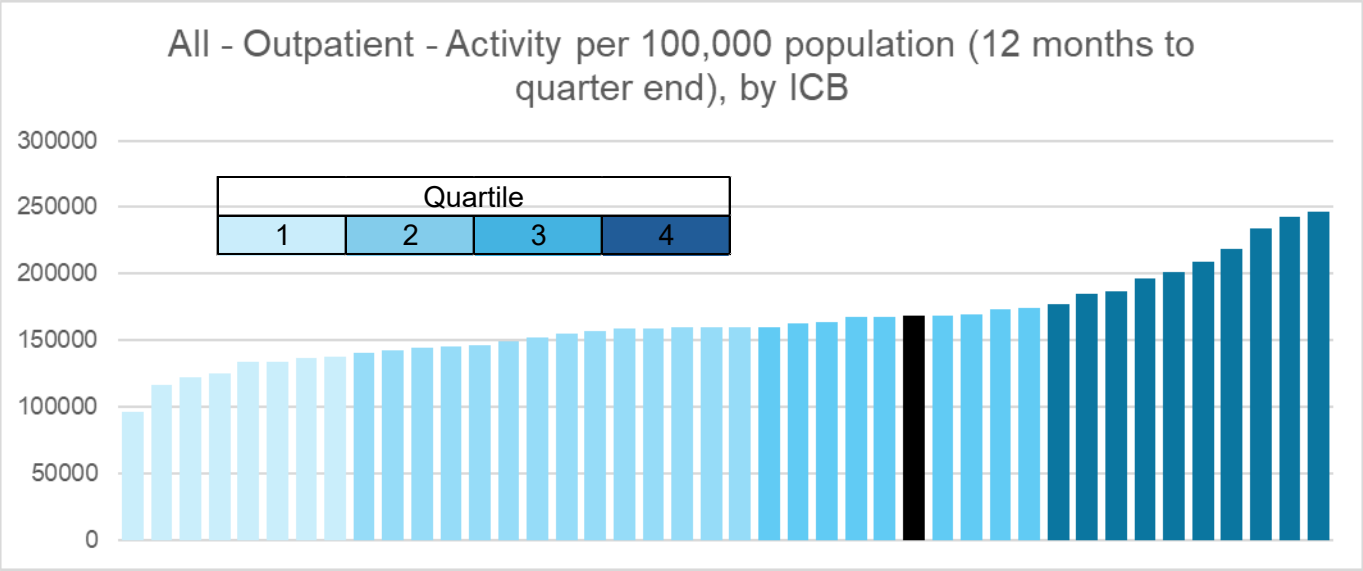
Opportunity Assessment – Non-Elective Inpatients

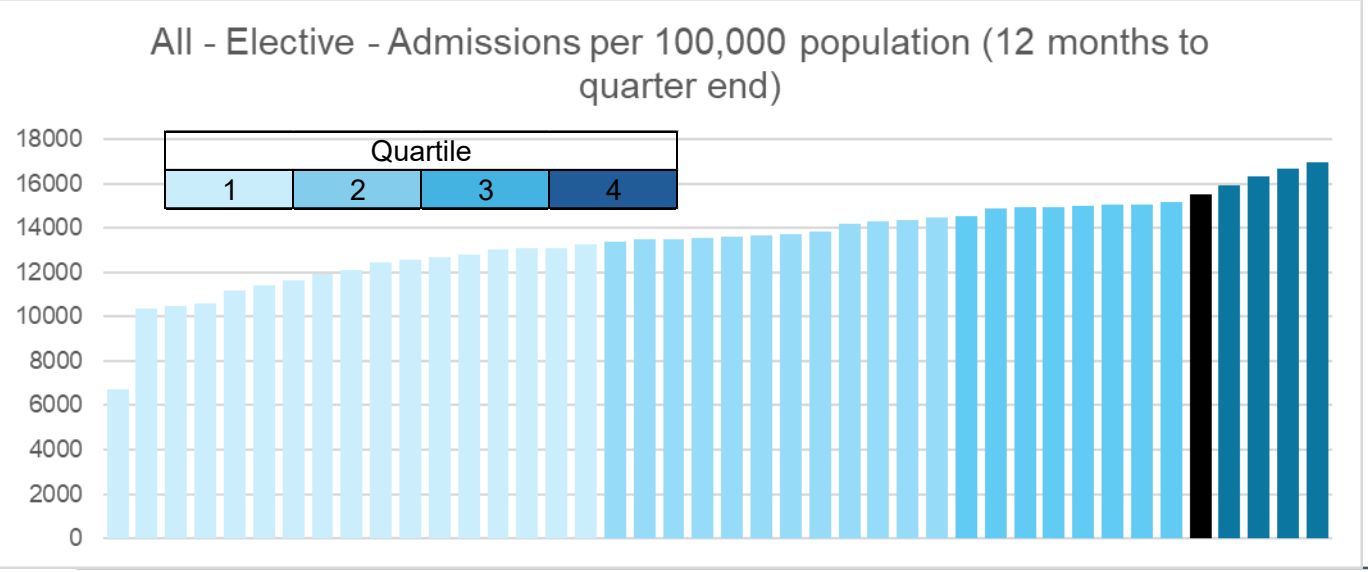
- Opportunities are highlighted at ICB sub-ICB level where we have a higher rate of admissions per population than our peers in the Midlands, then split by in system and out of system activity.

Non Elective Inpatients

			ICB rate per population		ICB Numerator			Sub ICB Rate							
Opportunity	Metric	SSOT Status	Peer	SSOT	Peer	SSOT	Var	CC	ES	NS	SES	SAS	SOT	In System	Out of System
All Non Elective	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	7,723	7,827	91,987	99,272	7,285	7,687	7,604	7,553	7,521	6,941	9,039	5,578	1,707
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	54,915	53,682	681,776	707,198	25,422	57,513	54,673	49,075	56,281	45,691	58,377	8,691	16,731
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£270k	£285k	£301m	£368m	£67m	£300,885	£297,665	£256,934	£294,486	£246,093	£309,993	£29,247,484	£37,752,516
Problems of the Gastro-intestinal system	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	973	1,026	10,693	12,990	2,297	995	906	1,081	919	884	1,233	2,145	152
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	6,185	6,862	71,722	89,197	17,475	8,019	5,570	6,795	6,129	6,397	7,973	12,582	4,893
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£32k	£38k	£36m	£49m	£13m	£40,375	£34,615	£37,984	£33,942	£34,177	£44,327	£8,899,316	£4,100,684
Problems of the Genitourinary system	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	540	627	5,267	8,100	2,833	594	544	650	551	565	775	2,275	558
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 4	3,646	4,195	39,410	56,122	16,712	4,266	3,441	4,104	4,048	3,841	5,058	11,789	4,923
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£17k	£20k	£17m	£26m	£9m	£21,155	£17,104	£19,292	£18,491	£18,343	£23,374	£4,827,431	£4,172,569
Problems of the Respiratory System	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	1,185	1,221	12,818	15,929	3,111	1,324	1,087	1,184	1,171	1,010	1,446	2,152	959
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	8,420	8,705	94,500	116,493	21,993	9,335	8,193	8,341	8,489	6,924	10,406	13,764	8,229
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£38k	£41k	£42m	£55m	£13m	£45,072	£38,782	£39,906	£39,831	£33,837	£48,945	£5,572,320	£3,427,680
Endocrine, Nutritional and Metabolic Disorders	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	223	208	2,637	2,881	244	233	209	202	228	198	256	142	102
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	1,613	1,624	20,015	21,463	1,448	1,727	1,744	1,342	1,643	1,486	1,847	615	833
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£6.9k	£7.6k	£8.5m	£10m	£0.2m	£7,782	£7,035	£6,758	£7,413	£6,937	£9,224	£130,614	£69,386

Model Health System - Elective and Outpatients





- The charts show Outpatients attendances and Elective Admissions per 100,000 population, indirectly standardised to take account of the differing age structure of populations across England. Data is for a 12-month period ending June 2024.
- The charts show the activity rate for all 42 ICBs in England. The ICB shown as black bar. Rate calculated from registered practice population of the ICB and is activity at all providers.
- For **Outpatient Activity**, the ICB has a rate of 168.5k attendances per 100k population and in **Quartile 3**.
- For **Elective admissions**, the ICB has a rate of 15.5k admissions per 100k population and in **Quartile 3.**

Opportunity Assessment – Elective Inpatients

- Opportunities are highlighted at ICB sub-ICB level where we have a higher rate of admissions per population than our peers in the Midlands, then split by in system and out of system activity.

Elective Inpatients

			ICB rate per population		ICB Numerator			Sub ICB Rate							
Opportunity	Metric	SSOT Status	Peer	SSOT	Peer	SSOT	Var	CC	ES	NS	SES	SAS	SOT	In System	Out of System
All Elective Admissions	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 3	14,859	15,515	161,326	199,636	38,310	14,871	14,960	15,785	14,543	16,550	16,111	28,964	9,346
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 3	12,573	12,782	136,926	165,509	28,583	12,224	12,024	13,212	12,007	13,107	13,570	23,553	5,030
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£184k	£194k	£201m	£250m	£49m	£208	£171	£196	£186	£205	£196	£33,220,276	£15,779,724
Cancer Elective Admissions	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	4,511	5,133	45,422	67,828	22,406	3,475	5,465	5,444	4,574	5,582	5,755	18,246	4,160
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 4	3,703	4,029	39,102	53,135	14,033	3,068	4,089	4,191	3,712	4,317	4,457	11,422	2,611
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 3	£37k	£40k	£42m	£53m	£11m	£36,745	£37,823	£41,650	£39,066	£41,694	£43,089	£7,931,859	£3,068,141
MSK Elective Admissions	Admissions per 100,000 population (12 months to quarter end)	CCG Quartile 4	1,297	1,673	14,981	21,588	6,607	2,482	1,575	1,417	1,563	2,047	1,395	2,864	3,743
	Bed days per 100,000 population (12 months to quarter end)	CCG Quartile 4	1,597	1,959	16,438	25,840	9,402	2,480	1,822	1,821	1,955	2,058	1,825	4,553	4,849
	Tariff weighted activity per 1,000 population (12 months to quarter end)	CCG Quartile 4	£44k	£54k	£51m	£71m	£20m	£67,609	£46,179	£51,688	£50,553	£63,914	£50,451	£11,423,828	£8,576,172

Glossary

Allocative efficiency

- This is the idea of doing the right things by providing the highest value health services with the available resources - transformation. It's an economic concept that measures how different resources are combined to produce different outputs. For example, a department might shift resources from treatment to preventative support to achieve the same outcomes more efficiently. Improving efficiency in the NHS

Technical efficiency

- This is the idea of doing things right by achieving the most output with the least cost - productivity. For example, a surgical department might reduce the length of stay for patients after an operation to increase the number of operations it can perform. Improving efficiency in the NHS

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**						
Date:	**19 December 2024**						
Title:	**Quality and Safety Report**						
Presenting Officer:	Heather Johnstone, Chief Nursing and Therapies Officer (CNTO)						
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement						
Document Type:	Report		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒	
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	Appendix A: Quality and Safety Report – Detail December 2024.						

(1) Purpose of the Paper:
To provide assurance to the Integrated Care Board (ICB) regarding the quality, safety, experience, and outcomes of services across the entire health economy.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	Click or tap to enter a date.
This paper is a combination of corresponding papers (D/S/I) presented and discussed at system Quality Group.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Risks identified and managed via the Board Assurance Framework and Corporate Risk Register.
CQC or Patient Safety	Updates provided against relevant organisations. Continuous Quality Improvement update aligns to known links between providers and systems.
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	Details contained within the report relating to providers by exception.
Equality & Diversity	Details contained within the report.
Due Regard: Inequalities	Update contained within the report.

Due Regard: wider effect	Quality Impact Assessment update supports the ICB, and system partners, having due regard to all likely effects of decisions.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in December 2024.

Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:

- Critical Incident
- Continuous Quality Improvement
- Mortality
- Patient Safety Incident Reporting Framework
- Deteriorating Patient Network
- Care Quality Commission
- Local Maternity and Neonatal System
- GP Collective Action

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report, seek clarification, and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail December 2024

1.0 Critical Incident

1.1 The system declared a critical incident from 26th November to 6th December 2024, due to severe urgent emergency care pressures, to support the reduction in delays, improvement of flow and balance of risk across all NHS organisations. Throughout this period the Chief Nursing Officers and Chief Medical Officers held daily touchpoint meetings to discuss any areas of clinical risk and support any associated system mitigations. Based on the success of the discussions in maintaining system support during times of increased clinical risk, it has system partners have agreed that weekly touchpoint meetings will continue throughout the winter period.

2.0 Continuous Quality Improvement (CQI)

2.1 The Quality and Safety Committee received the ICB's CQI Framework which sets out the vision that CQI will be an integral part of our business-as-usual approach, underpinning the delivery of our strategic plans to provide high quality health and care. This involves a cultural shift towards a widespread adoption of consistent improvement methodology being applied in all areas to create a culture where "improvement is everyone's business". The CQI Framework commits the ICB to actions that will realise our vision, aligned to the five components of NHS IMPACT (Improving Care Together). In the first instance building improvement capability and capacity with a focus on establishing a community of practice and embedding an improvement and learning culture. The ICB will use a blended improvement methodology approach, including the Institute for Healthcare Improvement's Model for Improvement and lean principles. This approach dovetails with the improvement methodology and training approaches used by healthcare system partners across the ICS and ensures that we will use the best methodology, appropriate technique, and combination of tools when making changes to strive for improvements. It is designed to sit alongside the ICB's organisational strategies to support achievement of our strategic aims.

3.0 Mortality

3.1 The inaugural meeting of the System Mortality Oversight Group (SMOG) took place on 18th September 2024. The SMOG aims to bring together clinical and care leaders across the system to examine and act on information and intelligence from deaths and embed sustainable action to prevent future deaths. The key intentions are to identify: (i) local opportunities to improve health outcomes, (ii) system wide opportunities to improve health outcomes, and (iii) levers to improve systems and processes across the health, care, and well-being economy. The next meeting will take place in January 2025.

3.2 A supportive system review of infant mortality across Staffordshire and Stoke-on-Trent is planned jointly with NHS England and the Office for Health Improvement and Disparities (OHID). The Staffordshire and Stoke-on-Trent Reducing Infant Morality Conference took place on 3rd December 2024 to review the work of the system Infant Mortality Group and system leads will work together with NHS England and OHID to develop a set of strategic actions aimed at improving outcomes and reducing infant mortality. Stillbirths and neonatal mortality continue to be reviewed at the Quality & Safety Oversight Forum monthly to identify any areas for learning and improvement.

4.0 Patient Safety Incident Reporting Framework (PSIRF)

4.1 To support the transition from the NHS Serious Incident Framework to PSIRF, meetings are taking place with care home providers with the aim of providing advice and guidance on how to manage and respond to patient safety incidents under the new framework. The ICB have worked with three care homes supporting them with the PSIRF process for patient safety incidents. This has identified some challenges regarding care homes accessing the national Learning From Patient Safety Events (LFPSE) platform and the ICB has been in liaison with NHS England to resolve this. This intelligence will form part of the learning for the implementation of PSIRF into the Care Home sector. Access to training was raised as a potential issue and advice has been given on where care homes can access resources, including utilising E-Learning for Health and the Health Services Safety Investigation Body.

5.0 Deteriorating Patient Network

5.1 The system's Deteriorating Patient Network is chaired by the Clinical Director for Urgent and Emergency Care and has systemwide attendance including independent care providers and Health Innovation West Midlands (HIWM). HIWM have implemented regular regional Deterioration Network meetings that consists

of updates regarding the Manging Deterioration Programme which includes reducing deterioration associated harm by improving the prevention, identification, escalation and response (PIER) to physical deterioration. There is an expectation that ICBs will use the PIER improvement toolkit to design and implement a managing deterioration plan. SSOT ICB have met with the Black Country ICB, who are accelerators for the implementation of PIER, to gain an understanding of how they have approached this.

5.2 Updates from the Deteriorating Patient Network are shared with the Nursing Home Quality Assurance and Improvement Group to support feedback and enable updates to be shared with system partners. The re-fresh of the 'Care Home Resource Pack' which was distributed as a hard copy resource by the Community Rapid Intervention Service Team in 2021, is underway with support from the Communications and Engagement Team for design and production. The re-fresh includes the addition of sepsis, constipation, delirium and further resource regarding ReSPECT and end of life as well as a section on learning disability with resources and recommended tools that can be used to support recognising deterioration. Once completed, there will be a training and communication plan with local authorities to engage with staff in care home providers to support the re-launch of the pack. Discussion has been held with the Staffordshire County Council regarding the addition of a question about deterioration to the care home monitoring toolkit. This will prompt discussion and promotion of the tools and Care Home Resource Pack which is available on MiDoS for Care and may also provide a way of obtaining data such as uptake and use of the resource pack and tools. A meeting has been arranged with Stoke-on-Trent City Council to discuss the addition of this question into the toolkit they utilise.

6.0 Care Quality Commission (CQC)

6.1 The CQC inspected Moorlands Neurological Centre, a neuro-behavioural hospital for adults who have an acquired brain injury, in May 2024 due to the change in provider, service specialism and associated regulated activities. At the time of the last inspection in December 2022 the centre was a learning disability service called the Woodhouse Independent Hospital and was rated 'Inadequate' by the CQC. The CQC inspection report was published in November 2024 confirming an overall rating of 'Good' and 'Good' in each domain. The CQC report that they 'saw staff treating patients as individuals, with dignity and respect. Patients said that staff were kind, caring and supportive. Family members and people who knew patients well were encouraged to be involved with the care and treatment of their relatives.'

6.2 The CQC have undertaken visits to the maternity departments of both The Royal Wolverhampton NHS Trust and University Hospitals of North Midlands NHS Trust (UHNM) in October and November 2024 respectively. Both Trusts report that initial verbal feedback was positive and are responding to requests for information by the CQC following the inspections.

7.0 Local Maternity and Neonatal System (LMNS)

7.1 The launch of the Staffordshire and Stoke-on-Trent & Shropshire Telford & Wrekin Collaborative LMNS meeting took place on 2nd October 2024. This collaborative meeting will focus on shared learning across the systems, benchmarking and enable peer review opportunities for providers.

7.2 A combined NHS England Midlands region and ICB led Maternity insight visit took place on 12th November 2024. Initial feedback was positive, and the visiting team observed sustained improvements following the previous reviews. Further, the UHNM Neonatal Peer Review took place on 22nd November 2024 led by West Midlands Neonatal Operational Delivery Network and supported by the LMNS. The Trust awaits formal feedback reports following both reviews.

8.0 GP Collective Action

8.1 A system-wide meeting has been established to understand impact of GP Collective Action. Partners continue to share the impacts upon their services including community nursing prescribing, shared care arrangements which has impacted upon mental health prescribing, antenatal prescribing and acting on investigations for pregnant women in the community setting. Patient safety remains partners utmost priority and actions are being taken to ensure that patients continue to receive their medication. However, this may require patients to attend other sites outside of their immediate community. Primary and secondary care interface meetings are in place where collective action impact and mitigations are discussed. Further, fortnightly meetings are also in place between the ICB, Local Medical Committee and providers to discuss the actions being taken, potential future action(s) and agreeing next steps including communication.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 09

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**19 December 2024**
Reporting Committee:	**Health and Care Senate (H&C Senate)**
Date of Meeting:	**14 November 2024**
Meeting Quorate Y/N?	**YES**
Presenter:	**Rachel Gallyot, Deputy Chief Medical Officer**
Author:	**Lia Pitarokoili, Head of Governance**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

(1) Integrated Medicines Optimisation Group (IMOG), September 2024:

The H&C Senate received the IMOG report. The NICE TA recommendations, discussed by IMOG, were all specialist drugs and were recommended for specialist prescribing only on the formulary. One of the items is a device for radiation therapy and, therefore, it was discussed that this will not appear on the formulary. Melatonin was only indicated for children and adolescents on the formulary, but since it has been realised that sometimes it is still required as they transition into adulthood, an amendment has been made to the wording on the formulary to reflect this.

There was a discussion around the fact that there is a lot of national public interest in using Wegovy and Mounjaro, for weight loss, and GPs are receiving pressure, from private providers, to prescribe. IMOG cannot support this, as these drugs are supposed to be provided with the wider support of a weight loss service. IMOG is trying to support GPs, with these requests, and it is likely that the Health & Care Senate will receive papers, in the future, regarding Wegovy and Mounjaro for weight loss.

Issues with referrals being rejected by UHDB and UHNM were highlighted. It was discussed that there are no weight loss services currently in place to support the prescribing of weight loss drugs, work is ongoing regarding a pilot for a Tier 3 weight loss service approach, however, this cannot be progressed until the NICE TA for Mounjaro is released, so that models of delivery can be considered. The H&C Senate agreed that the Planned Care team will provide an update for the ICB GP Newsletter regarding the current position on weight loss services for prescribing GLP-1s.

The H&C Senate approved the decisions as stated in the detailed report and the September IMOG minutes.

(2) Sensory Processing Needs Toolkit and Position Statement:

The H&C Senate received the Sensory Processing Needs Toolkit and related position statement for approval.

The toolkit forms part of the Graduated Approach to support to children and young people within an educational setting. It is intended to be used by teachers to support children and young people and offers information on supportive strategies to consider, how to conduct an environmental audit and suggestions

for calming activities, so that children can take part in daily activities in school. Professionals across four organisations (MPFT, NSCHT, Staffordshire County Council and Stoke-on-Trent City Council) came together to develop the toolkit to support the identified issues and develop a joint approach.
The position statement has been developed to provide guidance to professionals, practitioners and parents/carers who support children and young people facing challenges in managing their sensory processing needs and is based upon research and evidence. It is also in line with the ICB's Commissioning Policy Excluded and Restricted Procedures regarding Sensory Integration Therapy. The aim is to promote consistency among professionals and reduce uncertainty for families and provide a joint message from all agencies.

There was a discussion around the engagement that has been undertaken in the development of the toolkit, its dissemination and the progress around the various organisations' governance processes. It was agreed that undertaking a Quality Impact Assessment (QIA) would provide a good base in terms of how to evaluate the impacts and outcomes of the Toolkit.

The H&C Senate clinically approved the Sensory Processing Needs Toolkit and Position Statement.

(3) Development of Diagnostic Pathways (Breathlessness and Upper GI):
The H&C Senate was advised on ICS engagement, consultation and approval processes undertaken in the development of the two Diagnostic Pathways **(**Breathlessness and Upper GI).

The development process of the pathways was highlighted. There was a discussion around the dissemination process and the importance of an easily accessible digital solution, and it was agreed that conversations would be progressed with the Digital Team in order to achieve this.

It was highlighted that the purpose of those pathways is to encourage best practice, and further discussions would need to be undertaken regarding the delivery.

The H&C Senate did not approve the pathways as it was discussed that further amendments would be needed. It was agreed that the finalised pathways would be presented for approval at the H&C Senate meeting in December.

(4) NHS Oversight Framework (NHSOF) Portfolio Pack:
The H&C Senate received the NHSOF Portfolio Pack and agreed to support portfolios and providers, in monitoring and improving performance against their aligned metrics, through informing ongoing discussions around action planning.

It was agreed that the NHSOF Portfolio Pack would be presented to the H&C Senate on a quarterly basis.

(5) Prison Healthcare:
The H&C Senate was presented with information on Prison Healthcare. It was highlighted that planned care is an area of concern for detained estates and there are issues for prisoners in accessing the right planned care activity, both when detained, due to operational matters, and when released from prison.

Issues around the registration and de-registration of general practice as prisoners move in, and out, of prison were highlighted. Moreover, issues regarding sexual health data were raised, as these are only shared with direct patient consent, and despite System One and One Health, a lot of activity end up not being shared.

It was agreed that a workshop / wider meeting would be arranged in order to agree the healthcare needs of patients and create a position statement that would set out the aspirations to improve current practice.

ASSURE

None discussed.

System-ICB Risks / Board Assurance Framework (SBAF):

No Risks or SBAF reports were presented this month.

Policies Approved:

- ☑ The H&C Senate approved the SSoT Advice and Guidance Standards;
- ☑ The H&C Senate approved the SSoT ICS' Approach to Effective and Appropriate Prescribing of Oral Nutritional Supplements (ONS) for Adults Supported by the Food First Approach Policy, subject to a QIA being completed, pre-Board ratification.

Decisions to be Escalated to ICB Board or other Committees:

- ☑ The H&C Senate approved the decisions summarised in the Integrated Medicines Optimisation Group (IMOG), September 2024 report;
- ☑ The H&C Senate clinically approved the Sensory Processing Needs Toolkit and Position Statement.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 10

Report to:	**Integrated Care Board**					
Date:	**19th December 2024**					
Title:	**Report to the ICB Board on Performance and Finance**					
Presenting Officer:	Paul Brown – Chief Finance Officer					
Author(s):	Colin Fynn - Head of Intelligence and Analytics Matthew Shields - Head of System Finance Alex Robinson - Head of Transformation Delivery Unit (TDU)					
Document Type:	Report					
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* The financial impacts are as outlined in the body of the report.				
Appendices:	Performance and Finance Report					

(1) Purpose of the Paper:

The purpose of this paper is to provide the board with a summary of performance, programme delivery and finance as received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). It outlines at a high level the current position of key system metrics and aligned programme delivery against the Integrated Care System (ICS) Annual Operational Plan and our month 7 finance position.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (I)	27/11/2024
System Finance and Performance Committee (S,D)	03/12/2024

(3) Implications:

Legal or Regulatory	Monitoring performance is a statutory duty of the ICB.
CQC or Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team and pursued through the Clinical Quality Review Meeting (CQRM).
Financial (CFO-assured)	As outlined in the body of the report.
Sustainability	N/A

Workforce or Training	N/A
Equality & Diversity	N/A
Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☒
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The report was discussed at the System Finance and Performance Committee (SFPC) on the 3rd December 2024.

<u>Performance</u>
Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented. No formal escalations were presented via the System Performance Group (SPG).

Within Planned Care it was noted that University Hospitals of North Midlands (UHNM) are now out of NHS England (NHSE) Tier 1 oversight for elective, cancer and diagnostics, although a continuation of weekly calls with NHSE remains. University Hospitals of Derby and (UHDB) continue NHSE Tier 2 oversight but for electives only (cancer now stepped down). There is recognition that there remains much to do with longer waiters, with a very strong emphasis from NHSE for 65-week waiters to be zero by end of January. Acceptance this will be challenging given Urgent and Emergency Care (UEC) pressures, particularly during the critical incident phase.

Of the 65-week waiter specialities, Ear, Nose and Throat (ENT), while remain challenged, has made really good progress. The specialties of Pain and Gynaecology have come into areas of focus, with UHNM looking at both insourcing and outsourcing options if necessary to mitigate. Patient illness also causing some cancellations but confident of December activity at this stage.

The following action relating to A&E 4 hour waits was noted: Patients, arriving by ambulance that had been discharged with no input or intervention will require quantification in volume to understand the impact on current pressures and ambulance waits. An update on this audit is to be provided for the next SFPC meeting.

Mental Health, Learning Disability and Autism recognised long waiting times for assessments and a need to keep a focus on and in discussion at future Finance and Performance Committee.

Finance

At month 7, at a system level we are reporting a year-to-date deficit position of £29.3m, which is a £33.7m adverse variance against the revised plan (Month 6 variance to plan £29.8m). The year-to-date variance to plan sits within Integrated Care Board (ICB) (£20.6m) and University Hospital North Midlands (UHNM) (£14.1m) with small surplus at Midlands Partnership Foundation Trust (MPFT) (£0.6m) and North Staffordshire Combined Healthcare Trust (NSCHT) (£0.4m).

The system is formally reporting a forecast outturn of break even, as required. However unmitigated risks are quantified at £64m at Month 7. The Investigation and Intervention support team is in place and has the responsibility to support the system to improve on this outturn. The system leadership are actively engaged with the support team, and there are daily meetings taking place. The System Performance Group and System Finance & Performance Committee are working with the I&I team to ensure that controls are optimal and that all options that can be taken to improve the financial position whilst maintaining safety, are taken.

The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of October) to 24,595. Within that we have achieved a reduction in agency equivalent to 277 whole time equivalents (WTEs). Overall, the trend demonstrates the pay controls of organisations are having an impact, however there is a concern that since May the overall workforce numbers has risen each month.

Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS) 16 compliant against the allocations.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Acknowledge the high-level performance against the five priorities.
2. Acknowledge the high-level key programme deliverables update.
3. Acknowledge the financial position.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Performance and Finance Report

19th December 2024

Prepared for the ICB Board by the ICB Intelligence Team & Finance Team and the System Transformation & Delivery Unit (TDU)

Overview

This report contains for discussion:

1. An overview of key performance in September against each of the 5 priorities.
2. An overview of key points against each of the 5 priorities where performance is red.
3. A placemat that demonstrates at a high-level key programme deliverables within the 2024/25 operating plan.
4. A finance summary for the month 7 position.

Discussion from System Finance and Performance Committee (SFPC) on the 3rd December to note:

Performance

- Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented. No formal escalations were presented via the System Performance Group (SPG).
- Within Planned Care it was noted that University Hospitals of North Midlands (UHNM) are now out of NHS England (NHSE) Tier 1 oversight for elective, cancer and diagnostics, although a continuation of weekly calls with NHSE remains. University Hospitals of Derby and (UHDB) continue NHSE Tier 2 oversight but for electives only (cancer now stepped down). There is recognition there remains much to do with longer waiters, with a very strong emphasis from NHSE for 65-week waiters to be zero by end of January. Acceptance this will be challenging given Urgent and Emergency Care (UEC) pressures, particularly during the critical incident phase.
- Of the 65-week waiter specialities, Ears, Nose and Throat (ENT), while remain challenged, has made really good progress. The specialties of Pain and Gynaecology have come into areas of focus, with UHNM looking at both insourcing and outsourcing options if necessary to mitigate. Patient illness also causing some cancellations but confident of December activity at this stage.
- The following action relating to A&E 4 hour waits was noted: Patients, arriving by ambulance that had been discharged with no input or intervention will require quantification in volume to understand the impact on current pressures and ambulance waits. An update on this audit is to be provided for the next SFPC meeting.
- Mental Health, Learning Disability and Autism recognised long waiting times for assessments and a need to keep a focus on and in discussion at future Finance and Performance Committee.

Finance

- At month 7, at a system level we are reporting a year-to-date deficit position of £29.3m, which is a £33.7m adverse variance against the revised plan (Month 6 variance to plan £29.8m). The year-to-date variance to plan sits within Integrated Care Board (ICB) (£20.6m) and University Hospital North Midlands (UHNM) (£14.1m) with small surplus at Midlands Partnership Foundation Trust (MPFT) (£0.6m) and North Staffordshire Combined Healthcare Trust (NSCHT) (£0.4m).
- The system is formally reporting a forecast outturn of break even, as required. However unmitigated risks are quantified at £64m at Month 7. The Investigation and Intervention support team is in place and has the responsibility to support the system to improve on this outturn. The system leadership are actively engaged with the support team, and there are daily meetings taking place. The System Performance Group and System Finance & Performance Committee are working with the I&I team to ensure that controls are optimal and that all options that can be taken to improve the financial position whilst maintaining safety, are taken.
- The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of October) to 24,595. Within that we have achieved a reduction in agency equivalent to 277 whole time equivalents (WTEs). Overall, the trend demonstrates the pay controls of organisations are having an impact, however there is a concern that since May the overall workforce numbers has risen each month.
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS) 16 compliant against the allocations.

Ctrl and click on any underlined text for further detail

Overview of Key ICB Performance September 2024, unless specified - Priorities 1 and 2

1 Eliminate delays in access to treatment and long waits for care

Urgent and Emergency Care		
Category 2 Response target < 30m	10m 45s	▲
Accident & Emergency 4-hour wait (78% target by March 25) (UHNM) (October)	-6.7%	▼
Adult General & Acute (G&A) bed occupancy ≤92% (UHNM) (October)	9.7%	▲
Utilisation of Virtual Wards (target 80%) (ICB) (October)	-5.7%	▲
Ambulance Hours lost due to Handover delays > 15m (UHNM) (October)	1962	▲
12 hour in Emergency Department Performance (UHNM) (October)	11.3%	▲
Mental Health, Learning Disabilities & Autism		
Learning disability registers and annual health check (October)	0.9%	▲
Improve access to perinatal mental health services	-9.3%	▲
Improve access to Children and Young People Mental Health services	-7.5%	▲
Improve access to Transformed Adult Mental Health services (June)	-7.3%	▼
Access to a course of Talking Therapy	0.3%	▼
Mean week wait to start autism assessment (North: CYP/ adult) (August)	95/ 93	▲
Mean week wait to start autism assessment (South: CYP)	59	▲
Mean week wait to complete autism assessment (North: CYP/ adult) (August)	66/ 79	▲
Mean week wait to complete autism assessment (South: CYP)	81	▲
Children & Young People (CYP)		
Reduce CYP in residential care outside Staffordshire (October)	-25.0%	▼
Reduce CYP in residential care outside Stoke-on-Trent (October)	5.1%	▼

Planned Care		
Cost Weighted Activity. National published data. Position to July 2024	8.0%	▲
Elective Activity - Daycases	8.9%	▲
Elective Activity - Ordinary Elective	-5.1%	▲
Elective Activity - Outpatient Procedures	10.8%	▲
Elective Activity- Outpatient First Appointment	0.4%	▲
% Outpatient attends for first appointments or follow-up appointments with a procedure	0.6%	▲
Reduction in Outpatient Follow-up against 2019/20 baseline	15.6%	▼
Eliminate 65 week waits by September 2024	341	▼
Increase theatre utilisation (85% UHNM)	-10.3%	▼
Cancer 28-day Faster Diagnosis (77% target by March 2025)	-3.4%	▼
Cancer 62-day pathways % seen within 62 days (target 70% by March 2025)	1.0%	▼
Cancer non-specific pathway	21.7%	▲
% of lower GI suspected cancer referrals with Faecal Immunochemical Test result (Aug-	-23.7%	▲
Community Bed occupancy rate	0.2%	▲
Primary Care		
Dental Activity delivered (Q2)	-1.6%	▼
Medicines Optimisation		
Pharmacy First Provision – number of interventions (May)	8,086	▲

2 Improving access to high quality, sustainable primary care

Primary Care		
General Practice Appointments	1.6%	▼
General Practice Appointments in <2 weeks (85% target)	6.4%	▲
Additional Role Reimbursement Scheme Full Time Equivalent (Q2)	12.9%	▼
Workforce: GP Full Time Equivalent (Q2)	3.1%	▲
Planned Care		
Deliver increased diagnostic activity levels	9.8%	▲
Patients that receive a diagnostic test within 6 weeks (target)	-13.8%	▲
Mental Health, Learning Disabilities & Autism		
Recover the dementia diagnosis rate to 66.7% target	1.9%	▲

TRAFFIC LIGHT KEY

Against plan, if not available target:

Var	Under performing, with variance
Var	Met or over perform plan / target, with variance
Q	Quarterly Indicator

Against previous period

▼ ▲	Improvement
▼ ▲	Deterioration
-	No change

Overview of Key ICB Performance September 2024, unless specified - Priorities 3, 4 and 5

3 Delivering joined up proactive & preventative support & care

Mental Health & Learning Disabilities & Autism

Eliminating Out of Area Placements (October)	2	=
Talking Therapy Reliable Improvement (67% target)	5.0%	▼
Talking Therapy Reliable Recovery (48% target)	0.8%	▼
Severe Mental Illness health checks (Q1)	6.3%	n/a
Learning disability & Autism reliance on inpatient care (Adult) (October)	7.7%	▲
Learning disability & Autism reliance on inpatient care (CYP) (October)	50.0%	=
Learning Disability and/or Autism Mortality Reviews (100% target) (October)	0.0%	▲

End of Life, Long-term Conditions and Frailty

Prevalence rate of Palliative care registers (September)	-0.1%	▼
Patients receiving all 8 care processes for Diabetes -Type 1 (cumulative to September)	3.1%	▲
Patients receiving all 8 care processes for Diabetes -Type 2 (cumulative to September)	2.6%	▲
National Diabetic Prevention Programme - referrals	-3.8%	▼
National Diabetic Prevention Programme - commence	46.2%	▲

Children & Young People

Reduce emergency admissions for epilepsy (flat activity)	-61%	▼
Reduce emergency admissions for asthma (flat activity)	-69%	=

Maternity and Neonates

Stillbirth rate (UHNM only)	8.1	▲
Neonate Mortality rate per 1000 (UHNM only)	0.0	▼
Brain injury rate per 1000 (UHNM only)	2.0	=
The % of full - term babies admitted to a neonatal unit (UHNM only)	5.5%	▲

Improving Population Health

Children and Young People vaccination uptake - MMR2 (Q1)	0.50%	=
Children and Young People vaccination uptake - Pertussis maternal vaccination (Q1)	10.0%	▲
Hypertension: Percentage of patients treatment to recommended age specific thresholds (Q1)	67.10%	
Cholesterol: Percentage of patients with QRISK 20% or more treated with lipid lowering therapy (Q1)	1.70%	▲

4 Delivering compassionate care of the frail and elderly

Urgent and Emergency Care

80% discharges on Pathway 0 (October)	-0.7%	▼
Discharges on Pathway 1 (October)	0.1%	▲
Discharges on Pathway 2 (October)	0.9%	▲
Reduce number of discharges on Pathway 3 to below 1% (October)	-0.5%	▲

Improving Population Health

Increase uptake of Flu vaccination (October)	9.5%	n/a
Increase uptake of COVID vaccination (October)	10.9%	n/a

Integration

Prevent emergency admission Ambulatory care (Stoke-on-Trent) (Q1)	-28.6	n/a
Prevent emergency admission Ambulatory care (Staffordshire) (Q1)	+3.00	n/a
Improve access to fall service from A&E (Stoke-on-Trent) (Q1)	+48.85	n/a
Improve access to fall service from A&E (Staffordshire) (Q1)	+75.18	n/a
Discharge to usual place of residence (Stoke-on-Trent) (Q1)	+2.16%	n/a
Discharge to usual place of residence (Staffordshire) (Q1)	-0.78%	n/a

5 Supporting Care Home Residents

Urgent and Emergency Care

Achieve the 70% two-hour urgent community response standard (August)	6.4%	▲

Medicines Optimisation

Structured Medication Reviews in last 12 months (Q1)	7.7%	n/a

Integration

Admission to care homes	Q	

Primary Care

% of Care Home Patients with ReSPECT Documentation	1.9%	▼
% of Care Home Patients with a Personalised Care Plan	0.7%	▲
Mean number of Multidisciplinary Team meetings per care home resident aged >18	-6.2%	▼

TRAFFIC LIGHT KEY

Against plan, if not available target:

Var	Under performing, with variance
Var	Met or over perform plan / target, with variance
Q	Quarterly Indicator

Against previous period

▼ ▲	Improvement
▼ ▲	Deterioration
=	No change

Please note

- Priority 3 Hypertension – shown performance in %. Performance is higher than that of the national figure. Due to a change in the methodology for this indicator, it is no longer directly comparable to previous figures.
- Priority 4 Vaccination metrics: COVID-19 - programme commenced 3rd October so previous month is not available for comparison; Flu - previous month is not available for comparison.
- Priority 4 Integration Metrics: 23/24 Q4 positions are not available for comparison.
- Priority 5 Medicines Optimisation: Structured Medication Reviews in last 12 months – this is a new metric so previous data is not available for comparison.
- Priority 5 Q2 National Better Care Fund Reporting Template for Local Authorities has not included a figure for Care Home Admissions in the latest publication and has defined the quarterly breakdown as "not applicable"

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Accident & Emergency 4-hour Wait (UHNM) – Latest performance (October 2024) was 65.3%, down from 69.2% the previous month, and marginally better than the same period last year. This was 6.7% below both the target and plan.	1. Attendances increased by 6.95% across the system, equivalent to 27 patients per day compared to September 2024. 2. Year on year increase of 4.5% against October 2023.	1. Additional acute medic capacity working within Emergency Department (ED). 2. Reviewing additional capacity for a Rapid Assessment and Treatment (RAT) function at Royal Stoke Hospital, 24/7 focus on ambulance arrivals. 3. Audit of patients discharged that arrived by ambulance, and received no input or intervention, to identify missed opportunities for alternative pathways.
	Adult General & Acute (G&A) bed occupancy at UHNM ≤ 92% – Latest performance (October 2024) was 94.3%, up from 94% the previous month and 2% above target. Performance was 9.7% above the plan of 84.6% for October 2024.	1. Earlier than anticipated Infection prevention and control (IPC) restrictions related to COVID-19 and norovirus impacted on ability to maintain flow. 2. Increases in acuity of patients leading to week on week increases in 7, 14, 21+ day lengths of stay.	1. Multidisciplinary high intensity team working through base wards to support both simple and complex discharge identification agreed as weekly actions throughout winter. 2. Medical Director communications with Consultant workforce in relation to risk assessed discharge. 3. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards (IPS), Ward Standard Work, Your Next Patient, Home Care is Best Care).
	Virtual Wards (VW) – Latest performance for the first submission in November was 76.45% (07/11/2024), below plan for both occupancy and capacity. • North Sector – 128 occupied out of 170 beds (75.3%) • South-East Sector – 75 occupied out of 88 beds (85.2%) • South-West Sector – 20 occupied out of 35 beds (57.1%)	1. Bed sensors remain a problem for sub-Acute beds in the North Sector impacting on improved utilisation. 2. Good Hope continue to experience staffing issues in support of ward rounds and referrals to the virtual ward. Sub-Acute for Respiratory currently closed due to low referral levels.	1. Bed sensors issue being addressed with expected solution in place in next 4 weeks. 2. Additional focus to be applied in increasing utilisation by Chronic obstructive pulmonary disease (COPD) and High Intensity patients. 3. Winter funding approved for “Pull” Practitioner within UHDB with recruitment process to commence as soon as possible; aim is to improve use of Acute beds in the South-East Sector.
	Ambulance Hours lost due to Handover delays (UHNM) – October 2024 was 6,182 hours, up by more than 2,800 hours over September, and 1,960 hours above plan.	1. Increased seasonal respiratory illnesses within elderly population impacting on ambulance arrivals and flow. 2. Increase in ambulatory patients or self-presenting patients with greater clinical need impacting on assessment cubical capacity.	1. Health Care Professional (HCP) Conveyance Review. Integrated Care Coordination (ICC) reviewing HCP referrals to West Midlands Ambulance Service (WMAS) prior to dispatch. 2. Working with NHS England to increase the number of WMAS crews utilising ‘Call Before Convey’. 3. Implementation of Reducing Ambulance Handover Programme during November 2024.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Proportion of patients spending more than 12 hours in Emergency Department at UHNM – Latest performance was 11.3% for October 2024, up from 7.9% in September 2024. In comparison the Midlands average for October 2024 was 12%.	1. Earlier than anticipated IPC restrictions related to COVID-19 and norovirus impacted on ability to maintain flow. 2. Increases in acuity of patients resulting in increased clinical need.	1. Multidisciplinary high intensity team working through base wards to support both simple and complex discharge identification, agreed as weekly actions throughout winter. 2. Medical Director communications with Consultant workforce in relation to risk assessed discharge. 3. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards (IPS), Ward Standard Work, Your Next Patient, Home Care is Best Care).
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Perinatal MH Services - 980 women had at least one contact with the service in the rolling 12 months to September 2024. This is 100 (9.3%) under the monthly trajectory (1,080) but continuing to increase month on month, closer to plan than last month and higher than the same period last year (925). The system is one of 19 ICBs in England that did not achieve plan at month 6 and is in position 36 out of the 42 ICBs, putting it midway within the lowest quartile.	1. Error in the way NHS England (NHSE) allocate activity at a sub national level. 2. MPFT identified two technical issues causing their Mental Health Service Dataset (MHSDS) submissions to be lower than their locally reported activity. 3. NSCHT report a slight underperformance of 13 against their M06 plan.	1. NHSE have fixed the allocation error in the September 2024 submission and plan to apply retrospectively to previous months in due course. 2. Not all the Teams that deliver Perinatal activity were mapped against Service Type 02 in MPFT's MHSDS submission. MPFT have corrected and plan to resubmit previous months. 3. NSCHT is working to increase the number of face to face and video-conference contacts. 4. Investment has been released to increase the workforce, however the benefits may not be realised until later in the financial year. 5. The Chief Information Officer at NSCHT is leading on a data quality piece across the ICS and plans to work with all providers to share good practice.
	Improving Access to Children and Young People (CYP) MH Services – 14,185 CYP had at least one contact with community mental health services in the rolling 12 months to September 2024. This is approximately 1,100 (7.5%) under the monthly trajectory (15,339), however, has increased by 315 since last month, closer to plan than last month and higher than the same period last year (13,810).	1. Error in the way NHSE allocate activity at a sub national level. Waiting for the fix to be applied to previous months. Which is hoped will bring local and national reporting figures even closer to one another. 2. Some activity is not being captured at NSCHT following an internal pathway change. 3. Pathway changes at MPFT may have contributed to reduced activity, including Child and Adolescent Mental Health Service (CAMHS) Single Point of Access (SPA) triage and 2 Mental Health Support Teams (MHST) being in the early stage of establishment. There are no known data capture issues.	1. NHSE have fixed the allocation error in the September submission and an increase in activity has been noted. NHSE plan to apply the fix retrospectively to previous months in due course. 2. NSCHT are working on correcting the data capture issue and plan to resubmit once this has been resolved. This will potentially impact on performance until 23/24 is no longer included in the calculation. 3. MPFT are working on reconciling local access figures to MHSDS data submissions to determine if any internal pathway changes have led to a change in recording. 4. Portfolio has increased investment into CAMHS as result of refresh of the CYP MH Local Transformation plan in October 2024 however the benefits will not be realised until late in Q4. 5. Two new MHST's have been recruited to commence in January 2025 however the benefits will not be realised until late in Q4.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Transformed Adult MH Services – 11,985 adults had at least two contacts with the service in the rolling 12 months to June 2024. This is 939 (7.3%) under the monthly trajectory (12,924). Lower than the same period last year (13,135). Although NHSE updated the Core Data Pack on 21st November, the refreshed data for this metric will not be available until the end of the month because of data quality issues.	1. Error in the way NHSE allocate activity at a sub national level. 2. NSCHT report an underperformance against their September plan (of 598). 3. Awaiting local data from MPFT to enable comparison with the national figures. 4. Changes Health and Wellbeing don't currently include adult activity in their MHSDS submissions.	1. NHSE have fixed the allocation error in the September 2024 submission and plan to apply retrospectively to previous months in due course. 2. NSCHT are investigating activity levels in conjunction with services. 3. The portfolio is working with voluntary sector providers to facilitate improved MHSDS submissions. 4. Changes Health and Wellbeing plan to submit adult activity from April 2025.
	Wait to commence Autism assessment, against quarter 2 target of 17 weeks (NB: national target = 13 weeks) • CYP North (Aug) - mean wait of 112 weeks • CYP South (Sep) - mean wait of 76 weeks • Adult North (Aug) - mean wait of 110 weeks Wait to complete Autism assessment, against quarter 2 target of 36 weeks (NB: national target = 26 weeks) • CYP North (Aug) - mean wait of 102 weeks • CYP South (Sep) - mean wait of 117 weeks • Adult North (Aug) - mean wait of 115 weeks Please note: although MPFT (South) and NSCHT (North) differ in their mean waits to start an assessment, by assessment completion, mean waits are similar. Data from providers is now more closely aligned to feedback from patients and carers about waiting times.	1. Increasing demand: since April / May 2024, the total number of children waiting for an autism assessment to commence increased by 35% at MPFT and by 17% at NSCHT.	1. An interim improvement plan was presented at the MHLDA Delivery Group in November. 2. New Senior Responsible Officer (SRO)/Deputy SRO and key operational leads from NSCHT and MPFT part of collective regional NHSE improvement group. 3. Working group sessions commenced in September 2024. Main focus to improve pathways and experience (3 stages of waiting well, diagnosis, and post diagnosis support).

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Children and Young People (CYP)	Reduce CYP in residential care outside Stoke-on-Trent – 79.6% of placements were outside Stoke-on-Trent in October 2024. Up from 74.6% in the same month last year, but reduced since last month (86.7%). 50 (55.6%) of the 90 out of area placements, were over 20 miles away.	1. Local Authority (LA) data for Stoke-on-Trent – increasing numbers above the same month last year (which is the local target).	1. Stoke-on-Trent LA have prioritised a reduction of out of area residential placements for CYP; this workstream is owned and delivered by the LA, with numerical data on progress reported through to the CYP Programme Board dashboard. 2. Children's Improvement Board in place and led by LA with attendance from ICB. 3. In the LA led workstream, a Safeguarding task and finish group was established in Stoke-on-Trent in July 2024 to develop key actions to reduce the numbers of CYP going into care. An update on its effectiveness has been requested.
Planned Care	Elective (Inpatient) Activity - Ordinary Elective - In September 2024 there was 1,705 spells, against a plan of 1,797, Therefore under plan by 92 spells (-5.1% variance to plan). These are elective interventions where patients stay in hospital at least one night.	1. The number of elective inpatients is in line with 2023/24, however the plan for 2024/25 was uplifted by 7.7% above last year's outturn. 2. When combined with Day Case spells metric, there was a variance to plan of 7.4% in September 2024. Providers are encouraged to achieve a Day Case rate of 85%.	1. Analysis of Elective Recovery Fund (ERF) achievement by providers taking place at Contract Steering Group. Currently the ICB is achieving 109.5% (i.e. delivering 9.5% more activity than 2019/20 levels), exceeding the target set for the ICB by NHS England (100.2%), and almost meeting the ICB planned level (110%).
	Reduce Outpatient Follow ups v 2019/20 level - In September 2024 there were 17.3% more attendances than the planned level (based on achieving a 25% reduction by March 2025).	1. All main providers currently have levels of activity for outpatient follow-ups above 2019/20. In some cases, increased follow-ups are a result of treating patients with long waits on waiting lists. 2. Higher level of activity recorded in Independent Sector Providers (ISP) as more capacity available.	1. For ISP, the level of follow up appointments is being monitored, as part of the monthly reconciliation process, and challenged through contractual routes when necessary. 2. ICB working with providers to encourage Patient Initiated Follow Ups (PIFU).
	Eliminate 65 week waits by September 2024 - At the end of September 2024 there was 341 ICB patients waiting over 65 weeks (at all providers), against a plan of 0. Unvalidated data from the National Waiting List Dataset reports, at the end of October, there was 145 patients waiting within the ICB providers over 65 weeks, and 173 at non ICB providers.	1. Capacity continues to be an issue. 2. Out of 341 patients, 188 are at UHNM, 95 at UHDB, and 17 at Robert Jones & Agnes Hunt. 3. The specialties with highest numbers are Ear, nose and throat (ENT) (106), Orthopaedics (96), and General Surgery (37).	1. The tiering arrangements have been reviewed for 24/25 and UHNM have moved down to Tier 2 oversight for Elective, Diagnostics and Cancer with effect from 11th November 2024; UHDB remains in tier two for elective care only. 2. Patient by patient validations taking place and monitored as part of weekly submission to NHS England. 3. Ongoing analysis of 65 week waits cohort by specialty to inform any risk to planned delivery.

Local Priority

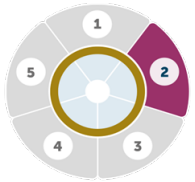
Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Planned Care	Increase theatre utilisation (UHNM) - In September 2024 theatre utilisation was 74.7% at UHNM, against the target of 85%.	1. Inefficient Perioperative Medicine Pathways; multiple outcomes due to this, for example on the day cancelled operations remain at 9%, and late starts (over 15 minutes) remain at 16%.	1. Perioperative Medicine Pathway Transformation Delivery groups continue to focus on future state pathway and finalising training on the digital screening tool; 2-year programme working with NHS England to deliver. 2. Theatre scheduling with theatre team and specialities in place; visiting other Trusts to follow best practice.
	Community services waiting list over 52 weeks - There was 45 ICB patient waiting over 52 weeks on the Community Health Services Waiting List at the end of September 2024. All patients are in Children and Young People Services, 2 in Audiology, 8 in Community Paediatrics Services and 35 in Dietetics.	1. Demand and capacity issues, particularly in dietetic services for children and young people.	1. Monthly meetings take place with MPFT and NHS England to review community waiting list long waiters.
Cancer	Faecal Immunochemical Test (FIT) - The percentage of patients referred with suspected lower gastrointestinal (GI) cancer, with a FIT result was 57.1% (year-to-date cumulative position to August 2024). Currently September data is unavailable. This is against a plan of 80.6%. This metric has shown a continual improvement (from 43.1% in April 2024),	1. Published data extracted directly from primary care clinical systems which does not reflect the actual level of performance due to coding issues. In practice around 70% of referrals in the ICB are compliant. 2. Referrals to UHNM are around 90% compliant and to UHDB, around 70%. 3. Referrals to UHNM have high level of compliance due to referrals being made via referral hub, ensuring FIT tests are available, however, referrals to other providers are not made through a different referral hub which means these referrals may not have the same level of scrutiny as those to UHNM.	1. The ICB is working with practices not achieving the standard, to improve coding and processes.
	Cancer 28 day waits (faster diagnosis standard) – In September 2024 72.47% of patients were told of cancer diagnosis within 28 days, against a target of 75.89%. This is at ICB level.	1. Reduction in performance at UHNM from 75.1% in August 2024 to 70.9% in September 2024.	1. The provisional October 2024 position reported by UHNM is currently at 79% with high data completeness.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Dental	Units of Dental Activity (UDAs) delivered has fallen below plan by 4.5% for 2024/25 Q2 and 1.6% year to date. A shortfall of 15,000 UDAs year to date.	1. Significant impact of the COVID-19 pandemic on dental services. Recovery of NHS provision has been slow and while the situation has improved, many patients are still unable to access the dental treatment they need due to capacity and workforce pressures. 2. Recruitment and retention of NHS dentists. 3. Lack of incentives for dentists to retain NHS activity.	1. The Dental Local Delivery Plan (LDP) has been developed focusing on improving dental access through the Health Equity Audit, oral health and supporting dental workforce including the 'golden hello' offer. The LDP will be taken through ICB governance for approval and will be presented to ICB Board in January 2025 for final sign off. 2. A Dental communication and engagement plan is in place to support the roll out of the LDP to the general public. The plan will be used to monitor feedback and activity through feedback surveys, social media, patient people panel and patient assembly, as well as Patient Advice and Liaison Service (PALS) and complaints. 3. The Primary Care Team continue to work with the Primary Care Commissioning Team at the Office of West Midlands on redistribution of contract activity from hand backs and contract terminations.



Local Priority

Improving access to high quality sustainable primary care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Primary Care - Workforce	Additional Roles Reimbursement Scheme (ARRS) - stands at 595.7 Full Time Equivalent (FTE) for September 2024, below the Q2 target of 684.3 FTE.	1. ARRS FTE fell due to a number of 6-month contracts coming to an end where Primary Care Networks (PCNs) had recruited temporary ARRS roles to utilise underspend. 2. Actual figures are based on National Workforce Reporting Service (NWRS) data and there are continued reporting discrepancies between these figures and ARRS claims. For September 2024 data, NWRS is showing 595.7 FTE and the ARRS claims portal is much higher at 669.4 FTE, so a difference of 73.7 FTE. A further breakdown for ARRS roles shows the under recording in NWRS is largely within the adult mental health practitioners staff group. Cumulative ARRS spend data (April to September 2024) shows budget utilisation at 97.4%.	1. Primary Care Workforce Local Delivery Plan has been developed and dashboard developed to aid monitoring. 2. Working with the PCNs and the Staffordshire Training Hubs (STH) to ensure that as many PCNs as possible take up the new flexibility of recruiting newly qualified GP under the ARRS scheme 3. Working with individual PCNs to ensure they are regularly reviewing and updating NWRS to improve accuracy of their submissions and are in line with claims made via the PCN claims portal. We anticipate changes in October and November following completion of the validation work. 4. Working with the clinical champions and the training hub to develop initial plans to implement the new flexibility to recruit newly qualified GPs under ARRS.
Diagnostic waits and activity	The % of patients waiting within 6 weeks for a diagnostic test at the end of September 2024 was 66.7%, against a plan of 80.5%. Number of diagnostic tests carried out in September 2024 was 48,909 against a plan of 48,670 (0.5% above plan). This is for the ICB patients at all providers. Performance against this metric in the NHS oversight framework remains in the lowest quartile, ranking 38 out of the 42 ICBs (October 2024 refresh).	1. The tests failing the 6-week plan in September 2024 were Magnetic Resonance Imaging, Non-Obstetric Ultrasound (NOUS), Echocardiography and Audiology. 2. By ICB main provider (all patients) the achievement in September 2024 was UHNM (56.5%), UHDB (75.6%), RWT (95.7%)	1. Echocardiography waiting times at UHNM are expected to reduce to 13 weeks by the end of October 2024 due to increased capacity in September 2024. Substantive capacity also starting in December 2024 2. Additional NOUS capacity at UHNM started at the end of October 2024.

Local Priority

Delivering joined up proactive and preventative support and care across all pathways

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability (LD)	Eliminating Out of Area Placements (OAP) – 3 active inappropriate adult acute mental health OAPs at the end of October 2024 (2 over plan). 1 reported by MPFT and 2 by NSCHT.	1. Unavailability of suitable beds at MPFT and NSCHT.	1. To review individual cases to determine if placing out of area was the only appropriate action and no other alternatives options available and repatriation back to resident units is expedited.
	Reliance on inpatient care for people with a learning disability and/or autism (under 18 years of age) 6 inpatients in October, no change to last month and 2 over the quarter 3 plan (4).	1. Case mix is becoming more complex. 2. The trend of late autism diagnosis in children is reported by NHSE as a national trend.	1. Invested in improved diagnosis process: funding from ICB to NSCHT and MPFT. 2. Fortnightly CYP inpatients analysis by a multi-disciplinary team (e.g. clinicians, therapists etc.) continues to develop to help coordinate discharges.
	Reliance on inpatient care for people with a learning disability and/or autism (adults) - there were 28 inpatients in October 2024, an increase of 1 patient since last month and 2 over the quarter 3 plan (26).	1. Transition from CYP to Adults will bring upward pressure on adult numbers. 2. Longer term inpatient number above national targets.	1. Multi team discharge plans for each individual. 2. Analyse and review hospital settings for longer term inpatients to understand each case in more detail and to support appropriate discharge plans.
Mental Health and Learning disability (MHLDA) Portfolio Delivery Escalation	ICS wide roll out of Oliver McGowan Training is currently under plan. Trajectory to recover is at risk due to the availability of trainers and the workforce during the winter period. (NHS only count); Tier 1 achieved 701/ 996 target (70.4%) at Month 6 Tier 2 achieved 1,034/ 1,830 target (56.5%) at Month 6.	1. Lack of training capacity to facilitate the programme and meet requirements of the workforce. 2. Volume of the workforce, aligned to statutory requirements for Care Quality Commission (CQC) regulated providers, in scope to receive training.	1. Single Tender Waiver (STW) has now been approved with additional capacity for expert by experience secured through Applied Suicide Intervention Skills Training (ASIST). Project Manager contract extended until March 2026. 2. All main NHS providers have agreed a collective approach to delivery based on current funding opportunities.

Local Priority

Delivering joined up proactive and preventative support and care across all pathways

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
End of Life (EOL), Long-term Conditions and Frailty (ELF)	Prevalence rate of patients on palliative care registers to 1% - In September 2024 there were 10,069 patients on a palliative care register; out of 1,203,385 registered patients this equates to 0.84%, against a target of 0.90%.	1. Performance has maintained at 0.84% throughout 2024/25, but not increased. Various factors including the pressures facing Primary Care and seasonal impact during summer period of Annual Leave. 2. GP collective action may affect future performance.	1. Training on Identification at End of Life will continue to be offered through Staffordshire Training Hub sessions are planned from October 2024 until July 2025.
	National Diabetic Prevention Programme – patients referred to the programme: In September 2024 there were 500 patients referred to the programme, against a target of 520. Target has been met every month except September 2024	1. There is a lag time in data being submitted to the national programme by providers. It is expected that the position for September 2024 will improve once the data is refreshed next month.	1. Work continues with primary care to refer appropriate patients to the programme.
EOL Programme Delivery Escalation	EOL Programme: Hospice Accelerated Beds project for step up and step-down care was evaluated and delivered agreed outcomes. The evaluation demonstrated that the project avoids admissions and supports early discharge.	1. The ICB has been unable to provide additional funding to keep these beds open.	1. 24/7 Advice line: a. Case for change is currently being taken through the ICB governance structure. b. Case for change has been presented at Health and Care Senate and was supported from a clinical perspective.

End of Life (EOF), Long-term Conditions and Frailty (ELF) - Other Key Points Aligned to this portfolio
• Pulmonary Rehabilitation (PR) contract for East and Southeast Staffordshire came to an end on 1st of May 2024. Options paper presented to Procurement Operational Group (POG) 15th of October 2024. POG recommendation, as this is a system cost pressure; needs discussion at System Performance Group (SPG). • Hybrid Closed Loop (HCL) – The recommendations from SPG were accepted at Finance and Performance Committee (F&PC) on 5th November 2024. HCL will be funded as per the business case. ELF and providers to work through implementation and benefits realisation.

Local Priority

Delivering joined up proactive and preventative support and care across all pathways

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Frailty - Programme Delivery Escalation	Frailty Programme: Severe frailty service re-design Test of Change led MPFT has been evaluated including an economic evaluation demonstrating impact and delivery of the project goals and national guidance/best practice. Frailty Programme: Scaling up of proactive falls projects.	1. An options appraisal to scale up the model across the ICS cannot progress without significant re-orientation of existing resources or investment from the ICS. 2. An options appraisal to scale up the model across the ICS cannot progress without significant re-orientation of existing resources or investment from the ICS.	1. Falls: An options appraisal to scale up the model including an economic evaluation will be completed by the end of November 2024.
Maternity and Neonates **(at University Hospitals North Midlands only (UHNM))**	Brain Injury Rate – above the benchmark rate in October 2023/24.	1. Rate remains at 2.0 per 1,000 in October 2024 with 1 reported Neonatal Brain Injury (Cooled) at UHNM again this month. 2. Small numbers are derived from crude data – quarter 1 and 2 counts are less this year than 2023/24 however local monitoring continues.	1. A request was made to the Provider to validate the data, which is ongoing (in November) – not complete due to system pressures. Will be raised at the next Quality and Safety Oversight Forum, 25th November 2024. 2. The Monitoring of brain injures continues through the Quality and Safety Forum [monthly] using the local intelligence from UHNM.
	The proportion of full - term babies admitted to a neonatal unit, measured through the Avoiding Term Admissions into Neonatal Units (ATAIN) programme – rate increase.	1. The proportion is above the October 2023/24 benchmark (of 4.1%) with 5.5% reported in October 2024. 27 babies in October, an increase from 19 in September.	1. The metric is continually monitored monthly in the Quality and Safety Forum. 2. As part of Clinical Negligence Scheme Trust (CNST), UHNM are on track to meet the requirement to attain safety action 3, to implement transitional care services and draw insights into to term admissions to the neonatal unit and undertake quality improvements to decrease admissions. 3. Discussed at Quality and Safety Oversight Forum (QSOF) on 28th of October 2024 increase in ATAIN babies due to increase in births and still < 6% national average, full audit for review at QSOF on 25/11/24.

Local Priority

Delivering compassionate care of the frail and elderly

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Discharges on Pathway 0 (ICB) - Performance in October 2024 deteriorated, falling from 79.2% to 76.9% which was 0.7% below plan. Current position as of 10th November 2024: 75.19%	1. Delays in discharges due to capacity availability and provider choice resulted in increased need for Discharge to Assess beds and short term reablement due to de-conditioning. 2. Planning assumptions included expectation of phase shift into Pathway 1 with an element of uplift into Pathway 2.	1. Continued focus on daily basis to ensure achievement of plan due to small variance. 2. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards (IPS), Ward Standard Work, Your Next Patient (YNP), Home Care is Best Care)
	Discharges on Pathway 1 (ICB) - Performance in October 2024 deteriorated, rising from 17.4% to 19% which was 0.1% above plan. Current position as of 10th November 2024: 19.58%	1. Position deteriorated in line with planned assumptions based upon historical pattens of discharge.	1. Variance over plan equates to 1 patient so no actions over and above those indicated in the surge plan to be taken.
	Discharges on Pathway 2 (ICB) – Performance in October 2024 deteriorated from 3.06% to 3.65% which was 0.92% above plan. Current position as of 10th November 2024: 4.62%.	1. Provider choice leading to delays as sourcing available beds is adding to time some patients are waiting for discharge impacting conditioning and package requirements. 2. Planning assumptions allowed for a degree of increase following historical patterns.	1. Multidisciplinary high intensity team working through base wards to support both simple and complex discharge identification agreed as weekly actions throughout winter.
Improving Population Health (IPH)	COVID-19 vaccinations in >65 years eligible group: - 57.0% of the eligible group have received vaccination in October, this is 10.9% below 2023/24 baseline of 67.9%.	1. The portfolio is engaging to understand the causes, but initial investigation has indicated this is multifactorial and seen across healthcare workers as well. This picture has been observed across region. 2. Last year COVID-19 delivery was accelerated and started earlier due to a peak in COVID-19 infections in early autumn. 3. Decreasing perception of risk from COVID-19 vaccination as the virus is increasingly perceived as causing mild illness that many now experience, and the vaccine does not prevent infection in the same way other vaccines do. 4. Ongoing concerns regarding COVID-19 vaccine side effects and vaccine safety that are a legacy of the accelerated licensing and astra Zeneca. 5. COVID-19 circulation in the population currently is low with flu and Respiratory syncytial virus (RSV) increasing.	1. Developing bespoke communications to highlight the importance of winter vaccines that will promote messaging in support of COVID-19 vaccine. 2. Fed back on coverage position to Trust workforce vaccination leads with some specific requests around communications and targeted vaccination in low uptake specialties. 3. GP engagement planned for next week to provide data feedback on current position and some specific asks on addressing vaccine inequalities. 4. Ongoing programme of community engagement by ICS partners targeting population groups that we know experience inequalities in COVID-19 and flu vaccine coverage with specific engagement currently with our South Asian Muslim community.

Local Priority

Delivering compassionate care of the frail and elderly

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Integration	Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions (Staffordshire Local Authority) – Latest indirectly age standardised rate (Q1 2024/25) indicated 217.8 admissions per 100,000 population, 3 above plan.	1. Clinical Coding issues at main Acute Provider. 2. Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions, for Stoke-on-Trent Local Authority, are currently reporting as under plan, but are likely to be affected by the same issue as the Fall related metric and as such are almost certainly understated.	1. The clinical coding backlog is being addressed by main acute providers and the issue is improving.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Stoke Local Authority) – Latest directly age standardised rate (Q1 2024/25) indicated 381.7 falls per 100,000 population versus the annual plan figure 1331. This is 48.85 above the quarterly equivalent plan figure.	1. The reported figure is “flex” position which is likely to be an under reporting. The accuracy of its ‘freeze’ position, published a month later, will improve. 2. Falls within Care Homes continue to be an area of concern.	1. Review of provision of Falls response from Staffordshire Fire and Rescue Service under Better Care Fund (BCF) and the service is only funded via Staffordshire however response is also being provided into Stoke splitting available resource. 2. Review of pathways and service offers within reactive services to maximise supports in the right setting and avoid Ambulance dispatches and ED conveyances, 3. Support more patients be managed within the community by aligning reactive workstreams with proactive workstreams. 4. Onboarding of the Long Lies policy to support patients remain at home.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Staffordshire Local Authority) – Latest directly age standardised rate (Q1 2024/25) indicated 437.2 falls per 100,000 population versus the annual plan figure 1,448. This is 75.18 above the quarterly equivalent plan figure.		
	Discharge to Usual Place of Residence (Staffordshire Local Authority) – Latest Performance for Q1 2024/25 was 92.72%, 0.78% below plan	1. Increases in discharges to short term Pathway 1 including Discharge To Assess (D2A) beds due to discharge pathway pressures.	1. Analysis of D2A pathways and timings completed by Integrated Discharge Hub (IDH) with findings built into the operating model.

Other Key Points Aligned to this priority
Integration metrics: – These are quarter measures, no updates to these metrics from last month until Q2 reporting which is expected in January 2025.

Local Priority

Supporting Care Home Residents

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Care Homes	Multidisciplinary Team Meetings (MDT) - year to date to September 2024 have fallen 6.2% below plan, delivering 4,419 meetings to date, a shortfall of 275 MDT meetings.	1. Capacity of Community Teams and Primary Care is stretched to allow MDT meetings to take place across all locations.	1. Primary Care Team are working with MPFT and NSCHT to ensure community teams are engaged and aligned to Care Homes. 2. Working with practices and networks to ensure delivery of the new Care Homes Universal Offer Specification which commenced 1st October 2024 and the Network Contract Directed Enhanced Service (DES) 3. Meeting with PCNs/practices to ensure MDTs are correctly coded.
Care Homes Programme Delivery Escalation	The Care Homes Programme was originally intended to form part of the Demand Management system collaborative.	1. Care Homes does not benefit from being aligned to a single Portfolio, which means that activities designed to support care home residents remain fragmented, with the potential for duplication and gaps.	1. Discussions continue to determine what care home activities, in partnership with the Local Authorities, could support the UEC Portfolio to deliver this year's Surge Plan. Areas being scoped include the use of a portable x-ray machine to support falls and the use of Diversional Therapist to support education and training of Care Home staff. 2. The work on specific services/interventions to support care homes will be included in the year one delivery (2025/26) of the Medium - Term Plan. The demand management collaborative continues to identify the specifics of the service / interventions for planning purposes.

Other Key Points Aligned to this priority
70% Urgent Community Response (UCR) – Issues within latest submission (September 2024) have removed the ability to identify 2-hour UCR Referral activity. Expectation is that a corrected position will be available next month.

Overview of Portfolio key deliverables 24/25 - Priorities 1 and 2

1 Eliminate delays in access to treatment and long waits for care

Planned Care

Elective Care: detailed delivery plans in place for referral optimisation and pathway harmonisation		-
Cancer: deliver schemes to improve early-stage diagnosis		-
Cancer - Improve referral quality		-
Diagnostics - implement diagnostic pathways under development		-
Diagnostics - complete demand management analysis and implement actions		▼

Mental Health, Learning Disabilities & Autism

Develop and implement improvement plan for autism diagnostics		-
Develop and implement system wide improvement plan for CYP access to Mental Health support		-
Develop and implement improvement plan for ADHD		-
Roll out of initiatives into the crisis response system e.g. Mental Health Response Vehicles, NHS 111 #2 and 24/7 crisis text lines		-
Delivery of the CYP Mental Health Local Transformation Plan		-

Children and Young People, Maternity & Neonates

Implement delivery plan to improve survival of babies and young children to reduce Infant Mortality		-

Urgent and Emergency Care

Access: High Intensity Users - expansion of service to cover Staffordshire and Stoke on Trent footprint		-
Access: Designation of Urgent Treatment Centres		-
In Hospital: Non-Elective Improvement Plan - to achieve key acute trust metrics (4 hour, 12 hour and General & Acute Capacity)		-
Post Hospital: Expand Integrated Discharge Hub in reach into Emergency Portals		-
Post Hospital: Standardise Ward Processes to support flow and discharges from the acute trust		-
Post Hospital: Standardise Ward Processes to support inreach into Frailty Services		-
Post Hospital: Review and Standardise End of Life Care Pathway response		-
Post Hospital: Embed the Voluntary Sector in the Integrated Discharge HUB		-
Post Hospital: Review and refresh Choice Policy to support timely discharges and flow		-
Post Hospital - submission of timely and accurate Data (Discharge SitRep) in line with national specification		-
Surge - Mobilisation of Workforce Plan needed to support Surge		-
Surge - Development and Delivery of Surge Plan to mitigate excess demand over winter		-

2 Improving access to high quality, sustainable primary care

Primary Care

Improving health outcomes via collaborative working across primary care and system partners		-
Provision of safe and high quality services within all Primary Care Services		-
Improving access to primary care (including patient experience)		-
Ensure fit for purpose estate provision, maximising shared space and digital alternatives		-
Reduce variation and commissioning universal access to services		-

Mental Health, Learning Disabilities & Autism

Implement improvement plan to increase number of people with LD on GP registers		-
Develop plan and activities to support preparation for dementia modifying treatment delivery		-

TRAFFIC LIGHT KEY

Against plan or target:

- On track
- Behind Schedule
- Mitigations Identified
- Complete
- Deliverable not yet commenced
- Cancelled / Superseded

Against previous period

- ▼ ▲ Improvement
- ▼ ▲ Deterioration
- - No change

Overview of Portfolio key deliverables 24/25 - Priorities 3, 4 and 5

3 — Delivering joined up proactive & preventative support & care across all pathways

End of Life, Long-term Conditions and Frailty		Mental Health & Learning Disabilities & Autism	
Scale up an enhanced Falls prevention program taking learning from test for change in one geographical area – May-Nov 24	-	System wide roll out of Oliver McGowan Training	-
Delivery of the PEoLC strategy pan Staffordshire	-	Expand the availability of Mental Health Support Teams in schools	-
Development of overarching Long Term Conditions Strategy	-	Co-create long term vision and service model to localise and realign MHLDA inpatient services (Inpatient Quality Transformation Programme)	-
Evaluation and business case for 24/7 advice and guidance	-	**Improving Population Health**	
Evaluate the accelerated beds to support with surge and other challenging time periods and scale up.	-	Health Inequalities: Published HI Strategy; HI Outcomes Framework agreed by all Partners, and; HI Finance Framework running in shadow form 2025/26	-
Children and Young People, Maternity & Neonates		Prevention Strategy published, and Reducing harm from Alcohol Strategy published	-
Implementation of the national delivery plan for maternity and neonatal care	-	Locality Development: Locality outcomes, incentives and governance in place	-
Children & Young People		PHM: Stage 1 Linked Data Set	-
Design and implement Long Term Conditions Programme - ASTHMA	-	Core20PLUS5: Maternity, Cancer, Respiratory, Hypertension, SMI	-
Design and implement Long Term Conditions Programme - EPILEPSY	-	LTP Prevention: Obesity, Tobacco, Alcohol, HIV, CVD, TB, AMR, Diabetes, Cancer	-
Design and implement Long Term Conditions Programme - DIABETES	-	Implement local vaccination improvement plans to increase uptake in unvaccinated cohorts	-
Implement Children with Complex Needs project	-	Establish collaborative working arrangements for vaccination commissioning in preparation for delegation of functions in April 2025 (actual delegation April 2026)	-
		Maximise uptake of childhood vaccinations and flu & pneumonia vaccinations in adults	-

4 — Delivering compassionate care of the frail and elderly

End of Life, Long-term Conditions and Frailty	
Enhanced care of severely frail patients in a community and domiciliary settings. Using the learning from the 2023/2024 pilot.	-
Refresh of frailty strategy	-

5 — Supporting Care Home Residents

Integration	
Care Homes System Recovery Programme	-

TRAFFIC LIGHT KEY

Against plan or target:

- On track
- Behind Schedule
- Mitigations Identified
- Complete
- Deliverable not yet commenced
- Cancelled / Superseded

Against previous period

- ▼ ▲ Improvement
- ▼ ▲ Deterioration
- - No change

Finance Summary – Month 7

- The following slides show the aggregate financial position as at month 7, compared to the year-to-date plan and sets out the position with regards to unmitigated risk to the agreed deficit of £90m, which during month 6 release of non-recurrent funding equivalent to the deficit agreed on the 12th June 2024 was transacted by NHSE.

- At month 7, at a system level we are reporting a year-to-date deficit position of £29.3m, which is a £33.7m adverse variance against the revised plan (Month 6 variance to plan £29.8m). The year-to-date variance to plan sits within ICB (£20.6m) and UHNM (£14.1m) with small surplus at MPFT (£0.6m) and NSCHT (£0.4m).

- Whilst we continue to work to secure as much recovery as possible, we note that between month 6 and 7 two issues without our control have been flagged. Firstly, the delegated dental underspend (estimated as £6m within the recovery plan) is now highly likely to be drawn back to the Centre with a resulting direct impact to the systems financial position and secondly a cost pressure in relation to ambulance delays is being flagged by West Midlands Ambulance Service which if passed out is estimated to cost Staffordshire and Stoke On Trent (SSOT) £1.5m. However, in the light of the formal commencement of Deloitte, our investigation and intervention (I&I) partner on 4th November, our Chief Financial Officer (CFOs) have collectively made the decision to maintain the net risk as reported at month 6 of £56m risk adjusted forecast out turn ((RAFOT) of £146m) but would note that to deliver this we need to identify a further £7.5m efficiencies not currently identified in the recovery plan. This also assumes that Deloitte identify sufficient savings to cover their fee.

- The reported system efficiency based on month 7 information is now assessed to outturn at £169.9m, which equates to 84% delivery against the annual efficiency plan of £203m. Furthermore, there remain some risks to the delivery of the £169.9m forecast which is being worked on by the Recovery Director and the system.

- The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of October) to 24,595. Within that we have achieved a reduction in agency equivalent to 277 WTEs. Overall, the trend demonstrates the pay controls of organisations are having an impact, however there is a concern that since May the overall workforce numbers has risen each month.

- Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. For month 8 we are being asked to provide specific Board approval that the provider operational capital, IFRS 16, and total capital departmental expenditure limit (CDEL) expenditure forecasts are accurate and robust.

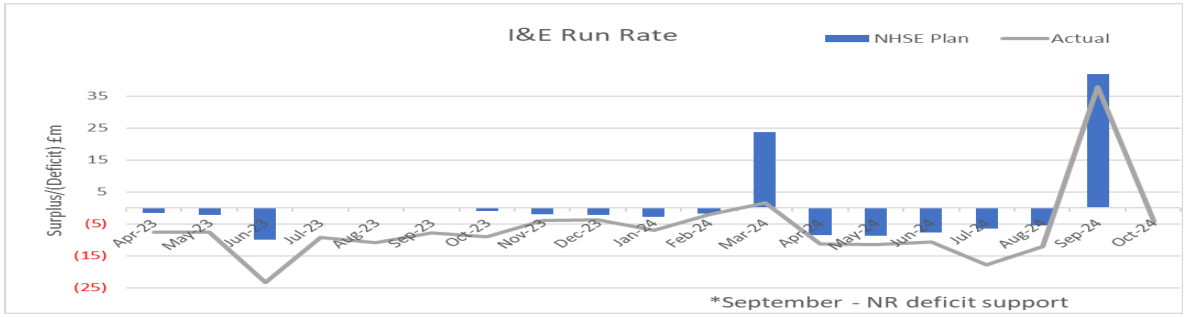
Month 7 Position

- Following the guidance to release, non-recurrent funding equivalent to the deficit agreed was transacted on the 12th June 2024. The System is reporting a year-to-date adverse position of £33.7m against a revised year to date (YTD) £4.3m surplus plan. The main drivers for the aggregate YTD position are efficiency slippage (£19.2m) and binding conciliation (£13.5m) with adverse impacts in Continuing Healthcare (CHC) (£9.4m) and medical staffing (£5.7m). These are partially offset by other non-recurrent mitigations (£14.5m) and Dental underspend (£3.0m).

- Within the £33.7m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £3.9m at Month 7, this will reduce monthly to no impact by year end.

	Month 7			Month 6		
System		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	2,988.3	3,008.6	20.3	2,502.2	2,510.9	8.6
Pay	(770.2)	(774.6)	(4.4)	(634.4)	(637.4)	(3.0)
Non Pay	(399.9)	(432.7)	(32.7)	(342.7)	(364.9)	(22.3)
Non Operating Items (exc gains on disposal)	(21.3)	(17.6)	3.7	(18.1)	(15.0)	3.1
ICB Expenditure	(1,792.5)	(1,813.1)	(20.6)	(1,502.5)	(1,518.8)	(16.2)
Total	4.3	(29.3)	(33.7)	4.6	(25.2)	(29.8)
			-1.1%			-1.2%

	Month 7			Month 6		
ICB		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Allocation	1,792.5	1,792.5	0.0	1,502.5	1,502.5	0.0
Expenditure	(1,792.5)	(1,813.1)	(20.6)	(1,502.5)	(1,518.8)	(16.2)
TOTAL ICB Surplus/(Deficit)	0.0	(20.6)	(20.6)	0.0	(16.2)	(16.2)
			-1.1%			-1.1%



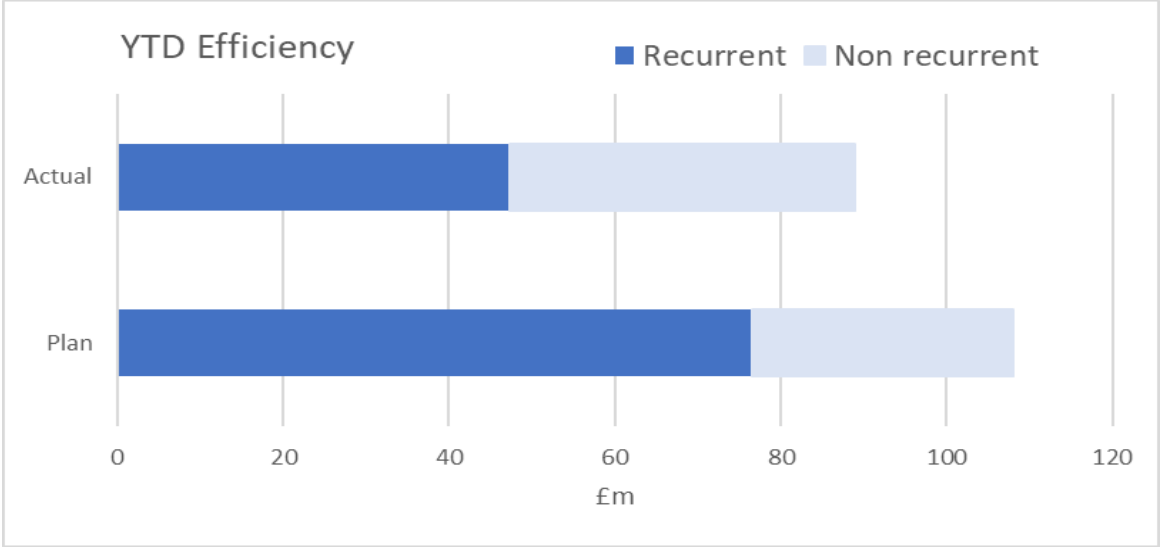
	Month 7			Month 6		
UHNM		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	690.1	712.2	22.1	576.8	588.3	11.5
Pay	(421.3)	(429.4)	(8.1)	(345.7)	(351.6)	(5.9)
Non-Pay	(245.2)	(274.7)	(29.5)	(210.1)	(231.3)	(21.3)
`	(21.6)	(20.2)	1.4	(18.5)	(17.3)	1.2
TOTAL Provider Surplus/(Deficit)	2.0	(12.2)	(14.1)	2.5	(11.9)	(14.4)
			-2.0%			-2.5%

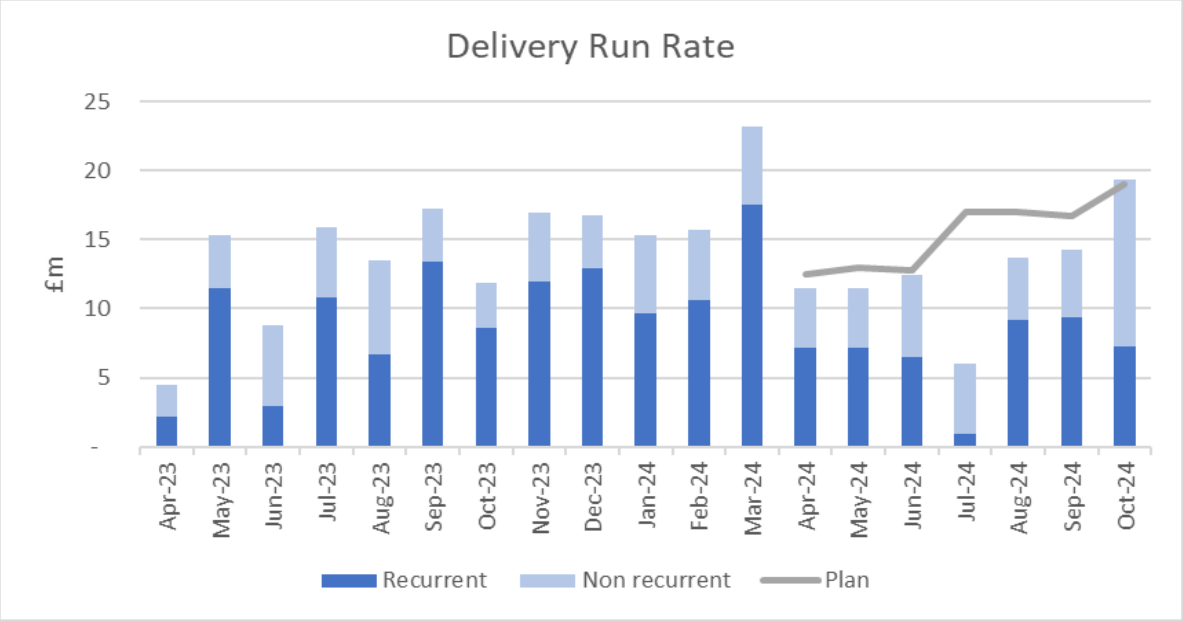
	Month 7			Month 6		
MPFT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	406.1	406.2	0.0	339.2	337.7	(1.5)
Pay	(288.6)	(287.7)	0.9	(238.8)	(238.1)	0.7
Non-Pay	(116.2)	(118.4)	(2.3)	(99.3)	(99.5)	(0.2)
Non Operating Items (exc gains on disposal)	1.3	3.3	2.0	1.3	2.9	1.5
TOTAL Provider Surplus/(Deficit)	2.8	3.4	0.6	2.4	3.0	0.6
			0.2%			0.2%

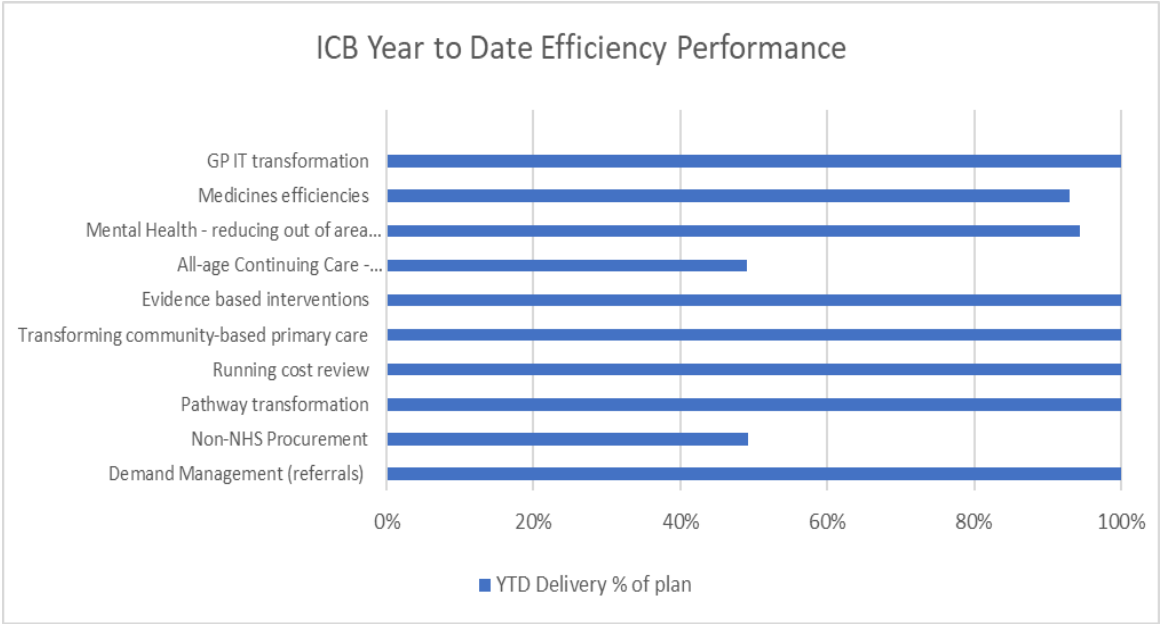
	Month 7			Month 6		
NSCHT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	99.6	97.8	(1.8)	83.7	82.3	(1.4)
Pay	(60.4)	(57.5)	2.9	(49.8)	(47.7)	2.1
Non-Pay	(38.6)	(39.6)	(1.0)	(33.3)	(34.1)	(0.8)
Non Operating Items (exc gains on disposal)	(1.0)	(0.7)	0.4	(0.9)	(0.6)	0.3
TOTAL Provider Surplus/(Deficit)	(0.4)	0.0	0.4	(0.4)	(0.1)	0.3
			-0.4%			-0.3%

Efficiency

- The system has delivered £88.9m of efficiency as of October 2024, this is £19.2m adverse against plan, which is largely at ICB (£12.1m) and UHNM (£6.9m)
- The system efficiency programme totals £203m with £33m forecast shortfall and of the remaining only £10m identified as high risk as of month 7 forecast, with work on going to identify further schemes
- Forecast delivery equates to 84% delivery against the annual efficiency plan of £203m
- There is a timing difference with UHNM showing more up to date information with the expected delivery of the stretch target for which in month 7 reported full delivery
- Recurrent schemes are £29.3m adverse at month 7. Key challenges remain to deliver the efficiency programme to meet the agreed deficit and within this, ensure the recurrent efficiency is met to not deteriorate the underlying position







Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 11

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**December 2024**
Reporting Committee:	**Finance and Performance Committee Parts A and B**
Date of Meeting:	**3 December 2024**
Meeting Quorate Y/N?	**YES – both Parts**
Presenter:	**Megan Nurse, Non-Executive Director and Committee Chair Josie Spencer, Non-Executive Director and Committee Vice Chair**
Author:	**Debbie Everden, Business Manager**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

PART A

NHSE Investigation and Intervention Regime: Phase 1 Discovery and Prioritisation Report
The report set out the findings of the Phase 1 Discovery and Prioritisation exercise undertaken by Deloitte/Kingsgate to identify opportunities to deliver immediate and medium term savings across the ICS. It set out areas of priority and next steps for implementation. Clinical engagement will take place throughout the work and the Health and Care Senate will take this forward.

The report identified the following opportunities and priorities which will form the basis of the Stage 2 work:

- Areas of grip and control which should be further enhanced based on the controls assessment, as agreed with SRO CFOs. These will deliver short term cash savings.
- Most of the savings from tightening grip and control will be realised within the workforce area, and in order to go further and faster in this area, organisations will need to consider further workforce measures.
- For CHC, opportunities for additional support would accelerate savings with respect to reviews in the immediate term with a deep dive required around the D2A pathway and S117; the Local Authorities will be included in examining opportunities for cost savings within S117. Analysis of the D2A to CHC pathway will be an initial area of focus. In order to realise larger savings into the medium term, a new operating model for CHC, building on the existing one, will need to be implemented to deliver continued improvement, increase productivity and cost optimisation.
- Acute spend with the Independent Sector is high and forecast to reach £60m if nothing is done. There are clear opportunities to re-direct flow and reduce unwarranted demand and variation. There are opportunities to improve productivity across all providers.
- For Enabling Functions there should be a focus on incremental changes targeted towards Digital and People Services instead of significant shared service models.
- The greatest non-pay opportunity is to improve the control of the consumption of contracted services e.g. agency workforce contracts, care home contracts, IS contracts etc.
- A review of transformation opportunities identified the need for additional support looking at the productivity of community services and a strategic focus on Urgent Care Demand Management and admissions avoidance.
- In addition to the 'high risk red actions' identified in the Recovery Plan (many of which were not supported by the System), additional areas should be further considered, and support would be

given to identify these; conversations have already taken place with CEOs to identify opportunities.
- An independent review of the System's Balance Sheet opportunities has commenced.

Other areas identified which were not in the original scope but were recommended for a review for savings potential included Estates and Prescribing. Opportunities in relation to out of area patient flow and expenditure which accounts for a sizeable proportion of ICB contract expenditure should be considered for delivery support.

The Committee approved Deloitte/Kingsgate progressing to Phase 2: Implementation of the I&I Regime. The Committee acknowledged that the contract was awarded on the basis that 15% of the fee would be contingent on delivery of the savings and that the CFO will write to Deloitte to confirm that we require Stage 2 to be delivered with the understanding that this clause will apply.

Month 7 System Finance Report

- At Month 7, at a System level we are reporting a year-to-date deficit position of £29.3m, which is a £33.7m adverse variance against the revised plan. Slippage in the efficiency programme is the key driver for the performance to Month 7.
- Whilst we continue to work to secure as much recovery as possible, 2 issues outside our control were flagged:
    - The delegated dental underspend (estimated as £6m within the Recovery Plan) is now highly likely to be drawn back to the Centre with a resulting direct impact to the System's financial position
    - A cost pressure in relation to ambulance delays is being flagged by West Midlands Ambulance Service which, if passed out, is estimated to cost £1.5m
- The System has assessed risk and is reporting unmitigated risk of £56.5m incorporating the green and amber recovery actions into the risk position; this will be reviewed at Month 8 in view of the I&I work. In addition to this there is c£8m gap not yet identified.
- Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as System partners have significantly reduced plans to meet this allocation.
- Total workforce has increased by 10 WTE since September 2024 (Substantive +152, Bank -154 and Agency +12 WTE).
- Overall, workforce is +323 WTE above plan and work will take place with the I&I team to slow the rate of recruitment and therefore reduce the workforce.

The expectation of NHSE is that the break-even plan will be achieved so further conversations will take place with the regulators to discuss the likely year-end position.

The Committee acknowledged the System position at Month 7 and the net risk reported.

System Recovery Programme Update/System Recovery Director Report

- At Month 7, the overall £203m efficiency plan forecast is £27.5m which is £26.8m adverse to plan for the year. The forecast has improved slightly by £0.8m compared to last month.
- System CIP delivery is now forecast to be £134.4m which is £14.4m adverse to plan. £8.3m of the green actions from the Recovery Plan have now been included within this forecast.
- The latest position against the Recovery Plan of £56m is a risk to delivery by £7.4m which has impacted since the plan was developed (a further £0.7m adverse movement since last month). The 2 main adverse movements are a reduction in the forecast benefit delivered by the Collaboratives of £4.7m and the claw back of dental funding underspend of £6m. The main favourable movement is a £5m increase to the expected benefit of the final ERF income reconciliation for 2023/24.
- The System Collaboratives continue to contribute to this negative variance because of the challenges that each has faced in delivering their part of the £40m stretch target. The Committee considered the updates for the Collaboratives.

The Committee acknowledged that during December the maturity of each System Collaborative and their plans for 2025/26 will be assessed. These assessments will need to feed the Medium Term Plan discussions.

The Committee together with the Recovery Director are keeping up the financial challenge on the work required to get back to plan, acknowledging that this is still at high risk of delivery.

System Performance and Programmes Report
The paper provided the Committee with an overview of performance and programme delivery at Month 6 against the ICS Operational Plan.

The paper also included analysis on community activity in response to an action from the Board. This confirmed that there aren't any significant technical or operational issues. School nursing for example will drop over the summer holidays, and community activity in general will be slightly reduced due to staff annual leave and patients on holiday.

The Committee considered the104ww, 78ww and 65ww position for Staffordshire and Stoke-on-Trent and out of System providers and acknowledged the continued improvement in respect of 65ww. The Committee acknowledged that UHNM are now in Tier 2 for planned care and cancer.

The Committee considered the escalations raised by the Mental Health and Learning Disabilities & Autism Portfolio and End of Life, Long-Term conditions and Frailty Portfolio, and the escalation in respect of the Care Homes delivery programme. The Committee remains concerned about the continued long waits for Autism assessments.

PART B

Month 7 ICB Finance Report
The paper reported the current and projected financial position of the ICB for the financial year 2024/25. As previously reported, NHSE released funding equivalent to the £90.0m deficit plan agreed on 12 June 2024, enabling the ICB to set a breakeven plan for 2024/25.

At Month 7 the ICB reported a year-to-date deficit position of £20.6m adverse variance against the revised breakeven plan. This reflects a £4.4m movement from a £16.2m deficit position at Month 6 due to the continuation of recurrent issues with minimal mitigating items during the month. We anticipate the year-to-date deficit to increase due to non-recurrent support plateauing during the remaining months of 2024/25.

We are unable to move the forecast away from the agreed plan until formal authorisation is gained from NHSE. Controls are in place for non-pay expenditure and work will take place with partners to manage the cash position as a System. The full cash position will be included in next month's report and reported to the Board.

2024/25 ICB Efficiency Programme
The paper provided an update on the progress to date against the ICB's £102.2m efficiency programme.

The current forecast indicates £62.9m of efficiency delivery for 2024/25, representing an adverse variance against the £102.2m efficiency target of £28m. The level of in-year savings currently forecasted to be delivered has exceeded the £62.7m delivered during 2023/24. However, the projected under-delivery presents a key financial risk to the ICB for both in-year and the forward look to 2025/26.

The Committee acknowledged the recovery actions being taken by the Recovery Director and organisation to improve the forecast position and the £23.1m risk to the ICB's underlying position as we exit 2024/25.

ADVISE

Part A

Medium Term Plan
The Committee received an update on the mitigated model developed to support the Medium Term Plan. The paper is also being presented to this Board meeting.

The Committee acknowledged that the modelling and opportunities were presented to the System Performance Group meeting on 27 November and the Group was supportive of the model as the intended approach and committed to pursuing the opportunities collectively. Conversations will take place with the regulators regarding cost improvements and any de-commissioning of services. It was acknowledged that a plan to take the model forward is required.

The Committee was assured on the work undertaken to finalise the Medium Term Plan mitigated model and the next steps outlined and approved the model and underpinning assumptions as the basis for the development of the Medium Term Plan.

UEC Pressures
The Committee received an update report relating to Urgent and Emergency Care (UEC) System pressures and a revised System surge update report. The report contained a summary of weekly operational performance, a RAG rated assessment of System activity against the assumptions that underpin the system surge plan, a System surge update report that illustrates capacity opened against plan, a summary of System focused delivery actions to mitigate the increased and sustained levels of UEC pressures being experienced in recent weeks and a summary of the High Intensity Team (HIT) work undertaken at Royal Stoke Hospital.

The Committee was informed that UEC pressures have been building over the last month and a half and nationally the NHS has had its busiest October on record. A System critical incident was declared on 26 November with support also been provided by the Local Authorities and the actions taken, including the bringing forward of winter schemes, were summarised. We continue to work positively with colleagues across the System to make sure that we have the right capacity open in the right places to cover off the pressures and any financial impact is being monitored and being balanced with ensuring patient safety.

System Transformation and Service Change Update
The paper provided the monthly overview of the clinical areas included within the system transformation and service change programme.

The Committee acknowledged updates around maternity and Urgent Treatment Centres (UTCs) and the UHDB clinical reconfiguration.

ICS Green Plan Quarterly Update
The paper provided an update on the work within the System to deliver our Green Plan and the agreed System ambitions for 2024/25. The highlight report provided an overview of progress to date, key tasks to be completed over the next quarter, and risks to internal programmes.

The Committee acknowledged that the intention is for Green Plans to be completed and approved by late spring, following the release of NHSE guidance and that a series of risks associated with NHS Net Zero will be incorporated into ICB and Trusts Risk Registers. The Committee was pleased to note that the ICS has been awarded £75k from NHSE to support an NHS Greener Digital project to accurately monitor and calculate carbon reduction impacts of digital transformation and cloud-based storage within data centres and the work taking place with Keele University.

Termination of Pregnancy (TOP) Commissioning Options
The paper provided an overview of the quality and finance issues with the current TOPs contract and an update on recent guidance, issued by NHSE, with regards to Improving Abortion Care.

The Committee approved the preferred option to go out to the market for lots on a Direct Award B basis acknowledging that this will create a cost pressure of c£1.44m for the ICB compared with the current budget. There will be a further paper presented to the Quality and Safety Committee when the procurement process has been completed.

Winter Assurance Visit
For information, the Committee received the letter sent by NHSE following the Winter Assurance Visit to Royal Stoke Hospital.

Any Other Business
Members were reminded of the request to complete the Committee Effectiveness Survey.

PART B

Budget Setting Principles (2025/26)
The paper set out the framework and principles that will be applied in setting the ICB statutory body budgets whilst working in conjunction to the development of the Medium-Term Plan. As with every financial year, it is vital that the ICB have agreed budgets in place prior to the commencement of the year to ensure that the management team is operating within the Standing Financial Instructions (SFIs).

The start point for the proposed budget will be developed based on the recurrent budget outlined within the Financial Plan submitted on 12 June 2024. Following the organisation's budgetary control policy, the January Committee meeting will receive a paper outlining the impact of in-year financial pressures and efficiency delivery against the underlying deficit brought into the current financial year of £167.8m.

The Committee approved the budget setting approach outlined within the report and noted that a monthly update will be brought to the Committee with the budget being presented to the Board for sign off at its March 2025 meeting.

Patient Choice and Provider Accreditation
The paper provided an update on the requirements to implement the national rules relating to patient's right to choose. It provided:

- An overview of the national regulations
- A description of the current risks and actions already taken to date to address these regulations
- A milestone plan to fully implement the regulations, and ensure that any provision secured through the choice regulations is consistent with the service, quality and capacity requirements of the ICS

The Committee noted a number of risks observed under the current market conditions, and the proposed action plan to address these that covers amendments to policies, rapid development of commissioned Service Specifications in Planned Care and Mental Health, strengthened communications to referrers and the public, and a connection to the Medium Term Plan process.

The potential cost pressure needs to be part of the conversation with regulators as the market-driven regulations are counter to the expectation to achieve the financial plan.

The Quality and Safety Committee will examine the quality of patient experience for some of the providers e.g. ADHD and Autism assessments.

Confidential: Voluntary Sector Review
The Committee received a report describing the process and outcomes of the VCSE review.

Specialised Commissioning Delegation – Update
The paper described the next phase of Specialised Commissioning services delegation to ICBs which is to be undertaken by April 2025. The paper is also being presented to this Board meeting.

The Committee:

- Was assured that the Task and Finish Group members are actively involved with the regional workstreams established to oversee the delivery against the delegation agreement.
- Acknowledged that Staffordshire and Stoke-on-Trent ICB have expressed an interest in Option 3 for the contracting arrangements with regards to the management of the NHS Lead Provider Collaboratives.
- Agreed that the regional specialised commissioning reports are presented to the Strategic Commissioning and Transformation Committee once this has been established.

Confidential: Essington Medical Practice Future Contract Arrangements
The paper provided an overview of the options available to the ICB with regard to the future commissioning arrangements of Essington Medical Practice.

The Committee approved the recommended option of Option 1 as detailed in the paper.

ASSURE

PART B

Procurement Operational Group Report
The report updated the Committee on the current procurement programme and work in progress. The Committee acknowledged that:

- There were no items to escalate, and no risks identified to escalate.
- All items contained within the paper have Decision Making Records and supporting documentation.
- All contract proposals were within the agreed budget values presented to the ICB Board on 21 March 2024.

For winter surge procurements:

- Due diligence is being undertaken to transact winter surge items in accordance with PSR.
- To date all Primary Care access direct awards have been endorsed.
- For existing contracts, the intention remains to modify existing contracts.

All Age Continuing Care Service Update
The paper provided an update on the progress, issues and risks in relation to the All Age Continuing Care (AACC) service transition from Midlands and Lancashire Commissioning Support Unit (ML) to the ICB from 1 April 2025.

The Committee noted that the project is progressing in line with agreed deliverables and milestones and there were no formal issues or risks that required escalation.

Primary Care Forum (PCF)
In order to have governance oversight, the Committee received a summary report of the meeting that took place on 12 November.

The Committee noted the PCF approval of the Local Dental Plan, noting potential financial and workforce implications. The Dental Plan will be presented to the January Committee meeting and Board meeting.

System-ICB Risks / Board Assurance Framework (SBAF):

PART A

System Risk Report
The report set out the 17 high scoring (12 and above) risks currently on the System Risk Register.

The Committee approved:

- The closure of Risk 1181 - Capital Regime, Risk 1233 - UHNM/MPFT NHS 111 Booking System (EDDI) and Risk 1246 - Capital Funding for IFRS16 Lease Costs.
- The addition of new Risk 1424 - Compliance with the allocation of the ICS 2025/26 Capital Departmental Expenditure Limits (CDEL).
- The increase in score from 16 to 20 for Risk 1219 - UHNM Electronic Patient Record (EPR).

- The reduction in score from 20 to 15 for Risk 1370 - Delivering timely patient care, reducing elective backlogs and achievement of ERF.

PART B

ICB Risk Report
The report set out the 4 high scoring (12 and above) risks currently on the ICB Risk Register.

The Committee discussed Risk 1397 Gordon Street Surgery – Estates and agreed a new target date of 31 January 2025.

The Committee approved the closure of Risk 1378 - TA943 hybrid closed loop systems for managing blood glucose levels in type 1 diabetes and Risk 1393 - Contracts not renewed by 1 April 2024 under the NHS Provider Selection Regime (PSR).

The Committee discussed key risks throughout the agenda and has good sight of the top risks for finance, performance, and transformation.

Policies Approved:

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles of both Parts have any likely future impacts on current policy matters.

Decisions to be Escalated to ICB Board or other Committees:

There were no escalations to Board Assurance Committees or to the ICB Board.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 12

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**December 2024**
Reporting Committee:	**People, Culture and Inclusion Committee (PCI) (Part1&2)**
Date of Meeting:	**13th November 2024**
Meeting Quorate Y/N?	**YES (Part 1 only but not required to be for Part 2 on this occasion)**
Presenter:	**Shokat Lal, Non-Executive Director & Committee Chair**
Author:	**Gemma Treanor, Head of ICS People Function**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

No alerts

ADVISE

(1) ICS Staff Psychological Wellbeing Hub

The Committee received an update regarding the ICS Staff Psychological Wellbeing Hub, and future funding. The SSOT Hub is hosted by North Staffordshire Combined Healthcare, established in May 2021 and funded nationally in response to the psychological impact of the coronavirus pandemic on staff. National funding ceased after the 2023/24 financial year but for 2024/25, a shortfall was identified via non-recurrent funding to extend the service. A business case to support continuation of the Hub was developed and considered by Trust Executive teams to determine potential funding options. However, due to the current financial climate no additional funding could be identified to support the Hub in its current format beyond the end of the financial year. Consequently, it is proposed that the Hub ceases to operate at the end of March 2025.

A discussion took place regarding the National funding ceasing, varying provision in NHS Trusts for staff psychological wellbeing, counselling and support, and the gaps in provision the service closing would create. Concerns were raised by members regarding the impact of the cessation of the Hub on the long-term impacts of Covid and ongoing wellbeing support.

Agreement was reached for CPOs (Chief People Officers) to discuss the next steps and bring back to the next Committee for further discussion.

ASSURE

(1) Strategic System Updates:

The Committee received assurance around the tight workforce controls as highlighted, the oversight that we have as a system, and the positive reflections of our workforce around key performance areas at the recent System Review Meeting with NHSE.

An update was provided on attendance at the Staffordshire County Council Health Overview and Scrutiny Committee (HOSC) by CPO representatives, with positive feedback concerning the approach to workforce health and wellbeing and sexual safety. Discussions took place regarding the challenges from HOSC

members around better integration and partnership working across the system to provide better care to our residents.

The Committee were updated on the progress of the Medium Term Plan (MTP) development and were assured that workforce is intrinsic, with recognition that a significant Organisational Development (OD) plan will be required to support design and implementation.

The Committee received an update from CPOs on Provider context, highlighting challenges with the workforce controls and additional pressure from the increased scrutiny. The Committee were assured on the measures and grip Trusts had on the workforce position and processes in place. Highlights were also provided regarding positive Trust actions concerning Sexual Safety and Equality, Diversity and Inclusion.

The Committee welcomed the news that several bids had been submitted by the ICS People Team to NHSE for workforce development funds. Further updates will be provided to the Committee and funds will be allocated and programmes designed via the Sub-Committees.

(2) Performance, Planning and Finance:

The Committee was updated on the financial position, the Recovery Plan and Investigation and Intervention (I&I) work commenced by Deliotte and Kingsgate. The current financial position remains challenged even with the Recovery Plan in place. The plans likely (green) actions are progressing well, less so for the possible (amber) actions which are proving challenging to deliver.

The I&I work has commenced with a prioritisation and discovery phase, focussing on 7 key areas: 1. CHC; 2. Workforce; 3. Operational Productivity; 4. Transformation; 5. Enabling Functions; 6. Contracts and Non-Pay; and 7. Programme Management. The Committee was assured that CPOs and workforce leads are engaged and working in partnership throughout this process, and open to recommendations to improve the workforce and financial position.

The Committee also welcomed the People Metrics report – M6 September position which provided an update on FY24-25 in year workforce position and position to plan FY24-25 plan.

Total workforce levels, as at Sep-24 equated to 24,250 wte which is currently +365 wte (+1.5%) above the operational workforce plan and is under establishment by -416 wte (-1.7%). In respect of FYTD24-25, the workforce has decreased by -128 wte (-0.5%). The over plan position is primarily driven by increases in bank workforce (+250 wte, +18.9%) above plan and substantive workforce (+265, +1.2% above plan) – which is in line with a reduction in agency.

However, agency utilisation has improved significantly; at a system level, SSoT is currently -151 wte below plan (-37.4%). Our overall temporary staffing (agency & bank) use is 7.5% which is -2.0% lower than the highest point in the last 12 months (Mar-24). Agency pay spend equates to 2.6% of total pay spend which is -0.6% lower than the NHSE target of 3.2% (agency pay spend of total pay spend). This is also £1.7m less than the highest point in the last 12 months (Nov-23).

Whilst turnover continues to decrease, sickness absence remains high and as this constitutes a steady trend, work in ongoing with providers to support people to remain in work and well.

The Committee was assured on the workforce position to plan, grip and control to support and inform wider decision making in respect of the people agenda.

(3) System Wide Sexual Safety Conference, Charter and new legislation

The Committee received an update and assurance regarding the implementation of the NHS Sexual Safety Charter and recent launch of new legislation.

Following the launch of the Sexual Safety in Healthcare Charter by NHSE in September 2023, all NHS Trusts signed up to the Charter and it's 10 principles by July 2024. The pre-election period and change in

government resulted in delays to national resources being released. However, these resources were published in October 2024 and all Trusts are on now on track to deliver against all principles, as well as meet the requirements of the new Worker Protection Act which also came into force on October 26th 2024 and which mirrors the Charter. As well as the work being undertaken internally by Trusts, there continues to be a System Sexual Safety Working Group, looking at opportunities to collaborate and best way to deliver a strong System wide response. The Sexual Safety conference was received well by system partners and attendees, with bitesize videos and resources now made available to all system partners.

The Committee was assured that this important topic is being coordinated and information cascaded to the workforce across the system, with involvement of non-NHS partners to share resources and approaches.

(4) System Surge Plan

The Committee was updated and assured around the System Surge plan, brought for formal approval from a workforce perspective. The System Surge plan articulates the system approach to mitigating the impacts upon all facets of the UEC system during periods of increased UEC demand over a 12 month period but specifically during the forthcoming winter period. The Plan describes three core principles of the system approach to surge and winter planning; Capacity plan, Escalation plan, Workforce plan.

A different approach has been taken to the workforce plan this year, focussing on a holistic approach to workforce availability and monitoring, as opposed to purely reporting WTE. It is recognised that with the current financial position, direct recruitment to gaps will be challenging therefore a focus on alternative skill mix, innovative solutions to filling the gaps and workforce wellbeing is required. Leavers, sickness and wellbeing will be monitored with local leads, assessing and mitigating risks to delivering the schemes throughout.

The Committee was assured that workforce leads are closely aligned to UEC leads to deliver the plan, and that the workforce elements are being robustly monitored.

(5) Workstream focus: Leadership

The Committee received an update on the High Potential Scheme and The Coaching and Mentoring Programme, in addition to a Staff Story focussed on the 'Tri-Sector Challenge'.

The Staff Story focussed on the 'Tri-Sector Challenge' and the Committee heard from Grace who shared her positive experiences of the programme and the impact it has had on her individually and her team. The story can be viewed here: West Midlands Tri-Sector Challenge 2024 - Grace's Story - YouTube

The HPS Cohort 2 report was shared with the Committee, outlining progress and valuable insights from the second cohort. 80% of cohort 1 and 63% of cohort 2 participants have *already* achieved career progression to more senior roles (even though HPS is 5-8 years plan) feeding our retention agenda and contributing to the reduction of vacancy and recruitment costs

The Coaching and Mentoring partnership activity report was also shared with the Committee, providing an update on access to offers. 57 staff accessed coaching in Q2, 28 of these relationships were within the SSOT Pool. 13 staff received mentoring and 22 mentors delivered mentoring in Q2. 58 hours of coaching accessed in Q2, costing £12,992 if purchased externally.

The Committee was assured that the OD plan and leadership programmes were on track, and welcomed suggestions from members regarding a local tri-sector challenge for SSOT to tackle some of our critical issues.

System-ICB Risks / Board Assurance Framework (SBAF):

(1) Risk Management process:
The Committee received an overview on the process of risk management as requested by the previous Committee.

Policies Approved:

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles have any likely future impacts on current policy matters.

Decisions to be Escalated to ICB Board or other Committees:

Nothing for escalation to ICB Board or other Committees.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 13

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**December 2024**
Reporting Committee:	**People, Culture and Inclusion Committee (PCI) (Part1&2)**
Date of Meeting:	**11th December 2024**
Meeting Quorate Y/N?	**YES**
Presenter:	**Shokat Lal, Non-Executive Director & Committee Chair**
Author:	**Gemma Treanor, Head of ICS People Function**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

No alerts

ADVISE

(1) ICS Staff Psychological Wellbeing Hub

The Committee received an update regarding the ICS Staff Psychological Wellbeing Hub, and future funding (as highlighted in the last Committee report). ICS Partners confirmed that internal and system conversations had taken place and funding options were being explored to enable an extension to the service. A short-medium term extension would allow for an in-depth scoping and System service offer design piece to be undertaken, exploring the opportunities to provide a System-wide Employee Psychological, Wellbeing and Support offer. A paper will be considered by the Committee in January following internal NHS Trust governance routes.

(2) Workstream focus: Employee Experience, Health and Wellbeing

The Committee received an update on the Employee Experience, Health and Wellbeing Sub-Committee, the strategic priorities for the workstream and programme activity. An area of particular concern being addressed by the PCI Committee is the deteriorating sickness absence position, with the current pressures and impact of various factors on employee experience, health and wellbeing. Impact on burnout, morale and culture was highlighted as a key risk and an area the Committee will continue to monitor as pressure increases and we head into the Winter months particularly.

Focussed discussions followed regarding a deep dive undertaken by the Employee Experience, Health and Wellbeing Sub-Committee into sickness rates increasing, with emphasis on Stress/Anxiety and Depression reasons for absence. It was noted that this is the top reason for absence, alongside Cold/Cough /Flu and Musculoskeletal in NHS Trusts with a similar picture across Primary Care and Social Care. The broader impact of sickness was highlighted, recognising the importance of focussing on improving health and wellbeing, rather than achieving targets.

Further deep dives into sickness reasons and data are planned alongside targeted programme activity to address the top sickness reasons via service offers (Staff Psychological Wellbeing Hub and internal

services, OH and vaccination promotion). Furthermore, system-wide resources are being collated to support overall improvement of experience, health and wellbeing.

(3) Strategic System Updates:

The potential impacts of a job evaluation exercise across nursing roles emerging nationally was highlighted, which could have a financial impact but also support retention. The Committee will monitor this and discuss further when additional information becomes available.

ASSURE

(4) Strategic System Updates:

An update was provided on the national NHS context, as outlined by Amanda Pritchard and Wes Streeting. This work will feed into the regional approach which John Drew (Regional CPO) is leading on and CPOs are engaged in this work. The 2025/26 Operational planning guidance is expected imminently and will require a different approach this year in view of the national and local position.

The Committee received an update from CPOs on Provider context, highlighting challenges with the recent system Critical Incident pressures and Deliotte and Kingsgate work. The Committee were assured on the measures and grip Trusts had on the workforce position and ongoing engagement with Kingsgate. Highlights were also provided regarding planning for the new ESR system, focussing on support to staff and leadership, progress around Sexual Safety training and Nursing Assistant and Trade Union engagement regarding pay.

NHSE provided an update regarding improvements in the System agency spend, sign up to the rate card and price cap compliance – highlighting further work required with UHNM to improve the price cap position.

The Committee was disappointed to hear that NHSE funding bid announcements had been paused, with confirmation that Entry Careers funding had been withdrawn. Further updates will be provided to the Committee.

(5) Performance, Planning and Finance:

The Committee was updated on the financial position, the Recovery Plan and Investigation and Intervention (I&I) phase completed by Deliotte and Kingsgate. The current financial position remains challenged even with the Recovery Plan in place, although the position is improving and the gap closing.

The discovery phase of the I&I regime is now complete with key areas identified to achieve the savings required including workforce. Extensive discussions took place regarding the engagement with Kingsgate and individual NHS Trust position. Chief People Officers have been meeting internally, with Kingsgate and System leads regarding the additional workforce measures and highlighted potential adverse impact of the proposals which need to be carefully considered. Further discussions are taking place to design approaches and processes to enhance controls e.g. around e-rostering, temporary staffing spend, vacancy scrutiny.

The Committee was assured that CPOs and workforce leads are engaged and working in partnership throughout this process and considering the recommendations to improve the workforce and financial position.

The Committee were updated on the progress of the Medium Term Plan (MTP) development and were assured that workforce is intrinsic, with recognition that a significant Organisational Development (OD) plan will be required to support design and implementation.

(6) Oliver McGowan Training Update & Recovery Plan

An update was provided on the Oliver McGowan Mandatory Training position across the System, and the national scrutiny around achieving the 30% NHS staff trained target by March 2025. Each system has been asked to develop a recovery plan for meeting the KPI in 2024/25 and as part of this, additional monthly reporting is being requested from system partners. Approximately 7.91% of applicable NHS Staff have been trained and a recovery plan is therefore required to support further measures to deliver the training. There is a risk that the 30% target will not be met in 2024/25.

Chief People Officers (and wider leads) are fully cited and liaising regarding the recovery approach and reporting requirements – asserting the commitment within Trusts to prioritise and deliver the training, whilst highlighting the challenges faced financially and operationally, particularly with current pressures and heading into Winter.

The Committee noted the update, recognising this is a national issue and the ICS is not an outlier. The Committee was assured regarding the approach to the recovery plan and agreed to the proposed governance process for improving and monitoring progress via Education, Training and Development Sub-Committee and CPOs, with formal escalation and management of risks to the PCI Committee as required.

(7) People Culture Inclusion Programme delivery

The Committee received the programme delivery highlight and assurance report, and were assured that programmes were on track.

(8) Workstream focus: OD Plan update

The Committee was assured that the OD plan and associated programmes were on track and welcomed focussed efforts over the coming months to establish the Sub-Committee and workstream activities to deliver the plan

System-ICB Risks / Board Assurance Framework (SBAF):

(1) Risk Register and SBAF:

The Committee received the People Risk Register and SBAF, discussing the risks in light of the System challenges and pressured environment. The Committee requested a review and mitigations via Sub-Committees of the agency and controls, and health, wellbeing and retention due to increased sickness absence, burnout and reduced morale.

The Committee noted the three static risks and agreed a review of the target score was required considering the current challenges and making the required improvements to achieve the target score of 4 for March 25.

Policies Approved:

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles have any likely future impacts on current policy matters.

Decisions to be Escalated to ICB Board or other Committees:

Nothing for escalation to ICB Board or other Committees.

NHS
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Integrated Care Board

Enclosure 14

AAA Escalation & Assurance Report from Committees[1]

Report To:	ICB Board
Date:	19th December 2024
Reporting Committee / Group:	ICB People, Culture and Inclusion Committee (Part B)
Date of Meeting:	11-12-2024
Meeting Quorate Y/N?	Yes
Presenter:	
Author:	N Walker, Project Lead (HR & Specialist)

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

None discussed.

ASSURE

Update from Head of People, OD and Inclusion: The Committee received an update from the Head of People, OD and Inclusion on key People Team Work Programmes.

The committee noted the update.

Quarter 2 2024-2025 Workforce Report: The Committee received a Quarter 2 2024-25 Workforce Report. The report included data on workforce size, turnover, sickness absence, training, appraisals.

The committee noted the report and was assured that the workforce metrics are monitored on an ongoing basis and when themes are identified these are addressed.

Domestic Abuse and Sexual Violence (DASV) Update: The Committee received an update on Domestic Abuse and Sexual Violence.

The committee noted the update and was assured around the work being undertaken to raise the awareness of DASV support among the workforce.

Workers Protection Act and NHS England's Sexual Safety Charter: The committee received an update on the Workers Protection Act 2023 which came into force on 26th October 2024 and the ICB's progress in adopting NHS England's Sexual Safety Charter.

The committee noted the update and was assured work was being undertaken to implement NHS England's Sexual Safety Charter.

ASSURE

System-ICB Risks / Board Assurance Framework (SBAF):

Nothing to be added.

Policies Approved:

The following HR policies, which have been renewed as per the Policy Renewal Plan, were approved by the PCI Part B Committee:

a. Employee Expenses Policy
b. Lone Working Policy
c. Management of Change Policy

Decisions to be Escalated to ICB Board:

No decisions to be escalated to ICB Board.

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Enclosure 15

AAA Escalation & Assurance Report from Committees[1]

Report To:	ICB Board Meeting held in Public
Date:	19/12/2024
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	19-11-2024
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	N Walker, Project Lead (HR & Specialist)

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

None discussed.

ASSURE

Confirmation of the Recruitment of a Chief People Officer: The Remuneration Committee received a paper on the recruitment process for a substantive Chief People Officer.

The committee approved the appointment of Mish Irvine as Chief People Officer.

ASSURE

System-ICB Risks / Board Assurance Framework (SBAF):

Nothing to be added.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:

No decisions to be escalated to ICB Board.