

**Staffordshire and Stoke-on-Trent
Integrated Care Board Meeting**

HELD IN PUBLIC

Thursday 18 July 2024

12.30pm-2.30pm

Royal Stoke University Hospital

**Trust Boardroom, University Hospitals of North Midlands NHS Trust
Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG**

[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 • Leadership Compact	Chair	Enc. 01	S	12.30pm	3
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			4-5
4.	Minutes of the Meeting held on 20 th June 2024 and Matters Arising	Chair	Enc. 03	A		6-17
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		18
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	12.35pm	
7.	Community Story – Vaccinations in Staffordshire and Stoke-on-Trent	Tara Jackson	Enc. 05	I	12.40pm	19-20

Strategic and System Development

8.	ICB Chair and Chief Executive Update	DP/PA	Enc. 06	I	12.55pm	21-29
9.	Transforming Mental Health Inpatient Services in Staffordshire and Stoke-on-Trent	Nicky Bromage/ Upkar Jheeta/ Laura Smith	Enc. 07	A	1.00pm	30-106
10.	Building a System Medium Term Plan	PB	Enc.08	I/S	1.05pm	107-119
11.	2024/2025 System Operational Plan	PB	Enc.09	A	1.10pm	120-169
12.	Staffordshire and Stoke-on-Trent Board Development Programme	Pauline Grant	Enc.10	A	1.20pm	170-178

System Governance and Performance

13.	Quality and Safety Report	HJ	Enc.11	S	1.30pm	179-182
14.	Staffordshire and Stoke-on-Trent Health and Care Senate Summary and Escalation Report	Dr Lorna Clarson	Enc. 12	I/R	1.35pm	183-187
15.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB MN	Enc. 13 Enc. 14	I/S S	1.40pm	188-204 205-211
16.	People Culture and Inclusion Assurance Report • 2023/2024 Annual Report • People, Culture Inclusion Committee	MI MI	Enc.15 Enc.16	I/S I/S	1.45pm	212-225 226-255 256-259

	Summary Report	SL	Enc.17	S		
17.	Q1 2024-2025 System Board Assurance Framework (SBAF) Update	CC	Enc.18	D/S	1.50pm	260-287
18.	Menopause Policy	TS	Enc.19	R	2.00pm	288-308
19.	ICB Emergency Preparedness Resilience and Response (EPRR) Policy	Phil Smith	Enc. 20	A/R	2.05pm	309-337

Committee Assurance Reports

20.	New Style Triple A (AAA) Committee Highlight & Escalation Report – Audit Committee July 2024 Trial Version	JHo	Enc.21	S	2.10pm	338-341
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Any other Business

21.	Items notified in advance to the Chair	All		D		
22.	Questions from the floor relating to the discussions at the meeting	Chair			2.15pm	
23.	Meeting Effectiveness	Chair				
24.	Close	Chair			2.30pm	
25.	Date and Time of Next Meeting 26 September 2024 at 1.00pm 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 11 JULY 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
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (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.
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.
1st April 2023	Mr	Peter	Axon	CEO ICB	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	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
26th July 2023	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)	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.
6th December 2023	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS 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.
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.
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.
24th April 2024	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
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
4th May 2023	Mr	Chris	Ibell	Chief Digital 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 July 2023	Ms	Mish	Irvine	ICS Director of People	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.

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
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.
3rd April 2023	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Local government employee (West Midlands region) and there are no direct or indirect interests that impact on the commissioning arrangements of the ICB (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.
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 Remuneration 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) Entry to be removed from register September 2024	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing)	(h) recorded on conflicts register.
4th October 2022	Mr	Jon	Rouse	Local Authority Partner Member and CEO of Stoke City Council	Stoke-on-Trent City Council	1. Employee of Stoke-on-Trent City Council, local authority may be commissioned by the ICS (June 2021 - ongoing) 2. Director, Stoke-on-Trent Regeneration Ltd, could be a future estates interest (June 2021 - ongoing) 3. Member Strategic Programme Management Group, Staffordshire & Stoke-on-Trent LEP, may have future financial relationship with the ICS (June 2021 - 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.
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.
17th May 2023	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**
 - 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)
 - 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
 - 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
 - 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
 - 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
 - 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)
 - Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
 - 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)
 - Other (to be specified)



**Staffordshire and Stoke-on-Trent
Integrated Care Board Meeting
HELD IN PUBLIC
Minutes of the Meeting held on
Thursday 20 June 2024
1.00pm - 3.00pm
Via MS Teams**

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 quorum (nine out of seventeen members) with three 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 (MDO) or the Director of Nursing & Therapies (CNT) • • three Independent Members, i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three colours.	✓	✓	✓									
Peter Axon (PA) Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	*	✓									
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓									
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	*	*									
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council		✓	*	✓									
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓									
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands NHS Trust		✓	✓	✓									
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	*	✓									
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓	✓									
Steve Grange (SG), Midlands Partnership NHS University Foundation Trust		*	✓	*									
Nicky Harkness (NH), Interim Chief Transformation Officer, Staffordshire & Stoke-on-Trent Integrated Care Board		*	✓	✓									
Participant Members:													
Simon Fogell (SF), Stoke-on-Trent Healthwatch			✓	✓	✓								
Baz Tameez (BT), Support Staffordshire		✓	*	✓									
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		*	✓	*									

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		*	✓	✓										
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 (People Directorate, Midlands Partnership University NHS Foundation Trust)		✓	✓	✓										
Pauline Grant, Associate Director of Organisational Development, People Directorate		*	*	✓										
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓										

		Action
1.	Welcome and Introductions	
	<p>DP welcomed attendees to the ICB Public Board meeting. DP 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.</p> <p>DP reminded members of the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and it guided the way they conducted business and he would return to that at the end of the meeting</p> <p>It was noted that the meeting was quorate.</p>	
2.	Apologies	
	Apologies were received from Jon Rouse and Tracey Shewan	
3.	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.	
4.	Minutes of the Meeting held on 16 May 2024	
	<p>The minutes of the meeting held on 16 May 2024 were AGREED as an accurate record of the meeting and were therefore APPROVED with the following amendments:-</p> <p>Typo page 10 – 2nd para should state “systems medium term financial plan”</p> <p>Last page “Ian Syme asked about notice given by Stoke CC regarding Home First service.”</p>	
5.	Action Log	
	<p>There were no actions to review.</p> <p>HJ agreed to give an update on the Birth Trauma Enquiry Report during the Quality Report later in the meeting.</p>	
6.	Questions submitted by members of the public in advance of the meeting	
	<p>Ian Syme</p> <p>1. Wheelchair service: Enclosure 9 Quality and Safety Report para 1.4.5 highlights increasing numbers of people waiting over 18 weeks for a wheelchair.</p> <p>(i) How many people are in fact waiting over 18 weeks for a wheelchair in our ICB/ICS i.e. latest numbers.</p> <p>Response:</p>	

	<p><i>We are working closely with our provider of wheelchair services who is AJ Mobility. We have 994 people who have been waiting over 18 weeks, of those 767 are adults and 227 are children. We are working with AJM to manage recovery and also work through that backlog and have been in contact with them on a regular basis and they are now part of our weekly meeting to discuss and manage the backlog. A report will go back through QSC to ensure the trajectory is met in terms of improvements.</i></p> <p>2. Finance and Performance Committee Report (4th June2024) Hospital Ambulance Liaison Officer(s); HALO The above report states that “Interim arrangements are in place to provide 24/7 HALO cover at RSUH, pending a formal model being agreed.” I formally asked a question to UHNM Board 6 June 2024 as to the ‘state of play’ re HALO presence at Royal Stoke and was told that there was now 24/7 HALO cover at Royal Stoke Hospital.</p> <p>(i) Are Interim arrangements now formalised and what is the ‘state of play’ re agreeing a formal model ensuring 24/7 HALO cover at Royal Stoke? (ii) Who will fund the formal model when agreed as I understand that some HALO cover provided by WMAS is WMAS core funded?</p> <p>Response: <i>HALO cover is in place, as flagged to this Board in May. This is based on an interim staffing model outside of core hours that WMAS provide us per their contract, the ICB is funding that interim element of that to ensure the model is in place 24/7 and that model is reliant on agency paramedics. UHNM colleagues are leading on the development of that substantive model to make it an integrated model as possible.</i></p>	
7.	<p>ICB Chair and Chief Executive Update</p>	
	<p>DP congratulated MPUFT on their great success at the HSJ Digital Awards.</p> <p>DP highlighted both the Learning from lives and death of people with learning disability and autistic people (LeDeR) at section 6.1 and at section 1.4 Clive Treacey’s story and emphasised that these were important docs that reminded everyone that they were part of quadruple aim alongside the Olive McGowan training that the Board had been undertaking.</p> <p>DP gave tribute to Tracy Bullock who was retiring at the end of June. He added that it was a tremendous result after 40 years’ service in the NHS and her time at UHNM for past 5 years and impact she had made to them and the system. He stated that it had been a pleasure working with her and on behalf of the Board and the system he thanked her for everything she had done and wished her a long and healthy retirement. TB thanked everyone and wished them all the best going forward.</p> <p>DP announced that Gill Hackett had also decided to retire at the end of the month and planned to travel and explore the United Kingdom. He added that Gill had done a super job at administering the Board with the standard of the minutes and the processes and the running of the Board had gone from strength to strength. He wished her all the very best for a long and happy retirement and thanked her on behalf of the Board and the System for everything she had done over the past 10 years.</p> <p>PA seconded his thanks to both Tracy and Gill.</p> <p>PA acknowledged that it was June and they did have some system pressures at the moment. UHNM were to be standing down the current critical incident but had been very pressured over the week. This had been linked to discharges, but also volume pressure and acuity. PA reiterated that the seasonal references were no longer apparent and the whole country was suffering from pressures all year round. As a system they had come together to resolve those issues and he thanked the people who had managed that.</p>	

	<p>PA reported that the System CEOs had spoken about embarking on a refresh of the Long Term Plan to play in solutions going forward to do the best in supporting the population. He was excited by the refresh and felt it was important to be able to produce high level medium forecasts, particularly in the proactive and preventative space.</p> <p>JHo also gave her thanks and wished good luck to both to Tracy and Gill. She echoed the Chair's thoughts around the Clive Treacey review and the recommendations from that review. She noted the increase in the number of ARR's reported and asked how they would be monitoring the impact of that increase and also how they would be monitoring the outcome of the recommendations in the review.</p> <p>HJ confirmed that the recommendations applied from the review would be monitored through the joint Adult Safeguarding Board.</p> <p>PEJ responded that the ARR's roles and stated that a significant number had been funded through additional funding from NHSE and they monitored carefully in terms of the role of the individual. PEJ added that over the years, there had been funding for training in those roles and they were now looking at how they could supervise those roles. PEJ agreed that they would bring a reasonable adjustment piece through QSC on what they do and how they were doing it.</p> <p>DP felt it would be useful to look at that reasonable adjustment piece more broadly for people with a physical disability etc., just in terms of how they were making sure that they were improving outcomes and tackling inequalities across that cohort across Staffordshire and Stoke-on-Trent, so that they would be able to access services like other members of the public.</p> <p>HJ highlighted section 6.2 in the report on the Maternity and Neonatal Independent Senior Advocate which was now fully operational and working alongside women, and their families. She felt it was relevant and wished to make sure that members had sight of that. She added that SSOT were one of the first to adopt the pilot and had recruited to that post who was now actively working with families, especially in light of the recent media interest.</p> <p>MN referred to the small changes campaign in the report and reiterated that it was a very positive and inspiring campaign that looked at how to make life easier for people with learning disabilities and autism.</p> <p>The Staffordshire and Stoke-on-Trent Integrated Care Board RECEIVED the report and were assured the leadership are working on each topic as raised.</p>	
<p>8.</p>	<p>2024/25 Recovery Plan</p>	
	<p>PB reported that they had agreed a system efficiency target of £203m for 2024/25, which would enable the system to deliver a £90m deficit position as at 31st March 2025, as agreed with NHSE.</p> <p>He added that the £203m would be delivered through organisational specific cost improvement plans (CIP) and five System Collaboratives (System Recovery Programme for 2024/25). Approximately 30% of the system efficiency plan was aligned to these five System Collaboratives.</p> <p>The System Collaboratives formed a cohesive approach for the capacity challenges, harnessing the collective expertise, resources and commitment of stakeholders and was an important step in delivering the £90m deficit and improving on that for the following year. He added that the five workstreams were now established and gave an update for each one.</p>	

	<p>Continuing Health Care – was a well-established system collaborative and had delivered significant financial impact last year. It was rooted strongly in clinical outcomes and provided the right care for patients and on the back of that they were making financial improvement.</p> <p>Demand Management – was looking at how they would fare as a system as they enter into winter. The workstream was focused on managing that activity so that they had a safe, patient experience over the whole of the winter. That was quantified as the bed gap and they were working to eliminate that through interventions which utilised the existing out of hospital care models that they currently had and was making good progress and on track.</p> <p>Contracts – This workstream would be focussing on reducing the spend as a system on contracts outside of Staffordshire. There was quite a long lead in time and were working on how quickly they could get the benefit of financial impact.</p> <p>Clinical value – This workstream was clinically driven and they were looking at where medicines were being subscribed and also pathways where there were alternatives using clinical evidence that had showed that there were some cases where they were over hospitalising people which also contributed to the bed challenge. He reported that there was good progress being made.</p> <p>Enabling Functions – this workstream would be focussing on non-clinical costs that were incurred as a system and were looking to work together within the efficiency programme.</p> <p>PB stated that they agreed with the system CEOs to work together collectively and capitalise on the opportunities they had.</p> <p>Overall there was good progress on the Recovery Programme and he would keep the Board updated on what they have been able to deliver.</p> <p>DP commented that the format of the paper was clear and well laid out. He added that it was good that CEOs were backing the plan and that they were also getting Non-Executive buy in through the Chairs of FPC across the patch. In terms of pace and granularity he stated that it was looking optimistic on the challenges that they were facing and asked if it was going fast enough. PB responded that initially they did not start as quickly as they would have want due to activity and Industrial Action, but he was confident that they now had the pace. He added that there was an issue about capacity as there was a lot of work to do, but everyone was really committed to doing it.</p> <p>JHo agreed that the format of the paper was a welcome start and it was important because they were wide scale programmes of collaborative working. She was clear that some of the pieces of work had a long lead in time, but it was not just about the resource, they needed to be very clear and transparent to notify those impacted on the lead in time and the progress that had been made.</p> <p>JHo also mentioned the complexity of reporting that they had and was concerned in the context of resource, that they were not duplicating and that they did not tie up resource in reporting. PB agreed that the lead in time was important and that they may struggle to get the impact. He added that they needed to do this properly and do it well to achieve lasting improvements but may also lead to part year slippage and he would keep the Board updated on that. PB stated that going forward they were planning to have an integrated report so that it was clear on what each organisation was asked to do together in one report.</p> <p>SL also agree on the way the report was laid out. He mentioned that the enabling functions, particularly around estates, as they could yield a lot of savings without impacting on the frontline.</p>	
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	<p>SL asked would be involved in addressing the low value interventions. PB confirmed that the programme was underpinned and supported by the Health & Care Senate which was important as those changes could only be made by clinicians. PA added that linking to the medium term plan, all the action they had were highly relevant and they would effectively create a suite of solutions to close the gap and mitigate the current position. PA reiterated that they had existing infrastructure to do a lot of the work and they were seconding individuals into each of the areas to coordinate the work across existing mechanisms.</p> <p>MN commented from a FPC point of view and gave assurance that the committee would be receiving this report on a monthly basis, with milestones set out. She added that they had improved significantly in collecting and reporting the data over the past 12 months and she had confidence with the data that was coming through.</p> <p>DP reiterated that the Board had appreciated the clarity of the report and thanked PB and the wider Executive team across the patch for coming together to drive the one plan approach. DP stated that there needed to be the linkage with quality impact assessments and the clinical piece and to ensure they were reported back with granularity as well.</p> <p>The Staffordshire and Stoke-on-Trent Integrated Care Board NOTED the progress to date on our system recovery programme noting the risk identified and mitigations put in place.</p>	
9.	<p>System OD (Organisational Development) Plan</p>	
	<p>PG advised that the purpose of the plan was to look at how they could align their strategic OD priorities around talent, leadership, culture and inclusion and within that, recognise the current context naturally that they were operating in, but also not losing sight of the longer term, emerging needs that they were going to have for the future workforce. This also presented a reminder that, whatever the weight of the pressures that they faced as organisations or as a system, if they did not look after their people they would be adding to the pressure in the long term.</p> <p>PG stated that all organisations would have their own existing people, plans and OD plans so whatever they did in the System plan it would be adding value and would give them what they need. She reiterated that it was not about adding additional work, but they would be looking at the areas of existing good practise opportunities where they could share learning from across providers. She stressed that it was an evolving draft plan and they were going to be working with all partners to shape what it would ultimately look like as an end plan over the next three months. They would be making sure that they were including principles around change OD principles, meaningful engagement, co-production and co-design, so as a system they would that they had a plan that that would speak to everyone and from everyone and have that buy in but also making sure that they were assessing their readiness for change as a system as well.</p> <p>PG felt that some of the Board conversations that had at this meeting were reflective of the conversations that were coming through in the themes in the plan. So there would be priorities around culture, psychological safety engagement. She advised that so far, specific engagement had been with NHS providers which had been reflected in the plan, but over the coming weeks and months, they were going to be continuing that engagement with other partners in education, primary care and local authorities. Then by the end, they would have a plan that was truly reflective of everybody and continuing to shape that.</p>	

	<p>PG informed the Board they would be able to bring an updated plan back to the Board in September or October for final sign off.</p> <p>DP felt that the process being enabling which would glue together the stakeholder plans. He stated that the psychological safety piece was a fascinating subject and mentioned that the Board would be having a special session on that in due process.</p> <p>PA thank PG and the other OD practitioners across the system for the work that had been done on the plan and felt that the sooner it was finished, the sooner they could embark on the journey to implement it. He stated that he and DP attended a session the previous day that discussed this point and what came up in the room was the relationship between individuals. So he felt that the plan underpinned everything they were looking to achieve over the next period.</p> <p>SL felt it was a great piece of work and referred to the point made about not creating additional work and they would only achieve transformational change with the right leadership, but as a Board to get this to happen, they all needed to embrace what work had taken place. SL would like to see more on the EDI (Equality, Diversity & Inclusion) which was an important issue in this very important piece of work.</p> <p>TB agreed that it was good progress and they needed to get to the next stage. She added that they had the list of priorities and needed to turn them into a road map on what they were going to do and by when. She reiterated that it was really good progress but they needed that level of detail in it. TB asked where the final document would be reported into the system. DP confirmed that it would go through PCI Committee. PG confirmed that the granularity would come into the final document, but it was currently reflective of NHS providers and they need to include the voice of primary care etc. She added that one of the groups would be EDI led and it would be at the forefront of what they were doing.</p> <p>BA echoed thanks to Pauline and others and agreed that it was aligned to national priorities and it was not forgetting their local values. She was glad engagement would continue and would be owned by people as it was important on how they, as leaders lived those values.</p> <p>DP reminded everyone that it was also aligned to the leadership compact and that this is the way they wanted to do business going forward and that everyone had accountability going forward.</p> <p>The Staffordshire and Stoke-on-Trent Integrated Care Board:- CONSIDERED the draft OD Plan, endorsing the principles and approach outlined, recognising their importance in addressing current challenges and fostering System resilience. ASSUMED ownership and leadership of the Organisational Development Plan when finalised aligning the necessary resources, including financial, human and technological, to support successful implementation of the Strategic OD plan</p>	
10.	<p>Fit and Proper Person Test (FPPT)</p>	
	<p>PW advised that the FPPT was a new requirement for the ICB and it was now a legal requirement for all Board members to have FPPT checks done annually to check their rightness and suitability to sit on the Board.</p> <p>He added that the Governance Team had now received assurance from partner organisations that each partner member representative were subject to FPPT in their own right and had all undergone their own local host employer declarations and were all fit and proper to sit on the ICB Board. He also stated that all personal attestations</p>	

	<p>within the ICB Executive and non-Executive cohort had all been undertaken and that the Chair’s attestation had been signed off by the Senior Independent Director.</p> <p>PW made the Board aware that the intention was that the FPPT would be aligned with appraisals for the following year, together with the new leadership competency framework.</p> <p>PW confirmed that the annual submission template had been completed for sign off and was ready to submit to NHSE within the next week, pending the Board’s assurances about the process having been done.</p> <p>The Staffordshire and Stoke-on-Trent Integrated Care Board RECEIVED the FPPT update and noting that all Board members have received an FPPT and that the Chair is assured that they are fit and proper for their roles on the Board.</p>	
<p>11.</p>	<p>Quality and Safety Report</p>	
	<p>HJ took the report as read, but highlighted the following:-</p> <p>HJ felt it was important to draw out and to note the positive progress that had been happening around the awards and the recognition for digital progress and the significant nominations and awards. She stated that some of them were in the Chair and CEO report, but even since it was written, there had been a long list of further short listed submissions from all providers in our area, despite the fact that they were working in quite a challenged system.</p> <p>HJ highlighted the out of area providers and their work to assure and ensure high quality services. Within her report there was reference to the work they did with their out of area providers and to the NHS Oversight Framework and the ratings of each of those provider in respect of that which gave an indication on how they compared to in area providers. HJ then reassured members that where quality and safety concerns were identified, they had a very strong working relationship with all of those providers and the lead ICBs.</p> <p>For patient safety partners, the national Patient Safety Strategy included an ambition for all systems to have at least one patient safety partner as a member of any key committees. Therefore with regard to patient safety and quality matters, they would be recruiting at least one vacancy, but on a voluntary basis so they were enhancing their volunteer workforce to support that.</p> <p>Wheelchairs – HJ reported that a quality visit was undertaken and that they were making sure that those at highest risk were getting prioritisation for wheelchairs.</p> <p>Linking back to the Action Log earlier in the meeting on birth trauma, HJ stated that it was being benchmarked so that they knew where their services stood in the findings of that report. She added that a report would go to LMNS Board in July and would be brought back to the ICB Board in September.</p> <p>JS referred to the issue around looked after children’s health assessments that was discussed at the Committee and confirmed that they had a trajectory that took them to July 2025, but assured the Board that the data was now more robust and they would be reviewing the health assessments at their next committee meeting in August. She reaffirmed that they were working to get those trajectories to the shortest time possible.</p> <p>JS also stated that there were a number of policies that have been recommended by the Committee for ratification by the Board.</p>	

	<p>DP stated that both the Quality & Safety Report and the Committee reports were complimentary to each other.</p> <p>JHo drew attention to oversight framework table in the 2 reports where there seemed to be a mixture of ratings and she asked what that meant to the ICB in practice. She also wanted to understand that of the 6 areas being measured, did it mean that if one area was rated at 3, would all 6 areas be rated at 3. PW confirmed that there was a detailed and complicated formula that transpired the ratings of the ICS that built the combined picture. PA added that the operating framework described the relationships, so what could be seen now may change over the coming months and may come into play in Q2 (July/Sept). He suggested that perhaps it would be worth bringing this back to the Board when the operating framework was finalised.</p> <p>The Staffordshire & Stoke-on-Trent ICB Board:</p> <ul style="list-style-type: none"> • RECEIVED the report and sought clarification and further action as appropriate • 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 decisions of the Quality and Safety Committee with regards to: <ul style="list-style-type: none"> ○ Stoke-on-Trent SEND Strategy ○ Domestic Abuse and Serious Violence Policy for ICB Employees Policy (subject to confirmation of an equality impact assessment having taken place) ○ Prevent Policy ○ The ICB Patient Safety Incident Response Framework Policy. 	
12.	Finance and Performance Report	
	<p>Finance</p> <p>PB confirmed that the report had been scrutinised by the FPC committee. He stated that with regard to the financial update, they did not produce a M1 report and would therefore be reporting from M2 at the next meeting in July.</p> <p>Performance</p> <p>UEC – They remain in Tier 2 oversight in terms of performance indicators. They had retained their overall improvement in 4 hour ED performance, but still needed to meet 78% by the end of the year. Ambulances were at 30 min 55 sec against a national target of 30 mins. He added that UHNM patients spending 12 hours in the department had also been improved. PS reported that the winter surge schemes had now been de-escalated in line with the ICB’s expected plans.</p> <p>PS advised that this week had been particularly challenging which resulted in a Critical Incident being declared at UHNM the previous day and they were coordinating actions across the system and would be moving out of critical incident, later today.</p> <p>PS had previously notified the Board about the Ambulance service and CQC Regulation 12 notice. He reported that WMAS had taken action to redirect as much capacity as they could to the front line to support ambulance response times and had put in additional investment in the number of ambulances on the road for the first part of this year. PS added that locally they were committed to reducing handover delays at hospital sites and were also working with the ambulance service in terms of alternative pathways. However, he added that there was a risk there from a quality perspective and also a financial and delivery perspective in terms of the sustainability of delivery over the course of the year.</p> <p>PS confirmed that they were now planning and finalising actions to minimise impact ahead of the Junior Doctor action planned on 31June to 2 July.</p>	

	<p>Planned care – Both UHDB and UHNM were remain in Tier 1 national oversight and the focus over recent months had been on maximising opportunities for planning to increase activity across daycare outpatients and diagnostics to support very of the operational standards for the population.</p> <p>PS reported that they were seeing positive delivery progress in terms of cancer, particularly at UHNM but there was significant risk around elective cohorts. 104 week-waits ended in May with 7 of which 4 were corneas who were taken as mutual aid from the Black Country. The other 3 were pop ups and were essentially linked to historical administrative processing issues. Both PS and the Chief Operating Officer at UHNM had agreed that this highlighted the need for further validation work to tackle data quality at source.</p> <p>To progress this work, the 78 week-waits were currently forecasting up to 44 at the end of June across Staffordshire and Stoke-on-Trent with 20 of those at UHNM and they were looking to eradicate those by the end of July.</p> <p>PS advised that there had been significant progress in terms of 65 week-waits cohort which was now at 5k at the end of May (last year was 37k). He added that they were anticipating some growth in June and July whilst the capacity was mobilised, but were focussed on clearing the 65 week-waits for September in line with national guidance.</p> <p>F&P Committee</p> <p>MN stated that they had a creaking capital programme in recent years, but they were seeing a few elements coming together this year which was showing deterioration of that position. This was highlighted as a risk at the June Finance & Performance Committee and further work was taking place to clarify the risk position impact. It emphasised the approach to capital allocation which also recognised the key role of capital in delivering their recovery plan and further reports were to be presented to the committee in August.</p> <p>MN stated that in relation to UHNM, they had been requested to take an additional 20 Junior doctors at 4 year cost of £300k which would impact on the current financial position and had been recognised by NHSE.</p> <p>DP thanked MN for the comprehensive Chair’s report for FPC.</p> <p>The Staffordshire & Stoke-on-Trent ICB Board</p> <ul style="list-style-type: none"> • NOTED the headlines, escalation and exceptions highlighted • NOTED the M12 summary and outturn financial position. • TOOK ASSURANCE from the conversations taken at F&P Committee. 	
13.	<p>Conflict of Interest Policy</p>	
	<p>PW explained that the full policy had been circulated to the Board to ratify the approval by the Audit Committee, as there were more members on the Board membership and the scope and scale of the conflict of interest policy which included related areas like procurement etc.</p> <p>He added that they were heading into new ways of working and new relationships. PW also advised that the NHS training requirements would reach further into Board and Committee members and would now need to complete levels 1, 2 and 3 on the ESR online system which would add a little more training burden to members.</p> <p>DP agreed that these policies needed to be kept under continual review and he would await any further guidance with interest.</p>	

	The Staffordshire & Stoke-on-Trent ICB Board RATIFIED the Conflicts of interest and Gifts and Hospitality Policy	
14.	Any Other Business	
	No other items of business raised.	
15.	Questions from the floor relating to the discussion at the meeting	
	<p>David Dundas He was a Westgate patient and at a recent meeting of the Patient Participation Group (PPG), a question was raised as to why they did not employ more medical staff and had been told the NHS were not allowed to.</p> <p><i>PEJ agreed to take this question offline to give a fully focussed answer. However, he stated that it was linked to the ARRS roles that had been discussed in the meeting and the ICB were not allowed to fund any additional GPs.</i></p> <p>Ian Syme In Enclosure 07 for the OD plan, he asked where did VSCE fitted into this plan.</p> <p><i>MI confirmed that the OD plan was in the early stages of the development and it would be representative of everyone, including VSCE. PG explained that she would be going out to the voluntary sector communities to ensure that were engaged and that would be happening between now and August. DP added that through the work that Garry Jones and Lisa Healings were doing there was a more formal structure to this and PG and the team could link into that going forward.</i></p> <p>Ian Syme asked for clarification from page 87 on how was it that there was an additional 20 foundation year one junior doctors would cost £300k and were they going to be reimbursed that money. He also asked for clarity about the Black Country ICB seeking an increase in funding and what did that mean.</p> <p><i>TB explained that there was a national drive to increase trainee doctors and what has happened was that all organisations had been asked to increase the numbers they had. She added that UHNM had initially increased by 50+ but towards the end of allocating these doctors, there were still a number of doctors who were not allocated a training place to work. She stated that they were under doctored and they were allocated another significant number of doctors that would come with a cost of £300k. However, nationally NHSE had agreed to fund that, but had not yet received confirmation of next year's money. She then stated that next year, that amount would double as they would also be playing for foundation year 2.</i></p> <p><i>PB explained that before covid, the commissioners paid for the activity of volume. Since then non elective care was paid on a non-elective basis. In terms of distribution there was only 50% of acute care provided by system partners with 30% by UHDB. Therefore 20% and in terms of the flows into Royal Wolverhampton hospital, but the contracting rules had changed and that was the essence of the dispute with the Black Country. He added that they have recognised that the Black Country have significant financial pressures, and it was just a dispute on the amount the ICB pay.</i></p> <p>Cllr Peters Asked on behalf of the PPG in Burton where they could not secure a chair and secretary to step up to run the PPG and was wondering how to ask the practice for admin support for this meeting.</p> <p><i>PEJ agreed to liaise offline and give Cllr Peter advice on how to progress.</i></p>	

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16.	Meeting Effectiveness	
	<p>The Chair confirmed that the meeting followed the compact.</p> <p>DP added that the papers had helped him to get through the meeting on time with the clarity of them and he also mentioned the respectful way in which both their colleagues and guests had behaved during the meeting in accordance with the leadership compact.</p>	
17.	Close	
	<p>There being no further business, the Chair closed the meeting.</p>	
18.	Date and time of Next Meeting	
	<p>18 July 2024 at 12.30pm held in Public – Royal Stoke University Hospital, Trust Boardroom, University Hospitals of North Midlands NHS Trust, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG</p>	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

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

Date of Meeting 18/07/2024

Open Actions							
Reference Number	Meeting Date	Agenda Item	Agenda No	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)
2024-24/001	18/05/2024	AOB - Birth Trauma Enquiry Report	16	HJ to bring a further update to Board in more detail once the review was completed by QSC.	26/09/2024	HJ	Due in September 2024

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	Whooping Cough Vaccination Story					
Presenting Officer:	Tara Jackson, Senior Communications and Engagement Manager					
Author(s):	Tara Jackson					
Document Type:	Report			If Other:		
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	--				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:						

(1) Purpose of the Paper:

As the number of whooping cough (also known as pertussis) cases across the country increases, pregnant women in Staffordshire and Stoke-on-Trent are being urged to make sure they protect their babies, and themselves, through vaccination.

Together with partners across the NHS and local authorities, the ICB will be launching a campaign to increase uptake of the vaccine over the coming months with the aim of protecting women and babies by urging pregnant women as possible to accept their offer of a whooping cough vaccination.

This paper is to highlight to the Board that in the meeting on 18 July, we will be showing a campaign video, filmed with Consultant Midwife at UHNM, Angela Hancock.

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

N/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

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Approved by QIA Panel on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>As the number of whooping cough (also known as pertussis) cases across the country increases, pregnant women in Staffordshire and Stoke-on-Trent are being urged to make sure they protect their babies, and themselves, through vaccination.</p> <p>Together with partners across the NHS and local authorities, the ICB will be launching a campaign to increase uptake of the vaccine over the coming months with the aim of protecting women and babies by urging pregnant women as possible to accept their offer of a whooping cough vaccination.</p> <p>To show the work that is being done across Staffordshire and Stoke-on-Trent, we will be showing a campaign video, filmed with Consultant Midwife at UHNM, Angela Hancock.</p>

(7) Recommendations to Board / Committee:
We ask that the Board notes the video and are happy for them to ask any questions about the Whooping Cough Vaccination Programme or the wider Vaccination Programme.

Report to:	Integrated Care Board					
Date:	18 July 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)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	Choose an item.				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> 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
7. Vaccinations

(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

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Reported to IG Group on</i> Click or tap to enter a date.
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Approved by QIA Panel on</i> Click or tap to enter a date.
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

(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 Primary care

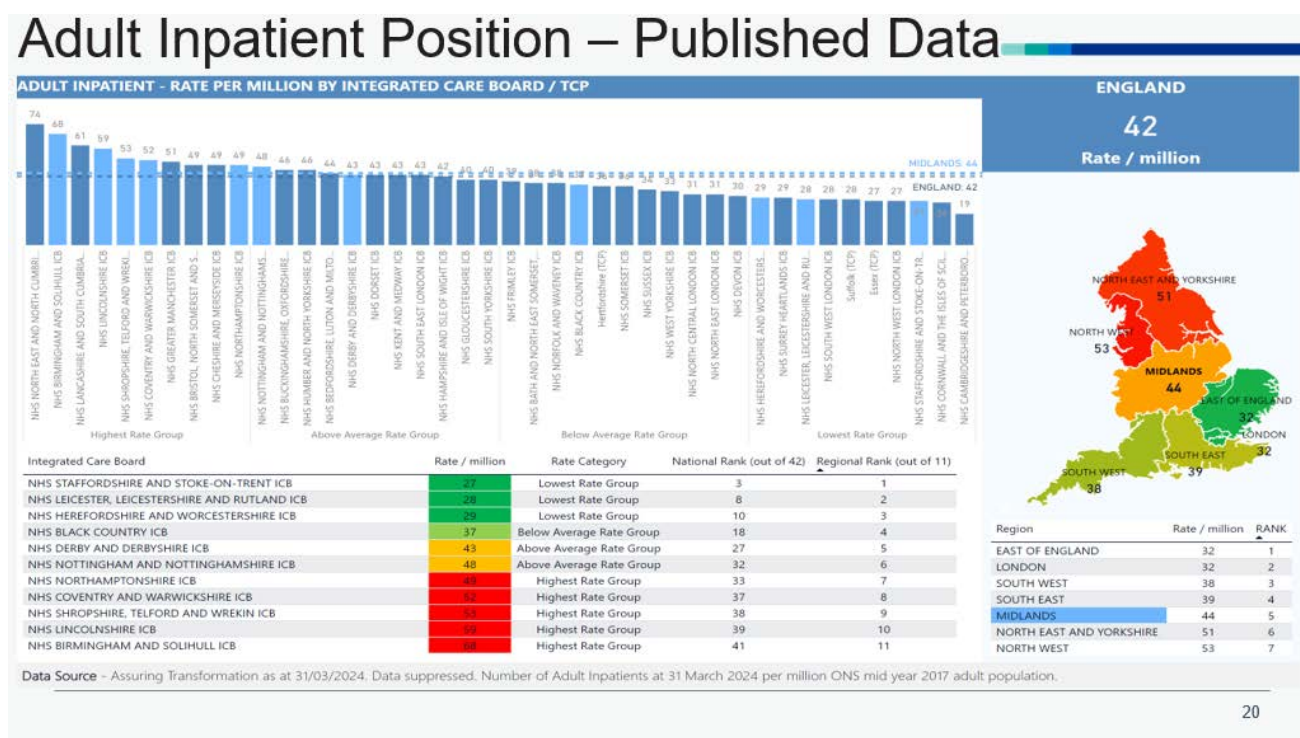
- Over 570 people attended the Stafford Town Primary Care Network Community Wellbeing event held on 25 June at Stafford Rangers Football Club.
- A number of support meetings are taking place with Primary Care Networks and senior primary care staff have been aligned to each of the 25 networks to build relationships and support delivery of the Network Contract Directed Enhanced Service (DES).

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- Learning Disability Champions within General Practice shared examples of quality improvement projects for people with Learning Disability as part of Learning Disability week (MENCAP)
- Continue to support Primary Care Networks and GP practices to increase the use of Pharmacy First Services. Pharmacies may be able to offer treatment and some prescription medicine for some conditions, without patients needing to see a GP.
- There is continued support for practices to increase the adoption and utilisation of the NHS App. The NHS App gives patients a simple and secure way to access a range of NHS Services.

1.1.1 Adult Inpatient Position

The below graph shows the latest Adult Inpatient Position, ranked from lowest to highest. Staffordshire and Stoke-on-Trent has the lowest Rate Group number of adult inpatients regionally and has the third lowest nationally.



1.2 NHS Confederation Expo

Mish Irvine, Chief People Officer, Gemma Treanor, Head of ICS People Function, and Amy Duffy, Senior Commissioning Manager, Staffordshire County Council, were invited to speak at the NHS Confederation Expo in June about their learning and approaches to collaborative and integrated workforce solutions across Health and Social Care organisations.

The session focussed on the 'Journey to Work' approach and how access to careers has increased through engaging with the population and using innovative ways of attracting, training and retaining people at Place level. The session was well received by the audience and the system has been invited to contribute to a case study on the collaboration across organisational boundaries.

1.2.1 Industrial Action

Junior Doctors took strike action for 5 days between 7am on 27 June and 7am on 2 July 2024. Within Staffordshire and Stoke on Trent, attendance at work by Junior Doctors was relatively

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high, with around half attending each day of action at the acute Trusts; numbers being higher within the Community Trusts. Providers felt well supported by medics during this period and relations remain positive. However, the Industrial Action certainly contributed to pressures during a particularly busy period, exacerbated by high levels of staff sickness.

GPs will be balloted on 29 July 2024 around Collective Action. It is envisaged that GP Practices will choose which actions to take and there is likely to be an ongoing period of change rather than a clear start and end, as with other forms of industrial action. Such actions could include limiting daily patient contacts and withdrawing permission for data sharing. Locally, the ICB has established a GP Collective Action Multi-Disciplinary Team in order to effectively plan for worse case scenarios.

1.2.3 Outreach – Care Leavers Project

In partnership with Amity Hub and Stoke-on-Trent College, the ICS Outreach Team have created an exciting and innovative Summer School, beginning on 10 July, which supports the commitment to the Care Leavers Covenant, supporting those with lived Care Experience into employment.

The aim of the seven-week programme is to support a cohort of Care Leavers, whose first language is not English, to maintain their English and Maths skills over the summer holidays when they are not attending college.

The programme will incorporate an induction, skills assessments, learner profiles, health and wellbeing sessions, health and social care information sessions as well as mock assessment and interview day followed by a celebratory event at the completion of the seven weeks.

The Outreach Team have worked in collaboration with system partners to develop course content, work booklets, training providers and the partnership working has been paramount.

1.3 Tony Ahmed to join the ICB Board

"We're delighted to announce that from this month Tony Ahmed will be joining us on the Board as a participatory non-voting member. This will be for an initial period of 6 to 9 months. Tony brings a wealth of Dental knowledge and experience having run his own Dental Practice in Staffordshire since 2003 and being a Fellow of the College of Dentistry. Tony has also been Chair of the Local Dental Network - Staffordshire and Shropshire - for more than 10 years."

1.4 NHS England – ICB Undertakings

These have arisen because NHS England have *“reasonable grounds to suspect that the ICB is failing or has failed to discharge one or more of its functions, or that there is a significant risk that it will fail to do so, in particular its (financial) functions (in the) NHS Act 2006”*. We can confirm that the ICB is now formally in ‘Undertakings’ with NHS England. The ICB has alerted our Regulator to the Board’s position on progressing those, which were shared in April 2024.

Oversight of how each of the required focus areas have been assigned to relevant ‘Board Assurance Committees’, agreed by each committee in July as part of the organisational response. Regular updates will be brought to the Board at future meetings on how we are working through those requirements. Further details can be sourced from:

[NHS England » NHS enforcement guidance](#)

[202404-SSOT-ICB-Undertakings-April-2024.pdf \(england.nhs.uk\)](#)

2.0 Finance

All systems were asked to resubmit plans for 2024/25 on 12 June. For Staffordshire and Stoke-on-Trent, the control total of £90m deficit remained unchanged. Each organisation has in place phased plans for the 12-month period which in aggregate show a month two year-to-date adverse position of £4.5m, which is a £22.7m deficit against the £18.1m deficit plan. This results from a £4.0m adverse position at University Hospitals of North Midlands NHS Trust (UHNM) and a £0.5m adverse position at the ICB, predominantly driven by slippage in efficiency as programmes develop. Plan risk is reducing on a daily basis, at the time of writing the plan includes an £87m net risk value with £50m of this being efficiency based.

The system has materially altered the capital plan in order to submit a balanced operational capital plan. For IFRS16 the System is not compliant against the indicative allocation by circa £4.5m, while awaiting the final allocation the System are reviewing commitments and valuations of leases. With pressure on operational capital too, we now face material risks providing major concern about the current year should our IFRS16 issue not be resolved.

3.0 Planned Care

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

The Integrated Care Board (ICB) and system partners continue to address the backlog of patients on the elective waiting list, with the ambition of treating all those waiting more than 78 weeks by the end of Quarter 1 2024, and 65 weeks by the end of Quarter 2 2024 in accordance with the national planning guidance. However, despite progress being made the rate of improvement has been impacted upon by the ongoing industrial action by both junior doctors and consultants. The above ambitions apply to all providers across the system. The Independent Sector continues to support our recovery.

NHS England have confirmed that the system will remain in Tier 1 for Elective Care and Cancer, with the addition of Diagnostics added within the weekly oversight.

Current position is as follows:

104-week waits:

There was one breach for June and there are zero forecasted breaches for July where the breach is attributable to University Hospitals of North Midlands NHS Trust (UHNM). However, there were 4 additional breaches reported at the end of June, these extra patients are Corneal transplant patients that UHNM have accepted as mutual aid from The Royal Wolverhampton NHS Trust (RWT). It was agreed that UHNM submit these as part of their active waiters, but nationally and regionally they would be excluded and reported under Birmingham and Black Country ICB.

There were 0 breaches at the end of June for patients who are outside of the system.

78-week waits:

For patients waiting beyond 78 weeks for treatment, the number of breaches across the system at the end of June was 16, all of which were at UHNM. The forecast position for the end of July is 7 (all at UHNM), with a forecasted position of 0 breaches for August.

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As previously reported the ICB does continue to track long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System. In the latest unvalidated data (30th June), there are currently 10 patients waiting over 78 weeks outside of the system, seven (three of these are at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) are on the admitted part of the pathway and three (one of these is at UHDB) are on the non-admitted part of the pathway. UHDB are on Tier 1 elective oversight and are subject to weekly monitoring by NHS England.

The current forecast for the end of June, for patients waiting 78+ weeks outside of the system, is 10 breaches, with four of these being at UHDB.

65-week waits:

Good progress is being made overall on the 65-week-wait cohort, the revised target is now September 2024, where previously it was March 2024. The number of breaches across the system at the end of June was 1,432 (1,408 at UHNM, two at Nuffield, two at Ramsay, 20 at Medefer). The forecast position for the end of July is 1,310 breaches (1,300 at UHNM, two at Nuffield, eight at Medefer), with a forecasted position of 1,010 (1,004 at UHNM and six at Medefer) for August.

For providers outside of the system, in the latest unvalidated data (30 June) the potential cohort of patients who could breach 65 weeks if not treated, by the end of September is 2,329 patients, 953 of these are on the admitted part of the pathway and 1,376 on the non-admitted pathway. It is noted, that 336 of these patients have been dated before the end of September.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) have seen a continued steady reduction in the 62-day backlog since September, however, there have been increases at some point over this time. As of 2 July, the 62-day backlog was 234 this is compared to 231 as of 2 June. UHNM are currently under their fair share allocation.

The 104+ day backlog has also seen a downward trend, with some increases at some points. As of 30 June, the 104+ backlog was 53, this is compared to 59 as of 6 June.

The position of 28-day faster diagnosis standard for cancer has seen a steady improvement since November but did see a slight decline in January. April's position was 69.14% against a Trust trajectory of 74.0%, May position was 75.8% against a Trust trajectory of 74.5%, June's current forecasted position is 76.5% against a Trust trajectory of 74.9%.

May provisional data for 62-day combined is 67.87% against a trust trajectory of 62.18%.

4.0 Urgent and Emergency Care (UEC)

Unvalidated four-hour performance in June reached 70.97%, the fourth month in a row of above 70% performance. This was slightly down on the 71.44% reported during May 24 which was achieved during a period of increased Type 3 demand but remained above plan (70.29%) for the month of June. Type 3 locations achieved 98.66% performance during June which was a 0.44 percentage point improvement over May. When comparing June 2024 to the same period last year the improvement was 2.4 percentage points over the 68.6% recorded during 2023. Overall

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attendances across all sites reduced by 6.6% whilst Emergency Admissions via A&E reduced by 8% during June, the equivalent of 9 patients a day throughout the month, and the 2nd consecutive month of reduced admissions.

Twelve-hour performance for June rose by 0.4 percentage points from 7.9% to 8.3% primarily as a result of reduced numbers in attendance whilst those spending more than 12 hours in the department remained static. When compared to the same period last year the increase was 0.6 percentage points, the equivalent of 10 patients per day throughout the month. County Hospital reported an improving position through June, but this improvement was mitigated by a worsening position at Royal Stoke.

Long Length of Stay (LoS) performance reported very little movement in the 7+ days cohort whilst both the longer cohorts of 14+ and 21+ saw increases of 0.4 and 0.8 percentage points respectively. These longer stays increase resulted in the increase in General and Acute (G&A) bed occupancy to 92.1% for June, the first time since February that the 92% threshold has been breached and only the 3rd time in the last 13 months to report above the threshold. When compared to the same period last year all 3 cohorts were below the 2023 position with 7+ reporting a 1.8 percentage point reduction, the equivalent of 22 patients per day. 14+ saw an equivalent reduction of 13 patients per day over June 2023, whilst for 21+ this figure was 8.

Category 2 Response Times through June started well but rose through the 30-minute mark for 3 out of the 4 weeks resulting in a 4-week average of 31 minutes 42 seconds which placed the system 4th out of 11 regionally, and 16th out of 42 nationally. This equates to the 2nd quartile for both comparisons with the latest week recording the system as 10th out of 42 nationally and in the first quartile. The average for 24/25 so far remains just over 1 minute above the 30-minute threshold at 31 minutes 16 seconds.

Medically Fit for Discharge (MFFD), whilst recording individual days where numbers rose, has averaged 111 for the month of June, only slightly up on the 110 reported through May. County Hospital has reported a number ranging from 7 to 30 whilst Royal Stoke has seen an ever-greater range in numbers stretching from 78 to 121.

COVID-19 bed numbers began in June on a downward path having peaked during the 2nd week of May. This continued throughout most of June, falling as low as 40 beds occupied by positive patients, however there was a sharp upturn through the end of the month with the rate of increase and numbers mimicking those seen in 2022 when the overall numbers reached 237 by the middle of July. The rate of increase over the end of June and beginning of July appears to have stalled at the 100 mark however, anecdotal evidence indicates COVID-19 is still in the community and increased absences amongst staff are now being seen. This would suggest that the latest increase in bed numbers is not over, and the coming week is likely to see further increases in bed occupancy. This is also evident through the number of COVID-19 patients attending A&E which is placing stress on the system due to infection prevention controls (IPC) and swabbing protocols.

5.0 Key figures from our population

	Last 3 to 4 months in current financial year				Comparator month			Change on same month previous year		
	Feb-24	Mar-24	Apr-24	May-24	Mar-23	Apr-23	May-23			
A&E and Walk in Centre attendances (UHNM)	19,952	21,864	21,417	23,516			21,841	1,675	7.7%	↑
A&E and Walk in Centre attendances (other providers)	17,579	18,860	18,666	19,728			18,728	1,000	5.3%	↑
Non elective admissions (UHNM)	7,578	7,865	7,634	8,433			7,591	842	11.1%	↑
Non elective admissions (other providers)	6,522	6,619	6,532	6,766			6,269	497	7.9%	↑
Elective and Day Case spells (UHNM)	7,551	7,395	7,304	8,214			7,099	1,115	15.7%	↑
Elective and Day Case spells (other providers)	8,439	8,237	8,424	8,753			8,058	695	8.6%	↑
Outpatient procedures (UHNM)	5,206	5,049	5,457	5,414			4,656	758	16.3%	↑
Outpatient procedures (other providers)	9,753	9,785	10,068	10,272			8,906	1,366	15.3%	↑
GP Appointments (all)	558,380	538,690	546,734	536,241			492,079	44,162	9.0%	↑
Physical Health Community Contacts (attended)	133,790	141,770	148,950			121,860		27,090	22.2%	↑
Mental Health Community Contacts (attended)	41,165	37,885			47,940			-10,055	-21.0%	↓

Most datasets are subject to change following refresh

NHS 111 - Due to the switchover to DHU, part way through April 2024, it is not currently possible to identify 111 call volumes from National data. A local solution is currently being investigated.

*Physical health contacts - latest month is provisional and subject to change and the dataset is sometimes one month behind other datasets depending upon publication timing.

**Mental health contacts - latest month is provisional and subject to change and the dataset is currently two months behind other datasets due to a delay in publication.

The comparison with the same month the previous financial year is the same month for most measures, apart from measures that lag one month behind. The month being compared is indicated by the absence of dark grey shading. Mental health contacts - April 2024 data is not due to be published until mid July so March 2024 is being compared to March 2023.

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). We will flag up if variation in these activities is abnormal.

6.0 Quality and safety

Following a joint quality and performance deep dive into the Non-Emergency Patient Transport (NEPTS) a number of common themes were identified to support an agreed improvement plan, this will be presented to the UEC Board at the end of June 2024. To promote the need for a continued collaborative approach an event took place on 4th June 2024 with representatives present from EMED group, Providers, ICB Quality and Urgent Care Teams. To reflect the value in a shared learning approach between providers and the positive feedback received following the event, it was agreed that further regular events will be organised to support the implementation of the plan.

With the continued focus upon improving quality and safety in partnership with our patient population work is progressing. The Nursing, Quality and Therapy team are actively seeking to recruit into the Patient Safety Partners (PSP) role within the ICB. The PSP role is integral to realising the recommendations made within the Framework for Involving Patients in Safety, bringing a different perspective on patient safety and informing how we learn taking a patient centred approach. It is expected that the successful candidates will work in partnership with staff

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to influence and improve the governance and leadership of safety at every level within our organisation and the wider ICS.

7.0 Vaccinations

The Spring COVID-19 vaccination programme concluded on 30 June 2024. There has been a very positive uptake this campaign with 99,678 vaccinations being administered within vaccination sites in Staffordshire and Stoke-on-Trent. 57.8% of the ~161,000 individuals who are eligible were vaccinated during the spring programme. This is the 3rd highest ICB within the Midlands NHS England Region.

Care home residents have been the priority for sites and all care homes have been visited with the majority of residents vaccinated with their COVID-19 Spring dose.

Vaccinations continue to be available over the summer for severely immunosuppressed individuals by request from a specialist/GP.

NHS England are currently undertaking an Expression of Interest process for COVID-19 vaccination programme providers from September 2024 to March 2026. This is open to all healthcare providers this time so may see additional sites from the traditional GP practices/PCNs, NHS Trusts and Community Pharmacies. Joint Committee on Vaccination and Immunisation (JCVI) are yet to announce detailed recommendations for the Autumn/Winter COVID-19 vaccination programme this year, but this is expected shortly.

David Pearson, ICB Chair

Peter Axon, ICB Chief Executive Officer

Enclosure No: 7.

Report to:	ICB Board					
Date:	18 th July 2024					
Title:	Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent					
Presenting Officer:	Upkar Jheeta (MPFT) Nicola Bromage (ICB), Laura Smith (NSCHT)					
Author(s):	Nicky Smith, Nicola Bromage, Laura Smith, Upkar Jheeta					
Document Type:	Strategy	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input checked="" type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO				
Any financial impacts: ICB or ICS?	Yes / No	NO				
Appendices:	Transforming Mental Health Inpatient Services in Staffordshire & Stoke on Trent Strategy					

(1) Purpose of the Paper:

Mental health inpatient services provide for children, young people, and adults, including people with a learning disability and autistic people. They form a vital part of a landscape of care, treatment, and support to individuals who are experiencing mental health conditions. Recent high-profile cases of quality failings in both NHS and Independent Sector hospitals, affecting children, young people, and adults, have rightly caused concern, sharpening the focus of providers, commissioners, and regulators on mental health inpatient provision

In 2022/23 the NHSE Mental Health, Learning Disability and Autism Quality Transformation Team undertook an extensive engagement exercise with key stakeholders. The aim of this exercise was to gather the views and expertise of individuals concerned with the commissioning, delivery, and improvement of mental health inpatient services.

A strong theme from these discussions was the need to consider the design of current inpatient provision for children, young people and adults, and its capacity to create, or undermine, the conditions for individuals (including staff) to flourish

This 'ask' included a clear request for a shared understanding of 'what good looks like' for mental health inpatient services and a call to action. To support commissioners and providers to build on existing good practice to ensure that every person who is admitted to an inpatient service, experiences safe, personalised, effective, and compassionate care.

NHSE provided guidance in a 'Commissioning Framework for Mental Health Inpatient Services', which is

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comprised of several workstreams and is aimed at improving the quality and safety of care that people experience in mental health, learning disability and autism inpatient settings.

Staffordshire and Stoke-on-Trent ICS have created a strategy for Transforming Mental Health Inpatient Services in Staffordshire and Stoke-on-Trent and have made a number of commitments to the local population. The Board is asked to note the strategy, approve the content and support the system delivery.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
MHLDA Portfolio Board (R)	04/07/2024
Staffordshire Joint Commissioning Board (I)	05/07/2024
Quality and Safety Committee (A)	10/07/2024

(3) Implications:	
Legal or Regulatory	Unknown impact of any political and policy change following 2024 General Election which may influence the requirements of this programme and/or how they are delivered - This dynamic strategy includes various scoping activities in Year 1, offering the flexibility to build-in and respond to any changes as required.
CQC or Patient Safety	The Culture of Care programme is a significant enabler for the inpatient quality transformation programme and delivery of this inpatient strategy in several ways including improved patient experience. This aligns with the core goal of the ICB's quality transformation programme – to improve the quality of care for patients in inpatient units. By adopting the programme's principles, the ICB and partners can ensure our inpatient strategy focuses on creating a safe, supportive, and recovery-oriented environment for patients.
Financial (CFO-assured)	Ensuring the long-term financial viability of in-patient services is essential. The strategy will consider cost-effective service models that deliver high-quality care while optimizing resource allocation. Financial challenges experienced by multiple system partners impact ability to work in a truly collaborative way - A system commitment to working in the best interests of service users and recognition that a focus on reducing inpatient admissions through community alternatives provides opportunity for improved outcomes and financial efficiencies across partner organisations.
Sustainability	Ensuring the long-term financial viability of in-patient services is essential. The strategy will consider cost-effective service models that deliver high-quality care while optimizing resource allocation. Culture of Care focuses on long-term sustainability by creating a culture that values staff well-being alongside patient care. This aligns with the need for our inpatient strategy to be sustainable and ensure a positive working environment for staff to attract and retain talent. A happy and well-supported workforce is more likely to deliver high-quality care.
Workforce or Training	The national shortage of mental health professionals can impact service delivery. The strategy will identify opportunities to attract and retain qualified staff, potentially through training initiatives and career development programs, whilst offering a range of therapeutic interventions to service users. Effective collaboration with system partners is crucial for smooth transitions between hospital and community settings. The strategy will

	<p>explore ways to strengthen partnerships and ensure a coordinated approach to care.</p> <p>Challenges include: Inequity of Provision; Discrepancies in staffing ratios between mental health trusts within the ICB create an uneven quality of care for patients. This can lead to poorer outcomes for patients in understaffed facilities. The programme must address disparities to ensure equitable access to high-quality mental health care. The current workforce may not be sufficient to achieve the ICB's ambitious transformation goals. Gaps may exist in specific professions, skillsets, or geographic areas. Filling these gaps requires targeted funding to attract and retain qualified personnel. Additionally, upskilling existing staff through training programs can further enhance their capacity to deliver on the new strategy.</p>
<p>Equality & Diversity</p>	<p>In establishing the underpinning evidence base for this strategy, the strategy will commit considerable resource to understanding where inequalities may be present within current inpatient services and pathways. A deeper understanding of local demographics and the varying needs of the populations across the ICB geography, supported by the concurrent development of the ICS Health Inequalities Strategy has been identified.</p>
<p>Due Regard: Inequalities</p>	<p>Mortality rates in people with SMI are high. In Staffordshire excess under 75 mortality rates in adults with SMI was 419.2%, compared to 385.9 across England. This appeared to be driven by high rates of cancer mortality. Similarly, premature mortality among people with SMI in Stoke-on-Trent is high, again with cancer being a particular area of concern, but this is in line with high rates of premature mortality across the general population of Stoke-on-Trent.</p> <p>A commitment has been made in the strategy to commission and deliver services where everyone counts, are treated with dignity and are safe, irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability of health conditions.</p> <p>Whilst there is an understanding of where inequalities may exist, the reasons are not understood. Only when we truly understand the reasons for inequality will we be able to take the appropriate action to address it. This must happen as part of a whole system approach and the established governance arrangements of which this programme is a part, ensures alignment across mental health, learning disability and autism services.</p>
<p>Due Regard: wider effect</p>	<p>By focusing on optimising bed use, developing integrated care pathways, and prioritising patient well-being, the strategy aims to improve access to effective care and ensure positive outcomes for individuals experiencing mental health challenges.</p> <p>This ICB strategy is not a static document. It will involve ongoing data analysis, service evaluation, and stakeholder engagement to ensure continuous improvement and responsiveness to evolving needs. By working collaboratively, the ICB and its partner providers can strive to deliver a robust, effective, and future-proof in-patient mental health service that meets the needs of the people of Staffordshire and Stoke-on-Trent.</p>

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required - Transforming Mental Health Inpatient Services in Staffordshire & Stoke on Trent is a joint strategy for the ICS. DPIA will be applied when appropriate in delivery of the strategy
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required - Transforming Mental Health Inpatient Services in Staffordshire & Stoke on Trent is a joint strategy for the ICS. EIA will be applied when appropriate in delivery of the strategy
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required - Transforming Mental Health Inpatient Services in Staffordshire & Stoke on Trent is a joint strategy for the ICS. QIA will be applied when appropriate in delivery of the strategy
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Four patient engagement events were scheduled for June 2024. Due to the pre-election period, these were stood down. The events will be scheduled for later in the year.

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>	BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>	BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>Mental health inpatient services provide for children, young people, and adults, including people with a learning disability and autistic people. They form a vital part of a landscape of care, treatment, and support to individuals who are experiencing mental health conditions. Recent high-profile cases of quality failings in both NHS and Independent Sector hospitals, affecting children, young people, and adults, have rightly caused concern, sharpening the focus of providers, commissioners, and regulators on mental health inpatient provision.</p> <p>In 2022/23 the NHSE Mental Health, Learning Disability and Autism Quality Transformation Team undertook an extensive engagement exercise with key stakeholders. The aim of this exercise was to gather the views and expertise of individuals concerned with the commissioning, delivery, and improvement of mental health inpatient services.</p> <p>A strong theme from these discussions was the need to consider the design of current inpatient provision for children, young people and adults, and its capacity to create, or undermine, the conditions for individuals (including staff) to flourish</p> <p>This ‘ask’ included a clear request for a shared understanding of ‘what good looks like’ for mental health inpatient services and a call to action. To support commissioners and providers to build on existing good</p>

practice to ensure that every person who is admitted to an inpatient service, experiences safe, personalised, effective, and compassionate care.

NHSE provided guidance in a 'Commissioning Framework for Mental Health Inpatient Services', which is comprised of several workstreams and is aimed at improving the quality and safety of care that people experience in mental health, learning disability and autism inpatient settings.

Purpose of the Framework

The commissioning framework for mental health services provided to adults including people with a learning disability and autistic people aims to ensure that patients receive high-quality, timely, and appropriate inpatient care. The framework sets out how Integrated Care Boards can use the funds they are currently investing in inpatient care to provide better services which are tailored to patient need.

The framework has been developed for use by those who have commissioning responsibility for the mental health needs of their local population. It is recognised that commissioning is a function and can be carried out by different individuals and organisations, separately and collaboratively, depending on local arrangements.

The framework focuses on the following care settings:

- Acute Inpatient Mental Health Services for Adults and Older Adults
- Acute Mental Health Inpatient Services specifically for Autistic Adults and Adults with a Learning Disability
- Adult Mental Health Rehabilitation Inpatient Services
- Children and Young People Mental Health, Learning Disability and Autism Inpatient Review

Aims of the Framework

To support and provide guidance to those responsible for the commissioning of mental health inpatient services. Within this, to advance the system wide requirement to ensure that services are local, inclusive and deliver safe, personalised, and therapeutic care.

To enable and support systems to develop local plans for change, so that inpatient provision better fits the needs of the population, makes more effective use of the funds available, and protects and improves the lives of citizens in their locality

Key Principles

- Person-centred care: Care should be tailored to the individual needs and preferences of each patient.
- Least restrictive setting: Care should be provided in the least restrictive setting possible.
- Early intervention: Care should be provided as early as possible.
- Recovery-focused approach: Care should focus on recovery and enable patients to live fulfilling lives.

Actions for Integrated Care Systems

ICBs are required to develop a 3-year plan to localise and realign adult inpatient services with a final published plan by July 2024.

Provider Collaboratives, working in Partnership with ICBs and the 'whole system' to complete their 'gap-analysis' against the draft future service model for CYP by the end of March 2024.

ICBs and Provider Collaboratives work together to develop a joint local implementation plan for CYP with a draft plan submitted to regional and national colleagues in December 2024 and a final plan submitted in March 2025

Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent Strategy

This strategy serves as a roadmap for the Integrated Care Board (ICB) and its partner providers, Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT) to develop a well-coordinated and responsive inpatient mental health service.

By focusing on optimising bed use, developing integrated care pathways, and prioritising patient well-being, the strategy aims to improve access to effective care and ensure positive outcomes for individuals experiencing mental health challenges. While this strategy outlines a positive vision, several key challenges need to be addressed:

- **Demand and Capacity Management:** Balancing the often-fluctuating demand for inpatient beds with available resources can be complex. The strategy will explore innovative approaches to managing bed occupancy rates and potentially reducing reliance on inpatient care through robust community support mechanisms and reducing/eliminating the use of out of area placements.
- **Workforce Shortages:** The national shortage of mental health professionals can impact service delivery. The strategy will identify opportunities to attract and retain qualified staff, potentially through training initiatives and career development programs, whilst offering a range of therapeutic interventions to service users.
- **Integration with System Partners:** Effective collaboration with system partners is crucial for smooth transitions between hospital and community settings. The strategy will explore ways to strengthen partnerships and ensure a coordinated approach to care.
- **Financial Sustainability:** Ensuring the long-term financial viability of in-patient services is essential. The strategy will consider cost-effective service models that deliver high-quality care while optimizing resource allocation.

Areas for Consideration within the Strategy

- **Population Demographics:** The strategy will take into account the specific demographics of our local population, including age distribution, prevalence of mental health conditions, and potential disparities in access to services. This data-driven approach will ensure the service model caters to the unique needs of the community.
- **National Policy:** Alignment with national directives for mental health service provision, such as the NHS Long Term Plan's focus on community-based care, will be a key consideration. The strategy will seek to find a balance that leverages the strengths of in-patient care while promoting community-based interventions whenever appropriate.
- **Collaboration and Stakeholder Engagement:** The success of the strategy hinges on fostering strong partnerships with mental health providers, local authorities, voluntary sector organizations, and critically, service users and their families. This collaborative approach will ensure a comprehensive and coordinated service that reflects the diverse needs and perspectives of all stakeholders.
- **Focus on Reasonable Adjustments and Support:** This strategy specifically addresses the needs of patients with learning disabilities (LD) and autism spectrum disorder (ASD) who may require inpatient mental health services.

This ICB strategy is not a static document. It will involve ongoing data analysis, service evaluation, and stakeholder engagement to ensure continuous improvement and responsiveness to evolving needs. By working collaboratively, the ICB and its partner providers can strive to deliver a robust, effective, and future-proof in-patient mental health service that meets the needs of the people of Staffordshire and Stoke-on-Trent.

(7) Recommendations to Board / Committee:

The Board is asked to note the Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent Strategy, approve the content and support the system delivery.

Transforming mental health inpatient services in Staffordshire and Stoke-on-Trent

2024-27



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- Introduction
- Our learning so far
- Bringing our commitments to life
- Governance
- Investment Plan
- Managing risk
- Our population health
- Our commitments
- Our enablers
- Delivery Plan
- Measuring impact

Introduction

This strategy serves as a roadmap for the Integrated Care Board (ICB) and its partner providers, Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) to develop a well-coordinated and responsive inpatient mental health service. **By focusing on optimising bed use, developing integrated care pathways, and prioritising patient wellbeing, the strategy aims to improve access to effective care and ensure positive outcomes for individuals experiencing mental health challenges.**

While this strategy outlines a positive vision, several key challenges need to be addressed:



Demand and capacity management: It can be complex to balance the often-fluctuating demand for inpatient beds with available resources. The strategy explores innovative approaches to managing bed occupancy rates and potentially reducing reliance on inpatient care – through robust community support mechanisms and reducing (with a view to ultimately eliminating) the use of out-of-area placements



Workforce shortages: The national shortage of mental health professionals can impact service delivery. The strategy identifies opportunities to attract and retain qualified staff – potentially through training initiatives and career development programmes – while offering a range of therapeutic interventions to service users



Integration with system partners: Effective collaboration with system partners is crucial for smooth transitions between hospital and community settings. The strategy explores ways to strengthen partnerships and ensure a coordinated approach to care



Financial sustainability: Ensuring the long-term financial viability of inpatient services is essential. The strategy considers cost-effective service models that deliver high-quality care while optimising resource allocation.

Introduction

The strategy encompasses a range of inpatient bed types catering to diverse needs:



While NHS providers deliver most of the inpatient provision within the ICB footprint, independent sector provision is also part of the local offer.

Considering how we make better use of this capacity will be a focus of the strategy as we seek to reduce and ultimately eliminate out-of-area placements.

Introduction

Areas for consideration within the strategy:



Population demographics: The strategy will consider the specific demographics of our local population – including age distribution, prevalence of mental health conditions, and potential disparities in access to services. This data-driven approach will ensure the service model caters to the unique needs of the community.



National policy: Alignment with national directives for mental health service provision, such as the NHS Long Term Plan's focus on community-based care, will be a key consideration. The strategy seeks to find a balance that leverages the strengths of inpatient care, while promoting community-based interventions whenever appropriate.



Collaboration and stakeholder engagement: The success of the strategy hinges on fostering strong partnerships with mental health providers, local authorities, voluntary sector organisations, and critically, service users and their families. This collaborative approach will ensure a comprehensive and coordinated service that reflects the diverse needs and perspectives of all stakeholders.



Focus on reasonable adjustments and support: This strategy specifically addresses the needs of patients with learning disabilities (LD) and autism spectrum disorder (ASD) who may require inpatient mental health services.

This ICB strategy is not a static document. It will involve ongoing data analysis, service evaluation, and stakeholder engagement to ensure **continuous improvement** and **responsiveness to evolving needs**.

By working collaboratively, the ICB and its partner providers can strive to deliver a **robust, effective, and future-proof** inpatient mental health service that meets the needs of the people of Staffordshire and Stoke-on-Trent.

Our population health



Geographical and social context

Staffordshire and Stoke-on-Trent (SSoT) ICB covers a diverse population, including some of the most deprived urban areas in the country and affluent rural countryside.



Deprivation: While the overall rate across SSoT is in line with the national average, this masks considerable variation:

- **England:** 21.67 Index of Multiple Deprivation (IMD) 2019 score
- **SSoT:** 20.64 IMD 2019 score

There are also large numbers of people living in Core 20 areas – 217,000 people (19% of the population).



Income: Average gross weekly pay for full-time workers is considerably lower than the national average:

- **England:** £645.80
- **Staffordshire:** £630.70
- **Stoke-on-Trent:** £568.20



Unemployment: While in line with the England average across the ICB, the number of long-term jobseeker benefit claimants in Stoke-on-Trent is higher than average.



Homelessness: Generally lower than the England average in Staffordshire, but higher than the England average in Stoke-on-Trent.



Ageing population: The ICB has an ageing population, with an under-representation of working-age adults compared to the England average, and an over-representation of people aged 55 and over.



Ethnicity: The 2021 Census indicates that the local population is considerably less ethnically diverse than the England average:

- **England:** 81% White, 9.6% Asian / Asian British
- **SSoT:** 91.31% White, 4.8% Asian / Asian British

Mental health inequalities at population level



Depression: Data from the Quality Outcomes Framework (QOF) suggests a higher-than-average rates of depression across SSoT:

- **England:** 12.7
- **Staffordshire:** 13.4
- **Stoke-on-Trent:** 17.9



Severe mental illness (SMI): The QOF data again points to a higher burden of disease in Stoke-on-Trent, with lower-than-average rates in Staffordshire.



Mortality rates in people with SMI: Excess under-75 mortality rates in adults with SMI are high across SSoT, which appear to be driven by high rates of cancer mortality:

- **England:** 385.9%
- **Staffordshire:** 419.2%



Premature mortality in people with SMI:

Similarly, rates in Stoke-on-Trent is high, with cancer being a particular area of concern – but this is in line with high rates of premature mortality across the general population of Stoke-on-Trent.

These findings highlight the importance of **physical healthcare** for the severe mental illness population.

Mental health inequalities at population level

In May 2023, the NHS published data on **detentions under the Mental Health Act 1983** for the whole country and every ICB. This was in response to research showing disparities in the use of the Mental Health Act across ethnic groups, with no explanation for the variation. The data measures rates of detention, including people who were detained (or 'sectioned') in hospital for assessment or treatment under the act. As well as providing the data by ethnicity, information by sex, deprivation and age was also included. The detention rate is the number of detentions under the act in healthcare services for every 100,000 people in the general population.



In terms of deprivation: Rates are lower across every deprivation decile in SSoT than the England average, with the exception of the 'third less deprived' group. There is a general trend towards higher rates of detention in more deprived groups than less deprived (for both England and SSoT):

- **England:** 40 per 100,000 in the least deprived group, 148 per 100,000 in the most deprived group
- **SSoT:** 36 per 100,000 in the least deprived group, 125 per 100,000 in the most deprived group



In terms of ethnic groups: National data shows that Black people were most likely to be detained under the Mental Health Act during 2021/22:

- **England:** 342 detentions per 100,000 Black people
- **England:** 72 per 100,000 White people

While rates in SSoT vary considerably across groups, and all other ethnic groups have a higher rate of detention than the White population, the very high rates seen nationally are not reflected in the local data. Although the rate of detentions in Black populations in SSoT is less than half the national rate, this does still represent considerable unexplained difference, which requires much greater understanding.

Our learning so far



Learning from local data analysis

In developing this strategy, we have drawn from a wealth of information that exists across our Integrated Care System (ICS) to understand the needs of our local population, what is working well, and where we need to do more to deliver high quality recovery-focused services that empower individuals and promote health equity through a trauma-informed approach.

We have undertaken focused activities to review current practice against the Commissioning Framework for mental health inpatient services, and drawn from a range of associated research, reports and performance data to ensure a holistic view.

To supplement the understanding gained from national data sources, local data was extracted and analysed. The dataset contained 2,795 episodes of inpatient care provided by MPFT and 3,150 from NSCHT. This represented the data of 1,931 individual patients from MPFT and 2,219 from NSCHT, everyone admitted to the in-scope wards between January 2021 and December 2023.

The data was broken down by sex, ethnicity, age and deprivation, with the following themes:



Sex: Female patients were more likely to have had previous recorded contact with adult mental health services and children and young people mental health services, while male patients were more likely to have had recorded contact with forensic services. Males were more likely to be formally admitted and have a flag indicating seclusion on their records, while females were more likely to have flags indicating both incidents and restrictive practice on their records.



Ethnicity: Patients with ethnic minority backgrounds were more likely to be formally admitted and have flags – indicating restrictive practice, seclusion and incidents.

Learning from local data analysis



Deprivation: Patients in the more deprived groups had a much greater number of previous referrals to adult services, and a greater proportion had a previous forensics referral. More deprived patients had a higher rate of incident flags on their records.



Age: Younger patients had more records of previous admissions, a greater proportion of restrictive practice flags, and a greater proportion of incident flags. Older people were more likely to be formally admitted.

Based on the results of this analysis, there are several avenues for further work:

- While there are clear differences in this data, very little is known about the **life experiences** of patients before they became inpatients, and therefore the factors driving these differences. A much broader view of case-mix and patient history will provide a greater understanding as to the underlying causes of the differences seen here
- Higher quality data regarding **demographic characteristics** such as sexuality is vital to understand the experiences of minority groups. Data relating to sexuality, gender identity, veteran status and disability was not presented here due to either very small numbers or lack of recording
- Information about **physical health** is lacking and would provide much greater insight into the overall health of inpatients.

Learning from our communities

Developing this strategy in the pre-election period resulted in the postponement of dedicated public engagement events. However, we have drawn on a range of other engagement and co-production activity to inform our approach – which we commit to continuing as an iterative process for the duration of this strategy and beyond.

Public consultation undertaken in 2023 in respect of alternatives to inpatient treatment reflected people's **desire to receive care and support closer to home and in the community – wherever possible.** This was balanced against concern for the impact on carers and families, and whether community services could fully meet need.

Over the last three years, our system has transformed adult community mental health services – receiving positive recognition at a regional and national level. But we know there is more to do as **we continue to embed these changes and reflect on feedback,** such as the 2023 Community Mental Health Survey. This includes **improving approaches to person-centred care** – such as reasonable adjustments associated with neurodiversity.

We understand much of the change required to improve inpatient quality sits outside of the inpatient setting. This is why our Year 1 Delivery Plan includes a series of 'deep dives' focused on our patient and service user journey (from pre-admission, during treatment, to post-admission):

- ✓ They will be multi-agency
- ✓ They will include the input and perspective of those with lived experiences
- ✓ They will be explored through the lens of health inequality.



Learning from our communities

Our three-year inpatient population health analysis demonstrated that health inequalities identified within mental health services nationally are present within our own system.

Action is required to **understand the reasons** for this, in order for us to take the appropriate steps to address them.

A **patient experience survey** exploring the relationship between protected characteristics and experiences of care and support will also inform the approach.

Our services are not delivered in a static environment, and **must constantly adapt** in response to changes in population need, support and service provision available across the Integrated Care Partnership.

The **deep dives** will support us to understand the impact of developments through community mental health transformation and beyond to ensure our pathways provide continuity and support and align with the objectives of the Inpatient Quality Transformation Programme.

Learning from our workforce

A recent S117 survey received 107 responses from practitioners working across the ICS in a range of disciplines.

Key themes explored included:



The findings from the survey and the views of our workforce strongly align with the aims of the Inpatient Quality Transformation Programme. They include improving the range of community support and crisis alternatives and the need to improve services for specific cohorts, for example crisis alternatives for older adults.

Learning from our workforce

Survey responses also reflected a need to ensure a holistic approach to care through inpatient and community settings through effective **multi-disciplinary team (MDT) approaches**. These incorporate a broad range of statutory and voluntary, community and social enterprise (VCSE) partners across a range of domains – including housing, substance misuse, and employment.

This feedback was further developed through a **system-wide workshop** for Staffordshire and Stoke-on-Trent, held in June 2024.

This strategy has developed while the local authorities have been leading the system S117 activity. However, **the significant interdependencies and shared objectives between the S117 activity and the Inpatient Quality Transformation Programme are now understood**, and will be reflected and managed through programme design and governance.

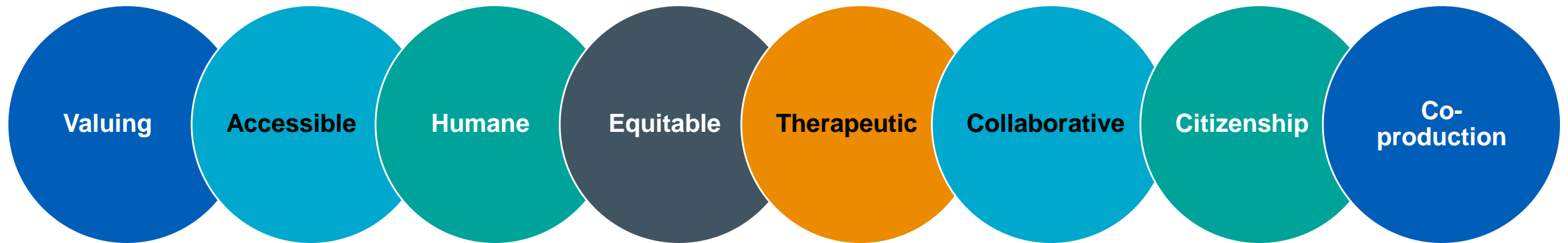
Opportunities for improvement were identified, which broadly align to five key themes:

- 1 Process**
- 2 Workforce development**
- 3 Market development**
- 4 Data**
- 5 Improved joint working**

Learning from our workforce

To assist in the development of this strategy, a range of staff from across our inpatient settings were involved in **workshops to support a self-assessment against nationally, co-produced 'I/We statements'**. These workshops offered an opportunity for honest reflection and high-quality discussion on what is working well, and where improvements are needed.

I/We themes:



The workshops identified variance across the thematic areas and the cohorts covered by this programme (adults, older adults, rehabilitation, and people with a learning disability and/or autism). **The average score across the self-assessment was three, with areas of strength identified within valuing, humane and therapeutic.**

The varying approaches within each trust will result in some differences, for example in relation to the role of lived experience and peer workers within inpatient settings. Self-assessment of the 'We' statements by our workforce must be set against assessment of the 'I' statements by service users and those with lived experience. This will form a key strand of activity during Year 1 of the programme.

Learning from audit activity

An in-depth audit against the Commissioning Framework for Mental Health Inpatient Services was undertaken on a targeted sample of patients from across all in-scope MPFT and NSCHT wards. The sample included patients discharged in the 12 months to April 2024 to better understand current practice and identify areas for future development. **Two audits were completed – one for the general patient population and one for patients with a learning disability and/or autism (LDA).** The audit format was adapted for the LDA audit.

General inpatient audit:

In total, **70 patients** were identified across MPFT and NSCHT from adult acute, PICU wards, and the rehabilitation ward at NSCHT.

Note that as the audit activity focused on evidence of adherence to standards within clinical records, a lack of evidence identified doesn't necessarily mean that the activity did not happen. However, **the importance of accurate record keeping is not underestimated, and will be a key determinant of how we measure the progress and impact of this strategy.**

Key themes from the audit:

- ✓ Strong evidence that care planning is undertaken based on assessment and that plans are available in the Electronic Patient Record (EPR)
- ✗ Less evidence of patient involvement in the development of care plans or patients having a copy of their care plan
- ✗ Less evidence of holistic assessment, records of advanced decisions, and reasonable adjustments
- ✓ Evidence relating to purposeful admissions shows standards are consistently met
- ✗ Inconsistent recording of purpose of admission being discussed with patients and carers
- ✗ Inconsistent application of factors related to discharge planning such as beginning within 72hrs
- ✓ Discharge was facilitated promptly and consistently followed up within 72hrs
- ✓ Limited evidence of a lack of community-based support being associated with delays for patients that were clinically ready for discharge.

Learning from audit activity

LDA audit:

In total **24 patients** were identified.

- At MPFT and NSCHT, patients were identified on adult acute and PICU wards
- No patients were identified from the older adult wards at NSCHT or MPFT
- No LDA patients were identified from the rehabilitation ward at NSCHT.

The **recording of and ability to identify patients with a learning disability and/or autism** across inpatient wards has already been identified as an area for improvement.

Key themes from the audit:

- ✓ Strong evidence of timely assessment on admission as well as admission being purposeful
- ✓ The purpose of admission was discussed with carers and uploaded to the EPR
- ✗ Inconsistencies in care planning, including patient involvement in care planning and providing a copy of the care plan
- ✗ At times, staff with additional training to better support LDA patients were not available
- ✓ Factors that could delay discharge were considered
- ✗ Discharge planning did not always occur within the recommended 72hr window after admission
- ✓ Follow-up within 72hrs of discharge occurred in most cases
- ✗ There were minimal records related to patients clinically ready for discharge but whose discharge had been delayed.

Our commitments

What good looks like in
Staffordshire and Stoke-on-Trent



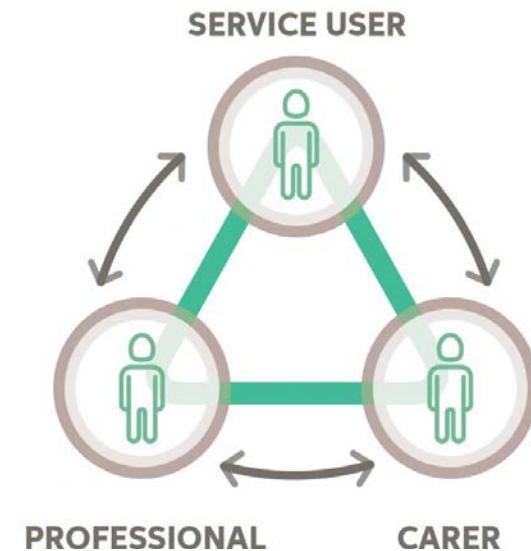
Valuing, co-production and lived experience

We are committed to involving and integrating people with lived experience into mental health services – recognising the profound impact this has on service design, delivery and outcomes.

We will continue to value the contributions of those with lived experience and ensure meaningful involvement through a range of methods and tailored communication approaches. **We will ensure the principles and approaches to ‘valuing’ translate through activity as part of the Host and Home Commissioner pilot to ensure equity of approach for those that are placed out of area.**

The **Triangle of Care** is currently used across both MPFT and NSCHT. This comprehensive framework enhances collaboration and partnership between mental health professionals, service users and carers, ensuring all three parties are actively involved and have a voice in the care process.

Through this strategy, **we will work to ensure consistency in the use of Triangle of Care** and explore opportunities to formally commit to an overarching framework for the ICS, such as **4Pi** (Principles, Purpose, Presence, Process and Impact).



Valuing, co-production and lived experience

Both trusts currently use peer recovery and lived experience roles in different ways. It is important for organisations to retain flexibility in approach, but we will work to ensure that where approaches may differ, the impact, outcomes and satisfaction of those with lived experience is equitable across providers and communities.

The **Culture of Care programme** will be a key enabler, with opportunities for sharing and responding to good practice, for example through action learning sets.

The trusts have worked collaboratively to successfully deliver the **Adult Community Mental Health Transformation Programme** which included the development of person-centred care planning. Further development and embedding of person-centred care plans within inpatient settings is a key component of this strategy, and critical to understanding and valuing the needs and wishes of service users.

Our approach will be informed by the data and learning arising from our **population health analysis**.

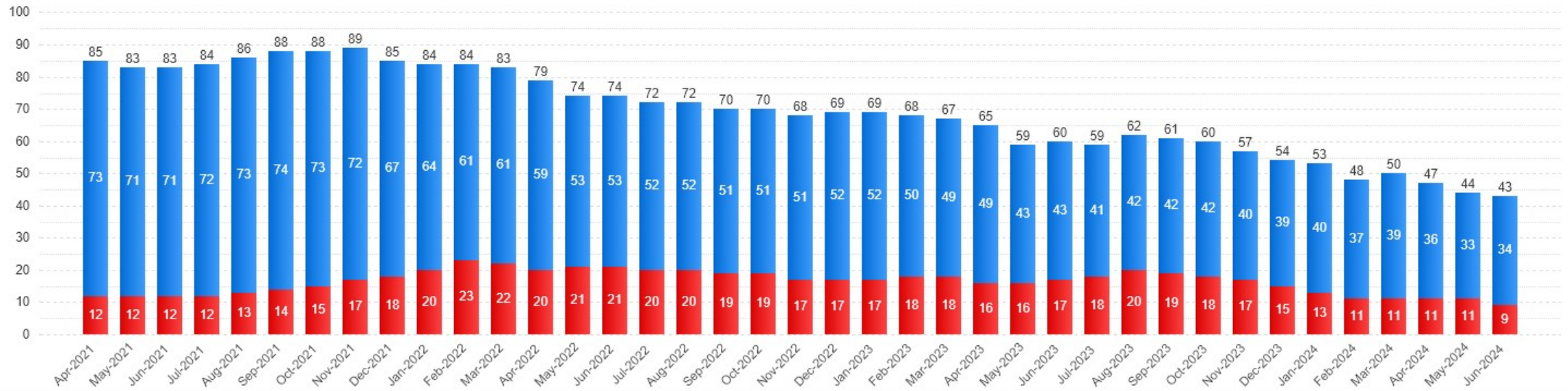
Accessible

We are committed to ensuring our services are needs-led and accessible to all who need them.

As a system, we manage demand for acute beds well within existing capacity, with relatively few out-of-area placements – but we have identified **female PICU beds as an ongoing challenge**. Historically, we have experienced greater pressures in **Level 2 rehabilitation**. **We have reduced the total demand for these placements by over 50% in the last three years through effective MDT approaches** that have supported the consideration and development of community-based alternatives.

Number of Patients OOA By Month

■ Placements <= 50 Miles ■ Placements > 50 Miles



Accessible

We are committed to delivering a further reduction in out-of-area placements through strategic commissioning approaches. These include the Home and Host Commissioner pilot to ensure better use of independent capacity within the ICB footprint, with participation in regional planning and commissioning approaches where appropriate.

We recognise that the needs of adults with a learning disability and/or who are autistic must be a central consideration. We must go further in understanding and delivering a **consistent approach to reasonable adjustments**, that would mean a greater proportion of this population (for whom out-of-area placements continue to be high) are able to have their needs met locally.

Within this, a focus on **person-centred care** will ensure that individual needs are considered, making clear that a consistent approach to delivering appropriate reasonable adjustments does not mean treating adults with a learning disability and/or autism as a homogenous group.

The **demand and capacity planning work** scheduled for Year 1 of the programme will be instrumental in ensuring we plan for and deliver provision that is reflective of the needs of our local population.

Humane

We are committed to delivering inpatient services that are person-centred and least restrictive. We have co-produced existing restrictive practice reduction strategies, and the impact of such strategies has been evident through reductions in the use of physical restraint and rapid tranquilisation.

Our providers have **invested in delivering trauma and psychologically informed training models** to staff that have been developed with the support of those with lived experience and their families. Models include the Institute of Conflict Management DMI training, Crisis Prevention Institute (CPI) safety interventions training and the Association for Psychological Therapies RAID training.

We will build on our success and seek to go further as we recognise inconsistencies in current approaches and opportunities for greater collaboration between our providers to share learnings. This will act as a key enabler as we roll out and successfully embed the Culture of Care programme.

Through a holistic and co-produced approach, we will ensure a multi-dimensional view of care – for example **consideration of environmental factors from the perspective of least-restrictive, trauma-informed and reasonable adjustments.**



The Association for Psychological Therapies



Humane

As part of our planning and delivery of improved commissioning approaches, including through our Host and Home Commissioner Pilot, **we will ensure these principles and commitment translate across independent sector provision** – including a move away from blanket restrictions to controlled access and egress systems determined by individual clinical assessment.

We will take the **learning** from successful MDT approaches used in the management and oversight of rehabilitation placements. We will apply this, as appropriate, to the **management of out-of-area acute placements**, which are fewer in number but of no less importance.

Equitable

We are committed to commissioning and delivering services where everyone counts, are treated with dignity and are safe – irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability of health conditions.

In establishing the underpinning evidence base for this strategy, we have committed considerable to resource to identify any inequalities in our current inpatient services and pathways. **We have a deeper understanding of local demographics and the varying needs of the populations across the ICB geography** – supported by the concurrent development of the ICS Health Inequalities Strategy. We also understand where there are gaps in our knowledge, for example being able to accurately report on the number of individuals with a learning disability and/or who are autistic across our inpatient wards. We are already taking action to address this.

A deep-dive into our inpatient population over the last three years has offered important insights but also raised more questions. **While we now understand where inequalities may exist, we do not always understand the reasons for this.** Only when we truly understand the reasons for inequality will we be able to take the appropriate action to address it. This must happen as part of a whole system approach and the established governance arrangements of which this programme is a part, ensures alignment across mental health, learning disability and autism services.

Our first step is engaging those with lived experience to seek their views and insight, along with that of our workforce. We will work collaboratively and use these insights to shape the subsequent programme of activity.

This will integrate and align with other relevant programmes as appropriate – for example implementation of Patient Carer Race Equality Framework and delivering the ICS Health Inequalities Strategy.

Therapeutic

Therapeutic care in mental health inpatient settings should be comprehensive, patient-centred and holistic. We are committed to delivering evidence-based services that demonstrate therapeutic benefit and support and sustain therapeutic relationships.

There is significant variance across our inpatient services in terms of the approach to therapeutic and trauma-informed care. While areas of good practice exist, more needs to be done to standardise approaches – including a focus on the patient journey to ensure **continuity through inpatient and community services**. We are committed to working systemically and in partnership to deliver **a co-produced model of therapeutic care that can sufficiently flex to the needs of individuals**, including consideration of protected characteristics.

Workforce is critical to delivering our commitments.

A full review of current MDT approaches will inform longer-term workforce planning and be reflected in each annual planning round over the life of this strategy.

Key principles for our approach, of which the Culture of Care Programme will be a key enabler:

- **Thorough assessment and person-centred care plans** that outline individual therapeutic goals, interventions and timelines
- An **appropriately skilled and experienced multi-disciplinary team** with the capacity to deliver therapeutic care that is subject to regular review
- A **supportive environment** that provides both physical safety and emotional support with appropriate spaces for therapy, recreation and individual reflection
- **Providing patients and their support network with appropriate information** about their condition and treatment options and encouraging them to take an active role in their treatment and recovery process
- Ensuring **integrative care that balances physical health needs with holistic approaches** that promote relaxation and broader wellbeing.

Collaborative

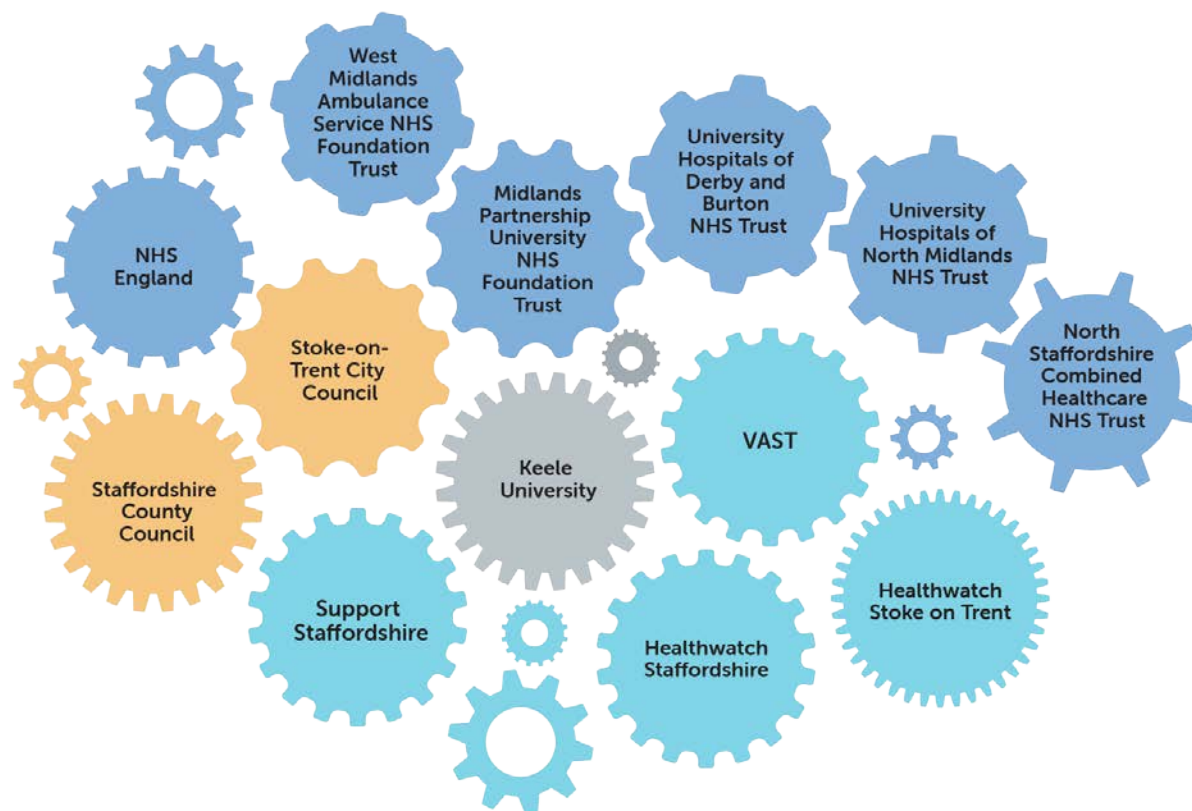
We will work in partnership across our system to ensure a range of appropriate and effective services that can support people within their local communities to ensure no-one is inappropriately admitted to hospital or experiences a delayed discharge.

We are committed to working with the people we provide care for and those that care for them – equipping our workforce with the skills and tools to do this consistently and effectively.

The successful development of the Wellbeing Colleges across MPFT and NSCHT is testament to this.

The system working group established to oversee its development has an immediate reporting line to the Staffordshire and Stoke-on-Trent Mental Health, Learning Disability and Autism Delivery Group. This includes representation from the ICB, MPFT, NSCHT, NHS England, Stoke-on-Trent City Council, Staffordshire County Council and a range of voluntary and community partners.

This has helped to ensure effective alignment and management of interdependencies with existing programmes of work.



Collaborative

Our system is participating in the **Midlands regional task and finish group** that has been established to support the development of this strategy and the delivery of the associated programme of work. This includes links with relevant Provider Collaboratives, and opportunities to explore regional working where appropriate – for example in relation to commissioning approaches to more specialist provision.

Collaboration is about far more than governance arrangements and we have identified the need for both a **‘top-down’ and ‘bottom-up’ approach to developing and delivering our strategic objectives.**

While existing governance supports collaboration, some partners are not currently represented or engaged as this strategy necessitates – including the full range of housing and accommodation providers.

As we move from initial strategy formulation to more detailed development and delivery, we will address this to ensure a more effective approach to the development of **long-term accommodation strategies** that will both prevent inpatient admissions and support with timely discharge.

Citizenship

We will make sure that mental health services support the active participation and social inclusion of adults with a mental health need within their local community. We will continue to respect the value of lived experience in service improvement and continue to invite people who have previously been underrepresented to have a voice.

Through our detailed analysis of inpatient admissions over the last three years, **we have improved our understanding of those individuals and groups who may be most at risk of or vulnerable to restrictive practice and othering.** Our Delivery Plan for Year 1 includes extensive activity to develop our understanding through public engagement, patient and staff surveys, plus further exploration of health inequalities data. With this enhanced understanding, we will be well placed to work collaboratively with those with lived experience, including (as part of the Culture of Care programme) to develop and implement plans to mitigate these risks during Year 2.

As a system, we have previously undertaken extensive mapping to identify the range of organisations and assets that support and represent the needs of the diverse communities we serve. We will use this knowledge to deliver a comprehensive programme of engagement into autumn 2024 that will shape our approach to citizenship within this dynamic strategy. We know **the landscape of our communities and supporting infrastructure is constantly shifting – the engagement programme will provide an important opportunity to update our knowledge and understanding.** This will be supported through the life of the programme by our governance arrangements which ensure appropriate representation and connectivity across the system.

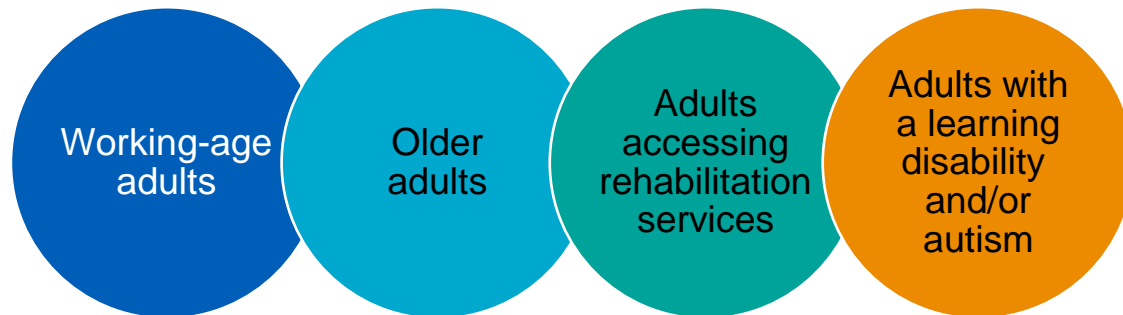
Through our demand and capacity scenario planning, we will focus on **alternative models of care**, informed by deep dives into the patient journey. These models will focus on reducing inpatient admissions and ensuring effective pathways across community and inpatient settings – achieving a collective vision shared by commissioners, providers, stakeholders and citizens that **promotes autonomy and improves quality of life.**

Bringing our commitments to life



Personalised care and shared decision making

In developing this programme and through our data analysis, we recognised the need to explore each thematic area of activity from the differing needs and perspectives of those who may fall within any of these cohorts:



This segmentation will be a feature of our approach, but will not detract from our understanding that delivering truly personalised care means treating every person as an individual regardless of any specific group characteristic.

Audit activity undertaken to inform the development of this strategy highlighted **inconsistencies in the extent to which personalised care and shared decision making was evidenced within patient records.**

Workshops undertaken with inpatient ward managers and matrons to inform a self-assessment against the 'I/We standards provided greater evidence of person-centred care and shared decision making. **Examples included:**

- Consistent use of multiple **communication methods**
- Individualised **wellbeing support** mechanisms
- Use of the **Power-Threat-Meaning framework** to support individual psychological formulations and person-centred care planning
- Activity planning that takes account of **personal preferences**, including those linked to culture and religious beliefs
- Well-embedded **patient advocacy services** and links to carers advocacy groups
- A range of opportunities to **capture, record and respond** to the voice and views of patients.

Personalised care and shared decision making

Areas for further development have been identified in terms of greater consistency in:



The role of and access to **lived experience within inpatient settings**



Application of **formal mechanisms to ensure involvement of carers**



Access to **translation services.**

Co-production of new, person-centred care plans was a key strength within the Adult Community Transformation Programme, and an area we will build on to deliver the Adult Inpatient Quality Transformation Programme.

Although MPFT and NSCHT adopted different approaches to the development of person-centred care plans as part of community transformation – including the extent to which this was rolled-out across inpatient settings – collaborative system working will ensure **consistent application of the underpinning principles and that differing approaches do not result in differences in the quality of care or outcomes.**

Through the Host and Home Commissioner Pilot, **we will work with independent providers to ensure that the principles and practice associated with personalised care and shared decision making are upheld.**

Purposeful admissions

To shape and determine purposeful admissions, we need a clear understanding of the offer of both community and inpatient services. **For an inpatient admission to be purposeful, it must be able to do and deliver something which cannot take place in the community.**



The continual evolution of the relationship, interface and pathways between community and inpatient services has supported us to reach a point where **in most cases, audit activity demonstrates a clear purpose of admission.**

The introduction of '**Red to Green**' has also had a positive impact in terms of ensuring that inpatient stays continue to be purposeful during the admission, **but further work is required to successfully embed the approach across all wards.**

Purposeful admissions

The focus moving forward will be on making sure that the purpose of admission can only be responded to effectively with inpatient treatment. There will be many facets to our approach. **As we review and develop our models of care, we hope to identify opportunities to strengthen current community provision so we can respond appropriately to the increasing levels of acuity that have been observed in our inpatient settings.**



This includes not only the need for appropriate and sufficient crisis alternatives, but also further development of early intervention. As part of this strategy, we are also scoping the feasibility of using predictive analytics within Community Mental Health Teams to support earlier identification of those at greater risk of reaching crisis – facilitating timely Intervention to manage this risk.

We will identify and transfer relevant learning from our **Complex Care** service which has significantly reduced the number of out-of-area rehabilitation placements through robust **MDT consideration** of alternatives and the **development of enhanced community services** to address gaps in support.

Therapeutic and trauma-informed care

The Adult Community Mental Health Transformation Programme delivered a range of positive changes that have impacted on therapeutic and trauma-informed care.



This has included **improvements to person-centred care planning and care pathways**, supported by wider developments including NHS Talking Therapies, and improved interfaces with primary care (such as through the Additional Roles Reimbursement Scheme)



Continuity of care is a focus for this strategy – ensuring joined-up **support is provided as part of a continuum across community and inpatient services**



Inpatient admissions must be **purposeful, of therapeutic benefit, and ideally short in duration** – the therapeutic framework and interventions offered must align to this

Therapeutic and trauma-informed care



Initial mapping has explored the range of therapeutic interventions and approaches currently delivered across our inpatient settings. **This highlighted examples of good practice, including group activities that are co-produced and co-delivered with lived experience peers** – but also a fragmented approach



Investments to upskill staff have not always been accompanied by the resource needed to successfully embed



There are differences in the levels and nature of **input from psychological professions**, and challenges identified in terms of the capacity of ward staff to deliver therapeutic interventions



Safer staffing also presents challenges to releasing the necessary capacity and achieving the level of therapeutic skill-mix desired.

Therapeutic and trauma-informed care

- **We will build on initial mapping and undertake a gap analysis to determine where and how resource should be focused.** This will provide a **framework that considers the full range of therapeutic interventions required and how trauma-informed approaches can support this**
- The gap analysis and framework will be considered as part of the planned wider review of the MDT and to understand who is best placed to deliver what forms of therapeutic intervention – recognising that **all members of the MDT have a role to play**
- The **relationship and interdependencies** between therapeutic and trauma-informed care and our work to further reduce restrictive practice are also noted
- In considering our approach, we have **identified opportunities** to build on current psychologically-informed training models (such as RAID – Reinforce Appropriate, Implode Disruptive) to ensure the impact of such training is maximised and sustained.

Proactive discharge planning and effective post-discharge support

In developing this strategy, we considered and engaged with the work of the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Partners in Care and Health on '**Achieving excellence in person-centred discharge from inpatient mental health settings**'.

- We will **explore local application and development of this framework**, the principles of which align with much of the feedback received during recent S117 system workshops
- In accordance with the principles of the framework, we will use this strategy to **promote and ensure parity for discharge from mental health settings within system planning and investment** – such as through the discharge grant and as part of wider spending plans for the Better Care Fund
- We have **identified a range of positive practice** that is currently supporting proactive discharge – including 'Red to Green' and the management of step-down approaches for out-of-area rehabilitation
- We continue to observe an **increase in average length of stay**, and face challenges with the number of **patients who remain on wards once clinically ready for discharge**.

Proactive discharge planning and effective post-discharge support

While we recognise increasing acuity is a factor, **as a system we have identified the need for better joined-up and enhanced partnership working to fully understand and address the current barriers to planning and delivering proactive discharge.**

- There is a desire amongst health and local authority partners to **pilot additional social work capacity within inpatient settings**, with the funding and mechanisms to achieve this currently being worked through.
- The **system-wide S117 activity will be a key enabler** – with use of tools such as the S117 Maturity Matrix supporting planning (effective planning is also required for those not eligible for S117 after care)
- We will build on **examples of good practice such as enhanced training and support for accommodation providers** as part of a broader accommodation strategy, recognising the complexities of this across the ICB footprint
- We will ensure that our positive progress in reducing restrictive practice within inpatient settings is built on when considering discharge planning and the **application of least-restrictive principles within the community.**

Care that advances health equality

The development of this strategy has included a significant focus on understanding where health inequalities are present within our existing inpatient services. A range of activities will be undertaken during Year 1 to inform and impact our approach to advancing health equality, including:



Patient and staff surveys focusing on protected characteristics and the impact on individual experiences of care and support. These will be conducted sequentially, so findings from patient surveys (including out-of-area patients) will inform the areas explored with staff. The findings will determine subsequent activity



A co-produced programme of environmental and practice audits and observations, making use of experts by experience, to determine actions required to improve reasonable adjustments and cultural competence. Recognising that offering reasonable adjustments in community settings can prevent admissions, the scope will extend beyond inpatient services where appropriate



A focus on reasonable adjustments and workforce development will be critical in addressing recent trends where an increasing number of adults and young people with autism who do not have a learning disability are admitted out-of-area. The planned deep dives into the patient journey will also hear experiences of young people with autism transitioning to adult services



Participation in the next phase of the National Mental Health Act Quality Improvement Programme delivered by the Virginia Mason Institute and The Public Service Consultants, in partnership with NHS England. Taking place from July 2024 to February 2025, this will build on learning from the pilot programme with an overarching focus on improving equity of experience for groups experiencing significant inequalities under the Mental Health Act.

Care that advances health equality



Scoping **opportunities to maximise the skills and impact of the workforce**, for example where there are trained learning disability nurses in general mental health nursing roles



Improving the **quality of data capture and recording across a range of characteristics**. Particular emphasis will be placed on capturing improved information on adults with a learning disability and/or autism needs – where there is an identified gap at present



Further development and **embedding of trauma-informed approaches** which recognise and address the impact of trauma, especially in communities with high levels of violence, discrimination and historical oppression



Ensuring activity within the programme is **aligned to the implementation of the ICS Health Inequalities Strategy** and those elements that focus on addressing the wider determinants of (mental) health.

Our enablers



Culture of Care

The Culture of Care programme is a significant enabler for the Inpatient Quality Transformation Programme and delivery of this strategy in several ways:



Shared vision and values: Promoting a national vision for improved mental health inpatient care, emphasising compassion, dignity, and recovery. This aligns with the goals of the ICB's quality transformation programme and inpatient strategy



Staff empowerment and development: Focusing on staff development and empowerment. This includes training on trauma-informed care, communication skills, and de-escalation techniques. This aligns perfectly with the need for a skilled and well-supported workforce within the ICB's inpatient facilities. Well-trained staff can create a more positive and therapeutic environment for patients – ultimately leading to better outcomes



Reduction in restrictive practices: Emphasising minimising the use of restrictive practices (seclusion and restraint) on patients. This aligns with the national aim of reducing reliance on such measures. By focusing on de-escalation strategies and building trusting relationships, the programme can help create a safer and more therapeutic environment for both patients and staff.

Culture of Care



Improved patient experience: Prioritising patient experience and recovery. This aligns with the core goal of the ICB's quality transformation programme – to improve the quality of care for patients in inpatient units. By adopting the programme's principles, the ICB and partners can ensure our inpatient strategy focuses on creating a safe, supportive, and recovery-oriented environment for patients



Collaboration and learning: Fostering collaboration and knowledge sharing between healthcare providers. This aligns with the need for the ICB to collaborate with various stakeholders, including patient groups, staff representatives, and potentially other mental health trusts within Midland's region



Building a sustainable model: Focusing on long-term sustainability by creating a culture that values staff wellbeing alongside patient care. This aligns with the need for our inpatient strategy to be sustainable and ensure a positive working environment for staff to attract and retain talent. A happy and well-supported workforce is more likely to deliver high-quality care.

Workforce

The adult mental health workforce plays a critical role in enabling the Inpatient Quality Transformation Programme and delivery of our strategy. Here is a breakdown of their impact and the challenges to consider.

Enablers

- **Therapeutic relationships:** A compassionate and caring workforce is essential to build trust with patients. Strong therapeutic relationships contribute to better treatment outcomes, patient engagement, and overall recovery. Staff who feel valued and supported are more likely to provide empathetic care – creating a positive environment for healing.
- **Safer staffing:** While it is a key focus and has some positives, safer 'staffing' doesn't always account for the diverse skillsets needed on a ward. Mental health teams require professionals beyond nurses such as occupational therapists, psychologists, social workers, lived experience experts and activity coordinators – who typically contribute to safer staffing numbers. Their interventions are crucial for patient recovery but might not directly impact these metrics – potentially limiting the number of these vital roles on wards.

Challenges

- **Inequity of provision:** Discrepancies in staffing ratios between local mental health trusts create an uneven quality of care for patients across the region. This can lead to poorer outcomes for patients in understaffed facilities. The programme must address disparities to ensure equitable access to high-quality mental health care.
- **Workforce gaps:** The current workforce may not be sufficient to achieve the ICB's ambitious transformation goals. Gaps may exist in specific professions, skillsets, or geographic areas. Filling these gaps requires targeted funding to attract and retain qualified personnel. Additionally, upskilling existing staff through training programmes can further enhance their capacity to deliver on the new strategy.

Continuous improvement

Continuous improvement (CI) is a fundamental enabler for the Inpatient Quality Transformation Programme and delivery of our strategy. Here's how CI fosters positive change:

Strengths

- **Culture of Care programme:** The fact that both local mental health trusts are participating in the first cohort of the Culture of Care programme signifies a strong commitment to CI. The programme emphasises data-driven decision making, staff empowerment, and collaborative problem-solving. This aligns perfectly with the goals of the inpatient transformation programme and ensures the ICB and MH trusts are working with a shared framework for improvement.
- **Action learning sets:** Inclusion in the same action learning sets within the Culture of Care programme facilitates invaluable knowledge sharing between the MH trusts. Learning from each others' successes and challenges helps identify and implement best practices across inpatient services.
- **Existing CI practices:** The fact that both MH trusts have already adopted CI approaches indicates a foundation for future improvement. This existing expertise will be leveraged to drive the transformation programme forward.
- **Collaboration with independent providers:** Integrating independent providers into the CI cycle will introduce fresh perspectives and innovative solutions. Shared learning with them can help identify areas for improvement, and potentially reduce reliance on out-of-area placements for patients.

Host and Home Commissioner

The Independent Sector and the Host Commissioner programme can be significant enablers for the Inpatient Quality Transformation Programme and delivery of our strategy. Here's how they contribute:



Improved quality and safety in independent providers: Staffordshire and Stoke-on-Trent ICB's pilot of the Host Commissioner programme focuses on improving quality, safety, and care within independent mental health providers. This directly aligns with our system goal of delivering high-quality inpatient services across the entire system. By ensuring independent providers meet high standards, our system can expand its network of reliable care facilities.



Reducing out-of-area placements: Currently, patients from our ICS occupy 35% of independent provider beds within the system. Making the best use of these beds for local patients is crucial for reducing out-of-area placements. The Host Commissioner programme can achieve this through:

- **Improved communication and collaboration:** The programme fosters better communication between the ICB and independent providers. This can streamline the placement process – ensuring local patients have priority access to available beds
- **Quality assurance:** By ensuring high standards in independent facilities, the ICB can build trust in the Independent Sector – making it a more viable alternative for local patients, and potentially reducing the need for out-of-area placements.

Host and Home Commissioner



Addressing bed shortages: The ICB has identified a need for additional beds, particularly in female PICU (Psychiatric Intensive Care Unit) and rehab units. Partnering with the Independent Sector offers an opportunity to address this shortage, as the ICB can:

- **Develop targeted proposals:** Work with independent providers to develop proposals specifically targeted towards independent providers with expertise in operating female PICU and rehab units – which has been highlighted as a need for our system.



Repatriation of out-of-area patients: By expanding capacity within the ICS, particularly in female PICU and rehab units, the ICS can facilitate the repatriation of patients currently placed out-of-area. This repatriation would offer several benefits:

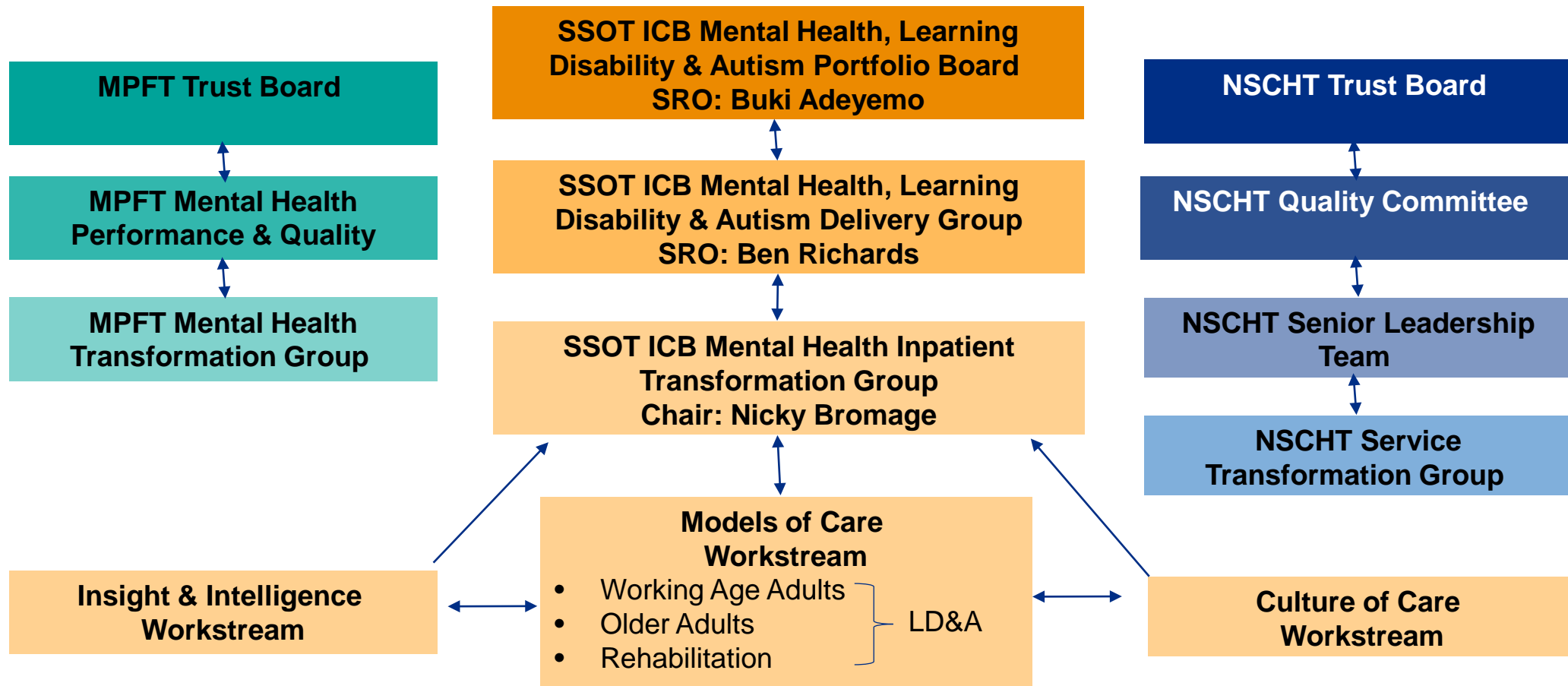
- **Continuity of care:** Patients can receive care closer to their homes and families, which can improve their wellbeing and recovery
- **Improved patient experience:** Being closer to home can significantly improve a patient's experience during treatment
- **Reduced costs:** Repatriation can potentially reduce the overall cost of care for the ICB.

Governance



Governance

The immediate governance arrangements for the programme are illustrated below. The identified workstreams may be subject to change as the programme evolves. Outside of this structure, the programme has links with wider system governance – including the Joint Commissioning Boards and Health and Wellbeing Boards for both Staffordshire and Stoke-on-Trent.



Delivery Plan



Year 1 Delivery Plan: Analysis and review

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

A Public engagement (months 1-6)

- Conduct focus groups and surveys with service users, families, and carers to **gather feedback on experiences, needs, and priorities**
- Organise public engagement sessions to **raise awareness** of the programme and gather community input.

B Patient and staff surveys (months 2-4)

- Develop and distribute surveys to patients and staff to **assess and identify areas for improvement, and capture workforce needs**
- Analyse survey data to **identify trends and develop action plans** based on the findings.

C Health inequalities analysis (months 3-5)

- Analyse data to **identify and understand existing inequalities** in access to and quality of inpatient services for different population groups
- Develop strategies to **address these inequalities** and **ensure equitable access** to high-quality care.

Year 1 Delivery Plan: Analysis and review

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

D Bed modelling and scenario planning (months 4-6)

- Develop a detailed model to **forecast inpatient bed requirements** based on projected population growth, patterns of service use, and anticipated changes in service delivery
- Conduct scenario planning exercises to **assess the impact of different service models** on bed needs – to be informed by multi-agency patient journey deep dives.

E Workforce gap analysis (months 5-7)

- Analyse current staffing levels across all disciplines and **compare them to projected needs** based on bed modelling and service transformation plans
- Identify existing workforce gaps and **develop strategies to address them**, including recruitment, training, and retention initiatives.

F Commence Culture of Care interventions (months 6-12)

- Partner with the national Culture of Care programme to **identify and implement relevant interventions for staff**, focusing on building compassion, communication skills, and de-escalation techniques
- Develop a train-the-trainer programme to **ensure long-term sustainability** of Culture of Care principles within the workforce.

Year 1 Delivery Plan: Analysis and review

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

G Outcome of Host and Home Commissioner pilot (months 8-12)

- Monitor and evaluate the effectiveness of the Host/Home Commissioner programme in **improving quality and safety standards** within independent providers
- Analyse the impact of the pilot on **reducing out-of-area placements** and **explore opportunities for further collaboration** with the Independent Sector.

Deliverables:

- **Public engagement report** summarising key findings and recommendations
- **Patient and staff survey reports** with action plans for improvement
- **Health inequalities analysis report** with targeted strategies for addressing inequities
- **Bed modelling report** with scenario planning results and recommendations
- **Workforce gap analysis report** with strategies to address identified gaps
- **Progress report** on the implementation of Culture of Care interventions
- **Evaluation report** on the Host and Home Commissioner pilot and its impact on service quality and out-of-area placements.

Year 2 Delivery Plan: Transformation

Year 2 goal: Implement a comprehensive strategy to transform inpatient services based on the findings from Year 1

Activities:

- **Develop a detailed service transformation plan** informed by the Year 1 analysis and stakeholder engagement
- **Implement service redesign initiatives** based on the chosen model (for example, establishing specialised units, creating new pathways for admission and discharge)
- **Continue rolling out Culture of Care interventions** and expand the programme to all staff
- **Address identified workforce gaps** through targeted recruitment, training, and development programmes
- **Monitor and evaluate the impact of service transformation** on key performance indicators such as patient outcomes, length of stay, and staff satisfaction
- **Analyse data from Year 1** to inform targeted interventions to address specific patient populations and service needs.

Deliverables:

- **Detailed service transformation plan** with clear timelines and milestones
- **Progress reports** on the implementation of service redesign initiatives
- **Ongoing monitoring and evaluation reports** on Culture of Care implementation and impact
- **Workforce development strategies** and action plans
- **Quarterly reports** on key performance indicators and service utilisation patterns.

Year 3 Delivery Plan: Consolidation

Year 3 goal: Embed the changes implemented in Years 1 and 2, and ensure their sustainability

Activities:

- **Continue to monitor and evaluate the impact of service transformation** on patient outcomes and service efficiency
- **Refine and adjust service models** based on ongoing data analysis and feedback from stakeholders
- **Identify opportunities for continuous improvement** and implement new initiatives to further enhance service quality
- **Foster a culture of innovation and continuous learning** within the workforce
- **Ensure ongoing collaboration** with the Independent Sector and the Host Commissioner programme.

Deliverables:

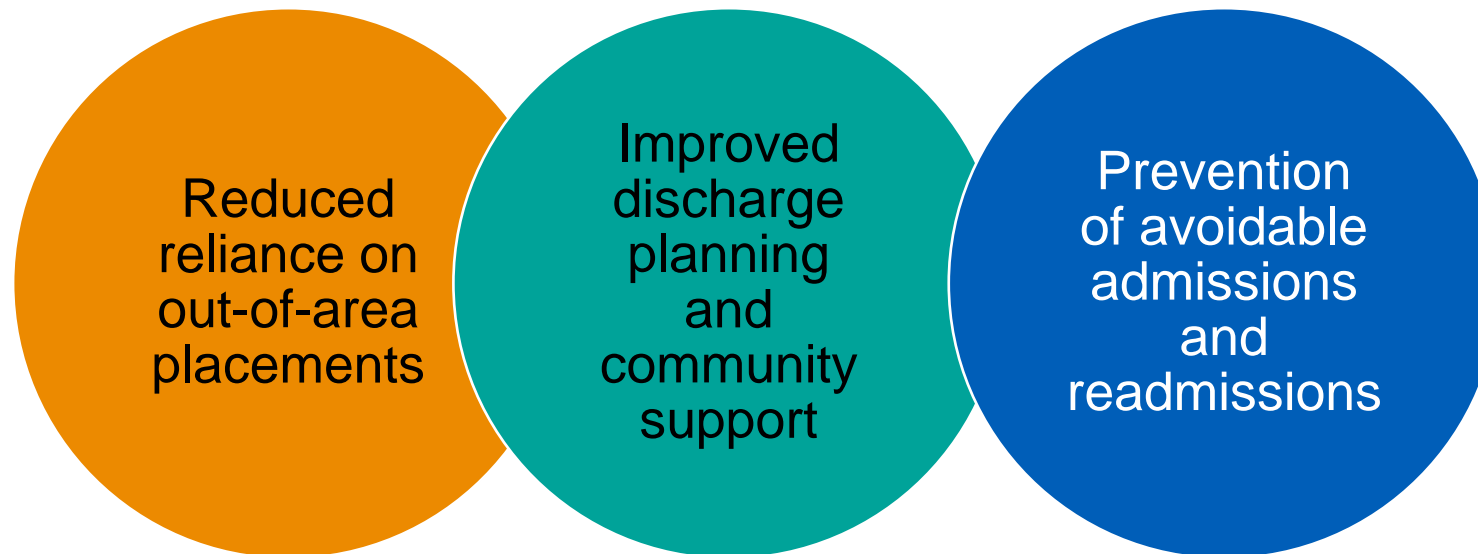
- **Final evaluation report** on the Inpatient Quality Transformation Programme
- **Recommendations** for further service improvement and ongoing monitoring
- **Strategies** for sustaining the positive outcomes achieved through the programme.

Investment Plan



Investment

This section outlines the investment plan for transforming inpatient mental health services in Staffordshire and Stoke-on-Trent over a three-year period. The aim is to create a more accessible, efficient, and recovery-oriented system, by focusing on:



The investment plan for Years 2 and 3 is indicative at this stage – recognising that some elements may be subject to change depending on the outcomes of Year 1 activity.

Year 1: Laying the foundations

Year 1 focus: Data, engagement, and workforce – utilisation of service development funding (SDF).

Public engagement and needs assessment:

- Funding will be allocated to conduct public involvement and gather feedback on the proposed strategy, preferred models of care, and lived experiences.

Bed modelling and scenario planning:

- Investment will support the Strategy Unit in developing a comprehensive bed model for the region. This will inform future strategies for acquiring beds, and ensure our resources are used as efficiently as possible.

Workforce development:

- Funding will be dedicated to establishing 'lived experience roles' within inpatient services. These roles will integrate service user perspectives into service delivery, and foster a culture of care
- Resources will also be directed towards creating roles to support patient discharge from inpatient units, ensuring a smooth transition back to the community
- Funding for reasonable adjustment schemes will allow for personalised support for service users with learning disabilities and/or autism on inpatient wards
- Further investment will be made in the workforce to strengthen approaches to therapeutic and trauma-informed care.

Year 1: Laying the foundations

Year 1 focus: Data, engagement, and workforce – utilisation of service development funding (SDF)

Crisis prevention and support:

- Investments will be made in the management and supervision tool (MaST) to identify individuals at high risk of mental health crisis. This enables proactive interventions to prevent avoidable admissions
- Collaborative schemes will be developed with the relevant local authorities and in partnership with voluntary, community and social enterprise organisations where appropriate, to explore crisis alternatives for marginalised communities – reducing reliance on inpatient care.

Evaluation and research:

- Funding will be allocated to establish an Inpatient Quality Transformation Evaluation and Research Support function. This will ensure ongoing monitoring and evaluation of the transformation programme's effectiveness, and inform future improvements.

Year 2: Implementation and system expansion

Year 2 focus: Bed acquisition and alternatives

Commissioning beds and crisis alternatives:

- Year 2 will see the development of commissioning models to reduce the need for out of area placements and improve the range of alternative crisis support services. This will be achieved through partnerships with voluntary, community and social enterprise organisations, housing organisations, and independent providers. This is based on the recommendations from the Year 1 bed modelling report
- Dedicated bed allocation schemes will be implemented for service users with learning disabilities and/or autism and young adults – addressing specific needs within these populations.

Year 3: Collaborative innovation

Year 3 focus: Sustainability through partnership

Funding bids for service development:

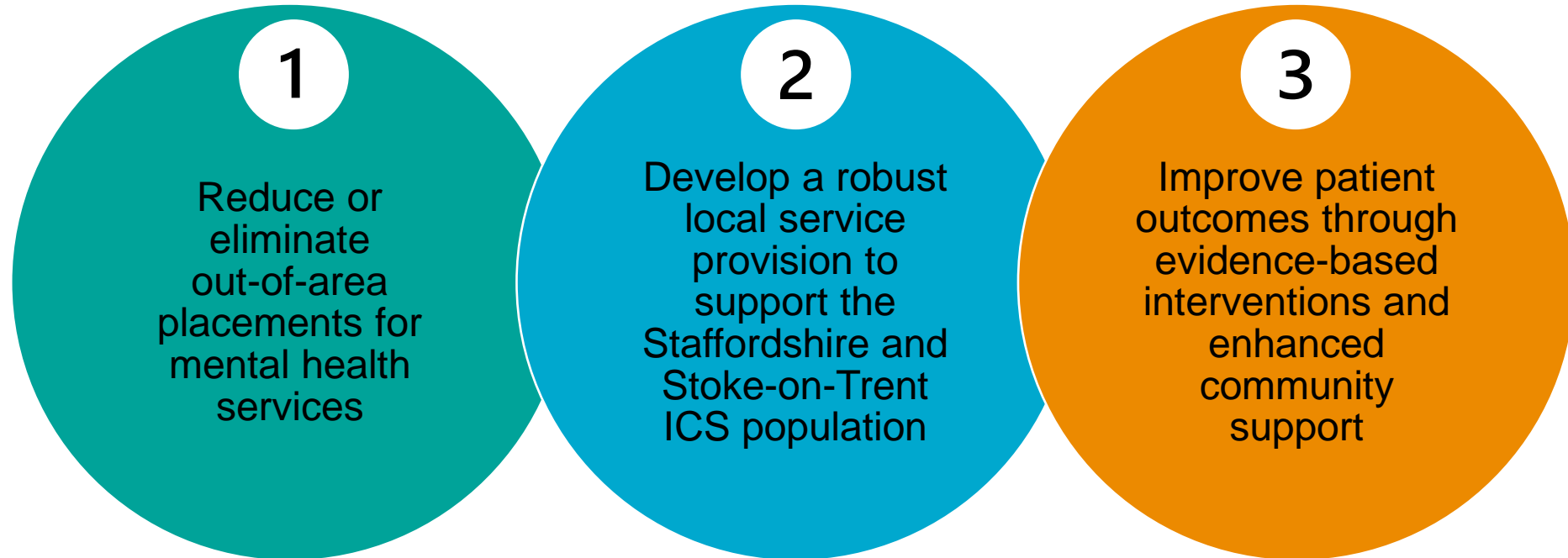
- Approaches for further innovation will be explored with an emphasis on sustainability through collaborative working across the partnership. Details of the approach will be developed during Year 2, but may include an open bidding process whereby partners are encouraged to submit proposals for innovative service developments and projects aligned with the strategic plan
- Proposals would be expected to use the learning from the programme to demonstrate impact against admission avoidance, reducing length of stay, facilitating quicker discharge, and preventing readmissions – ultimately reducing the need for inpatient beds.

Measuring impact



Core objectives

Our strategy aims to achieve several key objectives:



Proposed measurement framework

To assess the impact of our transformation programme, we will employ a comprehensive measurement framework encompassing various quantitative and qualitative data points:

<p>1 Reduce out-of-area placements</p>	<p>2 Develop local provision</p>	<p>3 Improve patient outcomes</p>	<p>4 Implement Culture of Care recommendations</p>
<ul style="list-style-type: none">• Monitor the percentage of patients requiring out-of-area placements compared to the baseline established in Year 1• Track the cost savings associated with reduced reliance on out-of-area placements.	<ul style="list-style-type: none">• Measure the increase in inpatient bed capacity within the ICB region, including beds commissioned from independent providers• Track the utilisation rate of new beds to assess their effectiveness in serving the local population• Monitor the development and expansion of community support services through partnerships with voluntary, community and social enterprise organisations.	<ul style="list-style-type: none">• Implement standardised Patient Reported Outcome Measures (PROMs) to track patient-reported changes in mental health symptoms before and after admission• Analyse the average length of stay for different patient populations to identify areas for improvement in discharge planning and community support• Track readmission rates within a defined timeframe (e.g. 30 days) to assess the effectiveness of discharge planning and post-discharge support• Conduct regular patient satisfaction surveys to gather feedback on the quality of care, communication, and overall care experience within inpatient facilities• Analysis of inpatient admissions demonstrates a positive trajectory in addressing health inequalities and how they present within our data set.	<ul style="list-style-type: none">• Measure staff satisfaction through surveys to assess the impact of implemented Culture of Care initiatives• Track the number of reported incidents and complaints to gauge improvements in patient safety and staff wellbeing• Conduct staff surveys to assess the extent to which staff feel empowered and equipped to deliver high-quality care.

Proposed measurement framework

5

Adhere to evidence-based practices

- Regularly **audit patient care records** to ensure alignment with National Institute for Health and Care Excellence (NICE) guidelines and best practices for specific mental health conditions
- **Track the implementation** of various evidence-based therapeutic interventions within inpatient units.

6

Effective Workforce Strategy

- Monitor progress in **filling identified staffing gaps** based on the Workforce Plan established in Year 1
- Track staff **training and development opportunities** offered within the programme
- Conduct staff surveys to **assess confidence and competence** in delivering planned therapeutic interventions.

7

Staff and patient satisfaction

- Conduct regular staff satisfaction surveys to **gauge overall morale**, sense of purpose, and job satisfaction within inpatient services
- Administer patient satisfaction surveys to **assess experience with care delivery**, communication, and overall service provision.

8

Additional impacts

- Evaluate the **financial impact** of the strategy by comparing costs associated with improved local service provision against the cost savings from reduced out-of-area placements
- Include **qualitative data** such as service user and staff feedback through focus groups or interviews to gain deeper insights into the programme's impact on experiences and recovery journeys
- Continuously monitor the effectiveness of implemented strategies and make adjustments as needed to ensure the **long-term sustainability** of the programme's positive impact.

Managing risk



Managing risk

The scale and complexity of this programme requires a robust approach to identifying and managing risk. Detailed and dynamic risk registers form part of the programme management and governance arrangements. The high-level risks and mitigations are summarised over the next two slides:

Risk area

- **Unknown impact of any political and policy change** following the 2024 General Election, which may influence the requirements of this programme and/or how they are delivered
- **Lack of capital funding** to progress the environmental improvements associated with a range of domains – including accessible, humane, therapeutic and equitable
- **Achieving the required level of flexibility within workforce planning** to respond to therapeutic requirements in the context of a financially challenged system.

Mitigation

- This dynamic strategy includes **various scoping activities** in Year 1 – offering the flexibility to build-in and respond to any changes as required
- **Working in partnership with Independent Sector providers** and where possible seek to influence, inform and respond to Capital Strategy developments and spending reviews
- A comprehensive **review of current MDT approaches** to identify opportunities to work differently within current resource limitations.

Managing risk

Risk area

- **The strategic direction of Independent Sector providers** operating within the footprint of the ICB does not align with our population needs
- **Financial challenges** experienced by multiple system partners impact the ability to work in a truly collaborative way
- **Pace of regional working** on areas such as demand and capacity planning may not align with our system activity
- **Provider-level risk around access to data and analytics** required to inform the programme due to a significant Electronic Patient Record upgrade falling within the first two years of the programme.

Mitigation

- **Working relationships and strategic planning opportunities** strengthened via Host and Home Commissioner arrangements, including regular meetings
- **A system commitment** to working in the best interests of service users and recognition that a focus on reducing inpatient admissions through community alternatives provides opportunity for improved outcomes and financial efficiencies across partner organisations
- **Activity is being planned concurrently** to ensure alignment of project plans and milestones. Effective coordination through regional task and finish group
- **Chief Digital Information Officer and Digital Transformation leads represented at different levels** within the programme governance structure – ensuring full awareness of the requirements and enabling effective planning and mitigation ahead of the upgrade.

Enclosure No: 08

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	Building a System Medium Term Plan					
Presenting Officer:	Paul Brown, Chief Finance Officer					
Author(s):	Paul Brown, Chief Finance Officer					
Document Type:	Report					
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	NO				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:						

(1) Purpose of the Paper:

In order to deal with the underlying deficit, we need a longer-term clear System strategy as trying to tackle the deficit year to year is not proving to be effective.

The paper describes a work programme and timeline, leading to the agreement to this multi-year plan.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Senior Leadership Team (CEOs)	20/06/2024
System Performance Group/Turnaround Board on 26/06/24 and Finance and Performance Committee on 02/07/24	

(3) Implications:

Legal or Regulatory	Failure of the ICS to achieve its financial duty to remain within its resource limit
CQC or Patient Safety	N/A
Financial (CFO-assured)	N/A
Sustainability	Delivery of the longer-term plan is key in achieving financial sustainability
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Approved by QIA Panel on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

(5) Integration with the BAF & Key Risks:						
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>	
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input checked="" type="checkbox"/>	
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>	
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>	

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>In 2023/24 the System posted a deficit of £91m and in 2024/25 we now have an agreed plan of £90m deficit, with significant risk to achieve this.</p> <p>The ICB is now in Undertakings. These Undertakings require the System to return to underlying balance by March 2026. We will need to model what it would take to achieve this timescale; we will also need to model other periods as many people are doubtful that a turnaround could be achieved that quickly.</p> <p>It is clear that the year-on-year planning process is doing nothing to dent the underlying deficit that was camouflaged during Covid. This underlying deficit has been in the System now for about a decade. Penalties now apply to those Systems in deficit and are we are losing much needed capital allocation as a consequence. The deficit is hampering our action to strategically develop services and tackle inequalities. We need a longer-term strategy that underpins and guides the action that we take.</p> <p>CEOs and the System Performance Group/Turnaround Board are supportive of the approach and the plan was approved at the System Finance and Performance Committee meeting on 2 July.</p> <p>Work will progress at pace over the summer and into the autumn. We need to use that period of time to develop the crucial underpinning components of this plan – a Demand and Capacity Model and an agreed approach to productivity improvement. Those methods and tools will enable the mature System conversation about the scope for financial improvement to take place in the early autumn, leading to conversations with Regulators about the timescales needed to achieve the transformations and financial improvement. Then in the first quarter of 2025, all parts of the System can focus on the detailed planning needed to implement the next year of this agreed trajectory.</p>

(7) Recommendations to Board / Committee:
<p>The ICB Board is asked to:</p> <ul style="list-style-type: none"> • Note the Medium Term Plan has been approved by the Finance and Performance Committee and is being presented to the Board for information/assurance.

Building a System Medium Term Plan

Proposal for the work programme for the year, leading to a multi-year plan to eliminate the underlying deficit



Background and Purpose of this Paper

In 2023/24 the System posted a deficit of £91m and in 2024/25 we now have an agreed plan of £90m deficit, with significant risk to achieve this.

The ICB is now in Undertakings. These Undertakings require the System to return to underlying balance by March 2026. We will need to model what it would take to achieve this timescale; we will also need to model other periods as many people are doubtful that a turnaround could be achieved that quickly.

It is clear that the year-on-year planning process is doing nothing to dent the underlying deficit that was camouflaged during Covid. This underlying deficit has been in the System now for about a decade. Penalties now apply to those Systems in deficit and as we are losing much needed capital allocation as a consequence. The deficit is hampering our action to strategically develop services and tackle inequalities. We need a longer-term strategy that underpins and guides the action that we take.

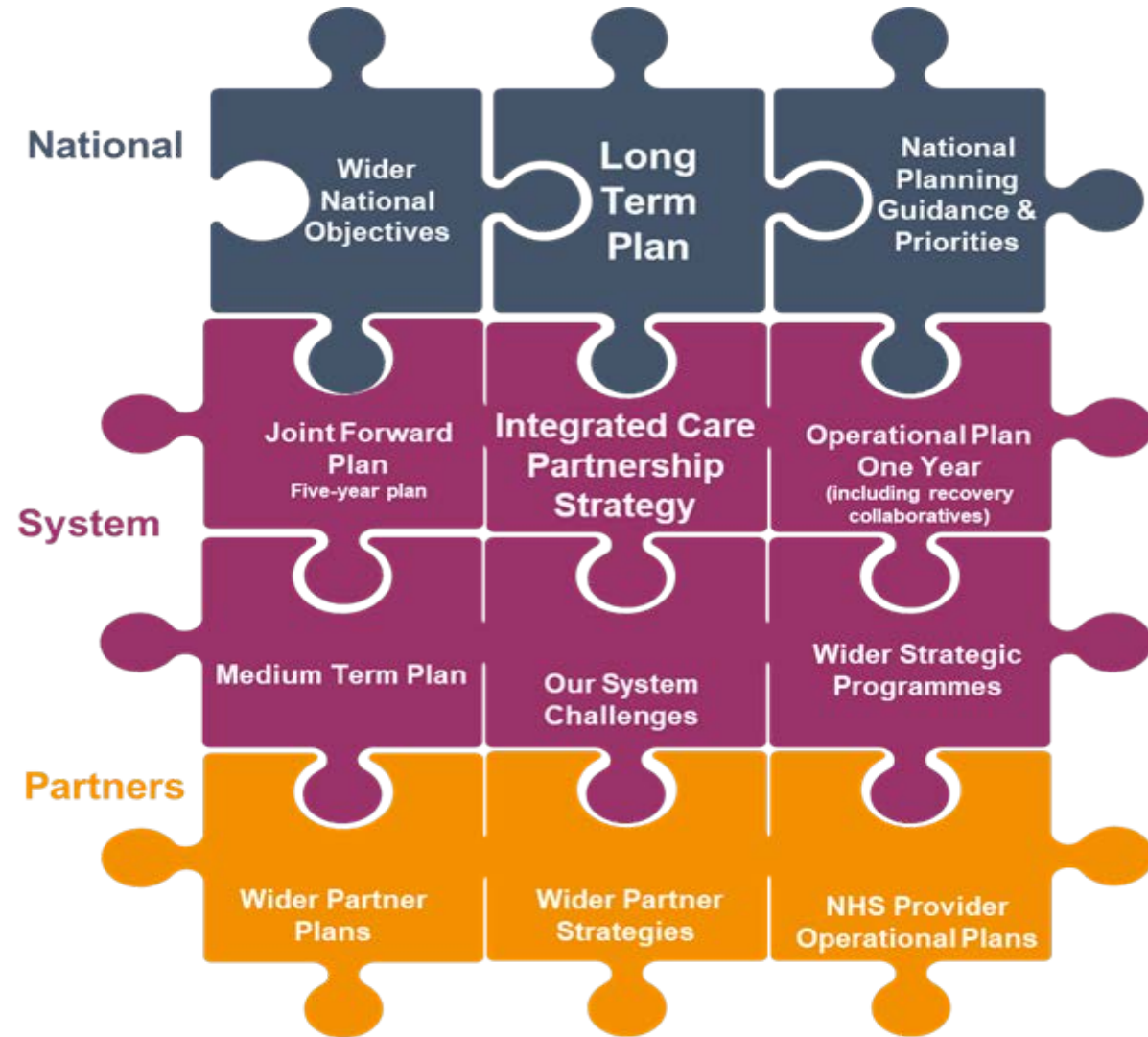
CEOs and the System Performance Group/Turnaround Board are supportive of the approach and the plan was approved at the System Finance and Performance Committee meeting on 2 July.

Work will progress at pace over the summer and into the autumn. We need to use that period of time to develop the crucial underpinning components of this plan – a Demand and Capacity Model and an agreed approach to productivity improvement. Those methods and tools will enable the mature System conversation about the scope for financial improvement to take place in the early autumn, leading to conversations with Regulators about the timescales needed to achieve the transformations and financial improvement. Then in the first quarter of 2025, all parts of the System can focus on the detailed planning needed to implement the next year of this agreed trajectory.

Drafts of this paper have been discussed with finance, strategy, operational and other colleagues and also discussed at the Health and Care Senate. The final version was approved at the System Finance and Performance Committee meeting on 2 July 2024.

Context

- This medium term plan needs to be seen in the wider context of the work taking place across the system on the implementation of national policy, and then the delivery of improvements through the network of providers.
- This medium term plan will define the solutions and actions that will ensure the delivery of the Integrated Care Strategy developed and owned by the Integrated Care Partnership. It will draw from that strategy, from the Joint Forward Plan and build on the work of the 2024/25 System Operational Plan.
- Once developed and agreed, the responsibility for delivery of the work programmes will be taken forward by System Collaboratives and then tasks will be delivered through provider operational plans.
- The graphic to the right shows how this work connects to the other system activities:



Guiding Principles

All changes will seek to sustainably maintain or improve the quality and safety of the service - the system to collectively agree the risk appetite and tolerance.

There will be full transparency of resources and clinical / operational models applied across the system

All resources will be considered – the functions managed by providers, alongside those managed by the ICB, including Primary Care and CHC

We will involve all partners in the development of the solution – this will include Local Authorities, NHS providers from other systems and key voluntary sector and private sector providers

The work will be owned by all disciplines – this will be a system strategy and will link to the system OD strategy. The solutions will cover this wider context and not to be seen as a purely financial plan

The end stage will lead to all organisations as having a financially sustainable underlying position. Organisations will continue to be individually responsible for delivering agreed financial targets as part of this agreed plan

The strategy will be clear on which elements are the responsibility of individual organisations, and which are the domain of system working. Accountabilities as part of this will be transparent and clearly defined for all to see.

Long term improvement will be enabled – a transformation fund will be needed to finance this

In 23/24 what worked well, and what less so?

Success Stories

- System Collaboratives bringing all partners together to tackle specific challenges
- Once we had a realistic plan, we hit it
- Significant improvement in system working and collaboration, including strong clinical engagement and involvement in the delivery of the recovery
- Evidence was used to underpin the plan
- We had an agreed Bed Model, ensuring we were all on the same page with the need for action

Learning Points

- We are planning one year to the next. We now need a more strategic and longer-term approach.
- Workforce, operational and financial planning were more aligned than in previous years, but there were still some significant gaps in alignment
- We lacked a sophisticated understanding of the relationship between demand and capacity

We came through a very challenging planning process as a united team. The successes listed above were the reasons for ultimately receiving the Regulator's support. We can build on this achievement and apply the learning points if we achieve the following three things:

1. Develop an agreed strategy that we all sign up to – this needs to be clinically and operationally led
2. Develop and apply an agreed system approach to improving productivity
3. Create and implement a system demand and capacity model – this needs to be practical and workable, so will need to make a potentially complex model something relatively simple and applicable

The Year ahead

We need to earn the agreement of NHSE to a medium term plan

To achieve that, we need to collectively build the underpinning evidence

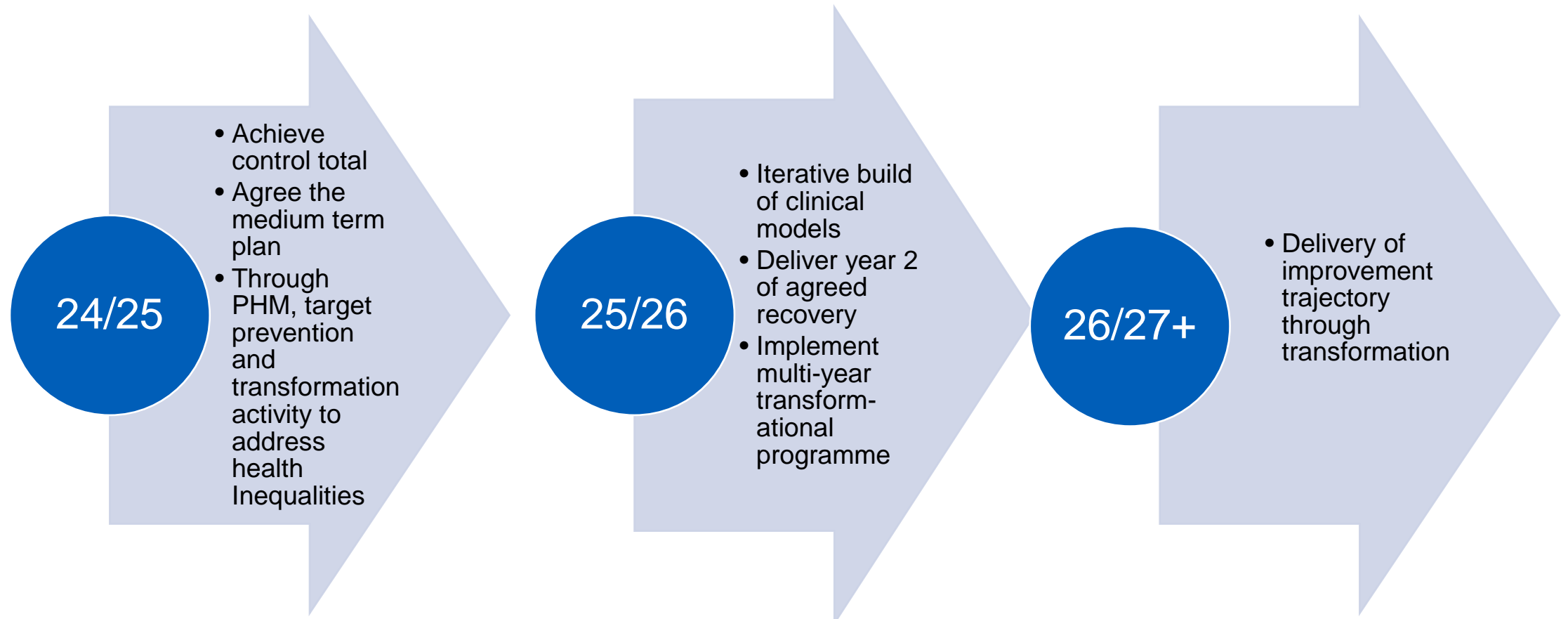
We need a work plan for the year ahead to achieve this goal

- **By end of July**
 - Verify the underlying position and confirm recurrency of savings
 - Build a baseline three-year activity, workforce and financial model
 - Providers baseline current productivity – agree currencies and costs
 - Model capital requirement
 - H&C Senate to lead on clinical prioritisation. System to agree potential for more radical options.
 - Horizon scan across other systems, to ensure we have captured all the best ideas
- **By end of September**
 - Agree the productivity improvement trajectory by provider
 - Agree efficiency targets – provider targets and system recovery improvements
 - Agree resource allocation methodology
- **By end of October**
 - Agree levels of activity, post demand management
 - Model into 2, 3, 4 and 5 year long term projection for activity, workforce and money – showing breakeven point that we can commit to
 - As a system, agree the medium term strategy to deliver these numbers, including clinical sign-off
- **By Christmas**
 - Agree the trajectory for return to financial sustainably with regulators
- **By March 2025**
 - Achieve the 2024/25 £90m target
 - Take the above into a detailed system operational plan for 2025/26

The Next Few Years

The system is currently in recovery. This phase sees us through to control of the run-rate and ensuring that the system position is improving. In this first phase we need to achieve the 24/25 control total and agree a multi-year trajectory. And then we need to move into a longer term transformational phase, where actions have longer term impacts on addressing inequalities and meeting the needs of our population.

The chart below shows how over the next three years we will move through from recovery into that transformational phase:



The Strategy

- The aim to develop a medium plan that will lead to the creation and agreement of a system medium term strategy with 5 parts:



Activity

- Agree activity levels to reflect demography, net of the demand management focus on keeping secondary care activity flat / reducing
- Apply clinical advice on removing low value activities
- Build a Demand and Capacity model for all aspects of capacity including Primary Care, MH and community



Clinical Model

- Develop and agree the underpinning models to deliver this activity safely and to a high level of quality
- Agree these clinical models across the pathway, including social care



Workforce

- We will base the workforce around the agreed activity plan
- The strategic aspiration is to create a more flexible workforce, so that people can be used more interchangeably across the pathway
- The overall workforce cost will be in line with the improving run rate over the strategic period



Productivity

- We need to provide more activity with the same resources
- All providers to agree year-on-year productivity improvement
- Over this year we will establish baselines, then agree improvement trajectories
- This will allow the system to increase the care outcomes achieved without increasing capacity



Income and Expenditure Run Rate

- Agree income by provider over the strategic period
- Set target for expenditure run rate to deliver the medium term targets
- Aim to make recurrent savings so that ULP is improving month-on-month

Building a system Demand and Capacity Model

- The system requires an Activity Driven Planning Tool which will:
 - Provide more granular levels of baselined capacity and workforce required to deliver expected demand
 - Quantify the impact that demand management, new pathways and productivity improvements reflecting the recovery pillars and service transformations set out within the ICS Strategy and JFP, have on the capacity and workforce over the 3–5-year period
 - Articulate the remaining gap which will need to be addressed in our next build of the JFP
 - Translate the activity and transformation opportunities into the impact on estates, workforce and finance
 - Understand the impact of demand, transformation and productivity improvements at an organisation level to help inform the future allocation of resources between system partners.
- Our intentions are to build on what we already have in place within the system e.g. the Bed Model and individual capacity models to enable us to:
 - develop a model which can be sufficiently granular to enable modelling of the anticipated impact of proposed transformations to support the development of cases for change
 - be sufficiently simple to be maintained as an ongoing tool
 - be sufficiently robust to support business cases for material investments required in services or infrastructure
- We will work with the Partners appointed by NHSE to support the ADEPT Programme to develop as much as possible through this funded approach and understand any residual gaps towards our future ambition.
- In undertaking this task we recognise that there have been previous failed attempts to construct this type of model. For success it needs to:
 - Be owned by providers – each provider to be responsible for setting the currencies and agreeing the current level of productivity
 - Kept simple – we need some fairly high level indicators that organisations can focus on, rather than an overly complex model that doesn't 'see the wood for the trees'

Modelling Focus

	Agree the inputs and assess the gap – end of July	Build the Activity Driven Planning Tool – by October
Demand modelling	Build from our current expectations of demographic and non-demographic growth as articulated within the JSNAs	Build on the MTF5 assumptions with further insights from PHM
Capacity modelling	<p>Roll forward current capacity models e.g. UHNM bed model and update for the demand above (end June)</p> <p>Factor in impact which current productivity plans are anticipated to deliver (1st week July)</p>	<ul style="list-style-type: none"> • Expand current acute bed model to include all beds plus consideration of beds provided by non-Staffordshire acute providers • Use comparative productivity data to inform opportunities for enhanced “throughput” of current capacity • Development of any additional capacity modelling for MH, Community and Primary Care where needed • Use the ADEPT modelling to review the capacity models and understand levels of opportunity or risk within the current modelled capacity • Overlay transformational components
Workforce	Workforce modelling to reflect capacity model (mid-July)	Workforce modelling, including impact on workforce redesign and medium-term recruitment trajectories arising from the transformations
Financial modelling	<ul style="list-style-type: none"> • Agree a set of pragmatic assumptions around inflation and income growth – focus on cost of delivery of services at the system level (mid-June) • Factor in impact of 24/25 recovery plans and efficiencies onto the recurrent start point (end June) • Update high level LTFM for the impact of the capacity modelling and assessment of the future levels of efficiency plus glide path trajectory to recurrent break-even (end July) 	<ul style="list-style-type: none"> • More detailed bottom-up costing approach based on the demand and capacity modelling. • Consideration of the future resource allocation model between System partners. • Clarity on revenue and capital implications of future transformations played into the model

Agreement and Next Steps

This paper has been discussed and agreed with CEOs, at the System Performance Group/Turnaround Board and with the Health and Care Senate.

The plan was approved at the System Finance and Performance Committee meeting on 2 July 2024.

Work will progress at pace over the summer and into the autumn. We need to use that period of time to develop the crucial underpinning components of this plan – a Demand and Capacity Model and an agreed approach to productivity improvement. Those methods and tools will enable the mature system conversation about the scope for financial improvement to take place in the early autumn, leading to conversations with Regulators about the timescales needed to achieve the transformations and financial improvement.

Then in the first quarter of 2025, all parts of the system can focus on the detailed planning needed to implement the next year of this agreed trajectory.

Report to:	Integrated Care Board					
Date:	18 th July 2024					
Title:	2024/25 System Operational Plan					
Presenting Officer:	Paul Brown – Chief Finance Officer					
Author(s):	Vicki Inch, Associate Director of Planning and Intelligence					
Document Type:	Report					
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input checked="" type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations – Click or tap here to enter text.</i>				
Any financial impacts: ICB or ICS?	Yes / No	YES <i>If Y, are those signed off by and date: The financial impacts are as outlined in the body of the report.</i>				
Appendices:	2024/25 System Operational Plan					

(1) Purpose of the Paper:

The purpose of the paper is to present the one-year system operational plan for approval.

This system operational plan has been co-ordinated by the Integrated Care Board (ICB) and co-produced with our NHS and Local Authority partners across the ICS. The draft plan has been received for comment/feedback at System Performance Group on 29th May 2024 and System Finance and Performance Committee on 4th June 2024. It has also been received and endorsed by system NHS provider Chief Executives and through their individual provider governance routes; University Hospital of North Midlands NHS Trust on 5th June 2024, North Staffordshire Combined Healthcare Trust on 13th June 2024 and Midlands Partnership University Foundation NHS Trust on 21st June 2024.

Feedback from the forums above has been addressed to inform the final plan.

The Integrated Care Board is asked to approve the final version of the 2024/25 System Operational Plan.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (I)	29/05/2024
System Finance and Performance Committee (S,D)	05/06/2024

(3) Implications:

Legal or Regulatory

We are required to respond to the NHS England (NHSE) National Planning Priorities as set out in the priorities and operational planning guidance 2024/25

CQC or Patient Safety	NA - this is available in the JFP
Financial (CFO-assured)	As outlined in the body of the report.
Sustainability	NA - this is available in the JFP
Workforce or Training	As outlined in the body of the report
Equality & Diversity	NA - this is available in the JFP
Due Regard: Inequalities	The plan draws on our emerging medium-term plans and focuses on transformation through proactive and preventative support for the population
Due Regard: wider effect	NA - this is available in the JFP

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Reported to IG Group on</i> Click or tap to enter a date.
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Approved by QIA Panel on</i> Click or tap to enter a date.
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:						
BAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>		BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>		BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>		BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>		BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The one-year system operational plan outlines the activities that will be undertaken in 2024/25 to support delivery of the agreed system priorities. It includes:</p> <ul style="list-style-type: none"> • how we will meet the national NHS objectives and our wider local operational priorities at system level within the context of our Integrated Care Partnership (ICP) Strategy and Joint Forward Plan (JFP). • the annual priorities and actions the ICS will take during 2024/25 to address the challenges it faces. • an overview of the agreed financial recovery programme outlining how we will return to a sustainable financial position. <p>The 2024/25 System Operational Plan contains:</p> <ul style="list-style-type: none"> • The local deliverables for the Integrated Care System (ICS) aligned to its 2 key aims and 5 annual operational priorities, setting out the contributions from the multi-disciplinary teams working across: <ul style="list-style-type: none"> • Urgent and Emergency Care; • Planned care including cancer and diagnostics; • End of Life, Long-Term Conditions and Frailty; • Primary Care; • Mental Health, Learning Disabilities and Autism; • Children and Young People and Maternity; • Improving Population Health

- The 35 objectives outlined by NHS England in the national planning guidance and subsequent submissions.
- The 5 system collaborative recovery programmes.

While this is a one-year plan it also draws on our emerging medium-term plans and a focus within that on transformation through the lens of proactive and preventative support offers for the population. Our longer-term priorities are covered in the JFP which we published in June 2023 and refreshed in March 2024. Each system partner has their own detailed Operational Plan or the equivalent and as such the contents of these is not replicated in the System Operational Plan, rather the plan focuses on the aspects which the system will work on collectively to deliver.

The plan also serves as a tool for monitoring and evaluation, enabling the ICS to track progress towards its goals and objectives over the course of the year. Existing assurance mechanisms will be used to understand compliance with progress reported to the System Finance and Performance Committee as part of gateway reviews of the plan which will be presented as a twice a year stock take.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

- Approve the 2024/25 System Operational Plan.

2024/25 System Operational Plan



Foreword

This year, 2024/25, will be the second full year of the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). We enter the financial year needing to continue to address our challenges in terms of increasing demand for healthcare, driven by demographic growth and exacerbated by health inequalities. This increased demand needs to be delivered within constrained resources, both in terms of availability of an appropriately skilled workforce and finance. We recognise that the NHS is not the only sector experiencing pressures and will continue to closely work with our local authority partners so that we do not create unintended consequences from any of the work we do this year. We are not alone and all systems across the country are grappling with broadly similar issues.

We have many achievements to look back on from 2023/24, which are outlined in more detail in our Annual Report. However, we need to continue to improve waiting times and access for all aspects of care, as well as delivering joined up proactive and preventative support and care across all pathways. We need to do this in the context of providing safe, timely and sustainable care and meeting the financial and workforce capacity challenge. In addressing our challenges during 2024/25 we have agreed we need to do the right thing for our communities, patients, staff and system.

As a system, we are required to respond to the NHS England (NHSE) National Planning Priorities as set out in the [priorities and operational planning guidance 2024/25](#). Our response to the national planning priorities is materially compliant with most national operational targets defined by NHS England. However, we have been unable to achieve a financial balance and which has left us with a financial deficit of £90m.

Principles of Addressing our Financial Challenge

Throughout 2023/24 we have come together as system leaders across organisations and disciplines, in particular to discuss the options for responding to the significant financial challenge that we have for 2024/25. This has resulted in agreement of a set of principles which we will work to throughout the year. Importantly that we will not take measures which adversely impact upon the safety of services provided and that the decisions we make do not adversely impact the access, experience or outcomes of any disadvantaged individuals, inclusion groups or communities.

Buki Adeyemo

Chief Executive Officer
North Staffordshire Combined
Healthcare NHS Trust

Peter Axon

Chief Executive Officer
Staffordshire and Stoke-on-Trent
Integrated Care Board

Tracy Bullock

Chief Executive Officer
University Hospital of North Midlands
NHS Trust

Neil Carr

Chief Executive Officer
Midlands Partnership University Hospital
Foundation TrustTrust

This System Operational Plan for 2024/25

We have developed this one-year system operational plan to outline in one place, the activities that will be undertaken in 2024/25 to support delivery of our agreed priorities. It includes the information required by NHSE to describe how we will meet the national NHS objectives and our wider local operational priorities at system level within the context of our ICP Strategy and Joint Forward Plan. We have an agreed financial recovery programme, which is a core part of our operational plan and is an essential first step in the return to a sustainable financial position for the system.

While this is a one-year plan it also draws on our emerging medium-term plans and a focus within that on transformation through the lens of proactive and preventative support offers for the population. Using our newly published Inequalities Strategy and through our Places, we will focus on integrated working, bringing a more holistic offer to local populations, ensuring that we gain better understanding of the needs of our residents and adjusting our service offer where needs be to fulfil these. This means that this plan also includes, for example, deliverables around Health Inequalities and Children and Young People, work which will make the most impact in the short term but also transformation actions which if we start now will have impact in future years.

As well as setting out our priorities, we use this document to hold ourselves to account for our delivery throughout the year.

System Collaboration and Partnership

The system has an agreed set of values in which it operates - these are set out in our Leadership Compact. At the local level, our task as an ICS is to inclusively address our challenges and continue to foster a conversation where everyone is engaged in shaping our plan and ensuring its collective execution. The development of the system operational plan emphasises the importance of leadership, continuing collaboration and partnership, recognising that sustainable progress requires a coordinated and multi-disciplinary approach.

Contents

- 4 Key Achievements in 2023/24
 - 5 Introduction
 - 6 System Plan on a Page
 - 8 What is in this plan
 - 9 Financial and Operational Context
 - 13 What will we be doing as a system during 2024/25
 - 33 Measuring our success
 - 36 Appendices
-

Key achievements in 2023/24

In 2023/24, as a system, we have achieved a wide range of things aligned to our Operational Plan delivery. A few highlights of this are set out in the diagram.

The ICB and provider organisations publish their annual reports which provide a summary of their activities for the financial year ended 31 March. Further details on key achievements are set out within those.

We coproduced and published a Quality Strategy, which supports delivery of the NHS Patient Safety Strategy and NHS Impact. As a system we also went live with Patient Safety Incident Response Framework last year and we have received positive national feedback on it.

We have built on our success with the falls response service by developing an additional service to transport patients who are ready for discharge back home. The service has helped 400 patients and avoided delays in getting patients home, reduces readmissions, and supports patients who did not have access to support from community networks on discharge.

42% more women accessed specialist community perinatal mental health services.

The dementia diagnosis rate remains consistently above the national target of 66.7%. With 71.9% performance this is among the highest diagnosis rate in the Midlands region.

UHNM have decommissioned the use of Desflurane from August 2023 ahead of the April 2024 deadline. As a system we are currently achieving our headline target reduction in emissions from inhalers.

In-year, we have seen an increase in demand across UEC services, however performance towards the 76% target has continued to improve across our system.

95% of our staff who work in health and social care have completed the Oliver McGowan e-learning, with an average of 88% completion across the ICS.

In April 2023, the ICB Board approved and published a GP Five-year Strategy which outlines the direction of travel for general practice in terms of how we will support its sustainability and development as well as playing a key role as a partner in the ICS.

The ICB agreed a proposal in December 2023 for a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre.

First ICB in the country to be awarded the Race Equality Code Quality Mark.

We met our agreed financial control total of £91m deficit.

We have all been working hard on our system recovery programme over the last 5 months and we have seen real success in 2023/24.

We have been commended for our work and best practice around CHC which has been shared with other systems.

A joint Strategy between Staffordshire County Council (SCC) and Staffordshire and Stoke-on-Trent ICB Living My Best Life: A Joint Strategy for Disabled and Neurodivergent people in Staffordshire (2023-28) was published.

Introduction

Our [ICP Strategy](#) (ICPS) and [Joint Forward Plan](#) (JFP) set out our ambitions around how all partners will work together to improve services for our people and communities

The purpose of the System Operational Plan 2024/25 is to outline at a high level the annual priorities and actions we will take during 2024/25 to deliver the ICPS & the JFP and address the challenges we face around

1. Our changing population and the impact on demand for health and social care
 2. Improving access to our services through improved productivity and new ways of working
 3. Managing service delivery within the resource constraints of the available capacity and financial envelope available.
- This is our [second system operational plan](#), co-ordinated by the Integrated Care Board (ICB) and co-produced with our system partners across the ICS
 - The system operational plan is [made up of a range of components](#) that collectively form a high-level outline of our key areas of focus during 2024/25. Each programme of work is directly linked back to our strategic priorities outlined in the ICP Strategy, JFP, our 2 key aims, 5 operational priorities for 2024/25 and the 35 national planning objectives set out in the [2024/25 National Planning Guidance](#)
 - [It is an inclusive plan](#) that has been co-developed with our system partners. From the outset we have been clear that our plans for 2024/25 will be owned across the system. Our clinicians have supported in the development of our plans either at a strategic level through the Health and Care Senate, leading specific pieces of work or through the portfolio clinical leads
 - The plan supports us to understand and articulate the roles and contribution to delivery by different teams and programmes, as well as highlighting areas for collaboration across the system. This collaborative approach is essential for maximising our impact and for leveraging the [expertise and resources of our diverse stakeholders](#).



System plan on a page for 2024/25

The image below demonstrates the linkages between the Integrated Care Partnership Strategy, the Joint Forward Plan and the 2024/25 System Operational Plan two key aims and priorities.

Integrated Care Partnership Strategy

Five Ps: These are the five things we need to change if we are going to make a difference:

- People and communities** working with people and communities to empower them to build healthy, supportive and thriving neighbourhoods
- Personalised care** holistic, integrated care designed around personal needs and preferences
- Personal responsibility** working with individuals to empower them to make healthy choices and manage their health and wellbeing as an active partner
- Prevention and health inequalities** promoting healthy decision making, optimising health and wellbeing and ensure fair and equal access for all
- Productivity** making best use of resources and targeting those in greatest need, or with greatest ability to benefit

Underpinned by Population Health Management (PHM)
improve population health outcomes through intelligent decision making.

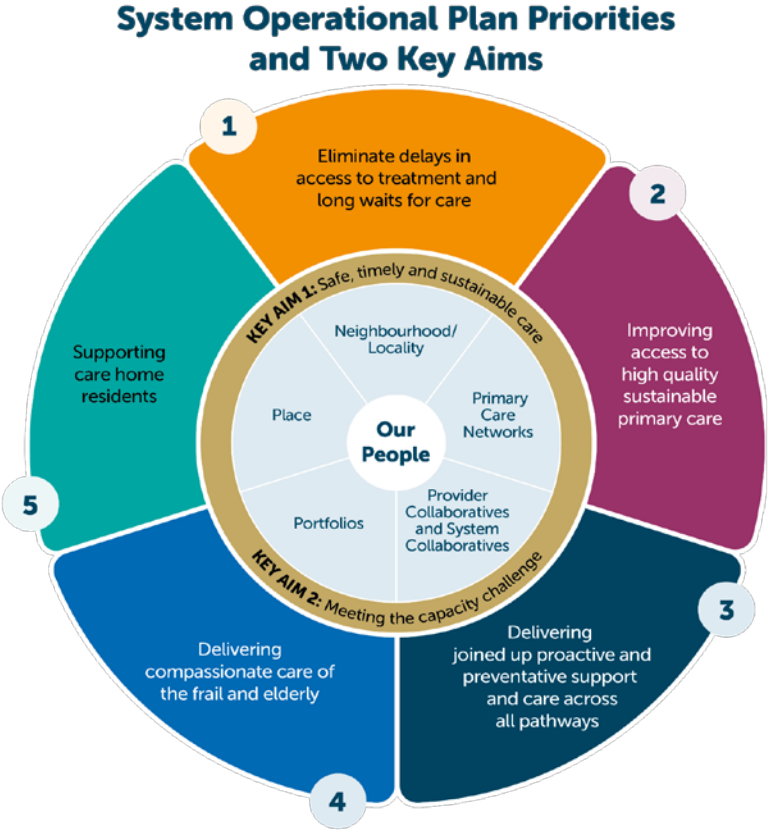
Achieved through

Joint Forward Plan (JFP)

Outlines our collective priorities over the period 2023 to 2028. It addresses the four core purposes of an ICS:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

Achieved through



Our Operational Plan 2024/25 Priorities and 2 Key Aims



- For 2024/25 we have set out 2 key aims and 5 high level operational priorities which are built from our understanding of the challenges we face locally and the national direction of travel
- Our two key aims – safe, timely and sustainable care and meeting the capacity challenge are golden threads throughout all our underpinning programmes of work
- The aims and priorities serve as guiding principles providing focus for our actions throughout the year
- They reflect that we cannot achieve what we need to without our people, partners and delivery architecture
- We know that prevention remains important for people living with a long-term illness and we will focus on delivering personalised care, empowering people to manage their conditions effectively
- Prioritising prevention and proactive support in our system operational plan reflects the growing evidence to supporting resources being shifted 'upstream'.

What is in this plan?

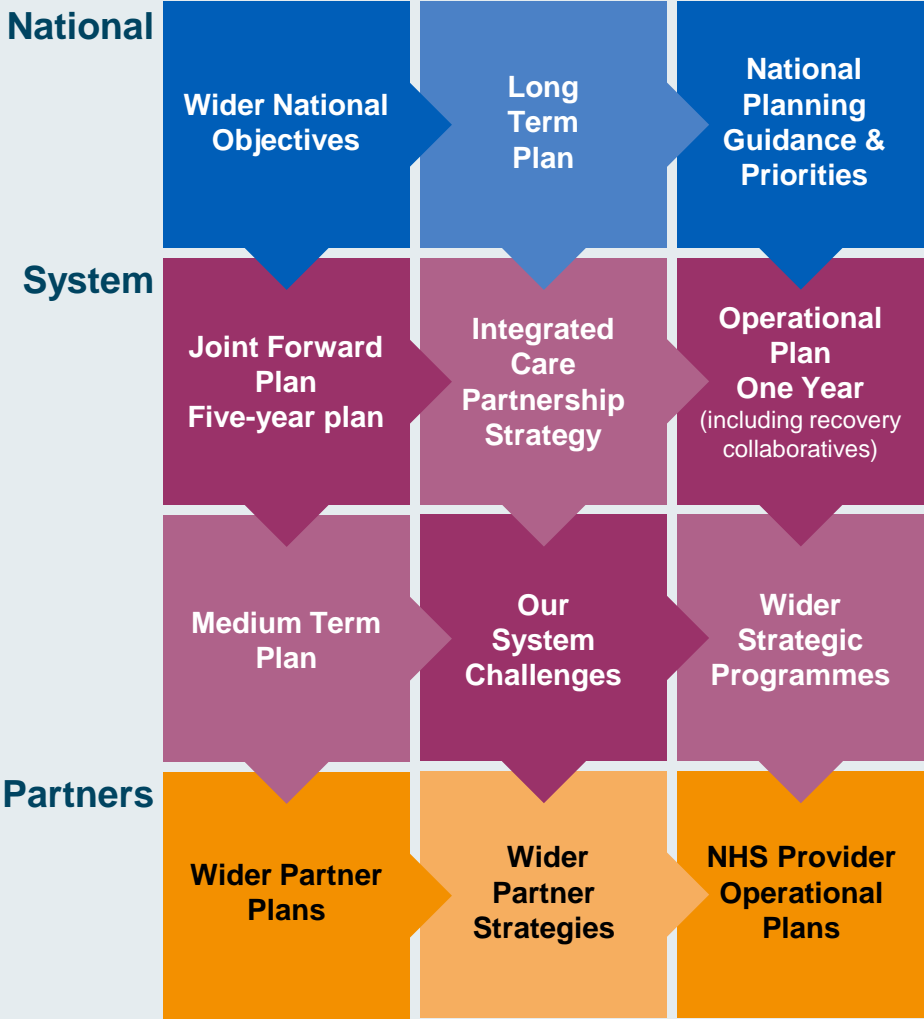
What is set out in this plan

- [Local deliverables aligned to our 2 key aims and our 5 annual operational priorities](#), setting out the contributions from the multi-disciplinary teams working within our portfolios
- The 35 objectives outlined by NHS England, aligning our efforts with national expectations including the key actions. Further details can be found [here](#) and in the [2024/25 national planning guidance](#)
- Our [5 system collaborative recovery programmes](#) which will deliver a mix of secondary care activity reduction, improved productivity and cash-out through targeted work and initiatives which contribute to the delivery of the system’s £203m efficiency programme.

What is not in this plan

- Many aspects of our priorities are longer term, these are covered in the Joint Forward Plan (JFP) which we published in [June 2023](#) and refreshed in [March 2024](#)
- The detailed of the work of our enabling functions and wider system Strategic areas including inequalities and delivering a net zero NHS is not included in this plan. This is available in the JFP
- Each system partner has their own detailed Operational Plan or the equivalent and as such we do not replicate the contents of those here, rather we focus on the aspects which we work on collectively to deliver.

The diagram shows how all of the component parts fit together.





**Staffordshire and
Stoke-on-Trent**
Integrated Care System

Financial and Operational Context

The following slides set out the financial and operational context to our plans.





Finance and Sustainability

Our system is collectively committed to delivering our financial duty of living within the financial resource made available to us and this commitment is set out within our Financial Strategy.

Our Financial Strategy is centred on our view that the optimum financial solutions come from the best clinical models. We enter the 2024/25 planning period with a high level of financial challenge, but with an explicit commitment by all partners to deliver a path to financial sustainability.

Our Financial Strategy describes a plan, which has clinical and operational buy in, and we can already demonstrate successes in key areas.

We recognise the need to make tough decisions and bear down on unwarranted variation and improve productivity.

Paul Brown, Chief Finance Officer

Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective 31

Deliver a balanced net system financial position for 2024/25

Context	<ul style="list-style-type: none"> The System was able to stay on track and deliver within the control total with a year-end position of £90.9m deficit for 2023/24 The System has an agreed plan for 2024/25 is £90.0m deficit To get to this point the System has an efficiency ask within the plans of £203.2m, equating to 8% of Revenue Resource Limit (RRL) At the point of setting the plan, there is a significant risk to delivery, currently reporting unmitigated risk value £87.8m.
Goal	<ul style="list-style-type: none"> The system needs to deliver a sustainable financial balance. We enter 2024/25 with an underlying deficit of £249m, if achieved recurrently, the efficiency plan will result in the system exiting 2024/25 with a much reduced underlying position (ULP) of £183m The agreement of a deficit control total for 2024/25 provides us with opportunity to deliver truly sustainable cost reduction The system aims to deliver recurrent breakeven as soon as possible and a key deliverable for 2024/25 will be a Medium-Term Financial strategy which will set the point at which breakeven will be achieved – target to be developed and agreed by October 2024.
Actions	<ul style="list-style-type: none"> SROs are in place for all of the recovery workstreams with System Collaboratives agreed to lead the recovery, to support in-year plan and contribute towards improving the underlying deficit 2024/25 emerging recovery programme includes Continuing Healthcare (CHC), Demand Management, Corporate Back Office & Estates, Clinical Value & Medicines and Contracts which are outlined here Agreement of System financial principles including a ‘Double Lock’ mechanism so that no part of the system takes decisions that would mean missing 2024/25 financial target or worsening the underlying position.



Our System Financial Principles

In agreeing to the deficit position, the system has agreed to the following principles in taking the swift action required to bring the financial position to plan. These key principles are:

- We will not take measures which adversely impact upon the **safety of services** provided and we will ensure that the decisions we make do not adversely impact the **access, experience or outcomes of any disadvantaged individuals**, inclusion groups or communities
- We will **work collectively to make the best use of the local pound**, and demonstrate value for money in the use of our collective resources
- We will **maintain and strengthen our controls** over pay and non-pay, and evidence the impact of those controls through improved metrics such as lower bank and agency spend
- We will **strengthen controls over corporate spend** by freezing vacancies, where safe to do so, and using opportunities to share resource across partners
- Recognising the difficulty in taking existing capacity out, we will **hold new allocations and new commitments** until we have delivered sufficient efficiencies to deliver our agreed financial plan
- Any business case that would worsen the financial position will be taken through **the system double lock process**.



Operational Context

Finance	We are operating within a constrained financial environment , with increasing demand in both volume and level of need for services. Balancing the budget while maintaining high-quality care and investing in essential infrastructure and technology poses a significant challenge.
Waits for Care	Services are still recovering with huge efforts ongoing to reduce the number of people waiting for treatment and care . Provision of urgent care services has been extremely challenging. Although performance is improving this means that our population have often experienced significant delays in accessing urgent and emergency care. Across the country, ambulance handover delays have reached critical levels, leading to considerable delays for people waiting in the community and the flow of patients from the ED into hospital.
Discharge	There has been pressure in discharging people from hospital and although we have made some progress in recent months, there is still further to go. Many are not discharged on a timely basis , and as a system we discharge more people into bed-based care rather than getting them home.
Demand for mental health services	Meeting the growing demand for mental health services , including early and timely access to the right help and support including at crisis point, is a challenge. Across the ICS, prevalence of depression, dementia and severe mental illness (SMI) have all increased since 2021/22, with depression reported in 2022/23 as 15.23% (up from 14.47%), dementia, 0.94% (up from 0.87%) and SMI, 0.82% (up from 0.78%).
Care in the usual place of residence	Delivering compassionate care and treatment in the usual place of residence is preferable – if safe to do so, with an appropriate care model in place. We know that admitting elderly people via busy emergency departments can shorten their lives and is often a poor experience. There are still people who are at the end of their life being admitted into hospital .
Frail Elderly Population	We need to reduce unnecessary hospital admissions for our frail elderly population through effective proactive interventions as well as providing rapid support at home when they become sub-acutely unwell. This requires effective out-of-hospital services including virtual wards, remote care systems and other community teams.
Children and Young People	Delivering joined up proactive support across all pathways and reducing unwarranted variation in the quality of the arrangements in services, for child safeguarding and care experienced by children and young people is a key area of focus for system partners . These are some of society's most vulnerable children and as partners, we recognise the challenges facing us as partners and the importance of ensuring that their needs are seen, and their voices are heard. There is a high level of concern for children and young people in complex environments and situations.

What will we be doing as a system Our Plans for 2024/25



Portfolio Commitment Statements

Each portfolio is led by a Senior Responsible Officer (SRO), supported by a team to deliver the portfolio ambitions for 2024/25.

The commitment statements outline, from each SRO, the high-level focus of the portfolio for 2024/25

Urgent and emergency care



Our commitment – Matthew Lewis, SRO

Working alongside the demand management collaborative and system partners we are committed to building on our achievements of 2023/24. We continue to focus on ensuring Urgent Care services provide a **consistent and simplified offer**, across our pre, in and post hospital patient pathways.

To achieve this, we will build on our system **Integrated Care Centre** to streamline patients to the most appropriate service to meet their needs. We will work to standardise services ensuring they are efficient and **deliver quality outcomes** whilst ensuring we meet our ambition that care will be designed around the principle of “what matters to me rather than what is the matter with me”.

End of life, long term conditions and frailty



Our commitment - Steve Grange, SRO

By working together with our stakeholders and partners we have worked hard to understand and be responsive to the needs of our local population. In 2023/2024 we produced strategies and a recovery programme for our population which was patient focused and outcomes based. We developed **new ways of collaborating** and underpinned all our work with population health management data and local feedback. We have worked with clinicians and partners to shape our programme to ensure changes make a meaningful difference.

We now have the tools to forecast demand in our localities and communities. This allows us to **target and tailor our approach for local people**. This year is all about delivery. Delivery of improvements within the clinical pathways of End of Life and Palliative care, Long Term Conditions and Frailty. As part of our **commitment to continuous improvement**, we will be monitoring progress against key performance indicators and implementing feedback mechanisms to drive ongoing enhancement of our services. Through dedication, innovation, and collaboration, we are **committed to providing the highest quality of care** for our community now and in the future.

Planned care



Our commitment – Helen Ashley, SRO

Working together with the Clinical Value and Contracts Collaboratives, the Planned Care Portfolio will continue to focus on the both the National Operational Planning requirements for access to Planned Care, Cancer and Diagnostic services as well as the transformation of patient pathways in order to **promote the use of alternatives to traditional outpatient and surgical interventions**.

With a greater focus on the management of demand the portfolio will seek to **establish robust mechanisms** to ensure the **best use of our limited resources**, as well the **best experience for our patients** in access specialist expertise for their care.

Primary Care



Our commitment - Paul Edmondson-Jones, SRO

Primary care serves as the cornerstone of the NHS, exemplified by the delivery of over 6.3 million appointments within a 12-month period solely within general practice in SSoT. In June 2023, the ICB launched its general practice strategy, developed collaboratively with GPs, to collectively **enhance quality, accessibility, patient experience and outcomes**. Currently in the delivery phase, the strategy integrates insights from the Claire Fuller report and emphasizes the establishment of integrated neighbourhood teams and personalized care, fostering a cohesive approach to patient care.

The ICB has assumed delegated responsibility for dentistry, pharmacy and optometry. Notably, a West Midlands dentistry strategy has been formulated alongside a health equity audit for SSoT, facilitating the development of a local plan to address improved access and health disparities. Our objectives and aspirations for primary care seamlessly align with our Integrated Partnership Strategy.

Portfolio Commitment Statements

Each portfolio is led by a Senior Responsible Officer (SRO), supported by a team to deliver the portfolio ambitions for 2024/25.

The commitment statements outline, from each SRO, the high-level focus of the portfolio for 2024/25

Mental Health and Learning Disabilities and Autism



Our commitment - Ben Richards, SRO

As a system, we are well on our journey to make mental health, learning and disability and autism everyone's business. Over the coming year, we will operationalise our investment in [perinatal mental health](#), [mental health ambulance provision](#) and [children's autism services](#), while still progressing our community and inpatient [mental health transformation and transforming care](#) (for people with a learning disability) programmes to deliver effective care for our population.

The impact (and challenge) that comes with the wider implementation of the [Oliver McGowan training programme](#) is not to be underestimated, both in terms of the operational challenges it will create but also in raising understanding across the whole health and social care system.

Maternity and Neonates



Our commitment - Heather Johnstone, SRO

The local maternity and neonatal system remain committed to bringing together all partners, including users of these services, to work to ensure [high quality, safe services](#) for mothers, birthing people and their babies.

We are equally committed to ensure services are [personalised and more equitable for women, babies and families](#). We will take every opportunity to learn from high profile maternity investigations to avoid reoccurrence in local services. We will listen to our families to support the [implementation of the single delivery plan at a local level](#) ensuring local arrangements remain relevant to local need.

Children and Young People



Our commitment - Jon Rouse, SRO

We are putting the health and wellbeing of our children and young people at the heart of the work of our ICS. We are determined that our kids get the [best start in life](#), including high quality maternity services. By engaging with children and young people, we will develop programmes that meet their priorities. We have already identified priorities such as [reducing infant mortality](#), [improving mental health](#) and [reducing obesity](#).

We want to provide [superb care close to home](#) for children with relatively common conditions such as asthma, diabetes and epilepsy, so they don't need to go into hospital as often. And we will also ensure that [we support children with complex needs](#) to the best of our ability, joining up their care and helping them to thrive within their communities.

Improving Population Health



Our commitment - Paul Edmondson-Jones, SRO

Our vision is to make Staffordshire and Stoke on Trent the healthiest place to live and work.

Our ambition is to work together putting people and communities at the heart of everything we do to ensure everyone has the opportunity to have [healthy, happy, safe and prosperous lives](#) with fair access, improved experience in better outcomes for all.

We are [Supportive, Inclusive, Collaborative](#).

Alignment of deliverables, priorities and ambitions

- The following slides set out high-level deliverables aligned to each of the 2024/25 annual 5 system priorities
- It does not seek to give all the detail in the high-level delivery plans but to provide an overview of how portfolios are contributing to our aims and priorities
- The content has been developed based on portfolio high level delivery plans, NHSE plan submission & key commitments and sets out our agreed recovery programme of work
- In their underpinning high-level delivery plans, each of our portfolios have mapped their deliverables against the 2024/25 five priorities, the JFP and the 5 Ps within the ICP Strategy. The two aims as detailed on [Our Operational Plan 2024/25](#) page, are golden threads throughout our approach to developing the plan. Each deliverable identifies measures of

success which may be a hard number or an output e.g. completion of a service review

- Each portfolio has also undertaken a gap analysis between their plans and the national guidance to ensure alignment with national objectives
- The heatmap below aims to demonstrate the distribution of deliverables and how they contribute to each element of our ICS ambitions. It uses colour to show the alignment between portfolios and operational priorities. The darker the colour in the cell, the greater the number of deliverables that align to the portfolio and the priority.
- The heatmap visually supports identifying where there may be interdependencies across portfolios. This concept will be developed into 2025/26 planning.

	Eliminate delays in access to treatment and long waits for care	Improving access to high quality, sustainable primary care access	Delivering joined up proactive and preventative support and care across all pathways	Delivering compassionate care of the frail and elderly	Supporting Care Home Residents	Improve outcomes in population health and health care	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS to support broader social and economic development	Working with people and communities	Personalised Care, holistic integrated care designed around personal needs and preferences	Personal Responsibility	Prevention & Health Inequalities	Productivity
	OP 1	OP 2	OP 3	OP 4	OP 5	JFP 1	JFP 2	JFP 3	JFP 4	ICP1	ICP2	ICP3	ICP4	ICP5
1. Urgent and Emergency Care	Dark	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
Planned Care	Dark	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
2. Diagnostics	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
Cancer	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
3. End of Life, Frailty and Long Term Conditions	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
4. Primary Care	Light	Dark	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
Medicines Optimisation	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
5. Mental Health	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
Learning Disability and Autism	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
6. Maternity & Neonates	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
Children and Young People	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light
7. Improving Population Health	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light	Light



Local Priority: Eliminate delays in access to treatment and long waits for care



Urgent and Emergency Care

Pre-hospital we will:

- Improve A&E waiting times by delivering an Integrated Care Centre (ICC) for UEC access, supported by suitable response services to meet the needs of all patients and stakeholders, through the demand management system collaborative by Q2 for MPFT elements then by Q4 through the Demand Collaborative
- Deliver a sustainable Acute Care at Home (ACAH) model that is standardised across the ICS by Q4
- Enhance/establish High Intensity User Services to support demand management in UEC across the whole system by Q4
- Designate Urgent Treatment Centres by Q2
- Increase referrals to Urgent Community response to 872 a month by Q4.
- Track performance of category 2 response times.

In hospital we will:

- Utilise the non-elective improvement programme (NELIP) to support delivery of the key objectives of the In Hospital programme throughout 2024/25
- Use GIRFT to ensure that we have the appropriate medical bed base for our demand, supported by the opening of a larger Same Day Emergency Care (SDEC) unit at Royal Stoke University Hospital (RSUH) by Q2
- Acute front door to see, treat and discharge /admit patients within 4 hours of arrival from the emergency department (ED) by Q4
- Ensure maximised efficiency and use of the County Site by Q4
- Maintain adult acute G&A beds to meet national targets by Q2
- Improve processes and standardise care, including for mental health patients from Q2.

- Embed fully functional bed management and system control centres (SCCs) by Q1
- Improve hospital discharge pathways increasing Pathway 1 and further reducing of pathway 2 and 3 discharges from Q2 onwards.

Post hospital we will:

- Deliver a consistent seven-day service and improve the discharge profile and targets by Q4
- Enhance the quality and timeliness of discharge for patients eligible for ongoing end of life community care support throughout 2024/25
- Develop and grow opportunities for the VCSE sector in discharge pathways by Q2
- Ensure consistent operational utilisation of the Choice Policy across our system
- Utilise virtual wards consistently across all parts of the County and ensure utilisation is consistently above 80% throughout 2024/25 by Q2.



Planned Care

We will:

- Deliver the national objectives focused on 65 week waits, activity, outpatient attendance and choice
- Continue to work towards the diagnostic target of 95% of patients receiving their tests within 6 weeks.

We will implement Digital Solutions to support Primary Care to:

- Access most recent/ correct referral form
- Ensure pathways developed at system level are clear and available to all
- Have access to an Integrated Care Centre for national guidance
- Develop tools to support clinical decision making.

We will Improve Efficiencies in Outpatient Management by:

- Developing and socialising advice and guidance guidelines
- Standardising referral forms for simplicity.

We will transform and harmonise clinical services across seven key pathways by the end of 2025/2026 across:

- Musculoskeletal
- Ophthalmology
- Weight management Scope referrals, identify transformation pathways around
- Community Dermatology
- Ear, Nose and Throat
- Women's health
- Gastrocolorectal.

We will develop clinical best practice pathways through:

- Implementing one stop diagnostic testing ahead of first outpatient appointments where possible, supporting primary and secondary care to improve workload and patient outcomes
- Mobilising Community Diagnostic Centres at Sir Robert Peel Hospital in Tamworth, Cannock Hospital and Stoke-on-Trent.



Cancer

We will:

- Deliver the national objectives focused on reducing the number of patients waiting over 62 days, meeting the 28-day faster diagnosis standard of 75% and increasing referrals by Q4.

National Objectives

2 to 9
11, 12



National Objectives

2 to 9
11, 12

Local Priority: Eliminate delays in access to treatment and long waits for care (continued)



Mental Health

We will:

- Improve Mental Health Urgent and Emergency Care (MH UEC) and Crisis Pathways by collaborating with the UEC Portfolio to roll out specialist mental health response vehicles integrate 24/7 crisis text lines and NHS 111 option 2 into the crisis response system by Q4
- Deliver an all age 24/7 crisis text service by Q4
- Review the local pathway for Adult ADHD assessment and diagnosis, treatment and intervention and develop neurodevelopmental pathway (including Autism) by Q3
- Improve access to perinatal mental health services and Maternal Mental Health services (MMHS) by operationalising the investment agreed by Q4
- Improve access to mental health support and eating disorder access for children and young people in line with the national ambitions by Q4
- Deliver the Early Intervention in Psychosis standard with the proportion of people experiencing first episode psychosis or with an ARMS (at risk mental state) by Q1
- Deliver the [Children and Young People's Mental Health Local Transformation Plan](#) by Q3
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000 by Q4.



Learning Disabilities & Autism

We will:

- Increase the rates of annual health checks towards 75% through the Health Facilitators roles and focusing on training and education.



Primary Care

We will:

- Develop a business case for equitable Urgent Home Visiting service working with the UEC portfolio and ensure patients have access to a safe and effective service that will avoid hospital admissions in Q1
- Develop a General Practice 2024/25 Winter Surge Plan by Q3.



Medicines Optimisation

We will:

- Implement Pharmacy First freeing up demand for GP appointments with at least 90% of pharmacies signed up to deliver the service by Q2
- Establish 5 community Pharmacy Independent Prescribing Pathfinders across the ICB to deliver at least 2000 consultations by Q4.



Dental

We will:

- Focus on the National Dental Recovery key areas for action including prevention, operational interventions and workforce / wider reform throughout 2024/25
- Undertake Mid-year reviews targeted at under delivering practices as of 30th September each year by Q3
- Implement the New Patient Premium for all dental practices who agree to be included in the scheme by Q1.



Children and Young People

We will:

- Co-produce an approach allowing people seeking support to know what's available and how to access it, establishing the best methods of communicating the mental health support offer for CYP.
- Reduce proportion of CYP <18 in residential care outside the ICS geography.



Digital

We will:

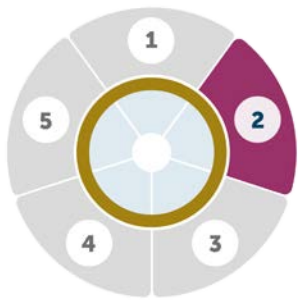
- Offer greater digital choice for self-help resources, screening, referrals, support digital pre-assessments, diagnostics and manage health and care services including the promotion of the NHSApp as a rolling programme of work throughout 2024/25
- Utilise the national Federated Data Platform to help maximise capacity, reduce waiting lists and co-ordinate care
- Roll out My Sense Assistive Technology by Q2
- Digital Road Maps will continue to be rolled out through the Pathology and Imaging networks.



Personalised Care

We will:

- Implement a single vision of integrated universal personalised care through social prescribing, personal health budgets, patient activation and choice, personalised care and support planning and shared decision making.



Local Priority: Improving access to high quality sustainable primary care



Primary Care

• A national [Delivery Plan for Recovering Access to Primary Care](#) (PCARP) was published by NHS England in May 2023. The System-Level Access Improvement Plan (SLAIP) has been written by SSoT ICB, in response to the national plan setting out how the system will deliver the 4 national ambitions; to empower people, to build modern general practices, to cut bureaucracy and build capacity.

We will:

- Implement the year 2 recommendations from the PCARP focusing recovery actions on implementing Modern General Practice Access throughout 2024/25
- Improve access to primary care through developing advanced telephony solutions, remote consultations, GP Connect (allowing NHS111 to book into GP appointment books) and further promotion of the NHS app to provide enhanced remote care to people throughout 2024/25
- Continue to focus on increasing workforce numbers, with more GPs and general practice nurses recruited and retained and a further increase of additional roles to compliment the general practice skill mix throughout 2024/25
- Implement the vision of the Fuller Stocktake report focussing on a population health management approach through building integrated neighbourhood teams, same day urgent access, prevention and personalised care throughout 2024/25

National Objectives 13

- Through use of our Local Enhanced Primary Care offer, ensure that all patients have access to services which enable patients to be seen and treated closer to home throughout 2024/25
- Provide safe and accessible premises that are fit for purpose for patient care and our general practice workforce throughout 2024/25
- Increase the number of patients attending prevention programmes eg. cervical screening, hypertension management and childhood immunisation throughout 2024/25
- Work with practices to promote and utilise the NHS app to support workload around GP registration and other administrative tasks throughout 2024/25
- Support practices who have received CQC rating below "good" to engage with GP Support Team, develop a CQC action plan and deliver improvements throughout 2024/25
- Identify any themes and trends from CQC reports to identify learning and support needs by Q3
- Ensure fit for purpose estate provision throughout 2024/25, maximising shared space and digital alternatives through:
 - A baseline of existing estate within primary care with a view to consolidation
 - Identifying current and future estates investment requirements based on local population health needs.
- To improve the interface between primary and secondary care throughout 2024/25.

We will:

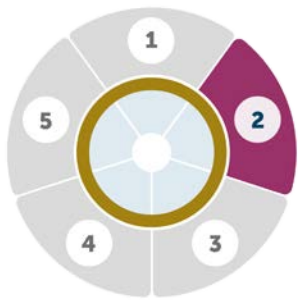
- Embed regular interface meetings between primary and secondary care teams
- Enhance cross-border arrangements to ensure seamless patient care
- Achieve 100% implementation of the four key asks in the Plan for Recovering Access to Primary Care with measurable improvements around onward referrals, complete care - fit notes and discharge letters, call and recall and clear points of contact throughout 2024/25.



Medicines Optimisation

We will:

- Support resilient pharmacy and Medicines Optimisation services through Production of an Integrated Pharmacy and Medicines Optimisation Strategy and Pharmacy workforce delivery plan. Both are expected to be complete by the end of August.



Local Priority: Improving access to high quality sustainable primary care (continued)



Planned Care

We will:

- Implement GP Direct Access for a number of modalities to include a full stock take of all diagnostics such as physiology/ phlebotomy etc, compared to historic focus on modalities such as CT/ MRI etc
- Develop clinical best practice pathways. focussing on:
 - Breathlessness, Upper Gastrointestinal, Lower Gastrointestinal, Liver and Gynaecology
 - Direct access to diagnostics for patients whose symptoms suggest low but zero risk of cancer as an alternative to an urgent cancer referral.



Cancer

We will:

- Promote more consistent primary care initiated “straight to test”. This deliverable is aligned to pathway development work for the Community Diagnostic Centres (CDCs)
- Ensure system wide coverage of Breast Pain Clinics
- Review process into late-stage cancers and look for common themes or trends identifying the inequalities and inconsistencies within primary care at the point of referral.



Mental Health

We will:

- Continue to use the MH Practitioner ARRS roles to improve the care and treatment for adults by Q1
- Focus on recovering the dementia diagnosis rate to 66.7% through:
 - Increasing efficiencies within the Memory Assessment Service (MAS) pathway
 - PCN MAS roadshows across the locality to increase awareness of services available and accessible locally to ensure ongoing flow of appropriate referrals into the service
 - The VCSE Outreach workers ongoing project for 2024-25.



Learning Disabilities and Autism

We will:

- Review GP registers to ensure the correct people with LDA are on them and develop robust systems to ensure GP practice reviews of the correct information from diagnosing organisations to increase those on the register by a set percentage increase per year
- Provide Primary Care training tool kits to support GPs deliver AHCs confidently throughout 2024-25.



Urgent and Emergency Care

We will:

- Deliver a ICC for UEC access with a response that provides a suitable alternative
- Deliver the system bed capacity and demand programme of work which includes the Getting It Right First Time (GIRFT) recommendations.



System Collaboratives

2

Demand Management

The system collaborative recovery programme for **Demand Management** contributes a set of key deliverables towards local priority 2, including the workstream which will **Integrated Care Centre (ICC) looking at:**

- UCCC extraction
- Definition – clear – hours and scope
- Service provision sitting behind ICC
- Trusted Assessor.

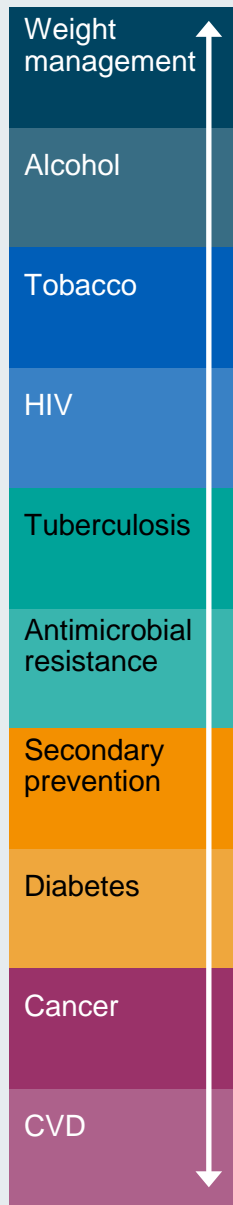
National Objectives

2, 3, 9, 10, 11, 19, 21, 22



Local Priority: Delivering joined up proactive and preventative support and care across all pathways

National Objectives 25, 26, 27



Improving Population Health

We will:

- Publish our Health Inequalities Strategy in Q1
- Develop our Alcohol Harm Reduction Strategy by Q2
- Develop our Prevention Strategy in Q3
- We will develop our 12 localities through our 2 Place Partnership Boards to build resilient communities and improve health inequalities and outcomes
- We will strengthen the role of the VCSE as an equal partner, also to improve health outcomes and tackle health inequality
- Support our portfolios to deliver and implement NHS Long Term Plan prevention programmes across the ICS, including:
 - Weight management - virtual T3 services and progress implementation of the Switch Programme, delivered through the Planned Care Portfolio
 - Alcohol Care Teams embedded in hospitals across the county, delivered by UHNM
 - Refinement of system tobacco dependence treatment services delivered by our acute providers
 - Evidence-based, smoking cessation offer available for at-risk populations, inpatients, pregnant women and for those with severe mental illness (SMI)
 - Continue a targeted approach to increasing vaccination uptake
 - Improving uptake of lifestyle services, Diabetes Prevention Programme, low calorie diets, the Digital Weight

- Management Programme and digitally supported self-management services, delivered through our Primary Care and ELF portfolios
- Restore diagnosis, monitoring / management of hypertension, atrial fibrillation, high cholesterol, diabetes, asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels delivered through our Primary Care, ELF and CYP portfolios
- Continue to deliver on personalised care commitments; social prescribing referrals, personal health budgets & personalised care & support plans are key enablers of population health & prevention across all portfolios where appropriate, through the Better Care Fund and locality development.



End of life, long-term conditions and frailty

Palliative and End of Life Care (PEoLC)

We will:

- In response to the six National Ambitions and the statutory duty on ICBs to commission PEoLC a programme of work is in place for 2024/25. This will include:
 - Development of an all age strategy for palliative care and end of life with supporting delivery plan by Q3
 - Increased usage of Palliative care registers by Q4
 - Review and assess benefits of 24/7 access including a Co-ordination and Advice Line identifying the case for sustainable delivery by Q3.

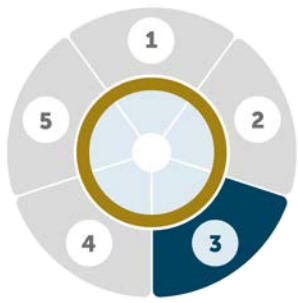
- Increase access and availability of palliative care medication by Q4
- Increase the number of people identified in the last year of life and the number and quality of Respect Plans in place and co-ordinated by Q4
- Enhance existing training for system workforce in response to the six National Ambitions by Q4.
- Undertake work to respond to the recommendations of the all parliamentary group report in relation to commissioning of specialist palliative care services by Q4.



Long-term conditions

We will:

- Reduce premature deaths from CVD and respiratory conditions
- Develop a Long-Term Conditions implementation plan by Q2
- Continue to focus on actions within the following projects:
 - Improve uptake of the eight care processes
 - Increase uptake of the National Diabetes Prevention Programme
 - Increase case finding and accurate diagnosis of chronic obstructive pulmonary disease (COPD)
 - Improve access to pulmonary rehabilitation.



Local Priority: Delivering joined up proactive and preventative support and care across all pathways (continued)



Mental Health

We will:

- Increase the number of adults and older adults completing a course of NHS Talking Therapies with at least 67% achieving reliable improvement and 48% reliable recovery by Q4 and including those who are currently under-represented to increase opportunities for liaison with physical health pathways and combining psychological treatment with employment support throughout Q1-Q4.
- In collaboration with our CYP Portfolio, increase access to mental health support for children expanding the availability of Mental Health Support Teams in Schools throughout Q1-Q4
- Continue to work towards eliminating inappropriate adult acute out of area placements during 2024/25
- Co-create the long-term vision and service model to localise and realign inpatient services and improve therapeutic inpatient care and provide reasonable adjustments for patients with LDA by Q2
- Review our community services to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge with complex rehab needs throughout Q1-Q4
- Support schools, aiming for dedicated mental health support teams to be fully implemented within the wave 10 schools with training and mobilisation to commence in wave 12 by Q4
- Deliver the national objectives and performance trajectories throughout Q1-Q4.
- Increase the proportion of people with SMI who have a full annual physical health check by Q4.



Learning Disabilities and Autism

Six workstreams developed to deliver against the priorities for learning disability and autism:

- Identification – multi organisation team has helped drive performance throughout 2024-25
- Place – project commenced by Support Staffordshire to equip VCSE sector to be more accessible to LDADS throughout 2024-25
- Universal services – dentists, opticians and wider preventative services are accessible to all with reasonable adjustments. This has been a lower priority with capacity aligned to higher priority workstreams by Q3
- Dedicated care and support – to develop a joint independent sector market with health and social Care that is fit for purpose e.g. CHC and S117. Capacity issues have delayed progress throughout 2024-25
- Community services – secondary mental health services for LDADS people. Data improvement plan to underpin service development plan throughout 2024-25
- Inpatient settings – appropriateness, with the right care locally supporting timely discharge, reducing reliance on inpatient care where appropriate. Physical conditions and mental wellbeing are both part of this workstream throughout 2024-25.

We will:

- Deliver the national objectives and performance trajectories focused around LDA throughout 2024-25

- Develop and implement plans to ensure that the Reasonable Adjustment Flag (RAF) is in place and that the Reasonable Adjustments (RA) are made to improve the care and support of people with a LDA and their families throughout 2024-25
- Continue to work towards targets around LeDeR reviews with 100% being undertaken within 6 months of notification of death throughout 2024-25
- Ensure all people with an LD have a health passport which highlights their care needs which can be shared across all partners by Q3
- Increase vaccination uptake for people with a LD and/or autism aiming for 62% of people receiving them by commencing stakeholder engagement in Q1 and implementation in Q2 and Q3.



Primary Care

We will:

- Continue to expand the role of Social Prescribing by relaunching the SPLW support meetings to review contract changes and support needed during Q1.



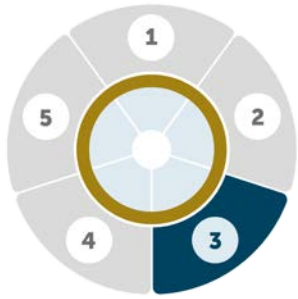
Medicines Optimisation

We will:

- Increase the use of powder-based inhalers which are equally effective but have a lower carbon impact on the environment and achieve a reduction in total carbon equivalent emissions of inhalers of 25% by Q4 compared to 2019/20 baseline
- Launch children's asthma guidelines with PCNs by Q1 and develop adult asthma and COPD guidelines by Q4.

National Objectives

17, 18, 19, 20,
21, 22, 23



Local Priority: Delivering joined up proactive and preventative support and care across all pathways (continued)



Children and Young People

We will:

- Work with our partners to develop and implement a systematic approach to infant mortality; focussing on pre-conception health, health inequalities and increased awareness of risk and protective factors
- Identify opportunities to promote a healthy lifestyle for our CYPs; with a planned Complication of Excess Weight (CEW) clinic supporting CYPs to operate from the Royal Stoke site by Q2
- Continue to support our CYPs and their families in managing their asthma through implementation of the national bundle of care; this includes an expansion of the Asthma Friendly Schools (AFS) programme (ongoing programme of work); community-based clinic for post discharge review (on-going programme of work) and implementation of asthma champions during Q1 and Q2
- Focus on improving the care of CYPs with epilepsy; reducing the variation in care received and supporting their mental health & wellbeing. For diabetes youth workers will continue to support CYPs to improve engagement with the diabetes clinical team
- Support children demonstrating behaviours of distress with the help they need so that they can fulfil their potential by refining our service models to better met their needs, enhancing cross-sector training so that professionals have the knowledge and skills to effectively support

these CYPs, and fostering a culture of trust and collaboration among service providers

- Work together to ensure our children and young people with SEND, and CYP's in care or under statutory protection have the right support at the right time, delivered by the right people.



Maternity and Neonates

We will:

- Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury by Q4
- Reduce inequalities in experience and outcomes for the groups who experience the greatest inequalities (Black, Asian and mixed ethnic groups and those living in the most deprived areas) by Q4
- Commission and fund safe staffing across maternity and neonatal services by Q3
- Monitor and support trusts to implement national standards by Q2
- Commission for and monitor implementation of personalised care for every woman by Q3
- Monitor the impact of work to improve safety culture, share learning and good practice across the system by Q3
- Work in partnership with local authorities to establish at least one women's hub by December 2024 and support and develop universal services for pregnancy and beyond in family hubs by Q3.



Planned Care

We will:

- Review and explore harmonisation of services across SSOT footprint including scope of referrals and identify transformation pathways across a range of planned care services including ENT, Gastro Colorectal and put in place the Women's Health Hub before December 2024.



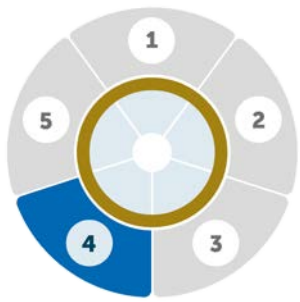
Cancer

We will:

- Continue to develop programmes designed to raise awareness of cancer symptoms and highlight importance of and access to cancer screening to reflect national campaigns
- Utilise information from the West Midlands Cancer Dashboard to aid priority setting
- Extend the NHS bowel cancer screening programme to include more age groups and ensuring effective surveillance of people with Lynch syndrome, to focus on ensuring familial links are fully explored
- Expand the Targeted Lung Health Checks (TLHC)
- Undertake an audit to review late-stage cancers and seek to differentiate and look for common themes or trends.

National Objectives

10, 15, 16, 27



Local Priority: Delivering compassionate care of the frail and elderly



End of life, long-term conditions and frailty

Frailty

We will:

- Implement collaborative care pathways that address the needs of older adults in each of the five key areas of the Frailty Strategy (Prevention and Healthy Ageing, Mild, Moderate and Severe Frailty, and Proactive Falls Prevention) to be more streamlined, integrated and patient-centred
- Refresh our frailty strategy and needs assessment, engaging with relevant stakeholders by Q3
- Evaluate the pilot of the 'My Health, My Way' platform, which targeted a cohort of 5,000 patients, who were over 65 with mild frailty EFI score, by end of Q3 and produce a business case for scale up in early 2025.



Urgent and Emergency Care

Pre hospital

We will:

- Put in place self-referral routes to fall response services
- Improve frailty and end of life pathways through regional benchmarking and pathway development.

In hospital

We will:

- Provide high quality responsive Frailty Care to effectively avoid unnecessary hospital admissions by delivering a MDT/agency frailty service within UHNM with access to community and social care services.

Post hospital

We will:

- Scale up social care services - working with local government and social care providers to optimise access to social care, including through continued use of Better Care Fund
- Reduce the volume of patients dying in hospital via earlier patient identification and case finding
- Enhance the quality and timeliness of discharge for patients eligible for ongoing EOL community care support.



Improving Population Health

We will:

- Increase uptake of flu and pneumonia vaccinations to help to prevent exacerbations and emergency admissions due to exacerbations of conditions such as COPD. This will be achieved by Q4.



Integration

We will:

- Deliver the Better Care Fund Plan 2023-25 through delivering the nationally mandated metrics including:
 - Avoiding unplanned admissions for people with chronic ambulatory care sensitive conditions or following a fall
 - Where possible, discharge people to their usual place of residence following an inpatient stay.
 - Reduce the number of discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care to below 1% by Q4.



System Collaboratives

1

Continuing Health Care

2

Demand Management

The system collaboratives recovery programme for [Continuing Healthcare](#) and [Demand Management](#) contribute a set of key deliverables towards this priority.

National Objectives

2, 3, 9, 10, 11, 19, 21, 22



Local Priority: Supporting Care Home Residents



Primary Care

We will:

- Co-produce and implement a revised Enhancing Health in Care Homes (EHCH) Local Enhancement Services (LES) specification with new local indicators to be identified and embedded with PCNs during Q1, alongside delivery of the Network Contract Directed Enhancement Service (DES).
- Conduct structured medication reviews in people aged 65 and over with eight or more prescription items and in care home residents who also tend to be on multiple drugs, launching the medicines optimisation SLA during Q1 and reviewing delivery during Q2, Q3, Q4
- Develop a consistent approach to weekly home round throughout 2024/25
- All new residents to receive a holistic admissions assessment to support their clinical needs.



Medicines Optimisation

We will optimise medicines use in care homes through:

- Promoting Structured Medical Reviews (SMRs) in care home residents who have not had a SMR in the last 12 months or are new residents to the care home and have not had an SMR yet or those discharged from hospital in the last 4 weeks throughout 2024/25.
- Improve medicines management processes in top 10 care homes, piloting our approach during Q1, Q2 review the impact and roll out during Q3 and Q4.



End of life, long-term conditions and frailty

Frailty

We will:

- Ensure patients with severe frailty experience best practice care in care homes and domiciliary settings, leading to better outcomes using the learning from the 2023/24 pilot.



Integration

We will reduce acute conveyances from care homes and support care home residents through:

- Proactive care planning to include RESPECT offer
- Embedding early identification of deteriorating patients
- Supporting MDT offer to care homes
- Establishing a register of care home residents
- Reviewing investment into services for Care Home residents
- Ensuring regular clinical reviews for Care Home residents
- Developing a clinical consensus and guidance for clinical management of care home residents
- Ensuring coverage of high-quality end of life plans
- Ensuring rapid and appropriate community response to clinical deterioration
- Identifying and address breaches of end-of-life care plans.



Urgent and Emergency Care

We will expand care outside of hospital through:

- Joining up new types of care outside of hospital including urgent community response, falls services, enhanced nursing home support and High Intensity Users.



Digital

We will digitise Adult Social Care through achieving the following targets:

- 90% CQC registered adult social care providers with digital care records by March 2024
- Supporting 57 care homes with National funding to meet the Digital Social Care Record minimum data standard.



System Collaboratives

1

Continuing Health Care

2

Demand Management

- The system collaborative recovery programme covering [Continuing Healthcare](#) and [Demand Management](#) contribute a set of key deliverables towards this priority.



Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective

31

Deliver a balanced net system financial position for 2024/25

Recovery Programme Overview

- The Recovery Programme contributes to our overall operational plan for 2024/25 and epitomises a concerted effort to address our 5 system priorities and in particular our 2 key aims. The programme is anchored by five system collaboratives covering:



- The programme embodies a shared commitment among stakeholders to address the unique challenges and opportunities facing the local healthcare landscape
- Together, these system collaboratives form a cohesive approach for our capacity challenges, harnessing the collective expertise, resources, and commitment of stakeholders
- Each system collaborative is producing a Stage 2 Full Case for Change Project Implementation Plan, which is a document that has been widely used in the Provider Collaborative Programme over the last 18 months. It is a key document which captures stakeholder buy in, identifies metrics for measuring success and confirms its approach to demonstrating financial sustainability, all of which are key design principles to delivering a successful collaborative
- The weekly recovery meeting (which was key to identifying and managing interdependencies in 2023/24), will continue with an extended membership.



Recovery Programme Pillars

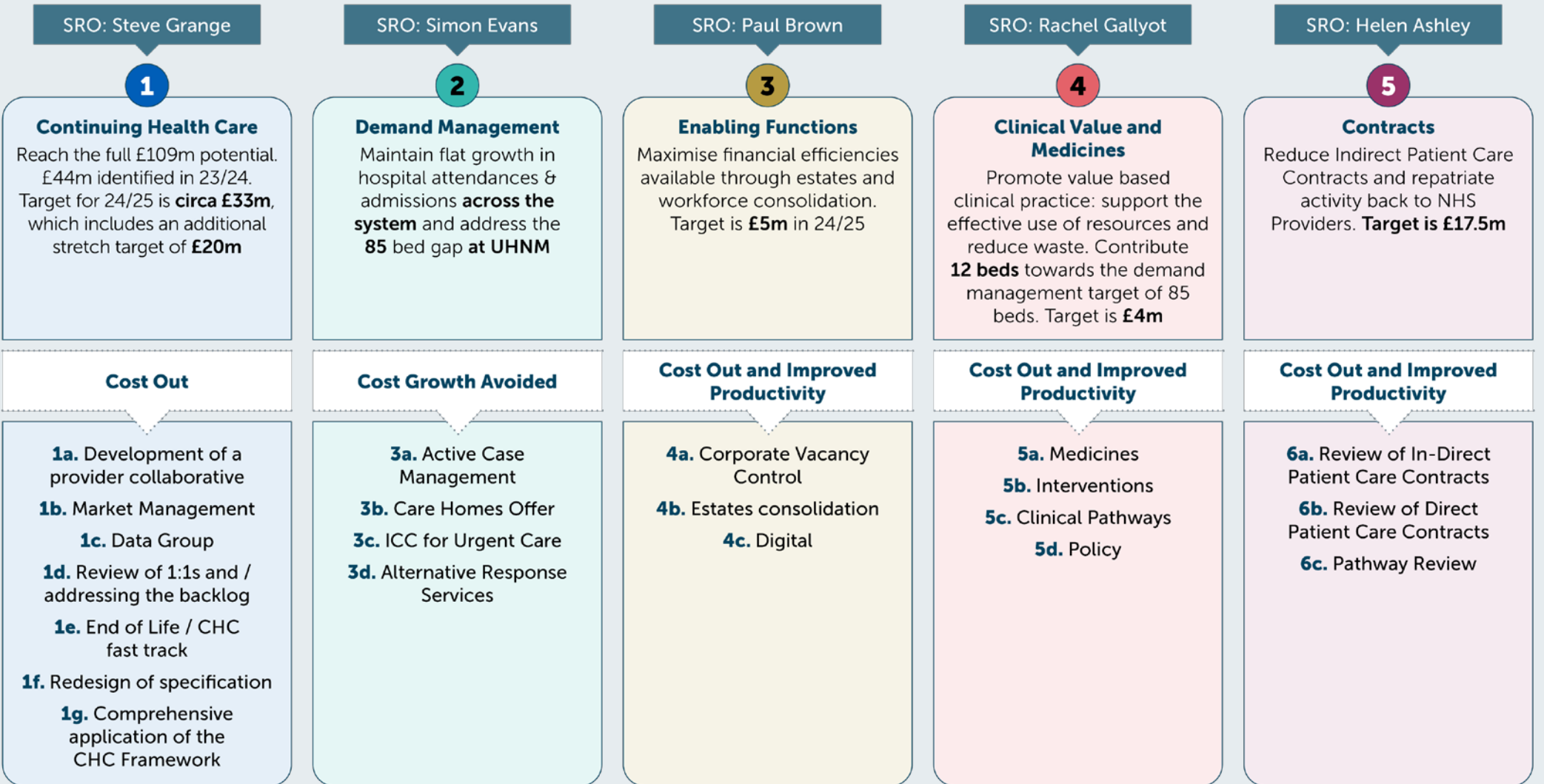
Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective 31

Deliver a balanced net system financial position for 2024/25



Please note: the scope of the provider collaboratives are still in development



Continuing Healthcare (CHC)

Collaborative Scope and Ambition

To reach the full £109m by the end of 2025/26 as part of a 3 year scheme. This includes delivering the £40m FYE from 2023/24 and delivering an additional £33m in 2024/25 (which includes a £20m stretch target).

Savings Type	Yes/No
Cost Out	£33m
Cost Containment	N/A
Improved Productivity	N/A

Commitment Statement – Steve Grange SRO

The CHC Provider collaborative has been established to provide **strengthened clinical leadership** and oversight with the aim to review and improve patient pathways, journey, and experience. This is against a backdrop of **improving the way that we use our resources** and ensuring that we develop new ways to work together as system partners for to benefit of local people.

Collaborative Underpinning Workstreams

- To create a **provider collaborative** aimed at bringing together the knowledge, leadership and intelligence of the system to focus on ensuring quality patient outcomes and the financial sustainability of CHC provision
- To build and develop long term sustainable working relationships with the **market**
- To pool the systems **data** into one location to create a single source truth to feed system reporting and other work streams allowing evidence based decisions and targeted interventions
- To drive out cost and ensure the most appropriate and **least restrictive care** is provided to patients
- To deliver a streamlined, personalised **end of life pathway**, that is timely, efficient and effective ensuring individuals with a rapidly deteriorating condition, that may be entering a terminal phase of life, are supported in the preferred place of care as quickly as possible
- To redesign the current **specification** to ensure it reflects the requirements of the CHC framework, the ICB, system partners and patients and families
- To ensure the comprehensive and robust application of the **CHC framework**.

Metrics Overview

Description	Original Target	Stretch Target	CIP Alignment	Q1	Q2	Q3	Q4	FYE
Review Expansion Programme – main focus on High Cost and PHB	£3.7m	£8m	ICB	£0.2m	£1.8m	£3m	£3m	£12m
Deliver End of Life / Fast Track Business Case	£1.3m	£3m	ICB	£0.750m	£0.750m	£0.750m	£0.750m	£3m
CHC Eligibility (Volume FNC)	£2.525m	£2.525m	ICB	£0.630m	£0.630m	£0.630m	£0.630m	£5.2m
Compliance with Pricing Structure	£1.360m	£1.360m	ICB	£0.339m	£0.339m	£0.339m	£0.339m	£1.360m
Inflation Constraint	£4.2m	£5.6m	ICB	£1.401m	£1.401m	£1.401m	£1.401m	£5.6m
CHC Care Assurance Cost	£0	£7m	ICB	£0.175m	£1.225m	£2.275m	£3.325m	£14.7m
Unidentified – confirm CHC or non CHC	£0	£5m	ICB	*	*	*	*	£11.7
TOTALS	£13.1	£33m	ICB	*	*	*	*	£53.560m

*Further metrics under development

Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective

31

Deliver a balanced net system financial position for 2024/25



Demand Management

Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective 31

Deliver a balanced net system financial position for 2024/25

Collaborative Scope and Ambition

This collaborative effort will require close coordination and communication between all stakeholders involved, including patients, the acute trust, VCSE and Voluntary sector, community providers, social care services, and other key partners. By working together towards a common goal, we can ensure that patients receive the right care in the right place at the right time, leading to better outcomes for all involved.

Key strategies for achieving this goal may include:

1. Establishing clear pathways for patient flow, including improved communication and coordination between all points of care
2. Ensure we have a consistent offer to Care Homes
3. Implementing alternative care models, such as virtual consultations and home-based care, to reduce the reliance on acute care beds
4. Enhancing community support services to provide patients with the necessary resources and assistance to manage their health outside of the hospital
5. Monitoring and evaluating progress towards reducing bed numbers and improving patient flow, with regular reporting and feedback mechanisms in place.

By working together towards these shared objectives, we can drive meaningful change in the healthcare system, ultimately leading to better outcomes for patients and a more efficient use of resources across the system.

Metrics Overview

Description	Baseline	Target	Q1	Q2	Q3	Q4
Maintain flat growth in admissions	In progress	0%	+3.5%	+2.7%	+0.0%	+0.0%
Address the 85 bed gap at UHNM	In progress	85	20	40	85	85
Any other capacity releasing opportunities	In progress	*	*	*	*	*

*Further metrics under development

- Maintain flat growth in admissions
- Address the 85 bed gap at UHNM
- Any other capacity releasing opportunities that arise from improvement
- Metrics to be determined in Q1 of 2024/24.

Commitment Statement - Simon Evans, SRO

Through the development of a highly focused collaborative we will deliver changes that will shift the provision of care outside of our hospitals supporting patients in the community in an efficient and effective way. The use of our services and resources will change such that those that have the greatest impact will grow and extend to meet the needs of patients. By doing this we will **reduce decompensation of vulnerable patients**, harm caused through poor access to emergency services and provide a wholly **better experience to patients** more of which are able to choose a local, community or home-based support. We will make some difficult decisions on services that don't meet this brief swiftly and we may reduce, delay or suspend some so that we are able to **focus our resources and efforts** on those that have greatest impact. In order to do all of this we will devise a mechanism of connecting patients (ICC) that will improve the way our services interact with each other and reduce delay

Collaborative Underpinning Workstreams

2a. Active Case Management

1. End of Life (Rapid Response to EoL)
2. Remote Monitoring
3. Frailty
4. Falls Pathways
5. Dementia
6. Deteriorating Patients
7. Active Case Management / Case Coordination.

2b. Care Homes Offer

1. Golden Thread / consistent offer to Care Homes
2. Care Coordination
3. Market Shaping
4. Advice & Guidance
5. End of Life (expansion of 24/7 Advice & Guidance Line).

2c. ICC for Urgent Care

1. UCCC extraction
2. Definition – clear – hours and scope
3. Service provision sitting behind ICC
4. Trusted Assessor.

2d. Alternative Response Services

1. Mental Health – 24/7 crisis line
2. Directory of Services – platform
3. Out of Hours support from Primary Care
4. Missed Opportunities Audit – TIA, community offer, palliative, Primary Care
5. Hospices.



Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective 31

Deliver a balanced net system financial position for 2024/25

Enabling Functions

Collaborative Scope and Ambition

Our ambition is to work collaboratively to maximise corporate back office, estates & digital efficiencies and savings across the ICS.

Savings Type	Yes/No
Cost Out	Yes
Cost Containment	Yes
Improved Productivity	Yes

Collaborative Underpinning Workstreams

- **Estates:** extracting savings from underutilised estate and selling surplus assets to generate capital receipts. The targets for 2024/25 are relatively modest and the goal is to complete the work so that there is a larger contribution from 25/26
- **Workforce** monitoring the delivery of organisational specific CIP Plans regarding Corporate Vacancies and identifying further opportunities to work collaboratively to deliver additional efficiencies
- **Digital** improving productivity and containing costs by maximising the use of RPA processes and Artificial Intelligence.

Commitment Statement - Paul Brown, SRO

The collaborative has three parts and each will have a nominated SRO. For estates we will be looking to build on the work of the system estates group to **capitalise on the opportunities of under-utilised estate**. An SRO will be agreed with system estates directors by the summer. On the workforce task, Mish Irvine is the SRO working with the CPOs from across the system. For Digital the SRO will be Chris Ibell, working with the CDOs from across the system.

The collaborative will deliver cash-out contributions from estates and corporate posts to contribute towards the £203m system efficiency programme. These targets are contained within the CIP targets of the 4 organisations. The digital programme is delivering non-cash benefits that will enable **more cost effective delivery of services** across the system.

Metrics Overview

Description	Organisation (s)	Target	Q1	Q2	Q3	Q4
Estates CIPs	ICB/UHNM/MPFT/NSCT	£1.901m	£475k	£475k	£475k	£475k
Corporate Vacancy Management CIPs	ICB/UHNM/MPFT/NSCT	£3.156m	£789k	£789k	£789k	£789k
RPA processes	MPFT/UHNM/ NSCT	£400k	*	*	*	£400k
UEC KPI PoC	MPFT	£150k	*	*	*	£150K
AI processes	MPFT/UHNM/ NSCT	£50k	*	*	*	£50K

*Further metrics under development

In summary three key metrics for 2024/25:

1. Cash out of £5m+
2. Measurable benefits to improve productivity (through digital)
3. Work completed to enable further significant savings in 25/26, particularly the use of the estate and selling off surplus estate.

**Profiling to be confirmed with each organisation



Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective

31

Deliver a balanced net system financial position for 2024/25

Clinical Value and Medicines

Collaborative Scope and Ambition

To promote value based personalised care together.

Savings Type	Yes/No
Cost Out	£4.0m
Cost Containment	MRI and Vit D demand will support
Improved Productivity	MRI demand: -981 Vit D testing demand: -11,675

Collaborative Underpinning Workstreams

The Collaborative will focus initially on the following four areas:

- **Medicines:** Prioritise medicines offering best value on specified clinical pathways
- **Interventions:** Reduce the number of low value clinical interventions and overuse of specific diagnostics
- **Pathways:** Design and implement value-based clinical pathways
- **Policy:** Supporting clinical implementation, analyse existing policies with restricted and excluded criteria, addressing areas where clinical practice deviates from guidance.

Commitment Statement – Rachel Gallyot, SRO

The Clinical Value and Medicines Collaborative will focus on protecting resources through the **promotion of clinical value: prioritising outcomes and reducing low value clinical interventions**. This will be delivered through targeted, specific programmes of work, identified and supported by data and evidence with a quality improvement approach. The Collaborative will **promote clinical value through medicine, interventions, clinical pathways and policy**. There will be a continuous focus on scoping new opportunities to maximise clinical value and building a culture of value based clinical practice.

Metrics Overview

Description	Target	Q1	Q2	Q3	Q4
Reduction in prescribing of Oral Nutritional Supplements	£3.0m reduction against baseline	*	£0.75m	£1.125m	£1.125m
Reduction in prescribing of Self-Care Medication (Targeted list in progress)	£1.0m reduction against baseline	*	*	£0.4m	£0.6m
Reduction in MRIs for Lower Back Pain	North: 1472 reduction in Lower Back MRI referrals (12-month effect – 981 over 8 months) South: In progress	*	245	368	368
Vitamin D testing	North: 17,512 reduction (12-month effect – 11,675 over 8 months) South: In progress	*	2,918	4,378	4,378
Reduction in NEL Bed days for Pneumonia*	7% reduction in <u>NEL bed days</u> for Avoidable Pneumonia Admissions. NOTE – coding will be further scrutinised. Growth factored in.	*	*	187	134
Reduction in NEL Bed days for UTI**	5% reduction in NEL bed days for Avoidable UTI Admissions	*	Targeted scoping underway		
Excluded and restricted opportunities	In progress: triangulation of Model Health System and local data	*	Targeted scoping underway focused on MSK		

*Further metrics under development

**These schemes will contribute to the demand management collaborative requirement to address the 85 bed gap at UHNM with circ 12 beds.



Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective

31

Deliver a balanced net system financial position for 2024/25

Contracts

Collaborative Scope and Ambition

- Ensuring maximum productivity (including ERF income) and driving value from contractual arrangements: by managing T&Cs, outcomes/ outputs
- Regaining control of growth and inflation pressures
- Delivering phase 2 plans around appropriate / sustainable use of IS via robust pathway management, including possible lead provider options.

Savings Type	Yes/No
Cost Out	Yes
Cost Containment	Yes
Improved Productivity	Yes

Collaborative Underpinning Workstreams

- Base Efficiency Programme:** ICB CIP target of 5.3% across all non-NHS contracts
- Independent Sector Partner Programme:** develop partnership approach for use of IS capacity at beneficial system marginal rate
- Stretch Target to bridge the £20m unidentified savings in system plan:** Deep dive contract review for decommissioning options alongside review of repatriation opportunities.

Commitment Statement – Helen Ashley, SRO

Historically the CCG and subsequently ICB has engaged in a number of external contracts in order to provide additional capacity to supplement NHS provision. Whilst additional capacity has an immediate short term gain, it introduces additional overheads and costs into an already challenged financial environment. Through the development of the system collaborative we will seek to ensure that we **drive value for money from our contracts**, and develop medium term sustainable plans to address any capacity shortfalls that currently exist.

Metrics Overview

Description	Baseline	Target	Q1	Q2	Q3	Q4
ERF Activity Target	2019	103%	110.30%	110.30%	110.30%	110.30%
Reduction in the Elective Waiting List Size	*	*	*	*	*	*

Description	Organisation	Target	Q1	Q2	Q3	Q4
Financial – IS Tariff Target	System wide	£3m	nil	£1m	£1m	£1m
Financial – Stretch Target	System wide	£8.5m	nil	nil	*	*
Financial – 5.3% CIP £6m	ICB	£6.1m	nil	£0.9m	£2.6m	£2.6m

*Further metrics under development



**Staffordshire and
Stoke-on-Trent**
Integrated Care System

Measuring our success

The following slides set out we will deliver and measure success of the 2024/25 System Operational Plan



How we will deliver and measure success of the plan

We will deliver our ambitions and priorities through a range of vehicles that have been set up to work at the level and scale required to make the biggest impact on improving population health and wellbeing in Staffordshire and Stoke-on-Trent.

All parts of the Staffordshire and Stoke-on-Trent governance structure will have a vital role to play in delivering this plan and in providing the necessary assurance to the Integrated Care Board.

The plan serves as a tool for [monitoring and evaluation](#), enabling the ICS to track progress towards its goals and objectives over the course of the year. Underpinning portfolio delivery plans have been developed which have the detailed deliverables and where appropriate metrics. By setting measurable targets and milestones, the plan allows for [ongoing assessment of performance](#) and the identification of any areas requiring adjustment or realignment. This iterative process of monitoring and evaluation is essential for ensuring [accountability and transparency within the organisation](#), as well as for demonstrating the effectiveness of its interventions to external stakeholders.

As partners, we will undertake a continuous appraisal of the position, performance, and delivery of the key priorities.

Each national and local deliverable is aligned to one of the portfolios or enabling workstreams which make up the delivery architecture for the system.

We will [use existing assurance mechanisms](#) to understand compliance with progress reported to the System Finance and Performance Committee as part of gateway reviews of the plan which will be presented as a twice a year stock take.

The weekly recovery meeting will continue with an extended membership to focus on the delivery of the system collaborative recovery programmes. Whilst each system collaborative is focused on a series of recovery objectives that will deliver in 2024/25, it will also be subjected to a series of Gateway Reviews. These reviews will be looking at how the recovery / transformation programme for 2025/26 is starting to take shape and mature. These will be informed by the transformation and BAU plans currently held by the Portfolios and the self-assessment of maturity using the Provider Collaborative Maturity Matrix.

Enablers

Successful delivery of our plans is dependent on the programmes of work in a range of our enabling work streams, functions and strategies including but not exclusive to the below. Further information about these can be found on the ICB/ICS Website and within our Joint Forward Plan.

<u>Working with People and Communities</u>	<u>Workforce and People</u>	<u>Quality</u>	<u>Data and Intelligence</u>	<u>Digital</u>	<u>Population Health Management</u>
<p>Public engagement and involvement have always been recognised as key enablers in supporting effective health and social care service planning and delivery across Staffordshire and Stoke-on-Trent.</p> <p>We recognise that our local people and communities need to be at the heart of everything that we do, informing all of our plans and priorities.</p>	<p>Our people will continue to be our biggest asset in ensuring the community receive the health and care services they need. We need to ensure that we look after and support them to deliver the best treatment and care in the most effective way for the benefit of the population we serve.</p> <p>Collaboration continues to be key, particularly in the landscape of considerable challenges both operationally and financially to ensure our footprint is one of the best places to live, learn and work.</p> <p>Our commitment to creating a more inclusive, compassionate culture and diverse workforce continues to be a priority, with a specific focus on enhancing inclusion in all aspects of our programmes.</p>	<p>Staffordshire and Stoke-on-Trent ICB's vision for quality is to ensure that services provided are safe, effective, and meet the needs of the population, providing the best experience and outcomes possible.</p> <p>Our Quality Strategy, co-produced with NHS partners, supports our collaborative approach to the delivery of the NHS Patient Safety Strategy and NHS Improving Patient Care Together. Building upon the foundations of system working that we have put in place and demonstrated by the positive engagement at our System Quality Group.</p>	<p>We are committed to ensuring that data driven decisions are at the centre of the transformation of our health and care system.</p> <p>To achieve this we have recently published a Data and Intelligence strategy which reflects our goals for a data centric culture and workforce; a unified data warehouse; overarching governance and information governance processes; intuitive reporting and insight and a virtual ICS-wide intelligence function.</p> <p>During 2024 we will develop a co-produced implementation plan for the strategy across the ICS.</p>	<p>From a resident's perspective, it is critical that each of us can engage digitally when accessing health and social care services, providing a seamless care journey, underpinned by accurate and up to date information.</p> <p>We shouldn't have to repeat the same information every time we see a new health and care professional.</p> <p>From a health and care provider perspective, information needs to be accessible at the point of care so that safer and better decisions can be made about people's care.</p>	<p>Working with Partners to embed population health management across Staffordshire and Stoke-on-Trent will support the growth of integrated health and care so that it is underpinned by intelligent decision-making.</p> <p>It will enable the use of linked data to understand risk and protective factors, so that we can target resources to those at increased risk of poor health outcomes or with the greatest potential to benefit from care, identify inequalities in access, experience, and outcomes of care to inform improvements, and proactively target preventative interventions and services to those identified as being at higher risk of illness or adverse events.</p>
<p>Tracey Shewan Director of Corporate Governance</p>	<p>Mish Irvine Chief People Officer</p>	<p>Heather Johnstone Chief Nursing Officer</p>	<p>Paul Brown Chief Finance Officer</p> <p>Chris Ibell Chief Digital Officer Data and Intelligence Strategy</p>	<p>Chris Ibell Chief Digital Officer</p>	<p>Paul Edmondson-Jones Chief Medical Officer</p>

Appendix 1

35 National Objectives

The following slide sets out the 35 national planning objectives for 2024/25, aligned to portfolios, enabling functions and the wider system.



2024/25 National Objectives aligned to portfolios

National objectives	2023/24 vs 2024/25	Portfolio/work area
2 Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	Kept – uplift from 76% to 78%	UEC
3 Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	Kept	UEC
4 Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Kept – extended deadline	Planned Care
5 Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	Kept	Planned Care
6 Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	New	Planned Care
7 Improve patients' experience of choice at point of referral	New	Planned Care
8 Improve performance against the headline 62-day standard to 70% by March 2025	Kept	Cancer
9 Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	Kept – uplift from 75% to 77%	Cancer
10 Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Kept	Cancer
11 Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Kept	Planned Care
12 Improve community services waiting times, with a focus on reducing long waits	New	Planned Care
13 Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	Kept	Primary Care
14 Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels	Kept	Primary Care
15 Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment	New	Maternity & Neonates
16 Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities	New	Planned care
17 Improve patient flow and work towards eliminating inappropriate out of area placements	Kept – added flow	Mental Health
18 Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	Kept	Mental Health
19 Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	Kept	Mental Health
20 Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	New	Mental Health
21 Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	Kept	Mental Health
22 Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	Kept	LDA
23 Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population	Kept	LDA
24 Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	Kept – uplift from 77% to 80%	Primary Care
25 Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	Kept – uplift from 60% to 65%	ELF
26 Increase vaccination uptake for children and young people year on year towards WHO recommended levels	New	IPH (Vaccinations)
27 Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	Kept	IPH

2024/25 National Objectives aligned to functions/enablers

National objectives		2023/24 vs 2024/25	Function/ Enabler
1	Implement the Patient Safety Incident Response Framework (PSIRF)	New	Quality
28	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions	Kept	Workforce
29	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors	New	Workforce
30	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	New	Workforce
31	Deliver a balanced net system financial position for 2024/25	Kept	Finance
32	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	New	Workforce
33	The NHS needs modern and sustainable infrastructure	Kept	System
34	Strong digital foundations for transformation, supporting access, quality and productivity.	Kept	Digital
35	Developing approach to building the components of system working: integrated neighbourhood teams, development of place-based partnerships, provider collaboratives and changes to commissioning and planning.	Kept	System

Appendix 2

Plan Metrics

- The following slide sets out the priority metrics for 2024/25 aligned to portfolio.
- We will be working to track each and attach to the key priorities to assess delivery against our ambitions.



Appendix 2: Plan Metrics

				2024/25				
Portfolio	Area	Metric	Baseline	Q1	Q2	Q3	Q4	
1. Eliminate delays in access to treatment and long waits for care	Urgent and Emergency Care	Ambulance	Category 2 response < 30 minutes	Managed by host commissioner	< 30 minutes	< 30 minutes	< 30 minutes	< 30 minutes
		Recovery	Improve A&E waiting times so that no less than 78% of patients are seen within four hours by March 2025 with further improvement in 2024/25 (UHNM)	67.30%	69.80%	71.00%	70.60%	78.0%
			Reduce adult general and acute (G&A) bed occupancy to 92% or below (UHNM)	91.30%	86.50%	82.70%	87.70%	90.41%
	Pre-hospital	Maintain 80% utilisation of virtual wards throughout 24/25 (ICB)	72%	81.00%	81.70%	81.60%	85.95%	
	Planned care, diagnostics and cancer	Planned Care	Deliver the system-specific elective activity target 103% (ICB)	102.88%	110.30%	110.30%	110.30%	110.30%
			Elective activities - Day Case	164,239 (2023/2024)	41,895	44,294	45,618	43,625
			Elective activities - Ordinary elective	19,132 (2023/24)	5,298	5,508	5,610	5,299
			Aim to deliver a reduction in OPFU in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2025 (ICB)	520,688 (2019/20)	175,777	180,747	181,207	180,348
			OP Procedures within ERF scope (ICB)	46%	47.27%	47.39%	47.37%	47.07%
			Eliminate waits of over 65 weeks for elective care by September 2024 (ICB)	1,583 (Feb 2024)	1,592	0	0	0
			Increase productivity and meet the 85% day case and 85% theatre utilisation expectations (UHNM)	System submission compliant	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory
		Diagnostic recovery	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (ICB)	76.68%*	80.25%	79.04%	82.11%	84.40%
		Cancer recovery	Meet the 28 day waits faster diagnosis standard 75% (ICB)	66.86% (Nov 2023)	74.64%	75.55%	76.50%	76.96%
			Reduce the number of patients waiting over 62 days (ICB)	218 (Nov 2023)	221	196	178	168
			Increase the number of patients with suspected cancer seen on a non-specific pathway following GP referral or referral from another service (ICB)	42 (Nov 2023)	83	148	127	140
Increase the percentage of lower GI suspected cancer referrals with an accompanying FIT result (ICB)			54% (Nov 2023)	79.49%	80.86%	80.64%	80.72%	
Increase productivity and meet the 85% day case and 85% theatre utilisation expectations (UHNM)	System submission compliant		UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory		
Mental Health	Perinatal access	Improve access to perinatal mental health services.	1,010 (12 mths to Feb-24)	1,012	1,080	1,147	1,215	
	CYP access	Improve access to mental health support for children and young people through increasing the number of under-18s supported through NHS-funded MH services.	13,455 (12 mths to Feb-24)	14,372	15,339	16,306	17,273 (at year end)	
	Talking Therapies	Increase the number of adults and older adults receiving a course of treatment.	12,825 (12 mths to Dec-23)	12,924	12,924	12,924	12,924 (at year end)	
Learning Disabilities and Autism	Autism Assessments	Minimise waiting times for autism assessment (median wait to commence assessment)	tbc with new data improvement plan	19*	17*	15*	13	
		Assessment completion 26 weeks	tbc with new data improvement plan	40*	36*	30*	26	
CYP	Complex Care	Reduce proportion of CYP <18 in residential care outside the ICS geography – Staffordshire	63.8% (Mar-24)	63.8%	63.8%	63.8%	63.8%	
		Reduce proportion of CYP <18 in residential care outside the ICS geography – Stoke-on-Trent	76.3% (Mar-24)	76.3%	76.3%	76.3%	76.3%	
Primary Care	Dental activity recovery	Recover dental activity towards pre-pandemic levels	1,368,062 (Apr-Feb)	406,922	475,554	460,922	453,606	
	Access	Pharmacy First Provision – number of interventions	0 (new service)	7,000	7,500	8,000	8,500	

*The baseline and quarterly trajectory for the percentage of patients receiving a diagnostic test within six weeks in line is based on waiting list positions as set out in the NHSE Operational Plan submission

Appendix 2: Plan Metrics

					2024/25			
Portfolio	Area	Metric	Baseline	Q1	Q2	Q3	Q4	
2. Improving access to high quality, sustainable primary care access	Primary Care	Access	Number of appointments delivered in general practice by end of March 2025	6,374,053	1,486,629	1,643,724	1,745,672	1,555,709
			General practice appointments in <2 weeks	91.89% (Jan-24)	85%	85%	85%	85%
		Workforce	Deliver Additional Role Reimbursement Scheme (ARRS) recruitment (WTE) by March 2025	587	644	684	691	696
			GP WTE (working towards ICB target) by March 2025	692	715	707	712	701
	Planned Care	Diagnostic recovery	Deliver increased diagnostic activity levels (ICB)	557135 (2023/24)	144,915	147,254	149,181	149,868
	Mental Health	Dementia diagnosis	Recover the dementia diagnosis rate to 66.7%.	72.4% (Mar-24)	71.90%	72.10%	72.10%	72.2% (at year end)

Appendix 2: Plan Metrics

				2024/25				
Portfolio	Area	Metric	Baseline	Q1	Q2	Q3	Q4	
3. Delivering joined up proactive and preventative support and care across all pathways	Mental Health	Out of area placements	Work towards eliminating inappropriate adult acute mental health out of area placements (OAP).	3 (Dec-23)	2	2	1	0
		Talking Therapies	Achieve national target of the proportion of people attaining reliable recovery.	49% (Dec-23)	48%	48%	48%	48%
			Achieve national target of the proportion of people attaining reliable improvement.	73%	67%	67%	67%	67%
		Adult mental health	Increase the number of adults and older adults supported by transformed community mental health services.	12,825 (12 mths to Dec-23)	12,924	12,924	12,924	12,924 (at year end)
	SMI physical health checks	Increase the proportion of people with SMI who have a full annual physical health check.	51% (12 mths to Q2)	54%	56%	58%	60% (at year end)	
	Learning Disabilities and Autism	Reliance on inpatient care for people with a learning disability and/or autism	The number of adults who are in inpatient care for a mental health disorder.	15 ICB (Mar-24) 9 NHSE (Mar-24)	12 14	12 14	12 14	12 14
			The number of under-18s who are in inpatient care for a mental health disorder.	8 (Mar-24)	6	5	4	3
		Learning Disability and/or Autism Mortality Review	100% of LeDeR reviews are undertaken within six months of notification of death.	100%	100%	100%	100%	100%
	End of life, long term conditions and frailty	PEoLC	Prevalence rate of patients on palliative care registers to 1%.	0.84% as of 4 th April 2024	0.84	0.9	0.95	1%
		Long-term conditions	Increase in the number of patients receiving all 8 care processes for Diabetes.	Type 1 41.7% (National Diabetes Audit)	*	*	*	45%
				Type 2 55.7% (National Diabetes Audit)	*	*	*	50%
			Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic NHSE target of 520 per month	1500 per quarter	1,560	1,560	1,560	1,560
	Ensure patients commence on the National Diabetic Prevention Programme following referral– support for patients who are pre-diabetic NHSE target of 260 per month	780	780	780	780	780		
	CYP	Long Term Conditions	Reduce hospital admission for asthma (flat activity)	198.1	198.1	198.1	198.1	198.1
Reduce hospital admission for epilepsy (flat activity)			83.6	83.6	83.6	83.6	83.6	
Maternity	A range of metrics are in development which will support the delivery of the Three-Year Delivery Plan for Maternity and Neonates linked to the NHSE National Data Set							

*Metrics are in development

Appendix 2: Plan Metrics

					2024/25			
Portfolio	Area	Metric	Baseline	Q1	Q2	Q3	Q4	
4. Delivering compassionate care of the frail and elderly	Urgent and Emergency Care	Post-Hospital	Improve number of discharges on Pathway 0 to 80% (ICB)	71%	79.20%	78.20%	78.20%	79.48%
			Reduce number of discharges on Pathway 3 to below 1% (ICB)	6%	0.30%	1.00%	1.00%	0.25%
	IPH	Vaccinations	Increase uptake of Flu and pneumonia vaccination	*	*	*	*	*
	Integration	Emergency Admissions (BCF)	Prevent emergency admission Ambulatory care (Stoke-on-Trent)	Awaiting confirmed 2023/24 baseline	302.0	290.1	361.8	322.9
			Prevent emergency admission Ambulatory care (Staffordshire)		214.8	195.6	231.4	215.8
		Falls (BCF)	Improve access to fall service from A&E (Stoke-on-Trent)	Awaiting confirmed 2023/24 baseline	1,331.4 annual plan			
			Improve access to fall service from A&E (Staffordshire)		1,448.1 annual plan			
		Discharge (BCF)	Discharge to usual place of residence (Stoke-on-Trent)	Awaiting confirmed 2023/24 baseline	92.9%	93.1%	92.0%	92.8%
			Discharge to usual place of residence (Staffordshire)		93.5%	93.4%	93.9%	94.1%

					2024/25			
Portfolio	Area	Metric	Baseline	Q1	Q2	Q3	Q4	
5. Supporting Care Home Residents	Urgent and Emergency Care	Emergency Admissions	High intensity users - emergency admission >65	*	*	*	*	*
		Pre-hospital	Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard (ICB)	79.80%	85%	85%	85%	85%
	Medicine Optimisation	Overprescribing	% of structured medication reviews (SMRs) conducted in general practice.	Based on % delivery of 15000 SMRs	15%	40%	70%	100%
	Integration	Admissions to Care Homes (BCF)	Admission to care homes (Stoke-on-Trent)	Awaiting confirmed 2023/24 baseline	489 annual plan			
			Admission to care homes (Staffordshire)		605 annual plan			

*Metrics are in development

Appendix 3

Finance 2024/25

The following slide sets out the headlines from the financial plans for 2024/25





Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

National Objective

31

Deliver a balanced net system financial position for 2024/25

Appendix 3 : Finance 2024/25 Submissions

Revenue

- The table on the right sets out the headlines from the financial plans submitted on 12 June 2024.
- Through national escalation we were challenged to be more ambitious. We were reminded that the NHS does not have the cash allocations to support this level of deficit. We were told that other systems have made more progress than we have. We were told that any deterioration from the 2024/25 outturn is not acceptable.
- CEOs asked the system to respond to the challenge, and a number of ideas were developed that would improve the system financial position without deteriorating our operational targets.
- On 25th April we came back together and agreed to make a further £40m improvement, taking the proposed system plan to a £90m deficit.
- A number of senior people in the system are uncomfortable with the level of financial risk we have taken into the plan, and we are all agreed that we cannot go any further unless operational or clinical targets were relaxed.
- We met with NHSE on 26th April and the progress made was acknowledged. The national CFO recognised that there is a significant level of risk in the plan. It was agreed that the system will now work with the Regional team to agree the underpinning detail to the delivery of efficiency improvements and to now focus on de-rising the plan.
- The deficit plan was agreed at the following national escalation meeting on 10th May.

	ICS	UHM	MPFT	NSCHT	ICB
I&E Position	(90,000)	0	0	0	(90,000)
Efficiency	203,166	56,600	37,890	6,400	102,276
Identified as high risk	58,122	21,980	8,016	2,276	25,850
Unidentified	17,800	5,100	0	1,200	11,500
Risks	(114,048)	(44,500)	(18,948)	(3,600)	(47,000)
Mitigations	26,200	20,000	4,000	2,200	
Net Risk	(87,848)	(24,500)	(14,948)	(1,400)	(47,000)
ULP	(249,144)	(58,069)	(21,104)	(2,105)	(167,866)
Agency plan	(40,366)	(24,711)	(11,346)	(4,309)	
Total pay expenditure	(1,267,108)	(690,535)	(477,633)	(98,940)	
Agency compliant plan (below 3.2%)	3.2%	3.6%	2.4%	4.4%	
Capital* (before IFRS 16)	40,588	18,578	20,559	1,451	
Total CDEL	108,209	72,325	30,078	5,806	

*Note compliant plan submitted

Capital

- The capital resource limit before International Financial Reporting Standard (IFRS) 16 is compliant with the allocation. However, should the planned brokerage related to the Outwoods scheme from Derbyshire not be available we will need to review the entirety of the programme
- The system remains non-compliant with the IFRS 16 capital allocation and is in discussion with NHSE regarding how the allocation was set as this does not take account of the impact of new services acquired by MPFT outside the system.

Appendix 4

Workforce 2024/25 operating plan

The following slide sets out the key points from the final workforce planning submission.





Appendix 4: Workforce 2024/25 Submission

FY24-25 Operating Workforce Plans - 12 June 2024 Submission

FY24-25 Plan (Mar-24 to Mar-25) – NHS Providers (WTE)

Summary

- Establishment is planned to increase from 24,135 to 24,388 by +253.
- The overall total workforce is planned to decrease from 24,287 to 23,798 by - 489.
- As of Mar-24 the total workforce staff in post is +152 above the establishment.

Staff Composition (Total WF):

- Substantive: +78
- Bank: - 403
- Agency: -165

Overall Total Workforce Movement:

MPFT: Decrease from 9,948 to 9,826 by -122.
NSCHT: Decrease from 1,819 to 1,809 by -10.
UHNM: Decrease from 12,520 to 12,162 by -358.

Staff Groups – Substantive WF Movement:

- Reg Nursing, Midwifery & HV's: +130
- Reg/Qual Sci, Therapeutic & Staff: +24
- AHPs: +9
- Reg/Qual Healthcare Scientists: No Change
- Support to Clinical staff: +63.4
- NHS Infrastructure Support: -156
- Medical & Dental: +17

FY24-25 Plan (Mar-24 to Mar-25) – Mental Health & Primary Care (WTE)

Primary Care: Increase from 3,458 to 3,615 increase of +157

Mental Health Workforce Plan: Increase from 3,373 to 3,392 by +19

FY24-25 Plan Development – NHS Providers (WTE)

FY24-25 Ops WF Plans		Revised plan 12/06/24					
		Mar-24 SIP	Mar-24 Establishment	Mar-25 SIP	Mar-25 Establishment	SIP Change Mar-24 to Mar-25	Establishment Change Mar-24 to Mar-25
MPFT	Substantive	9,099	10,137	9,120	10,328	21	191
	Bank	647		549		-98	
	Agency	202		157		-45	
	Total WF	9,948	10,137	9,826	10,328	-122	191
NSCHT	Substantive	1,656	1,871	1,656	1,809	0	-62
	Bank	130		146		16	
	Agency	33		8		-26	
	Total WF	1,819	1,871	1,809	1,809	-10	-62
UHNM	Substantive	11,191	12,127	11,268	12,251	77	123
	Bank	1,026		705		-321	
	Agency	303		209		-94	
	Total WF	12,520	12,127	12,182	12,251	-338	123
SSoT	Substantive	21,946	24,135	22,044	24,388	98	253
	Bank	1,803		1,400		-403	0
	Agency	538		374		-164	0
	Total WF	24,287	24,135	23,818	24,388	-469	253

Since the submission to NHSE on 21 March and subsequent plan development, the workforce increases planned have decreased. The increases planned are modest.

- **Total staff in post workforce detailed a decrease of -260 in the flash submission (17/04/24) and the planned decrease has increased further to -489, of which:**
 - Substantive was +224, now reduced to +78 (in this we know there is a TUPE incoming equating to +147).
 - Bank was -320, reductions further increased to -403.
 - Agency was -164 and remains static.
 - Establishment was increasing by +249, a slight increase to +253 is planned.
- Current workforce plan position as at 29 April (final plan in readiness for 2 May 24 NHSE submission), reflects SIP decreasing by -2.0% and establishment increasing by +1.0%, ideally these would be more closely aligned given headroom in establishment is there to support additionally of 24-7 services (statutory and mandatory training, annual leave etc.)

Key Local Aims

Safe, timely and sustainable care

Meeting the capacity challenge

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	SSOT Board Development Programme Proposal					
Presenting Officer:	Pauline Grant					
Author(s):	Pauline Grant					
Document Type:	Report	If Other:				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input checked="" type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	--				
Any potential / actual Conflict of Interest?	Yes / No	If Y, the mitigation recommendations – No				
Any financial impacts: ICB or ICS?	Yes / No	If Y, are those signed off by and date: No				
Appendices:	NA					

(1) Purpose of the Paper:

The purpose of this paper is to provide the Board with an overview of the proposed actions and approach to progressing a programme of Board Development for the ICB.

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

Date

(3) Implications:	
Legal or Regulatory	
CQC or Patient Safety	
Financial (CFO-assured)	
Sustainability	
Workforce or Training	
Equality & Diversity	
Due Regard: Inequalities	
Due Regard: wider effect	To ensure we can continue to execute our duties effectively as a Board

(4) Statutory Dependencies & Impact Assessments:

	Yes	No	N/A	Details
DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Initial proposal</i>

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Completion of Impact Assessments:	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If Y, Reported to IG Group on</i> Initial proposal
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Initial proposal</i> <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

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

1.0 Current Context

The expectation of integrated care boards (ICBs), trusts and primary care providers is that we work together to plan and deliver quality care for our population and deliver a balanced net system financial position in collaboration with integrated care system (ICS) partners. Staffordshire and Stoke on Trent ICS entered the 2024/25 planning period with a high level of financial challenge including an efficiency ask of £203.2m, equating to 8% of Revenue Resource Limit (RRL). We have commitment from all partners to deliver a path to financial sustainability and this means ensuring we have the right systems, structures, process and systems leadership in place needed to get us to this position. Key to delivery of our financial commitment to delivering recurrent breakeven as soon as possible is the Medium-Term Financial strategy, the Recovery Programme, anchored by 5 system priorities and continuing to prioritise the ambitions and deliverables set out in our 7 Portfolio areas of work.

2.0 Delivering Health and Care Leadership across SSOT

We have already achieved a great deal working together as a system however we still have more to do. The Medium Term Plan sets out our ambitions and objectives over the next few years needed to deliver on this.

3.0 The Importance of ICS Board Development

In order to operate effectively comprehending, leading and addressing the challenges within our system, it is necessary that we have in place a robust and ongoing programme of board development to ensure we can continue to develop effectiveness as an executive team sufficient to resolve our challenges whilst meeting the unfolding needs of the ICB and future needs for the ICS.

4.0 Developing Board Effectiveness

To ensure we can continue to work effectively as a board, we have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. The steps outlined in this proposal aim to address our gaps ensuring executive members can act with and for one another, balancing their own speciality and organisation priorities, whilst also contributing to and leading the system agenda, and that all members need to feel safe to do so. This involves a continued focus on building board effectiveness, developing relationships and taking action to develop as a unitary board.

5.0 Board Development Programme

The proposal for the board development programme will be delivered in 2 phases aimed at diagnosing

the areas for development followed by inputting the development needed – to commence immediately and take part of over a 3 month period. This will build on existing work and findings from this and other evidence from tabletop reviews to further refine this proposal.

Feedback from discussions around the needs for board development highlighted the need to identify dedicated time and space away from full board days to focus on development as a board. It is proposed that 3 half day face to face sessions are planned each year – a total of 6 over the next 18 months. The programme will incorporate development with the practical challenges the board needs to address including; Systems Leadership, EDI, Board Effectiveness and developing to become an even more effective team.

To ensure we can continue to gain momentum, whilst we further develop and finalise the Board Development programme, this will be followed by our first half day face to face session (date to be agreed), which will build on the introductory Psychological Safety session taking place in July.

(7) Recommendations to Board / Committee:

The Board is asked to support the recommendations to further design and deliver a robust Programme of SSOT ICB Board Development by

- Committing to take part in the further diagnostic phase to fully develop the Board Development Programme.
- Committing to take part in the Board development activities by attending the 3 half day, face to face, sessions each year – a total of 6 over the next 18 months.

Staffordshire and Stoke on Trent Integrated Board Development Programme
Proposal July 2024

1.0 Staffordshire and Stoke on Trent (SSOT) System - Current Context

Staffordshire and Stoke on Trent Integrated Care Board (ICB) is comprised of the Chair, ICB Executive and Non-Executive Board members; 3 NHS Provider Trust Chief Executives, 2 Local Authority Chief Executives and participant members from Primary Care and Healthwatch.

The expectation on us a unified group of leaders is that we work together to plan and deliver high quality care for the population of Staffordshire and Stoke on Trent and deliver a balanced net System financial position in collaboration with all our Integrated Care System (ICS) partners.

Staffordshire and Stoke on Trent ICS entered the 2024/25 planning period with a high level of financial challenge including an efficiency ask of £203.2m, equating to 8% of Revenue Resource Limit (RRL). We have commitment from all partners to deliver a path to high performing services for our population as well as financial sustainability, this means ensuring we have the right systems, structures, process and approach to Systems leadership in place needed to get us to this position.

A number of national drivers and guidance set the context for our work, framing local priorities for action in a number of areas including how we address persistent inequalities across different demographics and regions, recruitment, retention and the wellbeing of our skilled workforce, ongoing financial constraints and increasing demand in volume and level of need for services.

Our overall ICP Strategy (ICPS) identifies the things we need to change to make a difference and this includes a focus on **People and communities, Personalised care, Personal responsibility, Prevention and health inequalities and Productivity** all underpinned by **Population health management**. Our Joint Forward Plan (JFP) sets out how our ICS will achieve its purpose to **improve outcomes in population health and healthcare, tackle inequalities, enhance productivity and value for money and help the NHS support broader and economic development**.



Specifically for this year, our 2024/25 System Operational Plan defines local deliverables aligned to 2 key aims - **safe, timely and sustainable care** and **meeting the capacity challenge** – shaping 5 annual operational priorities to:

1. Eliminate delays in access to treatment
2. Improving access to high quality primary care
3. Delivering joined up proactive and preventative support and care across all pathways
4. Delivering compassionate care of the frail and elderly
5. Supporting care home residents

Key to delivery of our financial commitment and to deliver a recurrent breakeven position is are the development of the Medium-Term Financial strategy, the System Recovery Programme, which are anchored by 5 system priorities.

2.0 Delivering Health and Care Leadership across SSOT

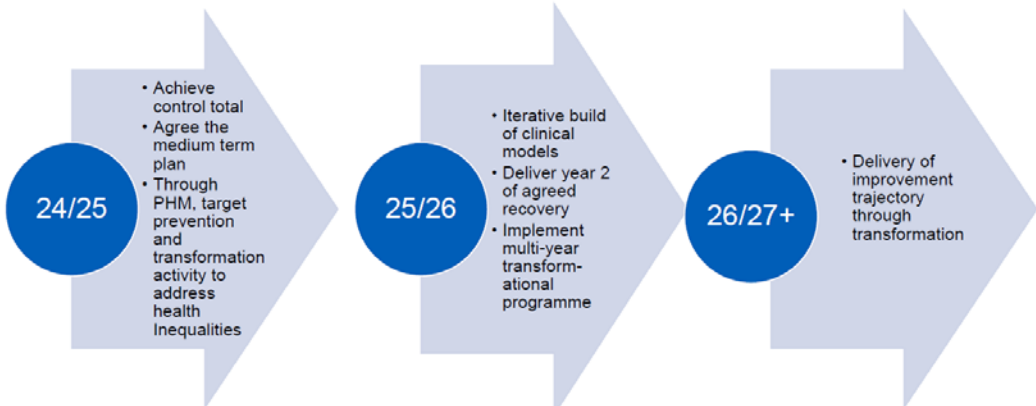
We have already achieved a great deal working together as a System. However the challenging context that we are working within underlines the need for us to continue on our collaboration journey to do even more. The Medium Term Plan, which is currently in development in conjunction with System partners, will set out our ambitions and objectives over the coming period.

Figure 2.1. Summary of Medium Term Plan Journey

The Next Few Years

The system is currently in recovery. This phase sees us through to control of the run-rate and ensuring that the system position is improving. In this first phase we need to achieve the 24/25 control total and agree a multi-year trajectory. And then we need to move into a longer term transformational phase, where actions have longer term impacts on addressing inequalities and meeting the needs of our population.

The chart below shows how over the next three years we will move through from recovery into that transformational phase:



Building a System Medium Term Plan

3.0 The Importance of ICS Board Development

It is recognised that our Board members are Executive leaders with extensive senior leadership experience and are leading their own organisations. However, in order for our ICB to operate as an entity capable of comprehending, leading and addressing the System challenges we have outlined above and the related complexities, it is necessary that we have in place a robust and ongoing programme of Board development. This will ensure that we can continue to develop effectiveness as an Executive team sufficient to resolve the challenges described whilst meeting the unfolding needs of the ICB and future needs for the ICS.

4.0 Developing our Board Effectiveness Programme

To ensure we can continue to work effectively as a Board, members have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. Executive directors need to act with and for one another, balancing their own Organisational, Speciality and Sector priorities, whilst also contributing to and leading the System agenda. It is imperative that we develop a Board Culture of Psychological Safety to allow our members to speak out, challenge and seek to understand in order to be effective.

It is imperative that the specific interventions within Board Development programmes are tailored to the requirements of the group of Board Members depending on the context they work in and direct feedback from Stakeholders. An initial diagnostic (in the form of table top reviews, Governance review and Board Development sessions) was carried out in late 2024/ early 2025 to understand these for our ICB.

Feedback highlighted the following areas for developing Board effectiveness:

- Feeling safe to raise to concerns and having an appropriate level of challenge in order to ensure issues can be effectively addressed
- Encouraging more mutual challenge and holding each other to account
- Making decisions collectively that translate into collaborative working outside of board sessions
- Modelling the behaviours of the SSOT Leadership Compact inside and outside of meetings
- Addressing behaviours not in line with our Leadership compact including displaying complete candour, compassion and making a conscious effort to understand different perspectives.

4.1 Board Effectiveness

Key themes identified during initial diagnostic:

Staffordshire and Stoke on Trent ICS

- Building a shared vision/ purpose
- Commitment and buy-in from all stakeholders to work collaboratively
- Creating shared accountability and mutual understanding including of risks and benefits
- Foster cultural change across wider ICS

4.2 Developing Relationships

Key themes identified during initial diagnostic:

- Creating a psychologically safe environment, building trust and good working relationships, and model behaviours of Leadership Compact
- Improved understanding around the challenges of faced by individuals in different positions on the Board

4.3 Working as a Unitary Board

Key themes identified in initial diagnostic:

- Clarity on roles and responsibilities including support and 'induction' for new board members
- Holding each other to account, providing responsive feedback, learning from areas that are already working well.

Therefore, we will prioritise the following areas for focus of our Board development programme:

- build effective working relationships, identifying and understanding individual styles and appreciating diversity
- create time and space for our Board members to provide each other with constructive and developmental feedback on their performance and behaviour and its impact on others
- create time and space to consider opportunities for role appreciation and negotiation, exploration of and agreeing mutual expectations, standards, processes and systems
- agree our decision making processes; how decisions are implemented, executed and reviewed

We will prioritise activities and interventions that build individual and Board effectiveness to address the challenges faced by our system and contribute to us:

- building positive habits needed for an effective board by creating a culture of constructive challenge
- fostering a climate of trust and candour, individual accountability, and regular review of our performance as a Board
- creating regular opportunities for external Board observation and feedback

5.0 Board Development Programme: Evolving Diagnostic and Delivery

The Board development programme will be delivered in 2 phases:

- 1) Diagnosing in more depth the areas for development; interviews with Board members, group feedback sessions with particular stakeholders, group discussions as a Board to review/reflect on, our outcomes/effectiveness collectively, observations of Board meetings.
- 2) Designing and delivering the development required as an evolutionary process as Board development is ongoing.

Ongoing activity within the diagnostic phase will focus on cultural and behavioural aspects to address the issues identified above. Initial sessions will therefore look to address factors related to individual effectiveness, relationships and connectedness. The further diagnostic period will commence immediately and **be carried out over a period of 3 months**. As the process of diagnosis unfolds we will identify and deliver priority areas for intervention into relation innovation and improvement and learning and capacity building.

5.1 Board Development Delivery

Feedback from the initial diagnostic highlighted the need to identify dedicated time and space away from full Board days to focus on development as a Board.

Therefore, it is proposed that **3 half day face to face sessions will be carried out each year – a total of 6 over the next 18 months**.

To date the Board has engaged in an introductory session on Equality, Diversity and Inclusion (9th May) and plans are in place for an introductory session on Psychological Safety (18th July). To ensure we can continue to gain momentum, whilst we further develop and finalise the Board Development programme, this will be followed by our first half day face to face session (date to be agreed), which will build on the introductory Psychological Safety session taking place in July.

5.2 Summary of initial Board Development Activities/Areas of Focus

Building a Board Culture of Psychological Safety

Session 1 – 18th July 2024

Staffordshire and Stoke on Trent ICS

- Shared understanding of Psychological Safety, its antecedents and potential benefits within and across an ICS
- Develop thinking and agreement on ICS approach

Session 2 – Half Day Session – date TBC

- Building clarity on the purpose and benefits of collaboration and the practical collective agreements needed to form the foundations for this, using the principles of building a psychological safety climate

Systems Leadership

Further sessions will be delivered to support the maximising of our potential to influence, collaborate and lead across systems, leveraging information to effectively design, plan and integrate services with shared vision and purpose:

- sessions that enable and encourage us to regularly revisit our vision and purpose, continually developing our visioning and strategic capabilities and providing regular opportunities to create, recreate and review these capabilities in the light of internal and external feedback
- provides opportunity to ‘horizon scan’, spending time understanding the strategic implications of national policy drivers, local developments and trends as well as time for scenario planning and future proofing

Building Individual Relationships and working Effectively as a Group

Following the diagnostic period a tool will be identified to support the Board to understand more about “self” and how they work in the context of the Board group e.g. SDI, Insight. This tool will support us to make decisions and operate effectively as a group to build on the System Leaderships sessions and have:

- a continued focus on thinking through and enacting appropriate leadership within the ICB and across the wider ICS, including a review of the effectiveness of the ICB in its role as System leader
- regular consideration of the nature and state of internal and external relationships with key stakeholders and proactive consideration of stakeholder and reputation management strategies

Equality, Diversity & Inclusion (EDI)

Further sessions with a focus on EDI will be delivered to support development of Board Leadership Competency Framework - Domain 3:

- ‘4a. I personally demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds

4b. I personally encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities'

6 Recommendations

The Board is asked to support the recommendations to further design and deliver a robust Programme of SSOT ICB Board Development by

- Committing to take part in the further diagnostic phase to fully develop the Board Development Programme.
- Committing to take part in the Board development activities by attending the 3 half day, face to face, sessions each year – a total of 6 over the next 18 months.

Pauline Grant
Associate Director of Organisational Development
July 2025

Report to:	Integrated Care Board					
Date:	18 July 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:				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:	Appendix A: Quality and Safety Report – Detail July 2024.					

(1) Purpose of the Paper:

To provide assurance to the Integrated Care Board 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.

10/07/2024

This paper is a combination of corresponding papers (D/S/I) presented and discussed at System Quality Group.

05/07/2024

(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.
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(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Approved by QIA Panel on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in July 2024.</p> <p>Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:</p> <ul style="list-style-type: none"> • National Patient Safety Alerts • Maintaining focus and oversight on quality of care and experience in pressurised services • Learning from the lives and deaths of people with a learning disability and autistic people (LeDeR) • Learn from Patient Safety Events (LFPSE) • Infection Prevention and Control • Online Safeguarding Training

(7) Recommendations to Board / Committee:
<p>Members of the Integrated Care Board are asked to:</p> <ul style="list-style-type: none"> • Receive this report and 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. • Ratify the decision of the Quality and Safety Committee with regards to: (i) ICS Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent Strategy.

Appendix A: Quality and Safety Report – Detail July 2024

1. National Patient Safety Alerts (NatPSA)

1.1 Sodium Valproate. In response to the Medicines and Healthcare products Regulatory Agency (MHRA) National Patient Safety Alert (NatPSA/2023/013/MHRA) advising of regulatory changes for oral valproate medicines, NHS partners have set up steering groups to oversee the implementation and delivery of all measures to ensure compliance with the alert and new regulations. The System Quality Group has received updates from all partners on how they are implementing the guidance, including the interface with general practice, on what remains a complex and challenging issue.

1.2 Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices. NHS partners have previously responded to the MHRA National Patient Safety Alert (NatPSA/2023/010/MHRA) advising of associated risk of death or severe injury from entrapment or falls. In response to NHS England and the challenges highlighted nationally, health system partners are reviewing their associated actions. Feedback is being collated by the ICB and will support NHS England in establishing an updated national position.

2 Maintaining focus and oversight on quality of care and experience in pressurised services

2.1 In light of the continued pressures within urgent and emergency care (UEC) pathways, all Boards have been asked to assure themselves that they are working with system partners to do all they can to: (i) provide alternatives to emergency department attendance and admission, and (ii) maximise in-hospital flow. Working collaboratively with the Chief Delivery Officer and UEC team, the Nursing and Therapies directorate are actively engaging with all system partners to ensure that quality, patient safety, experience, and outcomes are central to the system-level approach to managing and responding to significant operational pressures. This is in addition to actions already being taken to obtain assurance in relation to the quality and safety of care in UEC pathways, for example, site visits.

3. Learning from the lives and deaths of people with a learning disability and autistic people (LeDeR) programme

3.1 The System Quality Group received the LeDeR Programme Annual Report 2023/24 which gave an overview of the progress and impact of the LeDeR Programme in Staffordshire and Stoke-on-Trent, in its aims to reduce premature mortality, health inequalities and improve outcomes for people living with a learning disability and autistic people. The report highlighted the key achievements of the programme, as well as areas where further improvement and development is needed.

3.2 There has been a 29% increase in the total number of notifications received, when compared with the previous year; 111 notifications received in 2023/24 up from 86 in 2022/23. At the same time, the system has observed an increase in the average age of death for individuals (62 years) when compared with the two previous years (52 and 57 respectively). The highest causes of deaths for 2023/24 were: 1. cardiovascular disease 2. aspiration pneumonia 3. cancer and septicemia. These are consistent with previous years, however, there has been a significant reduction of deaths from aspiration pneumonia from previous years (down from 37% to 9%).

3.3 Where learning and improvements have been identified from reviews, these have been discussed at the LeDeR Steering Group, themed/trended, prioritised, and taken forward as 'Learning into Action' during 2023/24. Progress includes but is not limited to: (i) a LeDeR conference to highlight and raise awareness locally of the programme, (ii) an Advocacy Hub website produced by Asist for families, carers and professionals to provide advocacy support and resources, (iii) continued promotion of the health passport with primary care and the care sector including a frequency asked questions document, (iv) creation of pre-awareness animation video about Dysphagia, produced for LD and Autism residential homes, care homes and supported living providers to promote uptake of Dysphagia training, (v) rollout and implementation of Dysphagia training across the whole county by the Speech and Language Teams at Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust as part of 'Local Action into Learning' identified from previous reviews.

3.4 The system continues to observe consistently low notifications of deaths from our Ethnic Diverse Group (EDGs) and autism population and has worked collaboratively with system partners to raise awareness of the programme amongst these populations. At the time of writing, LeDeR leaflets have been translated/printed and will be shared with EDGs in the following languages: English, Arabic, Bengali, Kurdish, Panjabi, Polish, Romanian, and Urdu. Alternative and innovative ways to reach these groups are also being considered and attendance at local EDGs and autism charities/groups has been now established, which have been incredibly positive.

4. Learn from Patient Safety Events (LFPSE)

4.1 The LFPSE service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. Challenges remain across the country around the implementation of the full LFPSE system with all providers waiting a further upgrade. In line with this all incidents reported which meet the national or internal threshold for a Patient Safety Incident Investigation continue to require reporting to the ICB by providers and manually adding to STEIS (Strategic Executive Information System). STEIS is the system on which the NHS previously reported cases meeting the Serious Incident Framework criteria.

4.2 Further work is being undertaken with primary care, care homes, hospices, and other providers to enable them to report on the LFPSE system. A pilot has been agreed with Stafford Town Primary Care Network, supported by the ICB's primary care team and the Health Innovation Network to build upon existing work and support the roll out of LFPSE into general practice.

5. Infection Prevention and Control

5.1 All NHS partners have reported an increase of patients accessing services who have tested positive for variants of Covid-19. The UK Health Surveillance Authority dashboard highlights an increase in the overall population. All Trusts monitor cases to determine whether the threshold for the re-introduction of control measures has been reached. University Hospitals of North Midlands NHS Trust announced on 2nd July 2024 that they have re-introduced the wearing of fluid resistant surgical masks in all clinical areas. Masks and hand gel have been made available at entrances to all wards and clinical areas for staff, patients, and visitors to wear.

6. Online Safeguarding Training Platform

6.1 NHS providers across Staffordshire and Stoke-on-Trent, led by safeguarding colleagues from MPFT, are working collaboratively to develop a safeguarding training platform to make training accessible to everyone across the health economy and provide a variety of training opportunities relevant to various roles. The platform will enable the safeguarding health system to host live learning events and canvas feedback from those using the platform to improve our offer and test the knowledge skills and confidence of the workforce in relation to safeguarding. The platform will be launched in October 2024 and there is currently 39 hours' worth of learning available on the platform. Conversations are also taking place with NHS providers across the country who are expressing an interest in joining our training platform.

7. Decisions made by Quality and Safety Committee for Ratification

7.1 ICS Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent Strategy

7.1.1 Building upon the NHS England guidance, 'Commissioning Framework for Mental Health Inpatient Services', Staffordshire and Stoke-on-Trent ICS have created a strategy for Transforming Mental Health Inpatient Services in Staffordshire and Stoke-on-Trent and have made several commitments to the local population. The strategy serves as a roadmap for the ICB and its partner providers, MPFT and North Staffordshire Combined Healthcare Trust to develop a well-coordinated and responsive inpatient mental health service. By focusing on optimising bed use, developing integrated care pathways, and prioritising patient well-being, the strategy aims to improve access to effective care and ensure positive outcomes for individuals experiencing mental health challenges. Members of the QSC approved the ICS Transforming Mental Health Inpatient Services in Staffordshire & Stoke-on-Trent Strategy and have asked for a deep dive conversation at the committee within the next six months.

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	Staffordshire and Stoke-on-Trent Health and Care Senate Summary and Escalation Report					
Presenting Officer:	Lorna Clarson, Deputy Chief Medical Office and Clinical Director for Improving Population Health					
Author(s):	Dr Rachel Gallyot, Chair of Staffordshire and Stoke-on-Trent Health and Care Senate (H&CS)					
Document Type:	Report	If Other:				
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input checked="" type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:	1. Summary and Escalation Report					

(1) Purpose of the Paper:

The purpose of this report is to provide a summary and escalation report of the items discussed at the Staffordshire and Stoke-on-Trent Health and Care Senate meeting, which was held on 13th June 2024 and any approvals that were made in that meeting.

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

	Date
Staffordshire and Stoke-on-Trent Health and Care Senate	13/06/2024

(3) Implications:

Legal or Regulatory	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
CQC or Patient Safety	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
Financial (CFO-assured)	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
Sustainability	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Workforce or Training	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
Equality & Diversity	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
Due Regard: Inequalities	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.
Due Regard: wider effect	None arising directly from this briefing paper. The H&CS will identify any issues for escalation through the briefing paper and will engage with relevant colleagues on specific issues.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Not required for this report as it is for information. <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required for this report as it is for information.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Not required for this report as it is for information. <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required for this report as it is for information.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

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

The purpose of this report is to provide a summary and escalation report of the items discussed at the Staffordshire and Stoke-on-Trent Health and Care Senate meeting, which was held on 13th June 2024 and any approvals that were made in that meeting.

(7) Recommendations to Board / Committee:

The Staffordshire and Stoke-on-Trent Integrated Care Board is asked to

- Note the contents of the report.
- Ratify the approvals made at the Staffordshire and Stoke-on-Trent Health and Care Senate meeting held on 13th June 2024.

Summary and Escalation Report

Report of:	Staffordshire and Stoke-on-Trent Health and Care Senate
Chair:	Rachel Gallyot
Clinical & Professional Lead:	N/A
Date:	Meeting held on 13th June 2024

Key Discussion Topics	Summary of Item	Action including referral to other committees and escalation to Board
Items Approved		
Integrated Medicines Optimisation Group	<ul style="list-style-type: none"> • The Senate received the highlight report from the IMOG meeting held on 3rd April 2024 (copy attached). • The Senate noted a minor amendment to the ESCA for Lithium Prescribing regarding any incidental findings during monitoring, which will have an impact on Lithium prescribing or Lithium levels, then that should be conveyed back to the specialist by the GPs. • The Senate approved recommendations a) to d) from 3rd April 2024 IMOG. <ol style="list-style-type: none"> a) Five NICE Technology Appraisals for drugs were considered by IMOG. All were relevant for secondary care and therefore classified as red drugs. These were listed in the highlight report. b) Sections in chapters 4, 5 and 12 of the two SSOT formularies were harmonised. These sections refer to drugs used for headache, migraine, HIV infection, Hepatitis C infection, RSV infection and conditions affecting ear, nose and throat. c) An Effective Shared Care Agreement (ESCA) for prescribing of lithium in adults was reviewed and approved by IMOG. This single ESCA replaces separate ESCAs from NSCHT and MPFT. However, monitoring arrangements differ across SSOT: NSCHT provides all the monitoring (e.g., thyroid function etc.) for patients in North Staffordshire and Stoke-on-Trent whereas General Practice provides the monitoring for patients in South Staffordshire. d) A new formulary designation “Blue” is recommended by IMOG. This designation is to cover an interim situation when 	No escalations to other Committees or the Board.

	<p>commissioning arrangements are not fully in place for provision of NICE approved drugs. Blue designation would mean “Positive NICE TA and/or awaiting local clarification on place in therapy; Please contact your Medicines Optimisation team for more information.”</p>	
Strategic Items Discussed		
Senate Governance	<ul style="list-style-type: none"> • The Senate members received an update regarding the approval of the Senate as a sub-committee of the ICB, as an approvals Board, with the ability to approve matters of clinical strategy, policy, protocol and guidelines. The importance of alignment with the other committees, such as QS&C and F&PC was highlighted, together with the importance of the Senate being clear about what is in their remit to approve. • Discussions about membership and a vice chair will be undertaken at the next meeting. • A formal review of the Terms of Reference will be undertaken in 6 months. 	No escalations to other Committees or the Board.
2024/2023 System Recovery Programme	<ul style="list-style-type: none"> • The Senate received an update from Paul Brown regarding the ICBs current financial position, agreed deficit of £90m and the progress of the 5 recovery workstreams. • The Senate also received an overview of the proposed medium-term plan. The Senate were supportive of this, more proactive, approach but highlighted that capacity would need to be built, to undertake the more difficult work of implementing processes to review referrals and to educate the clinicians who were making the inappropriate referrals. 	No escalations to other Committees or the Board.
Clinical Values and Medicines (CV&M) System Collaborative	<ul style="list-style-type: none"> • The Senate received an update in respect of the CV&M collaborative operating model, including four ‘pillars’ of Pathways, Medicines, Intervention and Policy. • The Senate will continue to receive monthly updates regarding the collaborative, which is sponsored and endorsed by the Senate. • The Senate highlighted the importance of building links between the collaborative and existing work, within the portfolios, and assurances were given that every effort is being made, by the collaborative, to build those links and connections. • The Senate members were invited to be involved in the work of the collaborative, or to nominate any colleagues that may be able to support. 	No escalations to other Committees or the Board.
Frailty Strategy Refresh	<ul style="list-style-type: none"> • The Senate received an update regarding the Frailty Strategy Refresh from Farah Kidy, Public Health Registrar and Zafar Iqbal. • Discussions were held regarding high intensity users and governance issues with 	No escalations to other Committees or the Board.

	<p>utilising Health Navigation stratification, and it was agreed that an update on this would be logged as an action.</p> <ul style="list-style-type: none"> • Discussions were held regarding prevention and what can be done within the clinical workforce through the existing Making Every Contact Count (MECC) programme and this will be worked out outside of the meeting. 	
Staffordshire and Stoke-on-Trent Diabetes Strategy	<ul style="list-style-type: none"> • The Senate received a presentation from JamieRae Tanner, Public Health Consultant, outlining the development of the Staffordshire and Stoke-on-Trent Diabetes strategy, which was presented for feedback. • There were no questions or comments raised, by the Senate members, during the meeting. Engagement has already been undertaken, with primary and secondary care colleagues and the importance of ongoing feedback, during the development of the strategy, was highlighted. The Senate members were asked to provide any feedback, from themselves, or their colleagues via JamieRae Tanner, Zafar Iqbal or Rachel Gallyot. 	No escalations to other Committees or the Board.
Items for Information		
Medicines Optimisation Regionwide Advisory Group (MORAG)	<ul style="list-style-type: none"> • The Senate received an update from Mark Seaton, regarding the Medicines Optimisation Regionwide Advisory Group (MORAG) which is the new governance arrangement for medicines. • Discussions were held regarding medicines shortages and how they are affecting the system partners. Assurances were provided, that medicines shortages, and associated risks, is on the agenda for the Pharmacy Leaders Group and an update will be provided to the CPL group and Senate. 	No escalations to other Committees or the Board.

Quality Issues
Nothing further that hasn't been highlighted within the above.

Issues for escalation
No items for escalation

Enclosure No: 13.

Report to:	Integrated Care Board					
Date:	18 th July 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)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations – Click or tap here to enter text.</i>				
Any financial impacts: ICB or ICS?	Yes / No	YES <i>If Y, are those signed off by and date: The financial impacts are as outlined in the body of the report.</i>				
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 2 finance position.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (I)	26/06/2024
System Finance and Performance Committee (S,D)	02/07/2024

(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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Reported to IG Group on</i> Click or tap to enter a date.
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Approved by QIA Panel on</i> Click or tap to enter a date.
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:						
BAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>		BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>		BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>		BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>		BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The report is discussed at the System Finance and Performance Committee (SFPC).</p> <p><u>New Style</u></p> <p>The performance and delivery section of the report is structured for 2024/25 around the 5 key priorities agreed at the Integrated Care Board. The new structure and approach to the month 1 report was well received at SFPC. Based on feedback at SFPC and System Performance Group the report will be developed and refined further by the intelligence team and the TDU with Portfolio Teams and Executive Leads. Each piece of feedback has been logged and has clear actions and timelines to resolve. In addition, discussion at SFPC acknowledged that portfolios will need to strengthen their narrative on areas where performance or key deliverables are off track including, what the main risks impacting performance and programme delivery are, any escalation and actions being taken to support improvement.</p> <p><u>Performance and Delivery discussion</u></p> <p>Key points of discussion around performance at SFPC on 2nd July 2024 noted in particular:</p> <ul style="list-style-type: none"> The national ambition is for ICBs to maintain 80% utilisation of virtual wards throughout 24/25. Virtual Ward occupancy was 65.92% in April and 72.73% in May. Both capacity and occupancy of Virtual Wards was below plan in April and May. Latest weekly performance of virtual wards was reported at 66.67% as of 6th June 2024. The challenge continues to be seen in the South West, which is impacting on overall ICB achievement of the national ambition. Actions are in place to review all pathways to ensure appropriate utilisation. Work is ongoing with providers to improve utilisation. Extremely high demand for services at University Hospital of North Midlands resulting in the trust declaring a critical incident on 19th June 2024.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

- A deteriorating position was noted from previous escalations for Learning Disability Children and Young People inpatients. The May position was escalated by the portfolio due to 9 inpatients against trajectory of 3, 8 CYP with autism only. Placing the ICB as the second worst position in the Midlands. Audits are continuing and weekly meetings are taking place to maintain momentum.
- Portfolios and partners being clear on the actions that will shift the dial on the metrics and deliverables that are red.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Note the high-level performance against the five priorities.
2. Note the progress to date high-level key programme deliverables
3. Note the financial position as at M2.
4. Note and take assurance on the next steps in developing the performance and programmes sections for M2.

Performance and Finance Report

18th July 2024

Prepared for the ICB Board by the ICB Intelligence & Finance Team and the Transformation Delivery Unit



Overview

This report contains for discussion:

1. [Report Development](#) noting ongoing areas of development for the report
2. An [overview](#) of key performance in April against each of the 5 priorities.
3. [An overview of key points against each of the 5 priorities](#). This report is focussed on the 2024/25 operating plan on an exception-based approach
4. A [placemat](#) that demonstrates at a high-level key programme deliverables within the 2024/25 operating plan.
5. A [finance summary](#) of the month 2 position.

Discussion from SFPC to note:

The report is discussed at the System Finance and Performance Committee (SFPC). Key focus of the discussion around performance at SFPC on 2nd July 2024 noted in particular:

- The national ambition is for ICBs to maintain 80% utilisation of virtual wards throughout 24/25. Virtual Ward occupancy was 65.92% in April and 72.73% in May. Latest weekly performance of virtual wards was reported at 66.67% as of 6th June 2024. Both capacity and occupancy of Virtual Wards was also below plan in April and May. The challenge continues to be seen in the South West, which is impacting on overall ICB achievement of the national ambition. Actions are in place to review all pathways to ensure appropriate utilisation. Work is ongoing with providers to improve utilisation.
- Extremely high demand for services at University Hospital of North Midlands resulting in the trust declaring a critical incident on 19th June 2024.
- A deteriorating position was noted from previous escalations for Learning Disability Children and Young People inpatients. The May position was escalated by the portfolio due to 9 inpatients against trajectory of 3, 8 CYP with autism only. Placing the ICB as the second worst position in the Midlands. Audits are continuing and weekly meetings are taking place to maintain momentum.
- Portfolios and partners outlining clear actions that are being taken to support improvement on the metrics and deliverables that are red.

Ctrl and click on any underlined text for further detail.

Report Development for M2

- The structure and approach to the month 1 report was well received at SFPC.
- Based on feedback at SFPC and System Performance Group the report will be developed and refined further by the intelligence team and the TDU with Portfolio Teams and Executive Leads. Each piece of feedback has been logged and has clear actions and timelines to resolve.
- Further work is required on
 - finalising the locally defined metrics and data flows
 - making it clearer on the overview of key performance where data is quarterly and therefore not reported eg Mental Health metrics
 - data reporting issues around Urgent Community Response which Midlands Partnership University NHS Foundation Trust (MPFT) is investigating.
 - defining if and what Care Homes work sits in the Demand Management system collaborative vs in Portfolios for delivery currently being progressed by the System Collaborative leads
 - the Portfolio programme escalations to be moved into the main body of the report and aligned against the 5 system priorities
 - identifying which key deliverables for IPH will appear on the programme placemat. This work is underway between the TDU and IPH and will be available in the M2 report.
- Portfolios will strengthen their narrative on areas where performance or key deliverables are off track including
 - what the main risks impacting performance and programme delivery are
 - any escalation and actions being taken to support improvement.

Overview of Key Performance April 2024

Ctrl and click on the priority number for further detail.

①

Eliminate delays in access to treatment and long waits for care	
Urgent and Emergency Care	Mental Health, Learning Disabilities & Autism
Category 2 Response < 30m	Learning disability registers and annual health check
A&E 4hr (UHNM) 78%	Access to Perinatal Mental Health services
G&A beds adult	Access to Adult Mental Health services
Virtual Ward utilisation	Access to CYP Mental Health services
Planned Care	Access to a course of Talking Therapy
Cost weighted activity (YTD Feb 2024)	Autism assessment median wait to start
Elective Activity	Autism assessment median wait to complete
Outpatient Procedure Rate	Children & Young People
65 week waits	Reduce emergency admissions for epilepsy
Theatre utilisation	Reduce emergency admissions for asthma
Diagnostics waiting list	Reduce CYP in residential care outside Staffordshire
Cancer 28-day Faster Diagnosis	Reduce CYP in residential care outside Stoke-on-Trent
Cancer 62-day	Primary Care
Cancer non-specific pathway	Dental Activity delivered
Cancer Lower GI with FIT result	Pharmacy First Provision - number of interventions

②

Improving access to high quality, sustainable primary care access
Primary Care
General Practice Appointments
General Practice Appointments in <2 weeks
Additional Role Reimbursement Scheme (ARRS) Full Time Equivalent
Workforce: GP Full Time Equivalent
Planned Care
Diagnostics Activity
Mental Health, Learning Disabilities & Autism
SMI health checks
Dementia diagnosis

③



Delivering joined up proactive & preventative support & care
Urgent and Emergency Care
Urgent Community Response 872 by Q4
Discharge: Pathway 0 - 80%
Discharge: Pathway 3 (<1%)
Mental Health & Learning Disabilities & Autism
Eliminating Out of Area Placements
Talking Therapy Reliable Improvement
Talking Therapy Reliable Recovery
LD&A reliance on inpatient care (Adult)
LD&A reliance on inpatient care (<18)
LeDeR reviews
End of Life, Long-term Conditions and Frailty
Prevalence rate of Palliative care registers 1%
Increase in the Number of patients receiving all 8 care processes for Diabetes
National Diabetic Prevention Programme
Maternity and Neonates

④

Delivering compassionate care of the frail and elderly
Improving Population Health
Increase uptake of Flu and pneumonia vaccination
Integration
Prevent emergency admission Ambulatory care
Improve Access to Fall Service from A&E
Discharge to usual place of residence

⑤

Supporting Care Home Residents
Urgent and Emergency
High Intensity Users - emergency admission ≥ 65
Medicines Optimisation
Structured Medication Reviews in last 12 months
Integration
Admissions

TRAFFIC LIGHT KEY – against plan or target:
 Under performing
 Met plan / target, or over performing



Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Key points
<p>Urgent and Emergency Care</p>	<ul style="list-style-type: none"> • West Midlands Ambulance Service (WMAS) - call data is not available at the time of publication and will be updated when it becomes available. • Category 2 Response Times for the system for the week ending 10th June 2024 was 26m 57s which placed us 3rd out of 11 regionally, 7th nationally. The 4-week average of 28m 55s places us at 5th regionally, 14th nationally. Rapid handover protocols initiated at University Hospitals of North Midlands (UHNM) when required to aid flow. • A&E Waiting Times May Performance at UHNM was 71.4% which was 1.69% above plan and up from 70.2% in April. This is the highest reported performance since May 2021. Non-admitted 4-hour patients have continued to be the focus on actions to ensure proactive flow within the ambulatory area, audits undertaken to identify further areas of improvement. • Virtual Wards (VW) – Latest system Performance is 66.67% (6th June 2024) and below plan for both occupancy and capacity. Capacity has reduced due to Good Hope stepping back from supporting the provision of services in the South as staff are reallocated to support ward pressures. Referrals into service have also reduced in line with the seasonal reductions experienced last year. Capacity will continue to be an issue for the coming months and places a strain on our ability to achieve NHSE requirements of maintaining capacity levels from 2023/24 through 2024/25. • General and Acute (G&A) Bed Occupancy (UHNM) – reduced from 91.7% to 91.5% for May which is 3.7% above the plan for UHNM.
<p>Planned Care</p> <p>RTT</p> <p>Diagnostic Waiting List ≤ 6 weeks</p> <p>Cancer</p>	<ul style="list-style-type: none"> • Cost Weighted Average (CWA) - In February 2024, the latest figure published by NHSE, the ICB delivered 104.2% year to date (YTD), exceeding the revised plan of 100% for 2023/24 by 4.2% • Electives: In April, the ICB exceeded plans in both Outpatient procedure and Outpatient first appointment by total of 6,500 (11%). The % of Outpatient follow ups (OPFU) without a procedure is at 53.4%, which is below plan by 0.6%. The outpatient procedure rate in April was 46.6%, underperforming against plan (47.2%) by 0.6%. Both Ordinary and Day-case over performed against plan, by 1,382 (10.5%) for Day-case and 61 (3.8%) for Ordinary Elective. The over performance was driven mainly by NHS providers. • The ICB is underperforming against plan by 252 on Referral to treatment (RTT) pathways of 52+ weeks. For children under 18 years, the ICB underperformed against plan by 401. There were 312 less patients waiting than plan of 1,437 on 65+ weeks pathway, and the overall number of patients on RTT pathways was also lower than plan by 2,501, at 162,633 across the Staffordshire and Stoke-on-Trent (SSOT) system. • Across all nine diagnostic tests, the total volume of patients waiting less than 6 weeks for the Integrated Care Board (ICB) in April was 73%, 6% below plan (79.1%). Driven by Magnetic resonance imaging (MRI) (below plan by 8%) and Non-Obstetric Ultrasound Scan (NOUS) (below plan by 4%). • 68% of patients with suspected cancer were seen within 62 days above plan of 57% in April for the ICB. The number of suspected cancer patients seen within 62 days was above plan by 26% and so was the total patients seen (by 5.6%). • More patients in the ICB were told of diagnosis for cancer (6,112) in April than plan (6,088). However, at 72.1%, 2.1% less of patients in the ICB have been told within 28 days than plan in April (74.3%).



Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Key points
Primary Care	<ul style="list-style-type: none"> • Dental activity recovery – The ICB delivered 54.8% of contracted Units of dental activity (UDAs) for April (April had 16 scheduling days, significantly less than a normal scheduling month). Normalised to 21 scheduling days shows performance in in-line with the previous two years. • Dental Recovery Plan and results of Health Equity Audit to be reviewed in August 2024 to inform local plan (expected for publication October 2024)
Mental Health	<ul style="list-style-type: none"> • Access to a course of Talking Therapy: Exceeded the monthly plan by 17% (200) in April, (1,355 against a plan of 1,155). • Talking Therapies Reliable Recovery above plan at 51.3% in April (48% target) • Talking Therapies Reliable Improvement above plan at 72.7% in April (67% plan target met in April). • Access to Adult, Children and Young People (CYP) or Perinatal Mental Health (MH) services: April data not published until July.
Learning Disability & Autism	<ul style="list-style-type: none"> • Learning disability registers and annual health check: 2.9% in April. Although below the monthly phased trajectory (4.3%), at a similar position to the same period last year. (Please note this measure has a quarterly plan). • Autism - median wait to start assessment: in April, the median wait for CYP was 41 weeks in the North and 30 weeks in the South. For adults in the South, it was 51 weeks. All median waits increased by 1-2 weeks on the previous month. Provider reporting is in development with an improvement plan being developed.
Children & Young People	<ul style="list-style-type: none"> • Reduce hospital admissions for diabetes (flat activity) – the rate per 100k is 0.0 for 0-4 years and 2.5 for 5-10 year old cohort – both reduced on the March value. The 11-17 cohort remains at 5.2 admission per 100k population – unchanged from March. Current programme position as at April 2024: high level delivery plan in development to support roll out of Hybrid Closed Loop systems for CYP. Youth Workers fully embedded in the clinical teams and supporting CYP. A youth forum meeting was held February 2024 and 1:1 work commenced. • Reduce hospital admission for epilepsy (flat activity) - the rate per 100k is 3.4 for 0-4 years and 2.5 for 5-10 year old cohort – the 5-10 cohort reduced on the March value. The 11-17 cohort has reduced to 1 admission per 100k population – the lowest value since April 2023 at least. Current programme position as at April 2024: Following the publication of the Epilepsy bundle a system Project Group has identified priority area of focus as reducing the variation in care and supporting mental health and wellbeing. Programme Plans are under development. • Reduce hospital admission for asthma (flat activity) – The emergency admission rate for both the 0-4 and 5-10 cohort increased in April significantly, from 6.9 to 8.6 in the 0-4 years cohort and from 14.9 to 16.2 in the 5-10 years cohort. Current programme position as at April 2024: Engagement and baseline assessments for all 23 schools under wave 2 of the Asthma Friendly Schools programme is complete. Training session for Asthma Champions will be held in May following successful allocation of 46 of the advanced asthma training placements. CYP asthma prescribing guidelines approved March 2024.



Local Priority

Improving access to high quality sustainable primary care

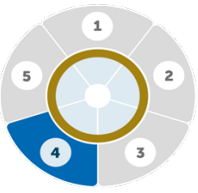
Area	Key points
Planned Care	<ul style="list-style-type: none"> • Diagnostic recovery – 1,629, (or 3.4%) more Diagnostic Tests were completed (than plan) in April. • Delivered less than 80% of tests planned for Flexi sigmoidoscopy (below plan by 109), Gastroscopy (below plan by 333) and Cardiology – echocardiography (below plan by 858).
Primary Care	<p>Access</p> <ul style="list-style-type: none"> • General Practice (GP) appointments - The overall number of appointments has exceeded the plan by 23.7% for April 2024, delivering 106,738 appointments above plan. • The % of appointments within 2 weeks from time of booking (within the 8 appointment categories) stands at 90.7% for April 2024, above the 2024/25 plan and National ambition of 85%. SSoT ICB consistently performs in the highest quartile Nationally for this indicator. System Level Access Improvement Plan - updated plan presented to ICB Public Board in May – actions progressing. • Pharmacy First – PCN (Primary Care Network) training/info sessions being delivered; Individual practices offered bespoke one-to-one sessions; Local community engagements being facilitated between the GPs and the Community Pharmacies teams, Working with Local Authority Public Health colleagues to promote the services and improve access for the population. • Workforce – Workforce Additional Roles Reimbursement Scheme (ARRS) stands at 592.9 Full Time Equivalent (FTE) for April 2024, below plan for Q1. Workforce - GP FTE has seen a slight increase, standing at 696.0 for April 2024, but falls below the plan for Q1. Local Primary Care Workforce Delivery Plan is in development for expected sign off in September 2024.
Mental Health	<ul style="list-style-type: none"> • Severe Mental Illness (SMI) physical health checks: Please note this measure has a quarterly plan so no data is available for M1. • Dementia diagnosis: at 72.4% in April, both the national target (66.7%) and monthly plan (71.9%) were met.



Local Priority

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

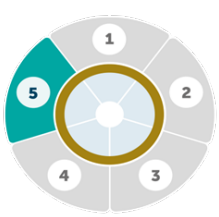
Area	Key points
<p>UEC</p>	<ul style="list-style-type: none"> • Urgent Community Response - Latest position as per the Community Services Dataset is for April 2024 well below plan of 872. April figure is indicative due to data quality concerns which Midlands Partnership Foundation Trust (MPFT) is investigating. • Discharges - Pathway 0 Discharges for May equate to 78.15%, 1.4% below plan, with Pathway 3 equating to 0.55%, 0.2% above plan. Voluntary and Community Sector (VCSE) posts have been recruited to provide discharge support and will commence during July. UHNM met the 80:20 pathway split for complex/timely discharges for the first time during the week commencing 27th May. Positive meeting held at the start of June with Stoke-on-Trent Local Authority colleagues around the Homeless pathway and process. Plans to develop an Integrated Care Centre (ICC) are to be worked up, along with the criteria and an Operational protocol to support. Transfer of Care (TOC) is only in place Monday to Friday and the process has been noticeably missed at the weekends, however there is currently no resource available to provide the required same level of cover at weekends. • Urgent and Emergency Care - Post-Hospital - There are growing delays in the Discharge to Assess (D2A) beds due to the strengthening of the eligibility process by the ICB, this started with Continuing Health Care (CHC) eligibility and has now extended to include Funded Nursing Care (FNC) applications and checklists. Further scrutiny of exit strategy recommendations is in place within the Integrated Discharge Hub (Home Care is Best care) but as professionals with registrations this for some staff is starting to impact morale when they have concerns over safety at home.
<p>Mental Health</p>	<ul style="list-style-type: none"> • Out of area placements: April data not published until July.
<p>Learning Disability & Autism</p>	<ul style="list-style-type: none"> • Reliance on inpatient care for people with a learning disability and/or autism: in April, we met the overall adult target for quarter 1 by 2 inpatients, whilst the Children and Young People element was 2 over target. (please note this measure has a quarterly plan). • Learning Disability and/or Autism Mortality Review: below the system target of 100% in April (40%), however continuing to improve month on month following recruitment and training of reviewers.
<p>End of Life, Long Term Conditions & Frailty</p>	<ul style="list-style-type: none"> • Prevalence rate of patients on palliative care registers to 1%. - TBC • Increase in the number of patients receiving all 8 care processes for Diabetes. - TBC • Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic NHSE target of 520 per month. - TBC



Local Priority

**Delivering
compassionate
care of the frail
and elderly**

Area	Key points
Improving Population Health	<ul style="list-style-type: none"> • Increase uptake of Flu and pneumonia vaccination - TBC
Integration	<ul style="list-style-type: none"> • Prevent emergency admission Ambulatory care - TBC • Improve Access to Fall Service from A&E - TBC • Discharge to usual place of residence - TBC
Continuing Health Care System Collaborative	<ul style="list-style-type: none"> • Being finalised through system recovery collaborative.
Demand Management System Collaborative	<ul style="list-style-type: none"> • Being finalised through system recovery collaborative.



Local Priority

**Supporting
Care Home
Residents**

Area	Key points
UEC	<ul style="list-style-type: none"> High Intensity Users – the current service focuses on the UHNM footprint and so a Business Case is in development to explore how the service can be expanded to cover the whole of the system. Standard Work is continued to be rolled out across all wards and timescales are currently being mapped out. Task and finish groups (Discharge Prescription (TTO), Transport, Diagnostics and Discharge processes) have been undertaking a root cause analysis exercise to support identifying actions to improve performance.
Meds Ops	<ul style="list-style-type: none"> Care home residents Structure Medication Reviews in last 12 months - TBC
Integration	<ul style="list-style-type: none"> Admission to Care homes - TBC
Continuing Health Care System Collaborative	<ul style="list-style-type: none"> Being finalised through system recovery collaborative.
Demand Management System Collaborative	<ul style="list-style-type: none"> Being finalised through system recovery collaborative.

Overview of Portfolio key deliverables 2024/25

UEC Portfolio		Primary Care Portfolio		Planned Care, Cancer & Diagnostics Portfolio		End of Life, Long-term Conditions and Frailty Portfolio		Children & Young People / Maternity Portfolio		Improving Population Health Portfolio		Mental Health / Learning Disabilities & Autism Portfolio	
Access: High Intensity Users	Purple	Improving health outcomes via collaborative working across primary care and system partners	Yellow	Elective Care: detailed delivery plans in place for referral optimisation and pathway harmonisation	Green	Scale up an enhanced Falls prevention program taking learning from test for change in one geographical area – May-Nov 2024	Yellow	Design and implement Long Term Conditions Programme - ASTHMA	Green			Develop and implement improvement plan for ADHD	Yellow
Access: Designation of Urgent Treatment Centres	Green	Provision of safe and high quality services within all Primary Care Services	Green	Cancer: deliver schemes to improve early-stage diagnosis	Green	Enhanced care of severely frail patients in a community and domiciliary settings. Using the learning from the 2023/2024 pilot.	Yellow	Design and implement Long Term Conditions Programme - EPILEPSY	Green			Develop and implement improvement plan for Dementia Diagnostic rates across the ICB geography	Green
In Hospital: Non-Elective Improvement Plan	Yellow	Improving access to primary care (including patient experience)	Green	Cancer - Improve referral quality	Purple	Delivery of the PEoLC strategy pan Staffordshire	Green	Design and implement Long Term Conditions Programme - DIABETES	Yellow			Develop and implement system wide improvement plan for CYP access to Mental Health support	Green
Post Hospital: Emergency Portals	Green	Ensure fit for purpose estate provision, maximising shared space and digital alternatives	Green	Diagnostics - implement diagnostic pathways under development	Green	Delivery of the LTC strategy pan Staffordshire	Yellow	Implement Children with Complex Needs project	Green			Develop and implement improvement plan for autism diagnostics	Green
Post Hospital: Ward Processes	Green	Reduce variation and commissioning universal access to services	Green	Diagnostics - complete demand management analysis and implement actions	Green	Refresh of frailty strategy pan Staffordshire	Yellow	Implement delivery plan to improve survival of babies and young children to reduce Infant Mortality	Green			Develop/Implement improvement plan to reduce the reliance on inpatient care for CYP with LD and/or A	Green
Post Hospital: Ward Processes Frailty	Blue							Implementation of the national delivery plan for maternity and neonatal care	Green			System wide roll out of Oliver McGowan Training	Green
Post Hospital: End of Life Care Pathway	Yellow											Implement improvement plan to increase number of people with LD on GP registers	Green
Post Hospital: Embed the Voluntary Sector in the Integrated Discharge HUB	Green												
Post Hospital: Choice Policy	Green												
Post Hospital - Data and National Discharge SitRep	Green												
Surge - Workforce	Yellow												
Surge - Development and Delivery of Surge Plan	Yellow												

TRAFFIC LIGHT KEY
On track
Behind schedule but mitigations should improve in year position
Mitigations identified but unlikely to improve position in year
Complete
 Cancelled / Superseded
Measurement under review / Plans not yet commenced

Finance Summary M2

This report details the aggregate financial position as at month 2.

Whilst for Staffordshire and Stoke on Trent, the control total of **£90m deficit remained unchanged**, due to the national planning resubmission on the 12th June and associated rephasing, much of the detailed monthly revenue and capital reporting process for systems was set aside.

Each organisation has completed internal reporting and in aggregate, the system is reporting a year-to-date adverse position of £4.5m, which is a £22.7m deficit against the £18.1m deficit plan against the 2nd May plan. This results from £4.0m adverse at UHNM and £0.5m adverse at the ICB, predominantly driven by slippage in efficiency as programmes develop.

The System has made progress in reducing the level of unidentified efficiency and **increasing the confidence levels** for the identified schemes:

- The unidentified efficiencies have reduced from £29.1m to £17.8m
- Efficiency schemes rated as high-risk have reduced from £91.5m to £58.1m

The system continues to report a net risk of £87.8m, with the key risks being:

- £50.0m Efficiency programme
- £27.5m Additional cost risk (capacity, pressures, inflation)
- £10.3m Income and contracts

From the provider workforce returns the system is over plan at month 2 by 138 whole time equivalent (wte) overall. There is a **positive movement** within as bank and agency has reduced considerably in actuals from April to May by 150 wte.

The system has materially altered the capital plan in order to submit a **balanced operational capital plan** and this is detailed within the quarterly capital update which is a separate item on the agenda. In-year capital reporting will commence from month 3 against the revised capital plan. For International Financial Reporting Standard (IFRS)16 the ICS is not compliant against the indicative allocation by circa £4.5m, while awaiting the final allocation the System are reviewing commitments and valuations of leases. With pressure on operational capital too, we now face some very significant risks and a major concern about the current year should our IFRS16 not be resolved.

As a system we are reviewing how we will report on the aggregated system position, including a key focus on the run rate including a focus on material changes in recurrent position and the impact of efficiencies. A revised report will be brought at month 3.

Month 2 Position

- The system is reporting a year-to-date adverse position of £4.5m, which is a £22.7m deficit against the £18.1m deficit plan.
- The adverse position is largely at UHNM. The Trust continues to work with its Division's to pull back the slippage.

System	Month 2		
	Plan	YTD	Variance
		£m	
Income	809.3	815.2	5.9
Pay	(210.1)	(212.0)	(2.0)
Non Pay	(113.4)	(122.3)	(8.9)
Non Operating Items (exc gains on disposal)	(5.8)	(4.9)	0.9
ICB/CCG Expenditure	(498.2)	(498.6)	(0.5)
Total	(18.1)	(22.7)	(4.5)
			-0.6%

ICB	Month 2		
	Plan	YTD	Variance
		£m	
Allocation	480.1	480.1	0.0
Expenditure	(498.2)	(498.6)	(0.5)
TOTAL ICB Surplus/(Deficit)	(18.1)	(18.6)	(0.5)
			-0.1%

UHNM	Month 2		
	Plan	YTD	Variance
		£m	
Income	187.7	194.4	6.7
Pay	(113.4)	(116.7)	(3.2)
Non-Pay	(68.4)	(76.3)	(7.9)
Non Operating Items (exc gains on disposal)	(6.2)	(5.7)	0.5
TOTAL Provider Surplus/(Deficit)	(0.3)	(4.3)	(4.0)
			-2.1%

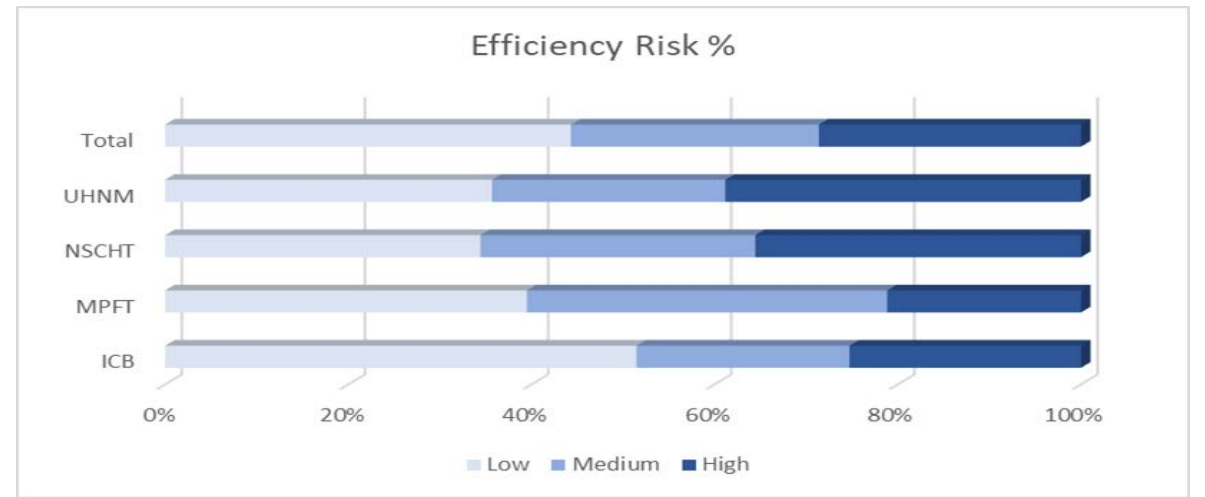
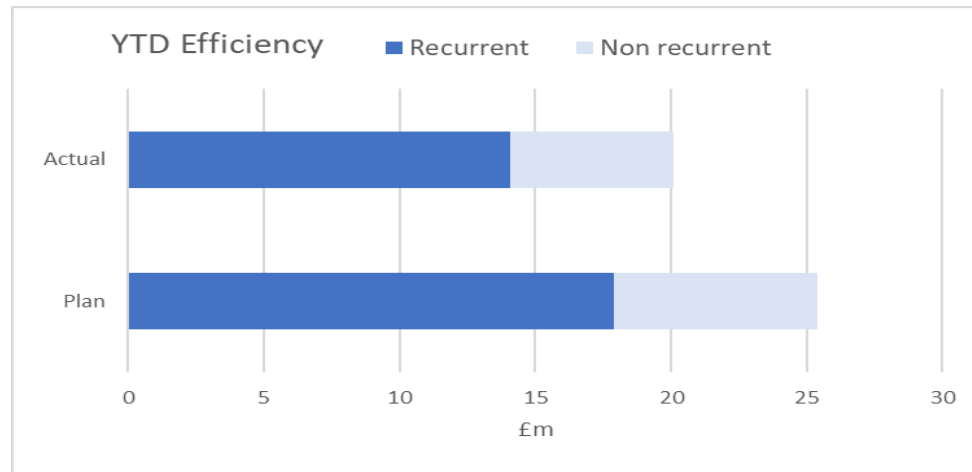
MPFT	Month 2		
	Plan	YTD	Variance
		£m	
Income	113.7	112.9	(0.8)
Pay	(80.0)	(79.2)	0.7
Non-Pay	(33.9)	(34.2)	(0.2)
Non Operating Items (exc gains on disposal)	0.7	1.0	0.3
TOTAL Provider Surplus/(Deficit)	0.5	0.5	0.0
			0.0%

NSCHT	Month 2		
	Plan	YTD	Variance
		£m	
Income	27.8	27.9	0.1
Pay	(16.6)	(16.1)	0.5
Non-Pay	(11.1)	(11.9)	(0.8)
Non Operating Items (exc gains on disposal)	(0.3)	(0.2)	0.1
TOTAL Provider Surplus/(Deficit)	(0.2)	(0.2)	(0.1)
			0.2%

Efficiency Delivery

- The system has delivered £20.1m of efficiency as of May 2024, this is £5.3m adverse against the 12th June submission, which is largely at UHNM. The Trust continues to work with its Division's to pull back the slippage
- The System efficiency programme totals £203m with the phasing being broadly flat. As at 12th June circa 9% remains unidentified with work on going to identify further schemes
- 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. All organisations have been ramping up assurance of delivery and the previously identified actions continue

Category	£m	ICB	MPFT	NSCHT	UHNM	Total
Acute		29	-	-	-	29
All-age Continuing Care		30	-	-	-	30
Community Healthcare		8	-	-	-	8
Corporate		0	2	0	2	4
Digital		-	0	0	-	0
Energy		-	-	0	3	3
Estates		-	1	0	1	2
Income		-	1	-	2	3
Medicine optimisation		-	1	0	1	2
Mental Health		2	-	-	-	2
Non-Pay		-	7	2	21	30
Pay Controls, Bank and Agency		-	19	1	12	33
Primary Care (inc. Primary Co-Commissioning)		18	-	-	-	18
Procurement		-	3	0	3	6
Productivity		-	-	-	6	6
Service Reviews		3	3	1	-	8
Unidentified		12	-	1	5	18
Total		102	38	6	57	203



Board Committee Summary and Escalation Report

Enc.14

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	2 July 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Integrated System Performance and Programmes Highlight Report	<p>The Committee received a draft revised reporting template which included an overview of performance against each of the 5 priorities in the 2024/25 Operating Plan and a placemat demonstrating performance against high-level key programme deliverables.</p> <p>The Committee noted:</p> <ul style="list-style-type: none"> • The ongoing work to define baselines for some local key metrics • The Lower Gastrointestinal (LGI) pathway continues to be the most challenged high volume pathway. Additional capacity is being put in place from August • Virtual Ward utilisation continues to be challenged across the south-west of the System • There are examples of growing delays in the Discharge to Assess (D2A) beds due to the strengthening of the eligibility process by the ICB. Further scrutiny of exit strategy recommendations is in place within the Integrated Discharge Hub • For Autism assessments, all median waits increased by 1-2 weeks on the previous month. Provider reporting is in development with an improvement plan being developed. 	<p>Board to note the potential impact that collective action in general practice could have across a range of priorities. Plans are being developed to mitigate this.</p> <p>Urgent Care challenges in respect of acuity, Covid-19, and capacity planning. Delivery of Demand Management System Collaborative is crucial. Integrating Quality and Safety colleagues re discussion around maintaining patient flow, experience and safety.</p> <p>Learning Disability and Autism Portfolio reports a deteriorating position on children and young people in inpatient care, with a current position of 9 against a trajectory of 3. This is the second worst position in the Midlands and requires a System- wide response.</p>

	<ul style="list-style-type: none"> The reluctance from practices to sign up to Optum which will impact on the ability to develop data to support the Reducing Health & Equalities Programme 	
ICS Month 2 Finance Report	<p>Month 2 is reporting a year-to-date deficit position of £22.7m which is a £4.5m adverse variance against the £18.1m deficit plan. This is driven by slippage in the efficiency programme.</p> <p>Unidentified efficiencies have reduced from £29.1m to £17.8m and efficiency schemes rated as high-risk have reduced from £91.5m to £58.1m.</p> <p>The System continues to report a net risk of £87.8m with the key risks being:</p> <ul style="list-style-type: none"> £50.0m Efficiency Programme £27.5m additional cost risk (capacity, pressures, inflation) £10.3m income and contracts <p>From the provider workforce returns, the System is over plan at Month 2 by 138 wte overall but there is a positive movement within as bank and agency has reduced in actuals from April to May by 150 wte.</p>	<p>Significant concern around System financial position at Month 2. System meeting taking place on 15 July to discuss further action to mitigate the level of risk.</p> <p>All Systems have been asked to notify where there are unsigned contracts with providers in their System. We have received that notification from Black Country about their providers and there is a significant cost pressure notified with regard to Urgent Care and the payment of the ERF that sums to a dispute of £13.3m. A 'binding conciliation' process is underway that will determine whether this is a further cost pressure.</p>
ICS Capital Update	<p>The System has materially altered the capital plan in order to submit a compliant 2024/25 plan. However, that is dependent on Outwoods being funded. It also assumes that the IFRS16 risk of £4.5m is funded – current advice from NHSE is that this is unlikely. MPFT are undertaking further investigations into the IFRS16 position.</p> <p>The Committee noted:</p> <ul style="list-style-type: none"> We had a penalty for missing financial break even in 2023/24 There are many strategic outline cases currently in motion to secure national funding for schemes The Capital Group are maximising the operational capital resource available to the System and have a current overcommitment of c£3m which to be compliant has been brokered internally via UHNM The Capital Group are 	<p>Board to note the significant risk to the System capital programme in 2024/25, and potential longer-term impact on services, safety and quality if our capital allocation as a System is not increased.</p> <p>A further report to be brought to the Committee in September providing a holistic position regarding current and future health and care capital requirements and programmes in SSoT; an update on Outwoods and the IFRS16 gap; and impact upon services and future plans.</p>

	<p>reviewing options on IFRS16 on revaluations and in-year commitments</p> <ul style="list-style-type: none"> • The commitments and pressures for 2025/26 already exceed the likely capital resource. <p>Longer term, the regional and national capital position is seriously constrained, and the Region hope is that the 10-year estates strategy work will help influence a more generous Spending Review settlement, so investing in this process to fully articulate the needs of the System is crucial.</p>	
System Efficiency Plan and System Recovery Programme Update	<p>The paper provided an update on the £203m efficiency plan for the System and the contribution of the System Collaboratives to the Month 2 position. 28% of the efficiency plan is led by a system collaborative.</p> <p>The committee focused on the Contracts, Demand Management and Enabling Functions Collaboratives.</p> <p>Agreement has been reached to deliver an additional 10% savings on corporate costs.</p> <p>Further clarity was requested on the Demand Management Collaborative, and Care Homes offer.</p> <p>The Contracts Collaborative target is at risk in year due to contract timings and complexity. Work is underway to show how this could be delivered over a longer time period.</p>	<p>The Month 2 position shows a variance against plan of £5.361m.</p> <p>We are behind in developing detailed delivery plans and a final deadline of 9 July has been set to provide these for all collaboratives.</p> <p>Additional schemes need to be identified and brought on line as soon as possible to address in-year slippage.</p>
Building a System Medium Term Plan and NHSE Productivity Paper	<p>To be presented to ICB Board.</p> <p>An NHS Productivity Publication was attached to this paper as an appendix. This detailed the factors driving the loss of productivity and the emerging plan to improve this position. A detailed plan to cover all aspects of productivity improvement is expected from NHSE by the end of the summer.</p>	<p>The Committee approved the System Medium Term Plan which is being presented to this Board meeting for information.</p>
Elective Care/Elective Recovery Plan	<p>The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position. The latest position will be presented to ICB Board.</p> <p>For 104ww, there were 3 breaches</p>	<p>Industrial Action in June will have an impact upon waiting times.</p>

	<p>for May and 4 breaches forecasted for June – although 3 of these relate to Cornea Patients transferred from out of area. For 78ww, the number of breaches across the System at the end of May was 39 with 20 forecast for the end of June and zero for July. Good progress has been made for the 65ww although capacity mobilisation to achieve route to zero by the end of September is a risk at UHNM.</p> <p>The Committee noted the position for long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System.</p> <p>Future Tier 1 oversight packs will also include Diagnostics performance and associated improvement actions.</p>	
Digital Transformation Progress Update	The paper provided an update on the Digital Transformation 2024/25 Work Programme and key achievements.	There will be significant capital requirements to deliver our digital transformation ambitions.
System Transformation and Service Change Update	<p>The Committee noted that:</p> <ul style="list-style-type: none"> • The ICB has received the final report from West Midlands Clinical Senate following the panel review of the proposal for the Freestanding Midwifery-led Birthing Units. This has been circulated to ICS leads to formally respond to the recommendations to send back to the Senate and for inclusion within the pre-consultation business case. • Communication and engagement around the UEC Strategy and Urgent Treatment Centres is due to commence at the end of July. Promotion activity ahead of engagement events will commence on 15 July. 	
Report on Financial Recovery Plan and Grip and Control	<p>In response to the deficit, the ICS was required by NHSE to commission an independent assessment to comment on the robustness of the Financial Recovery Plan and underpinning Cost Improvement Plans, and review and comment on the cost control structures in place.</p> <p>Each organisation has considered its response to the detailed assessment and a high level review of the progress against the recommendations has now taken</p>	<p>The review provided positive external assurance of the level of grip and control within the System.</p> <p>Suggestions for further areas of focus will be taken forward.</p>

	place.	
System Risk Register	<p>There are 21 risks on the System Risk Register of which 15 are high scoring (12 and above).</p> <p>The Committee approved one new risk and an increase in risk score for one risk.</p> <p>The Committee has good sight of the top risks for finance, performance and transformation.</p>	
Quarter 1 2024-25 System Board Assurance Framework Update	The report set out the refreshed System Board Assurance Framework (SBAF) for Quarter 1 2024-25.	The Committee considered the Q1 scores and controls/assurance assessments for the risks it has oversight of and approved the SBAF.
ICB Undertakings	<p>For the year 2024/25, the System response to the Undertakings will be covered through existing agenda items. A “Reporting Map” of Committee-owned items showed how these align with existing agenda papers in line with the need to brief the Audit Committee and the ICB Board of satisfactory delivery.</p> <p>For 2025/26 the Undertakings will be covered through the Medium Term Financial Plan.</p>	
ICS Oversight Framework	For information, the Committee received the letter following the ICB System Review Meeting held on 23 May with NHSE and the letters to UHNM, MPFT and NSCHT following meetings held with the ICB during June.	
PART B		
ICB Month 2 Finance Report	<p>The paper reported an ICB year-to-date deficit position of £18.6m against a planned deficit of £18.1m, creating an adverse variance to plan of £0.5m.</p> <p>The £90.0m deficit plan submitted on 12 June contained 3 key un-mitigated risks which remain following the Month 2 reporting cycle:</p> <ul style="list-style-type: none"> • £23.0m – System Collaborative efficiency programme • £14.4m – Fixed/Variable ERF contracting methodology • £9.6m – 24/25 NHS contract agreements. <p>All key risks will reach a point of clarity during July and the ICB will have more certainty on the financial gap to plan requiring mitigation.</p>	The Committee approved the ICB’s Month 2 forecast position of a £90m deficit and noted that there remains £47m unmitigated risk.

ICB Efficiency 2024/25	<p>The paper provided an update of the progress to date against the ICB's £102.2m efficiency programme.</p> <p>At this stage, the Efficiency Oversight Group or System Collaborative Group has approved £78.3m of in-year PIDs with a full year effect of £91.6m covering 93% of the original £79.2m efficiency target. However, £23.9m remains as un-identified efficiency at this point and presents a key risk to the ICB's financial position.</p>	<p>The Committee noted that the full year effect savings identified within plans and the current forecast suggest achievement of plan and therefore holding the organisation's underlying deficit of £106.3m static.</p> <p>The £23m System Collaborative saving will be profiled from July onward.</p> <p>FPC will continue to receive a monthly report on efficiency performance.</p>
Procurement Operations Group Report	<p>The paper reported the key activities involving procurements being co-ordinated by the Procurement Operations Group (POG).</p> <p>The Committee noted:</p> <ul style="list-style-type: none"> • The updates within the open procurement programme • The pre-election impact on the ICB's ability to issue procurement notices • Modifications to contracts transacted during the contract term. 	
Medicines Optimisation Report 2023/24	<p>The paper provided an update on the Medicines Optimisation Service Level Agreement (SLA) with General Practice.</p> <p>The Committee noted that:</p> <ul style="list-style-type: none"> • Around 90% of practices are actively engaging in delivery of the SLA • The level of activity conducted by practices is substantial as indicated by the number of patients whose treatment has been reviewed • The SLA promotes better quality prescribing as well as incentivising prescribing cost reduction. 	<p>The Committee was pleased to note that:</p> <ul style="list-style-type: none"> • The SLA achieved cost saving of £4.8 million over a 2 year period • Total investment amounted to £1.473 million and therefore return on investment is 224%.
Primary Care Forum Report	<p>In order to have governance oversight, the Committee received a summary report of the meeting that took place on 11 June.</p> <p>The Primary Care Commissioning Assurance Framework submission for 2023/24 covering all Primary Care contractors was included for information.</p>	
ICB Risk Register Report	<p>There are 13 risks on the ICB Risk Register of which 4 are high scoring (12 and above).</p>	

	The Committee approved 3 new risks, the closure of 2 risks and the proposed increase in score for one risk.	
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Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions that took place at the Committee. Specific risks are highlighted above, and in the FPC Risk Register.

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	People Culture and Inclusion Assurance Report					
Presenting Officer:	Mish Irvine, Chief People Officer ICB					
Author(s):	Helen Conway, ICS Strategic Workforce Planning Lead Gemma Treanor, Head of ICS People Function					
Document Type:	Report			If Other:		
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	NO				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:	People Culture and Inclusion Assurance Report					

(1) Purpose of the Paper:

The purpose of this paper is to provide a summary of workforce position, challenges, risks and mitigation via People Culture and Inclusion programme activities considered at ICB People Culture and Inclusion Committee (PCI).

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

	Date
People Culture and Inclusion Committee	08/05/2024

(3) Implications:

Legal or Regulatory	Delivery of Local people Plan, Joint Forward Plan and Long term Workforce Plan. NHSE workforce controls and reporting. ICB statutory duty for education and training
CQC or Patient Safety	NHSE reporting and assurance on workforce planning and metrics
Financial (CFO-assured)	External funding supports delivery of schemes including NHSE, ICB, being monitored and reported. Specific challenges in relation to agency, operating plan and workforce affordability in line with financial envelope.
Sustainability	Across all programmes. Specific activity linked to Green/Sustainability plans
Workforce or Training	Across all programmes – detailed in report
Equality & Diversity	Across all programmes – detailed in report
Due Regard: Inequalities	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers

Due Regard: wider effect	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers
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(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

(5) Integration with the BAF & Key Risks:						
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>	
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input checked="" type="checkbox"/>	
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input checked="" type="checkbox"/>	
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>	

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The report outlines the current position regarding workforce within SSOT. System level oversight and monitoring of people metrics, controls and performance against operational plan continues in partnership with NHS Providers. The current operating environment and financial position remains pressured, with additional scrutiny continuing in workforce reconciliation, implementation of PWC recommendations and agency reduction. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements will be key to the operating plan delivery and recovery programme – at organisational and system level. A PCI Committee Development session took place in May to assess current People context, risks, organisation and partner activities and to set the vision for the Committee throughout 2024/25 and beyond. Structures and priorities have been revised and will be considered and approved at the PCI Committee on 10th July 2024.</p> <p>The following areas are detailed in the report:</p> <ul style="list-style-type: none"> - Current workforce position - Operational Workforce Plan - People risks - People, Culture and Inclusion Programme delivery

(7) Recommendations to Board / Committee:
The Integrated Care Board is asked to: Note the workforce position, operating plan submission, risks and mitigations in place to address.

ICS People Culture & Inclusion Performance and Assurance Report

SSOT ICB Board in Public

July 2024



Executive summary

This report will outline:

- An executive summary outlining key headlines and escalations in relation to People, Culture and Inclusion
- Current workforce metrics, position and controls
- Operational Planning
- Risks /challenges and mitigation
- People Programme delivery

Executive Summary:

- This report outlines the current position regarding workforce within SSOT. System level oversight and monitoring of people metrics, controls and performance against operational plan continues in partnership with NHS Providers. The current operating environment and financial position remains pressured, with additional scrutiny continuing in workforce reconciliation, implementation of PWC recommendations and agency reduction. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements will be key to the operating plan delivery and recovery programme – at organisational and system level. A PCI Committee Development session took place in May to assess current People context, risks, organisation and partner activities and to set the vision for the Committee throughout 2024/25 and beyond. Structures and priorities have been revised and will be considered and approved at the PCI Committee on 10th July 2024.
- The following areas are highlighted:
- **People Metrics** - Total workforce levels, as at May-24 equated to 23,932 wte which is currently +133 wte (+0.6%) above the operational workforce plan, the over plan position is mainly due to bank use, although for context the level of bank use has decreased from Mar-24 and is closer to the expected average level of use. We have a positive position in respect of temporary staffing, as of May-24 temporary staff usage equated to 7.6% of the total workforce, which is the lowest point in the last 12 months. We have also made great strides in agency reduction with agency spend equating to £2.9m, which equates to 2.7% (0.5% below the NHSE target) of the total staffing spend - this continues to be a significant achievement.
- **Operational Workforce Planning** – Further to the 2nd May submission to NHSE, there was a further requirement from NHSE to submit revised plans. As our wider operational plan had already been approved by NHSE, respective ICB and provider Executives, the only update required was the incorporation of an additional F1 junior doctors as requested by NHSE.
- **Workforce Controls** – Since the initial independent assessment from PwC, they have now undertaken a high level review of the progress against the recommendations and reviewed a brief selection of documentation provided by the ICB to further summarise the progress made against the recommendations. Although existing grip and control was acknowledged in the PWC review, System and Providers have worked to improve the processes further, this ultimately means that a total of 62 (100%) recommendations accepted have either been completed (49 recommendations/79%) or at implementation stage (13 recommendations/21%).
- The ICS **People risks** reflect the current risks across the partner organisations and have been robustly reviewed via the People Collaborative Board and Steering Groups. The top risks to the system are: Agency usage and spend; Employee Wellbeing/Retention; and Slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage. Risks will be further reviewed at the PCI on 10th July 2024
- People, Culture and Inclusion **Programme delivery** is overall on track, with actions in place to address those areas challenged (e.g. WRES/WDES standards and Staff Psychological and Wellbeing Hub funding). Following the review of PCI Committee and 2024/25 programme delivery priorities, a revised governance, meeting and programme focus has been proposed to PCI for consideration and approval. The revision reflects the current people challenges and financial climate, outlining programme activities which will address the risks.

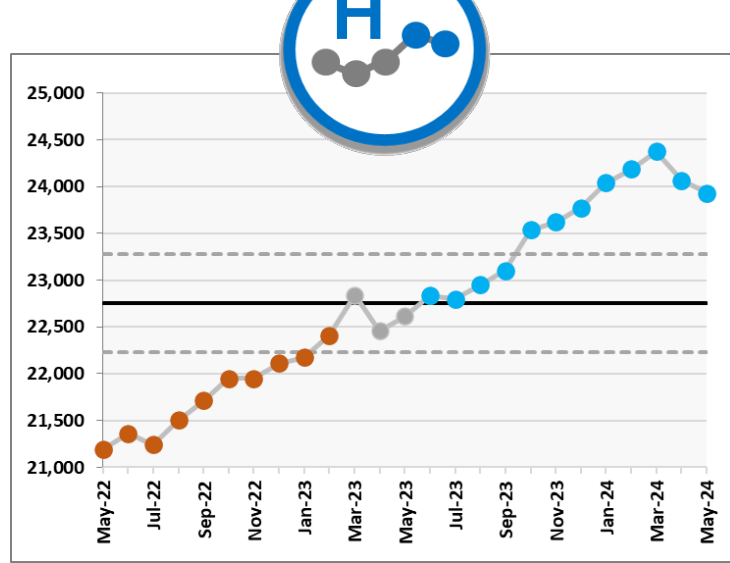
Workforce position and controls



Current Workforce Position: May 24

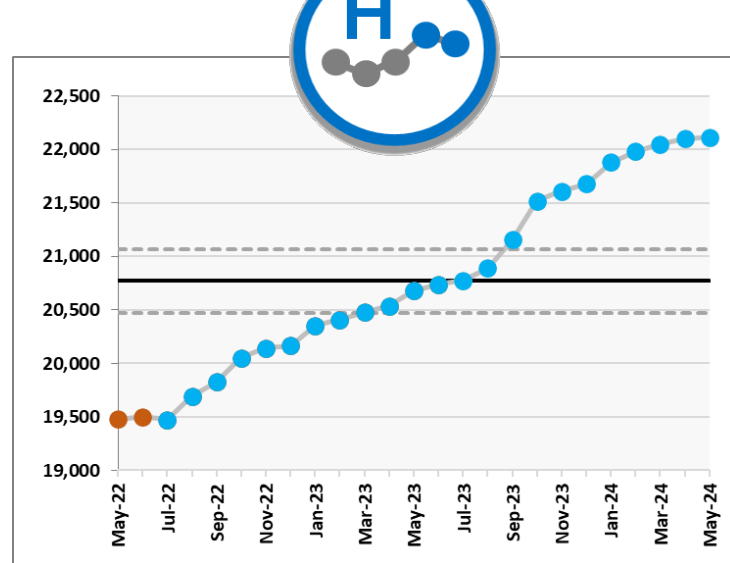
Staff in Post (Total Workforce wte)

May 24: **23,932**
 Position to Plan: **+133**
 12M Change: **+1,317**
 FYTD Change: **-136**



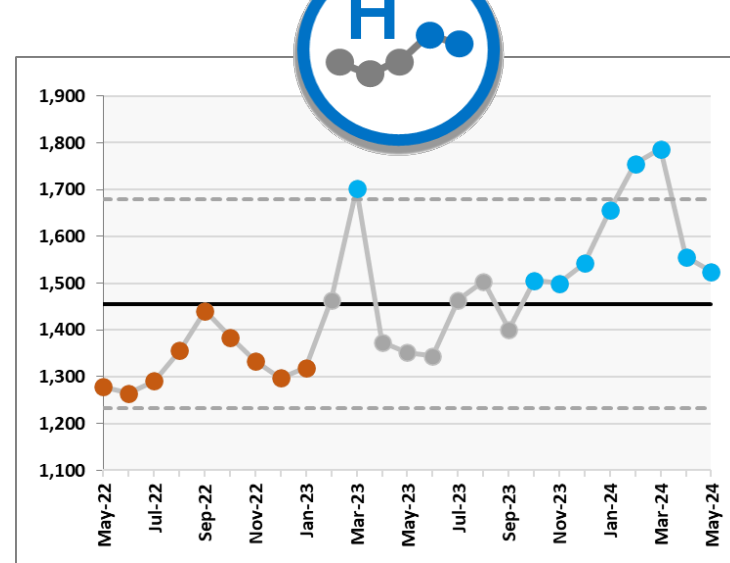
Staff in Post (Substantive wte)

May 24: **22,116**
 Position to Plan: **+16**
 12M Change: **+1,437**
 FYTD Change: **+13**



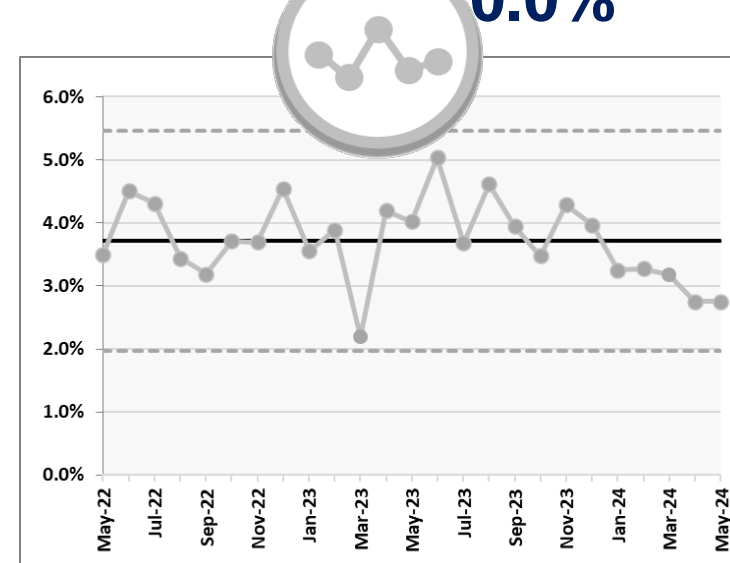
Bank Workforce

May 24: **6.4%**
 Position to Plan: **+258**
 12M Change: **+0.4%**
 FYTD Change: **-0.1%**



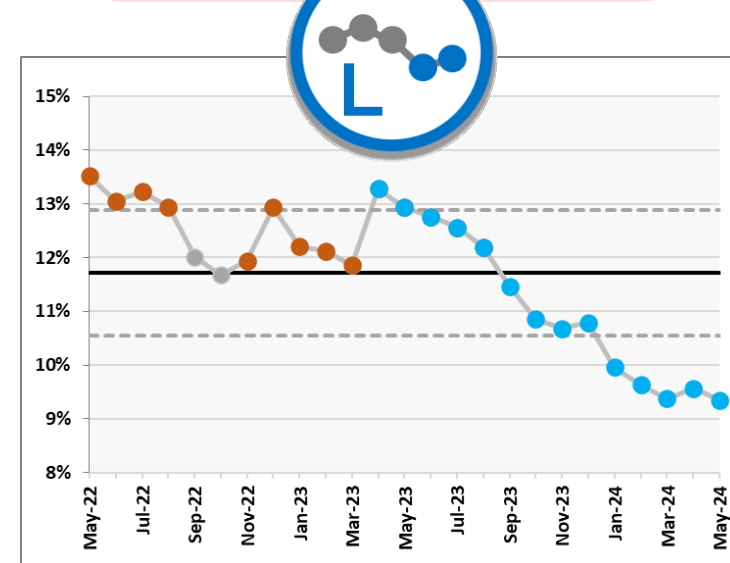
Agency Spend (% of total pay spend)

May 24: **2.7%**
 Plan Position (FYTD): **-18.4%**
 12M Change: **-1.3%**
 FYTD Change: **0.0%**



Vacancies (%)

May 24: **9.3%**
 12M Change: **-3.6%**
 FYTD Change: **+0.2%**



Staff in Post Actual vs Plan

Overall: +133 wte above plan
NHS Infrastructure: +125 wte above
Medical and Dental: +29 wte above
Registered Nursing: +19 wte above
Support to Clinical: -17 wte below
Registered S,T&T: -18 wte below

Substantive Staff in Post Actual vs Plan

Overall: +16 wte above plan
NHS Infrastructure: +112 wte above
Registered Nursing: +1 wte above
Medical and Dental: on plan
Registered S,T&T: -25 wte below
Support to Clinical: -70 wte below

Bank Workforce Actual vs Plan

Overall: +258 wte above plan
Registered Nursing: +96 wte above
Support to Clinical: +73 wte above
Medical and Dental: +43 wte above
NHS Infrastructure: +34 wte above
Registered S,T&T: +11 wte above

Agency Workforce Actual vs Plan

Overall: -140 wte below plan
Registered Nursing: -78 wte below
NHS Infrastructure: -21 wte below
Support to Clinical: -20 wte below
Medical and Dental: -18 wte below
Registered S,T&T: -4 wte below

Vacancies

Vacancies total 2,281 wte (9.3%), this is the lowest level of vacancies the system has had in the last 12 months, and is -754 below the highest position in the last 12 months.

Staffordshire & Stoke-on-Trent NHS: May 2024

NHS Workforce

Total Workforce

23,932 WTE

Currently +1,134 wte (Jul23)

Substantive

22,116 WTE

Currently +1,374 wte (Jun23)

Bank

1,525 WTE

Currently +181 wte (Jun23)

Agency

291 WTE

Currently -458 wte (Jun23)

Temporary Workforce

7.6%

Currently -2.0% (Mar24)

Agency Spend

£2.9M (2.7%)

Currently -£2.0M (Jun23)

Vacancies

2,281 wte (9.3%)

Currently -754 wte (Jun23)

Joiners

175 wte

Currently 12 Month Low

Leavers

138 wte

Currently -104 wte (Mar24)

12 Month Rolling KPI's (%)

8.8%

Turnover
Rate

Currently -1.2% (Jul23)

5.3%

Sickness
Absence Rate

Currently 12-Month High

93.8%

Mandatory
Training

Currently +0.9% (Nov23)

82.6%

AFC
Appraisal
Rate

Currently +5.5% (Dec23)

68.0%

Medical
Appraisal Rate

Currently -16.9% (Mar24)

Other Health and Care Workforce

SSOT ICB Workforce

272 WTE

Primary Care Workforce

2,872 WTE

Social Care Workforce

20,000 WTE

Dentistry Workforce

610 Headcount

Operational Planning



5. Workforce - FY24-25 Operating Workforce Plans – 12th June Submission

FY24-25 Plan (Mar-24 to Mar-25) – NHS Providers (WTE)

Summary

- Establishment is planned to increase from 24,135 to 24,388 by +253.
- The overall total workforce is planned to decrease from 24,287 to 23,818 by -470.
- As of March 2024 the total workforce staff in post is +152 above the establishment.

Staff Composition (Total WF):

- Substantive: +98
- Bank: - 403
- Agency: -165

Overall Total Workforce Movement:

MPFT: Decrease from 9,948 to 9,826 by -122.
NSCHT: Decrease from 1,819 to 1,809 by -10.
UHNM: Decrease from 12,520 to 12,182 by -338.

Staff Groups – Substantive WF Movement:

- Registered (Reg) Nursing, Midwifery and Health Visitors: +130
- Registered/Qualified (Qual) Scientists, Therapeutic and Staff: +24
- Allied Health Professionals: +9
- Reg/Qual Healthcare Scientists: No Change
- Support to Clinical staff: +63.4
- NHS Infrastructure Support: -156
- Medical and Dental: +37***

In the latest submission 20 wte additional F1 junior doctors have been incorporated at the request of NHSE.

FY24-25 Plan (Mar 2024 to Mar 2025) – Mental Health and Primary Care (WTE)

Primary Care: Increase from 3,458 to 3,615 increase of +157

Mental Health Workforce Plan: Increase from 3,373 to 3,392 by +19

3) FY24-25 Plan Development – NHS Providers (WTE)

FY24-25 Ops WF Plans		Revised Plan 12/06/2024					
		Mar-24 SIP	Mar-24 Establishment	Mar-25 SIP	Mar-25 Establishment	SIP Change Mar-24 to Mar-25	Establishment Change Mar-24 to Mar-25
MPFT	Substantive	9,099	10,137	9,120	10,328	21	191
	Bank	647		549		-98	
	Agency	202		157		-45	
	Total WF	9,948	10,137	9,826	10,328	-122	191
NSCHT	Substantive	1,656	1,871	1,656	1,809	0	-62
	Bank	130		146		16	
	Agency	33		8		-26	
	Total WF	1,819	1,871	1,809	1,809	-10	-62
UHNM	Substantive	11,191	12,128	11,268	12,251	77	123
	Bank	1,026		705		-321	
	Agency	303		209		-94	
	Total WF	12,520	12,128	12,182	12,251	-338	123
SSoT	Substantive	21,946	24,135	22,044	24,388	98	253
	Bank	1,803	0	1,400		-403	0
	Agency	538	0	374		-165	0
	Total WF	24,287	24,135	23,817	24,388	-470	253

Since the submission to NHSE on 2nd May, the operational workforce plan has remained largely unchanged with the exception of 20 additional F1 doctors. Overall in the year there is a plan to decrease the workforce, and where there are increases, the increases planned are modest.

5. Workforce – FY24-25 Performance to Plan

FY24-25 Operating Plan

Total Workforce Staff in Post

Apr 2024: 24,067 wte

May 2024: 23,932 wte

Apr2024 to May2024 Change:
-136 wte, -0.6% decrease

May 2024 Position to Plan:
+133 wte, +0.6%

Substantive Workforce Staff in Post

Apr 2024: 22,102 wte

May 2024: 22,116 wte

Apr2024 to May 2024 Change:
+13 wte, +0.1% increase

May 2024 Position to Plan:
+16 wte, +0.1%

Bank Workforce Staff in Post

Apr 2024: 1,556 wte

May 2024: 1,525 wte

Apr2024 to May 2024 Change:
-32 wte, -2.0%

May 2024 Position to Plan:
+258 wte, +20.3%

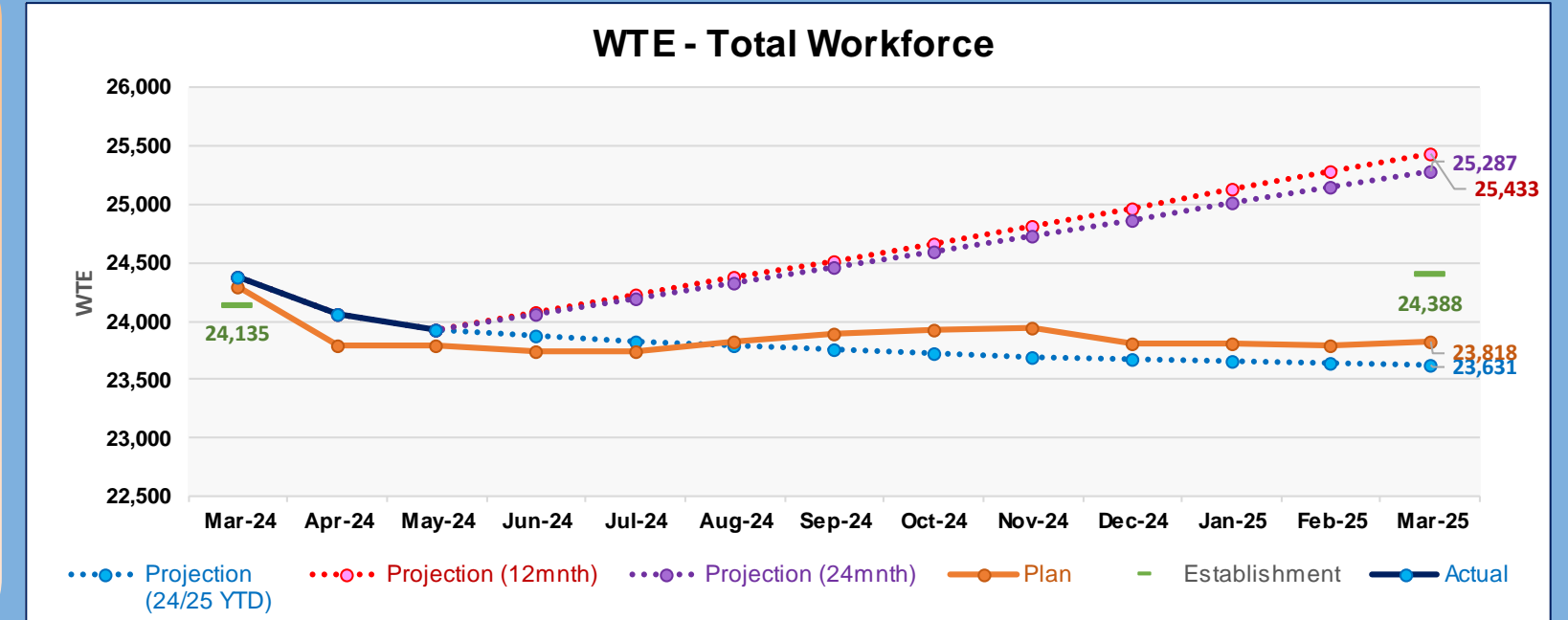
Agency Workforce Staff in Post

Apr 2024: 409 wte

May 2024: 291 wte

Apr 2024 to May 2024 Change:
-118 wte, -28.7%

May 2024 Position to Plan:
-140 wte, -32.5%

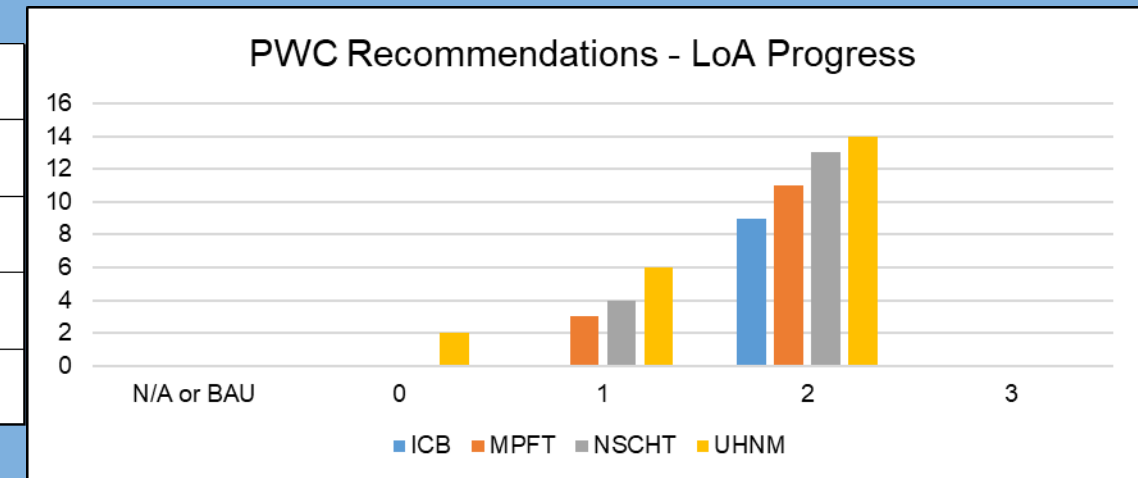


- For May 2024 the total workforce has decreased by -136 whole time equivalent (wte), (-0.6%) from Apr 2024. This position is however +133 wte above plan (+0.6%).
- In respect of substantive staff, the Apr 2024 to May 2024 resulted in a slight increase of +13 wte (+0.1%). This is slightly above plan by +16 wte (+0.1%).
- Bank workforce has decreased since Apr 2024 by -32 wte (-2.0%), however is above plan by +258 wte (+20.4%).
- Agency workforce has decreased by -118 wte (-28.7%) and is also below plan by -140 wte (-32.5%).
- NHSE Agency % target of total pay spend as reduced from 3.7% to 3.2% in FY24-25, currently the combined financial year to date system agency spend position equates to 2.7% of total pay spend.

- Workforce reconciliation currently being finalised which draws findings of additionality of workforce, against Care Hours Per Patient Data and model health system indicators. Correlation analysis being developed to test relationship between factors.
- Jun 2024 progress of recommended workforce controls are detailed to the right, stating current implementation leave of absence (LoA).
- 16 recommendations that were already business as usual or not accepted.
- Therefore there are a total of 62 recommendations which have been accepted and are currently in the following LoA levels:
 - 2 recommendations which are currently LoA 0 (3%)
 - 13 recommendations which are currently LoA 1 (21%) effectively are working towards implementation
 - 47 recommendations which are currently LoA 2 (76%) and are fully implemented
- We are committed to cease the use of off-framework agency use by end of June 2024.

Workforce Grip & Control

N/A	Recommendation not considered for adoption (mitigation/rationale provided/already BAU)
0	No adaptation, improvement or introduction of recommended requirements
1	Recommended actions are understood with an action plan developed
2	Implementation of recommended action fully implemented
3	Efficacy of improvement measured and evaluated. Potential opportunity for learning to scale up



SSoT PWC Recommendations LoA	0	1	2	3
External / agency controls and authorisation processes	0	2	16	0
Internal temporary staff controls and authorisation processes	0	2	9	0
Pay Controls	0	0	4	0
Temporary Staffing Governance	0	3	6	0
Temporary Staffing Governance and External / agency controls and authorisation processes	0	0	4	0
Vacancy Control	2	6	8	0
Total	2	13	47	0

Workforce challenges, risks and mitigation



5. Workforce - Risks, challenges and mitigation

The Risks and Challenge

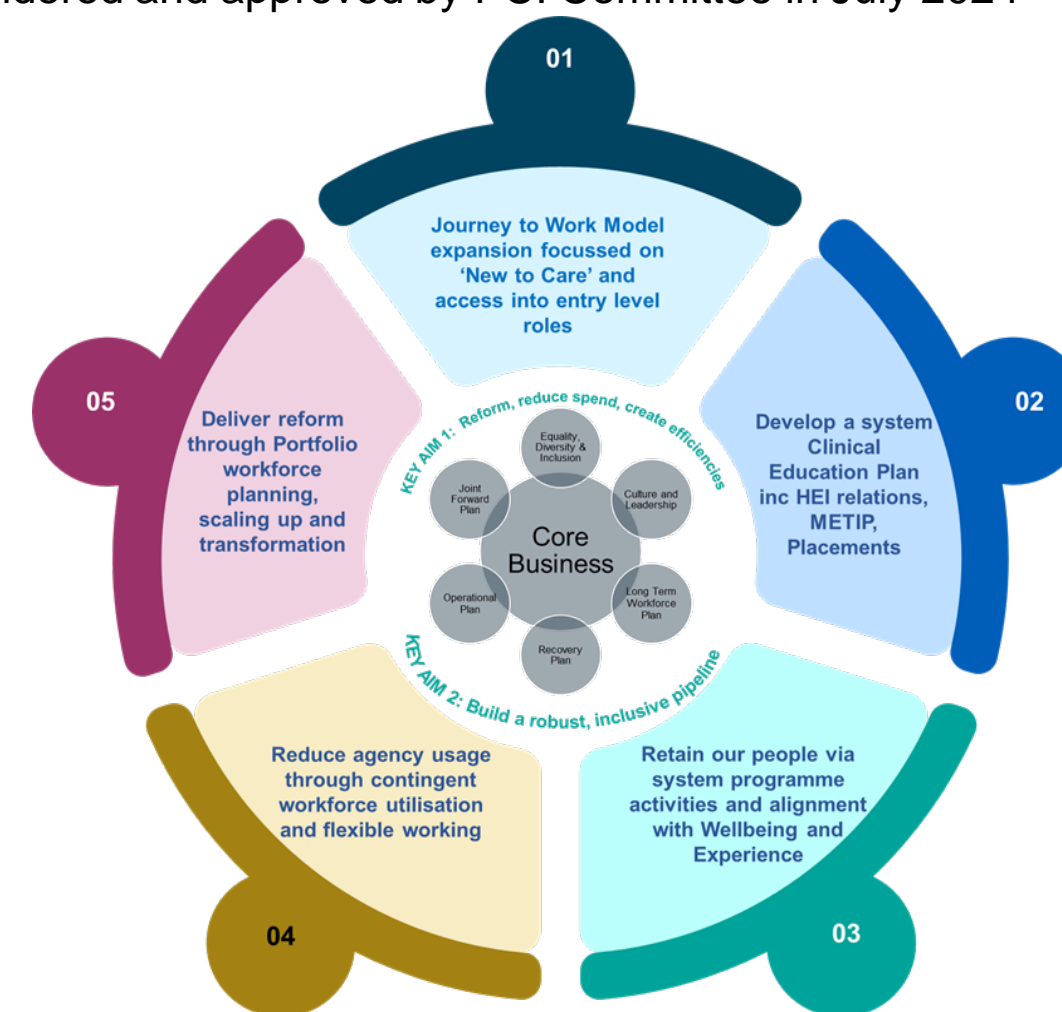
People risks

- The following risks are identified on the People Culture and Inclusion Risk Register:
 - Agency usage and spend
 - Care Home and Home Care Workforce Capacity
 - Ability to deliver the Local People Plan programmes, People Operating Model and Long Term Workforce Plan
 - Employee Health Wellbeing and Retention
 - Slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage
 - Ability to deliver the Long Term Workforce Plan and create a sustainable future pipeline
 - Industrial Action – Junior Doctors and GP pending ballot outcome
- Ongoing discussion regarding system culture during times of increased pressure, scrutiny and financial climate.- risk being developed by OD leads and mitigated by the system OD plan currently in development.
- A review has been completed of the risks in a Personal Care Institute (PCI) Development Session held on 20th May to ensure that the risks reflect the workforce challenges in 2024/25.
- The Board Assurance Framework ‘Sustainable Workforce’ also reflects the 2024/25 impact and controls.
- Mitigating actions to reduce the impact of the risks are outlined in the People Programme Priorities, activities and programme delivery, alongside organisational level actions.

FY24-25 People Programme Priorities

ICS People Culture and Inclusion Programme Delivery:

- The 2023/24 ICS People Annual Report has now been finalised and captures the achievements across the system in delivering the local People Plan and LTWP – included in this pack.
- At the PCI Development session in May 2024, robust discussion took place regarding current challenges and programme delivery to mitigate the risks, deliver transformation and support recovery.
- Whilst the priorities outlined below remain, delivery plans have been reviewed for FY24-25 to ensure activities are focussed on the areas which will generate the greatest impact and benefit in addressing the challenges. The revised programme will be considered and approved by PCI Committee in July 2024



People Culture and Inclusion Programme delivery



ICS People, Culture and Inclusion Programme Delivery

- Progress within programmes against agreed targets and metrics is reported via People Collaborative Board and People Culture and Inclusion Committee
- Below highlights from May-June 2024 activities. Amber ratings = WRES/WDES – further improvements required to meet standards and workforce to be representative with parity across the system; Psychological Wellbeing Hub subject to business case to extend service beyond November 24.
- Following the review of PCI Committee and 2024/25 programme delivery priorities, a revised governance, meeting and programme focus has been proposed to PCI for consideration and approval. The revision reflects the current people challenges and financial climate, outlining programme activities which will address the risks.

Workforce supply – resourcing and retention	Workforce transformation and future pipeline	Equality, diversity and inclusion (EDI)	Employee experience, health and wellbeing	System culture and collaboration	Leadership and talent
<ul style="list-style-type: none"> • ICS People Hub inc Social Care and Admin Hubs • Contingent Workforce Deployment inc Reserves • Redeployment service • Retention Programme • New to Care - access to jobs, outreach into communities • Attraction and Inclusive Recruitment • Resourcing diagnostics: focus on shortage occupation, agency reduction 	<ul style="list-style-type: none"> • Portfolio and profession workforce planning and transformation • Programme delivery e.g. System Recovery programme • NHSE Workforce Development and Education funding – including Multi-professional Education and Training Investment Plan (METIP) • Education, Training and Development inc Clinical Placement Project • Widening participation – including J2W, ICS Apprenticeships, National T-Levels Pilot • Educational Engagement (in partnership with CYP) • ICS Strategy (Digital, Green) 	<ul style="list-style-type: none"> • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) • Staff networks • WRES Champions • Reciprocal Mentoring • #InclusiveHR Scheme 	<ul style="list-style-type: none"> • Employee Experience & Wellbeing insights • Employee Wellbeing & Wellbeing Strategy • Staff Psychological Wellbeing Hub • Wellbeing resources and events • Occupational Health Provision 	<ul style="list-style-type: none"> • PCN OD programme • System OD Plan 	<ul style="list-style-type: none"> • High Potential Scheme • Coaching and Mentoring Pool

RAG Key:

- On Track
- Some elements behind schedule but mitigations in place
- Significantly behind schedule
- Complete
- New programme

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	People Culture and Inclusion 2023/24 Annual Report					
Presenting Officer:	Mish Irvine, Chief People Officer ICB (Interim)					
Author(s):	ICS People Team					
Document Type:	Annual Report					
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	Choose an item.				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	2023/24 ICS People Culture and Inclusion Annual Report					

(1) Purpose of the Paper:

To present the 2023/24 ICS People Culture and Inclusion Annual Report, providing a summary of the achievements in implementing People strategies and plans, delivering programmes in line with the local People Plan and National Long Term Workforce Plan, addressing the workforce challenges and delivering innovative solutions.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
People Collaborative	12/06/2024
People Culture and Inclusion Committee	10/07/2024

(3) Implications:

Legal or Regulatory	Delivery of Local people Plan, Joint Forward Plan and Long term Workforce Plan
CQC or Patient Safety	NHSE reporting and assurance on workforce planning and metrics
Financial (CFO-assured)	External funding supports delivery of schemes including NHSE, ICB, being monitored and reported. Specific challenges in relation to agency, operating plan and workforce growth delivery in line with financial envelope,
Sustainability	Across all programmes. Specific activity linked to Green/Sustainability plans
Workforce or Training	Across all programmes – detailed in report
Equality & Diversity	Across all programmes – detailed in report

Due Regard: Inequalities	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers
Due Regard: wider effect	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Not applicable in relation to this report. If Y, Reported to IG Group on Click or tap to enter a date.</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Not applicable in relation to this report. If Y, Approved by QIA Panel on Click or tap to enter a date.</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The annual report captures the milestones and achievements we have collectively delivered across the ICS People Culture and Inclusion agenda in collaboration with partners from across the system. It describes the local context and challenges faced in 2023/24, the change in landscape and financial pressures alongside the ongoing operational and clinical pressures. The report considers how we align national strategy to local plans (NHS Long Term Workforce Plan), our approach and progress towards delivering those plans. The report summarises the achievements and impact in delivering programmes to address workforce challenges across the ICS, within each People Plan and LTWP domain. Whilst the report describes 2024/25 plans, it is acknowledged that these are currently being refreshed in line with the PCI Development session recommendations, system context and priorities.</p>

(7) Recommendations to Board / Committee:
<p>For information and assurance to ICB Board on the delivery of People, Culture and Inclusion programmes in 2023/24 in line with the local People Plan, NHS Long Term Workforce Plan, Joint Forward Plan and system priorities, and in addressing the system workforce challenges and risks Ongoing support and engagement of partners in the delivery of People, Culture and Inclusion Programmes</p>

Staffordshire & Stoke-on-Trent Integrated Care System

People, Culture and Inclusion Programmes

Annual Report 2023-2024



Contents

- Introduction
- Foreword
- Tribute to Paul Draycott
- System context in 23/24
- Benefits
- People, Culture and Inclusion Achievements 23/24
- Journey to Work
- Widening Participation
- Supply
- Education, Training and Development
- Retention, Experience and Wellbeing
- Workforce Planning and Information
- Transformation
- Leadership and Talent
- Organisational Development
- Equality, Diversity and Inclusion
- NHS Staff Survey Results
- People, Culture and Inclusion 24/25
- Thank you



Introduction

As we reflect on 2023-2024, we acknowledge the challenges that we have faced as a health and social care system. The ongoing financial and operational pressures, including those posed by industrial action and post-pandemic recovery, have tested our resilience. However, our people have continued to demonstrate unwavering commitment, going above and beyond to provide the best possible care to our local population.

At the heart of our vision is the commitment to looking after the health and wellbeing of our workforce – our people. We recognise the incredible efforts they have made and are dedicated to supporting them in every way we can.

We are grateful for the collaboration and support of our partners and leaders, who have worked together to develop innovative solutions to navigate the complex issues we face.

This annual report will explore the milestones and achievements we've reached together, the current initiatives we are undertaking and our future plans.

Looking forward to 2024/2025, we will be focusing on working together to achieve financial balance for the system, finalising our organisational development plan, continual prioritisation of equality, diversity and inclusion work, developing our local long-term workforce plan with a focus on improving future supply, retention and wellbeing, education and training and widening participation.

We hope this report will serve as a testament to the hard work and dedication of our exceptional people, and as a roadmap for the future of health and social care in Staffordshire and Stoke-on-Trent.



Foreword

Reflecting on the past year, I am continually amazed by the incredible achievements of our People, Culture and Inclusion Programmes. This Annual Report serves as testament to the incredible progress we have made together. The key pillar of these successes has been the commitment and dedication of our workforce especially in the face of considerable challenges operationally and financially. As well as the collaboration of our leaders and partners to make Staffordshire and Stoke-on-Trent one of the best places to live, learn and work.

I am particularly pleased to see the commitment our system has to Equality, Diversity and Inclusion and the collaborative work programmes we've delivered this year. We are committed to creating a more inclusive culture and diverse workforce, and we will continue to prioritise this work in the coming year, with a focus on enhancing EDI in all aspects of our programmes.

Whilst we know that our working environment will continue to be challenging, I am excited for the opportunities that lie ahead for 2024/2025 and am confident that, together, we can make a positive impact on the lives of the communities we serve and the people who make this possible.

Mish Irvine, Interim ICB Chief People Officer



I am again hugely impressed by the passion and innovation demonstrated in this report. It reflects our collective efforts over the last year in delivering the Local People Plan, responding to the workforce challenges and developing innovative approaches. Our system has continued to work collaboratively to look after our people and design and implement programmes to deliver a sustainable workforce for the future.

It was reassuring to see that priorities outlined in the Long Term Workforce Plan were aligned to our local vision and activities. I do recognize however the challenges facing the system as we head into 2024/25 and we cannot underestimate the impact this will have on our People and our capacity to innovate and design new ways of working which will benefit our people, services and population.

And finally, I wanted to acknowledge the 2023 NHS Staff Survey results and our system scoring the highest in the Midlands region. It is comforting to know that the experience of our workforce continues to improve. We know that there is further work to do to address areas for improvement and to overcome some of the challenges we face. Looking after our People is more important than ever.

Shokat Lal, Non-Executive Chair of SSOT People, Culture and Inclusion Committee



Remembering our colleague, Paul Draycott NSCHT Chief People Officer 1967 – 2024

We sadly lost our dear colleague Paul Draycott at the start of 2024. Paul had re-joined North Staffordshire Combined Healthcare as the Chief People Officer in January 2023, from Southern Health NHS Foundation Trust, where he was also Chief People Officer.

Paul was well known to many of our own staff, having previously served as Combined Healthcare's Director of Leadership and Workforce for four years. As such, he was a key member of the Trust's leadership team, which began Combined's improvement journey Towards Outstanding.

Paul had over 35 years' experience in the NHS, initially as a general nurse. He had workforce and organisational development experience across mental health, community, acute and commissioning and this was his fifth Director post.

Paul had also recently served as the Hampshire and Isle of Wight lead for workforce inequalities and his long-standing track record and commitment to the inclusion agenda was particularly well-known and respected.

Paul's legacy shines through in this Annual report, his passion for Equality, Diversity, Inclusion and compassionate leadership had a longstanding impact on the culture of our system. One of Paul's favourite motos was 'it ain't what you do it's the way that you do it'.

We hope to further Paul's incredible work and passion through our programmes and collaboration, adopting his compassionate approach - with our People at the heart of all we do.

System context – delivering the NHS Long Term Workforce Plan

The **NHS Long Term Workforce Plan (LTWP)** sets out a strategic direction for the long term, as well as action to be taken locally, regionally, and nationally in the short to medium term to address workforce challenges. It details the actions that will be taken in the coming years to address the identified shortfall in addition to, and building on, actions and investment already committed. The actions fall into three priority areas: Train, Retain, Reform, supported by strategic workforce planning. The plan reiterates the need to ensure the right people, with the right skills, are in the right place, at the right time to provide high quality care, whilst improving outcomes and experience.

Staffordshire and Stoke-on-Trent continues to face workforce challenges, in the context of unprecedented operational pressures, Industrial Action and post-pandemic recovery. A significant challenge for SSOT is affordability and growth on the scale outlined in the LTWP, which will contribute to the financial deficit, in the backdrop of a national requirement to increase capacity in priority areas including Urgent and Emergency Care (UEC), Elective and Mental Health to contribute to system recovery. Therefore, work is ongoing to align the national assumptions with local planning and trajectories.



In 2024-25 and beyond, effective integrated and transformational planning will be crucial to optimise service demand, achieved by utilising the current workforce efficiently and driving reform according to the plan. Operational planning will continue to inform strategic decisions, balancing three key factors: activity, finance, and workforce. This approach is supported by a robust data set on the workforce, with ongoing development planned to incorporate granular insights from Social Care, Primary Care, and the Voluntary Sector.



We continue to work closely with Social Care partners to understand the Adult Social Care workforce and await the publication of a social care workforce plan. Skills for Care have identified that we will need to further increase posts by nearly a third across SSOT - as a result we will continue to work closely with Adult Social Care (ASC) partners to understand the Social Care workforce, required growth and implementing the priorities within the NHS LTWP.

The plans recommendations around the priority areas of Training, Retain and reform reassuringly align with the approach and vision for our ICS people, culture and inclusion programmes. We will continue to work with partners to develop approaches and activities to implement the recommendations which are locally designed to meet the needs of our people and population.

System context – People Metrics 1

Staffordshire & Stoke-on-Trent NHS: March 2024



NHS Workforce

Total Workforce

24,378 WTE

Currently +1,922wte (Apr23)

Substantive

22,051 WTE

Currently +1,515wte (Apr23)

Bank

1,786 WTE

Currently +442wte (Jun23)

Agency

541 WTE

Currently -209wte (Jun23)

Temporary Workforce

9.5%

Currently 12-Month High

Agency Spend
£3.9M (3.2%)

Currently -£1.1M (Jun23)

Vacancies

2,280 wte (9.4%)

Currently -866wte (Apr23)

Joiners

219 wte

Currently +9wte (Jun23)

Leavers

242 wte

Currently 12-Month High

12 Month Rolling KPI's (%)

9.0%

Turnover Rate

Currently -1.5% (Apr23)

5.2%

Sickness Absence Rate

Currently -0.5% (Apr23)

93.4%

Mandatory Training

Currently +0.5% (Nov23)

79.7%

AFC Appraisal Rate

Currently +2.6% (Dec23)

84.9%

Medical Appraisal Rate

Currently 12-Month High

Other Health and Care Workforce

SSOT ICB Workforce

272 WTE

Primary Care Workforce

2,872 WTE

Social Care Workforce

20,000 WTE

Dentistry Workforce

610 Headcount



System context – People Metrics 2

NHS Providers – Year in Review – Mar-23 to Mar-24

1) Total Workforce (WTE)

**Staff in Post
(Total Workforce wte)**
 Mar 24: 24,378
 Mar 23: 22,842
 12M Change: +1,536
 FYTD Change: +1,922

Staff in Post & Ops Plan

- Following the operational planning process for FY23-24, H2 plans were revised for Nov-23 to Mar-24.
- Despite this reset FY23-24 SSoT total workforce exceeded the planned staff in post by +629 wte by Mar-24, with increases in year of +1,536 wte.
- Closing position for Mar-24, marked the first point in the year where actual staff in post exceeded establishment.

2) Substantive WF (WTE)

**Staff in Post
(substantive wte)**
 Mar 24: 22,051
 Mar 23: 20,480
 12M Change: +1,571
 FYTD Change: +1,515

Staff in Post & Ops Plan

- At the end of FY23-24 the substantive workforce was +287 wte above the operational workforce plan.
- As of Mar-24 all staff groups had actual workforce levels which were above the operational workforce plan:
 - Support to Clinical (+292 wte)
 - NHS Infrastructure (+187 wte)
 - Reg Sci, Ther & Tech (+77 wte)
 - Medical & Dental (+60 wte)
 - Registered Nursing (+48 wte)

3) Bank Workforce (WTE)

**Bank Usage
(% of total staff)**
 Mar 24: 7.3%
 Mar 23: 7.5%
 12M Change: -0.1%
 FYTD Change: +1.2%

Bank Usage

- Bank workforce closing position for FY23-24 was +344 wte above operating plan.
- Bank utilisation strengthened from Oct-23 with increases thereafter to Mar-24.
- All staff groups are above operational plan:
 - Registered Nursing (+180 wte)
 - Support to Clinical (+143 wte)
 - NHS Infrastructure (+77 wte)
 - Medical & Dental (+46 wte)
 - Reg Sci, Ther & Tech (+2 wte)

4) Agency WF (WTE)

**Agency Spend
(% of total pay spend)**
 Mar 24: 3.2%
 Mar 23: 2.2%
 12M Change: +1.0%
 FYTD Change: -1.0%

Agency Workforce

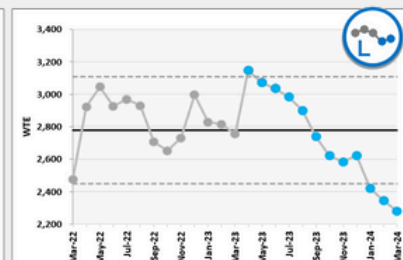
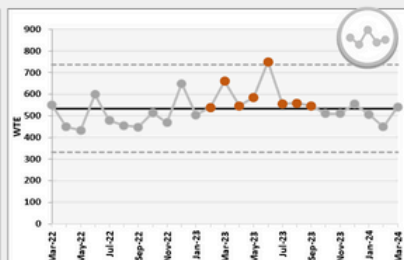
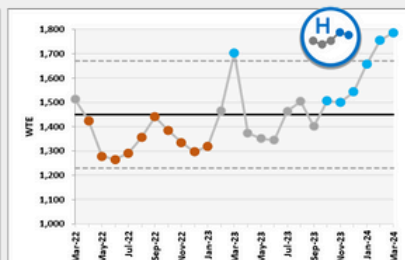
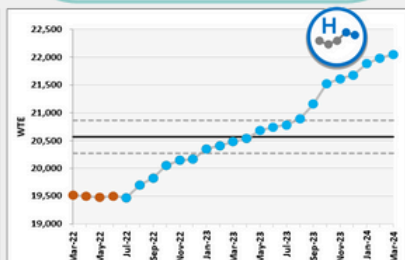
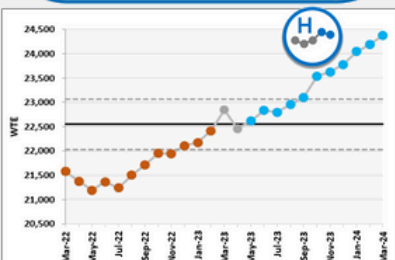
- Closing position for Mar-23 resulted in being slightly below operational plan by -2 wte below plan.
- Agency spend for FY23-24 was 3.9% which is +0.2% above the 3.7% target (NHSE target).
- Areas of sustained use relate to medical and registered nursing.
- SSoT continues focus through WF grip and controls to further reduce reliance on agency.

5) Vacancies (WTE)

Vacancy (%)
 Mar 24: 9.4%
 Mar 23: 11.9%
 12M Change: -2.5%
 FYTD Change: -3.9%

Vacancy

- SSoT vacancy levels have continued to decrease throughout the year
- As of Mar-24 SSoT has 866 wte less vacancies in comparison with Apr-23.
- Given financial challenge a vacancy management process has been implemented which has been expanded in some areas for all staff groups and accompanied by QIA to understand the non-fill impact.



KPI

- Turnover** levels continue to improve. Significant activity is underway at system level to continually address the levers that impact retention.
- Sickness** is an improved position. A health and wellbeing committee has commenced to understand the key issues and develop structured improvement in these areas.
- Making data count principles as recommended by NHSE are adopted to enable ease of interpretation and clearly understand trends of improvement or deterioration.



Benefits Realisation

Our approach to measuring success and impact of People, Culture and Inclusion programmes

Understand & Scope

Use workforce plans, data, education and pipeline information to identify areas for improvement.

Design

Collaborate, Research, Best Practice.

Engage

Involve health and care partners, wider partners, workforce, public and education.

Implement

Create clear project plans with milestones and outcomes.

Test

Trial, monitor progress & outputs of projects.

Listen & Adapt

Engage stakeholders, review & refine.

Assess the Impact

Use metrics and individual journeys to determine success.

Scale & Spread

Roll-out across programmes, organisations and sector boundaries.

*Underpinned and monitored via the People Culture and Inclusion governance and Committee structure



Virtual Work Experience delivered of



5 bespoke programmes

To engage and inform young people on health and care careers.

966 individual contacts made by Outreach Team from March '23 to Feb '24 . 87 Application and interview support.



100 staff members have joined the Health and Care Careers Force to promote careers to young people



Phase 2 of Retention Programme completed with a reduction in leaver rates



People, Culture and Inclusion achievements 2023-24

Finalists in 2 categories

- Enhancing Workforce Engagement, Productivity
- Wellbeing through Digital & Improving Back Office Efficiencies through Digital – received Highly Commended in this category.



Awarded T-Levels Pilot in Staffordshire & Stoke-on-Trent and grew placement provision to **81 students**

58 Apprentices have started on programmes, with 79% of those either remaining on programmes or working within the system



NSCG Winner Promoting Apprenticeships Campaign 2024



28 people have graduated from Cohort 2 of the High Potential Scheme



Robust & intuitive People Metrics and reporting



£152,000 levy shared in 2023, supporting over 9 apprentices.



One-to-one support to **over 40 colleagues** who are differently abled through our ICS Differently Abled Buddy Scheme.

Over 9000 hours worked by People Hub Staff on an 'any day, any hour basis'



System collaboration on the implementation of coaching and mentoring culture across SSOT ICS.



1416 Health and Wellbeing Hub Referrals



36 participants completed New Futures from across the ICS (100% of those who embarked on the programme)



Over 220 attendees to ICS Inclusion School sessions

First year delivery of Joint NHS Occupational Health Contract



Journey to Work

Outreach and inclusive recruitment activities – working with refugees & seldom heard communities



College and University engagement to strengthen clinical education pathways and access to courses at all levels



Offering workplace learning initiatives including T-Levels & Apprenticeships

Secondary School Engagement - Virtual Work Experience Programmes



Clear and accessible, innovative system wide career pathways - joint funded roles, rotations, careers across boundaries



Primary School careers Engagement linked to CYP physical & mental health offers



Looking after our people with psychological and wellbeing services



Improving employee experience leading to better retention



Developing new non-registered opportunities and access to jobs for people NEW 2 CARE



Developing leaders and securing our talent pipeline

Our 'Journey to work' model describes our approach to attracting, training and retaining our workforce; and the areas we will focus on collaboratively at system level. The model focusses on:

- Partnership working to develop the One Workforce approach with NHS, Primary Care, Councils, Social Care and Voluntary sectors.
- Productivity will only be gained by sharing our workforce over organisational boundaries
- Supporting our local population to access jobs and careers, reducing health inequalities and improving population health
- Attracting and training a different type of workforce
- Increasing support into entry level jobs
- Looking after our people to keep them well and with us

Equality, Diversity Inclusion and Compassion as a Golden Thread



Workstream Progress and Achievements



Widening participation

Educational engagement

Virtual Work Experience

Online e-learning platform engaging and informing school aged young people on health and care careers.

- Delivery of 5 bespoke programmes: Mental Health, Primary Care, Hospital, Social Care and Maternity.
- Reaching over 4,000 students in over 80 schools and colleges. Collaborated with over 150 colleagues from across the system to create reusable careers resources/content.
- Delivery of content on-demand = increased accessibility and engagement.
- HSJ Digital Awards 2023 - Highly Commended 'Improving Back Office Efficiencies'.

Creation of Health and Care Careers in Staffordshire and Stoke-on-Trent Hub.

Career Experiences - Events and webinars - Career prep videos - Employability skill builders - Teacher and student resources.

Health and care Careers Force

Careers Ambassador Network for SSOT. Project to bring careers events, speakers and education visits together and deliver at scale to all schools

- 75 clinical & 25 non-clinical ambassadors from across the system
- 14 events attended by 16 ambassadors from UHNM, MPFT, NSCHT and ICB
- Delivering in person talks, workshops, careers advice and attending careers events
- 86 primary and secondary schools supported
- Partnership working with I Care Ambassadors

Student volunteer recruitment to strengthen model. Ambassador charter and membership badge. Exploration of corporate volunteering policy. System wide Health and Care Careers Fair/Roadshow

Careville Primary School Project

Health and Care Careers promotion. Informing, inspiring, challenge gender stereotypes, raise aspirations, instil values.

- Animated project designed for primary school children. Featuring a fictional town 'Careville' and 'Little Helper' characters
- Collaboration with Staffordshire University and system providers to film bespoke job role content
- 20 reusable videos covering a range of clinical and non-clinical roles
- Bespoke resources for KS1 and KS2, including teacher packs, worksheets accessories and role play equipment

Development of Careville concept, to increase scale of project offer, including resources (digital and physical).

Health and Care Careers Resources

Bespoke careers information for students and young people across SSOT. Providing navigation across health and care employers.

- System careers map featuring health and care employers across SSOT
- Career categories for clinical and non-clinical roles
- Place based marketing – SSOT as a great place to learn, live and work
- Pathway information, volunteering, wex and vwex
- Accessibility enabled, available digitally
- Scalable model for wider use in system attraction
- Extended resources to include career category sheets and career bios

Scaling of resources and increased engagement with young people across our communities. Collating and Sharing resources across system networks.

Alignment to CYP Portfolio and Recovery Programme to tackle inequalities and improve health outcomes



Widening Participation

T-levels & Apprenticeships

Apprenticeships



Supporting system-wide rotational apprenticeship programmes from levels 2 to 7, including the utilisation of apprentice levy

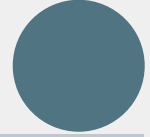
- Level 2 Healthcare Rotational Apprenticeship in Primary, Secondary and Social Care settings. Working closely with our outreach team to open opportunities to those in seldom heard communities. 58 Apprentices have started on programmes, with 79% of those either remaining on programme or working within the system. Regional SME Employer of the Year Winner 2022 and NSCG Winner Promoting Apprenticeships Campaign 2024.
- 13 cross sector rotational PTPT Pre-Registration Pharmacy Technician Apprentices, working in primary, secondary care and community pharmacies.
- Created Physician Associate apprenticeship in partnership with Keele University. 13 apprentices with 4 employers. Only system in the country who progressed with the apprenticeship in 2023.
- 10 Nurse Associates appointed within the system, with the first cohort about to enter year two of their training.
- £152,000 apprenticeship levy shared in 2023, supporting over 9 apprentices. Over £2million shared since 2019.

System wide Apprenticeship Strategy to expand apprenticeship opportunities and roles across SSOT. Continue to support new to care employees within SSOT. Working with partners to plan cohorts for 24/25.

Work collaboratively with local HEI's to expand higher level apprenticeships opportunities.

Continue to promote levy share opportunities.

T-Levels



Department for Education project to raise the profile of T levels and increase the number of industry placements

- Raised the profile of T Levels through a working group and providing a toolkit of resources to encourage new providers to offer placements
- Sustainable system-wide operational strategy for T Level engagement created.
- Working in partnership with local education providers.
- Memorandum of Understanding signed by all organisations and education providers
- Increased the number of IPs in the ICS. Placements have grown from 30 to 80.
- Shared best practice through creation of case study to share with the DfE and system partners to show evidence of T Levels student progression as a result of quality placement provision and partnerships.

Career progression webinar for T Levels students within the system. Twelve months project evaluation to be done. Strategy agreed and signed off. Increase placement numbers. MoU signed off by the partners and education providers. More case studies and narratives developed.

Placement numbers tracked to show current placement data and destination information.

The Social Care Hub



Created with Staffordshire CC's Care Market Development

Team, providing care homes with rapid, short term, trained 'Reserves' covering sickness and holidays, as well as permanent staff

- From July 2023, we accessed the Skills for Care Rapid Induction programme on a weekly basis.
- Engaged with local managers' networks and transformed the Hub's offer to now primarily support Providers with perm recruitment.
- Hub is now a bank of employment ready, trained individuals that can carry out shadow shifts as part of an interview process. This recruitment service is free for System partners.
- As of March '24, the Hub is supporting the recruitment of 13 permanent roles and 33 candidates trained and ready

Our aim is to further promote our offer and become a preferred supplier of quality social care trained staff across SSOT, saving Providers the expense of recruiting and paying agency fees. We aim to provide a provisional list of available staff within 48 hours of enquiry and contact candidates within 24 hours of application, bringing us in line with private sector agencies.

Companion Volunteer Programme



Launched in partnership with UHNM to bolster volunteer engagement across the System and support our Trusts, particularly in times of surge.

- 27 volunteers provided - compliant and ready for shifts at UHNM
- Recruitment focuses on volunteers having the right values and behaviours.
- Supports the health and wellbeing of our community, giving Companions the opportunity to improve the experiences of patients, whilst experiencing what it is like to work in health care

Continuation and growth of the programme with UHNM. Development of the programme into other areas such as MPFT, UHDB

Supply Resourcing

The Clinical Hub



Nursing Assistant 'Reserves' for UHNM. Designed to support surge within the acute trust, following consultation with System Partners.

- Through collaboration with UHNM, People Hub secured places on monthly Nursing Assistant Induction, giving our Reserves the same training as permanent staff, making them more helpful to wards.
- A number of People Hub Reserves have gone on to secure longer term placements and permanent roles.
- 1032 clinical shifts for UHNM April 23 - Feb 24
- 37 People Hub colleagues have completed a UHNM induction
- Over 9000 hours worked by People Hub Staff on an 'any day, any hour basis'

Continuation of collaborative working with UHNM
Extension of the programme into other locations in line with need and in preparation for next Winter eg. Community Hospitals in East Staffs

The Admin Hub



Established to assist our Primary Care Partners by building a bank of EMIS trained administration staff to cover in times of sickness and holidays.

- 22/'23 - East Staffs launch
- 23/'24 – expansion of offer into North Staffs.
- 'Reserves' are checked to NHS standards and receive online 'EMIS' training.
- To put the theory of training into practice, we have worked with various GP Practices to provide valuable shadow shifts.
- Launch of 'Lantum' software and use of the platform to offer admin staff to Practices, saving Primary Care both time and money.

Expansion of North Staffs Admin Hub. Full roll out of the Lantum platform to book shifts, streamlining payroll with a swifter booking process. Roll out of service into South Staffordshire.

Supply Outreach



Outreach Engagement

To engage with the diverse communities of Staffordshire and Stoke-on-Trent to promote inclusive career training and work opportunities in health and social care settings



New2Care Campaign

Supporting individuals with no previous care experience, but with the right values find, a role in health and care to suit their needs

- Expressions of Interest resulting from campaign - **145**
- Referrals to People Hub or Partner organisations - **29**
- Pending Interview - **5**
- Appointments so far - **6**
- Phase 2 currently in progress. Expressions of interest - **104**



- **Care Leavers' Covenant** – Use NHSE Universal Family funding to reach out to Care Leavers and Care Experience individuals; support Trusts, local authorities and charitable/voluntary organisations to engage and interact with Care Leavers to promote work opportunities and support their Journey to Work, improving employability for health and care roles
- Scoping establishment of a Summer School to support care leavers and young people during the holidays, developing employability
- Continued engagement with young people to learn what they would value to support them into work across SSOT
- Continued collaboration with Prince's Trust, Job Centres, YMCA, Amity Hub, Disability Solutions
- Partnership development of adult community provision (training for 25+); contributing to curriculum development
- Increase activity with Voluntary Sector, sourcing placements and opportunities.
- Alignment and partnership working with EDI workstream and Improving Population Health Portfolio



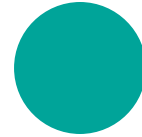
ACHIEVEMENTS

- **966** individual contacts made by Outreach Team from March '23 to Feb '24
- **16** have been supported into training, including Functional Skills and ESOL
- **87** Application and interview support
- **59** customers have been supported into employment

24/25 DELIVERABLES

Education, Training & Development

Workstream



The Education, Training & Development Steering Group brings together partners from across the health and care system to collaborate and deliver the Education, Training & Development elements of the ICS People Plan and Joint Forward Plan.

- Phase 1 coordination of METIP at system level
- Agreement of seven main areas of focus for the group to include;
- Clinical Education, Training & Development
- Higher Apprenticeships
- Widening Participation
- Student Pipeline & Funding
- Student Experience & Retention
- Career Progression & development
- Appointment to Clinical Education Lead and Placement Project Lead posts

Develop Delivery Plans to support the achievement of the strategic aims and objectives of the Group.

Propose and jointly consider solutions to improve and expand education, training & development across the system.

Completion of the first phase Clinical Placement Project

Delivery of Joint Forward Plan ambitions to reform Education, Training and development across the system

Staffordshire Training Hub – Primary Care



- Winners in the 2023 GP Awards category 'HCP Education Programme Provider of the Year'
- GPN Foundation School launched in September 2023 across SSOT to support excellence in General Practice Nurse training. Currently 15 x GPN Trainees in Cohort 1
- Ongoing delivery of NHSE Continuing Professional Development Funding programme for GPNs and AHPs
- Recruited 2 x GPN Educators to support the nursing workforce, (including SNAs, HCSWS) training and education, and peer support
- STH ARRS Facilitator has supported ARRS roles workforce and PCNs, in collaboration with newly appointed STH ARRS Ambassadors who are developing individual peer support and CPD meetings
- Support the ICS in delivery of the Pharmacy Technician and Physician Associate Apprenticeship schemes
- Launched the Non-clinical Apprenticeship programme – recruiting new or upskill the existing workforce at Level 3, 5 and 7, to support succession planning
- Launched Differently-Abled Buddy Scheme offers across Primary Care. Funding secured to deliver the scheme until March 2025.

- Ongoing coordination and facilitation of training and education offers across Primary Care
- Launching General Practice Long Service Awards in June 2024
- Implement virtual Practice Managers Peer Support Network group
- Facilitating delivery of the Stoke-on-Trent, North Staffordshire, Stafford and Surrounds Protected Learning Time (PLT) monthly live sessions (on behalf of ICB)

All Partners



Flexible Working & Flex Retirement: The Team ran a workshop, highlighting the importance of Flex working at the Workforce Summit October 2023

- Workforce Summit workshop well attended
- Case studies filmed & shared at Nov Roundtable event

- Continue to build Flex Working Network
- Continue to gather best practice examples of flex
- Support NSCHT with Self Rostering Pilots

Social Care



Care Friends App: supporting recruitment and retention of staff with the right values
Wellness Boxes Pilot: making staff feel valued. Wellbeing Champions: enhance engagement/dissemination of H&WB offers to SC staff.

- Care Friends - 2 live pilots, 27 staff using app over the 2 pilots, 4 roles advertised, 71 applications, 6 interviewed, 1 recruited and 3 awaiting checks
- Welcome Boxes – funded 120 boxes for 10 providers, some of which ordered more due to such positive staff impact. Used for 'Employee of the month', completion of training, positive client feedback
- Champions – 29 Champions signed up so far with more coming on board, first network meeting planned.

- Continue with pilots, gather feedback and evaluate impact, support Partners to plan future initiatives based on learning

NSCHT



Preceptorship: one of the Nursing & Midwifery five HIAs. Aligning NSCHT Preceptorship Programme to NHS England's (2022) National Preceptorship Framework for Nurses with the ambition to achieve Gold Standard & accreditation

- 41 Preceptees started the new programme
- Gold Standard IQM awarded
- 30 Credit accreditation agreed with Keele Uni
- Continue to gather feedback & present to key stakeholders, identifying improvement areas
- Support cohorts 2 and 3 (approx 75)

MPFT



•Retirement Focus Group: update policy and SOP to ensure NHS offer
•Corporate Welcome: review current portal & information available to new starters in a bid to create an excellent first impression/ showcase opportunities, benefits and rewards and recognition on offer.
•Promotion of Flex Working

- Retirement - Project team initiated & scoping meeting held. Policies / SOPs updated.
- Corporate Welcome - HR, OD, Learning & Development and Recruitment functions are reviewing current processes and portal with the aim of updating online information.
- Flex - Identification of good practice examples eg. Community Nursing - this was used as a national case study

- Revise approach to Trust Induction & Welcome with potential to re-introduce face to face Corporate Induction.

Retention



UHNM

HCSW Induction & first 90 days Flex Working Leadership Development Programme 23/24: working with NHSE to test offer

- 13 HCSWs interviewed & feedback shared: 75% would benefit from more training for the role throughout the 90 days. 50% agreed the level of induction/training/new starter support was acceptable, whilst 25% disagreed.
- Trust was successful with bid to receive bespoke support from Timewise who facilitate workshops and create action plans around flex working
- Feedback results of First 90 Day programme to Care Coaching team and support development of robust induction programme

Primary Care



•H&WB Quality Outcomes Framework QI Module: Assisting practices with capturing data
•Development of Exit Questionnaire to capture information from leavers to inform themes
•GP Staff Survey Pilot 2023, providing PC staff with opportunity to share work experiences
•GP Placement Project: secondary & comm care.

- QOF - Designed survey to send to 142 Practice Managers. Successful 65% return rate. Analysed results and suggested next steps, support and actions for practices to improve their staff H&WB
- Exit questionnaire and interview templates developed/shared with Clinical Champions. Live link hosted by STH
- Staff Survey - 21/25 PCNs represented by at least 1 person. 1337 invitations to survey sent
- GP Placements - Clinical Champions, STH & ICS Retention Partner led on planning pilot. High interest from GPs, resulting in 8 placements in Cohort 1.

- Support analysis of all data including QOF survey results, exit questionnaires and staff survey. Make recommendations and help produce action plans, evaluate the impact of all initiatives.

ACHIEVEMENTS

24/25 DELIVERABLES

ACHIEVEMENTS

24/25 DELIVERABLES

Experience & Wellbeing

Occupational Health



A joint Occupational Health contract between NHS partners went live in April 2023

- The first joint OH contract for our system
- Effective collaboration between Partner Organisations
- Reduction in DNA's due to the implementation of a new process for appointment booking process agreed between partners
- Optima Health and Wellbeing Sessions

Continue to review processes and assess the opportunities for improvements that will enhance staff experience. Review and refresh 'future' work that was identified during the Stakeholder events during the tender phase. Plan H&WB session for 24/25 with Optima following data analysis from MI reports and Intel from the H&WB steering group

Health & Wellbeing Steering Group



Bringing together ICS H&WB leads, to develop a strategy that focuses on ensuring that our workforce have an evidence based H&WB offer to support their physical and mental health

- Membership for the group identified - now includes representatives from Primary Care and Social Care
- 3 x workshops held to identify areas of focus for the group
- Governance arrangements agreed with group

Creation of a H&WB Strategy for SSOT ICS.
Identify opportunities for collaboration and system approach to H&WB initiatives/offers.
Continuous review of data to inform an evidenced based approach.
Provide Project Management/Project Support to collaborative initiatives.
Evaluation of collaborative initiatives to identify impact.

Staff Psychological Wellbeing Hub



The Hub provides a safe and confidential space for staff to prioritise their wellbeing and get themselves back on track so that they can be their best selves both at home and in the work place

May 2021 - February 2024

Hub Referrals: **1416**
Assessments completed: **1169**
Staff referred on to support services: **978**
Engagement Sessions carried out: **200**
Workshops designed: **48**
Workshops facilitated: **200**
Attendees welcomed: **3166**

Hub Website launch
Student nursing placements

24/25 funding business case outcome
Continue delivering engagement sessions and workshops
Podcast launch

Workforce Planning & Information (WFPI)

People Metrics



WF Planning



- Enabling ease of access to complex workforce information to inform fact-based decision making.
- Enhancing workforce information by incorporating making data count principles to enable identification of trends, improvements and adverse outcomes.
- Workforce reconciliation – understanding workforce levels and additionality to understand contribution to patient care and safety.
- Understanding opportunities for improvement from benchmarking resources, including Model Health System and CHPPD.
- Workforce information that has a touchpoint with all workforce improvement initiatives that contribute to effective patient care and experience, from workforce modelling, retention, health and wellbeing, EDI and Staff Survey.
- Enabling 2-way check and challenge of approaches, with the aim of applying good practice and scaling up.

- Facilitate the delivery of operational workforce plans whilst ensuring the plans are evidence based.
- Continuous improvement approach of workforce planning to ensure we have the workforce in the right place with the right skills, values & behaviours, within the financial envelope.
- Using insight to enable check and challenge of workforce plan viability and delivery.
- Collaboration, including identification of priorities and co-design of workforce planning improvement initiatives.
- Training and development provided to increase capacity and capability of the workforce planning community.
- Modelling of Long Term Workforce Plan to understand local application and impact.

- Continue development of people metrics and wider reference to quality, safety and performance metrics including correlation analysis.
- Workforce productivity and utilisation
- Benchmarking
- Ensure links with digital are maintained to ensure best practice in people metrics and insight.

- Continued collaboration with NHS providers, primary care and non-NHS mental health providers.
- Development of thresholds which provide trigger warnings of planning delivery against actual workforce levels.
- Continue to develop forecasting and modelling tools to understand potential scenarios and opportunities.



Workforce Systems & Controls



- ESR is the biggest workforce information system globally – a new ESR is currently being procured with implementation requirements on the horizon.
- Level of attainment approach to ESR and improvements to workforce controls, e.g. establishment controls in ESR (where not already implemented), with SME being shared across our providers through collaborative working.
- Development of reporting to understand workforce controls, implementation and effectiveness.

Strategy, Portfolio and Transformation

Strategy & Governance



- Development of Joint Forward Plan and refresh which outlines our long term aims and focus for our People, and delivery of the Education and training duty
- Local LTWP picture and development of a local long term workforce plan aligned our programmes and planning.
- Ongoing delivery of People Culture and Inclusion Committee requirements including development of robust reporting, structures, risk and BAF management

- Delivery of Joint Forward Plan via People Collaborative and Working Groups
- Refresh Local People Plan, aligned to LTWP and system priorities
- People Culture and Inclusion Committee Development session and review of Committee approach and governance
- BAF management and delivery of actions to mitigate People risks

Portfolio/System Priorities



- Support to System Recovery Plan
- Cancer workforce funding and project initiation
- Lead UEC workforce planning and supply inc Acute Care at Home workforce supply and retention, surge and escalation process development and supply of contingent workforce
- Primary Care – development of workforce strategy, workforce planning and transformation support across PCNs, local retention programme, skill mix review and new role recruitment (e.g. ANP), ARRS role and funding utilisation increases

- Lead workforce elements of the 2024/25 System Recovery Programme and Provider Collaboratives
- Maternity – NHS 3 year delivery plan, FMBU programme, Birthrate plus and Continuity of Carer.
- Primary Care – finalise and implement workforce strategy and continue supporting workforce planning and transformation, ongoing experience & retention activities, ARRS utilisation
- Support development of Learning Disability, Autism and Downs Syndrome Portfolio Workforce Plans



Transformation



- Development of 3 year Digital People Plan including Digital and Technology Workforce, wider workforce, future pipeline and systems.
- Scoping undertaken locally against Delivering People Services at Scale Framework – appointment of Project lead to support delivery in 2024/25
- Development of new roles across the system including first system PA Apprenticeship, SNA programmes across social care and primary care.

- Ongoing delivery of Digital People Plan including Leadership programme, systems, digital skills & securing future digital workforce supply
- Development of People Services at Scale programme
- Pathway and Portfolio Transformation

Our OD and culture work, including equality, diversity and inclusion; inclusive talent management and leadership development, will be further shaped by our System strategic OD plan. We will continue to work collaboratively with system partners to develop this plan by running a series of consultation workshops in Q1, aligning with Provider organisational plans and agreeing delivery priorities for 2024/25.

Organisational Development

ICB Development



Primary Care OD



ACHIEVEMENTS

- Supporting ICB development through delivery of workshops and activities aimed at building relationships and shared common purpose
- Facilitating Strength Deployment Inventory (SDI) and discovery coaching sessions
- Board development sessions
- Needs assessment and leadership development (exploring brave and authentic leadership)

- Needs assessment, OD programme designed, year 1 actions delivered
- Engagement with PCNs, GP Collaboratives, support for development and GP voice
- Maturity assessments, delivery of DISC assessments (primary care, PCN's), team based development workshops, increased cohort of Action Learning Set (ALS) facilitators
- Bespoke OD intervention to support Primary Care transformation in Workforce development, Access and the AVS service

24/25 DELIVERABLES

- Systems learning and leadership opportunities to be developed as part of the ICS OD plan.
- Mobilisation of OD Plan for ICB following needs assessment.

- Team coaching to attain high performance with Primary Care team.
- Delivery of stakeholder management training to cohort of 20.
- Increase in confidence in GP voice and representativeness
- Evidenced OD mindset in approaches to change and transformation in Primary care
- Increased engagement in collaborative working
- 50% increase in uptake in leadership development offers such as DISC, ALS, modules of taught learning.

SSOT OD collaborative



Provider Collaboratives



- Building relationships between OD leads and specialists across the system
- Agreeing development opportunity for OD within the system.
- Supporting system level operational developments.

- Needs assessments commissioned and delivered for 2 provider collaboratives
- Supported development of OD plans
- Engagement with OD system partners .
- Engagement and wellbeing support to Integrated Discharge Hub

- Mapping of OD skill across SSOT.
- Development plan to support upskill of OD profession. Improved and consistent OD offer to system transformation work e.g. provider collaboratives.

- Scoping OD resource required to support System Priorities at Provider Collaborative and Neighbourhood level.
- Increase confidence in OD mindset within Provider Collaboratives, so that this lens is used in delivery of transformation.

Equality, Diversity and Inclusion



Changing Mindsets and Culture



Taking Positive Action



Delivering Change



- Challenging blind-spots and established ways of thinking is a key requirement for delivering meaningful and sustainable change on inclusion.
- Over 2023-4 we have been educating our workforce and our leadership in a number of different ways to deepen insight and understanding on inclusion and – crucially – how to use this to bring about change.
- This includes our **Inclusion School** approach (over 200 attendances - which included both in person and online sessions in 23-24) and our **Comfortable Being Uncomfortable** programme (around 300 leaders participated with 95% saying it increased their confidence in having conversations on race, in being a race ally and to make positive difference at work).

- Delivering on inclusion necessitates addressing historical inequities to level the playing field and inspire confidence in minoritised groups. In 23-24 we've:
- Delivered a further round of our **New Futures** positive action on race development programme (36 Global Majority Heritage colleagues participated).
- Rolled out our **Differently Abled Buddy Scheme** and a range of disability-focused education across the ICS (450 people educated on disability inclusion; at least 91 confidential discussions taken place)
- Launched our **WRES Champions** (20 champions) and **Reciprocal Mentoring** approaches (12 pairings)
- Engaged with our **local communities** in a variety of recruitment and inclusion events

- Delivering on Inclusion means focusing on the outputs as well as the inputs
- In 23-24 we have made significant progress in improving the ethnic diversity and representativeness of our ICS workforce (Increased our Global Majority Heritage workforce from 14% to 16% in
- Increased the proportion of our workforce that are confident to declare disabilities and neuro-difference (from 3% to 5%)
- Improved belief in equal opportunities by Global Majority heritage colleagues
- Improved feeling valued, satisfaction with work adjustments and engagement in differently abled colleagues

Our EDI priorities and deliverables for 2024/25 will be shaped by our System OD plan which is currently in development.

Leadership and Talent

Our ambition for SSOT ICS over 2023-24 has been the continued focus on the development and retention of inclusive talent. Our newly formed Leadership and Talent Workstream Steering Group has enabled a foundation for working collaboratively with NHS, social care and Education partners to jointly agree our priorities. For 2023-24 we have remained committed to delivering Cohort 2 of the High Potential Scheme as we know that our focus on developing a diverse pool of senior level leaders helps us deliver our WRES targets, the NHS Long Term Plan and recommendations of the Messenger review in relation to leadership development and system talent management. Our system alumni programme has enabled us to strengthen our talent offer so that we can further build out our talent pipeline, pool and succession plans in 2024/25. Coaching and Mentoring remains a key enabling development offer to support the delivery of our programmes. We are committed to continuing to develop diverse pools of coaches and mentors to support our people's development.

High Potential Scheme

The 2-year scheme is an inclusive and compassionate leadership development programme. Its aim is to help accelerate the progression of senior level managers (typically Bands 8a-8d or equivalent) into executive level posts within 5-8 years of commencing the course. Our approach using the "potential" model forms a component part of developing our collective ICS Talent Pipeline for our diverse aspirant future leadership cadre.



HPS Achievements

- 36% of Cohort 2 participants promoted since starting scheme in Jan 2023
- 73% of participants progressed 1 year after graduating Cohort 1, of which 71% are female
- Over 100 stretch opportunities offered
- 244 stakeholders involved in delivering the programme cross the systems
- 3 teams of 6 taken to WME Trisector challenge, all mentioned in a shortlisted category; one individual winning Shining Star Award for team leadership.

HPS 24/25 DELIVERABLES

- 28 participants completing their second stretch assignments and showcase panels, amongst other activities before December 2024.
- HPS graduation event to take place 23rd January 2025.

Coaching and Mentoring Partnership

Our Partnership Group meet regularly to collaborate on the implementation of coaching and mentoring culture across SSOT ICS. Participation of the West Midlands Employers Coaching and Mentoring Pool, along with 40 other subscribing organisations has provided us with a regional offer to our ICS as well as providing our people with access to coaching sessions that would otherwise have cost in excess of £45,980 (Based on the 2020 Sherpa Survey).

ACHIEVEMENTS

- Our key achievements include:
- 7 coaches currently in training to grow our diverse pool
 - 28 trained external coaches
 - 43 internal coaches
 - 16 career development mentors registered in WME pool

24/25 DELIVERABLES

- To continue to promote the WME coaching and mentoring pool to staff to increase uptake.
- To grow our pool of career development mentors by training new mentors to enter the pool.

Leadership Alumni Master Classes

To support the development of our leaders across the system, we put on 4 masterclasses with leadership experts over the course of 2023/24. We heard from:

Maggie Alphonsi
Face of international women's rugby on 27 June 2023, 37 attended

Blaire Palmer
Journalist and author on 14 September 2023, 34 attended.

Steve Head
Full-time speaker, inspirational trainer, coach and author on 28 November 2023, 54 attended.

Deborah Henley
International speaker, author and coach on 8 February 2024, 49 attended

NHS Staff Survey 2023: Summary & Response

The People Promise summary indicators provide an overview of staff experience in relation to the seven elements of the People Promise. Scores were also reported Staff Engagement and Morale



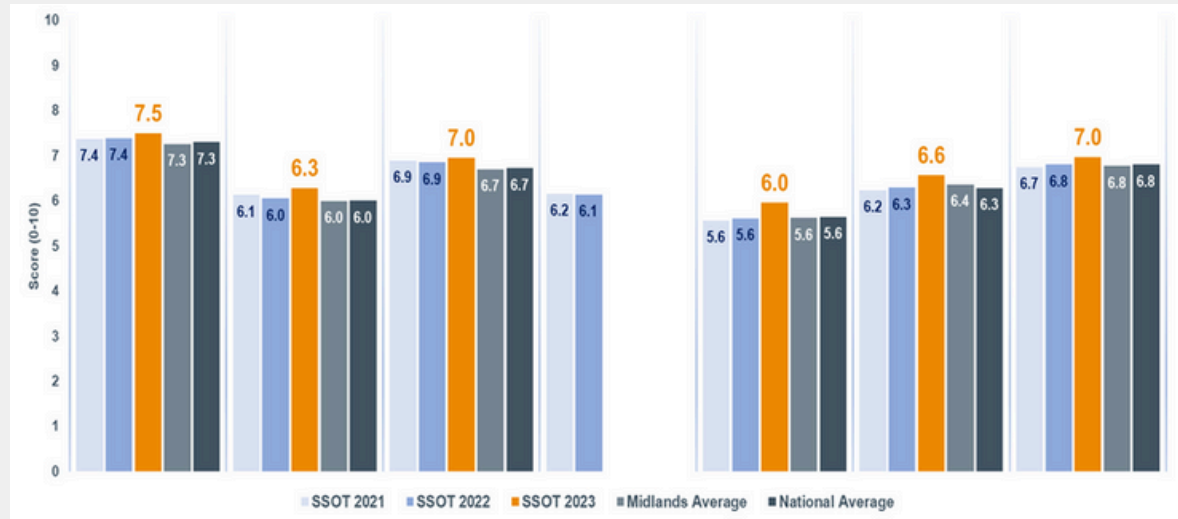
The results show that the ICS were the highest scoring system in the region. The system has also achieved higher scores or remained the same in all areas.

System wide workstreams/projects, and additional actions identified to take forward the results and address improvements:

- Reporting and governance around improvements via ICS People Committee
- Steering/working groups leading detailed analysis and work with partners to identify additional actions e.g. Retention, Employee Experience & Health & Wellbeing, Leadership & Talent, EDI
- In addition to Provider levels actions, specific system activities already underway include an ICS OD Strategy, Leadership programmes & approaches, targeted NHS OH offers, system approach to Sexual Safety Charter & training, Retention inc Flexible working programmes, system EDI development

Staff Engagement Theme Score 7.1
(7.0 in 2022). Scoring higher than the Midlands and National average on sub-scores.

Morale Theme Score 6.2
(6.0 in 2022) Scoring higher than the Midlands and National average on sub-scores.



Note: People Promise Elements, themes and sub-scores are scored on a 0-10 scales, where a higher score is more positive than a lower score. Safe and healthy scores are not yet available.

People Culture and Inclusion Priorities 2024/25

In 2024/25 People Culture and Inclusion Programmes will focus on the delivery of the LTWP locally, on collaboration and scaling; reform; productivity; access and entry level routes into health and care; securing our future pipeline; clinical and professional engagement and looking after our people.

Key principles and aims of activities will be to: Reduce spend, increase reform, create efficiencies to improve the quality of services, enhance the care and treatment of our population and to achieve financial stability.

In addition, the core business of the team will include delivery of: Inclusion in all we do, organisational development and leadership programmes, workforce oversight, system priorities and collaboratives, operational plan, NHS long-term workforce plan ambitions, workforce safeguarding/ governance, retention, delivering at scale, workforce transformation & planning, workforce systems improvement and implementation, targeted workforce supply and access initiatives.



2024/25 Programme Delivery

Overarching programmes outlined across the six workstreams will deliver the People Priorities, Long Term workforce Plan at a local, and support delivery the system priorities, recovery programme and financial balance. Workstreams are led by Senior Responsible Officers, with delivery facilitated by working groups and partner activities

Programme Activity						
MPFT Chief People Officer	ICB Chief People Officer	UHNM Chief Nursing Officer	NSCHT Chief People Officer	UHNM Chief People Officer	ICB Chief Executive Officer	NSCHT Chief People Officer
Workforce supply	Workforce planning and transformation	Education, Training & Widening Participation	Equality, diversity and inclusion (EDI)	Employee experience, health and wellbeing	System culture and collaboration	Leadership and talent
<ul style="list-style-type: none"> Attraction and inclusive recruitment – at scale and cross-sector Recruitment practice including RPA New to Care – access to jobs, outreach into communities Contingent system workforce deployment, ICS People Hub Retention Programme Redeployment Service 	<ul style="list-style-type: none"> Operational Workforce Planning Workforce oversight and utilisation inc agency reduction, vacancies, rostering System Recovery Programme People Services at Scale Pathway Planning and Transformation Digital People Plan 	<ul style="list-style-type: none"> Education, Training and Development Strategy inc Clinical Placement Project Workforce Development and Education funding and commissions Widening participation – including J2W, Apprenticeships, National T-Levels Pilot Educational Engagement (in partnership with CYP) 	<ul style="list-style-type: none"> Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Staff networks WRES Champions Reciprocal mentoring #InclusiveHR Scheme 	<ul style="list-style-type: none"> Employee Experience & Wellbeing Strategy Occupational Health Provision Staff Psychological Wellbeing Hub Wellbeing resources and events 	<ul style="list-style-type: none"> PCN OD programme System OD Plan 	<ul style="list-style-type: none"> High Potential Scheme Coaching and mentoring pool Scope for Growth pilot
Underpinned and enabled by						
Clinical Senates/ Groups	Delivering at Scale and Productivity	Workforce planning	People Metrics	Operating Plan	Joint Forward Plan	Financial Strategy

With huge thanks...

to our Partners

Without the support and contributions of our partners and workforce, we would not have been able to achieve or make the difference we have.

We look forward to continuing our work with all partners with our people at the heart of everything we do.



Primary Care Networks



Independent Care Providers



Board Committee Summary and Escalation Report

Enc.17

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal, ICB Non Executive Director (PCI Chair)
Executive Lead:	Mish Irvine, ICB Chief People Officer (Interim)
Date:	Wednesday 10 th July 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	<p>The Committee received the Journey to Work video, following the sharing of the concept and story at the ICB Board.</p> <p>The video was well received by the Committee and members were pleased with the way the video brings together the work the system partners are doing in connecting with the local community, supporting our local population into careers and jobs, engaging with schools and how we look after and retain our people.</p> <p>The Committee welcomed the plans to further develop the video and concept to include our work and commitments around EDI, Leadership and Talent, and to include how we work with the voluntary sector.</p> <p>Video Link: https://www.youtube.com/watch?v=tww6vMf82QA</p>	
People Position, Performance and Planning	<p>2024/25 Operational Planning</p> <p>The Committee received an update on the overall 2024/25 System Operational Plan from the ICB Director of Planning, describing how the plan has been developed to outline high level annual priorities and actions to address the challenges the system faces. This is our second system operational plan, co-ordinated by the ICB and co-produced with system partners across the ICS.</p> <p>Committee members were also presented with an overview of the FY24-25 operational workforce plan in the papers and assured regarding the established links between finance, performance and workforce colleagues.</p> <p>Committee members noted the update and requested further updates to track the progress of the plan, specifically from a people perspective.</p> <p>Medium Term Plan</p> <p>A summary of the Medium Term Plan was presented to the Committee. The Director of Planning outlined the</p>	

	<p>aims of the plan in tackling the financial deficit in year and longer-term, including the work programme and timeline for the plan which has been developed in collaboration with system partners.</p> <p>The Committee noted the contents of the plan and the updates provided. Members held a discussion regarding the crucial People/workforce elements of the plan, the risks associated with workforce supply, retention and wellbeing and the key role this Committee will play in monitoring and enabling delivery of the plan.</p> <p>People metrics and controls Included in the PCI papers for assurance, position and positive movement noted. Members involved in submitting information and data were thanked.</p>	<p>People Metrics, Controls and Planning update provided in the ICB Board papers</p>
<p>People Culture and Inclusion Programme Assurance</p>	<p>2023/24 Annual Report The Committee received the ICS People Culture and Inclusion Annual Report for 2023/24 programme activities, achievements and project highlights for ratification.</p> <p>Programme Assurance Members received a high level summary of the People Culture and Inclusion Programme activities and assurance regarding delivery and progress. The Committee was assured that the programmes were on track and being monitored via the People Collaborative Board.</p> <p>System OD Plan The Committee received an update on the progress in developing the System OD Plan. The Plan will strategically shape our ICS Organisational Development approach and activities, guiding the focus for ICB Board Development and associated leadership and modelling of system culture and collaboration, as well as setting the scope and direction of agreed ICS strategic OD priorities. The plan is being developed collaboratively by system partners with oversight and endorsement from the Committee and the ICB Board.</p> <p>The Committee considered the Plan, endorsing the principles and approach outlined, recognising their importance in addressing current challenges and fostering System resilience, agreed to support in gaining provider organisational executive ownership and leadership of the Organisational Development Plan when finalised, encouraged alignment of the necessary resources to support successful implementation of the plan and approach.</p> <p>Further engagement and sessions with key stakeholders will take place over the summer, with final engagement sessions during September prior to finalising the plan. An updated and final version of the Plan will be presented back to October PCI</p>	<p>PCI Annual Report provided in ICB Board papers for information and assurance.</p>

	Committee.	
People Culture and Inclusion Risks	<p>The Committee received an overview of the current People risks.</p> <p>Permission was sought from the Committee to close Risk 1193 which is now captured more accurately in two new standalone risks - <i>Slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage; Ability to deliver the Long Term Workforce Plan and create a sustainable future pipeline.</i> Whilst the Committee supported this proposal in principle, leads were asked to review the short term risk to ensure the wording adequately articulated the challenge.</p> <p>A discussion took place regarding the proposal to merge the two industrial action related risks – one captures the overarching strike action risk, another specifically articulates the risk associated with GP collective action should it go ahead. The Committee rejected the proposal to merge on the basis that the GP action carried wider system implications, and not purely workforce risk. The risk leads agreed to revisit and the two risks will remain separate.</p> <p>All other risks remain unchanged and managed in accordance with mitigation outlined, system and organisational activity</p> <p>Committee members received assurance regarding the robust review and development of the 2024/2025 SBAF.</p>	
Strategic People, Culture and Inclusion Updates and current context	<p>The Committee was provided an update on the current People Culture and Inclusion context in following areas:</p> <ul style="list-style-type: none"> • NHS Confederation Expo – The ICB CPO and Head of ICS People attended to present and showcase the SSOT approach to workforce integration. A number of sessions were attended to understand the National NHSE direction of travel and to learn from other systems on key people matters • QSRM feedback was received by the Committee and members were reassured that the meeting went well overall with NHSE assured that workforce planning, controls and programme activities were addressing the key challenges facing the system. • Enabling Functions Recovery Programme workstream – update was provided regarding the agreed process and next steps. • Skills for Care Workforce Strategy launch – will be held on 18th July 2024 and it is hoped that the strategy will support local planning and activities and compliment the partnership working already established. The Committee will welcome the Head of Midlands Skills for 	

	Care at the next PCI for an update and discussion regarding local implementation.	
PCI Development and review	<p>The Committee received an update on the PCI Development session held in May, with a detailed report included in the papers of the discussions held and proposals.</p> <p>A proposed new meeting, governance and programme structure was presented to the Committee and a rich discussion took place regarding the recommended future direction. The Committee highlighted reservations regarding the disestablishment of the People Collaborative and devolving responsibility to Steering Groups. Members proposed an additional discussion between CPOs to review the feedback and consider the best approach with some urgency.</p> <p>Members reflected on the importance and pivotal role the Committee plays and will continue to play in enabling system recovery, delivery of the Medium Term Plan, securing a robust pipeline and looking after our people. Additionally, members highlighted the importance of plans and strategies being approved by the Committee and providing assurance to the ICB Board on all people matters.</p> <p>The Committee will receive an update and approve a revised structure at the next meeting in September.</p>	Next People Collaborative Board to be held as a workshop to develop and implement the proposed new structure following further CPO discussion and clarity.

Risk Review and Assurance Summary

The following points were highlighted by the Committee:

- The People elements are critical to enabling delivery of the 2024/25 Operational Plan and achieving the Medium Term Plan aims. Therefore a focus on People and the wider implications surrounding recovery and achieving financial balance need to be carefully managed and overseen by the Committee.
- Assurance that the workforce position, metrics and controls are being robustly monitored.
- Ongoing delivery of People, Culture and Inclusion programme activities in line with system and financial context.
- Assurance received regarding management of People Risks with clear actions and mitigation agreed and formulation of the 2024/25 BAF.
- PCI Committee Structure to be discussed further and refined by CPOs and People Collaborative Board following feedback.

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	Q1 2024-25 System Board Assurance Framework (SBAF) Update					
Presenting Officer:	Claire Cotton, Director of Governance, UHNM					
Author(s):	Lia Pitarokoili, Head of Governance and Tracey Revill, Governance Manager/IG Operational Lead					
Document Type:	Report					
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input checked="" type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	NO				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	SBAF Report					

(1) Purpose of the Paper:

The enclosed report sets out the refreshed System Board Assurance Framework (SBAF) for Quarter 1 2024-25 and is provided to the ICB Board for oversight and assurance. The SBAF has been presented to all the sub-committees of the Board throughout July 2024.

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

Click or tap here to enter text.

Date

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(3) Implications:

Legal or Regulatory	UK Corporate Governance Codes and Controls Assurance Audits. SBAF completion is a key component of the ICB's Risk Management Strategy.
CQC or Patient Safety	There are no implications for CQC or other regulators
Financial (CFO-assured)	Managing financial risks will help mitigate Financial Management Concerns
Sustainability	Managing 'Greener NHS' risks will help mitigate Sustainability Concerns
Workforce or Training	Mitigation of workforce risks to meet the requirements of NHS Long Term Workforce Plan. There are no training implications resulting from this paper

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Not applicable in relation to this report. If Y, Reported to IG Group on Click or tap to enter a date.</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not applicable in relation to this report.
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why Not applicable in relation to this report. If Y, Approved by QIA Panel on Click or tap to enter a date.</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not applicable in relation to this Report

(5) Integration with the BAF & Key Risks:						
BAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>		BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>		BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>		BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>		BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>A development session was held with ICB Board members on the 21st March 2024 to discuss and agree the strategic objectives for the ICB going into 2024/25.</p> <p>The attached SBAF provides the ICB Board with those revised/refreshed objectives and the first quarter update for 2024/25. The SBAF as a dynamic document has been reformatted and will continue to be developed and improved in terms of format and function throughout 24/25 and beyond.</p> <p>The SBAF includes eight Strategic Risks which provide coverage of the four Strategic Ambitions. The Strategic Framework is set out in Section 2 of the current report. Strategic Ambition 2 (Address inequalities in access, experience and outcomes from health and care services) and Strategic Ambition 3 (Achieve a sustainable and resilient ICS) are the most threatened, each with 5 Strategic Risks posing a threat.</p> <p>The top 3 Strategic Risks for this quarter are SBAF 4 (Reducing Health Inequalities), SBAF 6 (Sustainable Finances) and SBAF 8 (Sustainable Workforce), all scoring High 20.</p> <p>There are 2 actions that are ‘Delayed’ and these are within SBAF 3 (Proactive and Needs Based Community Services).</p> <p>The majority (5/8) of Strategic Risks have a ‘Partial Assurance’ rating although SBAF 3 (Proactive and Needs Based Community Services), SBAF 5 (High Quality, Safe Care Outcomes) and SBAF 8 (Sustainable Workforce) have ‘Acceptable Assurance’ rating.</p> <p>The Q2 2024/25 SBAF will be presented to Board on the 17th October 2024 following its submission to all Board Committees.</p>

(7) Recommendations to Board / Committee:

The ICB Board is asked to discuss and confirm whether the Q1 risk scores and assurance assessments are an accurate reflection of the position, discuss the adequacy of controls and assurances and note that the Q1 2024-25 SBAF has been presented at ICB Committees in July.

Integrated Care Board

System Board Assurance Framework (SBAF)

Quarter 1 2024/25



1 Introduction and Overview

Situation

The System Board Assurance Framework (SBAF) provides a structure and process which is designed to focus the Integrated Care Board (ICB) on the key strategic risks which might compromise the achievement of its Strategic Ambitions (SA). In identifying those risks, consideration is given to the key controls in place to mitigate the impact of risk and the sources of assurance which the Board can rely upon to determine the effectiveness of those controls. Where gaps in control or assurance are identified, further actions are identified which are aimed at either providing additional assurance or to reduce the likelihood or consequence of the risk, towards the target. The target risk score or 'tolerance' is aligned with our Risk Appetite Statement (appendix 4 of our Risk Management Strategy).








Background

The Board approved the Integrated Care Partnership (ICP) Strategy in March 2023, which set out a Strategic Framework including four Strategic Ambitions, around which the SBAF has been structured. This Strategic Framework is set out in section 2 below.

To refresh the SBAF for 2024/25, a Board Development session was held in March 2024. This provided opportunity to review each strategic risk and determine whether it remained relevant, with a particular focus on ensuring that they were described at a system wide level. Whilst it was agreed that each risk would be carried forward into 2024/25, some minor changes were agreed and have been considered when updating the SBAF this quarter.

The SBAF is a dynamic, ever evolving document which has and will continue to be developed and improved in terms of format and function throughout 2024/25 and beyond.

Assessment

	The top 3 Strategic Risks for this quarter are SBAF 4: Reducing Health Inequalities, SBAF 6: Sustainable Finances and SBAF 8: Sustainable Workforce, all scoring High 20 .
	SBAF 8: Sustainable Workforce has seen an increase in risk from High 16 at Quarter 4 2023/24 to High 20 at Quarter 1 2024/25 in recognition of the workforce pressures and financial position in health and social care
	SBAF 1: Responsive Patient Care (Urgent & Emergency) has seen a decrease in risk from High 20 at Quarter 4 2023/24 to High 15 at Quarter 1 2024/25 due to the improvements seen.
	SBAF 5: High Quality, Safe Care Outcomes has the highest number of linked operational risks (27) whereas SBAF 2: Responsive Patient Care (Elective) and BAF 3: Proactive planning and delivery of Integrated Locality Based Community Services have the lowest number of linked operational risks (4 each).
	There are no actions which are 'Problematic' at this stage, although there are 2 actions that are 'Delayed' ; these are within SBAF 3: Proactive planning and delivery of Integrated Locality Based Community Services.
	Strategic Ambition 2: Address inequalities in access, experience and outcomes from health and care services and Strategic Ambition 3: Achieve a sustainable and resilient Integrated Care System are the 'most threatened', each which 5 Strategic Risks posing a threat.
	The majority (5 / 8) of Strategic Risks have a ' Partial Assurance ' rating although SBAF 3: Proactive planning and delivery of Integrated Locality Based Community Services, SBAF 5: High Quality, Safe Care Outcomes and SBAF 8: Sustainable Workforce have ' Acceptable Assurance '.

Recommendations

Committees are asked to:

- Discuss and confirm whether the Q1 Risk Scores and Assurance Assessments are an accurate reflection of the position
- Discuss and comment on the adequacy of Controls and Assurances and consider whether the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance
- Note that further work is to be undertaken on Committee Business Cycles to ensure full alignment with the BAF

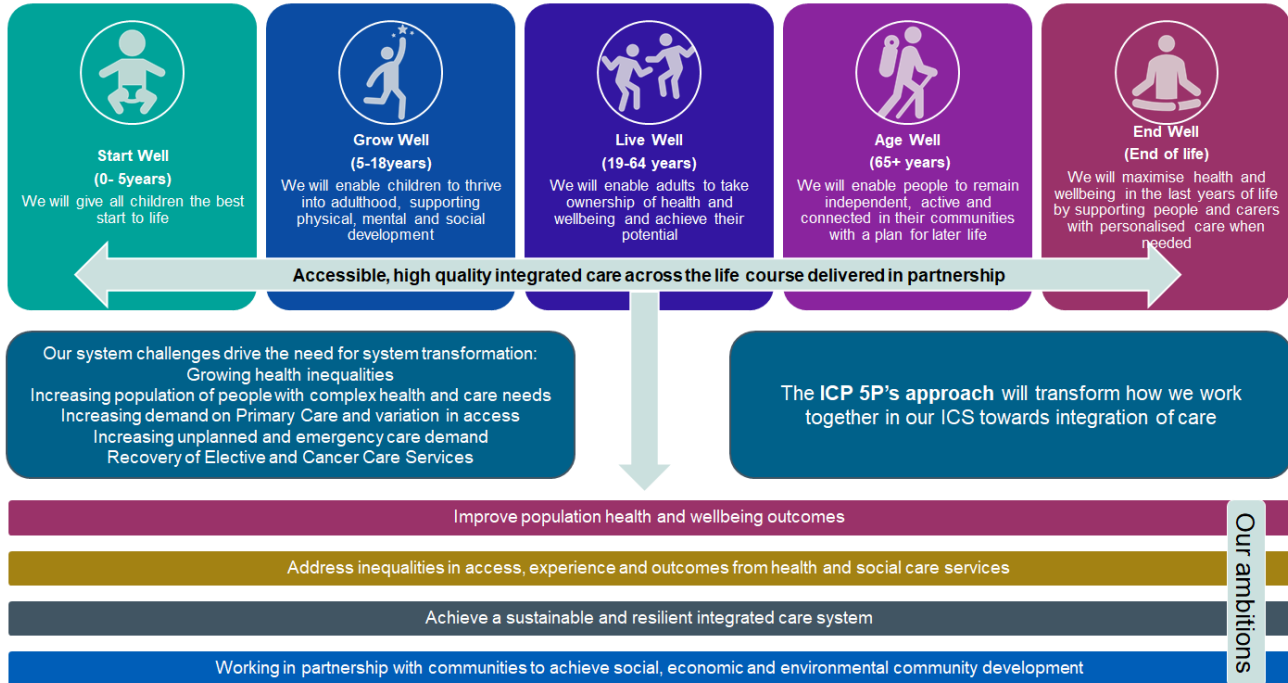
Additional Information

- The SBAF can be viewed on SharePoint: [Staffs CCGs | Communications and Governance - BAF and Risk Register - All Documents \(sharepoint.com\)](#)
- The following tables set out the keys used within the SBAF for Action Plans and Assurance Assessment Ratings

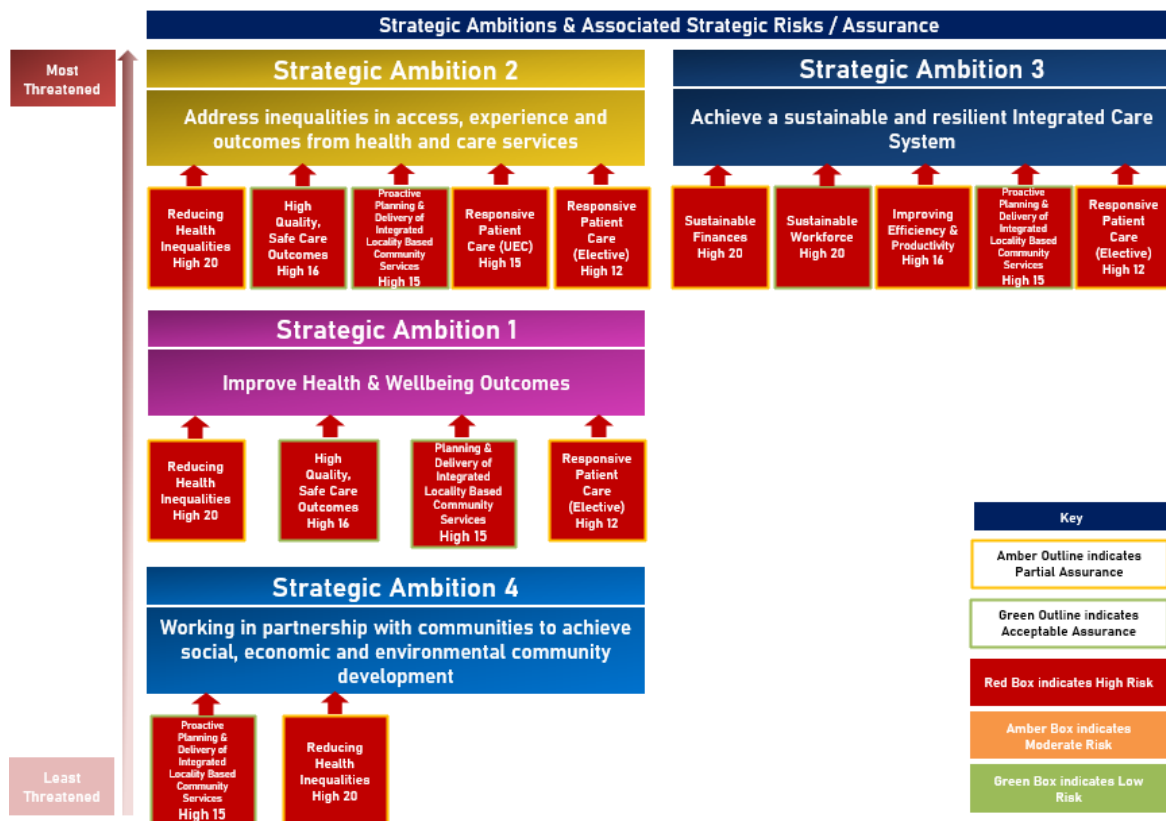
Action Plans – Key to Progress Ratings		Assurance Assessment Ratings	
Complete / BAU	Action completed, now business as usual	Significant Assurance	High level of confidence in delivery of existing mechanisms / objectives
On Track	Improvement on trajectory, on track, or completed	Acceptable Assurance	General confidence in delivery of existing mechanisms / objectives
Problematic	Delivery remains feasible, actions not completed, awaiting further interventions	Partial Assurance	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
Delayed	Off track / trajectory / milestone breached. Recovery plan required.	No Assurance	No confidence in delivery

2 Strategic Framework

The Strategic Ambitions identified within the SBAF form part of the Strategic Framework within the [ICP Strategy](#).



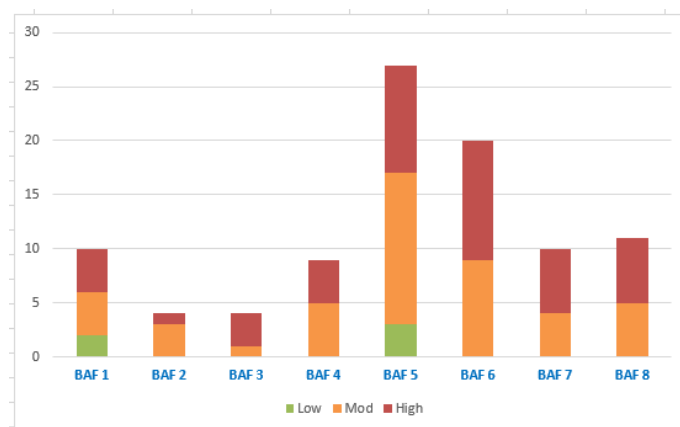
3 Threat to our Strategic Ambitions



4 Summary Board Assurance Framework (SBAF)

No.	Strategic Risk Title	Q1			Q2			Q3			Q4			Target			Risk Movement	Assurance Assessment	Action Plan	Linked Risks	Threat to Ambitions	
		L	C	S	L	C	S	L	C	S	L	C	S	L	C	S						Date
SBAF 1	Responsive Patient Care - Urgent & Emergency Care	3	5	High 15										3	5	High 15	31/03/2025	↓	Partial Assurance			SA2
SBAF 2	Responsive Patient Care - Elective	4	3	High 12										2	3	Mod 6	31/03/2025	→	Partial Assurance			SA1 SA2 SA3
SBAF 3	Proactive Planning & Delivery of Integrated Locality Based Community Services	3	5	High 15										2	4	Mod 8	31/03/2024	→	Acceptable Assurance			SA1 SA2 SA3 SA4
SBAF 4	Reducing Health Inequalities	4	5	High 20										2	2	Low 4	31/03/2028	→	Partial Assurance			SA1 SA2 SA4
SBAF 5	High Quality, Safe Care Outcomes	4	4	High 16										3	3	Mod 9	31/03/2025	→	Acceptable Assurance			SA1 SA2
SBAF 6	Sustainable Finances	4	5	High 20										4	3	High 12	31/03/2025	→	Partial Assurance			SA3
SBAF 7	Improving Efficiency & Productivity	4	4	High 16										3	3	Mod 9	31/03/2025	→	Partial Assurance			SA3
SBAF 8	Sustainable Workforce	4	5	High 20										4	4	High 16	31/03/2025	↑	Acceptable Assurance			SA3

5 Strategic Risk Heat Map and Linked Risks



Risk Profile:

- **Top 3 Scoring Strategic Risks** are SBAF 4: Reducing Health Inequalities, SBAF 6: Sustainable Finances and SBAF 8: Sustainable Workforce
- SBAF 5: High Quality, Safe Care Outcomes, SBAF 6 and SBAF 8 have the highest number of **linked operational risks**

6 System Strategic Risk Map

The System Strategic Risk Map is currently being refreshed and will be included at Q2.

7 System Board Assurance Framework (SBAF)



SBAF 1: Responsive Patient Care – Urgent & Emergency Care

Finance & Performance Committee | Chief Delivery Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If the Urgent and Emergency Care (UEC) system does not have sufficient and appropriate capacity across the entire system pathway to meet demand and support flow,		
Event	then should demand outstrip capacity, there will be pressure points within the UEC system,		
Effect (Consequence)	resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance and non-delivery of operational planning targets.		
SA1	Improve Health and Wellbeing Outcomes	SA3	Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	SA4	Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	3				3	The consequence of not having the correct capacity in the UEC system will inevitably impact on delivery and patients not able to access the UEC they require. The biggest risk is having long waits for ambulances in the community.	Low 2 ↓
Consequence	5				5		Mod 4 ↓
Risk Level	High 15				High 15		High 4 ↓

Rationale for Risk Score and Progress Made in the Quarter:

For Q1 the key priority areas for improvement remain 4-hour Emergency Department (ED) performance towards achieving 78%, 12-hour ED performance, and reducing ambulance handover delays and therefore category 2 performance.

Our UEC governance infrastructure ensures collective leadership for system oversight for delivery and improvement, with all system partners. We had a surge plan with oversight in place across 23/24 which outlined investment across UEC pathways to increase capacity. To support improvement in 24/25 and beyond, a Demand Management Collaborative has been created with Chief Operating Officer (COO) Senior Responsible Officer (SRO) leadership. This collaborative will lead the development of a demand management plan across the system to identify areas for efficiency and to mitigate the identified bed deficit of 85 beds* to agreed manageable levels. A system review of winter lessons learned was undertaken in May 2024, and will be utilised to develop further plans for 24/25.

There are a number of initiatives that will impact upon system capacity for 24/25 including those outlined in the system Joint Forward Plan (JFP) 2023-28:

- Continued focus on the in-hospital improvement programme, and right sizing of medical capacity at University Hospitals of North Midlands NHS Foundation Trust (UHNM). Funding was received in 23/24 for a modular unit at Royal Stoke University Hospitals, this funding will provide additional assessment capacity as well as bedded capacity.
- Continued development of our acute care at home collaborative, and the Development of a system single point of access.
- Focus on designation of Urgent Treatment Centres (UTC) and development of our UTC model across Staffordshire and Stoke-on-Trent (SSOT).
- Continued work on our integrated discharge model and increasing numbers of pathway 0 patients.
- Continued improvement in bed occupancy to 92% or below.

Key Controls Framework

- Daily System Control Centre (SCC) & Daily System calls.
- Regional Capacity Calls attended by System Control Centre.
- System UEC Priority Plan/Operational plan – the system has agreed a 7-point focused plan to drive improvements across the UEC system. As part of the national operational plan SSOT has submitted a Short Form Business Case to the national team to increase the Royal Stoke capacity by 45 beds to meet demand during 23/24 peak surge.
- System UEC 23/24 Surge Plan has been developed through a multidisciplinary approach and has been signed off through an extension governance route including all partner organisational Boards.

- The SCC was mobilised in December 2022 and remains in place. The SCC proactively manages the daily capacity and demand across the system and leads daily system COO calls to manage pressure.
- System Escalation Plan –the refreshed system escalation plan has been developed with system partners. Following consultation with regional NHSE colleagues, the UEC Board signed off the revised System Escalation Plan on 13th December to ensure there is an appropriate framework for managing risk and escalation across the ICS.
- System UEC Strategy – whilst outlining longer term plans of improvement, the UEC Strategy development ensures that the UEC Portfolio has a clear vision for UEC development, any in year improvements will be striving to meet the improvements set out in the long-term System UEC Strategy.
- ICB Finance & Performance Committee and System Performance Group; these groups are tasked with being assured on delivery and offer good-strength controls into the decision-making processes, supporting the other principal controls outlined. Surge reports monthly to these forums.

Assurance Map					
Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)					
2nd Line (system)	System Performance Report to Finance & Performance Report to Finance & Performance Committee and ICB Board.	•			
	Monthly updates to System Delivery Group.	•			
	Monthly updates to Finance and Performance Group.	•			
	Monthly update to System Performance Group.	•			
	Monthly update to Finance and Performance Committee.	•			
	Fortnightly SLT update.	•			
	Surge Plan Assurance by:				
<ul style="list-style-type: none"> • UEC Board. • Children & Young People (CYP) Programme Board. • UEC Clinical Advisory Group. • Finance & Performance Committee. • UHNM Trust Board. • Clinical Senate. • SOTCC Operational Business Meeting. • MPFT Trust Board. • SCC Health & Care Senior Leadership Team. • Staffordshire Health Overview & Scrutiny Committee • System Quality Committee. • ICS People, Culture & Inclusion Committee. 					
3rd Line (external)	Tier 2 UEC Improvement framework – Executive monthly.	•			
	Surge Plan Assurance.	•			
	NHS England - Surge Plan Assurance Template.	•			
	NHS England Regional Assurance Visit/Peer Review.	•			

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	•
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> • Residual bed capacity gap. • Workforce deliverability across all areas of UEC pathway. • Industrial Action (IA). • Surge beyond the predicted peak. • Covid restrictions applied in Care Home market. • Unforeseen demand due to major incident. • Individual organisation risk management. 	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	24/25 Surge Plan to be agreed by ICB Board	Agreed trajectory to close capacity gap.	Chief Delivery Officer	30/08/24	Surge Plan in development. Interdependency with Demand Management collaborative.	Problematic	
2	Delivery of System UEC Improvement Plan against trajectory	Achieve Operational Plan requirements. Bed occupancy – 92% or below Cat 2 response – 30 mins.	Chief Delivery Officer	31/03/25	Operational plan subject to revision – however, action plans and delivery underway. Improvements seen in 23/24, to be continued into 24/25.	On Track	
3	System Escalation Plan	Plan to cover risk arising from: <ul style="list-style-type: none"> • Bed capacity gap. • Surge beyond predicted peak. • Covid restriction in Care Homes. 	Chief Delivery Officer	30/10/24	Plan for 24/25 to be developed in line with ambitions of System Collaborative for Demand Management.	On Track	
4	Industrial action	There are plans in place to deal with each incidence of industrial action	Chief Delivery Officer	31/03/25	This remains a risk as the level and frequency of the industrial action are unknown.	On Track	
5	Workforce deliverability across all areas of UEC pathway	Overarching workforce plan, underpinned by workstream & service level plans including transformation, supply, training and OD.	Chief Delivery Officer/ Chief People Officer	31/03/25	Approach to workforce plan agreed, scoping underway within workstreams and services to identify workforce requirements, risks and plans to mitigate.	On Track	



SBAF 2: Responsive Patient Care - Elective

Finance & Performance Committee | Chief Delivery Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If the system fails to deliver on the specific expectations set out in the 2024/25 (and earlier) planning guidance relating to waiting time recovery,		
Event	then cancer and planned care waiting times will not reduce in line with national expectations,		
Effect (Consequence)	resulting in potential patient harm and reputational damage to the ICS in addition to a potential loss of Elective Recovery Fund (ERF).		
SA1	Improve Health and Wellbeing Outcomes	●	SA3 Achieve a sustainable and resilient Integrated Care System ●
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4 Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4				2	The tolerance of failing to deliver against this risk should be low as underachievement will have a knock-on effect to subsequent milestones. All efforts must therefore be focussed on delivery.	Low 0 →
Consequence	3				3		Mod 3 ↓
Risk Level	High 12				Mod 6		High 1 →

Rationale for Risk Score and Progress Made in the Quarter:

- Despite 13 periods of Industrial Action in 23/24, significant progress has been made in reducing the 104, 78 and 65-week wait patient cohorts, with an expectation that we will achieve zero 78s by July 2024, and an expectation that 65-week waits will be cleared by September 2024.
- As a system we have effectively utilised Independent Sector capacity to support clearance of long waits.

Key Controls Framework

- Weekly tier 1 accountability meetings with NHSE.
- 2024/25 operational plan delivery and reporting.
- Portfolio performance steering group (reporting to portfolio Board).
- Weekly meetings in place to ensure maximisation of independent sector capacity and tracking of long wait patients.
- Regular monitoring backlogs of Staffordshire and Stoke-on-Trent patients in other systems to ensure equitable access to recovery milestones.
- Weekly meeting with UHNM to review specialty level challenges, to support transfer of long waiters to alternative providers. Including focus on rescheduling/reprioritising listed patients to achieve the milestones.
- UHNM improving productivity through Getting it Right First Time (GIRFT) review and best practice adoption.
- NHS England (NHSE) supporting provision of mutual aid monitored through weekly meetings.
- Review of core capacity and demand across the system.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Weekly Elective Oversight Management Group (EOMG).	●			
	Weekly COO Group.	●			
2nd Line (system)	System Performance Report to Finance & Performance Committee and ICB Board.	●			
	Portfolio Performance Steering Group (reporting to Portfolio Board).	●			
3rd Line (external)	NHSE oversight via Tier 1 meeting .	●			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- Capacity plans in some specialties to meet demand and support recovery – ICB team to maintain focus on development of appropriate community capacity to direct patients to the most appropriate setting through commissioning and contracting of additional provision.
- Industrial Action impact – need to fully understand impact of Industrial Action in elective cancellations which compromises delivery of ambitions.

Further Actions

(Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	Complete/BAU	On Track
						Delayed	Problematic
1	Review Independent Sector (IS) contractual opportunities to expand provision.	Identification of additional capacity and support achievement of ERF ambitions.	Chief Delivery Officer	30/09/24	Plan in development.		
2	Develop plan for focused speciality review with end of end pathway approach.	Identification of opportunities to reduce duplication and improve productivity.	Chief Delivery Officer	30/09/24	Plan in development.		
3	System capacity and demand review.	Greater understanding of opportunities for productivity improvement.	Chief Delivery Officer	31/10/24	Identification of resource to undertake the review and development of scope is underway.		
4	System collaborative for contracts to develop plans for efficiency and delivery of elective activity.	Increased delivery of activity and continued reduction of long wait patients supporting Elective Recovery.	Chief Delivery Officer & SRO System Collaborative	31/10/24	Plan in development.		



SBAF 3: Proactive Planning and Delivery of Integrated Locality Based Community Services

Quality & Safety Committee | Chief Transformation Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we do not deliver integrated community services based on population need,
Event	then services will remain reactive and generic and not sensitive to the needs of the population,
Effect (Consequence)	we will continue to see increases in demand and acuity of need.

SA1	Improve Health and Wellbeing Outcomes	●	SA3	Achieve a sustainable and resilient Integrated Care System	●
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4	Working in partnership with communities to achieve social, economic and environmental community development	●

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	3				2	The consequence of not mitigating this risk and moving to a more proactive needs-based community model of care is that our system will remain reactive and reliant on services, particularly secondary and UEC. This will not meet the needs of our population, will challenge the sustainability of services and is not in line with our strengths-based strategy for our population.	Low 0 →
Consequence	5				4		Mod 1 ↑
Risk Level	High 15				Mod 8		31/03/26

Rationale for Risk Score and Progress Made in the Quarter:

The Improving Population Health Portfolio has been established (June 2023) and the Portfolio Board is meeting regularly. Partners have agreed the delivery structure of the portfolio as:

- ICB/S Delivery (to meet NHS statutory requirements in partnership).
- ICP Strategy Development (to turn the ICP Strategy into reality with the 5 P's across the life course, underpinning strategies and development of Place/localities), and;
- ICS Transformation (to find and engage system-wide support around shared priorities and joint endeavours).

Delays to Digital and Population Health Management (PHM) programmes regards the secondary use of data has led to a review of the PHM programme to scale, spread and sustain a PHM approach across SSOT at all levels.

The programme has continued to work with our partner (Optum), the biggest difficulty remains Information Governance (IG) and data sharing which, although solutions have been identified and are now being implemented, continue to provide significant challenge, particularly regards timescales. Work is ongoing around the necessary DPIA and CAG applications in order that we can share data for secondary use.

During Q3 23-24 the PHM Programme undertook an options appraisal and procurement exercise to enable bulk extracts of GP data into a linked dataset. Procurement has concluded, the contract has been awarded and mobilisation commenced in Q4. It is expected that GP data extraction will commence towards the end of Q1 of 24-25 which will be a significant step forward.

Through PHM led discussions at both Staffordshire and Stoke-on-Trent Place Development Boards and within the IPH Portfolio Board, there is now agreement of the localities that make-up the two Place's aligned with UTLAs:

- Staffordshire – District and Borough Council alignment (8).
- Stoke-on-Trent – Geographical alignment (4).

A proposal for locality and neighbourhood development and how the NHS might support that through the close involvement of Primary Care Networks (PCNs), the development of Integrated Neighbourhood Teams and the intelligent use of PHM and other data. This has been progressed through various Boards and is supported by the VCSE and local councils.

The Health Inequalities (HI) Strategy progressed through to ICP on 3 June 2024 and received positive approval of the principles outlined. There are proposals in development for a supporting HI Financial Framework that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme into the VCSE through localities/neighbourhoods. Preparations are also underway for a shared HI Outcomes Framework Workshop held on 21 June 2024.

Key Controls Framework

- PHM Partner contracted to support scale, spread and sustain of PHM approach for SSOT.
- Portfolio governance heavily partnership based with District/Borough Council (community) leadership in role of CE Sponsor.
- People and Communities is one of the 5P's of the ICP Strategy.
- Place Development Boards have agreed the construct of 'Place'.
- IPH Team (manage the implementation of the PHM Programme to scale, spread and sustain a PHM approach across SSOT).
- IPH Portfolio Programmes (cross working to ensure health inequalities and preventative actions are considered during intervention design).
- Other Portfolios (matrix working with other portfolios to design interventions and deliver transformational change).
- H&CS (provides a system health and care viewpoint on any PHM processes being implemented and interventions being designed).
- IPH Portfolio Board (provides strategic oversight and is the portfolio aligned with this risk).
- ICP (has ICS partnership wide oversight).
- Establishment of IPH Portfolio Board.
- Defined scope of IPH Portfolio and all incumbent programmes and projects.
- CSU Procurement guidance to ensure procurement exercise is robust.
- Report procurement exercise outcome to ICB EWT.
- GP Data Extract procurement completed, and contract awarded and being mobilised.
- Locality/Neighbourhood plans/proposals well-articulated and co-produced.
- HI Strategy developed collaboratively through workshops and extended partnership discussions through to ICP.
- HI Strategy principles formally endorsed on 3 June by ICP.
- Regular bi-monthly reporting to QSC continues along with scheduled Deep Dives.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	IPH Team Meetings: MS Planner reviewed to assure programme actions are on track for delivery (weekly).	•			
2nd Line (system)	Quality & Safety Committee: IPH Portfolio Progress update provided to assure committee of progress (bi-monthly).	•			
	Finance & Performance Committee: IPH elements of Quarterly Stocktake and ICS Operational Plan to provide assurance against LTP and 1YOP delivery.	•			
3rd Line (external)	Regional HI Programme: IPH Portfolio Progress Reports for progress assurance against LTP.	•			
	Regional Prevention: IPH Portfolio Reports for progress assurance against LTP.	•			
	NHSE: IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery.	•			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	•
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- Data and Information Governance issues regards the sharing of data for the purpose of secondary use - solutions identified and being progressed.
- Formalising arrangement regards Place and localities - outcomes and financial frameworks being developed.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Develop HI Strategy.	Additional control through shared strategy for SSOT.	Chief Medical Officer	31/03/24	HI Strategy co-developed with Partners following HI workshop in January 2024.		
2	ICP Approval of HI Strategy.	Additional control through shared strategy for SSOT.	Chief Medical Officer	30/06/24	HI Strategy principles approved by ICP 03/06/2024.		
3	Stakeholder Engagement of HI Strategy.	Additional assurance.	Chief Medical Officer	30/09/24	New action - engagement plan to be developed.		
4	Resolve data and information governance issues regards GP data extraction.	Additional control through secure and legal basis to extract data.	Chief Medical Officer	30/11/23 delayed 30/06/24	GP Data Extract procurement completed, contract awarded and mobilised, data transfer expected end Q1.		
5	Work with the Digital Programme to resolve data and information governance issues regards the sharing of data for the purpose of secondary use.	Additional control through secure and legal basis to use data.	Chief Digital Officer	31/03/24 delayed 30/09/24	Working with Digital Programme, section 251 being reviewed.		
6	Develop HI Outcomes Framework.	Additional Control.	Chief Medical Officer	30/09/24	Preparation meeting held in readiness for first of three Partner HI Outcomes Framework Workshops on 21/06/2024.		
7	Develop HI Financial Framework.	Additional Control.	Chief Medical Officer	31/12/24	Proposals for allocation of HI budget developed and being finessed with Finance and Partners.		
8	Develop governance for locality and community delivery.	Additional governance.	Chief Transformation Officer	31/03/25	New action - plan to be developed.		
9	Run 'shadow' year of Locality governance with outcomes and finance frameworks 2025/26.	Additional assurance.	Chief Transformation Officer	31/03/26	New action - plan to be developed.		



SBAF 4: Reducing Health Inequalities

Quality & Safety Committee | Chief Medical Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we are unable to work together as an Integrated Care System across organisation and sector boundaries,		
Event	then we will less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent,		
Effect (Consequence)	resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced.		
SA1	Improve Health and Wellbeing Outcomes	●	SA3 Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4 Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4				2	Tolerance is low as reducing health inequalities and working in partnership impacts on 3 of the 4 Strategic Ambitions. The target date is long-term and as such risk scoring would be expected to reduce over that period as health inequalities improvement is made and can be demonstrated.	Low 0 →
Consequence	5				2		Mod 5 ↓
Risk Level	High 20				Low 4		High 4 ↑

Rationale for Risk Score and Progress Made in the Quarter:

Early targets for progress to reduce health inequalities were set against the agreement of an Integrated Care Partnership Strategy which was published at the end of March 2023, (this was reflected in the target risk). Evaluation of the reduction of health inequalities will be over a longer period (c. 10 years) and the target risk will be reviewed on this basis. The foundations to achieving this has been progressed in terms of the Integrated Care Partnership Strategy, procurement of a partner to support the scale, spread and sustainment of a Population Health Management approach for SSOT that will positively impact on HI, HI is included throughout the 1YOP and JFP.

The Improving Population Health Portfolio has been established (June 2023) and is now meeting quarterly. Partners have agreed the delivery structure of the portfolio as ICB Delivery (to meet NHS statutory requirements in partnership), ICP Strategy Development (to turn the ICP Strategy into reality with the 5Ps across the Life Course, underpinning strategies and development of Place/localities), and ICS Transformation (to find and engage system-wide support around shared priorities and joint endeavours).

Key to improving health inequalities of the SSOT population is the development of Place and localities in partnership. Through PHM led discussions at both Staffordshire and Stoke-on-Trent Place Development Boards, there is now agreement of the localities that make-up the two Place's aligned with UTLAs:

- Staffordshire – District and Borough Council alignment (8).
- Stoke-on-Trent – Geographical alignment (4).

A proposal for locality and neighbourhood development and how the NHS might support that through the close involvement of PCNs, the development of Integrated Neighbourhood Teams and the intelligent use of PHM and other data. This has been progressed through various Boards and is supported by the VCSE and local councils.

The Health Inequalities (HI) Strategy progressed through to ICP on 3 June 2024 and received positive approval of the principles outlined. There are proposals in development for a supporting HI Financial Framework that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme into the VCSE through localities/neighbourhoods. Preparations are also underway for a shared HI Outcomes Framework Workshop to be held on 21 June 2024.

Key Controls Framework

- ICP Strategy approved with a focus on 5P's across the life course which all centre on reducing health inequalities across SSOT.
- Place Development Boards have agreed the construct of 'Place'.
- ICB impact assessment and business case templates include consideration of HI.
- IPH Team (manage the implementation of the HI Programme to reduce inequalities across SSOT).
- IPH Portfolio Programmes (cross working to ensure work to reduce health inequalities is led by intelligence) Other Portfolios (matrix working with other portfolios to design interventions and deliver transformational change).

- H&CS (provides a system health and care viewpoint that will always consider HI impact).
- ICP (has ICS partnership wide oversight).
- Clarity of governance and delegated authority to Place and Portfolio.
- Defined scope of IPH Portfolio and all incumbent programmes and projects.
- Bi-monthly assurance reporting to Quality & Safety Committee (accountable for BAF 4).
- Procurement for GP Extraction Tool complete, contract awarded and being mobilised.
- Locality/Neighbourhood plans/proposals well-articulated and co-produced.
- HI Strategy principles formally endorsed on 3 June by ICP.
- Regular bi-monthly reporting to QSC continues along with scheduled Deep Dives.

Assurance Map						
Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	
1 st Line (organisation)	IPH Team Meetings: MS Planner reviewed to assure programme actions are on track for delivery (weekly).	•				
	Quality & Safety Committee: IPH Portfolio Progress update provided to assure committee of progress (bi-monthly).	•				
2 nd Line (system)	Quality & Safety Committee: IPH Portfolio – Health Inequalities Deep Dive.	•				
	Finance & Performance Committee: IPH elements of Quarterly Stocktake and ICS Operational Plan to provide assurance against LTP and 1YOP delivery.	•				
3 rd Line (external)	Regional HI Programme: IPH Portfolio Progress Reports for progress assurance against LTP.	•				
	Regional Prevention: IPH Portfolio Progress Reports for progress assurance against LTP.	•				
	NHSE: IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery.	•				

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	•
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> • Maintaining stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners. • Shared understanding and development of delivery vehicles that ICP Strategy priorities can be owned. 	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Develop HI Strategy.	Additional control through shared strategy for SSOT.	Chief Medical Officer	31/03/24	HI Strategy co-developed with Partners following HI workshop in January 2024.		
2	ICP Approval of HI Strategy.	Additional control through shared strategy for SSOT.	Chief Medical Officer	30/06/24	HI Strategy principles approved by ICP 03/06/2024.		
3	Stakeholder Engagement of HI Strategy.	Additional assurance.	Chief Medical Officer	30/09/24	New Action - plan to be developed.		
4	Develop HI Outcomes Framework.	Additional Control.	Chief Medical Officer	30/09/24	Preparation meeting held in readiness for first of three Partner HI Outcomes Framework Workshops on 21/06/2024.		
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	

5	Develop HI Financial Framework.	Additional Control.	Chief Medical Officer	31/12/24	Proposals for allocation of HI budget developed and being finessed with Finance and Partners.	
6	Run 'shadow' year of Locality governance with outcomes and finance frameworks 2025/26.	Additional assurance.	Chief Medical Officer	31/03/26	New Action - plan to be developed.	



Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If we cannot ensure high quality, equitable and safe patient care,		
Event	then we will be unable to achieve high standards of quality and safety,		
Effect (Consequence)	resulting in actual or potential harm to patients, loss of reputation, intervention from regulators, failure to deliver our statutory quality duties and increased costs associated with poor standards of care		
SA1	Improve Health and Wellbeing Outcomes	●	SA3 Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4 Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks		
Likelihood	4				3	<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">31/03/25</div> <div style="font-size: 0.8em;">The system will prioritise quality and safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures.</div> </div>	Low	3	↑
Consequence	4				3		Mod	14	↑
Risk Level	High 16				Mod 9		High	10	↑

Rationale for Risk Score and Progress Made in the Quarter:

All areas progressing well, but some challenges remain across the system:

- Both UHNM and UHDB have significantly reduced their vacancy rates following successful recruitment campaigns in 2023/24. UHNMs Neonatal Unit is now also fully staffed with the business case for an increase in medical staffing has been approved.
- West Midlands Clinical Senate FMBU Panel meeting took place April 2024 and feedback was positive. Both UHNM and UHDB have re-established the Home Birthing Service by the commencement of booking women in from 1st April 2024.
- The Quality Strategy has been approved at ICB Board. An implementation plan has been developed which underpins the delivery of the strategic objectives, this has also been presented to and accepted by the Quality and Safety Committee. Quarterly updates are scheduled within the QSC business cycle to monitor progress and escalate as appropriate.
- The Patient Safety Incident Response Framework (PSIRF) is embedded within our NHS providers, who are working in line with their PSIRF policies and plans. ICB oversight is being maintained in accordance with current guidance. Further work has been commenced to support primary care in achieving compliance. Our care home providers are also being supported in a pragmatic approach to PSIRF.
- Paediatric Audiology Services Improvement Programme continues to progress against the national specified targets. Contract SDIP for achievement of Improving Quality in Physiological Services (IQIPS) accreditation for paediatric audiology services has been added to provider contracts as identified by NHS. Discussions are ongoing within the Bronze cell regarding the feasibility of achieving the ask with key issues escalated to the national team for consideration.
- Learning From Patient Significant Events (LFPSE) has been embedded with the 3 local NHS trusts for reporting. ICB oversight is continuing to develop with a local SOP being progressed, this is reliant upon digital processes owned by NHSE and Incident System providers which requires a platform upgrade to Taxonomy 6. Once in place it is expected that there will be a seamless transition from STEIS.
- Enhanced quality surveillance is in place within the Wheelchair Service.
- Following the identification of a significant backlog with a service commissioned out of area, a step-in arrangement put into place for LeDeR reviews. Update reports are received via SQG.
- The number of Initial Health Assessments (IHA) and Review Health Assessments (RHA) completed for Looked After Children within agreed timescales remains below the compliance target, additional clinical capacity is currently being sought by UHNM and MPFT to assist with a reduction in the current backlog. The plan in place indicates recovery will not be met until July 2025. The ICB are working with NHSE and LAs on how this recovery plan can be expedited. All children who are waiting for IHA and RHAs are being risk assessed.
- Concerns have been raised with regards to the adult ADHD pathway. MPFT, with ICB support, have conducted a review and identified a number of patients who will require re-assessment and potential changes to their current medication regime. A plan is in place to mitigate the risk to all patients.
- All Age Continuing Health Care remains a focus from a quality and financial position. Improvements are being seen in both.
- SEND is seeing increased demand on services which is being monitored through the SEND and CYP governance routes and reported into SQG and QSC.

- Following a decision to terminate the current contract at Gordon Street practice a caretaker provider has stepped in to provide services from alternative locations. Monitoring by the Primary Care team is in place and reported through to SQG regarding the impact of this change.
- System Maternity and Oversight group has been stood down as a result of positive improvements the maternity services at UHNM. Oversight of the transformation plans will continue through the ICB governance routes including the Local Maternity and Neonatal Service Board.

Key Controls Framework

- Quality Impact Assessment agreed and implemented (Policy and Procedures).
- ICB Quality Strategy with agreed outcomes.
- Quality features as an enabler to all portfolios and all have allocated quality links.
- Quality Improvement Group/network established and sharing best practice. Meets quarterly.
- Local Maternity and Neonatal Service Partnership Board and Quality and Safety Oversight Forum (sub-group) and attendance at relevant internal UHNM meetings. Meets Monthly
- Strong maternity transformation plan
- Established system wide Safeguarding arrangements – Second Stage of Provider collaborative agreed and first meeting has taken place
- Portfolio groups/boards or other meetings which meet monthly.
- CQC attends monthly QSISM meeting and has regular contact with the LAs for individual services where there are concerns.
- Health watch attendance at SQG on a monthly basis.
- Reporting to and attendance at NHSE meetings, ERSM meets monthly with QRSM is quarterly.
- Nursing Home Quality Assurance and Improvement Group (NHQAIG) – system partner attendance which meets monthly.
- Care Home quality framework monitoring.
- All Age Continuing Health Care has a robust governance process in place and reports internally through QSC, F & P and externally to NHSE against progress.
- LeDeR group including system partner attendance and shared learning as well reporting into QSC (quarterly) and LDAP board monthly.
- Quarterly Health Economy Infection Prevention meeting as well as weekly informal IPC Leads meetings.
- PSIRF bi-annual collaborative learning events and feeds into regional meeting.
- PSIRF monthly oversight meetings and all providers who have transitioned to PSIRF.
- Bi-monthly patient specialist meeting – with all partners PSS.
- Midlands IPC BAF.
- Health Safeguarding and Looked after Children Forum which meets monthly.
- Independent hospital quality quarterly assurance meetings.
- Bronze, silver and gold cell meetings bi-weekly – Paediatric Audiology Improvement Programme.
- Contract quality review meetings undertaken monthly.
- Progress report and impact received by CYP and QSC regarding RHA & IHA delays.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1 st Line (organisation)	Monthly Quality and Safety Assurance report to ICB Board.	•			
	Bimonthly Assurance paper and Chair Update from Quality & Safety Committee to ICB Board.	•			
	Bi-Monthly LMNS report to Quality & Safety Committee.	•			
	Bimonthly Assurance paper from SQG to Quality & Safety Committee.	•			
	Monthly Assurance papers to SQG.	•			
	Bi- Monthly People & Communities Assembly to Quality & Safety Committee.	•			
	Quarterly Quality Strategy implementation plan updates to Quality & Safety Committee.	•			
	Tri-annually QIA Assurance report to Quality & Safety Committee.	•			
	Tri-annually CQI sub-group report to Quality & Safety Committee.	•			
	Quarterly LeDeR Assurance Report to SQG.	•			
	Quarterly SEND update and assurance report to SQG.	•			
	Bi-Monthly Assurance report to Quality & Safety Committee - Paediatric Audiology Improvement Programme.	•			

	Assurance report re: IHA/RHA received by Quality & Safety Committee (Ad hoc or included in Safeguarding report).	•			
	CHC assurance reports to Quality & Safety Committee.	•			
2 nd Line (system)	Monthly Provider Update/Assurance reports to SQG.	•			
	Bimonthly PSIRF oversight report to SQG.	•			
	Quarterly Soft Intelligence/Complaints report to SQG.	•			
	Monthly Provider Update and Assurance report to SSoT LMNS Partnership Board.	•			
	Monthly Provider Update and Assurance reports to Staffordshire and Stoke-on-Trent Health Safeguarding and Looked after Children Forum.	•			
	Deep Dive presentation to QSC.	•			
	Infection Prevention Control (Health Economy Group) Update/Assurance report to QSC received quarterly.	•			
	Monthly Paediatric Audiology Improvement Programme provider updates to SQG.	•			
	Monthly CQRM meetings escalation report to SQG.	•			
	Quarterly Update and Assurance report to Regional Quality Group – NHSE led.	•			
3 rd Line (external)	Provider CQC Assurance Reports SQG.	•			
	Monthly NOF Assurance Report (UHNM).	•			
	Quarterly System Review Meeting Assurance Report.	•			
	Quarterly NOF Assurance Report (NSCHT/MPFT).	•			
	Escalation to Paediatric Audiology Improvement Silver & Gold cells (ad hoc).	•			
	Bi-monthly Midlands Nursing and Midwifery Excellence network report .	•			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	•
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- IHAs/RHAs action plan mitigations to be revisited with the support of Providers, NHSE and LA to look at innovative ways of working to impact positively on the backlog. Presently legislation impacts on who can carry out IHAs.

Further Actions

(Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	Complete/BAU	On Track
							Delayed	Problematic
1	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the IHA challenges locally, regionally and nationally.	Reduction in timeline.	Assistant Chief Nursing & Therapies Officer	30/07/25	Q1 – NHSE are driving discussions forward to look at using other staff other than medical practitioners. ICB looking at additional resource to reduce the back log further.			



SBAF 6: Sustainable Finances

Finance & Performance Committee | Chief Finance Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If financial cost pressures are not controlled,		
Event	then we will not achieve our statutory financial duties,		
Effect (Consequence)	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduce capital resources, reduced opportunity to apply for additional funds, impacting on services and waiting lists.		
SA1	Improve Health and Wellbeing Outcomes	SA3	Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	SA4	Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4				4	Tolerance is high as costs related to maintaining patient safety and workforce issues may cause additional financial demand.	Low 0 →
Consequence	5				3		Mod 9 ↑
Risk Level	High 20				High 12		High 11 ↑

Rationale for Risk Score and Progress Made in the Quarter:

The Financial Plan for 2024/25 is a deficit plan of £90.0m, agreed with NHSE. Achievement of the 2024/25 plan requires the in-year delivery of £203m system savings which includes a £40m system stretch target. A System-wide Recovery Plan is being designed for 2024/25 to manage the delivery of the efficiency target. The system net risk identified at the time of the plan submission is £88m resulting in a higher risk level in Q1 than the target risk for the end of the year.

Key Controls Framework

- System Financial Plan agreed.
- Recovery Plan agreed.
- System Collaborative Programme implemented.
- Monthly monitoring delivery of all efficiency plans by the Transformation Delivery Unit (TDU) across the system
- Reporting on progress through System Performance Group and Finance and Performance Committee.
- Monthly budget holder meetings to ensure delivery remains on track.
- Weekly meeting of System Chief Finance Officers.
- Weekly System/IFP finance deputies meetings held to support System meetings.
- Weekly System Collaborative Programme meetings.
- Weekly System CFO meeting.
- Fortnightly System Senior Leadership Team meeting.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Monthly System finance reports articulating risk / mitigations.	●			
2nd Line (system)	Monthly System Finance Report to Finance & Performance Committee.	●			
	Monthly Collaborative Programme report to F&P Committee.	●			
3rd Line (external)	Monthly System Performance Report to Finance & Performance Committee.	●			
	Annual value for money assessments completed by external auditors.	●			
	Annual Internal audit review of efficiency programme plans and delivery planned in Q3 24/25.	●			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- The Financial Plan has significant gaps in the identification and delivery of efficiency schemes, the system is working towards a Financial Plan for the year to ensure all risks are understood and mitigated wherever possible.
- The Financial Plan is a best-case scenario and consequently the System is working towards a Financial Plan for the year to ensure all risks are understood and mitigated wherever possible.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap.	Additional Assurance.	Chief Finance Officer	30/09/24	To be reported to Recovery Board (SPG) and Finance and Performance Committee.		
2	System Finance and Operational teams to develop a medium-term plan to define the transformational solutions and actions that will ensure the delivery of the integrated care strategy and trajectory for return to financial sustainability.	Additional Assurance.	Chief Finance Officer	31/12/2024	Progress to be reported to System Finance and Performance Committee.		



SBAF 7: Improving Efficiency and Productivity

Finance & Performance Committee | Chief Finance Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If the ICB and provider partners are unable to develop and deliver recurrent efficiency schemes and productivity gains, during 2024/25 required to address the system recurrent deficit of c. £183m,		
Event	then we will fail to achieve the operational improvements, aligned with the national agenda, which underpin our performance targets and fail to deliver the recurrent financial efficiency requirements which underpin delivery of our statutory financial target of breakeven,		
Effect (Consequence)	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunities to apply for additional funds, impacting on services and waiting lists.		
SA1	Improve Health and Wellbeing Outcomes	SA3	Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	SA4	Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4				3	Efficiency and Productivity improvement is an essential ingredient of the System Plan and so a lower risk appetite target has been set.	Low 0 →
Consequence	4				3		Mod 4 ↑
Risk Level	High 16				Mod 9		High 6 ↓

Rationale for Risk Score and Progress Made in the Quarter:

It has been agreed by System Performance Group (SPG) that work on efficiency and productivity targets will be delegated to providers with the addition of system efficiency collaboratives to assist in delivering a further system stretch efficiency target. The 2024/25 financial and operation plans reflect significant unidentified and high-risk efficiency schemes and consequently the higher likelihood of this risk occurring is currently assessed.

Key Controls Framework

- Monthly monitoring of the delivery of all efficiency plans by the TDU across the system and reporting on progress through System Performance Group and Finance and Performance Committee.
- Weekly System Collaborative Programme meetings.
- Weekly System/IFP finance deputies meetings held to support System meetings.
- Weekly System CFOs meeting.
- Fortnightly System Senior Leadership Team meetings.

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (organisation)	Monthly System finance reports articulating risk / mitigations.	●			
	Responsibility for acute productivity improvement to be taken forward by UHNM. Progress to be reported to System Finance and Performance Committee.	●			
2nd Line (system)	System Finance Report to Finance & Performance Committee.	●			
	System Performance Report to Finance & Performance Committee.	●			
	Productivity Report to System Performance Group.	●			
3rd Line (external)	Annual value for money assessments completed by external auditors.	●			
	Internal audit review of efficiency programme plans, and delivery planned for Q3 2024/25.	●			

Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- The national team look at productivity through an acute lens. The System is planning to widen this to include all other elements of productivity.

Further Actions

(Additional Assurance or to Reduce Likelihood / Consequence)

Complete/BAU

On Track

Delayed

Problematic

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap.	Additional Assurance.	Chief Finance Officer	30/09/24	To be reported to Recovery Board (SPG) and Finance and Performance Committee.	
2	Develop and apply an agreed system approach to improving productivity encompassing all sectors.	Additional assurance.	Chief Finance Officer	30/09/24	To be reported to the Finance and Performance Committee quarterly.	
3	Create and implement a system demand and capacity model	Additional assurance.	Chief Finance Officer	31/10/24	Progress to be reported to Finance and Performance Committee.	



SBAF 8: Sustainable Workforce

People, Culture & Inclusion Committee | Chief People Officer

Risk Description and Impact on Strategic Ambitions

Cause (Likelihood)	If recruitment activity reduces due to financial pressures; and there is an ongoing reduction in recruitment to non-registered and / or trainee posts,		
Event	then workforce gaps will increase, employee health and wellbeing will be affected, and turnover may increase; and the future pipeline will destabilise.		
Effect (Consequence)	resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.		
SA1	Improve Health and Wellbeing Outcomes	SA3	Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	SA4	Working in partnership with communities to achieve social, economic and environmental community development

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4				4	Tolerance is high in recognition of the workforce pressures and financial position in health and social care. It may not be possible to deliver the Long-Term Workforce Plan, secure a robust future pipeline, retain people in the current climate and deliver the demand within the workforce constraints. The system work programmes will focus on reform, collaboration, productivity, maintaining safe staffing levels, and developing operational and innovative approaches to reduce the impact.	Low 0 →
Consequence	5				4		Mod 5 →
Risk Level	High 20				High 16 31/03/25		High 6 ↑

Rationale for Risk Score and Progress Made in the Quarter:

Recognising the financial challenges and change in landscape for 2024/25, the overarching risk reflects the current workforce challenges and system position.

Summary of the risk register and rationale for the Qtr.1 score as follows:

- Extensive work was undertaken via the PCI Committee in 2023/24 to review and test risks to ensure they are reflective of the system-wide health and social care workforce challenges.
- All risk scores on the risk register are currently 16 or under.
- In addition to individual risk actions, the overarching risk is being addressed via targeted programmes of work, interventions and collaborative work at system and organisational level with evidence of an improved position in several areas including retention and sickness. Additionally, the Education training and development workstream is making significant progress in developing approaches to strengthen the future pipeline.
- Increased scrutiny and oversight of workforce controls, driven by national requirements and system financial deficit including agency usage and spend, vacancies, system financial deficit, and productivity.
- Overall delivery of the ICS People Plan and Long-Term Workforce Plan is led by the ICS People Function and programme delivery across all schemes is currently on track. The plan covers several schemes and programmes which seek to secure the future pipeline, reform workforce models, develop new ways of working and unregistered roles, retain our people, improve their experience and health & wellbeing, create an inclusive and compassionate culture, develop our leadership and talent. The system EDI agenda is a crucial element of the plan and all programmes.

Key Controls Framework

- A number of strategies and plans provide direction and a framework including ICS People Plan and strategic delivery plan, ICS Operational Workforce Plan, National NHS Long Term Workforce plan (translated locally and plans reviewed to respond to the ambitions and targets).
- NHS Chief People Officer (CPO) forum.
- Joint CPO/Chief Finance Officer (CFO) forum to align, agree and work in partnership.
- System People report to ICB Board.
- Contingent workforce models including ICS People Hub and Reserves.
- ICS People Team members of system call/process in operation during surge and escalation. Robust escalation process in place for contingent workforce and mutual aid.
- System scrutiny around workforce utilisation, recruitment activity and agency spend in line with the operational workforce plan and financial strategy – inc. vacancy oversight with NHS partners.

- System Workforce Planning Group including collaboration on strategic, portfolio and operational planning.
- System Attraction and Inclusive Recruitment Group – newly established, high impact actions identified.
- System Education, Training and Development Group – strategy, and delivery plans on track.
- System Retention Steering Group, strategy and delivery plans on track.
- System Employee Experience and Health and Wellbeing Group – strategy in development, workstreams identified and plans on track.
- System Organisational Development (OD) Plan development on track – delivery plan in development.
- System Leadership and Talent Steering Group, strategy and delivery plans on track.
- System Equality, Diversity & Inclusion (EDI) Group and programme activities under review.
- NHSE support and review meetings.

Assurance Map					
Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1 st Line (organisation)	Trust People Committees (review and assurance)	•			
	People Metrics, Key performance indicators and assurance reporting.	•			
	People Risk Register and Board Assurance Framework.	•			
	NHS Trust and ICB Vacancy Oversight process and meetings.	•			
	Trust vacancy oversight panels.	•			
2 nd Line (system)	ICS People, Culture & Inclusion Committee	•			
	People Metrics, Key performance indicators and assurance reporting presented.	•			
	Operational Plan and workforce Controls reporting, monitoring and assurance.	•			
	Annual deep drive of high scoring risks driving the BAF risk.	•			
	ICB Board	•			
	ICS People Culture and Inclusion Committee highlight and People Assurance Report.	•			
	People Deep Dive planned for 2024 (date to be confirmed).				
	Finance & Performance Committee	•			
3 rd Line (external)	People Metrics Report presented including agency, vacancies, workforce position, workforce controls and performance against operational plan.	•			
	NHSE - System Review Meetings -	•			
	People Metrics and KPI report presented to assure performance against Operational plan, JFP and LTWP.	•			
	NHSE – Regional Workforce Transformation and Development teams	•			
	Quarterly review meetings to report and assess the progress of workforce development funding spend.	•			
Monthly review meetings for national/ regional programmes (including T-Levels and retention) to assure progress of programme activity and funding.	•				

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	•
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> • Capacity to meet additional reporting requirements from NHSE. • Ability to meet demand and Long-Term Workforce Plan growth with financial deficit, workforce controls, supply, future pipeline, and availability of registrants. • Workforce development funds limited from NHSE and other sources to support innovative future workforce supply solutions and programmes. 	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)					Complete/BAU	On Track
					Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	Collaboratively review and update the ICS People Plan in line with NHS and Social Care Long Term Workforce Plans.	Additional Assurance	Chief People Officer	31/03/25	PCI Development session held in May to review PCI programme focus, priorities and plans – outputs being analysed and development of a refreshed plan in progress. Involvement in review of draft Social Care Workforce Plan.	
2	Further mapping and alignment of long-term workforce plan trajectories against the local position and our gap.	Additional Assurance	Chief People Officer	31/03/25	Ongoing work aligned to 2024/25 Operational Plan and programme activities underway in line with delivery plans.	
3	Establish CPO and CNO/CMO forum to join up and agree actions to address critical workforce challenges and quality impact assess.	Additional Assurance	Chief People Officer	31/03/25	Regular discussion and relationships built. Work underway to establish forum. Senior ICS people representation now on Quality and Safety Committee.	
4	Horizon Scanning for alternative workforce development funding sources.	Additional Assurance	Chief People Officer	31/03/25	Ongoing work via People Collaborative and Steering groups.	

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	Menopause Policy					
Presenting Officer:	Tracey Shewan, Director of Corporate Governance					
Author(s):	Tracey Revill, Governance Manager/IG Operational Lead					
Document Type:	Policy	If Other:				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input checked="" type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	--				
Any potential / actual Conflict of Interest?	Yes / No	-- <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	-- <i>If Y, are those signed off by and date:</i>				
Appendices:						

(1) Purpose of the Paper:

As the Menopause is now a recognised condition, the ICB have implemented a Menopause Policy to provide staff and managers with guidance when the menopause impacts individuals and impacts on their work.

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

Date

Staff Engagement Group

23/02/2023

People, Culture and Inclusion Committee

12/07/2023

(3) Implications:

Legal or Regulatory	Menopause is now a recognised medical condition and should be considered in line with any other medical condition.
CQC or Patient Safety	Considered not applicable.
Financial (CFO-assured)	Loss of time on sickness due to the Menopause could have a financial impact on the ICB.
Sustainability	To keep people working where possible when going through the Menopause.
Workforce or Training	Staff to be made aware of the policy and their requirement to follow the guidance.
Equality & Diversity	Applies to all ICB staff
Due Regard: Inequalities	The policy covers all individuals..
Due Regard: wider effect	Considered not applicable.

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If N, why</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EIA completed and signed off 20/01/2023
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If N, why</i> <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The Menopause policy is a new policy as this is now a recognised medical condition. The policy has been circulated to Menopause Ambassadors and SEG Group for comments. Comments received have been incorporated into this policy.</p> <p>The policy was approved at the People, Culture and Inclusion committee on the 12th July 2023. The policy is currently on the website and IAN marked “subject to approval”</p>

(7) Recommendations to Board / Committee:
<p>The ICB Board is asked to ratify the Menopause policy which has been approved by the People, Culture and Inclusion Committee.</p>

Menopause Policy

Policy Number	
Version:	0.2
Ratified by:	
Date ratified:	
Name of originator/author:	Tracey Revill
Name of responsible committee/individual:	People, Culture and Inclusion
Date issued:	
Review date:	
Date of first issue	
Target audience:	All ICB employees

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
Document shared virtually	Menopause Ambassadors	May 2023

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
Staff Engagement Group	23 rd February 2023
People, Culture and Inclusion Committee	12 th July 2023
ICB Board	

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
0.1	New policy	01/11/2022	T Revill

IMPACT ASSESSMENTS – available upon request

	Stage	Complete	Comments
EIA	1	20/01/2023	EIA signed off

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This policy applies to the Staffordshire & Stoke-on-Trent Integrated Care Board.

Where the term Staff is used this includes Non-executive Directors, Clinicians and contractors working on behalf of the ICB.

1.0 Purpose

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), (“the Employers”) recognise that the menopause can bring issues for individuals which can impact upon their work. It is to the benefit of us all that we, as an employer and system leader for the NHS, work with staff to support them in these circumstances to find mutually beneficial arrangements, maximising staff retention and wellbeing. In recognition of this and in line with organisational values, this policy outlines the range and potential impact of ‘distressing’ symptoms of the menopause to promote understanding of what our colleagues are going through. It underlines the need for recognition of the psychological impacts of peri/menopause/post being reflected in organisational policy and practice, as well as the physical impacts, addressing any potential for occupational health provision and line manager support falling short of need and identifies where advice and support can be found. This policy also outlines the actions for managers that are expected to be extended to staff in order to maximise wellbeing. The actions below clarify what the Employers expect of their managers.

Menopause is predominantly experienced by women and most existing research is based upon cisgender women; thus this document focuses on that experience. However, it is important to acknowledge that transgender, non-binary and intersex workers may also experience the menopause. Some of the information in the main policy may apply to these individuals but since they will also have specific needs and experiences, a separate section on trans, non-binary and intersex workers and the menopause has been included, also included is a section on the ‘male menopause’.

Menopause experiences differ (in part due to possible medication/surgeries). There is an extended discussion of the impact of menopause on colleagues with protected characteristics and trans colleagues [GMW-1.pdf \(nipsa.org.uk\)](#).

This policy has been created in partnership with trade unions as a commitment to work to improve response to menopause across the NHS.

2.0 Scope

Those who haven’t been through menopause – or may have experienced only minor symptoms - may find it hard to understand the significant impact that it can have on those who suffer more significant symptoms. Approximately 75% of women experience menopause symptoms and nearly a quarter of these are reported as severe. Over 70%¹ of women report that they feel unsupported at work, even though one in five (19 per cent) say their symptoms have a detrimental effect on their work. One in ten women said they have even considered leaving their job².

This policy recognises the potential impact on wellbeing at work and consequently the risk of losing excellent staff who might otherwise have been retained and seeks to raise awareness with managers and colleagues to ensure that staff receive a sympathetic and supportive response so that appropriate ways of support can be offered and it defines the expectations of our staff in supporting this transition.

3.0. Definitions

The menopause transition is a natural phase of life when women and some trans and non-binary people stop having periods as a result of hormonal **changes**, a decrease in oestrogen levels. It usually occurs between the ages of 45 and 55 and typically lasts between four and eight years, although it can last longer. Premature menopause can

¹ <http://www.fom.ac.uk/wp-content/uploads/Menopause-Focus-Infographic.pdf>

² <https://www.gov.uk/government/publications/menopause-transition-effects-on-womens-economic-participation>

happen naturally for 1 in 100 individuals (or because of illness or surgery). This may also be more common in trans, non-binary or intersex workers where hormonal treatments or surgeries may affect the age at which menopause starts.

- **Menopause;** a biological stage that refers to the time in life when periods stop and the natural reproductive cycle ends. Usually it is defined as having occurred when there has not been a period for 12 consecutive months (for those reaching menopause naturally). The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.
- **Perimenopause;** The time leading up to menopause when ovulation cycles and periods can be irregular, continuing until 12 months after the final period. The perimenopause is also known as the menopausal transition or climacteric.
- **Postmenopause;** The time after menopause has occurred, starting when there has not been a period for 12 consecutive months.

As a result of the greater numbers of women in the workforce, many women are working more years in peri and post menopause than in their fertile years. The need to manage both work and family and/or caring responsibilities as mentioned above can present significant challenges at this time of life, when we may feel we need to work longer to generate sufficient pension support.

Evidence suggests that many staff still feel uncomfortable discussing menopause at work. Recent studies indicate that women may hide and/or self-manage their symptoms, developing a degree of paranoia about how their performance might be affected, or work harder to compensate.

4.0 Symptoms of menopause

The body can be affected by menopause in numerous ways, causing a myriad of symptoms, some of which will affect performance at work more specifically and as a result will potentially require consideration more than others. (See appendices 1, 2).

While symptoms vary greatly, they commonly include:

- fatigue
- insomnia;
- hot flushes and/or night sweats;
- clumsiness;
- irritability;
- reduced concentration;
- loss of confidence;
- Feeling of loss of self;
- mood swings;
- palpitations;
- anxiety and worry;
- dizziness;
- memory loss, problems with recall and/or brain fog;
- depression;
- headaches;
- recurrent urinary tract infections;
- Sexual Health; and
- joint stiffness, aches and pains

During menopause mental health symptoms can present low mood, anxiety, sleep problems, which then lead to tiredness, fatigue, a cycle that is exacerbated as the symptoms continue. Brain fog leading to reduced concentration, poor information retention and a reduced ability to learn can significantly affect confidence adding to low mood. Existing or pre-existing conditions may be exacerbated, for example, depression.

These symptoms can impact on an individual's performance in terms of coping strategies, pressure of dealing with deadlines and especially where there are changing priorities. They may also experience a lack of confidence, anxiety or panic disorder.

As a result of low levels of reproductive hormones, many of the symptoms listed above can also be experienced by post-menopausal people and may require ongoing support.

5.0 Scope

The organisation recognises and values our diversity and trans inclusive culture, we recognise that people of diverse gender expressions and identities experience menopause. This is therefore, not just an issue for female colleagues - although the physical and psychological symptoms of menopause do mainly affect women, menopause can also directly and indirectly affect others both within the workplace and at home. This can include male and female colleagues, non-binary and intersex colleagues, family members, and same sex partnerships. This policy applies to all employees of the Employer, including those on fixed term appointments. It does not apply to agency staff or contractors although a supportive approach should be taken if they do raise issues.

6.0 Principles

Employees must maintain awareness of, and comply with, the Employer's policies and procedures and behave in a manner that upholds the NHS Constitution and the Employers' values.

7.0 Confidentiality

Our aim is to handle related matters with due regard for the privacy of all individuals involved. This policy is for implementation alongside additional Occupational Health services which offer self-referral to menopause specialist nurses via a clinical assessment.

The organisation also has "Menopause Ambassadors" for staff to contact, their role will be to be an advocate, listen, signposting and provide support.

If an employee is unable to talk to their line manager, they can request a discussion with an alternative manager, a trusted colleague, trade union representative or the Ambassadors in the role of advocate can join the discussion to provide support to the employee.

Managers should remember that the effects of the menopause may result in the need to treat a colleague differently from other staff for a period. It is good practice to discuss with the employee how they wish any questions from their peers/colleagues to be managed. Confidentiality must be respected unless the employee indicates that they do not mind their team being informed in a tactful and respectful way.

8.0 The working environment

The working environment may inadvertently exacerbate menopausal symptoms and increase discomfort at work. It is also important to consider the culture which includes the values and behaviours of the workplace as well as the physical space. Working in a team which demonstrates respect and consideration can mitigate the potential for negative experiences during the menopause such as physical or emotional issues.

The main types of workplace related issues are due to:

- High workplace temperatures, humidity
- Poor ventilation
- Perceived overcrowding and noise; no access to a quiet or restful space
- Problems with accessing rest or toilet facilities
- Lack of access to drinking water
- Dryness and lack of natural light

It is important for organisations to consider the working environment and to explore what simple, practical steps could be taken to ensure the workplace is comfortable and promotes an inclusive and supportive culture.

9.0 Workplace adjustments

The **checklist** in the manager's section of the menopause toolkit can be used to facilitate a discussion between a staff member, line manager or someone who they feel comfortable speaking to. The checklist may be helpful in identifying any workplace adjustments that may be useful in supporting menopausal symptoms at work. Any adjustments can then be added into a Workplace Adjustment Passport.

It is best practice for employees and line managers to review adjustments on a regular basis as needs may change.

[09-01-How to have a menopause conversation as a manager \(hubspotusercontent-na1.net\)](https://www.hubspotusercontent-na1.net)

Here are some general ideas on possible adjustments to consider:

- Change working hours or consider remote home.
- Reduce travel and consider dialling into meetings.
- Allow for frequent toilet breaks, especially during long meetings.
- The need to take a break, get up and walk about where stiffness and joint pain is an issue.
- Recognise the potential problem of increased absence in the application of the sickness.

Whilst flexible working allows an individual the opportunity to manage their symptoms by altering their working pattern absence policy, line managers should have regular one to ones with their staff and record any symptoms/difficulties experienced and work to provide a suitable resolution.

The purpose of such adjustments is to provide a supportive work environment by removing barriers, wherever possible, that get in the way of an individual doing their job to the best of their ability.

10.0 Managing absence and performance

Menopause in itself is not an illness, but there may be times when the symptoms of menopause transition are severe enough to cause the employee to take sickness absence, or for it to affect performance. Because this issue is intensely personal, a manager may not be aware that any impacts are menopause related. A manager should make all reasonable efforts to ensure an employee is able to share information confidentially to help manage their symptoms whilst at work.

- If the impact of the menopause is resulting in the employee being absent from work, or it is affecting their performance, line managers and employees should consider if an

occupational health assessment would be appropriate, to ensure the best support can be put in place for the employee.

- A workplace adjustment passport may be necessary, after which they can decide how best to support their member of staff.
- When managing an employee with a disability or prolonged sickness (such as someone suffering symptoms related to the menopause) line managers must always follow the departmental supporting attendance process.
- Managers should exercise discretion on sickness absence relating to menopause to avoid trigger point warnings, for example when someone suffers severe menopausal symptoms - they should always seek Occupational Health (OH) advice and/or speak to a HR caseworker for further advice.

11.0 Protected characteristics

Menopause at work is covered by equality legislation related to age and gender and to the duty to provide a safe workplace under Health and Safety legislation.

11.1 Trans, non-binary and intersex employees and the menopause

Transgender, non-binary and intersex workers may experience the menopause, either due to age related hormonal changes or hormone treatments and surgeries. Some trans, non-binary and intersex workers may not wish to disclose their menopausal symptoms as this may mean disclosing their trans or intersex status. It can therefore be particularly difficult for these employees to access support and/or ask for adjustments. Within each of these groups people's needs will be different and so it is important to listen to people on an individual level and allow them to take the lead on their required adjustments.

11.2 Male Menopause

Just as women suffer from the menopause it is not uncommon for some men to experience changes in their bodies, which can also result in changes in their mood and other aspects of their lives, just as it impacts on women. Whilst not much is known/mentioned about the male menopause, we recognise that this does exist. The following link sets out some information; [The 'male menopause' - NHS \(www.nhs.uk\)](http://www.nhs.uk)

12.0 Policy implementation

Managers and colleagues who want to support colleagues going through the menopause may be uncertain how to raise the subject and offer support. Increased media coverage and availability of online support and guidance make conversations in the workplace more normalised and less taboo. Menopause transition does not necessarily lead to reduced performance at work and may be managed with consideration, understanding and in some circumstances, with workplace flexibility.

13.0 Expectations of staff

Menopause symptoms are highly individual; they can be sensitive and cause embarrassment for some for varied lengths of time, so it is entirely understandable for staff to feel unable to share and explore sensitive and personal symptoms with their managers. There are options to help you do this:

- Seek support, advice or info from the NHSE/I Menopause Network, and/or Menopause Ambassadors who can offer 1:1 supportive signposting.

- Approach someone in the workplace with whom you do feel comfortable discussing your issues who could support you in the conversation – e.g. a colleague, other manager or trade union representative.
- Differences like gender and culture may be a barrier to raising this issue so it might be that there is a more senior manager you can discuss it with first. The intention would not be to avoid your line manager but to explore what might be possible and explore support or discuss what might be addressed with your immediate line manager

If individuals do feel able to discuss symptoms, the suggestions below may be helpful to raise with the line manager;

- Sharing your experience and/or symptoms with colleagues to promote understanding if you feel comfortable.
- Recording and monitoring your symptoms and/or their severity may be helpful to understand how your wellbeing may be affected and how you can seek support.
- Considering a change in working hours or pattern or remote working if/when you are office based.
- Whether you could work from home more frequently or at short notice when your symptoms are bad.
- Consider a reduction in travel or increased comfort breaks, dialling into some meetings.

If a member of your team does change working pattern or flexibilities in order to support wellbeing and/or symptoms management, we expect all staff to behave in a professional, responsible and sensitive manner and be supportive and respectful.

14.0 Expectations of managers

If an employee chooses to approach you to discuss issues with their menopause it may be as a line manager or as a manager they feel able to discuss their situation with – for instance due to a shared culture - you must appreciate that the symptoms experienced are very personal, no one individual can be compared with another and as a result of the highly personal nature of symptoms the member of staff may not wish to discuss with their line manager. When an employee shares issues about the menopause, you should gain an understanding of what the employee is likely to need from you. You can use the information provided in this policy to help you start a conversation about the menopause and just as we advise that staff can access resources via the Menopause Network, you may also find the specialist resources and experience helpful, especially for signposting advice to staff. If you are not the line manager for the individual, you can help them explore options for raising work related issues.

In recognition of this sensitivity, you may also wish to contact the ICB Menopause Ambassadors for support.

Further information and signposting advice is available via the Menopause Network.

You should:

- Ensure that all information shared by the employee is treated in the strictest confidence and is not shared further without the employee's consent.

- Listen to and gain an understanding of any concerns your employee has about their issues or symptoms, avoiding assumptions.
- Discuss timescales and leave requirements if this has been raised as part of the discussion. It is worth underlining that peri-menopause and menopause symptoms do not have an indicative timeline for resolution.
- Take account of individual and business needs but be supportive when dealing with requests for work flexibility or leave, being mindful of the importance of being supportive of attendance at appointments and the unpredictability of symptoms.
- If more support is needed you will find it helpful to agree a support plan to identify the adjustments made to the working arrangements of that staff member.

Line managers must:

- Be prepared to discuss the points that the member of staff brings to them - promote supportive conversations about the menopause and its effects and be aware of the personal nature of these conversations: this can be a subject that requires sensitivity and must be kept under review as there is no defined end date.
- Be open to a request to have someone to support them in the conversation because of the personal nature of the discussion.
- Recognise that every experience of the menopause will be individual. Do not use your own personal experience, or that of any friends, relatives or other staff members to measure whether you believe that the staff member's symptoms are reasonable.
- Consider any changes impacting performance, attendance or behaviour and whether the impact of menopause and its distressing symptoms may be an issue – do not launch capability or conduct processes before these elements have been reasonably considered.

**As this policy offers a supportive approach through menopause, performance issues are not referenced beyond this note.*

- Provide dedicated time and quiet space for 1:1s; promote avenues of support, signposting and links to organisational resources such as associated guidance, flexible working, special leave and any changes to the working environment such as quiet spaces that you can facilitate.
- Set and demonstrate expected standards of behaviour.
- Where additional support is required, provide information on specific health and wellbeing services.
- Promote a culture and environment that values diversity, shows dignity, respect, fairness and equality.
- Do not tolerate or express what you consider to be 'workplace banter'.
- Be aware all cisgender women (and some trans, non-binary and intersex colleagues) will experience a menopause; specific information is available via the Menopause Network.

- Be aware there is a subjective range of symptoms from vasomotor (hot flushes) to mental ill-health, dryness of the eyes, excessive bleeding, brain fog and aphasia (losing words mid-sentence); all of which could present colleagues in a less favourable way.
- Discuss and agree any reasonable flexible working arrangements request - consider night sweats and/or insomnia which may require working from home or flexible working hours. Any issues that have been raised in terms of home working space, flexibility, caring responsibilities and anxiety for example as a result of working more distanced may need longer term support.
- Short notice leave of absence may be required to manage exacerbation of symptoms, lengthy periods of back-to-back meetings may need built in comfort breaks if heavy bleeding is experienced.
- Reasonable adjustments may be part of our formal organisational offer in relation to disability – and should be considered in instances where required for menopause.
- Work with the employee to consider physical working areas that minimise the distress they may suffer – considering, for instance, access to ventilation and private space when needed.

15.0 Support: what staff can expect from the organisation

The Employers are committed to supporting and maximising the wellbeing of its workforce and the provision of fair, respectful and inclusive working environments for all. This menopause policy is underpinned by the principles of support, culture and awareness. It aims to provide information and support for employees who are directly and indirectly affected.

The organisation has a positive attitude to the menopause and will work proactively to make flexible working adjustments (link to flexible working policy) where necessary as part of our commitment to staff. The Employers recognise that the menopause is a very individual experience therefore different levels and types of support and adjustments may be needed.

Information about access to specialist menopause support is available from the **Human Resources Advisory team**.

Support is available to everyone via the following:

- Access to trained **advisors, Menopause Ambassadors and Mental Health First Aiders** to provide independent and objective support.
- The **Employee Assistance Programme (EAP)** Care First, offers a confidential counselling support service for all staff.
- Informal support and signposting can also be accessed via Staff Networks (link to Staff Networks information page).
- Training and awareness raising sessions will be provided for all managers and staff both at recruitment, in management development and as an advocated best practice approach.
- Staff who are members of a trade union can access support and information from them.

- The Employers coaching offer may be helpful in providing a confidential mechanism for exploring managing issues staff are experiencing.

15.1 ICB Menopause Network

We ensure everyone is supported and health and wellbeing is the highest priority for the network.

The Menopause Network spans the whole of the Employers, there are specific resources on the Network pages on the intranet.

There are dedicated 'Teams Network' pages with direct links to external resources, peer to peer support and advice and guidance.

The network has developed a formal 'Toolkit' – this includes a dedicated space for individuals to map out symptoms and the frequency these are experienced. This can support personal knowledge and could also help with 1:1 conversations with colleagues (see Appendix 2).

The group links via the Chair to the Cross-Government Menopause Working Group to progress and develop guidance, policy and awareness. The group also links with the Women's Development Network.

15.2 Monitoring

The policy underlines collection and provision of workforce data/intelligence which could help guide our further policy development and implementation in this area;

- The Employers will offer staff opportunities to have confidential discussions about their personal experience through their line manager, HR, trade unions or staff networks so that this is sensitively fed into reviews of policies.
- As a result of the commitments above, the effects of the menopause shall be taken into account in the implementation of sickness absence, capability, disciplinary and performance policies ensuring that any factors are reasonably considered
- The ICB commits to ongoing review of the support offer and implementation of this policy as part of its annual policy review and staff engagement. Further engagement will be sought from the Menopause Network.

16.0 Impact Assessments

16.1 Policy impact assessment

As part of the development of this policy, its impact on the business has been assessed; no detrimental issues were identified.

16.2 Equality and health inequality analysis

As part of the development of this policy, its impact on equality has been analysed and no detriment identified.

17.0 Associated Documentation

The most recent copies of the Employers policies and procedures are available on IAN.

18.0 Data Protection

Any processing (i.e. handling or storing etc.) of personal identifiable information; during the application of this policy; must be compliant with relevant data protection laws - the Data Protection Act (DPA) 2018 and the General Data Protection Regulation (GDPR). Please consult; as appropriate; either NHS England's, or NHS Improvement's IG Policy for more information.

Subject to Approval

Appendix 1:

The symptoms of menopause

During menopause a person's **brain and mood** can be affected causing: low mood, depression and anxiety; sleep problems which then leads to tiredness, fatigue and/or dizziness; brain fog leading to reduced concentration, poor information retention and a reduced ability to learn; unexplained mood swings, irritability and emotional outbursts. These symptoms can impact on an individual's performance in terms of coping strategies, pressure of dealing with deadlines and priorities. They may also experience a lack of confidence, anxiety or panic disorder.

Individuals can experience **hair** loss or hair can become thin, lacklustre and brittle. Some have **mouth** problems such as bleeding gums and a dry mouth. This can lead to bad breath. They may also experience taste changes and strange oral sensations including a burning tongue.

The **heart** can be affected, causing palpitations and an increased risk of heart disease. The **lungs** can be affected as they may develop new allergies or existing allergies can become worse. For example, asthma, hay fever, dermatitis (see skin/nails below).

The **abdomen** and **gut** can be affected as people may gain weight, develop bloating, abdominal cramps, Irritable Bowel Syndrome (IBS), sickness or nausea and women can experience **urogenital problems** which bring about greater urgency and/or more frequent trips to the toilet.

Irregular **periods** can be brought about by an unpredictable pre-menstrual tension and menstrual cycle, heavy bleeding, water retention and bloating.

Individuals can suffer from general skin itchiness and formication (feels like something crawling about under the skin), allergies such as dermatitis and thinning skin. Also, nails can become dry and brittle.

People develop problems with their **muscles, joints, nerves and bones**. This can lead to muscle pain and weakness, joint pain, osteoporosis / loss of bone density and nerve function may be affected.

Some can suffer from sudden changes to body temperature, which include daytime sweats and flushes; sudden heat or redness in face; night-time sweats and flushes.

Other symptoms of the menopause (of which there are at least 34 recognised as part of the menopause) can also include loss of libido, vagina dryness and or atrophy, weight gain, bladder symptoms, such as urgency, frequency and mild incontinence, breast pain and headaches.

Appendix 2.

Mapping the symptoms of menopause for yourself or to support a conversation about wellbeing at work

Symptoms of menopause are very individual and can be embarrassing. Sensitive conversations are needed to explore what support may be helpful to maximise wellbeing. Included below is a template (guide) to assist with understanding how to support staff experiencing issues through the menopause. This list demonstrates how and when symptoms may impact on the individual. **This list should be supported with an introduction that underlines the sensitive and confidential nature of the discussion and what mechanisms or routes to support there are in addition (such as Occ Health specific support). Managers shall reiterate that support can be kept under review as symptoms change.**

Symptom	Location you have the symptom (if both tick both)		Severity of the symptom				How frequently do you experience the symptom						Adjustments you feel may assist (Examples included)
	Home	Work	Mild	Moderate	Intense	Severe	Less than monthly	Monthly	Weekly	Daily	Hourly	Constant	
Hot flushes													Fan/ extra uniform/ close to a window/ access to showers if applicable
Night Sweats													Flexible shift times
Irregular Periods													Procedures allowing for flexibility without drawing attention (Panel meetings etc.)
Loss of Libido													
Vaginal Dryness													
Mood Swings													Inform the team/colleagues to be mindful. Quiet/ Private breakout room.
Fatigue													Flexible shift times.
Hair Loss													Flexibility and sensitivity
Sleep Disorders													
Difficulty Concentrating													Flexibility in breaks.
Memory Lapses													Aide memoirs
Dizziness													Access to fresh drinking water and quiet areas
Weight Gain													Access to food preparation facilities to allow healthy eating options
Incontinence													Procedures allowing for flexibility without drawing attention (Panel meetings etc.) Access to showers/extra uniform if applicable
Bloating													
Allergies													
Brittle Nails													
Change in Odour													Access to showers/lockers to store toiletries/extra uniform if applicable

Symptom	Location you have the symptom (if both tick both)		Severity of the symptom				How frequently do you experience the symptom						Adjustments you feel may assist. (Examples included)
	Home	Work	Mild	Moderate	Intense	Severe	Less than monthly	Monthly	weekly	Daily	Hourly	Constant	
Irregular Heartbeat													
Depression													
Anxiety													
Irritability													
Panic Disorder / Attacks													
Breast Pain													
Headache													<i>Access to a private room</i>
Joint Pain													
Burning Tongue													
Electric Shocks													
Digestive Problems													
Gum Problems													
Muscle Tension													
Itchy Skin													
Tingling Extremities													
Osteoporosis													

Subject to Approval

Appendix 3.

The recent BMA survey underlines this in recognition of the gender pay and pension gaps;

[Challenging the culture on menopause for working doctors report \(bma.org.uk\)](https://www.bma.org.uk/press-releases/2020/04/challenging-the-culture-on-menopause-for-working-doctors-report)

Appendix 4.

A note about COVID-19

According to current medical advice, COVID-19 is not likely to be a significant additional risk to menopausal women per se, but menopause is a time women begin to have increased risk for heart disease and type 2 diabetes, once they lose the protective effects of oestrogen. These co-morbidities definitely increase risk for women who may contract COVID-19.

Women in menopause could potentially see an increased vulnerability to severe symptoms although there is early work to explore the role of oestrogen in having a protective function, so women who are not on hormone therapy during menopause might be more at-risk than those without a decline in oestrogen.

References and additional information

There are more women in the workforce than ever before³; in the NHS women make up over 75% of the workforce and nearly half of all very senior managers are women. As women are working longer, they are often managing the demands of work and home life whilst also dealing with caring responsibilities (around 25% of women also have a caring role) at the same time as menopause.

At the time of policy development (03/2021) the NHS faces challenges;

- The average age of menopause is 51 years, 43 years is the average age of women working in the NHS.
- There are significant numbers of operational/clinical staff who work in uniform, provide shift cover and front line patient care; NHSEI represents policy and best practice, so must offer a proactive stance
- There are around 100,000 staff vacancies, of which nearly 40% are nursing gaps which remains a female dominated workforce
- High staff turnover; 1 in 5 staff left a post between 2017-18
- The largest groups affected by attrition are nurses with an 8.5% reduction and midwives reduced by over 3% since 2016

Protected characteristics and the legal framework

- Under the Equality Act 2010, menopause is largely covered under three protected characteristics: age, sex and disability discrimination.
- The Health and Safety at Work Act 1974 provides for safe working, which extends to the working conditions when experiencing menopausal symptoms.
- ACAS has introduced new codes of practice surrounding flexible working.

Discrimination may be direct or indirect;

- Direct discrimination; an employee is treated less favourably because of a protected characteristic, so in the case of menopause, it could relate to gender or age.
- Indirect discrimination is where a provision, practice or criteria is discriminatory in relation to a protected characteristic. So, even if a neutral policy (for example, flexible working) is applied across the organisation, it may be considered to place some women at a particular disadvantage compared with men.

Disability refers to; A physical or mental impairment, which has a substantial and long-term adverse (12 months or more) effect on the ability to carry out normal day-to-day activities. In the case of menopause, we do not have a firm deadline for symptoms to decline or end. In this case menopause can easily fall within the disability definition.

³ <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/timeseries/lf25/lms>

NHS Choices – menopause

[The menopause - Women's Health Concern \(womens-health-concern.org\)](https://www.womens-health-concern.org/)

Other useful links:

[09-01-How to have a menopause conversation as a manager \(hubspotusercontent-na1.net\)](https://hubspotusercontent-na1.net)

[How to offer Menopause Support \(peppyhealth.com\)](https://peppyhealth.com)

[GMW-1.pdf \(nipsa.org.uk\)](https://nipsa.org.uk)

[Menopause and the workplace | NHS Employers](#)

[Supporting menopausal women can help the NHS staffing crisis | Comment | Health Service Journal \(hsj.co.uk\)](#)

[NHS England » Supporting our NHS people through menopause: guidance for line managers and colleagues](#)

Subject to Approval

Report to:	Integrated Care Board					
Date:	18 July 2024					
Title:	ICB Emergency Preparedness Resilience and Response (EPRR) Policy					
Presenting Officer:	Phil Smith, Chief Delivery Officer					
Author(s):	Katie Weston, EPRR Strategic Lead					
Document Type:	Policy	If Other:				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input checked="" type="checkbox"/>	Ratification (R)	<input checked="" type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i>				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i>				
Appendices:	ICB Emergency Preparedness Resilience and Response (EPRR) Policy					

(1) Purpose of the Paper:

The paper presents the ICB EPRR Policy, which underpins all emergency preparedness activities within the ICB, setting out the ways in which the organisation is committed to delivering the duties as set out in the Civil Contingencies Act (2004), the Health and Care Act 2022, and the NHS EPRR Framework 2022. The Policy has been presented to and approved at Audit Committee on 01 July 2024, and is presented to ICB Public Board for approval and ratification.

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

	Date
ICB Executive Team	27/06/2024
ICB Audit Committee	01/07/2024

(3) Implications:

Legal or Regulatory	ICBs are legally required to have suitable arrangements in place to place for major incidents and events that might diversely impact on statutory or essential ICB functions or on the sustained delivery of commissioned health services. Legal interdependencies include the NHS Act 2006 (as amended) - s252A (9), the NHS England EPRR Framework 2022, and associated EPRR annual assurance core standards NHS Standard Contract – Service Condition 30 (Emergencies and Incidents).
CQC or Patient Safety	Nil
Financial (CFO-assured)	Nil
Sustainability	Sustainability and climate change adaptation is considered throughout all EPRR processes, as set out in the adjoining policy.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Workforce or Training	Training for on-call managers is set out within the ICB On-Call Policy against the NHS Minimum Occupational Standards for EPRR.
Equality & Diversity	An equality impact assessment is in process.
Due Regard: Inequalities	As above
Due Regard: wider effect	As above

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If N, why - In progress</i> <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In progress
	QIA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If N, why - Advised this is not required for this document. Any QIA is completed as required for any associated policies or plans as part of EPRR workstreams</i> <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Not required

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	<input type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input type="checkbox"/>	BAF6	Sustainable Finances	<input type="checkbox"/>
BAF3	Proactive Community Services	<input type="checkbox"/>	BAF7	Improving Productivity	<input type="checkbox"/>
BAF4	Reducing Health Inequalities	<input type="checkbox"/>	BAF8	Sustainable Workforce	<input type="checkbox"/>

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

The EPRR Policy as presented is largely unchanged from the 2023 version, with the current version as enclosed approved by Audit Committee on 01 July 2024. The Policy was highlighted as good practice and as fully compliant with the NHS annual assurance process (core standards) during the 2023, and is presented to the Board as part of its annual review. Some minor changes have been made within the Policy which reflect an amendment of terminology from older terms such as 'gold' and 'silver' command levels, to 'strategic' and 'tactical' respectively, in line with national guidance; the inclusion of the Portfolio Director for Delivery and Improvement as a deputy to the Accountable Emergency Officer as listed; amendment of reference to the EPRR Support Manager to UEC Operations Team recognising structural changes within the Directorate, providing greater resilience opportunities; and finally amendment to the schedule of the ICB EPRR Working Group from quarterly to twice yearly as a minimum, which is amended to reflect a more appropriate cadence balanced against the level of EPRR business put forward to this group.

(7) Recommendations to Board / Committee:

Board are asked to consider the accompanying EPRR Policy in the context of the executive summary above, and approve and ratify the policy for inclusion within the ICB suite of policies.

Staffordshire and Stoke-on-Trent ICB Emergency Preparedness, Resilience, and Response (EPRR) Policy

Version:	2.1
Ratified by:	ICB Public Board
Date ratified:	18 July 2024 – v2.1
Name of originator/author:	Katie Weston, EPRR Strategic Lead
Name of responsible committee/individual:	Phil Smith, Accountable Emergency Officer
Date approved by Committee/individual:	01 July 2024
Date issued:	19 July 2024
Review date:	July 2027
Date of first issue	01 July 2022
Target audience:	All ICB employees

Document History

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
Katie Weston (EPRR Manager) and Jane Moore (SRO for EPRR)	Staffordshire CCGs Executive Management Team	25 May 2022
Katie Weston (EPRR Manager) and Jane Moore (SRO for EPRR)	Staffordshire and Stoke-on-Trent ICB Public Board	01 July 2022
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Executive Management Team	8 June 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Audit Committee	19 June 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Public Board	20 July 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Executive Management Team	27 June 2024
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Audit Committee	01 July 2024
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Public Board	18 July 2024

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
ICB Public Board	01 July 2022
ICB Audit Committee	19 June 2023
ICB Public Board	20 July 2023
ICB Audit Committee	01 July 2024
ICB Public Board	18 July 2024

VERSION CONTROL

Version	Version / Description of amendments	Date	Author
1	New policy	01 July 2022	Katie Weston
2	Updated policy in accordance with EPRR annual assurance comments from NHSE	21 July 2023	Katie Weston
3	Annual review of content. No changes to overall policy content. Inclusion of UEC Operations Team and Portfolio Director for Delivery and Improvement. Amendment of references to gold and silver command levels, to strategic and tactical respectively. Amendment from annual review to three-yearly review in line with NHSE guidance.	19 July 2024	Katie Weston

IMPACT ASSESSMENTS – AVAILABLE ON REQUEST

	Stage	Complete	Comments
Equality Health Impact Assessment	Submitted		
Quality Impact Assessment	N/A		
Data Protection Impact Assessment	Submitted		

Staffordshire and Stoke-on-Trent Integrated Care Board
Emergency Preparedness, Resilience and Response (EPRR) Policy

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1. Introduction

- 1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could range from severe weather to an infectious disease outbreak or a major transport accident.
- 1.2 The Civil Contingencies Act (CCA) 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022 requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients. This work is referred to in the NHS as EPRR.
- 1.3 Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Board ICB is defined as a Category 1 Responder and therefore have a statutory obligation to deliver the following civil protection duties as defined under the CCA 2004:
 - Assess the risk of emergencies occurring to inform contingency planning
 - Put in place emergency plans
 - Put in place business continuity management arrangements
 - Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
 - Share information with other local responders to enhance co-ordination
 - Cooperate with other local responders to enhance coordination and efficiency
- 1.4 In addition to meeting legislative duties, the ICB is required to comply with guidance and framework documents, including but not limited to:
 - NHS England EPRR Framework
 - NHS Core Standards for EPRR annual assurance self-assessment
 - ISO 22301 – Societal Security – Business Continuity Management Systems - Requirements
 - NHS England Business Continuity Framework
- 1.5 Assurance against the effectiveness of arrangements will be achieved through the testing and exercising of plans for critical services in accordance with the above guidance.
- 1.6 This document outlines how the ICB complies with its statutory responsibilities and EPRR obligations, detailing the minimum requirements for planning and responding to a major incident and or a business continuity incident.

2. Legal Framework

- 2.1 The Civil Contingencies Act 2004 (CCA) establishes a statutory framework of roles and responsibilities for local responders. The CCA is supported by Regulations (The CCA 2004 (Contingency Planning) Regulations) and statutory guidance EPRR. Responsibilities of service providers are set out in the NHS Act 2006 as amended by section 46 (9, 10) of the Health and Social Care Act 2012, and Health and Care Act 2022. This is supported by the NHS EPRR Guidance NHS Framework, and the NHS Core Standards for EPRR annual assurance self-assessment.
- 2.2 NHS-funded organisations that are not NHS Trusts or foundation trusts (e.g., Primary Care, out of hours providers, independent sector, and third sector providers) are not listed in the CCA 2004, however NHS England and the Department of Health and Social Care expect them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary, and proportional to the scale of service provision. While not listed under the CCA, these organisations may have EPRR obligations under the NHS Act 2006 and / or NHS Contracts and the ICB expectations and arrangements for supporting these obligations is outlined in the policy statement.

3. Policy Statement

- 3.1 The SSOT ICB are committed to the delivery of effective EPRR arrangements for business continuity, critical, or major incidents which may occur, to enable the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies. Each type of incident as listed has the potential to impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented.
- 3.2 The SSOT ICB will therefore ensure the necessary resources are in place to plan for and respond effectively to such incidents, including representing the ICS and wider health economy within a tactical coordination role in incidents requiring multi-agency response; establish an effective incident control centre as required; and lead post-incident recovery for the local health economy.
- 3.3 The ICB will operate a 24/7 On-Call Manager function, who will respond to incident notification and surge management / capacity issues, as detailed in section 8.
- 3.4 The SSOT ICB will establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies 24/7, including representation of the NHS at Strategic and Tactical Coordinating Groups, and supporting NHS England in discharging their EPRR functions locally, supporting ICS tactical coordination during level 2-4 incidents (as defined in the Incident Response Plan).
- 3.5 The SSOT ICB will maintain business continuity plans to support its ability to maintain its statutory roles and essential functions in the event of a critical or major incident and support

rapid recovery of these services. Due consideration will also be given to the potential impact of any proposed services changes on the ability of the NHS to effectively plan for and respond to an incident, and commissioned services will therefore be considered throughout.

- 3.6 The ICB accept their statutory duty as a category 1 responder as part of the creation of ICBs, and commit to undertaking the category 1 duties as set-out under the CCA. The relevant duties will be embedded throughout arrangements, as detailed further in the ICB EPRR Strategy and Incident Response Plan, and in conjunction with Local Resilience Forum, NHS, and regional / national bodies.
- 3.7 The ICB will commit to the training, testing, and exercising of on-call and ICC staff, policies and arrangements to ensure a process of continuous improvement.
- 3.8 In addition to the above, the ICB will work in partnership with commissioned services to:
 - Take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency
 - Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
 - Support NHS England in discharging its emergency preparedness, resilience and response functions and duties locally
 - Seek assurance that provider organisations are properly prepared to deal with an emergency, and are compliant with relevant guidance and standards
- 3.9 Commissioners and Providers must give due consideration to the potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and / or respond to an incident or emergency and ensure effective EPRR is maintained.

4. Purpose

- 4.1 NHS England (NHSE) requires that all ICBs prepare and test arrangements in response to emergency and business continuity incidents. This policy outlines the requirements to which SSOT ICB must adhere to and the way in which these will be delivered. The policy applies to all aspects of the ICB's operations and services. The process of EPRR is the responsibility of the whole organisation and is driven by the Audit Committee through the Accountable Emergency Officer. The EPRR governance structure is detailed at section 8.

5. Aim and Objectives

- 5.1 The aim of the EPRR policy is to ensure the ICB can support the ICS and wider local health economy in its response to an emergency / incident, whilst maintaining essential services for the populations of SSOT.
- 5.2 The objectives of the EPRR Policy are to ensure the ICB:
- 5.2.1 Has adequate plans to prepare for, respond to and recover from incidents as a Category 1 responder;
 - 5.2.2 Gains assurance that local NHS commissioned health services and the local health system has adequate plans to prepare for, respond to and recover from incidents;
 - 5.2.3 Operates within the legal framework for:
 - a. Civil Contingencies Act (2004)
 - b. Health & Social Care Act (2022)
 - 5.2.4 Meets its obligations under the NHS England EPRR Framework and NHS Core Standards for EPRR annual assurance self-assessment.

6. Scope

- 6.1 The scope of the arrangements for the response to emergency incidents covers all levels of incidents, as described in NHS EPRR Framework 2022, as per figure 1 below.
- 6.2 The ICB will be responsible for the coordination of Level 1 and 2 incidents within its area of operations, and will provide support to NHS England (NHSE) in the response to Level 3 and 4 incidents.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Figure 1: NHS incident response levels

7. Underpinning EPRR Principles

- 7.1 In order to prepare, respond, and recover effectively to any incident impacting the organisation, the six underpinning principles of EPRR will be utilised throughout as outlined below:
- 7.1.1 **Preparedness and anticipation** – the ICB will anticipate and manage the consequences of incidents and emergencies by identifying risks and impacts where possible, achieved through clarity of role and responsibilities, development of suitable plans and arrangements, and the testing and exercising of plans.
 - 7.1.2 **Continuity** – response arrangements will complement existing functions to ensure familiar ways of working, whilst being rapid and scalable to ensure delivery of actions in an incident or emergency
 - 7.1.3 **Subsidiarity** – decisions will be taken at the lowest appropriate level, with coordination at the highest necessary level, working with NHS organisations within the ICS to form the building blocks of response
 - 7.1.4 **Communication** – effective communication is critical to response, warning and informing, and therefore reliable and timely information flows to responders, stakeholders, and the public will be a priority
 - 7.1.5 **Cooperation and integration** – effective coordination and information sharing will be promoted and exercised between and within the ICB, ICS, local, regional, and national tiers of response to build positive relationships built on mutual trust and understanding, including supporting mutual aid requests and coordination where necessary
 - 7.1.6 **Direction** – the use of a strategic aim and supporting objectives for response will be used to deliver clarity of purpose, and will be agreed and understood by all involved in management of the incident.

8. Governance

ICB EPRR Governance

- 8.1 The Accountable Emergency Officer (AEO) holds executive authority and responsibility for ensuring that the organisation complies with EPRR legal and policy requirements in the ICB. This position must be fulfilled by an Executive Board-Level Director and therefore is fulfilled by the Chief Delivery Officer on delegation from the Chief Executive Officer. Responsibilities of the AEO may be discharged through one or more deputies, however responsibility for ensuring compliance will remain with the AEO.
- 8.2 The AEO will report on an annual basis to the Public Board of the ICB the organisations readiness and preparedness activities, and will include the following:

- 8.2.1 Training and exercises undertaken by the organisation
 - 8.2.2 Summary of business continuity incidents, critical incidents, and major incidents experienced by the organisation
 - 8.2.3 Lessons identified and learning undertaken from incidents and exercises
 - 8.2.4 The organisation's compliance position in relation to the latest NHS England EPRR assurance process
- 8.3 An EPRR and Business Continuity Group will be established with representation from nominated leads from key services within the ICB, and will meet at least twice yearly. This group will consult on the priorities and interdependencies of the work programme, with the AEO remaining responsible for annual approval of the work programme. Oversight will be achieved with monthly briefings to the EPRR Senior Leadership Team, including the AEO on a bi-monthly basis.
- 8.4 Delivery of the EPRR work programme will be fulfilled by the EPRR Team Delivery Group, led by the EPRR Strategic Lead, to coordinate ICB EPRR projects and CCU Link Officer delivery.

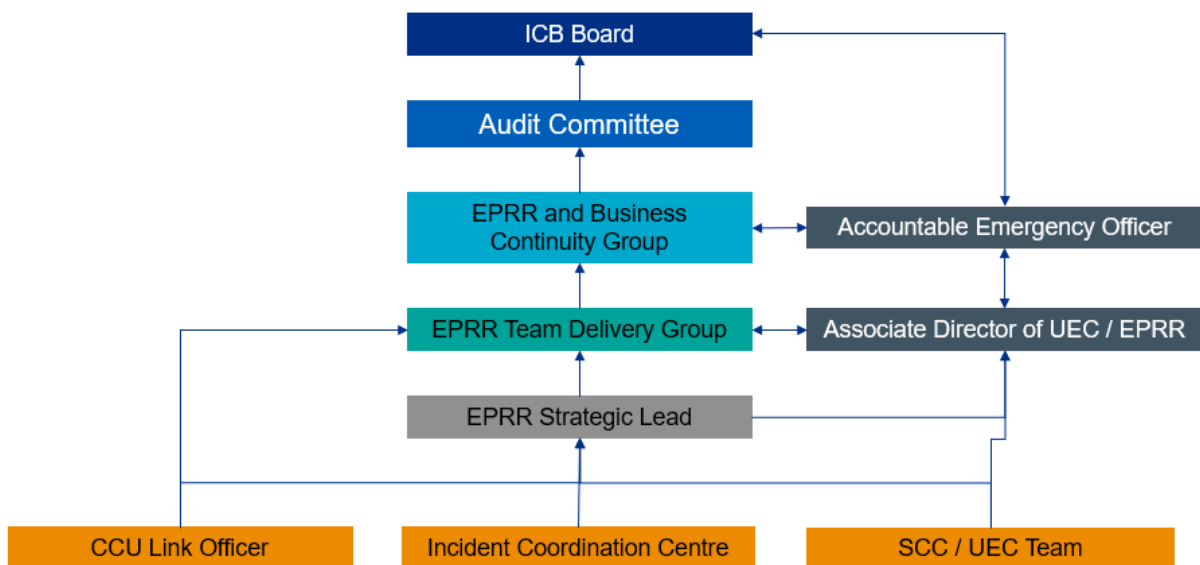


Figure 2: ICB EPRR Governance Structure

- 8.5 The AEO will represent the ICB at the Staffordshire Resilience Forum (SRF), while noting NHS England, and the Staffordshire NHS Trusts and NHS Foundation Trusts are also SRF members. The ICB will represent the Staffordshire NHS system partners at the relevant subgroups of the SRF, as per the Staffordshire LRF NHS representation agreement.

Local Health Resilience Partnership

- 8.6 LHRPs provide strategic forums for joint EPRR planning across a geographic area and support the health sector's contribution to multi-agency planning through the LRF. These

forums are co-chaired by the ICB AEO and a local Director of Public Health (DPH) to provide public health expertise and local leadership on EPRR matters to ensure resilience is commissioned effectively, reflects local risk, and that members develop and maintain effective health planning arrangements for incidents.

- 8.7 LHRP will coordinate the health input to NHS England, UKHSA, and local government in ensuring member organisations develop and maintain effective health planning arrangements for incidents.
- 8.8 LHRPs are not statutory organisations and accountability for EPRR remains with individual organisations. Each constituent organisation remains responsible and accountable for their effective response to incidents in line with their statutory duties and obligations.
- 8.9 The AEO, or a nominated representative with delegated authority to authorise plans and commit resources on behalf of the organisation, will attend LHRP on behalf of the ICB.
- 8.10 The AEO will utilise the LHRP to maintain the involvement and support of LHRP partners at a strategic and tactical level.
- 8.11 The secretariat function sits with the ICB and the EPRR Strategic Lead will ensure the LHRP sits quarterly, but at minimum on a six-monthly basis.
- 8.12 As per the LHRP terms of reference, the Health Emergency Planning Officer's Group (HEPOG) will be chaired by the ICB EPRR Strategic Lead, and sit as a subgroup of LHRP. The focus of the group is to undertake strategic and tactical EPRR work to support the requirement to ensure NHS-funded organisations have effective, coordinated structures in place to adequately plan, prepare, and exercise response arrangements. The Health Risk Management Group (HRMG) will sit jointly with HEPOG to provide a system approach to risk identification, mitigation and consequence management.
- 8.13 Further health resilience sub-groups may be convened at the direction of LHRP under HEPOG. Such groups will be determined on a need basis by the Co-Chairs of LHRP and in liaison with the LRF to ensure a coordinate approach to project delivery, and avoid duplication of workstreams.
- 8.13 The ICB will provide a route of escalation for resilience planning issues to the LHRP relating to commissioned provider EPRR preparedness.
- 8.14 NHS England and ICBs will coordinate health services at the LRF level, and ICBs will ensure coordination across local ICSs, facilitated through LHRP and local EPRR planning groups, to discharge the legal duties of cooperation between responders and health organisations

9. Roles and Responsibilities

Accountable Emergency Officer

- 9.1 The Health and Care Act (2022) places a duty on relevant service providers to appoint an individual to be responsible for discharging their duties under section 46, 252a, identified as the Accountable Emergency Officer (AEO).

- 9.2 The AEO will be an Executive Board-Level Director responsible for EPRR, with executive authority and responsibility for ensuring the organisation complies with legal and policy requirements, and has the appropriate authority, resources, and budget to direct the EPRR portfolio. This role will be undertaken by the Chief Delivery Officer, on delegated authority from the Chief Executive Officer as outlined at section 8.1. The responsibility for EPRR sits with the Board and therefore Non-Executive Directors will assure themselves that the EPRR requirements are being met through engagement with appropriate committee plans, EPRR reports to the Board, and supporting the dovetailing of EPRR arrangements with ICB portfolios and priorities.
- 9.3 The AEO will discharge the duty of the Chief Executive Officer to provide an EPRR report to the Board, no less than annually, stating: the ICB's readiness and preparedness activities; resourcing for EPRR delivery; training and exercising undertaken by the organisation; a summary of business continuity incidents, critical incidents and major incidents experience by the organisation; lessons identified and learning undertaken from incidents and exercises; and the organisation's compliance position in relation to the latest annual assurance process for EPRR.
- 9.4 The AEO provides assurance that strategies, systems, training, policies, and procedures are in place to ensure an appropriate response for their organisation in the event of an incident, to maintain the public's protection, and maximise the NHS response.
- 9.5 The AEO will be aware of the legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.
- 9.6 The AEO or a nominated deputy has a duty to co-chair the Local Health Resilience Partnership (LHRP) Group, providing local leadership on EPRR matters to all NHS-funded organisations and maintaining engagement across the local health and social care system to ensure resilience is commissioned effectively, reflecting local risk.
- 9.7 The AEO or nominated Director level deputy will attend the strategic level Staffordshire Resilience Forum (SRF) meeting, to engage and cooperate with responder agencies across the LRF.
- 9.8 Specifically, the AEO is responsible for:
- Ensuring the organisation, and any sub-contractors, is compliant with the EPRR requirements as set out in the CCA 2004, the 2005 regulations, the NHS Act 2006, the Health and Care Act 2022, and the NHS Standard Contract, including the NHS England Emergency Preparedness, Resilience and Response Framework 2022, and the NHS Core Standards for EPRR annual assurance self-assessment
 - Ensuring that the organisation is properly prepared and adequately resourced for dealing with an incident
 - Ensuring that the organisation, commissioned providers, and sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301

- Ensuring the organisation has a robust system escalation plan that provides an integrated organisational response and that it has been tested with other providers and partner organisations in the local area served
- Ensuring that the organisation complies with any requirements of NHS England, in monitoring compliance
- Providing NHS England with such information as it may require for the purpose of discharging its functions
- Ensuring the organisation is appropriately represented by director level engagement to effectively contribute to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate

9.9 This role is deputised by the Portfolio Director for Delivery and Improvement.

Associate Director for Urgent and Emergency Care Operations and EPRR

- 9.10 The Associate Director for UEC Operations and EPRR (ADO) is responsible for monitoring the delivery of the EPRR work programme, reporting progress against this to the ICB EPRR and Business Continuity Working Group, and escalating priorities or issues to the Accountable Emergency Officer where appropriate.
- 9.11 The ADO will deputise for the Chief Delivery Officer and Portfolio Director for Delivery and Improvement where appropriate.
- 9.12 The ADO will support the EPRR Strategic Lead in chairing the ICB EPRR and Business Continuity Working Group as necessary and approve papers to be submitted from this group to the ICB Audit Committee in agreement with the Accountable Emergency Officer.

EPRR Strategic Lead and UEC Operations Team

- 9.13 Supported by the UEC Operations Team / System Coordination Centre (SCC), the ICB EPRR Strategic Lead is responsible for delivery of the EPRR functions and duties as per the CCA (2004), EPRR Policy, and EPRR Framework (2022), including ensuring plans and arrangements are reviewed regularly. The inclusion of the SCC within the team structure enables resilient operations 7 days per week in line with the NHSE requirements for a 7-day operational SCC function.
- 9.14 The EPRR Strategic Lead reports to the ADO for UEC and EPRR, who is responsible for ensuring the progress of the EPRR work programme and provide a point of escalation for the EPRR Strategic Lead.
- 9.15 Formal accountability for the EPRR Team delivery remains with the Accountable Emergency Officer (Chief Delivery Officer), as per the EPRR Governance Structure outlined in section 8.
- 9.16 The EPRR Strategic Lead will ensure that the ICB plans jointly with the SSOT Integrated Care System, NHS England Midlands, Acute Trusts, Community and Mental Health Providers, Primary Care, Local Authorities, and other Category 1 and 2 responders as required.

- 9.17 The EPRR Strategic Lead will chair the SSOT ICB EPRR and Business Continuity Group, supported by the ADO.
- 9.18 The EPRR Strategic Lead will represent the ICB at LRF tactical level meetings, NHS EPRR Network meetings and multi-agency EPRR events, as per the Staffordshire LRF NHS representation agreement, ensuring discussions are dovetailed with those of HEPOG and HRMG, and information is gathered for escalation to the relevant LRF group, and updated following LRF meetings are shared with system partners.
- 9.19 The EPRR Strategic Lead will chair the Health Emergency Planning Officers Group (HEPOG) and Health Risk Management Group (HRMG) as per the relevant group terms of reference, and support system coordination planning and preparedness through the system EPRR work programme priorities as set by LHRP.
- 9.20 The EPRR Team will work to support the Greener NHS agenda through the consideration of climate change and adaptation within plans as appropriate. The Sustainability portfolio sits within that of the Chief Transformation Officer and so the EPRR Team will work with portfolio leads to give due consideration to this within EPRR plans and policies as appropriate.

CCU Link Officer

- 9.21 The ICB commission EPRR resource from Staffordshire Civil Contingencies Unit (CCU) to support the delivery of the ICB EPRR work programme two days per week. This resource will be utilised to provide advice and support on multi-agency emergency planning matters, whilst supporting internal arrangements as required, including the delivery of training and exercising to staff identified within the ICB On-Call Policy, and On-Call Managers as listed under section 10 of this Policy, supporting the delivery business continuity programme, and other duties as requested, such as plan support and debriefing.
- 9.22 This role reports directly to the EPRR Strategic Lead. The individual(s) working as contractors via this Partnership Agreement with CCU are not permitted to make decisions or commit resource on behalf of the organisation. In the absence of the EPRR Strategic Lead, the CCU Link Officer will report to and escalate any urgent matters to the Associate Director for Urgent and Emergency Care Operations and EPRR.
- 9.23 Any additional work requested of the CCU Link Officer by other members of the ICB should be agreed with the EPRR Strategic Lead to ensure capacity and continued delivery of the EPRR work programme.

Directorate Leads for Business Continuity

- 9.24 Each Directorate will have identified leads from each team to support business continuity planning where their service area is identified as maintaining critical/essential services within the ICB. This role holder will continue to review essential functions and contingency

arrangements for their team and will discharge their business continuity arrangements with support from the Directorate Business Continuity Recovery Team during incidents.

10. Command and Control

- 10.1 A clear command and control structure is in place to ensure individuals involved in the response to an incident are clear of their role and responsibilities, including a clear reporting arrangement for escalation for decision making, and cascade of key information.
- 10.2 Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. To fulfil our EPRR requirements, the ICB will operate a 24/7, 365 day, on-call function.

On-Call Managers

- 10.3 The ICB are committed to providing a resilient and dedicated on-call mechanism to enable 24/7 receipt and action of incident notifications, achieved through the on-call manager arrangements.
- 10.4 On-Call Managers are responsible for coordinating the local NHS response to an incident; responding to any NHS England Midlands Operations Centre (MidsROC) resource requests, and the provision of incident situation reports to MidsROC. The ICB operates a two-tier system, with a Tactical (Silver) On-Call Manager (SOC) and a Strategic (Gold) On-Call (GOC) Manager, performed by staff at Band 8c/8d, and Band 9 and VSM respectively. The On-Call Managers are supported by an ICB Clinical Lead On-Call on a 24/7 basis for any clinical escalations required.
- 10.5 A Director with delegated authority to allocate resources should always be available to make strategic decisions for the organisation, providing a point for escalation and decision making, or undertake the role of Strategic Commander for the ICB/ICS or SCG where necessary. This will be facilitated by the GOC Manager.
- 10.6 The on-call rota is managed by the Urgent and Emergency Care Operations Team and published by the Team to all On-Call Managers and partners across the ICS and Civil Contingencies Unit (CCU).
- 10.7 The SOC Manager is the nominated first point of contact for the organisation and will triage calls and manage these accordingly.
- 10.8 The Strategic (Gold) On-Call Manager provides a point of escalation for the SOC Manager for decision making, especially in critical or major incidents, or an incident which has the potential to significantly disrupt business as usual operations and delivery of key services; impact the health of SSOT communities; prevent delivery of statutory responsibilities; or have the potential to negatively impact the reputation of the organisation. Both roles may need to attend the incident coordination centre if established either physically or virtually.
- 10.9 Both roles dovetail with command, control, and coordination (C3) structures established across the Integrated Care System, wider local health economy, and local resilience forum. This is outlined in further detail within the ICB and ICS Incident Response Plan.

Incident Coordination Centre

- 10.10 The ICC supports the Incident Management Team (IMT) and On-Call Managers to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved through the utilisation of a formal structure, which facilitates suitable and sufficient arrangements to effectively manage the response to an incident.
- 10.11 Arrangements for the ICC are flexible and scalable to cope with a range of incident scales and hours of operation required, and will require strict adherence to information storage policies to ensure a record of the incident, including any key decisions, actions, and rationale can be retained, as outlined in the ICB and ICS Incident Response Plan.
- 10.12 The outline for the Incident Coordination Centre and IMT is contained within the Incident Response Plan.

11. Risk Management Strategy

- 11.1 To comply with the NHS England EPRR Framework, and NHS EPRR Core Standards annual assurance self-assessment, the ICB is required to assess the risk, no less frequently than annually, of any emergencies or business continuity incidents occurring, which affect or may affect the ability of the ICB to deliver its functions.
- 11.2 In implementing this, the EPRR Strategic Lead will ensure EPRR processes are represented and recorded within the ICB Risk Management Strategy, allowing for the identification, assessment, mitigation, and escalation of risk to the ICB Board.
- 11.3 The risk management process will be carried out in accordance with the ICB Risk Management Strategy, and escalation of EPRR risks will take place as follows:

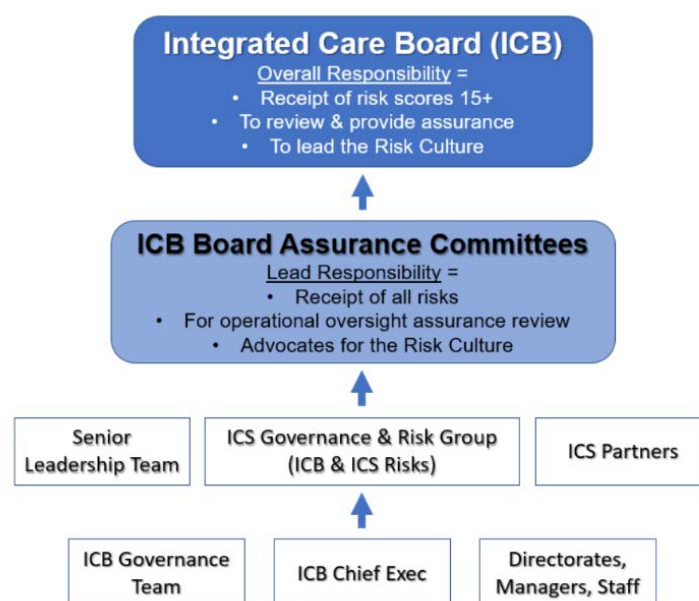


Figure 3: Extract from the ICB Risk Management Strategy

- 11.4 The ICB on behalf of the ICS will participate in the Local Resilience Forum Risk Assessment Working Group (RAWG) and will chair the Health Risk Management Group (HRMG) as a subgroup of LHRP. The ICB will review current and emerging risks highlighted by RAWG within the Community Risk Register, and risks identified by HRMG, and ensure appropriate plans are put into place.
- 11.5 The EPRR Strategic Lead will be responsible for ensuring that risks are regularly considered and reviewed, and any risk that has the potential of resulting in an emergency or business continuity interruption is included on the risk register and appropriate mitigating actions identified. Where a particular risk requires a specific response plan is created, the EPRR Strategic Lead will include this in the EPRR work programme.
- 11.6 The EPRR Strategic Lead will work with the LRF and LHRP to support the development of any multi-agency plan requiring health input.
- 11.7 The LHRP will consider and contribute to the Community Risk Register developed by the LRF, with assessments used to inform the planning and strategy set by the LHRP.

12. Business Continuity Management

- 12.1 Business continuity management (BCM) is an essential tool in establishing an organisation's resilience to maintain their business prioritised activities. BCM gives organisations a framework for identifying and managing risks that could disrupt normal services.
- 12.2 The ICB Business Continuity Plan (BCP), and associated Directorate or Service level plans, will be developed and maintained in accordance with the ICB Business Continuity Policy and Strategy, ISO 22301, NHS EPRR Core Standards, and NHS England's Business Continuity Management Framework.
- 12.3 BCP's will contain anticipated potential risks, including their likelihood and impact in a business impact analysis; an assessment of critical services and business critical activities, and their respective acceptable level of continued service during an incident; identification of dependencies and key stakeholders; communication; and defined roles and responsibilities.
- 12.4 This will be outlined in more detail within the Business Continuity Strategy, including a process for assessing the effectiveness of the BCM system (BCMS) through debriefs or after-action reviews.

13. Incident Response Plan

- 13.1 The ICB Incident Response Plan (IRP) will be developed and maintained in accordance with the civil protection duties outlined for category one responders under the CCA (2004), the NHS England EPRR Framework (2022), and the EPRR Annual Assurance requirements.
- 13.2 The plan will ensure the ICB has the capacity and capability to respond to a variety of incidents of any level, in a way which ensures the health, safety and wellbeing of patients,

service users, communities, and staff, minimises disruption to the health services, and facilitates an effective and efficient return to normal service levels.

- 13.3 The IRP will be integrated and complementary of business continuity arrangements to ensure an early recognition of resource implications can be considered, and assurance can be provided internally and externally of the organisation's ability to respond while maintaining essential services while responding to an incident that has the potential to affect health or patient care.
- 13.4 The IRP will:
- Define an incident and the types of incidents the ICS may be expected to respond to;
 - Establish roles and responsibilities for response, ensuring incident response role holders are aware of the stakeholders for consultation and informing during decision making;
 - Contain a command, control, and coordination (C3) framework for response to enable on-call staff and Directors to make informed decisions against a clear decision-making process;
 - Outline the dovetailing of C3 arrangements with the wider local health economy, MidsROC, and the LRF, including situation reporting as requested;
 - Identify internal, external, and stakeholder communication arrangements prior to, during and after an incident, in line with the ICB strategy for media and communications;
 - Outline the process for recovery from an incident

14. Mutual Aid

- 14.1 The response to the Coronavirus has demonstrated the effectiveness of joint working in incident response, to enable challenges arising across organisational boundaries to be approached with collaborative resources, varied skillsets, and identify solutions to support the promotion of safety, health and wellbeing of communities and responders.
- 14.2 In incidents requiring multi-agency response, mutual aid requests will be put forward to the Local NHS Strategic Command (LNSC) Group, to enable escalation of requests into the Staffordshire Tactical and Strategic Coordinating Groups. Mutual aid requests will also be highlighted within Situation Reports to NHSE for consideration at a regional level.
- 14.3 The ICB will support the requesting, coordination, and maintenance of mutual aid requests for staff, equipment, services, and supplies.
- 14.4 NHS England Midlands will be responsible for the coordination and implementation of mutual aid requests if a disruptive incident occurs across several counties/regional footprint. The ICB, through the Local NHS Strategic Command, will respond to any requests received to provide mutual aid during a major or significant incident or emergency.
- 14.5 Clinical networks will retain a key role in coordinating their specialist capacity.
- 14.6 In the event that mutual aid, business continuity, and commissioning options are considered as not appropriate, inaccessible, or exhausted, it may be appropriate to consider requesting support from the military under the Military Aid to Civilian Authorities (MACA) requesting process. All requests should be submitted to NHS England (national) at the earliest

opportunity, and must be approved by the Chief Executive Officer, AEO, or an Executive Director on delegated authority as Gold On-Call Managers. Further detail and the request form is available in the ICB Incident Response Plan.

15. Information Sharing

- 15.1 Within the civil protection duties as outlined in the CCA 2004, the ICB and local responders have a duty to share information to support preparedness, response, and recovery to incidents of any type.
- 15.2 The One Staffordshire Information Sharing Protocol and SRF Information Sharing Agreement are in place across the Staffordshire Local Resilience Forum, and outlined the principles and standards of conduct and practice in the sharing of information, including the promotion of good practice.
- 15.3 Throughout any sharing of information, the Information Governance team must be consulted, and decisions made in line with the Freedom of Information Act (2000), the General Data Protection Regulations (2016), the Caldicott Principles, safeguarding requirements, and Civil Contingencies Act (2004).

16. Maintenance of Plans

- 16.1 The EPRR Team will be responsible for ensuring the ICB incident response and business continuity plans, and associated guidance and training documents are reviewed at regular intervals, in line with any changes to local and national guidance, organisational change, lessons identified, and training needs of the organisation.
- 16.2 Policy development, consultation, and ratification will be in line with the ICB Development and Management of Controlled Documents Policy. Any plans or arrangements which are not categorised as a controlled document will utilise the policy as a best practice process.

17. Implementation, Monitoring and Review

- 17.1 Effective communication methods will be established to ensure this Policy and its contents are embedded in organisational knowledge. The document will be shared with the Executive Team and the teams within the EPRR Governance Structure, in addition to on-call and operational teams. It will remain available on the System Coordination Centre SharePoint site for all staff access, and will be published on the ICB website.
- 17.2 Assurance in respect of EPRR arrangements will be provided to the ICB Audit Committee and ICB Public Board, and annually to NHS England through the EPRR Core Standard Assurance Process.
- 17.3 Effectiveness of arrangements will be reviewed following incident debriefs, incidents of note outside of Staffordshire and Stoke-on-Trent (e.g. the Manchester Arena Inquiry, Covid Inquiry), release of new or updated policy and guidance, and any National Resilience Standards as appropriate, to drive forward an agenda of best practice across all EPRR domains.

- 17.4 The Policy will be reviewed on a three-yearly basis by the EPRR Strategic Lead to ensure effectiveness and compliance against current guidance and legislation, unless any significant amendment to policy or working practice as outlined at 17.3 denotes otherwise.
- 17.5 An Equality Impact Assessment is available on request.
- 17.6 Should any queries arise regarding the content of this policy, the individual should contact the ICB EPRR Strategic Lead to discuss, and any amendments will be considered accordingly.

18. Training and Exercising

Staff Training

- 18.1 Staff undertaking roles and responsibilities as listed within this policy will be trained in line with the frequency outlined in the Training Needs Analysis, and according to the NHS England EPRR competencies (national minimum occupational standards for EPRR).
- 18.2 Individuals must commit to undertake appropriate training annually (unless denoted otherwise by an accredited course) for their role in line with the ICB On-Call Policy and annual training and exercise schedule, to ensure skills are maintained.
- 18.3 The EPRR Strategic Lead will produce a training needs analysis annually, supported by detailed training records and personal training and exercising portfolios for on-call and ICC staff, in line with the minimum occupational standards for EPRR and the Skills for Justice National Occupational Standards (NOS) framework.
- 18.4 Individuals holding incident response roles will be responsible for maintaining their EPRR training portfolios to support development in role, highlighting areas for further development to the EPRR Strategic Lead.
- 18.5 The EPRR Support Manager will maintain the central record of training undertaken and upcoming expiry to maintain competence across teams.
- 18.6 Associate Directors are responsible for ensuring that staff within their Directorates and Teams are aware of relevant EPRR and business continuity training and are encouraged to attend recommended courses.

Testing and Exercising

- 18.7 To ensure the effectiveness and embed knowledge of emergency plans, these must be tested regularly to ensure they are fit for purpose, staff are confident in delivering their roles to support response, and roles listed in the plan fit for purpose and encapsulate necessary functions and actions.
- 18.8 Throughout the exercising process, members of staff can practice their skills, and increase their knowledge and confidence in a safe environment.

- 18.9 Plans can be assured through confirm and challenge of content, allowing for the identification of any gaps or areas for improvement, which will be logged for continuous development and for audit purposes for later reference if required.
- 18.10 The EPRR Strategic Lead is responsible for ensuring policies and arrangements are tested and exercised in line with the annual training and exercise schedule and as set out in the NHS England EPRR Framework (2022).
- 18.11 This includes a minimum expectation as set out below:

Exercise Type	Minimum Frequency	Outline
ICC equipment test	3 months	Test of the functionality of ICC equipment.
Communications (ICB arranged)	6 months	Test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. These exercises are conducted both in-hours and out-of-hours on a rotational basis and should be unannounced.
Table-top	12 months	Discuss the response, or specific element of a response, to an incident with relevant staff and partners, and can provide validation of a new or revised plan.
Business continuity	12 months	Discuss the response, or specific element of a response, to an incident impacting key services to enable testing of business continuity planning arrangements with relevant staff and partners.
Live play	3 years	Live test of arrangements and includes the operational and practical elements of an incident response. NB. If an organisation activates its plan for response to a live incident this replaces the need to run an exercise, providing lessons are identified and recorded and an action plan developed.
Command post	3 years	Tests the operational element of command and control and requires the setting up of the Incident Coordination Centre (ICC). It provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of exercise, and should also test communication and information flows into multi-agency partners. A real incident activation replaces the need to run an exercise, subject to the identification, logging, and actioning of any lessons identified.

- 18.12 Exercises will be designed relevant to local risk, as defined in section 9 of this policy, and will aim to meet the needs of the organisation and any stakeholder engaged within warning and informing elements of the exercise.
- 18.13 Post-exercise reports will be produced by the EPRR Team to capture lessons identified and ensure learning is embedded into policies, arrangements and training where required.
- 18.14 Staff performing an on-call role will be required to attend NHS and LRF multi-agency exercises to ensure they are familiar with multi-agency arrangements, plans, and C3 structures.

19. Lessons Identified

- 19.1 NHS funded organisations are required to share information of lessons identified through exercising or incident response across the wider NHS through a common process coordinated through the LHRP.
- 19.2 Reviewing lessons from incidents ensures the ICB can identify opportunities for continuous improvement and embed these into EPRR arrangements.
- 19.3 Within 48 hours after an incident, the EPRR Strategic Lead will conduct a hot debrief with staff involved to capture any immediate learning and enable staff to de-escalate / decompress following an incident.
- 19.4 Within 28 days, the EPRR Strategic Lead will conduct a cold debrief with those involved in the incident for its duration, and the lead-in to consider preparedness steps, as appropriate.
- 19.5 Where deemed necessary, a multi-agency debrief will be requested / commissioned through the Civil Contingencies Unit, ideally to be held within eight weeks of close of the incident
- 19.6 The results of both debriefs which will form a lessons identified report and an action plan for the implementation of any lessons identified, which will be produced within four weeks of the debrief.
- 19.7 The report will be supported by actions plans, with timescales and accountable owners, and any recommendations to update any relevant plans or procedures and identify any training or exercising required.
- 19.7 The Lessons Learnt Report will be shared with the ICB EPRR and Business Continuity Group and ICB Governance Structures for EPRR as outlined, and will form part of the annual report to Audit Committee and ICB Board.
- 19.8 Reports will be sharing across the ICS to share lessons, via the LHRP Health Emergency Planning Officers Group (HEPOG).
- 19.9 The EPRR Strategic Lead will ensure lessons are shared with NHSE Midlands EPRR team as part of the regional process for sharing of lessons.

20. Audit Arrangements

- 20.1 The policy will be audited throughout the year both internally and externally. The EPRR Strategic Lead will also ensure that any appropriate external audits tools and assurance processes are conducted on a regular basis, such as the NHS EPRR Core Standards Assurance self-assessment return to NHS England.
- 20.2 EPRR, including business continuity will be aligned to the requirements of the organisation's audit programme, and will implement any post audit improvement plans or recommendations to support continuous improvement.

21. Equality and Diversity

- 21.1 An equality impact assessment has been completed for this policy to ensure plans developed under this Policy have due regard to reflect the impact on and from health inequalities in preparing for, responding to, and recovering from incidents. This can be accessed on request.

22. Supporting Documentation and Policies

- 22.1 In addition to meeting legislative duties, ICBs are required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Planning Framework 2022
- NHS Core Standards for Emergency Preparedness, Resilience and Response Annual Assurance

- 22.2 This policy is to be read in conjunction with:

- EPRR Strategy
- ICB and ICS Incident Response Plan
- Business Continuity Strategy and Business Continuity Management System
- Corporate Business Continuity Plan
- On-Call Managers Handbook

- 22.3 The following ICB policies support this Policy:

- Health and Safety Policy
- Information Governance, Data Protection and Security Policy
- Information Governance Handbook
- Procurement Policy

23. Definitions and Glossary

Definitions

Business Continuity:

The capability of the organisation to continue delivery of products or services at acceptable pre-defined levels following a disruptive incident

Business Continuity Incident:

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Business Impact Analysis:

The process of analysing activities and the effect that a business disruption might have upon them

Business Continuity Plan:

Documents the procedures that guide the organisation to respond, recover, resume, and restore to a pre-defined level of operation following a disruption to business continuity

Critical Incident:

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Emergency:

- a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom, or*
- b) An event or situation which threatens serious damage to the environment of a place in the United Kingdom, or*
- c) War, or terrorism, which threatens serious damage to the security of the United Kingdom*

Emergency Preparedness:

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

Incident Response Plan:

Outlines how the ICB will respond to a critical or major incident.

Major Incident:

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

For the NHS this will include any event defined as an emergency.

Resilience:

Ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

Response:

Decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders, including those associated with recovery.

System Critical Incident:

Under the NHS England EPRR framework 2022, there is no mechanism for declaring a system-wide critical incident. To do this, all Trusts and the ICB must individually declare a critical incident, before the ICB makes a declaration on behalf of the system (decision in collaboration with system partners) to declare a System Critical Incident. This must be reported to NHSE Midlands First On-Call with an accompanying SBAR report.

Glossary

AEO	Accountable Emergency Officer
BCM	Business Continuity Management
BCP	Business Continuity Plan
C3	Command, Control and Coordination
CCA (2004)	Civil Contingencies Act (2004)
CCU	Civil Contingencies Unit
CPX	Command Post Exercise
DPH	Director of Public Health
EPRR	Emergency Preparedness, Resilience and Response
HEPOG	Health Emergency Planning Officers Group
HRMG	Health Risk Management Group
ICB	Integrated Care Board
ICS	Integrated Care System
IRP	Incident Response Plan
LHRP	Local Health Resilience Partners
LNSC	Local NHS Strategic Command
LRF	Local Resilience Forum
MIDSROC	NHS England Midlands Region Operations Centre
NHSE	NHS England
NHS NOC	NHS England National Operations Centre
NOS	National Occupational Standards
RAWG	Risk Assessment Working Group
SCC	System Coordination Centre
SCG	Strategic Coordinating Group
SRF	Staffordshire Resilience Forum
TCG	Tactical Coordinating Group
TTX	Table-Top Exercise
UEC	Urgent and Emergency Care

24. References

- Civil Contingencies Act 2004
- The Health and Social Care Act (2022)
- NHS Constitution
- The NHS England Emergency Preparedness Framework 2022
- NHS England Business Continuity Management Framework (service resilience) (2013)
- NHS Core Standards for Emergency Preparedness Resilience and Response Annual Assurance
- ISO 22301 – Societal Security – Business Continuity Management Systems – Requirements
- Cabinet Office, Emergency Preparedness (2006) (as amended)
- National Occupational Standards (NOS) for Civil Contingencies

Enclosure No: 21

Report to:	Integrated Care Board				
Date:	18 July 2024				
Title:	New Style Triple A (AAA) Committee Highlight & Escalation Report – Audit Committee July 2024 Trial Version				
Presenting Officer:	Julie Houlder, Audit Committee NED Chair				
Author(s):	Paul Winter, Associate Director of Corporate Governance				
Document Type:	Business Plan	If Other:			
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S) <input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	(check as necessary)
Is the decision within SOFD powers & limits	Yes / No	YES			
Any potential / actual Conflict of Interest?	Yes / No	YES If Y, the mitigation recommendations – PART B Meeting only to avoid non-ICB influence on the decisions			
Any financial impacts: ICB or ICS?	Yes / No	NO If Y, are those signed off by and date:			
Appendices:	ONE (the proposed Undertakings Action Plan and SSOT ICB's reply to NHSE)				

(1) Purpose of the Paper:

This new style “Triple A” (AAA) Audit Committee Highlight & Escalation Report is being trialled today, intended in the same way as the current versions do, so as to update ICB Board on the latest developments arising from Board Assurance Committees. In this case, as for the most-recent (July) meeting of our Audit Committee, agreed with the Committee Chair for testing today.

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

Weekly Execs meeting / NEDs meeting throughout April-June 2024

Date

(3) Implications:

Legal or Regulatory	2022 Health & Care Act + aligned Statutory Guidance
CQC or Patient Safety	Regulatory aspects pertaining to CQC / Well-Led (re ICS assessments)
Financial (CFO-assured)	n/a
Sustainability	n/a
Workforce or Training	A formal ICB training programme (one per each Directorate and with NED Chairs) has just started and will progress ready for October formal roll-out
Equality & Diversity	n/a
Due Regard: Inequalities	All ICB Committees / Sub-Committees must adhere to the ‘Quadruple Aim’
Due Regard: wider effect	All ICB Committees / Sub-Committees must pay due regard to the statutory duty

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Not required <i>If Y, Reported to IG Group on</i>
	EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required
	QIA	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Not required <i>If Y, signed off by QIA on</i>
Has there been Public / Patient Involvement?		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not required

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>	BAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
BAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>	BAF6	Sustainable Finances	<input checked="" type="checkbox"/>
BAF3	Proactive Community Services	<input checked="" type="checkbox"/>	BAF7	Improving Productivity	<input checked="" type="checkbox"/>
BAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	BAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>To help optimise efficiency, it has been agreed that we adopt a tool from the Good Governance institute, designed to ensure that our Board can be better appraised of issues discussed at Board Assurance Committee / their Sub-Committee meetings, acting under delegated powers. One of the main challenges is how effectively we Alert, Assure and Advise the Board of what occurs at those. The 'Triple A (AAA)' mechanism provides a new way to writing our current Highlight & Escalation Reports.</p> <p>The Board are also asked to note that a 'AAA' blended reporting approach will also take place at the same time. In order to reshape how formal reports are prepared for the Board and Committees, using the same broad approach. (And supported by internal training on what a good management report should look like, to help Authors aid their Readers).</p> <p>A Committee AAA Highlight & Escalation Report to Board will:-</p> <ul style="list-style-type: none"> - Summarises the key points of a Committee meeting for up-to-Board reporting; - As well as providing salient governance facts (date held etc), it provides summary information; like - Was the meeting quorate / What learnings might be shared - The key agenda items discussed + links to the SBAF incl. a review of Key Risks to objectives etc; - What matters are being escalated or de-escalated and need consideration. <p>Pending Board's views, this style is being formally rolled out across all the other 'Board Assurance Committees' from October 2024 onwards. Any feedback today to help improve those is welcome.</p>

(7) Recommendations to Board / Committee:
<p>The Board is asked:</p> <ul style="list-style-type: none"> - To CONSIDER the trial run of the new Board Reporting approach as requested via the Audit Committee on behalf of ICB Board, providing any feedback to the ICB Governance Team; and - To be ASSURED on the key outputs of that committee's latest meeting, as part of its Business Cycle.

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	ICB Board
Date:	17th July 2024
Reporting Committee:	Audit Committee
Date of Meeting:	1st July 2024
Meeting Quorate Y/N?	YES
Presenter:	Julie Houlder, Non-Executive Director
Author:	Paul Winter, Associate Director of Corporate Governance

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

Outstanding Actions from a Medicines Optimisation Internal Audit Report: Members were advised by RSM (Internal Audit) that there are currently a number of actions being postponed / rescheduled due to capacity concerns, this requiring offline assurances on progress towards their longer-term solution.

PSIRF (Patient Safety Framework) Audit: Members received an update on audit plans yet to be undertaken in 24/25, and noted how those will help SBAF assurances progression later in the year.

Continuing Healthcare Advisory Audit: Members thanked RSM colleagues for their report into new collaborative working arrangements, and wished to alert the Board that pan-Collaborative ownership of all the advisory findings need to be considered by all parties, to ensure the new arrangements fully embrace these helpful comments.

ADVISE

Counter Fraud Compliance Standards: Members commended a positive annual submission of the ICB's Counter Fraud Functional Standard Return, shared as part of the 23/24 Annual Report. The green rating assesses the ICB as fully compliant with the requirements, with demonstrative evidence of the impact of work undertaken available. The Committee thanked everyone for their work on achieving this.

Head of Internal Audit Opinion (HOIA): RSM's full opinion shows a positive, "above the line" status for the 23/24 financial year, which was commended by all. *The [ICB] has an adequate and effective framework for risk management, governance and internal control. [Work] has identified further enhancements [to] ensure that it remains adequate and effective.* Overall, 9 audit reports were found to be of positive assurance to the organisation.

ICB Undertakings: the Committee approved the overall ICB Programme Plan that assigns each of NHS England's required activities to a lead committee; including those for Audit as holding the overall oversight role for ICB committees, on behalf of the Board.

ASSURE

Q1 SBAF Report: this provided the Committee with an overall positive view of the processes supporting the new SBAF approach (as discussed in more detail on page 2). Some minor formatting enhancements to help Readers navigate the reports better are being addressed by the Governance Team.

Single Tender Waivers Update: the Committee received positive assurances about the STW analysis and confirmed their assent to these, notifying the Finance Team of a few minor enhancements to be made offline on improving how non-process decisions are taken going forward.

ASSURE (continued)

2024/25 Local Counter Fraud Specialist (LCFS) Plan: the Committee welcomed the proposed workplan of the LCFS in the year to come; and was pleased to note the progress of the programme overall.

2023/24 NHS Data Security & Protection Toolkit (DSPT) Compliance: the Committee commended the ICB, CSU and Health Informatics Service for achieving a fully “Standards Met” submission for the ICB, noting the enhanced reporting requirements set out this year and including the positive assurances found by Internal Audit in their mandatory verification of the ICB’s submission.

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

Q1 2024-25 SBAF Report: a full Q1 analysis was received for discussion and requested for assurances. It was noted that the Audit Committee’s meeting was before the other 3 Board Assurance Committees’ own receipt of the same: all scheduled later in July. (A review of meeting dates to avoid this happening again, moving dates if so required, is currently under way). The Committee requested that the Objective Owners of *SBAF6* & *SBAF7* ensure the two remain strongly interlinked for the rest of the SBAF year.

July System & ICB Risk Registers: The Audit Committee received and noted the System and ICB Risk Register Reports; and noted the ICB Risk Register Report.

The Committee discussed and confirmed its views as to Q1 SBAF / All Risk scores and assurance assessments being an accurate reflection of the current position, with some specifics highlighted within the AAA sections above.

Policies Approved:

The Committee received and duly approved the following policies, presented by the named teams:

- The EPRR Policy, by the UEC Team;
- The Anti-Fraud & Bribery Policy, by the Governance Team;
- The Losses & Special Payments and Cash & Treasury Management Policies, by the Finance Team.

Decisions to be Escalated to ICB Board:

- Chairs Report – new style.
- There were no escalations to other Board Assurance Committees (beyond noting the SBAF items flagged in the AAA sections, for awareness).