NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting

HELD IN PUBLIC

Staffordshire County Council, Council Chamber, County Buildings, Martin Street, Stafford, ST16 2DH

Thursday 21st November 2024
12.30pm – 2.30pm

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

	Agenda Item	Lead(s)	Enc	A/R/S /D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	12.30pm	
2.	Leadership Compact	Chair	Enc 01	A		3
3.	Conflicts of Interest	Chair	Enc 02	---		4-5
4.	Minutes of meeting held on 17th October 2024	Chair	Enc 03	A		6-19
5.	Action Log - progress update on actions	Chair	Enc 04	D		20
6.	Questions submitted by members of the public in advance of the meting	Chair	---	D	12.35pm	---
7.	Community Story Keep warm, keep well community energy scheme – transforming health and the environment	Chair	Enc 05	I/S	12.45pm	21-30
Strategic and System Development						
8.	ICB Chair and Chief Executive Update	DP/PA	Enc 06	I	12.55pm	31-40
9.	System Level Access Improvement Plan	PEJ	Enc 07	D/S	1.05pm	41-95
10.	System Surge Plan for Winter	PS	Enc 08	R	1.15pm	96-110
11.	Medium Term Plan	PB/ED	Enc 09	I/S	1.25pm	111-125
System Governance and Performance						
12.	Quality and Safety Report System Quality and Safety Committee AAA Chairs Escalation Report	HJ JS	Enc 10 Enc 11	S I/S	1.35pm	126-130 131-134
13.	Staffordshire and Stoke on Trent Health and Care Senate Summary and Escalation Report	PEJ	Enc 12	I/S	1.45pm	135-138
14.	ICS Finance and Performance Report Finance and Performance Committee Assurance Report	PB/PS MN	Enc 13 Enc 14	I/S I/S	1.55pm	139-161 162-168

15.	People Culture and Inclusion Assurance Report People, Culture and Inclusion Committee AAA Report	MI	Enc 15 Enc 16	I/S I/S	2.05pm	169-181 182-184
16.	Staffordshire and Stoke on Trent ICB Remuneration Committee Summary and Escalation Report	SL	Enc 17	I/S	2.15pm	185-187

Any Other Business						
17.	Items notified in advance to the Chair	All	---	D	2.20pm	
18.	Questions from the floor relating to the discussions at the meeting	Chair	---			
19.	Meeting Effectiveness	Chair	---			
20.	Close	Chair	---		2.30pm	
21.	**Date and Time of Next Meeting** 19th December 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 NOVEMBER 2024

Key

Declaration completed for financial year 2024/2025

Declaration for financial year 2024/2025 to be submitted

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

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

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

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

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent

Integrated Care Board PUBLIC Meeting

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

Mish Irvine (MI), Chief People Officer, Staffordshire & Stoke-on-Trent ICB (People Directorate, Midlands Partnership University NHS Foundation Trust) *(in attendance for item 11 and 14)*		✓	✓	✓	✓	A	✓					
Nicky Harkness (NH), Programme Director Provider Collaborative, Staffordshire & Stoke-on-Trent Integrated Care Board		A	✓	✓	✓	✓						
Pauline Grant (PG), Associate Director of Organisational Development, People Directorate *((in attendance for item 11)*		A	A	✓	✓		✓					
Kay Johnson (KJ), Executive Assistant, Staffordshire & Stoke-on-Trent ICB					✓		✓					
Lisa Ellis, Executive Support Officer, Staffordshire & Stoke on Trent ICB						✓	A					
Clare Cotton (CC), University Hospitals of North Midlands NHS Trust *(in attendance for item 15)*					✓		✓					
Dr N Tony Ahmed (TA), Dental Participant Board Member					✓	✓	✓					
Eric Gardiner (EG), Chief Finance Officer, North Staffordshire Combined Healthcare NHS Trust						✓						
Nicola Bromage, (NB), Associate Director, MHLDA, Staffordshire & Stoke-on-Trent ICB *(in attendance for item 10)*							✓					
Ben Richards, (BR), Chief Operating Officer, NSCHT & SSOT ICH MHLDA Programme SRO *(in attendance for item 10)*							✓					
Deborah Hargreaves, (DH), Senior Service Manager, NSCHT *(in attendance for item 10)*							✓					
Upkar Jheeta, (UJ), Head of Mental Health Transformation, MPFT *(in attendance for item 10)*							✓					
Lisa Agell, (LA), Operations Director, MPFT *(in attendance for item 10)*							✓					
Jacqui Charlesworth, (JC), Director of Operational Finance, Staffordshire & Stoke-on-Trent ICB *in attendance for item 13)*							✓					
Rachel Gallyot, (RG), Deputy Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB *(in attendance for item 16)*							✓					

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting and advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. The meeting is being recorded and will be available on the ICB website after the meeting. DP reminded members of the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and guides the way business is conducted.	
	Apologies	
	Apologies were received from: Josie Spencer Non-Executive Director Neil Carr Chief Executive, Midlands Partnership NHS University Foundation Trust Paul Edmondson-Jones Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB Paul Brown Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB	
2.	**Confirm Quoracy**	
	DP confirmed that the meeting was quorate.	
3.	**Leadership Compact**	
	Received and noted.	

4.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
5.	**Minutes of the Meeting held on 26th September 2024**	
	The minutes of the meeting held on 26th September 2024 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED** subject to amendment of recording of SC attendance.	
6.	**Minutes of the Annual General Meeting held on 26th September 2024**	
	The minutes of the Annual General Meeting held on the 26th September 2024 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
7.	**Action log**	
	No live actions.	
8.	**Questions submitted by members of the public in advance of the meting**	
	Question One – submitted by Ian Syme **Medical Examiners:** *An enhanced role for Medical Examiners was recommended by 'The Shipman Inquiry" 2005 by the 'Mid Staffs Inquiry' 2013 and also by the 'Morecombe Bay Inquiry' 2015.* *Finally, September 9th 2024 that enhanced role of Independent Medical Examiners came into force and the Medical Examiner System is now statutory* *At UHNMs Board meeting 9th October 2024 mention was made at the surprising High numbers of 'community deaths' and also within UHNMs Highlight Report 'Quality and Governance Committee October 3rd 2024 this statement* *'Ongoing work with GPs around delays in referral of deaths to the Medical Examiners Service.' (Page 171 of 179 -UHNM Board Papers pack).* *a. Is the ICB fully aware of the situation as described above?* *b. What if any lessons have been learned and thus mitigated to ensure the Medical Examiners role can function in its entirety without such encumbrances given the supposedly 'high numbers' and 'delays by GPs' in referring deaths to Medical Examiners?* *c. Is the situation re delays in referring deaths and 'high numbers' unique to Northern Staffordshire (in effect UHNMs immediate catchment) or more extensive regionally?* *d. The ICB has an important role to play in co-ordinating work between healthcare providers, facilitating partnership work, and ensuring there are appropriate processes for receiving and acting on intelligence and issues detected by medical examiners.* *Is the ICB assured that the resources allocated to them for medical examiner offices have been made fully available to appropriate NHS trusts and to the medical examiner offices?* **Response provided by Dr R Gallyot** Thank you for your question.	

As you rightly state the enhanced role of the ME System to cover all community deaths finally came into force on 9th September 2024 and is now a statutory service. I am pleased to say that, following a year of hard work by the ME services at UHNM, UHDB and RWT we have 100% of GP Practices in SSoT fully engaged with the right IT equipment, software and data sharing agreements in place and able to refer deaths to the appropriate service.

The statement you refer to in UHNM Board papers was written only 2 weeks after the new service became statutory and it is far too early to draw any conclusions. In the first two weeks of running the service had an average of 85 deaths referred as opposed to the 70 per week that was estimated by the regional team as part of the roll out. It was noted at the meeting, by verbal comment, that the Trust had seen a lower than average number of deaths in hospital over that 2-week period. It may be that this is a result of all the work being done to reduce the very high numbers of residents in SSoT that die in hospital, but it is far too early to draw any conclusion. We will need to continue to monitor the figures over the next 6 months as recommended by NHSE is the roll out protocols.

The statement made mention that there were some teething issues, such as some delays in GPs referring deaths to the service. Once again, this is only to be expected in a new service and each of our 3 ME services (including UHNM) will continue to monitor all aspects of referral and feed back to GPs and to ourselves at the ICB. We will work with the service and the GPs to understand any issues and how we can all work together to make sure the new service is working optimally. Once again, we will be in a position in 6 months to have gathered enough information to be able to demonstrate any teething issues, how they were resolved and demonstrate optimal performance.

Regarding the question about comparisons across our 3 services and with other regional services, it is again far too early to draw any meaningful conclusions. All services are required to have monitored progress over the first 6 months, submitted the information to NHSE and they will then look at any learning, including benchmarking performance, across the Region. We will be taking an update to Quality and Safety Committee once we have the results from the 6-month audit and will be reporting progress regularly in the meantime.

Finally, regarding resources, all relevant resources made available to the system have been allocated appropriately to the ME services.

Response provided by Jacky Aw

I think there are two parts one about the quality and the numbers which I can't comment on, but ongoing monitoring will reflect this. Staffordshire and Stoke-on-Trent ICB were part of the national pilot around the medical examiner referral, before it became statutory in September. There has been an eighteen-month delay in this going live nationally. I would like to reassure Mr Syme that we have also piloted the digital death certificate referral, so we are at the front edge of implementation of these things. As you can imagine trying to change a wholesale system overnight is not the easiest feat. There are some teething problems, there are the registrars, the crematoriums and funeral directors all involved. I want to reassure as a frontline GP this is one of the smoothest transitions we've had, where there's been a wholesale change of system.

Response provided by Dr Simon Constable

In support of Rachel and Jacky I think it's difficult to overstate how much of a big change in clinical practice this is. We have had a bit of time to get used to it in hospitals, but the further roll out has been a significant change. It's too early to draw any conclusions from any numbers at this stage and that we have got to look back for a least six to twelve months if not a full calendar year to draw comparisons and of course of death rates, which will be closely monitored at all levels. I wish to take this opportunity to commend the service that we have got locally and to continue to support it.

	Question 2 – submitted by Ian Syme **Home First:** *Stoke-on-Trent LA gave notice earlier this year that it will be withdrawing from some 'aspects' of the Local 'Home First' initiative.* *That withdrawal is now only 6 months in the future i.e. April 2025.* *What's the present state of play regarding this?* **Response provided by Phil Smith** Thank you for the question. There are no active plans to withdraw any aspects of Home First. However, we are working through a collaborative exercise with partners to review all the Better Care Fund schemes to ensure that when we get into the next financial year, we are targeting that resource effectively to meet the needs of the population. There's also a commitment from partners that any changes to services will be enacted in a managed way. Looking further ahead into the medium term, our strategy is very much about delivering care closer to home, developing integrated offers which support care needs being met in the community. Therefore, as part of the work outlined, we can expect there to be greater emphasis on developing community based preventative offers going forwards rather than a reliance on in hospital care and therefore on discharge support. DP thanked Ian Syme for the questions submitted.	
9.	**ICB Chair and Chief Executive Update**	
	DP introduced the ICB Chair and Chief Executive Update report. DP shared with members how pleased he was to see under 1.1.2 to the impact of the veteran friendly accreditation roll out across the patch and under 1.1.3 the development of the Women's Health Hubs. DP highlighted to members the Director of Public Health Annual Report that has been produced by Dr Richard Harling MBE, which is welcomed and very helpful. PA highlighted to members the information provided around vaccinations and the core activity which is taking place along with the supplemental work in terms of vaccine subsets of the population. Members were informed of the visit to the system from Claire Fuller, NSHE National Medical Director which took place at Burton Hospital. System partners attended the visit to discuss achievements, challenges and opportunities across the Primary Care agenda and related matters such as provider collaboration and Place evolution. PA shared with members that there were lots of positive messages on the day. PA highlighted to members the ongoing work that is taking place around the medium-term plan and that clarity around levels of funding is being awaited following the government budget announcement, which will help determine a clinical optimised system. JH raised the following questions and requested they be taken as actions. **Actions:** • The impact of palliative care prevalence. What is the link between that and the position that we are in with regards to continuing healthcare? The prevalence link between the two. • Practice Open Day in Barlaston event. This is a good initiative. The possible extension of that in terms of supporting our communities to help themselves.	

	• This links to the SBAF. Community activity has dropped significantly and that must have had an impact on the other metrics. DP thanks JH for the questions raised and the option to take as actions. **The Board:** **RECEIVED:** the report **ASSURED:** the leadership are working on each topic as raised.	
10.	**ICB Review of Intensive & Assertive Community Mental Health Care - SSOT Action Plan**	
	NB was in attendance to present the ICB Review of Intensive & Assertive Community Mental Health Care – SSOT Action plan. Members were informed that this is a high level overview comes out of the learning and the CQC review of Nottinghamshire Healthcare Foundation Trust following the Valdo Calocane case. It was highlighted that NHSE wrote to all systems asking ICBs to conduct a review. To support a response NHSE established an expert advisory group which consisted of Royal Collage of Psychiatrists, Consultants across assertive outreach, forensics, secure rehab mental health in terms of overseeing its response to this recommendation. Members were highlighted to: • Response and measures the NHS has already undertaken • National Overview • Context and background • Individuals in scope of needing intensive and assertive community mental health care • Organisations and specific leads involved in the review • The ICB review process • NHSCHT/MPFT policies and practices reviewed • Short term actions • Long term actions • What happens after reviews have been completed DP thanked NB and the team for the presentation and was pleased to note that the VCSE sector and primary care have been involved. JH stated that it was helpful to see the split of actions into ‘short term’ and ‘longer term’. The short term actions shows that there are different ways of working and using the systems and the people that we have in place. The longer-term actions are where there would be a requirement for investment. JH enquired around the link to funding and how these feeds into 2025/2026 planning, in order we see these as priority. BR clarified that there are a few of the short term actions that are just within the provider gifts and that they are progressing and both trusts have taken them through their own trust’s governance process, which are being presented back in six months’ time to be updated on progression. A lot of the actions do not require funding. The big-ticket items are the longer term ones. There are not any finances attached yet. NB responded to advise that as part of the submission of the review is to inform future spending options in terms of being able to effectively support his much broader patient cohort. This will inform the action planning process and the policy direction from the national team. SL thanked the team for the presentation and enquired about understanding where the gap is in the system, particularly in terms of Staffordshire and Stoke-on-Trent along with the involvement of families and service users in the end-to-end experience with several different agencies. SL highlighted where agencies are moving the whole challenge from one place to another and	

	signposting people. SL highlighted that there was not a reference around race from a diversity point of view. NB thanked SL for the valid points raised. NB responded to advise that the gap is the level of scale and depth that is required to engage with individuals to ensure that the level of treatment is there. In terms of other pieces of work, we have delivered a lot of population health needs analysis, and this is where we need to better record race and ethnicity and how we respond to those needs. UJ advised that in the 'longer term' actions there is a specific workstream around how we test the proportionality of some of the standard operating procedures that we are developing with people with lived experience. BR respond to advised that the cohort of patients looked at was developed by our clinicians looking at our local demographics and our local need. HJ thanked UJ for highlighting the importance of people not known to existing services, as these are potentially a hidden group of people who we will want to work with on all these work areas. BT stated the VSCE is an important partner and reiterated that they along with other voluntary organisations tend to know what's going on in relevant areas. BT highlighted the challenge of GPPR and terms of people not wanting to share their information. BT advised members of the importance of creating a 'safe space' where people can share information. **The Board**: **NOTED:** the detailed review undertaken against the national guidance and the proposed high level actions across the system to ensure alignment with national guidance and resource implications that may be required to enable full compliance. **NOTED:** timescales and leads for actions across the ICS are to be allocated and reported to Quality Safety Committee by end of Q3. **NOTED:** there will be an NHSE review of the system return. NHSE will collate national trends from the reviews to use to inform future policy, as well as communicate the outcomes to the CQC and Department of Health and Social Care	
11.	**Staffordshire and Stoke- on -Trent ICS Strategic OD Plan**	
	MI introduced the Staffordshire and Stoke-on-Trent ICS Strategic OD Plan. MI took the opportunity to thank PG and all colleagues within the organisation that have taken part in building this collaborative high level strategic plan for our organisational development requirements as a system. Members were advised that the recommendations within the plan are high level strategic objectives that will be progressed over the next three months. Work will take place with OD colleagues to try to understand what our delivery plans are going to be and to ensure that we have the resource to deliver them and to reconfirm the priority levels, our timelines and our milestones. MI highlighted that indicative timelines have been included, however they do need to be revisited and considered with the development of the medium term plan and all of our organisational objectives. Members were informed that following on from the plan being presented at provider boards, the plan will be presented to the ICB Board in the next three months to discuss the specific deliveries PG took the plan as read. PG highlighted to members the following points: • A lot has changed since the initial start of the development of the plan and the landscape is very different now • The plan has been directed by our partners in terms of what we see in the plan now	

- The plan set out our ambitions as to where we want to go and the desired approach for OD across our system, guiding principles
- The plan is a reminder of the purpose of the plan which is to strategically shape the over OD approach
- The plan focusses on fostering collaboration, leadership culture, enhancing inclusivity and belonging – making sure these are golden threads throughout everything we do
- The main areas of change since the plan was presented to board are the main areas around wider engagement with a wider group of our stakeholders and partners
- Further engagement is to be undertaken, which will include staff networks
- The plan needs to be socialised more widely beyond our OD communities
- Broader conversations to take place around the delivery model and the resource needed to deliver the plan
- Where the ownership sits for some of the objectives
- It will be an iterative journey and plan

DP thanked PG and acknowledged the huge amount of work that's took place.

SL thanked MI and PG for the plan and acknowledged that further work is to be done. SL advised that we mustn't lose sight of some clarity against some of the outcomes, how will the system look different as a result of adopting this plan and the work that we want to do, in particular identifying some of those success measures.

SL confirmed that he will be happy for the progress and monitoring of the plan be undertaken at the People Culture and Inclusion Committee.

SL asked if a member of the public looked at the plan what will be different for the services received.

MI responded to advise that culture and inclusive culture runs all the way through the plan in terms of what our provider colleagues have said and what we also believe in. What we will want to see, are our patients and our population seeing a much more inclusive approach to the services they receive. Work is taking place with staff network groups, and we are also reaching out into the wider community to hear from the population to enable an understanding how best our workforce can engage with communities. Metrics will be worked up in partnership with our providers depending on the service that we are delivering.

JH advised members that the plan was discussed in detail and the People, Culture and Inclusion Committee with provider colleagues who acknowledged the hard work that's taken place. JH highlighted that the next piece of work is critical, endorsement of the high level objectives that are set out in the plan. JH advised that we need to be clear that the delivery with the additional piece of work is going to be 2025/2028.

PA discussed the 'left shift principle', moving resources and activity to more of a proactive and preventative set of environments. Members were advised that this is a cultural challenge. This activity is as important as any of the clinical redesign work.

BA thanked colleagues for the hard work that has taken place and wished to support JH comments in terms of adopting the objectives. BA advised the importance of the plan being visible in terms of resources and dedication.

The Board:

APPROVED: The Organisational Development Strategic Plan, endorsing the principles, approach, strategic priorities and objectives identified for delivery and necessary to addressing current challenges whilst fostering system resilience.
ASSUME: executive ownership and leadership of the Organisational Development plan, supporting alignment of the necessary resources, including financial, human and technological, to ensure successful implementation of the agreed objectives.

12.	**Quality and Safety Report**	
	HJ presented the report which was taken as read. HJ highlighted to members key points. HJ highlighted that following the presentation of the ICB Review of Intensive & Assertive Community Mental Health Care – SSOT Action plan, there is a section in the presentation around the work that's been undertaken on the pilot for the Home and Host Commissioner Programme It refers to some experiential learning. Members were advised that the experiential learning relates to the time when we had several homes for people with learning disabilities, where we had to take rapid action following a CQC action and close homes and move people. HJ stated that this learning has been invaluable and is now fed into the national programme. Members were advised that the pilot and the self-assessment has been completed and highlighted that we have due processes in place to maintaining the oversight of quality and safety of our patients, even when they are in an out of area facility. HJ informed member that a lot of work has been undertaken around looked after children. Work has taken place with resources in place to reduce the backlog of looked after children's cases. This has resulted in reduced timelines for recovery. HJ advised that its optimistic that this will improve further. Members were informed that the maternity prescribing section within the report highlights primary care not prescribing for antenatal prescription for pregnant women in the community setting. It refers to Patient Group Directions for Aspirin and Ferrous Sulphate (iron tablets) . HJ clarified this means that people who are suitably trained, qualified and deemed to be competent, will be signed off to be able to give the drugs needed, particularly during pregnancy. HJ informed members of the positive work around quality improvement that's being undertaken across the patch, in Staffordshire and Stoke-on-Trent and working closely with Shropshire, Telford and Wrekin. Members were informed that the Joint Collaborative Network now has 550 members. HJ advised that there was no sperate Chairs report this month due to a deep dive being undertaken at the Quality Committee. MN raised a query around the antenatal prescriptions and asked for clarification if this is just a system issue or a national issue and if mitigations will be in place in time. HJ responded to confirm this is a national issue and not exclusive to Staffordshire. HJ advised that it's in relation to the GP contract and that work is presently happening to ensure this is in place with a prediction of November as a starting point to go 'live'. There shouldn't be any delays on those patients who need these drugs. HJ advised that an alternative arrangement will be made if they are not available through, the Patient Group Directions route. JR asked what projection forward we have made or what scenario planning have we done around the potential impacts of the GP action, with respect to limiting numbers of appointments, particularly as we go into winter. PS responded to advise that monitoring of activity levels is taking place, particularly as we head into winter. However, there is nothing conclusive to date that demonstrates the GP action is having an impact. PS informed members that regional discussions take place on a regular basis and the Board will be advised if any changes in trends. RG advised work is taking place with the LMC, nationally and locally to understand the impact of the collective action. **The Board:** **RECEIVED:** the report, seek clarification and further action as appropriate.	

	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.	
13.	**ICS Finance and Performance Report**	
	JC was in attendance to present the report. Members were informed that the month five financial position forecast has been scrutinised by the System and Performance Committee. JC highlighted that at the end of month five, the system reported an adverse variance to plan of 25.8 million and the system identified an unmitigated risk of 103 million. Members were informed that the system is working towards and together to identify the delivery of additional actions that are needed to deliver the financial plan for 2024/2025. JC highlighted that an external supplier is being appointed to support in delivering the required financial recovery. PS highlighted that in relation to Urgent and Emergency Care there has been some positive momentum in the first part of the year, however, there has been significant pressures from September onwards. As a result, category two response times for ambulances for our population have gone beyond the 30-minute national standard to almost 35 minutes. PS advised that the has been a step change in terms of growth of ambulance delays at hospital. The demand picture is being seen across the region. Members were informed that a Winter Risk Event has taken place to share learning and reaffirm plans and commitments as we head into winter. A surge plan will be presented for ratification at the next Board meeting. PS highlighted that NHSE will be carrying out an assurance visit ahead of winter. Members were advised that there has been progress in relation to patients waiting beyond 65 weeks and our overall activity levels across the population against the weighted activity metric are 109% at the end of quarter one. PS shared that there are challenges across a couple of specific specialities. There has been progress in terms of backlogs of surveillance and general waiters for endoscopy. There are issues with non-obstetric ultrasound, which is linked to staffing capacity. PS highlighted that all our trajectories are on track. **The Board** **NOTED:** the high-level performance against the five priorities **NOTED:** the high-level key performance deliverables update **NOTED:** the financial position <u>Finance and Performance Committee Summary and Escalation Report – October</u> MN presented the Finance and Performance Committee Summary and Escalation Report. Members were advised that we will not achieve the agreed system financial outcome of the 90 million deficit. The recovery plan has been agreed and work is underway supported by the system recovery Director, the plan is presented each month for assurance. MN advised that the recovery plan does not bridge the gap between our current position and the agreed 90 million deficit plan. Members were informed that we are entering into the investigation and intervention process directed by NHSE. MN highlighted that 43% of emergency care day cases and elective activity for the population within the system, flows outside the system into Derbyshire, Black County and Birmingham. This reinforced the importance of close relationships with those systems and providers and that we need to work closely with all partners in transformation work and improving patient experience. JH highlighted the need to triangulate between activity workforce and finance, using data which will be critical as we go into 2025/2026 planning.	

	The Board: **RECIVED and NOTED:** the report presented	
14.	**People Metrics – M5 August position**	
	MI presented the people metrices M5 August position. Members were informed that the oversight process this month is slightly different due to the changed People, Culture and Inclusion governance structure. MI highlighted that at the next meeting there will be two reports presented. Members were informed that the overall metrics are looking positive. In Stoke-on-Trent our turnover and our vacancies are at the lowest point in the last 12 months. MI highlighted that sickness rates are starting to increase; this is being explored with provider colleagues and HR are addressing concerns. Positive feedback has been received in terms of our oversight, our understanding of the workforce issues and how we are working collaboratively. <u>People Culture and Assurance Report</u> MI provided a verbal update. Members were informed that a debate around QRSM and workforce measures and controls took place. The committee are clear that an MDT approach is required, with clinical, operations and workforce colleagues working together to ensure that our services are safe, and patients are getting the best care. Members were advised that a conference around sexual safety took place with system providers, with attendance from the police and domestic violence charities. MI shared that it is Black History Month, and several events are taking place, which all system partners are invited to. **The Board:** **RECIVED:** the workforce position to plan grip and control to support and inform wider decision making in respect of the people agenda.	
15.	**Quarter 2 2024-2025 System Board Assurance Framework (SBAF) Update**	
	CC was in attendance to present the Quarter 2, 2024-2025 SBAF update. Member were advised that the SBAF has been presented to the ICB Committees and are referenced in the Executive Summary. Members were advised that along with herself, ICB colleagues were invited to MPFT Audit Committee to present the SBAF as they are keen to obtain a better understanding of its format and content. CC highlighted that the Finance and Performance Committee report demonstrates some good scrutiny of the document and that there have been conversations held in relation to the levels of risk and the assurance ratings, which are going to be revisited at Quarter 3. Members were informed that the Executive Summary highlighted that there are two strategic ambitions that the SBAF is demonstrating the most threat to. • Addressing inequalities • Achieve a Sustainable and resilient ICS Top three risks: • Reducing health inequalities • Sustainable finances • Sustainable workforce	

	It was highlighted that workforce has a higher level of assurance associated which was confirmed at the quarterly review. It was highlighted that there are six of the eight strategic risks, where they have been assessed as having a partial assurance rating. CC reminded colleagues that purpose of SBAF is to drive the agendas of the committees and reflect if the committees are receiving assurance needed. CC shared that we continue as a system to be identified as 'good practise' in this area. The SBAF continues to develop and evolve. DP thanked CC and acknowledged the work that's being undertaken. JH shared with members that at the Audit Committee further reviews took place to strengthen and improve ownership and ways of reporting. JH highlighted the risk around activity of community and recommended a focus at Board around community activity, community programmes. JH advised that the Audit Committee requested that each SBAF risk in committees is looked at and assessed in the light of our continued financial position and the impact on each of the other risks. **The Board:** **DISCUSSED:** and confirmed the Quarter 2 risk scores and assurance assessment are an accurate reflection of the position. **DISCUSSED:** and confirmed the adequacy of those controls and assessments.	
16.	**Staffordshire and Stoke- on- Trent Health and Care Senate Summary and Escalation Report**	
	RG was in attendance to present the Staffordshire and Stoke-on-Trent Health and Care Senate Summary and Escalation Report. The paper was taken as read. Members were advised that Senate approved the system approach to malnutrition policy subject to QIA and EIA processes. The Senate approved IMOG recommendations a, b and C from the meeting held on 5th June 2024 and IMOG decisions a, b and c from the meeting held on 3rd July 2023. There was no Adult Social Care, or PCN/LMC representation at the meeting, so the paper will be sent to them for ratification. All approvals are subject to Quality and Safety Committee and Finance and Performance Committee sign off, in accordance with their functions outlined in their terms of reference. RG advised that the Senate held good discussions around the medium term plan, the path to remission and diabetes and the positive outcomes received. DP enquired in relation to obtaining quoracy at meetings. RG clarified that these issues have now been addressed. **The Board:** **NOTED: the contents of the report** **RATIFIED:** the approvals made at the Staffordshire and Stoke-on-Trent Health and Care Senate meeting held on the 12th September 2024**.**	
17.	**Staffordshire and Stoke- on -Trent ICB Remuneration Committee Summary and Escalation Report**	
	The report was taken as read and there were no issues to raise. **The Board:**	

	RECEIVED and Noted the report.	
18.	**Items notified in advance to the Chair**	
	JH advised that a written report will be circulated, however wished to highlight escalation, alerts from the Audit Committee to members, one of which is around risk management, which has been discussed. JH advised that the committee received the first report of the overall ICB undertaking programme that assigns each of the required activities to a lead committee. Members were advised that discussions around the status of some of the actions took place. Actions have been flagged as ' green'. This was queried as some were still subject to ongoing formal investigation and intervention work with NHSE. Members were advised that due to the Audit Committee, meeting quarterly discussions took place around the importance of each committee having an oversight of actions aligned to it. JH shared that two audit reports were received. One was advisory on Public Health Management. There were several recommendations which are being implemented. It highlighted that there are multiple facets, and an update has been requested at the next Audit Committee meeting. JH highlighted that updates regarding external and internal audit procurement were received. JH advised that the Audit Committee approved a change to financial delegation limits. Any purchase order raised with a value greater than £20,000, now requires approval from the Director of Finance, prior to the purchase order being raised. This is in line with our provider colleagues. DP thanks JH for the update provided and agreed with the challenge raised around the green ratings.	
19.	**Questions from the floor relating to the discussions at the meeting**	
	Question one raised by Ian Syme *ICS Strategic Organisation Development Plan will require greater resource and managerial input, how is this going to be addressed in the future?* PA responded to advised that the Darzi review talks a length about management capacity being depleted. We need to employ dedicated people to be able to have those confident conversations have the space to be able to so and bring clinicians into those discussions where possible. It's a question of how we double run, develop and deliver proactive preventive services at the same time as having to deliver the reactive side of things. PA advised that we need to very honest and clear within our plans for next year and beyond, about the capacity requirement that we are going to have to deliver the plan. MI stated that we need to thing about the workforce transformation in a different way. Working more collaboratively with our external partners, with colleagues who we haven't traditionally planned with or traditionally worked with, to understand both the management capacity form an OD and culture perspective, but also our new models of care and the workforce model. MI highlighted that we have management in other areas and other organisations and if we can harness that system approach, it will help us in terms of our capacity. **Question two raised by Ian Syme** *You are going to be facing a quite significant challenges this winter?*	

	PS responded to advise that its a very delicate balancing act to ensure that we can continue to meet all our obligations while delivering safe, effective emergency care over winter. PS clarified that there has been no additional external funding announced at this point, but reaffirmed the system does have a responsibility to make sure we have the capacity, and we are able to deliver quality and safe care, meeting the needs of the population over winter. As such we have local budgets in place to ensure we can do this. PS highlighted that the Surge Plan will be presented at the next meeting. PS advised that a robust value for money assessment has taken place on all the investments that we are going to be making over winter from our local resources to ensure that what we are doing will have the maximum impact on peoples care and outcomes for winter. PS confirmed that in relation to elective care, the plan is based on a principle of being able to maintain our existing run rate around elective activity and meet targets. PS highlighted that mechanisms are in place day to day around planned care, ensuring that we are directing our resource towards the areas of greatest risk at any time. PA advised that we collectively acknowledge that this winter will be challenging, Finances are challenging. There is a bottom line is that we will ensure that we provide safe services and urgent and emergency care is a top priority. PA advised how we mange this will need to be dynamic and make decisions that are best for the patients and our population. Clinically risk assess as a set of partners and make decisions that are the safest.	
20.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the Leadership Compact.	
21.	**Close**	
	There being no further business, the Chair closed the meeting.	
22.	**Date and time of Next Meeting**	
	21st November 2024 at 12.30pm held in Public, Staffordshire County Council, Council Chamber, County Buildings, Martin Street, Stafford, ST16 2DH.	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Open Actions

Agenda item	Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
9	17/10/2024	ICB Chair and CEO Update	Received from Julie Houlder in response to the report: •The impact of palliative care prevalence. What is the link between that and the position that we are in with regards to continuing healthcare? The prevalence link between the two. •Practice Open Day in Barlaston event. This is a good initiative. The possible extension of that in terms of supporting our communities to help themselves. •This links to the SBAF. Community activity has dropped significantly and that must have had an impact on the other metrics.	TBC	HJ PEJ PS	

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**21 November 2024**					
Title:	Keep Warm, Keep Well community energy scheme – transforming health and the environment					
Presenting Officer:	Louise Stockdale, Head of Transformation and Sustainability, UHNM Fiona Miller, Chief Executive Officer, Beat the Cold					
Author(s):	Louise Stockdale and Fiona Miller					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

The purpose of this paper is to inform the Staffordshire and Stoke-on-Trent Integrated Care Board of the University Hospitals of North Midlands (UHNM) Keep Warm, Keep Well (KWKW) community energy scheme, and the newly developed, digital KWKW scheme implemented at the Moorcroft Medical Centre, Hanley. It will outline future plans in place to expand the KWKW scheme across the Staffordshire and Stoke-on-Trent 'one public estate', jointly led by the ICB and UHNM, with a focus on the local and national significance of the KWKW scheme.

(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.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	The KWKW scheme aligns to the principles of the ICS Green Plan
Workforce or Training	N/A - No specific training implications; workforce matters are inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty

Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

This paper will inform the Staffordshire and Stoke-on-Trent Integrated Care Board of the UHNM Keep Warm, Keep Well (KWKW) community energy scheme, and the newly developed, digital KWKW scheme implemented at the Moorcroft Medical Centre, Hanley. It will outline future plans in place to expand the KWKW scheme across the Staffordshire and Stoke-on-Trent 'one public estate', jointly led by the ICB and UHNM, with a focus on the local and national significance of the KWKW scheme.

To recognise the significance of the KWKW scheme for people within Staffordshire and Stoke-on-Trent, we will be sharing Matthew's story, who was referred to Beat the Cold through the Childhood Asthma Pilot with Moorcroft and Moss Green. Matthew's case is a perfect example of what is possible through a truly integrated care system, by bringing key partners together, including Staffordshire and Stoke-on-Trent Integrated Care Board, North Staffordshire Combined Healthcare, the Primary Care Network with Moorcroft and Moss Green, and the voluntary sector with Beat the Cold, and then employing digital transformation capabilities through Graphnet, and One Health and Care records. With this, we have truly been able to make a difference for Matthew and his family.

(7) Recommendations to Board / Committee:

We ask that the Board acknowledges the contents of this report and presentation and recognises the significance of the Keep Warm, Keep Well scheme, both nationally and locally. We would like the Board to note the proposed expansion of the scheme, thereby reducing the population need for primary and secondary health services. We are happy for the Board to ask any questions.

Keep Warm, Keep Well community energy scheme – transforming health and the environment

1. Purpose of the Report

The purpose of this report is to inform the SSOT ICB of:

1. The UHNM *Keep Warm, Keep Well* (KWKW) community energy scheme
2. The newly developed, digital KWKW scheme implemented at the Moorcroft Medical Centre, Hanley.
3. Future plans in place to expand the KWKW scheme across the SSOT 'one public estate', jointly led by the ICB and UHNM.
4. The local and national significance of the KWKW scheme.

2. What is KWKW?

In 2016, UHNM (Estates, Facilities and PFI) delivered a ground-breaking community energy scheme, named '*Keep Warm, Keep Well'*. The scheme was made possible through a partnership between:

- University Hospitals North Midlands (UHNM)
- Staffordshire Community Energy Limited (SCE)
- Staffordshire fuel poverty charity Beat the Cold (BtC)

The KWKW scheme seeks to prevent readmissions of vulnerable patients whose health conditions are at risk of being exacerbated by living in a cold and damp home.

KWKW has been recognised by both the BMJ and HSJ, winning both awards in 2020 and 2022 respectively.

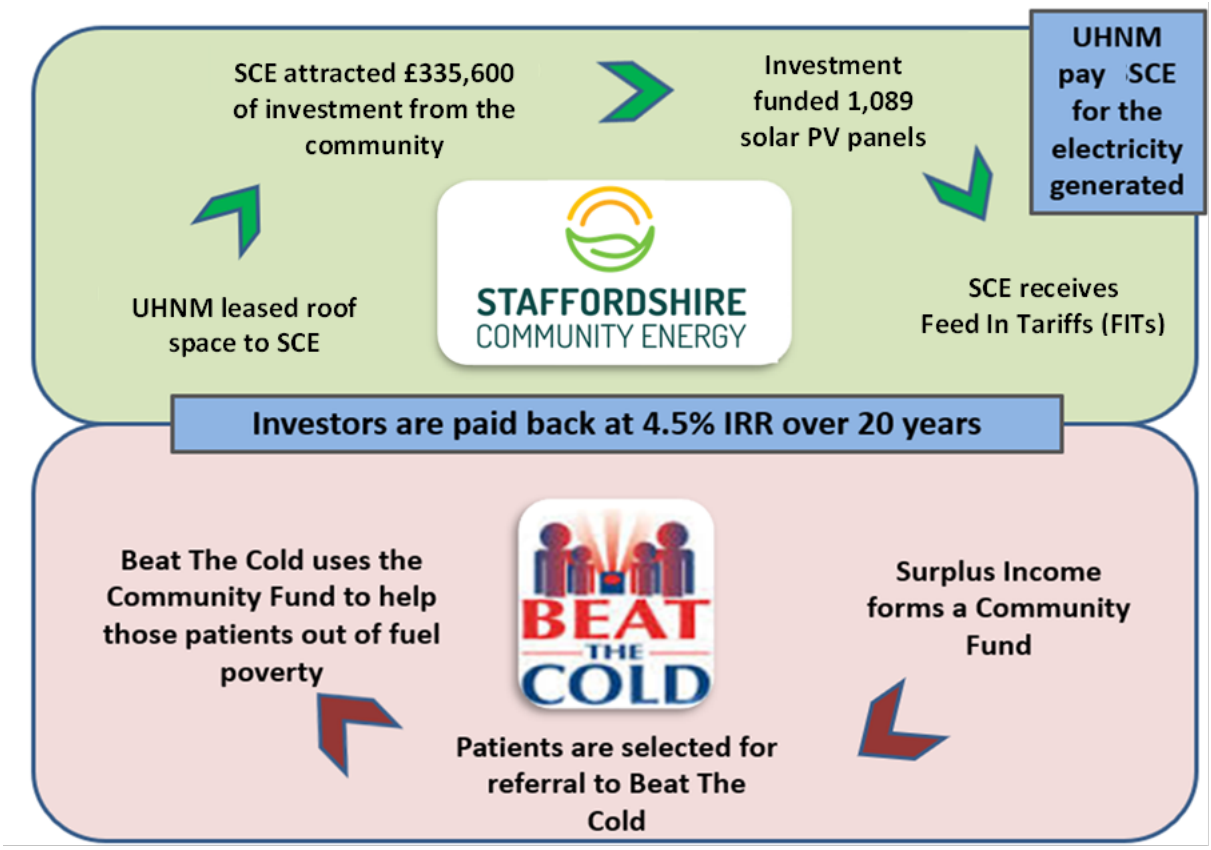
3. How does KWKW work?

In 2016, SCE successfully raised £335,600 through public investment ('share raise') to enable the installation of 1089 Solar Photovoltaic panels on the Royal Stoke and County hospital roofs. UHNM hosts its roof space to SCE, with an accompanying lease for 20 years. UHNM now buy the electricity generated by the PV panels at a reduced tariff (index linked to RPI), which reduces Trust demand from the grid (volatile and subject to rises). This means a cheaper, more resilient energy supply for the Trust.

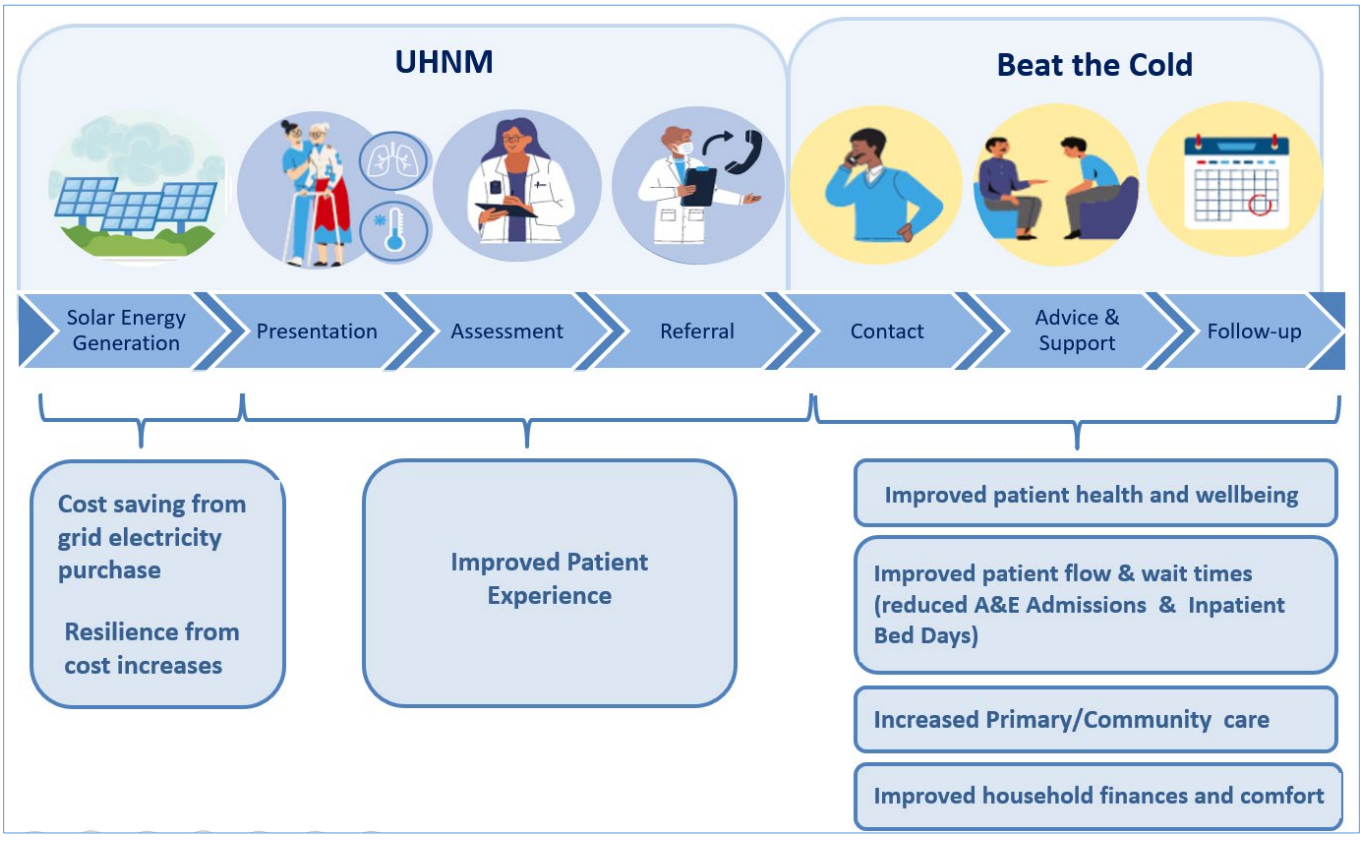
The solar energy Feed-in-Tariffs (government guaranteed for 20 years) are added to the payments that UHNM makes for the electricity, to create income for the project. This income facilitates both a return for the investors and a surplus which accumulates into an annual 'community fund'. The community fund is critical to the project and there is an agreement to spend this on alleviating fuel poverty in Staffordshire. This is currently achieved through a patient intervention, delivered by expert charity, Beat the Cold (BtC).

The scheme operates to the principle of informed patient consent. UHNM Consultants in Respiratory and Elderly Medicine and their teams currently engage (face to face) with appropriate patients and then pass their information to BtC (using an electronic referral form). Upon discharge, a member of BtC will contact the patient and arrange a home visit (or call) where an intervention will be delivered to help facilitate a safe temperature and affordable warmth. This service/ intervention is funded entirely by the 'community fund' and is at zero cost to UHNM.

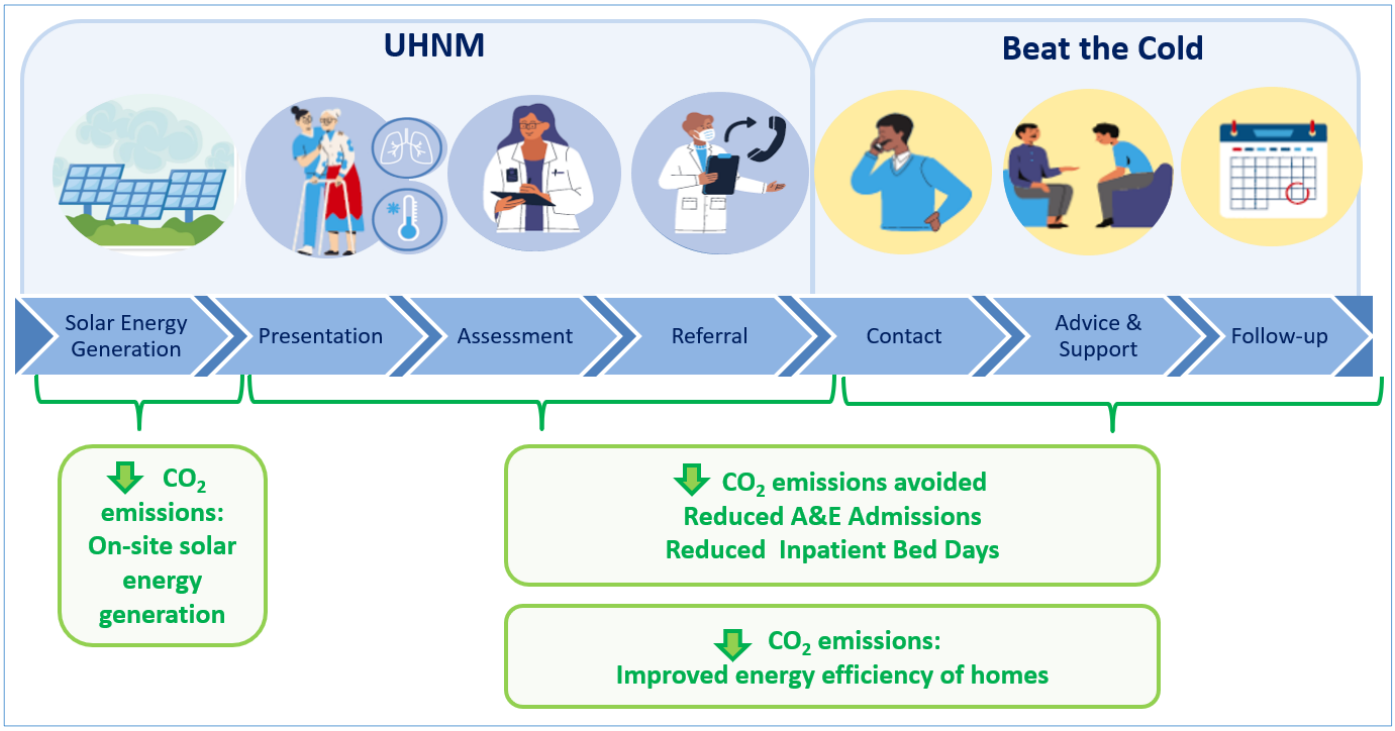
KWKW: *Scheme Overview*



KWKW Benefits: *Financial and Social*



KWKW Benefits: *Environmental*



4. Fuel Poverty Intervention: *Rationale for Action*

- As a result of the recent energy crisis, 6.5 million UK households are now in fuel poverty[1]. The unprecedented rise in energy tariffs over the past two years combined with poor housing and low incomes, means that more people than ever before are struggling to afford the cost of heating and falling into debt.
- The NHS in England spends £1.3 billion each year treating preventable conditions caused by cold and damp homes.
- NHS England warns that rising rates of fuel poverty will become a public health emergency; causing and exacerbating physical and mental illness, contributing to preventable deaths, reduced life expectancy and widening health inequalities[2].
- It is estimated that for every cold-related death there are eight non-fatal hospital admissions[3].
- Fuel poverty is increasing the need for local health and social care service.
- Addressing energy inefficient housing and bringing all homes up to a minimum standard of thermal efficiency is regarded as having the strongest positive impact on the poorest households[4].
- Stoke-on-Trent was recently named as having the highest levels of fuel poverty in the UK, with 22.1% of the population living in fuel poverty, against an England average of 13.1%.

5. Fuel Poverty: *Health Impact*

NICE Guidance[5]

[1] National Energy Action (NEA) | Energy Crisis
[2] Could the energy crisis cause a public health emergency? | NHS Confederation
[3] Department of Health (2009)
[4] the-health-impacts-of-cold-homes-and-fuel-poverty.pdf (instituteofhealthequity.org)
[5] NICE Guidelines: *Excess winter deaths and illness and the health risks associated with cold homes*

Living in cold conditions is a risk to health. The health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather. An increase in death rates due to a drop in temperature can happen when temperatures drop below 6°C.

A wide range of people are vulnerable to the cold. This is either because of a medical condition that stops people moving around to keep warm or circumstances such as being unable to afford to keep warm. NICE Guidance refers to vulnerable groups including:

- People with cardiovascular conditions.
- People with respiratory conditions (in particular, COPD and childhood asthma).
- People with mental health conditions.
- People with a disability.
- Older people (65 and older).
- Households with young children (from new-born to school age).
- People on a low income and residing in deprivation.

Living in a cold home: Health Impacts[6]

Cold housing and fuel poverty not only have direct and immediate impacts on health, but also indirect impacts and a wider effect on well-being and life opportunities.

Direct health impacts

The direct health impacts of living in a cold home can be divided into higher risk of mortality and increased morbidity rates. Direct health impacts include:

- Onset and exacerbation of cardiovascular and respiratory diseases.
- Exacerbation of arthritis and rheumatisms.
- Increase in minor illnesses such as colds and flu.
- Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes.
- Mental health is negatively affected by fuel poverty and cold housing for any age group.
- More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems.

Indirect health impacts

Significant improvements in health-related quality of life can be achieved when targeting home improvements in low-income households. The level of energy efficiency affects people with low incomes more severely because it affects life chances and choice of spend of disposable income on other items such as food. Poor families face the choice to 'heat or eat' - either less money can be spent on basics such as a sufficient, healthy diet (with health impacts such as obesity or malnutrition), or less can be spent on heating homes to a safe temperature. Indirect health impacts include:

- Negative impact on children's educational attainment, emotional wellbeing and resilience.
- Negative impact on dietary opportunities and choices.
- Negative impact on dexterity and increased risk of accidents and injuries in the home.

6. Who are Beat the Cold?

Beat the Cold[7] (BtC) are a Staffordshire based charity, whose aim is to reduce fuel poverty, and cold related ill health. BtC are commissioned by, and work in partnership with, Staffordshire Local Authorities to support those who live in, or are at risk of fuel poverty, or whose health could be detrimentally affected by a cold home.

What services do BtC offer?

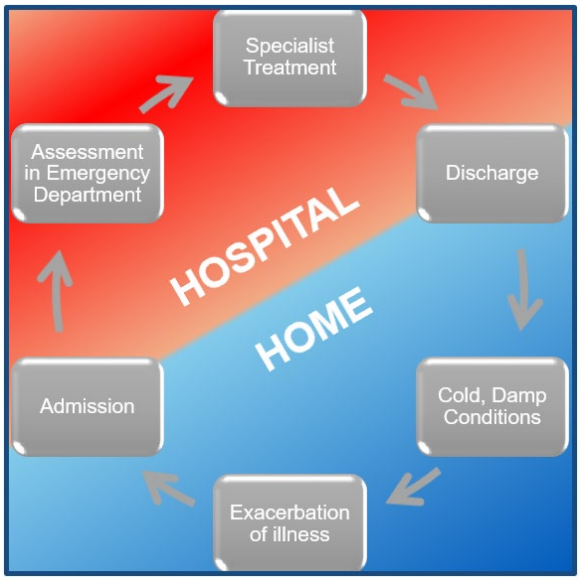
BtC trained advisors provide front line affordable warmth services to the vulnerable. This may include:

- Register eligible patients on their supplier 'Priority Services Register' to ensure receipt of entitled support.
- Provide behavioural change advice to make the most of the energy usage.
- Ensure patients are claiming the correct means tested and disability benefits.
- Identify applicable grants from Local Authorities or energy companies to improve thermal comfort.

[6] the-health-impacts-of-cold-homes-and-fuel-poverty.pdf (instituteofhealthequity.org)
[7] Beat the Cold – Stoke-on-Trent and Staffordshire's Fuel Advice Charity (beatcold.org.uk)

What is the impact of BtC Intervention?

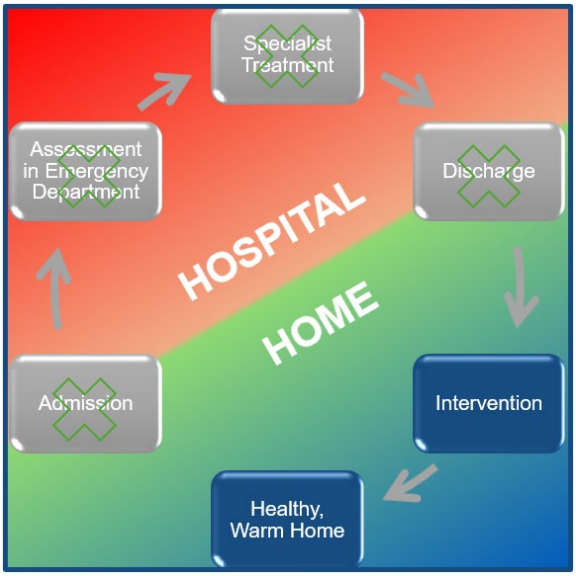
a) Fuel Poverty: *Readmission cycle*



Ongoing cycle leading to:

- Preventable A&E attendance and admissions
- Preventable readmissions
- Hospital inundation
- Poor patient flow and delayed discharge for all
- Poor health economics
- Poor patient experience
- Poor sustainability

b) BtC intervention: *Breaking the cycle*



Breaking the cycle:

- Less preventable admissions and readmissions
- Less inundation
- Improved flow and discharge for all
- Better health economics
- Better patient experience
- Better sustainability

BtC Case Study

- Low-income family with young children, in a terraced home in Hanley
- Household health conditions included childhood asthma
- Household referred to Beat the Cold by UHNM Respiratory Department (Childhood Asthma Nurse). Beat the Cold provided fuel poverty advice and made a referral to SOTCC Safe and Warm Homes team in November 2023
- Upon inspection, the home had significant rising damp. Under the Safe and Warm programme, works were funded and finalised by February 2024

"Since having the measures installed in my house, my family's health issues will be improved drastically. I feel much more comfortable moving into the winter months and at ease in my own home. I am very happy with the work that's been completed." - Resident

7. Continued Development of KWKW

In 2023, the KWKW project lead (Louise Stockdale, Head of Transformation and Sustainability, UHNM) participated in a placement with the NSCHT Transformation Management Office (TMO), specifically working with their newly acquired Moorcroft Medical Centre in Hanley. The population of the Moorcroft Medical Centre falls into the 'most deprived decile', thereby creating a strong rationale for the roll out of the KWKW fuel poverty referral pathway.

One Health and Care (OHC)

OHC[8] is a confidential digital shared care record, used by Health and Social care organisations across Staffordshire, Stoke-on-Trent, Shropshire and the Black County. It allows professionals, directly involved in patient health and care, to view relevant information to provide better and safer care. Graphnet[9] is the supplier of OHC and patient information that can be viewed includes:

- Name, date of birth, sex, address, telephone number, NHS number.
- Registered GP practice and GP.
- Hospital referrals, admissions, discharges and clinics attended.
- Medications, allergies, ongoing and historic conditions, immunisations and diagnoses.
- Care plans.
- Mental health information.
- Social information.

The benefits of using OHC include:

- Identifying cohorts of patients who need proactive support.
- Providing case management that operates across organisational boundaries.
- Giving the medical team around the patients access to all relevant information.

Moorcroft Medical Centre, Hanley

Piloting the use of the OHC digital shared care record at Moorcroft Medical Centre was seen as an opportunity to replace face-to-face referrals, thereby developing and improving the KWKW scheme. OHC would enable a more targeted, proactive, patient-centred, integrated fuel poverty referral pathway thereby facilitating a reduction in primary care inundation and preventable secondary care emergency admissions.

Following lengthy multi-organisational engagement (ICB, Graphnet, NSCHT and the Moorcroft Medical Centre) and Information Governance process to demonstrate access based on a 'direct patient care' purposes, the Moorcroft Medical Centre began accessing OHC (from 31st May 2024) to rapidly identify Moorcroft patients who need proactive support to alleviate fuel poverty.

OHC data is accessed each month, and the following patient criteria determines those patients referred to BtC for an expert intervention:

1. Childhood Asthma (under age 18)
2. Fuel poor quintiles 1 & 2
3. Most Deprived Indices of Multiple Deprivation (IMD)

The selected patients are sent a text message using GP software to inform them that they have been identified as likely to benefit from the free KWKW scheme, administered by BtC. The message contains a link to a digital leaflet which describes in more detail the reasons why they have been referred, details of the service offered, informing them that BtC will contact them and how to opt out.

Future proposal

In July 2024, BtC applied for grant support from the National Energy Action (NEA) *Warm Homes, Healthy Futures* fund[10], with a proposal based upon expanding the Moorcroft Medical Centre *Keep Warm, Keep Well* scheme.

The bid was highly praised for the Moorcroft Medical Centre approach to addressing a pertinent cause of poor health outcomes. As such, it is with great delight to report success in securing funding to deliver an intervention by BtC for up to 1,000 patients, across an ambitious delivery period of November 2024 to January 2026 (15 months).

[8] One Health and Care - Staffordshire and Stoke-on-Trent, ICS (staffsstokeics.org.uk)
[9] Shared Care and Data Solutions | Graphnet Health
[10] Warm Homes, Healthy Futures - National Energy Action (NEA)

The *Warm Homes, Healthy Futures* fund, will mirror the existing *Keep Warm, Keep Well* scheme, however selection for referral will be based upon the following expanded patient criteria:

1. Health condition or vulnerable group (respiratory, cardiovascular, poor mobility, over 65+, Severe Mental Illness)
2. Frequent acute care admission or readmission (2+ per annum)
3. Most fuel poor quintiles 1 & 2

Nationally, the KWKW scheme at Moorcroft Medical Centre represents a first of a kind whereby a primary care organisation hosts a data led, targeted, patient-centred referral pathway. It exemplifies a truly integrated solution to a local cause of poor health outcomes, facilitated by a multi sector partnership. In addition, Uptake of the OHC digital shared care record to identify cohorts of patients who need proactive support is reported as low across SSoT. As such, the scheme is also regarded as pioneering locally.

8. Expansion of KWKW

In 2023, the expansion of the KWKW scheme was recognised as an ICS Estates 'Priority'. Soon after, a Task and Finish (T&F) group was established and is currently being led in partnership between UHNM and the ICB Greener Delivery programme.

The objective of the T&F Group is to expand KWKW so that it becomes a system-wide scheme, utilising the SSoT 'one public estate' to host a larger solar PV installation. This will increase the Community Fund and reach of the fuel poverty intervention to a higher number of the SSoT population.

The following SSOT system partners are engaged and fully supportive of utilising their estate for KWKW:

- University Hospitals of North Midlands NHS Trust (UHNM)
- Midlands Partnership University NHS Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- Staffordshire County Council (SCC)
- Stoke-on-Trent City Council (SoTCC)
- NHS Property Services (NHS PS)
- Community Healthcare Partnerships (CHP)
- Primary Care

This project has been led with a collaborative ethos i.e. the 'one public estate' is a collective resource that can be used to deliver multiple, overarching benefits. As such, roof space across SSoT has been put forward by the Estates teams to assess its feasibility to host solar PV installations as part of the KWKW community energy scheme expansion. Crucially, this approach proposes to utilise OHC in order to enable the referral of the most vulnerable of the population (replicating the achievements at Moorcroft Medical Centre), to BtC.

A paper outlining the full scheme details together with financial, environmental and social benefits will be issued for approval within 2025.

9. Recommendations

The ICB is asked to:

- Acknowledge the contents of this report and presentation.
- Recognise the significance of the *Keep Warm, Keep Well* scheme, both nationally and locally.
- Endorse the proposed expansion of the scheme, thereby reducing the population need for primary and secondary health services.

10. Matthew's Story

Matthew* is 14-years old and lives in Stoke-on-Trent with his mum, Jenny*, and four siblings in a 3-bedroom semi-detached local authority property. The home is based in an area with high Indices of Multiple Deprivation, and the household income consists of benefits including Income Support, Child Tax Credits, Personal Independent Payment,

and Disability Living Allowance. Jenny cannot work as she has been classed as ‘long-term sick’ due to her mental health conditions. The household often struggles to afford necessities, including food alongside gas and electricity which both need to be topped up on a prepayment meter.

Matthew was diagnosed with asthma at a young age; it was typically mild and managed at home with inhalers. In 2020, Matthew sadly lost his father, and ever since, Jenny shared that his asthma has been getting worse. Throughout this time, the family have encountered several further tragic circumstances including losing additional family members, and Jenny has understandably struggled to cope.

Matthew’s asthma was becoming a worry as it could seemingly flare up at any point without warning. In early 2024, Jenny watched as Matthew struggled to breathe whilst at home. She shared, “It was so frightening watching Matthew gasping for air, he couldn’t speak, and I genuinely thought he was going to die.” Jenny took him straight to visit the GP where a nebuliser was immediately administered and an ambulance called. On arrival at University Hospitals of North Midlands (UHNM), Matthew was taken into the care of the clinical team and admitted to intensive care. Jenny was told that her son was very poorly, and she said that she, “Genuinely feared the worst.” Fortunately, after the intensive treatment provided by the medical team, Matthew made a recovery and was discharged. Although the asthma condition is currently being managed at home with inhalers, Jenny has been living in fear of another flare-up.

The household was referred to Beat the Cold through the Childhood Asthma Pilot with Moorcroft and Moss Green. Jenny received a text message and a digital leaflet about the scheme which invited her to call Beat the Cold for energy advice, and she telephoned the same day to take up the offer. Jenny said, “The message came just at the right time and as soon as I saw that we could get further support for Matthew’s asthma, I was straight on the phone because I just keep panicking.” Beat the Cold has been working with the family since May 2024 and during this time, a number of interventions have been provided to support with Matthew’s asthma condition in the home setting. These have included advice on air quality, damp, condensation, mould and ventilation, safe heating temperatures using thermostatic radiator valves to control costs, support to address draughts around exterior doors, fuel vouchers to enable affordable warmth during colder spells, food vouchers to support with nutrition and therefore better body temperature regulation, adding the household to National Grid Priority Service Register for urgent power restoration in event of a cut, and liaising with the local authority to alleviate damp problems in Matthew’s bedroom and the bathroom, as the spores could exacerbate his asthma condition.

Aside from practical interventions, Jenny has found it so useful to have somebody there to support the family after such a difficult time and it has given her peace of mind. She shared, “I don’t have much support around me, especially after losing family members, and it is so good just having someone there to listen and help.” Following Beat the Cold’s intervention, Matthew and his mum have been left with an improved sense of wellbeing and are also grateful to know that their Energy Advisor is available for any future support. Matthew’s asthma is becoming more manageable, and the interventions have supported with this.

Beat the Cold’s Chief Executive Officer, Fiona Miller, shared, “Matthew’s case is a perfect example of what is possible through a truly integrated care system. By bringing key partners together, including Staffordshire and Stoke-on-Trent Integrated Care Board, North Staffordshire Combined Healthcare, the Primary Care Network with Moorcroft and Moss Green, and the voluntary sector with Beat the Cold, then employing digital transformation capabilities through Graphnet, and One Health and Care records, we have truly been able to make a difference for Matthew and his family. By reaching patients with heath inequalities, we are addressing the wider determinants of health, including social and economic factors, and improving wellbeing in our community.”

**Names have been changed to protect identities*

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

Report to:	**Integrated Care Board**					
Date:	**21 November 2024**					
Title:	Chair and Chief Executive Officer Report					
Presenting Officer:	David Pearson, Chair, and Peter Axon, CEO					
Author(s):	David Pearson, Chair, and Peter Axon, CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

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

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

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

7.0 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
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

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

1.0 System and general update

1.1 Medium-Term Plan

Working with partners, substantial progress has been made in our approach to develop the medium-term plan (MTP). As part of the process, the task and finish group has focused on Modelling Activity Baselines for an unmitigated scenario. The initial phase of the MTP development concentrates on co-producing an unmitigated base model, setting out the projected impact of demographic shifts and health inequalities on service demand, with expected increases in accident and emergency, emergency admissions, community care, mental health, and primary care. Collaboration with partners has enabled agreement on the finance, activity and workforce assumptions, which have been used in developing the unmitigated baseline. This initial phase of work has been signed off and agreed as reasonably modelled and sufficiently accurate to set out the scale of change required by the system. This model will form part of the intelligence used to develop the mitigated model, which is the next phase of developing the MTP.

1.2 Primary care

1.2.1 Events

Seisdon Primary Care Network Health and Wellbeing event

Held with members of the public and stakeholders in Wombourne, the Seisdon Primary Care Network (PCN) Health and Wellbeing event took place on Thursday 17 October, run by health and wellbeing coaches, social prescriber link workers and care co-ordinators. This followed a similar event that took place on 20 September in Codsall.

Meir Primary Care Network Cancer Awareness event and MacMillan Coffee morning

Held on 25 October 2024, speakers from breast, lung and bowel screening services presented to patients together with members of the PCN wellbeing team to encourage screening uptake. The presentation was particularly aimed at supporting patients who have not responded to invites or not attended screening appointments.

Patient Education Event – South Stoke Central

South Stoke Central delivered their latest Patient Education Event on 04 November with over 80 patients in attendance. The event centred around cancer awareness, particularly focusing on the signs and symptoms of breast, lung and bowel cancers.

Loxley ploughing event

Sister Rose Bain, based at Barton Family Practice, used her Queen's Nursing Institute qualification to provide support to the local farming community. Rose was asked by Staffordshire Agricultural Society to attend the Loxley ploughing event on 14 September, where she ran a 'health hub' for farmers to have their blood pressure checked, along with offering other health and lifestyle advice. Rose has been asked to attend again next year, whilst looking at additional ways to help the farming community with their health.

1.2.2 East Staffordshire Social Prescribing case study

Local football club charity, Burton Albion Community Trust, in partnership with East Staffordshire PCN, have utilised the power of innovative social prescribing technology to catalyse neighbourhood health creation, generating valuable insights on neighbourhood needs. To ensure primary care services are meeting the local resident's needs, the focus of the model aims to reduce the local footfall in GP practices and levels of inequality. The collaboration aims to achieve health creation that responds to neighbourhood needs and harnesses the power of a community to generate health.

As published in the Kings Fund circular, you can read the article on the NHS Confederation site – Using social prescribing technology for health creation in East Staffordshire.

1.2.3 General Practice Long Service Award

The Staffordshire Training Hub (STH) launched the General Practice Long Service Award in June 2024, to recognise people working in Staffordshire and Stoke-on-Trent who have dedicated 25 to 50 years of service to General Practice and the wider NHS. The inaugural presentation ceremony was held at Uttoxeter Racecourse on Wednesday 06 November, recognising their long service and commitment to General Practice. Throughout the afternoon guests enjoyed live music and afternoon team, as recipients across Staffordshire and Stoke-on-Trent were celebrated and presented with their Long Service Award certificate and pin badge. In total, the event celebrated over 4,000 years of service with 80 of the 115 awardees attending on the day. It was an opportunity to shine a well-deserved spotlight on General Practice and the individuals who have dedicated their lives to a profession that is driven by caring for others.

1.3 People team

1.3.1 Black History Month

During October, ICS Partners celebrated Black History Month. The theme was "Reclaiming Narratives" which aimed to foster positive representations of Black history through various mediums, countering prevalent negative narratives. A combination of forums, events and celebrations took place to promote important messages, creating opportunity for our workforce to come together, share experiences and raise awareness. Colleagues from across the system promoted the national "Show Racism the Red Card" campaign on 18 October, encouraging people to participate in showing solidarity against racism. An anti-racist toolkit has also been developed through combined efforts across the system, aimed at enhancing educational resources and Board capabilities.

1.3.2 System OD (Organisational Development) Plan

The System OD Plan was ratified by the People, Culture and Improvement (PCI) Committee, previously approved by the integrated Care Board (ICB), acknowledging the collaborative efforts of partners involved in its' design and development. The plan will now be taken forward, driven by a delivery plan and resources identified to progress the priority areas.

1.3.3 Workforce Oversight and Assurance

The current workforce position reflects that Staffordshire and Stoke-on-Trent is currently above plan, however below establishment. There continues to be significant improvements in how workforce resource is utilised, reducing the reliance on high-cost agency and as a result, being more reliant on the bank workforce for temporary workforce solutions. Although sickness absence has decreased in the last twelve months, this area is considered to a be an opportunity supported by the delivering our health and wellbeing strategy across the system.

The PCI Committee continues to be assured on the workforce position, by a robust monthly provider oversight approach, which has been developed in conjunction with NHS providers and is reviewed monthly to understand opportunities for improvement and good practice learnings for scale and spread.

2.0 Finance

During month 6, the guidance to release non recurrent funding equivalent to the deficit agreed on 12 June 2024 was transacted. The system is reporting a year-to-date adverse position of £29.8m against a revised break-even plan. The main drivers for the aggregate year-to-date position are efficiency slippage (£19.9m) and binding conciliation (£14.8m) with adverse impacts in medical staffing (£3.7m) and

Continuing Healthcare (CHC) (£5.9m). These are partially offset by other non-recurrent mitigations (£16.9m) and Dental underspend (£2.7m). Within the £29.8m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £5.1m at month 6, this will reduce monthly to no impact by year end.

The system has responded to the initial Investigation and Intervention requirements with weekly reporting commenced and external support procurement process having been completed. The expectation nationally is that this support will enable the system to return to the plan. The system is reporting unmitigated risk of £56.5m at month 6 incorporating recovery plan actions from both the green and amber actions.

3.0 Planned Care

On 8 November 2024, University Hospitals North Midlands (UHNM) received a letter from NHS England to confirm that following a review of elective and cancer performance, UHNM will be moving to Tier 2 oversight for Elective, Cancer and Diagnostics from the week commencing 11 November, which is a de-escalation from Tier 1. This is an excellent achievement and recognises the hard work across the system to reduce waiting times for elective care and cancer treatment.

Tier 2 will continue to involve regular (at least fortnightly) meetings, with Regional and National colleagues where required, to discuss delivery progress and additional necessary support from the relevant parts of NHS England, as well as agreeing the performance criteria for de-escalation from Tier 2.

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

Appendix 1: Summary table of breaches

	104+ week wait patients			78+ week wait patients			65+ week wait patients		
	October	November	December	October	November	December	October	November	December
University Hospitals of North staffordshire	0	0	0	8	4	0	127	92	85
of which Corneal	0	0	0	0	0	0	2	0	0
Nuffield North Staffordshire	0	0	0	0	0	0	0	0	0
Ramsay	0	0	0	0	0	0	0	0	0
Medefer	0	0	0	0	0	0	0	0	0
System Providers Total	**0**	**0**	**0**	**8**	**4**	**0**	**127**	**92**	**85**
Out of System Providers	**2**	**0**	**0**	**6**	**17**	**35**	**173**	**311**	**847**

The table in appendix 1 shows the 104, 78 and 65 week wait breaches for October, November and December as per 08 November 2024.

Predicted positions for October, November and December for providers within the Staffordshire and Stoke-on-Trent system are validated and risk assessed positions, given by providers on the weekly return as per 06 November 2024.

The weekly waiting list minimum dataset (WLMDS) is used to provide the forecasted position for the providers outside of the system. This is the number of patients not dated before the end of the stated month. WLMDS submission as per 03 November has been used. To note, these are unvalidated and not risk assessed.

The next target will be zero patients waiting 52 weeks or longer for first definitive treatment by the end of March 2025. In the latest unvalidated data, as per 03 November, there are 4,512 patients waiting 52+ weeks, with 2,388 of these being at UHNM. For providers outside of the system, there are currently 2,086 patients waiting longer than 52 weeks, with the remainder 38 patients being at our hosted Independent Sector Providers (ISP) in Medefer, Nuffield and Ramsay. To note, this is the current position and not a forward look to end of March 2025. This is for Staffordshire and Stoke-on-Trent patients only.

3.2 Cancer Performance

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

The final September position at UHNM for 28-day Faster Diagnosis standard was 70.9% against a trajectory of 76%.

The provisional October position at UHNM is currently 79% with high completeness.

September's position for University Hospitals of Derby and Burton (UHDB) is 72.7% against a trajectory of 75.5%, and UHDB's incomplete October position is 74.9% against a trajectory of 75.8%.

The final September position at UHNM for the 31-day target was 93.3% against a target of 95%

The final September position at UHDB was 90.4% against a trajectory of 86.5%, with October's incomplete position currently at 89.8%.

The final September position at UHNM for the 62-day combined standard was 65.9% against a trajectory of 65.5%.

October position for UHNM is currently incomplete as histology confirms cancer on some outstanding resections.

North Midlands and Cheshire Pathology Service (NMCPS) currently report 95% of resections by 24 days.

The final September position at UHDB for 62-day combined standard was 71.6% against a trajectory of 64%, and the UHDB provisional position for October is 67.3%, against a trajectory of 6%.

Further and ongoing actions include:

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

Planning for reduction and clearance of 52ww cohort.

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

Receive the updated position in relation to recovery of the long wait position and cancer performance for the ICB.

4.0 Urgent and Emergency Care (UEC)

The latest Category 2 response time for last week was up almost 2 minutes, totalling at 38 minutes and 53 seconds. This remained 8 minutes below plan for the month, which placed us at 6th regionally and 25th nationally, whilst the four-week average of 43 minutes 07 seconds placed the system at 6 out of 11 regionally, and at 22 out of 42 nationally.

October's average handover time at UHNM further deteriorated to just over 1 hour, 40 minutes, compared to 1 hour the previous month, with increased delays being experienced at both Royal Stoke and County Hospital. This resulted in a position 49 minutes above plan.

Work towards compliance with the Ambulance Handover Trajectory saw West Midlands Ambulance Service (WMAS) complete 52.6% of handovers at UHNM within 45 minutes, down from 65.87% in September and below the targets of 85% for Royal Stoke and 96.5% for County Hospital.

'All types' of attendance at UHNM increased by 6.95%, which is the equivalent of 27 more patients each day throughout the month, with increases reported across all Type 1 and Type 3 locations. Overall, there was a drop of 4.5 percentage points in patients being assessed within 15 minutes, falling from 66.1% to 61.6%. The number of Type 1 attendances to be seen within the first hour fell by 14%, resulting in less than one out of every four patients being seen within the first hour. Emergency admissions via the emergency department dropped 1.8% during October 2024 and remained almost 15% below the same period last year.

Four-hour performance during October fell to 65.3%, a shortfall of 6.7 percentage points against plan, a drop of 3.9 percentage points over August, and 0.1 percentage points above October 2023. Type 1 locations bore the brunt of this pressure with a reduction of 6.2 percentage points from 49.9% to 43.7%, whilst Type 3 locations held steady at 98.8% during the month.

Twelve-hour performance saw a 3.4 percentage point increase from 7.9% to 11.3% in line with front door pressures and delays, with the majority of the impact seen at Royal Stoke, although County Hospital was not immune to the rise. The position of 11.3% for October 2024 was 0.7 percentage points below the regional average for the month but 3.8 percentage points above the same month last year.

Bed Occupancy for September for both adult general and acute beds and adult and paediatric general and acute beds continued to increase and remained significantly above plan, with both reaching 94.3%. All Long Patient cohorts (7+, 14+ and 21+ days) increased by the equivalent of over 20 patients per day throughout the month.

During October, UHNM discharged 76.9% of patients on Pathway 0, which is 0.7 percentage points below plan (77.6%) and a reduction of 2.3 percent points in September. Discharges to Pathway 3 at 0.5% remain below plan (1.1%) for the fourth month, but did increase 0.2 percentage points during the previous month.

Virtual Wards occupancy has increased through the month with the latest SitRep submission, as of 24 October, reported that 73.7% of the increased capacity of 293 beds were occupied, with the North achieving 70.6%, the South-East 89.8%, and the South-West 48.6%. Additional beds to bolster the South-West are due to come online in the weeks ahead.

5.0 Key figures from our population

		Last 4 months in current financial year				Comparator month		Change on same month previous year		
		Jun-24	Jul-24	Aug-24	Sep-24	Aug-23	Sep-23	No.	%	Direction
*	111 calls received	28,329	28,415	27,073	25,879					
	Percentage of 111 calls abandoned	3.6%	3.1%	2.7%	2.1%					
	A&E and Walk in Centre attendances (UHNM)	22,068	21,793	20,079	20,891		20,880	11	0.1%	↑
	A&E and Walk in Centre attendances (other providers)	19,595	19,765	18,026	18,067		18,141	-74	-0.4%	↓
	Non elective admissions (UHNM)	7,562	8,278	7,746	8,455		7,407	1,048	14.1%	↑
	Non elective admissions (other providers)	6,294	6,922	6,327	6,220		5,912	308	5.2%	↑
	Elective and Day Case spells (UHNM)	7,370	8,299	8,612	9,057		6,570	2,487	37.9%	↑
	Elective and Day Case spells (other providers)	8,306	8,941	8,265	8,510		7,843	667	8.5%	↑
	Outpatient procedures (UHNM)	7,988	8,808	7,327	7,479		6,701	778	11.6%	↑
	Outpatient procedures (other providers)	12,395	13,451	12,260	12,480		12,003	477	4.0%	↑
	GP appointments (all)	503,567	552,045	485,982	537,554		580,922	-43,368	-7.5%	↓
**	Physical Health Community contacts (attended)	148,165	159,690	145,185	143,930		129,825	14,105	10.9%	↑
**	Mental Health Community contacts (attended)	41,520	45,190	39,530		43,590		-4,060	-9.3%	↓

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

Most datasets are subject to change upon refresh.

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

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

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays). We will flag up if variation in these activities is abnormal.

6.0 Quality and safety

Staffordshire and Stoke-on-Trent's Maternity and Neonate Voices Partnership have received two nominations for the national WaterWipes award, which celebrates and recognises the incredible work of healthcare professionals involved in maternity, neonatal and postnatal care. The winner will be announced on 17 November 2024.

The ICB has previously reported upon the work that is being undertaken to achieve the statutory compliance timescale for the initial and annual review health assessments of children who are currently in local authority care. Additional funding has been provided to Midlands Partnership University NHS Foundation Trust (MPFT) and UHNM to address the issue, and a recovery plan has been agreed. The projected recovery timescale was expected to be July 2025, but through collaborative work undertaken with our partners, recovery has been more rapid than originally predicted and is now anticipated that Staffordshire and Stoke-on-Trent will achieve the target before the end of the financial year.

Both Staffordshire and Stoke-on-Trent Safeguarding Children Partnerships are required to produce their revised arrangements by December 2024, following the publication of Working Together 2023. The ICB,

as a statutory member of both partnerships, has contributed to the revised arrangements and will continue to be accountable for the delivery of the partnership plans. A new thematic Joint Target Area Inspections (JTAI) has also been announced with the Care Quality Commission (CQC) forming part of the inspection framework. It is expected that they will inspect health providers as part of the process, which both partnerships are preparing for.

7.0 Vaccinations

The COVID-19 and Flu Vaccination programme commenced on 03 October 2024 and performance to date for Staffordshire and Stoke-on-Trent has been positive, with performance in key cohort groups above or in line with regional performance. There are over 150 sites across Staffordshire and Stoke-on-Trent providing COVID-19 and flu vaccinations over the winter period. Delivery is primarily within PCNs, supported by pharmacies and the MPFT Targeted Vaccination Team. COVID-19 and flu infections remain low, but we are starting to see increased circulation in the population. Detailed breakdown of uptake is provided below.

7.1 COVID-19 Vaccination Programme uptake

As of 08 November 2024, there has been a total of 190,371 COVID-19 vaccinations given, which is 39% of the eligible population. Staffordshire and Stoke-on-Trent are the third highest performing system in the region. The regional average for the Midlands is 33% and performance ranging from 23% to 45%.

Staffordshire and Stoke-on-Trent are the third highest ICB for care home vaccination uptake in the region, with uptake of 59.29%. This is above both regional (52.6%) and national average (55.33%). Other system performance in the region is from 44.39% to 62%

Current uptake for the 65+ cohort is at 56.97%, being the second highest performing in the region, against national average of 51.93% and 50.56%. Range of performance across the region is 37.69% - 62.17%.

Under 65 at-risk uptake is at 20.90%. Staffordshire and Stoke-on-Trent performance is above both regional (16.77%) and national average (17.75%). Performance across the region is from 10.51% to 24.58%.

Frontline healthcare worker uptake is at 23.54%. Staffordshire and Stoke-on-Trent performance is in line with national average (22.09%) and above regional average (19.26%).

Social care workers total at 12.92%, in line with the regional average of 12.54%.

7.2 Flu Vaccination Programme Uptake

As of 08 November 2024, there has been a total of 286,666 total flu vaccinations given across the system, with an uptake of 42.94% across Staffordshire and Stoke-on-Trent. This is above regional average of 39.68%.

Key cohort uptake is outlined below:

- Care Home Uptake – 71.7% in line with regional average of 69.1%
- Primary School age children – 30.5% above regional average of 27.3%
- Secondary Age – 12.7% - below regional average of 14.6%
- 65+ - 68.3% - above regional average of 66.5%
- Under 65 at risk – 35.6% - slightly above regional average of 33.3%
- Children 2-3 – 34.3% - slightly above regional average of 31.1%
- Frontline Healthcare workers – 30.1% above regional average of 27.01%
- Social Care workers – 22.3% slightly above regional average of 21.08%.

The ICS partnership working groups on winter vaccinations and vaccine inequalities are undertaking work to establish the reasons behind the lower COVID-19 vaccine uptake compared to flu vaccination uptake. If this is an established national trend, local messaging will be developed to support the COVID-19 vaccination uptake.

Care Homes and housebound patients are a priority for the next weeks of the programme.

Programmes of targeted engagement work with General Practice and population groups who have lower uptake of these critical winter vaccinations is being undertaken jointly by the NHS and council to address evidence of inequalities in vaccine coverage.

Communications support continues to promote vaccinations, focussing on winter vaccines for COVID-19, flu and additionally this year, Respiratory Syncytial Virus (RSV). We are also mid-way through a multi-platform communications campaign to promote Pertussis vaccination to pregnant women.

A meeting with the Chairmen of two local mosques took place in early November to solidify the beginning of a long-term engagement relationship. Their support for vaccination promotion was secured and we are undertaking some bespoke communications for their communities with their input to help address inequalities and lower uptake in this demographic.

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

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07

Report to:	**Integrated Care Board**					
Date:	**21 November 2024**					
Title:	**System Level Access Improvement Plan (SLAIP)**					
Presenting Officer:	Dr Paul Edmondson-Jones & Sarah Jeffery					
Author(s):	Mel Mahon, Tracey Cox, Vicky Oxford, Andy Hadley					
Document Type:	Strategy		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☒	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix 1 – SSOT System level access improvement plan					

(1) Purpose of the Paper:

To present the most recent Staffordshire & Stoke-on-Trent System Level Access Improvement Plan to the forum for information and assurance.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Primary Care Forum for Assurance and Information	12/11/2024
Integrated Care Board for Assurance and Information	16/05/2024

(3) Implications:

Legal or Regulatory	NHS England have requested that the updated SLAIP is again presented to ICB Boards in November 2024.
CQC or Patient Safety	This is a plan that aims to improve access for our patients and improve the experience they have. All practices are CQC registered and any impact on patient safety should be a positive one.
Financial (CFO-assured)	All finances referenced in the plan are national allocations which finance are aware of.
Sustainability	N/A
Workforce or Training	The plan looks to address the current challenges facing the primary care workforce, through retention schemes and new training opportunities.
Equality & Diversity	The plan ensures the actions being taken to address access are equitable for the public and practice workforce.

Due Regard: Inequalities	The plan addresses the health inequalities within the system and ensures that investment in areas of need is being provided equitably
Due Regard: wider effect	Health & Wellbeing of GPs and Practice staff are considered within the plan.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☒	☐	*If N, why* No new information is being collected *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	An EIA will be developed for each key programme of work within the SLAIP
	QIA	☐	☐	☒	*If N, why* No service change so not applicable *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☒	☐	☐	There is a section within the plan that describes the patient engagement that has taken place.

(5) Integration with the BAF & Key Risks:

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

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

General practice is seen as the bedrock of the healthcare system, it remains the first point of contact for many people seeking health services in their local community. It plays an important 'gatekeeper' role, ensuring as many people as possible receive the care they need close to home. GPs and their teams make up the vast majority of NHS contacts that take place, in Staffordshire & Stoke on Trent (SSOT) more than six million appointments took place last year (2023/2024)

General practice is under extreme pressure with intense workload and workforce challenges and is struggling to maintain a level of service that meets the demand and accessibility needs for our patient populations. People want to be able to get through on the telephone and know how their appointment is going to be dealt with. The ICBs ambition is to enable people to have more choice around when, where and how they access general practice, to have greater continuity where this is needed and to have a positive experience. To support this ambition, the ICB has worked with practices to ensure 100% have the ability to accept online GP registrations, a 55% increase on achievement since May 2024.

A national 'Delivery Plan for Recovering Access to Primary Care' was published by NHS England in May 2023 to help to address these challenges and ensure that general practice can keep at pace with the growing demand and be sustainable and resilient now and in the future. This System-Level Access Improvement Plan (SLAIP) has been written in response to the national plan and works through the 4 national ambitions; to empower people, to build modern general practices, to cut bureaucracy and build capacity.

A draft System Level Access Improvement Plan was presented to the ICB Public Board in May November 2023 and May 2024 with a requirement for a further update of the plan to be presented to the ICB Board in November 2024.

The Improvement Plan provides an update of work undertaken, progress towards the national ambitions and ongoing focus for 2024-25.

This plan will continue to evolve and grow, and the ICB intends to apply the 5 principles of the NHS Improving Patient Care Together (IMPACT) to help us continually improve our approach to access:
1) Continue to build on our shared vision and purpose.
2) Continue to invest in people and culture, this will reach across the ICS, ICB and into general practice through the workforce programme and Organisational Development (OD).
3) Develop leadership behaviours through the PCN Maturity Matrix that will then act as the foundation for change over time.
4) Build improvement capability and capacity; this will be evidenced throughout this plan as described in the PCARP.
5) Embed improvements into management system and processes. The four main aims of the PCARP are to; reduce bureaucracy, build capacity through its workforce, empower people and implement the modern general practice model, all of which embeds the IMPACT principles.

(7) Recommendations to Board / Committee:

The Board is asked to note the contents of the plan and discuss any amendments required.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Recovering Access to Primary Care Improvement Plan

November 2024

Contents

1. Executive Summary

General practice is seen as the bedrock of the healthcare system, it remains the first point of contact for many people seeking health services in their local community. It plays an important 'gatekeeper' role, ensuring as many people as possible receive the care they need close to home. GPs and their teams make up the vast majority of NHS contacts that take place, in Staffordshire and Stoke-on-Trent (SSOT) **over six million appointments took place last year** (2023/2024).

General practice is under extreme pressure with intense workload and workforce challenges and is struggling to maintain a level of service that meets the demand and accessibility needs for our local population. **People want to be able to get through on the telephone at 8am** and know how their appointment is going to be dealt with. The Integrated Care Board (ICB) ambition is to enable people to have more choice around when, where and how they access general practice, to have greater continuity where this is needed and to have a positive experience.

A national 'Delivery Plan for Recovering Access to Primary Care' was published by NHS England in May 2023 to help address these challenges and ensure that general practice can sustain the growing demand and be resilient now and in the future. The System-Level Access Improvement Plan (SLAIP) is in response to the national delivery plan and aligns to the 4 national ambitions; **to empower people, to build modern general practices, to cut bureaucracy and build capacity**.

In SSOT **96% of practices are now using digital telephony systems** and there is commitment from the remaining 4% to advance as soon as operationally possible. GP practices have already **achieved a 90% target for people to access their own patient records**, book appointments and order repeat prescriptions through use of the NHS App, and further support will be provided to outline the advantages of these systems.

It is important that the SSOT population understands how general practice is transforming. *The workforce is changing.* If a patient with a musculoskeletal issue contacts the surgery, they may be redirected to a First Contact Physiotherapist (FCP) in the first instance. **Getting the communications right is vital** to ensuring the changes taking place are recognised and understood by our population.

In SSOT, 712 Whole Time Equivalent (WTE) posts have been recruited to, such as FCPs, Mental Health Nurse Specialists, Advanced Nurse Practitioners, Paramedics and many more.

28,231 referrals have been made in the last 12 months within SSOT to the Community Pharmacy Consultation Service (CPCS) creating additional capacity within the system. The ICB is working with other community providers to increase the number of **services our people can self-refer to. The plan was to have 6 services mobilised by March 2024, however two services, Audiology and Weight Management are live** and there is some limited musculoskeletal, podiatry and falls services available by self-referral with work continuing to make these available for self-referral during 2024.

Improving access for our people cannot be done by primary care in isolation, there are many interdependencies with other work programmes and providers across the system who have a part to play. There needs to be a renewed focus on our model of care which builds on the Fuller Stocktake Report, around population health management and integrated teams whilst continuing to develop and deliver the ongoing work that already exists across the various programmes.

Our ICB is made up of 7 key portfolios which operate as a matrix approach to deliver the ICS priorities, aims and ambitions, underpinned by 4 enabling functions with quality assurance, improvement and safety running throughout. It is essential that our Primary Care portfolio works in collaboration with our other portfolios, enabling functions and provider collaboratives to deliver the access ambitions, for example:

- The **Urgent and Emergency Care (UEC)** portfolio will work with us to ensure same day urgent access pathways are in place and work for our population and will reduce the number of contact points currently being experienced by patients between providers.
- **Population Health Management** will support us to understand where inequalities lie, where access may be more difficult for some than others.
- **End of Life, Long Term Conditions, Frailty, and the Mental Health** portfolios will help us to ensure the appropriate appointment types/times are in place, for example patients may need a 20-30min appointment to ensure holistic physical and mental health checks can be undertaken, or comprehensive care planning can take place having identified our moderate to severe frailty patients.

This plan will continue to evolve and develop and the ICB intends to apply the 5 principles of the NHS Improving Patient Care Together (IMPACT) to help continually improve our approach to access:

1) Continue to build on our **shared vision and purpose**.
2) Continue to **invest in people and culture**, this will reach across the ICS, ICB and into general practice through the workforce programme and Organisational Development (OD).
3) Develop **leadership behaviours** through the PCN Maturity Matrix that will then act as the foundation for change over time.
4) Build **improvement capability and capacity**; this will be evidenced throughout this plan as described in the PCARP.
5) Embed **improvements into management system and processes**. The four main aims of the PCARP are to; reduce bureaucracy, build capacity through its workforce, empower people and implement the modern general practice model, all of which embeds the IMPACT principles.

The four building blocks from the Fuller stocktake integrate into our existing work programmes and golden threads that will underpin the work we do with general practice for the benefits of our population. This is demonstrated in **appendix 1.**

Signed

Dr Paul Edmondson-Jones
Chief Medical Officer, Deputy Chief Executive and Senior Responsible Officer (SRO) for the System Level Access Improvement Plan (SLAIP)

2. Our Local Picture

Staffordshire and Stoke-on-Trent ICB-PCN and GP Practices

The current GP registered population for SSOT is 1,197,362 (March 2024). The population continues to increase year-on-year, with a 3.4% increase since April 2019. This increase is expected to continue in excess of 1.2 million by 2035 (6% increase). The largest increase is expected within age group 65+, whilst the younger age groups will see little variation.

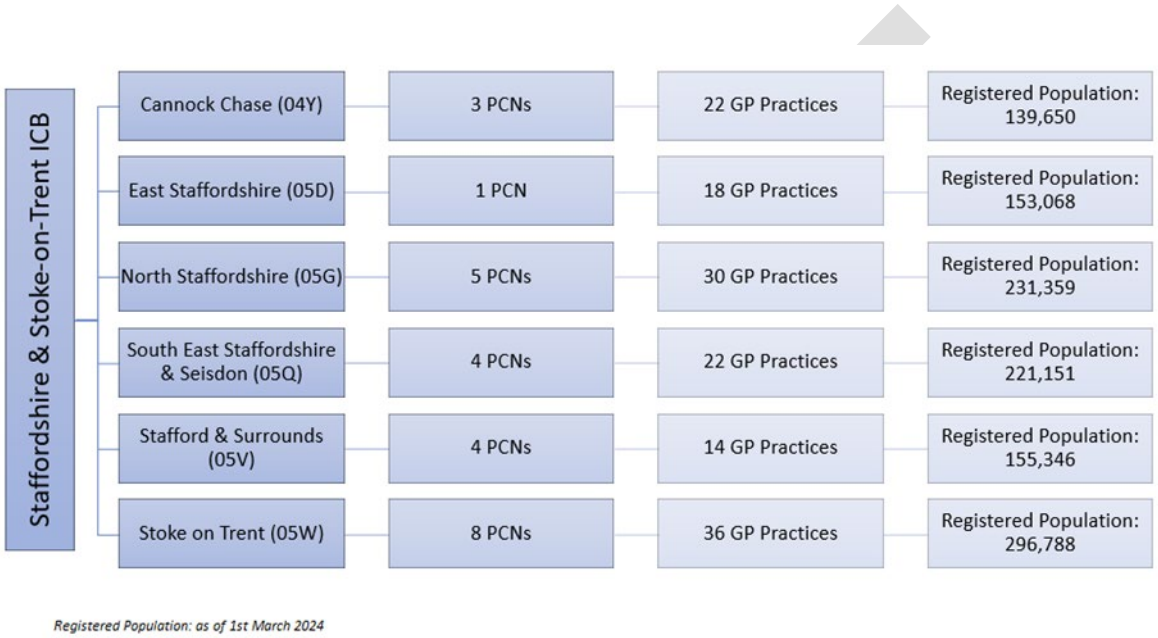


Figure 1: Population break down by locality

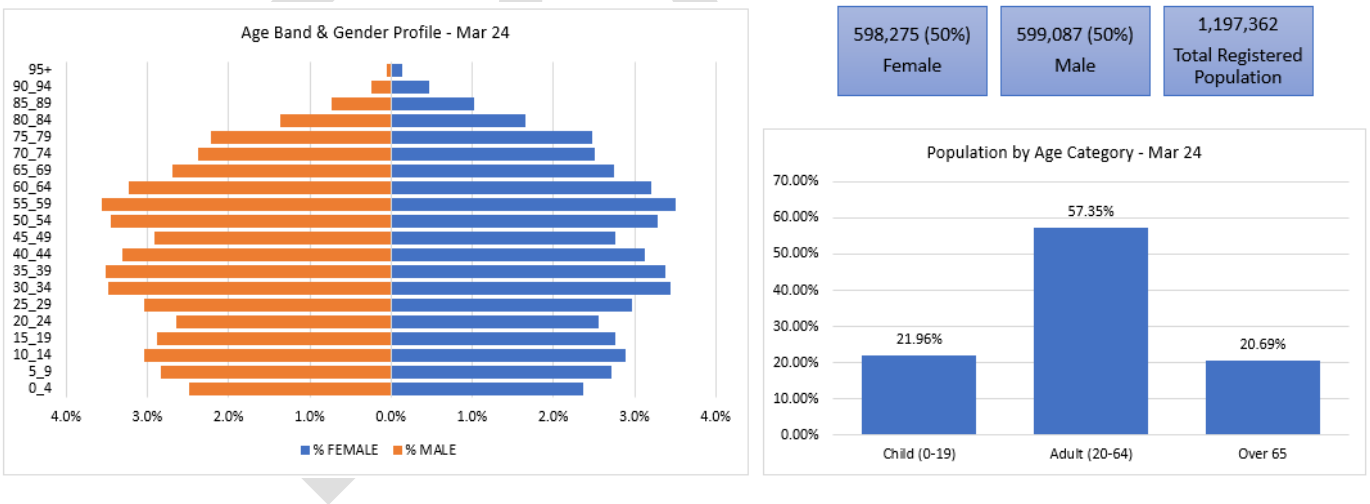
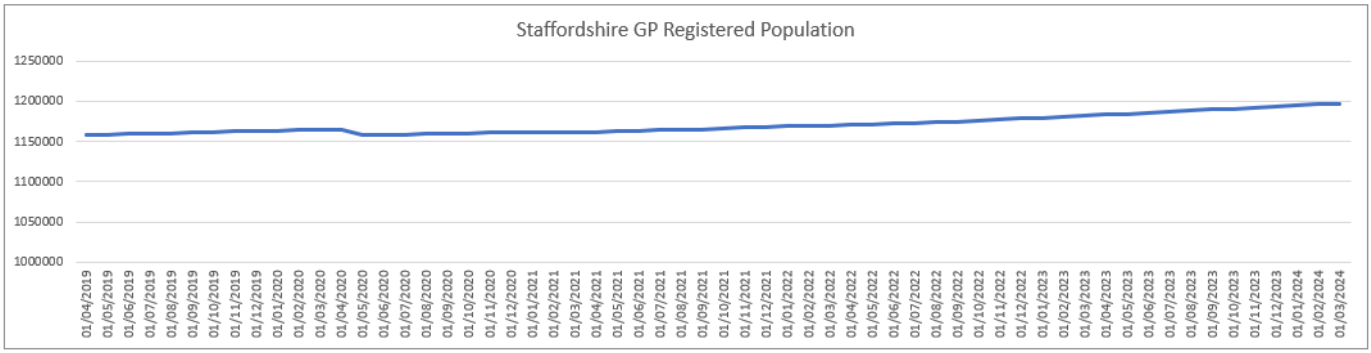


Figure 2: Age and Gender profiles



Data Source: NHS Digital - GP Registered Population Publication

Appendix 2 outlines the location of our Primary Care Networks.

Appointments in General Practice

Below are the key headlines for appointments in general practice with the increased number of appointments being offered in general practice supporting the Government commitment to deliver 50million more general practice appointments than in 2019:

Appointments risen since Covid-19 with a **peak 621,388** in October 23

In January 24 activity was **25.5% higher** than same period in 2019/20.

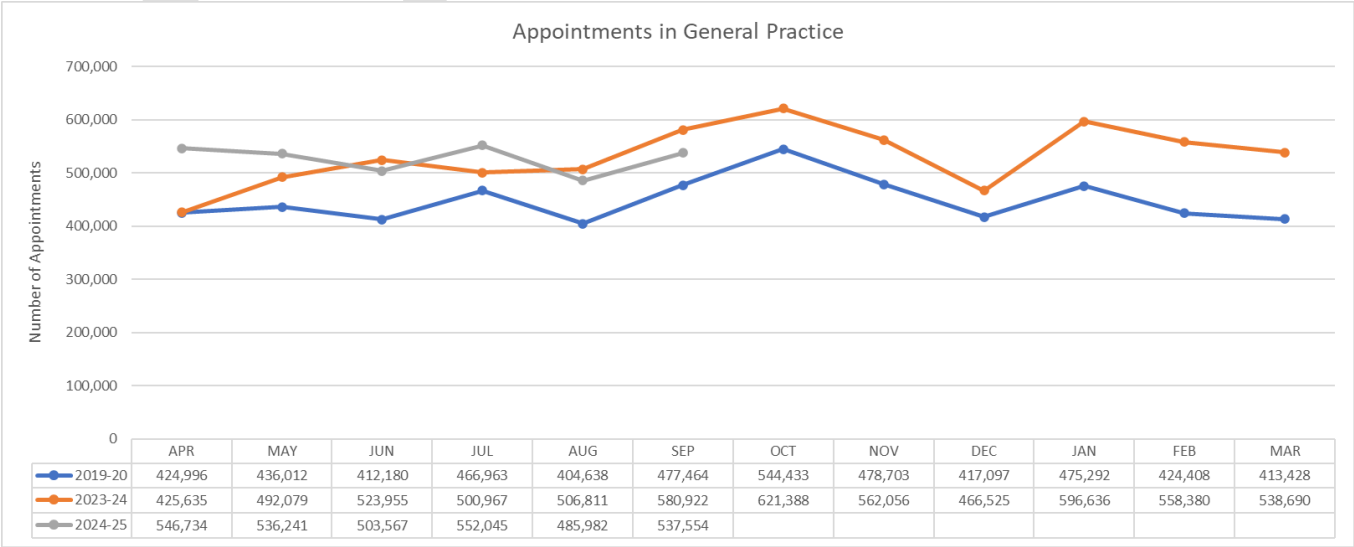
Face-to-face (January 24) **70.1%,** higher than the **national average of 66.6%**

Practice variation ranges from **32% to 98%** for **face-to-face**, with 66% of practices above the national average.

91.9% of appointments took place **within 2 weeks** from time of booking, **above the national threshold (>90%).**

Sub-ICB comparison shows 4 out the 6 SSoT locations are in the **highest performing quartile** nationally for appointments within 2 weeks.

Figure 3 Appointments in General Practice from April 19 to Jan 24



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2019-20	424,996	436,012	412,180	466,963	404,638	477,464	544,433	478,703	417,097	475,292	424,408	413,428
2023-24	425,635	492,079	523,955	500,967	506,811	580,922	621,388	562,056	466,525	596,636	558,380	538,690
2024-25	546,734	536,241	503,567	552,045	485,982	537,554						

Figure 4: Appointment types compared across England & Midlands ICBs

	12 months -Oct 23 to Sep 24			Current Month Sep 24		
	England	Midlands	SSoT ICB	England	Midlands	SSoT ICB
No. of Appointments	360,686,700	70,075,801	6,505,798	29,867,595	5,833,489	537,554
Appointments per 10,000 Weighted Pop.	58,030.5	59,464.2	53,204.6	4,805.4	4,950.1	4,396.1
% Appointments Face to Face	66.5%	68.2%	69.9%	65.5%	67.2%	69.4%
% Face to face with GP	40.9%	40.9%	40.8%	40.5%	40.5%	39.5%
% Appointments with GP	45.3%	44.9%	43.1%	44.6%	44.2%	42.0%
% Same Day Appointments (all national categories)	43.5%	44.8%	47.1%	43.2%	44.9%	46.4%
% 14 Day Appointments (all national categories)	82.3%	82.2%	85.9%	81.9%	82.0%	85.6%
% 14 Day Appointments (8 national nategories)	88.0%	88.5%	91.3%	88.3%	89.1%	91.4%

General Practice Workforce

The overall number of GPs has steadily declined from 2015 to mid-2018. GP Numbers subsequently increased, reaching a peak of 717 Full Time Equivalent (FTE) by November 2021. Since this point there has been a downward trend until December 2022 which saw a steep increase to GPs in Training Grade Specialty Trainee (ST) 2. A further increase has been seen over recent months, with the overall GP numbers at 729 FTE for September 2024.

A year-on-year comparison to October 2024 shows the number of fully qualified GPs has remained stable at around 500 FTE. There has been no decrease within the GP training grades over the last 12 months, where this had dropped by 5% the year before. Over the same timeframe the Nurse staffing group has remained stable.

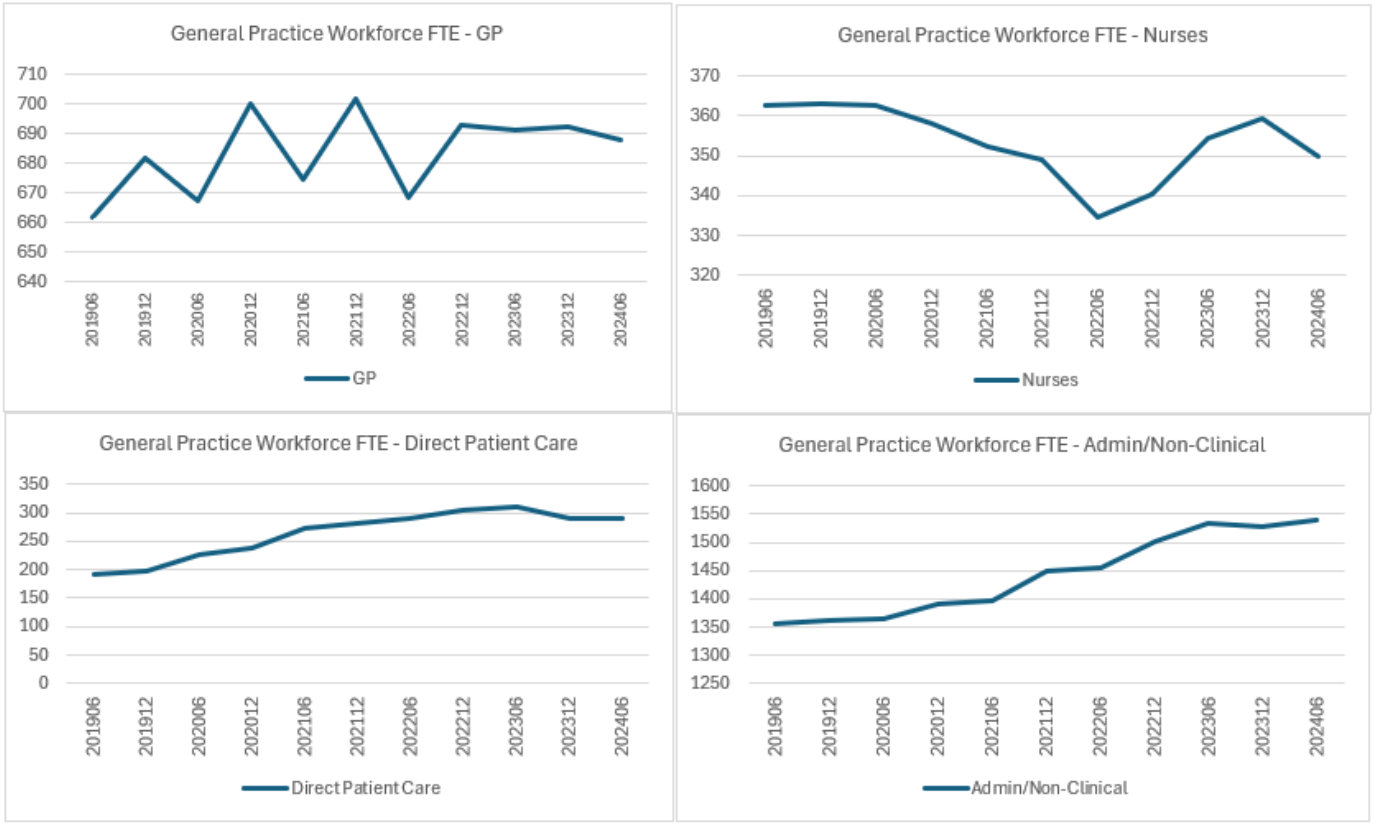
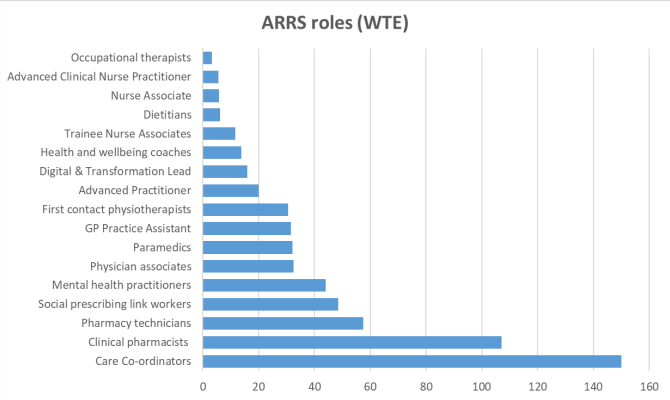


Figure 5: The GP FTE and Direct Patient Care (DPC) FTE as a rate per 10,000 weighted population are lower for SSOT compared to the National rate, whereas the rate for Nurses is marginally higher than National.

Primary Care Networks (PCNs) are continuing to recruit to additional roles to utilise their ARRS allocations with PCNs having 695 WTE in place at September 2024. The additional roles support changing and expanding the workforce in primary care to provide additional capacity for people, providing personalised and preventative care to our people.



SSOT also performed well within the Midlands region in relation to coverage of certain ARRS roles, SSOT had:

- 100% coverage for Personalised Care Roles – this is at least 1FTE in place by the end of March 2023
- 95% coverage for Mental Health Practitioner Roles, this means at least 0.5FTE in place and SSOT is the highest in the Midlands.
- 100% coverage of Pharmacists and Pharmacy Technicians, at least 1FTE in place.
- 72% coverage of Paramedic roles, at least 0.2FTE in place and SSOT are the highest in the Midlands.

The ICB works closely with the Staffordshire Training Hub (STH) team, including the Additional Roles Reimbursement Scheme (ARRS) facilitator, who with the ARRS Ambassadors, supports the PCNs and the ARRS workforce colleagues with their development, along with initiatives to aid recruitment and retention. Further detail on work in progress is detailed in section 5 of this report.

People's Experience

Access to general practice remains one of the highest priorities for our communities. The National GP Patient Survey results for 2023 show an increased number of positive ratings for 4 out of 5 of the key questions compared to 2022 results. This contrasts with the national trend which predominantly decreased.

The ICB recognises there is variation in people's experience of accessing general practice, in particular, people being able to contact their surgery by telephone or being able to navigate the GP website. This was also reflected in a report by Healthwatch Staffordshire on access.

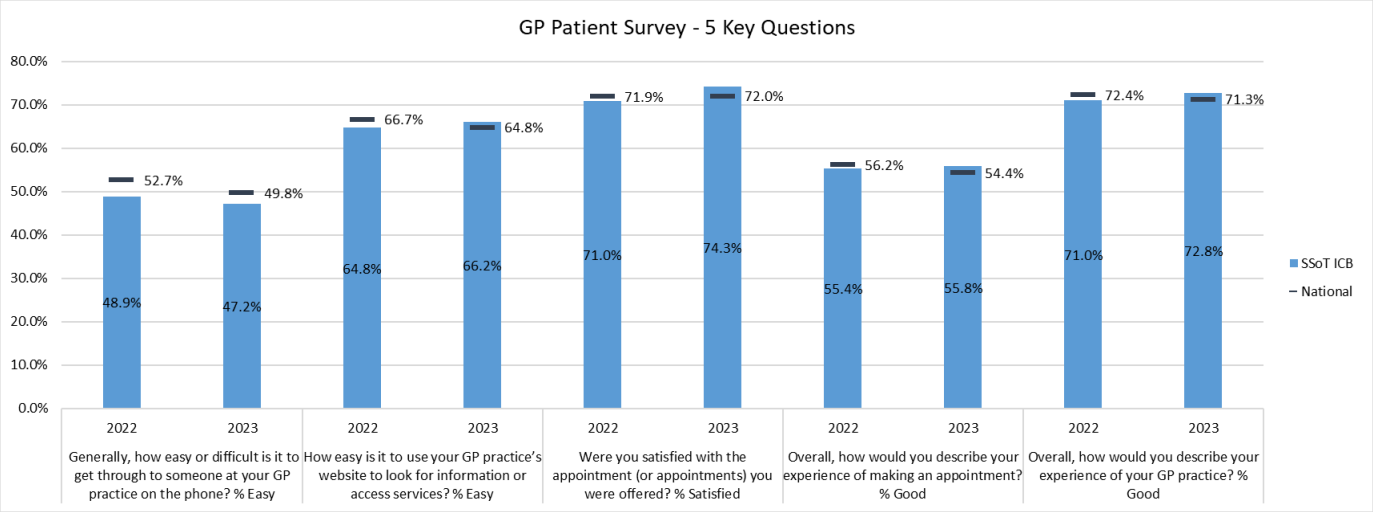


Figure 6: GP Patient Survey Results

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle for people accessing general practice services in which they have an opportunity to feedback their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

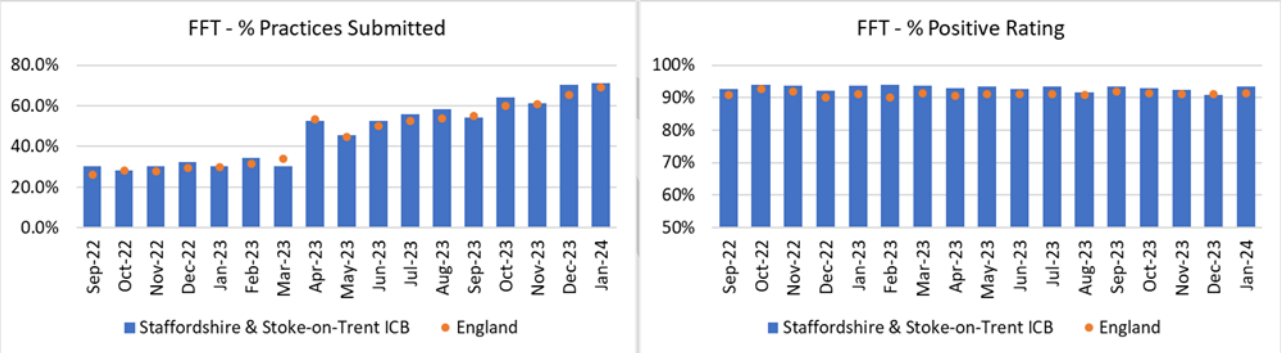


Figure 7: FFT Results from September 2022 to January 2024

A large proportion of general practices have input from Patient Participation Groups (PPGs). These are groups of people who wish to be involved in improving their local general practice services. The ICB will continue to work with PPGs to gain valuable insight and support practices in gathering more local real-time feedback, which can be used to shape improvement. Locally, PCNs are involving PPGs across their PCNs.

3. Health Inequalities (HI)

What Staffordshire and Stoke-on-Trent looks like through a Health Inequalities lens

Stoke-on-Trent is one of the 20% most deprived districts in England. People's health and life expectancy is below the England average for both men and women. There are disparities in life expectancy between the most and least deprived areas. Obesity for both children and adults are higher than the England average. The prevalence of smoking is higher than the England average. Under 75 mortality rates for cardiovascular diseases and cancer are also worse than the England average.

The average deprivation score (IMD) reports Staffordshire is lower than the England average. Life expectancy is similar to the England average for both men and women, although this varies between the most and least deprived area of Staffordshire. Obesity in adults is higher than the England average. Smoking prevalence in adults is lower than the England average prevalence. Rates of employment, homelessness and violent crime are better than the England average. Tables and deprivation maps can be found in **appendix 3**.

What Support is Available

The ICB supports and enables general practice to provide a consistently high level of care, address unwarranted variation, and improve access, quality, and outcomes by using a population health management approach, currently being rolled out across SSOT. PCNs and practices are in the process of receiving HI focused Population Health Management data training from May 2024.

PCNs across SSOT have all identified a HI Lead who are championing and working with colleagues across the PCN, system health partners including the voluntary sector to identify, develop interventions and engage with patient focus groups to tackle neighbourhood health inequalities.

East Staffs PCN and its member practices have participated in the national Complete Care Communities programme, establishing a community and provider engagement programme to focus on Diabetes care in the area. The PCN and GP practices worked closely with public health, patient experts, health and care providers, community partners focusing on integration opportunities and a plan on a page for whole system community management has been developed. The initiative is supported through the implementation of the Joy App, a community and health connectivity platform. A community and health 'reach out' event was attended by 250 people and the work has resulted in the publication of a patient information booklet with a distribution of 10,000 hard copies within the community.

Several PCNs have identified cohorts of people whereby access to GP services can be improved, to support them in receiving care, for example, people with learning disabilities can

often find it difficult navigating the appointment system or do not engage, when invited to attend for their annual health check. Healthwatch Staffordshire also collected valuable patient experiences on this issue and feedback from people with lived experience has also been provided by Staffordshire County Council to support people to access healthcare. PCNs have been working with Learning Disability Nurses within the community and mental health charities to establish reasonable adjustments and interventions that can implemented in how practices communicate and provide care for people.

The ICB primary care team also support practices to deliver against a Quality Improvement Framework (QIF), which are standards that are over and above those that are already nationally defined in the Quality Outcomes Framework (QOF). The QIF identifies those areas of deprivation and provides additional funding to those practices to enable them to focus on long term condition management to try and close the inequalities gap.

GP practices across Staffordshire and Stoke-on-Trent have been focusing on reducing health inequalities and supporting access to services through participation in the ICB engagement scheme focusing on becoming 'friendly practices'.

GP practices participated in 'practice friendly' evidence-based frameworks to provide an opportunity to better advocate for their patients and to help tackle health inequalities and provide accessible healthcare for those who need it.

Actions included focused staff training, identified practice leads, recording additional information to support patients with their needs, increased knowledge and signposting to services, updated accessible websites, notice boards and resources, changes to registration forms and processes, longer appointments, patient / carer point of contact at GP practices, better relationships with voluntary sector organisations, hospices and local authorities.

422 'practice friendly' schemes have been implemented including Veteran Friendly RCGP, Dementia friendly, Safe Surgeries toolkit, Digital inclusion, Deafness & Hearing loss, Daffodil standard for end of life care, Green impact for health toolkit.

'Practice friendly' schemes has resulted in positive feedback by patients, increased uptake in reviews, increased carer registration and condition registration, reduction in DNAs, changes to practice communications, increased use of translated resources, reduced carbon footprint schemes

Equality and Health Inequalities Impact Assessment (EHIA)

A Health Inequalities strategy is currently in development. This will articulate a system-wide approach to tackling health inequalities, particularly in access, experience and outcomes, in line with our new legal duties. This work will also include working alongside quality assurance and improvement leads in addressing inequalities and variation for services commissioned by the ICB.

4. PCN and Practice Actions

PCN Capacity and Access Improvement Plans

The PCN access improvement plans have included the general practice elements of the National Delivery Plan for the Recovery of Access to Primary Care and focus on key areas to support improved patient experience of general practice;

- patient experience of contact,
- ease of access and demand management, and
- accuracy of recording in appointment books

The PCN improvement aim to address the challenges and risks presented to us around general practice access. Challenges include increased demand on general practice related to local demographics and an increase in the number of people aged 70+ with increasing dependency and some with multiple long-term conditions. There has been an increased demand for appointments and prescriptions, an increase in queries relating to hospital referrals and appointments and telephone access is impacted by referral queries and vaccination queries.

The PCN improvement plans detail actions the PCNs and their GP practices are undertaking with the aim of improving access for people;

- a commitment to move to Cloud Based Telephony (CBT) for analogue practices and number of PCNs are developing plans to move to one CBT system in the future once individual GP practice contracts come to an end. The commitment includes plans to implement greater functionality for cloud-based telephony such as call back options and queue functionality
- Use of the NHS England GP website improvement and benchmarking tool to ensure all practice websites are offering a consistent message and are up to date with the latest information to support easy information finding for people, reducing the need to telephone GP practices to request information
- Participation in digital inclusion work to support people to access online tools such as the NHS App online consultation and promotion of these tools to increase patient awareness
- Implementation of Patient Online Record Access
- Utilisation of Additional Roles Reimbursement Scheme (ARRS) Funding to secure additional roles within PCNs, offering greater choice of appointments to people
- Communication campaigns to inform people of GP practice teams, including ARRS roles
- Working with community pharmacists to utilise the Community Pharmacy Consultation Service where appropriate for people
- Exploration of the creation or growth of PCN PPG groups to support engagement with practice populations to improvement patient experience
- PCN plans for community collaboration and working with community groups to provide support and information to people
- Use of care navigation and accessing training

Further themes captured from the plans can be found in **appendix 4**.

Some specific examples that PCNs identified within their plans are captured below, this is not an exhaustive list but provides a flavour of the actions being taken locally:

PCN Area	Action being taken
North Staffordshire	Digital Inclusion sessions are being held in GP practices within the PCN to support people to access information digitally where appropriate.
North Staffordshire and Stoke-on-Trent	A pilot project is taking place with a focus on backend workflow turnaround i.e. dealing with administration such as patient letters/tasks etc. Actioning the workflow within a specific time period following receipt has seen a reduction in telephone calls, appointment requests, patient queries and tasks. Staff satisfaction and morale has also increased due to a reduction in patient complaints and queries.
South Staffordshire	A General Practice Team leaflet has been produced for people who do not have online access, detailing the different ARRS roles and Health Care Practitioners available in general practice.
South West Staffordshire	Consistent messaging on websites across the PCN to inform people of services available in addition to general practice and consistent advice on usage of services including general practice.
South East Staffordshire	Use of a web-based community connectivity app platform used by the public and health professionals and links directly into our GP systems.

A Social Prescribing holistic community model using The Joy App improves health outcomes, reduces demand in Primary Care and provides a return on investment.

- 2100 clients successfully supported
- 98% satisfaction score
- 37% uplift in personal well- being captured ONS4
- 10,000 activity reduction in clinical interventions
- 73% clients reside in postcodes associated with areas of High Deprivation
- 40+ organisations referring into the Social Prescribing service
- 30% of all referrals come from organisations other than GP Practices
- 108 referrals to other organisations made by Social Prescribers
- £500k secured for people in 4 months through the form filling service

PCNS are utilising the IIF payments to support the implementation of their plans.

Challenges in delivering PCN Capacity and Access Improvement Plans

PCNs have highlighted workforce recruitment and retention as a concern within their improvement plans. During 2022/23 available funding for ARRS roles was not fully utilised due to recruitment challenges. The ICB has worked with PCNs to support them to develop plans to utilise ARRS funding to recruit staff to additional roles. The need for suitable estate to accommodate additional roles has also been highlighted within some plans and this has been captured as part of the PCN Estates Plans (see section below).

Elements for delivery in the PCN Improvement Plans are linked to work taking place at a national level and delays to national work could impact on local delivery. Delays in the publication of national frameworks, for example for the purchase on online consultation tools, may result in delays to implementation of PCN Improvement Plans. To mitigate this risk, the ICB has ensured that online consultation tools are available for all GP practices to utilise whilst the longer-term purchase of an ICB online consultation tool progresses. Information webinars and support available has been shared with GP practices and PCNs to facilitate understanding of the tools available and the benefits to people and practices.

PCN Estate Plans

The toolkit to support the PCN Estate Plan production had two objectives:

- To enable each PCN to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs.
- To support the production of capital investment plans for PCNs and help ICSs to aggregate and prioritise local primary care investment requirements against other system demands for capital.

Each PCN Strategic Estate Plan has short-, medium- and long-term options for estate identified within them. All 25 plans have estate investment/development needs in some form.

The following next steps have been taken/are in place to develop the estate plans within SSOT:

- The ICB received the aggregated version of the 25 PCN Estate Plans from CHP. The aggregated version summarises the 25 plans.
- Each PCN Estate Plan has been reviewed by the ICB. Prioritisation of schemes within the plans has been completed.
- The ICB will utilise the aggregated version, along with the individual plans, to respond to any planning application and to prioritise any funding that is made available to the ICB, this includes future Premises Improvement Grant funding and any additional space requests.
- The ICB plans to continue to work with PCN's where there is a prioritised project to undertake option appraisals / feasibility studies.

5. ICB Actions

1. Empower patients by rolling out tools they can use to manage their own health, and invest up to £645 million over two years to expand services offered by community

Through development of the Integrated Care Partnership (ICP) Strategy, 5 'Ps' have been agreed as operating principles and commitments by Partners. Personal responsibility supports the empowerment of people.

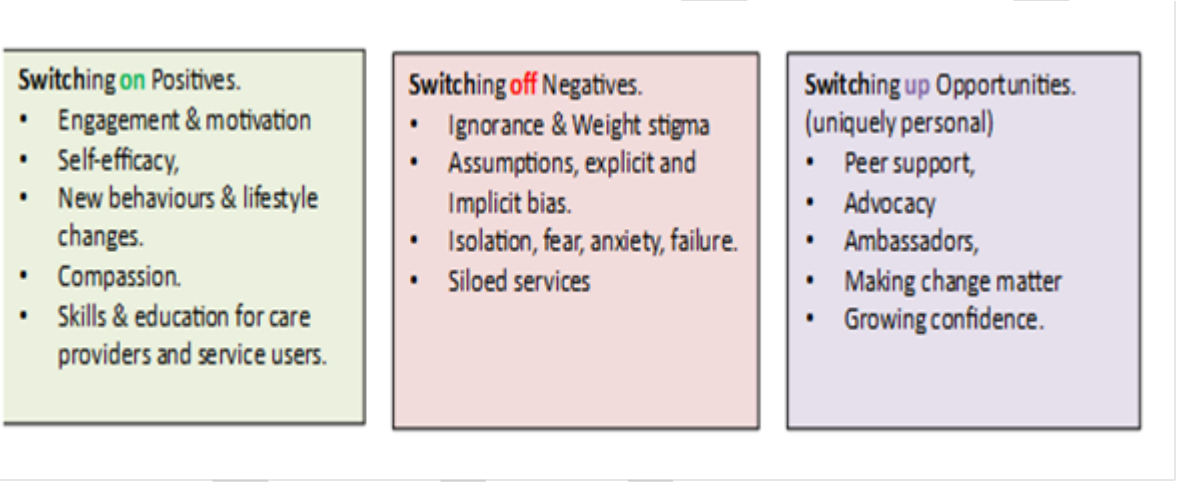
Figure 8: The 5 P's

Self-Referral Pathways

Progress has been made for several self-referral pathways to help empower people and encourage them to take control of their own health. A readiness assessment has been completed for NHSE and provides further details around these pathways. In summary:

- **Community Musculoskeletal and Podiatry's** referral service aim is to help patients to improve and manage problems that affect their muscles, joints and soft tissues without the need of a Primary Care Referral. Patients that live in the East of the Staffordshire are already able to self-referral themselves for MSK conditions and over 60% of patients that attend this service have self-referred. It was hoped that during quarter 4 of 2023-24, the provider would have rolled out this model across the rest of SSOT however it has been recognised that this is not thought to be the most efficient model of delivery. The service provider is exploring and piloting different models of self-referral in other localities to assess delivery to inform the future service model.
- **Audiology for older people including hearing aid provision**. Self-referral for patients with hearing loss was successfully launched in September 2023, ahead of the target date of December 2023. People who require NHS funded hearing assessments and hearing aids can now refer themselves to NHS community audiology (hearing) services without the need for a Primary Care Referral.

- **Weight Management Service.** The development of weight management services across the ICS went through its planning phase in 2023. The desired outcome is to implement comprehensive, integrated weight management services that allows various pathways and evidenced-based options as appropriate for individual service users. The ICS new weight management service model is named SWITCH (Staffordshire & Stoke-on-Trent's Weight-related Interventions Tailored in Care for Health) and is being rolled out during 2024. SWITCH adopts a biopsychosocial approach where pathways are tailored to individuals' needs. Individuals' pathways may include psychology, wellbeing, social connections, dietetics, physical activity, weight-loss pharmacotherapy and bariatric surgery. SWITCH was launched in April 2024 as a 12-month pilot. SWITCH is a specialised service offering to support people with managing the many contributing factors that can make reaching lifestyle and/ or weight goals difficult. It is designed to listen to participant's strengths, goals, concerns and challenges to achieving personalised lifestyle goals along with how they would like to achieve them. The support from the SWITCH multidisciplinary team then aims to offer appropriate assistance in reaching these personalised goals.



- **Wheelchair Services**. Work has been underway to ensure that as part of the new service, which commenced in April 2023, people can re-refer themselves, having been accepted, into the service. The current provider is to develop a self-referral pathway. National guidance is being sought due to referrals requiring clinical assessment. The providers website identifies how people can be referred.
- **Community Equipment Services**. The current model does not include a self-referral route; however, the service is currently under review, and this formed part of the options appraisal during 2023/24. Work is ongoing with system partners to plan for the future of the service and work is progressing to determine timescales.
- **Falls services**. Self-referral pathways are in place in certain parts of the ICB footprint. Self-referral currently in place within South Staffordshire Falls Team through telephone only. Work currently underway with the Northern Staffordshire Falls Team to replicate the model.
- **Reactive Falls Pathway** - Self referrals into the Falls Service is available in North through Stoke Local Authority. This is a Telecare offer and is only in Stoke-on-Trent due to being an internal service offer. This is being reviewed.

The ICB will continue to enhance and promote self-referral pathways, ensuring healthcare staff and patients can readily understand the availability of self-referral locally. This will support the national aim of increasing use of these pathways during 2024-25.

Digital Empowerment

Enable people in over 90% of practices to see their records by 1st November 2023 and practice messages, book appointments and order repeat prescriptions using the NHS App

95% of practices in SSOT are now offering Full Prospective Access (FPA). Engagement with practices around promoting the use of the NHS app for record access will continue to take place and work to date has supported the achievement of the national target of 75% by 31st March 2024.

To make it easier to join a new practice, NHS England has simplified the forms and created an easy-to-use online registration service that is also available on the NHS App. The ICB has worked with practices and PCNs to encourage publicity of the NHS App and the new online GP registration process, with 100% practices putting this in place prior to the December 2024 deadline.

Online Access

The ICB has been working closely with NHSE and the National Commercial and Procurement hub to ensure high-quality online consultation, messaging and booking tools are available to general practice across SSOT. The launch of the Digital Pathways framework has been suspended and a revised launch date is not expected at this time. The ICB has stayed in close contact with the National Commercial and Procurement hub and NHS England to ensure this did not halt our procurement of Digital pathway tools for practices

All practices across SSOT have access to online consultation, messaging and booking tools to aid the delivery of the PCN Access Recovery plans. NHS England have set up a data set to monitor Submissions via Online Consultation Systems in General Practice. This currently contains data from April to September 2023. The next publication will allow the ICB to demonstrate progress made by practices around volumes of online consultations. The ICB are working closely with NHS England to understand when this next data set will be published. The ICB are also working closing with solution suppliers and Redmoor Health to ensure practices are supported to utilise these tools effectively.

All practices across SSOT currently have access to solutions which enable the booking of routine appointments. The ICB facilitated a Primary Care Digital Workshop webinar to ensure practices and PCNs are aware of the solutions available and how best to embed these into their practice workflows.

Facing escalating patient volumes and overwhelmed telephone lines, the practice adopted a digital software solution to revolutionise patient engagement. This platform enabled patients to initiate online consultations for various non urgent requests, effectively reducing the strain on phones lines and administrative staff

- A significant reduction (35%) in total call volume.
- Enhanced efficiency, with reception staff processing double the number of consultations compared to the traditional model of managing requests via phone calls.
- Improved patient satisfaction, with over 90% of patients rating the service as excellent and showing a preference for online consultations.
- Integration of additional functionalities such as online prescription requests and self-booking appointments, further enhancing convenience for patients and streaming administrative workflows.
- Majority of patients have taken up this mode of interaction which in turn frees up the phone lines for those patients that prefer a traditional way of contacting the practice.

The use of the NHS App is being promoted to our GP practices and the people of SSoT and is also included in the work of the Digital Inclusion Pilot being undertaken by a number of our PCNs.

The ICB will be looking to share best practice from peer PCNs and practices who are already successfully integrating these solutions and support will be made available from the solution providers to encourage the adoption and mobilisation of booking functionality where not currently enabled.

The ICB will also continue to engage with practices to understand which tools will be required to support the shift to the Modern General Practice Access model.

The ICB will engage with PCNs via its established Digital and Transformation Lead meetings to understand any areas of opportunity which can be supported by the tools available via new NHS England developed Digital frameworks.

A key focus of the digital work in 2024-25 will be supporting GP practices, PCNs and patients to use the online repeat prescription function and to enable patient access to their digital health record and the NHS App.

Challenges to delivering Digital Empowerment

Whilst digital tools have demonstrated potential in improving experience for both people and GP practices, there are challenges to delivering digital empowerment:

- Practices managing fluctuating demand across the day and ensuring a timely response to patient enquires.
- Adapting to evolving patient preferences and technological advancements in digital healthcare platforms.
- Maintaining a balance between digital and traditional modes of communication to cater for differing patient needs and preferences. These include accessibility challenges for patients unfamiliar with digital tools or those with limited internet access.
- Clinical triage: The variability in the quality and quantity of information provided by patients poses challenges for clinical triage. Balancing the need for thorough assessment with efficient resource utilisation remains a key consideration.
- Clinician Fatigue: The continuous nature of clinical triage via e-Consult can lead to clinician fatigue.

The move to maximise the potential of digital tools highlights the need for robust reporting functions within the digital tools to support trend analysis and inform decision making. This will support GP practices to allocate resource based on demand patterns experienced. Training for staff and digital inclusion for patients is key in the use of digital tools and the ICB will continue to support practices their work towards this. GP practices will be encouraged to focus on clinical triage protocols and criteria to enhance efficiency and accuracy of clinical assessments as well as prioritising clinician well-being through workload management strategies and support mechanisms.

Pharmacy

Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription only medicines for seven common conditions.

This service enables SSOT pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) without the need to visit a GP. The Common Conditions service launched locally as an extension of the Community Pharmacist Consultation Service on 31st January 2024 and the service is available in 229 pharmacies across SSOT.

This significantly expands the current Community Pharmacist Consultation Service (CPCS) and Extended Care Enhanced Service and the ICB will continue to work collaboratively with pharmacy colleagues including the Local Pharmaceutical Committee and general practices to promote utilisation of these services to improve access for people. Currently Staffordshire and Stoke-on-Trent ICB is consistently one of the top referring systems in the Midlands region to the local CPCS. In a twelve month period (January 2023-January 2024), 28,000 referrals were made to the service for our people by GP practices. Stoke-on-Trent Overview and Scrutiny Committee is also supportive of the Pharmacy First service and in its deep dive report into Primary Care Access, recommended the continuation of work to promote and encourage use of the service.

The Independent Pharmacist Prescribing Pilot Pathfinder Project provides increased scope for this to provide an extra 2,400 extra appointments across our pathfinder sites by March 31st,

2024, because of the EOI proposed by our Community Pharmacy Clinical Leads to NHS England which resulted in SSOT being awarded the highest number of sites across the Midlands Region.

Expand Pharmacy Oral Contraception (OC) and Blood Pressure (BP) Services

There are now 153 pharmacies offering oral contraception services across SSOT, with more achieving accreditation each month. Although service uptake has been slow across the region, the aim is to achieve 500 referrals each month by April 2024.

Viraj Parmar at Blythe Bridge Pharmacy in Stoke-on-Trent said;

> *"Since April, we have seen more than 75 women for oral contraception consulations. They are all really pleased to be able to pop into a local place at a time that suits them. I am thrilled to be doing more and seeing more people directly. I am sure it is a trend that will continue."*

There are 224 community pharmacies currently delivering 4,800 BP checks each month, the aim is to deliver 6,000 by the end of the 2023/24 financial year. The ICB are building on their success by supporting contractors who have lower numbers to support their output.

Four new pathfinder sites will start BP medication prescribing to support treatment-to-target objectives and improve access to GP by moving over these cohort of people to Community pharmacy. One of our Community Pharmacies in Stone, Staffordshire received 200 APBM referrals testifying to the reduced waiting times for ABPMs vis-à-vis Secondary care longer waiting times.

Closer working relationship between GP practices and pharmacies will be key in realising the benefits of the plan for people and practices.

An oversight group has been established to support collaborative working between ICB, Local Pharmaceutical Committee, GP Practices and pharmacies.

A scheme of engagement has been launched and information on Pharmacy First as been presented at three GP engagement sessions and a webinar was attended by 80+ practice staff.

Every PCN has been offered a separate training/information session with eight delivered to date. Individual GP practices have also been offered bespoke one-to-one sessions. GP practices are being encouraged to engage with pharmacy colleagues as part of the PCN and emerging integrated neighbourhood team working arrangements.

The use of the Local Services Tool within EMIS is encouraged and the use of the Directory of Service, Service Finder to increase referral rates from GP practices is being promoted.

The national toolkit for the service has been shared to promote awareness and a GP intranet Dashboard has been redesigned to provide a resource for GP practices on the Pharmacy First services as well as blood pressure and oral contraception services. Resources include a GP Toolkit and Care navigator support kit.

Community Pharmacy Clinical Leads will be engaging with the Local Authority Public Health Colleagues during 2024-25 to promote the services and improve access for the population.

The ICB will continue to encourage GP practices to refer people where clinically appropriate to pharmacy services and will support our people to access pharmacy service to support growth of patient volumes across the pharmacy service by March 2025.

2. Implement 'Modern General Practice Access' so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message.

PCNs have committed to providing Modern General Practice Access by transitioning from analogue to digital telephony, accessing support and training for care navigation, digital transformation and capacity backfill.

Currently 102 GP practices have confirmed their intentions to apply for funding to support implementation of a Modern General Practice Access model 39 for the North, 33 South West, 21 South East) and 60 applications have been received to commence implementation, practices are confirming their intentions via a memorandum of understanding process. The ICB will continue to engage with GP practices and PCNs to increase the number of practices committing to implementation during 2024/25 to support contractual requirements for Modern General Practice Access.

The ICB continues to work with GP practices to support the identification and implementation of their models throughout 2024/25 and will be encouraging practices to participate in the General Practice Improvement Programme to facilitate identification and implementation of their models.

Care Navigation

Care Navigation commenced in SSOT in September 2017 as part of the General Practice Five Year Forward View (GPFV) programme across GP Practices.

Non-clinical staff undertake Care Navigation to effectively signpost patients who contact a GP Practice to the most appropriate staff member to meet their health needs.

It is essential for Care Navigators to understand roles within practice and local services in order to signpost effectively and safely, including the additional roles that are available to Primary Care Networks (PCNs).
Care Navigation supports the aim of making it easier for people to contact a GP practice to ensure everyone who needs an appointment with their GP Practice gets timely assessment and an appointment according to clinical need.

A new National Care Navigation Training programme has commenced and to date, 89 General Practice staff across SSOT have received training through the programme. The ICB has invested an additional training programme to develop Care Navigators to support people and 255 general practice and PCN staff have been trained across SSOT via this route. Information on Pharmacy First has recently been added to the Care Navigation training to support implementation and utilisation of pharmacy services for our people.

Care Navigation training and implementation helps to:

- Improve the knowledge of people and GP practice staff around the different consultation methods available.
- Raise awareness of the different professionals now working in general practice and additional skills they bring to patient care.
- Increase the utilisation and satisfaction of using different professionals in general practice.
- Support people and GP practice staff understand future changes around integrated care partnerships and how this benefits their care

The ICB continues to encourage general practice and PCN staff to access national and local training opportunities so they can continue to provide a Care Navigation offer for people.

Digital Inclusion Pilot

The ICB has developed a digital inclusion pilot to support development of skills, confidence and motivation by upskilling people on the basic NHS online tools, such as the NHS App, that will give people the opportunity for greater control of their own healthcare. Stoke-on-Trent Overview and Scrutiny Committee highlighted the importance of digital inclusion in its recent deep dive report into Primary Care Access. The pilot is a collaboration between GP practices and PCNs and local authorities.

The pilot initially encompassed six PCNs and has been expanded during 2023/24 to include a further nine PCNs. The pilot aims to:

- Increase patient and public engagement on digital services
- Improve accessibility for people that either struggle to access digital services or have little confidence in using features such as NHS App or online consultation
- Provide a convenient and better experience for people
- Create 'Digital Champions' across PCNs to support digital literacy
- Improve capacity in general practice by reducing the need for people to contact practices where they are willing to use self-service digital means, e.g. for repeat prescriptions or access to medical records
- Where appropriate, introduce people to quality apps to benefit their health condition
- Promote greater use of nhs.uk, NHS app, GP online services and 111 online symptom checker
- Reduce digital exclusion

Currently five of six PCNs have completed phase 1 of the pilot with one continuing towards completion and the nine PCNs within phase 2 of the pilot are progressing towards delivery.

Digital Inclusion - What did we do?

PCN member practices identified an NHS APP Ambassador and organised a community event to encourage patients to sign up to the NHS App, as well as increase usage by those who already had a log in.

Patients were supported with downloading / accessing the app and helping them to resolve real time issues they were having with the app in person on the day.

There were more than 600 scans of the NHS App QR code on the day

There is ongoing promotion of the NHS APP through GP practice competition for best display of NHS APP promotion and pull up banners in practices.

Behavioural Science Project

The Behavioural Science project aims to utilise the combined application of Demand Management, Behavioural Science and Operational Excellence disciplines to balance demand and improve engagement, demand and flow of services across the system.

The project supports:

- An understanding of the current demand patterns that people across Staffordshire create when engaging with Primary and Urgent Care services including GP practices, GP Out of Hours (OOH) services, NHS 111 and the Ambulance service.
- The use of behavioural science to illicit how and why people select their chosen access point for the services they believe they require and how this can inform the engagement and transformation strategies required to optimise best use of these services across the system.
- Use population analytics and key performance data to drive operational excellence to meet the integrated delivery requirements needed to optimise access across these services and the system.

Build a staff toolkit to support local people to identify and select the most appropriate service to meet their needs by improving their knowledge, confidence and decision-making. Emerging schemes from the project include:

- Optimising the role of prescribing link workers
- Enhancing patient access to GP appointments
- Addressing DNAs in GP practice
- Improving health outcomes for patients with type 2 diabetes and learning disabilities
- Patient Participation Group Development

The Behavioural science work has also resulted in the development of a Cancer DES toolkit to support delivery of the related requirements within the PCN DES and an access toolkit has also been developed which is currently being tested within pilot GP practices.

Behavioral Science - What did we do?

Behavioral science techniques utilized in GP practice communications have supported a reduction in DNAs from 4% to 2% (equivalent to 100 appointments per month)

Use of social media posters, TV calling screen, reception display.

Commitment: encouraging patients who book appointments in person to write the appointment down or, on the phone, to repeat the appointment back to the receptionist

Framing Effects: use of positive framing to highlight the percentage of patients who attended appointments using the new posters

Social Norms: Deployment of a new text reminder message including reference to the percentage of patients attending and encouraging people to cancel unwanted appointments

Practice reminder messages now implemented with built in nudges to remind patients of upcoming appointments , these are sent 7/3/1 day before an appointment

Move to Digital Telephony

SSOT had a total of 7 GP practices that were identified as having an analogue based telephony system and were added to a priority list. All 7 sites have been supported by the ICB Digital team and NHS National Commercial and Procurement Hub to sign a new contract with a fully approved cloud-based telephony system from the Better Purchasing Framework. These practices are due to 'go live' with their new cloud-based telephony systems by 31st March 2024.

In phase 2 of the project, a further 67 GP practices were identified as not using a cloud-based telephony system or did not meet all the criteria of the functionality required to be fully cloud based. These practices were successfully nominated by the ICB Primary Care Digital Function to receive funding to procure a new fully approved cloud-based telephony system from the Better Purchasing Framework. Due to supplier demand and concerns that the continued drive for a phase 2 live service could impact the PCARP key deliverable of all phase 1 analogue practice being moved to digital telephony by the target date. The ICB Primary Care Digital Function continue to engage with and support GP practices to have their new telephony systems fully operational as soon as possible, with only a few now remaining due to external works being carried out by telephony providers.

3. Build capacity so practices can offer more appointments from more staff than ever before.

Workforce

SSOT ICB has a Primary Care Workforce Implementation Group (WIG) to provide the strategic direction and oversight for the workforce programme that has the overall aim of increasing capacity within general practice. The WIG is currently developing a workforce delivery plan that will align with the national workforce long term plan.

Reporting to the WIG is an Additional Roles Reimbursement Scheme (ARRS) task and finish group which is driving forward various supportive initiatives to ensure that 100% of the ARRS funding is utilised by PCNs. For example, sharing good practice on ARRS recruitment and retention, and providing timely PCN level ARRS finance information.

The ICB closely monitors expenditure and workforce plans to ascertain unclaimed funding that can be redistributed to other PCNs. The ICB is looking to pilot schemes to support PCNs with the supervision of the ARRS roles to aid retention and release capacity. The ICB works closely with the Staffordshire Training Hub (STH) team including the ARRS facilitator who with the ARRS Ambassadors support the PCNs and the individual ARRS workforce with their development and initiatives to aid recruitment and retention.

The ICB and the STH ARRS Facilitator have undertaken projects to raise the awareness of the ARRS roles and what they can deliver for the PCNs. The STH have launched various programmes of support including an offer for funded supervision support to First Contact Practitioners (FCPs) to complete Stage 1 and 2 of the Roadmap Supervisor Verification (RMSV) Roadmap.

The ICB has worked very closely with the two system mental health providers to ensure that PCNs adopted the Mental Health Practitioner (MHP) ARRS roles over the last three years. All roles are integrated with the secondary care mental health services to ensure that there is a smooth transition between secondary and primary care. The roles are integrated within the PCN workforce to ensure that people have access to multi-disciplinary team within primary care to best meet their needs.

Mental Health Practitioners (MHP) – how the role was successfully implemented

Communication has been key in the current success of the MHP roles. Clinic timetables were drafted to support MHPs into post showing how these roles need to operate differently to other ARRS funded roles, MHPs not being purely about additional appointments. Standardised recording of activity was set up which enables data reports to be shared with PCNs. In addition to sharing the data related to activity, patient feedback from the patient satisfaction survey is shared, which supports the longer length of appointments and the value of having more time to talk to someone in their GP practice.

Joint working relationships with other ARRS roles has also been part of the MHP success, e.g. forming PCN mental health and wellbeing multi-disciplinary team (MDT) where case discussion and supervision can take place. MHPs being managed centrally by mental health providers has limited the isolation that ARRS roles can suffer.

The providers continually review the partnership arrangements with the PCNs and how the service is developing based on stakeholder feedback. Feedback has resulted in the roles bridging the gaps and providing a better interface between primary and secondary care, having access to specialist mental health support. The results show that the roles are fully embedded in the PCN, are working closely with other ARRS roles to provide a MDT approach resulting in improved outcomes for patients. The feedback also recognised the impact the roles have had on reducing demand on GPs, quicker access to mental health support, more confidence in dealing with mental health problems and more joined up working.

The ICB work closely with the ICS People Hub and system partners to ensure that we can build the sustainability and growth of the ARRS roles across the system.

The ICB are seeing an increase in the recruitment of the new roles and currently all PCNs have a named Digital and Transformation Lead.

Working in partnership to support retention

The STH host two GP Clinical Workforce Champions and the ICS People Hub host a full-time Retention Partner to support with retention schemes and projects across all roles within primary care. System Development Funding (SDF) has been deployed for local GP retention initiatives within primary care.

Numbers on the GP Fellowship scheme have increased during 2023-24 through intense engagement at GP trainee meetings, practice leads and regional practice managers meetings. The STH created a short animated video to succinctly promote the GP Fellowship Scheme which is available to view at GP Fellowship Animation Video - YouTube. Currently 30 GPs are enrolled on the scheme including 11 new GPs who joined the scheme in the January 2024 Cohort. All GP fellows receive monthly facilitated Peer Group supervision sessions to allow them to network, build relationships and support each other and CPD events are organised to allow them to continue to develop, upskill and update. The Coaching and Mentoring team funded via the NHSE Supporting Mentors Scheme is now well established and had excellent feedback in latest fellows bi-annual survey.

In September 2023, the STH launched the General Practice Nurses (GPN) Foundation School, which has significantly increased numbers in the GPN fellowship scheme. All newly recruited GPN Fellows also have the option to take part in the weekly teaching sessions to receive interactive education including cluster sessions with GP Trainees. This GPN scheme offers a substantial level of support, learning and flexibility. GPNs benefit from a ready-made network built around them to support their confidence and reduce the sense of isolation. The scheme builds on current good practice by bringing together a range of existing schemes into one standard offer. GPN Fellows also have the opportunity to undertake a leadership programme, QI projects, clinical supervision and additional CPD.

The STH team have created a short animated video to succinctly promote the GP Fellowship Scheme to local nurses, which is available to view at GPN Fellowship Animation Video - YouTube

Further expand GP specialty training to make it easier for newly trained GPs who require a visa to remain in England

GP Practices are encouraged to take advantage of a valuable resource to retain GP Trainees outside the UK or to recruit a GP who are not settled workers. The STH launched a bursary for

GP Practices to become an official Skilled Worker Visa sponsoring Practice via the Home Office. To date, the SDF have supported 15 x Practices in SSOT to become a sponsoring practice.

The STH have the Indefinite Leave to Remain (ILR) Scheme to support overseas doctors who have accepted permanent GP posts in SSOT with ILR costs of up to £2,400. As part of this scheme there is a commitment from the GP to work in SSOT for at least two years after the approval of the costs. To date, the SDF have supported 10 x GPs in SSOT to become a sponsoring practice.

The STH have a GP Facilitator to lead on the NHSE General Practice Fellowship Scheme. To date, 13x GPs have completed and graduated the two-year programme, and currently there are 15x GPs in the first year and 9x GPs in the second year with a further 6x GPs since January 2024.

The Coach and Mentor team are now well established to support the GP Fellows and feedback for both the scheme and Coach/Mentors has been excellent.

The STH has engaged with all their GPVTS groups in SSOT and encouraged ST3s to join the STH mailing list, so they are aware of the level of support available. In addition to these meetings, the STH has created a short, animated video which has been uploaded to the STH website and which the GP Facilitator will show at engagement meetings with Practices and GPs. This video can be viewed at:
https://youtu.be/QKHbW21agjk?si=uMoJoA_g6wsIDE9e

Encourage experienced GPs to remain in practice through the Pension Reforms announced in the Budget and create simpler routes back to practice for the recently retired

The ICB will actively promote and deliver any new Government policies to encourage experienced GPs to remain in practice. Once pension reforms have been agreed nationally, the ICB plan to run a webinar to highlight the changes and what this means for our local GPs.

4. Cut bureaucracy to give practice teams more time to focus on their patients' clinical needs.

Primary – Secondary Care Interface

The ICB has developed a single Primary Care and Secondary Care Consensus Agreement that has been signed up to by all organisations across Staffordshire and Stoke-on-Trent. The Consensus Agreement aims to facilitate effective working between primary and secondary care organisations and details responsibilities to support this.

An established Primary and Secondary Care Interface Group is running in North Staffordshire and Stoke, led by University Hospitals of North Midlands (UHNM) to include Primary Care, Nursing and LMC colleagues. The aim of the group is to oversee the delivery of improved working across the primary-secondary care interface to improve productivity, efficiency, resilience, patient and clinician experience including all partners.

A similar group in South East Staffordshire has also been established and this is led jointly between University Hospitals Derby and Burton and the ICB clinical lead.

These groups will support the delivery of improved working across the primary-secondary care interface to improve the productivity, efficiency, resilience, patient and clinician experience. All collaborative work will aim to reduce inequities in care provision and any unwarranted variation in outcomes for our people.

The National Delivery plan for Recovering Access to primary Care makes reference to four key areas within the Primary-Secondary Care interface work and the current position at our local Trust is:

Onward Referrals

Consistency in implementing onward referrals across the trust varies, with acknowledgment of the ability but inconsistent practice. Overall, there is recognition that while a framework exists, actual implementation and consistency may not always meet the standards. Suggestions for improvement include better communication, standardised pathways, and increased clinician awareness. Challenges include referrals not aligning with specialties seen and a lack of standardisation due to lack of fail-safe system to help navigate across multiple pathways. Improved communication between specialties and primary care is needed to ensure appropriate referrals.

Complete Care (Fit Notes and Discharge Letters)

Fit notes:

Handwritten fit notes are issued for both outpatients and inpatients. Digital implementation was expected by November 2023 but has faced delays. Challenges included delays with digital implementation and the need for awareness among healthcare professionals regarding appropriate timeframes for sick leave. This is now live within UHNM.

Discharge letters:

There is a clear "GP Actions" section on the front page of discharge letters, and the GP actions are also listed under a separate heading on outpatient letters. Additionally, descriptions of medications that require reconciliation with rationale for any changes are included.

Suggestions for improvement include involving primary care networks (PCNs) to lead and support the development of clear standards and pathways with a patient experience focus, and more collaboration between hospital and primary care systems to enable patients to book appointments for required blood tests nearer to home to improve patient experience.

There is a dedicated messaging ability within the Consultant Connect to connect Outpatient service and GP liaison for GP queries. There is no overall named lead for resolving issues and improving the interface with primary care. However, we have a collaborative forum with clinical lead and admin support. It was agreed to channel escalations through this resource.

Clear points of contact

There is a dedicated messaging ability within the Consultant Connect to connect Outpatient service and GP liaison for GP queries, indicating early compliance. There is currently no overall named lead for resolving the operational issues and improving the interface with primary care

however the ICB is currently developing a proposal to develop a dedicated GP Liaison mailbox for operational queries in addition to to introduction of a new role of Primary Care Partnerships Manager, to be embedded in the acute sites an work across the interface. This is currently in the development phase and will require joint funding between system partners.

There is a need to raise awareness and socialise the existing points of contact within primary care to ensure that they are utilised effectively. This may involve communication and training sessions for primary care colleagues to familiarise them with the available resources and encourage their use in facilitating communication with secondary care.

The ICB will continue to work with system partners to facilitate the primary-secondary care interface work and this will be a key focus for 2024-25 as part of NHS England's deliverables.

The ICB will continue to work with system and cross border partners to improve the primary-secondary interface and this will be a key focus in 2024-25, reflecting the National Delivery Plan for Recovering Access to Primary Care Year 2 actions.

The ICB will work with local authorities and other partners including national agencies to support the adoption of the Bureaucracy Busting Concordat, reducing the administrative burden for GP practices.

IT System Connectivity – Improve the Digital Infrastructure between General Practice and Community Pharmacy

SSOT is currently on track to deliver vastly improved interconnectivity between Community Pharmacy and GPs systems. These will streamline referrals, provide additional access to relevant clinical information from the GP record, and share structured updates quickly and efficiently following a pharmacy consultation back into the GP patient record.

There are three major projects:

- **Local Services Module**: commissioned by primary care, EMIS system enables a one-click referral directly for referral of BP checks, oral contraception consultation and minor ailments directly from GP systems to the patient's community pharmacy of choice. **This is now live** and are already seeing a return on investment with more referrals and improved data visibility at system level.
- **Interconnectivity with GP Clinical Systems**: via the Independent Pharmacist Prescribing Pilot Pathfinder Project which is going live on November 2023. This gives the pilot community pharmacies direct access to GP systems for prescribing-**SSOT has the highest number of pathfinder sites in the NHS England Midlands region**. There are five models; three of which fulfil specific commissioning needs including the Anticoagulation Prescribing Service in Burton on Trent, CPCS+ service in Tamworth for deprived areas and the vulnerable asylum seeker population, Stoke CPCS+ site to reduce pressure on our OOH provider.
- **OneHealthandCare:** 240 community pharmacies in SSOT are the only pharmacy cohort in the Midlands in active onboarding consultations to be linked to OneHealthandCare joint care records being negotiated by the SSOT Community Pharmacy Clinical Leads working through the requirements analysis and governance frameworks so the pharmacy can have a full 360-degree view of the people care from secondary care, primary care, mental health, care homes, community services, GP and Dietetics.

Antimicrobial Resistance (AMR)

The ICB is undertaking a review and re-alignment of local AMR leadership, governance and clinical pathways, diagnostic pathways across the ICS, local priorities around antimicrobial stewardship and IPC to reflect the ICS population needs. A further review of Antimicrobial Prescribing and Medicines Optimisation (APMO) working group with clinical leadership from General Practice and Pharmacy is being developed.

Intelligence from NHS model health system AMR dashboard, local data and engagement with stakeholders is being utilised to review progress against local priorities for APMO and develop new plans for the ICS, with projects undertaken to address a key priority of optimising antimicrobial prescribing in General Practice. Supporting national AMR strategy and local priorities, utilising Service Level Agreements with General Practices to enable audit reviewing local practice in APMO in General Practice and promote adoption of TARGET toolkit approach. The APMO Working Group will continue to drive quality improvement in antimicrobial prescribing in General Practice through strategy, local interventions and guidance reflecting evidence based best practice.

General Practice Improvement Programme (GPIP)

Uptake of the General Practice Improvement Programme in SSOT:

Offer Type (Phases A, B & C, D, E)	Spaces Utilised	SSoT Proportionate Allocation
Practice Intensive (no longer in place nationally)	1	N/A
Practice Intermediate	14	26
Local Improvement (launched Oct 2023 and under revision to reflect more local requirements	0	20
PCN GPIP Support Level Framework	3	N/A

Within the Midlands region, SSOT currently has a lower proportion of practices signing up to the intermediate support offer than its proportionate allocation. Three PCNs are signed up to the PCN wide support offer.

All GP practices are being offered a facilitated assessment as part of the GPIP Support Level Framework to help them to identify which level of support would benefit them, and the people registered with their practice, the most (intermediate, universal).

A barrier to participation in the General Practice Improvement Programme is that there is no additional funding being applied to GPIP (outside the 70% IIF for CAIP) and it is not a contractual requirement for GP practices to participate. Staffordshire and Stoke-on-Trent saw 43% of their GP practices participate in the national Accelerate Programme which ran prior to GPIP which has impacted on uptake for GPIP.

The link between the transition to Modern General Practice Access and the GPIP SLF is being highlighted to practices to promote uptake. Practices converting from analogue telephone systems to cloud-based telephony systems are also being encouraged to participate to support them to explore and secure the benefits of moving to cloud-based telephony.

A requirement of PCARP is for the development of a local intermediate support offer and the local offer is being revised to move away from the national 13 week programme to reflect the local need of practices identified through facilitated assessments and feedback. The local intermediate support offer will be led and in part delivered by our GP Support Team with additional support from the wider team subject matter experts and external partners. This offer will enable an additional 20 GP practices access to the General Practice Improvement Programme, however we will be opening the local offer up to a larger number of practices to support the delivery of their PCN Improvement Plans and the transition to Modern General Practice Access Models. The local GPIP Support Level Framework offer will be available into 2024-2025.

Examples of the domains within the local offer and the proposed intervention support is shown in Appendix 6.

The ICB will take on further responsibility for GPIP during 2024-25 as the national offer is being phased out and it is expected that from 2025-26, ICBs will be responsible for local delivery of the GPIP programme with more details on what is expected to be shared by NHS England during November/December 2024.

Health and Wellbeing to support GP and primary care staff retention.

The strong links to health and wellbeing and work / life balance in staff retention is a crucial aspect of the work with particular emphasis on supporting the Quality Improvement Module on health and wellbeing of the Quality Outcomes Framework and the introduction of the General Practice Staff Survey as an early adopter and the planned introduction of a standardised and impartial exit questionnaire and interview process.

The ICB has put in place the Vivup app, a health and wellbeing tool which is available to all general practice staff across Staffordshire and Stoke-on-Trent.

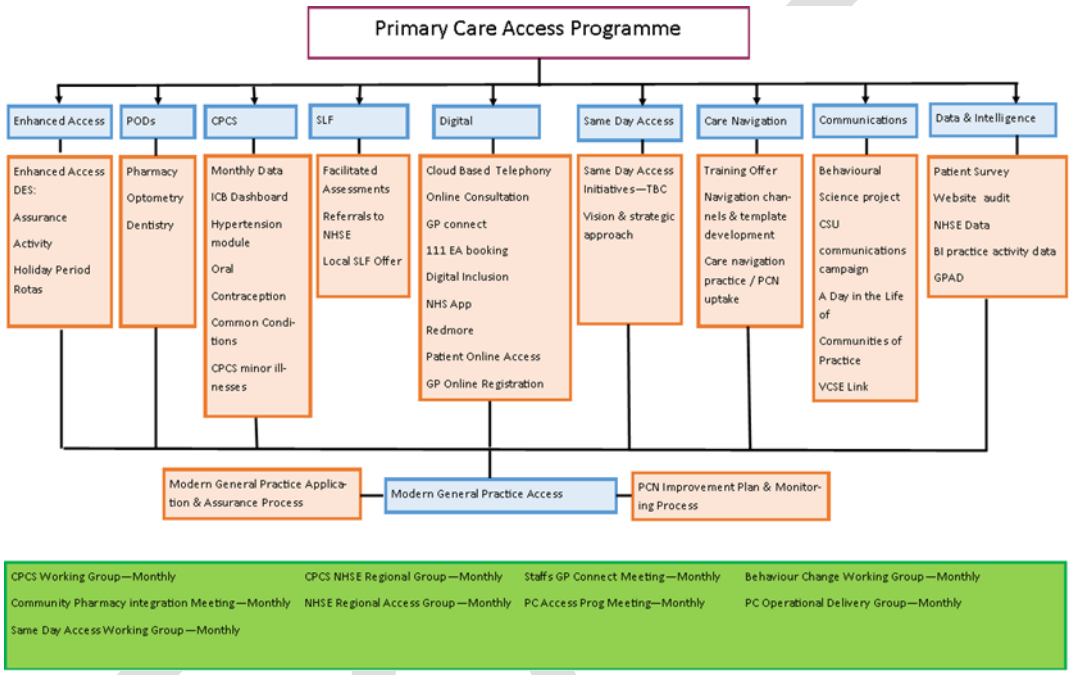
Four priority areas have been identified by a project steering group which has representation from the ICB. Identified priority areas each have a working group to bring together activity from the wider system and collaborate. There is named representation on each group from each sector / organisation.

- Flexible working and flexible retirement – case studies of good practice, rostering
- Exit data – data improvement, consistent approach across the system, stay conversations, increase engagement, staying in touch
- Onboarding and new starter support – for example preceptorship, legacy mentors, welcome / the first 90 days
- Career development and progression – line manager support, access to training, itchy feet conversations

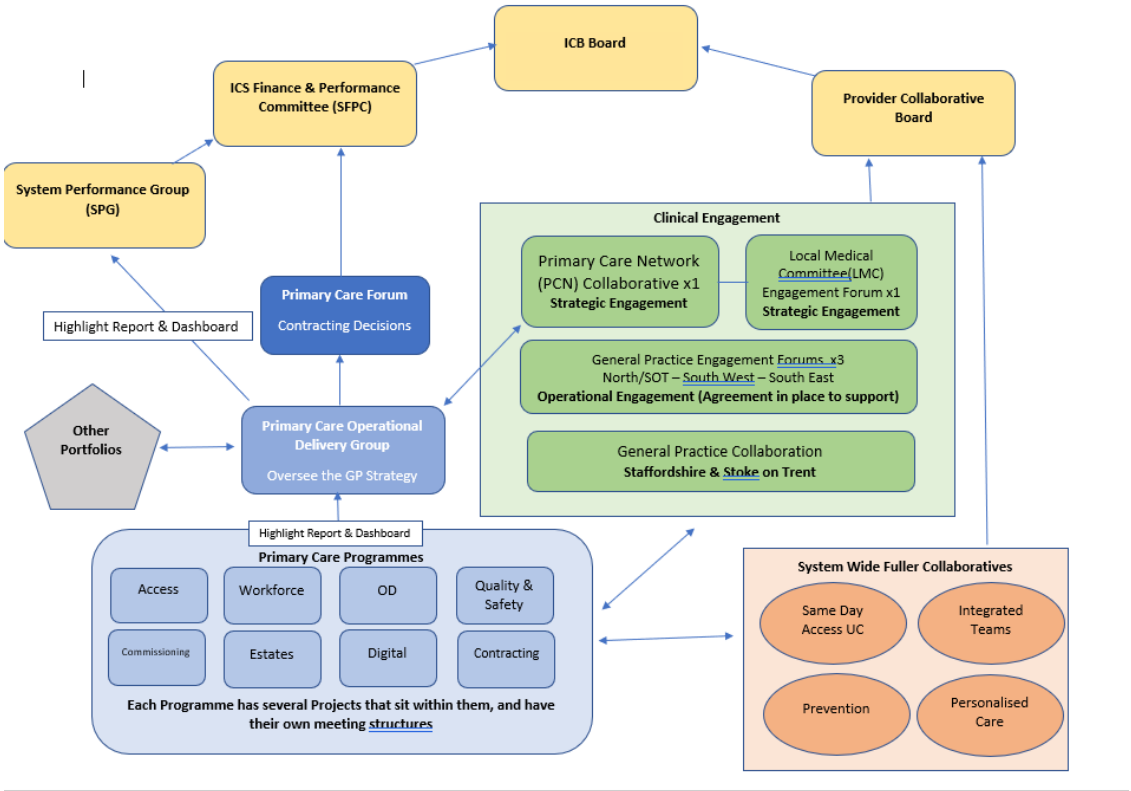
6. Delivery Trajectories & Governance

Governance

The Primary Care Access Programme has established a programme architecture and board meeting to ensure the key deliverables of the PCARP are being monitored and tracked month by month. This architecture can be seen below:



The access programme then reports into the Primary Care Operational Delivery Group (PCODG) which has links to the clinical engagement forums and the Primary Care Forum (PCF) which feeds into the ICB Board - System Finance and Performance Committee. These meetings take place on a monthly basis. Governance chart can be seen below:



Metrics and Trajectories

General Practice Appointments Data (GPAD)

The ICB works with practices and PCNs to record their appointments on General Practice Appointments Data (GPAD). We have a dedicated primary care analyst who downloads data on a monthly basis so the ICB can understand and see where there may be gaps and where practices may need further support.

PCNs and practices will accurately record all appointments and comply with GPAD guidance. Practices will review and ensure full utilisation of digital tools including telephony with call-back functionality and queuing enabled, online consultation and messaging tools.

Operating Plan 24/25 – Reviewed by month and Year to date verses activity plan.

- Appointments in General Practice (Reported in Primary Care Portfolio Dashboard)
- Percentage seen within 14 days of booking an appointment for the 8 national categories

Metrics reported monthly via the Primary Care Portfolio Dashboard

Access
Appointments in General Practice (verses plan)
Appointments in General Practice DNA Rate %
Appointments in General Practice F2F %
Appointments in General Practice Telephone %
Appointments in General Practice % Same Day
Appointments in General Practice % within 2 weeks* (8 National Categories)
Total number of social prescribing referrals in year into social prescribing link workers (cumulative)

Pharmacy First – Referrals to service from general practice
Pharmacy First – Number of Practices that have made a referral to service

Digital
% people enabled to book/cancel appts online
% people enabled to order repeat prescriptions online
% people enabled to view detailed coded records online
NHS App registrations (number)
NHS APP percentage registered
NHS 111 Provider Searching only - Booked Appointments
NHS 111 Provider Searching only - Search for Slots
NHS 111 Provider Searching only - % Slots vs Bookings
All Provider Searching - Booked Appointments
All Provider Searching - Search for Slots
All Provider Searching - % Slots vs Bookings
Number of practices with no successful booking (last 4 weeks from month end)

Quality	
CQC Ratings	Overall CQC rating - General Practice - Outstanding
	Overall CQC rating - General Practice - Good
	Overall CQC rating - General Practice - Requires Improvement
	Overall CQC rating - General Practice - Inadequate
	Overall CQC rating - General Practice - No Data Available for reporting period
Annual Patient Survey	Generally, how easy is it to get through to someone at your GP practice on the phone? (% Easy)
	How helpful do you find the receptionists at your GP practice? (% Helpful)
	Were you satisfied with the type of appointment (or appointments) you were offered? (% Satisfied)
	Overall, how would you describe your experience of making an appointment? (% Good)
	Last time you had a general practice appointment, how good was the healthcare professional at each of the following?: Giving you enough time (% Good)
	Last time you had a general practice appointment, how good was the healthcare professional at each of the following?: Listening to you (% Good)
	Last time you had a general practice appointment, how good was the healthcare professional at each of the following?: Treating you with care and concern (% Good)
	Overall, how would you describe your experience of your GP practice? (% Good)
	How easy is it to use your GP practice's website to look for information or access services?
Friends and Family Test	FFT - % Positive experience
	FFT - % GP practice submitting data

Network Contract DES – Investment and Impact Fund (IIF) guidance for 2024/25 (reported in Primary Care Portfolio Dashboard)

ACC-08: Percentage of appointments where time from booking to appointment was two weeks or less*

(Appointments delivered by the general practice under eight national appointment categories: General Consultation Acute; General Consultation Routine; Unplanned Clinical Activity; Clinical Triage; Walk-in; Home Visit; Care Home Visit; Care Related Encounter but does not fit into any other category).

7. Investment into Primary Care

The ICB is utilising the following funds to invest in practices, GPs and the wider workforce during 2024-25 to allow them the time and space to develop and evolve. Without this investment practices will be unable to release staff to attend training, webinars, workshops and invest in new technology systems as they become available.

Service Development Funding (SDF)	£2,482,000
Fellowships	£464,000
Supporting GP Mentors	£63,000
GP Infrastructure	£254,000
PCARP cloud-based telephony	£702,000
PCARP transition cover	£259,000
Transition Funding for Modern General Practice Access	£864,000

Investment plans for 2024-25 will be developed as allocations and NHS England guidance on key areas is confirmed.

PCNs are also receiving funding via the IIF to support implementation of their PCN Improvement Plans. This is paid at an average of £11,500 per month per PCN (based on list size) and is being utilised to deliver a range of initiatives as detailed under Section 9 of this Plan. In addition to the initiatives detained under Section 9, IIF funding has also been used to support delivery of the PCN Improvement Plans:

- Support role supervision
- Investing in practice resources – websites, televisions in waiting areas
- Staff training (and backfill)
- Training staff and people in digital inclusion
- PCN and practice health and wellbeing events
- Survey creation
- Capacity and access improvement plan delivery
- Transition to online consultation tools
- Review and actions on DNAs and frequent attenders
- Transition to cloud based telephony
- Engagement and actions on non-patient facing workload
- Online patient registration
- GPAD coding and training

GP Support Team

The GP Support Team offers direct advice, guidance and support to our GP practices, sharing good practice and experience to facilitate improvements in general practice.

The GP Support Team is involved in our work on the GPIP Support Level Framework, offering facilitated assessments to our GP practices to help them identify how the Support Level Framework can give them an understanding of what they do well and how they might benefit from development support to do better in other areas. The GP Support Team will also be

providing a local Intermediate GPIP offer to 20 GP practices to compliment the provision available nationally.

Finance Assurance

Manual payment will be made to practices ensuring funding reaches practices in the most timely and efficient manner, as opposed to practices having to submit an invoice to receive such funds. Expenditure will be monitored on an ongoing basis and discussed via monthly budget meetings between both the Finance and Primary Care Team whilst ensuring the funding is being utilised in line with national guidance. Updates will be reported to the Primary Care Forum.

The ICB is also working with PCNs and Practices to identify where funding may be required and assessing the modern general practice element to support practices implement their new models.

8. Communications & Patient Engagement

Progress to Date

Since the beginning of 2021, the ICB has been engaging people and practices to tailor communications activities in a way that will increase understanding and knowledge around how general practice is working in a post-COVID world.

Our communications team has been liaising with several patient groups and practices to ask what the key issues were that primary care was facing. From this, feedback was shared with more groups and asked if there was anything that had been missed. This gave us the starting point for our 'post COVID evolution of general practice' public campaign. This campaign included elements such as:

- Videos showing new staff roles in local practices: Meet the Primary Care Team at Wolverhampton Road Surgery – YouTube
- A poster outlining why GP practices were operating the way they were taking in to account that COVID-19 still plays a factor in how people could be seen
- Social media assets for surgeries and partners to use
- Posters outlining the volume of appointments and types of appointments in general practice post COVID

Our strong communications approach has been achieved by undertaking public surveys, testing campaign messaging and imagery with members of the public, developing materials with practices, and asking for feedback from local voluntary sector partners.

The ICS People's Panel was used for patient/public feedback, and an online session was held with GPs. There were 131 responses from members of the People's Panel, and the engagement report infographic can be viewed in appendix 3. By listening to the public, we were able to adapt our campaign for the better.

There are a number of campaigns that have been launched following the same methodology and fall part of the improving access communication delivery plan, these are outlined below as headlines, further detail can be found on the ICBs websites and Facebook pages.

Together against abuse	Access Campaign Tagline "know"	GP Support Team	The NHS App and its uses
Pharmacy Minor Injuries	Pharmacy oral contraception	Self-Referral to Audiology	Self-Referral to Digital Weight Management

Since the launch of the PCARP, the ICB has shared the primary care campaign plans at regional NHSE/ICB meetings and have been highly commended as best practice for communicating the contents of the delivery plan. As such, regional communications colleagues have presented our local plans to national NHSE communications colleagues, highlighting our local system is advanced compared to neighbouring systems. In terms of engagement and communications efforts to deliver on the communications objective set out in the delivery plan, ongoing monitoring will continue to build on these plans to ensure they are effective.

Delivery Plans

Campaign	Timescales
Use of national NHS app campaign materials promoting NHS App/library collab	November - ongoing
Over the counter medicines and vitamins campaign materials	Posting organically November – ongoing Paid for advertising across Meta, out of home advertising, and radio ads going out for 8-10 weeks across November, December and into January 2025
National pharmacy oral contraception programme campaign: Initial comms to GPs Comms to ICB staff Public campaign materials in use	 March May August – ongoing
National pharmacy blood pressure checks campaign	Ongoing
Local Primary Care Access Campaign (paid-for activity): Phase one (access/care navigators/ARRS roles/staff abuse/other ways to access care) – social media ads (Facebook and Instagram), audio ads via Spotify, out-of-home ads, partner toolkit, primary care toolkit, webpage and press release Phase two (as above) – social media ads, continuation of webpage, printed materials to 142 GP practices in SSOT Phase three (ARRS roles) – suite of videos (explaining individual roles, also available in BSL and translated captions on YouTube), updated webpage, social media ads (Facebook and Instagram), radio ads, out-of-home ads, partner toolkit, primary care toolkit, podcasts and press release Phase three (ARRS roles) social media posts Phase four – focussing more of digital access and how people can access their healthcare online and through the NHS app. Recognising that this is not always possible for some cohort	 Summer 2022 Autumn/winter 2022 Summer 2023 Sharing organically across social media 2024 – ongoing in place of phase four materials. Planned to pause for festive period Awaiting funding to be granted.
Self-referral programmes: Digital weight management Audiology Podiatry/physio/falls service/wheelchairs/other equipment services	 Self-referral ended in March 2024. Awaiting evaluation of the self-referral pilot, with potential to bring this back. October – ongoing Comms to take place once these services launch locally – no social media going out currently, as comms have not been given the go ahead for any further self-referral services
Use of national NHS111 mental health option 2 campaign materials	October - ongoing
Use of Pharmacy First ‘common conditions’ campaign materials	Paused November, awaiting refresh of materials

Use of national GP online consultations campaign materials	Expected 2024/25

9. Conclusion

The ICB General Practice Five Year Forward Strategy outlines our commitment to make Staffordshire and Stoke-on-Trent one of the healthiest places to live and work. It recognises the challenges that general practice faces where demand is greater than its capacity, impacting on a stressed and overburdened workforce and on the experiences of patients. This pressure is then felt within the wider healthcare system due to people having to seek alternative ways to support their needs.

Transitioning to a new way of working as an Integrated Care System (ICS) provides a unique opportunity to reset our relationship with people and communities to one where people are treated as active partners in their own health and wellbeing rather than passive recipients of services. Understanding the views of local people will help to explore ideas such as the smarter use of technology, providing care in different settings closer to home, and look for new ways to reduce health inequalities.

The aim is to support general practice as a critical partner of the health and care system not only to sustain, but to flourish, overcoming the challenges of workload, workforce and estates and embracing the new roles and opportunities set out in the Fuller Stocktake Review and national policy.

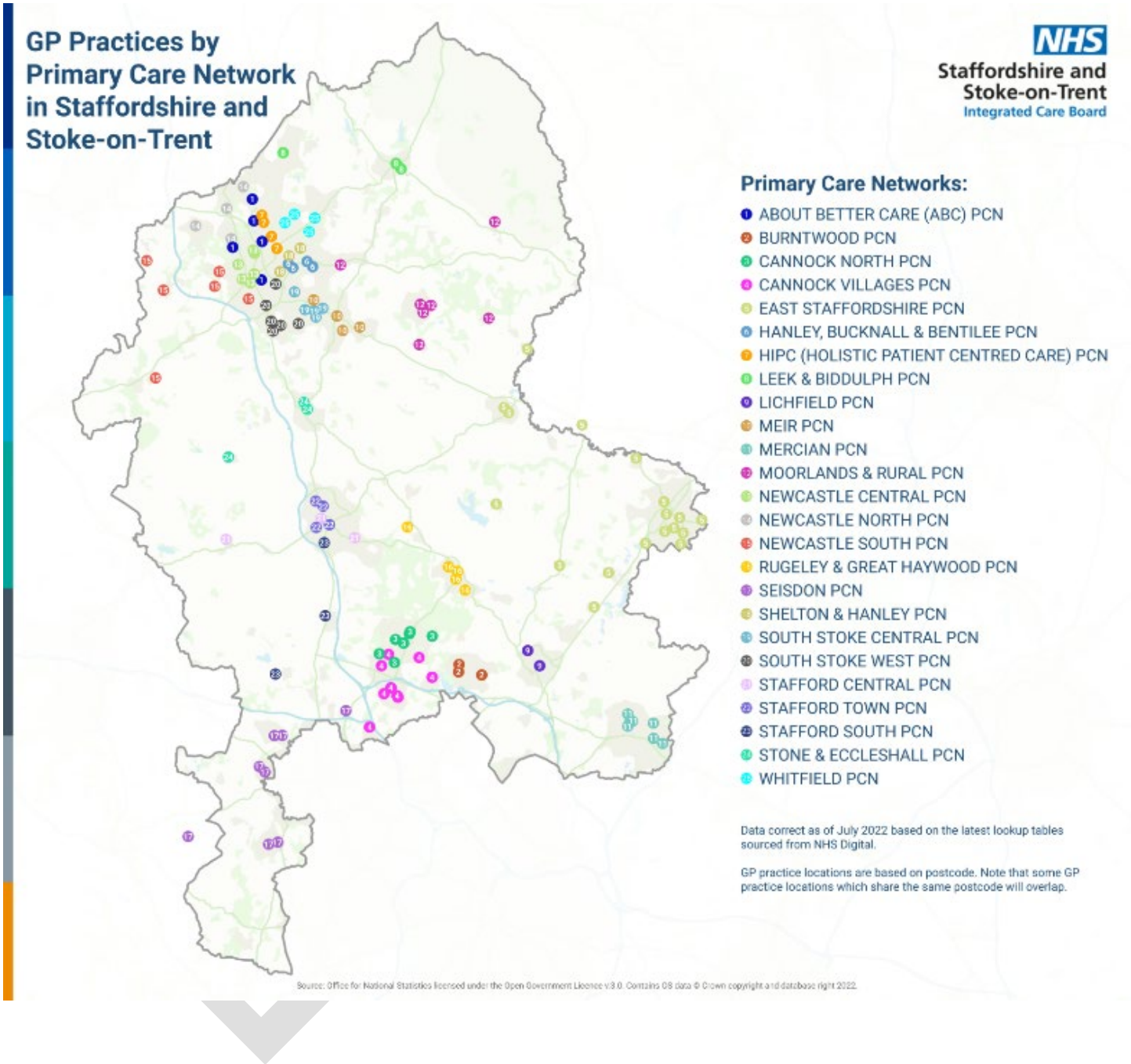
The System Level Access Improvement Plan is Staffordshire and Stoke-on-Trent's response to delivery of the requirements in the National Delivery Plan for Recovering Access to Primary Care and demonstrates the system commitment to improving patient experience of access to primary care. The plan also supports the Government commitments to deliver 50million more appointments in general practice and increase general practice staffing numbers.

Progress continues to be made on the elements within our system plan and this will be monitored with regular updates provided to NHS England and an update on progress and delivery of the System Level Access Improvement Plan will be presented to the ICB Board in November 2024. Whilst work will continue to deliver the whole plan, key areas of focus for 2024-25 include:

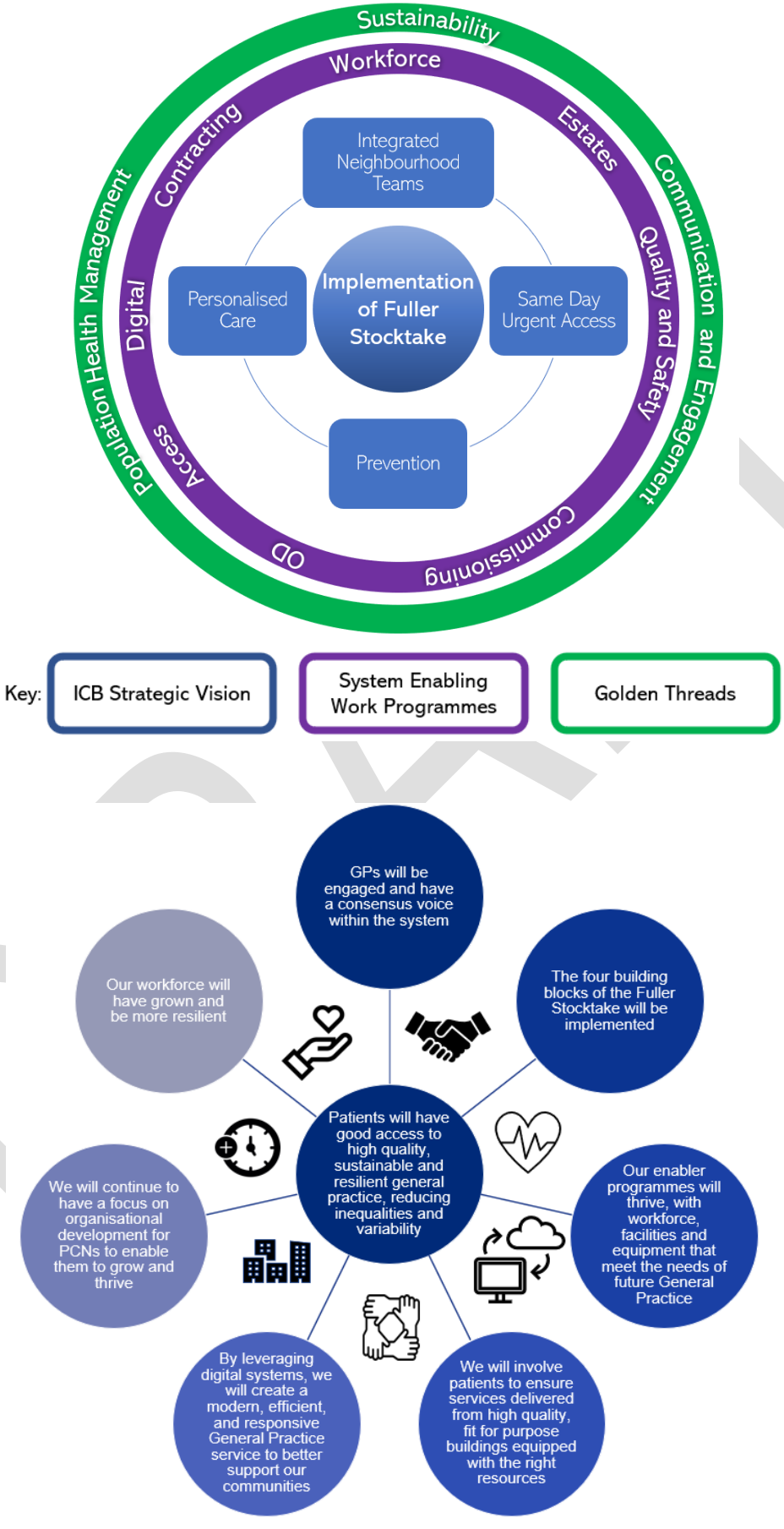
- Empowering patients through the increased use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions, expand Self-Referrals to appropriate services and expand uptake of Pharmacy First services
- Implementation of Modern General Practice Access – digital telephony, usable and accessible online journeys for patients and faster care navigation, assessment, and response
- Building Capacity - continue with the expansion and retention commitments in the Long Term Workforce Plan (LTWP)
- Cutting Bureaucracy - further progress on implementation of the four Primary Care Secondary Care Interface recommendations and make online registration available in all practices

10. Appendices

Appendix 1 Staffordshire and Stoke-on-Trent ICB Primary Care Network Map



Appendix 2 General Practice Strategy



Appendix 3 Health Inequalities

Quintiles Best Worst | Better 95% | Similar | Worse 95% | Compared with England

	Time Period	Staffordshire	Stoke-on-Trent	West Midlands	England
Life expectancy at birth-Male	2018 - 20	79.3	75.9	78.5	79.4
Life expectancy at birth-Female	2018 - 20	83.1	79.7	82.5	83.1
Healthy life expectancy at birth-Male	2018 - 20	63.1	55.9	61.9	63.1
Healthy life expectancy at birth-Female	2018 - 20	60.7	55.1	62.6	63.9
Reception: Prevalence of overweight (including obesity)	2021/22	25.0	25.4	23.7	22.3
Year 6: Prevalence of overweight (including obesity)	2021/22	37.8	44.7	40.8	37.8
Percentage of adults (aged 18+) classified as overweight or obese	2020/21	68.7	68.7	66.8	63.5
Percentage of physically active adults	2020/21	65.9	57.5	66.8	65.9
Smoking Prevalence in adults (18+) - current smokers (APS)	2021	9.9	16.5	13.8	13.0
Self-reported wellbeing - people with a low satisfaction score (%)	2021/22	7.6	4.9	5.2	5.0
Infant mortality rate (per 1,000)	2018 - 20	5.0	6.5	5.6	3.9
Premature mortality in adults with severe mental illness (SMI)	2018 - 20	103.8	192.7	110.7	103.6
Suicide rate	2019 - 21	11.9	16.4	10.7	10.4
Deprivation score (IMD 2019)	2019	16.6	34.5	25.3	21.7

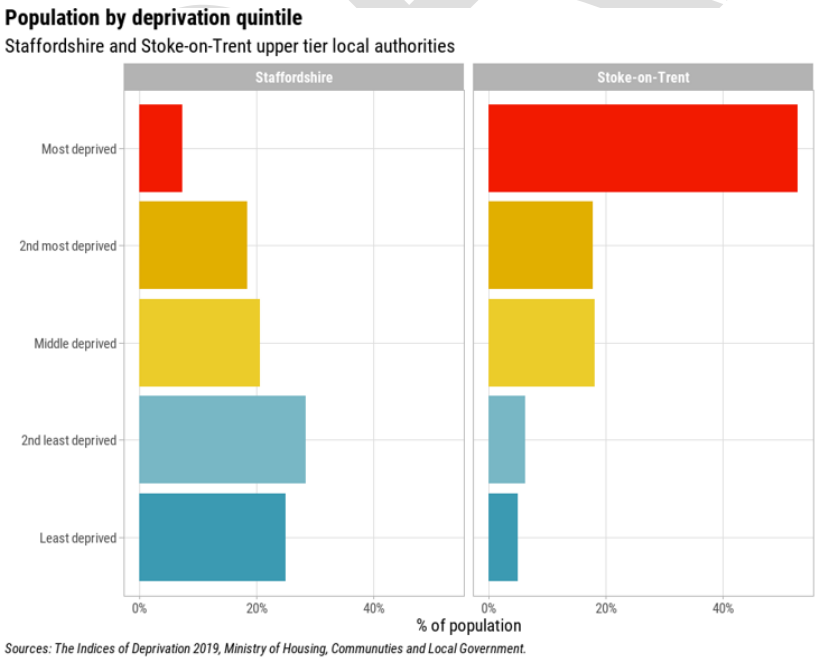
Data Source: Fingertips PHE - https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Ethnic Group

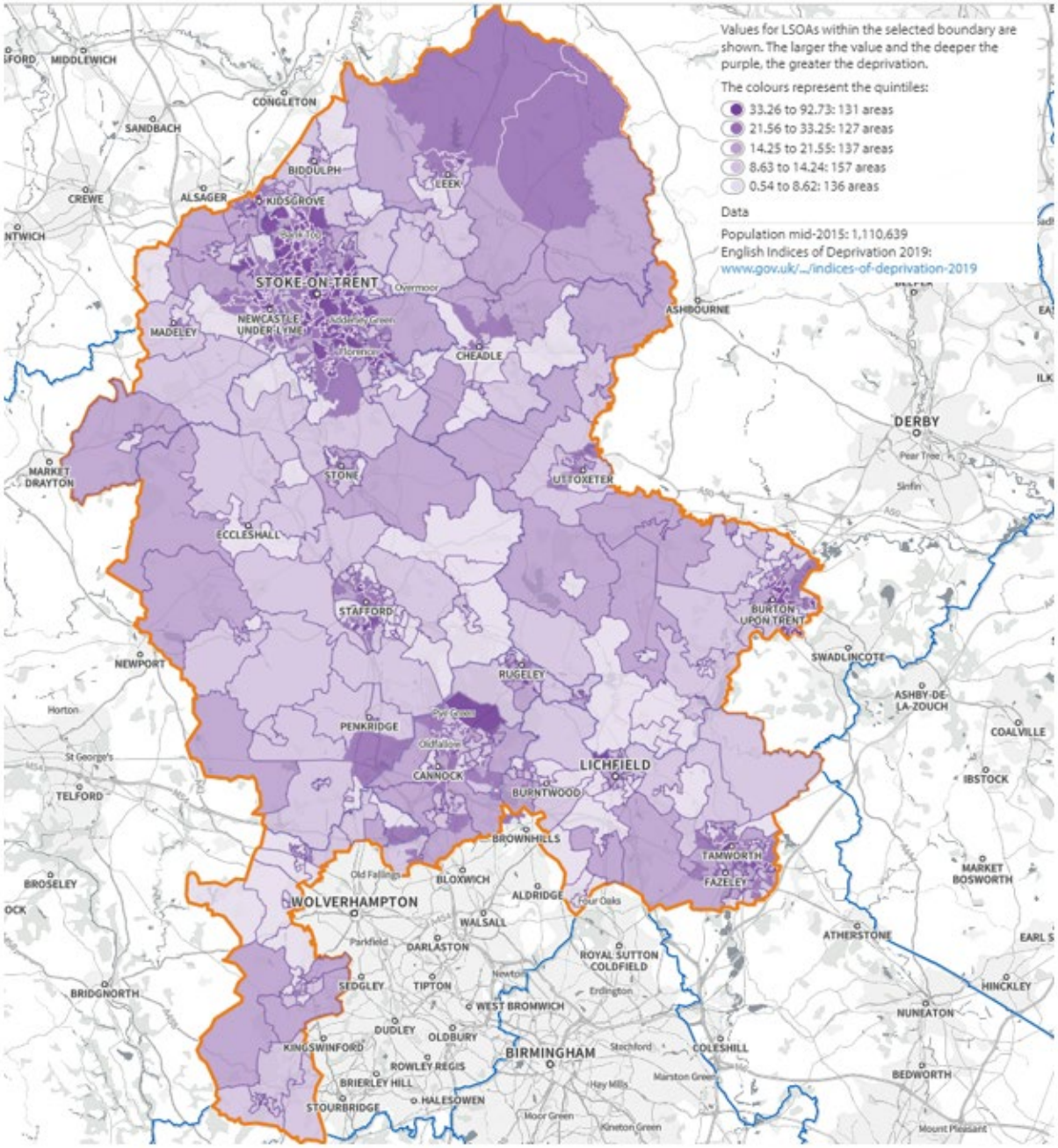
Area name	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	White	Other ethnic group
Stoke-on-Trent	9.9%	2.7%	2.3%	83.5%	1.7%
Cannock Chase	1.2%	0.5%	1.4%	96.6%	0.3%
East Staffordshire	9.3%	1.1%	2.2%	86.3%	1.1%
Lichfield	2.3%	0.6%	1.9%	94.8%	0.4%
Newcastle-under-Lyme	3.8%	1.0%	1.6%	92.9%	0.7%
South Staffordshire	2.8%	0.9%	2.0%	93.7%	0.5%
Stafford	3.0%	1.1%	1.9%	93.4%	0.7%
Staffordshire Moorlands	0.7%	0.2%	0.9%	98.0%	0.2%
Tamworth	1.4%	0.6%	1.9%	95.8%	0.4%
SSOT Total	**4.8%**	**1.2%**	**1.9%**	**91.3%**	**0.8%**
England & Wales	**9.3%**	**4.0%**	**2.2%**	**81.7%**	**2.1%**

Source: 2021 Census

Deprivation



Sources: The Indices of Deprivation 2019, Ministry of Housing, Communuties and Local Government.



Source: Shape Atlas - https://shapeatlas.net/

Appendix 4 Themes from PCN Access Improvement Plans

25 PCN Access Improvement Plans were submitted to the ICB and were approved in July 2023.

Patient Experience of Contacting GP Practices

- Development of internal patient surveys to support practices to understand patient views and potential improvements in advance of the publication of the 2024 National Patient Survey results.
- Deep dives into the National Patient Survey results for 2023
- A commitment to undertake care navigation training to improve / implement care navigation for people.
- PCN plans to record Friends and Family data to ensure all GP practices are submitting this in line with contract requirements
- Practices plans to communicate the Friends and Family survey to people in different formats - text, paper, online

Ease of access and demand management

- PCN plans for utilisation of PCN Digital Leads to drive forward CBT and online consultation solutions
- Exploration of alternative triage models
- PCN pilots around on the day access
- PCN intentions to implement Modern General Practice Access models

Accuracy of recording in appointment books

- Planned Improvements on GPAD recording
- Plans to follow national guidance on National Appointment Slot mapping
- Review of activity recording for ARRS roles to ensure appropriate activity is mapped and recorded and roles match smart cards
- Practice staff and ARRS staff to receive training on recording appointments in relevant appointment books to accurately capture the workload/ appointments
- Plans to regularly review GPAD dashboard data

General Themes

- PCN / practice intentions to explore the Support Level Framework
- Plans to seek out and share good practice within and between PCNs. A number of PCNs will also look at variances between practices - what are the differences, why and how can practices be consistent in their approach
- Plans to Monitor and review PCN access improvement plans

Appendix 5 Primary Care Communications People Panel Results

Staffordshire and Stoke-on-Trent Integrated Care System

MAKING YOUR VOICE COUNT

People's Panel: Primary Care Access

In April 2022, we asked our People's Panel what they thought about our ideas (designs and messages) to help people understand the different ways they can access healthcare.

131 people responded to our survey:

- 45-54 **23%**
- 55-64 **23%**
- 65+ **29%**

11% receive some form of benefits

28% have some form of disability or long term health condition

Feedback on our designs and messages:

General Practice:

- **68%** use the term 'GP surgery' and 29% use the term 'GP practice' (rather than 'primary care')
- From 2 options, **66%** preferred design A
- From 3 options, **60%** preferred the message '... working in ways which are beneficial for patients, for staff, for you...'
- From 2 options, **75%** preferred the tagline 'Know how we're working'
- Many did not like the word 'efficient' as it felt inappropriate, impersonal and suggests a focus on cost cutting rather than on patient care

Staff abuse:

- From 2 options, **86%** preferred the message 'Care about us, caring for you. Our staff are human too'
- From 3 options, **56%** preferred the tag line 'Know your words, know your actions'
- From 3 options, a majority of **44%** preferred the ending 'Support your NHS staff and stand with us against abuse'

NHS App:

- From 2 options, **74%** preferred the message 'The NHS app is there for you to help access your healthcare. You can use the NHS app 24/7 to: Book appointments, Order repeat prescriptions, View your health record, Get health advice.'
- From 3 options, **52%** preferred the tagline 'Know how to access your care'

Extended workforce:

- From 2 options, **70%** preferred the message 'Your GP is supported by a qualified team of health professionals who will support you with your health needs'
- From 3 options, **60%** preferred the tagline 'Know who can help'

Care navigation:

- From 2 options, **88%** preferred the message 'You may be asked questions about you and your health. This is to ensure we find you the right care'
- From 3 options, **63%** preferred the tagline 'Know why we ask'

* All bases are unweighted

Appendix 6 – GP Improvement Programme – Local Support Level Framework and Proposed Intervention Support

Domain	Module Building Blocks	Intervention Support
Supporting access to the right person or service	• Understanding and Use of Demand and Capacity Data • Use of Care Navigation • Use of Online Consultation Systems, Messaging and Digital Appointment Self Booking Tools • Use of Digital Patient Facing Services: ❖ viewing electronic record ❖ ordering repeat prescriptions ❖ communicating with GP practice ❖ booking GP appointments ❖ checking test results ❖ registering with GP practice ❖ NHS App • Website Maturity • Patient Communications • Improving Telephony Journeys • Management of Non Patient-Facing Workload • Long Term Condition Management • High frequency users	• Hands on training and intervention • Implementation support such as development of implementation processes including governance • clinical review of triage system • System development training and support • Benchmarking and improvement tool utilisation • Facilitated reviews of data • Training and support to develop strategies. i.e. communications strategy • Measurement of non patient facing work such as interpretation of data and work plan development • review of governance and skill mix • review of recall systems and risk stratification • Develop a MDT approach to managing high frequency users
Quality and Safety	• Continuity of Care (Ongoing relationship with a clinical team or a	• Training ad utilisation of RCGP toolkit • Review of current alert management processes

	member of a clinical team) • Prescribing Safety • Use and Understanding of Prescribing Data • Learning and Quality Improvement Culture • Safety Climate	• Developments of alerts management processes • Review of current high risk drug management processes • Development of high risk drug management processes • Educational session on the use and understanding of prescribing data, (Open prescribing.net/EPAC and supportive supervision and peer review) • Educational session on learning and quality improvement • Development of QI programme • Scoping of practice • Educational sessions for all staff • Review/ develop proactive systems to manage clinical risk
Leadership and Culture	• Leadership Structure • Leading with Care • Vision and shared purpose	• Organisational development session • Education session on supervision • Organisational development session (on leadership and culture) • Review and develop a communication strategy • Review processes and provide / support supervision documentation
Stakeholder Engagement	• Engagement With PCN • Patient Feedback • Patient Engagement and Involvement	• Organisational development sessions • Educational session on QI from patient feedback • Support the effective utilisation of patient engagement • Sharing experiences from other practices

Workforce	• Use of Wider Roles including ARRS roles • Staff Turnover and Sickness Rates • Succession Planning	• audit sessions on workforce mix • Review of used/ unused appointment slots (internally and externally booked) and review whether booked appropriately • Educational session on data interpretation • Implementing exit interviews • Strategic development sessions
Indicative Behaviour	• Current CQC Rating • Patient Survey Data (Overall experience section) • QOF data	• Action planning for those practices who are inadequate or requires improvement

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**21 November 2024**					
Title:	**System Surge Plan**					
Presenting Officer:	Phil Smith					
Author(s):	Tom Bailey					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☒	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* Finance aspects to be scoped as plan is developed.				
Any impacts on ICB Undertakings?	**Yes / No**	YES *If Y, are those signed off by and date:* Underpinning approach to ICB planning for Winter and periods of Surge.				
Appendices:	System Surge Plan 2024/25 PowerPoint Slide deck presentation					

(1) Purpose of the Paper:

The Integrated Care Board is ask to ratify the decision of the System Finance and Performance Committee and confirm approval the System Surge Plan for 2024/25.

The System Surge plan articulates the system approach to mitigating the impacts upon all facets of the UEC system during periods of increased UEC demand, specifically during the forthcoming winter period.

The System Surge Plan describes three core principles of the system approach to surge and winter planning, namely;

- The System Capacity plan
- The System Escalation plan
- The System Workforce plan

Each component is designed to support system partners in proactively putting into place provision to address the forecast increases in demand expected during the winter period. The forecast activity has been calculated utilising the System Capacity model and builds upon previous work to forecast bed requirements and activity levels during the forthcoming months.

The collective development of the System Surge plan outlines the many initiatives and schemes that have been or will be implemented to provide mitigation to these pressures and to facilitate the system collective efforts to manage demand during winter. The schemes outlined within, and funded via, the

System Surge plan represent additionality to those actions taken by providers as part of internal winter planning measures.

These schemes are costed, and the Finance appendix illustrates the costs, impact and overall budget position. The winter/surge budget has been assessed with regard to current system recovery plan and financial constraints, balanced against optimising patient safety and mitigation of excess demand.

The Integrated Care Board is asked to review the components of the System Surge Plan in order to ensure that all aspects have been considered and addressed adequately and ratify the decision of the System Finance and Performance Committee to approve the System Surge Plan.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
UEC Board (S/D)	22/08/2024
UEC Board (A)	26/09/2024
UEC Clinical Advisory Group (A)	26/09/2024
System Quality and Safety Committee (A)	09/10/2024
SSOT Health and Clinical Senate (A)	10/10/2024
UHNM Trust Board (A)	10/10/2024
SOTCC Operational Business Meeting (A)	29/10/2024
System Performance Group (A)	30/10/2024
MPFT Trust Board (A)	31/10/2024
Finance and Performance Committee (A)	05/11/2024

(3) Implications:	
Legal / Regulatory	System-wide risk relating to non-delivery of Winter Plan. Performance implications will necessitate regulatory oversight and scrutiny.
CQC / Patient Safety	The System Escalation plan component of the System Surge Plan is intended to outline and define system responsibilities for risk management and escalation. Quality involvement from all partners will be integral throughout development of the plan – the Quality & Safety Committee is to receive, review and approve the system surge plan to mitigate risks. Quality Impact Assessment will be undertaken. All providers are CQC registered.
Financial (CFO-assured)	Spend commitments will be regularly presented to system CFOs throughout the development of the plan – linked to Surge/Winter Plan initiatives and schemes. Any additional funding received from NHSE will be assessed initially by the system surge MDT, with appropriate assurance and reporting mechanisms put into place. Monthly reports to UEC Board and UEC Delivery Group are in place to ensure oversight and assurance. The ICB Finance team is a quorate member of the System Surge MDT and UEC Delivery Groups. The Finance and Performance Committee will be asked to approve the spend commitments once finalised, post discussion and agreement in principle at UEC Board and System Performance Group and with System CEOs.
Sustainability	Risks relating to de-escalation and ensuring funded schemes are stood down in timely fashion will be added to Risk Register as in previous years. The System Surge Plan will extend into Q1 2025/26 to ensure de-escalation trajectories are built into the plan at the outset.
Workforce / Training	Workforce risks are managed via System Workforce plan & escalated via Risk Register.

Equality & Diversity	Equality Impact Assessment to be undertaken. No current risks identified.
Due Regard: Inequalities	Impact assessments will be undertaken for all aspects of the System Surge/Winter plan to ensure adequate assessment of inequalities and access to services. Initiatives will be developed with the aim of providing equality of care for all stakeholders and patient groups. Where possible, geographic equity has been implemented to ensure equal access to primary care and other area-specific services.
Due Regard: wider effect	The wider effects of the approval and implementation of the System Surge/Winter plan are manifold are relate to all parts of the health system within Staffordshire and Stoke-on-Trent. While the plan will articulate the approaches utilised to address access to urgent and emergency care, the initiatives and schemes to be developed will aim to facilitate an improved patient journey, experience and, most pertinently, patient outcomes. To achieve this, a holistic view of the UEC pathway will be considered and action taken to ensure that all points in the patient journey (from admission avoidance to ED 'front door' and all the way through to home first discharges and social care access and support) are supported to ensure optimal patient flow is in place to mitigate the impacts of periods of surges in demand and winter pressures. The System plan will also seek to ensure the protection of Elective Care activity as a requisite foundation to maintain system performance with regard to elective recovery.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	Completed
	QIA	☒	☐	☐	*If N, why* Click or tap here to enter text. *If Y*, Approved off by QIA Panel on 29/10/2024
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

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

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

The ICB System Surge Plan has been developed in collaboration with all System partners to map out a Staffordshire and Stoke-on-Trent wide plan in advance of winter. The proposed approach is to present the plan in three primary component parts;

- System Capacity Plan – Containing details of all schemes (including those funded by the ICB, system partner organisations and, if made available, via NHSE winter monies) designed to provide

increased capacity over the winter period, the impacts of those schemes, timescales and funding source(s).

- System Escalation Plan – Outlining the measures to be taken when there are extreme patient safety risks within the system. The Escalation plan is designed to minimise and mitigate risk by sharing risks across the system.

- System Workforce Plan – Setting out the workforce plan to support delivery of the Winter Plan, including additional workforce recruitment and retention initiatives, enhanced bank rates and provider and system level activities to manage workforce risks. The number of additional staff required per each scheme is also presented alongside Risks and Mitigations to ensure a realistic approach to winter.

In addition, the System Surge Plan contains information outlining:

- Additional approved capacity schemes
  Those schemes that, upon implementation, will offer tangible capacity.

- Additional approved enabling schemes
  Those schemes that have a significant impact upon management of increased demand for UEC services, but do not provide a physical bed space. Included within these schemes is the system Integrated Care Coordination (ICC) offer. This provides a single point of access (SPoA) and is integral to system responsiveness and management moving forward.

- Additional approved enabling schemes provided by alternative budgets
  These schemes are extremely important to delivery of the system surge plan and have been approved for implementation but are funded via existing and alternative budgets. The schemes within this section are already accounted for in respective baseline allocations.

- A summary of all proposed schemes and initiatives and a clear indication of whether the respective scheme is being implemented for the first time or has been utilised previously to good effect to mitigate excess demand pressures.

At the forefront of all UEC planning work is the commitment to address ambulance handover delays and to take forward initiatives designed to facilitate 45-minute ambulance handovers. This key regionally led workstream aims to mitigate ambulance hours lost awaiting handover and is integral to all UEC delivery.

The system surge plan outlines UHNM commitments to maintaining quality and patient safety throughout the winter period and a thorough view of ‘in hospital’ activities and initiatives to mitigate excess demand and surge. Included within this element of the system surge plan is work relating to improving hospital processes. This work is underpinned by the supporting policies relating to corridor care, Your Next Patient (YNP), the ED rapid offload policy and hospital standards work.

Contained within the system surge plan is a summary of all Mental Health and Children and Young People (CYP) workstreams and considerations being undertaken in order to ensure a holistic approach and management of system capacity during the winter surge period.

All schemes and initiatives within the System Surge plan have been costed and subject to scrutiny via the illustrated governance/approval routes. All spend commitments are within the available System budgets.

Within the appendices of the system surge plan information relating to a fuller overview of the in hospital, out of hospital, local authorities, mental health and primary care approaches to winter planning are included alongside the system Communications plan.

The System Surge Plan has been developed via a Multidisciplinary Team (MDT) approach, ensuring that all system partners, and ICB directorates, are sighted on activities, initiatives and mitigations planned

across the system. This level of collaboration and engagement is designed to ensure that action taken to address issues in one part of the system do not negatively impact upon another.

Development in this way seeks to ensure that clinical, finance, patient safety and communications partners will be involved and sighted at all stages to ensure a holistic system approach to development of the plan.

Underpinning the development of the System Surge Plan are the outputs from the 2023/24 Winter Lessons Learned event which the ICB hosted and facilitated in April 2024. The actions and outputs are outlined and at the forefront of system planning during this cycle.

In addition, all System Risks (as held and reported via the ICB Risk Register) are outlined within the plan to ensure that all partners and providers are sighted on pertinent risks and the mitigations in place ahead of the anticipated surges in demand and winter pressures.

The agreed governance route for all decisions relating to the development of the System Surge plan, and the sign-off processes in place is included to ensure oversight, scrutiny, challenge and review from a range of organisations, non-executives and experts to foment development of the plan and ensure that it adequately addresses considerations from across the ICS.

The scale of the challenge faced across the ICS during the forthcoming winter period is illustrated utilising outputs from the System Capacity model. These outputs show the scale of anticipated excess demand across the system and focus upon the anticipated acute pressure expected to be placed upon medical beds at the Royal Stoke Hospital site. The forecast demand represents an increase upon levels experienced in 2023/24 but the primary pressure point (namely medical bed base at RSUH) mirrors that observed in previous years.

Modelling for 2024/25 does however suggest that there are significant increases to excess demand expected at both County Hospital and Queen's Hospital, Burton. The system surge MDT meeting has ensured, and will continue to ensure, that considerations for these sites are fully explored and mitigated via the system surge plan and an illustration of the forecast pressures are included within the presentation pack.

The system approach to mitigating bed pressures is visually presented via waterfall diagram to illustrate how each of the agreed "capacity" schemes will offset a proportion of the expected demand. Where capacity is situated outside of the acute hospital, an acute bed equivalent value has been calculated.

In addition, the System Demand Management collaborative is represented at the System Surge MDT group and demand management initiatives are assessed and, where appropriate, included within the surge plan. The demand management focus this year is on development and building capacity to provide tangible impact in the medium term, aligned closely to the system medium term planning work stream.

Any additional funding that may become available will be assessed and scoped by the System Surge MDT meeting, with appropriate reporting and governance oversight of proposed decisions via the System Delivery Group, UEC Board and the system Finance and Performance Committee.

A full Quality Impact Assessment (QIA) and full Equality Impact Assessment (EIA) have been undertaken and approved to ensure consideration of the impact of schemes from quality, patient safety and equality perspectives.

The ICB approach to System Surge planning is once again based upon adherence to the ICS Partnership Leadership Compact. The compact will be presented regularly at the outset of all meetings and governance forums to ensure that, regardless of levels of system pressure, that the wider system team works in a respectful and progressive manner.

Note: the plan is an evolving document and will be under constant review.

Review and scrutiny of the system surge plan will continue throughout implementation and delivery with recalibration as required during periods of escalated demand.

The full System Surge Plan is available to view here: **System Surge Plan 2024/25**

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to: Ratify the decision of the Finance and Performance Committee and confirm approval of the System Surge Plan for 2024/25.

1. Introduction

The Staffordshire and Stoke-on-Trent ICS System Surge Plan has been developed in partnership with all constituent organisational partners within the ICS.

This includes:

- University Hospital North Midlands (UHNM)
- Midlands Partnership University Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare Trust (NSCHT)
- Staffordshire County Council
- Stoke-on-Trent City Council
- University Hospitals of Derby and Burton (UHDB)
- West Midlands Ambulance Service (WMAS)

Engagement with provider partners that serve the ICS population but sit within other ICSs has been carried out to ensure a joined-up approach and to factor in relevant considerations from partner organisations.

Additionally, partner organisations from the voluntary care sector are engaged via the Integrated Discharge Hub (IDH) and South Staffordshire Transfer of Care hub to facilitate referrals and ensure that the full breadth of VCSE offers are available to patients and that utilisation is maximised.

The System Surge Plan is presented within three distinct comprising parts, namely the;

- System Capacity Plan
- System Escalation Plan
- System Workforce Plan.

An overview and summary of these component parts of the System Surge Plan is included within this paper.

The System Surge Plan has been developed via a collaborative multi-disciplinary team (MDT) approach to ensure engagement, awareness and involvement of all system partners. The inextricable links between services provided by system partner organisations, and the ramifications of targeted improvement work within one sphere of the wider system, dictates that this involvement has been critical to ensuring the buy-in and sign-off of the Plan by all system partner organisations.

The System Surge Plan has received enhanced review and scrutiny and has been subject to governance approval from a range of internal and external governance forums. The System Surge Plan has been presented for approval to the below forums:

- UHNM Trust Board meeting (10 October)
- North Staffordshire Combined Healthcare Trust Board meeting (30 October)
- MPFT Trust Board meeting (31 October)
- Stoke-on-Trent City Council Operational Board Meeting (29 October)

- Staffordshire County Council Health and Care Senior Leadership Team (5 November)
- System Health & Care Clinical Senate (10 October)
- ICB Urgent and Emergency Care Board (26 September)
- ICB Urgent and Emergency Clinical Advisory Group (26 September)
- ICB System Performance Group (30 October)
- ICB Finance and Performance Committee (5 November)
- ICB System Quality & Safety Committee (9 October)
- People, Culture and Inclusion Committee (13 November)
- ICB Public Board (21 November)

In addition, the System Surge plan was presented to NHS England, during the Winter Assurance visit undertaken at Royal Stoke Hospital on 25 October.

The System Surge Plan is a 'live' document and will be under continual review to ensure that all activities and decisions are made to enhance the system response to the forthcoming winter period.

The System Surge plan links closely with the national UEC recovery and improvement plan and is developed and implemented alongside the wider work streams of the Delivery portfolio.

All relevant System Risks (as held and reported via the ICB Risk Register) are outlined within the plan to ensure that all partners and providers are sighted on pertinent risks and the mitigations in place ahead of the anticipated surges in demand and winter pressures.

2. NHS England Winter Assurance visit

As part of the regional oversight arrangements, a team from NHS England carried out a system Winter Assurance Visit to Staffordshire and Stoke-on-Trent at the Royal Stoke hospital site on Friday October 25th.

The visit included winter assurance presentations from system partners, followed by a patient pathway walkthrough, initial feedback and discussion and a formal written summary of the visit and associated actions.

Formal NHS England feedback highlighted the positive assurance NHS England colleagues took regarding system leadership, noting the "clear ownership and engagement from key partners (including local authorities)", as well as the strong patient safety focus and prioritisation with "effective risk sharing mechanisms in place across the care pathway".

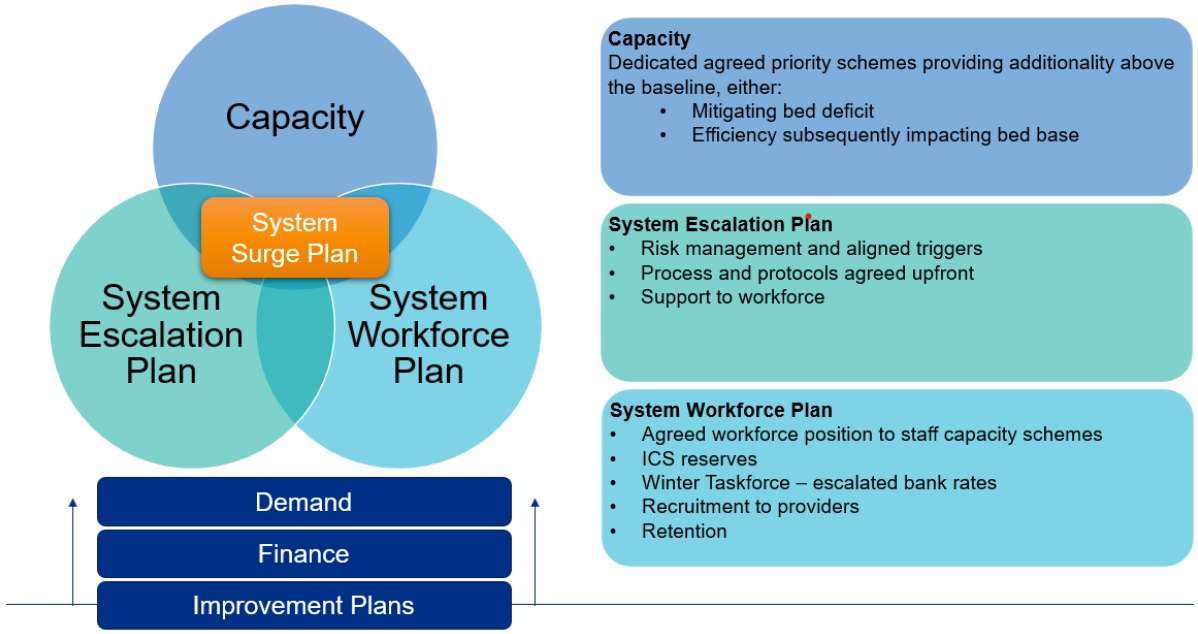
Positive feedback was also received regarding staff engagement, strong Standard Operating Procedures (SOPs), inpatient capacity modelling, streaming and redirection processes and the system workshops to further develop the System Escalation Plan.

NHS England also reiterated key areas for system focus relating to adherence to policies and procedures in place (such as the Hospital Full protocol and UHNM Trust internal standards), alongside continued focus on ambulance handovers, escalation, frailty services and ensuring that the delivery of the system surge plan is calibrated to meet operational realities and emergent challenges.

3. System Winter Plan Components

The three component parts of the System Surge Plan are briefly described in Figure 1 (below):

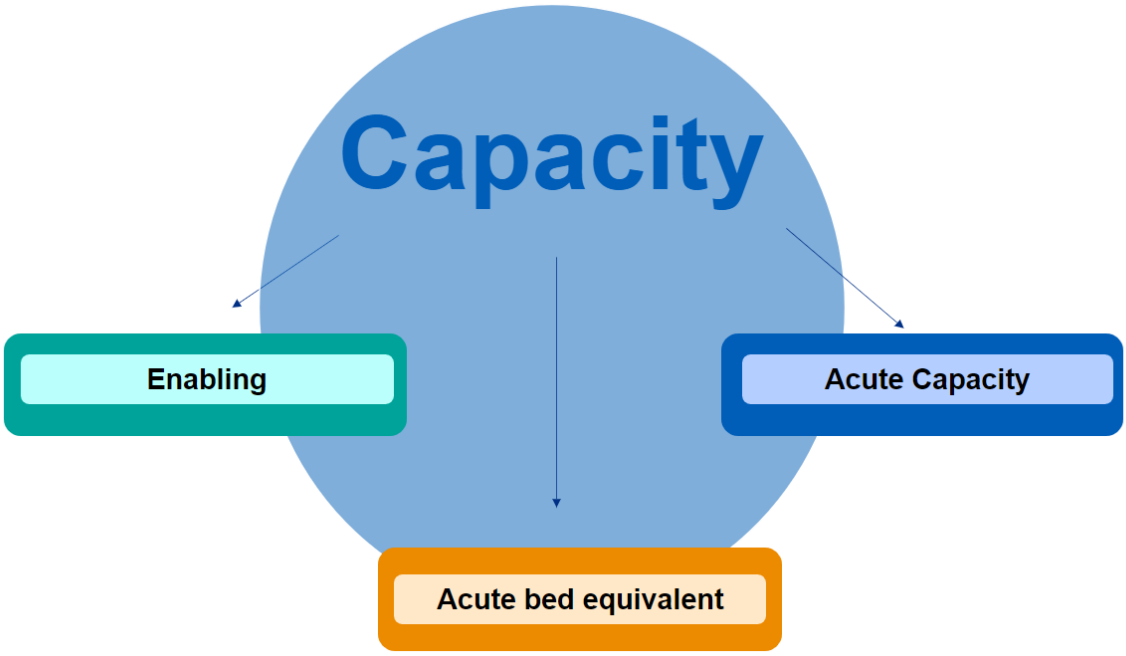
Figure 1:



System Capacity Plan

Figure 2 illustrates the underpinning types of “capacity” implemented within the System Surge Plan.

Figure 2:



The System Capacity Plan is assessed and presented in three parts; described as “Enabling”, “Acute Capacity” and “Acute Bed Equivalent” capacity. Underpinning the System Capacity Plan, extensive bed modelling has been undertaken to ensure that mitigations and schemes/initiatives developed and mobilised are proportionate to the levels of demand expected this winter. Initiatives and schemes with the Plan outline system actions to address and mitigate the forecast bed deficit, albeit delivery is dependent on the availability of workforce to deliver. This is a significant risk detailed on the risk register.

The system capacity model (developed in collaboration with PWC ahead of winter 2022/23) factors in system demand from previous years, levels of flu and Covid-19 infections and related impact upon the system, the system bed base, patient flows, community bed base, virtual wards, ambulance conveyance information, staffing levels, elective demand and activity and other contributing factors.

The system bed model has been refreshed to include 2023/24 actual episodic data and, via development with performance and information colleagues from across the system, is now equipped to present forecast demand and bed need information at a divisional level.

Assessment of forecast demand and pressures at a divisional level illustrates that the area of greatest forecast pressure is the medical bed base at Royal Stoke University Hospital (RSUH). Modelling also forecasts increased pressures upon the bed base at County Hospital and work with colleagues from University Hospitals of Derby and Burton (UHDB) shows a similarly increased level of excess demand and associative pressure at Queen’s Hospital, Burton.

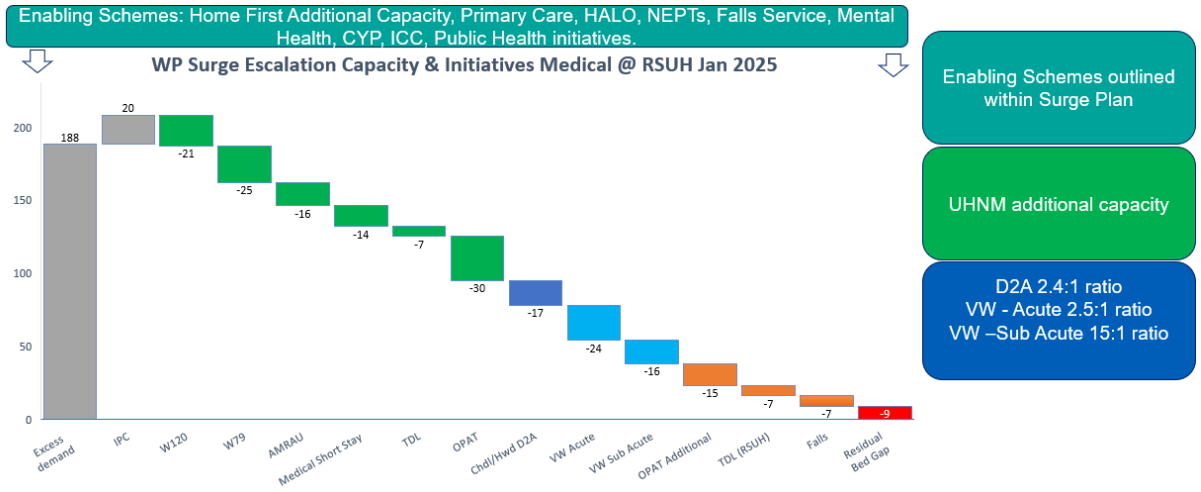
Wider modelling indicates that the other divisions within UHNM have sufficient capacity to meet expected levels of non-elective demand.

As a result, schemes and initiatives have been developed in order to primarily target mitigations and impact upon the medical bed base at Royal Stoke, with additional

initiatives implemented to ensure mitigation for the County and Queen's hospital sites. The divisional forecasts are presented within the System Surge Plan and reflect the levels of demand and pressure experienced last year.

The Figure 3 Waterfall diagram (below) illustrates the anticipated RSUH Medical excess demand and system mitigations. The residual deficit during December and January is forecast to be circa 9 beds.

Figure 3.



The System modelling is based upon a 'worst case scenario' set of data and assumptions. These assumptions are underpinned by the UK Health Security Agency (UKHSA) projections and infectious disease prevalence modelling for winter 2024/25.

This a deliberate step and is designed to try and ensure optimal system resilience during the winter period. The underpinning assumptions are presented fully within the System Surge Plan and are modelled upon the impacts of Covid-19, Flu and other seasonal diseases peaking simultaneously and during periods of increased non-elective demand.

All system modelling takes into account the mandated protection of elective and cancer capacity and activity – to address the backlog of need and comply with the Elective Recovery Fund. This represents continuation of the 2023/24 approach but is a shift from earlier planning cycles and limits the ability of acute trusts to 'outlie' non-elective patients into elective beds.

The system bed model allows members of the ICS team to proactively model demand and capacity, as well as testing out scenarios (such as increased/decreased Covid-19 or flu impacts) on a 'live' basis to ensure a robust system contingency is in place as winter progresses.

Within the System Capacity Plan, there are three categories outlined. These relate to:

- Acute capacity; physical beds within an acute hospital.

- Acute bed equivalent capacity: community beds or schemes that yield and equivalent tangible impact.
- Enabling schemes; schemes that are designed to provide vital initiatives or programmes of work to mitigate increased non-elective and are fundamental to system delivery, but do not offer a tangible and quantifiable 'bed impact'. For example, additional primary care appointments.

All capacity schemes are detailed within the System Surge Plan.

Despite system-wide collaboration and work, there remains a small residual capacity deficit in January 2025. This forecast deficit is significantly reduced when assessed against those of previous winters. Work remains ongoing to source additional capacity and proactive assessment of further opportunities in the event of further funding being received is in place via the System Surge MDT forum.

System Escalation Plan

The System Escalation Plan has been further developed for 2024/25 and is designed to provide system resilience during times of increased demand and pressure, learning from previous experience as the system has become rapidly stressed leading to the development of unmitigated risks.

The Escalation Plan seeks to address issues in light of the increased levels of demand which has contributed to systems pressures, including ambulance handover delays, workforce challenges and increased clinical risk.

The principles underpinning the System Escalation Plan relate to agreed parameters and triggers dictating enhanced action, the need for all partner organisations to be sighted on risk along the entire patient pathway and agree escalation actions to minimise and mitigate risk by sharing risk across the system.

To enact the System Escalation Plan, appropriate structures and forums have been put into place, these include;

Regular System Chief Operating Officers (COO) call (including representation from all partner organisations – including West Midlands Ambulance Service and Local Authorities).

System Clinical leadership meeting – a forum to include Nursing Directors, Medical Directors, Directors of Adult Social Care and other clinical leaders.

The continued delivery the ICS System Co-ordination Centre (SCC) as commenced during December 2022 and recognised regionally and nationally as an exemplar.

The System Escalation Plan will define system actions in response to critical incidents, escalated OPEL status and other urgent events/incidents.

System Workforce Plan

The System Workforce Plan has been led by the ICS People Function and sets out the plan to support delivery of the System Surge Plan, including the additional winter capacity schemes and initiatives being implemented across the system.

Underpinning the plan is targeted work with providers to ensure that additional workforce numbers required to support each scheme are in place. The plan details actions being taken to recruit/supply this additional workforce (including provider and system level activities), workforce risks and mitigations.

Workforce has been identified throughout the Surge Planning process as presenting the most significant challenge facing the system as we enter the winter period. Increased sickness rates, staff turnover and vacancies across the system all factor into this enhanced level of challenge and risk. Despite a robust System Workforce Plan, the workforce risks are not fully mitigated and remain significant.

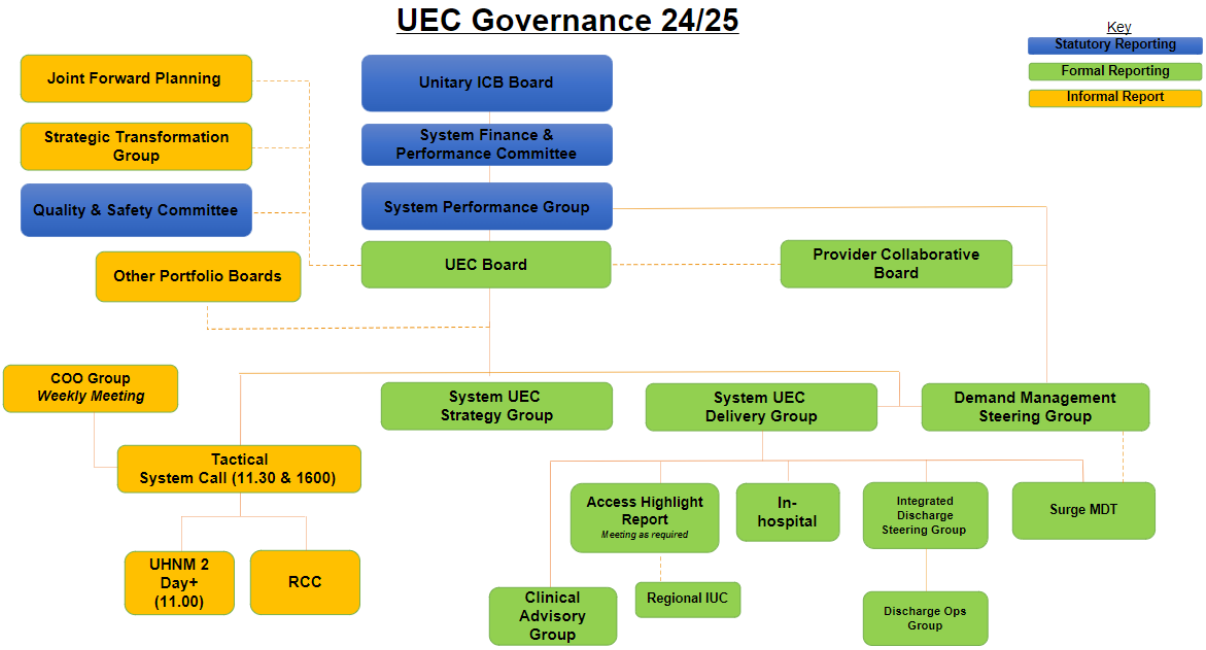
To mitigate these challenges, a collaborative and innovative approach to workforce supply has been developed and adopted to try to engage previously untapped pools of staff and provide attractive offers to incentivise existing staff, or those that may wish to return to work. The workforce plan builds upon system-wide actions and work undertaken previously.

Processes and forums have been put into place to ensure that partner organisations can model and assess workforce supply on a continual basis, to ensure that any one part of the system is not detrimentally affected, leading to wider impact. This holistic approach has led to a degree of system collaboration designed to mitigate demands of individual organisations in order to balance the wider need across the entire healthcare system.

4. Summary and Next Steps

The Staffordshire and Stoke-on-Trent ICS System Surge Plan will continue to be evaluated and evolved according to need as we move through the winter period and beyond. The Surge Planning process has been closely aligned to the UEC Delivery Group, UEC Board and associative workstreams and will remain as a concurrent process to ensure synergies and coalescence with other system priorities. An overview of the full governance cycle in place to ensure appropriate review, challenge, oversight and action is included below in Figure 4 to illustrate the mechanisms utilised and the reporting processes in place.

Figure 4:



To ensure appropriate review, oversight, scrutiny and management throughout the winter period, the weekly System Surge Plan MDT meeting will continue, overseeing mobilisation, recalibration and assessment of operational pressures and issues. Co-Chaired by the ICB Head of Urgent Care and UEC Delivery and Improvement Lead, with representation from senior system operational staff, this forum will continually re-evaluate schemes and utilisation of resources across the system, recommending proactive decisions regarding the deployment of resource to mitigate winter pressures and other events/incidents and reporting directly to UEC Delivery Group and UEC Board, with close links to the System Demand Management collaborative and steering group.

The System Surge Planning MDT has direct links to senior System operational teams and a direct relationship to ensure operational awareness, input, oversight and action.

During previous periods of escalated Winter pressures and in response to the system declaration of a “critical incident” the system mobilised a Winter Steering Group, chaired by the ICB Chief Executive and with input from all system Chief Operating Officers and clinical leaders. This remains a contingent measure to ensure system-wide escalation, if required.

The System Surge Plan will remain a ‘live’ document and be recalibrated as required to try to ensure that the ICS addresses winter pressures in a robust, compassionate and holistic means, prioritising patient care and access and minimising risks to patient safety and system staff and resources.

5. Recommendation

The Integrated Care Board is asked to: Ratify the decision of the Finance and Performance Committee and confirm approval of the System Winter Plan.

Appendix 1: System Surge Plan slide deck.

System Surge Plan 2024/25

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 09

Report to:	**ICB Board**					
Date:	**21st November 2024**					
Title:	**Medium Term Plan (MTP) Progress Update**					
Presenting Officer:	Paul Brown, Chief Finance Officer; Elizabeth Disney, Chief Transformation Officer					
Author(s):	Co-produced with members of the Base Model (MTP) - Task and Finish Group					
Document Type:	Report					
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Medium Term Plan (MTP) Update					

(1) Purpose of the Paper:
The purpose of this paper is to provide the board with an outline of progress made on developing the unmitigated model for the MTP and the next steps to develop a mitigated model.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (D)	30/10/2024
System Finance and Performance Committee (A,I)	5/11/2024

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The paper recaps what the medium-term plan (MTP) is, the case for change driving the plan, the progress we have made to date on developing the base model (unmitigated), next steps to explore closing the financial gap and the next steps for the mitigated model.

What is the MTP?

We are all seeking to meet the dual challenge of unprecedented demand for our services and significant financial constraints. Our ICS is no different, and this means that for 2025/6, and each year that follows, we will need to focus on a clear set of priorities that will help us to meet both of those challenges. The MTP will describe our key priorities and any transformation/shifts in our care model that we will need to focus on to achieve it, whilst aiming to stay within the budget we have been allocated. We are seeking to show that over a 5-year period we can return the system to a recurrent financial position, whilst meeting the health needs for our population.

This work is taking place in two phases. The first stage which is nearing completion, is the development of a model that shows a pathway to recurrent balance. This will then be followed by work running up to the 2025/26 plan, on the underpinning transformation, productivity and system optimisation required.

The unmitigated model

The combination of health inequalities and an ageing population mean that demand faced by our services outstrips capacity, and this will only worsen without action (unmitigated). Through setting up a Task and Finish Group we have progressed the Modelling Activity Baselines for what we have termed an 'unmitigated' scenario. We have worked with our partners to get agreement on the numbers and the assumptions made when building the activity model, the currencies used eg beds, contacts and the baselines used.

We expect to see an increase in population of 3.9% by 2036 with the population aged over 70 increasing by 20.8% Services which treat older patients are likely to see the biggest increase in demand. 19% of the population using Type 1 A&E are under 18. Rates of mental health need are growing at a faster rate

in CYP than amongst adults. As a system we have a circa 10% underlying deficit which has to be addressed to return the system to a financially sustainable place.

Without action it is projected at a high level that we will see a 2.9% increase in Type 1 Accident and Emergency activity, 2.7% increase in daycase and elective, 4.3% increase in emergency admissions and 2.7% increase in outpatients. Demand for community services increase by 6%, Mental Health services will see a 2.7% increase and Primary Care 7% increase in demand. We will need 473 WTE additional workforce and our underlying financial deficit will rise to over £600m within 5 years.

Next Steps
The Task and Finish Group will continue to focus on development of the mitigated model. This will be a system model that will show the opportunities to create a recurrent financial balance for the system. We will be utilising population health data and tools to support the development of key elements of the mitigated model as well as other intelligence such as Model System data, GIRFT and wider intelligence from our clinical community to understand which opportunities offer the biggest impact. A set of conclusions and proposed next steps will be developed for SPG in November and the Health & Care Senate in December.

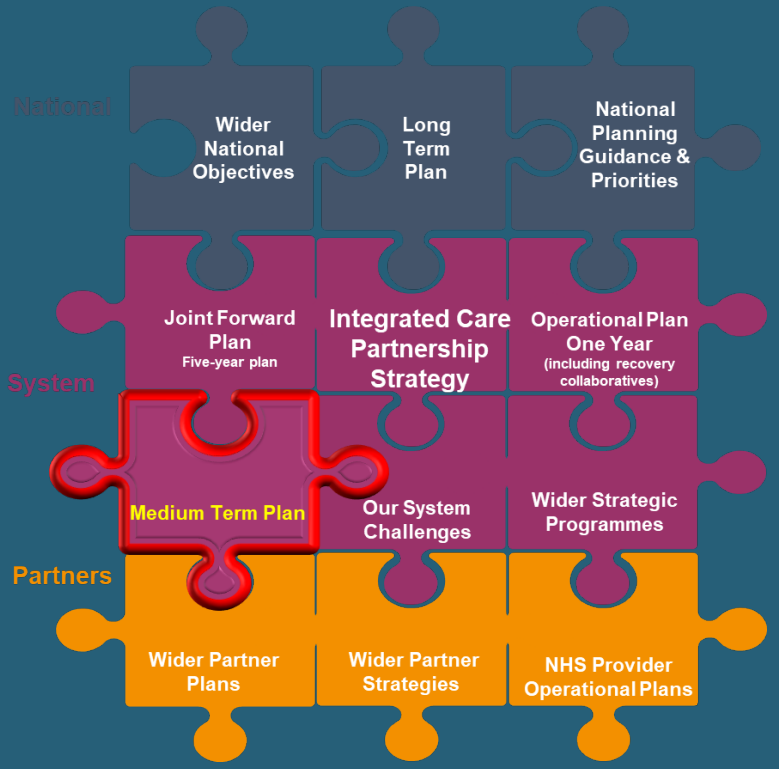
This will then pave the way for the detailed work-up of the transformation, productivity and system optimisation plans that will lead to clinical and financial improvement.

(7) Recommendations to Board / Committee:

1. Be assured on the progress made to date on the MTP and the next steps outlined.

Staffordshire and Stoke-on-Trent Integrated Care System

Medium Term Plan (MTP) Update



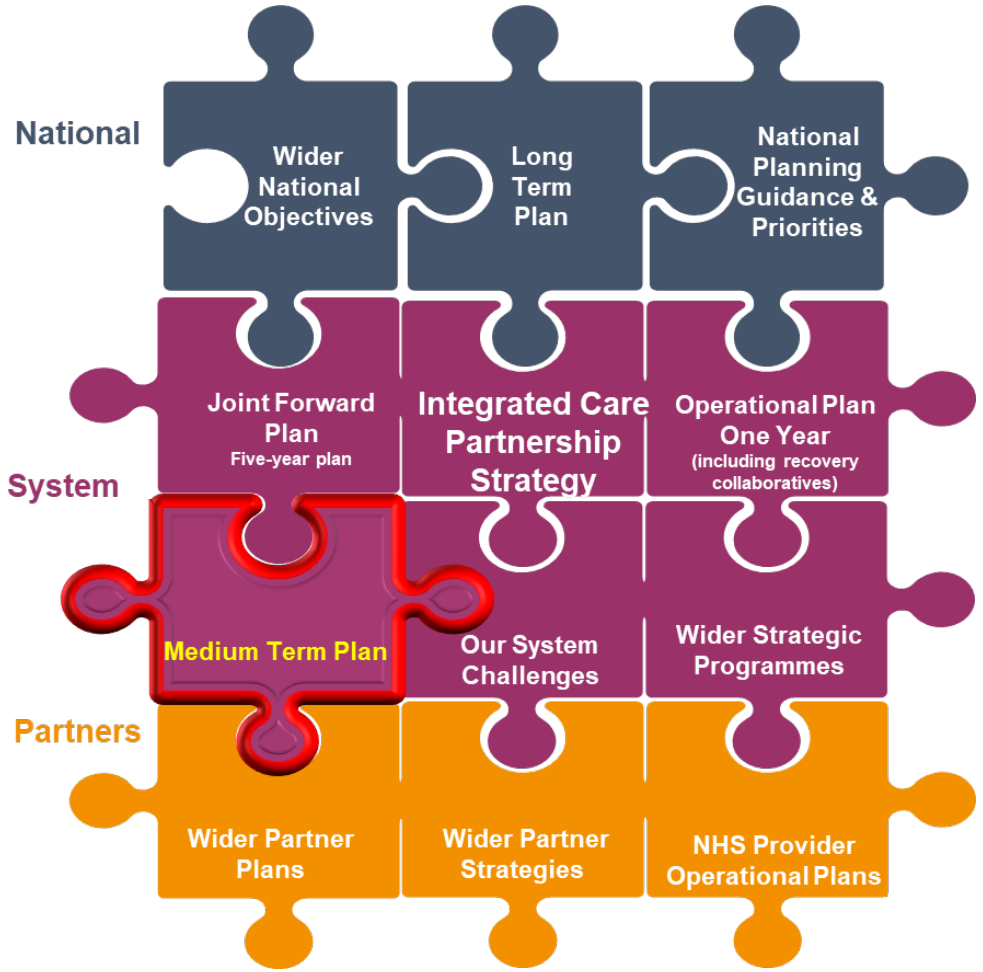
Executive Summary

- The following slides recap what the medium-term plan (MTP) is, the case for change driving our medium-term plan, the progress we have made to date on developing the base model (unmitigated), next steps to explore closing the financial gap and the next steps for the mitigated model.
- We expect to see an increase in population of 3.9% by 2036 with the population aged over 70 increasing by 20.8% Services which treat older patients are likely to see the biggest increase in demand. 19% of the population using Type 1 A&E are under 18. Rates of mental health need are growing at a faster rate in CYP than amongst adults. As a system we have a circa 10% underlying deficit which has to be addressed to return the system to a financially sustainable place.
- We are all seeking to meet the dual challenge of unprecedented demand for our services and significant financial constraints. Our MTP will describe our key priorities and any shifts in our care model we will need to focus on to achieve it
- The work of the current Task and Finish group was discussed at the System Performance Group (SPG) on 30th October and will continue up to the next SPG on 27th November and Health & Care Senate on 12th December.
- Through setting up the Task and Finish Group we have progressed the Modelling Activity Baselines for the unmitigated scenario.
- The unmitigated model identifies that without action that we are likely to see a 2.9% increase in Type 1 Accident and Emergency activity, 2.7% increase in daycase and elective and 2.7% increase in outpatients. Demand for community services is expected to increase by 6%, Mental Health services will see a 2.7% increase and Primary Care demand increase by at least 7%. We will need 473 WTE additional workforce and our underlying financial deficit will rise to over £600m within 5 years.
- The Task and Finish Group will now focus on development of the mitigated model based on a detailed opportunity assessment drawn from all available comparative sources.
- We will need to translate transformation benefits into revised organisational level activity, workforce and finance plans with robust ICS wide challenge on delivery from 1 April 2025. Risk is that we deliver transformation that costs more as we deliver both the new services/capacity and retain the old ones
- Delivery of transformation and productivity will require multi-year delivery with phasing and sequencing being important to this alongside a structured and data- and evidence-led approach.

What is the medium-term plan (MTP)?

We know that changes to the demographics of our population alongside an increase in the numbers of people living with multiple health conditions will further test both the services we provide and the budget which we have to provide them.

- The MTP will set out where, as a system, we want to get to in 5 years.
- It will need to get us to something very different which
  - gives us better outcomes for our population
  - a better experience for people who use our services and our workforce
  - supports recovery of our financial position
  - enables us to operate in a financially and operationally sustainable manner
  - ensures we deliver our performance requirements
- We will build our MTP by understanding where we are now, what the future will look like if we don't make changes and how that will be mitigated through transformation, best practice and productivity.
- The first year of our MTP will be our 2025/26 system operational plan and will become a cornerstone of the ICS response to the NHS Long Term plan



Summary: The case for change driving our medium-term plan

An increase in population of 3.9% by 2036 with the population aged over 70 increasing by 20.8%

Services which treat older patients are likely to see the biggest increase in demand

19% of the population using Type 1 A&E are under 18

Rates of mental health need are growing at a faster rate in CYP than amongst adults

As a system we have a c 10% underlying deficit which has to be addressed to return the system to a financially sustainable place

For urgent care – 2.9% increase in Type 1 accident and emergency activity meaning, 4.3% increase in emergency admissions

- 28 additional 999 ambulance calls per day.
- 17 additional conveyances to hospital per day.
- Increased conveyances will contribute to an additional 24 attendances per day at Type 1 A&E departments.
- An additional 17 emergency admissions per day.
- Number of beds required for additional emergency admissions is 120 per day. The split between provider would be approximately 23 for RWT, 28 for UHDB, 58 for UHNM, and 10 at Good Hope.

For planned care 2.7% increase in day cases and elective, 2.7% increase in outpatients meaning

- 18 additional Day Case and Elective procedures per working day.
- Assuming Day Case and Elective rates remain the same that would require an additional 8 beds at all providers.

Demand for community services is expected to increase by 6%

- District Nursing increase of 260 contacts per working day. Increased number of people with complex needs requiring community nursing care and increased acuity of caseloads needing more experienced nurses (B7 and above).
- Home Based Intermediate Care Service increase of 25 contacts per day. Driven by an ageing population with significant co-morbidities & lifestyle choices.

Mental Health 2.7% increase meaning

- Mental health services expect the number of contacts will be an additional 42 patients per working day.

Primary Care 7% increase in demand

Finance the underlying deficit rises to over £600m within 5 years

- Coming into 2025/26 the system has an underlying deficit of £280m before growth and cost pressures.
- The cost of the unmitigated demand growth is £13m and £19m additional cost pressures, so in total £32m
- £24.6m of this being an increase in the pay bill
- Without action, the underlying deficit rises to over £600m within 5 years

Workforce - 473 WTE additional workforce

- Using the system wide average pay cost of £52k, we would need an indicative 473 wte of additional workforce.

Unmitigated Model

The combination of health inequalities and an ageing population mean that demand faced by our services outstrips capacity, and this will only worsen without action (unmitigated).

- Through setting up a Task and Finish Group we have progressed the Modelling Activity Baselines for the unmitigated scenario.
- We have worked with our partners to get agreement on the numbers and the assumptions made when building the activity model, the currencies used eg beds, contacts and the baselines used. We have been clear on our assumptions.
- We have discussed that the level of clarity in the activity model and the approach will look different for different providers and service areas. This is based on the level of greater level of detail that is available for acute services versus other settings of care eg primary care, community and mental health services. Measuring Mental Health demand isn't straight forward due to the wide variety of services. There is also no established data or currency to measure complexity of cases or acuity.
- We have completed a desk top review of current system plans focusing on understanding where they contribute to decreasing demand, decreasing cost or increasing productivity.
- This work will inform the mitigated model.
- A summary of the headline figures are outlined on the next slide.
- Discussion at SPG focused around whether the unmitigated model is reasonably modelled and is sufficiently accurate to set out the scale of change required by the system.

Summary of Unmitigated Levels of Activity – 2027/28 against baseline and other opportunities for consideration

Unplanned Care

2.9% Increase in Type 1 A&E attends

0.9% Increase in Type 3 A&E attends

4.3% Increase in emergency admissions

Other Opportunities for consideration

- Non-Elective admissions the ICS has unwarranted variation to peers for Genitourinary, Gastro-intestinal and Respiratory conditions.
- 19% of the population using Type 1 A&E are under 18. High attendance rates linked to deprivation. Inequalities in Accident and Emergency department attendance, England - Office for National Statistics

Planned Care

2.7% Increase in Day Cases and Elective

2.7% Increase in Outpatient attendances

Other Opportunities for consideration

- Productivity measures such as use of day case for the BADS procedures. Latest position reported by Model System is that 629 bed days could be saved per quarter by achieving benchmarked rates.
- Theatre efficiency can be measured using capped efficiency rates. Latest system position reported by Model System is 80.1%
- Outpatients; First to Follow-Up, PIFU initialisation, DNA rate and Outpatient Capacity Usage

Community and Mental Health

6.0% Increase in Community Contacts

2.7% Increase in Mental Health Contacts (MPFT)

Other Opportunities for consideration

- For children and young people, the latest evidence suggests that rates of mental illness may be growing at a faster rate than amongst adults.
- Expected increase in demand for community services for older adults such as District Nursing, MSK and Intermediate Care

Primary Care

7% per year in demand

- 2024/25 there has been 7% increase in appointments. This has mainly been delivered by increased capacity of Direct Patient Care (ARRS). It is expected that Primary Care activity has reached a ceiling, however there will continue to be an increase in demand, although not possible to quantify.

Other Opportunities for consideration

- Understanding variation in Primary Care medicines spend. ICB spend £19.8m versus peer median of £15.7m

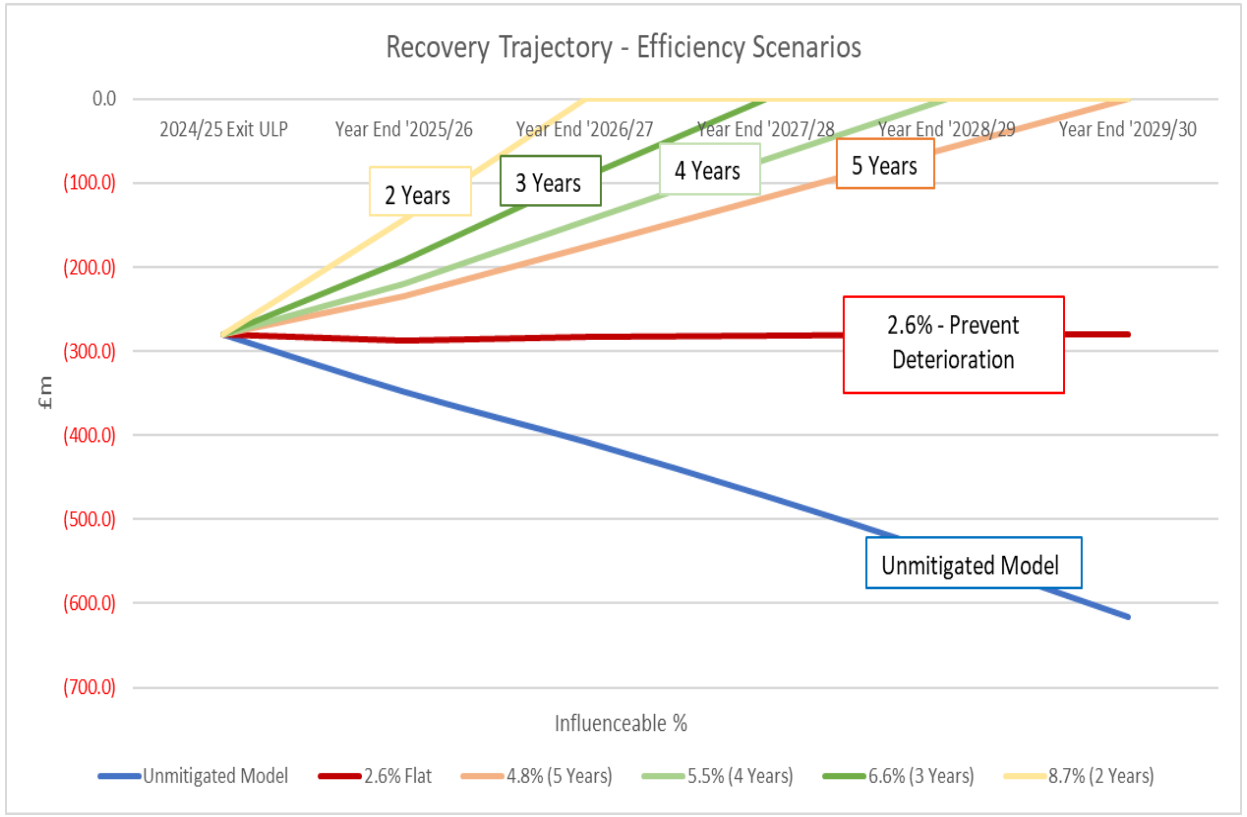
Unmitigated Levels of Activity impact on finance and workforce

- Bridging from exit underlying position to the unmitigated model for 2025/26 is summarised in the table below.
- The local assumptions, cost pressures and impact of growth have been assessed at an organisation level based on 2024/25 actual costs and aggregated for the system. It should be recognised that this is high level modelling only
- Of these drivers only cost pressures and growth link to wte. Of the cost pressure £14.7m relates to pay and of the growth £9.9m relates to pay.
- Using the system wide average pay cost of £52k, this provides an indicative **473 wte of additional workforce** requirement for an unmitigated model. NB this does not seek to include any impact of changes in models of care or build in aspects of the long term workforce plan.

Unmitigated Model	£m	WTE Change	Description
2024/25 Exit ULP	(280.3)	0.0	
Cost uplift (CUF) impact	(2.2)	0.0	Cost base larger than income
OOA tariff deflator	(8.8)	0.0	Part of the 'Mitigated model' each year
Local Assumption (CHC,Pres)	(25.1)	0.0	Over and above national inflation
Cost pressure (0.5%)	(19.0)	282.7	Non-activity pressures (eg. Quality, Safety)
Growth	(13.0)	190.4	Cost to deliver the expected demand
Unmitigated Exit ULP 2025/26	(348.4)	473.1	

The long-term financial outlook

- Financial projections have been built up provider teams.
- Based on the ‘unmitigated’ model which includes demographic and population health projections
- The model looks to eliminate the recurrent underlying position, and further work is required to link to annual plan
- Rather than using the total cost base we have shown as influenceable % of total expenditure to show the real challenge we face
- Assumed the historic debt would require repayment once at breakeven



Next Steps to explore closing the financial gap

- How much of the gap is closed by productivity plans

- How much of the gap is closed by existing system collaboratives

- The residual gap to be delivered through demand management and transformation

  Includes the impact on non-Staffordshire provider spend and other expenditure e.g. Prescribing, CHC

Mitigated Model – The Future

Mitigated means how we meet the needs of the population in different ways and make change in how we do things on a sustainable basis and for better outcomes

- The Task and Finish Group will now focus on development of the mitigated model based on a detailed opportunity assessment drawn from all available comparative sources.
- The mitigated model is the prework to the development of MTP and to give a guide for multi-year approach. Importantly it also sets the framework for the work on transformation.
- This needs to be underpinned by a medium-term workforce strategy and other important enablers.
- We will need to work collaboratively across disciplines – including clinicians, managers, workforce, quality and analysts – to draw the proportionate conclusions and transformation actions to inform our decision making.

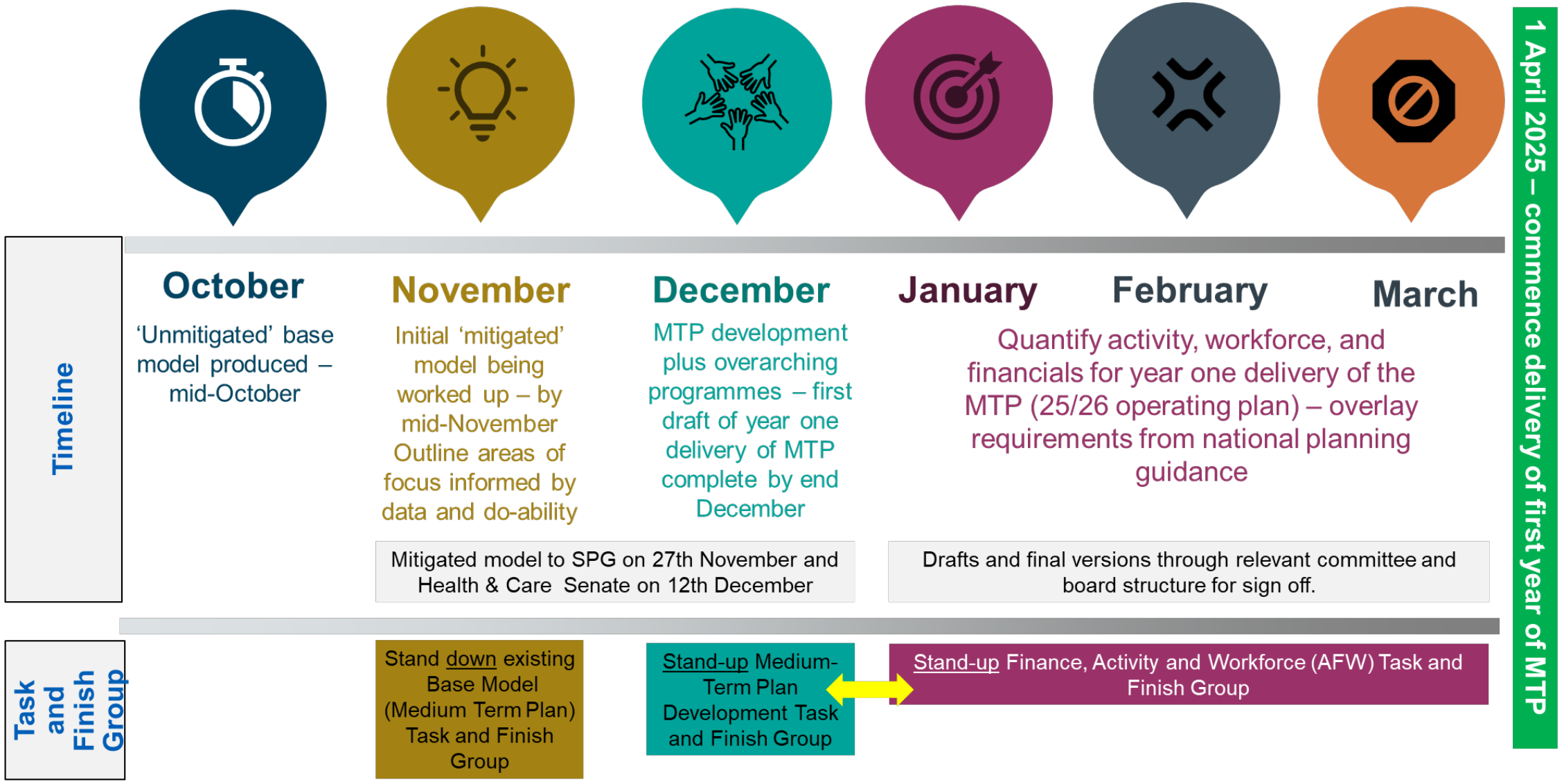
Next Steps

1. We will be exploring with NHSE more insight into the Model System data and productivity measures for providers outside our ICS.
2. We will be utilising the OPTUM Pathfinder Tool to support the development of key elements of the mitigated model as well as other intelligence such as Model System data, GIRFT, wider intelligence from our clinical community to understand which opportunities offer the biggest impact.
3. Providing a set of proposals and next steps for SPG and the Health & Care Senate to consider
4. CFOs and CPOs agree the financial and workforce costs that would be required to deliver this mitigated activity at the improved levels of productivity. This mitigated model would be profiled to show the path back to recurrent breakeven by year five.

Mitigated Model – Summary

Now until March 2025	1 April 2025 onwards
Productivity plans	Delivery of productivity and transformation
Transformation and system optimisation plans	Delivery of the financial benefit

High Level Timeline



Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 10

Report to:	**Integrated Care Board**					
Date:	**21 November 2024**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Lynn Tolley, Assistant Chief Nursing and Therapies Officer (CNTO)					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail October 2024.					

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

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

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

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

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

- Community Nursing Demand and Capacity
- Paediatric Diabetes
- Wheelchair Services
- Learning from the lives and deaths of people with a learning disability and autistic people programme
- Patient Safety

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report, seek clarification, and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.
- Ratify the decision of the Quality and Safety Committee with regards to: assurance that the ICS are working in partnership to maintaining focus and oversight on quality of care and experience in pressurised services.

Appendix A: Quality and Safety Report – Detail November 2024

1. Community Nursing Demand and Capacity

1.1 System Quality Group (SQG) received a presentation from Midland Partnership University NHS Trust Community Nursing's Head of Service and Professional Lead. The presentation outlined the increase in demand – referrals have more than doubled since 2022 – driven by national and regional priorities to increase out of hospital care, patient expectations, the expectations, and impact of changes by other providers, and support to care homes. Further, GP Collective Action has been reported to be impacting upon community services particularly with regards to electronic referrals and community nursing prescription requests. SQG were told that, whilst the community nursing workforce is fully established, there are an increasing and significant number of visits being rescheduled daily. NHS England's representative shared that the Community Nursing Safer Staffing Tool is going to be relaunched in January 2025 and MPFT shared that they are agreeing metrics to demonstrate the value of community nursing with system partners. Discussions also took place with local authority representatives about opportunities to upskill care home staff. All partners agreed to increase visibility of increasing community referrals and associated impacts on patients within other system forums.

2 Paediatric Dietetics

2.1 Demand and associated waiting times for paediatric dietetic services continues to increase. This is a risk which in time may lead to a detrimental impact on the future health of the child and their long-term goals/aspirations. Due to the pressure across the clinical pathways, all service providers have implemented mitigations to address the increase in demand and wait times, however, this continues to be a worsening position. All partners have a risk recorded on their organisational risk register which is held at Board level. A system wide review is underway to establish a robust understanding of the demand and capacity of the service and ensure that there is an equitable offer to all residents in Staffordshire & Stoke-on-Trent. Discussions have taken place at the Children & Young People's Programme Board in July and System Quality Group in November 2024 to increase awareness. Discussions are underway to enhance the clinical oversight and management of the immediate risks and mitigations.

3 Wheelchair Services

3.1 Throughout 2023/24 there was a growing number of service users who waited over 18 weeks to have their wheelchair and/or other equipment supplied. Consequently, there has been a corresponding increase in feedback from patients who are dissatisfied with waiting times and communication. Contractual plans are in place to recover wheelchair assessment and delivery performance to 92% within 18 weeks over the next 12 months (July 2025). Monthly meetings are in place to maintain oversight and partnership working and the ICB is collaborating with the provider to quantify the level of risk within the caseload and strengthen the quality governance arrangements including sharing best practice from NHS system partners to update the duty triage guidelines including reprioritisation and clinical harm review. Quality visits have been undertaken by the ICB in December 2023, May 2024 and a further visit is scheduled in November 2024.

3.2 The total number of service users waiting over 18 weeks has decreased for five consecutive months. The service, alongside clinical prioritisation, are reviewing longest waiters to ensure actions to progress their episode of care are taken.

3.3 Stoke-on-Trent Overview and Scrutiny Committee published a joint review with recommendations in September 2024. Specifically, that the ICB and provider 'regularly meet with and listen to wheelchair users and their families to jointly communicate the collaborative plans to improve the service for wheelchair users'. The ICB is joining the provider's Service User Group in November 2024 to engage with service users. Further, a meeting has been arranged with Healthwatch Staffordshire to discuss and strengthen our communications plan.

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

4.1 SQG received the LeDeR Programme Quarter 2 2024/25 report 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, including (i) excellent person-

centred care delivered from professional carers, (ii),excellent MDT working between health and social care professionals, and (iii) a very comprehensive Distress and Discomfort Assessment Tool completed by care home staff to enable people to understand when people with a learning disability were content and distressed. As well as areas where further improvement and development is needed.

4.2 The report highlighted the considerable progress against the National Key Performance Indicators. The ICB has made considerable progress in reducing the backlog of reviews inherited from the previous service provider. All reviews have now been allocated to reviewers and have either been completed or are currently being worked through. Positive practice, learning and improvements continue to be highlighted and implemented through the LeDeR Governance Panel and Steering Group. The LeDeR Steering Group now meets face to face on a quarterly basis, with workshop style meetings taking place to discuss and produce system wide actions and to develop the LeDeR system wide action plan. The reviews also highlighted areas for improvement which have been shared with relevant providers and stakeholders via the LeDeR governance panel or outside the meeting and will help to drive improvements in the areas/services. They will also form part of the LeDeR system wide action plan.

5. Patient Safety

5.1 The ICS hosted the second Patient Safety Incident Response Framework (PSIRF) Bi-Annual Learning Event in October 2024. The event, designed to share feedback from the implementation of PSIRF and learning from completed learning responses, was very well attended by NHS Trusts both in and out of system, non-NHS organisations, Black Country ICB, NHS England, Health Innovation West Midlands, Staffordshire University, and the Coroner's Office. Presentations included, Patient Safety Not Scrutiny – the SSOT Way, Using Appreciative Inquiry to Support System-wide Safety Improvement and Rowan's Rule – Learning from the Local Maternity and Neonatal System. There was energised feeling in the conference as partners proudly shared their experiences and learning. Planning is already underway for the next event in 2025.

5.2 To align with the ethos of PSIRF, it is anticipated that ICBs will work differently when using Learning From Patient Safety Events (LFPSE) than they did under the Serious Incident Framework. This involves a move to a more holistic view of patient safety events, and away from reactive investigations with strict timescales. It is expected ICBs will take an interest in safety data and the picture it represents overall, and less in the detail of individual events and their management. To support this change to working practices, a Standard Operating Procedure (SOP) for LFPSE has been introduced to ensure all staff within the ICB are aware of what the system is used for, who can have access and how to use the system and data.

5.3 The ICB has updated the SOP for Management of System Intelligence. The SOP defines the processes for the collection, management, and reporting of 'system intelligence,' including clinical and patient feedback across the ICB. System intelligence is defined as information that does not fall into the complaints, incidents, or safeguarding category, but which can provide the ICB with valuable intelligence on patient experience/safety. It should be recognised that the 'system intelligence' process will not provide an incident or complaints management function and separate processes exist for these purposes. ICB system intelligence will be shared and triangulated with relevant providers.

6. Decisions made by Quality and Safety Committee for Ratification

6.1 Maintaining focus and oversight on quality of care and experience in pressurised services (PRN01417)

6.1.1 In response to continued pressures within the Urgent and Emergency Care (UEC) pathways and in light of the recent Dispatches investigation, the national NHSE executive team wrote to all ICBs and provider executive teams outlining actions required to maintain focus and oversight on quality of care and experience in UEC services.

6.1.2 Quality Safety Committee(QSC) and Urgent Emergency Care (UEC) Board received a paper which provides assurance that the ICB and partners can demonstrate compliance with the six key objectives outlined within the letter with recognition that there is commitment to continually evolve and improve services to maintain patient safety and improve flow across UEC pathways reflecting the objectives set out within he Urgent and Emergency Improvement plan.

6.1.3 QSC were assured that pathways are in place to support timely discharge from hospital to home, and that the CQC fundamental standards of quality are adhered to even at times of pressure. It was recognised that there is a variance in oversight of ED harms between University Hospital of North Midlands and University Hospital of Derby and Burton, with both approaches compliant with the requirements set out by the NHSE executive team. Members were reminded that the primary responsibility to seek and provide assurance regarding UHDB services remains with Derby and Derbyshire ICB and as such the Staffordshire team will work with colleagues in Derbyshire to seek the relevant levels of assurance.

6.1.4 It is the recommendation of QSC that the ICB Board receive assurance that the ICS is compliant across the six key objectives set out within letter PRN01417: Maintaining focus and oversight on quality of care and experience in pressurised services in line with the NHSE executive team request.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 11

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**November 2024**
Reporting Committee:	**Quality and Safety Committee (Q&SC)**
Date of Meeting:	**9 October 2024**
Meeting Quorate Y/N?	**YES**
Presenter:	**Josie Spencer, Non-Executive Director & Committee Chair**
Author:	**Lia Pitarokoili, Head of Governance**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

(1) Quality Impact Assessment:

The Committee received a report on the Quality Impact Assessment (QIA) work programme and the actions being taken to ensure that the ICB fulfils its statutory duty to have regard to all likely effects of decisions in relation to (a) the health and well-being of the people of England and (b) the quality of services provided to individuals.

The Committee was alerted that eight QIAs have been completed retrospective to decisions within the period June to September 2024. This was in breach of the ICBs Statutory Duty and associated QIA Policy, NHS Planning Guidance 2024/25 and management action from Internal Audit in December 2023.

The Committee was assured around the QIA work programme and mitigating actions, however there was a discussion around work that still needs to be done to ensure QIAs are completed in time especially in relation to the existing financial pressures and challenges.

ADVISE

(1) Intensive and Assertive Community Mental Health Care Review:

NHSE has asked all ICBs to review policies and practices regarding the care of people with severe mental health illness who require treatment but where engagement constitutes a challenge (2024/25 NHS Priorities and Operational Planning Guidance). The guidance covers:

- The characteristics and presentations of individuals in scope
- Themes and lessons for services from severe untoward incidents
- The features of intensive and assertive community care
- How ICBs should undertake local reviews (ICBs are being asked to report any gaps in provision and the barriers that are preventing good care for this group).

The Committee was not fully assured, noted the existing gaps and was advised around the short-term actions and what needs to be done after the reviews have been completed. Using the outcomes of reviews, longer term action plans to address gaps should be developed and presented at the next Public Board meeting, before the end of Quarter 3.

(2) Looked after Children Health Assessments:

The Committee was advised on the ICB's duties and responsibilities in relation to Looked After children, as set out in statutory guidance and legislation. This includes a duty to cooperate with local authority requests to undertake health assessments and ensure support and services to Looked After Children are provided

without undue delay. Within our ICB, there have been significant delays in completing Initial Health Assessments (IHAs) and Review Health Assessments (RHAs), with long waitlists, resulting in health assessments being completed out of statutory timescales.

The Committee was updated on the current risk, compliance and progress against the recovery plan, the ongoing challenges and quality assurance. Positive progress against the recovery plan has been noted. The data has demonstrated a slight improvement in compliance for timeliness with both IHAs and RHAs, but with a significant reduction in the waiting time for IHA appointments at UHNM. RHA average waiting times have also reduced slightly. Adoption medical reports are being completed within the requested timescales for court.

(3) Maternity Service Change Public Consultation Plan:

The Committee received the public consultation plan and was advised that this has been developed to meet the requirements of relevant legislation and good practice (NHS Act 2006 Duty to involve, Equality Act 2010, Planning, assuring and delivering service change for patients (2018, inc. 2022 addendum). The Committee was advised that the future of birthing services at the freestanding midwife-led birthing units (FMBUs) is being explored. These are units at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield, where women with low-risk pregnancies could choose to give birth. The two FBMUs were closed for births during the COVID-19 pandemic, to ensure safe staffing at the consultant-led units at Royal Stoke University Hospital and Queen's Hospital, Burton. The ICB is currently undertaking a service change programme in relation to the birthing services that are temporarily closed. The draft public consultation plan outlines the ICB's approach to the planned public consultation expected to start in December 2024.

The Committee reviewed and approved the Maternity Service Change Public Consultation Plan, pre-Board ratification.

ASSURE

(1) System Surge Plan:

The Committee received the System Surge Plan for 2024/25 that was developed with all System partners. The plan articulates the system approach to mitigating the impacts upon all facets of the UEC system during periods of increased demand, specifically during the forthcoming winter period. It describes three core principles of the system approach to surge and winter planning; the System Capacity plan; the System Escalation plan; the System Workforce plan. Each component is designed to support system partners in proactively putting into place provision to address the forecast increases in demand expected during the winter period.

The governance mechanisms and related risk register risks were detailed within the system surge plan. A regular reporting cycle is in place with clear oversight and challenge to ensure appropriate and efficient development and implementation of the schemes, initiatives and capacity outlined to provide mitigation during periods of increased demand and surge. A full QIA is in progress and will build upon that undertaken in previous years to ensure that assessment of impacts from a quality perspective is at the forefront of delivery and implementation.

The Committee was advised that forecasted demand shows significant increases in required UEC capacity during winter 2024/25. The system plan outlines mitigatory escalation capacity but there remains a residual level of demand that cannot, as yet, be mitigated. There remain capacity initiatives proposed that require final agreement relating to funding and a decision or direction not to fund these schemes could lead to an increased level of risk and residual bed deficit.

The Committee was advised that the System Surge plan will be presented to all System Trust Board meetings (or local authority equivalents) for review, challenge and assurance prior to final review at ICB Board in November.

The Committee approved the System Surge Plan for 2024/25 subject to continual review and improvements, pre-Board ratification.

(2) Gordon Street Surgery Quality Report:
The Committee welcomed the report and received the quality concerns raised by the current caretaker provider at Gordon Street Surgery. The Committee was assured on the current position, the mitigating actions that tackle these concerns and the next steps regarding premises and patient engagement.

(3) Safeguarding Quality and Safety Highlight Report:
The Committee was assured that ICB as statutory safeguarding partner has oversight of health system safeguarding activity in line with the statutory guidance and supported adding a new risk regarding young people not being discharged from Tier 4 in a timely way to the ICB Risk Register.

(4) Maternity & Neonatal Update Report:
Assurances updates were provided in relation to key quality assurance, quality improvement and patient safety activity relevant to Maternity and Neonatal Services provided to women and babies in SSoT.

(5) System Quality Group Report:
The Committee received a report that provided an overview of the System Quality Group (SQG) meetings in September and October with partners from across health, social care, and the wider ICS in attendance. The Committee was advised on SEND concerns and antenatal prescribing by GPs and was assured around all other Quality Matters that are being monitored and jointly managed.

(6) Continuous Quality Improvement (CQI) Sub-Group Update
The Committee was assured around the progress made to date with this CQI Sub-Group. There were no risks and escalations highlighted and the Committee discussed and agreed that the QI project has delivered tangible improvements.

(7) Paediatric Hearing Services Improvement Programme (PHSIP) Q2 update report
NHS England's Newborn Hearing Screening Programme (NHSP) commenced in 2023 with the ask that all local areas stand up a strategic 'Bronze' Cell to lead the required improvements across local paediatric hearing services. The ICB and partners responded to this and have since October 2023 been responsible for the development and delivery of an agreed action plan.

The Committee was assured that the SSoT PHSIP links to the ICB and system programmes of work and strategic direction (High Quality, Safe Care Outcomes) and that the action plan is on tract against the national quality programme key milestones.

(8) Home and Host Commissioner
The ICB, supported by NSCHT and MPFT, have completed a self-assessment against the NHS England Midlands Mental Health – Host and Home ICB Guidance pilot programme. The Home Commissioner responsibilities are new within the pilot guidance and improvement actions have been identified to formalise and strengthen governance and escalation processes. A workshop is scheduled in October 2024 to review the toolkit assessment and actions in partnership with local NHS mental health providers.

The Committee recognised the system level working and was assured in relation to the ICB's self-assessment against the Host Commissioner Guidance which demonstrates that there are processes in place for quality oversight of specialist mental health inpatient units within the SSoT geographical area. The ICB's quality governance arrangements are also well established and build upon the Clinical Commissioning Groups' experience and learning.

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

(1) Q2 2024-25 SBAF Report:

A full Q2 analysis was received for discussion and for assurance. Q&SC has lead oversight of SBAF3, 4 and 5. There was a discussion around the Improving Population Health Portfolio key findings emerging from the Internal Audit Progress Report submitted to Audit Committee in October 2024 and it was agreed that those would need to be reflected in the actions and updates of Quarter 3 SBAF.

The Committee approved the SBAF and confirmed the adequacy of controls / assessments in its lead SBAF Objective areas.

(2) October System & ICB Risk Registers

The Committee received and noted the System and ICB Risk Register Reports. For the System Risks, there are **14** risks in total: 5 high scoring (12+); 9 are medium risks. For the ICB Risks, there are **5** risks, of which 3 are high scoring (12+); 1 medium and 1 low.

The Committee discussed the high-scoring risks where status has remained static for some time, acknowledging that mitigating actions should be continually reviewed so that the Committee can be assured that the risks will achieve their target scores by the set target dates. The Committee was satisfied there were no new risks and:

- approved the closure of the System Risk 1178 (Medical Examiner Role);
- approved the closure of the ICB Risk 1369 (LeDeR Improvement Trajectory).

Policies Approved:

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

Decisions to be Escalated to ICB Board or other Committees:

☑ The Q&SC approved the Maternity Service Change Public Consultation Plan, pre-Board ratification;
☑ The Q&SC approved the System Surge Plan for 2024/25 subject to continual review and improvements, pre-Board ratification

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 12

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**November 2024**
Reporting Committee:	**Health and Care Senate (H&CSenate)**
Date of Meeting:	**10 October 2024**
Meeting Quorate Y/N?	**YES**
Presenter:	**Rachel Gallyot, Deputy Chief Medical Officer**
Author:	**Lia Pitarokoili, Head of Governance**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

(1) Adult Asthma Improvement Project:

H&C Senate received the Adult Asthma Improvement Project for approval for the clinical and quality aspects of the pilot project.

There has been a discussion around the comparison of Staffordshire and Stoke-on-Trent ICS position for asthma complications, against other ICSs and that it is very pertinent. It was noted that the pilot will commence in November and will be completed between January - March 2025. The Respiratory Clinical Group will have oversight of the pilot and, as part of the approval process for further implementation, the data will be presented to the Long-Term Conditions Board and the H&C Senate.

It was noted that the outcomes being sought are an uptake in combination inhalers and a reduction in reliever inhalers (SABA). In the longer term, outside the scope of this pilot, the morbidity and patient progression will be tracked. The overall aim is to switch patients onto combination inhalers and ensure that they have got an asthma management plan, that they understand, and can implement before an asthma exacerbation. It was highlighted that the change in moving patients from reliever, and preventer, inhalers to a combination, will require patient behaviour change and education, regarding the benefits of the fast-acting combined therapy and the advantage of only requiring one inhaler. There will be a need to educate schools as well.

Regarding the strategy for the ICS wide implementation plan it was discussed that the project is currently at the proof-of-concept phase and has dedicated funding from the pharmaceutical company to pilot up to 50 practices, including the pharmacist resource. An implementation would need to be developed, once proof-of-concept has been gained and confirmation of where the project sits within the workstreams.

The Adult Asthma Improvement Project was clinically approved by the H&C Senate.

(2) System Surge Plan:

The H&C Senate was advised on the System Surge plan that articulates the system approach to mitigating the impacts upon all facets of the UEC system during periods of increased UEC demand, specifically during the forthcoming winter period. The Plan describes three core principles of the system approach to surge and winter planning, namely the System Capacity plan, the System Escalation plan and the System

Workforce plan. Each component is designed to support system partners in proactively putting into place provision to address the forecast increases in demand expected during the winter period.

There was a discussion around work undertaken with the Workforce Team regarding sickness forecasting and engagement with providers to ensure that the schemes and initiatives can be implemented. The communications plan was shared with the H&C Senate, and it was noted that an extraordinary QIA panel had been arranged, to ensure that all the schemes have been impact assessed.

Specific governance issues were highlighted within the Community Rapid Intervention Service (CRIS) and Home First and it was confirmed that the Discharge to Assess (D2A) models have their own internal governance processes, while the CRIS team should be escalating issues within their own governance structures. It was confirmed that support will be provided offline to the CRIS team to address those issues.

Assurances were provided that whilst the focus this year was on preserving funding in primary care, and retaining core services, there was an intention for future engagement about what primary care could offer, on a collective basis, to carry out in a primary care setting, to take away pressure from secondary care in times of crisis. It was also highlighted that given the current weight of work, and collective action, it is important to maintain current activity levels in primary care because any reduction in activity would have a significant impact across the system.

Lastly, the need to increase prevention work between winter 2024 & 2025 was noted, as well as the need to align some of the preventative services that would stop people from attending ED, rather than shifting activity.

The System Surge Plan was clinically approved by the H&C Senate.

(3) 24/7 Palliative and End of Life Care (PEoLC) Advice Line Service Review:

The H&C Senate received the 24/7 PEoLC Advice Line Service Review and was informed on the following:

- the impact of the 24/7 advice and guidance line;
- the alignment with the future commissioned service model for specialist palliative care;
- the relationship/integration with the 24/7 Single Point of Access and other response services and;
- the options for commissioning of 24/7 advice and guidance for 2025/26.

It was noted that Health and Care Act 2022 states a legal duty on ICBs to commission palliative care services under s3(1) NHS Act 2006 (as amended) and the NICE guidelines NG142 and NG61 recommendations for end of life care services were presented.

In 2023/24 local Hospices made an offer to the ICS to implement a 24/7 Advice Line to support patients, carers and professionals. The 24/7 advice line provides 24 hour medical and nursing advice to allow assessment, advice and active management seven days a week. The Hospices offered to provide 100% of funding for the 24/7 Advice Line and subject to evaluation confirming ‘proof of concept’ to seek system funding for continuation of delivery. This was on the basis that the ICB agreed to consider the evaluation of the pilot and whether, or not, it would be prepared to provide future funding.

The quality and safety aspect and respecting a patient’s choice, of where they want to die, was highlighted. There was a discussion around service availability for commissioners, across SSoT ICS, whether the same response would be received, regardless of where the patient called from and it was confirmed that the adviceline was available, reasonably standardised across the country and accessible to West Midlands Ambulance Service (WMAS) staff.

The 24/7 PEoLC advice line was clinically approved by the H&C Senate.

(4) Vitamin D Testing and Prescribing Guidance:

The report set out adult testing and prescribing guidelines for Vitamin D deficiency based on national policy and best practice. NICE has very strong guidance around testing for Vitamin D, and in most cases recommends a supplement as a first course of action rather than testing. The guidance suggests only a small number of cases where testing should be appropriate, and yet Vitamin D continues to be one of the

fastest growing tests. Utilising the UHNM Benchmarking Partnership Report our relative test rate for Vitamin D testing is 10.8% higher than our peers. Vitamin D testing has been identified by the System as a rapid improvement project within 24/25 and is being accelerated through the system provider collaborative for clinical value and medicines. Through implementation of updated testing and prescribing guidance and support to primary care clinicians, the System aims increase productivity by reducing the number of tests carried out by circa 8,500 in year.

The H&C Senate was asked to approve the testing guidelines on the basis that population screening by measuring Vitamin D levels is unnecessary and is only indicated in certain circumstances. It was noted that prescribing guidelines for Vitamin D for certain conditions are to be reviewed at the Integrated Medicines Optimisation Group in December 2024 and would come back to H&C Senate for approval.

The H&C Senate approved the guidelines pre-Board ratification but noted that further discussions need to be undertaken regarding implementation.

(5) Integrated Medicines Optimisation Group (IMOG), August 2024:

The H&C Senate received the IMOG report and there was a discussion around the usual NICE TA recommendations, with the majority being for secondary care use only. There was one drug, called Atogepant for migraine, which was recommended for initiation in secondary care and continuation in primary care. The migraine pathway has been updated and now includes Atogepant. IMOG added Freestyle Libre 3 to the formulary, which is a glucose monitoring sensor, licensed for use with the Hybrid Closed Loop (HCL) System in pregnant women. It is being designated red because insulin pump therapy, and ancillary items, are currently issued by secondary care.

Penthrox®, a device containing anaesthetic gas used for pain relief in traumatic injuries, was discussed and it was noted that University Hospitals of North Midlands (UHNM) would like to use this instead of nitrous oxide. Trial data demonstrates that it is more effective that nitrous oxide and evidence suggests that it reduces length of stay in ED. It is marginally more expensive, just over £3k per year, but this is not a significant increase.

The H&C Senate approved the decisions summarised in the detailed report and IMOG minutes subject to continual review and improvements.

(6) Development of Diagnostic Pathways:

The H&C Senate received the relevant report and was provided with a summary update on the progress of the Phase 1 development of the Diagnostic Pathways. The H&C Senate was assured on the ICS engagement, consultation and approval processes undertaken in the development of the Phase 1 Diagnostic Pathways.

The Phase 1 (Liver and Lower Gastrointestinal) Diagnostic Pathways were presented. These full pathways have been developed by the Community Diagnostics Centre (CDC) Steering Group, which has representation from all providers, while they have also been presented to the GP Engagement Groups and Confirm and Challenge Groups, within UHNM and UHDB, and feedback gained has been incorporated into the pathways. The aim of having localised pathways is to reduce variation in practice and to ensure that, when required, the correct diagnostics are utilised. The locations of the CDCs, in Hanley, Tamworth and Cannock, have partly been chosen due to deprivation, which helps to address the inequalities aspect. The intention of the pathways is to join up primary, secondary and community care and two interface groups have been established, to focus on implementation. The pathways are intended for digital use, however, there is no current digital platform in place, so work is ongoing on this aspect. Any differences in how the providers work will be reflected in the pathways. The next stage will be implementation and utilisation, which will require clinician behaviour change, to ensure that the right diagnostics are utilised at the right time for the patient.

The H&C Senate was advised that Phase 2 Diagnostic Pathways (Upper Gastrointestinal, Breathlessness and Gynaecology) would be presented for approval to the November or December 2024 meeting and Phase 3 during 2025.

The H&C Senate approved the Phase 1 (Liver and Lower Gastrointestinal) Diagnostic Pathways for implementation across the SSoT ICS noting that, where there are slight variations with existing UHDB and RWT diagnostic pathways, these shall be reviewed with the acute providers during the implementation phases. Where adjustments are required, these shall be reflected within the pathways applicable to those systems.

ASSURE

None discussed.

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

(1) Q2 2024-25 SBAF Report:

A full Q2 analysis was received for assurance. The top 3 Strategic risks were included in the paper, with a total of 2 being problematic (within SBAF3), and a total of 3 delayed actions (within SBAF1).

(2) October System & ICB Risk Registers

The H&C Senate received the System and ICB Risk Register Reports for information and re-assurance on the management of risks overseen by Quality and Safety Committee. For the System Risks, there are **14** risks in total: 5 high scoring (12+); 9 are medium risks. For the ICB Risks, there are **5** risks, of which 3 are high scoring (12+); 1 medium and 1 low.

There were no new risks, and the H&C Senate noted that two risks were identified and approved for closure by Quality & Safety Committee:

- the System Risk 1178 (Medical Examiner Role);
- the ICB Risk 1369 (LeDeR Improvement Trajectory).

Policies Approved:

☑ The H&C Senate approved the Vitamin D Testing and Prescribing guidelines pre-Board ratification;

Decisions to be Escalated to ICB Board or other Committees:

☑ The H&C Senate approved the decisions summarised in the Integrated Medicines Optimisation Group (IMOG), August 2024 report;
☑ The Adult Asthma Improvement Project was clinically approved by the H&C Senate;
☑ The System Surge Plan was clinically approved by the H&C Senate;
☑ The H&C Senate approved the Phase 1 (Liver and Lower Gastrointestinal) Diagnostic Pathways for implementation across the SSoT ICS;
☑ The 24/7 PEoLC Advice Line Service Review was clinically approved by the H&C Senate.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 13

Report to:	**Integrated Care Board**					
Date:	**21st November 2024**					
Title:	**Report to the ICB Board on Performance and Finance**					
Presenting Officer:	Paul Brown – Chief Finance Officer					
Author(s):	Colin Fynn - Head of Intelligence and Analytics Matthew Shields - Head of System Finance Alex Robinson - Head of Transformation Delivery Unit (TDU)					
Document Type:	Report					
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* The financial impacts are as outlined in the body of the report.				
Appendices:	Performance and Finance Report					

(1) Purpose of the Paper:

The purpose of this paper is to provide the board with a summary of performance, programme delivery and finance as received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). It outlines at a high level the current position of key system metrics and aligned programme delivery against the Integrated Care System (ICS) Annual Operational Plan and our month 6 finance position.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (I)	30/10/2024
System Finance and Performance Committee (S,D)	05/11/2024

(3) Implications:

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report was discussed at the System Finance and Performance Committee (SFPC) on the 5th November 2024.

<u>Performance</u>

Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented.

Escalations to the SFPC were discussed including the 65-week wait trajectory and the urgent care position.

The target was to have zero 65 week waits by the end of September. Although this was not met significant progress has been made to reduce the numbers. The trajectory to the end of November was shared and the ICB are working up the route to zero. ENT is the particular area of risk. It was noted that performance remains in line with other ICBs, who are facing comparable challenges in achieving the target of zero 65-week waits.

It was noted that since mid-September, the operational position regarding emergency and urgent care performance has been significantly challenged. This has been due, in large part, to the substantial impact of COVID-19, alongside an increase in patient acuity levels. Average ambulance handover times deteriorated to 1 hour 40 minutes during September. Our strategic focus remains on maintaining strong front-door management managing demand effectively across multiple entry points, particularly through collaboration with NHS 111 services, the ambulance service, and our Integrated Coordination Centre. As part of the system surge plan, we have accelerated the activation of several key initiatives to address increased demand and alleviate current system pressures. Early implementation of these measures aims to enhance our response capability and maintain patient flow.

Finance

At month 6, at a system level there is a £29.8m adverse variance against the revised plan (Month 5 variance to plan £25.8m). There is significant risk to the requirement to achieve the planned position.

The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of September) to 24,581 from the levels in March 2024. Within that we have achieved a reduction in agency equivalent to 289 whole time equivalents (WTEs). Overall, the trend demonstrates the pay controls of organisations are having an impact however there is a concern that although workforce levels are lower than they were in March, there have now been 5 months where they have risen, and the system is now above plan by almost 400 posts. Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS)16 compliant against the allocations.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Performance and Finance Report

21st November 2024

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

Overview

This report contains for discussion:

1. An overview of key performance in August against each of the 5 priorities.
2. An overview of key points against each of the 5 priorities where performance is red.
3. A placemat that demonstrates at a high-level key programme deliverables within the 2024/25 operating plan.
4. A finance summary for the month 6 position.

Discussion from System Finance and Performance Committee (SFPC) on the 5th November to note:

The report is discussed at the System Finance and Performance Committee (SFPC).

Performance

Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented.

Escalations to the SFPC were discussed including the 65-week wait trajectory and the urgent care position.

The target was to have zero 65 week waits by the end of September. Although this was not met significant progress has been made to reduce the numbers. The trajectory to the end of November was shared and the ICB are working up the route to zero. ENT is the particular area of risk. It was noted that performance remains in line with other ICBs, who are facing comparable challenges in achieving the target of zero 65-week waits.

It was noted that since mid-September, the operational position regarding emergency and urgent care performance has been significantly challenged. This has been due, in large part, to the substantial impact of COVID-19, alongside an increase in patient acuity levels. Average ambulance handover times deteriorated to 1 hour 40 minutes during September. Our strategic focus remains on maintaining strong front-door management managing demand effectively across multiple entry points, particularly through collaboration with NHS 111 services, the ambulance service, and our Integrated Coordination Centre. As part of the system surge plan, we have accelerated the activation of several key initiatives to address increased demand and alleviate current system pressures. Early implementation of these measures aims to enhance our response capability and maintain patient flow.

Finance

At month 6, at a system level we are reporting a year-to-date deficit position of £25.2m, which is a £29.8m adverse variance against the revised plan (Month 5 variance to plan £25.8m).

The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of September) to 24,581. Within that we have achieved a reduction in agency equivalent to 289 whole time equivalents (WTEs). Overall, the trend demonstrates the pay controls of organisations are having an impact however there is a concern that overall workforce numbers have now risen over 5 months.

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

Ctrl and click on any underlined text for further detail.

Overview of Key ICB Performance August 2024 (Q1 2024), unless specified - Priorities 1 and 2

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

Urgent and Emergency Care		
Category 2 Response target < 30m	8mins 15secs	▼
Accident & Emergency 4-hour wait (78% target by March 25) (UHNM) (September)	-2.9%	▼
Adult General & Acute (G&A) bed occupancy ≤92% (UHNM) (September)	10.9%	▲
Utilisation of Virtual Wards (target 80%) (ICB) (September)	-7.4%	▲
Ambulance Hours lost due to Handover delays > 15m (UHNM) (September)	579	▲
12 hour in Emergency Department Performance (UHNM) (September)	7.9%	▲
Mental Health, Learning Disabilities & Autism		
Learning disability registers and annual health check (September)	1.4%	▲
Improve access to perinatal mental health services	-10.1%	▲
Improve access to Children and Young People Mental Health services	-7.6%	▼
Improve access to Transformed Adult Mental Health services (June)	-7.3%	▼
Access to a course of Talking Therapy	6.0%	▼
Mean week wait to start autism assessment (North: CYP/ adult)	559% / 547%	▲
Mean week wait to start autism assessment (South: CYP)	318%	▲
Mean week wait to complete autism assessment (North: CYP/ adult)	183% / 219%	▲
Mean week wait to complete autism assessment (South: CYP)	200%	▬
Children & Young People (CYP)		
Reduce CYP in residential care outside Staffordshire (September)	-19.7%	▲
Reduce CYP in residential care outside Stoke-on-Trent (September)	14.2%	▲

Planned Care		
Cost Weighted Activity. National published data. Position to June	10.5%	▲
Elective Activity - Daycases	2.1%	▼
Elective Activity - Ordinary Elective	-4.7%	▲
Elective Activity - Outpatient Procedures	3.8%	▼
Elective Activity- Outpatient First Appointment	-1.9%	▼
% Outpatient attends for first appointments or follow-up appointments with a procedure	-0.4%	▼
Reduction in Outpatient Follow-up against 2019/20 baseline	17.3%	▲
Eliminate 65 week waits by September 2024	42.3%	▲
Increase theatre utilisation (85% UHNM)	-7.7%	▲
Cancer 28-day Faster Diagnosis (77% target by March 2025)	1.0%	▼
Cancer 62-day pathways % seen within 62 days (target 70% by March 2025)	3.5%	▲
Cancer non-specific pathway	-1.9%	▼
% of lower GI suspected cancer referrals with Faecal Immunochemical Test result	-23.7%	▲
Community Bed occupancy rate	-1.4%	▼
Primary Care		
Dental Activity delivered	1.6%	▲
Medicines Optimisation		
Pharmacy First Provision – number of interventions (May)	5,230	▲

2 Improving access to high quality, sustainable primary care

Primary Care		
General Practice Appointments	6.0%	▲
General Practice Appointments in <2 weeks (85% target)	6.3%	▼
Additional Role Reimbursement Scheme Full Time Equivalent (Q1)	8.6%	▼
Workforce: GP Full Time Equivalent (Q1)	3.8%	▼
Planned Care		
Deliver increased diagnostic activity levels	0.6%	▼
Patients that receive a diagnostic test within 6 weeks (target)	-14.4%	▼
Mental Health, Learning Disabilities & Autism		
Recover the dementia diagnosis rate to 66.7% target	1.8%	▲

TRAFFIC LIGHT KEY

Against plan, if not available target:

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

Against previous period

▼ ▲	Improvement
▼ ▲	Deterioration
▬	No change

Overview of Key ICB Performance August 2024 (Q1 2024), unless specified - Priorities 3, 4 and 5

3 Delivering joined up proactive & preventative support & care

Mental Health & Learning Disabilities & Autism

Eliminating Out of Area Placements (September)	150%	▲
Talking Therapy Reliable Improvement (67% target)	5.2%	▼
Talking Therapy Reliable Recovery (48% target)	4.5%	▼
Severe Mental Illness health checks (Q1)	6.3%	n/a
Learning disability & Autism reliance on inpatient care (Adult) (Q1)	0%	▲
Learning disability & Autism reliance on inpatient care (CYP) (Q1)	20%	▼
Learning Disability and/or Autism Mortality Reviews (100% target) (September)	-16.7%	▲

End of Life, Long-term Conditions and Frailty

Prevalence rate of Palliative care registers (September)	-0.1%	▬
Patients receiving all 8 care processes for Diabetes -Type 1 (cumulative to September)	2.9%	▲
Patients receiving all 8 care processes for Diabetes -Type 2 (cumulative to September)	2.3%	▲
National Diabetic Prevention Programme - referrals	6.7%	▼
National Diabetic Prevention Programme - commence	9.6%	▲

Children & Young People

Reduce emergency admissions for epilepsy (flat activity)	-65%	▼
Reduce emergency admissions for asthma (flat activity)	-47%	▼

Maternity and Neonates

Stillbirth rate (UHNM only)	4.0	▲
Neonate Mortality rate per 1000 (UHNM only)	4.0	▼
Brain injury rate per 1000 (UHNM only)	2.0	▲
The % of full - term babies admitted to a neonatal unit (UHNM only)	3.8%	▼

Improving Population Health

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

4 Delivering compassionate care of the frail and elderly

Urgent and Emergency Care

80% discharges on Pathway 0 (September)	1.8%	▲
Discharges on Pathway 1 (September)	-1.4%	▼
Discharges on Pathway 2 (September)	0.2%	▼
Reduce number of discharges on Pathway 3 to below 1% (September)	-0.6%	▼

Improving Population Health

Increase uptake of Flu vaccination (Sept - March)		
Increase uptake of COVID vaccination (Sept - Jan.)		

Integration

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

5 Supporting Care Home Residents

Urgent and Emergency Care

Achieve the 70% two-hour urgent community response standard (September)	6.42%	▲

Medicines Optimisation

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

Integration

Admission to care homes	Q	

Primary Care

% of Care Home Patients with ReSPECT Documentation	2.9%	▲
% of Care Home Patients with a Personalised Care Plan	0.1%	▼
Mean number of Multidisciplinary Team meetings per care home resident aged >18	2.0%	▲

TRAFFIC LIGHT KEY

Against plan, if not available target:

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

Against previous period

▼ ▲	Improvement
▲ ▼	Deterioration
▬	No change

Please note

- Priority 3 Hypertension – shown performance in %. Performance continues to be higher than that of the national figure. Due to a change in the methodology for this indicator, it is no longer directly comparable to previous figures.
- Priority 4 Vaccination metrics: COVID-19 - programme commences 3rd October (data release to be confirmed); Flu - first set of data available end of October for September eligible cohorts.
- Priority 4 Integration Metrics: 2023/24 Q4 positions are not available for comparison.
- Priority 5 Medicines Optimisation: Structured Medication Reviews in last 12 months – this is a new metric so previous data is not available for comparison.
- Priority 5: Q2 National Better Care Fund Reporting Template for Local Authorities has not included a figure for Care Home Admissions in the latest publication and has defined the quarterly breakdown as "not applicable"

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Accident & Emergency 4-hour Wait (University Hospitals North Midlands (UHNM)) – September 2024 69.2%, down from 72.9% the previous month and the first time in 7 months below the 70% mark. This was 7.8% below target and 2.9% below plan. Performance against this metric in the NHS Oversight framework remains in the lowest quartile, ranking 36 out of the 42 ICBs in August.	1. 22% increase in Paediatric attendances at Type 1 locations. 2. Increased Acuity of attending patients requiring more complex care and treatments within Accident & Emergency (A&E). 3. Bed flow constricted due to discharge delays within the complex patient cohort with No Criteria to Reside numbers increasing through the month at Royal Stoke.	1. Developing and implementing additional pathways from Emergency Department (ED) into Enhanced Primary Care. 2. University Hospital North Midlands (UHNM) reviewing Emergency Department. ambulatory pathway for speciality referred patients. 3. Enhanced senior in first triage (SIFT) role to commence during October within ED.
	Adult General & Acute (G&A) bed occupancy at University Hospitals North Midlands (UHNM) ≤ 92% – Latest performance (September 2024) was 93.7%, up from 91.3% the previous month and 1.7% above target. Performance was 10.6% above the plan of 83.1% for September.	1. Bed availability impacted by continual Infection Prevention Control (IPC) restrictions relating to continuation of Covid and emerging Norovirus. 2. 4.5% increase in Emergency Admission via A&E over previous month. 3. 7+ day Length of Stay (LoS) cohort of patients increased to 45.5% of bed base during September due to discharge delays.	1. Recommendation for review of planned occupancy trajectory.
	Virtual Wards (VW) – Latest performance for the final submission in September was 73.3% (26th September 2024), below plan for occupancy, however capacity was above plan. • North Sector – 126 occupied out of 170 beds (74.1%) • South-East Sector – 74 occupied out of 83 beds (89.0%) • South-West Sector – 12 occupied out of 35 beds (34.3%)	1. Decrease in Remote Monitored patients within North is due to acuity of patients within Acute Trust for Step Down (SED). 2. South-East sector experiencing staffing issues with supporting ward rounds and referrals. Referrals have also dropped due to the time of year. 3. Inconsistency of process and data capture within South-West sector highlighted.	1. Review current virtual ward service in line with new NHS England (NHSE) specification. 2. Continued recruitment support pull practitioner role within the South to increase identification and utilisation of bed base. 3. Working to address data capture issues through use of iPortal to capture uniform data. 4. Enhanced test of change with Frailty assessment unit at County supporting increased flow from the acute and increased virtual ward utilisation
	Ambulance Hours lost due to Handover delays (UHNM) – September 2024 was 3,361 hours, up by more than 1,500 hours over August, and 579 hours above plan. Ahead of the full launch for Ambulance Handover trajectory delivery on 14th October UHNM reported a compliance of 59.6% (w/c 7th October 2024) against a target of 95% by December 2024.	1. Increased handover delays due to reduced flow through A&E and into the bed base. 2. Increased Acuity of patients requiring more complex care and treatments within A&E restricting available space for offload.	1. Internal Hospital Ambulance Liaison Officer (HALO) Test of Change commenced September 2024 – to support improved off load process. 2. Development of reducing ambulance handover task and finish group to support NHSE ask of 45-minute handover

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Proportion of patients spending more than 12 hours in Emergency Department at UHNM – Latest performance is 7.9% for September 2024, up from 5.7% in August. In comparison the Midlands average for September 2024 was 10.4%. A summary of out of ICB provider performance is provided earlier in this pack.	1. Bed flow constricted due to discharge delays within the complex patient cohort with No Criteria to Reside numbers increasing through the month at Royal Stoke. 2. Increased Acuity of attending patients requiring more complex care and treatments within A&E.	1. Acute Medical Rapid Assessment Unit (AMRA) continues to support timely intervention for medical patients. 2. Reviewing ability to increase discharge lounge capacity at Stoke and County sites to improve flow through the trust. 3. Planned increase capacity for winter of Outpatient Antibiotic Therapies capacity supporting flow of patients through the trust and out of ED in a more timely fashion.
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Perinatal Mental Health (MH) Services - 950 women had at least one contact with the service in the rolling 12 months to August 2024. This is 107 (10.1%) under the monthly trajectory (1,057). Closer to plan than last month. Slightly higher than the same period last year (925). Performance against this metric in the NHS Oversight framework has moved to the lowest quartile, ranking 39 out of the 42 ICBs.	1. Potential impact of a change in the way NHSE allocate activity to Commissioners. 2. Midlands Partnership University NHS Foundation Trust (MPFT) identified two technical issues causing their Mental Health Service Dataset (MHSDS) submissions to be lower than their locally reported activity. 3. North Staffordshire Combined Healthcare Trust (NSCHT) report a slight underperformance of 24 against their M05 plan.	1. Awaiting a response from NHSE to identify if there has been a change in activity levels across England. 2. MPFT are correcting the technical issues and anticipate an improvement in the October submission (September activity, published November). They also plan to correct and resubmit previous months. 3. NSCHT is working to increase the number of face to face and video-conference contacts. 4. Investment has been released to increase the workforce, however the benefits may not be realised until later in the financial year. 5. The Chief Information Officer at NSCHT is leading on a data quality piece across the Integrated Care System (ICS) and is due to report on progress at the November Mental Health, Learning Disabilities and Autism (MHLDA) Delivery Group.
	Improving Access to Children and Young People (CYP) MH Services - 13,870 CYP had at least one contact with the service in the rolling 12 months to August 2024. This is 1,147 (7.6%) under the monthly trajectory (15,017). Lower than the same period last year (14,065).	1. Potential impact of a change in the way NHSE allocate activity to Commissioners. 2. MPFT report higher figures locally, indicating potential issues with data capture in their MHSDS data submissions. 3. Some activity is not being captured at NSCHT following an internal pathway change. 4. NSCHT report an underperformance of 1,236 against their Month 5 plan.	1. Awaiting a response from NHSE to identify if there has been a change in activity levels across England. 2. MPFT are working on reconciling local access figures to MHSDS data submissions to determine if any internal pathway changes have led to a change in recording. 3. NSCHT are working on correcting the data capture issue and plan to resubmit once this has been resolved. This will potentially impact on performance until 2023/24 is no longer included in the calculation. 4. Portfolio to review CYP MH workforce levels within Child and Adolescent Mental Health Services (CAMHS) as part of the refresh of the CYP MH Local Transformation plan for October 2024. 5. The Chief Information Officer at NSCHT is leading on a data quality piece across the ICS and is due to report on progress at the November Delivery Group.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Transformed Adult MH Services – 11,985 adults had at least two contacts with the service in the rolling 12 months to June 2024. This is 939 (7.3%) under the monthly trajectory (12,924). Lower than the same period last year (13,135).	1. Potential impact of a change in the way NHSE allocate activity to Commissioners. 2. NSCHT report an underperformance against their M05 plan (of 538). 3. Awaiting local data from MPFT to enable comparison with the national figures. 4. Changes Health and Wellbeing do not currently include adult activity in their Mental Health Service Dataset MHSDS submissions.	1. Awaiting a response from NHSE to identify if there has been a change in activity levels across England. 2. NSCHT are investigating activity levels in conjunction with services. 3. The portfolio is working with voluntary sector providers to facilitate improved MHSDS submissions. 4. The Chief Information Officer at NSCHT is leading on a data quality piece across the ICS and is due to report on progress at the November Delivery Group.
	Wait to commence Autism assessment, against target of 17 weeks – in August: • CYP North - mean wait of 112 weeks (559% over target) • CYP South - mean wait of 71 weeks (318% over target). • Adult North - mean wait of 110 weeks (547% over target). Wait to complete Autism assessment, against a target of 36 weeks - in August: • CYP North - mean wait of 102 weeks (183% over target). • CYP South - mean wait of 108 weeks (200% over target). • Adult North - mean wait of 115 weeks (219% over target). Please note: although MPFT (South) and NSCHT (North) differ in their mean waits to start an assessment, by assessment completion, mean waits are similar.	1. Increasing demand: since April / May 2024, the total number of children waiting for an autism assessment to commence increased by 44% at MPFT and by 17% at NSCHT.	1. Provider reporting is in development, including a dashboard and infographic which was shared at the September Learning Disabilities and Autism (LDA) Programme Board. 2. Work is going through the Mental Health portfolio to understand data quality and the patients on the waiting list. 3. A report and improvement plan is being developed by the portfolio lead, this will be presented to the ICB Mental Health meeting and then shared with NHSE. 4. ICB working with ICS to support a collective regional action plan with our NHSE colleagues. Midlands workshop planned for November. 5. Working group sessions commenced in September. Main focus to improve pathways and experience (3 stages of waiting well, diagnosis, and post diagnosis support).

Local Priority

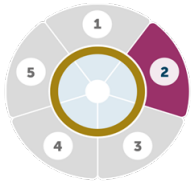
Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Children and Young People (CYP)	Reduce CYP in residential care outside Stoke-on-Trent – 86.7% of placements were outside Stoke-on-Trent in September 2024. Up from 72.5% in the same month last year. 51 (52%) of the 98 out of area placements, were over 20 miles away.	1. Local Authority (LA) data for Stoke-on-Trent – increasing numbers above the same month last year (which is the local target).	1. Stoke-on-Trent LA have prioritised a reduction of out of area residential placements for CYP; this workstream is owned and delivered by the LA, with numerical data on progress reported through to the CYP Programme Board dashboard. 2. Children's Improvement Board in place and led by LA with attendance from ICB. 3. In the Local Authority led workstream, a Safeguarding task and finish group was established in Stoke-on-Trent in July 2024 to develop key actions to reduce the numbers of CYP going into care. An update on its effectiveness has been requested.
Planned Care	Elective (Inpatient) Activity - Ordinary Elective - In August 2024 there was 1,763 spells, against a plan of 1,849, Therefore under plan by 86 spells (-4.7% variance to plan). These are elective interventions where patients stay in hospital at least one night.	1. The number of Elective Inpatients is in line with 2023/24, however the plan for 2024/25 was uplifted by 7.7% above last year's outturn. 2. When combined with Day Case spells metric, there was a variance to plan of 1.3% in August 2024. Providers are encouraged to achieve a Day Case rate of 85%.	1. Analysis of Elective Recovery Fund (ERF) achievement by providers taking place at Contract Steering Group. Currently ICB is achieving 109% (i.e. delivering 9% more activity than 2019/20 levels), exceeding the target set for the ICB by NHS England (101%), and close to meeting the ICB planned level (110%)
	Reduce Outpatient Follow ups v 2019/20 level - In August 2024 there were 17.3% more attendances than the planned level (based on achieving a 25% reduction by March 2025). Independent Sector Provider follow up activity is 1515 above plan.	1. All main providers currently have levels of activity for outpatient follow-ups above 2019/20. In some cases, increased follow-ups are a result of treating patients with long waits on waiting lists. 2. Higher level of activity recorded in Independent Sector Providers as more capacity available, and providers encouraged to submit to Secondary Uses Service (SUS).	1. For Independent Sector Providers, the level of follow up appointments is being monitored, as part of the monthly reconciliation process, and challenged through contractual routes when necessary. 2. ICB working with providers to encourage Patient Initiated Follow Ups (PIFU).
	% Outpatient attends for first appointments or follow-up appointments with a procedure - In August this was 47.0% against a target of 47.4%. This metric partly derived from the metric Elective Activity - Outpatient First Appointment In August there was 773 appointments less than plan (-1.9%).	1. The year-to-date rate is 47.2% for April to August 2024, against a target of 47.3%, therefore the metric is only marginally below target. 2. The level of first and procedure appointments is achieving target for April to August 2024 (year-to-date), however follow-up appointments (without procedures) is above planned levels affecting the level of compliance.	1. Level of follow-up being monitored as outlined in above metric.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Planned Care	Eliminate 65 week waits (ww) by September 2024. At the end of August there was 771 ICB patients waiting over 65 weeks (at all providers), against a plan of 542. Unvalidated data from the National Waiting List Dataset reports, at the end of September, there was 208 patients waiting within the ICB providers over 65 weeks, and 165 at non ICB providers (111 at University Hospitals of Derby and Burton (UHDB)).	1. Capacity continues to be an issue. 2. Out of 771 patients, 523 are at UHNM, 161 at UHDB, 23 at Royal Wolverhampton Trust (RWT), and 16 at Medefer. 3. The specialties with highest numbers are General Surgery (103), Orthopaedics (132), Ears, Nose and Throat (157, nearly all at UHNM), and Respiratory Medicine (143, all at UHNM).	1. Continue to maximise the contribution of the independent sector where appropriate. 2. Patient by patient validations taking place and monitored as part of weekly submission to NHSE England. 3. Ongoing analysis of 65ww cohort by specialty to inform any risk to planned delivery.
	Increase theatre utilisation (UHNM) - In August 2024 theatre utilisation was 77.3% at UHNM, against the target of 85%.	1. Inefficient Perioperative Medicine Pathways; multiple outcomes due to this, for example on the day cancelled operations remain at 9%, and late starts (over 15 minutes) remain at 16%.	1. Perioperative Medicine Pathway Transformation Delivery groups continue to focus on future state pathway and finalising training on the digital screening tool; 2-year programme working with NHSE to deliver. 2. Theatre scheduling with theatre team and specialities in place; visiting other Trusts to follow best practice.
Cancer	Faecal Immunochemical Test (FIT) - The percentage of patients referred with suspected lower gastrointestinal (GI) cancer, with a FIT result was 57.1% (year-to-date cumulative position to August 2024). This is against a plan of 80.6%. This metric has shown a continual improvement (from 43.1% in April 2024),	1. Published data extracted directly from primary care clinical systems which does not reflect the actual level of performance due to coding issues. In practice around 70% of referrals in the ICB are compliant. 2. Referrals to UHNM are around 90% compliant and to UHDB, around 70%. 3. Referrals to UHNM have high level of compliance due to referrals being made via referral hub, ensuring FIT tests are available, however, referrals to other providers are not made through a different referral hub which means these referrals may not have the same level of scrutiny as those to UHNM.	1. The ICB is working with practices not achieving the standard, to improve coding and processes.
	Cancer non-specific pathway – The number of patients referred to UHNM onto a non-specific symptom's pathway was 53 in August 2024, against a target of 54.	1. This is the first month in 2024/25 which the target was not achieved. For the period April 2024 to August 2024 there has been 38% more referrals than the target value.	1. Continue to monitor monthly values.



Local Priority

Improving access to high quality sustainable primary care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Primary Care - Workforce	Additional Roles Reimbursement Scheme (ARRS) - stands at 588.7 Full Time Equivalent (FTE) for June 2024, below the Q1 target of 644 FTE. Data for August 2024 shows a decrease to 580.2 FTE.	1. ARRS FTE fell due to a number of 6-month contracts coming to an end where Primary Care Networks (PCNs) had recruited temporary ARRS roles to utilise underspend. 2. Actual figures are based on National Workforce Reporting Service (NWRS) data and there are reporting discrepancies between these figures and ARRS claims. For August 2024 data, NWRS is showing 580.2 FTE and the ARRS claims portal is much higher at 669.8FTE (a difference of 89.6 FTE). A further breakdown for ARRS roles shows the under recording in NWRS is largely within the adult mental health practitioners staff group. Cumulative ARRS spend data (April to August 2024) shows budget utilisation at 97.9%.	1. Task and Finish group is working with PCNs to ensure they utilise 100% of their ARRS budget as there is no ability to undertake an unclaimed funding process this year. 2. PCN workforce plans and challenges are being discussed as part of PCN Support meetings. 3. The primary care team are working with individual PCNs to ensure they are regularly reviewing and updating NWRS to improve accuracy of their submissions and are in line with claims made via the PCN claims portal. 4. The ICB are working with the clinical champions and the training hub to develop initial plans to implement the new flexibility to recruit newly qualified General Practitioners (GPs) under ARRS. The latest guidance has now been shared with PCN's.
	GP Full Time Equivalent (FTE) - stands at 687.9 for June 2024, below the Q1 target of 715 FTE. Data for August 2024 shows a substantial increase to 731.1 FTE. If this remains stable for September 2024, then the Q2 target will be achieved.	1. A limited number of vacancies are being advertised for salaried or partnership roles in the ICB because practices are not finding it financially viable to replace a leaving GP with another GP. 2. Practices are using a wider skill mix of staffing roles e.g. nursing and ARRS roles which are more financially viable. 3. The issue is a nationwide one and NHSE have recently conducted a deep dive exercise into the issue.	1. The Workforce Implementation Group (WIG) is developing a workforce delivery plan for sign off in Autumn 2024. 2. Retention plans are being mobilised and new schemes are being developed. All schemes are evaluated at the end of the scheme. These evaluations will be reported via WIG. 3. The primary care team continue to work with practices to encourage accurate reporting of GP Trainees.
Diagnostic waits and activity	The % of patients waiting within 6 weeks for a diagnostic test at the end of August 2024 was 64.4%, against a plan of 78.8%. This is for the ICB patients at all providers. Performance against this metric in the NHS Oversight framework remains in the lowest quartile, ranking 37 out of the 42 ICBs.	1. The tests failing the 6-week plan in August 2024 were Magnetic Resonance Imaging, Non-Obstetric Ultrasound, Dexa scans, Echocardiography and Audiology. 2. By ICB main provider (all patients) the achievement in August 2024 was UHNM (57.7%), UHDB (76.5%), RWT (93.6%). 3. Workforce and capacity still an issue at UHNM. Also increased demand. For Non-Obstetric Ultrasounds the waiting list is increasing by up to 300 per week. 4. The waiting list for Dexa scans is small compared to other tests, with 546 patient waiting (with 22 waiting over 6 weeks).	1. Echocardiography waiting times at UHNM are expected to reduce to 13 weeks by the end of October 2024 due to increased capacity in September 2024. Substantive capacity also starting in December2024. 2. Non-Obstetric Ultrasound capacity at UHNM has been secured to start at the end of October 2024. 3. Extra endoscopy capacity has reduced the backlog for surveillance, planned and diagnostic waiting list.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability (LD)	Eliminating Out of Area Placements (OAP) - there were 5 active inappropriate adult acute mental health OAPs at the end of September 2024 (3 over plan). Two over plan at an ICB level (2).	1. Unavailability of suitable beds at MPFT.	1. To review individual cases to determine if placing out of area (OOA) was the only appropriate action and no other alternatives options available.
	Reliance on inpatient care for people with a learning disability and/or autism under 18 years of age - there were 6 inpatients in August, a reduction of 1 patient on last month. This measure has a quarterly plan (Quarter 2 = 5). September 2024 data awaited.	1. Case mix is becoming more complex. 2. The trend of late autism diagnosis in children is reported by NHSE as a national trend.	1. Invested in improved diagnosis process: funding from ICB to NSCHT and MPFT. 2. Fortnightly case CYP inpatients analysis by a multi-disciplinary team (e.g. clinicians, therapists etc) continues to develop to help coordinate discharges.
	Learning from Lives and Deaths (LeDeR) - of 6 eligible reviews due for completion in September 2024, 5 (83.3%) were completed within 6 months against target of 100%. Eligible reviews are those which have not been placed on hold due to external investigations.	1. An inherited backlog following a contract change. 2. One review breached because a focused review was unable to be discussed at governance panel and therefore was unable to be closed/signed off.	1. The service reports an increased standard and quality of reviews and an increase in the number of focused reviews now completed. 2. There are now only 2 reviews to be allocated for notifications from October 2024. This is a significant improvement.
Mental Health and Learning disability (MHLDA) Portfolio Delivery Escalation	ICS wide roll out of Oliver McGowan Training is currently under plan. Trajectory to recover is at risk due to contract for project manager post holder and expert by experience contract, delivered by Asist, which is due to cease in March 2025 and future arrangements unconfirmed. Tier 1 achieved 641 / 711 target at Month 5 Tier 2 achieved 502 / 1017 target at Month 5	1. Lack of training capacity to facilitate the programme and meet requirements of the workforce. 2. Volume of the workforce, aligned to statutory requirements for Care Quality Commission (CQC) regulated providers, in scope to receive training.	1. Single Tender Waiver (STW) is being progressed and the Establishment Control Process is underway. 2. All main NHS providers have agreed a collective approach to delivery based on current funding opportunities.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Maternity and Neonates **(at University Hospitals North Midlands only (UHNM))**	Neonate Mortality Rate – above the benchmark rate in September 2023/24.	1. A rate increase from zero neonatal deaths in September 2023/24 to 2 in September 2024, raising the rate to 4.0 (per 1,000). 2. Small numbers are derived from crude data which do not take into account congenital anomalies.	1. Request made to UHNM to validate the data. 2. Monitor neonatal deaths and [Provider] actions through the Quality and Safety Forum monthly. 3. UHNM mortality leads are a part of the ICS infant mortality group to support the implementation of actions, which are in development.
	Brain Injury Rate – above the benchmark rate in September 2023/24.	1. Rate increase to 2.0 per 1,000 in September 2024 from 0.0 in September 2023/24, due to 1 reported Neonatal Brain Injury (Cooled) at UHNM. 2. Small numbers are derived from crude data – quarter 1 and 2 counts are less this year than 2023/24 however local monitoring continues.	1. A request was made to the Provider to validate the data. 2. Monitor brain injures through the Quality and Safety Forum monthly.
	The proportion of full - term babies admitted to a neonatal unit, measured through the Avoiding Term Admissions into Neonatal Units (ATAIN) programme – rate increase.	1. The proportion is above the September 2023/24 benchmark (of 3.6%) with 3.8% reported in September 2024. Small numbers and is below the national average of 6%.	1. Metric is monitored monthly in the Quality and Safety Forum. 2. Request will be made to UHNM, to provide feedback on the increase in admissions at the next Quality and Safety forum, Tuesday 28th October 2024. 3. As part of Clinical Negligence Scheme Trust (CNST), UHNM are on track to meet the requirement to attain safety action 3, to implement transitional care services and draw insights into to term admissions to the neonatal unit and undertake quality improvements to decrease admissions.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
End of Life, Long-term Conditions and Frailty	Prevalence rate of patients on palliative care registers to 1%. In September 2024 there were 10,069 patients on a palliative care register. Out of 1,203,385 registered patients this equates to 0.84%, against a target of 0.90%	1. Performance has maintained at 0.84% throughout 2024/25, but not increased. Various factors including the pressures facing Primary Care and seasonal impact during summer period of Annual Leave. 2. GP collective action may affect future performance.	1. Training on Identification at End of Life will continue to be offered through Staffordshire Training Hub sessions are planned from October 2024 until July 2025. 2. Analysis of data to identify opportunities for a targeted approach to individual practices and PCNs.
End of Life - Programme Delivery Escalation	End of Life (EOL) Programme: Hospice Accelerated Beds project for step up and step-down care was evaluated and delivered agreed outcomes. The evaluation demonstrated that the project avoids admissions and supports early discharge. 24/7 Advice Line – Case for change has been presented at Clinical Senate and was supported from a clinical perspective	1. The ICB has been unable to provide additional funding to keep these beds open. 2. 24/7 Advice line will be presented to the System Finance and Performance Committee in November 2024.	1. 24/7 advice line- Case for change is currently being taken through ICB governance structure.
Frailty - Programme Delivery Escalation	Frailty Programme: Severe frailty service re-design Test of Change led by MPFT has been evaluated including an economic evaluation demonstrating impact and delivery of the project goals and national guidance/best practice. Frailty Programme: Scaling up of proactive falls projects.	1. An options appraisal to scale up the model across the ICS cannot progress without significant re-orientation of existing resources or investment from the ICS.	1. Falls: An options appraisal to scale up the model including an economic evaluation will be completed by the end of November 2024.

Other Key Points Aligned to this priority
Cholesterol: % of patients with QRISK 20% or more treated with lipid lowering therapy - Quarter 1 data shows performance of 64.0%, 1.7% above the baseline of 62.3%. Performance is on an upward trend and remains higher than the national figure.

Local Priority

Delivering compassionate care of the frail and elderly

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Discharges on Pathway 2 (ICB) – Performance in September 2024 improved from 3.69% to 3.06% which was 0.17% above plan. Current position as of 13th October 2024: 3.62%.	1. Actual numbers on Pathway 2 fell from 196 to 157, second lowest level of last 12 months, however complex nature of some discharges continues to require Pathway 2.	1. Discharge Pathway 2 remains a focus for Integrated Discharge Teams. However, as it was off-plan by only 0.17%, no additional action has been identified.
Integration	Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions (Staffordshire Local Authority) – Latest indirectly age standardised rate (Q1 2024/25) indicated 217.8 admissions per 100,000 population, 3 above plan.	1. Clinical Coding issues at main Acute Provider the data submitted for the period is not complete and as such an accurate representation cannot be identified to match against plans for a true assessment of progress. 2. Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions for Stoke-on-Trent Local Authority is currently reporting as under plan but is likely to be affected by the same issue as the Fall related Metric and as such is almost certainly understated.	1. With the window for submission now closed, there is no opportunity for an update and a subsequent correction to the uncertain position. However, the clinical coding backlog is being addressed by main acute providers and the issue is improving. 2. There are also indications of a similar issue recurring within the Q2 reporting window and analytical process will be replicated if that is found to be true.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Stoke Local Authority) – Latest directly age standardised rate (Q1 2024/25) indicated 381.7 falls per 100,000 population versus the annual plan figure 1331. This is 48.85 above the quarterly equivalent plan figure.	1. The reported figure is likely to be an understatement of the actual position, due to the nature of the 'flex' position of Secondary Care User Service (SUS) data. The accuracy of its 'freeze' position, published a month later, will improve. 2. Falls within Care Homes continue to be an area of concern.	1. Review of provision of Falls response from Staffordshire Fire and Rescue Service under Better Care Fund (BCF) to take place as service only funded via Staffordshire however response is also being provided into Stoke splitting available resource. 2. Review of pathways and service offers within reactive services to maximise patients are supported in the right setting and avoid Ambulance dispatches and ED conveyances, 3. Alignment of reactive workstreams with proactive workstreams to support more patients be managed within the community. 4. Onboarding of the Long Lies policy to support patients remain at home.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Staffordshire Local Authority) – Latest directly age standardised rate (Q1 2024/25) indicated 437.2 falls per 100,000 population versus the annual plan figure 1448. This is 75.18 above the quarterly equivalent plan figure.		
	Discharge to Usual Place of Residence (Staffordshire Local Authority) – Latest Performance for Q1 2024/25 was 92.72%, 0.78% below plan	1. Discharge pathway pressures resulted in increases in discharges to short term Pathway 1 including Discharge To Assess (D2A) beds.	1. Analysis of D2A pathways and timings completed by Integrated Discharge Hub (IDH) with findings integrated into the operating model by the end of October.

Local Priority

Supporting Care Home Residents

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Care Homes	Multidisciplinary Team Meetings (MDT) year to date to August have fallen 2% below plan, delivering 3713 meetings to date, a shortfall of 103 MDT meetings.	1. Capacity of Community Teams and Primary Care is stretched to allow MDT meetings to take place across all locations.	1. Primary Care are working with MPFT, practices and networks to progress MDT meetings in line with the new Care Homes Universal Offer Specification commencing 1st October 2024 and the Network Contract Directed Enhanced Service (DES).
Care Homes Programme Delivery Escalation	The Care Homes Programme was originally intended to form part of the Demand Management system collaborative.	1. Care Homes does not benefit from being aligned to a single Portfolio, which means that activities designed to support care home residents remain fragmented, with the potential for duplication and gaps.	1. Discussions are already underway to determine what care home activities, in partnership with the Local Authorities, could support the UEC Portfolio to deliver this year's Surge Plan. 2. With the appointment of a new Senior Responsible Officer (SRO) for the Demand Management System Collaborative, conversations continue to determine what longer term transformational activities are needed for 2025/26. 3. The work on specific services/interventions to support care homes will be included in the year one delivery (2025/26) of the Medium -Term Plan. The demand management collaborative continues to identify the specifics of the service/interventions for planning purposes.

Other Key Points Aligned to this priority
70% Urgent Community Response (UCR) - exceeded target by 6.4% in August, however Urgent Community Response (UCR) referrals were under plan (of 872) by 247. Analysis of the latest provisional data for September shows that of the 3156 calls referred into Integrated Care Coordination (ICC) overall 16% came from Care Homes, 9% were Call Before Convey from WMAS and ~30% resulted in advice/guidance or signposting. Of the total calls relayed in from West Midlands Ambulance Service (WMAS) 61.5% were rejected with 39% rejected due to being clinically inappropriate. Whilst comparative data for August is not available due to the change in software at the Provider anecdotally, the situation is believed to be similar.

Overview of Portfolio key deliverables 2024/25 - Priorities 1 and 2

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

Planned Care

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

Mental Health, Learning Disabilities & Autism

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

Children and Young People, Maternity & Neonates

Implement delivery plan to improve survival of babies and young children to reduce Infant Mortality	On track	–

Urgent and Emergency Care

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

2 Improving access to high quality, sustainable primary care

Primary Care

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

Mental Health, Learning Disabilities & Autism

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

TRAFFIC LIGHT KEY

Against plan or target:

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

Against previous period

▼	Improvement
▲	
▼	Deterioration
▲	
–	No change

Overview of Portfolio key deliverables 2024/25 - Priorities 3, 4 and 5

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

End of Life, Long-term Conditions and Frailty

- Scale up an enhanced Falls prevention program taking learning from test for change in one geographical area – May-Nov 24
- Delivery of the PEoLC strategy pan Staffordshire
- Development of overarching Long Term Conditions Strategy
- Evaluation and business case for 24/7 advice and guidance
- Evaluate the accelerated beds to support with surge and other challenging time periods and scale up.

Children and Young People, Maternity & Neonates

- Implementation of the national delivery plan for maternity and neonatal care

Children & Young People

- Design and implement Long Term Conditions Programme - ASTHMA
- Design and implement Long Term Conditions Programme - EPILEPSY
- Design and implement Long Term Conditions Programme - DIABETES
- Implement Children with Complex Needs project

Mental Health & Learning Disabilities & Autism

- System wide roll out of Oliver McGowan Training
- Expand the availability of Mental Health Support Teams in schools
- Co-create long term vision and service model to localise and realign MHLDA inpatient services (Inpatient Quality Transformation Programme)

Improving Population Health

- Health Inequalities: Published HI Strategy; HI Outcomes Framework agreed by all Partners, and; HI Finance Framework running in shadow form 2025/26
- Prevention Strategy published, and Reducing harm from Alcohol Strategy published
- Locality Development: Locality outcomes, incentives and governancce in place
- PHM: Stage 1 Linked Data Set
- Core20PLUS5: Maternity, Cancer, Respiratory, Hypertension, SMI
- LTP Prevention: Obesity, Tobacco, Alcohol, HIV, CVD, TB, AMR, Diabetes, Cancer
- Implement local vaccination improvement plans to increase uptake in unvaccinated cohorts
- Establish collaborative working arrangements for vaccination commissioning in preparation for delegation of functions in April 2025 (actual delegation April 2026)
- Maximise uptake of childhood vaccinations and flu & pneumonia vaccinations in adults

4 — Delivering compassionate care of the frail and elderly

End of Life, Long-term Conditions and Frailty

- Enhanced care of severely frail patients in a community and domiciliary settings. Using the learning from the 2023/2024 pilot.
- Refresh of frailty strategy

5 — Supporting Care Home Residents

Integration

- Care Homes System Recovery Programme

TRAFFIC LIGHT KEY

Against plan or target:

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

Against previous period

- Improvement
- Deterioration
- No change

Finance Summary – Month 6

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

- At month 6, at a system level we are reporting a year-to-date deficit position of £25.2m, which is a £29.8m adverse variance against the revised plan (Month 5 variance to plan £25.8m). The year-to-date variance to plan sits within ICB (£16.2m) and UHNM (£14.4m) with small surplus at MPFT (£0.6m) and NSCHT (£0.3m).
- The system is reporting unmitigated risk of £56.5m at month 6 incorporating recovery plan actions from both the green and amber actions. This reflects the assumption that all green and amber rated recovery actions are implemented in full. Since this assessment, we have been informed by Region that national have now decided to recover the dental underspend after all. This will lead to a deterioration in the position at Month 7 unless further recovery items can be identified to cover the additional gap.
- It has been made clear to us that this outturn is not acceptable. The system has responded to the initial Investigation & Intervention requirements with weekly reporting commenced and external support procurement process having been completed. The expectation nationally is that this support will enable the system to return to the plan.
- With the inclusion of the green rated schemes, the system efficiency outturn is now assessed at £179.5m (7.1%). There is therefore a shortfall of £24m against the annual efficiency plan which was £203m. Furthermore, there remain some risks to the delivery of the £179.5m forecast which is being worked on by the Recovery Director and the system.
- The system workforce numbers (substantive + bank + agency) were 24,704 in March and they have now fallen (end of September) to 24,581. Within that we have achieved a reduction in agency equivalent to 289 WTEs. Overall, the trend demonstrates the pay controls of organisations are having an impact, however there is a concern that overall workforce numbers have now risen over 5 months.
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS) 16 compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. There is slippage on national Public Dividend Capital (PDC) with Community Diagnostic Centres (CDC) and Targeted Investment Fund (TIF) 2 schemes.

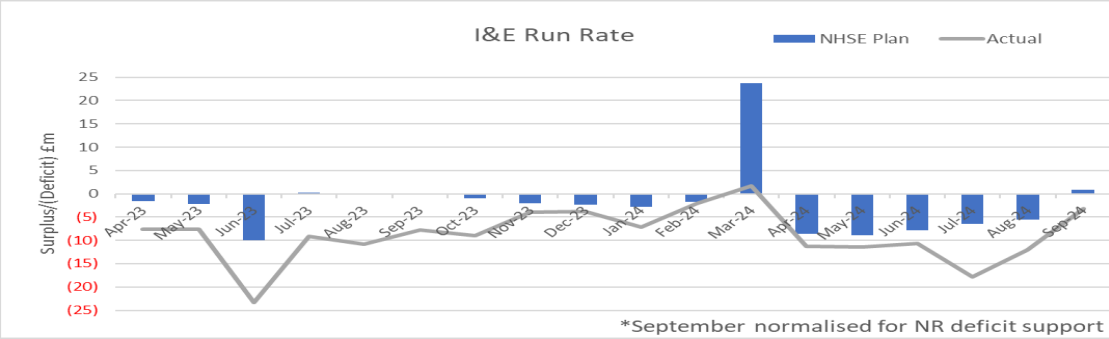
Month 6 Position

- During month 6 the guidance to release non recurrent funding equivalent to the deficit agreed on the 12th June 2024 was transacted. The system is reporting a year-to-date adverse position of £29.8m against a revised break-even plan. The main drivers for the aggregate year to date (YTD) position are efficiency slippage (£19.9m) and binding conciliation (£14.8m) with adverse impacts in medical staffing (£3.7m) and continuing healthcare (£5.9m). These are partially offset by other non-recurrent mitigations (£16.9m) and dental underspend (£2.7m).

- Within the £29.8m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £5.1m at Month 6, this will reduce monthly to no impact by year end.

System	Month 6 £m Plan	Month 6 £m YTD	Month 6 £m Variance	Month 5 £m Plan	Month 5 £m YTD	Month 5 £m Variance
Income	2,502.2	2,510.9	8.6	2,044.0	2,050.4	6.4
Pay	(634.4)	(637.4)	(3.0)	(528.5)	(530.5)	(1.9)
Non Pay	(342.7)	(364.9)	(22.3)	(285.7)	(303.4)	(17.6)
Non Operating Items (exc gains on disposal)	(18.1)	(15.0)	3.1	(14.9)	(12.4)	2.5
ICB Expenditure	(1,502.5)	(1,518.8)	(16.2)	(1,252.2)	(1,267.4)	(15.1)
Total	4.6	(25.2)	(29.8)	(37.4)	(63.2)	(25.8)
			-1.2%			-1.3%

ICB	Month 6 £m Plan	Month 6 £m YTD	Month 6 £m Variance	Month 5 £m Plan	Month 5 £m YTD	Month 5 £m Variance
Allocation	1,502.5	1,502.5	0.0	1,211.1	1,211.1	0.0
Expenditure	(1,502.5)	(1,518.8)	(16.2)	(1,252.2)	(1,267.4)	(15.1)
TOTAL ICB Surplus/(Deficit)	0.0	(16.2)	(16.2)	(41.1)	(56.3)	(15.1)
			-1.1%			-1.3%



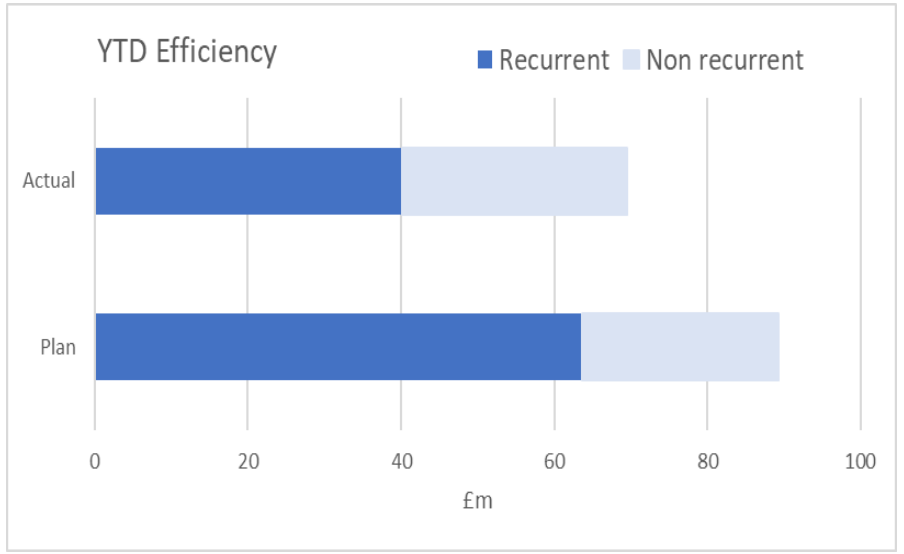
UHNM	Month 6 £m Plan	Month 6 £m YTD	Month 6 £m Variance	Month 5 £m Plan	Month 5 £m YTD	Month 5 £m Variance
Income	576.8	588.3	11.5	480.2	488.6	8.5
Pay	(345.7)	(351.6)	(5.9)	(287.9)	(292.6)	(4.6)
Non-Pay	(210.1)	(231.3)	(21.3)	(174.7)	(191.1)	(16.4)
`	(18.5)	(17.3)	1.2	(15.4)	(14.3)	1.1
TOTAL Provider Surplus/(Deficit)	2.5	(11.9)	(14.4)	2.1	(9.4)	(11.4)
			-2.5%			-2.3%

MPFT	Month 6 £m Plan	Month 6 £m YTD	Month 6 £m Variance	Month 5 £m Plan	Month 5 £m YTD	Month 5 £m Variance
Income	339.2	337.7	(1.5)	283.0	282.2	(0.8)
Pay	(238.8)	(238.1)	0.7	(199.1)	(198.3)	0.8
Non-Pay	(99.3)	(99.5)	(0.2)	(83.1)	(83.7)	(0.6)
Non Operating Items (exc gains on disposal)	1.3	2.9	1.5	1.3	2.4	1.1
TOTAL Provider Surplus/(Deficit)	2.4	3.0	0.6	2.1	2.6	0.6
			0.2%			0.2%

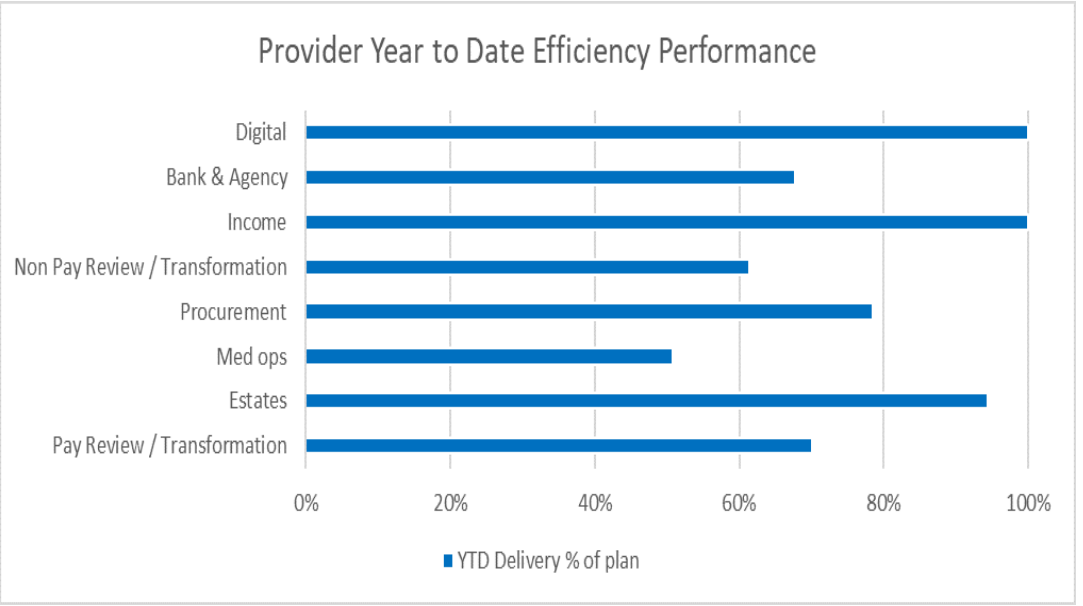
NSCHT	Month 6 £m Plan	Month 6 £m YTD	Month 6 £m Variance	Month 5 £m Plan	Month 5 £m YTD	Month 5 £m Variance
Income	83.7	82.3	(1.4)	69.7	68.4	(1.3)
Pay	(49.8)	(47.7)	2.1	(41.4)	(39.6)	1.8
Non-Pay	(33.3)	(34.1)	(0.8)	(27.9)	(28.6)	(0.6)
Non Operating Items (exc gains on disposal)	(0.9)	(0.6)	0.3	(0.7)	(0.5)	0.3
TOTAL Provider Surplus/(Deficit)	(0.4)	(0.1)	0.3	(0.4)	(0.2)	0.2
			-0.3%			-0.3%

Efficiency

- The system has delivered £69.5m of efficiency as of September 2024, this is £19.9m adverse against plan, which is largely at ICB (£14.1m) and UHNM (£5.3m)
- The system efficiency programme totals £203m with £52.6m high risk as of month 6, with work on going to identify further schemes
- Recurrent schemes are £23.5m adverse at month 6. 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
- The table below shows the position that the recovery plan would lead to taking into account the delivery of the green actions (£179.5m) which will improve the reported month 6 forecast delivery £160.4m.



Financial Improvement Summary	Plan £m	Risk Adjusted Position £m	Likely Recovery Actions £m	Recovery Plan £m
Organisational CIP				
ICB	47.9	38.5	8.3	**46.8**
UHNM	56.6	46.6	5.7	**52.3**
MPFT	37.9	38.7	2.4	**41.1**
NSCH	6.4	6.4	0.7	**7.1**
Collaboratives				
Continuing Healthcare	32.5	11.0	9.4	**20.4**
Clinical Values & Medicine	4.0	4.0	0.0	**4.0**
Contracts	17.8	7.8	0.0	**7.8**
Total Improvement	**203.1**	**153.0**	**26.5**	**179.5**
% of RRL	**8.0%**	**6.1%**	**1.0%**	**7.1%**



Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 14

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**November 2024**
Reporting Committee:	**Finance & Performance Committee (F&PC): Parts A + B**
Date of Meeting:	**5 November 2024**
Meeting Quorate Y/N?	**YES – both Parts**
Presenter:	**Megan Nurse, Non-Executive Member & Committee Chair**
Author:	**Paul Winter, Associate Director of Corporate Governance**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

(1) Month 6 Finance Reports - Parts A + B:

For the System, the key points to alert to ICB Board include:

- *The System year-to-date position of £29.8m adverse to plan at M6*
- *Slippage in the efficiency programme is the key driver for the performance to M6*
- *The System has assessed risk and reporting unmitigated risk of £56.5m incorporating the 'Green' and 'Amber' rated programmes' recovery actions into the risk position*
- *The System has responded moving into the Intervention & Investigation Regime and appointed an external partner to support this work*
- *The System has a compliant capital plan for 2024/25 however, there is potential slippage on national programmes and opportunities to mitigate this are being examined.*

Discussions centred on the risks to future years' capital programmes and focused in on assurances around the Workforce KPIs (latest positions on Agency & Bank usage); plus on the reported 'Amber' schemes and the relative confidence levels on future delivery of these: e.g. clawback of Dental underspend. The Committee felt assured by the reported levels of risk feeling appropriate – reference to the Recovery Programme papers also discussed in the next section; acknowledged the System position at M6 (£29.8m adverse to plan); and the net risk reported at M6 (£56.5m)

For the ICB's position discussed in Part B, the Committee noted during M6 NHSE issued guidance to release funding equivalent to the (£90.0m) deficit plan agreed on 12 June 2024, enabling SSOT ICB to set a breakeven plan for 2024/25. Note: this adjustment is presentational only and does not impact the risk being flagged by the ICB.

At M6, the ICB reported a YTD deficit position of £16.2m adverse variance against the revised breakeven plan. This reflects a £1.1m adverse movement from a £15.1m deficit position at M5, with continuation of recurrent issues, recently offset by crystallisation of agreed recovery actions mitigating underlying issues.

Key pressures remain, driving the YTD to remain consistent to previous months, including:

- *Efficiency delivery against the ICB's £102.2m annual target*
- *The outcome of the binding conciliation exercise*
- *The underlying cost of CHC packages continues in excess of the 23/24 planned exit position*
- *The Recovery Plan submitted to NHSE on 13 Sept 2024 included agreed Green & Amber mitigations totalling £29.8m, against a previously flagged risk assessment of (£67.8m), setting a revised risk assessment for the ICB of a (£38.0m) deficit. This excludes £15.0m of red actions yet to be supported.*

Significant progress has been made against the mitigations identified within the Recovery Plan, but this is still at high risk of delivery.

(2) Recovery Plan & Programme Update incl. ICS Recovery Director Report, Part A // ICB Efficiency Programme, Part B:

(Note: while these 3 items were separately discussed, they remain strongly interlinked)

At M6, the overall £203m efficiency plan is showing a £19.8m negative variance against a plan of £89.3m. This remains consistent with the M5 position. All of the four established 'System Collaboratives' remain behind plan at M6. Each has identified a range of risks & mitigations discussed at the weekly System Recovery meeting on 24 October. The PMO have now completed an assessment of what opportunities exist within 'Enabling Functions', both in-year and for 2025-26. Of particular note:

- *Continuing Healthcare – at M6, the collaborative is £11.5m adrift from plan. The Q1 upward trend in cost has been halted in Q2 and is showing some encouraging signs of improvement, influenced by the recovery actions. However, the forecast spend is £238.8m, which equates to an overspend of £30.2m. The forecast saving against the original £32.5m target is now £20.4m*
- *Demand Management – the deliverables for the programme for 24/25 have been finalised with operational plans in place for the delivery. These will be overseen by the surge planning process and UEC Portfolio. Any emerging cost pressures as a result of having insufficient beds will continue to be monitored by the weekly System recovery meeting*
- *Clinical Value & Medicines – a 'deep-dive' was presented by the Collaborative Director. The Oral Nutritional Supplement scheme is yet to go live. Work continues to finalise the QIA; operational leads are in place. The original financial savings from Q2 are being re-profiled, the forecast for delivery has been reduced to £0 whilst the benefit expected in 24/25 is profiled and estimated*
- *Contracts – the forecast for Independent Sector Savings target has been revised to £0 following a review of the capacity / discount offer against UHNM's plan (incl. both the operational plan to reduce waiting list sizes and also CIP plans to achieve maximum ERF in year). The economic case to save £200k is offset by a combined cost up to £2.5m to UHNM and the scheme is not economically viable. Further smaller contractual savings have been identified to be reported on next month*
- *Enabling Functions – a review of corporate service costs using Model Health System data (providers) / Running Cost Allowance data (ICB) shows most areas performing well against benchmarks, with plans in place to deliver a cumulative CIP plan of c.£3.5m in 24/25. Any further opportunities require a more radical redesign of service provision and we need to determine the level of System appetite to embark on this, especially as many functions will be needed to design / deliver the Medium Term Plan. There will also be levels of investment required to enable potential changes.*

Enhanced Committee focus remains a strong assurance to Board. The Committee together with the Recovery Director are keeping up the financial challenge on the work required to get back to plan.

Further work is ongoing to drive further delivery of CIP across the SSOT ICS.

The current forecast for the Collaboratives' financial improvement delivery is £26.7m against a plan of £54.3m (£27.6m adverse). The forecast has improved by £1.9m since the last Recovery Director report. However, the improved forecast from the CHC Collaborative has been partially offset by reductions in forecasts from Clinical Values & Medicines and Contracts Collaboratives.

(3) System Performance & Programmes Report, Part A:

The Committee received the M5 / August report outlining the current position of key System metrics and aligned programme deliverables against the ICS Operational Plan alongside a Q2 overview of the key NHS Oversight Framework (NHSOF) KPIs.

- *Performance of 24/25 Operational Planning Measures shows a number of areas that are at variance to plan or target – the report outlined the key drivers of underperformance / programme delivery, along with key actions and escalations put forward by Portfolios, aligned to the 5 System Priorities*

- *Two specific 'Alerts' discussed in the meeting were in relation to the Planned Care 65-week waits position, with the current actual number waiting in excess of plan; and the UEC ambulance handover metrics, showing deterioration against the 30-minute Category 2 standard as at the end of September*
- *Of the total of 44 ICB aggregated NHSOF indicators: a total of 8 are ranked lowest quartile in Q2 24/25; 2 are new to the lowest performing quartile having declined from Q1:diagnostic activity waiting time (>6 weeks) and Women accessing Specialist Community Perinatal Mental Health Service*
- *The remaining 6 which are: C. Difficile & E.coli infection rates, antimicrobial resistance, neonatal deaths, 2-hour urgent Community Response Referrals, and A&E 4 hours*

The Committee received the escalation from the System Performance Group relating to the target of zero 65ww by the end of September not being achieved but acknowledged the considerable progress made in reducing the 65ww.The Board is alerted to the very challenging UEC operational pressures experienced from September onwards, following a period of sustained improvement earlier in the year. This has led to increased delays in terms of ambulance response times, and delays at Emergency Departments.

(4) Q2 Portfolio Self-Assessment Stocktake Report, Part A:

The Committee received a stocktake overview, focussing in on the "Red" risk-rated schemes & programmes at the end of September as also presented at System Performance Group on 30 October:

- *UEC's rating is in relation to ongoing CRIS / Ambulance handover issues*
- *Planned Care's rating is in relation to the same 65wk+ issue reported above, with the addition of Advice & Guidance non-compliance*
- *Cancer's rating is in relation to reporting arrangements and non-compliance versus standards as such: including Non-Obstetric Ultrasound issues at UHNM suggest compliance issues, with actions / work ongoing to improve this*
- *Medicines Optimisation's position is regarding the incremental impact of Collective Action on 24/25 schemes compliance*
- *Children & Young People report issues with specialist nursing (audiology) discussed at several points of the meeting*
- *Digital is continuing to report ongoing issues with Electronic Patient Record: EPR*

ADVISE

(1) NHS Oversight Correspondence (incl. reference to Undertakings Compliance), Part A:

The Committee were advised of NHSE's letters to the ICB / ICS from the latest round of formal engagement meetings (System Review Meeting and Quarterly System Review Meeting, Sept/Oct 2024), for information and oversight. All and any actions agreed during these meeting will be monitored through the agreed framework processes.

The System financial position remains the key area of challenge and System Partners are working together to ensure action is taken to manage the impact in 2024/25 whilst bringing forward the planning to ensure momentum for 2025/26.

The Committee welcomed an overview from the CFO on the unmitigated risks described in the letters, and our System's efforts to get back to the £146m position. Committee Members focussed in on these and their detailed risk assessments, prior to acknowledging the letters received from NHSE.

The Committee also received (later on in the agenda) the latest Undertakings Dashboard report for the ICB, covering its principal actions as are updated following each F&PC meeting (in arrears), part of the wider Undertaking Programme led on Board's behalf by the ICB Audit Committee.

(2) Medium Term Plan (MTP) Progress Update, Part A:

The Committee discussed this in the context of the financial planning & delivery issues also picked up in the 'Alerts' section. The paper provided an outline of progress made on developing the unmitigated model for the MTP and the next steps to develop a mitigated model, via engagement with System CFOs.

The Committee discussed the work ongoing via Task & Finish Groups and welcomed the full report on the mitigated model to come back to the December meeting of the Committee; prior to the detailed implementation work of the agreed next steps, commencing in January 2025. It was noted that this work will have a strong reliance on capital investments in the future.

(3) VCSE Healthy Communities Alliance Update, Part A:

The Committee received a comprehensive presentation that reported on the current key issues and matters from the lead officers of the Alliance. It considered the contents of the presentation; and was assured on the updates given on the new priorities and enhanced role / remit of the Alliance Assurance Group, plus the joint focus on the Commissioning & Procurement priority. The recent VCSE Review of Grants was discussed. It was noted that this had taken longer than planned, in the interests of ensuring maximum involvement and engagement, but that meant that it was not possible to give the full 6 months' notice in 2024-25 of termination or alteration of any individual contracts or grants. Paul Edmondson-Jones apologised for the delay and confirmed that the guarantee of a minimum of 6 months' notice would be honoured even though that meant notice extending into 2025-26. The VCSE reminded the Committee that there had been no uplift in the level of grants to reflect inflation or other cost pressures and it was agreed that we would need to jointly review all grants and contracts to ensure that activity expected reflected the funding available. The Committee thanked the Alliance presenters for a clear provision of the necessary facts and activities required, especially the illustrative Case Study example provided within the presentation itself.

(4) Transformation Update, Part A:

This paper provided the monthly overview of the clinical areas included within the System transformation and service change programme. A slide pack was presented, including the latest version of the monthly service change return to NHSE, and the high-level Work Plan. The Committee noted the recent completion of the UEC programme and wished to advise the ICB Board on the reported 1500+ survey responses received from all stakeholders / community groups in the 11-week period this was open for.

(5) AOB Item – Annual Committee Effectiveness Survey, Parts A & B:

The Committee wishes to advise the Board that it launched this year's survey process and will be receiving a full report once the survey period has concluded.

(6) Joint Position Statement on Financial & Operational Interdependencies between Derby & Derbyshire / Staffordshire & Stoke-on-Trent ICBs, Part B:

The Committee advises the Board that it received an initial paper, that set out an agreed joint view and proposed way forward to tackle the challenges that exist between the two ICBs based upon the operational, financial / accounting mechanisms in place.

The Committee welcomed the ICB's commitment to these, noting the positivity in addressing ongoing work that has just commenced to form a view on necessary joint actions to address these challenges. While also noting certain complexities of pan-System working and impacts on Elective Recovery Fund: ERF; and acknowledging the related, ongoing conversations with NHSE Region.

(7) Procurement Operations Group (POG) Updates, Part B:

The Committee also noted the routine report received from the POG, including an escalation from a previous open action pertaining to the Patient Choice policy (relating to use of the Independent Sector) is to be examined strategically by the System and included in the Medium Term Plan, coming to the Committee in December. Also acknowledging no notifications having been received on ongoing Provider Selection Regime open procurement exercises. After discussion of the risks and to avoid delay, the

Committee approved delegation to the Procurement Operations Group to agree the procurement route for the winter contracts.

(8) All Age Continuing Care Service Update

The Committee received a report which provided an update on the progress, issues and risks in relation to the AACC service transition. Options for the digital solution are being examined and need to be finalised before the next Committee meeting. Therefore, the Committee acknowledged the decision would be approved by the Chief Finance Officer to procure and contract with the Access Group via the YPO Framework, if this is agreed as the preferred option.

ASSURE

(1) System Capital Prioritisation, Part A:

The Committee was asked to be assured that the System Capital Group will continue with its work to develop a viable 25/26 Capital Plan based on the work the Providers are undertaking to categorise their BAU plans. For the strategic prioritisation, the ICB Chief Transformation Officer and provider Directors of Strategy will take forward the thinking on the principles as part of the medium-term planning task.

(2) System Surge Plan, Part A:

The ICB System Surge Plan has been developed in collaboration with all System Partners to map out a Staffordshire & Stoke-on-Trent wide plan in advance of winter. The proposed approach is to present the plan in three primary component parts:

- *System Capacity Plan – details of all schemes (incl. those funded by the ICB, System partners and, if made available, via NHSE winter monies) designed to provide increased capacity over the winter period, the impacts of those schemes, timescales and funding source(s)*
- *System Escalation Plan – the measures to be taken when there are extreme patient safety risks within the system. The plan is designed to minimise and mitigate risk by sharing risks across the System.*
- *System Workforce Plan – to support delivery of the Winter Plan, incl. additional workforce recruitment & retention initiatives, enhanced bank rates and Provider / System level activities to manage workforce risks: the number of additional staff required per each scheme is also presented alongside Risks & Mitigations to ensure a realistic approach to winter*

In addition, information outlining:

- *Additional schemes recommended for approval; that, upon implementation, will offer tangible capacity*
- *Additional enabling schemes recommended for approval that have a significant impact upon management of increased demand for UEC services, but do not provide a physical bed space (e.g. the System Integrated Care Co-ordination: ICC offer)*
- *Additional enabling schemes not recommended for approval, in order to ensure that the winter budget can provide a contribution to the overall System recovery savings (those still valuable & would ideally, be implemented otherwise)*
- *Additional enabling schemes provided by existing & alternative budgets already accounted for in respective baseline allocations*

The Committee reviewed and recommended approval of the System Surge Plan; noting that next month's meeting would receive a 'deep dive' into the ICC scheme noted above.

(3) CHC Collaborative Update, Part A:

The Committee received an overview of the Collaborative, outlining its origins, the formulation of its overarching vision, and the process by which the initial projects were selected alongside an account of cost savings achieved during 23/24 and insights into how these were realised. With the savings targets identified for 24/25, examining the activities and progress made during Q1-Q2, offering a clear picture of how these ambitions are being pursued.

The Committee acknowledged the delivery challenges / risks / successes of the CHC Collaborative to date and supported the future planned activity / its impact on the System financial position.

(4) Primary Care Forum (PCF)

The Committee received an Escalation & Highlight Report on the items discussed at the Primary Care Forum that took place on 8 October 2024 and any decisions that were made in that meeting, covering:-

- *M6 Finance Report on delegated & non-delegated Primary Care (Inc. GP & the 'POD' services)*
- *Two Confidential Risks identified for closure*
- *Monthly POD report update and quality update*
- *An update on GP Collective Action*
- *Two Confidential GP Practice issues discussed*
- *The General Practice Quarterly Quality report*

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

No Risk or BAF reports were presented this month.

However, the Committee discussed key risks throughout the agenda.

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

Decisions to be Escalated to ICB Board or other Committees:
☑ **Part B – Procurement Operations Group Report, to ICB Board (for ratification):** The Committee approved the enactment of the 3-year extension to the Home Oxygen contract for the ICB, acknowledging that the contract will end on 31 May 2030, for ratification by the ICB Board ☑ **Part B – Prescribing / Medicines Optimisation Decision, to ICB Board (for awareness):** The Committee approved a proposal to develop a prescribing cost improvement plan (CIP) that will be based on a gain share model with General Practice; in order to improve the quality and safety of prescribing, as well to deliver cost savings in prescribing. The Committee approve the proposal so that the ICB Medicines Optimisation Team can develop the full scheme, noting that the LMCs will be engaged during the work up of the full scheme. **There were no escalations to other Board Assurance Committees.**

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 15

Report to:	**Integrated Care Board**					
Date:	**21 November 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: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	NO				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	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	13/11/2024
Click or tap here to enter text.	Click or tap to enter a date.

(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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report outlines the current workforce position 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 and oversight framework. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements are key to the operating plan delivery and recovery programme – at organisational and system level.

The following areas are detailed in the report:
- Workforce Assurance, Oversight, Metrics & Controls
- Workforce Challenges, Risks & Mitigations

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to: Note the workforce position, operating plan, risks and mitigations in place to address.

Staffordshire and Stoke-on-Trent Integrated Care System

ICS People Culture & Inclusion Performance and Assurance Report

SSOT ICB Board in Public

November 2024

Executive summary

This report will outline:

- An executive summary outlining key headlines and escalations in relation to People, Culture and Inclusion
- Workforce Assurance, Oversight, Metrics & Controls
- Workforce Challenges, Risks & Mitigations

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, which continues in partnership with NHS Providers. The current operating environment and financial position continues to be pressured, with continued scrutiny on workforce additionality following implementation of PWC grip and control measures and also current investigation and intervention position. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements are key to the operating plan delivery and recovery programme – at organisational and system level.

The following areas are highlighted:

- **Workforce Assurance, Oversight, Metrics & Controls** –
  - Oversight of the workforce position continues to be reviewed on a monthly basis in conjunction with our providers to understand key priorities, risks and improvement opportunities. The approach is supported by NHSE endorsed 'Making Data Count ' principles utilising data science approaches to measure data and performance. This approach is particularly important in the workforce field where trend is not always compliant with a linear trend or cumulative in nature and a level of movement tolerance is critical to ensure efforts are focused on the right activities and proportionate response. Key workforce indicators are reviewed with providers on a monthly basis through a regular assurance and oversight meeting. This approach will provide a foundation in which workforce metrics can inform MDT oversight approach, i.e. triangulation with activity and finance.
  - Since Mar-24 our workforce has decreased by -124 wte. Total workforce levels, as at Sep-24 equated to 24,250 wte which is currently +364 wte (+1.5%) above the FY24-25 operational workforce plan and is currently -416 below budgeted establishment (-1.7%). The over plan position is mainly driven by substantive workforce (+265, +1.2%) and an increased reliance on bank workforce (+250, 18.9%) to support the reduced utilisation of agency workforce. There continue to be significant achievements in our agency utilisation, which currently equates to 2.6% of total pay spend (0.6% below the NHSE target of 3.2%) and is below plan by -151 wte (-37%).
- The ICS **People risks** reflect the current risks across the partner organisations and have been robustly reviewed via the Sub-Committees and Delivery 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 were robustly reviewed at the PCI Committee on 16th October 2024
- People, Culture and Inclusion **Programme delivery** is overall on track, with programmes and activity in place to address system challenges and risks.

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce Assurance, Oversight, Metrics & Controls

The following providers a brief overview of the workforce position in respects of challenges and achievements:

- **Our SSOT Total workforce has decreased by 128 wte since March 2024 (+373 Substantive, -212 Bank and – 289 on Agency)**
- Our combined bank and agency workforce is **7.5% of our total workforce**. This is **-2.0% lower** than the highest point in the past 12 months (Mar-24).
- FYTD **agency spend is 21.4% below plan** and is a decreasing trend.
- **Agency spend** is **currently £2.4m which equates to 2.6% of total pay spend** which is 0.6% below the reduced agency use measure of 3.2% in FY24-25 (previously 3.7%). This is also a decreasing trend.
- **Agency WTE as a result has also decreased**, currently at 252 wte for Sep-24 which is -302 less than the highest point in the last 12 months (Dec-23).
- **Turnover rate is currently 8.7%** which is currently **-0.8% below the highest rate in the last 12 months (Oct-23)** and is a decreasing trend.
- **AfC appraisal rates currently 87.9% - currently +10.7% above the lowest point in the last 12 months (Dec-23)** and is an increasing trend.

Although the above is positive we are continually focusing on improving the position:

- Working to ensure we are compliant with the agency policy – i.e. next steps for price cap compliance.
- Sickness absence rates currently equate to 5.3% which is in line with the average for the past 24 months. Although the current position is reflective of trend this remains a key area of improvement opportunity to help out people be well, stay well and be supported at work.

SSOT Workforce Variance to Plan by Provider NHS Trust (M6)

Staffordshire and Stoke-on-Trent Integrated Care System

	UHNM	MPFT	NSCHT
Total Workforce (wte)	+397	-16	-16
Substantive (wte)	+132	+149	-16
Bank (wte)	+330	-90	+11
Agency (wte)	-65	-74	-65
Reasons for Variation	- 42 newly qualified nurses, however due to preceptorship periods, bank is not expected to reduce proportionately for this reason. This will be the same for midwives in Oct-24. - Bank use decreased from M5, use predominantly due to ERF activity, Theatres, Urgent Care, Vacancy cover, Sickness cover and Nursing Assistant 121s	- Increased substantive staff due to recruitment to vacancies and new service acquisition	- Increased substantive staff due to recruitment to vacancies - High cost agency due to hard to fill Consultant posts in LD/CAMHs - Plan in place to recruit from trainee pool post CCT - Adecco engaged to support recruitment to hard to fill Consultant posts
Mitigating Actions	- Exec Led monthly assurance meetings to deep dive agency/bank use, vacancies, sickness, overtime, WLIs - Robust Vacancy control in place	- Substantive staff increase entirely offset by reduction in bank/agency spend - Monthly analysis of temp staffing dashboards and performance against pay bill targets by Care Group - Quarterly workforce movement analysis and deep dive actions by People team - Robust Vacancy control in place	- Substantive staff increase entirely offset by reduction in agency and bank - Exec level analysis of bank/agency use - Robust Vacancy control in place

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce challenges, risks & mitigations through programme activity

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 - *considered reduction in score due to improvement, however remains unchanged with further review planned at 13th November PCI.*
  - 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 – *includes risk surrounding future of Staff Psychological Wellbeing Hub service*
  - 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 – *reduction in score pending possible further nursing action.*
  - Primary Care Retention and GP Collective action (jointly managed risks)

- The System Board Assurance Framework 'Sustainable Workforce' also reflects the 2024/25 impact and controls.

FY24-25 People Programme Delivery

ICS People Culture and Inclusion Programme Delivery highlights:

- The ICS People, Culture and Inclusion (PCI) Committee continues to oversee system programmes which support innovation and improvement in risks and challenges. All programmes are on track and delivering impact across the seven workstreams and priority areas.
- NHS organisations are addressing increased sickness rates and focussing on health and wellbeing of the workforce, working in partnership with non-NHS organisations to share practice and offers via the ICS Experience, Health and Wellbeing Workstream.
- Black History Month was celebrated by organisations and colleagues across the system during October including events, networks and sharing resources.
- Widening participation and access programmes continue with significant progress being made in educational engagement (primary and secondary schools, and colleges), T-Levels and Apprenticeships. Focus on entry level careers and new to care approach with local residents – linked to Anchor Employer approach.
- The system OD plan is now being implemented following ratification by the PCI Committee and ICB Board.

Staffordshire and Stoke-on-Trent Integrated Care System

People Metrics Appendices

- System Monthly Position
- System Trend
- Provider Summary

Staffordshire & Stoke-on-Trent NHS: September 2024

Staffordshire and Stoke-on-Trent Integrated Care System

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Workforce

Total Workforce
24,250 WTE
Currently +713 wte (Oct 23)

Substantive
22,424 WTE
Currently +907 wte (Oct 23)

Bank
1,574 WTE
Currently +74 wte (Nov 23)

Agency
252 WTE
Currently -302 wte (Dec 23)

Temporary Workforce
7.5%
Currently -2.0% (Mar 24)

Agency Spend
£2.4M (2.6%)
Currently -£1.7M (Nov 23)

Vacancies
2,243 wte (9.1%)
Currently -381 wte (Dec 23)

Joiners
331 wte
Currently +166wte (Jun 24)

Leavers
187 wte
Currently -55 wte (Mar 24)

Other Health and Care Workforce

SSOT ICB Workforce
329 WTE

Primary Care Workforce
2,872 WTE

Social Care Workforce
20,000 WTE

Dentistry Workforce
610 Headcount

12 Month Rolling KPI's (%)

8.7% Turnover Rate
Currently -0.8.% (Oct 23)

5.3% Sickness Absence Rate
Currently -0.1% (Jul 24)

93.6% Mandatory Training
Currently +0.7% (Nov 23)

87.9% AFC Appraisal Rate
Currently +10.7% (Dec 23)

80.6% Medical Appraisal Rate
Currently -4.3% (Mar 24)

Current Workforce Position: September 24

Staffordshire and Stoke-on-Trent Integrated Care System

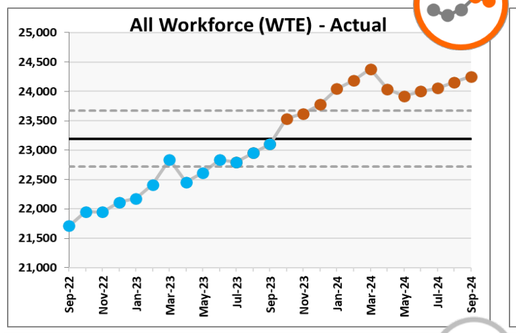
Staff in Post (Total Workforce wte)

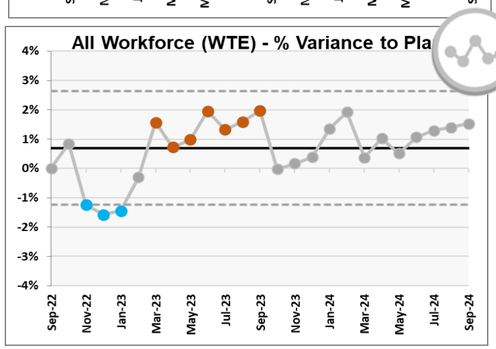
Sep 24: **24,250**

Position to Plan: **+364**

12M Change: **+1,147**

FYTD Change: **-128**





Actual vs Plan

Overall: +364 wte above plan
Registered Nursing: +142 wte above
Registered S,T&T: -39 wte below
Support to Clinical: -112 wte above
NHS Infrastructure: +218 wte above
Medical and Dental: +82 wte above

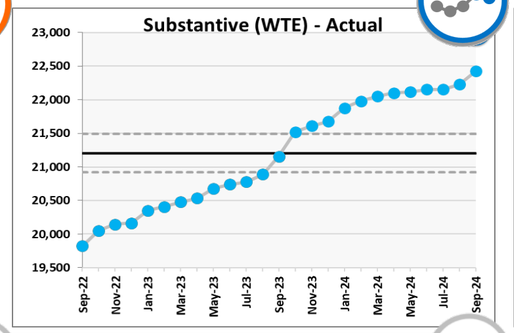
Staff in Post (Substantive wte)

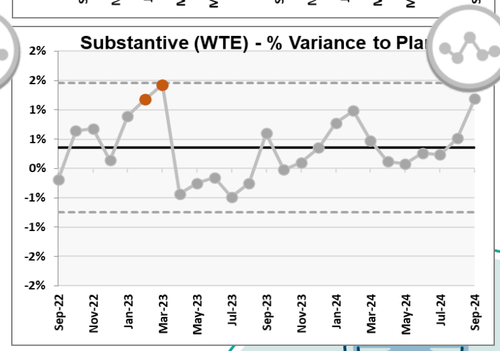
Sep 24: **22,424**

Position to Plan: **+265**

12M Change: **+1,268**

FYTD Change: **+373**





Actual vs Plan

Overall: +265 wte above plan
Registered Nursing: +86 wte above
Registered S,T&T: +52 wte below
Support to Clinical: - 135 wte below
NHS Infrastructure: +205 wte above
Medical and Dental: +59 wte below

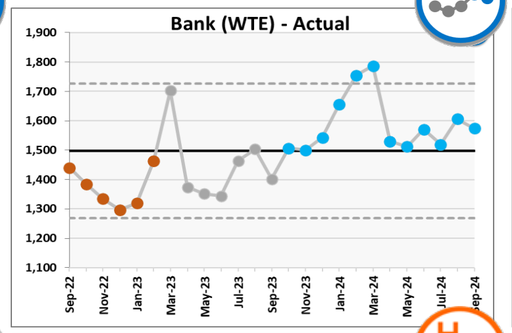
Bank Workforce

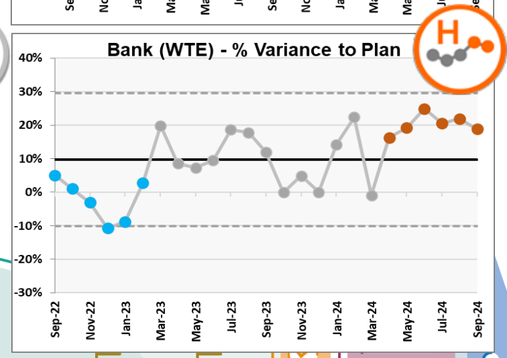
Sep 24: **1,574**

Position to Plan: **+250**

12M Change: **+173**

FYTD Change: **-212**





Actual vs Plan

Overall: +250 wte above plan
Registered Nursing: +107 wte above
Registered S,T&T: +9 wte above
Support to Clinical: +56 wte above
NHS Infrastructure: +29 wte above
Medical and Dental: +49 wte above

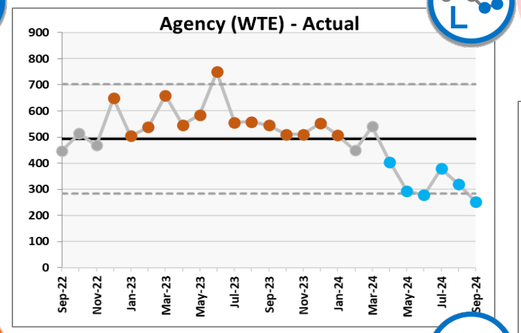
Agency Spend (% of total pay spend)

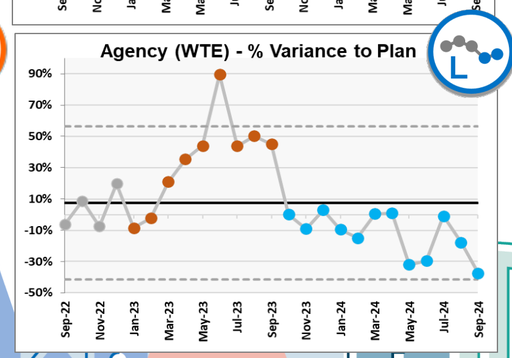
Sep 24: **2.6%**

Plan Position (FYTD): **-21.4%**

12M Change: **-4.0%**

FYTD Change: **-3.2%**





Actual vs Plan

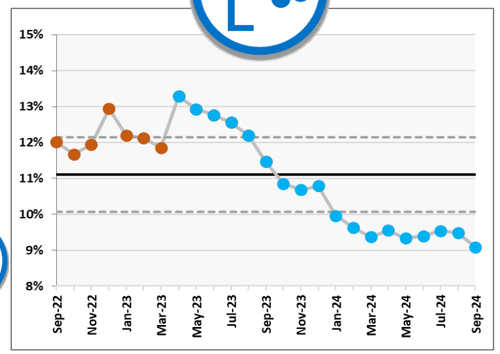
Overall: -151 wte below plan
Registered Nursing: -50 wte below
Registered S,T&T: -22 wte below
Support to Clinical: -34 wte below
NHS Infrastructure: -16 wte below
Medical and Dental: -25 wte below

Vacancies (%)

Sep 24: **9.1%**

12M Change: **-2.4%**

FYTD Change: **-0.3%**



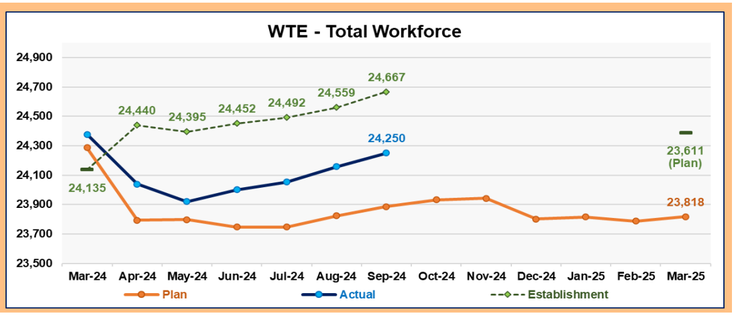
Vacancies

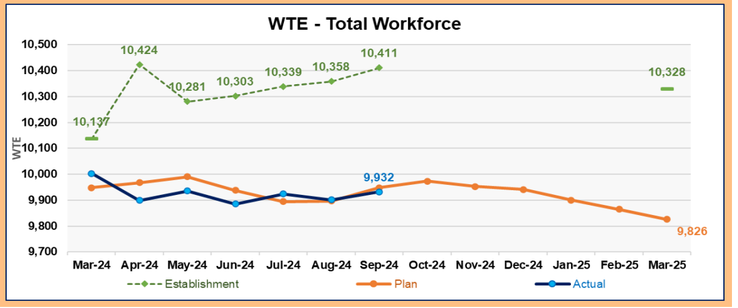
Vacancies total 2,243 wte (9.1%), this is the lowest level of vacancies the system has had in the last 12 months

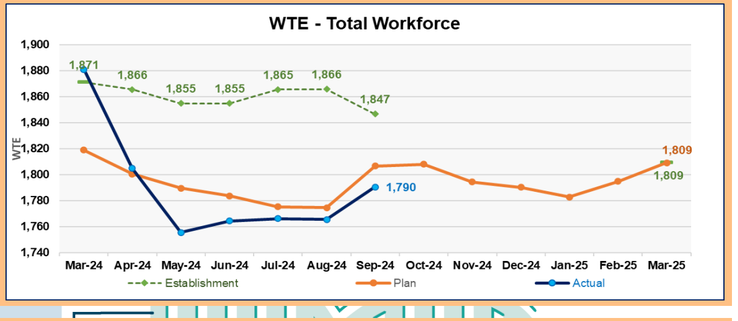
5. Workforce – FY24-25 Performance to Plan

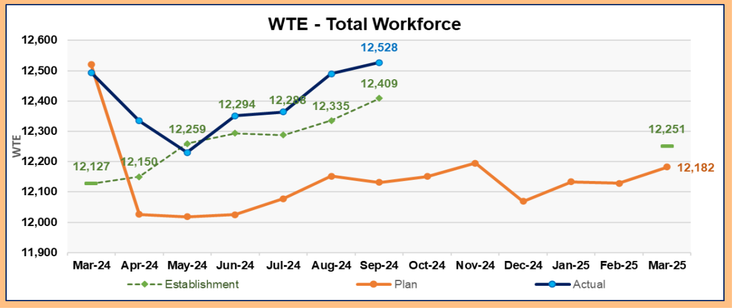
Staffordshire and Stoke-on-Trent Integrated Care System

	Total Workforce	Substantive	Bank	Agency
SSOT	31st Mar 24: 24,378 wte Sep-24: 24,250 wte FYTD Change: -128 wte / -0.5% Sep-24 Position to Plan: +364 wte / +1.5% above plan	31st Mar 24: 22,051 wte Sep-24: 22,424 wte FYTD Change: +373 wte / +1.7% Sep-24 Position to Plan: +265 wte / +1.2% above plan	31st Mar 24: 1,786 wte Sep-24: 1,574 wte FYTD Change: -212 wte / -11.9% Sep-24 Position to Plan: +250 wte / +18.9% above plan	31st Mar 24: 541 wte Sep-24: 252 wte FYTD Change: -289 wte / -53.4% Sep-24 Position to Plan: -151 wte / -23.6% under plan
MPUFT	31st Mar 24: 10,003 wte Sep-24: 9,932 wte FYTD Change: -71 wte / -0.7% Sep-24 Position to Plan: -16 wte / 0.2% above plan	31st Mar 24: 9,154 wte Sep-24: 9,363 wte FYTD Change: +209 wte / +2.3% Sep-24 Position to Plan: +149 wte / +1.6% above plan	31st Mar 24: 647 wte Sep-24: 466 wte FYTD Change: -181 wte / -28.0% Sep-24 Position to Plan: -90 wte / -16.2% under plan	31st Mar 24: 202 wte Sep-24: 104 wte FYTD Change: -98 wte / -48.5% Sep-24 Position to Plan: -74 wte / -41.8% under plan
NSCHT	31st Mar 24: 1,881wte Sep-24: 1,790 wte FYTD Change: -91 wte / -4.8% Sep-24 Position to Plan: -16 wte / -0.9% under plan	31st Mar 24: 1,732 wte Sep-24: 1,654 wte FYTD Change: -79 wte / -4.5% Sep-24 Position to Plan: -16wte / -0.9% under plan	31st Mar 24: 113 wte Sep-24: 126 wte FYTD Change: +13 wte/ +11.9% Sep-24 Position to Plan: +11wte / +9.4% above plan	31st Mar 24: 36 wte Sep-24: 10 wte FYTD Change: -26 wte / -71.5% Sep-24 Position to Plan: -11wte / -52.7% under plan
UHNM	31st Mar 24: 12,494 wte Sep-24: 12,528 wte FYTD Change: +34 wte / +0.3% Sep-24 Position to Plan: +397 wte / +3.3% above plan Sep-24 Position to Establishment -118 wte above establishment	31st Mar 24: 11,165 wte Sep-24: 11,408 wte FYTD Change: +243 wte / +2.2% Sep-24 Position to Plan: +132 wte / +1.2% above plan	31st Mar 24: 1,026 wte Sep-24: 982 wte FYTD Change: -44 wte / -4.3% Sep-24 Position to Plan: +330 wte / +50.5% above plan	31st Mar 24: 303 wte Sep-24: 138 wte FYTD Change: -165 wte / -54.5% Sep-24 Position to Plan: -65 wte / -31.9% under plan









Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 16

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**November 2024**
Reporting Committee:	**People, Culture and Inclusion Committee (PCI) (Part1&2)**
Date of Meeting:	**16 October 2024**
Meeting Quorate Y/N?	**YES**
Presenter:	**Shokat Lal, Non-Executive Director & Committee Chair**
Author:	**Lia Pitarokoili, Head of Corporate Governance**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

(1) ICS Strategic OD Plan:

The Committee received the final ICS OD Strategic Plan 2024-2027. The need to work together as system partners to operationalised and implement the System OD Plan was stressed.

It was noted that the Staffordshire and Stoke on Trent Strategic Organisational Development plan prioritises inclusion and belonging to address systemic disparities in health experiences and outcomes, particularly for marginalised groups. It emphasises the need to close the gap in workforce experiences and outcomes, acknowledging the existence of racism and discrimination within systems.

In order to succeed, Integrated Care Systems must foster collaboration among historically competitive provider organisations by developing a shared vision, building connections, and resolving conflicts. This collective engagement approach is crucial for addressing financial challenges and implementing necessary changes. The plan, co-designed with system partners, aims for transformational change to meet the needs of the workforce and local communities effectively.

The Committee acknowledged the work that had gone into developing the plan. There was a discussion around the importance of the plan particularly in the current system context, socialising the plan across the system and the resource to support implementation of the plan. It was noted that Leads would develop an implementation and communication plan and consider the resourcing implications – via the OD Sub-Committee. An update will be brought back to the November PCI Committee.

ASSURE

(1) Strategic System Updates:

The Committee received assurance around the tight workforce controls, the oversight that we have as a s system, and the positive reflections of our workforce around key performance areas. There was reassurance that the agency performance has reduced significantly since March 2024. Moreover, our workforce has reduced since March 2024 and from a spend perspective, this constitutes a positive outcome especially since the system is still delivering in a more productive way.

There has been an increase in sickness absence and as this constitutes a steady trend, we are working with providers internally to support its reduction while at the same time we are promoting our health and well-being strategy across the system.
It was acknowledged that we still have a significantly financially challenged position, however the actual financial pressures in our system are not linked to workforce spend.

There was a discussion around monitoring of quality and safety and that safety, activity and delivery are fundamental while we need to have an MDT approach to any decisions that we make; decisions about reducing workforce cannot be made in isolation and this is not only a CPO area, but also a clinical as well as operational one. Every decision that is made must have a quality impact assessment linked to it which will ensure to identify core quality and safety risks, particularly anything that will impact on patients while watching very carefully for any adverse outcomes in terms of both patient harm and general patient experience.

(2) Performance, Planning and Finance:

Level 4, I&I was discussed including establishing strong links between workforce, finance and activity. This will become even more important as the System moves through I&I.

The Medium term plan is linked to the delivery of the Long term plan and we need to be clear on the outcomes of Lord Darzi's report and how/in what form those could be delivered.

The Committee also welcomed the People Metrics report – M5 August position which provided an update on FY24-25 in year workforce position and position to plan FY24-25 plan.

Total workforce levels, as at Aug-24 equated to 24,157 wte which is currently +333 wte (+1.4%) above the operational workforce plan and is under establishment by -604 wte. The over plan position is primarily driven by bank workforce which is +286 wte (+21.7%) above plan and substantive workforce which is +116 (+0.5%) above plan. Positively agency workforce is currently -69 wte (-17.8%) below plan and is a decreasing trajectory. In respect of FYTD, the workforce has decreased by -221 wte (-0.9%).

Our overall temporary staffing use is 8.0% which is -1.6% lower than the highest point in the last 12 months. We have also made great strides in agency reduction with agency spend equating to £2.6m, which equates to 2.4% (0.8% below the NHSE target) of the total staffing spend. This is also currently £1.5m less than the highest position in the last 12 months, which continues to be a significant achievement. The next area of focus in agency improvement will include ensuring compliance with pay cap spend.

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

(3) PCI Development and Review - progress updates

Assurance updates were provided in relation to the EDI, OD, Leadership, Supply and Productivity Sub-Committee development.

The Committee received a report that provided updates on the implementation of the revised Committee governance and meeting structure and was assured that the implementation plan is progressing and is being robustly managed. The Committee discussed and supported the implementation of the new structures.

(4) Surge Winter Plan update

The Committee was updated and assured around the Surge winter plan which will be brought for formal approval at the November PCI meeting.
The Plan has already started being circulated to the formal System and ICB governance structures. There is the capacity element within the plan, the escalation and surge process and the workforce plan that would need to support all that. The System is working collaboratively to understand where the workforce gaps are and plan the activities around workforce as required.

(5) People Culture and Inclusion Programme Assurance:

Programme delivery and assurance to PCI Committee has been reviewed to further strengthen reporting and triangulation with workforce risks and metrics. Ongoing support and engagement of partners in the delivery of People, Culture and Inclusion Programmes was noted. Overall delivery of the programmes and projects continues to be driven and monitored via the SROs, Programme leads and current Steering /Delivery Groups. All programmes were noted to be on track or new/not started.

Staff Psychological Wellbeing Hub at risk of service closure should the business case not be approved to extend beyond March 25. The business case is currently being refined and will be monitored by CPOs and the Experience, Health and Wellbeing Steering Group. Further update to be provided at the next PCI Committee.

The Committee was assured around the programme delivery and mitigation of the risks.

(6) Strategic People, Culture and Inclusion updates:

The Committee was updated and received assurances on the regional CPO meeting, People Board and Talent Board, Sexual Safety Charter and the associated ICS Conference, the latest state of the Adult Social Care Sector and Workforce in England and the next steps following the July 2024 review as well as the Skills England that has been launched which is driving growth and widening opportunities.

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

(1) Q2 2024-25 SBAF Report:

The Committee received the Q2 SBAF for discussion and for assurance offline, prior to the meeting. PCI has lead oversight of SBAF8 (Sustainable Workforce). The Committee approved the SBAF offline and confirmed the adequacy of controls / assessments in its lead SBAF Objective area.

(2) October System & ICB Risk Registers

The Committee received and noted the System Risk Register Report. For the System Risks, there are **10** risks in total: 8 high scoring (12+); 2 are medium risks.

The Committee:

- Agreed to add a new Risk: Impact of financial challenges and pressures on system culture
- Agreed to reduce the Risk 1194 (Industrial Action)
- Agreed for the ICB Primary Care Team to review the Primary Care risks

Policies Approved:

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

Decisions to be Escalated to ICB Board or other Committees:

Nothing for escalation to ICB Board or other Committees.

NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

Enclosure 17

AAA Escalation & Assurance Report from Committees[1]

Report To:	ICB Board
Date:	21/11/2024
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	17-10-2024
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	N Walker, Project Lead (HR & Specialist)

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
None discussed.
ADVISE
None discussed.
ASSURE

[1] **Refers to Section 1.3(a) –** Adapted examples from the March 2024 Board papers – PCI / F&PC / Q&S reports to Board

Very Senior Manager (VSM) Pay Recommendation 2024/25 : The Remuneration Committee received a report on VSM pay recommendation for 2024/25.
The committee agreed to enact the 2024/25 NHS VSM pay recommendation of 5% with effect from 1st April 2024.

ASSURE

Very Senior Manager (VSM) Pay Strategy : The Remuneration Committee received a report on the proposed VSM Pay Strategy.
The committee agreed to the introduction of the VSM Pay Strategy.

Recruitment to the vacant Non-Executive Member (NEM) post: The Remuneration Committee received a report on the proposed appointment to the vacant NEM post.
The committee agreed to the appointment of the vacant NEM and the parameters of this new appointment.

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

Nothing to be added.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:

No decisions to be escalated to ICB Board.