

**Staffordshire and Stoke-on-Trent  
Integrated Care Board Meeting  
HELD IN PUBLIC  
Via MS Teams**

**Thursday 20<sup>th</sup> February 2025  
1.00pm – 3.00pm**

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

	Agenda Item	Lead(s)	Enc	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	1.00pm	
2.	Leadership Compact	Chair	Enc 01	A		3
3.	Conflicts of Interest	Chair	Enc 02	---		4 - 5
4.	Minutes of meeting held on 16 <sup>th</sup> January 2025	Chair	Enc 03	A		6 - 18
5.	Action Log - progress update on actions	Chair	Enc 04	D		19
6.	Questions submitted by members of the public in advance of the meeting	Chair	---	D	1.10pm	

**Strategic and System Development**

7.	ICB Chair and Chief Executive Report	DP/PA	Enc 05	I	1.20pm	20 - 28
8.	Planning and Allocations	PB	Enc 06	I/S	1.30pm	29 - 38

**System Governance and Performance**

9.	Quality and Safety Report	HJ	Enc 07	S	2.00pm	39 - 42
10.	ICS Finance and Performance Report	PB/HA	Enc 08	I/S	2.10pm	43 - 69
	Finance and Performance Committee AAA Chairs Report	MN	Enc 09	I/S	2.30pm	70 - 85
11.	People, Culture and Inclusion Committee AAA Report	SL	Enc 10	I/S	2.35pm	85 - 88
12.	Staffordshire and Stoke on Trent ICB Audit Committee AAA Chairs Report	JH	Enc 11	I/S	2.40pm	89 - 92
13.	Staffordshire and Stoke on Trent ICB Strategic Commissioning and Transformation Committee	DP	Enc 12	I/S	2.45pm	93 - 96

**Any Other Business**

14.	Items notified in advance to the Chair	All	---	---	---	
15.	Questions from the floor relating to the discussions at the meeting	Chair	---		2.50pm	

16.	Meeting Effectiveness	Chair	---		---	
17.	Close	Chair	---		3.00pm	
18.	<b>Date and Time of Next Meeting</b> <b>20<sup>th</sup> March 2025 at 12.30pm – 2.30pm held in Public,</b> Boardroom, Executive Offices, Springfield, Royal Stoke University Hospital, University Hospitals of North Midlands NHS Trust, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG					

# ICS Partnership leadership compact



## Trust

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



## Courage

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



## Openness and honesty

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



## Leading by example

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



## Respect

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



## Kindness and compassion

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



## System first

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



## Looking forward

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

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

**Key**  Declaration completed for financial year 2024/2025  
 Declaration for financial year 2024/2025 to be submitted

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

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken to mitigate identified conflicts of interest
20th September 2024	Dr	Buki	Adeyemo	Chief Executive Officer	North Staffordshire Combined Healthcare Trust (NSCHT)	Nothing to declare	1. Board of Governors University of Wolverhampton (ongoing) 2. Mental Health Network, NHS Confederation, NHS CEO Representative (ongoing)	Nothing to declare	Nothing to declare	(h) interest recorded on the Conflicts Register
15th July 2024	Mr	Nadeem Tony	Ahmed	ICB Participatory (non-voting) member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director of Dentaire Ltd and TT Partners Ltd, Principal dentist at Dentaire Dental Care (ongoing)	1. Chair of Local Dental network - Shropshire and Staffordshire (ongoing)	Nothing to declare	1. Brother is an ENT surgeon and head of department at QE Hospital Birmingham (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) interest recorded on the Conflicts Register.
11th July 2024	Ms	Helen	Ashley	Acting CEO	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	Nothing to declare	1. Member of Derbyshire Community Health Services FT (2014 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
25th June 2024	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u13 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
23rd July 2024	Mr	Peter	Axon	CEO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th January 2025	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director of The Valley of Care Ltd, 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 2024 - ongoing)	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)	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 (MPFT)	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing) 4. Visiting Professor - Wagner College, New York (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
simon	Mr	Simon	Constable	Chief Executive	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	1. Visiting Professor, University of Chester (2015 ongoing) 2. General Medical Council Responsible Officer and Designated Body is Dr Eileen Marks and Liverpool University Hospitals NHS Foundation Trust (2019 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
13th September 2024	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
8th November 2024	Ms	Elizabeth	Disney	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Brother is Clinical Lead and Consultant at UHNM (1st September 2024 to date). 2. Brother's partner is owner-operator of Nature and Nurture Psychology, a child and family psychology service based in Staffordshire (November 2024 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on the conflicts register.
10th April 2024	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employed session a week (0.1 wte) by MPFT as Head of SSoT PH Alliance (as a locum public health consultant) (June 2024 - ongoing)	1. Fellow of the Faculty of Public Health (FFPH) and registered with the GMC (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
10th July 2024	Mrs	Lisa	Ellis	Executive Support Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken to mitigate identified conflicts of interest
25th 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
7th January 2025	Ms	Mahishmi	Irvine	Chief People Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	1. YMCA Trustee (September 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.
12th December 2024	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Remuneration Committee (September 2022 - December 2024) Declaration to be removed June 2025. 3. Chair of Mid Cheshire Hospitals Foundation Trust (January 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)



**Staffordshire and Stoke-on-Trent Integrated Care Board  
HELD IN PUBLIC – via MS Teams  
Thursday 16<sup>th</sup> January 2025  
12.30pm – 2.30pm**

Members:	Quoracy	18/04/24	16/05/24	20/06/24	18/07/24	26/09/24	17/10/24	21/11/24	19/12/24	16/01/25	20/02/25	20/03/25	
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quorum (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 (NTO) • 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		✓	A	✓	✓	✓	✓	✓	✓	✓			
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	A	✓	✓			
Phil Smith (PS) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	A	✓			
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	A	✓	A		
Dr Paul Edmondson-Jones (PEJ) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	A	✓	✓			
Elizabeth Disney (ED), Chief Transformation Officer						A	✓	✓	✓	✓			
Julie Houlder (JH) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✓	✓	✓			
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓	✓	A			
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓	✓	✓			
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	✓	✓	✓			
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	A	A	A	✓	✓	A	✓	✓			
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council		✓	A	✓	A	A	✓	✓	✓	A			
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	A	✓	✓	A	✓	✓			
Dr Simon Constable (SC) Chief Executive Officer, University Hospitals of North Midlands NHS Trust						✓	✓	✓	A	A			
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	A	✓	✓	A	A	A	A	✓			
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓	✓	✓	A	✓	✓	✓	✓			
<b>Participant Members:</b>													
Simon Fogell (SF), Stoke-on-Trent Healthwatch			✓	✓	✓	✓	✓	✓	A	✓	✓		
Baz Tameez (BT), Healthwatch Support Staffordshire			✓	A	✓	✓	✓	✓	A	A	✓		
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		A	✓	A	✓	✓	✓	✓	✓	A			
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		A	✓	✓	✓	A	✓	✓	✓	✓			
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓				
Mish Irvine (MI), Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓	✓				
Dr N Tony Ahmed (TA), Dental Participant Board Member					✓	✓	✓	✓	✓	✓			
Lisa Ellis, Executive Support Officer, Staffordshire & Stoke on Trent ICB						✓	A	✓	✓	✓			

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

<b>In attendance:</b>															
Claire Cotton, Director of Governance, University Hospitals of North Midlands NHS Trust					✓		✓					✓			

		Action										
<b>1.</b>	<b>Welcome and Introductions</b>											
	<p>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.</p> <p>DP reminded members of the importance of the Leadership Compact document which was used in all the meetings transacted by the ICB and guides the way business is conducted.</p> <p>DP referred to the current pressure within the urgent care system and advised that Executive colleagues and other key members of staff may need to be excused during the meeting.</p>											
	<b>Apologies</b>											
	<p>Apologies were received from:</p> <table> <tr> <td>Megan Nurse</td> <td>Non-Executive Member, Staffordshire &amp; Stoke-on-Trent ICB</td> </tr> <tr> <td>Heather Johnstone</td> <td>Chief Nursing and Therapies Officer, Staffordshire &amp; Stoke-on-Trent ICB</td> </tr> <tr> <td>Tracey Shewan</td> <td>Director of Communications, Staffordshire &amp; Stoke-on-Trent ICB</td> </tr> <tr> <td>Dr Simon Constable</td> <td>Chief Executive, University Hospitals of North Midlands NHS Trust</td> </tr> <tr> <td>Patrick Flaherty</td> <td>Chief Executive, Staffordshire County Council</td> </tr> </table>	Megan Nurse	Non-Executive Member, Staffordshire & Stoke-on-Trent ICB	Heather Johnstone	Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB	Tracey Shewan	Director of Communications, Staffordshire & Stoke-on-Trent ICB	Dr Simon Constable	Chief Executive, University Hospitals of North Midlands NHS Trust	Patrick Flaherty	Chief Executive, Staffordshire County Council	
Megan Nurse	Non-Executive Member, Staffordshire & Stoke-on-Trent ICB											
Heather Johnstone	Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB											
Tracey Shewan	Director of Communications, Staffordshire & Stoke-on-Trent ICB											
Dr Simon Constable	Chief Executive, University Hospitals of North Midlands NHS Trust											
Patrick Flaherty	Chief Executive, Staffordshire County Council											
	<b>Confirm Quoracy</b>											
	DP confirmed that the meeting was quorate.											
<b>3.</b>	<b>Leadership Compact</b>											
	Received and noted.											
<b>4.</b>	<b>Conflicts of Interest</b>											
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.											
<b>5.</b>	<b>Minutes of the Meeting held on 19<sup>th</sup> December 2024</b>											
	The minutes of the meeting held on 19 <sup>th</sup> December 2024 were <b>AGREED</b> as an accurate record of the meeting and were therefore <b>APPROVED</b> .											
<b>6.</b>	<b>Action log</b>											
	Action log reviewed and updated accordingly.											
<b>7.</b>	<b>Questions submitted by members of the public in advance of the meeting</b>											
	<p>Question one - Mr Ian Syme:</p> <p><i>Dentistry: I put a question to the September 2024 ICB as to “the state of play” of the West Midland Dental Strategy. The ICB informed me that the West Midland Dental Strategy would be presented to the January 2025 ICB Meeting. As the West Midlands Dental Strategy is not amongst January 2025 papers.</i></p>											

	<p>a) <i>What is causing the delay in placing that strategy into the public domain?</i>  b) <i>When will that strategy be put before an ICB public meeting for debate and discussion?</i></p> <p>PEJ thanked Mr Syme for his question and advised that the West Midlands Dental Strategy has been drafted and all five ICBs are working together to finalise a local plan. He added that there is a delay for all of the West Midlands ICBs and colleagues are seeking clarity on funding nationally and regionally and when this might be released. He provided assured that we are taking the opportunity to tackle the issues faced locally and work is also taking place locally on redistributing dental activity. He added that it is anticipated that plan and strategy will come to the Board meeting by the end of March.</p> <p>Question Two - Mr Ian Syme</p> <p><i>Quality and safety - QSC 11/12/2024, regarding System Quality Group Report  Reference is made of UHNM ED harm reviews and that such had been agreed yet now superseded by NHSE requests. Furthermore, it was identified that Queens Burton have a different harm reviews process overseen by Derbyshire ICB. As this clearly is of concern to the QSC</i></p> <p>a) <i>Has the Queens Burton situation now been added to the risk register as requested but QSC?</i>  b) <i>Clarification please as to why the harm reviews process re Queens Burton necessitates that concern?</i>  c) <i>Could a flavour of the NHSE requests that have superseded the initial UHNM ED harm reviews process be given please.?</i></p> <p>In the absence of HJ, the following responses were provided in relation to the questions above:</p> <p>a) We can confirm that the action was completed, and the risk does sit on the risk register</p> <p>b) Concern was raised with regards to the timeliness of notification when harm has been identified within Queens Hospital Burton Emergency Department. Staffordshire and Stoke-on-Trent ICB receive retrospective updates via the monthly contract quality review meetings.</p> <p>c) Template will be shared with Ian Syme, which provides further context.</p>	<p>PEJ</p>
<p><b>8.</b></p>	<p><b>ICB Chair and Chief Executive Update</b></p>	
	<p>DP presented the report and advised that the ICB has established a new Committee, Strategic, Commissioning and Transformation Committee and the first meeting took place in January, in which he chaired. He advised that the ICB is currently in the process of recruiting a Non-Executive Member of the Board who will chair this Committee and an announcement will be made in due course.</p> <p>DP thanked community pharmacists who continue to provide covid and flu vaccinations and emphasised the need for people to get vaccinated, if eligible.</p> <p>DP highlighted the Investigation and Interview regime continues and advised that focus is on the planning for 2025/2026, which will be a very challenging position.</p> <p>PA referred to the newly formed Strategic, Commissioning and Transformation Committee and advised that this is a vital part of our governance structure going forward and this Committee will focus on defining the plans in terms of allocative and technical efficiency and will have clearly define expectations for this year.</p> <p>JH referred to the 2025/2026 planning process, in particular community transformation and asked when will we see a shift in resource as part of 2025/2026. PA stated that transformation does take time, as there are number of contractual implications, but added that not all transformation is at</p>	

	<p>this scale and confirmed that during 2025/2026 there will be a phased approach, as there is an opportunity to make incremental smaller changes, whilst ensuring the linkages to the larger projects.</p> <p>JH referred to the high number of flu cases, in particular the number of hospital admissions and asked if data is being collected to establish if those patients who have been admitted have been vaccinated. PEJ confirmed that 100% vaccination status is recorded and agreed to establish the percentage and let JH know and report back to the next Board meeting.</p> <p><b>Members of the ICB Board received the report and were assured that the leadership are working on each topic as raised.</b></p>	<p><b>PEJ</b></p>
<p><b>9.</b></p>	<p><b>Cyber Update</b></p>	
	<p>CI presented the report and thanked colleagues for providing the opportunity to present this to the Board. He advised that in September 2024 a number of changes were introduced to the data security and protection toolkits (DSPT) requirements, also referred to as CAF aligned DSPT, which ensures that the cyber assessment framework aligns with the DSPT to strengthen our cyber security and providing assurance for all Government organisations, not just NHS organisations.</p> <p>CI stated that Lard Darzi’s report highlighted that one of the key focus areas was the analogue to digital and advised that there has been a significant increase in cyber-attacks across the public sector over the past few years and emphasised the need to ensure we are well prepared, as there is an increased reliance on digital solutions.</p> <p>It was highlighted that the Department of Health and Care have produced a Cyber Security Strategy through to 2030 and the DSPT is being enhanced and strengthen, as there is a need to focus on cyber resilience and what we would need to do in the event of a major incident and we are currently working with our EPRR colleagues.</p> <p>CI referred to the digital element and the framework in which we work, which consists of three main pillars:</p> <ul style="list-style-type: none"> <li>Digitise</li> <li>Connect</li> <li>Transform</li> </ul> <p>CI advised that we need a plan for maintaining cyber security and a process for managing the cyber risk.</p> <p>CI provided assurance that over the past 18 months we have established a cross Cyber Security Group, which also includes representatives from our Local Authorities and have developed a Staffordshire and Stoke on Trent Cyber Security Strategy, which will be finalised by the end of this year. He also added that cyber security is on our BAF (Board Assurance Framework) and risk register and have a number of actions to mitigate the risks. It was noted that a Security Operation Centre has been developed and Staffordshire and Stoke on Trent ICB is the only ICB in the country to have a security operation centre which operations 24 hours a day, seven days a week, 365 days of the year, which is a testament to the interworking across the system.</p> <p>CI advised that a cyber simulation event took place last year with regional, national and EPRR colleagues and an action plan has been developed to ensure that the correct procedures are in place for when an incident occurs and added that the event will be repeated in the next few months. He added that not all cyber incidents are serious but emphasised the need to be clear when something impacts a critical system.</p> <p>CC highlighted the significant risk of cyber security across the country, which is heighten due to the move from analogue to digital and confirmed that it is included in the risk register and added that due to the nature of cyber risk advised that the ICB may want to give some consideration</p>	

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	<p>when we move into the BAF for 2025/26 this as a strategic risk within the BAF. She also added that the Audit Committee handbook is clear on its overview of cyber risk and advised from a UHNM perspective she has produced a similar report, which highlights the national context and the controls and assurances in place and suggested including this as part of the Audit Committee cycle of business, which will provide further assurance. DP requested further executive discussions and discussions at Audit Committee via JH and report back to a future Board with an update.</p> <p>BT welcomed the update and stated that it is reassuring that the ICB is working with system partners.</p> <p>SL thanked CI for the assurance and referred to the increase in ransom demands, nothing that there have been many organisations that have paid ransom costs and asked has there been any discussions centrally or approach regarding this, nothing that central Government are proposing to introduction legislation. CI assured colleagues that he will raise awareness of any change in legislation.</p> <p>PS confirmed that cyber security forms part of the EPRR programme of work for this year and stated that it is good that we have gained such pace in terms of establishing the Security Operational Centre (SOC) which has supported colleagues who are on-call.</p> <p>DP thanked CI for championing this on behalf of the system and noted the significant amount of work which is being undertaken to manage the potential cyber threat.</p> <p><b>Members of the ICB Board received and noted the report and noted awareness.</b></p>	<p><b>CI/JH</b></p>
<p><b>10.</b></p>	<p><b>Quality and Safety AAA Report</b></p>	
	<p>JS presented the report on behalf of the Quality Committee and advised that there was no meeting in January, due to system pressures and challenges.</p> <p>DP referred to the Darwin Centre update within the report and stated that it would be useful for the Board via the Quality Committee to understand the impact of the issues for the system. JS confirmed that she will address these issues with HJ and will continue to provide the Board with assurance.</p> <p>BA referred to the Darwin Centre and advised that a further meeting has taken place, in which the ICB and Provider Collaborate have been involved. She added that the meeting was very positive and highlighted the importance of having the same definition for escalation.</p> <p><b>Members of the ICB Board:</b></p> <ul style="list-style-type: none"> <li>• <b>Received the report.</b></li> <li>• <b>Were assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.</b></li> <li>• <b>Note the decision of the Quality and Safety Committee with regards to: Continuous Quality Improvement Framework.</b></li> </ul>	<p><b>JS/HJ</b></p>
<p><b>11.</b></p>	<p><b>Quality and Safety AAA Chairs Report</b></p>	
	<p>JS presented the report and advised that concerns have been raised regarding emergency department (ED) harm review process and advised that there is more work to do to gain assurance and HJ and the team are working though the detail and added that this will be included on the risk register.</p> <p>JS referred to the “Advice” section on the report and advised that the Committee received a presentation regarding intensive and assertive community mental health care treatment review and plan and stated that a significant amount of work has been undertaken in response to the</p>	

	<p>issues, more work is required and a further presentation will be provided to the Committee in March.</p> <p>JS referred to the “Assure” section and advised that there are a lot of challenges and pressures in the system where quality remains a focus and highlighted that there are also a lot of areas where there is a lot of good work and assurance.</p> <p>DP thanks JS for the update and highlighted that he was pleased to note that the ICB Quality Team have been supporting UHNM, particular around the impact of some of the waiting times and pressures in the emergency department and advised that colleagues may be aware of the recently published report by the Royal College of Nursing regarding acute pressures and the need to ensure we support our colleagues within the provider organisations, to maintain dignity and quality of care in such times of challenge.</p> <p>NC referred to the intensive and assertive community mental health care treatment review and plan and advised that Combined Healthcare and Midlands Partnership Trust have undertaken a significant amount of work. He also referred to the Valdo Calocane report, which is due to be published imminently and advised that all organisations will need to review their position against the report.</p> <p><b>Members of the ICB Board received and noted:</b></p> <ul style="list-style-type: none"> <li>• <b>The Quality &amp; Safety Committee approved the Continuous Quality Improvement Framework.</b></li> <li>• <b>The Quality &amp; Safety Committee approved the SEND Quality Assurance Framework – Quality Assurance Methodology</b></li> <li>• <b>The Quality &amp; Safety Committee approved the VCSE Alliance Memorandum of Understanding</b></li> </ul>	
12.	<p><b>Staffordshire and Stoke on Trent Health and Care Senate Summary and Escalation Report</b></p>	
	<p>PEJ presented the report, which reflects the meeting which took place in December and advised there are no alerts for the Board. He referred to the “Advise” section and highlighted the breadth of topics which are discussed at the Health and Care Senate.</p> <p>PEJ advised that the Health and Care Senate receives the SBAF and risk register in twice a year, for information.</p> <p>DP welcomed the report and acknowledged the breadth of the agenda and the which links to the Quality and Safety Report and wider engagement, which ensures that we have the right balance and also ensures that we are keeping patients safe.</p> <p>JH commended the report and acknowledged that this reflects December’s meeting and referred to the national guidance which was published at the end of December regarding weight management and acknowledged that this may not have been discussed at the Senate as yet and asked about the roll out programme. PEJ stated that the guidance is mandatory for ICBs and the implications are enormous and stated that the weight management drugs offer a wonderful opportunity in terms of health of the population. He added that a Working Group has been established and are working with NHS England, looking at how the roll out programme will be implemented, as it is a 12 year roll out programme. He added that the Working Group will be looking at the priorities, funding, prioritisation and will provide an update at the next Health and Care Senate, then to the Strategic, Commissioning and Transformation Committee and Board as appropriate. PEJ advised that there may be a number of complaints from patients regarding the prioritisation and added that there are a number of patients who are purchasing these drugs without the appropriate care and support.</p>	

	<p>NC referred to the Healthy Ageing and Frailty Strategy and celebrated the work of Dr Farah Kidy around frailty and advised that going into next winter, severe frailty has to be a priority and stated that funding has been identified for Dr Kidy to continue for the next three years.</p> <p>The ICB Board received the report and noted:</p> <ul style="list-style-type: none"> <li>• That the H&amp;C Senate approved the decisions summarised in the Integrated Medicines Optimisation Group (IMOG), October 2024 report.</li> <li>• That the Senate approved the Healthy Ageing and Frailty Strategy.</li> <li>• That the Senate approved the All-Age Respiratory Strategy.</li> <li>• That the Senate approved the Breathlessness and Upper GI pathways.</li> <li>• That the Senate approved the Lower Back Pain guidance</li> </ul>	
<p>13.</p>	<p><b>ICS Finance and Performance Report</b></p>	
	<p>PB presented the finance element of the report and highlighted the clinical challenges and financial pressures continue to be very challenging during this financial year. He advised that the month 8 position is positive, as it is the first month where we have a small surplus and stated that there are signs that some of the measures being taken are starting to come to fruition. He reminded the Board that the start of the financial year we were reporting a deficit of £100 million and following the measures that have been identified, we are currently forecasting a deficit of £56 million. It had since been agreed by the National Team that the dental funding would be withdrawn and forwarded back to the centre, which resulted in a further £8 million gap, which has been covered off and a forecasted position of £56 million continues to be forecasted for year end.</p> <p>PB advised that the Investigation and Intervention regime commenced in August last year and is proving helpful and work continues. He advised that workforce is the biggest cost and there has been some growth in the workforce, which is not affordable and emphasised the need to reduce workforce across the system, whilst ensuring the need to be safe and beneficial for the patient pathway.</p> <p>PB stated that the Investigation and Intervention regime has significantly focused on continuing health care (CHC) and there has been significant improvements, which are benefiting the patients and added that there has been a 12% reduction in the CHC caseload, however, no financial gain has come to fruition as yet, due to the inbuilt delays due to the process of moving patients onto different pathways and also advised that colleagues are working on the whole pathway position, with the support from Deloitte's and it is anticipated that this will deliver benefits.</p> <p>PB advised that the Investigation and Intervention regime is also focussing on productively, particular the elective process at UHNM and to establish better use of operating theatres, how we maximise the way we work with the independent sector to ensure that patients are treated at the appropriate place. He added that PEJ is leading on the clinical optimisation workstream and also advised that work is progressing in relation to the balance sheets where there is potential to release previous costs.</p> <p>It was highlighted that colleagues continue to meet with the Investigation and Intervention Team on a daily basis and there is full commitment from the whole system. There has been improvement in the run rate, however we have been advised that we must break even, but assurance cannot be given at this stage that we will break even. However, it is expected that there will be some improvement in the months ahead and the system is doing everything it can, whilst maintaining safe services.</p> <p>JR referred to the CHC reduction of 12% which is a dramatic reduction, but not without risk and asked are we going to track the key indicators around the cohort we are turning down to ensure we are not doing any harm, particularly the rate of re-admission. PB provided assurance this is a clinically lead team, which is not financial driven and stated that every decision is taken with the best interests of the patient.</p>	

<p>He added that as a system we continue to be an outlier, which is not good from a clinical perspective. He provided assurance that those clinical measures are reviewed by the team and decisions are made on a CHC assessment and clinical needs of the patient and thanked Local Authority colleagues as this has been undertaken jointly. DP thanked PB for the response and requested that this is also confirmed by HJ and emphasised that patient safety is paramount and comes first and is constantly monitored.</p> <p>JH referred to the pressures within the system and in terms of being able to assess harm or the impact on the patient experience and stated as a Board the need to look at complaints, freedom of information requests and assess any potential impact. DP referred to the cover sheets that accompany all agenda items are requested that these are completed correctly, ensuring any financial impacts or any impacts on the ICB undertakings are noted.</p> <p>JH also referred to the financial position and the fast-approaching year end and stated that the Board currently meets monthly and receives an update on the financial position and asked do we need to meet on as an extra-ordinary Board. DP agreed and assured colleagues that we have the flexibility to establish an extra-ordinary Board if required. PA advised that HJ is exec lead for CHC, who ensures that there are links between CHC and the unintended consequence risks going forward are linked into the 2025/206 planning process through quality and safety mechanisms are in place.</p> <p>JR stated that if we start losing a higher proportion of appeals in respect of CHC it would suggest we are not getting it right.</p> <p>PS provided an update in relation to the performance element of the report, in particular winter and referred to the national context and recent media interest where it was reported that national data showed that last year calendar year was the busiest one ever for A&amp;E and ambulance services in December had the highest number of ambulance conveyances in one month. Flu is higher than reported last year, alongside covid and RSV and due to exception demand and seasonal illness which are impacting on the ability to deliver care, a number of Trusts across the county and within the system have declared critical incidents and the local context mirrors the rapid rise in pressure early into the winter season, which resulted in a system wide critical incident being declared at the end of November, which was stood down early December, however, we have had further critical incidents declared across the system since.</p> <p>PS highlighted that compared to this time last year, demand is different but in line overall year to date, with periods of intense surge and advised that within UHNM during November and December they had 5% higher demand than the same period last year and the Haywood Walk-in Centre was 9% higher.</p> <p>PS stated that there were significant infection spikes in norovirus during November and this is the second highest seasonal flu demand we have experienced in recent years. He added that infection prevention control continues to be extremely challenging with high levels of flu, covid and other seasonal illnesses, with further spikes in cases expected over the coming weeks. He also added that there has been an increase in major, trauma and stroke demand, along with significant ambulance arrivals, for example on Monday of this week, UHNM had 179 ambulance arrivals in one day, which is the highest since August 2021.</p> <p>PS stated that for our population there have been some unacceptable delays across the urgent care pathway, particularly in relation to ambulance response times, which have deteriorated, resulting in category two deteriorating to 39 minutes in November and it is expected that the December position is over 50 minutes delay.</p> <p>PS advised that as of today, the system remains in high escalation and UHNM remain in a business continuity incident, which will be reviewed later today. In terms of the response and the early arrival of winter, the surge plan has been deployed and additional actions have been brought forward, including primary care winter hub capacity, community hospital bed capacity and additional spot purchase of discharge to access beds.</p>	<p>HJ</p>
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<p>He added that there has been success and further development to the single point of access, with the establishment of the Incident Co-ordination Centre and additional staff have been deployed into the unit, which has seen a 20% increase in demand over the past month and it was highlighted that we are the first system within the region to go live for a 24 hours a day, seven days a week facility for a single point of access for care professionals. He added that there is also continued focus on our care home population and colleagues are working with care homes to promote the model. Colleagues are also working our local ambulance services to promote the use of “call before convey” and as from next week this will be 24 hours a day, seven days a week model from the ambulance service perspective and in addition the age boundary will also reduce and will be applicable to all adults.</p> <p>Work continues towards to the 45-minute ambulance handover protocol to ensure delays are minimised, however this has been comprised due to the pressure in the system. Within the acute footprint decisions have been taken around the risk assess “use of your next patient”, including boarding onto wards and the use of corridors and due to the pressures, there has been a stand down of elective work and colleagues are working to mitigate and risk and patients will be rescheduled as soon as possible. Colleagues are working to identify additional capacity and mutual aid from other NHS partners.</p> <p>PS reported that the system has worked very effectively to support colleagues within the acute setting to identify patients suitable for discharge and to support patients to onward services. He also reported that UHNM have invited NHS England to review their internal urgent emergency care pathways and have also appointed an Urgent Emergency Care Performance Director.</p> <p>PS advised that due to the ongoing pressures within the system, staff sickness has increased across the system and advised that regular debriefs and data reviews are carried out, which will be presented to the Finance and Performance Committee and will provide a full view of winter, which will support the formal learning event scheduled for the spring.</p> <p>PS concluded by reiterating that the situation remains extremely challenging but provided assurance that the leadership across the system has functioned well, daily conversations continue to be had and colleagues continue to work collaboratively to support with the pressures.</p> <p>DP thanked PS for the overview and referred to page 3 overview of the report and the high number of red rated performance indicators and noted that a large majority are linked to the current pressures and asked for assurance that they are being monitored, particularly as the ICB has its quarterly review with NHS England in the next few weeks. PS acknowledged the deterioration and stated that daily strategic calls are in place where colleagues review the matrix and it is anticipated with additional external support the position will improve over the next few months.</p> <p><b>The ICB Board received the report and:</b></p> <ul style="list-style-type: none"> <li>● <b>Acknowledged the high-level performance against the five priorities.</b></li> <li>● <b>Acknowledged the high-level key programme deliverables update.</b></li> <li>● <b>Acknowledged the financial position.</b></li> </ul>	
<p><b>Finance and Performance Committee Assurance Report</b></p>	
<p>JS presented the report on behalf of MN and advised that there are no escalations to highlight to the Boad. She reiteration that the ICB does not have a route to achieve break even position at year end at the present time. She added that the Investigation and Intervention Team continue to identify savings, but at the present time this will not provide a break-even position.</p> <p>JS advised that the Committee received a presentation regarding the urgent emergency care from the Integrated Co-ordination Team, which was well received and highlighted the good initiatives and highlighting the need to ensure finance and quality are aligned to ensure that patients receive the right service at the right time.</p>	

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	<p>It was noted that the Committee received a presentation regarding the current position regarding the pulmonary rehabilitation services in East and Southeast Staffordshire and approved the principles highlighted within the presentation and acknowledged that further work is required.</p> <p>JS advised that the Committee agreed a contract for the acute visiting service. She also added that the capital position for 2025/2026 will be discussed at the next Finance and Performance Committee and an update will be provided within the Chairs AAA report at the next ICB Board.</p> <p><b>The ICB Board received and noted the report.</b></p>	<b>MN</b>
<b>14.</b>	<b>People, Culture and Inclusion Committee Assurance Report</b>	
	<p>MI presented the report and advised on a positive perspective workforce turnover is 8.6% and agency turnover is 2.3% against a target of 3.2%, which is really positive and a credit to all providers in terms of the work undertaken round productively and processes. It was noted that we do remain over our operational planning figure, which will have a financial impact and we are currently 467 over our operational plan, with the majority being within the acute sector and linked to some funded activity and ERF.</p> <p>MI advised that over the next 12 months we need to consider how we can support the increased use of workforce where it is needed and the reduction of the workforce where we can be more efficient and added that each provider organisation are working with the Investigation and Intervention Team and are looking at a number of areas and processes and emphasised that all providers have Financial Control Recovery Group, which meet on a weekly basis and are looking at each vacancy control process, establishments and how workforce is being utilised and added that these groups are clinically led, ensuring patient safety and productively changes, which will ensure improved workforce well-being.</p> <p>MI added that work continues to look at how our workforce can be trained to move across the system and work in a different way that can support our population.</p> <p><b>The ICB Board were asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Note the workforce position, operating plan, risks and mitigations in place to address.</b></li> </ul>	
	<b>People, Culture and Inclusion Committee AAA Report</b>	
	<p>SL presented the report and advised that there are no alerts to highlight to the Board and advised that the Committee received an update in relation to the:</p> <ul style="list-style-type: none"> <li>• Financial position and medium-term plan</li> <li>• I&amp;I regime</li> <li>• ICS Staff Psychological Wellbeing Hub</li> </ul> <p>SL advised that the Committee received a staff story regarding ICS placement programme, in which paramedic student shared her story following her participation in the programme, which was a powerful example of working across the system and suggested that this is brought to a future ICB Board meeting.</p> <p><b>The ICB Board received and noted the report.</b></p>	
<b>15.</b>	<b>Staffordshire and Stoke- on -Trent ICB Remuneration Committee Summary and Escalation Report</b>	
	<p>SL presented the report and advised that there are no escalations for the Board and advised that the Committee received and update regarding:</p>	

	<ul style="list-style-type: none"> <li>• Chief Executive’s appraisal</li> <li>• 2024/2025 annual pay review for our local CPL pay framework</li> <li>• Confirmation of appointment to the vacant Non-Executive Member post</li> <li>• Recruitment to the vacant Non-Executive Member post</li> <li>• Partial retirement for the Chief Nursing and Therapies Officer</li> </ul> <p><b>The ICB Board received and noted the report.</b></p>	
<b>16.</b>	<b>Quarter 3 System Board Assurance Framework</b>	
	<p>CC presented the report and provided assurance that it has been presented through the usual governance processes and paid credit to PW and his team for compiling the report.</p> <p>The top three risks scoring high 20 are:</p> <ul style="list-style-type: none"> <li>Reducing health inequalities</li> <li>Financial</li> <li>Workforce sustainability</li> </ul> <p>CC advised that there have not been any changes in the risk level during this quarter and in terms of assurance, six out of eight of the strategic risks have been given a partial assurance rating, whilst two out of eight, which are quality and workforce have an acceptable assurance rating.</p> <p>CC referred to the business cycle and advised that there is an opportunity for Committees to consider where there is partial assurance against the risks, what are the gaps that we need to address in terms of assurance for the Committees.</p> <p>CC advised that within the report there has been an introduction of trajectories for risk reduction and the report also sets out where the risk is lightly to be at the end of Quarter 4.</p> <p>CC was pleased to report that the SBAF has received national recognition and she and TS were invited to sit as panellists on a National Audit Committee Chairs session, where they presented the work that has been undertaken as a system regarding board assurance.</p> <p>CC referred to the earlier update regarding cyber security and stated as we approach the end of the financial year, colleagues need to reflect on the content of the SBAF for 2025/2026 and the possibility of brining in new strategic risks, for example cyber security and requested that Board conversations are held in the new future. She also suggested an area of exploration within the 2025/2026 BAF and how we summarise the operational/quality risks and what does this mean for the strategic risks.</p> <p>DP congratulated CC and TS for receiving national recognition. He referred to the gap analysis in terms of partial assurances on the partial assurances, agreed that it is timely that this is undertaken and requested that she links in with JH to take this forward.</p> <p>JH advised that the Audit Committee spent a significant amount of time discussing risks and the SBAF and stated that the Audit Committee are concerned that there are a number of risks that are not moving and haven’t for six months and have therefore referred those risks back to the relevant Committee to challenge whether the right mitigations are in place and review the target risk score. CC referred to the Board Assurance guidance, in which there is now greater emphasis on triangulation for assurance and stated that we need to work together where appropriate on the assurances that are relevant to all Committees.</p> <p>JH provided an update following the last Audit Committee, which took place this week and advised that the Committee confirmed the re-appointment of Grant Thornton as our external auditors. She also advised that the compliance level against EPRR against our national standards is now</p>	<b>CC/JH</b>

	<p>substantial and added that there is partial compliance in three areas including business interruption.</p> <p>It was highlighted that the Audit Committee discussed the financial accounts timetable, which will be presented to the Board in June. The Committee also received three internal audit reports, which highlighted that the green plan was reasonable, key financial control were substantial and there as an advisory report on personal health budgets and the recommendations will be discussion at the next meeting. The Committee received a presentation regarding population health and a summary regarding health inequalities, population health and prevention.</p> <p>JH concluded by adding that the Board Seminar scheduled for next week, will focus on strengthening our levels of assurance and also stated that the Committee reflected on the outcome of the review of the Audit Committee effectiveness and actions will be put in place.</p> <p><b>The ICB Board received the report and:</b></p> <ul style="list-style-type: none"> <li>• <b>Confirmed that the Quarter 3 and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.</b></li> </ul> <p>The ICB Board also received and noted the update following the recent Audit Committee.</p>	
17.	<p><b>Items notified in advance to the Chair</b></p>	
	<p>No items were notified to the Chair and no other items of business were raised.</p>	
17.	<p><b>Questions from the floor relating to the discussions at the meeting</b></p>	
	<p>Mr Ian Syme thanked members of the Board for an interesting meeting, specifically PS for a comprehensive update in relation to urgent care. He also thanked PW and the Communication Team for assisting/responding to his pre-submitted questions.</p> <p><u>Question one – Mr Ian Syme</u></p> <p>Mr Syme referred to the cyber security agenda item, high level report and highlighted the public facing information within digitalisation, for example NHS App, EPR and asked how we are getting through to the general public that they can trust the safety and security of these Apps, as there is a significant amount of sensitive data contained within them.</p> <p>CI thanked Mr Syme for the question and advised that work is being undertaken with local libraries to improve the training and guidance for people to register and use the NHS App effectively and to access differ forms of information. And added that from a technical perspective is it important to ensure access to our systems is strongly managed and controlled and require multi-authentication to access CI also added that the NHS App Team focus on ensuring that the information is held securely and access and all users can access the information in a secure fashion.</p> <p><u>Question two – Mr Ian Syme</u></p> <p>Mr Syme referred to the Darwin Centre in particular the level three oversight and advised that he had noted within NSCHT reports to their Board the high use of agency nurses and asked who manages this centre as it is Specialised Regional centre of CAMHS and will this change in light of specialised commissioning changes in 2025.</p> <p>BA advised that NSCHT currently manager the Centre and confirmed that it is a regional centre, commissioned with West Midlands provider collaborative.</p>	

	<p>Mr Syme asked if West Midlands Collaborative is part of NHS England.</p> <p>BA stated that this was specialised commissioning, which has been devolved to the Provider Collaborative that is led by Birmingham Women and Children’s and will change as part of the specialised commissioning changes this year.</p> <p><u>Question three – Mr Ian Syme</u></p> <p>Mr Syme stated that he attended the UHNM January Board and noted that they are predicting a £23 million deficit at year end and stated that we need to get rid of the £56 million, which is over and above the £90 million that has already been covered, within the next three months and asked how is this going to be achieved without shutting down services and what are the consequences if we don’t achieve the £56 million variance.</p> <p>PB stated that the £23 million is the unmitigated risk and is part of the £56 million and stated that we have been told that we must break even at year end, however, we don’t have a pathway to break even as yet, although good progress is being made and earlier indications are showing that improvement has been made in month 9 and will be able to establish by month 10 if we will achieve break even. He added that conversations will be held with the regulators if we do not achieve a break-even position and added that there will be penalties if we do not and there will also be a loss of capital and levy charged for next year.</p> <p>Mr Syme stated that we are not being profligate and added that the system has faced massive surges in demand and asked if these messages are being relayed to NHS England.</p> <p>PB confirmed that NHS England are aware and stated that there is a limited amount of money but emphasised that NHS England have asked us to break even. PA referred to the Darzi Report which highlighted a summary of the challenges we face across the NHS, including significant reductions in management capacity to enable transformation and added that the Centre do repeatedly mention to all systems the deterioration they see in the data of productivity levels and stated that the challenge is the speed of improvement.</p>	
<b>18.</b>	<b>Meeting Effectiveness</b>	
	The Chair confirmed that the meeting followed the Leadership Compact.	
<b>19.</b>	<b>Close</b>	
	There being no further business, the Chair closed the meeting.	
<b>20.</b>	<b>Date and time of Next Meeting</b>	
	20 <sup>th</sup> February 2025 at 1.00pm – 3.00pm, held in Public, via MS Teams	

<b>ACTION STATUS KEY</b>
<b>ACTION DUE</b>
<b>ACTION PENDING</b>
<b>ACTION COMPLETE</b>

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

<b>Open Actions</b>						
<b>Agenda item</b>	<b>Meeting Date</b>	<b>Agenda Item</b>	<b>Action</b>	<b>Due Date</b>	<b>Responsible Officer</b>	<b>Outcome/update</b> (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
9	19/12/2024	<b>Specialised Commissioning Delegation</b>	ED presented the report which highlights the next phase, which focuses on acute specialised services, mental health, learning disability, autism and specialised services and outlines how we are engaged with conversations with regional teams. She added that there are a range of working groups which have been established to oversee the transition and formal governance arrangements are in place that oversee the delivery. It was noted that the ICB has re-established its internal Working Group, which will focus is on the safe transition and a further paper will come to the Board in March.	<b>20/03/2025</b>	Elizabeth Disney	Paper will be presented at the March meeting
8	16/01/2025	<b>Chair and CEO Report</b>	JH referred to the high number of flu cases, in particular the number of hospital admissions and asked if data is being collected to establish if those patients who have been admitted have been vaccinated. PEJ confirmed that 100% vaccination status is recorded and agreed to establish the percentage and let JH know and report back to the next Board meeting.	<b>20/02/2025</b>	Paul Edmondson-Jones	
9	16/01/2025	<b>Cyber update</b>	CC highlighted the significant risk of cyber security across the country, which is heighten due to the move from analogue to digital and confirmed that it is included in the risk register and added that due to the nature of cyber risk advised that the ICB may want to give some consideration when we move into the BAF for 2025/26 this as a strategic risk within the BAF. She also added that the Audit Committee handbook is clear on its overview of cyber risk and advised from a UHNM perspective she has produced a similar report, which highlights the national context and the controls and assurances in place and suggested including this as part of the Audit Committee cycle of business, which will provide further assurance. DP requested further executive discussions and discussions at Audit Committee via JH and report back to a future Board with an update.	<b>15/05/2025</b>	Chris Ibell	
13	16/01/2025	<b>ICS Finance and Performance Update</b>	JR referred to the CHC reduction of 12% which is a dramatic reduction, but not without risk and asked are we going to track the key indicators around the cohort we are turning down to ensure we are not doing any harm, particularly the rate of re-admission. PB provided assurance this is a clinically lead team, which is not financial driven and stated that every decision in taken with the best interests of the patient.  He added that as a system we continue to be an outlier, which is not good from a clinical perspective. He provided assurance that those clinical measures are reviewed by the team and decisions are made on a CHC assessment and clinical needs of the patient and thanked Local Authority colleagues as this has been undertaken jointly. DP thanked PB for the response and requested that this is also confirmed by HJ and emphasised that patient safety is paramount and comes first and is constantly monitored.	<b>20/02/2025</b>	Heather Johnstone	

**Enclosure No: 05**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	20 February 2025					
<b>Title:</b>	Chair and Chief Executive Officer Report					
<b>Presenting Officer:</b>	David Pearson, Chair, and Peter Axon, CEO					
<b>Author(s):</b>	David Pearson, Chair, and Peter Axon, CEO					
<b>Document Type:</b>	Report			If Other: Click or tap here to enter text.		
<b>Action Required (select):</b>	<b>Information (I)</b>	<input checked="" type="checkbox"/>	<b>Discussion (D)</b>	<input type="checkbox"/>	<b>Assurance (S)</b>	<input type="checkbox"/>
	<b>Approval (A)</b>	<input type="checkbox"/>	<b>Ratification (R)</b>	<input type="checkbox"/>	<i>(check as necessary)</i>	
<b>Is the decision within SOFD powers &amp; limits</b>	<b>Yes / No</b>	Choose an item.				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	NO If Y, the mitigation recommendations – Click or tap here to enter text.				
<b>Any financial impacts: ICB or ICS?</b>	<b>Yes / No</b>	NO If Y, are those signed off by and date: Click or tap here to enter text.				
<b>Any impacts on ICB Undertakings?</b>	<b>Yes / No</b>	NO If Y, are those signed off by and date: Click or tap here to enter text.				
<b>Appendices:</b>	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

<b>(2) History of the paper, incl. date &amp; whether for A / D / S / I (as above):</b>	<b>Date</b>
N/A	

**(3) Implications:**

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

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<b>Sustainability</b>	N/A for the report
<b>Workforce / Training</b>	N/A no specific training implications / workforce matters inherent to each topic
<b>Equality &amp; Diversity</b>	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
<b>Due Regard: Inequalities</b>	Access to services and reducing inequalities is implicit throughout
<b>Due Regard: wider effect</b>	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
<b>Completion of Impact Assessments:</b>	<b>DPIA</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, Reported to IG Group on</i> Click or tap to enter a date.
	<b>EIA</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.
	<b>QIA</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If N, why</i> Click or tap here to enter text. <i>If Y, signed off by QIA on</i> Click or tap to enter a date.
<b>Has there been Public / Patient Involvement?</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Click or tap here to enter text.

### (5) Integration with the BAF & Key Risks:

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

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

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### (7) Recommendations to Board / Committee:

To receive the report and be assured the leadership are working on each topic as raised.
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### 1.0 System and general update

#### 1.1 Chair David Pearson's visit to North Staffordshire Combined Healthcare NHS Trust

On 05 February 2025, Chair David Pearson was invited to visit North Staffordshire Combined Healthcare NHS Trust (NSCHT). The overall visit was led by NSCHT Chief Executive Dr Buki Adeyemo, Chief Operating Officer Ben Richards, Deputy Operating Officer Rachael Birks and Associate Director Donna Cantrell.

David had the opportunity to see the all-age telephone and walk-in crisis care access under one roof, an innovation that has been continuously developed since November 2019. He talked to frontline staff about the challenges of implementing the Right Care Right Person arrangements, along with issues around funding for out of area patients. David shared thanks to Aisling Birch, Crisis Care Service Manager, Craig Lythgoe, Crisis Care Deputy Team Manager, and Leanne Norman, Crisis Care Centre Team Manager.

David was shown the facilities being developed through 'Project Chrysalis' in the new Ward 2, commenting on the calming atmosphere and use of artwork that creates a welcoming environment. He praised Sarah Larvin, Ward 2 Deputy Ward Manager, as great example of a young leader in the NHS.

David was involved in discussions around NSCHT's innovative use of virtual reality, including a library of virtual reality tours of all Combined Healthcare sites to provide engaging and informative experiences of NSCHT facilities and locations. The aim of this is to increase accessibility, particularly for service users and their families who might be nervous about engaging with services.

Examples of this can be found at: <https://my.matterport.com/show/?m=EAkSaQKmVE> and <https://my.matterport.com/show/?m=dHurVqC8iHi>

Additionally, David was shown a CVR video experience created by NSCHT to help frontline healthcare staff create conversations, increase understanding and empathy towards those with delirium. The training film aims to provide a real-life experience by placing the viewer inside the head of a patient with delirium. In 2024, Combined Healthcare announced that the film had gone international with the launch of a Danish language version, produced in partnership with Gødstrup Hospital, Herning, Denmark.

The training film is available at: <https://youtu.be/J-jT5AtsmOo?si=x38i6KxefOqJQSIA>



#### 1.2 Community Transformation

Following an initial system workshop on 17 December 2024, system partners met again on 23 January 2025 to discuss Community Transformation as part of the Medium-Term Plan. The workshop aimed to review the proposed model of care, a draft of which had been developed utilising feedback from the first workshop, and to agree priorities for year one (2025/2026).

Commitments and next steps include:

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- The development of a whole system approach, with the use of Population Health management approaches
- A segmentation model, to look at what services we would look to be delivering against a population segmentation model. This includes mapping services/interventions onto each segment and a reorganisation of those services against a model of care, with clear parts for IPH, Primary Care, ELF Planned Care and UEC portfolios to be delivering during 2025/2026.
- The development and agreement of a core offer or core model for community-based services across our geography for implementation during 2025/26. The focus for this model will be the complex needs and end of life segments.
- The agreement to use data to identify other evidence-based interventions that should be implemented in 2025/2026. These will be interventions that specially address high usage of bedded acute or social care services, where community or home-based alternatives might be possible. This will be planned and commissioned through the portfolios and delivered through the provider collaboratives.

This programme of work will be aligned with the new neighbourhood health guidance, which was outlined in the 2025/26 operational planning guidance and has 6 core components, which include: Population Health Management, Modern General Practice, Standardising Community Health Services, Neighbourhood Multidisciplinary Teams (MDTs), Integrated Intermediate Care ('Home First' Approach) and Urgent Neighbourhood Services.

### 1.3 Primary care

#### 1.3.1 IT equipment donation

In December 2024, the ICB worked with Primary Care to send 1500 wireless keyboard and mouse bundles out to local schools and charity partners, with the aim to improve digital capability within the local population. General practices were unable to use the equipment as they had no smartcard reader, prompting the ICB to distribute them to ensure they were utilised efficiently and avoid wastage. The team have received many letters of thanks from school children and VAST, who stated 'The equipment will have a great impact, particularly where digital exclusion remains a significant challenge. This equipment helps bridge this gap, enabling individuals to access the tools and resources they need to thrive, supporting work in our community and making a real difference in people's lives.'

#### 1.3.2 National Apprenticeship Week

National Apprenticeship Week took place throughout the week of 10 February 2025. Employing apprentices provides practices and primary care networks (PCNs) with a valuable opportunity to strengthen their teams by investing in new talent or upskilling existing staff. This approach enhances workforce capability while promoting long-term growth, retention, and sustainability within Primary Care.

By embracing apprenticeship roles, practices and PCNs can support professional development, equipping team members with the skills and expertise needed to meet evolving workforce and healthcare demands, playing a crucial role in workforce planning and ensuring a well-prepared and resilient Primary Care team for the future.

The Staffordshire Training Hub Administration and Leadership Apprenticeship Programme, delivered in collaboration with the PMA, offers comprehensive support to general practice. Apprenticeships are available at Levels 3 to 7, tailored to meet practice and PCN needs in administration, management, and leadership. To further support practices and PCNs, the programme includes a £1,000 bursary per apprentice - helping offset the administrative time. Since its launch in late 2023, the Staffordshire Training Hub have supported 17 apprentices and their respective practices and PCNs across Staffordshire and Stoke-on-Trent, driving both personal and professional workforce development across Primary Care.

### 1.4 People team

#### 1.4.1 Performance to 2024/2025 Plan

At Month 9, Staffordshire and Stoke-on-Trent is significantly above the planned workforce growth for 2024/2025, which is attributed to increases in substantive and temporary workforce, business cases requiring additional workforce, and challenges around the Cost Improvement Programme scheme delivery. The increase was noted and challenged by People, Culture and Inclusion members, with assurance provided regarding the ongoing work with Trust chief people officers, chief finance officers and the NHSE Regional team.

#### 1.4.2 Operational Planning 2025/2026

The Committee received an update regarding the 2025/2026 allocations and a summary of the recently published 2025/26 operational planning guidance. Members were advised on the timescales and priorities, including Elective Care, A&E, General Practice, Dental, Mental Health and Learning Disabilities and Autism. The enablers around 'living within budget, reducing waste and improving productivity' were discussed with particular focus on the workforce elements including temporary staffing and implementing the People Promise. The Committee acknowledged the significant challenges, and further discussions will take place at the March and April meetings with iterations of the plan shared with members for assurance.

#### 1.4.3 Medium-Term Plan and Workforce Transformation

The Committee was provided with an overview of the Medium-Term Plan development status. Discussion centred around Community Transformation, alongside the workforce implications and opportunities. Members considered the significant behavioural, cultural and leadership implications of a transformation programme of this size and the transition from current ways of working to a new model. It was acknowledged that organisations would need to work together and differently to utilise our collective resources across our system and organisational boundaries to deliver the transformational change required. Community and workforce involvement across all sectors and staff groups was identified as a key enabler to the development and success of the transformation.

#### 1.4.4 People Plan Refresh and 2025/2026 Delivery Plan

An overview of the approach to refresh the system plan and development of the 2025/2026 delivery plan was provided to the Committee. Discussions took place regarding the alignment of the plan to the Operating Plan, Medium-Term Plan, portfolios, system priorities, and the people promise. It was acknowledged that we will need to consider the 10-year Health Plan and refreshed Long Term Workforce Plan once published later this year. The Committee welcomed the refresh of the People Plan, development of the 2025/2026 Delivery Plan and engagement and coproduction approach with system partners.

#### 1.4.5 Equality Diversity and Inclusion

System partners will be celebrating Race Equality Week during 03 - 09 February, supported by passionate changemakers who are committed to leading and advancing race equality in their organisations, gathering and sharing resources provided by NSCHT. LGBTQ+ History Month also takes place throughout February, with events led by Midlands Partnership University NHS Foundation Trust's (MPFT) LGBTQ+ Network planned to take place. These events will be promoted across all ICS organisations.

### 2.0 Finance

As a system we continue to focus on the delivery of our financial recovery plan. At Month 9, the position continues to be relatively positive with signs of improvement to the run rate. At a system level we are reporting a year-to-date deficit position of £29.5m, which is a £32.8m adverse variance against the revised plan (Month 8 variance to plan £33.3m). The year-to-date variance to plan sits within ICB (£14.8m) and UHNM (£19.7m) offset by small surpluses at MPFT (£0.9m) and NSCHT (£0.7m). In Month 9 we have reduced our system unmitigated risk from £56m to £39m. This £17m improvement has been achieved through a combination of increased certainty in terms of delivery of planned efficiencies, notably with improvements to Continuing Health Care starting to crystallise, coupled with the benefit of Elective Recovery Fund delivery. We continue to work to identify any additional short-term opportunities with

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delivery plans for those being worked up and implemented. We continue to focus to deliver a financial outturn as close to a breakeven position as possible.

Work on financial and operational planning for 2025/26 is now well underway, with confirmation of the operational targets as well as the revenue and capital allocations being received on 30 January. We are currently working through the impact of the planning guidance, including the financial implications with a first cut of plans being completed at the end of February.

### 3.0 Planned Care

University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) continue to be in tier 2 elective oversight.

Urgent emergency care pressures have impacted planned care procedures, although cancellations have been mitigated where possible.

New national priorities and success measures for elective care for 2025/26 were published on 30 January 2025 as part of NHS operational planning guidance. These measures seek to further reduce patient waiting times and improve cancer diagnosis and treatment timeframes.

### 3.1 Elective Waits - 104, 78 and 65 week waits summary

Appendix 1: Summary table of Referral to Treatment (RTT) breaches. The numbers detailed are for Staffordshire and Stoke-on-Trent patients only.

	December - Number of patients		
	104+ weeks	78-103 weeks	65-77 weeks
University Hospitals of North Midlands	0	11	84
Nuffield North Staffordshire	0	0	0
Ramsay	0	0	0
Medefer	0	0	0
<b>System Providers Total</b>	<b>0</b>	<b>11</b>	<b>84</b>
<b>Out of System Providers</b>	<b>0</b>	<b>4</b>	<b>73</b>

The table in Appendix 1 shows the 104, 78 and 65 week waits for December. The December month end Referral to Treatment (RTT) submission has provided the December position for both providers outside of the system and within the system. This is the latest published data available.

### 3.2 Cancer Performance

Appendix 2: Summary table of Cancer compliance. The numbers detailed are a trust wide position.

Provider	Cancer Standard	December - Number of patients				
		Treated	Within Standard	Breaches	% compliance	Target
University Hospitals of North Midlands	28-day Faster Diagnosis	3457	2585	872	74.8%	75.0%
	31-day target	1242	1158	84	93.2%	96.0%
	62-day combined target	598	415	183	69.4%	85.0%
University Hospitals of Derby and Burton	28-day Faster Diagnosis	3680	2706	974	73.5%	75.0%
	31-day target	1586	1412	174	89.0%	96.0%
	62-day combined target	812	581	231	71.6%	85.0%

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The table in Appendix 2 shows the November performance for 28-day Faster Diagnosis, 31-day target and 62-day combined target. Please note this is the provider position, not solely SSoT patients, and is taken from the published Cancer Waiting Times data, with the latest data available being November.

Further and ongoing actions include:

- Continued focus on clearance of long wait patients.
- Continued focus on faster cancer diagnosis and treatment.
- Focus on the new national priorities and success measures for 2025/26, to further reduce the time people wait for elective care and cancer diagnosis and treatment.
- 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 the week ending 02 February 2025 deteriorated to 46 minutes and 27 seconds, which is an increase of 16 ½ minutes. This was 12 minutes above plan, placing the system 35th nationally and 9th regionally. The 4-week average of 46 minutes and 27 seconds placed the system 26th out of 42 nationally, and 7th out of 11 regionally.

January's average handover time at UHNM continued to be pressured during periods of surging demand, however, continued focus on working towards ambulance handover compliance resulted in an improved average of 1 hour, 46 minutes and 43 seconds, down from 1 hour and 58 minutes last month. Overall time lost because of handovers decreased by 410 hours, due to the focus on quicker handovers taking the total to just below 6900 hours, a position which was still significantly above plan by 3230 hours. Efforts to improve the handover performance through the Ambulance Handover trajectory continued to deliver good periods of performance through the month, however, maintaining prolonged periods of high handover performance is proving to be challenging. Overall, January's achievement of 56.89% of handovers within the required time was a 7% improvement for December but remained 8.1% below the plan target for the month.

'All types' of attendance at UHNM decreased by 3.2%, equating to around 24 patients fewer each day with the decrease in numbers split between Type 1 and Type 3 locations. Patients receiving their initial assessment within 15 minutes improved by 8.4% to 67.7% for the month, and there was a 20% increase in Type 1 attendances seen within the first 60 minutes. Emergency Admissions via A&E increased to 2.5% for the month, equivalent to a daily increase of between 4 and 5 patients. When compared to the same period last year, the overall level of reduced emergency admissions equated to 8.7%, which is approximately 17 patients fewer per day.

Four-hour performance during January increased by 4 percentage points to 66.4%, a shortfall of only 0.23 percentage points against plan. Type 1 locations experienced a 2% reduction in attendances through the month, reporting a 6.4 percentage point increase in performance, totalling 46.7%, whilst Type 3 locations also reported reduced patient attendances and an improved position of 97%, up 1.2 percentage points on the previous month.

Unvalidated 12-hour performance improved by 0.8 percentage points, with 10.9% of attendances spending 12 hours or more in the Emergency Department, equivalent to almost 1 in every 9 attendees. The regional average for this period was 12.7%, and when compared to the same period last year, performance was a minimal 0.4 percentage points worse.

Bed Occupancy for January, for both Adult General and Acute (G&A) and all G&A increased, resulting in an occupancy rate of 92.6% for all G&A, up from 91.5%, equating to 1.6 percentage points below plan. Following the push to ensure patients could go home for Christmas, January traditionally sees increased in all long-stay cohorts (7+, 14+ and 21+ days), which was the case for January 2025 as we saw an

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

increase of 2.2 percentage points for 7+ days, 3.3 percentage points for 14+ days, and 2.4 percentage points for 21+ days.

Due to changes in the reporting framework for discharges, we are not presently able to provide breakdowns of the Discharge Pathways for the month of January, however, evidence from weekly submissions appears to indicate similar proportions in Pathway 1 and Pathway 2 Discharges to the previous month, with Pathway 0 likely to report below 75% for the third consecutive month.

Virtual Wards occupancy for the latest submission (24th January) reported as 210 patients in a VW bed, and whilst the capacity of 293 continued to be below plan for the month occupancy levels remained above 70% reaching 71.7% for the second submission of January 2025. When split between the various sectors the North reported a reduced occupancy of 67.1%, the South-East 87.5%, and the South-West 54.3%.

Covid infections continue to persist with 13 beds occupied by the end of the month, whilst flu infections having reduced through the month accounted for 31 beds. This placed pressure on a bed base continuing to deal with an additional 17 beds closed due to diarrhoea and vomiting infections.

### 5.0 Key figures from our population

	Last 4 months in current financial year				Comparator month		Change on same month previous year		
	Sep-24	Oct-24	Nov-24	Dec-24	Nov-23	Dec-23	No.	%	Direction
* 111 calls received	25,879	28,587	31,094	35,886					
Percentage of 111 calls abandoned	2.1%	2.2%	2.1%	1.5%					
A&E and Walk in Centre attendances (UHNM)	20,891	22,519	21,450	21,894		20,205	1,689	8.4%	↑
A&E and Walk in Centre attendances (other providers)	18,112	19,276	18,755	18,763		17,608	1,155	6.6%	↑
Non elective admissions (UHNM)	7,875	8,178	7,429	7,875		7,631	244	3.2%	↑
Non elective admissions (other providers)	6,169	6,942	6,855	6,862		6,160	702	11.4%	↑
Elective and Day Case spells (UHNM)	8,714	9,129	8,457	7,672		6,413	1,259	19.6%	↑
Elective and Day Case spells (other providers)	8,536	9,323	8,786	7,583		7,407	176	2.4%	↑
Outpatient procedures (UHNM)	8,097	9,258	9,095	8,163		6,635	1,528	23.0%	↑
Outpatient procedures (other providers)	13,926	15,343	13,288	11,663		10,298	1,365	13.3%	↑
GP appointments (all)	537,554	706,063	564,561	508,968		466,525	42,443	9.1%	↑
** Physical Health Community contacts (attended)	148,255	161,510	149,760	135,770		122,865	12,905	10.5%	↑
** Mental Health Community contacts (attended)	42,100	47,055	44,815		44,520		295	0.7%	↑

\* 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. The increase in December is expected to be related to the additional bank holidays for the festive period, which are normally NHS 111's busiest days of the year. Also likely to be linked to the additional winter pressures experienced across the system.

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/ Physical Health contacts).

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

## **6.0 Quality and Safety**

### **6.1 Patient Safety agenda**

The Quality Nursing and Therapy Directorate continues to lead the Patient Safety agenda, ensuring it remains a top priority for the ICB and wider NHS partners. The Associate Director for Quality, Patient Safety and Maternity has undertaken the role of Patient Safety Specialist (PSS) for the organisation. Having now completed the NHS accredited level three and four Patient Safety Training, she will utilise this to embed a Safety Culture approach across the organisation. She will be joined by two further patient safety specialists who have recently been appointed alongside a Patient Safety Partner (PSP). The Patient Safety Partner role reflects the importance that patients, families and carers have upon improving NHS patient safety. This post is undertaken on a voluntary basis. The PSS and PSP will work together to focus on the requirements and as such, there will be a specific Patient Safety Specialist Element to the System Quality Strategy for 2025 – 2026.

### **6.2 Regional and ICB led Maternity Insight visit**

A combined regional and ICB led Maternity Insight visit took place on the 12 November 2024. Minor concerns were identified requiring more work to support staff and to build resilience across the workforce, but overall, staff described their working environment as positive. The visiting team were pleased to observe sustained improvements following the previous reviews, and a palpable change remains evident. The final report has been shared with the UHNM team with a collaborative approach to planning and delivering the agreed actions that will support continuous improvement.

### **6.3 UHNM Neonatal Peer Review**

The UHNM Neonatal Peer Review took place on the 22 November 2024, led by West Midlands Neonatal Operational Delivery Network and supported by the Local Maternity and Neonatal System (LMNS). Overall, the visit was positive, and staff were welcoming and keen to share improvements. The ethos of the unit was clearly family focused with specific focus on the inclusion of siblings. The initial feedback relating to areas for improvement identified the limited allied health professionals (AHP) provision currently available, with the recommendation of a need to increase these services. This has been added as a risk to the LMNS risk register, and the draft report has been shared with the trust for review.

**David Pearson, ICB Chair**

**Peter Axon, ICB Chief Executive Officer**

**Enclosure No: 06**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	20 February 2025					
<b>Title:</b>	2025/26 Planning Update for ICB Board					
<b>Presenting Officer:</b>	Paul Brown, Chief Finance Officer					
<b>Author(s):</b>	ICB Planning Team					
<b>Document Type:</b>	Report			If Other: Click or tap here to enter text.		
<b>Action Required (select):</b>	<b>Information (I)</b>	<input checked="" type="checkbox"/>	<b>Discussion (D)</b>	<input type="checkbox"/>	<b>Assurance (S)</b>	<input checked="" type="checkbox"/>
	<b>Approval (A)</b>	<input type="checkbox"/>	<b>Ratification (R)</b>	<input type="checkbox"/>	<i>(check as necessary)</i>	
<b>Is the decision within SOFD powers &amp; limits</b>	<b>Yes / No</b>	YES				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
<b>Any financial impacts: ICB or ICS?</b>	<b>Yes / No</b>	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
<b>Any impacts on ICB Undertakings?</b>	<b>Yes / No</b>	YES <i>If Y, are those signed off by and date:</i> The planning process includes activity, finance and workforce elements.				
<b>Appendices:</b>	2025/26 Planning Update for ICB Board					

**(1) Purpose of the Paper:**

These slides set out a summary of the planning guidance, high level system timeline and submission expectations.

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

**Date**

System Performance Group (D)

29/01/2025

System Finance and Performance Committee (D)/

04/02/2025

**(3) Implications:**

<b>Legal / Regulatory</b>	Part of the NHS England regulatory planning process.
<b>CQC / Patient Safety</b>	Quality of care, access and outcomes are an area of focus in the planning process.
<b>Financial (CFO-assured)</b>	Finance and use of resources are an area of focus in the planning process.
<b>Sustainability</b>	Sustainability is a key part of the planning process.
<b>Workforce / Training</b>	Workforce is a key aspect of the planning process.
<b>Equality &amp; Diversity</b>	Equality & Diversity is a key aspect of the planning process.

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

<b>Due Regard: Inequalities</b>	Due regard for inequalities is a key aspect of the planning process
<b>Due Regard: wider effect</b>	Planning will be system focussed and have regards to the wider effect.

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

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

<b>(6) Executive Summary, incl. expansion on any of the preceding sections:</b>
<p><b>Overview of 2025/26 Operational planning guidance</b></p> <ul style="list-style-type: none"> <li>NHS England (NHSE) published the 2025/26 Operational Planning Guidance on 30th January, introducing new assurance requirements and a shift towards outcome-focused priorities. The guidance acknowledges significant financial and operational pressures, requiring difficult decisions to ensure sustainability.</li> <li>NHS England regional teams will support plan development, coordinate national team input, and lead on plan assurance.</li> <li>The first phase of the national planning guidance shared in January included a set of productivity and efficiency opportunities for each trust and system to assist the identification and planning of opportunities for 2025/26 with an outline of methodology, limitations and data sources.</li> <li>All organisational boards will be required to submit assurance statements as part of the returns to NHSE. These have not yet been published.</li> <li>A Board-to-Board meeting with NHSE will follow plan submission.</li> </ul> <p><b>Overview of priorities and tough decisions expectations</b></p> <p>The national priorities for the NHS in 2025/26 focus on improving patient outcomes by:</p> <ul style="list-style-type: none"> <li>Reducing the time people wait for elective care</li> <li>Improving A&amp;E waiting times and ambulance response times</li> <li>Improving access to general practice and urgent dental care</li> <li>Improving mental health and learning disability care</li> </ul> <p>To achieve these goals, ICBs and providers must:</p> <ul style="list-style-type: none"> <li>Live within the budget allocated, reducing waste and improving productivity</li> <li>Maintain collective focus on the overall quality and safety of our services</li> <li>Address inequalities and shift towards prevention</li> <li>Make the shift from analogue to digital</li> </ul>

**Local Approach and Timeline**

- Across all organisations we are currently working through the impact of the planning guidance, including the financial implications with a first cut of plans being completed at the end of February.
- The local timeline sets out the local key milestones for ensuring discussion and sign off of plans prior to submission and in order to meet the submission deadlines.

**(7) Recommendations to Board / Committee:**

The Integrated Care Board is asked to:

1. Acknowledge the release of the 2025/26 national planning guidance, provider efficiency and productivity packs and financial planning guidance and allocations.
2. Acknowledge the local milestones
3. Acknowledge the need for the Board to submit assurance statements on 25<sup>th</sup> March as part of the full submission to NHSE.

# 2025/26 Planning Update for ICB Board

February 2025



# Overview of 2025/26 Operational planning guidance

The 2025/26 Operational planning guidance was published by NHS England on 30th January [NHS England » 2025/26 priorities and operational planning guidance](#)

These slides set out a summary of the planning guidance, high level system timeline and submission expectations.

Key points to note are:

- some differences to previous years in levels of detail required for submissions and the addition of explicit assurance statements.
- a reduced number NHS priorities for 2025/26, encouraging a [shift from focusing on inputs to achieving better patient outcomes](#).
- recognition that the NHS faces significant financial and operational pressures that will require [difficult decisions](#) to be made by all organisations to ensure sustainability.
- [Financial planning guidance and allocations](#) were formally released Thursday 30<sup>th</sup> January with the clear requirement for a balanced financial plan (inclusive of control total) with guidance outlining
  - Greater ICB control over how funding is used to meet local need
  - NHS organisations [to reduce their cost base by at least 1% and achieve 4% improvement](#) in productivity
  - Forensic focus” needed on workforce – including plans to address the activity per WTE gap compared to pre-covid levels

- NHS England regional teams will support plan development, coordinate national team input, and lead on plan assurance.

A robust [board led check and challenge process](#) must take place within individual organisations. All Boards will be required to submit an assurance statement as part of the returns to NHS England (NHSE). A Board-to-Board meeting with NHS England will follow plan submission.

## Local Response to the guidance and allocations

- Across all organisations we are currently working through the impact of the planning guidance, including the financial implications with a first cut of plans being completed at the end of February.
- The guidance shared in January included a set of [productivity and efficiency opportunities](#) for each provider and system to assist the identification and planning of opportunities for 2025/26. These will be to be used to inform and develop opportunities as part of the local planning process.
- Formal governance is in place through System Finance and Performance Committee.
- A weekly battle rhythm is in place to develop and support the review and assurance of plans, including a task and finish group focused on activity, finance, and workforce, as well as weekly meetings involving Chief Executives, Chief Finance Officers, and organisational Directors of Strategy.

By clicking any underlined text, you will be taken to the published guidance

# Overview of priorities

The national priorities for the NHS in 2025/26 focus on improving patient outcomes by:

Reducing the time people wait for elective care

Improving A&E waiting times and ambulance response times

Improving access to general practice and urgent dental care

Improving mental health and learning disability care

To achieve these goals, **ICBs and providers must:**

Live within the budget allocated, reducing waste and improving productivity

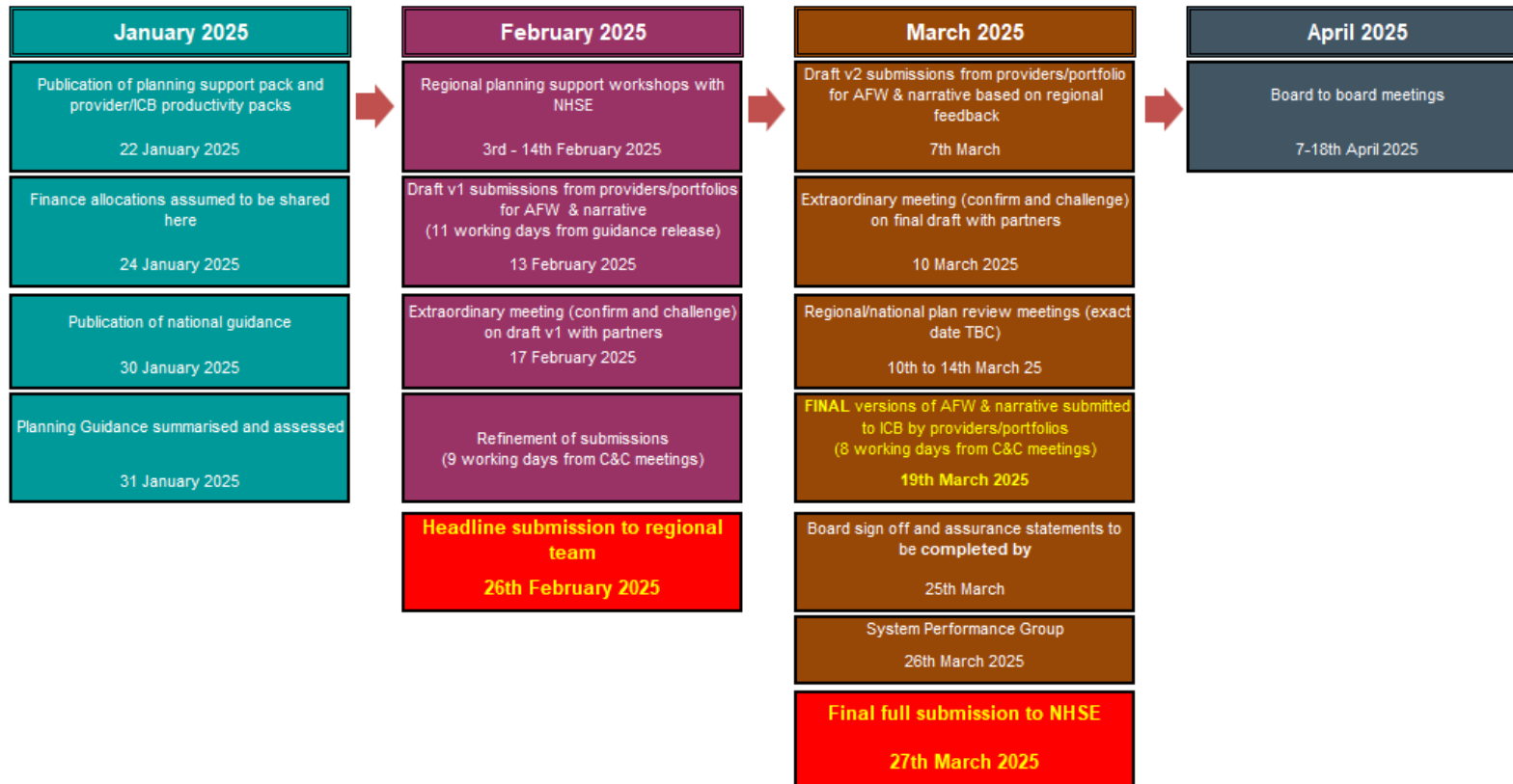
Maintain collective focus on the overall quality and safety of our services

Address inequalities and shift towards prevention

Make the shift from analogue to digital

# Local Timeline

- The timeline below sets out the local key milestones for meeting the submission deadlines.
- Formal governance is in place through System Finance and Performance Committee.
- A weekly battle rhythm is in place to develop and support the review and assurance of plans, including a task and finish group focused on activity, finance, and workforce, as well as weekly meetings involving Chief Executives, Chief Finance Officers, and organisational Directors of Strategy.
- A Board-to-Board meeting with NHS England will follow plan submission, which will be the opportunity for boards to demonstrate why they are assured that plans - maximise productivity/efficiency opportunity; - are deliverable and key risks understood; local prioritisation decisions are necessary and justified



# *Annex*



# Submission Expectations

- The [headline plan submission to regional team \(26<sup>th</sup> February\)](#) is designed to support plan review meetings and provide line of sight to national position ahead of ICBs and provider boards signing off plans will comprise of
  - Headline financial, operational, and workforce plans
  - Ambulance plan - Ambulance trust level submission covering forecast demand and capacity, and planned delivery against key performance metrics. Must be [discussed and agreed with partner ICBs](#) ahead of submission
  - Delivery plan 'checklist' based on the key actions set out in planning guidance.
  - Productivity / efficiency plan - Description of activities to deliver the opportunities in the productivity and efficiency data packs, with quantified impact and phasing
- Then with the addition of for the [final submission to national team \(27<sup>th</sup> March\)](#) of
  - Plan overview
  - Full Board assurance statements
  - Full numerical submissions
- Guidance indicates that a robust [Board led check and challenge process](#) must take place within individual organisations. All Boards will be required to [submit an assurance statement](#) as part of the returns to NHS England. These have not yet been released in full but the guidance indicates that the board has to have
  - systematically reviewed and assured itself that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26.
  - reviewed its existing quality and finance governance arrangements and put in place a robust clinically led process to support local prioritisation decisions.
  - assured itself of the deliverability of its plans and identified mitigating actions to address key delivery challenges and risks. ensuring effective allocation of resources

# Allocations and financial outlook

## Guidance outlines that

- 2025/26 will **mark a financial reset**, requiring systems to develop affordable plans within set allocations. This includes maximising productivity, tackling waste, and prioritising resources to best meet local health needs.
- NHS England will transfer a larger share of funding directly to local systems, **with minimal ringfencing**, giving leaders greater autonomy to plan and deliver efficient services. Service Development Funding (SDF) is now rolled into core allocations. However, all parts of the NHS must now operate within their allocated budgets.
- Funding must also cover final pay settlements, increased employer national insurance contributions, elective backlog improvements, and new NICE-mandated treatments.
- To achieve financial sustainability, **providers must reduce costs by at least 1% and improve productivity by 4%**, while also addressing new pressures and non-recurrent savings from 2024/25.
- **ICBs and providers must exhaust all efficiency opportunities** before considering service reductions, ensuring compliance with legal duties.
- ICB and provider boards are expected **to evaluate both short- and medium-term impacts on quality, finances, and population health when making resource decisions**. Plans must consider the needs of all age groups, including children and young people.

- the NHS faces significant financial and operational pressures, **requiring tough and difficult decisions** to ensure sustainability.
- balancing operational priorities within the available funding while laying the foundations for future reforms will necessitate reducing or ceasing expenditure in some areas and driving unprecedented productivity improvements in others.
- open and transparent discussions with staff, the public, and stakeholders at all levels—organisation, place, and system—will be essential in tackling inefficiencies, reducing waste, and addressing unwarranted variation.
- local leaders will be supported in making **tough decisions** where they are demonstrably aligned with population needs and the best use of available workforce, ensuring resources are maximised for clinical services.

## Local Response to the guidance and allocations

- Work on financial and operational planning for 2025/26 is now well underway, with confirmation of the operational targets as well as the revenue and capital allocations being received on 30 January.
- We are currently **working through the impact of the planning guidance**, including the financial implications with a first cut of plans being completed at the end of February.
- NHSE have clearly outlined they expect a balanced financial plan inclusive of control total to be submitted.

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	20 February 2025					
<b>Title:</b>	Quality and Safety Report					
<b>Presenting Officer:</b>	Heather Johnstone, Chief Nursing and Therapies Officer (CNTO)					
<b>Author(s):</b>	Lee George, Associate Director – Quality Assurance and Improvement					
<b>Document Type:</b>	Report	If Other: Click or tap here to enter text.				
<b>Action Required (select):</b>	<b>Information (I)</b>	<input type="checkbox"/>	<b>Discussion (D)</b>	<input type="checkbox"/>	<b>Assurance (S)</b>	<input checked="" type="checkbox"/>
	<b>Approval (A)</b>	<input type="checkbox"/>	<b>Ratification (R)</b>	<input type="checkbox"/>	<i>(check as necessary)</i>	
<b>Is the decision within SOFD powers &amp; limits</b>	<b>Yes / No</b>	YES				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
<b>Any financial impacts: ICB or ICS?</b>	<b>Yes / No</b>	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
<b>Any impacts on ICB Undertakings?</b>	<b>Yes / No</b>	NO				
<b>Appendices:</b>	Appendix A: Quality and Safety Report – Detail February 2025.					

**(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.

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

**(3) Implications:**

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

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

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

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

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

<b>(6) Executive Summary, incl. expansion on any of the preceding sections:</b>
<p>The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in February 2025.</p> <p>Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:</p> <ul style="list-style-type: none"> <li>• Urgent and Emergency Care</li> <li>• The Social Care Academy</li> <li>• Continuous Quality Improvement</li> <li>• All Age Continuing Care</li> <li>• Learning from the lives and deaths of people with a learning disability and autistic people</li> <li>• Care Quality Commission</li> <li>• Darwin Centre</li> </ul>

<b>(7) Recommendations to Board / Committee:</b>
<p>Members of the Integrated Care Board are asked to:</p> <ul style="list-style-type: none"> <li>• Receive this report, seek clarification, and further action as appropriate.</li> <li>• 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.</li> </ul>

## Appendix A: Quality and Safety Report – Detail February 2025

### 1.0 Urgent and Emergency Care (UEC)

1.1 UEC pressures continue across the system and remain a key quality risk. This is attributed to UEC pressures for both the ambulance service and Emergency Departments (ED). The ICB has been working closely with University Hospital of North Midlands NHS Trust (UHNM) since April 2024 in undertaking and reviewing harm reviews for patients waiting over 8 hours in an ambulance. In November 2024 NHS England

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

introduced a mandated process for these patients as well as those waiting over 48 hours in the emergency department (ED) for admission/transfer/discharge.

1.2 The ICB's Quality Leads have agreed with UHNM that as part of the ED harm review process, a bimonthly informal visit to UHNM ED departments will be undertaken. The visits will focus on the fundamentals of care where patients are waiting lengthy times in waiting areas or areas that are not standard e.g. ED corridors. The visits will be undertaken jointly with UHNM's patient experience team. The first visits took place to both Royal Stoke University Hospital ED and County Hospital ED in January 2025; there were no urgent areas of concern, and some positive feedback received from patients.

1.3 Discharge flow from the acute trust has been identified as an issue which impacts upon patient care and safety. Clinical members of the ICB have supported the introduction of a High Impact Team model which reflects best practice as described within NHS England's Improving Hospital Discharge guidance. Working collaboratively with the clinical and operational teams at UHNM a series of themes and recommendations have been made which would support improved flow. It is anticipated that these will be translated into quality improvement initiatives embedded within pathways and processes. Discussions are currently underway with other NHS providers regarding the potential for the ICB to support a similar approach across the UEC system.

### 2.0 The Social Care Academy

2.1 The Social Care Academy, a partnership between Staffordshire County Council, Stoke-on-Trent City Council, Staffordshire and Stoke-on-Trent ICB and Skills for Care, has now launched. The overall aim of the Academy is to work with providers to deliver adult social care placements and offer training and adult learning opportunities with a 'new to care' focus, for example, by recruiting and training those who have never worked in care before. The Academy brings training across Staffordshire and Stoke-on-Trent together into one singular, easy to access portal.

### 3.0 Continuous Quality Improvement (CQI)

3.1 The latest joint, Shropshire, Telford and Wrekin ICS and Staffordshire and Stoke-on-Trent ICS, QI Network meetings took place in October 2024 and January 2025 exploring creativity and the links between patient safety and quality improvement respectively. The total membership of the network continues to grow with 650 people now on the distribution for these events – an increase of 100 members on the last reported position – with new members joining from across primary care, care homes and social care.

3.2 A joint discussion took place in November 2024, between the Patient Safety Specialists and Continuous Quality Improvement Leads across system partners, exploring the success and challenges of embedding quality improvement within the implementation of the Patient Safety Incident Review Framework. The meeting highlighted many shared opportunities across partners. It was agreed that further joint discussions would be beneficial. In the meantime, conversations continue within both the CQI Sub-group and the Patient Safety Specialist meetings.

3.3 It has been identified that colleagues working across the ICS need to develop quality improvement skills that are both transferable and recognised. The CQI training at UHNM has been accredited by the Lean Competency System (LCS) which is the industry standard accreditation approach affiliated academically to Cardiff University. The team are exploring an opportunity to extend this licence activity to colleagues in the system. This is multi-step process which has begun by starting the accreditation of ICB based Quality team members so they can act as accredited trainers on a future ICS programme delivery. Licence extension will be required and additional approvals sought from the LCS, but it is hoped that this can be achieved within 2025.

3.4 The ICB's Chief Nursing and Therapies Officer and Associate Director – Quality Assurance and Improvement have joined the NHS IMPACT ICB Network for Improvement. The network is aimed at ICBs to create dedicated time, space and attention to support the application of improvement across a system. The first meeting took place in January 2025 and was chaired by Dr Amar Shah - National Clinical Director for Improvement. Discussions included how to best share approaches that peers can learn from each other and common challenges that we to think through together.

#### **4.0 All Age Continuing Care (AACC)**

4.1 In September 2024, there was a backlog of 505 Continuing Healthcare (CHC) overdue reviews (ODR). As a result of the implementation of the review expansion programme in October 2024, all these reviews have now been completed except for 150 individual reviews that cannot be completed at this time as the individual is in receipt of 1:1 care which is being proactively reviewed and case managed by the Integrated Holistic Assessment Team (IHAT). When this has concluded, the CHC review will be completed and systems and processes established to ensure timely reviews in future.

4.2 The mobilisation of the service transition from 1<sup>st</sup> April 2025 is progressing well. The formal TUPE consultation process commenced on 15<sup>th</sup> January 2025 and will run for 45 days.

4.3 A multi-agency task and finish group was established with key leads from partners within the ICS to review and update the Joint Operational Protocol (JOP) for Continuing Healthcare. The JOP was originally developed and implemented in 2019, since this time there has been several changes to processes rendering the protocol out of date and often, confusing for the workforce to utilise when supporting individuals through the CHC assessment process. The launch of the JOP is now underway, in the format of a pre-recorded webinar that will be uploaded to relevant organisations intranets. This method was previously utilised to launch the S117 protocol and was effective in communicating to a large group of staff.

#### **5.0 Learning from the lives and deaths of people with a learning disability and autistic people (LeDeR) programme**

5.1 SQG received the LeDeR Programme Quarter 3 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 considerable progress against the National Key Performance Indicators and in reducing the backlog of reviews inherited from the previous service provider. There now remains one review to be completed, which is from December 2022. This review is unable to be completed at present, as there remains an external investigation in progress. During the quarter, Staffordshire and Stoke-on-Trent experienced 1 breach (review that was not completed within the nationally set 6-month timeframe) this was due to the LeDeR governance panel requesting further information and assurance prior to approving/signing off the review.

#### **6.0 Care Quality Commission (CQC)**

6.1 Following the publication of its official report into medical services at County Hospital, the CQC has confirmed that the overall rating for all services at County Hospital has now moved to 'Good' from 'Requires Improvement'. The Trust's rating remains as 'Requires Improvement' overall.

6.2 The CQC published inspection reports for Brewood Medical Practice and Millrise Medical Practice CQC published in November 2024. Both practices received an overall rating of 'Good'.

6.3 The CQC have undertaken visits to the maternity departments of The Royal Wolverhampton NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust and University Hospitals of North Midlands NHS Trust. The reports are all awaited.

#### **7.0 Darwin Centre**

7.1 The Darwin Centre is a 15-bed regional Child and Adolescent Mental Health (CAMHS) inpatient service. In December 2024 the West Midlands CAMHS Provider Collaborative moved the Centre into level 3 oversight. Representatives from the ICB's quality team, North Staffordshire Combined Healthcare NHS Trust and the Collaborative have met in December 2024 and January 2025 and an improvement plan is in place. There are no restrictions on placements. The Collaborative have confirmed that from their monitoring there is evidence of service improvement, and a further monitoring visit will take place when the Collaborative will formally review the oversight level.

**Enclosure No: 08**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	20 February 2025					
<b>Title:</b>	<b>Report to the ICB Board on Performance and Finance</b>					
<b>Presenting Officer:</b>	Paul Brown – Chief Finance Officer					
<b>Author(s):</b>	Colin Fynn - Head of Intelligence and Analytics, Matthew Shields - Head of System Finance, Alex Robinson - Head of Transformation Delivery Unit (TDU)					
<b>Document Type:</b>	Report	If Other: Click or tap here to enter text.				
<b>Action Required (select):</b>	<b>Information (I)</b>	<input checked="" type="checkbox"/>	<b>Discussion (D)</b>	<input type="checkbox"/>	<b>Assurance (S)</b>	<input checked="" type="checkbox"/>
	<b>Approval (A)</b>	<input type="checkbox"/>	<b>Ratification (R)</b>	<input type="checkbox"/>	<i>(check as necessary)</i>	
<b>Is the decision within SOFD powers &amp; limits</b>	<b>Yes / No</b>	YES				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
<b>Any financial impacts: ICB or ICS?</b>	<b>Yes / No</b>	YES <i>If Y, are those signed off by and date:</i> The financial impacts are as outlined in the body of the report.				
<b>Any impacts on ICB Undertakings?</b>	<b>Yes / No</b>	YES <i>If Y, are those signed off by and date:</i> The impacts on undertakings are as outlined in the body of the report				
<b>Appendices:</b>	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 and 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 9 finance position.

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

	<b>Date</b>
System Performance Group (I)	29/01/2025
System Finance and Performance Committee (S,D)	04/02/2025

**(3) Implications:**

<b>Legal / Regulatory</b>	Monitoring performance is a statutory duty of the ICB.
<b>CQC / Patient Safety</b>	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).
<b>Financial (CFO-assured)</b>	As outlined in the body of the report.
<b>Sustainability</b>	N/A

## NHS Staffordshire and Stoke-on-Trent Integrated Care Board

<b>Workforce / Training</b>	N/A
<b>Equality &amp; Diversity</b>	N/A
<b>Due Regard: Inequalities</b>	N/A
<b>Due Regard: wider effect</b>	N/A

### (4) Statutory Dependencies & Impact Assessments:

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

### (5) Integration with the BAF & Key Risks:

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

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

The report was discussed at SFPC on 4<sup>th</sup> February 2025.

#### Performance

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

An overview of the detailed care home metrics was provided highlighting the ongoing tactical work promoting the use of the Integrated Care Coordination Centre (ICC) as a single point of contact for Care Homes, helping to find alternatives to ambulance call outs. We are taking insights/learning from other regions such as Leicestershire and Lincolnshire to develop tactical and system-wide solutions before we head in the next surge planning round.

The committee were updated on the overall mental health and learning disability indicators which are showing positive trends however, inappropriate out of area placements have increased. Regular reviews of bed capacity and placement within the system are ongoing between commissioners and providers to ensure timely placements and reduce reliance on prolonged stays in the emergency department or acute wards. An action for the next meeting was agreed to understand how long out of area patients are waiting before repatriation. The preventative and proactive agenda of the Community Transformation programme will target the End of Life and Frailty escalations with regards to revenue and resource.

#### Finance

Following the receipt of funding to cover the planned deficit which was £90m at the start of the year, the plan is now to break even.

Following on from the month 8 position remaining flat, the month 9 position continues to be relatively positive with signs of improvement to the run rate. At a system level we are reporting a year-to-date deficit position of £29.5m, which is a £32.8m adverse variance against the revised plan (Month 8 variance to plan £33.3m). The year-to-date variance to plan sits within ICB (£14.8m) and University Hospitals of North Midlands (UHNM) (£19.7m) offset by small surpluses at Midlands Partnership University Foundation Trust (MPFT) (£0.9m) and North Staffordshire Combined Healthcare Trust (NSCHT) (£0.7m).

Given the increasing certainty as we move towards the year end and understand potential benefits from the Investigation and Intervention (I & I) regime and Elective Recovery Fund (ERF) performance, the System has reduced the unmitigated risk to £39m which is an improvement from month 8 of £56.5m.

Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS16) compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. In month 8 there was a new declaration required to get specific Board approval that their provider operational capital, IFRS 16, and total capital departmental expenditure limit (CDEL) expenditure forecasts are accurate and robust. This process and approval has been completed by our provider organisations.

The reported system efficiency based on Month 9 information is now assessed to outturn at £180.4m, which equates to 88.8% delivery against the annual efficiency plan of £203.2m. We continue to work with the I & I team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented.

The system workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and are currently (end of December) 24,890. There has been a sharp rise in the numbers of agency staff into December. Despite the pay controls of organisations having been reviewed both as a system and by the I & I team, there is a concern that since May the overall workforce numbers has risen each month.

### **(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.

# Performance and Finance Report

20<sup>th</sup> February 2025

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



## This report contains for discussion:

1. An [overview of key performance](#) in November 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 9 position.

## Discussion from System Finance and Performance Committee (SFPC) on the 4<sup>th</sup> February to note:

### Performance

- Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented.
- An overview of the detailed care home metrics was provided highlighting the ongoing tactical work promoting the use of the Integrated Care Coordination Centre (ICC) as a single point of contact for Care Homes, helping to find alternatives to ambulance call outs. We are taking insights/learning from other regions such as Leicestershire and Lincolnshire to develop tactical and system-wide solutions before we head in the next surge planning round.
- The committee were updated on the overall mental health and learning disability indicators which are showing positive trends however, inappropriate out of area placements have increased. Regular reviews of bed capacity and placement within the system are ongoing between commissioners and providers to ensure timely placements and reduce reliance on prolonged stays in the emergency department or acute wards. An action for the next meeting was agreed to understand how long out of area patients are waiting before repatriation. The preventative and proactive agenda of the Community Transformation programme will target the End of Life and Frailty escalations with regards to revenue and resource.

### Finance

- Following the receipt of funding to cover the planned deficit which was £90m at the start of the year, the plan is now to break even.
- Following on from the month 8 position remaining flat, the month 9 position continues to be relatively positive with signs of improvement to the run rate. At a system level we are reporting a year-to-date deficit position of £29.5m, which is a £32.8m adverse variance against the revised plan (Month 8 variance to plan £33.3m). The year-to-date variance to plan sits within ICB (£14.8m) and University Hospitals of North Midlands (UHNM) (£19.7m) offset by small surpluses at Midlands Partnership University Foundation Trust (MPFT) (£0.9m) and North Staffordshire Combined Healthcare Trust (NSCHT) (£0.7m).
- Given the increasing certainty as we move towards the year end and understand potential benefits from the Investigation and Intervention (I&I) regime and Elective Recovery Fund (ERF) performance, the System has reduced the unmitigated risk to £39m which is an improvement from month 8 of £56.5m.
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS16) compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. In month 8 there was a new declaration required to get specific Board approval that their provider operational capital, IFRS 16, and total capital departmental expenditure limit (CDEL) expenditure forecasts are accurate and robust. This process and approval has been completed by our provider organisations.
- The reported system efficiency based on Month 9 information is now assessed to outturn at £180.4m, which equates to 88.8% delivery against the annual efficiency plan of £203.2m. We continue to work with the I & I team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented.
- The system workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and are currently (end of December) 24,890. There has been a sharp rise in the numbers of agency staff into December. Despite the pay controls of organisations having been reviewed both as a system and by the I & I team, there is a concern that since May the overall workforce numbers has risen each month.

Ctrl and click on any underlined text for further detail

# Overview of Key ICB Performance November 2024 - Priorities 1 and 2

1

Eliminate delays in access to treatment and long waits for care			
Urgent and Emergency Care		Planned Care	
Category 2 Response target < 30m (December)	10m 07sec ▲	Cost Weighted Activity, National published data, Position to September 2024	14.2% ▼
Accident & Emergency 4-hour wait (78% target by March 25) (UHNM) (December)	-6.8% ▼	Elective Activity - Daycases	-1.0% ▼
Adult General & Acute (G&A) bed occupancy ≤92% (UHNM) (December)	2.3% ▼	Elective Activity - Ordinary Elective	-5.6% ▲
Utilisation of Virtual Wards (target 80%) (ICB) (December)	-2.9% ▲	Elective Activity - Outpatient Procedures	10.9% ▼
Ambulance Hours lost due to Handover delays > 15m (UHNM) (December)	2804 ▲	Elective Activity- Outpatient First Appointment	1.7% ▼
12 hour in Emergency Department Performance (UHNM) (December)	11.7% ▲	% Outpatient attends for first appointments or follow-up appointments with a procedure	2.1% ▼
<b>Mental Health, Learning Disabilities &amp; Autism</b>		Reduction in Outpatient Follow-up against 2019/20 baseline	17.3% ▲
Learning disability registers and annual health check (December)	0.1% ▲	Eliminate 65 week waits by September 2024	179 ▼
Improve access to perinatal mental health services	-6.7% ▲	Increase theatre utilisation (85% UHNM)	-11.3% ▼
Improve access to Children and Young People Mental Health services	-8.1% ▲	Cancer 28-day Faster Diagnosis (77% target by March 2025)	-1.0% ▼
Improve access to Transformed Adult Mental Health services (Sep)	-7.3% ▼	Cancer 62-day pathways % seen within 62 days (target 70% by March 2025)	2.4% ▲
Access to a course of Talking Therapy (Oct)	7.3% ▲	Cancer non-specific pathway	-2.2% ▼
Mean week wait to start autism assessment (North: CYP)	92 ▲	% of lower GI suspected cancer referrals with Faecal Immunochemical Test result (April to August 2024). Metric discontinued due to change in Direct Enhanced Services (DES) specification; result need to be recorded in the 21 days leading up to the referral	-23.7% -
Mean week wait to start autism assessment (South: CYP) (Oct)	16 ▼	Community Bed occupancy rate	0.3% -
Mean week wait to complete autism assessment (North: CYP)	70 ▼	<b>Primary Care</b>	
Mean week wait to complete autism assessment (South: CYP) (Oct)	57 ▼	Dental Activity delivered (Q2)	-1.6% ▼
<b>Children &amp; Young People (CYP)</b>		<b>Medicines Optimisation</b>	
Reduce CYP in residential care outside Staffordshire	-15.7% -	Pharmacy First Provision – number of interventions (May)	8,086 ▲
Reduce CYP in residential care outside Stoke-on-Trent (December)	0.4% ▼		

2

Improving access to high quality, sustainable primary care			
Primary Care			
General Practice Appointments	2.8% ▼		
General Practice Appointments in <2 weeks (85% target)	6.0% ▲		
Additional Role Reimbursement Scheme Full Time Equivalent (Q2)	12.9% ▼		
Workforce: GP Full Time Equivalent (Q2)	3.1% ▲		
Planned Care			
Deliver increased diagnostic activity levels	4.3% ▼		
Patients that receive a diagnostic test within 6 weeks (target)	-14.2% ▼		
Mental Health, Learning Disabilities & Autism			
Recover the dementia diagnosis rate to 66.7% target	1.7% ▼		

**TRAFFIC LIGHT KEY**

Variations are against the plan as priority, against the target if no plan is available

Var	Red - under performing against plan or target, with variance to plan or target
Var	Green - performing against plan or target, with variance to plan or target
Q	No data available as the indicator is reported Quarterly

Arrow colour reflects performance, direction to show change from the previous period

▼	Improvement in performance against previous period - drop in value
▲	Improvement in performance on the previous Period - increase in value
▼	Decline in performance against previous period - drop in value
▲	Decline in performance against previous period - increase in value
-	No change in performance on the previous month

**Please note**

- Priority 1 Lower IG – Defined metric has now discontinued.

# Overview of Key ICB Performance November 2024 - Priorities 3, 4 and 5

3

Delivering joined up proactive & preventative support & care					
Mental Health & Learning Disabilities & Autism			Children & Young People		
Eliminating Out of Area Placements	10	▲	Reduce emergency admissions for epilepsy (flat activity)	-69%	▼
Talking Therapy Reliable Improvement (Oct) (67% target)	4.8%	▼	Reduce emergency admissions for asthma (flat activity)	-47%	▼
Talking Therapy Reliable Recovery (Oct) (48% target)	2.4%	▲	Maternity and Neonates		
Severe Mental Illness health checks (Q2)	2.3%	▼	Stillbirth rate (UJNM only)	2.0	▼
Learning disability & Autism reliance on inpatient care (Adult) (December)	-1	▼	Neonate Mortality rate per 1000 (UJNM only)	0.0	▼
Learning disability & Autism reliance on inpatient care (CYP) (December)	2	■	Brain injury rate per 1000 (UJNM only)	2.0	▼
Learning Disability and/or Autism Mortality Reviews (100% target) (December)	0.0%	▲	The % of full - term babies admitted to a neonatal unit (UJNM only)	4.2%	▲
End of Life, Long-term Conditions and Frailty			Improving Population Health		
Prevalence rate of Palliative care registers (December)	-0.1%	▼	Children and Young People vaccination uptake - MMR2 (Q2)	-0.8%	▼
Patients receiving all 8 care processes for Diabetes -Type 1 (cumulative to December)	3.1%	▲	Children and Young People vaccination uptake - Pertussis maternal vaccination (Q1)	10.0%	▲
Patients receiving all 8 care processes for Diabetes -Type 2 (cumulative to December)	2.7%	▲	Hypertension: Percentage of patients treatment to recommended age specific thresholds (Q1)	67.10%	■
National Diabetic Prevention Programme - referrals	-1.9%	▼	Cholesterol: Percentage of patients with QRISK 20% or more treated with lipid lowering therapy (Q1)	1.70%	▲
National Diabetic Prevention Programme - commence	26.9%	▼			

4

Delivering compassionate care of the frail and elderly			
Urgent and Emergency Care			
80% discharges on Pathway 0 (December)	-5.3%	▲	
Discharges on Pathway 1 (December)	4.2%	▼	
Discharges on Pathway 2 (December)	0.6%	▼	
Reduce number of discharges on Pathway 3 to below 1% (December)	0.5%	▲	
Improving Population Health			
Increase uptake of Flu vaccination (November)	5.0%	▲	
Increase uptake of COVID vaccination (November)	10.3%	▲	
Integration			
Prevent emergency admission Ambulatory care (Stoke-on-Trent) (Q1)	-28.6	n/a	
Prevent emergency admission Ambulatory care (Staffordshire) (Q1)	3.00	n/a	
Improve access to fall service from A&E (Stoke-on-Trent) (Q1)	48.85	n/a	
Improve access to fall service from A&E (Staffordshire) (Q1)	75.18	n/a	
Discharge to usual place of residence (Stoke-on-Trent) (Q1)	2.16%	n/a	
Discharge to usual place of residence (Staffordshire) (Q1)	-0.78%	n/a	

5

Supporting Care Home Residents			
Urgent and Emergency Care			
Achieve the 70% two-hour urgent community response standard (November)	13.3%	▲	
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	-2.0%	▼	
% of Care Home Patients with a Personalised Care Plan	0.3%	▼	
Mean number of Multidisciplinary Team meetings per care home resident aged >18	-12.3%	▼	
TRAFFIC LIGHT KEY			
Variances are against the plan as priority, against the target if no plan is available			
Var	Red - under performing against plan or target, with variance to plan or target	▼	Improvement in performance against previous period - drop in value
Var	Green - performing against plan or target, with variance to plan or target	▲	Improvement in performance on the previous Period - increase in value
Q	No data available as the indicator is reported Quarterly	▼	Decline in performance against previous period - drop in value
		▲	Decline in performance against previous period - increase in value
		■	No change in performance on the previous month

**Please note**

- Priority 3 Hypertension – shown performance in %. Performance is higher than that of the national figure. Due to a change in the methodology for this indicator, it is no longer directly comparable to previous figures.
- Priority 4 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
<p><b>Urgent and Emergency Care (UEC)</b></p>	<p><b>Category 2 Response Time - West Midlands Ambulance Service (WMAS) -</b></p> <p>Latest Performance (December 2024) was 53 mins 51 seconds, up 14 minutes on the previous month and 10 minutes above plan.</p>	<ol style="list-style-type: none"> <li>1. Reducing ambulance handover delays implemented on 11<sup>th</sup> November 2024. Due to Critical Incident implementation has been intermittent, positive impact has been seen on selected days where demand has allowed full implementation.</li> <li>2. Return of vehicles into community to respond to outstanding calls remains constrained by increased handover delays.</li> <li>3. Infection prevention and control (IPC) constraints within Emergency Department (ED) and the bed base restrict patient flow out of ED impacting ability to offload patients at times of high pressure.</li> <li>4. Continued high level of complex needs of patients arriving by ambulance and through ED front door mandating prioritisation of these patients over lower acuity attendances.</li> </ol>	<ol style="list-style-type: none"> <li>1. Alternative Hospital Ambulance Liaison Officer (HALO) model approved by UEC Board in December. Further 12-week test of change currently being mobilised.</li> <li>2. Review of data in line with NHS England (NHSE) guidance around ED attendance suitability, with a plan to review communications and target audiences accordingly based upon output and findings. The first of a series of scheduled meetings took place on 14<sup>th</sup> January 2025.</li> </ol>
	<p><b>Accident &amp; Emergency 4-hour Wait UHNM</b></p> <p>Latest unvalidated performance (December 2024) was 64.2%, down from 64.8% the previous month, and 1.6% worse than the same period last year. 6.8% below plan and 14.6% below target.</p>	<ol style="list-style-type: none"> <li>1. Internal Professional Standards constraints within ED and the bed base are restricting patient flow out of ED either through discharge or movement to a ward.</li> <li>2. Increase in month-on-month attendances at County Hospital (9% growth in last 3-month attendances over the previous year) above plan causing a reduction in performance at County Hospital Stafford which has historically been stable.</li> <li>3. Type 3 seen 11.4% increase in 3 month average over the previous year.</li> </ol>	<ol style="list-style-type: none"> <li>1. NHSE UEC Clinical Lead supporting external review of ED Department, pathways and flow. First attendance was on the 8th January with future dates to be agreed between UHNM and NHSE.</li> <li>2. UHNM have appointed a UEC Improvement Director commencing on 13<sup>th</sup> of January 2025.</li> <li>3. UHNM Non-Elective Programme refresh undelay to support improvement journey and targeted oversight of delivery programmes.</li> </ol>
	<p><b>Adult General &amp; Acute (G&amp;A) bed occupancy at UHNM ≤ 92%</b></p> <p>Latest unvalidated performance (December 2024) was 92.2%, down from 92.8% the previous month and 0.2% above target.</p> <p>Performance was 2.8% above the plan of 89.4% for December 2024.</p>	<ol style="list-style-type: none"> <li>1. IPC constraints within ED and the bed base have significantly restricted patient flow out of the department.</li> <li>2. Increase proportions of long-stay (14+ &amp; 21+ Length of Stay) during November 2024 restricted available bed base as discharge delays for more complex requirements of increasing Pathway 1 and Pathway 2 discharges were seen.</li> </ol>	<p>Improvement seen and actions planned continue:</p> <ol style="list-style-type: none"> <li>1. Multidisciplinary high intensity team (HIT) continue to work through base wards on an increased weekly basis to support both simple and complex discharge identification.</li> <li>2. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards, Ward Standard Work, Your Next Patient, Home Care is Best Care).</li> <li>3. UHNM Medicine Division are implementing new daily protocols to manage flow through Medicine Bed Base and increased discharge numbers.</li> </ol>



**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
<p><b>Urgent and Emergency Care (UEC)</b></p>	<p><b>Virtual Wards (VW)</b> Latest performance on 27<sup>th</sup> December 2024 was 79.5%, below plan for both occupancy and capacity.</p> <p>North – 77.1% South-East – 96.6% South-West – 48.6%</p>	<ol style="list-style-type: none"> <li>1. The positive increase in utilisation led to just a 0.48% variance from the target, equivalent to less than one patient.</li> <li>2. Staff sickness impacted ability to complete first visits for patients entering onto a virtual ward.</li> </ol>	<ol style="list-style-type: none"> <li>1. Appointment of a dedicated virtual ward practitioner at Queens Hospital Burton (QHB) to increase utilisation further.</li> <li>2. Increasing staffing resilience including bank staff to support short term absence in conjunction with the ICS People Hub.</li> </ol>
	<p><b>Ambulance Hours lost due to Handover delays &gt;15 mins (UJNMM)</b></p> <p>December 2024 was 7,277 hours, up 1,200 hours over November 2024 and 2,800 hours above plan.</p>	<ol style="list-style-type: none"> <li>1. IPC constraints within ED and the bed base restrict patient flow out of ED impacting ability to offload patients at times of high pressure.</li> <li>2. Continued high level of complex needs of patients arriving by ambulance and through ED front door mandating prioritisation of these patients over lower acuity attendances.</li> </ol>	<ol style="list-style-type: none"> <li>1. Test of Change – Overnight Integrated Care Coordination Centre (ICC) equivalent underway to support admission avoidance during the overnight period 7 days per week.</li> <li>2. Call Before Convey went live on Monday 13<sup>th</sup> of January 2025 – West Midlands Ambulance Service (WMAS) in conjunction with the ICB, extending ‘Call Before Convey’ initiative to all patients over the age of 18 and operational 24/7 to support alternatives to an ED conveyance.</li> <li>3. Following Critical Incident (CI) refresh of the Reducing Ambulance Handover Programme implemented in November 2024 has been undertaken with increased scrutiny and oversight from UJNMM and WMAS.</li> </ol>
	<p><b>Proportion of patients spending more than 12 hours in Emergency Department at UJNMM</b></p> <p>Latest unvalidated performance; 11.7% for December 2024, up from 10.8% in November 2024. In comparison the Midlands average, for December 2024, was 12.7%.</p>	<ol style="list-style-type: none"> <li>1. IPC constraints within Emergency Department (ED) and the bed base restrict patient flow out of ED impacting ability to offload patients at times of high pressure.</li> <li>2. Continued high level of complex needs of patients arriving by ambulance and through ED front door mandating prioritisation of these patients over lower acuity attendances.</li> </ol>	<ol style="list-style-type: none"> <li>1. Multidisciplinary high intensity team (HIT) continue to work through base wards on an increased weekly basis to support both simple and complex discharge identification.</li> <li>2. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards, Ward Standard Work, Your Next Patient, Home Care is Best Care).</li> <li>3. NHSE UEC Clinical Lead supporting external review of ED pathways and flow.</li> <li>4. UJNMM have appointed a UEC Improvement Director commencing on 13<sup>th</sup> of January 2025.</li> </ol>

**Other Key Points Aligned to this priority**

**Flu Beds:** Whilst Covid numbers have reduced, Flu numbers have increased through December 2024 and have significantly risen over the latter half of the month as the surge experienced nationally has been replicated at regional and local levels. The 29 patients occupying beds with flu at the beginning of the month grew to 101 at the end of the month, however, there are emerging signs that the rate of new cases is reducing and as such the surge may have peaked at a lower level than that seen during 2022.



**Local Priority**

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

Area	Under Plan or Target / Delivery Off trak	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
<b>Mental Health (MH) and Learning disability and Autism (LDA)</b>	<p><b>Improving Access to Perinatal MH Services</b> – 1,050 women had at least one contact with the service in the rolling 12 months to November 2024.</p> <p>This is 75 (6.7%) under the monthly trajectory (1,125) but continuing to increase month on month, closer to plan than last month and higher than the same period last year (925).</p> <p>The system is one of 19 ICBs in England that did not achieve plan at month 7 and is in position 34 out of the 42 ICBs, putting it within the lowest quartile.</p>	<ol style="list-style-type: none"> <li>1. MPFT identified two technical issues causing their Mental Health Service Dataset (MHSDS) submissions to be lower than their locally reported activity. Published data is currently around 100 below local data for the sub ICBs that MPFT serve.</li> </ol>	<ol style="list-style-type: none"> <li>1. MPFT have corrected the technical issues and resubmitted previous months for the current financial year. This will potentially impact on performance until 2023/24 is no longer included in the rolling 12 month calculation.</li> <li>2. Additional Mental Health Investment Standard (MHIS) investment has been released to increase access but also to strengthen the current offer to meet Perinatal Quality standards and provide a reduction in time waiting for treatment; increased ability to provide care with infants up to 24 months of age; reduction in admissions to inpatient units; increase in the treatment interventions available. As this is based on recruitment to workforce the benefits may not be realised until later in the financial year.</li> </ol>
	<p><b>Improving Access to Children and Young People (CYP) MH Services</b> – 14,685 CYP had at least one contact with community mental health services in the rolling 12 months to November 2024.</p> <p>This is 1,299 (8.1%) under the monthly trajectory (15,984) but an increase of 180 CYP compared to last month, the 3rd month where an increase has occurred and slightly higher than the same period last year (14,680).</p> <p>The system is one of 19 ICBs in England that did not achieve plan at month 7 and is in position 29 out of the 42 ICBs, putting it towards the lower end of the middle quartile.</p>	<ol style="list-style-type: none"> <li>1. NSCHT reported a number of data capture issues, which have now been fixed locally.</li> <li>2. MPFT have indicated that they may not have sufficient eligible referrals, arising from the adoption of a Whole School Approach by Mental Health Support Teams' (MHSTs) and Attention deficit hyperactivity disorder (ADHD) referrals being directed to the Community Paediatric Service, which are not reportable under the MHSDS. MPFT have also reported that some subcontractor activity may not be being flowed to the MHSDS.</li> <li>3. Activity is lower than expected at 'Action for Children', partly arising from reduced referrals in 2023/24 and possibly also relating to missing Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) codes.</li> </ol>	<ol style="list-style-type: none"> <li>1. A CYP MH Access Review paper was shared at the Mental Health and LDA Delivery Group in December 2024 and with the CYP Board on 6th January 2025. The review of the CYP mental health access metric seeks to provide a comprehensive analysis of how effectively mental health services are accessed by CYP. By examining current data and access patterns, we aim to identify areas where access may be limited or inequitable, ensuring that all CYP, regardless of their background, receive timely and appropriate care.</li> <li>2. NSCHT plan to resubmit 2024/25 in February 2025, however the full benefit won't be realised until 2023/24 is no longer included in the rolling 12 month calculation.</li> <li>3. MPFT are reviewing data capture and service configuration as part of a Performance Improvement Plan.</li> <li>4. Action for Children plan to submit missing codes from January 2025.</li> <li>5. Increased investment into Child and Adolescent Mental Health Services (CAMHS) as result of refresh of the CYP MH Local Transformation plan in October 2024, however the benefits will not be realised until late in 2024/25 Quarter 4.</li> <li>6. Two new Mental Health Support Teams have been recruited to commence in January 2025 however the benefits will not be realised until late in 2024/25 Quarter 4.</li> </ol>



**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
<p><b>Mental Health (MH) and Learning disability and Autism (LDA)</b></p>	<p><b>Improving Access to Transformed Adult MH Services</b> – 11,930 adults had at least two contacts with the service in the rolling 12 months to September 2024. This is 994 (7.7%) under the monthly trajectory (12,924). Lower than the same period last year (13,145).</p> <p><b>October 2024 data is not due to be released until 22<sup>nd</sup> January 2025.</b></p> <p>The system is one of 11 ICBs in England that did not achieve plan at month 6 and is in position 35 out of the 42 ICBs, putting it within the lowest quartile.</p>	<p>Drivers identified in <b>M7</b> remain in place and will be reviewed after October data is available.</p> <ol style="list-style-type: none"> <li>1. NSCHT and MPFT are both potentially under reporting.</li> <li>2. Changes Health and Wellbeing don't currently include adult activity in their MHSDS submissions.</li> </ol>	<p>Actions planned in <b>M7</b> will be reviewed after October data is available.</p> <ol style="list-style-type: none"> <li>1. NSCHT are planning reporting improvements that will look to support the service in understanding this decline and in highlighting possible areas of improvement.</li> <li>2. MPFT are looking to report on adult access locally through a contract variation once they have reconciled local figures against the published dataset. Local reporting to be sent through by the end of January.</li> <li>3. Changes Health and Wellbeing plan to submit adult activity from April 2025.</li> </ol>
	<p><b>Wait to commence Autism assessment, against quarter 3 target of 15 weeks (NB: national target = 13 weeks)</b></p> <ul style="list-style-type: none"> <li>• CYP North (Nov) - mean wait of 107 weeks (up from 89 last month)</li> <li>• CYP South – see note *</li> </ul> <p><b>Wait to complete Autism assessment, against quarter 3 target of 30 weeks (NB: national target = 26 weeks)</b></p> <ul style="list-style-type: none"> <li>• CYP North (Nov) - mean wait of 100 weeks (down from 128 last month)</li> <li>• CYP South – see note *</li> </ul> <p>* the mean waiting times at MPFT in November are based on a small sample of patients. Outsourced activity will be included from next month, which will provide a more accurate figure.</p>	<ol style="list-style-type: none"> <li>1. Increasing demand remains as the main driver: since April 2024, the total number of children waiting for an autism assessment to commence increased by 12% at MPFT and by 29% at NSCHT. Caseloads (open referrals) have also increased by 2% at MPFT and by 13% at NSCHT.</li> </ol>	<ol style="list-style-type: none"> <li>1. Interim improvement plan feedback collated in December 2024 and January 2025. Feedback to be used in workshop scheduled for 24<sup>th</sup> January 2025 to review Learning Disability &amp; Autism Programme (LDAP) workstreams.</li> <li>2. New Senior Responsible Officer (SRO)/Deputy SRO and key operational leads from NSCHT and MPFT are receiving guidance from the system working group relating to autism pathway improvements. This is an ongoing process. There is recognition that a person-centred approach is required.</li> </ol>
<p><b>Children and Young People (CYP)</b></p>	<p><b>Reduce CYP in residential care outside Stoke-on-Trent</b> – 76.9% of placements were outside Stoke-on-Trent in December 2024. 43.3% of the placements were within 20 miles of Stoke on Trent.</p> <p>Similar to the same month last year (76.5%), but an improved position on last month (78.0%).</p>	<ol style="list-style-type: none"> <li>1. Local Authority (LA) data for Stoke-on-Trent – as last month increasing numbers above the same month last year (which is the local target).</li> </ol>	<ol style="list-style-type: none"> <li>1. Work is ongoing to reduce the overall number of residential placements in Stoke-on-Trent City Local authority (LA). Where young people are placed out of area and at a distance, the LA is reviewing these placements on a regular basis, and where possible looking to either step young people out of residential care or return them to a more local placement.</li> </ol>



**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	<p><b>Elective (Inpatient) Activity - Ordinary Elective and Day cases</b></p> <p>In November 2024, there were 111 less Ordinary Elective spells than planned, and 153 less Day cases than planned.</p>	<ol style="list-style-type: none"> <li>There was a reduction in activity levels, when comparing November 2024 to October 2024, for ICB patients at all main providers: <ul style="list-style-type: none"> <li>University Hospitals North Midlands - 4%</li> <li>University Hospitals Derby &amp; Burton (UHDB) - 8%</li> <li>Royal Wolverhampton -4%</li> <li>University Hospital Birmingham -9%</li> </ul> </li> <li>Urgent &amp; Emergency Care (UEC) pressures have impacted on elective procedures. Elective capacity has been converted to beds to support non-elective trauma cases. Cancellations have been clinically prioritised but included a small number of cancer surgeries during the system critical incident. Winter pressures are expected to continue to impact in Quarter 4.</li> </ol>	<ol style="list-style-type: none"> <li>During periods of UEC pressures, clinical prioritisation is applied. Additional day case and outpatient appointment opportunities are being identified. Cancellations are subject to clinical oversight. Patients are rebooked as soon as possible.</li> <li>Additional capacity is being explored to mitigate, including both at NHS and independent sectors providers.</li> </ol>
	<p><b>Reduce Outpatient Follow ups v 2019/20 level;</b></p> <p>In November 2024 there were 17.3% more attendances than the planned level (based on achieving a 25% reduction by March 2025).</p>	<p>Drivers remain the same as identified in <b>M7</b>:</p> <ol style="list-style-type: none"> <li>In some cases, increased follow-ups are a result of treating patients with long waits on waiting lists.</li> <li>Higher level of activity recorded in Independent Sector Providers (ISP) as more capacity available.</li> </ol>	<p>Actions planned in <b>M7</b> continue to drive performance improvement:</p> <ol style="list-style-type: none"> <li>Work being undertaken to set a ratio of follow-ups within the Independent Sector contracts.</li> <li>ICB working with providers to encourage Patient Initiated Follow Ups (PIFU).</li> </ol>
	<p><b>Eliminate 65 week waits by September 2024</b> - At the end of November 2024 there was 179 ICB patients waiting over 65 weeks (at all providers), against a plan of 0.</p> <p>The latest forecast based on National Waiting Lists Data and provider returns, predicts that at the end of December there will be 115 breaches at UHNM (all commissioners) and 89 predicted at out of area providers (ICB patients).</p>	<ol style="list-style-type: none"> <li>Capacity in NHS providers, as well as Winter emergency pressures, continues to be an issue, as well as a high level of demand.</li> <li>Out of 179 patients, 103 are at UHNM, 55 at UHDB, and 10 at Robert Jones &amp; Agnes Hunt.</li> <li>Issues within particular specialities are a driver of the position. The specialties with highest numbers are Orthopaedics (49, with 30 at UHDB), Ear Nose and Throat (ENT) (37, with 33 at UHNM), and General Surgery (31, with 25 at UHNM).</li> </ol>	<ol style="list-style-type: none"> <li>Additional workforce in place at UHNM for ENT and Orthopaedics.</li> <li>Additional clinics taking place as well as weekend working.</li> <li>Maximising outpatient appointments and day cases where overnight beds restricted due to Winter pressures.</li> </ol>

**Other Key Points Aligned to this priority**

**Community Services Waiting List:** – At the end of November 2024, there were 37 patients waiting over 52 weeks for treatment in Community Services. All these patients were in Children and Young People Services (CYP). 34 patients in Dietetics, 2 in Community Paediatric Services and 1 in Audiology. ICB, Midlands Partnership Foundation Trust and NHS England meet regularly to review performance.



**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	<p><b>Increase theatre utilisation at UHNM</b></p> <p>In November 2024 theatre utilisation was 73.7% at UHNM, against the target of 85%.</p>	<p>1. UHNM are working towards 78% capped theatre utilisation target (which is a 4% increase on 2023/24). Progress has been made and at Quarter 2 2024/25 had reached 79%. Performance has dipped due to Winter pressures and critical incident in Quarter 3 2024/25.</p>	<p>1. Focus is on patient cancellations (did not attend or unfit for surgery), looking at perioperative pathway transformation opportunities.</p> <p>2. UHNM continue to maintain internal disciplines around booking processes and have resolved discrepancies between UHNM and Model Health data, which is now aligned.</p>
	<p><b>Cancer 28 day waits (faster diagnosis standard)</b></p> <p>In November 2024, 75.52% of ICB patients (all providers), with an urgent cancer referral, were told they have Cancer, or Cancer is definitively excluded within 28 days (against an ICB target of 76.55%).</p>	<p>1. Reduction in performance for ICB from October 2024 (76.39%) to November 2024 (75.52%). This is driven by 1.5% reduction in performance at UHDB (October 2024 against November 2024). Also, for the same period, a 0.4% reduction in performance at UHNM.</p>	<p>1. Performance of metric monitored through Tier 2 framework with joint meetings with UHNM and NHS England.</p>
Cancer	<p><b>Faecal Immunochemical Test (FIT)</b></p> <p>At the end of August 2024, the Direct Enhanced Services (DES) specification for this indicator changed. The new specification is that all FIT tests results are recorded in the 21 days leading up to the referral. This is not directly comparable to previous metric.</p>	<p>1. Issues identified in previous metric will still be valid. Issues remain with data extracted from Primary Care clinical system reflecting operational reality.</p> <p>2. 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</p>	<p>1. Locally ICB will monitor performance of new metric and work with Primary Care to improve compliance.</p>
	<p><b>Cancer non-specific pathway</b></p> <p>The number of patients referred to UHNM onto a non-specific symptom's pathway was 44 in November 2024, against a target of 45.</p>	<p>1. This metric is based on small values, both actual and target, therefore individual months below plan will not be linked to specific factors. Cumulatively for the period April 2024 to November 2024 this metric has been above plan by 26%</p>	<p>1. Continue to monitor monthly values.</p>

**Other Key Points Aligned to this priority**

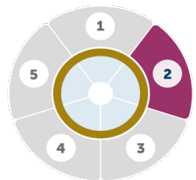
**Cancer 62 days:** – percentage seen within 62 days is back to green in November 2024 after dip in performance in October 2024. However, the total number of patients seen and seen within 62 days are under plan in November 2024.



**Local Priority**

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Dental	<p>Units of Dental Activity (UDAs) delivered fell below plan by 4.5% for 2024/25 Q2 and 1.6% year to date by the end of Q2, a shortfall of 15,000 UDAs.</p> <p>Data for October and November 2024 has seen an increase to the number of UDAs delivered (97.7% for October 2024 and 82.7% for November 2024). If the increase continues into December 2024, the Q3 target will be achieved.</p>	<ol style="list-style-type: none"> <li>1. Significant impact of the Covid-19 pandemic on dental services. Recovery of NHS provision has been slow and while the situation has improved, many patients are still unable to access the dental treatment they need due to capacity and workforce pressures.</li> <li>2. Recruitment and retention of NHS dentists.</li> <li>3. Lack of incentives for dentists to retain NHS activity.</li> </ol>	<ol style="list-style-type: none"> <li>1. The Dental Local Delivery Plan (LDP) has been developed focusing on improving dental access through the Health Equity Audit, oral health and supporting dental workforce including the 'golden hello' offer. . The draft LDP was presented at November Primary Care Forum (PCF); the plan was approved and amendments were recommended before it is taken through to ICB Governance and approval processes.</li> <li>2. A Dental communication and engagement plan is in place to support the roll out of the LDP to the public. The plan will be used to monitor feedback and activity through feedback surveys, social media, patient people panel and patient assembly, as well as Patient Advice and Liaison Service (PALS) and complaints.</li> <li>3. The Primary Care Team continue to work with the Primary Care Commissioning Team at the Office of West Midlands on redistribution of contract activity from hand backs and contract terminations.</li> </ol>



**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
<p><b>Primary Care - Workforce</b></p>	<p><b>Additional Roles Reimbursement Scheme (ARRS)</b> - stands at 595.7 Full Time Equivalent (FTE) for September 2024, below the Q2 Plan of 684.3 FTE. Data for November 2024 stands at 600.8 FTE, but there is still a large increase required to reach the Q3 Plan by December 2024.</p> <p>Plan and actual figures do not include additional GP's now included in the scheme.</p>	<ol style="list-style-type: none"> <li>Actual figures are based on National Workforce Reporting Service (NWRS) data and there are continued reporting discrepancies between these figures and ARRS claims.</li> <li>For November 2024 data, NWRS is showing 600.8 FTE and the ARRS claims portal is much higher at 690.8 FTE, so a difference of 90.3 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 November 2024) shows budget utilisation at 97.5%.</li> </ol>	<ol style="list-style-type: none"> <li>Primary Care Workforce Local Delivery Plan has been developed and dashboard developed to aid monitoring via Workforce Improvement Group (WIG). Next WIG meeting is planned for 24<sup>th</sup> of January 2025.</li> <li>Validation work is ongoing with individual Primary Care Networks (PCNs) where there is variation between claims and NWRS. The importance of accurate reporting and support with validation work is being raised at the PCN Collaborative Meeting on 17/01/2025.</li> <li>PCNs are struggling or reluctant to recruit additional roles due to challenges with unclear plans for the PCN Contract past March 2025.</li> </ol>
<p><b>Diagnostic waits and activity</b></p>	<p><b>The % of patients waiting within 6 weeks for a diagnostic test</b> - at the end of November 2024 was 68.7%, against a plan of 82.9%.</p> <p>Number of diagnostic tests carried out in November 2024 was 52,486 against a plan of 50,307 (4.3% above plan).</p> <p>This is for the ICB patients at all providers.</p> <p>Performance against this metric in the NHS Oversight Framework remains in <b>the lowest quartile</b>, ranking 38 out of the 42 ICBs (November 2024 refresh (latest available)).</p>	<ol style="list-style-type: none"> <li>UHNM have reported a 10.24% increase in GP referrals compared to 2022/23. Across all tests and providers there were 11,320 patients waiting over 6 weeks at the end of November 2024, of which 9,146 were waiting for a Non-Obstetric Ultrasound (NOUS) (81% of all waits over 6 weeks). The majority of these patients were at UHNM where 37.0% of patients were waiting over 6 weeks, compared to 92.6% at UHDB and 99.3% at Royal Wolverhampton Trust. At the end of November 2024, there was improvement in the total waiting list, and those waiting over 6 weeks for Magnetic Resonance Imaging and Echocardiography tests.</li> </ol>	<ol style="list-style-type: none"> <li>UHNM insourced additional NOUS capacity with Hassan Diagnostics from the end of October 2024. Further additional capacity is planned from Quarter 4 2024/25 at the Cannock Community Diagnostic Centre (CDC).</li> </ol>



**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
<b>Mental Health (MH) and Learning disability (LD)</b>	<p><b>Eliminating Out of Area Placements (OAP)</b> - 11 active inappropriate adult acute mental health OAPs at the end of December 2024 (10 over plan). 9 reported by MPFT and 2 by NSCHT.</p>	<ol style="list-style-type: none"> <li>1. Unavailability of suitable beds at MPFT and NSCHT.</li> <li>2. A directive from NHSE mandating that mental health patients who are medically fit from a physical health perspective should not remain in acute hospitals or Accident and Emergency departments but must be transferred to inpatient mental health beds immediately has led to placing people out of area to ensure they are assessed appropriately.</li> </ol>	<ol style="list-style-type: none"> <li>1. Individual cases are reviewed to determine if placing out of area was the only appropriate action and no other alternatives options available and repatriation back to resident units is expedited.</li> </ol>
	<p><b>Reliance on inpatient care for people with a learning disability and/or autism (under 18 years of age)</b> - 6 inpatients in December 2024, no change to last month and 2 over the quarter 3 plan (4).</p>	<ol style="list-style-type: none"> <li>1. Case mix is becoming more complex.</li> <li>2. The trend of late autism diagnosis in children is reported by NHSE as a national trend.</li> </ol>	<ol style="list-style-type: none"> <li>1. A multi-team approach to ensure discharge plans are person centred is an evolving and ongoing process (e.g. communication between teams is as efficient as possible).</li> <li>2. Analysis of referral patterns contributing to delayed autism diagnoses in females. The findings will be shared with key stakeholders to improve understanding of factors such as masking behaviours and social pressures that disproportionately impact young females.</li> </ol>



**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
<b>End of Life (EOL), Long-term Conditions and Frailty (ELF)</b>	<p><b>Prevalence rate of patients on palliative care registers to 1%</b> In November 2024 there were 9,879 patients on a palliative care register. This equates to 0.82% of the registered practice population against a target of 0.90%.</p>	<p>Driver identified remains the same as in <b>M7</b>:</p> <ol style="list-style-type: none"> <li>Pressures facing Primary Care and seasonal impact during summer period of Annual Leave.</li> </ol>	<p><b>Action planned in M7 continues to aim to drive improvement in performance:</b></p> <ol style="list-style-type: none"> <li>Training on Identification at End of Life will continue to be offered through the Staffordshire Training Hub, sessions are planned from October 2024 until July 2025.</li> </ol>
	<p><b>National Diabetic Prevention Programme – patients referred to the programme</b> In November 2024 there were 510 patients referred to the programme, against a target of 520. Target has been met every month except September 2024 and November 2024.</p>	<ol style="list-style-type: none"> <li>There is a time lag in data being submitted to the national programme by providers. It is expected that the position for November 2024 will improve once the data is refreshed in February 2025</li> </ol>	<ol style="list-style-type: none"> <li>Work continues with primary care to refer appropriate patients to the programme.</li> </ol>
<b>EOL Programme Delivery Escalation</b>	<p><b>24/7 Advice Line</b> Case for change has been presented at Clinical Senate and was supported from a clinical perspective.</p>	<ol style="list-style-type: none"> <li>Service currently delivered through Hospice funding. Requirements to demonstrate need and source recurrent funding from April 2025.</li> </ol>	<ol style="list-style-type: none"> <li>Report presented at the System Performance Group (SPG) on 18<sup>th</sup> December 2024. Approval in principle with actions aligned to Medium Term Plan.</li> </ol>
<b>LTC Programme Delivery Escalation</b>	<p><b>Pulmonary Rehabilitation (PR) contract in East and Southeast Staffordshire</b> Current contract comes to an end 1<sup>st</sup> May 2025.</p>	<ol style="list-style-type: none"> <li>Current contract in place. Contract ends on 1<sup>st</sup> May 2025. Decision needs to be made on future delivery of service.</li> </ol>	<ol style="list-style-type: none"> <li>Report presented at SPG on 18th December. Approval in principle with actions aligned to Medium Term Plan.</li> <li>Report was presented (Part B) at the System Finance and Performance Committee on 7<sup>th</sup> January 2025.</li> </ol>
<b>Frailty - Programme Delivery Escalation</b>	<p><b>Frailty Programme</b> 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.</p> <p><b>Frailty Programme:</b> Scaling up of proactive falls projects.</p>	<p>Driver identified remains the same as in <b>M7</b>:</p> <ol style="list-style-type: none"> <li>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.</li> </ol>	<ol style="list-style-type: none"> <li>Falls: Further alignment of all falls programmes to be completed and considered as part of Medium Term Plan.</li> <li>Decision to be presented at the ELF board in January 2025.</li> </ol>



**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
<p><b>Maternity and Neonates</b> <b>(at UHNM only)</b></p>	<p><b>Brain Injury Rate</b> - Monthly rate above the 2023/24 benchmark rate in November 2024.</p>	<ol style="list-style-type: none"> <li>The rate decreased to 2.0 per 1,000 in December 2024 with 1 reported Neonatal Brain Injury (Cooled) at UHNM; this rate is above the 2023/24 benchmark value of 0.0 in the same month.</li> <li>Small numbers are derived from crude data. The Quarter 1 count is less this year than 2023/24, but the Quarter 2 count is above (6.0 in 2023/24 compared to 0.0 in 2022/23); local monitoring continues.</li> </ol>	<ol style="list-style-type: none"> <li>Ongoing work with UHNM to improve data quality and ensure we receive verified data.</li> <li>Continue to Monitor Brain Injury rate through the Quality, Safety and Oversight Forum (QSOF) on a monthly basis, which focuses on learning, themes identified and areas for improvement.</li> </ol>
	<p><b>The proportion of full - term babies admitted to a neonatal unit</b>, measured through the Avoiding Term Admissions into Neonatal Units (ATAIN) programme</p>	<ol style="list-style-type: none"> <li>The percentage of babies admitted (of all births) increased to 4.2% in December 2024, an increase on the prior month (3.9%) and above the 2023/24 benchmark (same month) value of 3.6%. It is important to note 4.2% is well below the national target of 6%.</li> </ol>	<ol style="list-style-type: none"> <li>To monitor and analyse emerging themes and trends with the Business Intelligence team (using Provider data) and identify areas for further development and improvement with the Provider, for discussion and review in QSOF (date of next meeting in January 2025 to be agreed).</li> <li>UHNM have introduced 'buccal 40% glucose' for the treatment of hypoglycaemia which should see a reduction in admissions; data will be monitored each month (from January 2025 onwards) and reviewed with the Provider in QSOF.</li> </ol>
<p><b>Improving Population Health (IPH)</b></p>	<p><b>Children &amp; Young People Vaccination uptake - MMR2</b> - as reported last month, 87.0% of the eligible group have received vaccination in September, 1.2% below the 2023/24 baseline of 88.2%</p> <p>Staffordshire and Stoke on Trent ICS remains above regional and national achievement and the decrease that we have seen locally is reflective of national and regional trend.</p>	<p><b>Drivers remain the same as reported in M7:</b></p> <ol style="list-style-type: none"> <li>The MMR values are relatively close (often <math>\pm 1\%</math>) this is random variation depending on the size of the numerators and denominators.</li> <li>Causes are multifactorial but vaccine hesitancy in the population, general practice access and the quality of data and timeliness of reporting contribute to this trend.</li> </ol>	<p><b>Action planned remain the same as reported in M7:</b></p> <ol style="list-style-type: none"> <li>Ahead of the delegation of immunisation programmes by NHS England, an ongoing initiative focuses on addressing vaccine inequalities. ICS partners are collaboratively implementing community and general practice engagement, targeted communications, and evidence-based interventions to improve 0-5 immunisation coverage and reduce disparities.</li> </ol>



**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
<b>Urgent and Emergency Care (UEC)</b>	<p><b>Discharges on Pathway 0 (ICB) -</b> Performance in December 2024 improved marginally, rising from 74.18% to 74.23%, which was 5.25% below plan.</p> <p>Current Year to date (YTD) position as of 31<sup>st</sup> December 2024: 76.89%</p>	<ol style="list-style-type: none"> <li>1. Discharge Facilitation 7-day workforce model continues to be delayed.</li> <li>2. Voluntary and Community Sector: Continue to see service gaps and long-term sickness at County Hospital (Stafford) mixed with short-term sickness at Royal Stoke University Hospital.</li> <li>3. Increased acuity of admitted patients resulting in escalated requirements on discharge.</li> </ol>	<ol style="list-style-type: none"> <li>1. UHNM Medicine Division continue to implement command and control to manage flow through Medicine Bed Base and increased discharge numbers.</li> <li>2. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards, Ward Standard Work, Your Next Patient (YNP), Home Care is Best Care)</li> <li>3. Senior clinicians and system partners continues to support identification for discharge patients including moving appropriate patients to pathway 0 where clinically appropriate.</li> </ol>
	<p><b>Discharges on Pathway 1 (ICB) -</b> Performance in December 2024 improved marginally, falling from 21.03% to 20.91% which was 4.17% above plan.</p> <p>Current YTD position as of 31<sup>st</sup> December 2024: 19.06%</p>	<ol style="list-style-type: none"> <li>1. Discharge Facilitation 7-day workforce model delayed.</li> <li>2. Workforce resilience waning due to increasing sickness and stress levels.</li> </ol>	<ol style="list-style-type: none"> <li>1. Integrated Discharge Hub (IDH) continue to support appropriate pathways including enhanced support into portals.</li> <li>2. ICB Workforce Team working with providers to identify underlying issues for increasing absence levels.</li> <li>3. Senior clinicians and system partners continue to support identification for discharge patients including moving appropriate patients to pathway 0 where clinically appropriate.</li> </ol>
	<p><b>Discharges on Pathway 2 (ICB) -</b> Performance in December 2024 improved marginally, falling from 4.21% to 4.08% which was 0.56% above plan.</p> <p>Current YTD position as of 31<sup>st</sup> December 2024: 3.51%.</p>	<ol style="list-style-type: none"> <li>1. Risk aversion in support for patients with high-level residential requirements continues to be an issue.</li> </ol>	<p>Actions planed last month continue to aim to drive performance improvement.</p> <ol style="list-style-type: none"> <li>1. Multidisciplinary high intensity team working through base wards to support both simple and complex discharge identification agreed as weekly actions throughout winter.</li> <li>2. Continue to work with Local Authority partners to ensure appropriate flow through the Discharge To Assess (D2A) bed base.</li> </ol>



**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
<p><b>Improving Population Health (IPH)</b></p>	<p>Covid-19 vaccinations in &gt;65 years eligible group: - as reported last month, 53.0% of the eligible group have received vaccination in November 2024 as reported last month, this is 10.3% below 2023/24 baseline of 73.3%.</p>	<p>Drivers remain the same as reported in <b>M7</b>:</p> <ol style="list-style-type: none"> <li>1. Last year Covid-19 delivery was accelerated and started earlier due to a peak in Covid-19 infections in early autumn.</li> <li>2. Decreasing perception of risk from Covid-19 vaccination as the virus is increasingly perceived as causing mild illness that many now experience and the vaccine does not prevent infection in the same way other vaccines do.</li> <li>3. Ongoing concerns regarding Covid-19 vaccine side effects and vaccine safety that are a legacy of the accelerated licensing and Astra Zeneca.</li> </ol>	<p>Actions planned remain the same as reported in <b>M7</b>:</p> <ol style="list-style-type: none"> <li>1. Bespoke Communications: Develop tailored communications to emphasise the importance of winter vaccines, including messaging that supports Covid-19 vaccine uptake.</li> <li>2. Trust Feedback and Targeted Actions: Provide feedback on vaccine coverage to Trust workforce vaccination leads, including specific communication requests and targeted vaccination efforts for low-uptake specialties.</li> <li>3. GP and Primary Care Networks (PCN) Engagement: Encourage GP practices and PCNs to deliver targeted messaging to patients to boost vaccine uptake.</li> <li>4. Community Engagement Programme: Continue an ongoing ICS-led community engagement programme targeting groups facing inequalities in Covid-19 and flu vaccine coverage, including focused efforts with the South Asian Muslim community.</li> <li>5. Walk-in Clinics: Organised for January 2025 to improve vaccine access in areas with low uptake.</li> </ol>



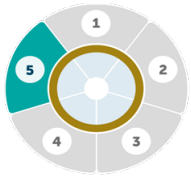
**Local Priority**

**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
<b>Integration</b>	Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions (Staffordshire Local Authority) - Latest indirectly age standardised rate (quarter 1 2024/25) indicated 217.8 admissions per 100,000 population, three above plan.	Driver identified for <b>Quarter 1</b> below will be reviewed updated during the 3 <sup>rd</sup> week of January 2025 in line with Better Care Fund (BCF) reporting: 1. Clinical coding backlogs at the main Acute Provider are directly impacting the accuracy of the performance data against this metric as well as the fall-related metric.	Action planned for <b>Quarter 1</b> below will be reviewed and updated during the 3 <sup>rd</sup> week of January 2025 in line with BCF reporting: 1. The clinical coding backlog is being addressed by main acute providers and the issue is improving. However, the update is not expected until end of January when quarter 2 report is now due.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Stoke Local Authority) - Latest directly age standardised rate (quarter 1 2024/25) indicated 381.7 falls per 100,000 population versus the annual plan figure 1,331. This is 48.85 above the quarterly equivalent plan figure.	Drivers identified for <b>Quarter 1</b> below will be reviewed updated during the 3 <sup>rd</sup> week of January 2025 in line with BCF reporting: 1. Under reporting or delays in data reporting. 2. The reported figure represents the "flex" position and is likely an underestimation. Greater accuracy is expected in the "freeze" position, which will be published a month later	Actions planned for <b>Quarter 1</b> below will be reviewed and updated during the 3 <sup>rd</sup> week of January 2025 in line with BCF reporting: 1. Review of provision of Falls response from Staffordshire Fire and Rescue Service under BCF. 2. Review of pathways and service offers within reactive services to maximise supports in the right setting and avoid Ambulance dispatches and conveyances. Update is expected at the end of January when quarter 2 report is due. 3. Support more patients be managed within the community by aligning reactive workstreams with proactive workstreams. 4. Onboarding of the 'Long Lies' policy to support patients to remain at home.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Staffordshire Local Authority) - Latest directly age standardised rate (quarter 1 2024/25) indicated 437.2 falls per 100,000 population versus the annual plan figure 1,448. This is 75.18 above the quarterly equivalent plan figure.		
	Discharge to Usual Place of Residence (Staffordshire Local Authority) - Latest Performance for quarter 1 2024/25 was 92.72%, 0.78% below plan.	Driver identified for <b>Quarter 1</b> below will be reviewed updated during the 3 <sup>rd</sup> week of January 2025 in line with BCF reporting: 1. Increases in discharges to short term Pathway 1 including Discharge To Assess (D2A) beds due to discharge pathway pressures.	Action planned for <b>Quarter 1</b> below will be reviewed and updated during the 3 <sup>rd</sup> week of January 2025 in line with BCF reporting: 1. Analysis of Discharge To Assess (D2A) pathways and timings completed by IDH with findings built into the operating model.

**Other Key Points Aligned to this priority**

**Integration metrics:** – The latest round of BCF reporting is scheduled for the 3<sup>rd</sup> week of January and as such these metrics will be in a position to be updated prior to the report being presented. Associated narrative will be updated at the same point in time.



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	<p>Multidisciplinary Team Meetings (MDT) - year to date to November 2024 have fallen 12.3% below plan, delivering 5,852 meetings to date, a shortfall of 820 [MDT] meetings.</p>	<ol style="list-style-type: none"> <li>Capacity of Community Teams and Primary Care is stretched to allow MDT meetings to take place across all locations.</li> </ol>	<ol style="list-style-type: none"> <li>Primary Care are represented at the Demand Management Collaborative for care homes to help unblock barriers.</li> <li>The Primary Care Team are working with MPFT and NSCHT to ensure community teams are engaged and aligned to Care Homes and working to identify risk and issues.</li> <li>Continuing to work with practices and networks to ensure delivery of the new Care Homes Universal Offer Specification which commenced 1<sup>st</sup> October 2024 and the Network Contract DES.</li> <li>Meeting with PCNs / practices to ensure MDTs are correctly coded.</li> <li>Interface meetings with MPFT and three localities are being set up to help build relationships.</li> </ol>
	<p>The percentage of Care Home Patients with Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation – this has fallen slightly below plan for November 2024, standing at 58.0% against the November 2024 plan of 60.0%, a shortfall of 159 patients with ReSPECT in place.</p>	<ol style="list-style-type: none"> <li>Challenges stemming from a shortage of MDTs taking place, limiting the ability to effectively conduct Advanced Care Planning discussions in a timely way.</li> <li>Substantial variation identified between practices with ReSPECT plans in place.</li> </ol>	<ol style="list-style-type: none"> <li>Primary Care Team are contacting those PCNs who are furthest away from target to review Enhance Health &amp; In Care Homes programme (EHCH) delivery and identify risks &amp; issues.</li> <li>ReSPECT Programme is supported by the Quality Improvement Framework (QIF) with practices to increase uptake and reduce variation.</li> <li>Practices continue to be encouraged to engage with the Digital ReSPECT Programme to increase the number of digital plans – 13 practices are now participating.</li> <li>ReSPECT Training taking place during January 2025 and has been offered out to practices.</li> </ol>
Care Homes Programme Delivery Escalation	<p>The Care Homes Programme forms part of the Demand Management system collaborative for 2025/26.</p>	<ol style="list-style-type: none"> <li>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.</li> <li>EHCH has stalled and is waiting for further direction from the Demand Management Collaborative.</li> </ol>	<ol style="list-style-type: none"> <li>Third Care Homes Workshop planned for 22<sup>nd</sup> January 2025 – aim to agree actions and action owners.</li> </ol>

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

1

2

Eliminate delays in access to treatment and long waits for care	
Planned Care	Urgent and Emergency Care
Elective Care: detailed delivery plans in place for referral optimisation and pathway harmonisation	Access: High Intensity Users - expansion of service to cover Staffordshire and Stoke on Trent footprint
Cancer: deliver schemes to improve early-stage diagnosis	Access: Designation of Urgent Treatment Centres
Cancer - Improve referral quality	In Hospital: Non-Elective Improvement Plan - to achieve key acute trust metrics (4 hour, 12 hour and General & Acute Capacity)
Diagnostics - implement diagnostic pathways under development	Post Hospital: Expand Integrated Discharge Hub in reach into Emergency Portals
Diagnostics - complete demand management analysis and implement actions	Post Hospital: Standardise Ward Processes to support flow and discharges from the acute trust
Mental Health, Learning Disabilities & Autism	
Develop and implement improvement plan for autism diagnostics	Post Hospital: Standardise Ward Processes to support inreach into Frailty Services
Develop and implement system wide improvement plan for CYP access to Mental Health support	Post Hospital: Review and Standardise End of Life Care Pathway response
Develop and implement improvement plan for ADHD	Post Hospital: Embed the Voluntary Sector in the Integrated Discharge HUB
Roll out of initiatives into the crisis response system e.g. Mental Health Response Vehicles, NHS 111 #2 and 24/7 crisis text lines	Post Hospital: Review and refresh Choice Policy to support timely discharges and flow
Delivery of the CYP Mental Health Local Transformation Plan	Post Hospital - submission of timely and accurate Data (Discharge SitRep) in line with national specification
Children and Young People, Maternity & Neonates	Surge - Mobilisation of Workforce Plan needed to support Surge
Implement delivery plan to improve survival of babies and young children to reduce Infant Mortality	Surge - Development and Delivery of Surge Plan to mitigate excess demand over winter

Improving access to high quality, sustainable primary care	
Primary Care	
Improving health outcomes via collaborative working across primary care and system partners	Provision of safe and high quality services within all Primary Care Services
Improving access to primary care (including patient experience)	Ensure fit for purpose estate provision, maximising shared space and digital alternatives
Reduce variation and commissioning universal access to services	
Mental Health, Learning Disabilities & Autism	
Implement improvement plan to increase number of people with LD on GP registers	Develop plan and activities to support preparation for dementia modifying treatment delivery

TRAFFIC LIGHT KEY	
Variances are against the plan as priority, against the target if no plan is available	
Var	Red - under performing against plan or target, with variance to plan or target
Var	Green - performing against plan or target, with variance to plan or target
Q	No data available as the indicator is reported Quarterly
Arrow colour reflects performance, direction to show change from the previous period	
▼	Improvement in performance against previous period - drop in value
▲	Improvement in performance on the previous Period - increase in value
▼	Decline in performance against previous period - drop in value
▲	Decline in performance against previous period - increase in value
-	No change in performance on the previous month

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

3

4

5

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

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 <span style="color:red">■</span> -	
Refresh of frailty strategy <span style="color:green">■</span> -	

Supporting Care Home Residents	
Integration	
Care Homes System Recovery Programme <span style="color:red">■</span> -	

TRAFFIC LIGHT KEY	
Variances are against the plan as priority, against the target if no plan is available	
<span style="color:red">■</span> Var	Red - under performing against plan or target, with variance to plan or target
<span style="color:green">■</span> Var	Green - performing against plan or target, with variance to plan or target
<span style="color:yellow">■</span> Q	No data available as the indicator is reported Quarterly

Arrow colour reflects performance, direction to show change from the previous period	
▼	Improvement in performance against previous period - drop in value
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▲	Decline in performance against previous period - increase in value
-	No change in performance on the previous month

## Finance Summary – Month 9

The following slides detail the aggregate financial position as at month 9. Following the receipt of funding to cover the planned deficit which was £90m at the start of the year, the plan is now to break even. The national team remain clear that we must get back to breakeven.

Following on from the month 8 position remaining flat, the [month 9 position continues to be relatively positive with signs of improvement to the run rate](#). At a system level we are reporting a year-to-date deficit position of £29.5m, which is a £32.8m adverse variance against the revised plan (Month 8 variance to plan £33.3m). The year-to-date variance to plan sits within ICB (£14.8m) and UHNM (£19.7m) offset by small surpluses at MPFT (£0.9m) and NSCHT (£0.7m).

At month 9 the System has formally reported a surplus forecast of £1.2m at NSCHT in line with their continuing run rate and efficiency delivery. This has been offset by a corresponding deficit in the ICB to maintain a nil net balance for the System. [As a system we are still not able to move the overall forecast away from breakeven](#).

Given the increasing certainty as we move towards the year end and understand potential benefits from the I & I regime and ERF performance, [the System has reduced the unmitigated risk to £39m](#) which is an improvement from month 8 of £56.5m. This has been achieved through a combination of increased certainty in terms of delivery of planned efficiencies, notably with improvements to Continuing Healthcare (CHC) starting to crystalise, coupled with the benefit of ERF delivery.

The reported [system efficiency is now assessed to outturn at £180.4m, which equates to 88.8% delivery against the annual efficiency plan of £203.2m](#). We continue to work with the I & I team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented, many of which support delivery of opportunities set out in the Medium-Term Model.

It should be noted that at the time of drafting this report [we still await confirmation of two key factors from NHSE around the extent of any cap to ERF and the anticipated clawback of the dental underspend](#). This guidance was initially anticipated w/c 13<sup>th</sup> January. Therefore, within the month 9 net risk we have not factored any adverse impact of the ERF cap and continue to assume that overspends in pharmaceutical, ophthalmic and dental (POD) are netted off against the dental underspend. Once the 2024/25 year end letter is received, we will urgently assess the impact on our unmitigated risk.

The system workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and are currently (end of December) 24,890. There has been a sharp rise in the numbers of agency staff into December. Despite the pay controls of organisations having been reviewed both as a system and by the I & I team, there is a concern that since May the overall workforce numbers has risen each month.

Our [capital reporting](#) is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. In month 8 there was a new declaration required to get specific Board approval that their provider operational capital, IFRS 16, and total CDEL expenditure forecasts are accurate and robust. This process and approval has been completed by our provider organisations.

# Month 9 Position

The System is reporting a year-to-date **adverse position to plan of £32.8m** against a revised YTD £3.4m surplus plan. The main drivers for the aggregate YTD position are efficiency slippage (£28.4m) and binding conciliation (£22.1m) with adverse impacts in CHC (£10.3m) and medical staffing (£6.2m). These are partially offset by other non-recurrent mitigations (£19.5m), ERF delivery (£11.5m) and Dental underspend (£3.0m).

Within the £32.8m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £2.8m at Month 9, this will reduce monthly to no impact by year end.

System	Month 9		
	Plan	£m YTD	Variance
Income	3,858.8	3,889.8	31.0
Pay	(991.9)	(996.3)	(4.4)
Non Pay	(512.3)	(562.1)	(49.8)
Non Operating Items (exc gains on disposal)	(27.7)	(22.6)	5.2
ICB Expenditure	(2,323.5)	(2,338.3)	(14.8)
Total	3.4	(29.5)	(32.8)
			-0.8%

Month 8		
Plan	£m YTD	Variance
3,430.7	3,456.0	25.3
(881.0)	(884.2)	(3.2)
(456.1)	(498.1)	(42.0)
(24.5)	(20.1)	4.4
(2,065.1)	(2,082.8)	(17.7)
4.0	(29.3)	(33.3)
		-1.0%

UHNM	Month 9		
	Plan	£m YTD	Variance
Income	886.3	916.1	29.7
Pay	(543.1)	(551.8)	(8.7)
Non-Pay	(314.1)	(356.5)	(42.4)
Non Operating Items (exc gains on disposal)	(27.7)	(26.1)	1.7
TOTAL Provider Surplus/(Deficit)	1.4	(18.3)	(19.7)
			-2.1%

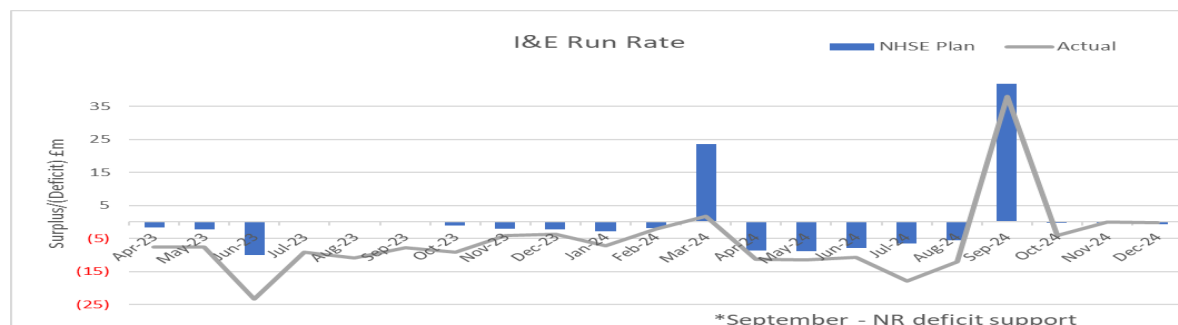
Month 8		
Plan	£m YTD	Variance
788.2	813.7	25.5
(482.3)	(489.3)	(7.0)
(279.6)	(316.5)	(36.9)
(24.7)	(23.1)	1.5
1.6	(15.3)	(16.9)
		-2.1%

ICB	Month 9		
	Plan	£m YTD	Variance
Allocation	2,323.5	2,323.5	0.0
Expenditure	(2,323.5)	(2,338.3)	(14.8)
TOTAL ICB Surplus/(Deficit)	0.0	(14.8)	(14.8)
			-0.6%

Month 8		
Plan	£m YTD	Variance
2,065.1	2,065.1	0.0
(2,065.1)	(2,082.8)	(17.7)
0.0	(17.7)	(17.7)
		-0.9%

MPFT	Month 9		
	Plan	£m YTD	Variance
Income	521.3	524.7	3.3
Pay	(371.2)	(370.0)	1.2
Non-Pay	(149.1)	(155.8)	(6.7)
Non Operating Items (exc gains on disposal)	1.3	4.3	3.0
TOTAL Provider Surplus/(Deficit)	2.3	3.2	0.9
			0.2%

Month 8		
Plan	£m YTD	Variance
463.7	465.9	2.1
(329.8)	(328.8)	0.9
(132.5)	(137.2)	(4.6)
1.3	3.7	2.4
2.8	3.6	0.8
		0.2%

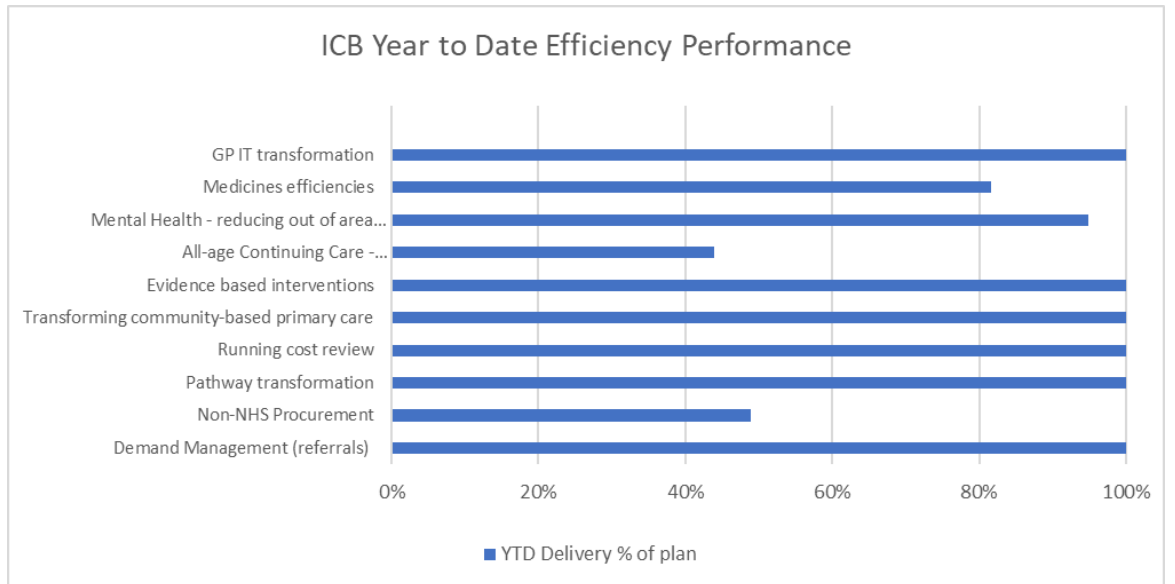
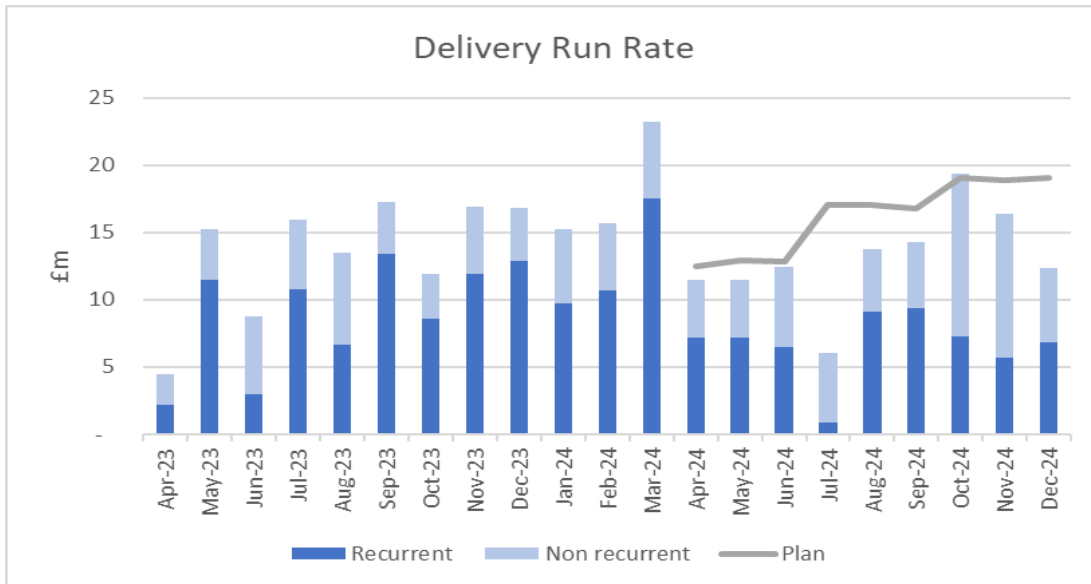
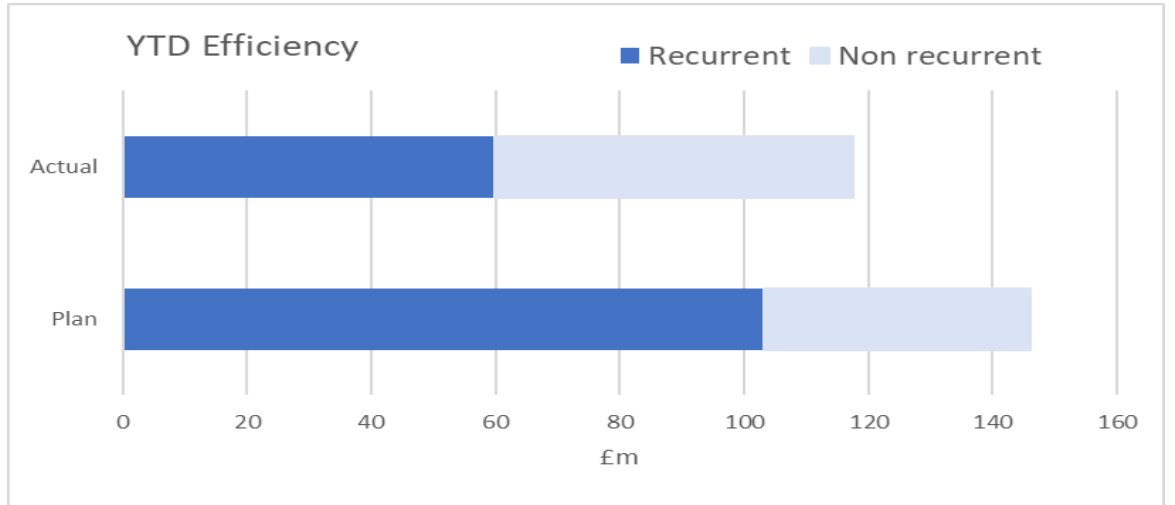


NSCHT	Month 9		
	Plan	£m YTD	Variance
Income	127.7	125.6	(2.1)
Pay	(77.6)	(74.5)	3.0
Non-Pay	(49.1)	(49.9)	(0.7)
Non Operating Items (exc gains on disposal)	(1.3)	(0.8)	0.5
TOTAL Provider Surplus/(Deficit)	(0.3)	0.4	0.7
			-0.5%

Month 8		
Plan	£m YTD	Variance
113.6	111.3	(2.3)
(69.0)	(66.1)	2.9
(43.9)	(44.4)	(0.6)
(1.2)	(0.7)	0.4
(0.4)	0.1	0.5
		-0.4%

# Efficiency

- The system efficiency programme totals £203.2m with £22.8m forecast shortfall. This is in line with last months reporting, with work on going to identify further schemes.
- Forecast delivery equates to 88.8% delivery against the annual efficiency plan of £203m
- Year to date the system has delivered £117.6m of efficiency, this is £28.4m adverse against plan, which is largely at ICB (£14.4m) and UHNM (£12.1m)
- Recurrent schemes are £43.2m adverse at month 9. 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



**AAA Escalation & Assurance Report from Board Assurance Committee**

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>February 2025</b>
<b>Reporting Committee:</b>	<b>Finance and Performance Committee Parts A and B</b>
<b>Date of Meeting:</b>	<b>4 February 2025</b>
<b>Meeting Quorate Y/N?</b>	<b>YES – both Parts</b>
<b>Presenter:</b>	<b>Megan Nurse, Non-Executive Director and Committee Chair</b>
<b>Author:</b>	<b>Debbie Everden, Business Manager</b>

**Key Escalation & Discussion Points from the Committee Meeting:**

**ALERT**

**PART A**

**Month 9 System Finance Report**

At Month 9, at a System level we are reporting a year-to-date deficit position of £29.5m, which is a £32.8m adverse variance against the revised plan. This is an improvement from the Month 8 position (variance to plan £33.3m) due to improvements to CHC starting to crystalise and the benefit of ERF delivery.

Given the increasing certainty as we move towards the year end, the System has reduced the unmitigated risk to £39m which is an improvement from £56.5m at Month 8.

We continue to work with the I&I Team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented. Whilst the Committee noted the improvement in the unmitigated position, it was recognised that we are unlikely to deliver the break-even position required. The expectation of NHSE is for the System to break even following the receipt of £90m of deficit support funding and the System continues to look for further improvement ideas to achieve this.

Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as System partners have significantly reduced plans to meet this allocation.

The paper reported the System workforce position as follows:

- NHS provider total actual workforce levels are significantly above plan by +748WTE (this is predominantly driven by the UHNM position)
- Total workforce overall has increased since November 2024 by +141WTE
- Total workforce for December 2024 is +171 above the March 2024 position
- Agency WTE has increased by +125 since November 2024

Despite the pay controls of organisations having been reviewed both as a System and by the I&I Team, there is a concern that since May the overall workforce numbers has risen each month. Providers have undertaken work to breakdown the areas where there have been increases and mitigations against further increases are being examined.

The Committee noted that the increase in agency use reported for UHNM was due to accruals from invoices relating to October and November and there has been a positive movement from agency to bank and substantive.

NHSE have offered to support with workforce planning for next year and there will be an MDT approach to the process.

The Committee acknowledged the System position at Month 9 and the net risk reported.

### **2024/25 System Recovery Programme**

#### System Recovery Programme Update

The paper provided an update on the four 'live' System Collaboratives and their contribution to the Month 9 position. For the Enabling Functions Collaborative, conversations around operational planning have started but this currently remains on hold whilst we review the latest productivity packs from NHSE and the outputs from the Tough Decisions Panel.

The Collaborative financial improvement forecast is £27.4m which is £26.9m adverse to plan for the year.

The Committee considered the updates for the Collaboratives:

- Continuing Healthcare – We now have a deeper understanding of the technical adjustments required and are confident that we are declaring everything that will support in-year delivery. We are reviewing the latest I&I analysis, which has identified further areas for exploration. The report showed the outcomes being delivered by the various review teams. Of particular note is the difference in the number of patients identified as needing a change in need. Five workstreams have been identified to form the basis of the plan for 2025/26.
- Demand Management - The fourth Care Homes workshop was held on 22 January, where we heard about the benefits of the model used in Leicestershire. This shared learning process will be repeated with Derby colleagues in a few weeks, in preparation for agreeing our own local model. A summary report and a set of recommendations has been produced and discussions will take place on what can be enacted at pace and what will form part of the longer-term transformation work.
- Clinical Value & Medicines – The main focus for the Oral Nutritional Supplements (ONS) project has been on communications with primary care, care homes and hospices in advance of 'go live' on 27 January. The Quality Improvement (QI) project in primary care will be launched next week and we will continue to engage with practices who are not part of the programme but have high levels of ONS prescription. The ONS Project is also now a feature of the Tough Decisions workstream and an increase in the efficiency target is being examined.
- Contracts – Integrated pathways for MSK and Ophthalmology remain our biggest areas of opportunity and scoping work is underway to look at lead provider models.

#### System Recovery Director Report

System CIP delivery is now forecast to be £153.0m which is £4.2m favourable to plan. £11.9m of the green actions from the Recovery Plan have now been included within this forecast (with a further £9.4m of green actions included within the Collaborative position aligned to CHC). Inclusion of all green Recovery Plan actions would see the forecast CIP delivery increase to £158.2m, £9.4m favourable to plan.

The Investigation and Intervention work is now approaching its conclusion with a view of benefits delivered in year and for future delivery included within the report. Consideration is being given to how the work is taken forward by either agreeing the use of internal resources and aligning them to the work that needs to continue or by continued selective external support.

The report provided an update on the tough choices workstream. The items included in the report are proposals for immediate action and there are further proposals that will be examined that will require longer to implement. The estimate of the savings potential ranges from a low estimate of £12.04m up to a high estimate of £39.59m in 2025/26, with a larger full year effect in the following year. This figure is dependent upon pace of implementation and level of appetite on target savings once full impact assessment is undertaken.

The next steps are to:

- Name an individual to lead each intervention

- Confirm the governance for decision making on each intervention
- Define a framework for managing the next steps: to include stakeholder engagement and full impact assessment prior to decision.

The Committee acknowledged the ongoing actions and plans to support recovery of the System financial position and the level of the financial challenge being faced based on the forecast outturn and Recovery Plan position.

### **System Performance and Programmes Report**

The paper provided the Committee with an overview of performance and programme delivery at Month 8 against the ICS Operational Plan and a summary of the key outputs from the Quarter 3 self-assessment stocktake exercise. The report also included metrics for care homes and key UEC metrics for out of System providers.

Following deterioration in the Category 2 response target, all high-level Urgent Care metrics against the priority to eliminate delays in access to treatment and long waits for care continue to be red rated. However, there has been no deterioration from the previous month.

The Committee considered the 104ww, 78ww and 65ww position for Staffordshire and Stoke-on-Trent and out of System providers and acknowledged the continued improvement in respect of 65ww.

The Committee discussed the continued deterioration in the inappropriate out of area placements for Mental Health, Learning Disabilities and Autism patients.

The Committee received updates from the Portfolio Leads for Care Homes, Delivering Compassionate Care for the Frail and Elderly and Mental Health, Learning Disabilities and Autism.

The Committee noted the 3 escalations raised by the End of Life, Long-Term conditions and Frailty Portfolio, and 1 escalation on the Care Homes delivery programme.

### **Capital Update**

This paper provided an update on the main capital schemes within the System, our in-year position and the risks to the delivery of the overall programme. It also summarised the progress with the 2025/26 plan and the 10-year capital plan submission which supports the infrastructure strategy.

The 2025/26 System capital plan is advancing with providers tabling the first cut plans to System colleagues through the System Capital Group. This includes the level of contractually committed schemes, which is just below the potential allocation, therefore there is little headroom for further schemes. This work will conclude in line with the planning timetable, with any changes to the forecast in Q4 2024/25 to be factored in but it is clear we are in the position of needing to reduce first cut plans to be compliant against the capital allocation.

The Committee discussed the significant challenges regarding capital funding of the EPR system and potential revenue implications. The Committee also discussed the System's understanding of the range of risks across the whole piece and the management of these through the Operating Plan.

The Board is asked to note the Committee's concern regarding strategic capital plans and the potential shortfall for next year (which could also include a penalty for failing to achieve break even).

## **PART B**

### **Month 9 ICB Finance Report**

The paper reported the current and projected financial position of the ICB for 2024/25. As previously reported, NHSE released funding equivalent to the £90m deficit plan agreed on 12 June 2024, enabling the ICB to set a breakeven plan for 2024/25.

At Month 9 the ICB reported a year-to-date deficit position of £14.8m adverse variance against the revised breakeven plan. This reflects a £2.9m improvement from a £17.7m deficit position at Month 8. This improvement was due to the receipt of an additional ERF allocation, but key pressures remain including:

- Efficiency delivery against the £102.2m annual target
- The outcome of the binding conciliation exercise
- The underlying cost of CHC packages continues in excess of the 2023/24 planned exit position.

Last month the ICB forecast was consistent with the £36.6m deficit recovery plan position. As no further clarity or guidance has materialised regarding the risk of re-basing the ERF 2019/20 baselines, the ICB can now release the potential £15.8m risk of rebasing against the risk position, improving the risk forecast to a £19.9m deficit. The ICB is unable to move the forecast away from the agreed plan until formal authorisation is gained from NHSE.

The Committee acknowledged the ICB is currently forecasting a significant improvement to the 'amber' recovery plan target of a £36.6m deficit.

The Committee acknowledged the ICB's Month 9 forecast position of breakeven, whilst noting the £19.9m level of risk to achieve the ICB's statutory duty.

### **2024/25 ICB Efficiency Programme**

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

The current forecast is £84.6m of efficiency delivery for 2024/25, representing an adverse variance against the efficiency target of £17.6m. The level of in-year savings currently forecasted to be delivered significantly exceeds the £62.7m delivered during 2023/24. However, it is understood that the £17.6m projected under-delivery is unacceptable and presents a key financial risk to the ICB both in-year and for 2025/26.

The Committee acknowledged the recovery actions being taken by the Recovery Director and organisation to improve the forecast position and the £34.5m risk to the ICB's underlying position as we exit 2024/25.

### **2025/26 Budget Setting Update**

The paper provided an update on the development of the ICB annual budget for the 2025/26 financial year and included a timeline based on final approval of the budget at the March meeting. However, the delayed release of the planning, operational and business rules guidance has resulted in an inability to produce full budgetary information for the Committee to take assurance at this point. The ICB has progressed areas within internal control to ensure we're in a strong position to overlay and respond to the guidance when received.

The clear expectation from NHSE is for a balanced plan to be submitted, plus a defined amount of deficit support to be confirmed. Following approval of a £167.8m underlying deficit as the ICB exits 2024/25 by the January Committee, the challenge to achieve a balanced plan is quantified but significant and presents a significant risk for the Board to note. The organisation is fully cognisant of the scale of the issue and the Executive Team has mobilised a six-week rapid programme of work, led by Portfolio Teams, to further develop operational and efficiency plans prior to go live on 1 April.

## **ADVISE**

### **PART A**

#### **2024/25 Financial Outlook**

Further financial improvement is expected when the Month 10 position is reported; further improvement is expected for the ICB, UHNM are expecting to hold their position, NSCH are planning to deliver a surplus and conversations are taking place with MPFT on a balance sheet improvement. The likely outturn position will be discussed with NHSE.

### **2025/26 Planning: National Planning Submissions and Local Timeline**

The report provided a high-level timeline for the 2025/26 planning process, a high-level summary of the planning support pack and a more detailed overview of the underpinning governance. The full detail of the planning support pack has been circulated to the relevant leads within organisations.

On 22 January NHSE shared a Planning Support Pack detailing expectations around plan sign off and a board assurance framework. All Boards will be expected, as a minimum, to confirm that they have:

- Systematically reviewed and assured themselves that there are plans in place to address the key opportunities to meet the national priorities for the NHS in 2025/26
- Reviewed their existing quality and finance governance arrangements and put in place a robust clinically led process to support local prioritisation decisions
- Assured themselves of the deliverability of its plans and identified mitigating actions to address key delivery challenges and risks

Alongside the Planning Support Pack, NHSE have also developed productivity and efficiency opportunities packs for each Trust and ICB and these have been shared directly with the relevant finance, operational, analytical, planning and workforce leads within provider organisations. More detailed opportunities packs for community, ambulance and mental health trusts are being finalised and will be cascaded. Other local opportunities such as local non-recurrent opportunities, other non-pay cost reductions, further estate opportunities, further productivity opportunities in other acute activity categories including diagnostics, critical care, rehab, etc. should also be considered.

Following the release of the allocations, the System will have a real terms reduction which is likely to lead to a deterioration in the underlying position. The funding for ERF will change to a fixed allocation which appears to be less than received this year; this will have to be managed in the context of reducing patient waiting times and the patient choice agenda. Funding for Specialised Commissioning also appears to be reduced. There will be some deficit support, but the level of efficiencies identified in the Medium Term Plan won't be sufficient so work of the tough choices workstream will also be key in managing the underlying deficit.

The Committee noted the reliance on timely provider submissions to support the development of the ICB System-level position on activity, finance, and workforce and agreed the local timelines.

### **UEC Pressures/System Surge Plan Update**

The paper provided an update on the management of ongoing System UEC pressures and outlined the actions undertaken as part of the System Surge planning process, including escalations and implementation of additional capacity to seek to mitigate the increased levels of demand and infectious disease prevalence.

System-wide assessment of the Surge Plan highlights that the majority of system capacity that was planned to be operational at this point is live and delivering against plan. The System Surge MDT forum (with representation from all System partners) is continuing to oversee delivery of the plan and assess potential mitigations that can be brought forward or increased in order to address current pressures.

The significant growth in ED demand at UHNM and UHDB over the last six months was also presented illustrating the level of pressure being experienced at both acute trusts in recent weeks and months.

Regarding the finances, the Committee noted:

- The allocation of budget in relation to the additional winter schemes continues to be proactively managed, with schemes adjusted or replaced where needed to ensure the greatest benefit of resources. This is completed weekly via the surge MDT
- The budget update as at the 28 January shows that following the deployment of additional actions/mitigations the current position remains within the original surge budget. This position is likely to change however once all additional costs of winter are collated.
- All partners continue to record their costs in relation to winter and provide assurance on a fortnightly basis via their respective finances leads and through to the System Surge MDT and ICB Executives

- Where required, decisions in relation to spend are discussed and agreed via respective Portfolio/Provider Executives and governance arrangements

Updates will continue to be provided to the Committee on a monthly basis and a full review of the winter period will be completed, including a formal lessons learnt event, in Spring 2025.

### **Digital Update**

The paper provided an update on the 12 Digital Initiatives following the 2024 Digital Maturity Assessment.

The withdrawal of the Cyber Strategy revenue funding has negatively impacted IT services due to financial investment in the project leaving a budget deficit. The paper highlighted the challenges being faced at UHNM due to the affordability of the iEPR and underinvestment in Digital:

- Cancelled appointments due to system being unavailable (200+ cancellations)
- Clinical diagnosis unable to be met due to systems being unavailable (650+ delayed diagnosis)
- Unable to treat patients due to systems being unavailable (600+ delayed treatment)
- Unable to discharge patients due to systems being unavailable (300+ delayed discharge)
- Unavailability of systems resulting in patient harm. (650+ occurrences of confirmed or suspected harm)

### **Finance and Performance Committee Terms of Reference**

In accordance with the formal requirement of the Committee to review its ToR at least annually and following amendments to reflect the Committee's role in relation to the Provider Selection Regime requirements and the role of the new Strategic Commissioning and Transformation Committee, the updated Terms of Reference were presented.

The Committee approved the Terms of Reference, and these are being presented to this Board meeting for ratification (attached).

## **PART B**

### **ICB/ICS Cash Strategy**

The paper outlined proposals for the deferral of payments to named suppliers/services in the event that the NHSE Treasury Team do not allow the ICB to drawdown the amount of cash it requires to meet its liabilities as they fall due.

Based upon the Month 8 reported financial position the ICB was forecasting a cash deficit across the 2024/25 financial year of circa £62m comprising an in-year risk position of £36m and movements of working capital of c£26m. The Month 9 reported financial position has shown an improvement against the Month 8 position which will result in a reduction to the ICB cash deficit.

The Board is to note the view of the ICB Finance Team, following a number of discussions with the NHSE Head of Treasury Management, is that the cash that the ICB requires to meet its liabilities as they fall due will be made available but that it was felt prudent to develop a contingency payment plan.

The Committee approved the proposal to defer specified providers/services March 2025 payments to April 2025 based on the methodology/proportions set out in the paper and acknowledged that this proposal was presented at a meeting of ICS CFOs/Deputies on 8 January 2025 where it was supported.

### **Procurement Operational Group Report**

The report updated the Committee on the current procurement programme and work in progress.

The Committee was assured that the contract modifications and awards detailed in the report have been reviewed in accordance with the Provider Selection Regime and supporting documentation is complete.

### **Section 117 Efficiency Oversight**

The paper provided an update on the progress of the efficiency delivery plan relating to S117 across the System.

As part of 2024/25 efficiency delivery plan for the ICB, S117 was identified as an area of focus. An Executive Steering Group has been established with attendance from all accountable organisation and is chaired by Staffordshire Local Authority Director of Adult Social Care and Public Health. In order to assess the efficiency opportunity, a pilot was developed including MPFT and NSCHT, initially beginning with a review of 20 individuals in receipt of 24hour care and support that were due to be reviewed as part of regular care processes in November and December 2024. The paper provided an overview of the pilot and findings and potential future recommendations.

The Committee acknowledged the oversight arrangements and progress of the work relating to S117 across the System and approved the new S117 joint governance process to enable appropriate decision making by the ICB and the Local Authorities as the accountable organisations for S117.

**Confidential: Voluntary Sector Review**

The Committee received a report describing the process and outcomes of the Stage 2 VCSE Review and supported the recommendations set out in the paper for ratification by the Board.

**ASSURE**

**PART A**

**Committee Effectiveness Survey Results**

The Committee discussed the report which provided information on feedback from Committee Members. This survey included assessment of Committee focus and business cycle, quality of papers provided, attendance, engagement and representation, meeting dynamics, data and reporting, and overall effectiveness.

The paper highlighted both the positive aspects of the Committee's operations and areas that Members felt needed improvement.

**PART B**

**Patient Choice and Provider Accreditation**

The paper provided an update on the progress and risks arising from implementing the action plan agreed the previous Committee meeting held on 3 December 2024.

The first Provider Accreditation Panel took place on 31 January and as there were no new requests to review, the Panel focussed on understanding process and pipeline requests. A number of training events and process mapping sessions have been taking in place across functional lead areas and with commissioning leads in affected Portfolios.

The Committee acknowledged that there are no new risks to report, and progress is being made in line within agreed milestone dates.

**All Age Continuing Care Service Update**

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

The Committee noted that the project is progressing in line with agreed deliverables and milestones, that there were no formal issues or risks that required escalation, that additional weekly checkpoint assurance meetings are in place to monitor progress and support early resolution of issues and fortnightly updates to ICB Executives are taking place.

**ICB Undertakings**

Further work is taking place to provide detail to NHSE related to the Undertakings and triangulate all the work taking place around recovery to show how we are delivering these.

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

**PART A**

**System Risk Report**

The report set out the 14 high scoring (12 and above) risks currently on the System Risk Register. The Committee noted that there are 8 risks that have remained static for six months or longer and one risk which has not been updated in line with the risk strategy and does not have any future actions identified. The Committee requested that the risk owners review these risks as appropriate.

**PART B**

**ICB Risk Report**

The report set out the 4 high scoring (12 and above) risks currently on the ICB Risk Register. The Committee noted that there are 3 risks where the score has remained static for six months or longer and requested that the risk owners review these risks as appropriate.

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

***Policies Approved:***

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

***Decisions to be Escalated to ICB Board or other Committees:***

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

## **TERMS OF REFERENCE (TOR)**

### **Finance and Performance (F&P) Committee PART A**

#### **(1) Introduction**

- 1.1 The Integrated Care Board (the Board or ICB) must ensure it can effectively discharge its full range of statutory functions and duties. This includes establishing Committees of the ICB, to support the Board and exercise any delegated functions, to help effective discharging of their range of functions.
- 1.2 The F&P Committee is one of six ICB Committees. The scope of the Committee is:
  - Delivery of the ICB annual plan including finance and performance;
  - Scrutinising system finance plans and performance to ensure that the system is addressing health inequalities.
- 1.3 It will work closely with the Quality & Safety Committee (QSC), Strategic Commissioning & Transformation Committee (SCTC) and People Culture & Inclusion Committee (PCI). Between the Committees, financial and operational performance will be considered alongside the delivery of high quality care and services.

#### **(2) Constitution and Authority (inc. Reference to Legislation or Guidance)**

- 2.1 The Finance & Performance Committee (the Committee or F&P) is established by the ICB as a Committee of the Board in accordance with its Constitution. These TOR set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with approval of the Board.
- 2.2 The Committee is a Non-Executive Committee of the Board and its members, including those who are not members of the Board or ICB staff are bound by the ICB's Constitution Standing Orders (the Standing Orders) and other key policies of the ICB. The Committee has no executive powers, other than those delegated in the Scheme of Reservation & Delegation (SoRD) and specified in these TOR. The Committee is authorised by the Board to:
  - Investigate any activity within its TOR, including oversight of assigned Risk Management and System Board Assurance Framework (SBAF) activities within its lead area;
  - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined;
  - Commission any reports it deems necessary to help fulfil its obligations;
  - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if considered necessary to fulfil its functions (in doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice);
  - Create 'Task & Finish' Groups to take forward specific programmes of work as considered necessary by members – the Committee shall determine the membership and TOR of any such sub-group in accordance with ICB's Constitution, Standing Orders and SoRD, but may not delegate any decisions to such groups.
- 2.3 For the avoidance of doubt, the Committee will comply with the Standing Orders, Standing Financial Instructions and SoRD, other than for any exceptions agreed by the Board.
- 2.4 Committee duties will be driven by ICB objectives and associated risks – an annual programme (cycle) of Committee business will be agreed by Members before the start of each financial year, however, this will be kept flexible to adapt to new and emerging circumstances, priorities, or risks.

- 2.5 The Committee Chair's report will be included in Board papers for the ICB and on the agenda of the Finance & Performance Committees of System Partners.

### **(3) Purpose and Core Duties**

- 3.1 The Committee is established to contribute to overall delivery of ICB objectives by providing oversight and assurance to the Board on the delivery of the core purposes as assigned below and expanded upon within the appendix:
- (a) To act as the single accountable System assurance and improvement enabler, providing assurance to ICB Unitary Board on ICB / System delivery of performance and finance duties;
  - (b) To be responsible for assuring ICB Unitary Board and NHSE about ICB's own delivery and those of System NHS providers under the ICB's Five-Year Forward Plans and Finance / Capital Plans required by ICS statutory duties, achieving this dual purpose in a sensitive, facilitative way, while delivering NHSE's "must-dos";
  - (c) To be responsible for setting the "golden threads" across all relevant parts of the ICB-ICS in terms of setting a clear, common purpose and shared delivery agenda – this must not just be for Finance and Performance matters, but also to include System-wide enablers like Estates, Capital, and financial aspects of Data & Digital programmes;
  - (d) To be a forum for Non-Executive assurance on current delivery issues and forward-looking collective programme plans decision-making within the delegated limits of individuals represented;
  - (e) To present to ICB Unitary Board clear proposals of collaborative System actions required to secure ICS-ICB aims and objectives pertaining to the "Quadruple Aim";
  - (f) To be responsible for approval under the double lock process of any Business Cases that will impact on the System's financial position;
  - (g) To be assured that the Provider Selection Regime (PSR) has been complied with and contracts have been legally awarded and approved within the financial envelope.

### **(4) Membership and Attendance**

#### ***The Membership***

- 4.1 Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 Members will together possess between them knowledge, skills and experience to effectively discharge the functions of the ICS / ICB, including any requisite technical or specialist issues pertinent to ICS / ICB business. When determining the membership of the Committee, active consideration will be made to diversity and equality.
- 4.3 Membership will be as follows:
- Chair: the ICB's Independent Non-Executive Member for Finance & Performance;
  - Vice-Chair: the ICB's Independent Non-Executive Member for Quality;
  - ICB Chief Finance Officer, Chief Delivery Officer, Chief Transformation Officer, Director of Governance, Chief Medical Officer, Chief Nursing Officer, Chief People Officer;
  - One or more Executive Directors from UHNM, NSCT, MPFT, UHDB, RWT (Trusts to decide their own nominations, those individuals to represent the Trust and report back into the Trust F&P Committee and Trust Board);
  - Representatives of Staffordshire County Council and Stoke City Council;
  - Representative of Voluntary Sector – VAST & Support Staffordshire to select;
  - The System Financial Recovery Director.

- 4.4 In addition, attendance may include the following:
- “In Attendance” members: Deputy Director of Governance, Director of Operational Finance, Director of Planning, Head of PMO, Head of Planning;
  - CEO and other ICB Directors to have the option to attend or to be invited for specific meetings or topics;
  - Trust CFOs, COOs and Directors of Strategy to be invited when required – e.g. if there is a specific performance issue that the F&P needs to discuss where that senior executive is needed to lead the discussion and answer questions;
  - To co-opt other, ad hoc members as required from the following when pertaining to specialist “deep dive” topics for F&P discussion, in order to ensure Subject Matter Expert input: Primary / Secondary Care, WMAS or Portfolios / Workstreams / Collaboratives.
- 4.5 Meetings will be structured as two-part meetings. Part (A) will cover System matters that requires the attendance of System Partners. Part (B) will consider ICB issues that have been delegated by the ICB Board. System Partners will be welcome to stay for both parts but will be free to leave after the completion of the Part (A) agenda. Voting members from the ICB will be authorised to vote in both Part (A) and Part (B); voting members from Partners will only be authorised to vote on Part (A) matters.
- 4.6 On a bi-monthly basis there will be a meeting of the Non-Executive Chair of the Committee with the Non-Executive Chairs of the Finance & Performance Committees from System partners. Executive Directors from the ICB and System will be invited as required.

#### ***Chair and Vice Chair***

- 4.7 The Committee will appoint these roles at its first meeting; and thereafter shall be chaired by those appointed, unless precluded by a Conflict of Interest for item(s) of business.
- 4.8 The Chair will be an Independent Non-Executive Member of the Board, on account of their specific knowledge, skills and experience making them suitable to chair the Committee. Members will appoint a Vice Chair who should also possess the same attributes to fulfil that role in the absence of the elected Chair.
- 4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these TOR.

#### ***Attendees***

- 4.10 Only Members as described above shall have the right to attend Committee meetings unless it is agreed to meet in public for part or all the agenda to be transacted. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter. These may include for example further representatives from Health & Wellbeing Boards, Primary, Secondary and Community Providers.
- 4.11 The Chair (or Vice Chair) may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

### **(5) Frequency, Quoracy and Decisions**

- 5.1 The Committee will meet monthly, at least ten times times a year; with arrangements and notice for calling meetings reflecting those as set out in ICB Standing Orders for Board meetings. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss issues on which they want the Committee’s advice.
- 5.2 In accordance with ICB Standing Orders, the Committee may meet virtually when necessary; and members attending using electronic means will be counted towards the quorum.

### **Quorum**

- 5.3 For a Part (A) meeting to be quorate, the Chair or Vice-Chair must be present, plus 3 Executive Members of ICB Board and 3 from Partners. For a Part (B) meeting to be quorate, the Chair or Vice-Chair must be present, plus 3 Executive Members of ICB Board.
- 5.4 If any Member has been disqualified from participating in an item on the agenda, by declaration of a Conflict of Interest, then that individual shall no longer count towards the quorum. If a quorum has not been reached, then the meeting may still proceed if those present agree. However, no binding decisions may be deemed as fully taken by the meeting until confirmed by all Members via offline 'virtual' methods outside of the meeting and before the next scheduled one (see section 5.7 below).

### **Decision Making and Voting**

- 5.5 Decisions will be taken in accordance with ICB Standing Orders. The Committee will ordinarily reach its conclusions by consensus. When this is not possible the Chair may call a vote. This should be seen as an exception to normal, routine decision-making.
- 5.6 Only members of the Committee may vote. Each ICB member (8 votes) and one Partner from each organisation (8 votes) is allowed one vote; and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair will hold the casting vote. Organisations can send a voting deputy to meetings where the voting member is absent.
- 5.7 Mirroring provisions set out within the Standing Orders, if an urgent or emergency decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct such business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

## **(6) Responsibilities of the Committee**

- 6.1 The Committee's detailed duties and core responsibilities are itemised within the appendix.
- 6.2 Matters delegated to the Committee by the Board (and as also defined by / covered within the SoRD) are also itemised within the appendix.

## **(7) Conflicts of Interest**

- 7.1 The Committee and all members or attendees present shall fully and continuously satisfy itself that all matters of ICB policy, systems and processes for the management of conflicts (including gifts & hospitality and bribery) are upheld in all meetings.
- 7.2 For the avoidance of doubt, any additional national or statutory policy requirements shall also guide the Committee's processes and procedures. This shall include sending any reports relating to non-compliance with ICB policy and procedures to the ICB Audit Committee.

## **(8) Etiquette, Behaviours and Conduct**

### **ICB Values**

- 8.1 All Committee members and attendees will be expected to conduct business in line with the ICB's stated values and objectives.
- 8.2 Committee members and those attending shall always behave in accordance with the ICB's Constitution, Standing Orders and Standards of Business Conduct Policy.

### **Equality and Diversity**

- 8.3 All members must demonstrably consider the Equality and Diversity implications of any or all decisions they make. Attendees will also be required to uphold the Equality Act and Public Sector Equality Duty in any of their engagements with the Committee.

### ***ICS Compact and ICB Meetings Charter***

- 8.4 In addition to the items noted in section 8.2, all members and attendees will be expected to adhere to the separate Integrated Care System (ICS) Partnership Leadership Compact key principles of 'Trust', 'Courage', 'Openness & Honesty', 'Leading by Example', 'Respect', 'Kindness & Compassion', 'System First' and 'Looking Forward'.
- 8.5 Similarly, all will be required to respect and apply the ICB Meetings Charter, which shall codify all the above and help with the logistics / practicalities of running an ICB meeting in line with the Constitution and Standing Orders.

### **(9) Accountability and Reporting**

- 9.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings shall be formally recorded by the secretariat. The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.
- 9.2 The Committee will provide the Board / Audit Committee with an annual statement of its effectiveness, timed to support finalisation of ICB Annual Accounts & Annual Report's Governance Statement (see section 11). This will summarise its conclusions from the committee effectiveness work it has done during the year, specifically commenting on:
- The fitness for purpose, completeness and embeddedness of the SBAF / Risk reporting obligations of the Committee within the ICB's organisational context;
  - The integration of governance arrangements to underpin the "Quadruple Aim" and Core Purposes of an ICB-ICS;
  - The appropriateness of the evidence that shows how the Committee is helping the ICB in fulfilling its regulatory requirements;
  - The robustness of the processes behind the Committee's decisions.

### **(10) Secretariat and Administration**

- 10.1 The Committee shall be supported with a secretariat function, which will include ensuring that:
- The agenda and papers are prepared and distributed in accordance with ICB Standing Orders; having been agreed by the Chair with the support of the relevant ICB Executive and Governance Lead;
  - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
  - Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
  - Maintenance and reporting of the Committee Conflicts of Interest Register (with the ICB Governance Lead);
  - Good quality minutes are taken and distributed in accordance with ICB Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
  - The Chair is supported to prepare and deliver reports to the Board;
  - The Committee is updated on pertinent issues / areas of interest / policy developments;
  - Actions are taken forward between meetings and progress against those is monitored.

## (11) Review

- 11.1 The Committee will review its effectiveness at least annually.
- 11.2 These TOR will be reviewed at least annually and more frequently if required. Any proposed amendments will be submitted to the Board for approval (and will not be deemed as operational until that agreement has been confirmed).

### Appendix - Committee Responsibilities and Duties

- ☑ Depending on the relative position of the System against the National Oversight Framework (NOF), to co-ordinate / lead / jointly conduct / participate in related discussions, interventions and provide upwards assurance on the collaborative delivery of the performance & finance requirements of the NOF via the associated governance arrangements across the ICS.
- ☑ To gain assurance from the ICB's Executive functions and provide assurance to the ICB Board on the following areas: Financial Strategy, Financial Planning, Financial Performance & Control, Capital, Financial Policy & Risk Management:
  - Oversight of Financial Strategy;
  - Development of ICB-ICS financial management information systems & processes;
  - A joint understanding of the System financial envelope;
  - Development of financial plans;
  - Assurance on development & delivery of performance improvement & efficiency agendas;
  - Oversight of the monthly financial performance of the System;
  - Assurance on the delivery of the agreed efficiency plans, reviewing Exception Reports;
  - Consider and propose the System financial architecture & financial controls required;
  - Ensure our System is able to meet VFM criteria and achieve financial sustainability;
  - Development and oversight of ICB-System Capital Plans;
  - Compliance with the financial aspects of the Provider Selection Regime (PSR).
- ☑ To co-ordinate all aligned non-corporate System governance / financial governance arrangements and necessary oversight mechanisms and structures that reflect these, including the respective roles of the ICB-ICS Partner and Regional NHSE Team.
- ☑ To approve financial Project Mandates for Transformational / System savings per agreed process proposals.
- ☑ To hold Portfolio SROs to account for delivery of agreed Financial Metrics, in liaison with the Strategic Commissioning & Transformation Committee (SCTC), to triangulate the impact of System Transformation programmes across finance, activity and performance aspects of the Commissioning Cycle.
- ☑ To advise the ICB Board and ICS Senior Leadership Team of any matter relating to the operational & financial performance of the System, either in the future or the past.
- ☑ To co-ordinate performance improvement actions between ICS partners for the benefit of patients
- ☑ Organisation-specific data will rarely be considered (being the responsibility of individual organisations). System-wide data will generally be the focus of consideration and be based on the most up-to-date sources. The focus will be on agreed priority metrics that assess delivery of the Performance Management agenda using KPIs & Balanced Scorecards where possible.

- ☑ No substantive matter of ICB-System strategy, planning, performance, or finance will be considered without having been debated at the Committee first.
- ☑ To promote visibility and ownership of the implied results of national planning returns by liaising with other, relevant ICB Board Assurance Committees.
- ☑ To take a shared, collective responsibility for the System's finances and performance, thereby providing assurance to ICB Board on the extent to which System Partners are working effectively together to integrate, deliver and improve local health & care services.
- ☑ To support NHSE Quarterly System Review Meetings (QSRM) by focussing on key strategic areas of escalation and exception. Where there are significant areas of concern requiring support, additional NHSE-led oversight arrangements will be instigated in line with the NOF.
- ☑ To receive at each meeting a high-level dashboard, with focused "deep dives" throughout the year, after gaining the views of the membership on the key areas of oversight to be assured upon and where / how the Committee can best add value to the System across its broad remit.

**AAA Escalation & Assurance Report from Board Assurance Committee**

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>February 2025</b>
<b>Reporting Committee:</b>	<b>People, Culture, and Inclusion Committee (PCI) (Part1 – Section 1 &amp; 2)</b>
<b>Date of Meeting:</b>	<b>3 February 2025</b>
<b>Meeting Quorate Y/N?</b>	<b>Y</b>
<b>Presenter:</b>	<b>Shokat Lal, Non-Executive Director &amp; Committee Chair</b>
<b>Author:</b>	<b>Gemma Treanor, Head of ICS People Function</b>

**Key Escalation & Discussion Points from the Committee Meeting:**

**ALERT**

No alerts

**ADVISE**

**(1) Performance, Planning and Finance:**

The Committee was updated on the financial position which remains challenged even with the Recovery Plan in place, although the position continues to stabilise, and the gap is closing.

**Investigation & Intervention regime**

Extensive discussion and consideration of the workforce position was covered in the Committee, with an overview of the overarching financial position and Deloitte/Kingsgate progress update. Cost improvements programmes continue to have a positive impact on the position, although the Provide Collaborative work hasn't realised the benefits hoped financially but the programmes continue to make significant strides in transformation and improving the services.

Month 9 sees a more positive position from a recovery perspective with the System expected to achieve a deficit of £39m approx. with the mitigation in place. Early Month 10 analysis is indicating a further improved position.

Initial I&I work with Deloitte/Kingsgate comes to an end this week formally, but work will continue around workforce, productivity, independent sector and tough choices. The Committee acknowledged this, the next steps and importance of keeping momentum going into 25/26. The Committee welcomed receiving a report at the March meeting which outlines and provides assurance around the work undertaken with Trusts regarding workforce.

**Performance to 2024/25 Plan**

The papers outlined that SSOT are significantly above the planned workforce growth for 2024/25, which is attributed to increases in substantive and temporary workforce, business cases requiring additional workforce, and challenges around CIP scheme delivery. The increase was noted by members and

assurance was provided regarding the ongoing work taking place with Trust CPOs, CFOs and with NHSE regional team. The System has received offers of support from the NHSE regional workforce team specifically around planning for next year and meetings are taking place this week to commence that support.

## **ASSURE**

### **(2) Performance, Planning and Finance:**

#### **2025/26 Operational Planning**

The Committee received an update regarding the 2025/26 allocations and a summary of the 2025/26 operational planning guidance very recently published. Members were advised on the timescales and priorities which include elective care, A&E, general practice and dental care and mental health and LDA. The enablers around living within budget, reducing waste and improving productivity were discussed with particular focus on the workforce elements including temporary staffing, implementing the People Promise.

Productivity and efficiency opportunities pack provided by National NHS England team is being assessed by the ICB and Trusts, with the expectation our System builds programmes around each area to deliver the savings identified.

The Committee acknowledged the challenges and the critical role of People leads in the development and delivery of the 2025/26 Operating Plan. Further discussions will take place regarding the plan at the March and April meetings with iterations of the plan shared with members for assurance.

### **(3) People Culture Inclusion Programme delivery**

The Committee received the programme delivery highlight and assurance report, and were assured that programmes were on track. Members were also advised that the 2024/25 Annual Report was currently being developed in partnership with leads from across the System.

### **(4) PCI Committee Effectiveness Survey**

The results of the Committee Effectiveness survey, completed annually with all Sub-Committees of the ICB Board, were shared with members and discussed at the meeting. The Committee welcomed the feedback and acknowledged the honest and constructive comments from members. Acknowledgement was given to the review of the Committee structure less than 6 months ago with further opportunity to embed and assess the effectiveness of the structure. Members acknowledged the progress made as a Committee since its' inception and the excellent partnership working achieved.

The Committee were advised of the ongoing discussions regarding the ICB Board and Committees review which would inform future reviews of this Committee. It was agreed that a further discussion will take place regarding the effectiveness and structure in April/May 2025.

### **(5) Strategic System Updates:**

The update focused on the ICB Chief Executive Officer and Chief Financial Officer's resignations and the process to fill those positions. Additionally, the Committee were advised that the ICB CPO and Head of ICS People Function were attending the Regional People Board to present on our collective work on outreach, inclusion and Journey to Work approach.

### **Medium Term plan**

The Committee was provided with an overview of the Medium Term Plan and current status, with a description of the five areas of work identified in the plan. The discussion centred around Community Transformation in this initial discussion and the workforce implications and opportunities.

Discussions took place around technology and digital opportunities, and how we can support the population and workforce to maximise the impact the solutions would have on health outcomes. The Committee was advised that there would be a focus on population health and utilising the data to inform the plan around inequalities and priorities for our System.

Members considered the significant behavioural, culture and leadership implications of a transformation programme of this size and the transition from current ways of working to a new model. It was acknowledged that organisations would need to work together and differently to utilise our collective resources across our System and organisational boundaries to deliver the change required. Community and workforce involvement across all sectors and staff groups was identified as a key enabler to the development and success of the transformation.

The Committee noted the next steps and requested further discussion and assurance around the development of the overall plan and workforce elements.

### **People Plan Refresh and 2025/26 Delivery Plan**

An overview of the approach to refreshing our System plan and development of the 2025/26 delivery plan was provided to the Committee. Members were advised of the proposed timeline and stakeholder involvement. Discussions took place regarding the alignment of the plan to the Operating Plan, Medium Term Plan, Portfolios, System Priorities, and the People Promise. It was acknowledged that we will need to consider the 10 year Health Plan and Long Term Workforce Plan once published later this year.

The Committee welcomed the refresh of the People Plan and development of the 2025/26 and plans to engage with System partners in the development.

### **(6) Workstream focus: Supply & Productivity**

The Committee received an update on the establishment of the new Supply and Productivity workstream and Sub-Committee. An initial workshop has taken place with leads to establish the vision and purpose for this workstream and the key areas of responsibility including supply, operational planning, workforce controls, strategic workforce planning and transformation. Further updates and assurance will be provided to the Committee as the workstream develops and embeds.

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

### **(7) Risk Register**

The Committee received the People Risk Register, discussing the risks considering the System challenges and pressured environment. The Committee noted the proposed risk scores, with agreement being reached regarding an increase in target scores from 4-9. The Committee however did not support the reduction of the residual score for Agency from 16 to 12 therefore the score will remain.

The Committee requested a detailed review of all risks via Sub-Committees and leads, with a focussed discussion to be held at the March Committee given the risk expiry dates at the end of March 2025.

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***Policies Approved:***

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles have any 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.

**AAA Chair's Escalation & Assurance Report from Board Assurance Committee**

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>February 2025</b>
<b>Reporting Committee:</b>	<b>Audit Committee</b>
<b>Date of Meeting:</b>	<b>13<sup>th</sup> January 2025</b>
<b>Meeting Quorate Y/N?</b>	<b>YES</b>
<b>Presenter:</b>	<b>Julie Houlder, Non-Executive Director</b>
<b>Author:</b>	<b>Paul Winter, Associate Director of Corporate Governance</b>

**Key Escalation & Discussion Points from the Committee Meeting:**

**ALERT**

Members wished to advise the ICB Board of a number of these from its latest meeting, for Board awareness and consideration, as follows:

**EPRR Annual Assurance Report:**

The Committee received positive assurances on the ICB's annual EPRR (Emergency Planning Resilience & Response) Assurance Standards compliance position. Confirming that the ICB is progressing well in terms of continuous improvement on compliance – increasing to 91.5% (previously 89.4%) against the standards; and overall achievement of the ICB delivery target.

There are 4 areas of partial compliance (duty to assess risk + risk management). With work undertaken in collaboration with the Governance Team on embedding a good EPRR Risk Management Framework across the ICS & Local Resilience Partnership. The others being: the Training & EPRR Exercise / Testing programme (Business Continuity systems); and commissioned Providers & Suppliers work, focusing on Business Continuity throughout the Tendering process.

The Board can be assured that partial compliance is not directly a consequence of the operational Business Continuity pressures that the system is experiencing around critical incidents. A new EPRR manager has been appointed to lead the development of Business Continuity Plans, following individual learning exercises after each incident.

**Capital Risks 2025-26:**

The Committee agreed to co-alert the Board (with F&P Committee, as lead committee) of the need for Board awareness and discussion of this risk, as recorded on the System Risk Register. Mitigations are in place and the Audit Committee is assured that the F&P Committee is assured; however this warrants further Board-level discussion of the high-scoring nature of the risk.

NOTE: There was also an "Alert" raised by the Committee on the static nature of several high-scoring risks, as covered in the 'Risk & SBAF' section below. However the Committee agreed to also flag this formally, given the Board does not receive Risk Registers for review as part of its own Business Cycle.

**Annual Committee Effectiveness Outturn Report, 2024-25:**

The Committee received and discussed its annual effectiveness review report. After clarifying a couple of minor matters to be actioned offline (ref. statistical confirmations of the numbers behind % scores and clarifying the numbers of respondents saying they were 'unable to answer' several questions as these were quite high in a number of instances); agreeing to apply the following 'Key Messages' points raised by members' comments and feedback, flagged to the Board as "Alerts" regarding committee learning:

- Visibility of Non-Executive Members to the wider ICB – further work to enhance this

- ☑ Inviting Partner Organisation Audit NEDs to periodically attend ICB Audit Committee meetings, when required for good leadership communications purposes

### ADVISE

#### **Financial Governance – Annual Accounts Timetable and Process:**

The Committee received an update on the indicative Final Accounts timetable and ICB plans, agreeing to a proposal for two extraordinary meetings of the Audit Committee to take place on 24<sup>th</sup> April 2025 (Draft Accounts) and the 19<sup>th</sup> June (Final Accounts).

#### **Personal Health Budgets (PHBs) Internal Audit:**

A deep dive into PHB had identified a number of improvements, including the need for a Quality Assurance mechanism to check and challenge assessments, decision support tools and support plans. The Committee were assured that the ICB would be reviewing its PHB Policy in conjunction with the ICB's Legal Team; with the Head of Service for All Age Continuing Healthcare to attend the next meeting to provide an update on PHB cases, recommendations and implications.

#### **(Operational) Issues Log Reporting:**

The Chair raised the need for ICB committee meetings to each be aware of ensuring that the governance process around 'Issues' (as opposed to Risks) were better understood at both the Issue Owner and Committee level. An action was assigned to the Governance Team to ensure that at each Committee agenda setting meeting, there was work undertaken to share awareness of any Issue Log matters that were likely to convert into full Risks, for improved oversight of these. This will ensure that members understand the governance process around Issues reporting and have greater visibility of these (in the absence of their not receiving operational Issues Logs at meetings).

#### **External Audit Services Contract Award:**

The Committee received an update on this mandatory contract award from the Chair; and was informed that the ICB would continue with the contract with the current provider, Grant Thornton LLP.

### ASSURE

#### **Reviews of Single Tender Waivers (STW) Register and Losses & Special Payments:**

A review of waivers was received, and members assured on the latest 3 additions to the register; discussing two made to: Staffordshire County Council (related to a scaling funding agreement, regarding money the ICB had received around discharge), and to Graphnet Limited (ongoing contract re. provision of the Shared Care Record). A review of losses and special payments was also presented to the Committee, confirming that there had been none of these incurred since the last meeting. The Committee agreed to pass on its assurances to the Board about this.

#### **STW Benchmarking Report:**

The report outlined assurances to the Committee that there was a similar number of waivers for last year, with a larger reduction in value and concerns around planning / the need for assurance around ICB providers. The Committee was assured that the forthcoming Procurement Act would be expected to see a decrease in STWs and alterations to STW documentation.

#### **Timings of Audit Committee meetings in 2025:**

An action was agreed for the Governance Team & Secretariat to review the meeting schedule of Audit Committee meetings, to ensure these fall better in line with ICB Board meetings in 2025.

#### **Counter Fraud Progress Report:**

Discussion took place on how to encourage ICB Staff to attend training sessions, with communications to staff to continue to raise awareness and understanding. It was agreed to utilise the ICB Team Brief as a communication platform to engage with staff around Cyber Awareness, Fraud Awareness and Freedom to Speak Up awareness, with available training sessions for each.

#### **Internal Audit Progress Reports:**

The Committee received positive assurances from the Portfolio SO regarding a Population Health Management (PHM) review having been closed recently and an update on the actions planned through 3 programmes of work relating to Health Inequality, PHM and Prevention, being taken forward through the work of the IPH Portfolio and Board.

A Green Plan Review received reasonable assurance, having identified there were numerous skills and expertise across System Partners, and that Green Plan guidance separate to the main Annual Planning Guidance was imminent, to help shape the forward plans of this ICS programme.

### ASSURE (continued)

#### ICB Governance:

The latest *Freedom of Information (FOI) Update Report* was received and the Committee assured that while there had been a small number of breaches, due to long-term sickness in the team and an increase in the number / complexity of requests, overall compliance was still very positive. The Committee was updated on future work being planned to increase training and awareness for senior ICB staff, to review the factors resulting in breach or near breach; and a system review of the process around digital support.

The latest *Gifts & Hospitality Register* was presented, and the Committee assured about 3 additions.

An update on the *ICB-ICS IG Data & Digital Committee* was provided, confirming that the sub-committee had recently met twice in its new, enhanced guise; and was progressing well in taking forward strategic debates around IG & Digital. The Audit Committee approved its amended Terms of Reference, incorporated within this AAA Report as an “Assure” matter. (The TORs are available on request).

#### ICB Annual Report 2023-24 Lessons Learned Review:

This confirmed that work had recently been undertaken with the national policy team to review how best NHSE can support ICBs in taking forward the suggestions of the Peer Learning (Governance) Network; where it should be confirmed in February if there would be any change to the contents etc of the NHSE reporting template. Local work had also been undertaken with the Staffordshire Health & Wellbeing Board (HWBB) to ensure the incorporation of better information on improving population health.

#### ICB Undertakings – Lead Committee Overview:

The Audit Committee retains strategic oversight of the progression toward mitigation of NHSE Undertakings on behalf of the Board (with Finance & Performance / Quality & Safety / People Culture & Inclusion Committees each owning a share of the agreed programme plan).

The Undertakings Dashboard was presented to assure the Committee, because it had previously challenged the amount of green RAG-Ratings assigned to actions, and a piece of work had recently been undertaken to triangulate this work with the work of the ICB Recovery Director / the Investigation & Intervention (I&I) work. Where it had been identified that by going to NOF Level 4, the Undertakings and I&I etc linked together; and so it was important to confirm how these areas update in line with I&I work.

The Committee agreed that representatives of Deloitte & Kingsgate would attend the next Audit Committee meeting to discuss the various internal controls going forward.

### System / ICB Risks & System Board Assurance Framework (SBAF):

**Q3 2024-25 SBAF Report:** owing to meeting timing issues, a full Q3 analysis was shared offline prior to the meeting for Committee Member discussion and requested assurances. Which were given on scores, process and report recommendations.

**System & ICB Risk Registers:** The Committee received and was assured on the System / ICB Risk Register Reports; while highlighting the relatively static nature of 10 high-scoring risks. The Committee endorsed a renewed approach for all recipient committees to more deeply discuss the Target Risk Scores and Mitigations for static risks; with a view to checking if these are signals warranting further review of the risk reduction trajectories and refresh of the mitigating actions – per the Risk Management Strategy.

### Policies Approved: pending minor clarifications or rewording to be considered, for those marked (\*)

- (1) The **Standing Financial Instructions (SFI) Policy** – confirming as part of approvals that the policy would be further reported back to the Audit Committee, following a refreshed Procurement section due to the Procurement Act, that would come into force in February 2025.
- (2) The **Anti-Fraud & Bribery Policy** – as part of approval, thanks were given to RSM for supporting the refresh and review of the policy, relating to enhanced descriptions of legislation change (the new

failure to prevent offence, due to come into force on 1<sup>st</sup> September 2025; and the Economic Crime Corporate Transparency Act, updating the links to the Counter Fraud Authority Strategy).

- (3) The ***Development & Management of Controlled Documents Policy*** – as part of approval of the policy, the newly-reformed Policy Review Group Terms of Reference were also approved.

### ***Policies Approved:*** pending minor clarifications or rewording to be considered, for those marked (\*)

- (4) The ***Conflicts of Interest: COI (incl. Gifts & Hospitality) Policy and Standards of Business Conduct Policy*** – (\*) these were approved; pending rewording of the COI policy requirement to review members' conflicts at the start of any meeting only, and not for each agenda item.
- (5) The ***Acceptance & Management of Petitions Policy*** – (\*) this was approved pending confirmation of whether signatories of any petitions must live within Staffordshire & Stoke-on-Trent area. With a post-meeting note confirming these do not have to be SSOT-only, in cases of any entries received from national or regional organisations; and owing to petitions originating outside of ICB control, with insufficient personnel capacity to review each, signatory by signatory, to check residence status.
- (6) The ***Social Media Policy*** – was approved in full.

### ***Decisions to be Escalated to ICB Board:***

**To seek Board Ratification** of the Audit Committee-approved policies noted in the previous section:

- (1) *Anti-Fraud & Bribery Policy*
- (2) *Development & Management of Controlled Documents Policy*
- (3) *Conflicts of Interest: COI (incl. Gifts & Hospitality) Policy*
- (4) *Standards of Business Conduct Policy*
- (5) *Acceptance & Management of Petitions Policy*
- (6) *Social Media Policy*

Please see below the link to the ICB website where these are published as drafts, for the Board to be able to view in full / and ratify -

[Our publications and policies - Staffordshire and Stoke-on-Trent](#)

**AAA Chair's Escalation & Assurance Report from Board Assurance Committee**

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>20<sup>th</sup> February 2025</b>
<b>Reporting Committee:</b>	<b>Strategic Transformation &amp; Commissioning Committee (SCTC)</b>
<b>Date of Meeting:</b>	<b>5<sup>th</sup> February 2025</b>
<b>Meeting Quorate Y/N?</b>	<b>YES</b>
<b>Presenter:</b>	<b>David Pearson, ICB Chair and Interim Committee Chair</b>
<b>Author:</b>	<b>Paul Winter, Associate Director of Corporate Governance</b>

**Key Escalation & Discussion Points from the Committee Meeting:**

**ALERT**

The Interim Chair welcomed Mike Lawton, the new ICB Non-Executive Member (NEM) for the Committee and advised that he would be taking over the chair role. The Interim (ICB) Chair will remain as Deputy Chair until a new NEM has been appointed.

Members wished to advise the ICB Board of a number of these from the second meeting of the new Committee, for Board awareness and consideration, as follows:

**SCTC Terms of Reference:**

The second draft TORs had incorporated all changes discussed at the first meeting and offline, to ensure there are no areas of duplication or unwarranted overlap. The TOR were submitted for approval prior to Board Ratification; and will continue to evolve / be reviewed frequently over the next six months as this new Committee establishes itself.

Some members were however still unclear about how the balance works on what SCTC leads and where it assists other Committees. It was agreed that we together work on this as part of natural development of this new committee. A further offline meeting between Lead Execs and the new Non-Exec Member Chair (Mike Lawton) will take place on clarifying exactly what this means in practice, and to address the points raised; in order that the TOR can be finalised then shared with other Committee members before being taken to March ICB Board for formal ratification.

**ADVISE**

**Specialised Commissioning Key Messages:**

The first of a series of standing agenda item reports was presented to the Committee; to provide an update on this area, in particular with Phase 2 delegations from NHS England. (Phase 1 last year was largely based around acute specialised services. The next Phase of Specialist Commissioning Delegation from April 2025 includes an additional number of acute specialised services and Mental Health, Learning Disability and Autism (MHLDA) specialised services.)

The paper also updated on the various governance arrangements in the West and East Midlands Region in terms of the various delegated groups and the Joint Committees who have oversight of all the work that is ongoing. Now this Committee has been established, all of these outputs will be routed through the SCTC, who will have responsibility for signing off the NHSE-ICB Delegation Agreement and Collaboration Agreement, prior to these being submitted to Board in March for final ratification.

The Committee considered the update on progress towards Phase 2 of specialised Commissioning Services; and was assured that the ICB has considered / provided feedback on the refreshed Collaboration & Delegation Agreements. Similarly in that the ICB has senior representation on the region-wide groups and progress shared with this committee accordingly.

**ADVISE (continued)**

**24/07 PEOLC Advice Line Service Review:**

The Health & Care Act 2022 states a legal duty on ICBs to commission palliative / end of life care services. The paper provides a Case for Change for the 24/7 advice line that's been funded over the last 12 months by three of our Adult Hospices. They agreed to undertake the advice line to look at 'proof of concept'. The paper also outlined the legal duties / NICE guidance the ICB has to consider.

The Committee approved the Case for Change after discussing and being assured about future patient / carer / family engagement activities planned; and subject to leads finalising the mandatory QIA.

**Paediatric Psychology Service Realignment:**

The SCTC was asked to consider a proposal to realign current service provision to support Children & Young People from across our system with epilepsy, whose care is currently under the management of UHNM. In doing so, agreeing to decommission the current offer with MPUFT; and realign the commissioning budget to North Staffs Combined Healthcare. MPUFT currently provide a small psychology service that historically was aligned to the children's Shugborough ward at County Hospital, as part of a wider offer for Children & Young People diagnosed with a long-term condition. Activity for this service is very low with the service underutilised. The service is not Commissioner-specified, with minimal service line reporting.

As there was uncertainty about the level of prior, organisational engagement, the Committee could not approve the proposal. The Interim Chair instead suggested the status quo of the current service be maintained as is, and for urgent discussion to take place outside of the Committee. Then included as a Matter Arising for the next meeting, where members are also asked to give some thought to the wider decision-making process and the structures that need to be better deployed in future, to ensure that these types of decisions are more effectively covered off going forward.

**ASSURE**

### **Service Transformation & Service Change:**

An update provided the latest monthly overview of the clinical areas included within the system programme; including the latest monthly service change return and high-level work plan (“swim lanes”).

The SCTC will receive a Maternity pre-Consultation Business Case at its March meeting. Assurances were given that all Impact Assessments for that service change proposal have been undertaken. Because of the delay due to the pre-election period in March-April, it was confirmed that the delay does not affect the timeline for potential consultation.

A UEC Final Report of Findings from the engagement undertaken late summer / early autumn last year has been completed; and a summary taken to the UEC Board. The SCTC was informed that presentation had been drafted for the UEC Technical Event, initially scheduled to be held 25<sup>th</sup> February 2025 – although since the meeting, this event has been stood down, and alternative arrangements made to take forward the findings in light of the national guidance.

A new programme of work for UHDB Clinical Reconfiguration covers 8 clinical areas; with a Case for Change expected at the end of March. Some of which may be service change requirements; and some may be internal configuration that does not impact on patient flow.

A second Community Transformation workshop was held on 23<sup>rd</sup> January with good attendance from all Partners. This further explored the population segmentation approach using the Pathfinder Tool; and there have been further conversations in terms of how to take that forward. Further discussions have also taken place in terms of Integrated Neighbourhood Teams, where new Operating Guidance for Neighbourhood Health has helped to cement the programme of work and our model for MDT working at both the Strategic and Place levels.

### **Primary Care Forum (PCF) Triple A Report:**

The Forum helps make decisions on statutory, delegated Primary Care responsibilities for Primary Medical / Dental / Ophthalmic / Pharmacy Services, as well non-delegated local matters (e.g. Locally Enhanced Services). A tiered governance structure across the West Midlands also makes decisions at a regional level as part of the delegated decision-making process.

## **ASSURE (continued)**

PCF conversations continue around exploring how to redistribute dental activity, as guided by a Health Equity Audit, for where there are Primary Dental ‘contract hand-backs’ or under-activity of dental units being redistributed into areas of greatest need.

Members agreed that there will need to be a ‘Part B’ for the SCTC as part of its wider Strategic Commissioner role, to ensure there are no unmanageable conflicts of interest. As there will also be some Strategic Commissioning decisions made that will have to be made by ICB personnel only.

### **Conflicts of Interest (COI) Management:**

Members agreed that given the wider ethos and purpose of this committee in having ICS Partners around the table for discussions, all future activities / agenda items will see the minutes flag where there are particular conflicts that need to be both acknowledged and well managed.

There may be occasions when there is an acute conflict (i.e. financial), and a member may participate but not guide the final decision-making. Professional, non-loyalty interest based views remain welcome, but an overtly organisational view may enact a conflict, so needs to be well minuted within the relevant sections of future minutes.

### **SCTC Annual Business Cycle:**

A first draft Business Cycle was presented to the Committee as a ‘starter for ten’, high-level version which will become more focused / detailed as the SCTC moves into the real business of the Committee. The standard section headers and broad programmes of work were presented; and these would be populated with more detail in the coming months. For this meeting, the Committee were asked to approve the initial contents regarding the wider purpose of the meeting, and what the key agenda items are (i.e. sub-committee updates etc), as a live document that will develop as the Committee matures.

The Committee approved the Business Cycle whilst recognising it remains a work-in-progress.

### **System / ICB Risks & System Board Assurance Framework (SBAF):**

#### **Q3 2024-25 SBAF Report and System & ICB Risk Registers:**

Full reports were shared for information, in order to raise member awareness of the likely / expected future discussions and assurances role that SCTC will have, similarly to that of our other Committees.

SBAF 3 and 4 are of interest to this Committee in terms of meeting the System / ICB Strategic Objectives. Moving forward into March, the Board will be refreshing the SBAF, so thought needs to be given on how to align this to the Medium-Term Plan (MTP) Priorities as well as the Strategic Objectives that get agreed for next year. Renewing the SBAF will need to align the Strategic Objectives belonging to this committee.

Similarly for the assigned risks belonging to the SCTC. Especially in terms of it being proactive in regularly reviewing risks to make sure that what has been described as the intended Risk Management process becomes the actual process, given this is a new committee.

The Chair also commented that it would be good for Committee assurance going forward to know that the System Risk Register is going to Stakeholder Boards as well as coming through the ICB structure to make sure that there is close alignment on system risk and integrated management of those.

It was agreed to follow up with System Partners outside the meeting about how effective the joint risk management process is in terms of engaging operational / strategic / clinical / financial / workforce leads across organisations in our system.

### **Policies Approved:**

N/A – as no new or bespoke ICB-ICS commissioning policies have yet been tabled to the Committee for approval, under its Board-delegated powers.

### **Decisions to be Escalated to ICB Board:**

The Committee agreed that while there were none of these, and that the Meeting & ICS Leadership Compacts were well adhered to, with members given the opportunity to raise any issues on the agenda or any risks, it was reflected that the second meeting required several areas to be communicated with Teams outside of the meeting, to help the next meeting improve. These were:

- ☑ Benefit clarity – making sure we can explain how we've assessed benefits and robust Benefits Realisation processes of the papers brought to SCTC;
- ☑ Papers should be clear about the patient, family, carer experience and standard;
- ☑ Impact assessments – papers shouldn't come without these and if they don't or fail to meet standards, then they won't come to the committee;
- ☑ The importance of being absolutely clear on Partner input into papers, including writing that down within the paper and being really clear on who has been consulted, who agreed what and what process has been used;
- ☑ Timeliness of Papers – these were issued in advance of the meetings, but it was requested that all Committee Members review papers ahead of the meeting and where there are areas of particular concern this gets raised with the Lead Exec beforehand to maybe present better-formed solutions in the meeting.