

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

**Thursday 16<sup>th</sup> January 2025  
12.30pm - 2.30pm**

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

	Agenda Item	Lead(s)	Enc	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	12.30pm	
2.	Leadership Compact	Chair	Enc 01	A		3
3.	Conflicts of Interest	Chair	Enc 02	---		4-5
4.	Minutes of meeting held on 19 <sup>th</sup> December 2024	Chair	Enc 03	A		6-15
5.	Action Log - progress update on actions	Chair	Enc 04	D		16
6.	Questions submitted by members of the public in advance of the meeting	Chair	---	D	12.40pm	

**Strategic and System Development**

7.	ICB Chair and Chief Executive Update	DP/PA	Enc 05	I	12.50pm	17-25
8.	Cyber update	CI	Enc 06	I/S	1.00pm	25-32

**System Governance and Performance**

9.	Quality and Safety Report AAA Report	LT	Enc 07	I/S	1.10pm	33-35
	Quality and Safety AAA Chairs Report	JS	Enc 08	I/S	1.20pm	36-39
10.	Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report	PEJ	Enc 09	I/S	1.25pm	40-43
11.	ICS Finance and Performance Report	PB/PS	Enc 10	I/S	1.30pm	44-71
	Finance and Performance Committee AAA Chairs Report	MN	Enc 11	I/S	1.40pm	72-78
12.	People, Culture and Inclusion Committee Assurance Report	MI	Enc 12	I/S	1.45pm	79-91
	People, Culture and Inclusion Committee AAA Report	SL	Enc 13	I/S	1.55pm	92-94
13.	Staffordshire and Stoke on Trent ICB Remuneration Committee Summary and Escalation Report	SL	Enc 14	I/S	2.00pm	95-96
14.	Quarter 3 System Board Assurance Framework	CC	Enc 15	D/S	2.05pm	97-129

**Any Other Business**

15.	Items notified in advance to the Chair	All	---	D	2.15pm	
16.	Questions from the floor relating to the discussions at the meeting	Chair	---		2.20pm	
17.	Meeting Effectiveness	Chair	---			
18.	Close	Chair	---		2.30pm	
19.	<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					

# 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 07 JANUARY 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	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  
Thursday 19<sup>th</sup> December 2024  
1.00pm – 3.00pm  
Via MS Teams**

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

		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 border="0"> <tr> <td>Neil Carr</td> <td>Chief Executive, MPFT</td> </tr> <tr> <td>Baz Tameez</td> <td>Healthwatch Support Staffordshire</td> </tr> <tr> <td>Simon Constable</td> <td>Chief Executive, UHNM</td> </tr> <tr> <td>Phil Smith</td> <td>Chief Delivery Officer, ICB</td> </tr> </table>	Neil Carr	Chief Executive, MPFT	Baz Tameez	Healthwatch Support Staffordshire	Simon Constable	Chief Executive, UHNM	Phil Smith	Chief Delivery Officer, ICB	
Neil Carr	Chief Executive, MPFT									
Baz Tameez	Healthwatch Support Staffordshire									
Simon Constable	Chief Executive, UHNM									
Phil Smith	Chief Delivery Officer, ICB									
<b>2.</b>	<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 21<sup>st</sup> November 2024</b>									
	The minutes of the meeting held on 21 <sup>st</sup> November 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>									
	No questions received.									
<b>8.</b>	<b>ICB Chair and Chief Executive Update</b>									
	<p>DP presented the report and formally advised that MN has been appointed as Chair for Mid Cheshire Hospitals NHS Foundation Trust and will step down at the end of the financial year and on behalf of the Board congratulated her on her new role and wished her all the best for the future.</p> <p>DP referred to item 6.1 – Quality and Safety Strategy and acknowledged that 65% of the plan has been delivered to date and it is anticipated that 100% will be achieved by quarter four, which is a great achievement given the current pressures across the system. He personally thanked JS, HJ and the wider team.</p>									

DP referred to item 6.2 - Nursing Times Award and advised that UHNM have received the 2024 Nursing Times Award for the Care of Older People and advised that he recently had the opportunity to meet the staff and patients and congratulated them on their award.

DP highlighted that December is Disability Awareness Month and stated that initiatives will be taking place across the system, including a system wide event which took place on the 17<sup>th</sup>.

PA referred to the urgent and emergency care system and advised that there are significant pressures in the system, with a peak in covid and flu cases and advised that there is a level of infection prevention control pressure within our hospitals. He encouraged colleagues and members of the public to get their flu and covid vaccination if they are eligible. He also requested the patients make full use of the widespread facilities, with general practice being the first point of call, then 111, walk-in centres, all of which will help to minimise A&E attendance. He thanked all colleagues involved within the urgent care facilities, authority partners and voluntary sectors. DP echo the comments on behalf of the Board.

JH referred to the dental spend, which had been allocated to the system and asked why this has been drawn back. PA advised that there was instruction that all dental underspend would be held and managed centrally and due to the financial challenges across the ICBs and providers, the restriction remains and will continue to be managed centrally.

JH referred to the current pressure within the urgent and emergency centres and stated that there is an increase in absence levels, noting that some of which will be seasonal illness, but noting that some will be due to wellbeing and anxiety and asked how this is being factored into the discussions with the Investigation and Implementation (I&I) process and regional partners. PA stated that system level health and wellbeing facilities have been operating for some time and has successfully supported members of staff across the system and added that colleagues are in discussions to extend the facility beyond this financial year.

MI advised that sickness levels across the system have increased, specifically due to respiratory illnesses. She added that there will be a level of scrutiny from Deloitte's, who will attend the January People Culture and Inclusion Committee. She added that she meets Deloitte's colleagues on a weekly basis to ensure that a clear governance process is established, which will identify trends and appropriate action will then be taken.

MN referred to the urgent and emergency care data and highlighted that all types of attendance at UHNM fell by 5%, emergency admissions increased by 2% in November, but remains at 7% below the same period last year and asked what this is telling us about the pressures we face. PA advised that we have an increased pressure in relation to patients over 70, particularly the moderate to severe frailty group. He added that the medium-term plan is looking to address this directly with the community transformation work. It was agreed to bring back to the next meeting to receive an update from PS.

JR referred to the current pressures across the system and the financial challenges and asked how colleagues are we going to maintain power of esteem between mental and physical health over the next couple of years. PA advised that mental health investment is in place and stated that the Board and Board Committees will operate transparency and there will be absolute visibility on our key performance indicators in relation to mental health, learning disabilities and autism and action will be taken rapidly when required.

DP advised that there is one amendment to the report, page 6 – Elective Waits, Medefer reporting one patient (not two) breaching 65 weeks and advised that the report will be updated and will be available on the website.

**Receive the report and be assured the leadership are working on each topic as raised.**

PS

9.	<b>Specialised Commissioning Delegation</b>	
	<p>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.</p> <p>JS noted that the paper explains the process and referred to the next steps of delegating the services and making improvements for the local population we serve and asked when we can have these conversations. ED stated that within the ICB Working Group they are looking at the safe transition, technical arrangements and the potential value, all of which will be undertaken through the formal governance arrangements that exist for the delegated services. She added that as services are delegated there will be more opportunity to focus on services as the model is embedded.</p> <p>DP stated that he is grateful to David Melbourne, Chair of Birmingham and Solihull ICB, who is co-ordinating a webinar on the 28<sup>th</sup> January, for Chairs and Non-Executive colleagues, which will focus on mental health and learning disability.</p> <p><b>The ICB Board are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Be assured that the task and finish group members are actively involved with the Regional workstreams established to oversee the delivery against the delegation agreement.</b></li> <li>• <b>To be advised that Staffordshire and Stoke-on-Trent ICB have expressed an interest in option three for the contracting arrangements with regards to the management of the NHS Lead Provider Collaboratives</b></li> <li>• <b>To agree that the regional specialised commissioning reports are presented to the Strategic Commissioning and Transformation Committee once this has been established.</b></li> </ul>	<b>ED</b>
10.	<b>Medium Term Plan</b>	
	<p>PB presented the report and advised that the medium-term plan was presented at the last Finance and Performance Committee (F&amp;P) and advised that the plan comprises of two phases, firstly the creation of the medium-term model, which has been completed and supported across the system.</p> <p>PB advised that as a system we have high levels of inpatient care for our population and clinical evidence has shown that this is not leading to better health outcomes and the medium-term plan will provide an opportunity to identify what fundamental changes are required over the next five years to lead to better health care outcomes and to achieve financial balance.</p> <p>It was noted that a number of helpful conversations across the system have taken place ensuring all colleagues are aligned and to agree what is required to deliver the medium-term plan.</p> <p>ED stated that the modelling has taken place, together with highlighting the implications across the system and focus will be on the next steps and community transformation and added that focus will be on four key areas, with delivery commencing from 1<sup>st</sup> April 2025.</p> <p>Community transformation Clinical optimisation Productivity Cash efficiencies</p>	

	<p>JH thanked PB and ED for the update and stated that the plan has been delivered with links that are being highlighted from I&amp;I process and strategic focus and referred to community transformation, which requires a change in training and skills and how has this been factored into the plan. ED stated that the ambition and level of change will require a different approach from the workforce and the way the workforce works together to ensure we create an environment where this is possible. She added that there are a number of multi-disciplinary teams who are already working together, however this needs to be done on a larger scale and colleagues are looking at how we support this change, the workforce plan and strategic workforce planning and culture and conversations are taking place at the Health and Care Senate, which involves our clinical leaders.</p> <p>MI referred to the strategic workforce planning and added that Staffordshire and Stoke on Trent is in a good position as they have been working together for a number of years on a system approach to workforce and have a huge amount of knowledge. She emphasised that it will be a huge challenge and will need all partners to be involved to ensure that all organisations to work together to ensure they are aligned.</p> <p>PF thanked colleagues for the presentation and noted the clarity on the challenge ahead and the approach and referred to the significant pressure colleagues are under from NHS England in relation to the financial challenge and asked if colleagues will have the time to achieve this, given the short-term external demands. PB stated that this will be challenging and conversations will take place with the regulators and stated that colleagues will be working a pace and provided assurance that the Board will be kept informed.</p> <p>PF acknowledged that this is change for the better and we must capture and understand the benefits and impacts, together with the impacts of the risks and asked what role this Board will have in relation to visibility in regard to change and the benefits. ED stated that there will be robust governance plans in place and the emerging plan will use three sub committees of the Board, namely the Clinical Senate, Commissioning and Transformation Committee and the Finance and Performance Committee and provided assurance that there will be full transparency, oversight and decision making by the ICB Board.</p> <p>BA thanked colleagues for the presentation and stated that this is not new to mental health colleagues and referred to wanting to get things perfect, for example skills for clinicians to work in a different way, mental health colleagues have been working with more of a freedom to do things different and this message needs to get communicated to clinicians. DP agreed and acknowledged it is about a different way of doing things.</p> <p>PA thank you to the teams for all the work on this and stated that this is an exciting piece that has a massive potential, noting the underlying problem still exists.</p> <p>JR referred to the control total and stated that resources are not distributed fairly across organisations across the system. PA agreed and stated that our influence spend is restricted and have a number of providers that we commission from that are outside the area and are talking to NHS England about this.</p> <p><b>The ICB Board are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Be assured on the work undertaken to finalise the MTP mitigated model and the next steps outlined.</b></li> <li>• <b>Ratify the approval decision of the System Finance and Performance Committee.</b></li> </ul>	
11.	<b>Quality and Safety Report</b>	
	<p>HJ thanked DP for referring to the Quality and Safety Strategy within the CEO/Chair report and provided assurance that colleagues are liaising with providers, offering support where required.</p>	

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

	<p>HJ presented the report and referred to general mortality and infant mortality and stated that a system wide Mortality System Group has been established, which will use the data and take any learning from the deaths that occur with the aim to prevent further deaths. She added that work is taking place regionally regarding reducing infant mortality, a conference took place on the 3<sup>rd</sup> December, which was well attended and positive feedback has been received and colleagues are linking with all partners.</p> <p>HJ referred to harm and the Deteriorating Patient Network, which means patients whose condition is worse from when they were admitted and stated that a network has been established and regular meetings take place and regular updates are receiving regarding the Manging Deterioration Programme which includes reducing deterioration associated harm by improving the prevention, identification, escalation and response (PIER) to physical deterioration.</p> <p>It was noted that our Local Maternity Neonatal System Board (LMNS) have set up a joint learning forum with Shropshire, Telford and Wekin and is well attended by colleagues across the system including Stoke on Trent and from the Shropshire system and work together to maximise the opportunities and share learning from evolving quality improvements.</p> <p>HJ advised that CQC have visited the maternity units at UHNM and Royal Wolverhampton NHS Trust and initial feedback has been position, however there are some data requirements and these will be monitored once the draft report has been received. She added that the CQC visited the Moorlands Unit and the outcome of the inspection has been rated as “good.”</p> <p>HJ provided assurance from a quality and safety aspect and the work around the medium-term plan, colleagues are playing a very active role in the oversight of the impact of the changes.</p> <p>DP welcomed the report, in particular the quality and safety assurance in relation to the medium-term plan.</p> <p><b>The ICB Board are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Receive this report, seek clarification, and further action as appropriate.</b></li> <li>• <b>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.</b></li> </ul>	
12.	<b>Staffordshire and Stoke on Trent Health and Care Senate Summary and Escalation Report</b>	
	<p>PEJ presented the report and advised that there are no alerts to bring to the attendance of the Board.</p> <p>PEJ referred to the Advise section and highlighted the different topics that are being presented to the Health and Care Senate and highlighted the importance of the role the Health and Care Senate is playing in relation to the medium-term plan and clinical optimisation, which will lead to clinical change. He stated at the November meeting the Senate received the Integrated Medicines Optimisation Group Report and also received the Sensory Processing Needs Toolkit and position statement for approval. It was noted that the Senate was advised on ICS engagement, consultation and approval processes undertaken in the development of the two diagnostic pathways, breathlessness and upper GI. The Senate also received a presentation on prison healthcare and it was agreed that a workshop would be arranged to agree the healthcare needs of patients and create a position statement that would set out the aspirations to improve current practice.</p> <p>PEJ advised that there were no Assures discussed at the meeting.</p> <p>JH welcomed the report which provides a good assurance report and referred to the sensory needs’ toolkit designed to be used in school settings and asked how schools were involved in the design. PEJ confirmed that the Local Authorities were involved, but not sure to what extent the schools were involved and agreed to gain an update for the next meeting.</p>	PEJ

	<p>DP welcomed the reported and requested that on behalf of the Board, thanks were passed onto Rachel Gallyot, the clinical community, care community and voluntary sector who all sit under the umbrella of the Health and Care Senate.</p> <p><b>Received and noted and endorsed the recommendations within the report.</b></p>	
<p><b>13.</b></p>	<p><b>ICS Finance and Performance Report</b></p>	
	<p>PB echoed the thanks for the Health and Care Senate and stated they are helping with the development of the medium-term plan and financial plan and highlighted the importance of delivery change and having significant input for our clinical colleagues.</p> <p>PB referred to the efficiency programme, which has been a success this year and stated that the initial target was £203 million, efficiencies are growing month on month and currently there is a £33 million shortfall, but the gap is closing. However, due to the other key risks, namely the out of area contracts and the clinical re-banding, this has resulted in a £64 million deficit plan and regulators have instructed the ICB that it must break even by the end of the financial year. He alluded to the question raised early be JH regarding dental underspend and advised that this can't contribute to the deficit position.</p> <p>PB added that the I&amp;I regime is being helpful and highlighted a number of areas which they are focusing on, which include enhance controls and the verdict on our control system is that we have a "standard control", however given the extent of the financial challenge we should be at "enhanced level", so all system providers have agreed to work towards this MI is working with workforce and finance colleagues and will focus on the whole cost programme. He added that CHC remains significant challenge and as a system we remain a national outlier, work continues and are seeing significant progress being made and looking at the CHC pathway.</p> <p>PB referred to tough choices, which is being led by PEJ, in which services that are not mandatory are being reviewed to established if there are potential savings and better productivity, for example better utilisation of theatres and day case facilities.</p> <p>PB provided assurance that there is a high level of intense work being undertaking and there are daily meetings with the I&amp;I and weekly meetings with all system Chief Executives.</p> <p>PB presented the performance element on behalf of PS, which covers the whole range of performance issues. He advised that there continues to be significant concerns about ambulance holds and acute performance and continues to be an area of concerns. He was pleased to advise that UHNM has been moved out of tier one for elective cancer and diagnostic care. However, University Hospital of Derby and Burton continue to remain in two.</p> <p>DP thanked PB for the update and referred to the overview of ICB performance, in particular slide 3 overview of key performance, in which there is a growing number of red ratings, in particular relating to the mental health, learning disability and autism and asked if we could understand the reasons regarding this.</p> <p>ED stated that there are three main areas:</p> <ul style="list-style-type: none"> <li>• Perinatal services, relating to access and quality and added that there is a data reporting issue that is being investigated, additional investment has been made to increase the workforce and a working group has been established to look at this area.</li> <li>• CAMS – there is a data reporting, made some additional investment in children's and family single point of access, there are some challenges and working to improve these.</li> <li>• ADHD – national issues, have agreed an improvement plan through the Portfolio Board and provided assurance that work focuses on this as across the system.</li> </ul> <p>BA advised that the perinatal services have also been discussed at the Regional Scrutiny Meeting it is anticipated that there will see the impact of the additional investment as from February.</p>	

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

	<p>She also referred to the access to adult and stated that there is not an efficient way of capturing data, as this does not match the mental health data and it is anticipated that there will be national improvement around this and colleagues need to develop new ways of working.</p> <p>JH referred to the key matrix and compared it to the portfolio objectives report, stating you would expect that the initiatives would have an impact and asked if colleagues can we be more specific in future reports. PB agreed to take this away and do this piece of work as part of the review.</p> <p><b>The ICB Board is asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Acknowledge the high-level performance against the five priorities.</b></li> <li>• <b>Acknowledge the high-level key programme deliverables update.</b></li> <li>• <b>Acknowledge the financial position.</b></li> </ul>	<b>PB</b>
<b>Finance and Performance Committee Assurance Report</b>		
	<p>MN presented the report and provided assurance that the issues raised regarding the red performance areas are being monitored. She advised that the Committee received an update report regarding the emergency care pressures and a revised system surge update.</p> <p><b>Received and noted.</b></p>	
<b>14.</b>	<b>People, Culture and Inclusion Committee AAA Report – Part 1&amp;2 November</b>	
	<p>SL presented the report and stated that feedback has been received following the sexual safety conference and the implementation of the sexual safety charter within healthcare and advised that the whole system has signed up to the charter.</p> <p><b>Received and noted</b></p>	
<b>People, Culture and Inclusion Committee AAA Report – Part 1&amp;2 December</b>		
	<p>SL presented the report and referred to the increase in staff sickness absence and provided assurance that colleagues continue to monitor sickness absence. He referred to the staff psychology wellbeing hub and advised that discussions are taking place to review the options for extending and continuing.</p> <p>SL advised that discussions took place regarding the medium-term plan and the links to the workforce and organisational development plan and strategically thinking regarding workforce planning.</p> <p>MI provided assurance that focus continues on staff health and wellbeing. She also advised that the Committee received November data and our operational figures have increased, so we are overperforming in terms of workforce in our system, primarily bank staff, which needs to be considered in the context of our financial position.</p> <p>MI referred to the staff psychology wellbeing hub and advised that a proposal will come to the next Board meeting and highlighted the importance of having a wellbeing service across the system.</p> <p><b>Received and noted.</b></p>	
<b>People, Culture and Inclusion Committee AAA Report – Part B December</b>		
	<p><b>Received and noted.</b></p>	

15.	<b>Staffordshire and Stoke- on -Trent ICB Remuneration Committee Summary and Escalation Report</b>	
	<p>SL presented the report and advised that the Committee formally ratified the substantive appointment for the role of Chief People Officer.</p> <p><b>Received and noted.</b></p>	
16.	<b>Items notified in advance to the Chair</b>	
	<p>No items were notified to the Chair and no other items of business were raised.</p>	
17.	<b>Questions from the floor relating to the discussions at the meeting</b>	
	<p>Ian Syme referred to the Finance and Performance Committee Assurance Report and requested clarity, stating acute spend is high in the independent sector and forecast to reach £60 million and need to reduce unwarranted demand and asked, who commissions the services and what is meant by unwarranted demand. PB stated that acute means elective activity and added that there are clear clinical guidelines in place and stated that pre-covid there was strong commissioning processes in place, but this is not the case now and this forms part of the workstreams which are being reviewed. He also added that the ICB commissions the service and the activity referrals are made by the GP.</p> <p>Ian Syme referred to the urgent emergency care situation which is deteriorating at a pace and stated he attended the WMAS Board meeting yesterday, in which it was highlighted that ambulance handover data shows a deterioration in November across the whole of the West Midlands and WMAS are reporting to lose £50,000 in ambulance lost hours and referred to the CEO/Chair report in which it states cost pressures of £1.5 million regarding ambulance delays and stated he understood that NHS England were releasing £10 million to the host Black Country ICB to address the cost pressures, yet WMAS have reported a cost pressure to them of £3.2 millions and asked for clarity.</p> <p>PA advised that WMAS originally required £20 million, not £10 million, £10 million was funded from the centre, then the six ICBs from across the system collectively that this would be shared across the six ICBs across the system. Ian Syme asked if this is a cost to the ICB. PA confirmed that this is an additional cost pressure of £1.5 million for the ICB which has not been accounted for.</p> <p>Ian Syme noted that there were 7,000 ambulance conveyances to Royal Stoke last month, which is an increase on the previous months and stated that nearly half ambulances were held for over an hour, this can't be sustainable and not good for the community and added that UHNM is the second biggest hospital in the West Midlands. PA agreed to ask PS and the team to provide a response. PA advised that the system is not seen huge increase in conveyances and the daily levels of ambulances arising at Royal Stoke are what we would expect this time of year. He added that colleagues are looking at the data and stated that the additional winter capacity has been opened and the flow within the hospital has improved. He added that there is an opportunity to work with WMAS and focus on areas that we need to improve on. JR added that the Health and Social Care Overview and Scrutiny are doing to review of the last critical review, which will be a value piece of work and asked Ian Syme if he wishes to contribute to.</p> <p>Ian Syme referred to the Quality and Safety System Mortality and asked how does the enhanced role of the medical examiner slot into this group and also asked will the group be furnished with coroner prevention of future death report, as there are a significant number of patients in the southern part of Staffordshire are out of our geographical area. HJ provided assurance that the prevention of future deaths report is received by the ICB and there are arrangements in place to monitor, including those out of area. PEJ provided assurance that the ICB has always monitored hospital deaths, however since September community deaths are now included and added that the report feeds into the Mortality Group, which feeds into the regional group.</p>	<p><b>PA/PS</b></p>

	<p>Ian Syme thanked the Board for all the hard work and specially thanked MN who will be missed when she leaves at the end of the financial year. DP thanked Ian Syme for his continuous attendance and contribution.</p> <p>SF took the opportunity to promote a project looking at people’s experiences of getting support through pregnancy and the actions that are taking place at grass route level and highlighted the following links:</p> <p><a href="https://engagingcommunities.welcomesyourfeedback.net/s/h0gtb4">https://engagingcommunities.welcomesyourfeedback.net/s/h0gtb4</a>  For birthing partners <a href="https://engagingcommunities.welcomesyourfeedback.net/s/8iro3o">https://engagingcommunities.welcomesyourfeedback.net/s/8iro3o</a>  More info on our website <a href="https://www.healthwatchstokeontrent.co.uk/news/2024-09-27/share-your-experiences-perinatal-mental-health-services">https://www.healthwatchstokeontrent.co.uk/news/2024-09-27/share-your-experiences-perinatal-mental-health-services</a></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>	
	16 <sup>th</sup> January 2025 at 12.30pm – 2.30pm, 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**

Open Actions						
Agenda item	Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
8	19/12/2025	ICB Chair and CEO Update	MN referred to the urgent and emergency care data and highlighted that all types of attendance at UHNM fell by 5%, emergency admissions increased by 2% in November, but remains at 7% below the same period last year and asked what this is telling us about the pressures we face. PA advised that we have an increased pressure in relation to patients over 70, particularly the moderate to severe frailty group. He added that the medium-term plan is looking to address this directly with the community transformation work. It was agreed to bring back to the next meeting to receive an update from PS.	16/01/2025	Phil Smith	
9	19/12/2024	Specialised Commissioning Delegation	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.	20/03/2025	Elizabeth Disney	Paper will be presented at the March meeting
12	19/12/2024	Staffordshire and Stoke on Trent Health and Care Senate Summary and Escalation Report	JH welcomed the report which provides a good assurance report and referred to the sensory needs' toolkit designed to be used in school settings and asked how schools were involved in the design. PEJ confirmed that the Local Authorities were involved, but not sure to what extent the schools were involved and agreed to gain an update for the next meeting.	16/01/2025	Paul Edmondson-Jones	
17	19/12/2024	Questions from the floor relating to the discussions at the meeting	Ian Syme noted that there were 7,000 ambulance conveyances to Royal Stoke last month, which is an increase on the previous months and stated that nearly half ambulances were held for over an hour, this can't be sustainable and not good for the community and added that UHNM is the second biggest hospital in the West Midlands. PA agreed to ask PS and the team to provide a response. PA advised that the system is not seen huge increase in conveyances and the daily levels of ambulances arising at Royal Stoke are what we would expect this time of year. He added that colleagues are looking at the data and stated that the additional winter capacity has been opened and the flow within the hospital has improved. He added that there is an opportunity to work with WMAS and focus on areas that we need to improve on. JR added that the Health and Social Care Overview and Scrutiny are doing to review of the last critical review, which will be a value piece of work and asked Ian Syme if he wishes to contribute to.	16/01/2025	Phil Smith	

**Enclosure No: 05**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 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 <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 <i>If Y, are those signed off by and date:</i> 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
7. ICB Governance

<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.

### 1.0 System and general update

#### 1.1 Community Transformation

System partners met on 17 December 2024 to discuss Community Transformation as part of the Medium-Term Plan. Attendees spent time reviewing the current operating model and challenges, before receiving a presentation from Lincolnshire Integrated Care System, who have utilised a population health management approach to improve and reconfigure their services outside of an acute setting. The workshop included a demonstration of segmentation of local data, and how this can support the system to understand the needs of the population and shape services around the patient. The aims of this and the next workshop scheduled for January 2025 are to develop a core model for community transformation and determine year one (2025/2026) priorities.

#### 1.2 Primary care

##### 1.2.1 Libraries supporting more people to use NHS App

In August 2024, the NHS announced a new partnership with libraries across England to help more people access online health services, including the NHS app. This is particularly important for more deprived communities where libraries are a local hub providing access to the internet. The NHS has been working with the National Health Literacy Partnership to provide toolkits and information resources to enable them to support their service users. With 1,400 libraries across England taking part, the roll out of this support is due to be launched locally in January 2025. GP Practices are being encouraged to nominate at least one member of staff to be an NHS App Ambassador within their practice, to assist service users with using the app.

##### 1.2.2 Fibromyalgia Support Group Creative Project

Social prescribers have been working with partners in East Staffordshire to improve the experience and quality of life for people who are living with Fibromyalgia. Over the past year, the work undertaken has seen a positive impact to their lives. To raise awareness, attendees from the Fibromyalgia support group worked in partnership with Arts Organisation People Express, to create a leaflet of original poetry and prints to explain their experience of living with Fibromyalgia. The aim of the leaflet is to provide a greater understanding of the condition, and to help others who may be seeking advice and support. Feedback from the group told us that medical professionals don't always understand their condition and the impact it has on their lives. Social prescribers and partners continue to work together to provide an improved understanding of the condition and its impact.

Please find a link to the leaflet created by the attendees of the Fibromyalgia support group - [Creative Voices by East Staffs Fibro Friends by PeopleExpress CommunityArts – Issuu](#)

##### 1.2.3 Autumn and winter vaccination programme 2024/2025

GP practices, Primary Care Networks and community pharmacies have delivered 221,000 COVID-19 vaccinations and 297,000 flu vaccinations over the winter period. Vaccination is a high priority action for the NHS, to protect people from serious illness and to support the NHS and adult social care resilience. To note, people may also be eligible for other vaccinations including the pneumococcal vaccine and the Respiratory Syncytial Virus (RSV) vaccine, and details around this continues to be shared with the public. These vaccinations help protect against serious illnesses that are more common in the winter, including pneumonia. Outreach activities for COVID-19 vaccinations will continue to take place at walk-in clinics until the end of January 2025, and flu vaccinations will be available until the end of March 2025.

#### 1.3 People team

##### 1.3.1 People and Workforce Health, Wellbeing and Morale

A continued area of focus is the health and wellbeing of our workforce. Collectively, as per the latest reporting month of November 2024, there has been higher sickness absence rates, which have peaked to

their second highest rate in the last 24 months. This highlights that it is critical to understand the drivers behind sickness absence and how to positively impact this, to support our workforce and to ensure that the services provided to the population are not adversely affected.

### 1.3.2 Planning

A Medium-Term plan model has been developed, covering a 5-year period (financial year 2025/2026 – financial year 2029-2030) with the first year of this plan also informing the operational plan. Partners recognised and agreed the change in workforce models, culture and leadership required to deliver care closer to home and reduce reliance on secondary care. New roles and pathways to support our workforce to deliver these will be a priority in the Staffordshire and Stoke-on-Trent People Plan, which will be developed in line with the Medium-Term plan.

Staffordshire and Stoke-on-Trent are significantly above our planned workforce growth for 2024/2025. This primarily sits within University Hospitals North Midlands (UHNM) both in substantive and bank workforce. A detailed piece of work is being carried out to understand this growth and action plan. All of which will align with the Medium Term Plans deliverables.

### 1.3.3 Investigation and Implementation regime

Extensive discussion and consideration of the workforce position took place at the People, Culture and Inclusion (PCI) Committee, as we enter a significant delivery phase of the Investigation and Implementation regime. Work continues to identify improvement opportunities directly between providers and the Investigation and Implementation organisation.

Following a review of the current processes and procedures, there is a good operating standard of mechanisms to support workforce control. However, there is an opportunity for the rigour of these processes to be improved to enable an environment of enhanced controls, and to ensure that there is sufficient scrutiny to challenge ways of working. All stages of the recruitment pipeline are being reviewed to ensure all opportunities are considered and exhausted to deliver care safely and efficiently.

Work is also ongoing to support the productivity of our providers, in particular UHNM. The Investigation and Implementation team are also focussing on the post acute discharge pathway, determining areas for improvement within Discharge to Assess capacity and other areas closely aligned with Continuing Healthcare Care services.

### 1.3.4 Education, Training and Development

Detailed discussion took place around the challenges currently being faced in this area and how, in the next 5 years, these issues can be mitigated. Areas of focus centred around ensuring adequate student placements are available, offering flexible and rotational roles and greater involvement in curriculum development. Partners agreed to pursue actions within their own organisations to promote a systemic model of workforce utilisation to offer more flexible and peripatetic roles. It was acknowledged that this process will take several years, with a focus on the high need areas. The points raised will be considered by the Senior Responsible Officer and Programme Lead and an action plan will be developed in line with the Medium-Term plan workforce implications, the NHS Operational Plan as part of the System People Plan.

## 2.0 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. During December a refresh of the outturn position indicated an additional c£8m of unmitigated risk on top of the post-recovery deficit of £56m (due to the central decision to claw back dental funding and additional ambulance costs), therefore providing for a deficit of £64m. The national team have been clear that we must get back to break even.

The month 8 position is relatively positive with early signs of improvement to the run rate. At a system level, we are reporting a year-to-date deficit position of £29.3m, which is a £33.3m adverse variance. The year-to-date variance to plan sits within the ICB (£17.7m) and UHNM (£16.9m), with small surpluses at

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

MPFT (£0.8m) and NSCHT (£0.5m). Consequently, the month 8 variance was successfully held flat for the reporting period due to a combination of proactive management and recovery actions (detail included within the Board main finance report). Consequently, we have now covered the £8m of additional unmitigated risk, and so our forecast outturn adverse variance is £56m (before further mitigation is applied).

We continue to work with the Investigation and Intervention (I&I) team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented. The key area of focus is moving from 'standard' pay and non-pay controls as assessed by the I&I team, to 'enhanced' controls. These enhanced controls will be in place within days, and we are hopeful that consequently, the level of unmitigated risk will fall in month 9 and 10.

### 3.0 Planned Care

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

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

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

Appendix 1: Summary table of breaches

	November - Number of patients waiting		
	104+ weeks	78-103 weeks	65-77 weeks
University Hospitals of North Midlands	0	10	93
Nuffield North Staffordshire	0	0	0
Ramsay	0	0	0
Medefer	0	0	0
<b>System Providers Total</b>	<b>0</b>	<b>10</b>	<b>93</b>
<b>Out of System Providers</b>	<b>0</b>	<b>7</b>	<b>69</b>

The table in Appendix 1 shows the 104, 78 and 65 week waits for November. The November month end Referral to Treatment submission has provided the November position for both providers outside of the system and within the system. This is latest published data available. The numbers detailed are for Staffordshire and Stoke-on-Trent patients only.

### 3.2 Cancer Performance

Please note the below is the provider position, not only Staffordshire and Stoke-on-Trent patients and is taken from the published Cancer Waiting Times data.

UHNM's October position for 28-day Faster diagnosis was 75.2% against a trajectory of 76.3%.

UHDB's October position was 75%.

UHNM's October position for 31-day target was 93.1%, against a national target of 96%.

UHDB's October position was 92.3%.

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UHNM October position for 62-day combined standard was 63% against a trajectory of 65.8%.

UHDB's October position was 69.9%.

Further and ongoing actions include:

- Continued focus on clearance of the 78 week waits cohort and 65 week waits cohort.
- Understand and prepare the move towards the new 18-week referral-to-treatment performance standard.
- 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 29 December improved to just over 34 minutes, which is an improvement of 40 minutes. This was 2 seconds below plan, and placed the system 15th nationally and 4th regionally, whilst the 4-week average of 58 minutes and 40 seconds placed the system 30th out of 42 nationally, and 7th out of 11 regionally.

December's average handover time at UHNM continued to be pressured during periods of surging demand and increased from the 1 hour 42 minutes reported last month, to 1 hour and 58 minutes for the latest month. Overall, time lost due to handovers increased by 1200 hours due to increased handover delays, making the total just below 7300 hours, a position 2800 hours above plan for the month. Efforts to improve the handover performance through the Ambulance Handover trajectory yielded some improved periods during the month, however, when necessary, it was stood down, yielding an overall achievement of 49.7% of handovers within the required time. This is 15% below the plan target for December.

'All types' of attendance at UHNM increased by 3.4% for the month, which equates to little change in the per day rate. Much of the increase during this period was seen in Type 3 locations whilst Type 1 locations reported the inverse reduction equivalent to around 10 patients per day across both sites. Patients receiving their initial assessment within 15 minutes reduced by 2.6%, which is just below 60% for the months. However, there was an 8.9% increase in Type 1 attendances seen within the first 60 minutes, reversing the downward trend of the previous 2 months. Emergency Admissions via the Accident and Emergency department rose 2.9% for the month, and this was equivalent to a slight per day reduction of one less patient. When compared to the same period last year, the overall level of reduced emergency admissions equated to 6.1%, which is approximately twelve patients per day.

4-hour performance during December reduced to 62.4%, a shortfall of 6.8 percentage points against plan and a drop of 2.4 percentage points below November. Type 1 locations, under intense pressure, reported a drop in performance of 4.8 percentage points to 40.2% for the month, whilst Type 3 locations were also pressured as patients sought alternate routes to treatments, with their performance falling to 95.8%.

Unvalidated 12-hour performance degraded by 0.9 percentage points to 11.7% of attendances spending twelve hours or more in Emergency Departments, equivalent to almost 1 in every 8 attendees. The regional average for this period was 12.5%, and when compared to the same period last year, performance was 2.4 percentage points worse.

Bed Occupancy for December for both Adult General and Acute and all General Acute reduced as Covid-19 numbers began to fall. The impact of the emerging flu surge was not felt until later in the month. As such, December saw an occupancy rate of 91.5% for all General and Acute, and whilst still above plan, and 3.1 percentage points above the same period last year, it was down 1.2 percentage points on the previous month. The push to ensure patients could go home for Christmas and focus on maximising discharges to support patient flow at times of severe pressure saw reductions in all the long stay (7+, 14+ and 21+ days) cohorts.

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 December, however, anecdotal evidence

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appears to indicate increases in Pathway 1 and Pathway 2 Discharges for a second consecutive month, with Pathway 0 likely to report below 75% for the first time since last year.

Virtual Wards occupancy for the latest submission, as of 27 December, reported at the highest level since the service was implemented almost 2 years ago. Whilst the capacity of 293 remained below plan for the month, occupancy levels ensured a reported position of 80%. When split between the various sectors, the North reported an occupancy of 77%, the South-East 96%, and the South-West 48%.

At the start of December, the system declared a Critical Incident and partners worked well together to reduce the escalated metrics and return to the performance achieved for the previous six weeks. However, performance then deteriorated and UHNM went back into a Critical Incident again shortly afterwards. Whilst performance during the Christmas week improved, the position has deteriorated further over the New Year period and is being closely monitored to time.

### 5.0 Key figures from our population

	Last 4 months in current financial year				Comparator month		Change on same month previous year		
	Aug-24	Sep-24	Oct-24	Nov-24	Oct-23	Nov-23	No.	%	Direction
111 calls received	27,073	25,879	28,587	31,094					
Percentage of 111 calls abandoned	2.7%	2.1%	2.2%	2.1%					
A&E and Walk in Centre attendances (UHNM)	20,079	20,891	22,519	21,457		20,017	1,440	7.2%	↑
A&E and Walk in Centre attendances (other providers)	18,027	18,103	19,263	18,711		17,644	1,067	6.0%	↑
Non elective admissions (UHNM)	7,746	7,875	8,179	7,818		7,632	186	2.4%	↑
Non elective admissions (other providers)	6,306	6,175	6,942	6,870		6,304	566	9.0%	↑
Elective and Day Case spells (UHNM)	8,612	8,714	9,129	8,741		7,246	1,495	20.6%	↑
Elective and Day Case spells (other providers)	8,258	8,519	9,302	8,648		8,877	-229	-2.6%	↓
Outpatient procedures (UHNM)	7,723	8,097	9,258	9,054		8,296	758	9.1%	↑
Outpatient procedures (other providers)	13,047	13,904	15,295	13,089		12,818	271	2.1%	↑
GP appointments (all)	485,982	537,554	706,063	564,665		562,056	2,609	0.5%	↑
Physical Health Community contacts (attended)	145,185	148,255	160,575			140,975	19,600	13.9%	↑
Mental Health Community contacts (attended)	39,530	42,100	47,055			46,070	985	2.1%	↑

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

Most datasets are subject to change upon refresh.

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

The comparison with the same month the previous year is the same month for most measures, apart from when measures lag one month behind (e.g. Mental/ 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 NHS Improving Care Together (IMPACT)

The NHS Improving Care Together (IMPACT) is a single shared NHS improvement approach to support organisations, systems, and providers at every level, and to underpin strategic development strategy using continuous quality improvement and learning methodology. The ICB has set up an IMPACT Collaborative (working group) who have sought feedback from system partners to develop actions. These actions will support the cultural shift towards widespread adoption of consistent improvement methodology and embed the principles of the components of the NHS IMPACT framework into our management systems and processes. The Quality and Safety Committee deep dive noted the progress made in adopting a Continuous Quality Improvement (CQI) approach to making successful and meaningful change, recognising the continued growth in the CQI network which has seen a 55% growth in membership over the last twelve months.

### 6.2 Integrated Holistic Assessment Team (IHAT)

Historically, the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) has had an over reliance on the use of restrictive care practice, such as one-to-one care within both health care and social care settings. Often, the use of such care is not always evidence based and there is a lack of justification of need, or the appropriate use of alternative options such as assistive technology. To address this, the system has implemented an Integrated Holistic Assessment Team (IHAT) to address the unnecessary over restriction of care and as such, deprivation of individuals' liberties. The team has been established to promote independence, improve outcomes and enable better experience for the population served whilst ensuring safe provision of care.

The IHAT commenced in November 2024 and to date, has undertaken 65 individual reviews, with 52% of these resulting in the reduction of removal of one-to-one care following assessment. The IHAT continues to build positive relationships with care providers, healthcare professionals and family members, to ensure and promote least restrictive care for individuals. A proactive multi-disciplinary case management approach supports care providers to ensure safety through assistive technology and ongoing referrals to core services, improving quality of life and promoting independence for individuals within their own home.

### 6.3 The End of Life (EOL) pathway

The End of Life (EOL) pathway implemented in December 2023 continues to demonstrate a positive impact and experience to the resident population of Stoke-on-Trent and Staffordshire. Pre-implementation, often individuals were delayed in hospital awaiting discharge between four and eleven days for care to commence to enable them to be discharged to their preferred place of care. This was often due to capacity constraints within home care provision, or because individuals could not be supported to return home safely. Since implementation, the pathway has consistently achieved the 48-hour target for care to commence whether that be supporting a hospital discharge or admission avoidance, with on average 96% of individuals supported to receive their end-of-life care within their preferred place.

## 7.0 ICB Governance

### 7.1 New Board Assurance Committee to lead on Strategic Commissioning & Transformation

The ICB has established a new Board Assurance Committee called the Strategic Commissioning & Transformation Committee, or SCTC for short. This important committee will lead on integrating all aspects of the traditional Commissioning Cycle, and will help us respond to the emerging, national strategic commissioning policy agenda for ICBs. (Our decision to develop this predates the policy shift, arising as an outcome of last year's Governance & Partnerships Review).

The inaugural meeting took place yesterday and was chaired by David Pearson, Chair of the ICB. The ICB is currently working through the recruitment process to appoint a Non-Executive Member who will Chair the Committee.

**David Pearson, ICB Chair**

**Peter Axon, ICB Chief Executive Officer**

**Enclosure No: 06**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 2025					
<b>Title:</b>	Cyber Security Status update					
<b>Presenting Officer:</b>	Chris Ibell Chief Digital and Informatics Officer					
<b>Author(s):</b>	Sally Deacon					
<b>Document Type:</b>	Other	If Other: Status update				
<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>	Choose an item.				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	Choose an item. <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 <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
<b>Appendices:</b>	Click or tap here to enter text.					

<b>(1) Purpose of the Paper:</b>
To provide ICB with a summary status as to our Cyber Security management

<b>(2) History of the paper, incl. date &amp; whether for A / D / S / I (as above):</b>	<b>Date</b>
Cyber Crisis Simulation event	April 2024
ICB Board Development session	October 2024
Cyber Security workshop	December 2024

<b>(3) Implications:</b>
<b>Legal / Regulatory</b>
<b>CQC / Patient Safety</b>
<b>Financial (CFO-assured)</b>
<b>Sustainability</b>
<b>Workforce / Training</b>
<b>Equality &amp; Diversity</b>
<b>Due Regard: Inequalities</b>
<b>Due Regard: wider effect</b>

<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 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 type="checkbox"/>		<b>BAF8</b>	Sustainable Workforce	<input type="checkbox"/>

<b>(6) Executive Summary, incl. expansion on any of the preceding sections:</b>
The ICB Cyber Risk is significant but there are a number of actions in place to mitigate, 2025 will have a focus on the ICS Incident Response planning.

<b>(7) Recommendations to Board / Committee:</b>
Noting and awareness

# Cyber Security Status Staffordshire, Stoke-on-Trent ICB



# NHS Cyber Strategy

## Context

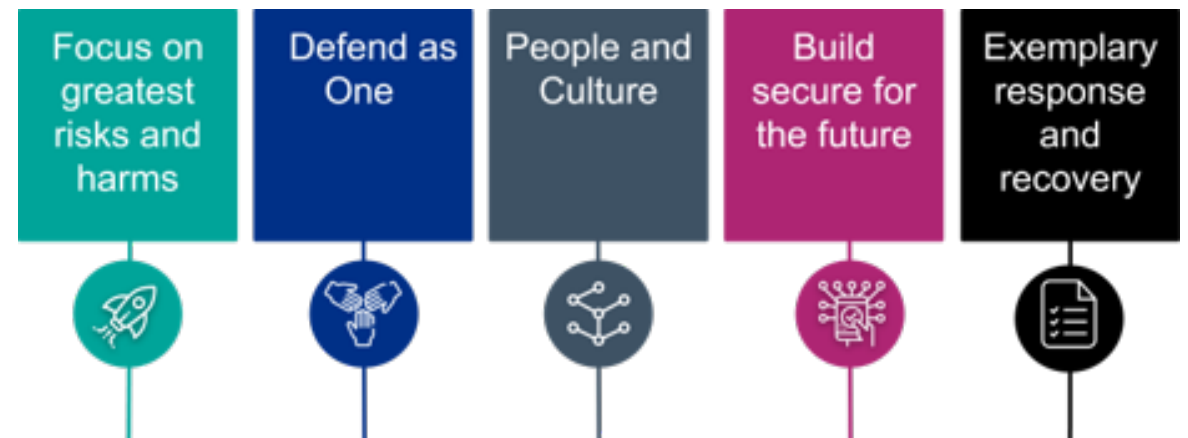
- Increased cyber-attacks on UK public sector including supply chain
- Increased reliance on digital solutions means increased risk of impact on clinical service resilience – **‘when, not if’** – need to be prepared
- Arrowe Park Hospital, Clatterbridge and Wirral Teaching Hospital (Nov 2024), Advanced (Adastra and Carenotes), Synnovis (Guys & St Thomas) and Global CrowdStrike issue are recent examples of significant impact to Health services as a result of cyber or system failure



## Increased national focus

- Department of Health and Social Care: Cyber Security Strategy to 2030
- Data and Security Protection Toolkit focus on Cyber Assessment Framework (CAF) from June 2025
- Focus on Cyber resilience and response within EPRR Core standards from 2024

### Cyber Security Strategy for Health and Adult Social Care 2023-2020 - 5 pillars



# What Good Looks Like Framework

## Safe Practice obligations for each ICS:

- Have a system-wide plan for maintaining robust cyber security, including development of centralised capabilities to provide support across all organisations
- Establish a process for managing the cyber risk with mitigation plans, investment and progress regularly reviewed at ICS level
- Have an adequately resourced ICS-level cyber security function, including a senior information risk owner (SIRO) and data protection officer (DPO)
- Ensure that you fully use national cyber services provided by NHSE
- Ensure the organisations in your ICS are supported to comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Assessment Framework.

# We have an ICS Cyber Strategy

- Cyber security is a priority for the ICS and its member organisations. It requires considerable time and resources to maintain an acceptable level of risk
  - It is entered in the ICB BAF as a high risk
- Increasing national expectation that ICS's will collaborate on cyber challenges, with ICB providing assurance
- It is a national requirement and covers up to 2030
  - Draft submitted
  - Final by 31 March 2025
- Using the ICS Cyber Security Group (includes NHS and Council Partners) as consultees.

**The Strategy confirms ICS key areas of focus and collaboration on Cyber security.**

# Our Digital Deliverables for Cyber

Our model is an **integrated ICS model** for the management of cyber security, through our **ICS wide Security Operations Centre (SOC)**.

- In operation 24/7 supporting Staffordshire Council, MPUFT, UHNM, NSCHT and Stoke Council
- The ICS SOC runs standardised vulnerability scanning and patching service
- Conducts Gap Analysis to Identify Areas for Improvement
- Standardised Reporting Metrics
- The SOC user group consists of all partners and enables knowledge sharing and standardisation of operation.

# Incident Response planning

Cyber-attacks can have significant impacts on our services to patients and how our clinicians and operations teams deliver these services

- NHSE Cyber Simulation Event identified 22 actions
  - Most actions relate to ICS processes and plans
- We have coordinated IG, EPRR and Digital/Cyber colleagues across the ICS to address actions and continue to embed an ICS approach to threat mitigation and incident response.
- The incident response approach builds upon existing organisational plans, DSPT submissions and EPRR system and regional plans.

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 2025					
<b>Title:</b>	Quality and Safety Report					
<b>Presenting Officer:</b>	Lynn Tolley, Assistant Chief Nursing and Therapies Officer					
<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 <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
<b>Appendices:</b>	Appendix A: Quality and Safety Report – Detail January 2025.					

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

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

<b>(3) Implications:</b>	
<b>Legal or Regulatory</b>	Risks identified and managed via the Board Assurance Framework and Corporate Risk Register.
<b>CQC or 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 or Training</b>	Details contained within the report relating to providers by exception.

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<b>Equality &amp; Diversity</b>	Details contained within the report.
<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.

### (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, Approved by QIA Panel 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 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 checked="" 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"/>

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

The System Quality Group and Quality and Safety Committee were not scheduled to meet in January 2025; this report is intended to highlight immediate emerging matters. The committee business cycle recommences in February 2025 and all escalations will be discussed.

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

Members of the Integrated Care Board are asked to:

- Receive this report, seek clarification, and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.
- Ratify the decision of the Quality and Safety Committee with regards to: Continuous Quality Improvement Framework.

<b>ALERT</b>
None.
<b>ADVISE</b>
<ul style="list-style-type: none"> <li>○ The Darwin Centre has been moved into level 3 oversight by the West Midlands CAMHS (Child and Adolescent Mental Health Service) Provider Collaborative. Representatives from the ICB’s quality team, North Staffordshire Combined Healthcare NHS Trust and the Collaborative met in December 2024 and an improvement plan is in place, which will be overseen by the Collaborative, who are regularly visiting both announced and unannounced. A further meeting is scheduled to take place at the end of January 2025.</li> <li>○ As part of the ongoing monitoring of the impact of pressures in the urgent care system, the Nursing and Therapies Directorate are working alongside provider colleagues and neighbouring systems to ensure and support the prioritisation of patient safety matters for all patients.</li> <li>○ The ICB quality team are focused on supporting University Hospital of North Midlands NHS Trust to undertake harm reviews for all 8-hour ambulance handover delays and long-waits within the emergency department and identify any learning to maintain standards in the quality of care. During this period of sustained pressure on the urgent and emergency care system and to ensure that staff are not diverted from delivering healthcare, the ICB’s nursing and therapies directorate have offered to support the completion of these reviews. Discussions are also scheduled at NHS England Midlands’ Regional Quality Group in January 2025 to share learning between systems.</li> </ul>
<b>ASSURE</b>
<ul style="list-style-type: none"> <li>○ System Quality Group / Quality and Safety Committee were not scheduled to meet in January 2025; this report is intended to highlight immediate emerging matters. The committee business cycle recommences in February 2025 and all escalations will be discussed.</li> </ul>

<b>System-ICB Risks &amp; Board Assurance Framework (SBAF):</b>
No Risks or SBAF reports presented this month.

<b>Decisions to be Escalated to ICB Board:</b>
Quality and Safety Committee (December 2024) approved the ICB’s Continuous Quality Improvement Framework. Details were shared in the report to Board in December. The Board are asked to ratify the decision of the Quality and Safety Committee.

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

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>16<sup>th</sup> January 2025</b>
<b>Reporting Committee:</b>	<b>Quality and Safety Committee (QSC)</b>
<b>Date of Meeting:</b>	<b>11 December 2024</b>
<b>Meeting Quorate Y/N?</b>	<b>YES</b>
<b>Presenter:</b>	<b>Josie Spencer, Non-Executive Director &amp; Committee Chair</b>
<b>Author:</b>	

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

**ALERT**

**System Quality Group Report**

The Committee received an overview of the System Quality Group (SQG) meetings in November and December with partners from across health, social care, and the wider ICS in attendance.

The Committee was alerted to the ED harm review process. The terms of reference and process for UHNM had been reviewed and agreed, although now superseded by NHSE requests. The ICB were advised that Queen's Hospital Burton have a different process monitored by Derby and Derbyshire ICB and will feed into the SSOT ICB harm review meeting by providing information through the Clinical Quality Review Meeting. Concerns were raised by members and the committee supported a new risk for the risk register.

The committee was alerted to the sustainability of the Paediatric Dietetic Service. MPFT had closed the service for enteral feeding referrals. This has now re-opened, however the committee was concerned as this was due to the recruitment of locums. UHNM are undertaking a three-month service review and have interim actions in place.

**ADVISE**

**Intensive and Assertive Community Mental Health Care Treatment Review & Plan**

The committee received a report and presentation which gave an overview of the review and plan.

An away day was held in November 2024 attended by all relevant partners and clinical agreement was obtained on the action plan and alignment of pathways.

NSCHT have established four task and finish groups with dedicated operational and clinical leads with specific timeframes. MPFT have a governance structure in place and have established a number of workstreams to support the plan.

A model for a seven-day assertive outreach and intensive support team was submitted to NHSE in mid-November.

Next steps include focussing on actions within the task and finish groups, strengthening the MDT culture across all teams, and updating SOPs to ensure alignment with NHSE principles. A further away day is planned for February 2025.

The committee will receive a presentation to the deep dive session in March 2025 on the progress and implementation of the action plan.

The committee accepted the recommendations within the report.

### **Perinatal Quality Surveillance**

The committee received an update on maternity and neonatal services accessed by women and babies from Staffordshire and Stoke-on-Trent.

From the 1<sup>st</sup> of November 2024 the Local Medical Committees have served notice and confirmed that GP practices across Staffordshire and Stoke-on-Trent will stop prescribing antenatal prescriptions or acting on investigations for pregnant women in the community setting. Mitigations have been put in place by UHNM. System meetings are in place to provide updates on the GP collective action and allow partners to escalate concerns and any impacts.

Due to the high rates of infant mortality across the system a joint OHID (Office for Health Improvement & Disparities) and NHSE supportive system review is planned. An infant mortality conference took place on the 3<sup>rd</sup> of December and an action plan is being developed

## ASSURE

### **Continuous Quality Improvement (CQI) Framework**

The committee received the CQI Framework for approval.

The framework sets out a vision that CQI will be an integral part of the business-as-usual approach and will underpin the delivery of strategic plans to provide high quality health and care aligned to NHS IMPACT. This will involve a cultural shift towards the widespread adoption of a consistent improvement methodology. The framework also commits the ICB to actions that will realise its vision. It is recognised there are differing levels of training, skills and experience across the ICB, and a pick list of training opportunities will be provided to ICB staff.

The committee was assured by the update received and **approved the Continuous Quality Improvement Framework.**

### **SEND Quality Assurance Framework – Quality Assurance Methodology**

The committee received the Quality Assurance Methodology for approval.

The quality assurance methodology had been drafted and agreed by the Staffordshire Children's Joint Commissioning Board. A phased approach is being taken with two main activities, a self-assessment process and implementation of a peer-review process.

The committee was assured by the update received and **approved the Quality Assurance Methodology.**

### **VCSE Alliance Memorandum of Understanding (MOU)**

The committee received the MOU for approval.

The MOU was first agreed in December 2022 and was revised following evaluation of its effectiveness and transfer of funding arrangements to the Health Inequalities budget.

The committee was assured by the update received and **approved the VCSE Alliance Memorandum of Understanding (MOU).**

### **People & Communities Assembly**

The committee received an update and were assured on the key achievements between August and December 2024, and the key actions for December 2024 – March 2025.

A discussion took place on risks and blockers including not engaging with seldom heard communities and managing public expectations within a financially constrained system. The committee requested more detail on how these are being managed in the next update. The committee heard how leads from the LeDeR programme, Maternity & Neonatal Voices Partnership (MNVP), and Patient Safety Partners are working together to engage with seldom-heard groups.

### **All Age Continuing Care**

The committee received an update and were assured on the progress that is being made in relation to All Age Continuing Care.

Achievements since August 2024 include:

- Reduction in sickness rates.
- Mandatory training and appraisal compliance remain positive.
- Active caseloads for continuing healthcare (CHC), funded-nursing care (FNC), fast-track and joint funding continue to reduce.
- A refreshed CHC Joint Operational Protocol was approved at both Staffordshire and Stoke-on-Trent Joint Commissioning Boards.
- Creation of an Integrated Holistic Assessment Team (IHAT) to look at restrictive care packages.

### **Infection, Prevention & Control (IPC)**

The committee received an update on infection, prevention and control activities across the system.

There has been an increase in the number of E. coli cases in quarter 2 compared to the same period in 2023/24. Assurance was provided the IPC team are monitoring this.

Adult emergency screening for sepsis underperformed against the August 2024 target, with 85% achieved. Fifty-nine cases were audited which revealed nine missed screenings in emergency portals. A standalone report on this is being planned.

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

No SBAF report was presented this month.

**(1) December System & ICB Risk Registers**

The Committee received and noted the System and ICB Risk Register Reports. For the ICS Risks there are **7 high scoring** risks; for the ICB Risks, there are **2 high scoring** risks.

The Committee discussed the high-scoring risks where status has remained static for some time, acknowledging that mitigating actions should be reviewed as required. There was a discussion around System Risk 1430 (Inadequate provision of Epilepsy Nurse Specialists) as well as System Risk 1238 (Paediatric Audiology) and the Committee was assured that further mitigating actions will be added to both System Risks. The Committee members agreed that the System Risk 1179 (Children and young people delayed discharges from Tier 4 hospitals) will need to be clarified further, split into two separate risks, and fed back to the Committee.

The Committee:

- approved the closure of the System Risk 1247 (Contractual Notice to CSU served risk to workforce stability);
- approved the addition of the new System Risk 1430 (Inadequate provision of Epilepsy Nurse Specialists);
- **did not approve the transfer of the ICB Risk 1236 (Wheelchair Service) to the Directorate Issues Log and instead agreed that the risk must be continuously monitored and managed by the Quality & Safety Committee and should remain in the ICB Risk Register as an enduring risk.**

**Policies Approved:**

None discussed.

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

- The Quality & Safety Committee approved the Continuous Quality Improvement Framework
- The Quality & Safety Committee approved the SEND Quality Assurance Framework – Quality Assurance Methodology
- The Quality & Safety Committee approved the VCSE Alliance Memorandum of Understanding

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

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>16<sup>th</sup> January 2025</b>
<b>Reporting Committee:</b>	<b>Staffordshire and Stoke-on Trent Health and Care Senate (Senate)</b>
<b>Date of Meeting:</b>	<b>12<sup>th</sup> December 2024</b>
<b>Meeting Quorate Y/N?</b>	<b>Yes</b>
<b>Presenter:</b>	<b>Paul Edmondson-Jones, Chief Medical Officer</b>
<b>Author:</b>	<b>Rachel Gallyot, Deputy Chief Medical Officer</b>

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

**ALERT**

None discussed.

**ADVISE**

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

The Senate received the highlight report which provided a summary and rationale of the key decisions from the Integrated Medicines Optimisation Group (IMOG) that took place on 4<sup>th</sup> September 2024.

- There were 3 NHSE funded NICE TAs all of which were specialist drugs recommended on the formulary for specialist prescribing only. There were 3 ICB funded NICE TAs, 2 of which were specialist drugs recommended for specialist prescribing only. Vibegron for treating symptoms of overactive bladder syndrome is recommended as GREEN on the formulary as it has similar properties to an existing drug (mirabegron) which is widely prescribed in primary care.
- The Melatonin Factsheet was revised to include children and adolescents and 'those transitioning into adulthood'.
- A generic version of Champix is now available and, the previously discontinued, Champix has been removed from the formulary and replaced with the new version, categorised RED for prescribing in specialist smoking cessation services only.
- The change of categorisation of Oral Nutritional Supplements (ONS) to AMBER-R has been fast tracked and is for specification by a dietician and for the patient to be reviewed and identified when ONS should be ceased.

In response to questions/comments raised by the Senate, the following clarification points were made:-

- The governance process for MPFT to progress the ONS pathways is booked for mid-January/beginning of February and the ICB will continue to support the ongoing process, and with any issues arising, after the 'go live' date of 27<sup>th</sup> January.
- There is prescribing support software available to support the AMBER-R rating and work is being undertaken to ensure that referrals to dietetic services are appropriate, as well as around highlighting the importance of the primary care element, with appropriate reviews and promotion of Food First, ahead of any referrals to dietetic services.
- There are links with Local Authority colleagues and a care homes forum, and the policy and guidance will be available, via the care homes MIDAS platform, along with some supporting national guidance. Engagement meetings are being arranged, to implement the training and education element for social care, and links have been strengthened with Support Staffordshire, and the social prescribing element, as well as with link workers who support with the discharge process.

- Clarification was provided that the Senate is being asked to approve the medicines decision, made by IMOG that, based on evidence ONS can be rated as AMBER-R.

The Senate **approved** the decisions summarised in the paper (a to d) and detailed in the Committee Report and IMOG minutes from the meeting held on 2<sup>nd</sup> October 2024.

## 2) Healthy Ageing and Frailty Strategy

The paper was taken as read. Farah Kidy delivered a presentation to the Senate titled 'Healthy Ageing and Frailty Strategy 2025-2030'. In response to questions/comments raised by the Senate, the following clarification points were made:-

- The aim of the Strategy is to align services, and the ongoing evaluation will help inform how services are developed.
- Delivery will be the responsibility of different portfolios, and pieces of work, and the next stage is the development of an action plan to delineate some of those responsibilities.
- The importance of prevention is agreed and has been the focus of the strategy group.
- Concerns were raised regarding the length of time, and level of expertise required, to complete the Comprehensive Geriatric Assessments (CGAs). The CGA is the only evidence-based intervention, which allows people to live more independently outside hospital, and for longer in their own homes, and there is evidence that CGAs undertaken in the community are also very effective, if interventions are implemented. It is accepted that undertaking CGAs properly will require more resource.
- A lot of resources need to be combined, to reduce duplication, variation and to increase the efficiency of resources in the system.
- The strategy will link into the Life Course approach, contained within the Integrated Care Partnership Strategy, which will address the broader prevention discussion, from an earlier age.
- There are a lot of interrelations, and complexities, when managing healthcare of older people, including links between falls with various drugs prescribed for primary prevention, which may not have a lot of benefit to the patient, as well as links with falls, eyecare and hearing aids.

The Senate **approved** the Healthy Ageing and Frailty Strategy and were assured about the public and patient involvement.

## 3) All Age Respiratory Strategy

The paper was taken as read. Farah Kidy delivered a presentation to the Senate titled 'All Age Respiratory Strategy 2025-2030'. In response to questions/comments raised by the Senate, the following clarification points were made:-

- Issues around data coding were discussed. The Senate were asked to recognise the importance of general practice data and of the digital strategy.
- Secondary care activity is lost due to there not being a requirement to code the patient diagnosis, just the attendance at the outpatient's appointment.
- The importance of focusing on the outcomes was highlighted and that empowering patients to manage their conditions requires ongoing education for healthcare professionals. The plans for this, and holistic approach, are written in the strategy.
- The scientific/evidence basis for the strategy regarding a specialist touchpoint for pneumonia patients was supported.

The Senate **approved** the All Age Respiratory Strategy and were assured about the public and patient involvement.

## 4) Development of Diagnostic Pathways

The Breathlessness and Upper GI pathways were last presented to the Senate on 14<sup>th</sup> November 2024 and, following feedback from a confirm and challenge exercise, held at University Hospital of North Midlands (UHNM), the following amendments have been made:-

Breathlessness:

- The addition of the frequency, quantity and colour of sputum.
- The separation of alternative diagnosis and cardiac aetiology.

Upper GI:

- Clarification that patients with suspected gallstones should be sent straight to ultrasound.

No further changes were made since the pathways were last presented.

The Senate **approved** the Breathlessness and Upper GI pathways.

### 5) Lower Back Pain Guidance

The paper was taken as read. Gary Free provided a verbal update:-

- SSOT is a high spender in relation to MRI scanning for low back pain.
- An audit has demonstrated that around two thirds of MRI scans did not need to be undertaken in primary care.
- The guidance provides indications for imaging in primary care and was developed with imaging colleagues and colleagues from MPFT.
- Changes to national guidance, in relation to cauda equina, have been incorporated into the guidance, which states that patients, with stable cauda equina, should be seen by urgent MSK services, rather than attending ED.
- The guidance clarifies that most people with back pain, and unilateral neurological symptoms, should be referred into, and managed by, MSK interface services.
- SSOT is an outlier in opioid and gabapentin usages, so the guidelines promote usage of weaker opioids, anti-inflammatories and only using gabapentin when indicated, for nerve pain.

In response to questions/comments raised by the Senate, the following clarification points were made:-

- The guidance is based on NICE guidance, and national guidance, and was developed with colleagues from MSK interface services, specialist spinal physiotherapy teams, from within MPFT, and imaging colleagues, from UHNM.
- Concerns were raised about capacity within the MSK services and that extending the pathways might lead to people seeking help elsewhere. Clarification was given that there is a requirement for 3-6 months of physiotherapy treatment, before a scan is considered, apart from in the case of cauda equina. The presenter also had concerns regarding capacity for referrals, for stable cauda equina within MSK services, however, the services assure that they do have capacity.
- The reduction of usage of gabapentin and opioids was supported by the Senate.
- Discussions were held regarding work needed with colleagues around red flag symptoms not necessarily being a spinal cord problem or syndrome and that, whilst desirable, the ability for GPs to be able to refer directly to neurosurgery is difficult, as it requires 24-hour MRI scanning, which is limited in SSOT.
- The importance of the wider general practice workforce having access, to the full diagnostic pathways, was highlighted as there have been some restrictions for some of the ARRS and ACP roles in accessing diagnostics, even at the most basic level.

The Senate **approved** the Lower Back Pain guidance.

### 6) Medium Term Plan – Mitigated Modelling

The paper was taken as read. The Senate received an update regarding the current financial position and the work being undertaken on the mitigated model.

- There is a requirement for exceptionally strong leadership and the combination of clinical, operational and financial leadership is helping to drive the next steps and development of the plan.
- The plan will need to be delivered from 1<sup>st</sup> April so, currently, the priorities for community transformation are being determined and engagement will be undertaken with the Senate, along with utilising the data to understand, and develop, the work that is already underway around clinical value and clinical optimisation

In response to questions raised by the Senate members the following clarification points were received: -

- The Senate highlighted the importance of what is driving the data in terms of the system being an outlier.

- The Senate highlighted that it is important to focus on the opportunity, as clinical and professional leadership, to make a difference in health outcomes, in SSOT, over the next 5 years and there was a plea for colleagues to be positive about the challenge ahead.
- Discussions will be held between RG, PB and ED around how to progress the Senates involvement but there was overall support for the way forward and a commitment from the Senate to support the plan.

The Senate were **assured** on the work undertaken to finalise the MTP mitigated model, and the next steps outlined. The Senate **approved** the model and underpinning assumptions as the basis for the development of the MTP. The Senate offered their support and commitment to have a dedicated session in the New Year.

#### 6) Demand Management Collaborative

Duane McLean provided a verbal update regarding the objectives, progress and the future focus of the Demand Management Collaborative.

In response to questions raised by the Senate members the following clarification points were received: -

- The Senate highlighted that proactive care is required for care homes and asked how the approach would be different this time. Leadership will be key in ensuring the joining up of different parts of the agenda, reducing duplication and ensuring that services are co-designed with care home users. Learning can be undertaken from other systems including Leicester, who are supporting care homes, and frailty patients in their own homes, with consultant call before you convey. It was accepted that this would require investment, or resources, to support, however, it is creating the right environment for 'invest to save' schemes.
- The Senate highlighted that the data in the earlier frailty strategy demonstrates that SSOT is an outlier in many ways.
- Demand management is about looking after people in appropriate settings and is patient focused. There is a need for the system to consider a collaborative community geriatrician offer, as there is a gap for patients in the SSOT.
- There is an upcoming community transformation meeting where some of the discussions around investment and spending funding in the right areas might start to be addressed.

The Senate **received** the Demand Management update.

### ASSURE

None discussed.

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

The Senate receives the SBAF and Risk Register, for information, in October and May.

#### **Policies Approved:**

None discussed.

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

- The H&C Senate approved the decisions summarised in the Integrated Medicines Optimisation Group (IMOG), October 2024 report;
- The Senate approved the Healthy Ageing and Frailty Strategy.
- The Senate approved the All Age Respiratory Strategy.
- The Senate approved the Breathlessness and Upper GI pathways.
- The Senate approved the Lower Back Pain guidance.

**Enclosure No: 10**

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 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 & 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 8 finance position.

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

	<b>Date</b>
System Performance Group (I)	18/12/2024
System Finance and Performance Committee (S,D)	07/01/2025

**(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

<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

<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>The report was discussed at the System Finance and Performance Committee (SFPC) on the 7th January 2025.</p> <p><u>Performance</u></p> <ul style="list-style-type: none"> <li>Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented. No formal escalations were presented via the System Performance Group (SPG).</li> <li>Within Planned Care it was noted within Diagnostics, performance is ranked 38 out of 42 Integrated Care Boards (ICBs). The most significant issue is within the modality of None Obstetric Ultrasound, which has the highest volume of tests across all modalities. There are long term workforce challenges that are being partially covered by additional short term external capacity that should help to recover the position.</li> <li>Recognition that Urgent Care and Planned Care have a good focus and understanding.</li> <li>Key performance metrics in Mental Health, Learning Disabilities &amp; Autism and the number of red metrics were noted. While some metrics are such as Eliminating Out of Area Placements (OAPs), may be volatile due to low numbers, the high financial cost implications of OAP were also noted. The programme escalations around the Care Homes delivery programme, the 24/7 Advice Line Case for Change (an End of Life (EOL) programme) and the severe frailty service re-design were acknowledged by the committee. These areas will be addressed in more detail through specific portfolio updates to SFPC in February and March meetings to gain deeper insights into the underlying issues and mitigating actions.</li> </ul>

### Finance

- The system is not currently in line to achieve the 2024/25 financial plan. We are formally required to forecast a breakeven position, but after 8 months we now have a deficit of £33.3m. We have assessed that we need further savings of at least £56m to eliminate this cumulative deficit and meet cost pressures associated with the high demand on services.
- That said, the month 8 position is relatively positive with early signs of improvement to the run rate.
- The year-to-date variance to plan sits within ICB (£17.7m) and University Hospitals of North Staffordshire (UHNM) (£16.9m), with small surpluses at Midlands Partnership University NHS Foundation Trust (MPFT) (£0.8m) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) (£0.5m).
- We continue to work with the Investigation and Intervention (I&I) team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented. The key area of focus is moving from 'standard' controls as assessed by the I&I team, to 'enhanced' controls. These enhanced controls will be in place within days, and we are hopeful that consequently, the level of unmitigated risk will fall in Month 9 (M9).
- The reported system efficiency based on M8 information is now assessed to outturn at £179.9m, which equates to 88.5% delivery against the annual efficiency plan of £203m. Furthermore, there remain some risks to the delivery of the £179.9m forecast which is being worked on by the Recovery Director and the system.
- The system workforce numbers (substantive + bank + agency) were 24,704 in March. Although these numbers dropped at the start of this financial year, they are now above the March numbers and are currently (end of November) 24,748. Within that we have achieved a reduction in agency equivalent to 288 Whole Time Equivalents WTE's).
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS16) compliant against the allocations.

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

The Integrated Care Board is asked to:

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

# Performance and Finance Report

16<sup>th</sup> January 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 October 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 8 position.

## Discussion from System Finance and Performance Committee (SFPC) on the 7<sup>th</sup> January to note:

### Performance

- Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented. No formal escalations were presented via the System Performance Group (SPG).
- Within Planned Care it was noted within Diagnostics, performance is ranked 38 out of 42 Integrated Care Boards (ICBs). The most significant issue is within the modality of None Obstetric Ultrasound, which has the highest volume of tests across all modalities. There are long term workforce challenges that are being partially covered by additional short term external capacity that should help to recover the position.
- Recognition that Urgent Care and Planned Care have a good focus and understanding.
- Key performance metrics in Mental Health, Learning Disabilities & Autism and the number of red metrics were noted. While some metrics are such as Eliminating Out of Area Placements (OAPs), may be volatile due to low numbers, the high financial cost implications of OAP were also noted. The programme escalations around the Care Homes delivery programme, the 24/7 Advice Line Case for Change (an End of Life (EOL) programme) and the severe frailty service re-design were acknowledged by the committee. These areas will be addressed in more detail through specific portfolio updates to SFPC in February and March meetings to gain deeper insights into the underlying issues and mitigating actions.

### Finance

- The system is not currently in line to achieve the 2024/25 financial plan. We are formally required to forecast a breakeven position, but after 8 months we now have a deficit of £33.3m. We have assessed that we need further savings of at least £56m to eliminate this cumulative deficit and meet cost pressures associated with the high demand on services.
- That said, the month 8 position is relatively positive with early signs of improvement to the run rate.
- The year-to-date variance to plan sits within ICB (£17.7m) and University Hospitals of North Staffordshire (UHNM) (£16.9m), with small surpluses at Midlands Partnership University NHS Foundation Trust (MPFT) (£0.8m) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) (£0.5m).
- We continue to work with the Investigation and Intervention (I&I) team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented. The key area of focus is moving from 'standard' controls as assessed by the I&I team, to 'enhanced' controls. These enhanced controls will be in place within days, and we are hopeful that consequently, the level of unmitigated risk will fall in Month 9 (M9).
- The reported system efficiency based on M8 information is now assessed to outturn at £179.9m, which equates to 88.5% delivery against the annual efficiency plan of £203m. Furthermore, there remain some risks to the delivery of the £179.9m forecast which is being worked on by the Recovery Director and the system.
- The system workforce numbers (substantive + bank + agency) were 24,704 in March. Although these numbers dropped at the start of this financial year, they are now above the March numbers and are currently (end of November) 24,748. Within that we have achieved a reduction in agency equivalent to 288 Whole Time Equivalent WTE's).
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard (IFRS16) compliant against the allocations.

Ctrl and click on any underlined text for further detail

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

1

2

Eliminate delays in access to treatment and long waits for care				
Urgent and Emergency Care		Planned Care		
Category 2 Response target < 30m	5min 23sec ▲	Cost Weighted Activity. National published data. Position to August 2024	11.8%	▲
Accident & Emergency 4-hour wait (78% target by March 25) (UHNM) (November)	-5.8% ▼	Elective Activity - Daycases	6.1%	▼
Adult General & Acute (G&A) bed occupancy ≤92% (UHNM) (November)	4.1% ▼	Elective Activity - Ordinary Elective	-4.3%	▲
Utilisation of Virtual Wards (target 80%) (ICB) (November)	-9.4% ▼	Elective Activity - Outpatient Procedures	11.2%	▼
Ambulance Hours lost due to Handover delays > 15m (UHNM) (November)	1910 ▼	Elective Activity- Outpatient First Appointment	5.1%	▼
12 hour in Emergency Department Performance (UHNM) (November)	10.8% ▼	% Outpatient attends for first appointments or follow-up appointments with a procedure	2.6%	▲
Mental Health, Learning Disabilities & Autism		Reduction in Outpatient Follow-up against 2019/20 baseline	14.4%	▲
Learning disability registers and annual health check (November)	0.5% ▲	Eliminate 65 week waits by September 2024	256	▼
Improve access to perinatal mental health services	-8.3% ▲	Increase theatre utilisation (85% UHNM)	-10.4%	▼
Improve access to Children and Young People Mental Health services	-7.4% ▲	Cancer 28-day Faster Diagnosis (77% target by March 2025)	0.2%	▲
Improve access to Transformed Adult Mental Health services (Sep)	-7.3% ▼	Cancer 62-day pathways % seen within 62 days (target 70% by March 2025)	-1.0%	▼
Access to a course of Talking Therapy	7.3% ▲	Cancer non-specific pathway	4.9%	▼
Mean week wait to start autism assessment (North: CYP)	74 ▼	% of lower GI suspected cancer referrals with Faecal Immunochemical Test result (Aug-24)	-23.7%	▼
Mean week wait to start autism assessment (South: CYP)	16 ▼	Community Bed occupancy rate	-0.4%	▼
Mean week wait to complete autism assessment (North: CYP)	81 ▲	Primary Care		
Mean week wait to complete autism assessment (South: CYP)	57 ▼	Dental Activity delivered (Q2)	-1.6%	▼
Children & Young People (CYP)		Medicines Optimisation		
Reduce CYP in residential care outside Staffordshire (November)	-15.7% -	Pharmacy First Provision – number of interventions (May)	8,086	▲
Reduce CYP in residential care outside Stoke-on-Trent (November)	1.2% ▼			

Improving access to high quality, sustainable primary care		
Primary Care		
General Practice Appointments	9.6%	▲
General Practice Appointments in <2 weeks (85% target)	5.6%	▼
Additional Role Reimbursement Scheme Full Time Equivalent (Q2)	12.9%	▼
Workforce: GP Full Time Equivalent (Q2)	3.1%	▲
Planned Care		
Deliver increased diagnostic activity levels	9.8%	▲
Patients that receive a diagnostic test within 6 weeks (target)	-13.8%	▲
Mental Health, Learning Disabilities & Autism		
Recover the dementia diagnosis rate to 66.7% target	1.9%	▼

TRAFFIC LIGHT KEY	
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 Key ICB Performance October 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 (November)	5 ▲	Reduce emergency admissions for epilepsy (flat activity)	-70% ▼
Talking Therapy Reliable Improvement (67% target)	4.8% ▼	Reduce emergency admissions for asthma (flat activity)	-77% ▼
Talking Therapy Reliable Recovery (48% target)	2.4% ▲	Maternity and Neonates	
Severe Mental Illness health checks (Q2)	2.3% ▼	Stillbirth rate (UHNM only)	4.1 ▼
Learning disability & Autism reliance on inpatient care (Adult) (November)	3.8% ▼	Neonate Mortality rate per 1000 (UHNM only)	2.1 ▲
Learning disability & Autism reliance on inpatient care (CYP) (November)	50.0% ▬	Brain injury rate per 1000 (UHNM only)	2.1 ▲
Learning Disability and/or Autism Mortality Reviews (100% target) (November)	-17.0% ▼	The % of full - term babies admitted to a neonatal unit (UHNM only)	3.9% ▼
End of Life, Long-term Conditions and Frailty		Improving Population Health	
Prevalence rate of Palliative care registers (September)	-0.1% ▬	Children and Young People vaccination uptake - MMR2 (Q2)	-0.8% ▼
Patients receiving all 8 care processes for Diabetes -Type 1 (cumulative to September)	2.9% ▼	Children and Young People vaccination uptake - Pertussis maternal vaccination (Q1)	10.0% ▲
Patients receiving all 8 care processes for Diabetes -Type 2 (cumulative to September)	2.4% ▼	Hypertension: Percentage of patients treatment to recommended age specific thresholds (Q1)	67.10%
National Diabetic Prevention Programme - referrals	5.8% ▲	Cholesterol: Percentage of patients with QRISK 20% or more treated with lipid lowering therapy (Q1)	1.70% ▲
National Diabetic Prevention Programme - commence	63.5% ▲		

4

## Delivering compassionate care of the frail and elderly

Urgent and Emergency Care		
80% discharges on Pathway 0 (November)	-4.2%	▼
Discharges on Pathway 1 (November)	3.3%	▲
Discharges on Pathway 2 (November)	1.3%	▲
Reduce number of discharges on Pathway 3 to below 1% (November)	-0.2%	▲
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 (August)	10.3%	▼
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	-0.3%	▼
% of Care Home Patients with a Personalised Care Plan	0.5%	▼
Mean number of Multidisciplinary Team meetings per care home resident aged >18	-10.8%	▼

TRAFFIC LIGHT KEY		Arrow colour reflects performance, direction to show change from the previous period	
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
Var	Yellow - performing against plan or target, with variance to plan or target	▼	Decline in performance against previous period - drop in value
Var	Red - under performing against plan or target, with variance to plan or target	▲	Decline in performance against previous period - increase in value
Q	No data available as the indicator is reported Quarterly	▬	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
<b>Urgent and Emergency Care (UEC)</b>	<p><b>Category 2 Response Time West Midlands Ambulance Service (WMAS)</b></p> <p>Latest Performance (November 2024) was <b>39 min 39 sec</b>, up 3 min 41 sec on the previous month and 5½ minutes above plan.</p>	<ol style="list-style-type: none"> <li>1. Increased handover delays impacted on return of vehicles into community to respond to outstanding calls.</li> <li>2. Category 2 call volumes into service increased 2.2% reaching highest volumes since April 2024 with breathing problems accounting for a high proportions as Covid-19 prolongs and Flu emerges.</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> </ol>	<ol style="list-style-type: none"> <li>1. Reducing ambulance handover delays implemented on 11<sup>th</sup> November 2024. Due to increased demand application of this has been intermittent, positive impact has been seen on selected days where demand has allowed full implementation.</li> <li>2. Alternative Hospital Ambulance Liaison Officer (HALO) model request going to UEC Board in December for approval. No confirmation provided at time of writing. The new proposed role transfers back to a clinical role to support re-direction of patients to alternative portals.</li> </ol>
	<p><b>Accident &amp; Emergency 4-hour Wait University Hospitals North Midlands (NNM)</b></p> <p>Latest performance (November 2024) was 64.8%, down from 65.3% the previous month, and marginally better than the same period last year. 5.8% below plan and 7.2% below target.</p>	<ol style="list-style-type: none"> <li>1. Internal Professional Standards (IPS) 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. Type 3 locations saw a reduction in performance as increased numbers were flowed into the Enhanced Primary Care Service (EhPC) from ED.</li> </ol>	<ol style="list-style-type: none"> <li>1. Additional acute medic capacity continues in ED.</li> <li>2. Targeted implementation of additional capacity for Rapid Assessment and Treatment (RAT) function at Royal Stoke.</li> <li>3. Throughout Critical Incident increased resource within EhPC to support assessment and treatment of lower acuity patients.</li> </ol>
	<p><b>Adult General &amp; Acute (G&amp;A) bed occupancy at UHNM &lt; 92%</b></p> <p>Latest performance (November 2024) was 92.8%, down from 94.3% the previous month and 0.8% above target.</p> <p>Performance was 4.1% above the plan of 88.7% for November 2024.</p>	<ol style="list-style-type: none"> <li>1. IPC constraints within ED and the bed base have significantly restricted patient flow,</li> <li>2. Increase proportions of long-stay (14+ &amp; 21+ Length of Stay) during November restricted available bed base as discharge delays for more complex requirements of increasing Pathway 1 and Pathway 2 discharges were seen.</li> </ol>	<ol style="list-style-type: none"> <li>1. Multidisciplinary high intensity team continue to work through base wards on a 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, IPS, 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>

**Other Key Points Aligned to this priority**

**Paediatric Beds:** – Both Paediatric G&A and Intensive Care (PICU) bed utilisation have been high, replicating the position experienced across both the region and nationally. Increasing Respiratory Syncytial Virus (RSV) admissions resulted in PICU occupancy of 91.7% for November, surpassing the 91.1% for the previous November and rising 32.6% over October 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
	<p><b>Virtual Wards (VW)</b> – Latest performance for the first submission on 5th December 2024 was 74.7%, below plan for both occupancy and capacity.</p> <p>Sector splits not currently available from the service for the latest submission.</p>	<ol style="list-style-type: none"> <li>1. Latest detailed breakdown report not currently available from service due to delays in report production.</li> <li>2. Update will be provided once the report is available.</li> </ol>	<ol style="list-style-type: none"> <li>1. Acute care at home (ACAH) Referral hub now taking direct incident coordination centre (ICC), Home First and Acute Visiting Service (AVS) referrals</li> <li>2. Overall quality action Plan in progress – 5 main actions: Increase in patients with more complex needs, Improve Documentation, Standardise Criteria, Ensure Medical Director in post, Increase out of hospital diagnostics</li> <li>3. High Risk of Delayed Discharge (HRD) test of change (TOC) – went live 2<sup>nd</sup> December 2024, Referral pathway/process into ACAH for Community Rapid Intervention Service (CRIS) or VW completed.</li> </ol>
<p><b>Urgent and Emergency Care (UEC)</b></p>	<p><b>Ambulance Hours lost due to Handover delays UHNM</b></p> <p>November 2024 was 6,072 hours, down by 110 hours below October, but 1,910 hours above plan.</p>	<ol style="list-style-type: none"> <li>1. Extended waits due to high acuity of clinical presentation at ED attendance which require more complex care in ED.</li> <li>2. SC constraints within ED and the bed base have significantly restricted patient flow that have impacted on the ability to offload patients in a timely way.</li> </ol>	<ol style="list-style-type: none"> <li>1. New initiative to drive up referrals to Call before Convey launching within WMAS 17<sup>th</sup> December 2024. Ensure all crews are utilising alternative pathways available via the incident coordination centre (ICC) ahead of conveyance where clinically appropriate</li> <li>2. Reducing ambulance handover implemented on 11<sup>th</sup> November 2024.</li> <li>3. New Structure within Medicine Division commencing 16<sup>th</sup> December 2024 to support getting back on track with ambulance handover delays</li> </ol>
	<p><b>Proportion of patients spending more than 12 hours in Emergency Department at UHNM –</b></p> <p>Latest performance 10.8% for November 2024, down from 11.3% in October 2024. In comparison the Midlands average for November 2024 was 11.7%.</p>	<ol style="list-style-type: none"> <li>1. IPC 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. High acuity of clinical presentation at ED attendance which require more complex care in ED.</li> </ol>	<ol style="list-style-type: none"> <li>1. Multidisciplinary high intensity team continue to work through base wards on a 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, IPS, 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
<b>Mental Health (MH) and Learning disability and Autism (LDA)</b>	<p><b>Improving Access to Perinatal MH Services</b> – 1,010 women had at least one contact with the service in the rolling 12 months to October 2024. This is 92 (8.3%) under the monthly trajectory (1,102) but continuing to increase month on month, closer to plan than last month and higher than the same period last year (905).</p> <p>The system is one of 19 ICBs in England that did not achieve plan at month 6 and is in position 36 out of the 42 ICBs, putting it midway within the lowest quartile.</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 calculation.</li> <li>2. Additional 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> – 14,505 CYP had at least one contact with community mental health services in the rolling 12 months to October 2024.</p> <p>This is 1,156 (7.4%) under the monthly trajectory (15,661), and lower than the same period last year (14,620). However, the number of CYP increased by 320 since last month and is closer to plan than last month.</p>	<ol style="list-style-type: none"> <li>1. NSCHT reported that some voluntary sector activity was not being recorded correctly.</li> <li>2. NSCHT also reported that a number of referrals had been discharged without a metric reportable contact being recorded (Autism Service and the core Child and Adolescent Mental Health Service (CAMHS)).</li> <li>3. MPFT have indicated that they may not have sufficient eligible referrals. Arising from 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 MHSDS.</li> <li>4. MPFT have reported that some subcontractor activity may not be being flowing to the MHSDS.</li> <li>5. 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. Preparing a Recovery Action Plan (RAP) for NHS England, which will set out action being taken to address the shortfall.</li> <li>2. NSCHT have fixed the voluntary sector recording issue, amended Autism Service records and are working with the core CAMHS service to identify reportable activity. NSCHT plan to resubmit once all of these measures have been resolved locally. Timing is to be confirmed.</li> <li>3. MPFT are reviewing data capture and service configuration as part of a Performance Improvement Plan.</li> <li>4. Action for Children have promoted their services in areas with lower than expected referrals. Plus, they are working towards improving data quality and plan to submit missing codes from January 2025.</li> <li>5. Increased investment into CAMHS as result of refresh of the CYP MH Local Transformation plan in October 2024 however the benefits will not be realised until late in Q4.</li> <li>6. Two new MHSTs have been recruited to commence in January 2025 however the benefits will not be realised until late in Q4.</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
<b>Mental Health (MH) and Learning disability and Autism (LDA)</b>	<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.</p> <p>This is 994 (7.7%) under the monthly trajectory (12,924). Lower than the same period last year (13,145).</p> <p>NSCHT and MPFT are both under performing against plan.</p>	<ol style="list-style-type: none"> <li>1. NSCHT and MPFT are both under reporting.</li> <li>2. Changes Health and Wellbeing don't currently include adult activity in their MHSDS submissions.</li> </ol>	<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 internal figures against the published dataset. Timescale awaited.</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 2 target of 15 weeks (NB: national target = 13 weeks)</b></p> <ul style="list-style-type: none"> <li>• CYP North (Oct) - mean wait of 89 weeks</li> <li>• CYP South (Oct) - mean wait of 31 weeks</li> </ul> <p><b>Wait to complete Autism assessment, against quarter 2 target of 30 weeks (NB: national target = 26 weeks)</b></p> <ul style="list-style-type: none"> <li>• CYP North (Oct) - mean wait of 111 weeks</li> <li>• CYP South (Oct) - mean wait of 87 weeks</li> </ul> <p>Data from providers is now more closely aligned to feedback from patients and carers about waiting times.</p>	<ol style="list-style-type: none"> <li>1. Increasing demand: since April / May 2024, the total number of children waiting for an autism assessment to commence increased by 13% at MPFT and by 24% at NSCHT.</li> </ol>	<ol style="list-style-type: none"> <li>1. An interim improvement plan was presented at the MHLDA Delivery Group in and the LDAP Board in November. Feedback about the improvement plan is being collated in December and January 2024.</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>
<b>Children and Young People (CYP)</b>	<p><b>Reduce CYP in residential care outside Stoke-on-Trent</b> – 78.0% of placements were outside Stoke-on-Trent in November 2024.</p> <p>Up from 76.8% in the same month last year, but reduced since last month (79.6%).</p>	<ol style="list-style-type: none"> <li>1. Local Authority (LA) data for Stoke-on-Trent – 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> <li>2. Every effort is made to place CYP within residential homes locally however due to Stoke-on-Trent's small geographical area it is not always possible; therefore from the 92 out of area placements 43.5% of placements are within our neighbouring authority Staffordshire.</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
<b>Planned Care</b>	<p><b>Elective (Inpatient) Activity - Ordinary Elective</b></p> <p>In October 2024 there was 1,921 spells, against a plan of 2,008, Therefore under plan by 87 spells (-4.3% variance to plan). These are elective interventions where patients stay in hospital at least one night.</p>	<ol style="list-style-type: none"> <li>1. The number of elective inpatients is in line with 2023/24, however the plan for 2024/25 was uplifted by 7.7% above last year's outturn.</li> <li>2. When combined with Day Case spells metric, there was a variance to plan of 4.9% in October 2024. Providers are encouraged to achieve a Day Case rate of 85%.</li> </ol>	<ol style="list-style-type: none"> <li>1. Analysis of Elective Recovery Fund (ERF) achievement by providers taking place at Contract Steering Group. The ICB achieved 112.0% in August 2024 (i.e. delivered 12.0% more activity than 2019/20 levels), exceeding the target set for the ICB by NHS England (100.2%), and meeting the ICB planned level (110%).</li> </ol>
	<p><b>Reduce Outpatient Follow ups v 2019/20 level</b></p> <p>In October 2024 there were 14.4% more attendances than the planned level (based on achieving a 25% reduction by March 2025).</p>	<ol style="list-style-type: none"> <li>1. In some cases, increased follow-ups are a result of treating patients with long waits on waiting lists.</li> <li>2. Higher level of activity recorded in Independent Sector Providers (ISP) as more capacity available.</li> </ol>	<ol style="list-style-type: none"> <li>1. For ISP, the high level of follow up appointments is being monitored, as part of the monthly reconciliation process, and challenged through contractual routes when necessary.</li> <li>2. ICB working with providers to encourage Patient Initiated Follow Ups (PIFU).</li> </ol>
	<p><b>Eliminate 65 week waits by September 2024 -</b></p> <p>At the end of October 2024 there was 256 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, predicts that at the end of November there were 116 breaches at UHNM (all commissioners) and 136 predicted at out of area providers (ICB patients).</p>	<ol style="list-style-type: none"> <li>1. Capacity in NHS providers continues to be an issue, as well as a high level of demand.</li> <li>2. Out of 256 patients, 130 are at UHNM, 86 at University Hospital of Derby and Burton (UHDB), and 16 at Robert Jones &amp; Agnes Hunt.</li> <li>3. The specialties with highest numbers are Orthopaedics (79, with 50 at UHDB) and Ear Nose and Throat (61, with 55 at UHNM).</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient by patient validations are taking place and monitored as part of weekly submission to NHS England.</li> <li>2. Ongoing analysis of 65 week waits cohort by specialty to inform any risk to planned delivery.</li> </ol>
	<p><b>Increase theatre utilisation (UHNM)</b></p> <p>In October 2024 theatre utilisation was 74.6% at UHNM, against the target of 85%.</p>	<ol style="list-style-type: none"> <li>1. Inefficient Perioperative Medicine Pathways; multiple outcomes due to this, for example on the day cancelled operations remain at 9%, and late starts (over 15 minutes) remain at 16%.</li> </ol>	<ol style="list-style-type: none"> <li>1. Perioperative Medicine Pathway Transformation Delivery groups continue to focus on future state pathway and finalising training on the digital screening tool; 2-year programme working with NHS England to deliver.</li> <li>2. Theatre scheduling with theatre team and specialities in place; visiting other Trusts to follow best practice.</li> </ol>



**Local Priority**

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

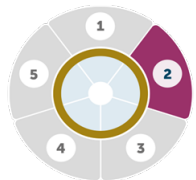
Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Cancer	<p><b>Cancer 62-day pathways. Total patients seen, and of which those seen within 62 days</b></p> <p>In October 2024 64.46% of patients were seen within 62 days, against a target of 65.48%. This is across all providers for ICB patients. October 2024 was the first month in 2024/25 where the ICB performance was below target.</p>	<ol style="list-style-type: none"> <li>1. The cancer types with lower compliance in October 2024 included Head and Neck (50.0%), Lung (53.4%), and Lower Gastrointestinal (55.0%). These cancers have higher number of breaches due to the requirements for multiple diagnostic tests before testament plans are confirmed.</li> <li>2. Lung cancer screening programme has meant more lung cancers are being diagnosed earlier. This means a greater proportion of patients can access anti-cancer treatment especially surgery as opposed to palliative care. This has increased demand on surgical services.</li> </ol>	<ol style="list-style-type: none"> <li>1. A phase 2 symptom-based pathways to be developed for Ear Nose and Throat (ENT) cancers that will include optimisation of urgent cancer referrals into the Head and Neck pathway. ICB implementing a tier 3 ENT pathway in Quarter 3 2025/26 which will reduce frequency of low cancer risk referrals ensuring there are appropriate clinical options for GPs, with lower waiting times.</li> </ol>
	<p><b>Faecal Immunochemical Test (FIT) -</b> Currently no update is unavailable since last month: The percentage of patients referred with suspected lower gastrointestinal (GI) cancer, with FIT result was 57.1% (year-to-date cumulative position to August 2024). Currently September data is unavailable.</p> <p>This is against a plan of 80.6%. This metric has shown a continual improvement (from 43.1% in April 2024),</p>	<p>No update from last month:</p> <ol style="list-style-type: none"> <li>1. Published data extracted directly from primary care clinical systems which does not reflect the actual level of performance due to coding issues. In practice around 70% of referrals in the ICB are compliant.</li> <li>2. Referrals to UHNM are around 90% compliant and to UHDB, around 70%.</li> <li>3. Referrals to UHNM have high level of compliance due to referrals being made via referral hub, ensuring FIT tests are available, however, referrals to other providers are not made through a different referral hub which means these referrals may not have the same level of scrutiny as those to UHNM.</li> </ol>	<p>No update from last month:</p> <ol style="list-style-type: none"> <li>1. The ICB is working with practices not achieving the standard, to improve coding and processes.</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
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 2024 has seen a large increase to the number of UDAs delivered (97.7% for the month). If the increase continues through November and December, 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> <li>4. October 2024 had more scheduling days; 25 compared to a normal month of 21.</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 LDP was approved at November Primary Care Forum and will be presented to ICB Board in January 2025 for final sign off.</li> <li>2. A Dental communication and engagement plan is in place to support the roll out of the LDP to the general public. The plan will be used to monitor feedback and activity through feedback surveys, social media, patient people panel and patient assembly, as well as Patient Advice and Liaison Service (PALS) and complaints.</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 October 2024 shows an increase to 603.5 FTE, but there is still a large increase required to reach the Q3 Plan by December 2024. 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 October 2024 data, NWRS is showing 603.5 FTE and the ARRS claims portal is much higher at 672.3 FTE, so a difference of 68.8 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 October 2024) shows budget utilisation at 97.1%.</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).</li> <li>Working with individual Primary Care Networks (PCNs) to ensure they are regularly reviewing and updating NWRS to improve accuracy of their submissions and are in line with claims made via the PCN claims portal. We anticipate further changes in November 2024 following completion of the validation work.</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 October 2024 was 66.7%, against a plan of 80.5%.</p> <p>Number of diagnostic tests carried out in October 2024 was 54,849 against a plan of 49,943 (9.8% above plan).</p> <p>This is for the ICB patients at all providers.</p> <p>Performance against this metric in the <b>NHS Oversight Framework</b> remains in the <b>lowest quartile</b>, ranking 38 out of the 42 ICBs (November 2024 refresh).</p>	<ol style="list-style-type: none"> <li>The tests failing the 6-week plan in October 2024 were Magnetic Resonance Imaging, Non-Obstetric Ultrasound (NOUS), Echocardiography and Audiology.</li> <li>By ICB main provider (all patients) the achievement in September 2024 was UHNM (59.9%), UHDB (79.0%), RWT (96.4%).</li> </ol>	<ol style="list-style-type: none"> <li>Additional Non-Obstetric Ultrasound (NOUS) capacity at UHNM started at the end of October 2024 resulting in increased activity.</li> <li>UHNM have made changes to the booking process for Magnetic Resonance Imaging tests to improve performance. UHNM have increased the numbers of schedulers supporting the Magnetic Resonance Imaging service and are reviewing options to increase efficiencies.</li> <li>Additional Echocardiography sourced at UHNM resulting in additional 158 slots per month. 6 week wait target expected to be met in Quarter 4 2024/25. UHNM have made changes made to booking process to improve performance</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>Mental Health (MH) and Learning disability (LD)</b></p>	<p><b>Eliminating OAPs</b></p> <p>6 active inappropriate adult acute mental health OAPs at the end of November 2024 (5 over plan). 4 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> </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></p> <p>6 inpatients in November 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 NHS England 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>
	<p><b>Reliance on inpatient care for people with a learning disability and/or autism (adults)</b></p> <p>27 inpatients in November 2024, a decrease of 1 patient since last month and 1 over the quarter 3 plan (26).</p>	<ol style="list-style-type: none"> <li>1. Transition from CYP to Adults will bring upward pressure on adult numbers.</li> <li>2. Longer term inpatient number above national targets.</li> </ol>	<ol style="list-style-type: none"> <li>1. 3 discharges are planned to take place in quarter 3.</li> <li>2. Review long term patients with long term medical treatments to re-assess discharge plan. To report back to NHS England Regional team March 2025.</li> </ol>
	<p><b>Learning from Lives and Deaths (LeDeR)</b></p> <p>Of 6 eligible reviews due for completion in September 2024, 5 (83.3%) were completed within 6 months against target of 100%. Eligible reviews are those which have not been placed on hold due to external investigations.</p>	<ol style="list-style-type: none"> <li>1. An inherited backlog following a contract change.</li> <li>2. One review breached because the governance panel wanted further information and assurance regarding a focused review before signing this off. This review was closed on 17/12/2024.</li> </ol>	<ol style="list-style-type: none"> <li>1. Reduction in backlog of reviews from 2023 (2 remaining and currently being worked on)</li> <li>2. Better Standard and quality of reviews produced by reviewers.</li> <li>3. Reviews being allocated in less than 2 months from notification.</li> </ol>
<p><b>Mental Health and Learning disability (MHLDA)</b> Portfolio Delivery Escalation</p>	<p>Integrated Care System (ICS) wide roll out of <b>Oliver McGowan Training</b> is currently under plan. Trajectory to recover is at risk due to the availability of trainers and the workforce during the winter period. NHS only count; Tier 1 achieved 665 / 1,422 target (46.8%) (November 2024). Tier 2 achieved 1,720 / 3,457 target (49.8%) (November 2024).</p>	<ol style="list-style-type: none"> <li>1. Lack of training capacity to facilitate the programme and meet requirements of the workforce.</li> <li>2. Volume of the workforce, aligned to statutory requirements for Care Quality Commission (CQC) regulated providers, in scope to receive training.</li> </ol>	<ol style="list-style-type: none"> <li>1. Primary Care have their own trainers (2) that started delivering training in December 2024.</li> <li>2. All main NHS providers have agreed a collective approach to delivery based on current funding opportunities.</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>End of Life (EOL), Long-term Conditions and Frailty (ELF)</b></p>	<p>Prevalence rate of patients on palliative care registers to 1%.</p> <p>In October 2024 there were 9,968 patients on a palliative care register. This equates to 0.83% of the registered practice population against a target of 0.90%</p>	<p>1. Pressures facing Primary Care and seasonal impact during summer period of Annual Leave.</p>	<p>1. Training on Identification at End of Life will continue to be offered through Staffordshire Training Hub sessions are planned from October 2024 until July 2025.</p>
<p><b>EOL Programme Delivery Escalation</b></p>	<p><b>24/7 Advice Line</b></p> <p>Case for change has been presented at Clinical Senate and was supported from a clinical perspective</p>	<p>1. There are wide reaching reforms within the Health and Care Act 2022, including the legal foundations for ICB's. An amendment has also meant that palliative care services are included in the section which specifies that ICB's have a legal responsibility to commission health services that meet their population needs and Performance Committee in December 2024.</p> <p>2. The report shares the impact of the 24/7 palliative and end of life care Advice Line pilot and provides the ICS with the information to inform a decision surrounding commissioning and provides options for commissioning of the overnight element of the 24/7 Advice Line for 2025/26.</p>	<p>1. 24/7 Advice Line Case for change is currently being taken through ICB governance structure. Update will be available in January 2025.</p>
<p><b>Frailty - Programme Delivery Escalation</b></p>	<p><b>Frailty Programme</b></p> <p>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>1. An options appraisal to scale up the model across the ICS cannot progress without significant re-orientation of existing resources or investment from the ICS.</p>	<p>1. Falls: An options appraisal to scale up the model including an economic evaluation has been completed at the end of November 2024.</p> <p>2. Decision to be presented at the ELF board in January 2025.</p>



**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>Stillbirth rate</b> Monthly rate is above the 2023/24 benchmark rate in November 2024.</p>	<p>1. A rate of 4.1 in November 2024 due to 2 reported stillbirths.</p>	<p>1. Continue to support UHNM to implement Saving Babies Lives Care Bundle (SBLCB) v3 through the Local Maternity and Neonatal System (LMNS) SBLCB quarterly implementation meetings. 2. Monitor stillbirths through Quality Safety and Oversight Forum (QSOF) monthly which focuses on learning, themes identified and areas for improvement 3. Ongoing monitoring of stillbirths against ethnicity and deprivation to support targeted work to reduce health inequalities</p>
	<p><b>Neonatal Mortality rate</b> Monthly rate is above the 2023/24 benchmark rate in November 2024.</p>	<p>1. A rate increase to 2.1 per 1,000 in November 2024, due to 1 neonatal death.</p>	<p>1. The office for Health Improvement and Disparities (OHID), ICB System leads and NHSE to develop an Infant Mortality action plan across the system which will incorporate Neonatal Mortality which will focus on data, preconception care and modifiable risk factors. 2. Continue to support UHNM to implement Saving Babies Lives Care Bundle (SBLCB) v3 through LMNS quarterly implementation meetings. The Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) passport was introduced in July 2024 and improvements have been made across the perinatal optimisation pathway. 3. Monitor Neonatal Deaths through the monthly Quality and Safety Oversight Forum (QSOF) which focuses on learning, themes identified and areas for improvement. 4. Monitor Neonatal Deaths against ethnicity and deprivation to support targeted work to reduce health inequalities.</p>
	<p><b>Brain Injury Rate</b> Monthly rate above the 2023/24 benchmark rate in November 2024.</p>	<p>1. Rate increased to 2.1 per 1,000 in November 2024 with 1 reported Neonatal Brain Injury (Cooled) at UHNM again this month. 2. Small numbers are derived from crude data – quarter 1 and 2 counts are less this year than 2023/24, local monitoring continues.</p>	<p>1. Arranging to meet with UHNM to review brain injury data and ensure we receive verified data. 2. Monitor Brain Injury rate through QSOF monthly which focus on learning, themes identified and areas for improvement.</p>



**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>Improving Population Health (IPH)</b></p>	<p>Children &amp; Young People Vaccination uptake - Mumps, Measles and Rubella (MMR)2</p> <p>87.0% of the eligible group have received vaccination in September, 1.2% below 23/24 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>	<ol style="list-style-type: none"> <li>1. 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>2. 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>	<ol style="list-style-type: none"> <li>1. 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
	<p><b>Discharges on Pathway 0 (ICB)</b></p> <p>Performance in November 2024 deteriorated, falling from 76.9% to 74.2% which was 4.2% below plan.</p> <p>Current Year to date (YTD) position as of 30<sup>th</sup> November 2024: 77.22%</p>	<ol style="list-style-type: none"> <li>1. Discharge Facilitation 7-day workforce model delayed. Financial risk related to the proposed model and infrastructure, so business case required to progress.</li> <li>2. Voluntary and Community Sector – 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 are implementing new daily protocols 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, IPS, Ward Standard Work, Your Next Patient (YNP), Home Care is Best Care)</li> </ol>
<p><b>Urgent and Emergency Care (UEC)</b></p>	<p><b>Discharges on Pathway 1 (ICB)</b></p> <p>Performance in November 2024 deteriorated, rising from 19% to 21% which was 3.3% above plan.</p> <p>Current YTD position as of 30<sup>th</sup> November 2024: 18.83%</p>	<ol style="list-style-type: none"> <li>1. Discharge Facilitation 7-day workforce model delayed. Financial risk related to the proposed model and infrastructure, so business case required to progress.</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. Due to NHSE and Commissioning Support Unit (CSU) reporting changes currently unable to access weekly data. No alternative data source currently available so we continue to pursue a resolution with NHSE by utilising NHS Federated Data Platform (FDP) when correct permissions are obtained from the national team.</li> <li>3. ICB Workforce Team working with providers to identify underlying issues for increasing absence levels.</li> </ol>
	<p><b>Discharges on Pathway 2 (ICB)</b> – Performance in November 2024 deteriorated from 3.65% to 4.21% which was 1.3% above plan.</p> <p>Current YTD position as of 30<sup>th</sup> November 2024: 3.44%.</p>	<ol style="list-style-type: none"> <li>1. Market appetite to support high level residential is difficult.</li> </ol>	<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. Working 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**

**Improving Population Health (IPH)**

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
	<p>Covid-19 vaccinations in &gt;65 years eligible group: - 53.0% of the eligible group have received vaccination in November 2024, this is 10.3% below 23/24 baseline of 73.3%.</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>	<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 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
Integration	<p><a href="#">Emergency Admissions for Chronic Ambulatory Care Sensitive Conditions (Staffordshire Local Authority)</a></p> <p>Latest indirectly age standardised rate (quarter 1 2024/25) indicated 217.8 admissions per 100,000 population, 3 above plan.</p>	<ol style="list-style-type: none"> <li>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.</li> </ol>	<ol style="list-style-type: none"> <li>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.</li> </ol>
	<p><a href="#">Emergency Hospital admissions due to Falls in People aged 65 and over (Stoke Local Authority)</a></p> <p>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.</p>	<ol style="list-style-type: none"> <li>1. Under reporting or delays in data reporting.</li> <li>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</li> </ol>	<ol style="list-style-type: none"> <li>1. Review of provision of Falls response from Staffordshire Fire and Rescue Service under Better Care Fund (BCF).</li> <li>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.</li> <li>3. Support more patients be managed within the community by aligning reactive workstreams with proactive workstreams.</li> <li>4. Onboarding of the 'Long Lies' policy to support patients to remain at home.</li> </ol>
	<p><a href="#">Emergency Hospital admissions due to Falls in People aged 65 and over (Staffordshire Local Authority)</a></p> <p>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.</p>		
	<p><a href="#">Discharge to Usual Place of Residence (Staffordshire Local Authority)</a></p> <p>Latest Performance for quarter 1 2024/25 was 92.72%, 0.78% below plan</p>	<ol style="list-style-type: none"> <li>1. Increases in discharges to short term Pathway 1 including Discharge To Assess (D2A) beds due to discharge pathway pressures.</li> </ol>	<ol style="list-style-type: none"> <li>1. Analysis of D2A pathways and timings completed by Integrated Discharge Hub (IDH) with findings built into the operating model.</li> </ol>

**Other Key Points Aligned to this priority**

**Integration metrics:** – These are quarterly measures, no updates to these metrics from last month until Q2 reporting which has been delayed until January 2025.



**Local Priority**

**Supporting Care Home Residents**

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
<p><b>Care Homes</b></p>	<p>Multidisciplinary Team Meetings (MDT) - year to date to October 2024 have fallen 10.8% below plan, delivering 5099 meetings to date, a shortfall of 615 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> <li>Relationships with MPFT and GP's are strained and compounded with Collective Action.</li> </ol>	<ol style="list-style-type: none"> <li>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>Working 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 Directed Enhanced Service (DES)</li> <li>Meeting with PCNs/practices to ensure MDTs are correctly coded.</li> <li>Interface meetings with MPFT and 3 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 has fallen slightly below plan for October 2024, standing at 57.2% against the October plan of 57.5%, a shortfall of 21 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>ReSPECT Programme is supported by the Quality Improvement Framework (QIF) with practices to increase uptake and reduce variation.</li> <li>ReSPECT Lead presented at November GP Engagement meetings to provide an update on ReSPECT Programme.</li> <li>A guide for clinicians has been shared to support early identification of patients for the Palliative Care Register and embedding ReSPECT.</li> <li>Practices have been encouraged to engage with the Digital ReSPECT Programme to increase the number of digital plans.</li> </ol>
<p><b>Care Homes Programme Delivery Escalation</b></p>	<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>Enhance Health &amp; In Care Homes. Programme (EHCH) has stalled and is waiting for further direction from the Demand Management Collaborative.</li> </ol>	<ol style="list-style-type: none"> <li>Care Homes Workshop held 11<sup>th</sup> December 2024 - areas of focus identified for agreement at the next Demand Management Collaborative Steering Group.</li> </ol>

- Other Key Points Aligned to this priority**
- 2-hour Urgent Care Referral activity remained below plan in October 2024, 640 versus a plan of 872.

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

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

Supporting Care Home Residents	
Integration	
Care Homes System Recovery Programme	

TRAFFIC LIGHT KEY	
Variances are against the plan as priority, against the target if no plan is available	
<b>Var</b>	Red - under performing against plan or target, with variance to plan or target
<b>Var</b>	Green - performing against plan or target, with variance to plan or target
<b>Q</b>	No data available as the indicator is reported Quarterly

Arrow colour reflects performance, direction to show change from the previous period	
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▲	Improvement in performance on the previous Period - increase 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 8

The following slides show the aggregate financial position as at Month 8. 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. In Month 7 we reported that we were £33.7m adverse to that breakeven plan. The outturn was that we had c£8m of unmitigated risk on top of the post-recovery deficit of £56m, due to the central decision to claw back dental funding and additional ambulance costs, therefore heading for a deficit of £64m. The national team have been clear that we must get back to breakeven.

The Month 8 position is relatively positive with early signs of improvement to the run rate. At a System level we are reporting a [year-to-date deficit position of £29.3m](#), which is a £33.3m adverse variance. [The year-to-date variance to plan sits within ICB \(£17.7m\) and UHNM \(£16.9m\), with small surpluses at MPFT \(£0.8m\) and NSCHT \(£0.5m\)](#). Consequently, the Month 8 the variance was successfully held flat for the reporting period due to a combination of proactive management and recovery actions, along with a catch up of releasing Elective Recovery Fund (ERF) relating to advice and guidance. Consequently, we have now covered the £8m of additional unmitigated risk, and so our outturn has reduced to the £56m in the recovery plan.

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 key area of focus is moving from ‘standard’ controls as assessed by the I&I team, to ‘enhanced’ controls. These enhanced controls will be in place within days, and we are hopeful that consequently, the level of unmitigated risk will fall in M9.

[The reported System efficiency based on Month 8 information is now assessed to outturn at £179.9m, which equates to 88.5% delivery against the annual efficiency plan of £203m](#). Furthermore, there remain some risks to the delivery of the £179.9m forecast which is being worked on by the Recovery Director and the System.

[For M1 to M7, the actual workforce position has been below FY2023/24 M12, however in November 2024 the current workforce position is +7 wte above March 2024](#). Excluding ICB workforce (i.e. aligned to what is submitted to NHSE via Provider Workforce Return (PWR) we are currently +31 wte above March 2024. Providers have successfully reduced the reliance on agency staff significantly. 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 and is significantly above the workforce plan overall position.

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

# Month 8 Position

Following the guidance to release non recurrent funding equivalent to the deficit agreed on the 12 June 2024 was transacted. The System is reporting a year-to-date **adverse position of £33.3m** against a revised YTD £4.0m surplus plan. The main drivers for the aggregate YTD position are efficiency slippage (£21.7m) and binding conciliation (£19.2m) with adverse impacts in continuing healthcare (CHC) (£13m) and medical staffing (£6.2m). These are partially offset by other non-recurrent mitigations (£18.4m) and Dental underspend (£3.0m).

Within the £33.3m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £3.2m at Month 8, this will reduce monthly to no impact by year end.

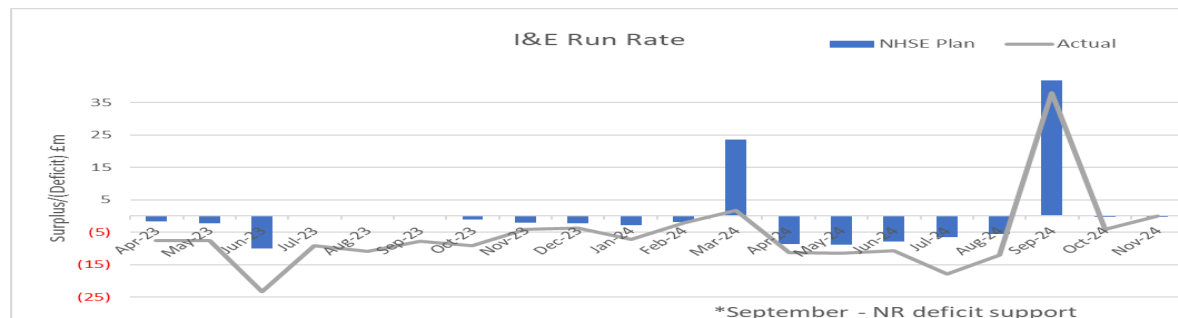
System	Month 8			Month 7		
	Plan	£m YTD	Variance	Plan	£m YTD	Variance
Income	3,430.7	3,456.0	25.3	2,988.3	3,008.6	20.3
Pay	(881.0)	(884.2)	(3.2)	(770.2)	(774.6)	(4.4)
Non Pay	(456.1)	(498.1)	(42.0)	(399.9)	(432.7)	(32.7)
Non Operating Items (exc gains on disposal)	(24.5)	(20.1)	4.4	(21.3)	(17.6)	3.7
ICB Expenditure	(2,065.1)	(2,082.8)	(17.7)	(1,792.5)	(1,813.1)	(20.6)
Total	4.0	(29.3)	(33.3)	4.3	(29.3)	(33.7)
			-1.0%			-1.1%

ICB	Month 8			Month 7		
	Plan	£m YTD	Variance	Plan	£m YTD	Variance
Allocation	2,065.1	2,065.1	0.0	1,792.5	1,792.5	0.0
Expenditure	(2,065.1)	(2,082.8)	(17.7)	(1,792.5)	(1,813.1)	(20.6)
TOTAL ICB Surplus/(Deficit)	0.0	(17.7)	(17.7)	0.0	(20.6)	(20.6)
			-0.9%			-1.1%

UHNM	Month 8			Month 7		
	Plan	£m YTD	Variance	Plan	£m YTD	Variance
Income	788.2	813.7	25.5	690.1	712.2	22.1
Pay	(482.3)	(489.3)	(7.0)	(421.3)	(429.4)	(8.1)
Non-Pay	(279.6)	(316.5)	(36.9)	(245.2)	(274.7)	(29.5)
Non Operating Items (exc gains on disposal)	(24.7)	(23.1)	1.5	(21.6)	(20.2)	1.4
TOTAL Provider Surplus/(Deficit)	1.6	(15.3)	(16.9)	2.0	(12.2)	(14.1)
			-2.1%			-2.0%

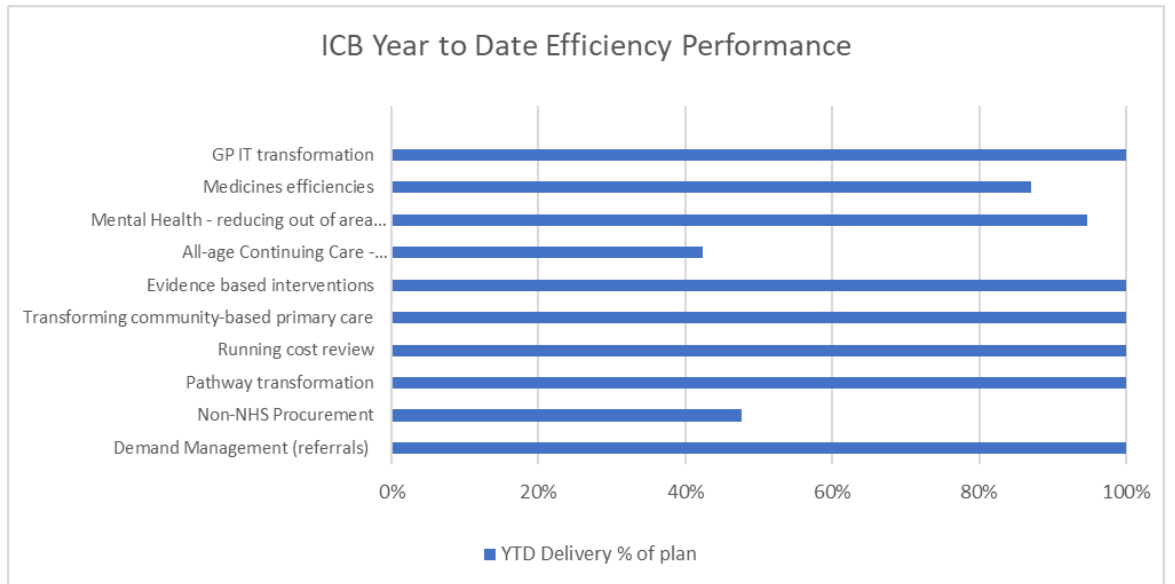
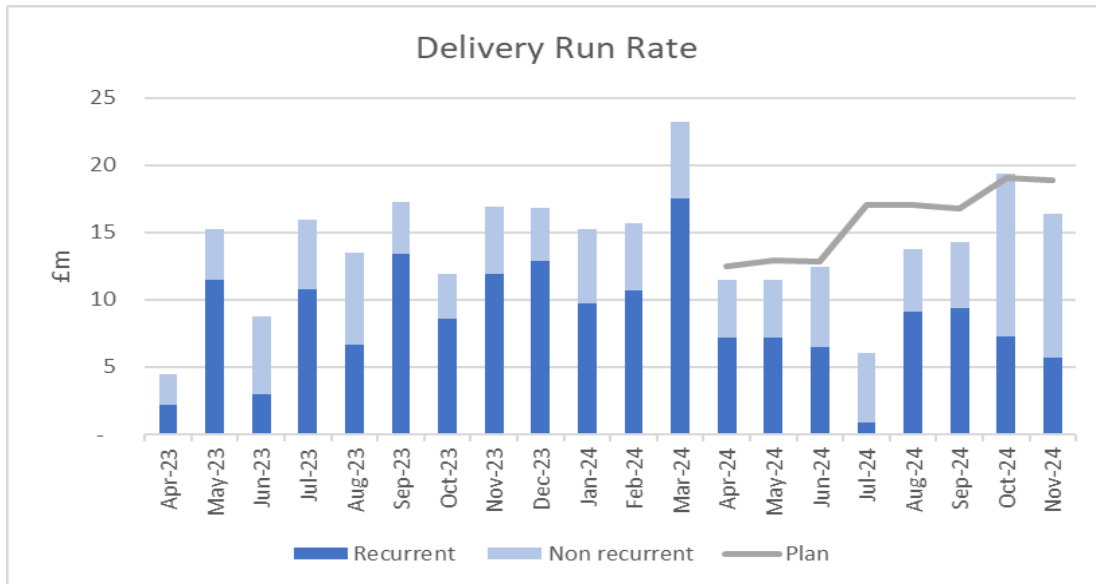
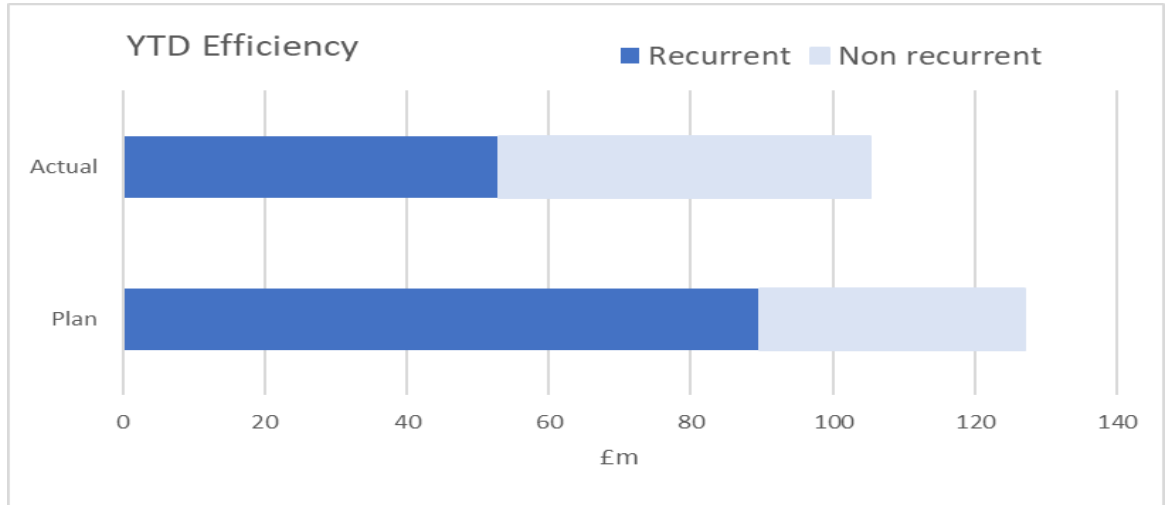
MPFT	Month 8			Month 7		
	Plan	£m YTD	Variance	Plan	£m YTD	Variance
Income	463.7	465.9	2.1	406.1	406.2	0.0
Pay	(329.8)	(328.8)	0.9	(288.6)	(287.7)	0.9
Non-Pay	(132.5)	(137.2)	(4.6)	(116.2)	(118.4)	(2.3)
Non Operating Items (exc gains on disposal)	1.3	3.7	2.4	1.3	3.3	2.0
TOTAL Provider Surplus/(Deficit)	2.8	3.6	0.8	2.8	3.4	0.6
			0.2%			0.2%

NSCHT	Month 8			Month 7		
	Plan	£m YTD	Variance	Plan	£m YTD	Variance
Income	113.6	111.3	(2.3)	99.6	97.8	(1.8)
Pay	(69.0)	(66.1)	2.9	(60.4)	(57.5)	2.9
Non-Pay	(43.9)	(44.4)	(0.6)	(38.6)	(39.6)	(1.0)
Non Operating Items (exc gains on disposal)	(1.2)	(0.7)	0.4	(1.0)	(0.7)	0.4
TOTAL Provider Surplus/(Deficit)	(0.4)	0.1	0.5	(0.4)	0.0	0.4
			-0.4%			-0.4%



# Efficiency

- The System has delivered £105.2m of efficiency as of November 2024, this is £21.7m adverse against plan, which is largely at ICB (£10.9m) and UHNM (£9.7m)
- The System efficiency programme totals £203.2m with £23.3m forecast shortfall. This is a £10m improvement on last month, with work on going to identify further schemes
- Forecast delivery equates to 88.5% delivery against the annual efficiency plan of £203m
- Recurrent schemes are £36.8m adverse at month 8. 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>16<sup>th</sup> January 2025</b>
<b>Reporting Committee:</b>	<b>Finance and Performance Committee Parts A and B</b>
<b>Date of Meeting:</b>	<b>7 January 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 8 System Finance Report**

At Month 8, at a System level we are reporting a year-to-date deficit position of £29.3m, which is a £33.3m adverse variance against the revised plan. This is a slight improvement from the Month 7 position due to the receipt of ERF and implementation of recovery actions. Therefore, the £8m of additional unmitigated risk reported last month has now been covered and so our outturn has reduced to the £56m in the Recovery Plan. 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, the concern was raised that we are still a long way off delivering the break-even position required.

Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as System partners have significantly reduced plans to meet this allocation. For Month 8 there was a new declaration required to get specific Board approval that 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.

Total workforce has increased by 7WTE since March 2024. Providers have significantly reduced the reliance on agency staff. 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 and is significantly above the overall workforce plan position. The workforce position for UHNM is currently 467WTE over plan and the Recovery Director is undertaking work to understand the pressures and reasons for the workforce increases; conversations will then take place with CEOs and work take place to examine where this can safely be decreased.

The Committee acknowledged the System position at Month 8 and the net risk reported.

**2024/25 System Recovery Programme**

System Recovery Programme Update

At Month 8, the overall £203m efficiency plan is showing a £27.8m adverse variance to plan for the year. The System Collaboratives continue to contribute to this negative variance because of the challenges that each has faced in delivering their part of the £40m stretch target.

The Committee considered the updates for the Collaboratives:

- CHC - The Month 8 position and in-month run rate continue to improve; we now have £17m of green and amber schemes forecast for delivery, with a continued focus on de-risking the remaining £2.6m of red schemes.
- Demand Management - A positive workshop was held with care home providers and primary care on 11 December to agree a set of objectives for 2025/26. A delivery plan is now under development which will examine how to improve the baseline position i.e. reducing inappropriate care home attendances and admissions.
- Contracts - The draft report from KPMG identifies some in year opportunities which have also been flagged through the I&I work. This amounts to circa £200-£300k net of any contingent fee and an action plan is under development to realise the savings. A PID has now been completed for the Mediquip contract, which should realise circa £500k in 2024/25.
- Clinical Value and Medicines - The QIA Panel for the ONS project took place on 19 December and was approved. The System has asked for a 'go live' date of 27 January for Phase 1 – Amber R drugs.

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

### System Recovery Director Report

System CIP delivery is now forecast to be £149.1m which is £0.3m 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 £154.3m, £5.5m favourable to plan.

The paper summarised the progress of the Investigation and Intervention work to 16 December. The team continues to work on implementation plans across all workstreams with SROs identified and revised meeting schedules in place to ensure delivery at pace. The I&I Team are undertaking a programme of work to assess the 'tough decisions' that the System should consider taking into account all potential impacts, both financially and to the provision of appropriate patient care. This will deliver a prioritised shortlist of options of interventions which will take cost out of the System. The paper provided a timeline and further detail for this work. The Committee acknowledged the difficulties regarding the 'tough decisions' however, if decisions were not made now then there could be even more difficult decisions to make in the future.

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. It is hoped that the support under the I&I Regime will help achieve this (initial indications are that there are opportunities that can be developed and put into place to deliver rate savings in the range of c.£1-2m per month in the current financial year) although at this stage the System does not have route back to break even.

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 7 against the ICS Operational Plan. The paper also provided key Urgent and Emergency Care 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 are now red rated.

For diagnostics, there has been a deterioration against the plan with the volume of patients and the length of time patients are waiting over 6 weeks increasing.

Performance against the Cancer 62-day pathways (target 70% by March 2025) has been positive since April but for the first time in 2024/25 this target has not been met.

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 considered the escalations raised by the Mental Health and Learning Disabilities & Autism Portfolio and End of Life, Long-Term conditions and Frailty Portfolio, and the escalation in respect of the Care Homes delivery programme. The Committee remains concerned about the continued long waits for Autism assessments and the red rating of metrics for Mental Health (MH) and Learning Disability and Autism (LDA). The Committee requested an update from each Portfolio Lead at their next meeting.

### **PART B**

#### **Month 8 ICB Finance Report**

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

At Month 8 the ICB reported a year-to-date deficit position of £17.7m adverse variance against the revised breakeven plan. This reflects a £2.8m improvement from a £20.5m deficit position at Month 7. 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.

At Month 8, our latest assessment is that the ICB's likely deficit position is to deliver the £36.6m deficit 'amber' risk assessment. We are unable to move the forecast away from the agreed plan until formal authorisation is gained from NHSE.

The Committee discussed the opportunities available for S117, working collaboratively with the Local Authorities, and requested clarity on the governance arrangements for the next Committee meeting.

The Committee acknowledged the ICB's Month 8 forecast position of breakeven, whilst noting the £36.6m 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 indicates £84.6m of efficiency delivery for 2024/25, representing an adverse variance against the £102.2m 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 recognised that the £17.6m projected under-delivery is unacceptable and presents a key financial risk to the ICB for both in-year and the forward look to 2025/26.

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

### **ADVISE**

#### **PART A**

##### **NHSE Oversight:**

- **NHSE Oversight Letters**
- **Shared Learnings on Financial Controls and Key Themes for Improvement**

The Committee received copies of the oversight letters following the ICB System Review Meeting on 26 November 2024 and the Quarterly Provider Oversight Meetings held with the ICB and UHNM on 12 December 2024, NSCHT on 13 December 2024 and MPFT on 16 December 2024.

The Committee acknowledged the positive comments regarding the move to Teir 2 for electives, the reduction in agency spend and the concerns regarding workforce levels, UEC performance and the financial position. NHSE had welcomed the strategic approach to financial recovery through the Medium Term Plan but the expectation is that we break even in 2025/26.

The Committee received a paper summarising the contents of papers received from NHSE sharing the key points of learning and opportunities from across the I&I Regime and the themes seen in more financially stable Systems and how these can be applied to the Staffordshire and Stoke-on-Trent System.

The paper also set out opportunities and areas which may lead to further improvement within the System as part of the recovery plans. A stocktake will take place with the I&I Team particularly regarding the financial control groups put in place, and the System-wide resource available to implement at pace. Any further opportunities will be presented to CEOs for agreement and plans to be put in place.

### **UEC Pressures**

The paper provided an update on the management of ongoing System UEC pressures and the actions undertaken as part of the System response to the Critical Incident. The report also included the latest System winter surge update report highlighting that the majority of capacity that was planned to be operational at this point is live and delivering against plan.

Regarding the finances, the Committee was assured that:

- The allocation of budget in relation to the additional winter schemes is proactively managed, with schemes adjusted or replaced where needed to ensure the greatest benefit of resources. This is completed weekly at the surge MDT.
- Costings in relation to additional actions are being recorded by organisations and regular updates shared via finances leads and the system surge MDT.
- Where required, decisions in relation to spend is being discussed and agreed via respective Portfolio/provider executives and governance arrangements.
- A full update on finances will be presented to the January UEC Board and February Finance and Performance Committee.

The Committee noted that a debrief took place with System partners to support identification of initial learning from the incident response and to support planning as we move through the remaining winter period. A further debrief took place on 7 January to explore learning in more detail and a report will be presented to the January UEC Board.

### **Integrated Care Co-ordination for Urgent Care**

The paper provided an overview of the Integrated Care Coordination (ICC) for Urgent Care. The multidisciplinary team acts as a single point of access to provide an ICC service for Urgent Care which is a nationally mandated required in the UEC Recovery Plan. The service provides patients with access to urgent care services through coordination of physical, social and mental health pathways.

The Committee welcomed the presentation and acknowledged the service's contribution to the prevention of ambulance dispatches and hospital conveyances, and the objectives to get patients the right service in the right place at the right time and to inform on alternative services to keep more people at home.

### **System Transformation and Service Change Update**

The paper provided the monthly overview of the clinical areas included within the system transformation and service change programme.

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

## PART B

### **Budget Setting Principles (2025/26)**

The paper sought the approval of the Committee to hold the ICB's recurrent deficit at the £167.8m brought forward from 2023/24 following developments during 2024/25 and for this to form the 'start point' to build the 2025/26 financial budget.

As reported in the efficiency programme paper, strong progress has been made against the highly challenging in-year target. However, a significant proportion of delivery has been derived from additional ERF income which can only be classed as non-recurring as the rules are anticipated to change for 2025/26. As a result, the organisation is forecasted to deliver a recurrent efficiency of £56.2m, leading to a £34.5m shortfall against target.

The Committee acknowledged the progress made against the key building blocks to create a 2025/26 financial budget by 1 April 2025 including the continuation of the maturing PID process and governance arrangements for 2025/26 and the need for a change in target setting process to create stronger links to the Medium Term Plan and acknowledge higher levels of delivery within 2024/25.

The Committee supported the 2025/26 efficiency targets being adjusted for 2024/25 performance and level of opportunity included within the Medium Term Plan acknowledging that further conversations need to take place within the organisation regarding how this will be implemented.

The Committee approved the ICB's recurrent 'start point' budget to be set at a £167.8m deficit and noted that a monthly update will be brought to the Committee with the budget being presented to the Board for sign off at its March 2025 meeting.

### **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.

The Committee approved the AVS contract award to Vocare Ltd on a 3-year contract with the option to extend for a further 2 years. The lifetime value of the award including the extension period is £4.14m.

### **Patient Choice and Provider Accreditation**

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

As at 20 December 2024, 18 providers had lodged a request with the ICB seeking accreditation, of which 9 relate to mental health (where the requirements to be accredited have a lower threshold than elective). A number of the requests have breached the 6-week requirement to process (this was to allow us to revise our processes) and the ICB met with the NHSE Patient Choice Team on 5 December to discuss one case where a provider had escalated seeking accreditation for general elective services. This has now been resolved with support from NHSE, and a specification has been shared with the provider to review.

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

### **Pulmonary Rehabilitation Services**

The paper provided a summary of the current position regarding pulmonary rehabilitation services in East and Southeast Staffordshire, an overview of the options available for the commissioning of pulmonary rehabilitation for 2025/26, and risks associated with each.

The Committee acknowledged:

- A decision is required regarding delivery of the service as the current contract will expire on 1 May 2025 and cannot be extend
- There is current inequity of provision due to historical commissioning decisions
- There is an opportunity to create a more comprehensive equitable service for patients
- There is a potential cost pressure with all of the options presented
- The paper was presented at the December System Performance Group meeting where there was support in principle of the recommended approach.

The Committee approved Option 4 - Modification of the service/activity into the main community and mental health contract.

## ASSURE

### PART A

#### Clinical Engagement

The paper provided a description of the Clinical and Professional Leadership in relation to the Medium Term Plan and System recovery actions.

The Committee was assured:

- The Medium Term Plan is underpinned by clinical leadership at every level, from governance and decision-making to implementation and evaluation
- The Health and Care Senate reports to the ICB Board on approvals of clinical strategy, clinical policy and pathways that will support the work in the Medium Term Plan
- The Clinical Value and Medicines Collaborative promotes and delivers the ambition of the Medium Term Plan through clinical optimisation, prioritisation and planning. The Clinical Value Collaborative Board will have oversight of the delivery and impact of the programmes in the Medium Term Plan and report to the Health and Care Senate
- The Chief Medical Officer is the SRO for the 'tough decisions' workstream and leads the clinical leadership in navigating these complex challenges to ensure decisions are grounded in clinical evidence and adhere to System priorities.

#### 2025/26 Planning Update

The paper detailed the proposals to enable the efficient and effective delivery of the NHSE technical planning submissions in response to the national operational planning guidance. It included a draft high-level timeline (pending confirmation of submission dates), governance structures and key outputs to support the planning process.

The Committee agreed the proposed governance structure and acknowledged that each organisation, including the ICB, will have its own in-year operating plan. The ICB Operational Plan will reflect key deliverables aligned to statutory duties. The first year of the Medium-Term Plan will be the System-level year one Operating Plan which will set out the key milestones, deliverables and KPIs/outcomes aligned with its key priorities.

### PART B

#### **Internal ICB Review of CHC Procurement Process**

The paper provided details of the internal review of the CHC procurement process undertaken by the ICB with a view to capturing any potential lessons and considerations for the future.

The Committee acknowledged the findings of the report and agreed the adoption of the recommendations, acknowledging that the implementation of the recommendations will be reported back to the Strategic Commissioning and Transformation Committee in Q1 2025/26.

#### **All Age Continuing Care Service Update**

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

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

**Primary Care Forum**

In order to have governance oversight, the Committee received a summary report of the meeting that took place on 10 December.

There were no decisions made at the meeting that required escalation to the Committee.

**ICB Undertakings**

The Committee received the latest dashboard showing performance against the Undertakings for information.

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

**PART A**

**Q3 2024/25 System Board Assurance Framework (SBAF) Update**

The report provided the refreshed SBAF for Q3 2024-25.

The Committee confirmed that the Q3 risk scores and assurance assessments are an accurate reflection of the position and the adequacy of controls and assessments with particular focus on SBAF 1, 2, 6 and 7.

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.

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 2025					
<b>Title:</b>	People Culture and Inclusion Assurance Report					
<b>Presenting Officer:</b>	Mish Irvine, Chief People Officer ICB					
<b>Author(s):</b>	Helen Conway, ICS Strategic Workforce Planning Lead Gemma Treanor, Head of ICS People Function					
<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>	NO				
<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 <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
<b>Appendices:</b>	Click or tap here to enter text.					

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

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

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

**Date**

People, Culture and Inclusion Committee

06/01/2025

**(3) Implications:**

<b>Legal / Regulatory</b>	Delivery of Local people Plan, Joint Forward Plan and Long-term Workforce Plan. NHSE workforce controls and reporting. ICB statutory duty for education and training
<b>CQC / Patient Safety</b>	NHSE reporting and assurance on workforce planning and metrics
<b>Financial (CFO-assured)</b>	External funding supports delivery of schemes including NHSE, ICB, being monitored and reported. Specific challenges in relation to agency, operating plan and workforce affordability in line with financial envelope.
<b>Sustainability</b>	Across all programmes. Specific activity linked to Green/Sustainability plans

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

<b>Workforce / Training</b>	Across all programmes – detailed in report
<b>Equality &amp; Diversity</b>	Across all programmes – detailed in report
<b>Due Regard: Inequalities</b>	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers
<b>Due Regard: wider effect</b>	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers

<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 checked="" type="checkbox"/>
<b>BAF3</b>	Proactive Community Services	<input 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>The report outlines the current workforce position within SSOT. System level oversight and monitoring of people metrics, controls and performance against operational plan continues in partnership with NHS Providers. The current operating environment and financial position remains pressured, with additional scrutiny continuing in workforce reconciliation and oversight framework. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements are key to the operating plan delivery and recovery programme – at organisational and system level.</p> <p>The following areas are detailed in the report:</p> <ul style="list-style-type: none"> <li>- Workforce Assurance, Oversight, Metrics &amp; Controls</li> <li>- Workforce Challenges, Risks &amp; Mitigations</li> </ul>

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

# ICS People Culture & Inclusion Performance and Assurance Report

SSOT ICB Board in Public

January 2025



# Executive summary

This report will outline:

- An executive summary outlining key headlines and escalations in relation to People, Culture and Inclusion
- Workforce Assurance, Oversight, Metrics & Controls
- Workforce Challenges, Risks & Mitigations

## Executive Summary:

This report outlines the current position regarding workforce within SSOT, system level oversight and monitoring of people metrics, controls and performance against operational plan, which continues in partnership with NHS Providers. The current operating environment and financial position continues to be pressured, with continued scrutiny on workforce additionality following implementation of PWC grip and control measures and also current investigation and intervention position. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements are key to the operating plan delivery and recovery programme – at organisational and system level.


The following areas are highlighted:


- **Workforce Assurance, Oversight, Metrics & Controls –**
  - Oversight of the workforce position continues to be reviewed on a monthly basis in conjunction with our providers to understand key priorities, risks and improvement opportunities. The approach is supported by NHSE endorsed 'Making Data Count' principles utilising data science approaches to measure data, performance and understand areas for improvement focus. This approach is particularly important in the workforce field where trend is not always compliant with a linear pattern or cumulative in nature and a level of movement tolerance is critical to ensure efforts are focused on the right activities and proportionate response. Key workforce indicators are reviewed with providers on a monthly basis through a regular assurance and oversight meeting. This approach will provide a foundation in which workforce metrics can inform MDT oversight approach, i.e. triangulation with activity and finance.
  - As at Nov-24 for the first time in FY24-25 workforce levels have exceeded the Mar-24 starting position by +7 wte. This is due to increases in the substantive workforce of +563 wte. Whilst decreases have been seen in both bank (-268 wte) and agency (-289 wte). Since Oct-24 position, the workforce has increased overall by +151 wte. This increase is largely driven by increases in substantive (+67 wte) and bank (+94 wte) whilst agency continues to remain relatively stable despite operational pressures, decreasing slightly by -10 wte. From an agency perspective, our current position is 2.3% agency of total pay spend for FYTD24-25 and since May 24 we have periodically been below plan overall as a system. For context, the Nov-24 position is just short of being £2m less than the highest point in the last 12 months (Nov-24).
  - Staff morale, health and wellbeing is high priority and current sickness absence levels are of concern, particularly during a period of significant operational pressure. Collectively we have a higher sickness absence rates and these have peaked at their second highest rate in the last 24 months in the latest reporting month of Nov-24. Sickness absence remains a key area of improvement opportunity to help our people to be supported at work to be well and stay well.
- The ICS **People risks** reflect the current risks across the partner organisations and have been robustly reviewed via the Sub-Committees and Delivery Groups. The top risks to the system are: Agency usage and spend; Employee Wellbeing/Retention; and slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage. Risks were robustly reviewed at the PCI Committee on 16<sup>th</sup> October 2024
- People, Culture and Inclusion **Programme delivery** is overall on track, with programmes and activity in place to address system challenges and risks.


# Workforce Assurance, Oversight, Metrics & Controls





The following provides a brief overview of the workforce position in respects of challenges and achievements:


- 


Our combined bank and agency workforce is **7.2% of our total workforce**. This is **-2.3% lower** than the highest point in the past 12 months (Mar-24).
- 

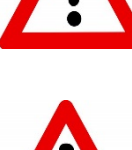
FYTD **agency spend is 22.4% below plan** and positively is remaining static in terms of performance, despite operational pressures.
- 


**Agency spend is currently £2.5m which equates to 2.3% of total pay spend** which is 1.0% below the reduced agency use measure of 3.2% in FY24-25 (previously 3.7% FY23-24). Although this is an increase from last month, Oct-24 was an outlier due to being exceptionally low. Nov-24 position is reflective of trend in the last 6 months. For context Nov-23 position was 4.3% and the highest point in the last 12M.
- 

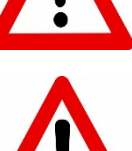
**Agency WTE remains relatively static between Oct-24 and Nov-24 decreasing by -10 wte** to 253 wte overall. This is however -301 less than the highest point in the last 12 months (Dec-23).
- 


**Turnover rate is currently 8.6%** which is currently -0.8% below the highest rate in the last 12 months (Nov-23) and remains static from Oct-24.
- 

**AfC appraisal rates currently 87.9% - currently +10.7% above the lowest point in the last 12 months (Dec-23).**
- 

**NHS provider total actual workforce levels are significantly above plan by +467 wte**, this is predominantly driven by the UHNM position.
- 

**Total workforce has overall increased since Oct-24 by +151 wte** (+67 wte Substantive, +94 Bank and -10 Agency)
- 

**Total workforce has remained relatively static since March 2024 increasing just by 7 wte, however we are now above the start point for the year.** (+563 Substantive, -268 Bank and -289 Agency)
- 

Work is underway to continually improve the agency position.
- 

Sickness absence rates currently equate to 5.4% which is in line with the average for the past 24 months. Although the current position is reflective of trend this remains a key area of improvement opportunity to help out people be well, stay well and be supported at work.

# SSOT Workforce Variance to Plan by Provider NHS Trust (M8)

	UHNM	MPFT	NSCHT
<b>Total Workforce (wte)</b>	<b>+452</b> <b>(+32 wte above establishment)</b>	<b>-13</b>	<b>+29</b>
<b>Substantive (wte)</b>	<b>+292</b>	<b>+176</b>	<b>+35</b>
<b>Bank (wte)</b>	<b>+235</b>	<b>-111</b>	<b>-3.6</b>
<b>Agency (wte)</b>	<b>-76</b>	<b>-79</b>	<b>-2.7</b>
<b>Reasons for Variation</b>	<ul style="list-style-type: none"> <li>- Substantive: NQN's, lower than planned turnover has led to increased staffing to plan. Also reflective of additonality for CDC and NHSE funding (corneal donation)</li> <li>- Bank usage higher than planned due to vacancies, sickness, high numbers of 1-2-1 requirements.</li> </ul>	<ul style="list-style-type: none"> <li>- Increased substantive staff due to recruitment to vacancies and new service acquisition</li> </ul>	<ul style="list-style-type: none"> <li>- Increased substantive staff due to newly qualified staff on boarding.</li> </ul>
<b>Mitigating Actions</b>	<ul style="list-style-type: none"> <li>- Exec Led monthly assurance meetings to deep dive agency/bank use, vacancies, sickness, overtime, WLIs</li> <li>- Robust Vacancy control in place</li> </ul>	<ul style="list-style-type: none"> <li>- Substantive staff increase entirely offset by reduction in bank/agency spend</li> <li>- Monthly analysis of temp staffing dashboards and performance against pay bill targets by Care Group</li> <li>- Quarterly workforce movement analysis and deep dive actions by People team</li> <li>- Robust Vacancy control in place</li> </ul>	<ul style="list-style-type: none"> <li>- Exec level analysis of bank/agency use</li> <li>- Robust vacancy control in place</li> </ul>

**SSoT NHS Provider actual to plan position: Total +467 wte, substantive +504 wte, bank 120+ wte, agency -157 wte**

# Workforce challenges, risks & mitigations through programme activity



## 5. Workforce - Risks, challenges and mitigation

The Risks and Challenge

### People risks

- The following risks are identified on the People Culture and Inclusion Risk Register:
  - Agency usage and spend - *considered reduction in score due to improvement, however remains unchanged with further review planned at 13<sup>th</sup> November PCI.*
  - Care Home and Home Care Workforce Capacity
  - Ability to deliver the Local People Plan programmes, People Operating Model and Long Term Workforce Plan
  - Employee Health Wellbeing and Retention – *includes risk surrounding future of Staff Psychological Wellbeing Hub service*
  - Slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage
  - Ability to deliver the Long Term Workforce Plan and create a sustainable future pipeline
  - Industrial Action – *reduction in score pending possible further nursing action.*
  - Primary Care Retention and GP Collective action (jointly managed risks)
- The System Board Assurance Framework 'Sustainable Workforce' also reflects the 2024/25 impact and controls.

FY24-25 People Programme Delivery

### ICS People Culture and Inclusion Programme Delivery highlights:

- The ICS People, Culture and Inclusion (PCI) Committee continues to oversee system programmes which support innovation and improvement in risks and challenges. All programmes are on track and delivering impact across the seven workstreams and priority areas.
- NHS organisations are addressing increased sickness rates and focussing on health and wellbeing of the workforce, working in partnership with non-NHS organisations to share practice and offers via the ICS Experience, Health and Wellbeing Workstream.
- Black History Month was celebrated by organisations and colleagues across the system during October including events, networks and sharing resources.
- Widening participation and access programmes continue with significant progress being made in educational engagement (primary and secondary schools, and colleges), T-Levels and Apprenticeships. Focus on entry level careers and new to care approach with local residents – linked to Anchor Employer approach.
- The system OD plan is now being implemented following ratification by the PCI Committee and ICB Board.

# People Metrics Appendices

- System Monthly Position
- System Trend
- Provider Summary



# Staffordshire & Stoke-on-Trent NHS: November 2024

## NHS Workforce

Total Workforce

**24,409** WTE

Currently +634 wte (Dec 23)

Substantive

**22,641** WTE

Currently +963 wte (Dec 23)

Bank

**1,515** WTE

Currently +95 wte (Oct 24)

Agency

**253** WTE

Currently -301 wte (Dec 23)

Temporary Workforce

**7.2%**

Currently -2.3% (Mar 24)

Agency Spend

**£2.5M (2.3%)**

Currently -£1.8M (Nov 23)

Vacancies

**2,272 wte (9.1%)**

Currently -351 wte (Dec 23)

Joiners

**215 wte**

Currently +50 wte (Jun 24)

Leavers

**143 wte**

Currently -99 wte (Mar 24)

## Other Health and Care Workforce

SSOT ICB Workforce

**339** WTE

Primary Care Workforce

**2,896** WTE

Social Care Workforce

**21,000** WTE

Dentistry Workforce

**610** Headcount

12 Month Rolling KPI's (%)

**8.6%**

Turnover  
Rate

Currently -0.8% (Dec 23)

**5.4%**

Sickness  
Absence Rate

Currently 12 Month High

**93.5%**

Mandatory  
Training

Currently +0.4% (Jan 24)

**87.9%**

AFC  
Appraisal  
Rate

Currently +10.7% (Dec 23)

**77.0%**

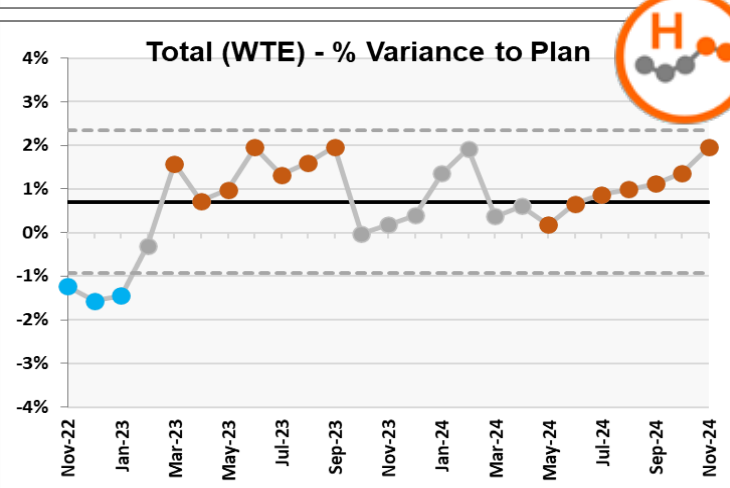
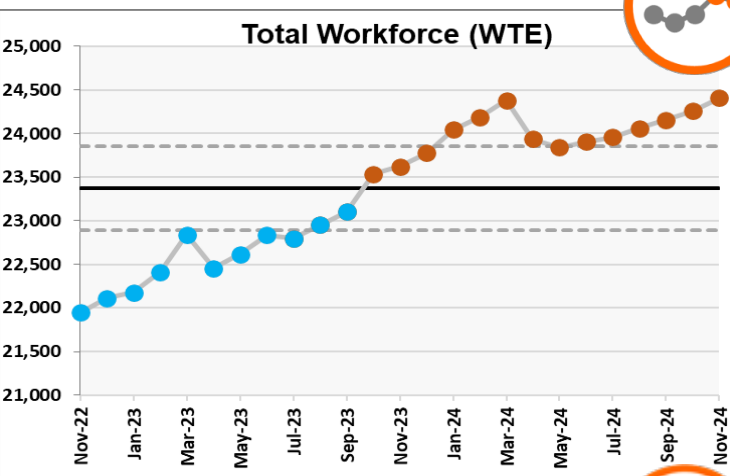
Medical  
Appraisal Rate

Currently -7.9% (Mar 24)

# Current Workforce Position: November 24

## Staff in Post (Total Workforce wte)

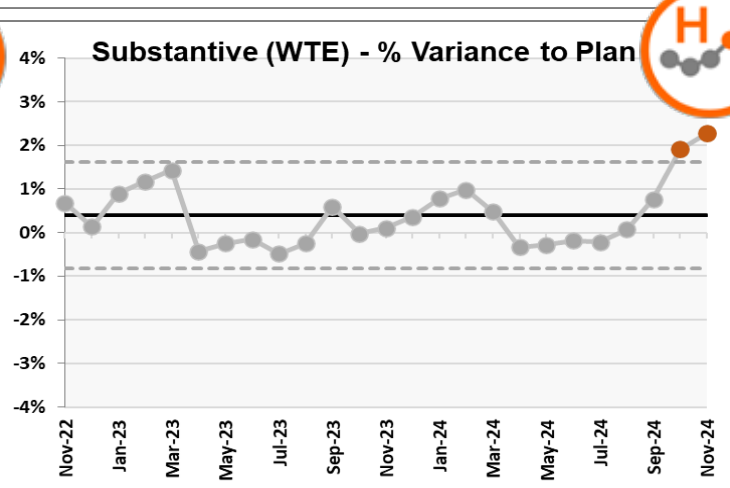
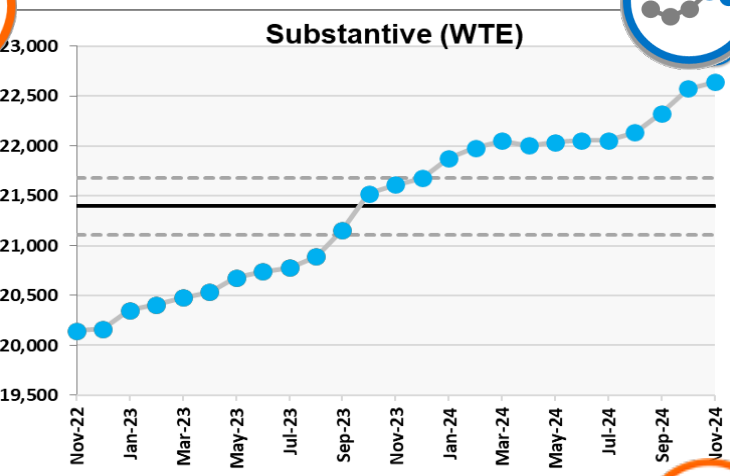
Nov 24: **24,409**  
 Position to Plan: **+467**  
 12M Change: **+787**  
 FYTD Change: **+31**



**Actual vs Plan**  
 Overall: **+467 wte above plan**  
 Registered Nursing: **+249 wte above**  
 Registered S,T&T: **+24 wte above**  
 Support to Clinical: **-30 wte below**  
 NHS Infrastructure: **+155 wte above**  
 Medical and Dental: **+96 wte above**

## Staff in Post (Substantive wte)

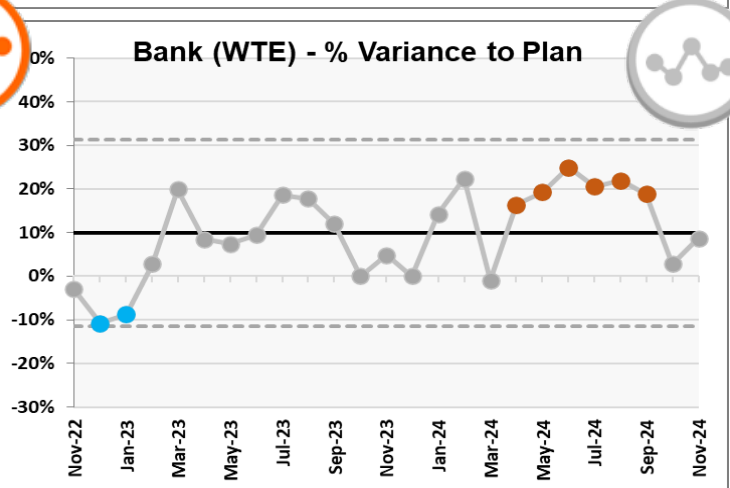
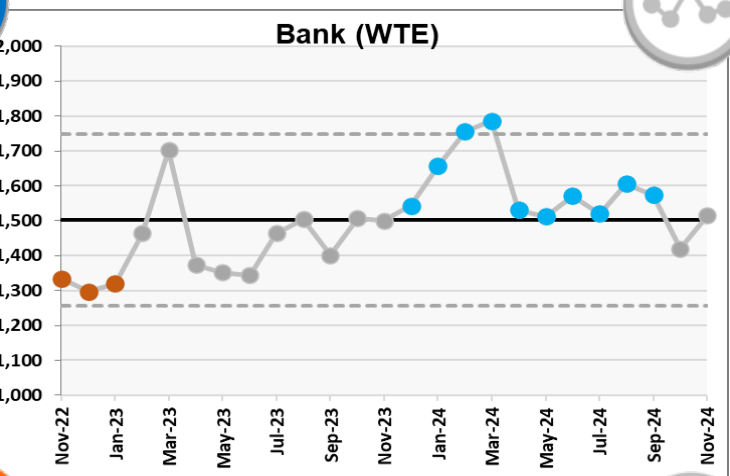
Nov 24: **22,641**  
 Position to Plan: **+504**  
 12M Change: **+1,029**  
 FYTD Change: **+590**



**Actual vs Plan**  
 Overall: **+504 wte above plan**  
 Registered Nursing: **+242 wte above**  
 Registered S,T&T: **+40 wte below**  
 Support to Clinical: **+1 wte above**  
 NHS Infrastructure: **+139 wte above**  
 Medical and Dental: **+81 wte below**

## Bank Workforce

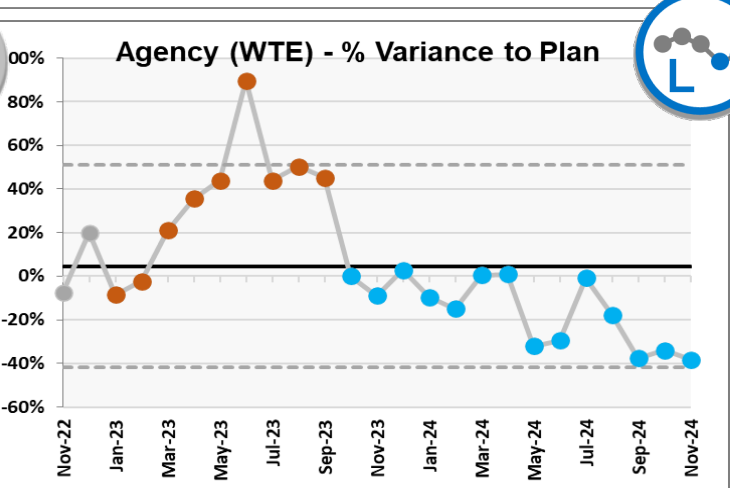
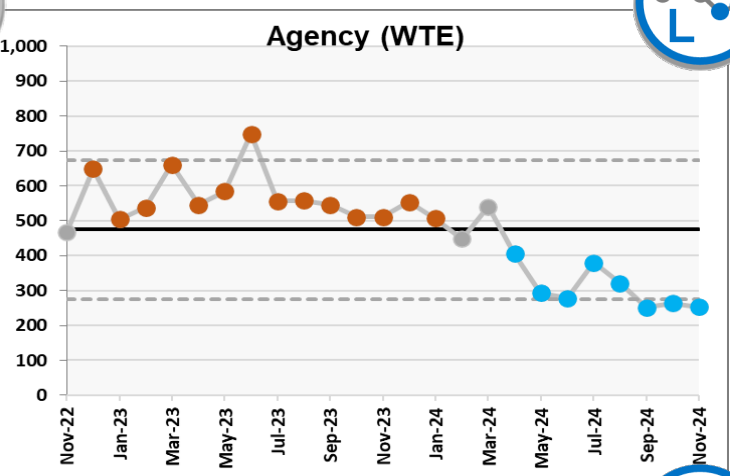
Nov 24: **1,515**  
 Position to Plan: **+120**  
 12M Change: **+15**  
 FYTD Change: **-272**



**Actual vs Plan**  
 Overall: **+120 wte above plan**  
 Registered Nursing: **+39 wte above**  
 Registered S,T&T: **+10 wte above**  
 Support to Clinical: **-11 wte below**  
 NHS Infrastructure: **+38 wte above**  
 Medical and Dental: **+44 wte above**

## Agency Spend (% of total pay spend)

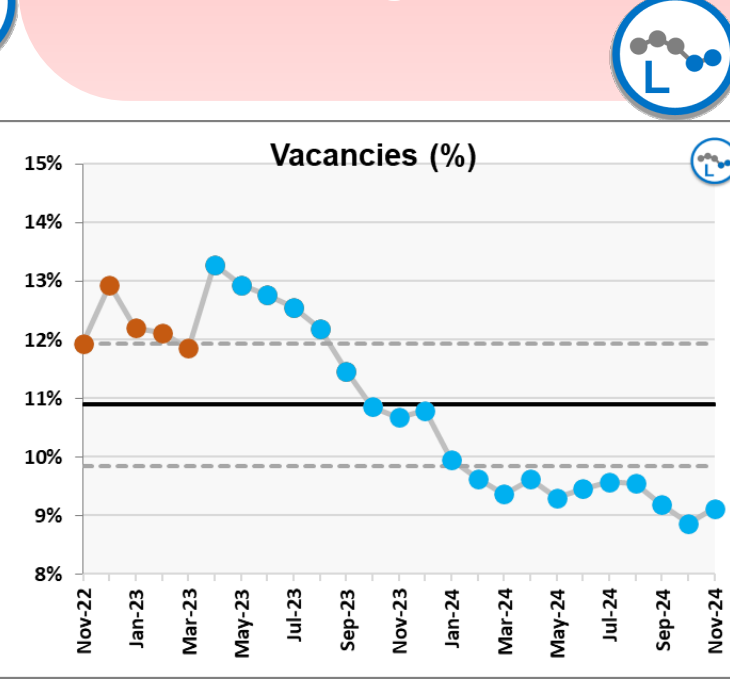
Nov 24: **2.3%**  
 Plan Position (FYTD): **-22.4%**  
 12M Change: **-1.9%**  
 FYTD Change: **-0.9%**



**Actual vs Plan**  
 Overall: **-157 wte below plan**  
 Registered Nursing: **-33 wte below**  
 Registered S,T&T: **-27 wte below**  
 Support to Clinical: **-20 wte below**  
 NHS Infrastructure: **-22 wte below**  
 Medical and Dental: **-29 wte below**

## Vacancies (%)

Nov 24: **9.1%**  
 12M Change: **-1.6%**  
 FYTD Change: **-0.3%**



**Vacancies**  
 Vacancies total **2,272 wte (9.1%)**, this is the second lowest level of vacancies the system has had in the last 12 months

# 5. Workforce – FY24-25 Performance to Plan

SSOT

## Total Workforce

31<sup>st</sup> Mar 24: 24,378 wte  
 Nov-24: 24,409 wte  
 FYTD Change:  
 +31 wte / +0.1%  
 Nov-24 Position to Plan:  
 +467 wte / +2.0% above plan

## Substantive

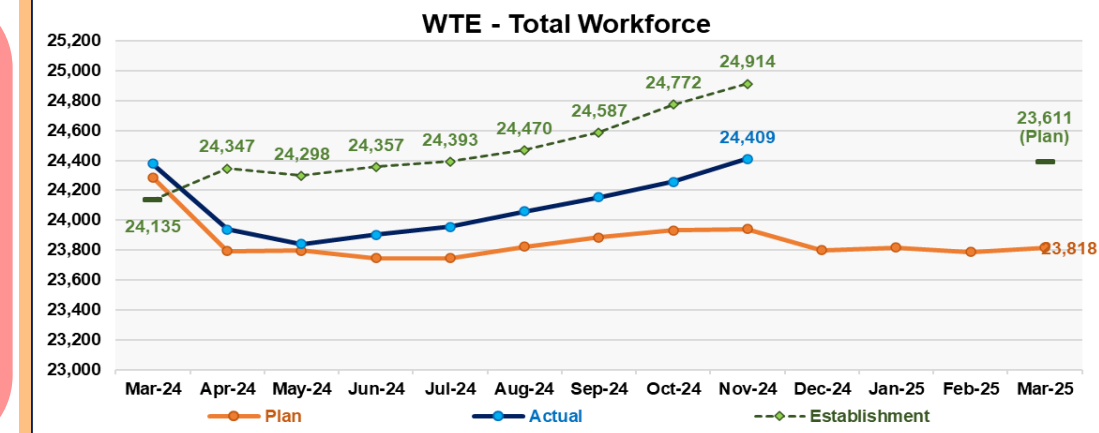
31<sup>st</sup> Mar 24: 22,051 wte  
 Nov-24: 22,641 wte  
 FYTD Change:  
 +590 wte / +2.7%  
 Nov-24 Position to Plan:  
 +504 wte / +2.3% above plan

## Bank

31<sup>st</sup> Mar 24: 1,786 wte  
 Nov-24: 1,515 wte  
 FYTD Change:  
 -272 wte / -15.2%  
 Nov-24 Position to Plan:  
 +120 wte / +8.6% above plan

## Agency

31<sup>st</sup> Mar 24: 541 wte  
 Nov-24: 253 wte  
 FYTD Change:  
 -288 wte / -53.2%  
 Nov-24 Position to Plan:  
 -157 wte / -38.3% under plan



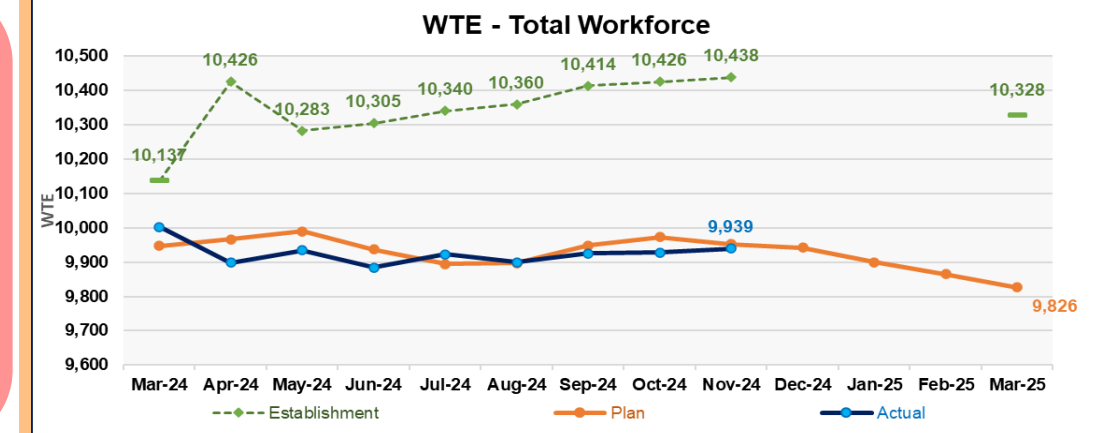
MPUFT

31<sup>st</sup> Mar 24: 10,003 wte  
 Nov-24: 9,939 wte  
 FYTD Change:  
 -64 wte / -0.6%  
 Nov-24 Position to Plan:  
 -13 wte / -0.1% under plan

31<sup>st</sup> Mar 24: 9,154 wte  
 Nov-24: 9,375 wte  
 FYTD Change:  
 +221 wte / +2.4%  
 Nov-24 Position to Plan:  
 +176 wte / +1.9% above plan

31<sup>st</sup> Mar 24: 647 wte  
 Nov-24: 473 wte  
 FYTD Change:  
 -174 wte / -27.0%  
 Nov-24 Position to Plan:  
 -111 wte / -19.0% under plan

31<sup>st</sup> Mar 24: 202 wte  
 Nov-24: 92 wte  
 FYTD Change:  
 -110 wte / -54.5%  
 Nov-24 Position to Plan:  
 -79 wte / -46.2% under plan



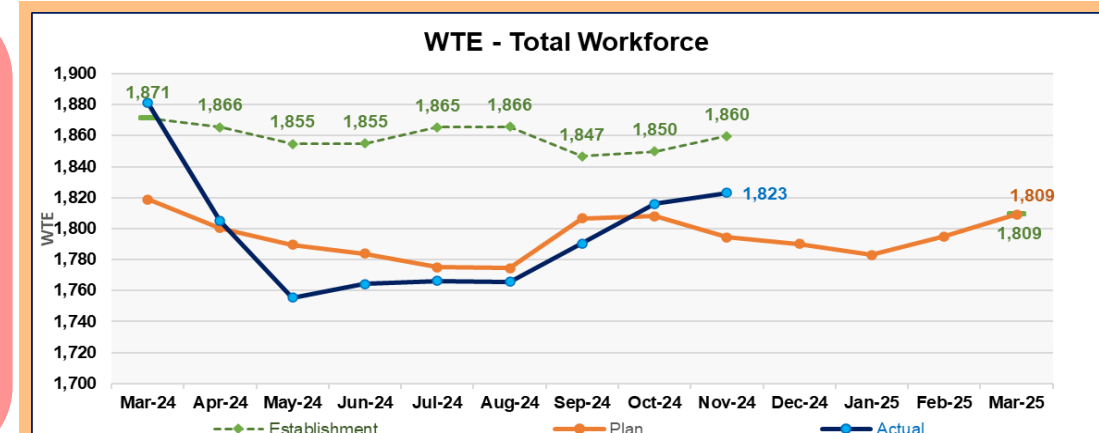
NSCHT

31<sup>st</sup> Mar 24: 1,881 wte  
 Nov-24: 1,823 wte  
 FYTD Change:  
 -58 wte / -3.1%  
 Nov-24 Position to Plan:  
 +29 wte / +1.6% above plan

31<sup>st</sup> Mar 24: 1,732 wte  
 Nov-24: 1,696 wte  
 FYTD Change:  
 -36 wte / -2.1%  
 Nov-24 Position to Plan:  
 +35 wte / +2.1% above plan

31<sup>st</sup> Mar 24: 113 wte  
 Nov-24: 116 wte  
 FYTD Change:  
 +3 wte / +2.9%  
 Nov-24 Position to Plan:  
 -4 wte / -3.0% under plan

31<sup>st</sup> Mar 24: 36 wte  
 Nov-24: 11 wte  
 FYTD Change:  
 -25 wte / -69.8%  
 Nov-24 Position to Plan:  
 -3 wte / -20.2% under plan



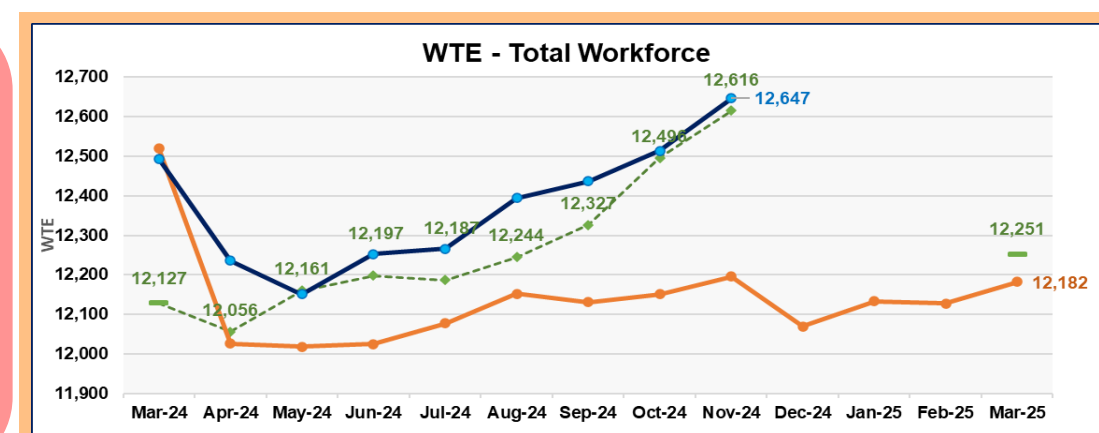
UHNIM

31<sup>st</sup> Mar 24: 12,494 wte  
 Nov-24: 12,647 wte  
 FYTD Change:  
 +153 wte / +1.2%  
 Nov-24 Position to Plan:  
 +452 wte / +3.7% above plan  
 Nov-24 Position to Establishment:  
 +32 wte above establishment

31<sup>st</sup> Mar 24: 11,165 wte  
 Nov-24: 11,571 wte  
 FYTD Change:  
 +406 wte / +3.6%  
 Nov-24 Position to Plan:  
 +292 wte / +2.6% above plan

31<sup>st</sup> Mar 24: 1,026 wte  
 Nov-24: 926 wte  
 FYTD Change:  
 -100 wte / -9.8%  
 Nov-24 Position to Plan:  
 +235 wte / +34.0% above plan

31<sup>st</sup> Mar 24: 303 wte  
 Nov-24: 151 wte  
 FYTD Change:  
 -153 wte / -50.3%  
 Nov-24 Position to Plan:  
 -76 wte / -33.4% under plan



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

<b>Report To:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>16<sup>th</sup> January 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>6 January 2025</b>
<b>Meeting Quorate Y/N?</b>	<b>YES</b>
<b>Presenter:</b>	<b>Shokat Lal, Non-Executive Director &amp; Committee Chair</b>
<b>Author:</b>	<b>Helen Conway, ICS Strategic Workforce Planning Lead and Nicola Forrest, People Programme Manager</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 and an update on the Medium-Term Plan work underway. The current financial position remains challenged even with the Recovery Plan in place, although the position is improving and the gap closing.

A Medium Term (MDT) model has been developed which will need to be delivered into a plan which enables the understanding of transformation and subsequent impact to our workforce. The medium-term plan will cover a 5-year period (FY25-26 – FY29-30) with the first year of this plan also informing the operational plan. Partners recognised and agreed the change in workforce models, culture and leadership required to deliver care closer to home and reduce reliance on secondary care. New roles and pathways to support our workforce to deliver these will be a priority in the SSOT People Plan which will be developed in line with the MDT.

The papers outlined that SSOT are significantly above our planned workforce growth for 2024/25. This primarily sits within UHNM both in substantive and bank workforce. A detailed piece of work is being carried out to understand this growth and action plan.

**I&I regime**

Extensive discussion and consideration of the workforce position was covered in the Committee as we enter a significant phase of the I&I requirement in terms of delivery. This provided an overview of our overarching financial position and Deloitte's/Kingsgate progress update. The current position to plan has been shared which indicates workforce additionality to that of the operational plan submitted for FY24-25 in Jun-24. Work continues to identify improvement opportunities directly between providers and the I&I organisation and ensure that the controls are appropriate to enable delivery of the plan.

Following review of the current processes and procedures, this review has helped ascertain that there is a good operating standard of mechanisms to support workforce control. However, there is opportunity for the rigour of these processes to be improved to enable an environment of enhanced controls and ensure that there is sufficient scrutiny to challenge ways of working. I+I colleagues will support an enhanced approach to the finance control and recovery groups in place organisationally, so all areas of workforce are considered in this way, whilst ensuring the organisation is equipped to make the best-informed decisions within each division/service lines of our organisations. This activity is focused on all stages of the recruitment pipeline to ensure all opportunities are considered and exhausted to deliver care safely and efficiently.

**People/Workforce Health, Wellbeing and Morale:**

A continued area of improvement focus is the health and wellbeing of our workforce. Collectively we have higher sickness absence rates, and these have peaked at their second highest rate in the last 24 months in the latest reporting month of Nov-24. This highlights that now more than ever it is critical to understand the drivers behind sickness absence and how we can positively impact this to support our workforce and there on in ensure the services that our population receives are not adversely affected.

With a full appreciation of the operational and financial challenges that our footprint faces, we need to remain cognisant of the impact on our employee experience and in turn patient experience, particularly whilst there is high operational pressure during winter months and instances of critical incident. Emphasis is being placed on health and wellbeing events in providers and the 2024 staff survey will provide an opportunity for further understanding of the drivers of sickness and opportunities for improvement. At System level, it has been announced that the Staff Psychological Wellbeing Hub has been supported to continue to provide an invaluable offer to staff from across all our organisations, including those within Social Care and Primary Car for a further 11 months from March '25 onwards. During this time, a comprehensive review will be undertaken with System Partners regarding our collective Health and Wellbeing offers.

**(2) ICS Staff Psychological Wellbeing Hub**

The Committee received an update regarding the ICS Staff Psychological Wellbeing Hub, and future funding (as highlighted in the last Committee report). ICS Partners confirmed that internal and system conversations had taken place, and funding has been secured for a short-medium term extension. Further discussions are needed to secure longer term funding for the Hub, or to scope alternative provision.

**ASSURE**

**(3) Strategic System Updates:**

The strategic system update focused on the current operational challenges, including critical incident escalation. Thorough consideration was given the duality of the impact of the operational pressures not only the impact on our people's morale and well-being in a time of operational pressure which has a double impact on our workforce, i.e. capacity to cope with additional activity whilst also being at risk of ill-health as an individual.

**(4) Staff Story: ICS Placement Programme**

The committee watched a video of the ICS Future Leaders Placement which took place in November 2024 and heard from Corrine, paramedic student who took part in the programme. The Placement was a week-long placement opportunity for pre-registration NMAHP students, with the aim to develop an understanding

of the ICS, increase leadership skills, increase confidence and support with retention and placements areas.

**(5) Workstream focus: Education, Training & Development**

The Committee received an update on the Education, Training & Development Sub-Committee, the strategic priorities for the workstream and programme activity. A detailed discussion took place around the challenges currently being faced in this area and how, in the next 5 years, we can mitigate against some of these issues. Areas of focus centred around ensuring adequate student placements are available, offering flexible and rotational roles and greater involvement in curriculum development. Partners agreed to pursue actions within their own organisations to promote a systemic model of workforce utilisation from the start of young people journeys (in schools/education) to development of courses and placements (HEIs) to offering more flexible and peripatetic roles. It was acknowledged that this will be a process that would take several years, and we need to focus on the high need areas, expand on good work already being carried out in Organisations and led by the System, to ensure we are productive.

The points raised will be considered by the Senior Responsible Officer and Programme Lead and an action plan will be developed in line with the Medium-Term plan workforce implications, the NHS Operational Plan as part of the System People Plan.

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

**(1) SBAF:**

The Committee received the SBAF, there were no escalations or queries on the paper.

After a discussion it was agreed that the SBAF needed to ensure it reflected longer term planning and solutions rather than just focussing on current issues.

***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 Escalation & Assurance Report from Committees<sup>1</sup>**

<b>Report To:</b>	ICB Board
<b>Date:</b>	16 <sup>th</sup> January 2025
<b>Reporting Committee / Group:</b>	Remuneration Committee
<b>Date of Meeting:</b>	19-12-2024
<b>Meeting Quorate Y/N?</b>	Yes
<b>Presenter:</b>	Shokat Lal
<b>Author:</b>	N Walker, Project Lead (HR & Specialist)

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

**ALERT**

None discussed.

**ADVISE**

None discussed.

**ASSURE**

**Update: CEO's appraisal/mini 360:** The Remuneration Committee received an update on the CEO's appraisal/mini 360. The committee noted the update.

**2024/25 Annual Pay Review for our local CPL pay framework:** The Remuneration Committee received a paper on the 2024/25 Annual Pay Review for our local CPL pay framework. The committee:

- Agreed a 6% cost of living award for our Local CPL Pay Framework in line with the Medical and Dental national cost of living rises, effective from 1<sup>st</sup> April 2024.
- Agreed that all future cost of living rises should be linked to those applicable to Salaried GPs in the national Medical and Dental staff group.
- Agreed to the proposal to incorporate the pay of ICB Primary Medical Service Partner Board Members into the Local Clinical & Professional Leadership Pay Framework.

**Confirmation of Appointment to the vacant Non-Executive Member (NEM):** The Remuneration Committee received a paper to update them on the appointment process to the vacant Non-Executive Member position, a further update confirming the process will be provided at the next meeting.

**Recruitment to the vacant Non-Executive Member (NEM) post:** The Remuneration Committee received a paper on the recruitment to the vacant Non-Executive Member (NEM) post. The committee:

- Approved the appointment to the forthcoming vacant NEM role.
- Approved the parameters for the NEM appointment.

**Chief Nursing and Therapies Officer – Partial retirement update:** The Remuneration Committee received a paper Chief Nursing and Therapies Officer – Partial retirement update. The committee:

- Noted the update of the CNTO arrangements
- Approved to support the continuation of the arrangements, subject to the continued employment of both current postholders.

**ASSURE**

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

Nothing to be added.

***Policies Approved:***

None discussed.

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

No decisions to be escalated to ICB Board.

<b>Report to:</b>	Integrated Care Board					
<b>Date:</b>	16 January 2025					
<b>Title:</b>	Q3 2024/25 System Board Assurance Framework (SBAF) Update					
<b>Presenting Officer:</b>	Claire Cotton, Director of Governance, UHNM					
<b>Author(s):</b>	Lia Pitarokoili, Head of Governance					
<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 checked="" 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>	NO				
<b>Any potential / actual Conflict of Interest?</b>	<b>Yes / No</b>	NO				
<b>Any financial impacts: ICB or ICS?</b>	<b>Yes / No</b>	NO				
<b>Any impacts on ICB Undertakings?</b>	<b>Yes / No</b>	NO				
<b>Appendices:</b>	SBAF report					

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

The enclosed report sets out the refreshed System Board Assurance Framework (SBAF) for Quarter 3 2024-25 and is provided to ICB Board for oversight and assurance. The SBAF has been presented or circulated offline to all ICB Committees during December 2024 - January 2025.

<b>(2) History of the paper, incl. date &amp; whether for A / D / S / I (as above):</b>	<b>Date</b>
Finance and Performance Committee (for Discussion and Assurance)	7/1/2025
People, Culture and Inclusion Committee (for Discussion and Assurance)	6/1/2025
Audit Committee (for Discussion and Assurance)	Circulated offline
Quality and Safety Committee (for Discussion and Assurance)	Circulated offline

**(3) Implications:**

<b>Legal / Regulatory</b>	UK Corporate Governance Codes and Controls Assurance Audits. SBAF completion is a key component of the ICB's Risk Management Strategy.
<b>CQC / Patient Safety</b>	There are no implications for CQC or other regulators
<b>Financial (CFO-assured)</b>	Managing financial risks will help mitigate Financial Management Concerns
<b>Sustainability</b>	Managing 'Greener NHS' risks will help mitigate Sustainability Concerns
<b>Workforce / Training</b>	Mitigation of workforce risks to meet the requirements of NHS Long Term Workforce Plan. There are no training implications resulting from this paper
<b>Equality &amp; Diversity</b>	N/A

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

<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"/>	N/A in relation to this Report
	<b>EIA</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A in relation to this Report
	<b>QIA</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A in relation to this Report
<b>Has there been Public / Patient Involvement?</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A in relation to this Report

<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>The System Board Assurance Framework (SBAF) sets out the principal risks to the achievement of the ICB’s Strategic Ambitions and constitutes a practical means through which the Committees and Board can assess delivery of these. The SBAF is also a primary source of evidence in describing how the ICB is discharging its responsibility for internal control. The SBAF sets out the key controls in place to manage these risks and the assurances available to support judgements as to whether the controls are having the desired impacts. It additionally describes any gaps in control that need to be addressed to achieve the target risk score or to improve adequacy of assurance and the actions to further reduce each risk to our Strategic Ambitions.</p> <p>The attached SBAF provides the Board with the Q3 update for 2024/25. For Q3 the SBAF objective owners have strengthened the rationale for risk score, emphasizing on key controls and assurances. A Q4 SBAF trajectory has also been introduced for each SBAF objective. The trajectory refers to the anticipated direction and projected trend of the risk over time. It contributes towards a proactive risk mitigation, the implementation of the right mitigating actions and more efficient risk management and proactive risk reduction. The SBAF as a dynamic document will continue to be developed and improved in terms of format and function throughout 24/25 and beyond.</p> <p>The SBAF includes eight Strategic Risks which provide coverage of the four Strategic Ambitions. The Strategic Framework is set out in Section 2 of the report.</p> <p>Strategic Ambition 2 (Address inequalities in access, experience and outcomes from health and care services) and Strategic Ambition 3 (Achieve a sustainable and resilient ICS) remain the most threatened, each with 5 Strategic Risks posing a threat.</p> <p>The top 3 Strategic Risks for this quarter remain SBAF 4 (Reducing Health Inequalities), SBAF 6 (Sustainable Finances) and SBAF 8 (Sustainable Workforce), all scoring High 20.</p> <p>There is in total 1 action that is ‘Problematic’ within SBAF 3 (Proactive Planning and Delivery of Integrated Locality Based Community Services). There are in total 6 actions that are ‘Delayed’, within SBAF 1</p>

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

(Responsive Patient Care – Urgent & Emergency Care), SBAF 2 (Responsive Patient Care (Elective)) and SBAF 7 (Improving Efficiency and Productivity).

The majority (6/8) of Strategic Risks have a 'Partial Assurance' rating although SBAF 5 (High Quality, Safe Care Outcomes) and SBAF 8 (Sustainable Workforce) have 'Acceptable Assurance' rating.

### **(7) Recommendations to Committee:**

The ICB Board is asked to discuss and confirm whether the Q3 risk scores and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.



Staffordshire and  
Stoke-on-Trent  
Integrated Care Board

# Integrated Care Board

## System Board Assurance Framework (SBAF)

Quarter 3 2024/25



# 1 Introduction and Overview

## Situation







The System Board Assurance Framework (SBAF) provides a structure and process which is designed to focus the Integrated Care Board (ICB) on the key strategic risks which might compromise the achievement of its Strategic Ambitions (SA). In identifying those risks, consideration is given to the key controls in place to mitigate the impact of risk and the sources of assurance which the Board can rely upon to determine the effectiveness of those controls. Where gaps in control or assurance are identified, further actions are identified which are aimed at either providing additional assurance or to reduce the likelihood or consequence of the risk, towards the target. The target risk score or 'tolerance' is aligned with our Risk Appetite Statement (appendix 4 of our Risk Management Strategy).

## Background

The Board approved the Integrated Care Partnership (ICP) Strategy in March 2023, which set out a Strategic Framework including four Strategic Ambitions (as set out in Section 2 below), around which the SBAF has been structured.

To refresh the SBAF for 2024/25, a Board Development session was held in March 2024. This provided opportunity to review each strategic risk and determine whether it remained relevant, with a particular focus on ensuring that they were described at a system wide level. As a result, it was agreed that each strategic risk would be carried forward into 2024/25, while some minor changes were agreed. The SBAF is a dynamic, ever evolving document which has and will continue to be developed and improved in terms of format and function throughout 2024/25 and beyond.

## Assessment

	The <b>top 3 Strategic Risks</b> for this quarter remain SBAF 4: Reducing Health Inequalities, SBAF 6: Sustainable Finances and SBAF 8: Sustainable Workforce, all scoring <b>High 20</b> .
	Risk levels have remained unchanged since Quarter 2 2024/25 with risk movement remaining static during Quarter 3 2024/25.
	SBAF 5: High Quality, Safe Care Outcomes has the <b>highest number of linked operational risks</b> (25 which has remained static since the last update) whereas SBAF 2: Responsive Patient Care (Elective) and SBAF 3: Proactive planning and delivery of Integrated Locality Based Community Services have the <b>lowest number of linked operational risks</b> (4 and 3 respectively, both of which have increased by 1 since the last update).
	There is in total <b>1 action which is 'Problematic'</b> at this stage within SBAF 3: Proactive planning and delivery of Integrated Locality Based Community Services. There are in total <b>6 actions that are 'Delayed'</b> ; within SBAF 1: Responsive Patient Care – Urgent & Emergency Care, SBAF 2: Responsive Patient Care (Elective) and SBAF 7: Improving Efficiency and Productivity.
	Strategic Ambition 2: Address inequalities in access, experience and outcomes from health and care services and Strategic Ambition 3: Achieve a sustainable and resilient Integrated Care System remain the 'most threatened', each with 5 Strategic Risks posing a threat.
	The majority (6/8) of Strategic Risks have a ' <b>Partial Assurance</b> ' rating although SBAF 5: High Quality, Safe Care Outcomes and SBAF 8: Sustainable Workforce have ' <b>Acceptable Assurance</b> '.

## Recommendations

Committees are asked to:

- Discuss and confirm whether the Q3 Risk Scores and Assurance Assessments are an accurate reflection of the position.
- Discuss and comment on the adequacy of Controls and Assurances and consider whether the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance.
- Note that further work is to be undertaken on Committee Business Cycles to ensure full alignment with the SBAF.

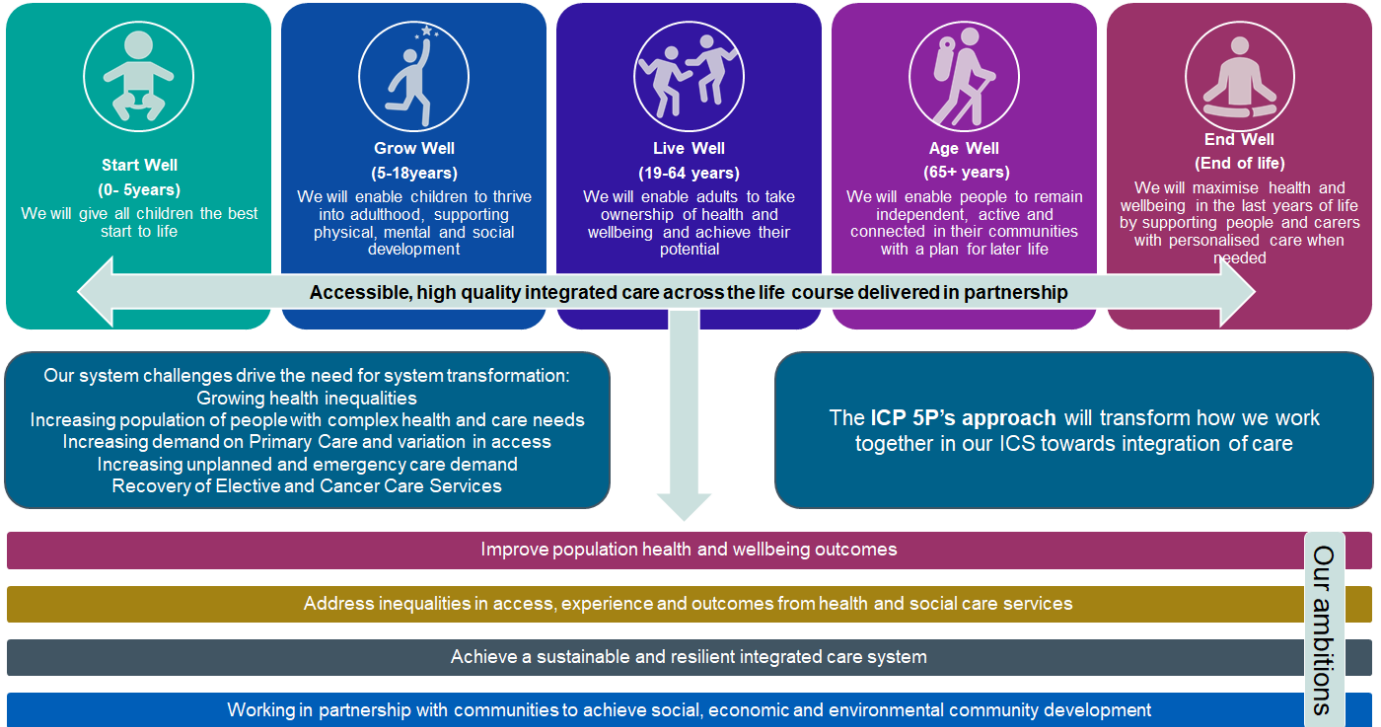
## Additional Information

- The SBAF can be viewed on SharePoint: [Staffs CCGs | Communications and Governance - BAF and Risk Register - All Documents \(sharepoint.com\)](#)
- The following tables set out the keys used within the SBAF for Action Plans and Assurance Assessment Ratings

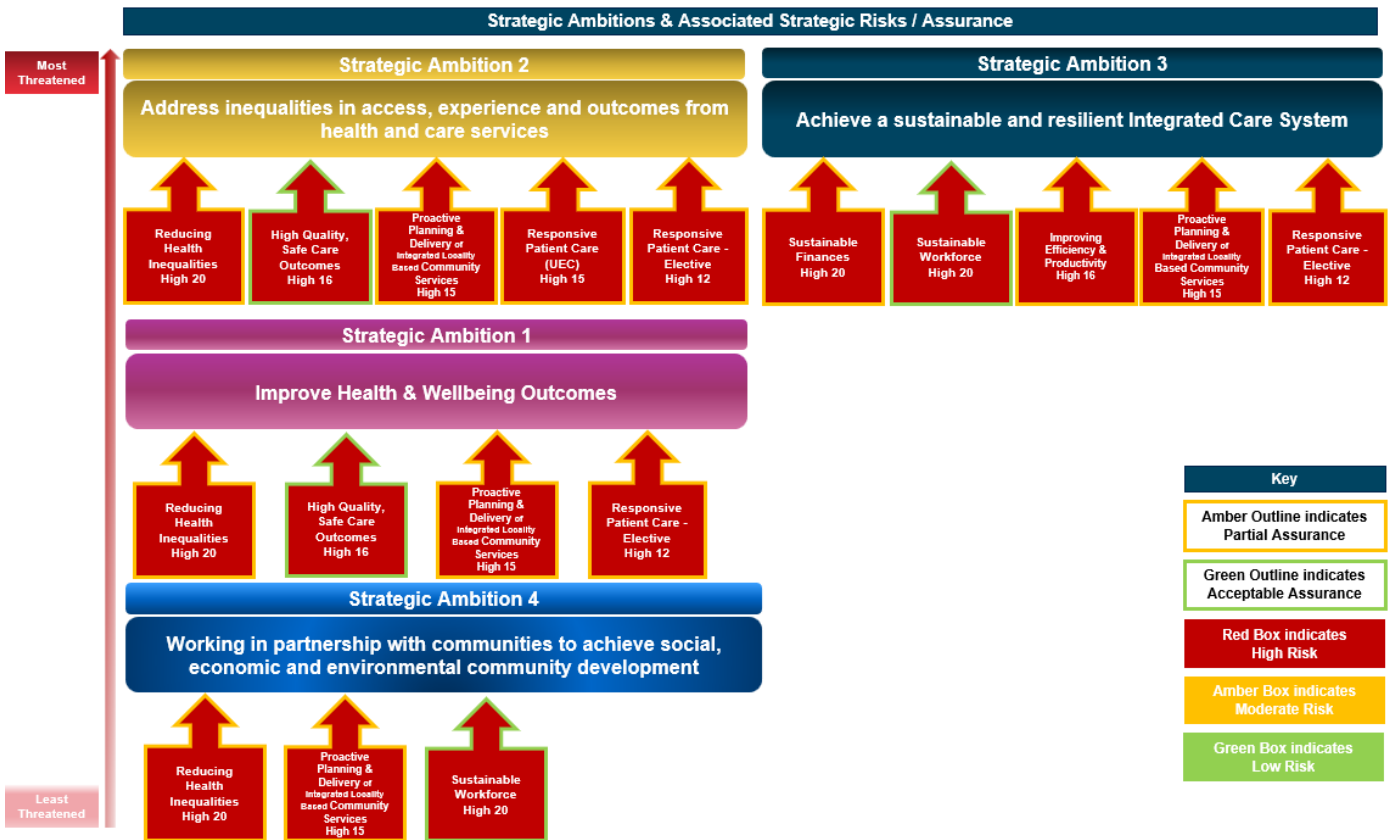
Action Plans – Key to Progress Ratings		Assurance Assessment Ratings	
<b>Complete / BAU</b>	Action completed, now business as usual	<b>Significant Assurance</b>	High level of confidence in delivery of existing mechanisms / objectives
<b>On Track</b>	Improvement on trajectory, on track, or completed	<b>Acceptable Assurance</b>	General confidence in delivery of existing mechanisms / objectives
<b>Problematic</b>	Delivery remains feasible, actions not completed, awaiting further interventions	<b>Partial Assurance</b>	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
<b>Delayed</b>	Off track / trajectory / milestone breached. Recovery plan required.	<b>No Assurance</b>	No confidence in delivery

## 2 Strategic Framework

The Strategic Ambitions identified within the SBAF form part of the Strategic Framework within the [ICP Strategy](#).



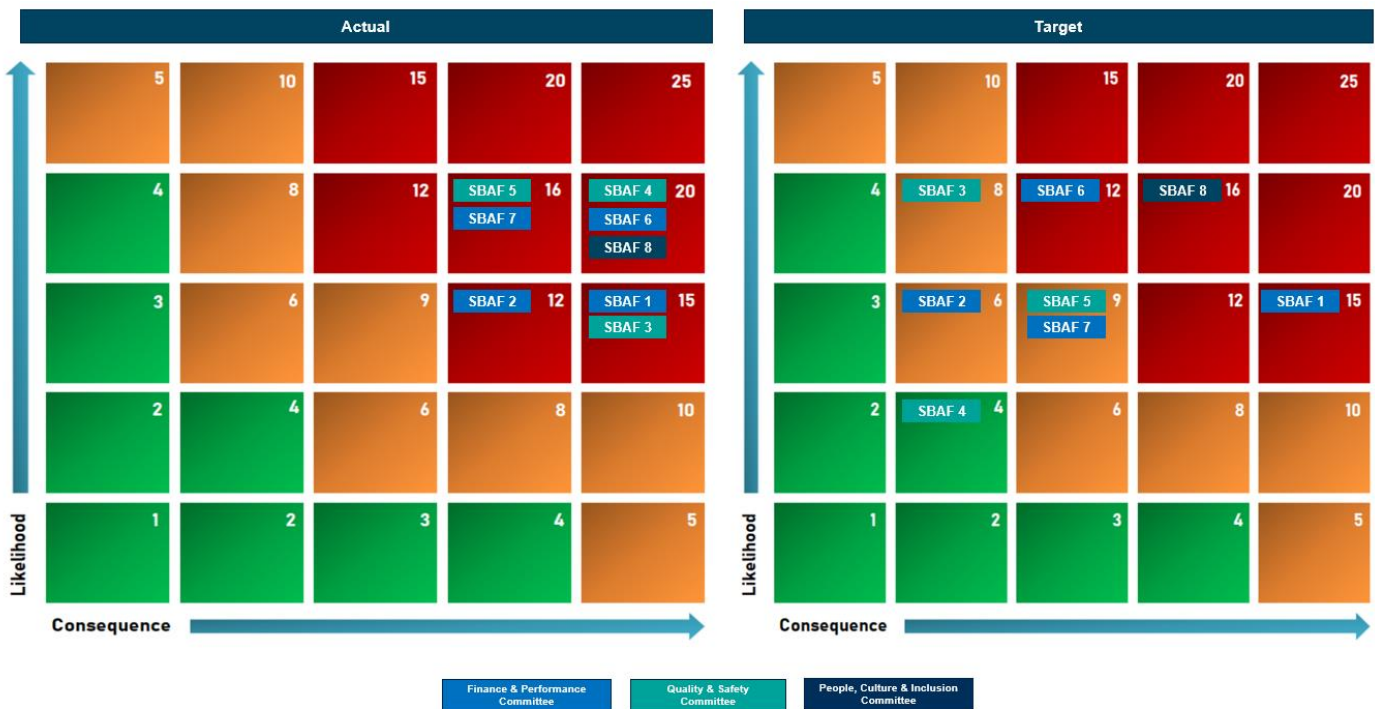
## 3 Threat to our Strategic Ambitions



# 4 Summary Board Assurance Framework (SBAF)

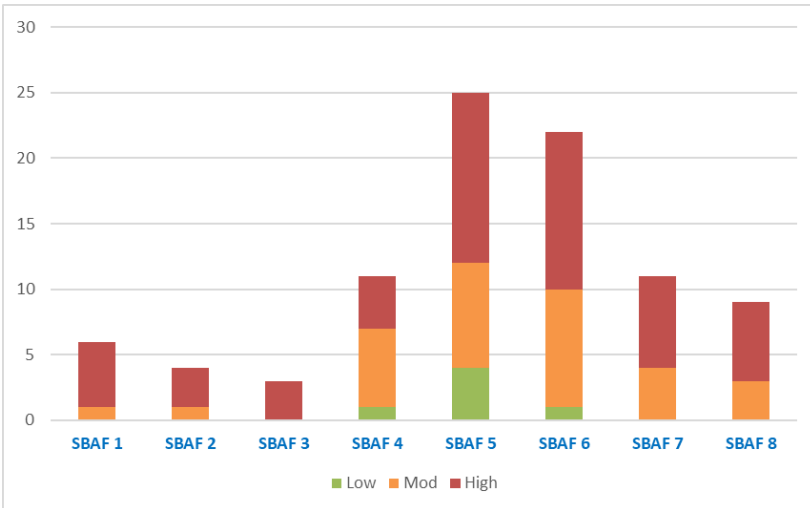
No.	Strategic Risk Title	Q1			Q2			Q3			Q4			Target		Risk Movement	Assurance Assessment	Action Plan	Linked Risks	Threat to Ambitions		
		L	C	S	L	C	S	L	C	S	L	C	S	L	C						S	Date
SBAF 1	Responsive Patient Care - Urgent & Emergency Care	3	5	High 15	3	5	High 15	3	5	High 15				3	5	High 15	31/03/2025	→	Partial Assurance			SA2
SBAF 2	Responsive Patient Care - Elective	4	3	High 12	4	3	High 12	4	3	High 12				2	3	Mod 6	31/03/2025	→	Partial Assurance			SA1 SA2 SA3
SBAF 3	Proactive Planning & Delivery of Integrated Locality Based Community Services	3	5	High 15	3	5	High 15	3	5	High 15				2	4	Mod 8	31/03/2026	→	Partial Assurance			SA1 SA2 SA3 SA4
SBAF 4	Reducing Health Inequalities	4	5	High 20	4	5	High 20	4	5	High 20				2	2	Low 4	31/03/2028	→	Partial Assurance			SA1 SA2 SA4
SBAF 5	High Quality, Safe Care Outcomes	4	4	High 16	4	4	High 16	4	4	High 16				3	3	Mod 9	31/03/2025	→	Acceptable Assurance			SA1 SA2
SBAF 6	Sustainable Finances	4	5	High 20	4	5	High 20	4	5	High 20				4	3	High 12	31/03/2025	→	Partial Assurance			SA3
SBAF 7	Improving Efficiency & Productivity	4	4	High 16	4	4	High 16	4	4	High 16				3	3	Mod 9	31/03/2025	→	Partial Assurance			SA3
SBAF 8	Sustainable Workforce	4	5	High 20	4	5	High 20	4	5	High 20				4	4	High 16	31/03/2025	→	Acceptable Assurance			SA3 SA4

# 5 Strategic Risk Heat Map



**Top 3 Scoring Strategic Risks** are SBAF 4: Reducing Health Inequalities, SBAF 6: Sustainable Finances and SBAF 8: Sustainable Workforce.

## 6 Linked Operational Risks



*SBAF 5: High Quality, Safe Care Outcomes and SBAF 6: Sustainable Finances have the highest number of **linked operational risks**.*

# 7 System Board Assurance Framework (SBAF)



## SBAF 1: Responsive Patient Care – Urgent & Emergency Care Finance & Performance Committee | Chief Delivery Officer

### Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If the Urgent and Emergency Care (UEC) system does not have sufficient and appropriate capacity across the entire system pathway to meet demand and support flow,		
<b>Event</b>	then should demand outstrip capacity, there will be pressure points within the UEC system,		
<b>Effect (Consequence)</b>	resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance and non-delivery of operational planning targets.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes		<b>SA3</b> Achieve a sustainable and resilient Integrated Care System
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	●	<b>SA4</b> Working in partnership with communities to achieve social, economic and environmental community development

### Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	3	3	3	3	3	The consequence of not having the correct capacity in the UEC system will inevitably impact on delivery and patients not able to access the UEC they require. The biggest risk is having long waits for ambulances in the community.	Low 0 →
<b>Consequence</b>	5	5	5	5	5		Mod 1 ↓
<b>Risk Level</b>	High 15	High 15	High 15	High 15	High 15		High 5 →
					31/03/25		

### Rationale for Risk Score and Progress Made in the Quarter:

For Q3 the key priority areas for improvement remain 4-hour Emergency Department (ED) performance towards achieving 78% by March 2025, 12-hour ED performance, and reducing ambulance handover delays and therefore category 2 performance.

Our UEC governance infrastructure continues to ensure collective leadership for system oversight for delivery and improvement, with all system partners. During 24/25 we again have a surge plan with oversight in place that replicates that of 23/24 which will outline investment across UEC pathways to increase capacity. To support improvement in 24/25 and beyond, a Demand Management Collaborative has been created with Chief Delivery Officer (CDO) Senior Responsible Officer (SRO) leadership. This collaborative continues to work with the UEC Portfolio to lead the development of a demand management plan across the system to identify areas for efficiency and to support the mitigation of the identified bed deficit of 85 beds to agreed manageable levels. The 24/25 plan includes learning and mitigation identified from the 23/24 system winter lessons learnt event.

As previously identified there continues to be a risk that GP Collective Action could impact on UEC demand. Depending on the level of actions taken by GP colleagues this has the potential to have a significant impact on UEC services across the system. At this time no adverse impacts have been identified. This continues to be monitored daily via system calls alongside weekly UEC representation at the Primary Care led GP Collective Action working group.

There are a number of initiatives that will impact upon system capacity for 24/25 including those outlined in the system Joint Forward Plan (JFP) 2023-28:

- Continued focus on the in-hospital improvement programme, and right sizing of medical capacity at University Hospitals of North Midlands NHS Foundation Trust (UHNM). Funding was received in 23/24 for a modular unit at Royal Stoke University Hospitals, which has supported the mobilisation of a new Acute Medical Rapid Assessment Unit (AMRAU). This unit provides both additional assessment and bedded capacity at the Royal Stoke site.
- Continued development of our acute care at home collaborative, and the Development of a system single point of access.
- Focus on designation of Urgent Treatment Centres (UTC) and development of our UTC model across Staffordshire and Stoke-on-Trent (SSOT).
- Continued work on our integrated discharge model and increasing numbers of pathway 0 patients.
- Continued improvement in bed occupancy to 92% or below.

## Key Controls Framework

- Daily System Control Centre (SCC) & Daily System calls.
- Regional Capacity Calls attended by System Control Centre.
- System UEC Improvement plan – the system has agreed a focused plan to drive improvements across the UEC system.
- System UEC 24/25 Surge Plan has been developed through a multidisciplinary approach and is currently going through partner organisations boards and will be presented to ICB Board for final ratification on 21<sup>st</sup> November.
- The SCC was mobilised in December 2022 and remains in place. The SCC proactively manages the daily capacity and demand across the system and leads daily system COO calls to manage pressure. Following recent peer review and assessment by NHS England the SCC has been recommended for national accreditation.
- System Escalation Plan, the refreshed system escalation plan was developed in December 2023 with system partners. This is currently being reviewed again in collaboration with our system partners ahead of sign off at the UEC Board. This annual review is to ensure there is an appropriate framework for managing risk and escalation, building on the learning from 23/24 and to incorporate the recently published revised OPEL frameworks by NHS England.
- System UEC Strategy – whilst outlining longer term plans of improvement, the UEC Strategy development ensures that the UEC Portfolio has a clear vision for UEC development, any in year improvements will be striving to meet the improvements set out in the long-term System UEC Strategy.
- ICB Finance & Performance Committee and System Performance Group; these groups are tasked with being assured on delivery and offer good-strength controls into the decision-making processes, supporting the other principal controls outlined. Surge reports monthly to these forums.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
<b>1<sup>st</sup> Line (organisation)</b>	Daily System Calls				
	Realtime data feeds and escalation via SHREWD				
	Weekly UEC Performance Reports	•	•	•	
	Monthly UEC MDT				
	Weekly COO Group Meeting				
<b>2<sup>nd</sup> Line (system)</b>	System Performance Report to Finance & Performance	•	•	•	
	Report to Finance & Performance Committee and ICB Board.				
	Monthly updates to System Delivery Group.	•	•	•	
	Monthly update to System Performance Group.	•	•	•	
	Monthly update to Finance and Performance Committee.	•	•	•	
	Fortnightly SLT update.	•	•	•	
	<b>Surge Plan Assurance by:</b>				
	• UEC Board.				
	• Children & Young People (CYP) Programme Board.				
	• UEC Clinical Advisory Group.				
	• Finance & Performance Committee.				
	• UHNM Trust Board.				
	• Clinical Senate.				
• SOTCC Operational Business Meeting.			•		
• MPFT Trust Board.					
• NSCHT Trust Board.					
• SCC Health & Care Senior Leadership Team.					
• Staffordshire Health Overview & Scrutiny Committee					
• System Quality Committee.					
• ICS People, Culture & Inclusion Committee.					
• Local Health Resilience Partnership (LHRP)					
<b>3<sup>rd</sup> Line (external)</b>	Tier 2 UEC Improvement framework – Executive monthly.	•	•	•	
	Surge Plan Assurance.	•	•	•	
	NHS England - Surge Plan Assurance Visit.	•	•	•	
	NHS England Regional Assurance Visit/Peer Review.	•	•	•	

## Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	•
No Assurance	No confidence in delivery	

## Gaps in Control or Assurance

### What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- Residual bed capacity gap.
- Workforce deliverability across all areas of UEC pathway.
- Industrial Action (IA) and impact of GP collective action.
- Surge beyond the predicted peak.
- Covid restrictions applied in Care Home market.
- Unforeseen demand due to major incident.
- Individual organisation risk management.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	24/25 Surge Plan to be agreed by ICB Board	Agreed trajectory to close capacity gap.	Chief Delivery Officer	30/09/24	Surge Plan developed and currently going through extended governance, expected to be complete by 21/11/2024	On Track	
2	Delivery of System UEC Improvement Plan against trajectory	Achieve Operational Plan requirements. 4-Hour ED Target Bed occupancy – 92% or below Cat 2 response – 30 mins.	Chief Delivery Officer	31/03/25	Action plans and delivery underway. Improvements seen in 23/24 continue to be seen in Q1 & Q2 but have fallen behind plan in Q3.	Problematic	
3	System Escalation Plan	Plan to cover risk arising from: <ul style="list-style-type: none"> <li>• Bed capacity gap.</li> <li>• Surge beyond predicted peak.</li> <li>• Covid restriction in Care Homes.</li> </ul>	Chief Delivery Officer	30/10/24	Plan for 24/25 in development in line with ambitions of System Collaborative for Demand Management.  Delayed due to NHSE delayed publication of new OPEL framework.	Problematic	
4	Industrial action & GP Collective Action	There are plans in place to deal with each incidence of industrial action. Plans for collective action in production.	Chief Delivery Officer	31/03/25	This remains a risk as the level and frequency of the industrial action are unknown.	On Track	
5	Workforce deliverability across all areas of UEC pathway	Overarching workforce plan, underpinned by workstream & service level plans including transformation, supply, training and OD.	Chief Delivery Officer/ Chief People Officer	31/03/25	Approach to workforce plan agreed, scoping underway within workstreams and services to identify workforce requirements, risks and plans to mitigate.	On Track	



# SBAF 2: Responsive Patient Care – Elective Care, Cancer and Diagnostics

Finance & Performance Committee | Chief Delivery Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If the system fails to deliver on the specific expectations set out in the 2024/25 (and earlier) planning guidance relating to waiting time recovery,		
<b>Event</b>	then cancer and planned care waiting times will not reduce in line with national expectations,		
<b>Effect (Consequence)</b>	resulting in potential patient harm and reputational damage to the ICS in addition to a potential loss of Elective Recovery Fund (ERF).		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	●	<b>SA3</b> Achieve a sustainable and resilient Integrated Care System ●
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	●	<b>SA4</b> Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	4	4	4	3	2	The tolerance of failing to deliver against this risk should be low as underachievement will have a knock-on effect to subsequent milestones. All efforts must therefore be focussed on delivery.	Low 0 →
<b>Consequence</b>	3	3	3	3	3		Mod 1 ↑
<b>Risk Level</b>	High 12	High 12	High 12	Mod 9	Mod 6		31/03/25 High 3 →

### Rationale for Risk Score and Progress Made in the Quarter:

Significant progress has been made in reducing the 104, 78 and 65-week wait patient cohorts. The target of zero 104 ww has been achieved, in September and October; and there are no forecasted breaches for forthcoming months. The 78ww progress is improving with 8 breaches currently being reported for October. The 65ww forecasted position for October is 127; and a route to zero trajectory is being developed.

As a system we have effectively utilised Independent Sector capacity to support clearance of long waits.

The additional risk of GP Collective Action is ongoing, although impacts appear to be limited to date. This continues to be monitored daily via PCCD representation at the Primary Care led GP Collective Action working group.

## Key Controls Framework

- Weekly tier 1 accountability meetings with NHSE.
- 2024/25 operational plan delivery and reporting.
- Portfolio performance steering group (reporting to portfolio Board).
- Weekly meetings in place to ensure maximisation of independent sector capacity and tracking of long wait patients.
- Regular monitoring backlogs of Staffordshire and Stoke-on-Trent patients in other systems to ensure equitable access to recovery milestones.
- Weekly meeting with UHNM to review specialty level challenges, to support transfer of long waiters to alternative providers. Including focus on rescheduling/reprioritising listed patients to achieve the milestones.
- UHNM improving productivity through Getting it Right First Time (GIRFT) review and best practice adoption.
- NHS England (NHSE) supporting provision of mutual aid monitored through weekly meetings.
- Review of core capacity and demand across the system.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
<b>1<sup>st</sup> Line (organisation)</b>	Weekly Elective Oversight Management Group (EOMG).	●	●	●	
	Weekly COO Group.	●	●	●	
<b>2<sup>nd</sup> Line (system)</b>	System Performance Report to Finance & Performance Committee and ICB Board.	●	●	●	

	Portfolio Performance Steering Group (reporting to Portfolio Board).	•	•	•	
3 <sup>rd</sup> Line (external)	NHSE oversight via Tier 1 meeting (will be replaced by Tier 2 meeting)	•	•	•	

Assurance Assessment	
Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
No Assurance	No confidence in delivery

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> <li>Capacity plans in some specialties to meet demand and support recovery – ICB team to maintain focus on development of appropriate community capacity to direct patients to the most appropriate setting through commissioning and contracting of additional provision.</li> <li>Industrial Action impact – need to fully understand impact of Industrial Action in elective cancellations which compromises delivery of ambitions.</li> </ul>	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Review Independent Sector (IS) contractual opportunities to expand provision.	Identification of additional capacity and support achievement of ERF ambitions	Chief Delivery Officer	30/09/24	All IS contracts have been reviewed to establish contract activity that can be reported through SUS and aligned to ERF.		
2	Develop plan for focused speciality review with end of end pathway approach.	Identification of opportunities to reduce duplication and improve productivity	Chief Delivery Officer	30/09/24	Governance process for phase one pathways concluding with Heath & Care Senate sign off. Implementation planning now underway and phase two pathways commencing.		
3	System capacity and demand review.	Greater understanding of opportunities for productivity improvement	Chief Delivery Officer	31/10/24	Opportunities for productivity improvement are ongoing, including GIRFT recommendations and pathway review.		
4	System collaborative for contracts to develop plans for efficiency and delivery of elective activity.	Increased delivery of activity and continued reduction of long wait patients supporting Elective Recovery	Chief Delivery Officer & SRO System Collaborative	31/10/24	The System continues to work together on eliminating 65+ week waits by the end of the calendar year and is developing a longer-term plan for elective activity.		



# SBAF 3: Proactive Planning and Delivery of Integrated Locality Based Community Services

Quality & Safety Committee | Chief Transformation Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If we do not deliver integrated community services based on population need,		
<b>Event</b>	then services will remain reactive and generic and not sensitive to the needs of the population,		
<b>Effect (Consequence)</b>	we will continue to see increases in demand and acuity of need.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	●	<b>SA3</b> Achieve a sustainable and resilient Integrated Care System ●
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	●	<b>SA4</b> Working in partnership with communities to achieve social, economic and environmental community development ●

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	3	3	3	3	2	The consequence of not mitigating this risk and moving to a more proactive needs-based community model of care is that our system will remain reactive and reliant on services, particularly secondary and UEC. This will not meet the needs of our population, will challenge the sustainability of services and is not in line with our strengths-based strategy for our population.	Low 0 →
<b>Consequence</b>	5	5	5	5	4		Mod 0 ↑
<b>Risk Level</b>	High 15	High 15	High 15	High 15	Mod 8		31/03/26

### Rationale for Risk Score and Progress Made in the Quarter:

The Improving Population Health Portfolio has been established (June 2023) and the Portfolio Board is meeting regularly. Partners have agreed the delivery structure of the portfolio as:

- ICB/S Delivery (to meet NHS statutory requirements in partnership).
- ICP Strategy Development (to turn the ICP Strategy into reality with the 5 P's across the life course, underpinning strategies and development of Place/localities), and;
- ICS Transformation (to find and engage system-wide support around shared priorities and joint endeavours).

Delays to Digital and Population Health Management (PHM) programmes regards the secondary use of data has led to a review of the PHM programme to scale, spread and sustain a PHM approach across SSOT at all levels.

The programme has continued to work with our partner (Optum), the biggest difficulty remains Information Governance (IG) and data sharing which, although solutions have been identified and are now being implemented, continue to provide significant challenge, particularly regards timescales due to GP Collective Action.

During Q3 23-24 the PHM Programme undertook an options appraisal and procurement exercise to enable bulk extracts of GP data into a linked dataset. Procurement concluded, the contract awarded, and mobilisation commenced in Q4. Whilst GP data extraction was expected to commence towards the end of Q1 of 24-25, this has been delayed due to the national bulk extraction assurance process (IM1) being paused for 3 months (ended September 2024), and GP DSA sign-up is impeded by GP Collective Action for which there is an unknown end (position being reviewed weekly and engagement with individual practices to encourage sign-up is continuous).

Through PHM led discussions at both Staffordshire and Stoke-on-Trent Place Development Boards and within the IPH Portfolio Board, there is now agreement of the localities that make-up the two Place's aligned with UTLAs:

- Staffordshire – District and Borough Council alignment (8).
- Stoke-on-Trent – Geographical alignment (4).

A proposal for locality and neighbourhood development and how the NHS might support that through the close involvement of Primary Care Networks (PCNs), the development of Integrated Neighbourhood Teams and the intelligent use of PHM and other data, has been progressed through various Boards and is supported by the VCSE and local councils.

The Health Inequalities (HI) Strategy progressed through to ICP on 3 June 2024 and received positive approval of the principles outlined. There are proposals in the latter stages of development for a supporting HI Financial

Framework (Locality Improvement Framework; LIF) that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme including localities/neighbourhoods. The first 'design' workshop for a shared HI Outcomes Framework was held on 21 June 2024, and the second 'develop' workshop held on 3 October 2024 and the third 'deliver' workshop which had a heavy LIF focus was held on 18 October 2024.

The LIF provides a basis to incentivise integrated locality working based on population need and reducing health inequalities. Each locality will have an allocation of funding based on deprivation and other factors and will be able to 'bid' to use this allocation for projects that will have clear and measurable impact on health outcomes, following changes in lifestyle and behaviour by working together as integrated community services.

All of the above describes the foundation work being undertaken to begin 2025/26 as a shadow year of integrated locality working, until this commences and is reviewed for effectiveness, the risk score will remain high.

## Key Controls Framework

- Portfolio governance heavily partnership based with District/Borough Council leadership in role of CE Sponsor.
- People and Communities is one of the 5P's of the ICP Strategy.
- Place Development Boards have agreed the construct of 'Place'.
- IPH Team (manage implementation programme to scale, spread and sustain PHM approach across SSOT).
- IPH Portfolio Programmes (cross working to ensure HI and Prevention are considered during design).
- Other Portfolios (matrix working with portfolios to design interventions and deliver transformational change).
- H&CS (provide system health and care viewpoint on any interventions being designed).
- IPH Portfolio Board (provide strategic oversight and is the portfolio aligned with this risk).
- ICP (has ICS partnership wide oversight).
- Establishment of IPH Portfolio Board.
- Defined scope of IPH Portfolio and incumbent programmes.
- CSU Procurement guidance to ensure procurement exercises have been/are robust.
- Report/ed procurement exercise outcomes to ICB EWT.
- PHM Partner contracted to support scale, spread and sustain of PHM approach for SSOT.
- GP Data Extract procurement completed, and contract awarded and being mobilised.
- Locality development plans well-articulated and co-produced.
- HI Strategy developed collaboratively through workshops and extended partnership discussions.
- HI Strategy principles formally endorsed on 3 June by ICP.
- Regular bi-monthly reporting to QSC continues along with scheduled Deep Dives (latest 13 November 2024).
- HI Outcomes Framework and Locality Improvement Framework in latter stages of development with partners.
- Alignment with large, locality-based initiatives i.e. Supportive Communities, Together Active, Family Matters.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
<b>1<sup>st</sup> Line (organisation)</b>	IPH Team Meetings: MS Planner reviewed to assure programme actions are on track for delivery (weekly).	•	•	•	
<b>2<sup>nd</sup> Line (system)</b>	Quality & Safety Committee: IPH Portfolio Progress update provided to assure committee of progress (bi-monthly moving to quarterly).	•	•	•	
	Finance & Performance Committee: IPH elements of Quarterly Stocktake and ICS Operational Plan to provide assurance against LTP and 1YOP delivery.	•	•	•	
<b>3<sup>rd</sup> Line (external)</b>	Regional HI Programme: IPH Portfolio Progress Reports for progress assurance against LTP.	•	•	•	
	Regional Prevention: IPH Portfolio Reports for progress assurance against LTP.	•	•	•	
	NHSE: IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery.	•	•	•	

## Assurance Assessment

<b>Significant</b>	<b>High level of confidence in delivery of existing mechanisms / objectives</b>	
<b>Acceptable</b>	<b>General confidence in delivery of existing mechanisms / objectives</b>	
<b>Partial</b>	<b>Some confidence in delivery of existing mechanisms / objectives, some areas of concern</b>	•
<b>No Assurance</b>	<b>No confidence in delivery</b>	

## Gaps in Control or Assurance

### What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- GP DSA sign-up for PHM to include primary care data in the linked dataset is impeded by GP Collective Action for which there is no known end (position being reviewed weekly and engagement with individual practices to encourage sign-up is continuous).
- Formalising arrangement regards Place and localities - outcomes and improvement frameworks in latter stages of development.
- Capacity of the IPH Team is low due to vacant posts and sickness.

### Further Actions

#### (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	Complete/BAU	On Track
						Delayed	Problematic
1	Stakeholder Engagement of HI Strategy.	Additional assurance	Chief Medical Officer	<del>30/09/24</del> 31/03/25	<i>New date 31/03/25</i> to allow all elements to be engaged upon collectively (Strategy plus Outcomes and Improvement Frameworks)		
2	Resolve data and information governance issues regards GP data extraction.	Additional control through secure and legal basis to extract and share data	Chief Medical Officer	<del>30/11/23</del> (1) <del>30/06/24</del> (2) <del>30/09/24</del> (3) 31/03/25	<i>New date 30/06/24</i> (1) GP Data Extract procurement completed, contract awarded and mobilised.  <i>New date 30/09/24</i> (2) National bulk extraction assurance process (IM1) paused for 3 months to 09/2024.  <i>New date 31/03/25</i> (3) GP DSA sign-up impeded by GP Collective Action. Unknown end review at Q4		
3	Work with the Digital Programme to resolve data and information governance issues regards the sharing of data for the purpose of secondary use.	Additional control through secure and legal basis to use data.	Chief Digital Officer	<del>31/03/24</del> 30/09/24	Working with Digital Programme, section 251 being reviewed. CAG application impacted by IM1 Pause (see above) CAG application submitted. Next steps to be identified by Digital Programme.		
4	Develop HI Outcomes Framework.	Additional Control	Chief Medical Officer	<del>30/09/24</del> 31/10/24	HI Outcomes Framework – all 3 planned workshops held: Workshop 1 'Design' 21/06/24. Workshop 2 'Develop' 03/10/24 Workshop 3 'Deliver' 18/10/24		

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
5	Develop HI Financial Framework.	Additional Control	Chief Medical Officer	31/12/24	Proposals for allocation of HI budget and LIF developed and being finessed with Finance and Partners.		
6	Develop governance for locality and community delivery.	Additional Control	Chief Transformation Officer	31/03/25	Work in progress		
7	Run 'shadow' year of Locality governance with outcomes and finance frameworks 2025/26.	Additional assurance	Chief Transformation Officer	31/03/26	Work in progress to ensure mobilisation from 31/03/25		



# SBAF 4: Reducing Health Inequalities

Quality & Safety Committee | Chief Medical Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If we are unable to work together as an Integrated Care System across organisation and sector boundaries,		
<b>Event</b>	then we will have less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent,		
<b>Effect (Consequence)</b>	resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	●	<b>SA3</b> Achieve a sustainable and resilient Integrated Care System
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	●	<b>SA4</b> Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	4	4	4	3	2	Tolerance is low as reducing health inequalities and working in partnership impacts on 3 of the 4 Strategic Ambitions. The target date is long-term and as such risk scoring would be expected to reduce over a longer period as health inequalities improvement is made and can be demonstrated.	Low 1 ↑
<b>Consequence</b>	5	5	5	5	2		Mod 6 →
<b>Risk Level</b>	High 20	High 20	High 20	High 15	Low 4		31/03/28

### Rationale for Risk Score and Progress Made in the Quarter:

Early targets for progress to reduce health inequalities were set against the agreement of an Integrated Care Partnership Strategy which was published at the end of March 2023, (this was reflected in the target risk). Evaluation of the reduction of health inequalities will be over a longer period (c. 10 years) and the target risk will be reviewed on this basis. The foundations to achieving this have been progressed in terms of the Integrated Care Partnership Strategy, procurement of a partner to support the scale, spread and sustainment of a Population Health Management approach for SSOT that will positively impact on HI, HI is included throughout the 1 Year Operational Plan and Joint Forward Plan.

The Improving Population Health Portfolio has been established (June 2023) and the Portfolio Board is meeting regularly. Partners have agreed the delivery structure of the portfolio as:

- ICB/S Delivery (to meet NHS statutory requirements in partnership).
- ICP Strategy Development (to turn the ICP Strategy into reality with the 5 P's across the life course, underpinning strategies and development of Place/localities), and;
- ICS Transformation (to find and engage system-wide support around shared priorities and joint endeavours).

Through PHM led discussions at both Staffordshire and Stoke-on-Trent Place Development Boards and within the IPH Portfolio Board, there is now agreement of the localities that make-up the two Place's aligned with UTLAs:

- Staffordshire – District and Borough Council alignment (8).
- Stoke-on-Trent – Geographical alignment (4).

A proposal for locality and neighbourhood development and how the NHS might support that through the close involvement of Primary Care Networks (PCNs), the development of Integrated Neighbourhood Teams and the intelligent use of PHM and other data, has been progressed through various Boards and is supported by the VCSE and local councils. This provides the infrastructure to be able to systematically reduce inequalities.

The Health Inequalities (HI) Strategy progressed through to ICP on 3 June 2024 and received positive approval of the principles outlined. There are proposals in the latter stages of development for a supporting HI Financial Framework (Locality Improvement Framework; LIF) that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme including localities/neighbourhoods. The first 'design' workshop for a shared HI Outcomes Framework was held on 21 June 2024, and the second 'develop' workshop held on 3 October 2024 and the third 'deliver' workshop which had a heavy LIF focus was held on 18 October 2024.

The LIF provides a basis to incentivise integrated locality working based on population need and reducing health inequalities. Each locality will have an allocation of funding based on deprivation and other factors and will be able

to 'bid' to use this allocation for projects that will have clear and measurable impact on health outcomes, following changes in lifestyle and behaviour by working together as integrated community services.

All of the above describes the foundation work being undertaken to begin 2025/26 as a shadow year of integrated locality working, until this commences and is reviewed for effectiveness, the risk score will remain high

## Key Controls Framework

- Portfolio governance heavily partnership based with District/Borough Council leadership in role of CE Sponsor.
- People and Communities is one of the 5P's of the ICP Strategy.
- Place Development Boards have agreed the construct of 'Place'.
- IPH Team (manage implementation programme to scale, spread and sustain PHM approach across SSOT).
- IPH Portfolio Programmes (cross working to ensure HI and Prevention are considered during design).
- Other Portfolios (matrix working with portfolios to design interventions and deliver transformational change).
- H&CS (provide system health and care viewpoint on any interventions being designed).
- IPH Portfolio Board (provide strategic oversight and is the portfolio aligned with this risk).
- ICP (has ICS partnership wide oversight).
- Establishment of IPH Portfolio Board.
- Defined scope of IPH Portfolio and incumbent programmes.
- CSU Procurement guidance to ensure procurement exercises have been/are robust.
- Report/ed procurement exercise outcomes to ICB EWT.
- PHM Partner contracted to support scale, spread and sustain of PHM approach for SSOT.
- GP Data Extract procurement completed, and contract awarded and being mobilised.
- Locality development plans well-articulated and co-produced.
- HI Strategy developed collaboratively through workshops and extended partnership discussions.
- HI Strategy principles formally endorsed on 3 June by ICP.
- Regular bi-monthly reporting to QSC continues along with scheduled Deep Dives (latest 13 November 2024).
- HI Outcomes Framework and Locality Improvement Framework in latter stages of development with partners.
- Alignment with large, locality-based initiatives i.e. Supportive Communities, Together Active, Family Matters.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
<b>1<sup>st</sup> Line (organisation)</b>	IPH Team Meetings: MS Planner reviewed to assure programme actions are on track for delivery (weekly).	•	•	•	
<b>2<sup>nd</sup> Line (system)</b>	Quality & Safety Committee: IPH Portfolio Progress update provided to assure committee of progress (bi-monthly).	•	•	•	
	Quality & Safety Committee: IPH Portfolio – Health Inequalities Deep Dive.	•	•	•	
	Finance & Performance Committee: IPH elements of Quarterly Stocktake and ICS Operational Plan to provide assurance against LTP and 1YOP delivery.	•	•	•	
<b>3<sup>rd</sup> Line (external)</b>	Regional HI Programme: IPH Portfolio Progress Reports for progress assurance against LTP.	•	•	•	
	Regional Prevention: IPH Portfolio Progress Reports for progress assurance against LTP.	•	•	•	
	NHSE: IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery.	•	•	•	

## Assurance Assessment

<b>Significant</b>	<b>High level of confidence in delivery of existing mechanisms / objectives</b>	
<b>Acceptable</b>	<b>General confidence in delivery of existing mechanisms / objectives</b>	
<b>Partial</b>	<b>Some confidence in delivery of existing mechanisms / objectives, some areas of concern</b>	•
<b>No Assurance</b>	<b>No confidence in delivery</b>	

## Gaps in Control or Assurance

**What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?**

- Maintaining stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners.
- Shared understanding and development of delivery vehicles that ICP Strategy priorities can be owned.
- GP DSA sign-up for PHM to include primary care data in the linked dataset is impeded by GP Collective Action for which there is no known end (position being reviewed weekly and engagement with individual practices to encourage sign-up is continuous).

## Gaps in Control or Assurance

### What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- Formalising arrangement regards Place and localities - outcomes and improvement frameworks in latter stages of development.
- Capacity of the IPH Team is low due to vacant posts and sickness

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Stakeholder Engagement of HI Strategy.	Additional assurance	Chief Medical Officer	<del>30/09/24</del> 31/03/25	<i>New date 31/03/25</i> to allow all elements to be engaged upon collectively (Strategy plus Outcomes and Improvement Frameworks)		
2	Develop HI Outcomes Framework.	Additional Control	Chief Medical Officer	<del>30/09/24</del> 31/10/24	HI Outcomes Framework – all 3 planned workshops held: Workshop 1 'Design' 21/06/24. Workshop 2 'Develop' 03/10/24 Workshop 3 'Deliver' 18/10/24		
3	Develop HI Financial Framework.	Additional Control	Chief Medical Officer	31/12/24	Proposals for allocation of HI budget and LIF developed and being finessed with Finance and Partners.		
4	Run 'shadow' year of Locality governance with outcomes and finance frameworks 2025/26.	Additional assurance	Chief Medical Officer	31/03/26	Work in progress to ensure mobilisation from 31/03/25		

# SBAF 5: High Quality, Safe Care Outcomes

Quality & Safety Committee | Chief Nursing & Therapies Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If we cannot ensure high quality, equitable and safe patient care,		
<b>Event</b>	then we will be unable to achieve high standards of quality and safety,		
<b>Effect (Consequence)</b>	resulting in actual or potential harm to patients, loss of reputation, intervention from regulators, failure to deliver our statutory quality duties and increased costs associated with poor standards of care		
SA1	Improve Health and Wellbeing Outcomes	●	SA3 Achieve a sustainable and resilient Integrated Care System
SA2	Address inequalities in access, experience and outcomes from health and social care services	●	SA4 Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
Likelihood	4	4	4	4	3	The system will prioritise quality and safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures.	Low 4 ↑
Consequence	4	4	4	3	3		Mod 8 ↓
Risk Level	High 16	High 16	High 16	High 12	Mod 9		High 13 ↑

### Rationale for Risk Score and Progress Made in the Quarter:

Quality, safety and equitable care are key priorities outlined within the ICBs agreed Quality Strategy. Throughout Q3 the Quality Safety Committee (QSC) received assurance that progress had been achieved in terms of delivering year one actions aligned to the Quality Strategy key priorities ensuring that:

- Patient safety and experience are central to care
- People are actively involved in the development and design of services
- Fair and equitable services for all
- A culture of transparency and continuous improvement is promoted to support shared learning

The Patient Safety Incident Reporting Framework (PSIRF) is now considered to be embedded within NHS providers with a shared learning approach adopted as demonstrated by the successful system learning event held in November 2024. Work has commenced to support the adoption of the PSIRF framework within the care home sector this will continue to progress throughout the remainder of 24/25.

A Standard Operating Procedure (SOP) for Learning From Patient Safety Events (LFPSE) has been introduced to support the ICB's change in working practices involving a more holistic view of patient safety events.

Delays across the Urgent and Emergency Care (UEC) pathways remain a risk as highlighted in the letter received by the ICB from the NHSE Executive team (PRN01417: Maintaining focus and oversight on quality of care and experience in pressurised services). All ICBs and Provider Executive teams were required to respond to confirming assurance that actions were in place system wide which focused upon maintaining patient safety and upholding the CQCs fundamentals of care. It was the recommendation of QSC and UEC Board that assurance be taken recognising that work continues to evolve the systems approach and plans particularly during the winter period.

Waiting times associated with paediatric dietetics and wheelchair services have seen an increase in feedback from patients who are dissatisfied with the delays in their care. Working in partnership with providers and the ICB programme lead progress is being made to understand the risk and potential harm waiting times may have upon patients whilst also working collectively to identify and implement mitigating actions where possible. An agreed improvement trajectory and harm review process in place with wheelchair provider.

The Learning from Lives and Deaths – People with a Learning Disability and Autistic People programme (LeDeR) has presented its Q2 2024/25 report providing an overview of the progress and key achievements of the programme including excellent person-centred care delivered from professional carers, Multi Disciplinary Team (MDT) working between health and social care professionals, and a comprehensive Distress and Discomfort Assessment Tool completed by care home staff to enable people to understand when people with a learning disability were content

and distressed. It has previously been reported that SSOT LeDeR programme had a backlog in reviews missing the National Key Performance Indicators. Through the work of the team following the decision to step in, there has been significant improvement with all reviews having been allocated with 83% of cases having been reviewed and completed within the expected six month timeframe.

Looked After Children Initial/Review Health Assessment compliance has been reported previously as below expected levels. Additional resources have been allocated and a recovery plan agreed with Q3 data predicting recovery by end of the financial year 2024/25.

Q3 has seen the All Age Continuing Health Care (AACHC) improvement programme step back up following the required pause whilst awaiting the outcome of NHSEs review of the procurement process. Work has moved at a pace to establish enhanced clinical oversight through the introduction of the Integrated Holistic Assessment Team (IHAT) who will work closely with patients, carers and providers to establish robust care planning which responds to individualised need. Joint decision panels are in place to support a system wide approach to eligibility for CHC funding.

The LMNS continues with oversight of Year 2 implementation of the Three-year delivery plan for maternity and neonatal services across the system through the Quality and Safety Oversight Forum (QSOF) with progress against the plan continuing. Due to the high rates of Infant Mortality across the system a Joint Office for Health Improvement and Disparities (OHID) & NHSE infant mortality supportive system review is currently being planned. The Staffordshire and Stoke-on-Trent (SSoT) Infant Mortality Conference will also take place on 3rd December to review the work of the Infant Mortality Group and the key areas of focus for this year.

The ICB Nursing and Therapy team are engaged and working with partners as part of the systemwide MDT which focuses upon understanding the impact of the GP Collective Action working together to mitigate any associated risks. An agreed local communication pack has been developed and shared.

## Key Controls Framework

- Quality Impact Assessment agreed and implemented (Policy and Procedures).
- ICB Quality Strategy with agreed outcomes.
- Local Maternity and Neonatal Service Partnership Board and Quality and Safety Oversight Forum (sub-group) and attendance at relevant internal UHNM meetings. Meets Monthly
- Established system wide Safeguarding arrangements – Second Stage of Provider collaborative agreed and first meeting has taken place
- Quality Safety Committee
- System Quality Group
- Reporting to and attendance at NHSE meetings, ERSM meets monthly with QRSM is quarterly.
- All Age Continuing Health Care has a robust governance process in place and reports internally through QSC, F & P and externally to NHSE against progress.
- LeDeR group including system partner attendance and shared learning as well reporting into QSC (quarterly) and LDAP board monthly.
- Portfolio groups/boards or other meetings which meet monthly
- Established system wide Safeguarding arrangements in place including Staffordshire and Stoke-on-Trent Safeguarding Partnership
- PSIRF monthly oversight meetings
- Contract quality review meetings undertaken monthly.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1 <sup>st</sup> Line (organisation)	Monthly Quality and Safety Assurance report to ICB Board.	•	•	•	
	Bimonthly Assurance paper and Chair Update from Quality & Safety Committee to ICB Board.	•	•	•	
	Bi-Monthly LMNS report, SQG Assurance Paper and Peoples Assembly update to Quality & Safety Committee.	•	•	•	
	Quarterly Quality Strategy implementation plan updates to Quality & Safety Committee.	•	•	•	
	Tri-annually QIA Assurance and CQI Sub group report to Quality & Safety Committee.	•	•	•	
	Quarterly LeDeR Assurance Report and SEND Update and Assurance Report to SQG.	•	•	•	

2 <sup>nd</sup> Line (system)	AD hoc assurance reports from IHA/RHA working group/CHC Assurance report and Paediatric Audiology Improvement Programme update received by Quality & Safety Committee	●	●	●	
	Monthly Provider Update/Assurance and escalation reports to SQG.	●	●	●	
	Bimonthly PSIRF oversight report to SQG.	●	●	●	
	Quarterly Soft Intelligence/Complaints report to SQG.	●	●	●	
	Monthly Provider Update and Assurance report to SSoT LMNS Partnership Board.	●	●	●	
	Update reports to Staffordshire and Stoke-on-Trent Health Safeguarding and Looked after Childre Strategic Oversight Group	●	●	●	
	Deep Dive presentation to QSC.	●	●	●	
	Neonatal Update to Infant Mortality Group			●	
	Infection Prevention Control (Health Economy Group) Update/Assurance report to QSC received quarterly.	●	●	●	
3 <sup>rd</sup> Line (external)	Quarterly Update and Assurance report to Regional Quality Group – NHSE led.	●	●	●	
	Provider's escalation of CQC activity to SQG.	●	●	●	
	Monthly NOF Assurance Report (UHNM).	●	●	●	
	Quarterly System Review Meeting Assurance Report.	●	●	●	
	Quarterly NOF Assurance Report (NSCHT/MPFT).	●	●	●	
	Escalation to Paediatric Audiology Improvement Silver & Gold cells (ad hoc).	●	●		
	ICS update to the Regional Infant Mortality Group			●	
	Update report to Regional Infant Mortality Group			●	
Bi-monthly Midlands Nursing and Midwifery Excellence network report.	●	●	●		

### Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	●
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

### Gaps in Control or Assurance

What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?

- IHAs/RHAs action plan mitigations to be revisited with the support of Providers, NHSE and LA to look at innovative ways of working to impact positively on the backlog. Presently legislation impacts on who can carry out IHAs.
- Maintaining Patient safety and achieving fundamentals of care within UEC pathways during periods of pressure requires further work
- Risk and potential harm which may be as a result of delays within specific community services
- Underperformance against LeDeR Key Performance Indicators
- Maintaining stability within maternity and neonatal workforce linked to the Ockenden recommendations
- Pause in CHC process has led to a delay in achieving agreed improvements

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Collaboration with system partners and regional and national ICBs to	Reduction in timeline	Assistant Chief Nursing &	30/07/25	Q1 – NHSE are driving discussions forward to look at using other staff		

	look at innovative ways of improving the IHA challenges locally, regionally and nationally.		Therapies Officer		other than medical practitioners. ICB looking at additional resource to reduce the back log further. <b>Q2</b> - IHA/RHA compliance remains below the expected levels. Proposal for reduction in the IHA process has been made to the Local Authorities which if approved is expected to improve the position. The plan is on track to deliver the required changes by July 2025 with an ambition to achieve at an early date where possible. <b>Q3</b> – Continued improving picture with revised trajectory which anticipates achievement of KPIS by the end of the financial year 24/25.	
2	ED Harms oversight approach with UHNM established which will see bi - monthly visits to ED supporting continuous learning and improvement approach.  Receive assurance reports via Derby and Derbyshire ICB (DDICB) regarding patient delays and impact specific to Queens Hospital Burton (QHB) site	Patients experience safe and effective care	Chief Nursing & Therapies Officer	30/03/25	<b>Q3-</b> Comprehensive winter plan presented and accepted by QSC outlining actions which will support the management of anticipated level of demand during the winter period. Meetings in place and thematic case review being undertaken to support learning and improvement.  Approach agreed with DDICB with reports to be shared within Q3.	
3	Collaborative approach to understanding and mitigating risk and potential harm resulting from delays within specific service provision	The potential for harms as a result of a delay is reduced	Chief Nursing and Therapies Officer	30/03/25	<b>Q3 – Wheelchair Service</b> - quality visits undertaken and monthly meetings conducted to review progress against trajectory within wheelchair services  <b>Paediatric Dietetics</b> - MDT working group commenced to support the production of a	

					rapid review of Paediatric Dietetics service. Escalation at System Quality Group and Childrens and Young Peoples Board. Service provider initiating business continuity plans – provider QIA undertaken to underpin measures.	
4	LeDeR Improvement plan in place which sustains achievement of Key Performance Indicators	Achieve the aims of LeDeR programme at a local and national level	Chief Nursing and Therapies Officer	30/03/25	<b>Q3</b> – Data indicates continued improvement in performance as a result of the step in process throughout Q3. Next step is to consider options regarding the future delivery of the programme.	
5	Maternity Transformation plan in place which outlines a 3-year approach to improving services.	Achieve Ockenden recommendations and respond to national guidance/requirements across maternity and neonatal services	Chief Nursing and Therapies Officer	30/03/26	<b>Q3</b> –LMNS Board continues to oversee delivery of the transformation plan, reported as being on track. Workforce numbers across Midwifery and Medical posts has seen an improvement. Insight visit conducted at UHNM site in Q3 reported as overall positive.	
6	System approach to improving outcomes of patients who are CHC eligible	Individualised and need appropriate care commissioned which supports optimum patient outcomes	Chief Nursing and Therapies Officer	30/03/25	<b>Q3</b> – Progress has been impacted upon as a result of the pause required to consider the outcome of the procurement process. Work has now recommenced with a focus upon enhancing the clinical oversight and case review of retrospective and prospective patients who are eligible for CHC funding.	



# SBAF 6: Sustainable Finances

Finance & Performance Committee | Chief Finance Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If financial cost pressures are not controlled,		
<b>Event</b>	then we will not achieve our statutory financial duties,		
<b>Effect (Consequence)</b>	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduce capital resources, reduced opportunity to apply for additional funds, impacting on services and waiting lists.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	<b>SA3</b>	Achieve a sustainable and resilient Integrated Care System
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	<b>SA4</b>	Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	4	4	4	4	4	Tolerance is high as costs related to maintaining patient safety and workforce issues may cause additional financial demand.	Low 1 →
<b>Consequence</b>	5	5	5	5	3		Mod 9 ↑
<b>Risk Level</b>	High 20	High 20	High 20	High 20	High 12		High 12 ↓

### Rationale for Risk Score and Progress Made in the Quarter:

The Financial Plan for 2024/25 is a deficit plan of £90.0m, agreed with NHSE. Achievement of the 2024/25 plan requires the in-year delivery of £203m system savings which includes a £40m system stretch target. A System-wide Recovery Plan is being designed for 2024/25 to manage the delivery of the efficiency target. The System net risk identified at the time of the plan submission is £88m resulting in a higher risk level in Q1 than the target risk for the end of the year.

Following the Month 4 position and forecast outturn, the System net risk has been increased to £103m. The £15m risk increase relates to the potential liability on the re-banding of Band 2 posts at UHNM materialising. £30m of the previously identified £88m risk has now crystallised following the outcome of the contracts binding conciliation process.

Following a review of the Month 4 financial position, the System has been categorised as Level 4 (greatest concern about financial delivery), also referred to as the Investigation and Intervention Regime. We are directed by NHSE to undergo a rapid intervention process to reduce the level of spend. A Recovery Plan has been developed and was submitted to NHSE on 13 September 2024. Currently this shows that the ICS will not achieve its £90m planned deficit position unless further savings can be identified.

The Q2 score is to remain at 20 as there remains a very high risk of missing the target, although work continues to close the gap on delivery of the financial improvements. This will be through a combination of improved delivery against existing schemes, development of new schemes and more assertive approaches around grip & control together with consideration of harder actions. The actions under the Recovery Plan and the support put in place under the Investigation and Intervention process will also play in.

The Q3 score remains at 20 as there still remains a very high risk of not achieving the £90m deficit plan. The System has achieved the highest ever level of efficiency of c£180m which is 7.1% of turnover however, this is short of the target that was set for 2024/25. Improvements have been made to the unmitigated risk which previously stood at c£100m (in addition to the £90 planned deficit). Due to the implementation of the green and amber recovery actions, the forecast deficit for the System is now £146m. The expectation of NHSE is that we achieve the efficiency target and the £90m planned deficit by year-end. As part of the Level 4 process, Deloitte working in partnership with Kingsgate have been appointed to undertake the Investigation and Intervention (I&I) work with the expectation that this will support the System to achieve the £90m deficit control total.

## Key Controls Framework

- Appointment of Deloitte to undertake the I&I work.
- Appointment of Financial Recovery Director.
- System Financial Plan agreed.
- Recovery Plan agreed.
- System Collaborative Programme implemented.

- Monthly monitoring delivery of all efficiency plans by the Transformation Delivery Unit (TDU) across the system
- Reporting on progress through System Performance Group and Finance and Performance Committee.
- Monthly budget holder meetings to ensure delivery remains on track.
- Weekly meeting of System Chief Finance Officers.
- Weekly System/IFP finance deputies meetings held to support System meetings.
- Weekly System Collaborative Programme meetings.
- Weekly System CFO meeting.
- Fortnightly System Senior Leadership Team meeting.

Assurance Map						
Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	
1 <sup>st</sup> Line (organisation)	Monthly System finance reports articulating risk / mitigations.	●	●	●		
	Monthly System Finance Report to Finance & Performance Committee.	●	●	●		
2 <sup>nd</sup> Line (system)	Monthly Collaborative Programme report to Finance & Performance Committee.	●	●	●		
	Monthly System Performance Report to Finance & Performance Committee.	●	●	●		
3 <sup>rd</sup> Line (external)	Annual value for money assessments completed by external auditors.	●	●	●		
	Annual Internal audit review of efficiency programme plans and delivery planned in Q3 24/25.	●	●	●		

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	●
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> <li>• The Financial Plan has significant gaps in the identification and delivery of efficiency schemes, the System is working towards a Financial Plan for the year to ensure all risks are understood and mitigated wherever possible.</li> <li>• The Financial Plan is a best-case scenario and consequently the System is working towards a Financial Plan for the year to ensure all new risks are understood and mitigated wherever possible.</li> </ul>	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	Delayed	Problematic
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap with the production of the Recovery Plan	Additional Assurance	Chief Finance Officer	30/09/24	To be reported to Recovery Board (SPG) and Finance and Performance Committee.		
2	System Finance and Operational teams to develop a medium-term plan to define the transformational solutions and actions that will ensure the delivery of the integrated care strategy and	Additional Assurance	Chief Finance Officer	31/12/2024	Progress to be reported to System Finance and Performance Committee.		

	trajectory for return to financial sustainability.					
3	Financial Recovery Director appointed to ensure that the System delivers its financial target for 2024/25 of a £90m deficit.	Additional Assurance	Chief Finance Officer	31/03/2025	Progress to be reported to Recovery Board (SPG) and System Finance and Performance Committee	
4	Deloitte working in partnership with Kingsgate appointed to undertake the Investigation and Intervention (I&I) work and support the System to achieve the £90m deficit control total.	Additional Assurance	Chief Finance Officer	31/03/2025	Progress to be reported to Recovery Board (SPG) and System Finance and Performance Committee	
5	Risk assessment to be completed against the 9 areas proposed in the GP Collective Action to assess any impact on the System Recovery Programme. The work is being completed centrally by the Primary Care Portfolio.	Additional Control	Chief Finance Officer/ Chief Medical Officer	31/12/2024	To be reported to Recovery Board (SPG) and Finance and Performance Committee	



# SBAF 7: Improving Efficiency and Productivity

Finance & Performance Committee | Chief Finance Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If the ICB and provider partners are unable to develop and deliver recurrent efficiency schemes and productivity gains, during 2024/25 required to address the system recurrent deficit of c. £183m,		
<b>Event</b>	then we will fail to achieve the operational improvements, aligned with the national agenda, which underpin our performance targets and fail to deliver the recurrent financial efficiency requirements which underpin delivery of our statutory financial target of breakeven,		
<b>Effect (Consequence)</b>	resulting in financial intervention from NHSE including reduced local discretionary decision making, reduced capital resources, reduced opportunities to apply for additional funds, impacting on services and waiting lists.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	<b>SA3</b>	Achieve a sustainable and resilient Integrated Care System
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	<b>SA4</b>	Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	4	4	4	4	3	31/03/25 Efficiency and Productivity improvement is an essential ingredient of the System Plan and so a lower risk appetite target has been set.	Low 0 →
<b>Consequence</b>	4	4	4	4	3		Mod 4 →
<b>Risk Level</b>	High 16	High 16	High 16	High 16	Mod 9		High 7 →

### Rationale for Risk Score and Progress Made in the Quarter:

It has been agreed by System Performance Group (SPG) that work on efficiency and productivity targets will be delegated to providers with the addition of system efficiency collaboratives to assist in delivering a further System stretch efficiency target. The 2024/25 financial and operation plans reflect significant unidentified and high-risk efficiency schemes and consequently the higher likelihood of this risk occurring is currently assessed. The delivery of the financial and operational plans requires full System participation including Primary Care so this may be impacted by the GP Collective Action.

Providers will continue to lead on driving productivity improvements in their own organisations but there will be agreed standardised improvement targets so that all are improving productivity in their organisation at the same rate. A Resource Model will be built to create a triangulated medium-term activity, workforce and financial plan.

The Q3 score is held at 16. The System has delivered £69.5m of efficiency as of September 2024, this is £19.9m adverse against plan, which is largely at the ICB (£14.1m) and UHNM (£5.3m). The System efficiency programme totals £203m with £52.6m high risk as of Month 6, with work on going to identify further schemes but these are unlikely to deliver in full in-year. Recurrent schemes are £23.5m adverse at Month 6. Key challenges remain to deliver the efficiency programme to meet the agreed deficit and within this, ensure the recurrent efficiency is met to not deteriorate the underlying position. Whilst there is a shortfall to close, the expectation is that further efficiency can be delivered through the I&I support.

## Key Controls Framework

- Monthly monitoring of the delivery of all efficiency plans by the TDU across the System and reporting on progress through System Performance Group and Finance and Performance Committee.
- Weekly System Collaborative Programme meetings.
- Weekly System/IFP finance deputies meetings held to support System meetings.
- Weekly System CFOs meeting.
- Fortnightly System Senior Leadership Team meetings.

## Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
<b>1<sup>st</sup> Line (organisation)</b>	Monthly System finance reports articulating risk / mitigations.	•	•	•	
	Responsibility for acute productivity improvement to be taken forward by Providers. Progress to be reported to System Finance & Performance Committee.	•	•	•	
<b>2<sup>nd</sup> Line (system)</b>	System Finance Report to Finance & Performance Committee.	•	•	•	

	System Performance Report to Finance & Performance Committee.	•	•	•	
	Productivity Report to System Performance Group.	•	•	•	
3 <sup>rd</sup> Line (external)	Annual value for money assessments completed by external auditors.	•	•	•	
	Internal audit review of efficiency programme plans, and delivery planned for Q3 2024/25.	•	•	•	

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	•
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> <li>The national team look at productivity through an acute lens. The System is planning to widen this to include all other elements of productivity.</li> </ul>	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap.	Additional Assurance	Chief Finance Officer	30/09/24	To be reported to Recovery Board (SPG) and Finance and Performance Committee.	13.09.24	
2	Develop and apply an agreed System approach to improving productivity encompassing all sectors.	Additional assurance	Chief Finance Officer	30/09/24	To be reported to the Finance and Performance Committee quarterly.  To be encompassed within the I&I work.		
3	Create and implement a System demand and capacity model	Additional assurance	Chief Finance Officer	31/10/24	Progress to be reported to Finance and Performance Committee.  Unmitigated model complete. Mitigated model to be presented to Finance and Performance Committee on 05.12.24		
4	A Resource Model to be built to agree the standardised improvement targets to be applied to all care settings and parts of the pathway	Additional Assurance	Chief Finance Officer	31/12/24	To be reported to Recovery Board (SPG) and Finance and Performance Committee.		
5	Deloitte working in partnership with Kingsgate appointed to undertake the Investigation and Intervention (I&I) work and identifying productivity opportunities will be a key line of this work.	Additional Assurance	Chief Finance Officer	31/03/25	To be reported to Recovery Board (SPG) and Finance and Performance Committee.		



# SBAF 8: Sustainable Workforce

People, Culture & Inclusion Committee | Chief People Officer

## Risk Description and Impact on Strategic Ambitions

<b>Cause (Likelihood)</b>	If recruitment activity reduces due to financial pressures; and there is an ongoing reduction in recruitment to non-registered and / or trainee posts,		
<b>Event</b>	then workforce gaps will increase, employee health and wellbeing will be affected, and turnover may increase; and the future pipeline will destabilise.		
<b>Effect (Consequence)</b>	resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.		
<b>SA1</b>	Improve Health and Wellbeing Outcomes	<b>SA3</b>	Achieve a sustainable and resilient Integrated Care System
<b>SA2</b>	Address inequalities in access, experience and outcomes from health and social care services	<b>SA4</b>	Working in partnership with communities to achieve social, economic and environmental community development

## Risk Scoring and Tolerance

Quarter / Score	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Trajectory	Target Score/Date	Risk Tolerance Statement	Linked Risks
<b>Likelihood</b>	4	4	4	4	4	Tolerance is high in recognition of the workforce pressures and financial position in health and social care. It may not be possible to deliver the Long-Term Workforce Plan, secure a robust future pipeline, retain people in the current climate and deliver the demand within the workforce constraints and current productivity levels. The system work programmes will focus on reform, collaboration, productivity, maintaining safe staffing levels, and developing operational and innovative approaches to reduce the impact.	Low 0 →
<b>Consequence</b>	5	5	5	4	4		Mod 3 ↓
<b>Risk Level</b>	High 20	High 20	High 20	High 16	High 16		31/03/25

## Rationale for Risk Score and Progress Made in the Quarter:

Recognising the financial challenges and change in landscape for 2024/25, the overarching risk reflects the current workforce challenges and system position.

Summary of the risk register, rationale for the Q3 score and progress as follows:

- Regular review and scrutiny around risks continues via PCI Committee, ensuring risks are reflective of the system-wide health and social care workforce challenges.
- All risk scores on the risk register are currently 16 or under.
- In addition to individual risk actions, the overarching risk is being addressed via targeted programmes of work, interventions and collaborative work at system and organisational level with evidence of an improved position in several areas including retention, wellbeing and strengthening the future pipeline.
- The agency position has improved significantly over the last quarter with a decreasing trend due to additional measures taking place at Trust and system level. Currently working with providers on next steps for price cap compliance.
- Whilst turnover is decreasing, sickness absence rates are steadily increasing therefore action being taken at Trust and system level to prevent further deterioration through prevention and targeted support. All monitored and driven via the ICS Employee Experience, Health and Wellbeing Sub-Committee.
- Increased scrutiny and oversight of workforce controls, driven by national requirements and system financial deficit in partnership with Deloitte and Kingsgate including agency usage, price cap, bank usage, vacancies, performance to plan and productivity.
- Overall delivery of the ICS People Plan and Long-Term Workforce Plan is led by the ICS People Function and programme delivery across all schemes is currently on track. The plan covers several schemes and programmes which seek to secure the future pipeline, reform workforce models, develop new ways of working and unregistered roles, retain our people, improve their experience and health & wellbeing, create an inclusive

and compassionate culture, develop our leadership and talent. The system EDI agenda is a crucial element of the plan and all programmes.

- Continued partnership working with ICB Primary Care team to support improvement and intervention in addressing workforce risks. GP Collective Action risk still live and being managed via MDT approach and monitoring. Seeing some impact on prescribing / investigating for maternity and district nursing. Latest data from Aug / Sept shows that GP appointments did drop slightly but ED attendances did slightly increase

Assurance Map						
Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4	
1 <sup>st</sup> Line (organisation)	<b>Trust People Committees (review and assurance)</b>	●	●	●		
	People Metrics, Key performance indicators and assurance reporting.	●	●	●		
	People Risk Register and Board Assurance Framework.	●	●	●		
	NHS Trust and ICB Vacancy Oversight process and meetings.	●	●	●		
	Trust vacancy oversight panels.	●	●	●		
2 <sup>nd</sup> Line (system)	<b>ICS People, Culture &amp; Inclusion Committee</b>	●	●	●		
	People Metrics, Key performance indicators and assurance reporting presented.	●	●	●		
	Operational Plan and workforce Controls reporting, monitoring and assurance.	●	●	●		
	Annual deep drive of high scoring risks driving the BAF risk.	●	●	●		
	<b>ICB Board</b>	●	●	●		
	ICS People Culture and Inclusion Committee highlight and People Assurance Report.	●	●	●		
	People Deep Dive planned for 2024 (date to be confirmed).					
	<b>Finance &amp; Performance Committee</b>	●	●	●		
3 <sup>rd</sup> Line (external)	<b>NHSE - System Review Meetings -</b>	●	●	●		
	People Metrics and KPI report presented to assure performance against Operational plan, JFP and LTWP.	●	●	●		
	<b>NHSE – Regional Workforce Transformation and Development teams</b>	●	●	●		
	Quarterly review meetings to report and assess the progress of workforce development funding spend.	●	●	●		
	Monthly review meetings for national/ regional programmes (including T-Levels and retention) to assure progress of programme activity and funding.	●	●	●		

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	●
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Gaps in Control or Assurance	
What are the gaps to be addressed to achieve the target risk score or to improve adequacy of assurance?	
<ul style="list-style-type: none"> <li>Capacity to meet additional reporting and assurance requirements from NHSE, and Deloitte.</li> <li>Ability to meet demand and Long-Term Workforce Plan growth with financial deficit, workforce controls, supply, future pipeline, and availability of registrants.</li> <li>Workforce development funds limited from NHSE and other sources to support innovative future workforce supply solutions and programmes.</li> </ul>	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						Complete/BAU	On Track
						Delayed	Problematic
No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG	
1	Collaboratively review and update the ICS People Plan in line with NHS and Social Care Long Term Workforce Plans.	Additional Assurance	Chief People Officer	31/03/25	PCI Committee revised structure and governance approved in September. Developing local approach – Skills for Care workforce Strategy, working with local partners on a delivery plan. ICS People Plan refresh commenced, in early stages, finalising for 2025/26.		
2	Further mapping and alignment of long-term workforce plan trajectories against the local position and our gap.	Additional Assurance	Chief People Officer	31/03/25	Ongoing work aligned to 2024/25 Operational Plan and programme activities underway in line with delivery plans. Awaiting national updates surrounding expected growth. Working with HEIs and partners to develop local education commissions and pipeline plan.		
3	Establish CPO and CNO/CMO forum to join up and agree actions to address critical workforce challenges and quality impact assess.	Additional Assurance	Chief People Officer	31/03/25	Regular discussion and relationships built. Senior ICS people representation now on Quality and Safety Committee.		
4	Horizon Scanning for alternative workforce development funding sources.	Additional Assurance	Chief People Officer	31/03/25	Ongoing work via Sub-Committees and Delivery groups		