NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting

HELD IN PUBLIC

Boardroom, Executive Offices, Springfield, Royal Stoke University Hospital, University Hospitals of North Midlands NHS Trust

Thursday 20th March 2025

12.30pm – 3.00pm

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

	Agenda Item	Lead(s)	Enc	A/R/ S/D/I	Time	Pages
1.	Welcome and Apologies	Chair	---	---	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 20th February 2025	Chair	Enc 03	A		6-16
5.	Action Log - progress update on actions	Chair	Enc 04	D		17
6.	Questions submitted by members of the public in advance of the meting	Chair	---	D	12.35pm	
Strategic and System Development						
7.	ICB Chair and Chief Executive Report	DP/PA	Enc 05	I	12.45pm	18-25
8.	2025/2026 National Operational Planning Submission	PB	Enc 06	I/S	12.55pm	26-32
9.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report Emergency Preparedness, Resilience and Response (EPRR) Policy	PS PS	Enc 07a Enc 07b	S R	1.05pm	33-47 48-78
10.	Pre-consultation Business Case – Birthing services previously provided at County Hospital and Samuel Johnson Community Hospital	HJ	Enc 08	A/S	1.15pm	79-265
11.	Specialised Commissioning Delegation Agreement, Collaboration Agreement and NHS Briefing	PW	Enc 09	A/I/S	1.30pm	266-275
System Governance and Performance						
12.	Quality and Safety Report Quality and Safety AAA Chairs Report	HJ JS	Enc 10 Enc 11	S I/S	1.45pm 1.55pm	276-279 280-282

13.	Staffordshire and Stoke on Trent Health and Care Senate AAA Chairs Report	PEJ	Enc 12	I/S	2.00pm	283-285
14.	ICS Finance and Performance Report Finance and Performance Committee AAA Chairs Report	PB/PS MN	Enc 13 Enc 14	I/S I/S	2.05pm 2.20pm	286-311 312-318
15.	ICS People, Culture and Inclusion Committee Report	MI	Enc 15	I/S	2.25pm	319-331
16.	Staffordshire and Stoke on Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report	ML	Enc 16	I/S	2.35pm	332-342
17.	Staffordshire and Stoke on Trent ICB Audit Committee AAA Chairs Report	JH	Enc 17	I/S	2.40pm	343-346
18.	Staffordshire and Stoke on Trent ICB Remuneration Committee AAA Chairs Report	SL	Enc 18	I/R	2.45pm	347-356

Any Other Business						
19.	Items notified in advance to the Chair	All	---	---	---	
20.	Questions from the floor relating to the discussions at the meeting	Chair	---		2.50pm	
21.	Meeting Effectiveness	Chair	---			
22.	Close	Chair	---		3.00pm	
23.	**Date and Time of Next Meeting** **Thursday 15th May, 1.00pm – 3.00pm, Council Chambers, County Buildings, Stafford**					

ICS Partnership leadership compact

Trust

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

Courage

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

Openness and honesty

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

Leading by example

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

Respect

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

Kindness and compassion

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

System first

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

Looking forward

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

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

Key

Declaration completed for financial year 2024/2025

Declaration for financial year 2024/2025 to be submitted

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

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
20th September 2024	Dr	Buki	Adeyemo	Chief Executive Officer	North Staffordshire Combined Healthcare Trust (NSCHT)	Nothing to declare	1. Board of Governors University of Wolverhampton (ongoing) 2. Mental Health Network, NHS Confederation, NHS CEO Representative (ongoing)	Nothing to declare	Nothing to declare	(h) interest recorded on the Conflicts Register
15th July 2024	Mr	Nadeem Tony	Ahmed	ICB Participatory (non-voting) member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director of Dentaire Ltd and TT Partners Ltd, Principal dentist at Dentaire Dental Care (ongoing)	1. Chair of Local Dental network - Shropshire and Staffordshire (ongoing)	Nothing to declare	1. Brother is an ENT surgeon and head of department at QE Hospital Birmingham (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) interest recorded on the Conflicts Register.
11th July 2024	Ms	Helen	Ashley	Acting CEO	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	Nothing to declare	1. Member of Derbyshire Community Health Services FT (2014 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
25th June 2024	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u13 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
23rd July 2024	Mr	Peter	Axon	CEO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th January 2025	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Director and shareholder of Kingdoms 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, but at some point it may 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	(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 September 2024	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust (MPFT)	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing) 4. Visiting Professor - Wagner College, New York (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st October 2024	Mr	Simon	Constable	Chief Executive	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	Nothing to declare	1. Visiting Professor, University of Chester (2015 - ongoing) 2. General Medical Council Responsible Officer and Designated Body is Dr Eileen Marks and Liverpool University Hospitals NHS Foundation Trust (2019 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
13th September 2024	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Foundation Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
8th Nobember 2024	Ms	Elizabeth	Disney	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Brother is Clinical Lead and Consultant at UHNM (1st September 2024 to date). 2. Brother's partner is owner-operator of Nature and Nurture Psychology, a child and family psychology service based in Staffordshire (November 2024 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on the conflicts register.
10th April 2024	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employed session a week (0.1 wte) by MPFT as Head of SSoT PH Alliance (as a locum public health consultant) (June 2024 - ongoing)	1. Fellow of the Faculty of Public Health (FFPH) and registered with the GMC (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
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.
16th December 2024	Mr	Mike	Lawton	Board Member	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employment with Black Country Housing Group (ongoing) 2. Employment with EMH Group, Leicester (ongoing)	Nothing to declare	Nothing to declare	1. Wife works as Specialist BMS in Pathology Lab UHNM (2024 - ongoing) 2. Son-in-Law works in procurement as a buyer for UHNM (2024 - ongoing) 3. Daughter works as a Pharmacist Trainer for Boots based in Nottingham (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 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 Renumeration Committee (September 2022 - December 2024) Declaration to be removed June 2025. 3. Chair of Mid Cheshire Hospitals Foundation Trust (January 2025 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register
8th April 2024	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Chair Land based College linked with Chester University (2018- 31st March 2024 retired)	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing)	(h) recorded on conflicts register.
11th April 2024	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. I sometimes do shifts for MPFT that I am not paid for (ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - March 2024) (Declaration to be removed from register September 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance Service (WMAS) (February 2021 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
9th April 2024	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
17th April 2024	Mrs	Josie	Spencer	Independent Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing) 2. Non-Executive Director for Coventry and Rugby GP Alliance (December - 31/05/2024 (To be removed from register November 2024)	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - 31/05/2024) (To be removed from register November 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
4th August 2024	Mr	Baz	Tameez	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
9th April 2024	Mr	Paul	Winter	Associate Director of Corporate Governance and DPO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

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

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board

HELD IN PUBLIC – via MS Teams

Thursday 20th February 2025

1.00pm – 3.00pm

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		✓	A	✓	✓	✓	✓	✓	✓	✓	✓	
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	A	✓	✓	✓	✓	
Phil Smith (PS) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	A	✓	A	
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	A	✓	A	✓	
Dr Paul Edmondson-Jones (PEJ) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	A	✓	✓	✓	
Elizabeth Disney (ED), Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB						A	✓	✓	✓	✓	✓	
Julie Houlder (JH) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Megan Nurse (MN) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓	✓	A	✓	
Shokat Lal (SL) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	A	✓	✓	✓	✓	✓	
Josephine Spencer (JS) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	A	✓	✓	✓	✓	
Mike Lawton (ML), Non-Executive Member, Staffordshire and Stoke on Trent ICB											✓	
Jon Rouse (JR) CEO, City of Stoke-on-Trent Council		✓	A	A	A	✓	✓	A	✓	✓	✓	
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council		✓	A	✓	A	A	✓	✓	✓	A	✓	
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	A	✓	✓	A	✓	✓	✓	
Dr Simon Constable (SC) Chief Executive Officer, University Hospitals of North Midlands NHS Trust						✓	✓	✓	A	A	✓	
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	A	✓	✓	A	A	A	A	✓	✓	
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓	✓	✓	A	✓	✓	✓	✓	✓	
Participant Members:												
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓	✓	A	✓	✓	✓	
Baz Tameez (BT), Healthwatch Support Staffordshire		✓	A	✓	✓	✓	✓	A	A	✓	A	
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		A	✓	A	✓	✓	✓	✓	✓	A	✓	
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		A	✓	✓	✓	A	✓	✓	✓	✓	✓	
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
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	✓	✓	✓	✓	
In attendance:												
Hayley Allison (HA), Portfolio Director Planned Care, Staffordshire & Stoke-on-Trent ICB											✓	
Anna Mather (AM), Healthwatch Support Staffordshire											✓	

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting and advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. The meeting is being recorded and will be available on the ICB website after the meeting. DP reminded members of the importance of the Leadership Compact document which was used in all the meetings transacted by the ICB and guides the way business is conducted. DP acknowledged that both PA and PB will be leaving the ICB in the summer and on behalf of the ICB Board, DP thanked both for their significant contribution to the system and advised that he is working closely with NHS England in relation to the recruitment process. DP welcomed Mike Lawton, new Non-Executive Member for Staffordshire and Stoke on Trent ICB and advised that he will be chairing the newly formed Strategic Commissioning and Transformation Committee.	
	Apologies	
	Apologies were received from: Paul Winter Baz Tameez - Anna Mather representing Phil Smith – Hayley Allison representing	
	Confirm Quoracy	
	DP confirmed that the meeting was quorate.	
2.	**Leadership Compact**	
	Received and noted.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register. It was noted that ML has submitted his conflicts of interest and they will be included in the March register.	
4.	**Minutes of the Meeting held on 16th January 2025**	
	The minutes of the meeting held on 16th January 2025 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
5.	**Action log**	
	Action log reviewed and updated accordingly.	

6.	**Questions submitted by members of the public in advance of the meting**	
	Submitted by Syed Abrar *"As the adoption of AI continues to shape the delivery of mental healthcare, what is the ICB's approach to leveraging these tools to enhance outcomes, improve efficiency, and ensure equitable access to services? Additionally, if you are a third-party that is able to support the ICB's strategy and priorities, who would be the best person to contact regarding this matter in the first instance?"* Response provided by CI. The ICB sees AI as a key element in digital transformation 'to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition'. In February 2024, our Digital Collaboration Forum approved the addition of AI to our "ICS Digital Initiatives" to develop use of AI to support our staff in decision making, diagnosis and completing complex tasks. We have a small number of projects underway, predominantly to support administrative functions within the ICB. Across our ICS providers we are using AI in some diagnostic areas, stroke care and patient engagement specifically in translation services. As with other digital healthcare technologies implementation must only be carried out when there has been robust clinical validation. In community and mental health services across Midlands Partnership NHS Foundation Trust, the Trust are adopting virtual assistants for 24/7 chatbot appointment viewing and cancellation, and referral screening tools for talking therapies in Shropshire, Telford & Wrekin, and Adult Mental Health. MPFT also adopt RPA (Microsoft Power Automate) for processing en masse repeatable administrative tasks for recruitment practice and clinical systems data management (e.g. Death registrations, spine tracing and data migration) and use AI to support administrative functions via Copilot. North Staffordshire Combined Healthcare NHS Trust also primarily use AI to support administrative functions, via Copilot. CI advised that he and Sally Deacon, Digital Transformation & OHC Lead Staffordshire & Stoke-on-Trent ICS would be happy to have further conversations.	
7.	**ICB Chair and Chief Executive Update**	
	DP presented the report and highlighted that he had been invited to North Staffordshire Combined Healthcare NHS Trust (NSCHT) and the visit was led by Chief Executive Dr Buki Adeyemo and her team and he had the opportunity to see the all-age telephone and walk-in crisis care access service and talk to frontline staff about the challenges of implementing the Right Care Right Person arrangements. He also advised that he was shown the facilities being developed through 'Project Chrysalis' in the new Ward 2, commenting on the calming atmosphere and use of artwork that creates a welcoming environment. He praised Sarah Larvin, Ward 2 Deputy Ward Manager, as great example of a young leader in the NHS. He added that he also attended a strategy event on the 10th February at Port Vale Football Club and participated in discussions around NSCHT's innovative use of virtual reality, including a library of virtual reality tours of all Combined Healthcare sites to provide engaging and informative experiences of NSCHT facilities and locations. PA provided an update in relation to the planning allocations and advised that a significant amount of work has taken place around the planning for this year and final agreements have taken longer than anticipated. He added that the financial envelope that we have been allocated is incredibly challenging and advised that colleagues are working hard as a collective and highlighted the three main areas of focus:	

	• Cost improvement programmes/cost efficiency programs • Allocative efficiency/moving resources to ensure we work in a different way • Tough choices, ensuring we submit plans that are balanced, more information will be presented to the Board at the next meeting PA provided assurance the colleagues are working hard to ensure that we can deliver the best possible plan within the resources that have been allocated. JH referred to the community transformation programme and requested assurance around the pace and governance arrangements, which are critical to achieving change. PA advised that there are significant areas of opportunity and stated that colleagues are developing eight key themes within the community transformation scheme and advised that it is important that we have joint agreement, using data and evidence. He added that it is a clear opportunity to be more pro-active to prevent admissions and stated that transformation requires considerable time to implement and discussions are being held with NHS England. He also added that there is regular interface with the various leads to ensure there is no gaps or overlap and resource is vital need to avoid duplication. JH acknowledged that transformation does take time and stated that there are a lot of systems across the country that have made good progress and asked if we are liaising with other systems to gain any learning. PA agreed and stated that Lincolnshire recently presented at a recent system wide workshop. ED added that colleagues learnt a lot from the workshop and added that as a system we have undertaken a significant amount of work and jointly with our Local Authority colleagues we have an opportunity to be more coherent and ensure system wide focus and evidence will be used to help inform our plans and will be learning from other systems across the country. JS welcomed the report and noted a number of positive outcomes comments and commended the primary care IT equipment donation and national apprenticeship week. JR stated that as a Board it is right that we look at the tough choices collectively and it is important that we are coherent in the overall approach. As an ICB we have to empower those closer to the front line to enable change, empower front line leaders to save money. **The ICB Board:** • **Received the report and were assured the leadership are working on each topic as raised**.	
8.	**Planning and Allocations**	
	PB presented the report and highlighted the process the ICB will be following and advised that the 2025/2026 Operational Planning Guidance was published on the 30th January and the ICB plan needs to be agreed and submitted by the 25th March. He added that there will be a system Board-to-Board meeting with NHS England to go through the plan. He added that ED and system Directors of Strategies are taking a lead role to ensure plans are triangulated across the system and numerous discussions are taking place with colleagues across the system. PB highlighted the national priorities for the NHS in 2025/2026: • Reducing waiting time for elective care • Improving urgent care and ambulance responses • Improving access to general practice and urgent dental care • Improving mental health and learning disabilities care PB provided assurance that the plans will focus on all of the priorities, however the ICB will operate within the allocated financial envelope and added that the expectation will be that the work on efficiency continuous the focus on productivity, capitalising on the workforce and treating more patients without increase the workforce, whilst maintaining and ensuring patient safety and continuing to address inequality and preventing inequalities and shifting from analogue to digital.	

	PB stated that the challenge is exceedingly difficult and the financial position is extremely difficult. He referred to the strike action, which has been resolved and wages uplifted and advised that the allocations do recognise this and inflation is included and stated that it is a challenging situation for the ICB and all our partners and work continues to maximise efficiency through efficiencies, the community transformation work and making decisions regarding tougher choices, which will be presented to the Board at a future meeting. DP welcomed the update and acknowledged the huge amount of work being undertaken. MN referred to the overview of priorities and the things we need to do to achieve the goals, which include operating within the allocated financial envelope reducing waste and improving productively and making the shift from analogue to digital and referred to the link regarding improving productively and making the shift from analogue to digital and noting that capital investment is key and added that as a system we will not break even and will penalised next year if we don't break even and stated that the system is significantly challenge. PB agreed and stated that there is a need for capital investment and acknowledged that as a system we must live with the expectation from the system to deliver the transformation agenda. ED added that there is a need to explore alternatives to conventional capital to undertake some of the digital innovations and looking at organisations that we might want to approach to develop the relevant types of technology and explore other opportunities. **The ICB Board:** • **Acknowledged the release of the 2025/26 national planning guidance, provider efficiency and productivity packs and financial planning guidance and allocations.** • **Acknowledged the local milestones.** • **Acknowledged the need for the Board to submit assurance statements on 25th March as part of the full submission to NHSE.**	
9.	**Quality and Safety Report**	
	HJ presented the report and referenced the continued pressure in urgent care and provided assurance that colleagues continue to work with UHNM in relation to harm reviews within the emergency department and also added that high impact team visits have been undertaken and look at what can be done to improve patient flow, all of which have had a positive impact on the urgent emergency care pathway. HJ apologised for not being present at the last meeting in which reference was made to the Darwin centre and confirmed that the centre is commissioned by NHS England and the ICB work closely with NHS England and all service providers and advised that following a visit from NHS England there is a comprehensive improvement plan and provided assurance that the ICB will continue to work with BA and her team to ensure that the service is sustained and provided assurance that there is no impact on admissions. HJ referred to the improvement journey in relation to continuing healthcare (CHC) and was pleased to report that the backlog of reviews has significantly reduced and stronger systems and processes have been established and colleagues are working together to prevent an accumulation of further backlogs in the future and reported that she is confident that based on progress to date it will be achieved, whilst it continues to have an impact on the financial position, the primary focus is ensuring best use of the continuing healthcare framework to ensure patients are receiving safe and high quality of care. It was noted that there is continued progress in the development of the continuous Quality Improvement Network, which is led by Midlands Partnership Foundation Trust and continues to go from strength to strength and works across Staffordshire and Shropshire and will bring significant improvement activity and improvements projects, which will link into the community transformation agenda.	

	HJ referred to the sustained improvement in learning from the lives and deaths of people with a learning disability and autistic people (LeDeR) programme and advised that there is only one overdue review and colleagues continue to work to maintain the improvement. HJ highlighted the development of the Social Care Academy and the potential opportunities for the population and help to enable use to grow our own workforce from a care home perspective. DP referred to the LeDeR programme and noted the real achievement from where the system has been historically, which is welcomed. He also referred to section six of the report, Care Quality Commission and highlighted that the County Hospital has been moved to "good" from "requires improvement" and also highlighted that Brewood Medical Practice and Millrise Medical Practice have both achieved overall ratings of "good" which is good to note. JH welcomed the report and referred to the alignment of continuous quality improvement, in particular the discharge element within urgent emergency care, which is an integral part of the community transformation programme and requested an update and assurance regarding the alignment. ED advised that there is a clear view on the areas we are going to focus on next year and whilst community transformation program is the umbrella for significant change, the work from across our portfolio areas including emergency care will be critical and one of the areas will focus on discharge and the integrated discharge hub arrangements and discussions are being held with Local Authority commissioning partners and provided assurance that learning will be fed into the transformation opportunities. BA referred to Darwin Centre and reported that has been further meeting and unannounced visit to the Centre and it remains that there are no concerns. MN referred LeDeR programme, which is welcome news and noted the considerable progress been made in reducing the backlog and asked if progress is being made in relation to outcomes for people with learning difficulties. HJ stated when developing services for people with learning disabilities and autism, there will be an element of matrix working across the system which will feed into the community transformation work. ED added that the plans for 2025/2026 are linked to the mental health, learning disability and autism portfolio and there are some specific actions regarding improving outcomes within these areas, including, ongoing focus on health checks, long standing and complex needs have comprehensive care packages which are being reviewed to ensure people gain life skills and are they able to life their best lives. MN acknowledged that a difference is being made for people with learning difficulties and reducing inequalities and requested that there is a continued ongoing focus on this area. DP advised that all Board members receive Oliver McGowan training later in the year and there will be an additional work will also be undertaken with the Board and system chairs, as necessary. **The ICB Board to:** • **Received this report, seek clarification, and further action as appropriate.** • **Were assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.**	
10.	**ICS Finance and Performance Report**	
	PB presented the Board and advised the Investigation and Intervention regime continues and it was noted that the reported system efficiency based on Month 9 information is now assessed to outturn at £180.4 million, which equates to 88.8% delivery against the annual efficiency plan of £203.2 million. We continue to work with the Investigation and Intervention Team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented and focuses continues in the following areas: • Enhanced controls, including workforce • CHC collaboration • Productivity • Use of the independent sector	

- Balance sheets

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

SC stated that external assistance is helpful to identify productivity issues and any external scrutiny is welcomed to ensure maximum productivity. NC agreed and stated the provider organisations are working very productively with the ICB.

MI provided an update on workforce in relation to the Investigation and Intervention regime and advised that the ICB is working with each provider organisation to refine their plans and are focusing on reducing bank and agency staff, using technology in a different way and job planning and rostering will be the next focus and will work closely with colleagues.

HA presented the performance element from the report. She advised that urgent emergency care remains incredibly challenging, due to rapid rises and spikes in pressure early in the winter season, which results in one system critical incident during November into December. She added that our emergency department has seen higher attendances than expected and there has been a 3.78% increase in attendance compared to the same period last year and bed occupancy has also remained high. She also added that infection rates continue to be of concern and infection prevention restrictions have a huge impact on patient flow and capacity and it was noted that the midlands position is very challenging and is experiencing the worst norovirus situation in over five years and 55% of beds have been lost due to norovirus this year, compared to the same time last year.

HA highlighted that for our population there has been unacceptable delays across the urgent emergency care pathway, in particular ambulance response times and reported in January the response time was 32 minutes, which is an improvement against the November and December response time which was circa 50 minutes. She added that across the system we have a number of lost hours due to ambulance delays which all sites, specifically UHNM.

HA reminded members of the Board that the Winter Surge Plan was presented at the November Board, which highlighted he actions to get us through winter. She added that the plan would be adjusted when needed according to the pressures within the system. She highlighted that a number of extra ordinary actions have continued, which include additional capacity in primary care, and additional spot pressure of community bed capacity and an increase in staffing in the single point of access, due to a 20% increase in demand which has provided support to patients onto alternative pathways and not going to an emergency department. She added that there is clear focus regarding care home support and out Integrated Co-ordination Centre has a key part to play and more work is required across the system regarding the process.

It was noted that HIT interventions continue to support the acute setting with the identification of discharges and work continues across the system to embed some of the learning from the interventions.

HA advised that there have been significant pressures on our workforce which had resulted in an increase in staff sickness across the system, however she was pleased to report that staff sickness is now reducing.

HA advised that a winter review is taking place and monthly updates are presented to the Finance and Performance Committee and all the findings and lessons learnt will be fed into our planning for future winters. She reported that the system has worked well and there has being great collaboration across all partners.

HA provided an update regarding planned care performance and advised there has been a long-standing wait time for patients requiring elective care, which resulted in a number of cancellations during the winter period, but was pleased to report that significant progress has been made in relation to out 78 week wait cohort and for March it is projected to significantly reduce. She also advised that our 65 week wait cohort is now under 200 patients, which is a massive achievement compared to 30,000 patients this time last year.

SC referred to the urgent care position specifically over the past couple of months and the overall numbers of increased in attendances and admissions does tell us that there is little resilience across the system. He referred to the increased infection rates which significantly adds to the pressure, especially in the older estate parts of the hospital, where there are no single patient rooms. He stated that there are a number of lessons learnt and urgency emergency care remains the number one priority across the system. He formally apologised to all patients and families that have been affected by the delays, which is not acceptable and as a system we are doing everything to mitigate this from a patient safety and patient experience point of view. He referred to community transformation and what is required and reported that the interface between all partners across the system is coming together and progress is being made.

SC was pleased to report that UHNM have appointed and Emergency and Urgent Care Recovery Director who will lead a programme for improvement. He also added that daily meetings take place across the system and the system continues to work well.

JR stated that on behalf of the Board he wanted to convey thanks to all the staff who have worked unbelievably hard throughout the winter and have gone above and beyond and colleagues should recognise all this work and honour them. DP agreed and stated that on behalf of the Board, recognition will be included in the summary report.

DP referred to the continue learning exercises going forward and asked how this is going to be different to previous years and how can we get the plan into a stronger position in readiness for next year.

HA stated that this year there has been a iterative review process, alongside a monthly governance process and monthly updates to the Finance and Performance Committee, all of which have helped to remain focused and she also added that the Urgent Emergency Care Board play huge part in the process and reported that there will be a “wash up” session with all partners, which will outline the learning and any changes that need to be made. She concluded by saying it has been a difficult winter and having the external support has helped and provided an additional focus to bring together all of the learning and as a system we will continue to work with all agencies, including the voluntary sector and alongside the communication transformation work and the review of the better care fund there will be opportunities to do things differently.

The ICB Board:

- **Acknowledged the high-level performance against the five priorities.**
- **Acknowledged the high-level key programme deliverables update.**
- **Acknowledged the financial position.**

Finance and Performance Committee Assurance Report

MN presented to the report and highlighted the huge amount of work being undertaken to achieve the financial position and added that the tough choices work stream is moving at pace. She referred to the work regarding supporting care homes and added that progress is being made in and there is clarity around the immediate and medium terms actions to improve support for care homes.

MN advised that there continues to be concern around the strategic capital plans and also advised that the Finance and Performance Committee reviewed its terms of reference and agreed amendments reflecting provider selection, regime requirements and the new Strategic

	Commissioning and Transformation Committee and requested ratification for the terms of reference from the Board. **The ICB Board:** • **Received and noted the report** • **Ratified the Finance and Performance Committee Terms of Reference**	
11.	**People, Culture and Inclusion Committee AAA Report**	
	SL presented the report and advised that the Committee received an update regarding the underlying theme for 2025/2025 operating plan and the medium-term plan in particular the transformation programme and referred to the behaviour, culture and leadership implications of the transformation work and activity and referred to the challenges for the workforce and the need for a collective resource across the system and how different organisations come together. He stated that there is more work to be done regarding behaviour, culture and leadership and stated that doing things differently require a different mindset and stated that though the People, Culture and Inclusion Committee they will continue to look at examples of how we can work differently. **The ICB Board received and noted the report.**	
12.	**Staffordshire and Stoke on Trent ICB Audit Committee AAA Chairs Report**	
	JH presented the report, which is a written report following her verbal update at the last meeting. **The ICB Board received and noted the report and ratified the following policies, which were approved at the last Audit Committee:** • **Anti-Fraud & Bribery Policy** • **Development & Management of Controlled Documents Policy** • **Conflicts of Interest: COI (incl. Gifts & Hospitality) Policy** • **Standards of Business Conduct Policy** • **Acceptance & Management of Petitions Policy** • **Social Media Policy**	
13.	**Staffordshire and Stoke on Trent ICB Strategic Commissioning and Transformation Committee**	
	DP presented the report and advised that he had chaired the two previous meetings and advised that going forward ML will chair the Strategic Commissioning and Transformation Committee. DP advised that the Committee have a real focus moving forward and stated that it was agreed at the second meeting that there are several areas, highlighted in the paper that will be communicated with colleagues to help the Committee evolve. **The ICB Board received and noted the report.**	
14.	**Items notified in advance to the Chair**	
	No items were notified to the Chair and no other items of business were raised.	
15.	**Questions from the floor relating to the discussions at the meeting**	
	Allison Gardner, MP for Stoke on Trent South.	

Allison Garnder advised that she previously worked for the NHS AI and Digital Regulation Service and offered assistant to any work on AI and governance. DP thanked Allison for the offer of support.

Allison Gardner, MP for Stoke on Trent South
Question one

Allison referred to the wheelchair services and highlighted that a number of MPs across the country are dealing with various cases and advised that there is one cases in particular within our system, in which the family are likely to go to the media with their concerns and it is likely to become public interest. DP thanks Allison for her statement as advised that ICB colleagues are meeting local MPs on Monday and stated that this will be discussed at that meeting. ED provided assurance that the ICB are aware of the challenges around the wheelchair services, which are around the wait time and reported that colleagues are working through with issues with the current provider. She added that there are challenges nationally and stated that as a commissioning organisation we are aware of the challenges and are working through these via our commissioning, contracting and quality route. She also added that there has also been a role for our Overview and Scrutiny Committee in which a number of recommendations were made at the end of last year and the ICB have been working through the recommendations and will report back to them on the findings. .

Ian Syme
Question one - CHC

Ian Syme referred to continuing health care and noted that the ICB is an outlier regarding the amount of continuing healthcare we finance and highlighted that fast-track continuing healthcare and asked for assurance that this is still being offered, specifically for patients at home. HJ provided assurance that fast track continuing health care is still provided and it is still possible to have care in your own how and where appropriate that can be provided through a personal health budget.

Ian Syme
Question two - UEC

Ian Syme referred to the Quality and Safety Report and acknowledged that the ICB is focusing on the fundamentals of care and the review of urgent and emergency care and the review of harm where patients are waiting in areas that are not standard, for example in an ambulance outside the emergency department. He also referenced he visits to UHNM and County Hospital and asked if ICB colleagues will be undertaking a visit at Queens Hospital in Burton and stated that reviews will be taking place in Good Hope Hospital and Wolverhampton Hospital and asked if the findings are reported back to the ICB. He also referred to harm reviews and stated that the Office of National Statistics (ONS) report analysed rates for emergency departments where the longer you wait the greater chance of harm, including excess deaths and asked how this is being taken into consideration.

HJ advised that we are not the lead commissioner for Queens Hospital but are working with colleagues to develop a strategy for how we can replicate some of the best practice we have done and added that they have their own systems and processes but are keen to co-operate.

HJ referred to the review of urgent and emergency care and the review of harm and the ONS report and stated that she could not provide assurance that there has been no harm and added as part of the work that is being done in response to the fundamentals of care there is a comprehensive review in which the findings of the ONS report are being applied to the work that is being undertaken

SC confirmed that harm reviews take place for anywhere where care is provided outside the normal scope, for example ambulances, corridor and provided assurance that his executive team are reviewing the data to mitigate the underlying issue.

	Ian Syme Question three – finance Ian Syme referred to the AAA Finance and Performance Chairs Report and note the significant improvement in the financial position. PB confirmed that the financial position has steadily improved over the past four months and the ICB is reported a £39 million year deficit against a deficit plan of £90million. Ian Syme Queston four – productively Ian Syme referred to productively and the land of diminishing return and referred to the reduction in workforce, however the increases in workforce are mainly within the acute sector and noted that the community and primary care have not seen an increased in workforce and asked how this is being factored in as it isn't one size fits all. PB stated that there has been workforce growth in all sectors and the highest is in the acute sector, given the on-going pressures and added that there has been an increased in clinical numbers across all areas.	
16.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the Leadership Compact.	
17.	**Close**	
	There being no further business, the Chair closed the meeting.	
18.	**Date and time of Next Meeting**	
	20th March 2025 at 12.30pm – 2.30pm. Boardroom, Executive Offices, Springfield, Royal Stoke University Hospital, University Hospitals of North Midlands NHS Trust, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Open Actions

Agenda item	Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
9	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
9	16/01/2025	**Cyber update**	CC highlighted the significant risk of cyber security across the country, which is heighten due to the move from analogue to digital and confirmed that it is included in the risk register and added that due to the nature of cyber risk advised that the ICB may want to give some consideration when we move into the BAF for 2025/26 this as a strategic risk within the BAF. She also added that the Audit Committee handbook is clear on its overview of cyber risk and advised from a UHNM perspective she has produced a similar report, which highlights the national context and the controls and assurances in place and suggested including this as part of the Audit Committee cycle of business, which will provide further assurance. DP requested further executive discussions and discussions at Audit Committee via JH and report back to a future Board with an update.	**15/05/2025**	Chris Ibell	

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 05

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

(1) Purpose of the Paper:

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

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

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

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

(3) Implications:

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

(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 ICB Board meetings update

Following up on the Best Practices recommendations outlined in the NHS England Insightful ICB Board publication, and further to the ICB's second annual 'Governance and Partnerships Review' conducted in late 2024, our ICB Board meetings held in public will now be held on a bi-monthly basis. The Board will continue to meet in the months in-between Board meetings, for ICB-ICS strategic development and strategy implementation assurance / oversight (non-formal business) sessions.

1.2 Announcement around ICB Reform

Over the last few months, both NHS England and the Department of Health and Social Care have been discussing closer working and ending duplication. Work is now underway on radically reforming the size and functions of the Centre to best support the frontline to deliver for patients and drive the Government's reform priorities. As part of the need to make best possible use of taxpayers' money to support frontline services, NHS England has informed us the size of ICBs will also be radically reduced by around 50% in line with changes to the centre. These plans are not a reflection on the work of our ICB. David Pearson, Peter Axon and the Executive Team will continue to provide updates as plans develop.

1.3 Primary care

1.3.1 Multi-Disciplinary Primary Care Acute Urgent Access Hubs

To increase patient access to primary care services, multi-disciplinary urgent access hubs have been in place since December 2024. These hubs have provided 2,600 additional same, and next day, urgent appointments, per week, for patients across Staffordshire and Stoke-on-Trent. Hubs will continue to be available for patients until 31 March 2025.

1.3.2 Veteran Friendly accredited GP practices in Staffordshire and Stoke-on-Trent

Within Staffordshire and Stoke-on-Trent, 92.9% of practices have now been veteran-friendly accredited. This is compared to 68% of practices reporting accreditation in February 2024. This is a voluntary initiative for practices to identify health issues and signpost veterans to relevant support as required. Staffordshire and Stoke-on-Trent ICB are reported to have the highest percentage of practices accredited out of 11 ICB's across the Midlands. This also places Staffordshire and Stoke-on-Trent ICB at 7 out of 42 ICB's in England.

1.3.3 The Staffordshire Training Hub showcases good practice across Primary Care Networks

The Staffordshire Training Hub is pleased to showcase stories amongst Primary Care Networks and practices who have introduced initiatives to support staff wellbeing, enhance patient outcomes and improve operational efficiencies. The first showcase story, 'Staff wellbeing in-house therapist' is an initiative at Longton Hall Surgery, where managing partner Mike Sheldon has implemented the initiative to provide free therapy treatments for staff every Thursday afternoon. Mike and other partners appreciate the pressures staff are under but believe that supporting their wellbeing is paramount. The full showcase story is available to read on the Staffordshire Training Hub website.

1.3.4 Prostate-specific antigen (PSA) blood testing

A PSA test is a blood test to improve checking for prostate conditions such as prostate cancer or an enlarged prostate. In Staffordshire, there are several PSA testing events taking place that will offer free PSA testing. The first two events are being held on 25 April at the Stone House Hotel and 27 April at Stafford Rangers Football Club.

1.3.5 Lyme Valley Medical Centre's transition to Digital Telephony

Located in Newcastle-Under-Lyme, Lyme Valley Medical Centre have moved to a new Digital Telephony system, with the transition supported by funding from the ICB. The practice noted that the benefits of this new system far outweigh the slight cost increase, reporting positive feedback from both patients and admin staff. Staff highlight the 'call back' feature as a significant benefit for managing the number of calls in the queue from the public. Clinicians also noted the benefits of the call recording feature, allowing them to listen back to calls with colleagues and review the information given to patients. Call recordings also provide the opportunity for admin staff to review calls with management and understand how these could have been handled differently. Moving forward, plans include using the call recordings as part of training when inducting new staff, along with being used as Key Performance Indicators (KPIs) within the appraisal process.

Five months on, the practice feel that Digital Telephony is well embedded. They review the performance reports with staff at the monthly practice meetings and staff appreciate receiving this feedback of their work.

2.0 Finance

As a system we continue to focus on the delivery of our financial recovery plan. At month 10, at a system level we reported a year-to-date deficit position of (£30.5m), which is a £33.3m adverse variance against the revised plan (Month 9 variance to plan £32.8m). The year-to-date variance to plan sits within ICB at £14.4m and University Hospitals North Midlands (UHNM) at £22.2m, with small surplus at Midlands Partnership Foundation Trust (MPFT) at £1.4m and North Staffordshire Combined Healthcare Trust (NSCHT) at £2.0m. Given the increasing certainty as we move towards the year end and capture the benefits from the Investigation and Implementation regime and Elective Recovery Fund performance, the system reduced the unmitigated risk to £30m in month 10, which is an improvement from month 9 of £39m. This has been achieved through a combination of NSCHT increasing their forecasted surplus position, coupled with balance sheet flexibility at MPFT.

Since submitting our Month 10 system return, we have identified further improvement and have now had agreement from NHSE that we formally move our forecasted position away from breakeven. Our revised forecast position is now therefore an £18m deficit.

Work on financial and operational planning for 2025/2026 is now well underway, with confirmation of the operational targets as well as the revenue and capital allocations being received on 30 January. There are inevitably a number of very challenging operational and financial targets, and the system is working collectively on addressing these. We continue to work with system partners to submit the 2025/2026 operating plan on Thursday 27 March and will confirm the details to the Public Board in April.

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 and infection prevention and control constraints have impacted planned care procedures, although cancellations have been mitigated where possible.

New national priorities and success measures for elective care for 2025/2026 were published on 30 January 2025 as part of NHS operational planning guidance. These measures seek to further reduce patient waiting times and improve cancer diagnosis and treatment timeframes.

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

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

	January - Number of patients waiting at month end		
	104+	78-103 weeks	65-77 weeks
University Hospitals of North Midlands	0	15	156
Nuffield North Staffordshire	0	0	0
Ramsay	0	0	0
Medefer	0	0	0
System Providers Total	0	15	156
Out of System Providers	0	2	47

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

3.2 Cancer Performance

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

		December - Number of patients				
Provider	Cancer Standard	Treated	Within Standard	Breaches	Target	% compliance
University Hospitals of North Midlands	28-day Faster Diagnosis	3,370	2,479	891	75.0%	73.6%
	31-day target	1,294	1,210	84	96.0%	93.5%
	62-day combined target	670	409	261	85.0%	61.0%
University Hospitals of Derby and Burton	28-day Faster Diagnosis	3,497	2,570	927	75.0%	73.5%
	31-day target	1,456	1,302	154	96.0%	89.4%
	62-day combined target	816	588	228	85.0%	72.1%

The table in Appendix 2 shows the December performance for 28-day faster diagnosis, 31-day target and 62-day combined target. Please note this is the provider position, not solely Staffordshire and Stoke-on-Trent patients. This is taken from the published Cancer Waiting Times data, with the latest data available being December.

Further and ongoing actions include:

- Continued focus on clearance of long wait patients.

- Continued focus on faster Cancer diagnosis and treatment.

- Focus on the new national priorities and success measures for 2025/26, to further reduce the time people wait for elective care and cancer diagnosis and treatment.

- To 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 times for a four-week average is 35 minutes and 49 seconds, dropping the system to 27th nationally and 8th regionally. As per 02 March 2025 week end, performance has risen to just over 49 minutes, compared to just over 38 minutes as previously reported. This is almost 19 minutes above plan and compares to 30 minutes and 24 seconds as reported last year.

February's average handover time at UHNM remained pressured and despite continued focus on working towards ambulance handover compliance saw a deterioration to just over 2 hours, up from the 1 hour 46 minutes average experienced during January. Overall time lost due to handover delays further decreased reducing to 6533 hours, down 333 hours on the previous month. However, when measured on a per day basis, it switches to a growth per day of nearly 12 hours. The 6533 hours reported for February is 4200 hours above plan, the equivalent of 151 hours per day lost above plan. This continued pressure on handovers resulted in a 2.8% reduction in handover compliance, falling to 54.9% which is 25.1% below the target of 80% for February.

‘All types’ of attendance at UHNM decreased by 5.4%, but due to the shorter month, there was an increase of the equivalent of 35 attendances per day, with the impact felt at both Type 1 and Type 3 locations. When compared to last year attendances, this is an increase of 2.25% and tracking up by 5.4% over the three-month period. Patients receiving their initial assessment within 15 minutes reduced by 4.1%, and there was a decrease equivalent to 16.5% in pro rata Type 1 attendances for people seen within the first 60 minutes. Emergency Admissions via Accident and Emergency saw a drop equivalent to almost 4 patients per day throughout the month, and when compared to the same period last year, the overall level of reduced emergency admissions equated to approximately 16 patients per day.

Four-hour performance during February dropped by 1.6%, reporting at 64.8%, and slipping 7.6% below plan for the month. Type 1 locations are experiencing a 6.9% reduction month-on-month but a 3.1% increase when analysed pro-rata due to the shorter month and saw a 2.6% reduction in performance to 44.1%. Type 3 locations also reported a reduction in performance, dropping 1.4% to 95.6% for the month.

Unvalidated 12-hour performance improved from 11.4% to 11.1% during February for attendances spending twelve hours or more in Emergency Departments, equivalent to almost 1 in every 9 attendees. The regional average for this period was 11.6%, and when compared to the same period last year performance was 1.7% worse off.

Bed Occupancy for February for both Adult General and Acute (G&A) and all General and Acute decreased, resulting in occupancy rates of 93% and 92% respectively, the latter of which was 1.5% below plan for the month. During this period, paediatric General and Acute bed occupancy increased marginally to 72.3%. Indicative of the delays experienced in discharging particular cohorts of patients UHNM reported no change in the average number of patients occupying a bed for 7 or more days, reporting marginal increased in those waiting 14 or more, and 21 or more, the latter of which increased to 17.3%, which equates to almost 1 in 6 beds.

Due to changes in the reporting framework for discharges, we are not able to provide breakdowns of the Discharge Pathways for the month of February at present. However, evidence from other supporting measures appear to indicate the likelihood of a deteriorating position, with Pathway 1 and Pathway 2 expected to report increased proportions. This will impact on the overall year-to-date position which was 76.5% Simple and Timely versus 23.5% Complex at the end of January 2025. UHNM Discharge Ready Date (DRD) data for December 2024, which is the latest available, indicated an average delay for those not discharged on their DRD of 3.37 days. This was an improvement on November and 0.16 days below the 6 month mean, however, increased No Criteria To Reside numbers as likely to stretch these numbers through January and February. In total, 1703 bed days were lost during December by delayed discharges, equivalent to 55 beds per day every day through the month.

Virtual Wards (VW) occupancy for the latest submission, recorded 21st February 2025, reported 216 patients in a VW bed. Whilst capacity increased over previous months, the growth of 5 beds remained 77 beds below planned capacity. Occupancy reported as 72.5%, split between 74.9% in the North sector, 83% in the South East sector, and 34.3% in the South West sector.

Infection prevention and control constraints continued to persist through February with COVID-19, flu and diarrhoea and vomiting infections closing a significant proportion of beds through the month.

5.0 Key figures from our population

		Last 4 months in current financial year				Comparator month		Change on same month previous year		
		Oct-24	Nov-24	Dec-24	Jan-25	Dec-23	Jan-24	No.	%	Direction
*	111 calls received	28,587	31,094	35,886	29,051					
	Percentage of 111 calls abandoned	2.2%	2.1%	1.5%	0.4%					
	A&E and Walk in Centre attendances (UHNM)	22,519	21,450	21,895	21,299		20,833	466	2.2%	↑
	A&E and Walk in Centre attendances (other providers)	19,301	18,753	18,751	17,120		17,666	-546	-3.1%	↓
	Non elective admissions (UHNM)	8,681	7,985	8,031	8,325		8,138	187	2.3%	↑
	Non elective admissions (other providers)	7,132	7,044	7,078	7,114		6,673	441	6.6%	↑
	Elective and Day Case spells (UHNM)	10,592	9,791	8,696	9,537		7,677	1,860	24.2%	↑
	Elective and Day Case spells (other providers)	9,595	9,072	7,866	8,608		8,441	167	2.0%	↑
	Outpatient procedures (UHNM)	13,000	12,224	10,995	12,743		7,135	5,608	78.6%	↑
	Outpatient procedures (other providers)	16,200	14,044	12,502	15,002		13,269	1,733	13.1%	↑
	GP appointments (all)	706,063	564,561	508,968	590,624		596,636	-6,012	-1.0%	↓
**	Physical Health Community contacts (attended)	161,510	149,760	137,680	157,660		143,115	14,545	10.2%	↑
**	Mental Health Community contacts (attended)	47,055	44,815	39,765		35,610		4,155	11.7%	↑

* NHS 111 - following the switchover to DHU in April 2024, published data is no longer available. Data is available through a local solution from June 2024 onwards. Please note due to the change in methodology it is not currently advisable to compare to the same month last year. The increase in December is expected to be related to the additional bank holidays for the festive period, which are normally NHS 111's busiest days of the year. Also likely to be linked to the additional winter pressures experienced across the system.

Most datasets are subject to change upon refresh.

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

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

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

6.0 Quality and Safety

6.1 Maternity and neonatal independent senior advocate (MNISA) pilot extension

Staffordshire and Stoke-on-Trent ICB have received confirmation that the maternity and neonatal independent senior advocate (MNISA) pilot has been extended until March 2026. The MNISA provides support and advocacy to families navigating investigation processes following a significant health complication, or the death, of a mother or baby. Over the past year, the MNISA has supported families to gain better understanding of what happened to them or their baby, ensuring families to feel listened to and heard. Working in collaboration with provider trusts, charities, primary care and the coronal service, we have been able to move forward projects that will really help to make a difference to the service we provide for families. This includes a programme that offers new parents the opportunity to attend basic baby life support training before giving birth or taking their new baby home from hospital. The MNISA role is currently being formally evaluated, giving stakeholders from Staffordshire and Stoke-on-Trent the opportunity to shape and influence the future. This will ensure that we can continue to make positive strides to support families who have experienced trauma and to continue to learn from the positives and negatives that they share of their experiences.

6.2 NHS England Midlands Mental Health Host and Home Integrated Care Board guidance pilot programme

The ICB, supported by NSCHT and MPFT, have completed a self-assessment against the NHS England Midlands Mental Health Host and Home Integrated Care Board Guidance pilot programme. The Home Commissioner responsibilities are new within the pilot guidance, and therefore, improvement actions have been identified to formalise and strengthen governance and escalation processes. These are being worked on using a system wide approach. As a system, we are developing a brochure to share with patients and families ahead of placement, aiming to align it with the Experience of Care Framework. There has been a review of the monthly system intelligence sharing Independent Hospital meetings to include by exception any reporting of services where Staffordshire patients are placed out of area.

David Pearson, ICB Chair

Peter Axon, ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

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

(1) Purpose of the Paper:
This paper provides an update on the ICS approach to the development of the response to the national priorities and planning guidance.

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

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

Executive Summary

- The national planning guidance and financial allocations were issued on 30th January 2025. In response, we submitted our initial headline submissions to NHS England (NHSE) on 26th February, covering workforce, productivity, operational performance trajectories and finance.
- The plan provides a system-wide perspective at a whole-population level, incorporating specific aspects relevant to the providers within our footprint.
- NHS England (NHSE) has also released a range of supporting tools including a Productivity Self-Assessment Toolkit to support organisations in identifying opportunities for efficiency and improvement. While this toolkit is not a mandatory submission, it serves as a valuable resource for organisations to evaluate and enhance their internal productivity plans and actions. Both the Integrated Care Board (ICB) and providers are actively engaging with the toolkit to inform and strengthen the development of their plans, ensuring a consistent and evidence-based approach to improving productivity across the system.

Next Steps

- To build on the headline submission, we are now focusing on the development of the final templates. These are due for submission by 27th March 2025. Each organisation within the system is currently reviewing its position to contribute to this process.
- A series of strategic system meetings are taking place throughout February and March to support the development of the final submission.
- The aim is to finalise the plan by the week ending 21st March, ensuring sufficient time for each statutory board to review and approve it before the 27th March submission deadline.

Board assurance and plan overview template:

- The Board Assurance and Plan Overview template was published on 3rd March.
- The document outlines the board assurance requirements for 2025/26 plans, including the statements that Integrated Care Boards (ICBs) and provider boards must submit.

- The purpose of the Board Assurance Statements are to provide assurance that all considerations around finance, workforce, activity have been addressed whilst ensuring that the ambitions for 2025/26 can be met and that quality of patient care is prioritised.
- The document also describes what is expected from the plan overview document which should be submitted as part of the full submission to NHS England.
- The assurance requirements have been factored into the ICS local timeline as part of the supporting governance.

Key milestones to submission:

- The slides set out a high-level overview of the key milestones up until submission at the end of March which include a number of system wide events to shape and inform plans.
- The system is working to conclude the plan week ending 21st March to enable each statutory board to sign off prior to the 27th submission deadline.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Acknowledge the key milestones up until submission including the system wide events.
2. Acknowledge the release of the Board Assurance and plan overview template.
3. Acknowledge the need for the Board to submit assurance statements on 27th March as part of the full submission to NHSE.

Staffordshire and Stoke-on-Trent Integrated Care System

National Operational Planning Submission Summary for ICB Board

Prepared by the ICB Planning Team

March 2025

Executive Summary

Purpose

This paper provides an update on the ICS approach to the development of the response to the national priorities and planning guidance.

Update

The national planning guidance and financial allocations were issued on 30th January 2025. In response, we submitted our initial headline submissions to NHS England (NHSE) on 26th February, covering workforce, productivity, operational performance trajectories and finance.

The plan provides a system-wide perspective at a whole-population level, incorporating specific aspects relevant to the providers within our footprint.

NHS England (NHSE) has also released a range of supporting tools including a Productivity Self-Assessment Toolkit to support organisations in identifying opportunities for efficiency and improvement. While this toolkit is not a mandatory submission, it serves as a valuable resource for organisations to evaluate and enhance their internal productivity plans and actions. Both the Integrated Care Board (ICB) and providers are actively engaging with the toolkit to inform and strengthen the development of their plans, ensuring a consistent and evidence-based approach to improving productivity across the system.

Next Steps

- To build on the headline submission, we are now focusing on the development of the final templates. These are due for submission by 27th March 2025. Each organisation within the system is currently reviewing its position to contribute to this process.
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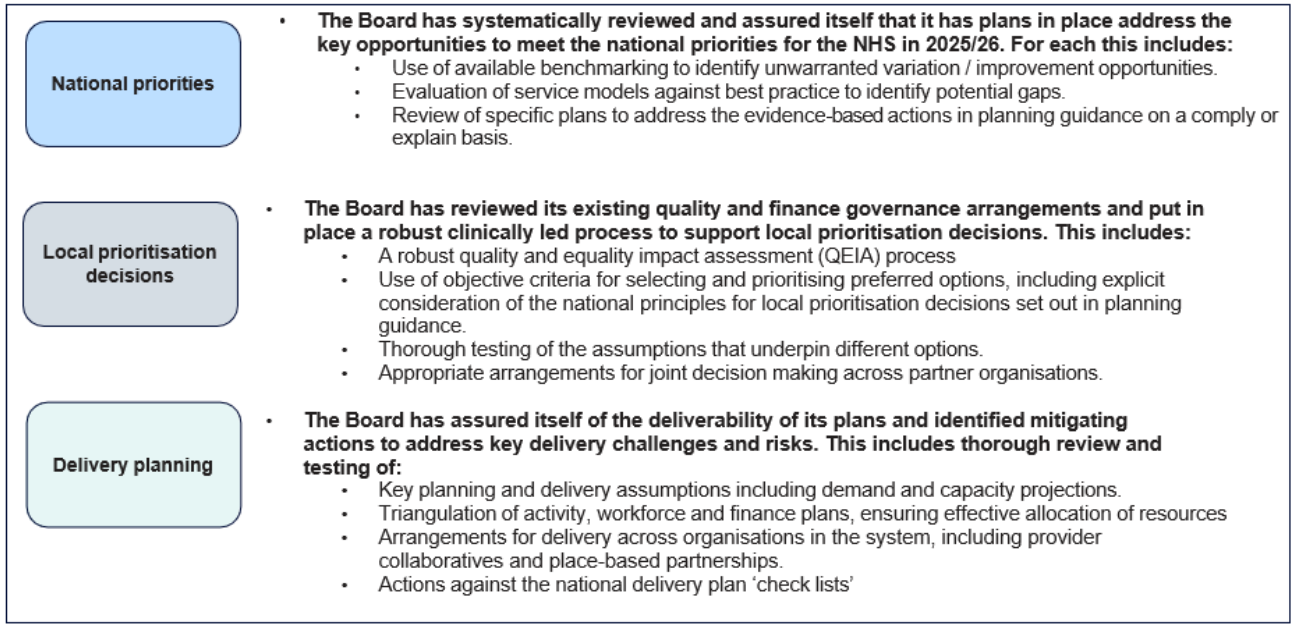
- The assurance requirements have been factored into the ICS local timeline as part of the supporting governance.



Key milestones to submission

Date	Activity
10th March	• Meeting with regional NHS team.
6th and 13th March	• System-wide strategic sessions building on meetings to date. These sessions are focused on Aligning activity, finance, workforce, and productivity improvements to support the NHS England (NHSE) submission.
17th March	• System milestone for submissions to the ICB
19th March	• Aggregate and finalise the submission.
26th March	• Board Assurance Statements completed and organisational boards assured on submissions
27th March	• Submit to NHSE

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07 a

Report to:	**Integrated Care Board**						
Date:	**20 March 2025**						
Title:	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report**						
Presenting Officer:	Phil Smith, Chief Delivery Officer and Accountable Emergency Officer; and Katie Weston, EPRR Strategic Lead						
Author(s):	Katie Weston, EPRR Strategic Lead						
Document Type:	Report		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒	
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	Choose an item. *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	NA						

(1) Purpose of the Paper:

The purpose of this report is to provide the ICB Public Board with a comprehensive overview of the ICB arrangements in place for Emergency Preparedness, Resilience and Response (EPRR); confirm the annual assurance position for 2024 of substantial compliance, and outline the action plan in place to maintain this compliance rating for 2025; and seek approval for those elements of the ICB arrangements requiring Board level approval.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
ICB Executive Team (I/A)	19/02/2025
ICB Audit Committee (S/A)	10/03/2025

(3) Implications:	
Legal / Regulatory	ICBs are legally required to have suitable arrangements in place to place for major incidents and events that might diversely impact on statutory or essential ICB functions or on the sustained delivery of commissioned health services, under: NHS Act 2006 (As amended) - s252A (9); NHS England EPRR Framework 2022; and associated EPRR annual assurance core standards; NHS Standard Contract – Service Condition 30 (Emergencies and Incidents).

CQC / Patient Safety	Nil
Financial (CFO-assured)	Nil
Sustainability	Nil
Workforce / Training	Nil
Equality & Diversity	Nil
Due Regard: Inequalities	Nil
Due Regard: wider effect	Nil

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☒	☒	*If N, why The report presents the annual position for EPRR to the Committee and any DPIA is completed as required for any associated policies or plans as part of EPRR workstreams.* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☒	☒	*The report presents the annual position for EPRR to the Committee and any EIA is completed as required for any associated policies or plans as part of EPRR workstreams.*
	QIA	☐	☒	☒	*If N, why The report presents the annual position for EPRR to the Committee and any QIA is completed as required for any associated policies or plans as part of EPRR workstreams.* *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☒	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

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

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

This annual report presents the current position of ICB emergency preparedness, resilience, and response to ICB Public Board. The report demonstrates positive progress against EPRR workstream priorities, including maintained substantial compliance position against the EPRR annual assurance process; excellent engagement in training and exercising across all On-Call Managers; priorities for the year ahead to further enhance organisational and system resilience; and presents an overview of incidents for the 2024-25 financial year, demonstrating an ability to respond to incidents across the ICB and system. The report also sets out progress and metrics against business continuity management.

(7) Recommendations to Board / Committee:

Recommendation 1: Board are asked to note the revised EPRR team structure and confirm the ICB has put in place adequate resources to meets its roles and responsibilities with respect to EPRR and Business Continuity planning.

Recommendation 2: Board are asked to note the 2024 EPRR annual assurance compliance rating of substantial compliance within the ICB.

Recommendation 3: Board are asked to note and support the EPRR annual assurance 2025/26 priorities as listed in section 5.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Emergency Preparedness, Resilience and Response (EPRR)
2024-25 Annual Report to the ICB Public Board

1. Background

1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

1.2 The Civil Contingencies Act (CCA) 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England EPRR Framework 2022 requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients.

2. Purpose

2.1 The purpose of this report is to provide the ICB Public Board with assurance of the ICB arrangements in place to fulfil the ICB obligations for EPRR, and seek approval for those elements of the ICB EPRR portfolio requiring Board level approval, in particular:

- Outline the resources available to support EPRR and seek confirmation that this resource is adequate.
- Confirm the ICB rating against the NHS Core Standards for EPRR annual self-assessment for 2024, including an update on upcoming ICB and ICS EPRR priorities.
- Provide a summary of any business continuity incidents, critical incidents, and major incidents experienced by the organisation and system in the past year, and an overview of the lessons process.
- Provide an overview of training and exercises undertaken by the organisation.

3. EPRR Structure and Resource

3.1 The EPRR team sits within the Urgent and Emergency Care (UEC) Operations Team to provide resilience across both portfolios, and recognise and manage the interdependencies between system capacity, patient pathways and pressures in daily operations and provide collaboration and escalation during planned or unexpected events and incidents.

3.2 The EPRR function is an example of matrix working, with delivery of the EPRR agenda fulfilled across the EPRR and UEC Operations Team, multiple directorates, and across the Integrated Care System to enable collaborative working.

3.3 The ICB EPRR resource is detailed overleaf.

3.4 In comparison to the 2024 position, resource has been enhanced to include the addition of a full-time band 7 EPRR Operational Manager post, and the inclusion of three band 6 UEC Managers in a matrix working capacity to support elements of the EPRR portfolio. In addition, the three band 8b System Coordination Centre Commanders have attended Principles of Health Command Training provided by NHS England to supplement resilience across the team and additional support to On-Call Managers. This provides a good resource increase to fulfil the EPRR duties as set out in the ICB EPRR Policy and enhance ICB and system resilience and delivery across the respective EPRR portfolios.

Position	Role	Band
Executive Director Lead / Accountable Emergency Officer (AEO)	Accountable Emergency Officer (AEO) and Executive Director with statutory responsibility for EPRR delivery.	VSM
Portfolio Director – Delivery and Improvement	Director level deputy for the Executive Director Lead as required.	9
Associate Director for UEC and EPRR	Associate Director Lead for UEC Operations and EPRR deputising for the EPRR Director Lead / Portfolio Director as required	8d
EPRR Strategic Lead	EPRR Lead responsible for delivery of EPRR functions against the work programme. Lead for the EPRR annual Core Standards self-assessment for the ICB and for assurance of the Core Standards returns by NHS service providers.	8b
EPRR Operational Manager	EPRR Operational Manager responsible for supporting the EPRR Strategic Lead in delivery of the EPRR work programme.	7
UEC Managers	Supporting the EPRR team in delivery of key EPRR projects, training, and incident response support.	3 x b6
On Call Staff	The organisation maintains a 24/7 response capability at a strategic (gold) and tactical (silver) level. These roles are held by post holders at VSM/Band 9, and Bands 8d/8c respectively. These individuals can deliver effective incident response to any incident affecting the system through training and exercising appropriate to their role.	
Directorate/ Service Leads for Business Continuity	Each Directorate has identified leads from each team to support business continuity planning where their service area is identified as maintaining critical/essential services within the ICB. This role holder will continue to review essential functions and contingency arrangements for their team.	
Directorate/ Service Business Continuity Recovery Teams	Each Team (for Business continuity purposes) has identified a business continuity recovery team that will lead the response to and recovery from an unplanned event or incident impacting the service or directorate.	

3.4 The NHS Core Standards for EPRR outlines the requirement for the organisation to appoint an AEO responsible for EPRR. This individual must be a Board level Director within their organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.

3.5 This role is delegated to the Chief Delivery Officer by the Chief Executive Officer, with the roles and responsibilities of the AEO set out within the ICB EPRR Policy. The AEO will discharge the duties of the Chief Executive Officer to provide EPRR reports to the Board, no less than annually, which this report seeks to achieve.

3.6 From April 2025, the ICB will no longer commission two days of EPRR additional support per week from Staffordshire Civil Contingencies Unit (CCU) based on the revised EPRR structure and resource, and the addition of a dedicated full-time EPRR Operational Manager post to the team.

3.7 Recommendation 1 - Board are asked to note the revised EPRR team structure and confirm the ICB has put in place adequate resources to meets its roles and responsibilities with respect to EPRR and Business Continuity planning.

4. EPRR Annual Assurance Position

4.1 NHS organisations are required to complete an annual self-assessment against a set of nationally mandated core standards, verified through a confirm and challenge process with NHS England, and report the results of this to the ICB Public Board.

4.2 The purpose of the NHS core standards for EPRR is to; enable health agencies across the country to share a common approach to EPRR, allow coordination of EPRR activities according to the organisation's size and scope, provide a consistent and cohesive framework for EPRR activities, and inform the organisation's annual EPRR work programme.

4.3 **2024 Core Standards compliance** – as reported to Audit Committee in December 2024, SSOT ICB achieved substantial compliance following the self-assessment, with no confirm and challenge process required due to an agreed self-assessment position with NHS England.

4.4 A breakdown of compliance against each core standard domain is outlined below:

Core Standard Domains	Total standards	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to Risk Assess	2	0	2	0
Duty to Maintain Plans	8	8	0	0
Command and Control	2	2	0	0
Training and Exercising	4	3	1	0
Response	5	5	0	0
Warning and Informing	4	4	0	0
Cooperation	6	6	0	0
Business Continuity	10	9	1	0
Total	**47**	**43**	**4**	**0**
Overall self-assessment:	**Substantial Compliance**			

4.5 Of the eleven ICBs in the Midlands region, six were substantially compliant, including SSOT ICB, with four ICBs achieving partial compliance, and one ICB achieving full compliance.

4.6 Across the system, the ICB, MPFT, and NSCHT achieved substantial compliance, UHNM partial compliance (self-reported), and Totally Group non-compliance. The system was rated as partially compliant overall, and achieved substantial compliance within the CBRN (Chemical, Biological, Radiological, and Nuclear) response domain. Totally Group will no longer be assessed by SSOT from 2025 as this will move to another Region and ICB based on contracts held nationally.

4.7 Good actions plans are underway to address compliance across the system, with monthly assurance discussions in place between the ICB EPRR Strategic Lead and individual Provider EPRR Leads to support this.

4.8 Regionally there has been year on year growth in the compliance of organisations in the region, with nearly half of all organisations achieving full or substantial compliance.

4.9 Recommendation 2 – Board are asked to note the 2024 EPRR annual assurance compliance rating of substantial compliance within the ICB.

5. EPRR Assurance 2025/26 Priorities

5.1 The 2022-2025 three-year ICB EPRR strategy set out to establish robust and scalable frameworks for EPRR policy and response arrangements within the ICB to enhance organisational resilience and compliance. Having achieved these and sustaining substantial compliance for a second year in 2024 at 91.5%, the strategy for the next three years will align with the compliance priorities identified during the assurance process and seek continuation of ICB and system resilience through the following priorities:

- Sustain substantial compliance against the EPRR annual assurance process
- Continue to build the competence and confidence of our on-call teams and incident commanders
- Enable and empower business continuity leads to be self-sufficient in preparing and maintaining service level arrangements against incidents and disruptive events
- Continue to develop robust EPRR risk management processes
- Work closely with commissioning and procurement teams to enhance supply chain resilience through the assessment of business continuity plans during the tendering process of our commissioned services

5.2 Across the system, the outcomes of the annual assurance process relating to areas of improvement aligned closely to the general trend across the region, with areas for improvement including wider staff awareness training for EPRR, business continuity management system monitoring and key performance indicators, assurance of service providers within business continuity, and CBRN exercising.

5.3 As reported to the Local Health Resilience Partnership (LHRP) on 10 February 2025, these areas will form areas for improvement for the system for the joint work programme, in addition to workstream focus areas including new and emerging pandemics, mass countermeasures, mass casualty, evacuation and shelter, excess fatalities, and cyber response arrangements.

5.4 A system EPRR away day is being arranged for March to support work programming for joint priorities and promote the sharing of expertise, learning, and collaboration to continue to develop a system approach to EPRR.

5.5 The 2025 EPRR annual assurance standards have been set and are being reviewed by the EPRR Strategic Lead with an aim to maintain substantial compliance for 2025. The ICB self-assessment for 2025 will be submitted at the end of August.

5.6 NHSE have confirmed the new set of standards for annual assurance are not expected until April 2026, for use in the 2027 self-assessment. This will be incorporated into the ICB EPRR work programme planning.

5.7 Recommendation 3 – Board are asked to note and support the EPRR annual assurance 2025/26 priorities and ICB EPRR strategy outline as listed.

6. Incident Updates - Business Continuity, Critical or Major Incidents

6.1 Incidents where a business continuity, critical, or major incident was declared by the ICB or Providers are listed below for information. A list of incidents of note, resulting in notification to the ICB but not reaching declaration thresholds are listed in section 7.

6.2 Incident debriefs are carried out as part of the continuous improvement cycle to ensure lessons from ICB, system, NHS England Region, Local Resilience Forum (LRF), or out of area can be

considered and embedded into EPRR arrangements as appropriate. The EPRR team hold a register of lessons and debrief reports to support the process outlined within the EPRR Policy.

6.3 Incident declarations due to UEC Pressures

Various dates as listed below. Incident declarations due to capacity and pressures across the UEC system, in line with system escalation plan arrangements to support response and patient safety.

- UHNM critical incident – 4-5 April 2024
- UHNM critical incident – 19-20 June 2024
- UHNM critical incident – 9-12 July 2024
- SSOT system critical incident – 26 November to 6 December 2024
- UHNM critical incident – 19-24 December 2024
- UHNM critical incident – 1-16 January 2025
- UHDB critical incident (QHB site) – 3-9 January 2025
- UHNM critical incident – 21 January 2025

6.4 UHNM Business Continuity Incident - Theatres Outage – 4-8 March 2024

Temporary closure of Royal Stoke cardiac theatres for deep clean and high-pressure ventilation.

6.5 UHNM Business Continuity Incident - IT Network Outage – 14-15 April 2024

Widespread IT network outage affecting multiple systems across UHNM, Leighton and Macclesfield Hospitals, links into Harplands Hospital, Haywood Hospital, Cobridge, and GP Practices impacted. Business continuity workarounds enacted.

6.6 UHNM Major Incident Standby/Hazardous Materials Exposure – 16-17 April 2024

Declaration of a major incident standby quickly reduced to classification as a hazardous materials incident. 7 patients self-presented to Royal Stoke following accidental exposure to a chemical at a gym in Stoke on Trent, with WMAS advising a potential for a further 30 individuals exposed.

6.7 MPFT Business Continuity Incident - Greyfriars Therapy Centre Lockdown – 7 June 2024

Lockdown of the Greyfriars Therapy Centre due to potential threat from a distressed member of the public entering the building. All staff and patients moved into safe location and Police called to support.

6.8 UHNM Business Continuity Incident - Theatres Outage – 18-19 July 2024

Temporary closure and deep clean of a number of Royal Stoke theatres due to discovery of dust particulate matter following maintenance work.

6.9 MPFT / NSCHT Business Continuity Incident - CrowdStrike IT Outage – 19-22 July 2024

International IT outage of CrowdStrike services impacting IT systems at MPFT and NSCHT. Business continuity arrangements put in place.

6.10 UHDB Business Continuity Incident - QHB Lightning Strike – 12 August-2 September 2024

Lightning strike to the Tom Davies building on the QHB site, impacting internal and external hospital phone lines, the bleep system and fire reporting system. Interim safety arrangements put into place during the outage until repairs were completed.

6.11 UHDB Queens Hospital Business Continuity Incident - Wet Decontamination Capacity – October-present

QHB site temporarily unable to deploy tent structure for wet decontamination of patients/self-presenters due to emergency department building works. Interim arrangements put in place with partners to continue to provide a capability to the site. New decontamination cabin due to be installed mid-February 2025.

6.12 UHDB Business Continuity Incident - IT Network Outage – 16-18 October 2024

IT network issues impacting several systems across both hospital sites. Business continuity arrangements in place to continue delivery.

6.13 UHDB Queens Hospital Business Continuity Incident - Bleep System Failure – 17-18 October 2024

Full bleep system failure overnight due to a fault on the system. Business continuity arrangements put in place via hand-held radios.

6.14 ICB/Primary Care Business Continuity Incident - Burst Water Main Impacting Norton Canes GP Practices – 5-6 November 2024

Burst water main in Norton Canes resulting in a temporary loss of water supply to three GP Practices serving patient population of 12,000. Sites closed and patients diverted to alternate sites during the outage until restoration and conclusion of site safety checks/infection prevention control testing of water. ICB declared incident on behalf of Primary Care.

6.15 UHDB Queens Hospital Business Continuity Incident - Security Incident – 25 November 2024

Threat made to staff and patients at Queens Hospital by a member of the public and site lockdown enacted. Incident deescalated and stood down within 3.5 hours.

6.16 UHNM Critical Incident Loss of Heating Systems – 16-18 December 2024

Loss of heating systems to the West Wing of the Royal Stoke site due to a leak and loss of pressure to the main site boiler. Impact to six wards, including frail and elderly, maternity block/delivery suite, oncology, haematology, and renal. Temporary heating and boilers put in place, planned caesarean sections rescheduled, discharges expedited where possible.

6.17 UHNM Business Continuity Incident - iPortal Outage – 6-7 February 2025

Unplanned disruption to iPortal clinical system following planned work overnight on 5/6 to support recent iPortal outages/network issues. Business continuity arrangements put in place.

7. Undeclared Incidents / Events of Note

7.1 A summary of incidents or planned events which did not meet the criteria for declaration as a business continuity, critical or major incident have been included for information.

7.2 In addition to those outlined previously, the ICB has successfully responded to the following consecutive and concurrent incidents during 2024-25, demonstrating an ability in the organisation to respond and support the ICS while delivering the EPRR work programme:

7.3 Brockley Square Fire Hanley Town Centre – 12 March 2024

Fire Service declared major incident relating to a fire in Brockley Square, Hanley. Tactical coordinating group established to consider potential for evacuation/shelter of nearby residents and impacts of smoke plume and contaminants.

7.4 Industrial Fire, Cley Road, Cannock – 9 May 2024

Significant industrial fire at a warehouse on Cley Road, Cannock, with considerable smoke plume and local disruption. Tactical coordinating group attended by the ICB and information shared across the system to support any community evacuation, patient transport delays, and impacts to community service delivery.

7.5 Rising Brook Water Contamination – July-October 2024

Elevated levels of lead contamination found in drinking water to several properties in an area of Rising Brook, Stafford, due to the build design of customers properties with lead pipework, and age of construction. The ICB supported tactical coordinating group meetings and chaired a health subgroup, with targeted communications sent to customers, directing customers to GPs if needed where they feel unwell etc.

7.6 County-wide Protests / Civil Unrest – August 2024

Several instances of public disorder across the county, particularly in Hanley and Tamworth, following the nationwide unrest following the Stockport murders. Impacts to several services across the system within impacted areas.

7.7 Henderson Grove Fire, Stoke – Sept 2024

Fire in a two-storey block of flats in Stoke-on-Trent impacting several properties. Residents evacuated but managed by the local authority. ICB attendance at tactical coordinating group meeting.

7.8 Kinver Power Outage – 10 December 2024

67 properties without power for several days in Kinver following Storm Darragh. Vulnerable persons identified by National Grid, and so joint work between the County Council, ICB and MPFT undertaken to identify potential patients in the area. All vulnerable individuals contacted and confirmed safe and well.

7.9 Outbreak Response

The ICB and system have responded to a small number of outbreaks across SSOT, including outbreaks of Hepatitis A and scabies at MOD Swynnerton within the Operation Lazurite (see 7.11) population. Response was led by UKHSA with support from the ICB, MPFT and UHNM. The ICB outbreak management documentation and system memorandum of understanding for outbreak management between relevant health partners continues to support outbreak responses, with specific outbreak pathways in place such as an Mpox pathway for community and GP practices.

7.10 Asylum seeker resettlement programme – ongoing

In response to the ongoing resettlement of asylum seekers within the County as part of Home Office resettlement schemes, the ICB have been involved in the provision of immediate and necessary health needs of individuals and have supported GP practices with registration of individuals and with appropriate health and care where required.

7.11 Operation Lazurite – October 2023 to present

The ICB is supporting NHSE and the Ministry of Defence (MOD) in an operation to relocated Afghan citizens and eligible family members under the Afghan Relocations and Assistance Policy (ARAP) who worked for or with the UK Government and British Armed Forces in Afghanistan in exposed or meaningful roles. Individuals have legal right to remain in the UK.

The ICB, GP First, and MPFT are supporting the provision of onsite health care services at the site in Staffordshire to appropriately manage any presenting initial health needs, reducing the impact on local NHS services. The MOD has provided funding to the NHS to support this provision. System partners are aware and supporting as required.

7.12 Walley's Quarry health impacts – 2021 to present

Since early 2021, residents in the vicinity of a North Staffordshire landfill site, Walley's Quarry have been flagging concerns with the local authorities, the Environment Agency, and other organisations about the potential impact of unpleasant odours on health and wellbeing. The ICB continues to represent the system at the Walley's Quarry SCG chaired by Staffordshire Fire and Rescue Service and support the health response as required. While the ICB are not the lead agency for health, support is provided to any Health tactical subgroup chaired by UKHSA, where it is necessary for this to be convened. Discussions are currently underway with Primary Care to consider symptom coding of patient presentations as part of the recommendations of recent independent studies commissioned by the County Council.

7.13 NHS Industrial Action - November 2022 to September 2024

Following 18 months of industrial action by NHS Unions, the British Medical Association on behalf of Junior Doctors accepted the Government pay deal in September 2024, ending the remaining industrial action within the NHS. Robust system plans and arrangements were in place throughout to respond to impacts of action.

8. EPRR Training, Development, Testing and Exercising

8.1 Under the NHS EPRR Annual Assurance standards and minimum occupational standards for EPRR, the ICB is required to have resilient and dedicated mechanisms and structures in place to enable 24/7 receipt and action of incident notifications. This is achieved through the ICB On-Call Manager mechanism to ensure appropriate points of escalation are in place, and as such it is crucial to ensure these individuals are suitably trained and competent in their roles to manage escalations, make decisions and identify key actions.

8.2 The ICB are committed to enabling individuals to complete required training in accordance with the NHS England EPRR competencies (minimum occupational standards) and are supported by a robust training outline.

8.3 Monthly development sessions are held for all Strategic (Gold) and Tactical (Silver) On-Call Managers with training and exercises delivered based on key risks and planning arrangements to support incident response competency. 6 of 12 sessions are mandatory across the year.

8.4 Additional training for On-Call Managers is delivered by the ICB EPRR Team, and on occasions by the Staffordshire Civil Contingencies Unit as part of the Partnership Service Level Agreement.

8.5 A training needs analysis and role specific training pathways are in place for all On-Call Managers to support their development, with personal development portfolios held by the EPRR team.

8.6 Key highlights of training in 2024/25 include:

- 100% of On-Call Managers have attended EPRR and UEC introduction training prior to starting On-Call.
- 100% of Strategic (Gold) On-Call Managers have completed NHS England's mandatory training for strategic level incident response – Principles in Health Command. This course has also been completed by the EPRR Team and System Coordination Centre Commanders to support the provision of tactical and strategic advice to On-Call Managers during incidents.
- The EPRR Senior Team have attended Multi-Agency Gold Incident Command training delivered by the College of Policing, with the Chief Delivery Officer also due to attend soon. This learning from this course is being developed into training for Strategic (Gold) On-Call Managers.
- The EPRR Strategic Lead attended public inquiry training during 2024, which will be fed into Strategic (Gold) On-Call training.
- Uptake of the monthly on-call development sessions has been excellent, with all On-Call Managers actively participating in discussions.
- Attendance at multi-agency exercises has increased across the On-Call team and Communications Team, supporting development of individuals in responding to a multi-agency or system wide major incident.
- On-Call Managers are encouraged to raise further areas of development and actively contribute suggestions to training and exercise schedules where areas are identified, with at minimum an annual feedback session to support development.
- An assessment of the required number of roles across a complex incident response structure has been undertaken by the EPRR team and has confirmed the ICB has sufficient resource available via the On-Call Managers to achieve this.

9. Exercises Completed during 2024-2025

9.1 The ICB are required to have a testing and exercising programme in place to safely test incident response arrangements, in a manner that is relevant to local risks, meets the needs of the organisation type and stakeholders, and ensure warning and informing arrangements are effective.

9.2 A full list of exercises delivered or attended by the ICB in 2024/25 is listed below:

Exercise	Type	ICB Participants
System Cyber Incident Response Exercise – 8 April 2024	System tabletop exercise facilitated by NHS England Digital Team to identify learning within system cyber and digital response arrangements.	EPRR and Cyber/Digital Leads. System partners including SSHIS, UHNM, UHDB, MPFT, Totally Group, CCU.
Exercise Toucan – 16 May 2024	National NHS England communications test cascade across ICBs and Providers.	System Coordination Centre, all Providers.
Exercise Abacus – 10 July 2024	NHSE and WMAS mass casualty patient distribution exercise to test initial regional casualty distribution numbers from the scene of an incident involving a significant number of casualties, to acute settings.	EPRR Strategic Lead
Exercise Harmony – 25 July 2024	Tabletop exercise with ICB On-Call Managers to test the response to various incident response arrangements including adverse weather, national power outage, mass casualty, and evacuation and shelter, as part of monthly development training.	ICB Strategic (Gold) and Tactical (Silver) On-Call Managers
High Consequence Infectious Diseases Exercise – 15 August 2024	System tabletop exercise to test the response to an incident involving a patient with symptoms of a high consequence infectious disease and the management of this patient.	EPRR, Public Health, IPC Team. System partners including UHNM, UHDB, MPFT, WMAS, UKHSA, Totally Group, CCU, Local Authority health and care.
Exercise Virus – 29 August 2024	Tabletop exercise with ICB On-Call Managers to test the response to pandemic and cyber incidents as part of monthly development training.	ICB Strategic (Gold) and Tactical (Silver) On-Call Managers
Rest Centre Exercise – Health Data – 16 August / 4 November 2024	Tabletop exercise to test the sharing of information from local authorities into the NHS for individuals requiring health support following a community evacuation due to an incident.	EPRR, CCU, Stoke on Trent City Council.
Exercise Raven / Exercise Crow – 3x tactical and 2x strategic exercises throughout 2024/25	Exercise Raven is a series of tactical and strategic tabletop exercises to test the multi-agency response to a fictitious significant waste fire at an industrial site, with community impacts, casualties, fatalities, air quality impacts, and evacuation and shelter considerations. Exercise Crow is the ICS bolt on exercise to enable NHS organisations to consider response, coordination and leadership of a system wide incident.	Silver and Gold On-Call Managers, EPRR team, Communications team, UEC System Coordination Centre Commander.
System Readiness for M-Pox Exercise – 11 December 2024	System tabletop exercise to provide assurance of the ability to deliver a coordinated response to a M-Pox case and or outbreak within the system.	EPRR, Public Health, IPC Team, Comms Team. System partners including UHNM, UHDB, MPFT, NSCHT, WMAS, UKHSA, CCU, Local Authority health and care.
Exercise Morse Code – six monthly	System communications exercise to ensure communications links were robust and in place to establish command and control structures for an incident scenario, utilising the Staffordshire and Stoke on-call rota.	CCU Link Officer, UEC / SCC Team, System partners.

9.3 Upcoming exercises include a suite of multi-agency incident exercises 'Exercise Raven' and 'Exercise Crow' throughout 2025/26 focusing on a biological incident and distribution of medical countermeasures.

9.4 Places on exercises will be offered to all staff on-call with priority given to those who have not participated in an exercise for some time. It is a requirement that all on-call colleagues will have the skills and knowledge necessary to operate as an On-Call Manager if an incident should occur and participation in exercises is a crucial part of this.

10. Business Continuity Monitoring and Evaluation

10.1 The ICB has in place a business continuity policy, strategy and management system (BCMS), which commits to monitoring and evaluating the effectiveness and performance of business continuity arrangements and drive continuous improvement.

10.2 The key performance indicators set within the BCMS are:

- KPI 1 - The ICB has in place a strategic and operational framework to ensure business continuity arrangements are established, maintained, and aligned to a cycle of continuous improvement.
- KPI 2 - The ICB has in place a process for assessing business impacts at a strategic and service level.
- KPI 3 - The ICB has in place robust business continuity plans to enable continued delivery of critical activities at a pre-defined level during a disruptive incident.
- KPI 4 - The ICB has arrangement in place to coordinate business continuity incidents at the strategic (Directorate and Corporate) level to support a whole organisational approach.
- KPI 5 - The ICB has in place a process to validate business continuity arrangements to ensure they are fit for purpose and reviewed as part of the EPRR continuous improvement process.
- KPI 6 - The ICB has in place a process to validate business continuity arrangements to ensure they are fit for purpose and reviewed as part of the EPRR continuous improvement process.

10.3 Business continuity plans at a service and directorate level are scheduled for review in Spring 2025. Progress metrics against the KPIs fully completed to time are as follows:

- KPI 1 - Business continuity policy in place and reviewed by Board in 2024
- KPI 1 - Annual audit undertaken by RSM in 2024, with a 2025 audit process under review by the EPRR Team
- KPI 1 - Quarterly review process of EPRR lessons in place to drive continuous improvement
- KPI 2 - Standardised business impact assessment (BIA) template in place at a service level
- KPI 2 - Strategic BIA updated within annual schedule
- KPI 3 - Standardised business continuity plan template in place at a service level
- KPI 4 - Documented process in place for business continuity, critical and major incidents
- KPI 5 - Annual training and exercise programme in place
- KPI 6 - Business continuity management training delivered to tactical (silver) on-call managers
- KPI 6 - Annual EPRR and business continuity update provided to all staff via Team Brief

11. Conclusion and Recommendations

11.1 EPRR is a statutory and essential function of Integrated Care Boards, and ensures the organisation can prepare for, respond to, and recover from any incident, regardless of the size, scale and duration. The ICB additionally provides a vital role as commissioner, in supporting the preparedness of our NHS providers within the Staffordshire ICS. Fundamental to delivery of the EPRR portfolio is commitment to resourcing, prioritisation, and importance of the EPRR agenda, and visible support from Executives, Committees, and Board.

11.2 ICB Public Board are therefore asked to note the arrangements in place as described within this report and consider and agree the recommendations as outlined:

- Recommendation 1: Board are asked to note the revised EPRR team structure and confirm the ICB has put in place adequate resources to meets its roles and responsibilities with respect to EPRR and Business Continuity planning.

- Recommendation 2: Board are asked to note the 2024 EPRR annual assurance compliance rating of substantial compliance with the ICB.

- Recommendation 3: Board are asked to note and support the EPRR annual assurance 2025/26 priorities as listed in section 5.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07 b

Report to:	**Integrated Care Board**						
Date:	**20 March 2025**						
Title:	**Emergency Preparedness, Resilience and Response (EPRR) Policy**						
Presenting Officer:	Phil Smith, Chief Delivery Officer and Accountable Emergency Officer; and Katie Weston, EPRR Strategic Lead						
Author(s):	Katie Weston, EPRR Strategic Lead						
Document Type:	Policy		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☐	
	Approval (A)	☐	**Ratification (R)**	☒	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	Choose an item. *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	NA						

(1) Purpose of the Paper:

The updated EPRR Policy has been updated outside of the usual three-year review cycle to reflect changes in the EPRR Team structure, as listed in sections 8.4 and 9 of the policy. The Policy now presents the updated governance structure at section 8.4 with the inclusion of the EPRR Senior Team who retain oversight of the ICB EPRR work programme.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
ICB Executive Team (I/A)	19/02/2025
ICB Audit Committee (S/A)	10/03/2025

(3) Implications:	
Legal / Regulatory	ICBs are legally required to have suitable arrangements in place to place for major incidents and events that might diversely impact on statutory or essential ICB functions or on the sustained delivery of commissioned health services, under: NHS Act 2006 (As amended) - s252A (9); NHS England EPRR Framework 2022; and associated EPRR annual assurance core standards; NHS Standard Contract – Service Condition 30 (Emergencies and Incidents).
CQC / Patient Safety	Nil

Financial (CFO-assured)	Nil
Sustainability	Nil
Workforce / Training	Nil
Equality & Diversity	Nil
Due Regard: Inequalities	Nil
Due Regard: wider effect	Nil

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☒	☐	☐	*If N, why - In progress at the time of writing this paper. DPIA is with CSU for review.* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	*Yes – initial EHIA completed and approved*
	QIA	☐	☒	☒	*If N, why - Not required for this Policy. Where a QIA is required for any associated policies or plans as part of EPRR workstreams, these will be done so accordingly.* *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☒	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

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

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

With the addition of the band 7 EPRR Operational Manager post to the ICB EPRR team structure, and the ICB no longer continuing the Additional Support Service Level Agreement for 2 days of dedicated Officer support per week from the Civil Contingencies Unit, the EPRR Policy has been updated accordingly to ensure roles and responsibilities of the EPRR Team are reflected accordingly, and governance/reporting structures were revised. Section 9 of the Policy has been updated in detail, in addition to the governance structure diagram (section 8.4) and the associated EPRR governance groups.

The associated section of the EPRR Annual Report (enclosure 7a) reflected these arrangements.

(7) Recommendations to Board / Committee:

ICB Public Board are asked to note the amendments as described and ratify the ICB EPRR Policy for use.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent ICB

Emergency Preparedness, Resilience, and Response (EPRR) Policy

Policy Number:	EPRR-P-001
Version:	3.1 – Draft for Approval
Ratified by:	ICB Public Board
Date ratified:	*20 March 2025*
Name of originator/author:	Katie Weston, EPRR Strategic Lead
Name of responsible committee/individual:	Phil Smith, Accountable Emergency Officer
Date approved by Committee/individual:	*20 March 2025*
Date issued:	*21 March 2025*
Review date:	March 2028
Date of first issue	01 July 2022
Target audience:	All ICB employees, directors, NEDs, managers, and contractors. It is also recommended to be adopt by ICB practices in the ICB footprint

Document History

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date
Katie Weston (EPRR Manager) and Jane Moore (SRO for EPRR)	Staffordshire CCGs Executive Management Team	25 May 2022
Katie Weston (EPRR Manager) and Jane Moore (SRO for EPRR)	Staffordshire and Stoke-on-Trent ICB Public Board	01 July 2022
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Executive Management Team	8 June 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Audit Committee	19 June 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Public Board	20 July 2023
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Executive Management Team	27 June 2024
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Audit Committee	01 July 2024
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Public Board	18 July 2024
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Executive Management Team	19 February 2025
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Audit Committee	10 March 2025
Katie Weston (EPRR Strategic Lead)	Staffordshire and Stoke-on-Trent ICB Public Board	*20 March 2025*

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
ICB Public Board	01 July 2022
ICB Audit Committee	19 June 2023
ICB Public Board	20 July 2023
ICB Audit Committee	01 July 2024
ICB Public Board	18 July 2024
ICB Audit Committee	10 March 2025
ICB Public Board	*20 March 2025*

VERSION CONTROL

Version	Version / Description of amendments	Date	Author
1	New policy	01 July 2022	Katie Weston
2	Updated policy in accordance with EPRR annual assurance comments from NHSE	21 July 2023	Katie Weston
3	Annual review of content. No changes to overall policy content. Inclusion of UEC Operations Team	19 July 2024	Katie Weston

	and Portfolio Director for Delivery and Improvement. Amendment of references to gold and silver command levels, to strategic and tactical respectively. Amendment from annual review to three-yearly review in line with NHSE guidance.		
3.1	Annual review of content and update of EPRR team structure, and inclusion of EPRR and Business Continuity Group and EPRR Senior Leadership Team roles and responsibilities.	13 February 2025	Katie Weston

IMPACT ASSESSMENTS – AVAILABLE ON REQUEST

	Stage	Complete	Comments
Equality Health Impact Assessment	Initial	Yes	
Quality Impact Assessment	N/A	N/A	
Data Protection Impact Assessment	In progress		

Staffordshire and Stoke-on-Trent Integrated Care Board

Emergency Preparedness, Resilience and Response (EPRR) Policy

Contents

1. Introduction

1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could range from severe weather to an infectious disease outbreak or a major transport accident.

1.2 The Civil Contingencies Act (CCA) 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022 requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients. This work is referred to in the NHS as EPRR.

1.3 Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Board ICB is defined as a Category 1 Responder and therefore have a statutory obligation to deliver the following civil protection duties as defined under the CCA 2004:

- Assess the risk of emergencies occurring to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance coordination and efficiency

1.4 In addition to meeting legislative duties, the ICB is required to comply with guidance and framework documents, including but not limited to:

- NHS England EPRR Framework
- NHS Core Standards for EPRR annual assurance self-assessment
- ISO 22301 – Societal Security – Business Continuity Management Systems - Requirements
- NHS England Business Continuity Framework

1.5 Assurance against the effectiveness of arrangements will be achieved through the testing and exercising of plans for critical services in accordance with the above guidance.

1.6 This document outlines how the ICB complies with its statutory responsibilities and EPRR obligations, detailing the minimum requirements for planning for, responding to, and recovering from an incident regardless of any scale and duration.

2. Legal Framework

2.1 The Civil Contingencies Act 2004 (CCA) establishes a statutory framework of roles and responsibilities for local responders. The CCA is supported by Regulations (The CCA 2004 (Contingency Planning) Regulations) and statutory guidance EPRR. Responsibilities of service providers are set out in the NHS Act 2006 as amended by section 46 (9, 10) of the Health and Social Care Act 2012, and Health and Care Act 2022. This is supported by the NHS EPRR Guidance NHS Framework, and the NHS Core Standards for EPRR annual assurance self-assessment.

2.2 NHS-funded organisations that are not NHS Trusts or foundation trusts (e.g., Primary Care, out of hours providers, independent sector, and third sector providers) are not listed in the CCA 2004, however NHS England and the Department of Health and Social Care expect them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary, and proportional to the scale of service provision. While not listed under the CCA, these organisations may have EPRR obligations under the NHS Act 2006 and / or NHS Contracts and the ICB expectations and arrangements for supporting these obligations is outlined in the policy statement.

3. Policy Statement

3.1 SSOT ICB are committed to the delivery of effective EPRR arrangements for business continuity, critical, or major incidents which may occur, to enable the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies. Each type of incident as listed has the potential to impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented.

3.2 SSOT ICB will therefore ensure the necessary resources are in place to plan for and respond effectively to such incidents, including representing the ICS within a tactical coordination role in incidents requiring multi-agency response; establish an effective incident coordination centre (ICC) as required; and lead post-incident recovery for the ICS.

3.3 The ICB will operate a 24/7 On-Call Manager function, who will respond to incident notification and surge management / capacity issues, as detailed in section 8.

3.4 SSOT ICB will establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies 24/7, including representation of the NHS at Strategic and Tactical Coordinating Groups, and supporting NHS England in discharging their EPRR functions locally, supporting ICS tactical coordination during level 2-4 incidents (as defined in the Incident Response Plan).

3.5 SSOT ICB will maintain business continuity plans to support its ability to maintain its statutory roles and essential functions in the event of a critical or major incident and support rapid recovery of these services. Due consideration will also be given to the potential impact

of any proposed services changes on the ability of the NHS to effectively plan for and respond to an incident, and commissioned services will therefore be considered throughout.

3.6 The ICB accept their statutory duty as a category 1 responder as part of the creation of ICBs, and commit to undertaking the category 1 duties as set-out under the CCA. The relevant duties will be embedded throughout arrangements, as detailed further in the ICB EPRR Strategy and Incident Response Plan, and in conjunction with Local Resilience Forum, NHS, and regional / national bodies.

3.7 The ICB will commit to the training, testing, and exercising of on-call and ICC staff, policies and arrangements to ensure a process of continuous improvement.

3.8 In addition to the above, the ICB will work in partnership with commissioned services to:

- Take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency
- Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
- Support NHS England in discharging its emergency preparedness, resilience and response functions and duties locally
- Seek assurance that provider organisations are properly prepared to deal with an emergency, and are compliant with relevant guidance and standards

3.9 Commissioners and Providers must give due consideration to the potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and / or respond to an incident or emergency and ensure effective EPRR is maintained.

4. Purpose

4.1 NHS England (NHSE) requires that all ICBs prepare and test arrangements in response to emergency and business continuity incidents. This policy outlines the requirements to which SSOT ICB must adhere to and the way in which these will be delivered. The policy applies to all aspects of the ICB's operations and services. The process of EPRR is the responsibility of the whole organisation and is driven by the Audit Committee through the Accountable Emergency Officer. The EPRR governance structure is detailed at section 8.

5. Aim and Objectives

5.1 The aim of the EPRR policy is to ensure the ICB can support the ICS and wider local health economy in its response to an emergency / incident, whilst maintaining essential services for the populations of SSOT.

5.2 The objectives of the EPRR Policy are to ensure the ICB:

5.2.1 Has adequate plans to prepare for, respond to and recover from incidents as a Category 1 responder;

5.2.2 Gains assurance that local NHS commissioned health services and the local health system has adequate plans to prepare for, respond to and recover from incidents;

5.2.3 Operates within the legal framework for:
a. Civil Contingencies Act (2004)
b. Health & Social Care Act (2022)

5.2.4 Meets its obligations under the NHS England EPRR Framework and NHS Core Standards for EPRR annual assurance self-assessment.

6. Scope

6.1 The scope of the arrangements for the response to emergency incidents covers all levels of incidents, as described in NHS EPRR Framework 2022, as per figure 1 below.

6.2 The ICB will be responsible for the coordination of level 1 (ICB only) and level 2 incidents (system) within its area of operations, and will provide support to NHS England (NHSE) in the response to Level 3 and 4 incidents.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Figure 1: NHS incident response levels

7. Underpinning EPRR Principles

7.1 In order to prepare, response, and recover effectively to any incident impacting the organisation, the six underpinning principles of EPRR will be utilised throughout as outlined below:

7.1.1 **Preparedness and anticipation** – the ICB will anticipate and manage the consequences of incidents and emergencies by identifying risks and impacts where possible, achieved through clarity of role and responsibilities, development of suitable plans and arrangements, and the testing and exercising of plans.

7.1.2 **Continuity** – response arrangements will complement existing functions to ensure familiar ways of working, whilst being rapid and scalable to ensure delivery of actions in an incident or emergency

7.1.3 **Subsidiarity** – decisions will be taken at the lowest appropriate level, with coordination at the highest necessary level, working with NHS organisations within the ICS to form the building blocks of response

7.1.4 **Communication** – effective communication is critical to response, warning and informing, and therefore reliable and timely information flows to responders, stakeholders, and the public will be a priority

7.1.5 **Cooperation and integration** – effective coordination and information sharing will be promoted and exercised between and within the ICB, ICS, local, regional, and national tiers of response to build positive relationships built on mutual trust and understanding, including supporting mutual aid requests and coordination where necessary

7.1.6 **Direction** – the use of a strategic aim and supporting objectives for response will be used to deliver clarity of purpose, and will be agreed and understood by all involved in management of the incident.

8. Governance

ICB EPRR Governance

8.1 The Accountable Emergency Officer (AEO) holds executive authority and responsibility for ensuring that the organisation complies with EPRR legal and policy requirements in the ICB. This position must be fulfilled by an Executive Board-Level Director and therefore is fulfilled by the Chief Delivery Officer on delegation from the Chief Executive Officer. Responsibilities of the AEO may be discharged through one or more deputies, however responsibility for ensuring compliance will remain with the AEO.

8.2 The AEO will report on an annual basis to the Public Board of the ICB the organisations readiness and preparedness activities, and will include the following:

8.2.1 Training and exercises undertaken by the organisation

8.2.2 Summary of business continuity incidents, critical incidents, and major incidents experienced by the organisation

8.2.3 Lessons identified and learning undertaken from incidents and exercises

8.2.4 The organisation's compliance position in relation to the latest NHS England EPRR assurance process

8.3 An EPRR and Business Continuity Group will be established with representation from nominated leads from key services within the ICB, and will meet twice yearly. This group will consult on the priorities and interdependencies of the work programme, with the AEO remaining responsible for annual approval of the work programme.

8.4 Delivery of the EPRR work programme will be fulfilled by the EPRR Team, lead by the EPRR Strategic Lead. Oversight will be achieved with monthly briefings to the EPRR Senior Leadership Team, including the AEO on a bi-monthly basis.

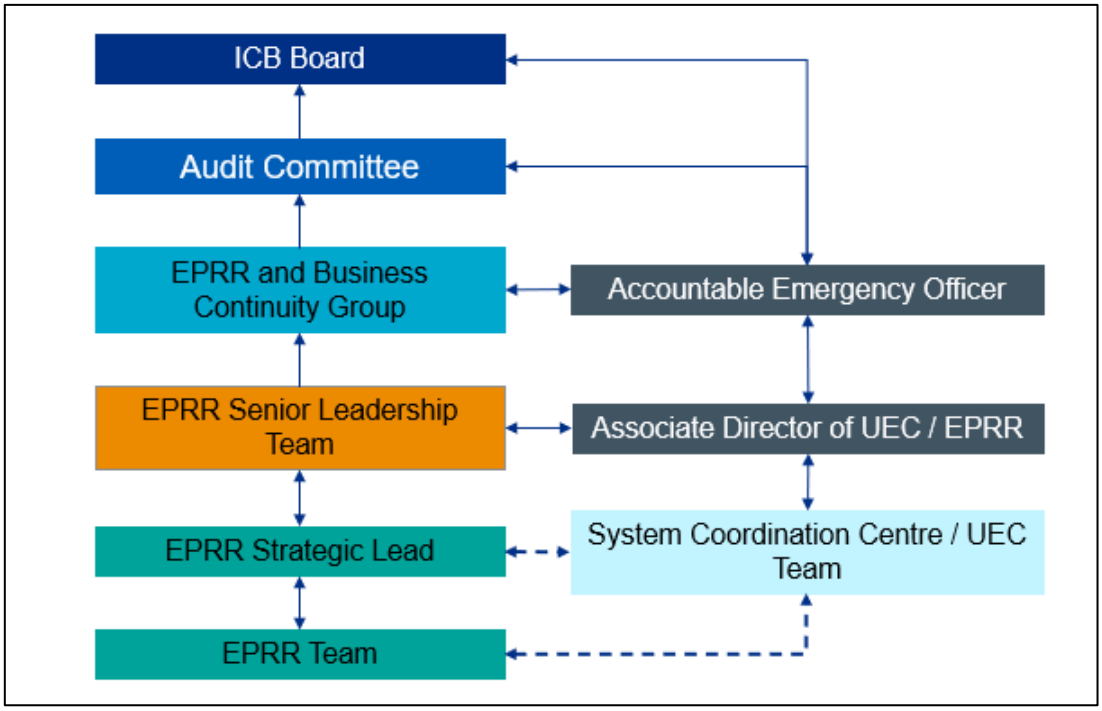


Figure 2: ICB EPRR Governance Structure

8.5 The AEO will represent the ICB at the Staffordshire Resilience Forum (SRF), while noting NHS England, and the Staffordshire NHS Trusts and NHS Foundation Trusts are also SRF members. The ICB will represent the Staffordshire NHS system partners at the relevant subgroups of the SRF, as per the Staffordshire LRF NHS representation agreement.

Local Health Resilience Partnership

8.6 LHRPs provide strategic forums for joint EPRR planning across a geographic area and support the health sector's contribution to multi-agency planning through the LRF. These forums are co-chaired by the ICB AEO and a local Director of Public Health (DPH) to provide public health expertise and local leadership on EPRR matters to ensure resilience is commissioned effectively, reflects local risk, and that members develop and maintain effective health planning arrangements for incidents.

8.7 LHRP will coordinate the health input to NHS England, UKHSA, and local government in ensuring member organisations develop and maintain effective health planning arrangements for incidents.

8.8 LHRPs are not statutory organisations and accountability for EPRR remains with individual organisations. Each constituent organisation remains responsible and accountable for their effective response to incidents in line with their statutory duties and obligations.

8.9 The AEO, or a nominated representative with delegated authority to authorise plans and commit resources on behalf of the organisation, will attend LHRP on behalf of the ICB.

8.10 The AEO will utilise the LHRP to maintain the involvement and support of LHRP partners at a strategic and tactical level.

8.11 The secretariat function sits with the ICB and the EPRR Strategic Lead will ensure the LHRP sits quarterly, but at minimum on a six-monthly basis.

8.12 As per the LHRP terms of reference, the Health Emergency Planning Officer's Group (HEPOG) will be chaired by the ICB EPRR Strategic Lead, and sit as a subgroup of LHRP. The focus of the group is to undertake strategic and tactical EPRR work to support the requirement to ensure NHS-funded organisations have effective, coordinated structures in place to adequately plan, prepare, and exercise response arrangements. The Health Risk Management Group (HRMG) will sit alongside HEPOG to provide a system approach to risk identification, mitigation and consequence management.

8.13 Further health resilience sub-groups may be convened at the direction of LHRP under HEPOG. Such groups will be determined on a need basis by the Co-Chairs of LHRP and in liaison with the LRF to ensure a coordinate approach to project delivery, and avoid duplication of workstreams.

8.14 The ICB will provide a route of escalation for resilience planning issues to the LHRP relating to commissioned provider EPRR preparedness.

8.15 NHS England and ICBs will coordinate health services at the LRF level, and ICBs will ensure coordination across local ICSs, facilitated though LHRP and local EPRR planning groups, to discharge the legal duties of cooperation between responders and health organisations

9. Roles and Responsibilities

Accountable Emergency Officer

9.1 The Health and Care Act (2022) places a duty on relevant service providers to appoint an individual to be responsible for discharging their duties under section 46, 252a, identified as the Accountable Emergency Officer (AEO).

9.2 The AEO will be an Executive Board-Level Director responsible for EPRR, with executive authority and responsibility for ensuring the organisation complies with legal and policy requirements, and has the appropriate authority, resources, and budget to direct the EPRR portfolio. This role will be undertaken by the Chief Delivery Officer, on delegated authority from the Chief Executive Officer as outlined at section 8.1. The responsibility for EPRR sits with the Board and therefore Non-Executive Directors will assure themselves that the EPRR requirements are being met through engagement with appropriate committee plans, EPRR reports to the Board, and supporting the dovetailing of EPRR arrangements with ICB portfolios and priorities.

9.3 The AEO will discharge the duty of the Chief Executive Officer to provide an EPRR report to the Board, no less than annually, stating: the ICB's readiness and preparedness activities; resourcing for EPRR delivery; training and exercising undertaken by the organisation; a summary of business continuity incidents, critical incidents and major incidents experienced by the organisation; lessons identified and learning undertaken from incidents and exercises; and the organisation's compliance position in relation to the latest annual assurance process for EPRR.

9.4 The AEO provides assurance that strategies, systems, training, policies, and procedures are in place to ensure an appropriate response for their organisation in the event of an incident, to maintain the public's protection, and maximise the NHS response.

9.5 The AEO will be aware of the legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

9.6 The AEO or a nominated deputy has a duty to co-chair the Local Health Resilience Partnership (LHRP) Group, providing local leadership on EPRR matters to all NHS-funded organisations and maintaining engagement across the local health and social care system to ensure resilience is commissioned effectively, reflecting local risk.

9.7 The AEO or nominated Director level deputy will attend the strategic level Staffordshire Resilience Forum (SRF) meeting, to engage and cooperate with responder agencies across the LRF.

9.8 Specifically, the AEO is responsible for:

- Ensuring the organisation, and any sub-contractors, is compliant with the EPRR requirements as set out in the CCA 2004, the 2005 regulations, the NHS Act 2006, the Health and Care Act 2022, and the NHS Standard Contract, including the NHS England

Emergency Preparedness, Resilience and Response Framework 2022, and the NHS Core Standards for EPRR annual assurance self-assessment

- Ensuring that the organisation is properly prepared and adequately resourced for dealing with an incident
- Ensuring that the organisation, commissioned providers, and sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301
- Ensuring the organisation has a robust system escalation plan that provides an integrated organisational response and that it has been tested with other providers and partner organisations in the local area served
- Ensuring that the organisation complies with any requirements of NHS England, in monitoring compliance
- Providing NHS England with such information as it may require for the purpose of discharging its functions
- Ensuring the organisation is appropriately represented by director level engagement to effectively contribute to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate

9.9 This role is deputised by the Portfolio Director for Delivery and Improvement.

EPRR Senior Leadership Team

9.10 The EPRR Senior Leadership Team (SLT) is comprised of the Portfolio Director for UEC Delivery and Improvement, Associate Director for UEC and EPRR (ADO), and the EPRR Strategic Lead, reporting to the Chief Delivery Officer (AEO).

9.11 The EPRR SLT is responsible for supporting the AEO to discharge their statutory duties as set out, embedding a strong EPRR and business continuity culture across the ICB, supporting training and exercising engagement, and maintaining an awareness of risks and issues relating to delivery of services.

9.12 The EPRR SLT meet monthly to monitor delivery of the EPRR work programme, any emerging risks, items of notes, and ongoing incidents, reporting progress against this to the AEO on a bi-monthly basis or more frequently if required.

9.13 The ADO will deputise for the Chief Delivery Officer and Portfolio Director for Delivery and Improvement where appropriate.

9.14 The ADO will support the EPRR Strategic Lead in chairing the ICB EPRR and Business Continuity Working Group as necessary and support the review of papers to be submitted to the various governance groups in agreement with the Accountable Emergency Officer.

EPRR Team

9.15 The EPRR Team reports to the EPRR Strategic Lead, who is responsible for ensuring the progress of the EPRR work programme and provide a point of escalation to the EPRR SLT.

9.16 Supported by the UEC Operations Team / System Coordination Centre (SCC) in a matrix capacity to enhance resilience, the ICB EPRR Team is responsible for delivery of the EPRR functions and duties as per the CCA (2004), EPRR Policy, and EPRR Framework (2022), including ensuring plans and arrangements are reviewed regularly. The inclusion of the SCC within the team structure enables resilient operations 7 days per week in line with the NHSE requirements for a 7-day operational SCC function.

9.17 Specifically the EPRR team will:

- Ensure ICB compliance with national policy, guidance and standards
- Ensure robust business continuity arrangements are in place aligned to ISO 22301 standards and Business Continuity Institute Good Practice Guidelines
- Ensure plans are in place to respond to incidents of varying scale and nature both as an ICB and ICS
- Ensure response staff are adequately training and exercised in line with the National Minimum Occupational Standards for EPRR
- Embed a process of continuous improvement across all aspects of EPRR
- Assess the risk, no less than annually, of any emergencies or business continuity incidents occurring, which affect or may affect the ability of the ICB to deliver its functions.

9.18 Formal accountability for the EPRR Team delivery remains with the Accountable Emergency Officer (Chief Delivery Officer), as per the EPRR Governance Structure outlined in section 8.

9.19 The EPRR Team will ensure the ICB plans jointly with the SSOT Integrated Care System, NHS England Midlands, Acute Trusts, Community and Mental Health Providers, Primary Care, Local Authorities, and other Category 1 and 2 responders as required.

9.20 The EPRR Strategic Lead will chair the SSOT ICB EPRR and Business Continuity Group, supported by the ADO.

9.21 The EPRR Strategic Lead, deputised by the EPRR Operational Manager, will represent the ICB at LRF tactical level meetings, NHS EPRR Network meetings and multi-agency EPRR events, as per the Staffordshire LRF NHS representation agreement, ensuring discussions are dovetailed with those of HEPOG and HRMG, and information is gathered for escalation to the relevant LRF group, and updated following LRF meetings are shared with system partners.

9.22 The EPRR Strategic Lead will chair the Health Emergency Planning Officers Group (HEPOG) and Health Risk Management Group (HRMG) as per the relevant group terms of reference, and support system coordination planning and preparedness through the system EPRR work programme priorities as set by LHRP.

9.23 The EPRR Team will work to support the Greener NHS agenda through the consideration of climate change and adaptation within plans as appropriate. The Sustainability portfolio sits within that of the Chief Transformation Officer and so the EPRR Team will work with portfolio leads to give due consideration to this within EPRR plans and policies as appropriate.

ICB EPRR and Business Continuity Group

9.24 The EPRR and Business Continuity Group is accountable to the AEO and will provide updates via the EPRR Strategic Lead to the ICB Audit Committee as appropriate. The group is chaired by the EPRR Strategic Lead, with support from the ADO for UEC and EPRR.

9.25 Attendance is at a Senior Manager level, usually formed of representatives from core services areas of the tactical (silver) on-call group, or their deputy.

9.26 The group meets twice yearly and is responsible for the implementation of EPRR documentation, acts as an authorising committee for operational EPRR plans, and monitors key performance indicators within business continuity and training/exercising.

9.27 The group can make recommendations to Audit Committee in the onward approval of policies and procedures requiring Board level sign-off.

Staffordshire Civil Contingencies Unit (CCU)

9.28 The ICB has in place a Service Level Agreement with Staffordshire Civil Contingencies Unit (CCU) to support planning, training, exercising, incident response support, and local resilience forum secretariat services. This resource will be utilised to provide advice and support on multi-agency emergency planning matters, and opportunities for training and exercising of on-call teams.

Directorate Leads for Business Continuity

9.29 Each Directorate will have identified leads from each team to support business continuity planning where their service area is identified as maintaining critical/essential services within the ICB. This role holder will continue to review essential functions and contingency arrangements for their team and will discharge their business continuity arrangements with support from the Directorate Business Continuity Recovery Team during incidents.

10. Command and Control

10.1 A clear command and control structure is in place to ensure individuals involved in the response to an incident are clear of their role and responsibilities, including a clear reporting arrangement for escalation for decision making, and cascade of key information.

10.2 Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. To fulfil our EPRR requirements, the ICB will operate a 24/7, 365 day, on-call function.

On-Call Managers

10.3 The ICB are committed to providing a resilient and dedicated on-call mechanism to enable 24/7 receipt and action of incident notifications, achieved through the on-call manager arrangements.

10.4 On-Call Managers are responsible for coordinating the local NHS response to an incident; responding to any NHS England Midlands Operations Centre (MidsROC) resource requests, and the provision of incident situation reports to MidsROC. The ICB operates a two-tier system, with a Tactical (Silver) On-Call Manager (SOC) and a Strategic (Gold) On-Call (GOC) Manager, performed by staff at band 8c/8d, and band 9 and VSM respectively. The On-Call Managers are supported by an ICB Clinical Lead On-Call on a 24/7 basis for any clinical escalations required.

10.5 A Director with delegated authority to allocate resources should always be available to make strategic decisions for the organisation, providing a point for escalation and decision making, or undertake the role of Strategic Commander for the ICB/ICS or SCG where necessary. This will be facilitated by the GOC Manager.

10.6 The on-call rota is managed by the Urgent and Emergency Care Operations Team. The ICB will maintain an On-Call Policy and Service Description outlining the requirements and expectations of the On-Call function.

10.7 The SOC Manager is the nominated first point of contact for the organisation and will triage calls and manage these accordingly.

10.8 The Strategic (Gold) On-Call Manager provides a point of escalation for the SOC Manager for decision making, especially in critical or major incidents, or an incident which has the potential to significantly disrupt business as usual operations and delivery of key services; impact the health of SSOT communities; prevent delivery of statutory responsibilities; or have the potential to negatively impact the reputation of the organisation. Both roles may need to attend the incident coordination centre if established either physically or virtually.

10.9 Both roles dovetail with command, control, and coordination (C3) structures established across the Integrated Care System, wider local health economy, and local resilience forum. This is outlined in further detail within the ICB and ICS Incident Response Plan.

Incident Coordination Centre

10.10 The ICC supports the Incident Management Team (IMT) and On-Call Managers to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved through the utilisation of a formal structure, which facilitates suitable and sufficient arrangements to effectively manage the response to an incident.

10.11 Arrangements for the ICC are flexible and scalable to cope with a range of incident scales and hours of operation required, and will require strict adherence to information storage policies to ensure a record of the incident, including any key decisions, actions, and rationale can be retained, as outlined in the ICB and ICS Incident Response Plan.

10.12 The outline for the Incident Coordination Centre and IMT is contained within the Incident Response Plan.

11. Risk Management Strategy

11.1 To comply with the NHS England EPRR Framework, and NHS EPRR Core Standards annual assurance self-assessment, the ICB is required to assess the risk, no less frequently than annually, of any emergencies or business continuity incidents occurring, which affect or may affect the ability of the ICB to deliver its functions.

11.2 In implementing this, the EPRR Strategic Lead will ensure EPRR processes are represented and recorded within the ICB Risk Management Strategy, allowing for the identification, assessment, mitigation, and escalation of risk to the ICB Board.

11.3 The risk management process will be carried out in accordance with the ICB Risk Management Strategy, and escalation of EPRR risks will take place as follows:

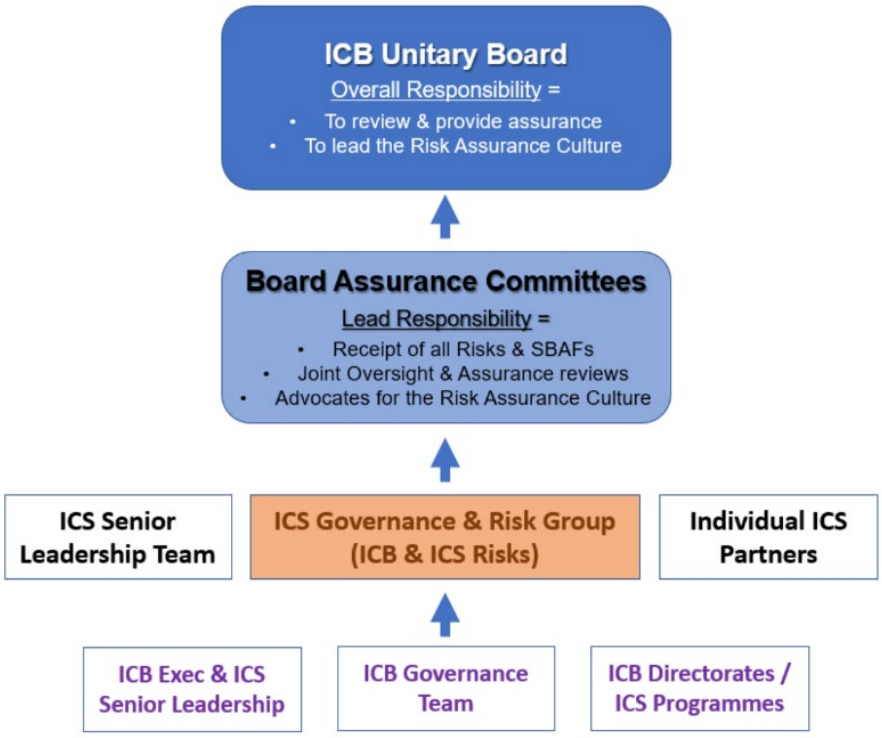


Figure 3: Extract from the ICB Risk Management Strategy

11.4 The ICB EPRR Team on behalf of the ICS will participate in the Local Resilience Forum Risk Assessment Working Group (RAWG) and will chair the Health Risk Management Group (HMRG) as a subgroup of LHRP. The ICB will review current and emerging risks highlighted by RAWG within the Community Risk Register, and risks identified by HRMG, and ensure appropriate plans are put into place.

11.5 The EPRR Strategic Lead will be responsible for ensuring that risks are regularly considered and reviewed, and any risk that has the potential of resulting in an emergency or business continuity interruption is included on the risk register and appropriate mitigating actions identified. Where a risk mitigation is required, the EPRR Strategic Lead will include this in the EPRR work programme.

11.6 The EPRR Team will work with the LRF and LHRP to support the development of system level response plans or multi-agency plans requiring health input.

11.7 The LHRP will consider and contribute to the Community Risk Register developed by the LRF, with assessments used to inform the planning and strategy set by the LHRP.

12. Business Continuity Management

12.1 Business continuity management (BCM) is an essential tool in establishing an organisation's resilience to maintain their business prioritised activities. BCM gives organisations a framework for identifying and managing risks that could disrupt normal services.

12.2 The ICB Business Continuity Plan (BCP), and associated Directorate or Service level plans, will be developed and maintained in accordance with the ICB Business Continuity Policy and Strategy, ISO 22301, NHS EPRR Core Standards, and NHS England's Business Continuity Management Framework.

12.3 BCP's will contain anticipated potential risks, including their likelihood and impact in a business impact analysis; an assessment of critical services and business critical activities, and their respective acceptable level of continued service during an incident; identification of dependencies and key stakeholders; communication; and defined roles and responsibilities.

12.4 This will be outlined in detail within the Business Continuity Strategy, including a process for assessing the effectiveness of the BCM system (BCMS) through debriefs or after-action reviews.

13. Incident Response Plan

13.1 The ICB and ICS Incident Response Plan (IRP) will be developed and maintained in accordance with the civil protection duties outlined for category one responders under the CCA (2004), the NHS England EPRR Framework (2022), and the NHS England EPRR Annual Assurance requirements.

13.2 The plan will ensure the ICB has the capacity and capability to respond to a variety of incidents of any level, in a way which ensures the health, safety and wellbeing of patients, service users, communities, and staff, minimises disruption to the health services, and facilitates an effective and efficient return to normal service levels.

13.3 The IRP will be integrated and complementary of business continuity arrangements to ensure an early recognition of resource implications can be considered, and assurance can be provided internally and externally of the organisation's ability to respond while maintaining essential services while responding to an incident that has the potential to affect health or patient care.

13.4 The IRP will:

- Define an incident and the types of incidents the ICS may be expected to respond to;
- Establish roles and responsibilities for response, ensuring incident response role holders are aware of the stakeholders for consultation and informing during decision making;
- Contain a command, control, and coordination (C3) framework for response to enable on-call staff and Directors to make informed decisions against a clear decision-making process;
- Outline the dovetailing of C3 arrangements with the wider local health economy, MidsROC, and the LRF, including situation reporting as requested;
- Identify internal, external, and stakeholder communication arrangements prior to, during and after an incident, in line with the ICB strategy for media and communications;
- Outline the process for recovery from an incident

14. Mutual Aid

14.1 The response to Covid-19 has demonstrated the effectiveness of joint working in incident response, to enable challenges arising across organisational boundaries to be approach with collaborative resources, varied skillsets, and identify solutions to support the promotion of safety, health and wellbeing of communities and responders.

14.2 In incidents requiring multi-agency response, mutual aid requests will be put forward to the Local NHS Strategic Command (LNSC) Group, to enable escalation of requests into the Staffordshire Tactical and Strategic Coordinating Groups. Mutual aid requests will also be highlighted within Situation Reports to NHSE for consideration at a regional level.

14.3 The ICB will support the requesting, coordination, and maintenance of mutual aid requests for staff, equipment, services, and supplies.

14.4 NHS England Midlands will be responsible for the coordination and implementation of mutual aid requests if a disruptive incident occurs across several counties/regional footprint. The ICB, through the Local NHS Strategic Command, will respond to any requests received to provide mutual aid during a major or significant incident or emergency.

14.5 Clinical networks will retain a key role in coordinating their specialist capacity.

14.6 In the event that mutual aid, business continuity, and commissioning options are considered as not appropriate, inaccessible, or exhausted, it may be appropriate to consider requesting support from the military under the Military Aid to Civilian Authorities (MACA) requesting process. All requests should be submitted to NHS England (national) at the earliest opportunity, and must be approved by the Chief Executive Officer, AEO, or an Executive Director on delegated authority as Strategic (Gold) On-Call Managers. Further detail and the request form is available in the ICB/ICS Incident Response Plan.

15. Information Sharing

15.1 Within the civil protection duties as outlined in the CCA 2004, the ICB and local responders have a duty to share information to support preparedness, response, and recovery to incidents of any type.

15.2 The One Staffordshire Information Sharing Protocol and SRF Information Sharing Agreement are in place across the Staffordshire Local Resilience Forum, and outlined the principles and standards of conduct and practice in the sharing of information, including the promotion of good practice. The ICB is a signatory organisation to these agreements.

15.3 Throughout any sharing of information, the Information Governance team must be consulted, and decisions made in line with the Freedom of Information Act (2000), the General Data Protection Regulations (2016), the Caldicott Principles, safeguarding requirements, and Civil Contingencies Act (2004).

16. Maintenance of Plans

16.1 The EPRR Team will be responsible for ensuring the ICB incident response and business continuity plans, and associated guidance and training documents are reviewed at regular intervals, in line with any changes to local and national guidance, organisational change, lessons identified, and training needs of the organisation.

16.2 Policy development, consultation, and ratification will be in line with the ICB Development and Management of Controlled Documents Policy. Any plans or arrangements which are not categorised as a controlled document will utilise the policy as a best practice process.

17. Implementation, Monitoring and Review

17.1 Effective communication methods will be established to ensure this Policy and its contents are embedded in organisational knowledge. The policy will be made available to all ICB staff. It will remain available on the System Coordination Centre SharePoint site for all staff access, and will be published on the ICB website.

17.2 Assurance in respect of EPRR arrangements will be provided to the ICB Audit Committee and ICB Public Board, and annually to NHS England through the EPRR Annual Assurance Process.

17.3 Effectiveness of arrangements will be reviewed following internal, system, and multi-agency incident debriefs, notable regional and national incidents (e.g. the Manchester Arena Inquiry, Covid Inquiry), release of new or updated policy and guidance, and any National Resilience Standards as appropriate, to drive forward an agenda of best practice across all EPRR domains.

17.4 The Policy will be reviewed on a three-yearly basis by the EPRR Strategic Lead to ensure effectiveness and compliance against current guidance and legislation, unless any significant amendment to policy or working practice as outlined at 17.3 denotes otherwise.

17.5 An Equality Impact Assessment is available on request.

17.6 Should any queries arise regarding the content of this policy, the individual should contact the ICB EPRR Team to discuss, and any amendments will be considered accordingly.

18. Training and Exercising

Staff Training

18.1 Staff undertaking roles and responsibilities as listed within this policy will be trained in line with the frequency outlined in the Training Needs Analysis, and according to the NHS England EPRR competencies (national minimum occupational standards for EPRR).

18.2 Individuals must commit to undertake training annually (unless denoted otherwise by an accredited course) for their role in line with the ICB On-Call Policy and annual training and exercise schedule, to ensure skills are maintained.

18.3 The EPRR Team will produce a training needs analysis annually, supported by detailed training records and personal training and exercising portfolios for on-call and ICC staff, in line with the minimum occupational standards for EPRR and the Skills for Justice National Occupational Standards (NOS) framework.

18.4 Individuals holding incident response roles will be responsible for maintaining their EPRR training portfolios to support development in role, highlighting areas for further development to the EPRR Team. On-Call Managers are required to attend a minimum of six monthly development sessions per year, and an exercise annually.

18.5 The EPRR Team will maintain the central record of training undertaken and upcoming expiry to maintain competence across teams.

18.6 Associate Directors are responsible for ensuring that staff within their Directorates and Teams are aware of relevant EPRR and business continuity training and are encouraged to attend recommended courses.

Testing and Exercising

18.7 To ensure the effectiveness and embed knowledge of emergency plans, these must be tested regularly to ensure they are fit for purpose, staff are confident in delivering their roles to support response, and roles listed in the plan fit for purpose and encapsulate necessary functions and actions.

18.8 Throughout the exercising process, members of staff can practice their skills, and increase their knowledge and confidence in a safe environment.

18.9 Plans can be assured through confirm and challenge of content, allowing for the identification of any gaps or areas for improvement, which will be logged for continuous development and for audit purposes for later reference if required.

18.10 The EPRR Team are responsible for ensuring policies and arrangements are tested and exercised in line with the annual training and exercise schedule and as set out in the NHS England EPRR Framework (2022).

18.11 This includes a minimum expectation as set out below:

Exercise Type	Minimum Frequency	Outline
ICC equipment test	3 months	Test of the functionality of ICC equipment.
Communications (ICB arranged)	6 months	Test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. These exercises are conducted both in-hours and out-of-hours on a rotational basis and should be unannounced.
Table-top	12 months	Discuss the response, or specific element of a response, to an incident with relevant staff and partners, and can provide validation of a new or revised plan.

Business continuity	12 months	Discuss the response, or specific element of a response, to an incident impacting key services to enable testing of business continuity planning arrangements with relevant staff and partners.
Live play	3 years	Live test of arrangements and includes the operational and practical elements of an incident response. NB. If an organisation activates its plan for response to a live incident this replaces the need to run an exercise, providing lessons are identified and recorded and an action plan developed.
Command post	3 years	Tests the operational element of command and control and requires the setting up of the Incident Coordination Centre (ICC). It provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of exercise, and should also test communication and information flows into multi-agency partners. A real incident activation replaces the need to run an exercise, subject to the identification, logging, and actioning of any lessons identified.

18.12 Exercises will be designed relevant to local risk, as defined in section 9 of this policy, and will aim to meet the needs of the organisation and any stakeholder engaged within warning and informing elements of the exercise.

18.13 Post-exercise reports will be produced by the EPRR Team to capture lessons identified and ensure learning is embedded into policies, arrangements and training where required.

18.14 Staff performing an on-call role will be required to attend NHS and LRF multi-agency exercises to ensure they are familiar with multi-agency arrangements, plans, and C3 structures.

19. Lessons Identified

19.1 NHS funded organisations are required to share information of lessons identified through exercising or incident response across the wider NHS through a common process coordinated through the LHRP.

19.2 Reviewing lessons from incidents ensures the ICB can identify opportunities for continuous improvement and embed these into EPRR arrangements.

19.3 Within 48 hours after an incident, the EPRR Team will conduct a hot debrief with staff involved to capture any immediate learning and enable staff to de-escalate / decompress following an incident.

19.4 Within 28 days, the EPRR Team will conduct a cold debrief with those involved in the incident for its duration, and the lead-in to consider preparedness steps, as appropriate.

19.5 Where deemed necessary, a multi-agency debrief will be requested / commissioned through the Civil Contingencies Unit, ideally to be held within eight weeks of close of the incident

19.6 The results of both debriefs which will form a lessons identified report and an action plan for the implementation of any lessons identified, which will be produced within four weeks of the debrief.

19.7 The report will be supported by actions plans, with timescales and accountable owners, and any recommendations to update any relevant plans or procedures and identify any training or exercising required.

19.8 The Lessons Learnt Report will be shared with the ICB EPRR and Business Continuity Group and ICB Governance Structures for EPRR as outlined, and will form part of the annual report to Audit Committee and ICB Board.

19.9 Reports will be sharing across the ICS to share lessons, via the LHRP Health Emergency Planning Officers Group (HEPOG).

19.10 The EPRR Team will ensure lessons are shared with NHSE Midlands EPRR team as part of the regional process for sharing of lessons.

20. Audit Arrangements

20.1 The policy will be audited throughout the year both internally and externally. The EPRR Strategic Lead will also ensure that any appropriate external audits tools and assurance processes are conducted on a regular basis, such as the NHS EPRR Core Standards Assurance self-assessment return to NHS England.

20.2 EPRR, including business continuity will be aligned to the requirements of the organisation's audit programme, and will implement any post audit improvement plans or recommendations to support continuous improvement.

21. Equality and Diversity

21.1 An equality impact assessment has been completed for this policy to ensure plans developed under this Policy have due regard to reflect the impact on and from health inequalities in preparing for, responding to, and recovering from incidents. This can be accessed on request.

22. Supporting Documentation and Policies

22.1 In addition to meeting legislative duties, ICBs are required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Planning Framework 2022
- NHS Core Standards for Emergency Preparedness, Resilience and Response Annual Assurance

22.2 This policy is to be read in conjunction with:

- EPRR Strategy
- ICB and ICS Incident Response Plan
- Business Continuity Strategy and Business Continuity Management System
- Corporate Business Continuity Plan
- On-Call Managers Handbook

22.3 The following ICB policies support this Policy:

- Health and Safety Policy
- Information Governance, Data Protection and Security Policy
- Information Governance Handbook
- Procurement Policy

23. Definitions and Glossary

Definitions

Business Continuity:

The capability of the organisation to continue delivery of products or services at acceptable pre-defined levels following a disruptive incident

Business Continuity Incident:

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Business Impact Analysis:

The process of analysing activities and the effect that a business disruption might have upon them

Business Continuity Plan:

Documents the procedures that guide the organisation to respond, recover, resume, and restore to a pre-defined level of operation following a disruption to business continuity

Critical Incident:

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Emergency:

a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom, or

b) An event or situation which threatens serious damage to the environment of a place in the United Kingdom, or

c) War, or terrorism, which threatens serious damage to the security of the United Kingdom

Emergency Preparedness:

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

Incident Response Plan:

Outlines how the ICB will respond to a critical or major incident.

Major Incident:

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

For the NHS this will include any event defined as an emergency.

Resilience:

Ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

Response:

Decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders, including those associated with recovery.

System Critical Incident:

Under the NHS England EPRR framework 2022, there is no mechanism for declaring a system-wide critical incident. To do this, all Trusts and the ICB must individually declare a critical incident, before the ICB makes a declaration on behalf of the system (decision in collaboration with system partners) to declare a System Critical Incident. This must be reported to NHSE Midlands First On-Call with an accompanying SBAR report.

Glossary

AEO	Accountable Emergency Officer
BCM	Business Continuity Management
BCP	Business Continuity Plan
C3	Command, Control and Coordination
CCA (2004)	Civil Contingencies Act (2004)
CCU	Civil Contingencies Unit
CPX	Command Post Exercise
DPH	Director of Public Health
EPRR	Emergency Preparedness, Resilience and Response
HEPOG	Health Emergency Planning Officers Group
HRMG	Health Risk Management Group
ICB	Integrated Care Board
ICS	Integrated Care System
IRP	Incident Response Plan
LHRP	Local Health Resilience Partners
LNSC	Local NHS Strategic Command
LRF	Local Resilience Forum
MIDSROC	NHS England Midlands Region Operations Centre
NHSE	NHS England
NHS NOC	NHS England National Operations Centre
NOS	National Occupational Standards
RAWG	Risk Assessment Working Group
SCC	System Coordination Centre
SCG	Strategic Coordinating Group
SRF	Staffordshire Resilience Forum
TCG	Tactical Coordinating Group
TTX	Table-Top Exercise
UEC	Urgent and Emergency Care

24. References

- Civil Contingencies Act 2004
- The Health and Social Care Act (2022)
- NHS Constitution
- The NHS England Emergency Preparedness Framework 2022
- NHS England Business Continuity Management Framework (service resilience) (2013)
- NHS Core Standards for Emergency Preparedness Resilience and Response Annual Assurance
- ISO 22301 – Societal Security – Business Continuity Management Systems – Requirements
- Cabinet Office, Emergency Preparedness (2006) (as amended)
- National Occupational Standards (NOS) for Civil Contingencies

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**20 March 2025**					
Title:	**Pre-consultation Business Case – Birthing services previously provided at County Hospital and Samuel Johnson Community Hospital**					
Presenting Officer:	Heather Johnstone – Chief Nursing and Therapies Officer, Helen Slater - Associate Director of Transformation.					
Author(s):	Helen Slater – Associate Director of Transformation, Gina Gill – Transformation Programme Lead. Fiona Waring – Senior Communications and Engagement Manager					
Document Type:	Choose an item.		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	1. Pre – consultation business case, 2. Pre-consultation business case appendices (available on the ICB's Board meeting webpage: https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/board-papers/2025/march-2025/enclosure-8-pcbc-appendices/), 3. Public consultation Plan, 4. Public facing consultation document.					

(1) Purpose of the Paper:

This paper provides the Board with the pre-consultation business case (PCBC) for birthing services previously provided at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield. Please note the appendices to the PCBC have been uploaded to the ICB's Board Meeting webpage here https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/board-papers/2025/march-2025/enclosure-8-pcbc-appendices/ This paper also describes the proposed approach to public consultation, subject to Board approval, as outlined within the draft public consultation plan appended to this paper.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
The proposal and updates throughout the programme have been considered by: West Midlands Clinical Senate Staffordshire County Council Health and Care Overview and Scrutiny Committee (OSC)	 18 April 2024 29 July 2024

Stoke-on-Trent Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee	08 August 2024
Derbyshire County Council Improvement and Scrutiny Committee - Health	August 2024
NHSE Stage 2 Assurance Panel	02 October 2024
SSoT ICB People and Communities Assembly	07 October 2024
SSoT ICB Quality and Safety Committee	09 October 2024
NHSE Stage 2 assurance discussion	21 January 2025
SSOT Strategic Commissioning and Transformation Committee	05 March 2025

(3) Implications:

Legal / Regulatory	The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services and influence ICB decisions at the level of participation they choose as set out in the NHS Act (2006). As part of the Public Sector Equality Duty as contained in section 149 of the Equality Act 2010, decision-makers need to adhere to the Brown Principles to demonstrate their due regard to the aims set out in the general equality duties. The Board must have due regard to the need to: • Eliminate discrimination • Advance equality of opportunity • Foster good relations between different people when carrying out their activities. To 'have due regard' means that in making decisions and in its other day-to-day activities a body subject to the duty must consciously consider the need to do the things set out in the general equality duty. We will consult the Local Authority Health Overview & Scrutiny Committee when the ICB is considering any proposal for: • A substantial development of the health service in the area, or • A substantial variation in the provision of a service. This is underpinned by S244 of the NHS Act 2006 and explained further by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The ICB has a legal duty under the Equality Act (2010) to promote equality through the services we commission and establish processes to hear the voices of local people irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. Planning, assuring and delivering service change for patients (PADs) is a key NHS guidance to consider. The guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports ICSs to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

CQC / Patient Safety	CQC – service specific inspections were completed at both Trusts during 2023 which identified areas for improvement within wider maternity services. Immediate plans were put into place to address the CQC actions and recommendations and both Trusts continue to work on the delivery of their quality improvement plans alongside overall maternity transformation programmes in line with national guidance. Patient Safety - Full details of the implications are outlined within the business case
Financial (CFO-assured)	None
Sustainability	The proposal does not impact our ambition to meet net zero. Both providers are currently auditing their storage and use of nitrous oxide which, depending upon the decision-making process, will be taken into consideration at that point.
Workforce / Training	Positive or neutral impact - Full details of the implications are outlined within the business case
Equality & Diversity	
Due Regard: Inequalities	
Due Regard: wider effect	

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☒	☐	☐	Stage 2 assessment approved 03/09/2024
	QIA	☒	☐	☐	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on 03/09/2024
Has there been Public / Patient Involvement?		☒	☐	☐	2019 – ongoing. Described in detail within Section 5 of the PCBC.

(5) Integration with the BAF & Key Risks:

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

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

The FMBU services (births only) at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield, were suspended at the beginning of the pandemic to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton

Whilst the initial closures were directly related to Covid 19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units.

Prior to the units closing on a temporary basis 94 women (8 per month) gave birth at County Hospital in Stafford and 220 women (18 per month) gave birth at Samuel Johnson Community Hospital in Lichfield (2019/20 activity). The units were staffed by midwifes on a 24/7 basis.

The Staffordshire and Stoke-on-Trent ICB, along with colleagues from the neighbouring Derby and Derbyshire ICB, have been working with the providers to outline the current position in relation to the FMBU's and the home birthing services provided by each organisation.

All parties recognised that the ongoing closure under the temporary service change arrangements could not continue and began to consider the next steps regarding service change proposals for future maternity provision across Staffordshire and Stoke-on-Trent.

Home birth services were also temporarily suspended at the start of the pandemic. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

In July 2023, the case for change on the future of intrapartum services at the FMBUs was presented to NHS England during a Stage 1 assurance meeting. No issues were raised by NHSE during the meeting and the feedback from NHSE was that the case was well presented with partners demonstrating a clear and robust understanding of the clinical model and the challenges the ICS is facing.

As a result, the ICB alongside system partners reinstated the service change process that was paused due to the pandemic and began to reassess proposals for the future of birthing services at Samuel Johnson Hospital, Lichfield and County Hospital, Staffordshire. The service change programme has been conducted in accordance with the NHSE guidance Planning, assuring and delivering service change for patients (https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf)

At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals. These were assessed against six essential criteria. During the event it was recommended that only one proposal is viable at this stage - which is to make permanent the temporary closure of intrapartum birthing services at County hospital and Samuel Johnson Community Hospital.

Following the technical event, a deliberative event with women and key stakeholders was held online in December 2023 to discuss the proposal for intrapartum services previously provided at County Hospital and Samuel Johnson Hospital. Further involvement was carried out with women who registered but were unable to attend the event.

A report of findings was developed by the Midlands and Lancashire Commissioning Support Unit (MLCSU) following the deliberative event and further involvement and was presented to the Maternity Service Change Steering Group.

The group formally received the report of findings and confirmed they were confident with the process that had been undertaken. The group was also asked to consider whether anything further needed to be considered within the business case in light of the feedback received.

For complex service change commissioners should consider clinical senate advice. Clinical senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

In April 2024, the Case for Change and associated clinical evidence was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the ICS articulated a credible case for change and the principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. As such, the Senate supported the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs) at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield.

On 02 October 2024, a Stage 2 Assurance meeting was convened with NHSE where the ICB and Trust Colleagues presented the clinical case for change and the proposal for the future of birthing services in Staffordshire.

Following the assurance panel on 02 October 2024 and through subsequent discussions, NHSE have confirmed they are assured that the proposals meet the five tests for service change as well as other good practice tests and are content for the ICB to proceed to consultation.

In line with the recommendations from NHSE, a series of amendments were made to the PCBC. Development of the business case has been through a robust process as described above and the activity undertaken meets the key legal requirements when proposing service change.

Based on the involvement activity to date it is recommended that the ICB undertake a 12-week public consultation. The aims of this will be to:

- articulate the case for change and the single viable proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs).
- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the proposal identified through the options appraisal process and wider involvement activity.
- reassure staff, service users, carers, carer representatives and other stakeholders about the scope of the proposal and the wider maternity clinical model.
- understand views about the process we have undertaken and the technical group's recommendation about the single viable proposal.

The consultation plan outlines the process for consultation and the methods used to conduct targeted engagement with service users, carers, carer representatives and other stakeholders which includes a survey, structured online events and drop in roadshow events.

This paper and associated documents were presented to the ICB Strategic Commissioning and Transformation Committee on 05 March 2025. The Committee was assured that a robust process had been undertaken through the work programme and supported the recommendations within the paper.

(7) Recommendations to Board / Committee:

The ICB Board meeting is asked to:

1. Approve the following
   - Pre-Consultation Business Case and appendices
   - Consultation Plan
   - Consultation Document

2. Approve the recommendation to proceed to public consultation on the single viable proposal to make permanent the temporary closure of birthing services previously provided at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield.

3. Approve the recommendation to undertake a public consultation for a period of 12 weeks.

Birthing Services at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

Pre-consultation business case for submission to NHS England

NHS Staffordshire and Stoke-on-Trent Integrated Care Board
University Hospitals of North Midlands NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust

DOCUMENT CONTROL SHEET

VERSION	DATE	OWNER	ACTION
0.1	24/06/2024	ICB	Chapters circulated to responsible leads for comment
0.2	24/07/2024	ICB	Feedback incorporated
0.3	16/08/2024	ICB	Additional feedback incorporated and exec summary included. Circulated to NHS England as early draft and to key ICS system leads.
0.4	11/09/2024	ICB	Additional feedback from system leads and NHS England incorporated.
0.5	06/01/2025	ICB	PCBC revised following Stage 2 NHSE assurance meeting
1.0	22/01/2025	ICB	PCBC revised following further discussion with NHSE
1.1	19/02/2025	ICB	Additional feedback from NHS England incorporated.

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Abbreviations and Definitions

AN	Antenatal – refers to the period during pregnancy and before the birth of a baby.
BSOTs	Birmingham Symptom Specific Obstetric Triage System.
CCG	Clinical Commissioning Group. These were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CNST	Compliance against the Clinical Negligence Scheme for Trusts.
CQC	Care Quality Commission.
DMBC	Decision-making business case.
DS	Delivery Suite.
ICB	Integrated Care Board. These replace CCGs in the NHS in England from 01 July 2022 and took on the NHS planning functions that were previously held by CCGs.
ICS	Integrated Care System. These are local partnerships that bring together NHS organisations local authorities and others to develop shared plans and joined-up services in their local area.
FMBU	Freestanding Midwifery Birth Unit. Throughout the document, birthing services at County Hospital and Samuel Johnson Community Hospital are referred to as FMBUs. This refers to the LDRP rooms (see below) that were available within these sites prior to March 2020.
Fetal	Both fetal and foetal are acceptable spellings. Throughout this document we have used the term fetal. The fetal stage of development begins around the ninth week and lasts until births.
GTT	Glucose Tolerance Testing.
HOSCs	Health Overview and Scrutiny Committees.
IoL	Induction of Labour.
Intrapartum	Intrapartum care is defined as the care of the women and their babies from the onset of labour and immediately after birth.
LDRP	Labour, Delivery, Recovery and Postpartum. These are the rooms that were available at County Hospital and Samuel Johnson Community Hospital where mothers give birth, bond with their baby and recover in one place until families are ready to go home.
LMNS	Local Maternity and Neonatal System. The LMNS is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices

	partnerships, who are work together to transform maternity services.
Low risk/high risk pregnancies	A low-risk pregnancy is where women have been healthy and well throughout the pregnancy with no known medical conditions. A high-risk pregnancy is any pregnancy that carries increased health risks for the woman or the unborn baby. This may include exiting medical conditions, the development of pregnancy-related health conditions during the pregnancy such as high blood pressure or diabetes, or may be due to complications with previous pregnancies.
MLCSU	Midlands and Lancashire Commissioning Support Unit.
MSW	Maternity Support Worker.
Neonatal	Newborn. Neonatal services are provided for newborn babies who need extra care.
NHS England	NHS England leads the National Health Service in England. It's an independent body whose main role is to set the priorities and direction of the NHS, whilst at the same time improving health and care across England.
NICE	National Institute for Health and Care Excellence. The organisation provides national guidance and advice to improve health and social care.
NIPE	Newborn and Infant Physical Examination.
Obstetric	In an obstetric unit, care is provided by a team of midwives and doctors. Midwives provide care to all women in an obstetric unit, whether or not they are considered at high or low risk and take primary responsibility for women with straightforward pregnancies during labour and birth. Obstetricians have primary professional responsibility for women at high risk of complications and for women who develop complications during labour and birth.
PCBC	Pre-consultation business case.
PN	Postnatal – refers to the period immediately after the birth of a baby.
Pregnant Women	Both pregnant women and pregnant people are acceptable phrases. Throughout this document we will refer to women or pregnant women.
RCM	Royal College of Midwives. Royal Colleges are professional bodies that are responsible for the development or and in training within their speciality.
RNs	Registered Nurses.

RCOG	Royal College of Obstetricians and Gynaecologists. Royal Colleges are professional bodies that are responsible for the development or and in training within their speciality.
SBLCB	Saving Babies Lives Care Bundle.
TSA	Trust Special Administrator.
TWB	Together We're Better.
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust.
UHNM	University Hospitals of North Midlands NHS Trust.
WMCS	West Midlands Clinical Senate.
wte	Whole time equivalent.

Purpose of this Document

The purpose of this pre-consultation business case (PCBC) is to:

- Describe the health needs of our combined geographies and set out the case for change: The case for change describes the key challenges faced by the local health economy – and explains why change is necessary.
- Describe the process we have followed: This describes the governance of the programme, and the process we have followed to ensure any recommendations or decision-making is supported by underlying evidence and local stakeholders.
- Describe how key stakeholders and the public have been engaged and involved in our process: Our early engagement has been extensive and captured a wide range of views. We also set out how we will plan to consult if a decision is made to proceed.
- Describe the clinical model and potential benefits thereof: The clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice.
- Set out our options consideration process: We have followed a standard approach to understand the possible options to address the challenges set out in our case for change and deliver our clinical model. This document describes a long list, initial tests to reach a short list, and the evaluation of the short list through defined criteria.
- Carry out an analysis of financial impact and affordability: We have used a range of financial metrics to assess the financial impact of the shortlisted options, and to test the affordability of each.
- Set out how we will assure and potentially implement our plans if a decision is made to move forward: This describes the role of assurance bodies and governance around decision-making.

While the below list is not exhaustive the PCBC seeks to:

- build alignment between NHS commissioners and local authorities and other stakeholders.
- build on the case for change.
- demonstrate that all options, benefits and impact on service users have been considered.
- demonstrate that the planned consultation will seek the views of service users and members of the public who may potentially be impacted by the proposals.

This document is not the final business case. Following consultation, a detailed decision-making business case (DMBC) will be produced which will be the basis for the final decision to proceed with any changes.

Scope

This document does not attempt to provide a full description of all maternity services, or service improvement plans across Staffordshire and Stoke-on-Trent. The scope of work described within this PCBC focuses on the birthing services that were offered at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield until March 2020 when they were temporarily suspended.

Other services offered across Staffordshire and Stoke-on-Trent are not within scope as there are no proposed changes to these services. These are:

- Antenatal and postnatal services offered at the County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
- Community-based clinics across Staffordshire and Stoke-on-Trent
- Obstetric-led services at Royal Stoke Hospital and Queen's Hospital, Burton
- Midwife-led services at Royal Stoke Hospital and Queen's Hospital, Burton
- Neonatal services
- Homebirth services

1 Executive summary

Birthing services at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield

Background

The Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), along with colleagues from the neighbouring Derby and Derbyshire ICB have been working with provider partners to outline the current position in relation to the birthing services that were previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

In 2018/19, system partners identified maternity services as one of five clinical areas for review and consideration of alternative future models of care. An options appraisal process commenced in 2019, which included patient and public involvement, however COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for local birthing services.
In 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield were temporarily suspended to consolidate the midwifery workforce at the main acute sites.

Home birth services were also temporarily suspended at the start of the pandemic and neither Trust has been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage until recently. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

During 2022 it was anticipated that both Trusts would be in position to reinstate services either as per the clinical model of 2020 (pre-COVID) or through the implementation of an ‘on-demand model’. However, workforce challenges in relation to recruitment and retention of staff meant that neither provider was able to implement a revised service offer. During this time, both organisations provided regular updates to the Local Maternity and Neonatal System (LMNS) Partnership Board and correspondence was maintained with NHSE via the service change assurance routes.

Due to continued staffing pressures throughout 2022/23, both organisations informed the ICB in April 2023 they were not in a position to reinstate services as per the model of care considered in 2021, therefore it was agreed that the service change and public involvement process would be re-established and further work would be undertaken to explore all possible proposals for future service provision.

County Hospital and Samuel Johnson Community Hospital have remained open for antenatal and postnatal care throughout this period and both Trusts continue to offer the choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen's Hospital, Burton.

Why change is needed

Before the temporary closure, the number of babies born in a Freestanding Midwifery Birth Unit (FMBU) was very low. Based on the number of births in 2019/20, this amounted to an average of eight per month at County Hospital in Stafford and 18 per month at Samuel Johnson Community Hospital in Lichfield. This has implications for our staff:

- The units had to be staffed 24/7, with two midwives present for a birth. The low number of births meant we were not making the best use of our staff's time. This is a concern, especially given staffing pressures.
- It is recommended that the units manage a minimum of 350 births per year for them to be clinically and financially viable – in other words, for the workforce to be used in the best way possible, to ensure they maintain their skills and competency, and for the services to give value for money. There were not enough births in the FMBUs to ensure this.

FMBUs are for low-risk pregnancies only. A Birthrate Plus® assessment completed for UHNM in 2022 showed that pregnancies are becoming more complex. Just over 83% (5,102) of all women who give birth at UHNM fall into the moderate or high-risk category. This means that just under 17% (1,045) are suitable for low-risk care – compared to 29% in 2017/18 (West Midlands Clinical Senate review). A similar level of complexity is seen at UHDB where the 2021 Birthrate Plus® assessment showed that just over 82% of all births fall into the moderate or high-risk categories.

There are around 10,500 births per year for the Staffordshire and Stoke-on-Trent population when we include births at all hospitals (including those that are outside of our area). Birthrate Plus® assessment can only be completed for a particular Trusts footprint and therefore cannot be completed for an ICB population as a whole. However, applying the trends being seen at UHNM and UHDB gives an estimate of the levels of low, and moderate or high-risk pregnancies for the local population. Staffordshire and Stoke-on-Trent would therefore expect 8,715 pregnancies each year to be moderate or high-risk, and 1,785 pregnancies to be low-risk.

Although the Trusts promoted birthing services at the FMBUs, the number of births there continued to fall, as most low-risk women were choosing to give birth in the midwife-led units at the main hospitals instead.

Providing safe services is vital. Recent investigations into maternity services have emphasised how important it is to maintain safe staffing levels in line with Birthrate Plus®. Both Trusts have had Birthrate Plus® assessments, and both have run

successful recruitment campaigns with the majority of posts filled however a proportion of these will still be working through their preceptorship programme. This requires a period of structured support from more experienced midwives for newly registered midwives whilst they integrate into their new team and place of work.

To run the birthing services at the FMBUs and safely staff them 24/7, a minimum of 12.15 experienced Band 7 midwives (whole-time equivalent) would be needed for each unit.

The skill mix ratio as a result of the proportion of newly qualified midwives mean that, at present, the Trusts cannot staff the FMBUs for births as well as safely staffing the services at Royal Stoke University Hospital and Queen's Hospital, Burton.

As the number of women with low-risk pregnancies is getting lower, we needed to consider:

- whether it is viable to re-open the units
- whether it would make the best use of our workforce if we did, because the low number of births mean midwives will struggle to maintain their skills and competencies if they are based at an FMBU.

Proposal development and patient and public involvement

Patient and public involvement is a priority for the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of maternity services in Staffordshire and Stoke-on-Trent from the outset. Figure 1 at the end of this section outlines the process we have undertaken over the past few years.

Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of birthing services in Staffordshire and Stoke-on-Trent from the outset. The ICB, along with UHNM and UHDB, used this collective feedback to inform the development of the proposals and this pre-consultation business case and its proposal for the future of birthing services formerly provided at County Hospital Stafford and Samuel Johnson Community Hospital, Lichfield.

The development of the proposals and patient and public involvement that ran alongside this fall into four phases:

- Phase one - the initial proposal development and the patient, public and stakeholder involvement that took place during 2019-20 as maternity services were considered as part of the wider Together We're Better transformation programme.
- Phase two – Targeted maternity involvement in 2020 as part of the Together We're Better transformation programme.

- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement to understand whether there were any additional considerations about the future of maternity services
- Phase four – Re-established proposal development process undertaken in 2023 along with public involvement to explore all possible proposals for future service provision.

At the time of the temporary closure, the transformation of maternity services had already begun and the ICB had completed various involvement activities to understand people's experiences of using maternity services. During 2019 and 2020, a range of activities were undertaken to listen to people and understand what worked well and what could be improved in health and care services as well as seeking views on emerging models of care and criteria for evaluating proposals. In 2021, post pandemic feedback was sought, together with views on the homebirth services and new models of care proposed at that time.

In April 2023, the service change and public involvement process was re-established and SSOT ICB have been working with colleagues from UHNM, UHDB and Derby and Derbyshire ICB to outline the current position in relation to the FMBUs and consider proposals for the future, as each Trust is using their workforce in a different way to deliver safe services. This service change programme has progressed in line with national and local strategy and policy and the key drivers for change within maternity and neonatal services.

At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals. These were assessed against six essential criteria. During the event it was recommended that only one proposal is viable at this stage - which is to make permanent the temporary closure of birthing services at County Hospital and Samuel Johnson Community Hospital. The closure relates to five low-risk birthing rooms (LDRP - Labour, Delivery, Recovery, Post-Partum) across the two sites (two at County Hospital and three at Samuel Johnson Community Hospital).

If the proposal were implemented, this would not directly impact the end-to-end pathway for maternity services. Women would continue to be assessed throughout their pregnancy to check for any developing risk factors or complications, which may require a change of delivery options. The proposal needs to be considered alongside the maternity clinical model which is:

- no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the Trust Special Administrator (for UHNM).

- No change to the provision of consultant-led services
- Midwife-led care would continue to be offered at Royal Stoke Hospital and Queen's Hospital, Burton, alongside consultant-led units.
- Reintroduce and grow the homebirth services.
- Develop and grow a continuity of carer model for the most vulnerable in the County.

Following the technical event, a deliberative event with women and key stakeholders was held online in December 2023 to discuss the proposal for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital. Further involvement was carried out with women who registered but were unable to attend the event.

A report of findings was developed by the Midlands and Lancashire Commissioning Support Unit (MLCSU) following the deliberative event and further involvement and was presented to the Maternity Service Change Steering Group.

The group formally received the report of findings and confirmed they were confident with the process that had been undertaken. The group was also asked to consider whether anything further needed to be considered within the business case in light of the feedback received.

Workforce and finance implications

The proposal makes permanent the temporary arrangements that have been in place since March 2020 when birthing services at County Hospital and Samuel Johnson Community Hospital were temporarily suspended.

Workforce plans have been developed in line with Birthrate Plus® to ensure the appropriate number of midwives according to the clinical needs of the local maternity population. These have not been developed in response to this proposal, instead they have been developed for overall maternity services to ensure the Trusts reach full workforce establishment with sustainable recruitments plans in place for the future workforce.

The single viable proposal described within this pre-consultation business case would not introduce any new models of care and end-to-end pathways would not be affected. The proposal has no direct implications on staffing levels however workforce plans are described within this document to demonstrate the longer-term workforce sustainability within overall maternity services.

Both Trusts have made significant investment to ensure they are at the full midwifery establishment in line with Birthrate Plus®. The additional investment within each of the Trusts mean they are able to safely staff maternity services under the current operating

model which mirrors the proposal within this pre-consultation business case. As a result, there are no additional staffing costs as a result of this proposal and no additional estates costs have been identified.

Impact analysis

Section 8 of this PCBC describes the quality, equality and travel impact assessments that have been completed for the single viable proposal. The assessments largely identify either a positive or neutral impact of the proposal. The key positive impacts include:

- Equity of provision across Staffordshire and Stoke-on-Trent
- Proximity to other clinical teams where required e.g. neonatal services
- Reduced need for emergency ambulance transfers
- Clinical sustainability and workforce sustainability

The equality impact assessment identifies the protected characteristics of pregnancy and maternity as the most likely to be impacted due to the travel implications. Whilst no negative or positive impacts were identified for other protected characteristics, this was identified following due consideration of the needs of the birthing population.

The negative impact identified relates to the potential travel implications/impact for those who are eligible to give birth at County Hospital or Samuel Johnson Community Hospital and who would have chosen to give birth there.

The travel analysis included within section 8.5.2 shows that the average travel time for women would increase by around 8 minutes compared to Baseline or by 6 minutes compared to the actual travel time.

Women within the Stafford area who utilised the FMBU (n=73) are most affected by the proposals with travel time increasing by around 14 minutes compared to actual travel time. While a number of patients are affected by the additional travel time of approximately 8 minutes on average, the travel analysis highlights choice of place of birth can be a factor over travel time as 25% of the cohort analysed chose to travel further to an FMBU rather than to their nearest maternity unit.

It is however noted that the proposal affects a relatively small number of births (around 344 per year) when compared to the overall number of births at UHNM and UHDB (around 15,033 per year)

Although the FMBU is temporarily closed to births, provision of other aspects of maternity care have continued through the FMBUs such as antenatal and postnatal clinics, therefore appointments and support for low-risk women during their pregnancy is provided closer to home.

Independent clinical review

For complex service change commissioners should consider clinical senate advice. Clinical senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

In April 2024, the Case for Change and associated clinical evidence was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the ICS articulated a credible case for change and the principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. As such, the Senate supported the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson in Lichfield.

The review panel has now published its report which includes five recommendations to support the transformation programme to move forward through the NHS England assurance process for major service changes.

The ICB have accepted the recommendations of the panel and have responded to these recommendations (see section 8.6), to inform this pre-consultation business case.

Key tests of change

The development of proposals and the associated assurance process has been undertaken in line with the process outlined within the Planning, Assuring and Delivering Service Change for Patients guidance[1].

Through the assurance process, NHS commissioners are required to apply the tests of service change. These include the Government's four tests of service change:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test.

The proposals for the services previously provided at County Hospital and Samuel Johnson Community have been developed in line with these tests.

The independent review panel (IRP) evidence submission to Lord Darzi's Independent Investigation of the National Health Service in England and the subsequent report from Lord Darzi's was published during the final stages of the PCBC development. The ICB

[1] p13, Planning, assuring and delivering service change for patients, NHS England 2018

has taken into account the recommendations regarding service change processes, and this is reflected throughout the PCBC.

Next Steps

This pre-consultation business case will be subject to NHS England assurance, before being reviewed by the NHS Integrated Care Board (ICB) as the statutory decision makers. The ICB will then determine the level of further involvement activity is required to inform a decision on long-term provision.

Throughout this process the ICB, UHNM and UHDB are committed to maintaining an honest and transparent dialogue about the challenges and opportunities faced locally. Importantly, partners remain open to new, viable considerations throughout this process. At the heart of this work, is delivering the best care possible for local patients.

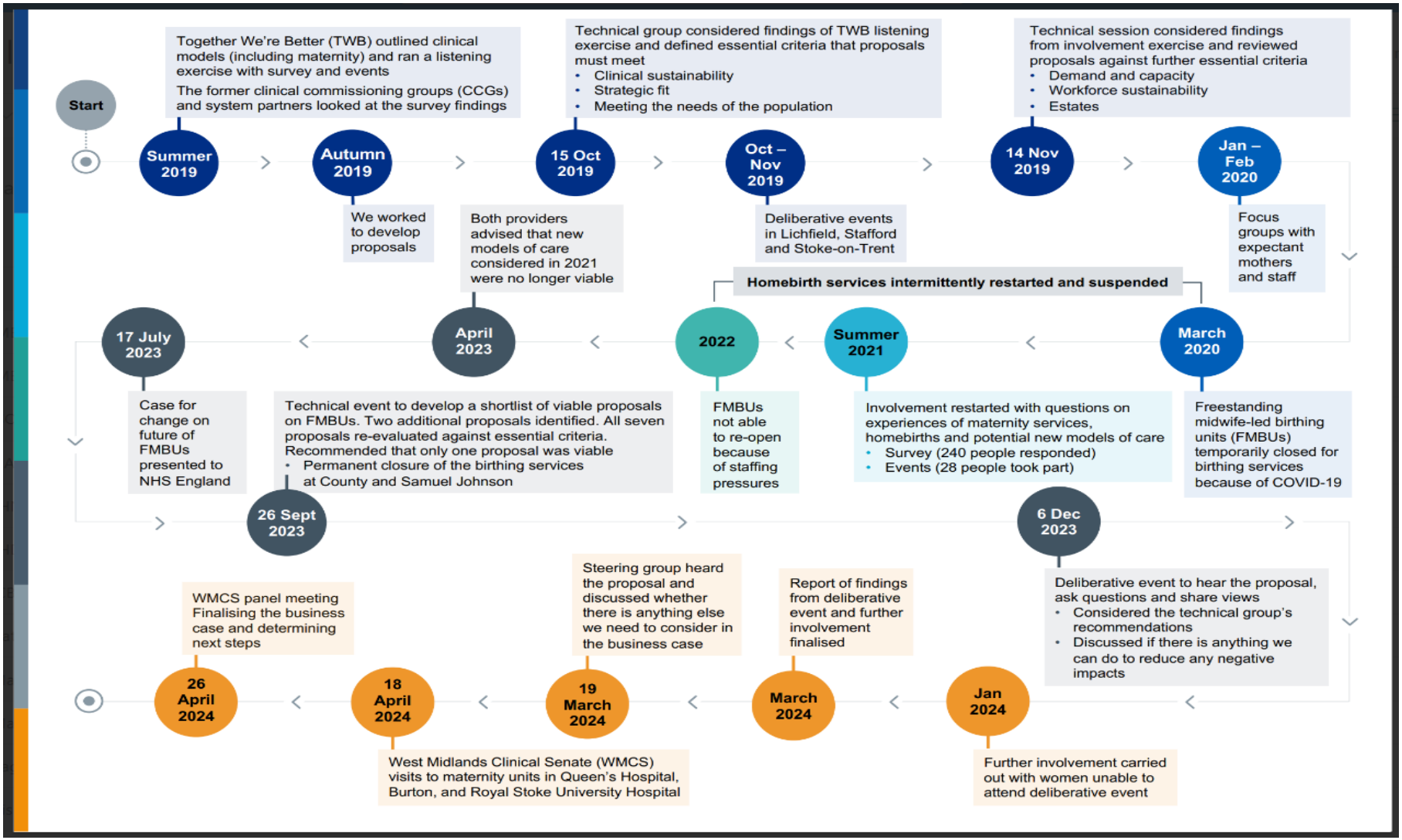


Figure 1: Process timeline leading to the development of proposals.

2 Introduction

Background

This pre-consultation business case (PCBC) is presented by Staffordshire & Stoke-on-Trent Integrated Care Board together with University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) to align commissioning arrangements for the provision of birthing services in Staffordshire and Stoke-on-Trent with national policy, system-wide strategic vision and the established operational position.

The geographic area covered in this proposal includes Staffordshire and Stoke-on-Trent. The proposal takes account of national best practice, clinical quality and safer staffing. It is set against the background of a challenged maternity system and the national 3-year delivery plan for maternity and neonatal services which aims to make care safer, more personalised and more equitable for women, babies and families.

Our vision and commitment

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together a range of partners who are responsible for planning and delivering health and care and for improving the lives of people who live and work in our area. The ICS is the geographical area in which health and care organisations work together. The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes, experience, and access.
- enhance productivity and value for money.
- help the NHS support broader social and economic development.

Meeting the needs of our population

It is well documented that health and wellbeing outcomes are impacted by a whole range of factors related to the circumstances in which we are born, grow, live, work and age. These are known as the ‘wider determinants’ of health. We recognise that there are many factors that impact on the wider determinants of health including socioeconomic factors, physical environment, health behaviours and health care. The biggest factor is socioeconomic where we need to collectively develop the building blocks to have the biggest impact. These building blocks are education, employment, family/social support, income and community safety.

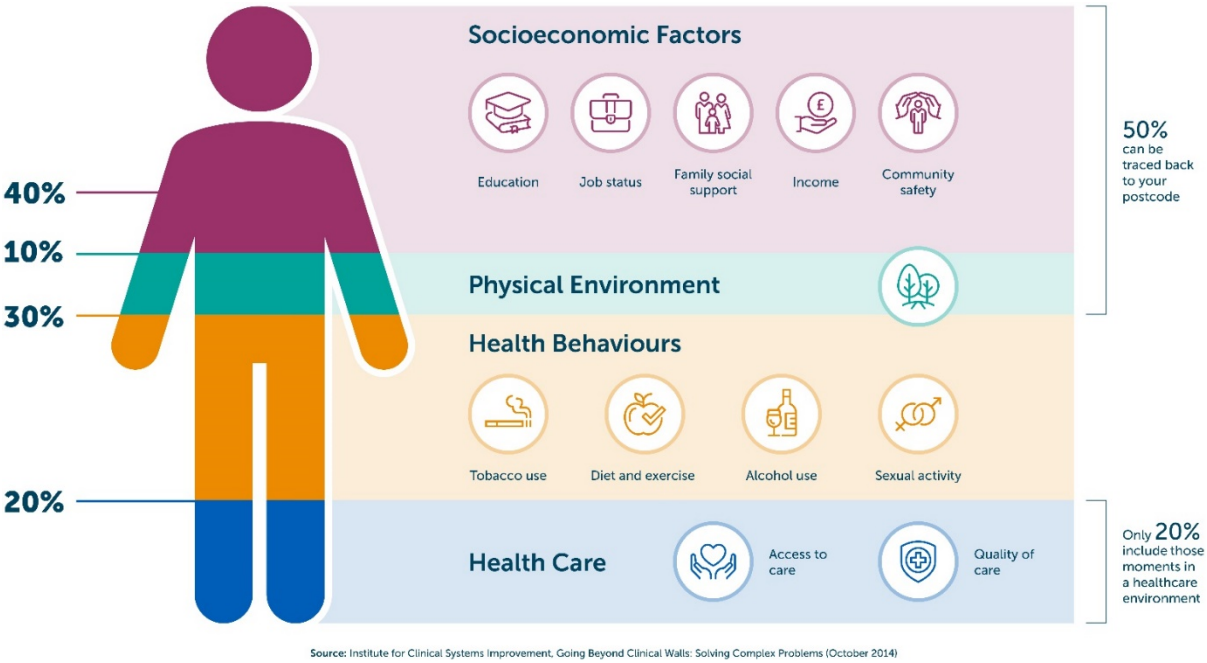


Figure 2: Social Determinants of Health Infographic
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

We know that inequalities can start before birth and can affect all stages in life ('across the life course'). They can impact on outcomes across housing, education, employment, healthy lifestyles, dental, mental health, physical health and loneliness.

Health inequalities in Staffordshire

Staffordshire County Council has recently undertaken a piece of work to analyse data to compare the outcomes of people living in the most deprived areas with the most affluent against the Staffordshire average.

It showed that someone living the most deprived area is:

- 90% more likely to have parents who smoke
- 12% more likely to have a low birth weight
- 2.5 times more likely to be in poverty
- 2.5 times more likely to claim unemployment benefits
- 49% more likely to experience fuel poverty
- 49% more likely to be living alone as an older adult.

Someone living in the most affluent area is:

- likely to live 3.7 years longer
- 47% less likely to have a hospital admission for dental decay
- 21% less likely to be overweight or obese (in year six)
- 41% more likely to achieve English and Maths grades

- 10% less likely to be admitted to hospital because of alcohol harm
- 46% less likely to die from coronary heart disease before the age of 75.

Figure 3: Health inequalities in Staffordshire

Health inequalities in Stoke-on-Trent

Figures for Stoke-on-Trent show:

- Ranked 13th out of 317 across the country for deprivation
- More than half of Stoke-on-Trent areas are in the two most deprived deciles
- The number of people in fuel poverty is higher than the England and West Midlands average
- 29% of children live in absolute low-income families
- The highest rate of infant deaths when compared to England and the West Midlands. This includes neonatal (in the first 28 days after birth) and post-neonatal (28-365 days after birth) deaths, premature births (born before 37 weeks), and low birth weight
- 1 in 6 women smoke through pregnancy (ranked 5th highest in England)
- The number of premature deaths is higher than the England and West Midlands average, with the main reasons being lung cancer, cardiovascular disease and respiratory.

Figure 4: Health inequalities in Stoke-on-Trent

In addition to the information outlined above, each year, there are around 10,500 births from within the Staffordshire and Stoke-on-Trent population with a higher level of multiple births in Stoke-on-Trent compared to Staffordshire, regional and national figures (2021).

Staffordshire low birth weight rates are largely in line with national rates, however there is increased incidence of low birth weight in Stoke-on-Trent. Very low birth weight rates vary between Staffordshire and Stoke-on-Trent, though are generally in line with the national rate.

There is variance across the Staffordshire and Stoke-on-Trent geography in the proportion of births to mothers from ethnic communities; in the Stoke-on-Trent area, the data is in line with national rates, however across the Staffordshire area in general there largely a much lower percentage of births to mothers from ethnic communities (except for East Staffordshire).

The general fertility rates are higher in Stoke-on-Trent when compared against Staffordshire, Regional and National figures, and the proportion of caesarean section

births across the Staffordshire and Stoke-on-Trent are virtually the same, but higher than regional and national rates.

The incidence of hospital admissions for babies under 14 days old is generally higher across the ICB compared to both regional and national figures.

There is variance in the rates of teenage mothers across the Staffordshire and Stoke-on-Trent. Staffordshire is generally in line with regional figures and slightly higher that national figures with Stoke-on-Trent seeing the highest rates in the locality and significantly higher than regional and national figures.

The table below shows pregnancy and birth data captured from the PHE Fingertips website: Source: Public Health England. Public Health Profiles. [09/05/2024] https://fingertips.phe.org.uk

Indicator	Year	Staffordshire	Stoke-on-Trent	Region	England
Percentage of deliveries to mothers from BAME groups	2022/23	9.5%	26.6%	31.1%	25.3%
General fertility rate	2022	53.1 per 1000	60.4 per 1000	55.4 per 1000	51.9 per 1000
Caesarean section	20222/23	38.1%	36.2%	37.6%	37.8%
Multiple births	2021	13.2 per 1000	16.4 per 1000	12.8 per 1000	13.7 per 1000
Low birth weight of all babies	2021	7.1%	8.1%	7.9%	6.8%
Very low weight of all babies	2021	1.2%	0.8%	1.4%	1.0%
Premature births (under 37 weeks gestation)	2019/20		94.2 per 1000	85.9 per 1000	77.9 per 1000
Stillbirth rate	2020-22	3.2 per 1000	3.8 per 1000	4.4 per 1000	3.9 per 1000
Admissions of babies under 14 days	2022/23	127.8 per 1000	203.1 per 1000	92.9 per 1000	84.8 per 1000
Teenage mothers	2022/23	0.9%	1.4%	0.8%	0.6%
Baby's first feed breastmilk	2020/21	63.3%	62.2%	68.3%	71.7%

Table 1: Public Health England pregnancy and birth data

The Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy provides the health and care strategy for the ICS. This strategy outlines how ICS partners will work in partnership to improve the health of our population, including pregnant women

and new families to improve health outcomes across the life course and prevent infant mortality.

In response to the Strategy an ICS Infant Mortality Steering Group and pre-conceptive health working group have formed with leads from stakeholder organisations in the Local Maternity and Neonatal System, Children and Young People and Family Services working in partnership.

These programmes of work have a specific focus on improving the health in women of conceptive age to reduce prevalence of women booking with poor health status or experiencing difficulty managing long term conditions that increase risk of adverse pregnancy and neonatal outcomes.

The developing system pre-conceptive care action plan will address how we improve health and wellbeing in women of conceptive age. Priorities for the action plan from stakeholder engagement, local data and evidence on best practice include:

- Improving community-based women's health service provision
- Access to contraception
- Delivering information and education on pre-conceptive health and healthy behaviours during pregnancy
- Partnership approach to addressing risk factors for poor health in pregnancy and poor neonatal pregnancy outcomes in pregnancy. This includes obesity and excess weight, alcohol, smoking and unmanaged long term health conditions.

3 The Strategic Context

3.1 Introduction

This service change programme is in line with national and local strategy and policy. This section sets out the key drivers for change within maternity and neonatal services and how this programme of work aligns to those strategies and policies.
It includes:

- National strategies and plans
- Local strategies and plans

3.2 National strategy and policy

3.2.1 Better Births

In 2016 the National Maternity Review report; Better Births[2] was published following a major review of maternity services that was initiated in 2015 as part of the NHS Five Year Forward view. The report sets out a clear vision for maternity services;

- **Personalised Care**, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
- **Continuity of carer**, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
- **Safer care**, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby, and family.
- **Multi-professional working**, breaking down barriers between midwives, obstetricians, and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** to provide and commission maternity services to support personalisation, safety, and choice, with access to specialist care whenever needed.
- **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

[2] NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care

To deliver the vision for the future of maternity services, the report outlines a number of recommendations for action, who should take responsibility within local systems and the timescales they should work toward.

3.2.2 The NHS Long Term plan

The NHS Long Term Plan[3] (LTP), formerly known as the 10-year plan, was published in 2019 setting out key ambitions for the NHS over the following 10 years until 2029. It reaffirms key national aims for maternity:

- achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025.
- expand the choices and control people have over their own care – from maternity to end of life.
- implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies.

A number of key drivers and enablers were identified plan to ensure delivery of the aims within the long-term plan. These include;

- Roll out of the Saving Babies Lives Care Bundle[4] (version 2) across every maternity unit in England. The care bundle includes evidence based and best practice care in 5 elements in order to reduce perinatal mortality.
- Establish Maternal Medicine Networks to ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.
- The Maternity Incentive scheme that rewards delivery of 10 key maternity safety actions through a Clinical Negligence Scheme for Trusts rebate.

3.2.3 The Ockenden report

The Ockenden report, published in December 2020[5], was written following a review of safety concerns at Shrewsbury and Telford Hospital NHS Trust. The report outlines 12 specific urgent clinical priorities within seven immediate and essential actions (IEAs) that were shared with Trusts/local maternity systems to improve the quality and safety of maternity services;

- **Enhanced Safety.** Trusts must work collaboratively to ensure serious incidents are investigated thoroughly and Trust Boards must have oversight of these.
- **Listening to women and their families.** Maternity Services must ensure women and their families have their voices heard.
- **Staff training and working together.** Staff who work together must train together and MDT Ward Round Twice Daily.

[3] NHS Long Term Plan, 2019
[4] NHS England » Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality
[5] OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (donnaockenden.com)

- **Managing complex pregnancy.** There must be robust pathways in place for managing women with complex pregnancies.
- **Risk assessment throughout pregnancy.** Staff must ensure that women undergo risk assessments in pregnancy at each contact.
- **Monitoring fetal wellbeing**. Dedicated leads for fetal monitoring who champion best practice in fetal surveillance.
- **Informed Consent.** Women must have access to accurate information to enable informed choice.

Local systems were required to complete a maternity services assessment and assurance tool which included;

- All 7 IEAs of the Ockenden Report
- NICE guidance relating to Maternity
- Compliance against the Clinical Negligence Scheme for Trusts (CNST) safety actions A current workforce analysis.

Systems were required to assess their current position against the above and provide assurance of effective implementation to their public Boards, Local Maternity System and NHSE/I regional teams.

A final report of the Ockenden review was published in March 2022[6]. The report builds on the initial immediate and essential actions and includes 15 recommendations for changes to all maternity services in England. The recommendations within the report fall into four key pillars;

- Safe Staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families;

Systems were required to implement the initial IEAs and report their compliance against the framework. Both Trusts completed the initial reporting requirements and continue to work within the framework as part of their Maternity Improvement Plans.

3.2.4 Birthrate plus®

In addition to implementing the key actions outlined within the Ockenden report, Trust Boards were required to confirm plans and timescales for implementing the Birthrate® Plus standard[7].

Birthrate® Plus is the only national tool available for calculating midwifery staffing levels. It is based on data that has been collected over many years and its use is

[6] OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)
[7] Home - Birthrate Plus®

strongly recommended by the RCM to undertake a systematic assessment of workforce requirements.

The tool is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.

In recognition of the continued workforce challenges that maternity services face, the target date for implementing the maternity continuity of carer model[8] (MCoC) was removed in September 2022. At the heart of the model is the vision that women have consistent, safe, and personalised maternity care and requires appropriate staffing levels to be implemented safely. Focus is instead placed on the retention and growth of the workforce and developing plans that take into account local requirements.

3.2.5 The 'Reading the signals' report

The Kirkup report, published in October 2022[9], was written following an investigation of maternity services at East Kent Hospitals University NHS Foundation Trust. The report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty

Shortly after the publication of the report, NHS England wrote to all systems and outlined the expectation for all Trusts and ICBs to review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

Staffordshire and Stoke-on-Trent ICB reviewed the report at the LMNS Partnership Board and ICB Quality and Safety Committee which in turn reported to the ICB Board. Agreement was received at each that the mechanisms for assurance were adequate and relied on the providers providing assurance through these mechanisms.

Within the letter, NHS England confirmed the upcoming publication of a single delivery plan for maternity and neonatal care but requested that systems do not delay implementing appropriate actions in response to the 'reading the signals' report.

3.2.6 Women's Health Strategy 2022

The Women's Health Strategy for England[10] (published in July 2022 and revised in August 2022) is a 10-year strategy that sets out a range of commitments to improve women's health across their life course. The strategy is underpinned by the findings

[8] B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf (england.nhs.uk)
[9] Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)
[10] Women's Health Strategy for England - GOV.UK (www.gov.uk)

of a listening exercise that generated nearly 100,000 responses from women across England. Views were sought on the following priority areas:

- menstrual health and gynaecological conditions
- fertility, pregnancy, pregnancy loss and postnatal support
- menopause
- mental health and wellbeing
- cancers
- the health impacts of violence against women and girls
- healthy ageing and long-term conditions

The findings of the survey were collated and resulted in a number of key ambitions within the strategy for each of the priority areas.

The key ambitions for pregnancy and maternity care are:

- the NHS is the best place in the world to give birth through personalised, individualised, and high-quality care. Women are treated as equal partners in the planning of their care throughout pregnancy, labour and the postnatal period. Their personalised care and support plans are dynamic and responsive to changes in their clinical needs and choices, and women are supported to make informed decisions during labour.
- disparities in outcomes and experiences of care for mothers and babies are reduced, and all women receive equitable maternity care that is responsive to their individual needs and choices.
- all women with significant medical conditions that pre-date or arise in pregnancy will receive timely specialist care and advice before, during and after pregnancy.
- NHS maternity services will be aspirational workplaces in which multidisciplinary teams work in safe environments and cultures of mutual respect where continuous learning for improvement is the norm.

The strategy outlines a number of key actions for maternity that are being addressed through the NHS England Maternity Transformation Programme such as delivering the Better Births vision to make care safer, more personalised, and more equitable. The strategy also refers to the publication of the refreshed delivery plan for maternity and neonatal services that will set out clear priorities for delivering the maternity and neonatal safety ambitions and providing more personalised care.

The strategy also encourages the expansion of women's health hubs to bring together essential women's services and is expected to include pre-conception advice.

3.2.7 National standards and aims

The three-year delivery plan for maternity and neonatal services was published in March 2023 and consolidates the improvement actions committed to in Better Births,

the Long-Term Plan, the Neonatal Critical Care review[11] and the independent investigation reports at both Shrewsbury and Telford Hospital NHS Trust and maternity and neonatal services in East Kent.

The delivery plan for maternity and neonatal services asks services to focus on four high level themes over the next three years to improve services. These are;

- Theme 1: Listening to women and families with compassion which promotes safer care.
- Theme 2: Supporting the workforce to develop their skills and capacity to provide high-quality care.
- Theme 3: Developing and sustaining a culture of safety to benefit everyone.
- Theme 4: Meeting and improving standards and structures that underpin the national ambition.

The plan outlines a framework for delivery with key actions and metrics identified within each theme. The plan does not introduce new standards for maternity and neonatal teams and instead aims to ensure existing best clinical practice, high quality data and digital tools are consistently implemented in order to address many of the concerns raised in NHS maternity and neonatal services that have been highlighted in recent years.

Theme 1: Listening to women and families with compassion which promotes safer care.

Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Both the National Maternity Review report; Better Births (2016) and the Ockenden Reports (2020, 2022) highlighted the need to ensure care is personalised, equitable and that families have their voices listened to. Several objectives are identified within the delivery plan to ensure these ambitions are met.

Theme 2: Supporting our workforce to develop their skills and capacity to provide high-quality care.

The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. This theme has been highlighted across a number of reports (Better Births 2016, Ockenden 2020 and 2022) over the years, with Trust Boards required to confirm plans and timescales for

[11] NHS England » Implementing the Recommendations of the Neonatal Critical Care Transformation Review

implementing the Birthrate Plus® standard. This standard is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account both of the local birth rate and the complexity of the caseload.

Furthermore, in recognition of the continued workforce challenges that maternity services face, the target date for implementing the maternity continuity of carer model (MCoC) was removed in September 2022. At the heart of the model is the vision that women have consistent, safe and personalised maternity care and requires appropriate staffing levels to be implemented safely. Focus is instead placed on the retention and growth of the workforce and developing plans that take into account local requirements.

This theme further highlights the need to support and develop the workforce and sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills. This plan is informed by the best available evidence such as the Quality Maternal and Newborn Care (QMNC) framework which underpins the NMC midwifery standards and follows the principles of NHS England's workforce planning guidance and builds on the NHS Long Term Plan and NHS People Plan which sets out how improving the experience of people working in the NHS will encourage them to stay in the NHS longer.

Theme 3: Developing and sustaining a culture of safety to benefit everyone.

An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report (2022) stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning.

Both the Better Births and the Ockenden reports clearly highlighted the need to improve the safety of maternity services and ensure professionals are working together across boundaries and ensure serious incidents are investigated thoroughly with Trust Board oversight of these. This theme identifies a number of key actions across three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

Theme 4: Meeting and improving standards and structures that underpin our national ambition.

To deliver the ambition set out in the plan, maternity and neonatal teams need to be supported by clear standards and structures. The plan does not introduce new standards for maternity and neonatal teams and instead aims to ensure existing best clinical practice, high quality data and digital tools are consistently implemented in

order to address many of the concerns raised in NHS maternity and neonatal services that have been highlighted in recent years.

Overall, the plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise their actions by bringing together learning and action from a range of national reports and plans into one cohesive document.

3.2.8 Operational Planning Guidance

The 2024/25 priorities and operational planning guidance[12] (March 2024) makes clear the commitment to transform maternity services to make care safer, more personalised and more equitable.

To achieve this, the guidance asks systems and services to implement the key actions related to the Three-year delivery plan's 4 high-level themes and use the success measures to monitor outcomes and progress.

The guidance further outlines a number of key actions for maternity and neonatal services:

- make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- reduce inequalities in experience and outcomes for the groups who experience the greatest inequalities (Black, Asian, and mixed ethnic groups and those living in the most deprived areas).
- increase fill rates against funded establishment by growing and retaining the maternity and neonatal workforce and continue to invest in the skills and capacity to provide high-quality care.
- agree safe staffing levels for the obstetric workforce in Trusts, and support Trusts to achieve them through action on recruitment and retention.
- ensure all women and families have personalised and safe care, with every woman offered a personalised care plan and being supported to make informed choices.
- consistently implement best practice, including the revised National Maternity Early Warning Score (MEWS)[13] and Newborn Early Warning Trigger and Track (NEWTT-2) tools[14].
- continue to develop a positive safety culture, including regular board-level review of the progress of a focused plan to improve and sustain culture.

For 2024/25 and the following two years, systems and services are also asked to support implementation of the Maternity Safety Package, which includes rollout of the reducing brain injury programme, training an additional 6,000 midwives in neonatal

[12] PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)
[13] New Maternity Early Warning Score to be implemented in the NHS | NIHR
[14] NEWTT2 | British Association of Perinatal Medicine (bapm.org)

resuscitation, nearly doubling the number of clinical staff receiving specialist training in obstetric medicine, funding 160 new midwife posts over three years, and funding to support the rollout of maternity and neonatal voice partnerships.

ICBs are also asked to work in partnership with local authorities to:

- establish and develop at least one women's health hub in every ICB by the end of December 2024 in the line with the core specification, improving access, experience, and quality of care. NHS England will work with ICBs to ensure that at least 75% have a hub in place by July 2024 that meets minimum requirements, including a virtual option.
- support and develop universal services for pregnancy and beyond in family hubs.

3.3 Local strategy and policy

3.3.1 ICP Strategy

Our strategic approach to understand the needs of the population and improving services for local people and communities is outlined in our Integrated Care Partnership Strategy[15] .

We will do this by;

- Improving health and wellbeing of our people and communities.
- Ensuring personalised care.
- Empowering individuals to take personal responsibility for their health and wellbeing.
- Focussing on prevention and health inequalities.
- Productivity – making best use of our resources.

3.3.2 Staffordshire and Stoke-on-Trent Joint Forward Plan

The Joint Forward Plan[16] (JFP) outlines how the Integrated Care System (ICS) will support the delivery of the ambitions articulated in the ICP Strategy describing our collective priorities over the period 2023 to 2028. The JFP describes how the ICB and its partner Trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of the population. These ambitions are aligned to the core national, regional and local strategic drivers of the NHS, including the NHS Long Term Plan (LTP), the Health and Care Act and the Core20PLUS5[17] approach. This document is the first JFP for NHS partners since the inception of the statutory ICS in Staffordshire and Stoke-on-Trent.

3.3.3 Alignment with ICS maternity plans

The local maternity and neonatal system team have led conversations with system partners to ensure our strategic direction is one that meets the requirements of the national directives but also meets the need of our population. The strategic vision is to:

- Empower women, and their partners, by putting them at the centre of their care so they have the best support.
- Design a service that supports women to access a team of midwives, who have worked with them to develop their own personal birth plan.
- Provide a network of places where women can choose to have their care, that are high quality and safe, have the right staff skill-mix and also represent value for money.

[15] Staffordshire and Stoke-on-Trent Integrated Care Partnership ICP Strategy (icb.nhs.uk)
[16] Staffordshire and Stoke-on-Trent Joint Forward Plan 2023-2028 - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)
[17] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

- To provide continuity of carer during pregnancy, birth and beyond to those most vulnerable in our community
- Make the best use of our staff, allowing them to work more flexibly and really get to know the women and families in their local communities.
- To develop and sustain a culture of safety which reduces inequalities in outcomes.

This vision coupled with the ICS' commitment in the Joint Forward Plan[18] to ensuring that all activities in the maternity and neonatal programme will support achievement of the four themes of the National Delivery Plan[19] is the strategic backdrop to the proposals for the future of the FMBUs.

3.3.4 The local maternity and neonatal system (LMNS)

The local maternity and neonatal system (LMNS) is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices partnerships, who are working together to transform maternity services in Staffordshire and Stoke-on-Trent.

Our LMNS, despite the challenges created by the pandemic, has continued to develop a system approach to maternity and neonatal care, identifying where we can make a positive change to our services and improve care for women, babies and their families.

Pre-Covid, the focus of the LMNS has been transformation. However, in line with national policy, the responsibility and make-up of the team has changed to ensure that as well as transformation, quality surveillance, governance and reporting of the systems services is robust.

The LMNS Partnership Board provides the strategic direction for development of maternity services and ensures that the deliverables as outlined in the 3-year delivery plan for maternity and neonatal care are achieved across the whole ICS on time and in a cost-effective manner. This together with the local Equity and Equality Action Plan[20] sets out how the system will work together to address the challenges identified and improve outcomes for those accessing our local services.

Strategic leadership, partnership engagement and assurance are delivered through the Board and wider project structures, ensuring the priorities set out in the delivery plan are realised. Assurance is provided to regulators and external partners, as and when required that the Staffordshire and Stoke-on-Trent system is delivering the requirements laid out in the national plan.

[18] Joint Forward Plan 2023-2028 - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)
[19] B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)
[20] View our equity and equality plan here.

The Staffordshire and Stoke-on-Trent LMNS partnership board has Memorandums of understanding in place with its neighbouring ICB's to support shared learning and working together, in particular with Derby and Derbyshire ICB as the lead commissioner of services at UHDB. We also work closely with Birmingham and Solihull ICB and Black Country ICB.

3.3.5 Maternity and Neonatal Equity and Equality Plan

The MBRACE-UK report[21] about maternal and perinatal mortality shows worse outcomes for those from black, Asian and mixed ethnic groups and those living in deprived areas. All Local Maternity and Neonatal system must implement a Maternity and Neonatal Equity and Equality Plan to set out how the system will work together to address the challenges identified and improve outcomes for those accessing local services by:

- improving equity for mothers and babies from black, Asian, and mixed ethnic groups and those living in the most deprived areas, and
- promoting race equality within staff groups.

All systems must work to address five key priorities:

- Priority 1: Restore NHS services inclusively.
- Priority 2: Mitigate against digital exclusion.
- Priority 3: Ensure datasets are complete and timely.
- Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes.
- Priority 5: Strengthen leadership and accountability.

Each priority includes key process and outcome indicators that each LMNS must monitor and report on their compliance.

Staffordshire and Stoke-on-Trent at their LMNS Partnership Board meeting in March 2024 agreed to fund a 12-month pilot Equality, Diversity and Inclusion (EDI) midwife to support the progression of the Equity and Equality Action plan. This will ultimately improve outcomes for those within the at-risk groups.

3.3.6 Maternity and Neonatal Independent Sector Advisor (MNISA)

The MNISA is a new senior role being piloted to support women and their families in England when they are involved in an investigation or complaint relating to their maternity or their baby's neonatal care.

The MNISA role aims to provide independent guidance and support to women and families affected by an adverse outcome following an episode of maternity or neonatal care, and to use this feedback to bring about system change and improvement.

[21] MBRRACE-UK_Maternal_Compiled_Report_2023.pdf (ox.ac.uk)

MNISA's receive specialist training to support families navigating some of the complex investigation processes which follow an adverse outcome such as a significant health complication or bereavement. Advocates are also able to share families feedback, compliments and concerns (with their permission) to ensure that they are listened to, heard and used to shape and improve care for women, babies and families.

The MNISA for Staffordshire and Stoke-on-Trent can provide support to any family who has received maternity or neonatal care at:

- The Royal Stoke University Hospital/County Hospital, Stafford (University Hospitals of North Midlands)
- Queen's Hospital, Burton/Samuel Johnson Community Hospital, Lichfield (University Hospitals of Derby & Burton)
- New Cross Hospital/Cannock Chase Hospital (Royal Wolverhampton Trust)

Recent reports and inquiries into maternity and neonatal care identify a range of adverse outcomes that can occur during care. During the initial pilot phase, the MNISA can support families if they have experienced any of the following adverse outcomes:

- Where a baby has been stillborn (after 24 weeks of your pregnancy).
- Where a baby has died at or in the first 28days after their birth.
- The baby's mother has died within one year of pregnancy/childbirth (and of a related cause).
- Unexpected or unplanned hysterectomy at/or within 6 weeks of pregnancy or childbirth.
- Unexpected admission to the critical or intensive care unit as a result of a complication associated with pregnancy/childbirth.
- Where a baby had, has or may have a brain injury.

The role of the MNISA is to guide families through any investigation and complaint processes and attend inquests/meetings with professionals with the families. The MNISA also supports families through the maternity and neonatal healthcare system to help them understand what happened to them or their baby and offer signposting to support organisations.

In addition to supporting families, the MNISA will regularly report to LMNS and Trust level boards, providing robust feedback and recommendations to improve service user experience and patient safety.

The role and learning themes identified across all MNISA pilots will be evaluated nationally to highlight key improvement areas. This is expected in the Autumn of 2025.

3.3.7 The maternity and neonatal voices partnership (MNVP)

The MNVP listens to the experiences of women and families and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

The Staffordshire and Stoke-on-Trent MNVP has an independent chair and includes a team of champions (volunteers who are local service users), a project support officer, the Local Maternity and Neonatal System, commissioners and providers (midwives, neonatal nurses and doctors) working together to review and contribute to the development and co-production of local maternity care.

Listening and responding to all women and their families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services within our system and helps address health inequalities. The MNVP's focus is to gather feedback from women/birthing people and their families around their experiences, to help shape the future of local maternity services and drive forward improvement.

Our Equity and Equality Action Plan aims are to improve equity for mothers and babies from black, Asian, and mixed ethnic groups and those living in the most deprived areas, and to promote race equality within staff groups. The MNVP will seek out and listen to these voices to ensure services are representative of the whole local population.

4 Birthing services case for change

4.1 Introduction

This section sets out the case for change for proposals for birthing services previously provided at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield.
It includes:

- Local context
- The clinical sustainability case for change
- The workforce sustainability case for change

4.2 Local context

Maternity services in Staffordshire and Stoke-on-Trent in recent years have been provided from a number of locations;

- Consultant-led births in Royal Stoke University Hospital and Queen's Hospital, Burton
- Midwife-led births in Royal Stoke University Hospital and Queen's Hospital, Burton
- Freestanding Midwifery birth units at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
- Home birth services

All women are asked about their preferred choice of place of birth during an assessment with the midwife. The midwife will take a number of factors into consideration including a woman's weight, age, overall health and any history of previous deliveries. The table below illustrates the differences between the maternity services available in our area and the key benefits of each of these.

Service	Current location	Suitable for high-risk pregnancy?	Other benefits
Consultant-led births	• Royal Stoke University Hospital • Queen's Hospital, Burton	**Yes**	• Doctors and specialists on hand • An epidural (pain-relief injection) can be given
Midwife-led births	• Royal Stoke University Hospital • Queen's Hospital, Burton	**No**	• Non-clinical environment • Low-risk births only • Less likely to need intervention • Close to consultant-led unit for ease of transfer
FMBUs **(temporarily suspended)**	• County Hospital, Stafford • Samuel Johnson Community Hospital, Lichfield	**No**	• Non-clinical environment • Low-risk births only • Less likely to need intervention
Homebirths	• In patients' homes throughout Staffordshire and Stoke-on-Trent	**No**	• Familiar environment with family around you • Less likely to need intervention, especially if not first birth

Table 2: maternity services by type and location

Freestanding Midwifery Birth Units are midwife-led units, separate from an acute hospital, where some pregnant women (considered low-risk) can choose to give birth. They do not provide immediate obstetric, neonatal, or anaesthetic care, so people may need to be transferred to an acute hospital if there are complications during or after birth.

Women also have the choice of alternative providers outside of Staffordshire and Stoke-on-Trent. Data from 2019/20 indicates that around 24% (26,732/11,468) of births for the Staffordshire and Stoke-on-Trent population occur in hospitals that are outside of our local area. Both local and out of area maternity services are illustrated in the below map.

Figure 5: Local and out of area maternity services

The table below provides further detail on the utilisation of services within the Staffordshire and Stoke-on-Trent area compared to services that border our local area and those that are out of area. These figures cover all birthing services. Since 2019/20 an additional 121 women have delivered in neighbouring area units however the data does not identify whether these were within consultant-led units or within midwife-led units.

	2019/20	2020/21	2021/22	2022/23	2023/24
In area services	8736 (76.18%)	8275 (75.60%)	8293 (74.82%)	8154 (73.31%)	7783 (72.94%)
Neighbouring area services	2582 (22.51%)	2527 (23.09%)	2642 (23.84%)	2770 (24.90%)	2703 (25.33%)
Out of area services	150 (1.31%)	144 (1.32%)	149 (1.34%)	199 (1.79%)	184 (1.72%)
Total	**11468**	**10946**	**11084**	**11123**	**10670**

Table 3: Maternity service utilisation

4.2.1 Royal Stoke Hospital

The University Hospitals of North Midlands NHS Trust provides general acute hospital services for approximately 900,000 people in Staffordshire, South Cheshire and Shropshire. The Trust also provides specialised services for three million people

across a wider area, including neighbouring counties and north Wales. These specialised services include cancer diagnosis and treatment, cardiothoracic surgery, complex orthopaedic surgery, laparoscopic surgery, the management of liver conditions, neurosurgery, neonatal intensive care, paediatric intensive care, renal and dialysis services, respiratory conditions, spinal surgery, trauma and upper gastrointestinal surgery. The Trust employs over 10,000 staff and has more than 1,250 inpatient beds. Services are provided at Royal Stoke University Hospital, County Hospital and a small number of community settings.

Royal Stoke University Hospital is the main site for all maternity services for the Trust, with County Hospital providing a range of antenatal and postnatal services. There were just under 6,000 deliveries in total during 2023/24. The Royal Stoke unit comprises of a delivery suite with maternity theatres, induction of labour beds and enhanced recovery area. There are antenatal and postnatal wards, a midwifery birth centre, a day care assessment area and maternity assessment unit (triage). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, fetal medicine and maternal medicine services. These services are available to pregnant women from across Stoke-on-Trent and Staffordshire.

In October 2014, the Mid Staffordshire NHS Foundation Trust (Stafford) was formally dissolved and services were transferred to University Hospitals of North Midlands NHS Trust and The Royal Wolverhampton Hospitals NHS Trust.

As part of this dissolution, the Trust Special Administrators (TSA) detailed a number of service moves that needed to take place in order to ensure clinical and financial sustainability. All of the proposed changes were validated by local clinical groups (commissioners and providers) and national clinical bodies including the relevant Royal Colleges.

As these were major changes to service provision, the proposals were subject to extensive consultation with the public, GPs and other stakeholders during summer/autumn 2013. A report and recommendations were delivered to the Secretary of State in December 2013. The proposals were signed off by the Secretary of State in February 2014. Implementation of those recommendations followed from November 2014.

One of the services that the TSA recommended to be moved during the consultation was consultant-led obstetrics. The two main factors behind the recommendation to move obstetrics were:

- a consultant-led obstetric unit needs other support services such as neonatology, paediatrics, intensive or critical care services, general surgery and anaesthetics. Many of these services had already been moved to the RSUH site as part of the TSA recommendations and therefore the consultant-

led obstetrics unit needed to move due to the interdependency of these services.

- the consultant-led obstetric unit in Stafford was one of the smallest maternity units in the country. In 2012/13 it ranked 127 out of 139 maternity services in England based on its number of births.

The TSA stated that a midwife-led unit would need to manage a minimum of around 350 births a year to cover the cost of the service and the evidence used in the draft report showed this number would not be achieved. This also aligned with the Royal College of Midwives' guidance for setting up and sustaining freestanding midwifery birth units.

4.2.2 County Hospital, Stafford

NHS England's publication *Better Births: Improving outcomes of maternity services in England* recommends the development of community hubs to: "help every woman access the services she needs, with obstetric units providing care if she needs more specialised services."

The Women's Unit, which was developed at County Hospital, has historically provided a range of services that the national review recommends in a community hub, including:

- consultant-led antenatal clinics
- community midwives base
- a homebirth team
- diagnostics including ultrasounds and glucose tolerance testing.

The Community Midwifery Team provide antenatal care, booking clinics, postnatal care and an on-call rota to support the homebirth service and the FMBU birth activity. It also means that all maternity-related outpatients and gynaecology procedures such as colposcopy, hysterectomy and urogynaecology clinics are physically co-located.
Antenatal services continue to be offered at County Hospital and include:

- Antenatal clinics throughout pregnancy
- Routine ultrasound scanning
- Glucose Tolerance Testing (GTT) clinics
- Vaginal birth after caesarean section clinics
- Lifestyle clinics
- Vaccination services

The Trust has continued to offer postnatal care at the unit in addition to the range of antenatal services that are offered. This also includes support services such as the bereavement service and the Birth Afterthought clinic.

Prior to the temporary closure of birthing services, the unit at County hospital provided a low-risk birthing option. This consisted of **two rooms** (Labour, Delivery, Recovery

and Post-Partum rooms, also known as LDRP rooms). These allow mothers to give birth, bond with their baby and recover in one place until families are ready to go home.

The temporary closure of birthing services at County Hospital means it is these two rooms that have not been utilised for births since March 2020. All other services as described above continue to be offered at the site with LDRP rooms available at Royal Stoke Hospital.

4.2.3 Queen's Hospital, Burton

The University Hospitals of Derby and Burton NHS Foundation Trust provides acute and community services to people in Derbyshire and Staffordshire. In total the Trust has around 1,700 beds and employs around 13,000 staff. The Trust is comprised of two hospitals; Royal Derby Hospital and Queens Hospital, Burton. University Hospitals of Derby and Burton NHS Foundation Trust also provides community inpatient services in Derbyshire and Staffordshire.

Queens Hospital Burton is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and Northwest Leicestershire. It provides a range of maternity services including both antenatal and postnatal ward as well as an antenatal clinic. There are approximately 2700 deliveries each year, with caesarean sections and options for pool-based birth.

Community services include community health inpatient services, community end of life services, community urgent care services and community services for adults. These are provided across three locations; Sir Robert Peel Hospital, London Road Community Hospital and Samuel Johnson Community Hospital. Across the Trust locations, University Hospitals of Derby and Burton NHS Foundation Trust has 75 wards and 50 operating theatres.

4.2.4 Samuel Johnson Community Hospital, Lichfield

The Samuel Johnson Community Hospital is part of University Hospitals Derby and Burton NHS Foundation Trust. The hospital provides a minor injuries unit, medical care and rehabilitation on two wards, maternity services and outpatients. The hospital is based in Lichfield, 13 miles from the main Trust site in Burton Upon Trent.

The community midwifery team based at Samuel Johnson Community Hospital provide antenatal care, booking clinics, postnatal care and have historically, run an on-call service to support the homebirth service and the FMBU birth activity.

Antenatal and postnatal clinics continue to be offered at the site and the newborn hearing screening team attend and host clinics.

Prior to the temporary closure of birthing services, the unit at Samuel Johnson Community Hospital provided a low-risk birthing option. This consisted of three rooms (Labour, Delivery, Recovery and Post-Partum rooms, also known as LDRP rooms). These allow mothers to give birth, bond with their baby and recover in one place until families are ready to go home.

The temporary closure of birthing services at Samuel Johnson Community Hospital means it is these **three rooms** that have not been utilised for births since March 2020. All other services as described above continue to be offered at the site with LDRP rooms available at Queen's Hospital, Burton.

4.2.5 Low risk maternity pathway

The figure below illustrates the routine care pathway for low-risk pregnancies.

Low-risk women are supported within their local community, rather than within an inpatient setting, for both antenatal and postnatal care. In addition to offering this support at County Hospital and Samuel Johnson Community Hospital, women can also access these services within alternative community sites or clinics held within GP practices across Staffordshire and Stoke-on-Trent.

Planning where to give birth begins early in pregnancy. Maternity staff in Staffordshire and Stoke-on-Trent are trained to provide up to date information to help support this individual care planning. Women who are at low risk of having complications are currently offered a choice of place of birth either at home, in an alongside midwifery birth centre or a consultant unit. Individual circumstances and choices, including what would happen if an obstetrician needs to be involved, are discussed and a personalised plan put in place.

Throughout the pregnancy the named community midwife undertakes a risk assessment at each contact and within the last trimester will support the woman to develop their birth plan. Discussions about the safest place to give birth are evidence based and those at low risk of complications are encouraged to choose a midwifery led care pathway in line with the Birthplace study[22].

- For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother and those women who had births in a midwifery led setting were far less likely to have a caesarean section, instrumental delivery or episiotomy.
- For women having a first baby, a planned home birth increases the risk for the baby.
- For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth.

[22] Microsoft Word - Report 1_Safety of birthplace and implications overview Feb 2016

- For women having a second or subsequent baby, the transfer rate is around 10%.

The birth plan includes the planned choice of place of birth, any special wishes for during labour such as who will support as birth partner and pain relief.

Both providers offer a home birth service where community midwives provide the care. Each Trust also offers a midwifery led care setting within the main maternity units.

Royal Stoke Hospital has 4 Midwifery led care (MLC) rooms which are close to the consultant unit with a very short transfer time if medical support is needed. This area is staffed by Midwives and support workers and is protected capacity for low-risk births. There is also a birthing pool here. Whilst there are designated rooms for low-risk births within the midwife-led unit at Royal Stoke, additional capacity is available within the consultant-led unit. If additional capacity were required, women would be supported to have a midwife-led birth within the consultant-led unit.

Queens Hospital, Burton have 2 rooms identified on the consultant birth centre for use by women on an MLC pathway. This is protected capacity for low-risk births but further rooms can be flexed to support low risk care if required. A birthing pool is available and Midwives are allocated from core maternity unit staff.

Both Trusts are committed to retaining midwifery led birthing options for women on a low-risk pathway as seeking the safest outcomes for mother and baby are paramount. Birthrate plus assessments (described in more detail in section 4.4) ensure there are the right number of midwives are in place to support both low and high-risk pathways. This assessment is completed every three years to take into account any changes in the local birthrate and the complexity of those births.

The birthing element (labour and birth) account for one day within a low-risk pathway and is the area within scope of this PCBC. The proposal would not directly impact the end-to-end pathway for maternity services. Women continue to be assessed throughout their pregnancy, as described above, to check for any developing risk factors or complications, which may require a change of delivery options. There would be no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the TSA (for UHNM).

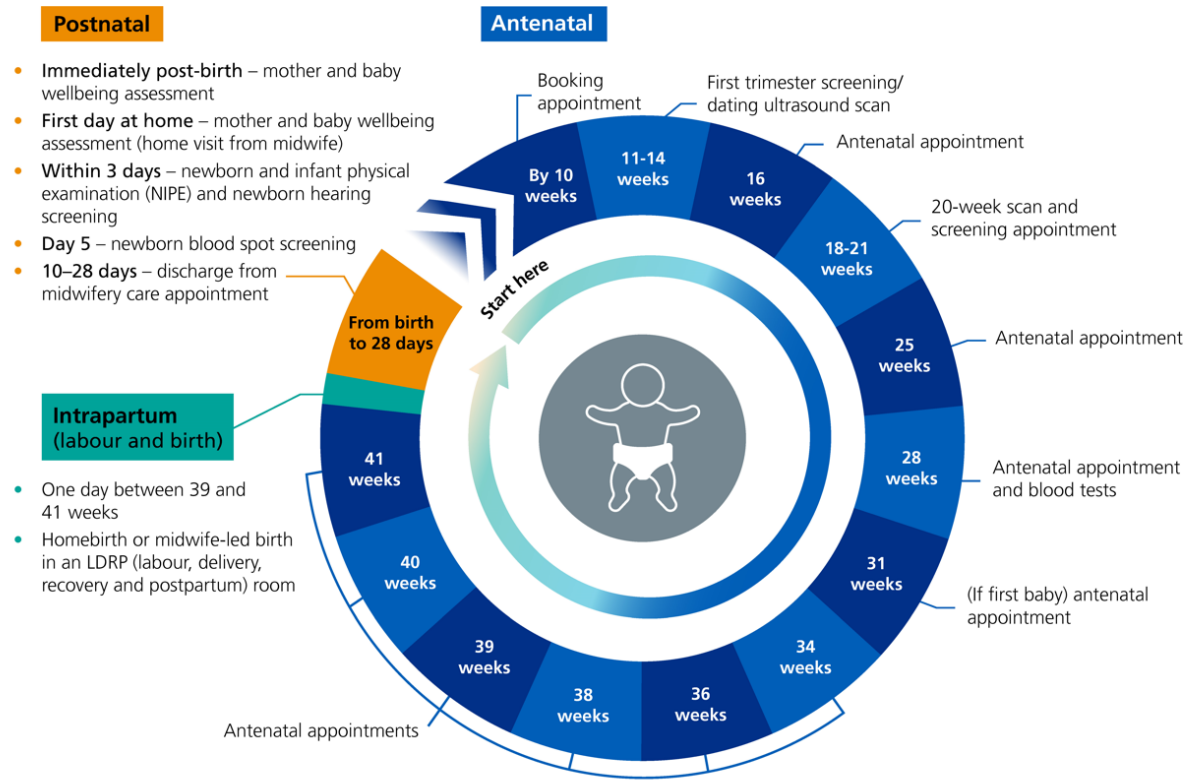


Figure 6: routine care pathway for low-risk pregnancies

4.3 Local challenges

Birthing services (labour and birth) at the Freestanding Midwifery Birth Unit (FMBU) at County Hospital, Stafford provided by University Hospitals of North Midlands and Samuel Johnson Community Hospital (SJH), Lichfield, provided by University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), were temporarily suspended in March 2020 at the beginning of the COVID-19 pandemic. This enabled maternity staff to be redeployed to the Trusts maternity units in accordance with guidance published by Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) in April 2020 *(Guidance for the provision of midwife led settings and homebirth in the evolving coronavirus pandemic, April 2020).*

Home birth services have also been intermittently suspended following the pandemic and neither Trust has been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage until recently. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

Whilst the initial closures were directly related to COVID-19, staffing challenges in the maternity workforce historically prevented both Trusts from being able to safely reopen these units to birthing services.

Given the learning from high profile investigations into maternity services e.g. Shrewsbury and Telford / East Kent / Nottingham there is greater focus on the delivery of safe staffing levels across the breadth of maternity services.

Both Trusts continue to provide antenatal and post-natal care at their FMBUs and offer the choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen's Hospital Burton.

The current position continues with the arrangements described above. Women who may have previously chosen to give birth in one of the FMBUs are offered a midwife-led birth at the acute Trusts. Women also have the option to give birth at home. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

4.4 Clinical sustainability case for change

A major influence for the proposal is the rising complexity of women being seen. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the number of midwives required to provide antenatal, intrapartum and postpartum care. Birthrate Plus® assessments are completed for a particular Trust's footprint based on clinical indicators of the wellbeing of the mother and infant(s) throughout labour and delivery within a given unit. The tool is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.

The Birthrate Plus® assessment completed in 2022 for UHNM also shows that the complexity of women at the birthing units has increased significantly over the years. 69.9% of women in the UHNM delivery suite are in the highest levels of complexity categories IV & V. These women would only be cared for at Royal Stoke University Hospital. 96.5 % of women on the delivery suite are moderate or high risk, which means that 83.2% of all women at UHNM are moderate or high risk overall.

The continued increase in case mix complexity means that potentially less than 17% of women may be suitable for low-risk care across the UHNM footprint (this was 29% in 2017/18 at the point the West Midlands Clinical Senate originally reviewed the service at UHNM).

UHNM Royal Stoke maintains a full service for the alongside Birthing Centre, offering low risk midwife-led care to all women who are suitable.

Despite repeated campaigns to promote the FMBU, women choosing to give birth there continued to fall. By 2019/20 this had dropped to less than 1.6% of all UHNM births.

It is also of note that the Birthrate Plus® assessment at UHNM did not take into consideration the provision of birthing services at Stafford as it was closed at the time. For UHNM to re-open birthing services at the FMBU with the same staffing model as before a further investment of 12.15wte band 7 midwives would be required.

The Birth-rate Plus® assessment completed in 2021 for UHDB identified that between 63.9% (QHB) and 68.9% (RDH) of women were in the two highest levels of complexity categories of care, IV and V, a percentage that is higher than the average for England of 58% (based on 55 maternity units from a wide range of size and location), and a figure that had risen by 6% since the previous Birth-rate Plus® assessment in 2017. These women would only be cared for at either QHB or RDH where there is obstetrician-led care. Overall, the 2021 Birthrate Plus® assessment showed that just over 82% of all births at UHDB fall into the moderate or high-risk categories.

Complexity of workload has continued to rise since 2021 with more women presenting with comorbidities and requiring consultant-led care. These factors substantially reduce the number of women suitable for low-risk care than prior to the temporary suspension of births at Samuel Johnson Community Hospital.

Similar to UHNM, UHDB saw low numbers of women choosing to give birth at the FMBU at SJH despite promoting the FMBU. In 2019/20, 2.5% of all UHDB births were at the FMBU.

Complexity of workload has continued to rise since the Trusts Birthrate Plus® reports were finalised with more women presenting with comorbidities and requiring consultant-led care. These factors substantially reduce the number of women suitable for low-risk care than prior to the temporary closures of birthing services at the FMBUs.

It is recognised that a whole system approach is required to improve the overall health of the population and in turn increase the number of low-risk pregnancies and births. The Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy outlines how ICS partners will work to improve the health of our population, including pregnant women and new families to improve health outcomes across the life course and prevent infant mortality (described in further detail in Section 2).

Better Births (2016) recommended that maternity services should develop a continuity of carer model to ensure safer care based on a relationship of mutual trust and respect

between women and their midwives. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the National Maternity Review.

During the pandemic in 2020, the full scale roll out of the model was paused, recognising the workforce challenges services were experiencing at the time.

Understanding the change in demographics of women in Staffordshire and Stoke-on-Trent has enabled both Trusts to develop equity and equality plans to support those most vulnerable and at risk of poorer outcomes including a targeted approach to continuity of carer. This enhanced model of care will ensure, that in line with the NHS Long Term Plan, communities in need can be targeted to ensure equity of outcomes is improved.

Both Trusts plan to introduce geographically based teams who will work with pregnant women from the most deprived areas and provide continuity of carer across the whole maternity pathway. Utilising the midwifery workforce in a more targeted way rather than through the FMBU will ensure those most in need are supported.

In 2019/20, 94 women (an average of 8 per month) gave birth at County Hospital and 220 women (an average of 18 per month) gave birth at Samuel Johnson Community Hospital. A previous Trust Special Administrator (TSA) review of maternity services at County Hospital recommended that the unit manage a minimum of 350 births per year to be clinically and financially viable. There were not enough births in the FMBU to ensure this. The number of births per year at the Samuel Johnson Community Hospital also fell short of this number.

The number of births within the FMBUs in the years prior to the temporary closure is included in the table below. There is no available data beyond March 2020 as the units have remained temporarily closed to births and therefore no women have given birth within these units.

Freestanding Midwifery Birth units	Number of Births				
	2015/16	2016/17	2017/18	2018/19	2019/20
Samuel Johnson Hospital	not available*	187	260	216	220
County Hospital	121	137	116	90	94

Table 4: Number of births at the freestanding midwifery birth units

*Due to the merger of Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals Foundation Trust and the subsequent merger of clinical system, data from 2015/16 is unavailable

The graphs below, show the demographics of women using the FMBUs. The graphs highlight where women gave birth within the FMBU or were transferred to an acute hospital after initially arriving at the FMBU. As the units have remained temporarily closed to births since March 2020, the most recent data from 2019/20 has been illustrated.

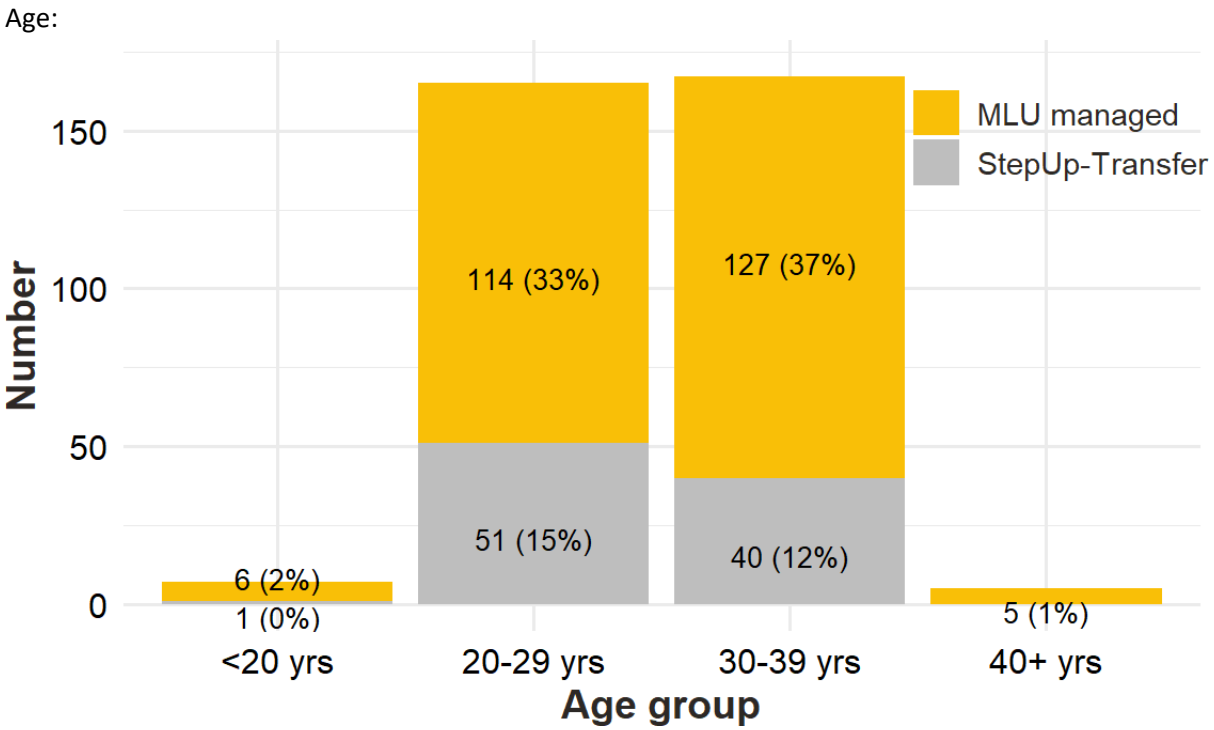


Figure 7: age group of people who used intrapartum services at the FMBUs during 2019/20

Deprivation:

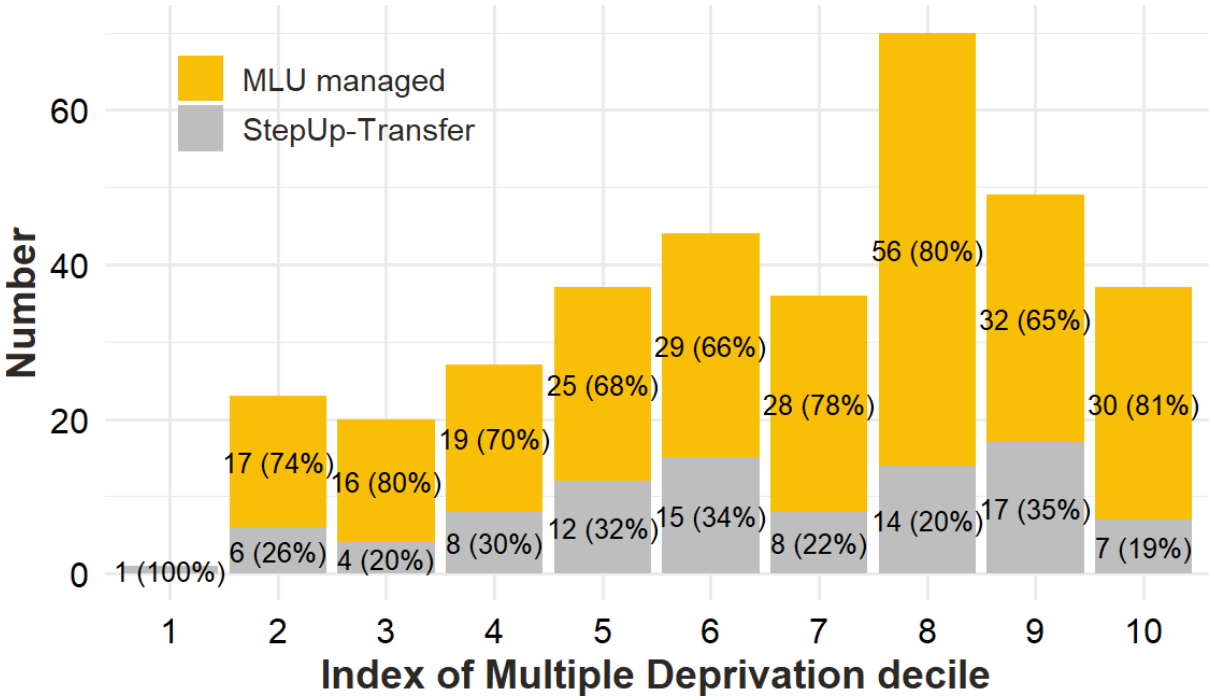


Figure 8: IMD deciles of people who used intrapartum services at the FMBUs during 2019/20

Ethnicity:

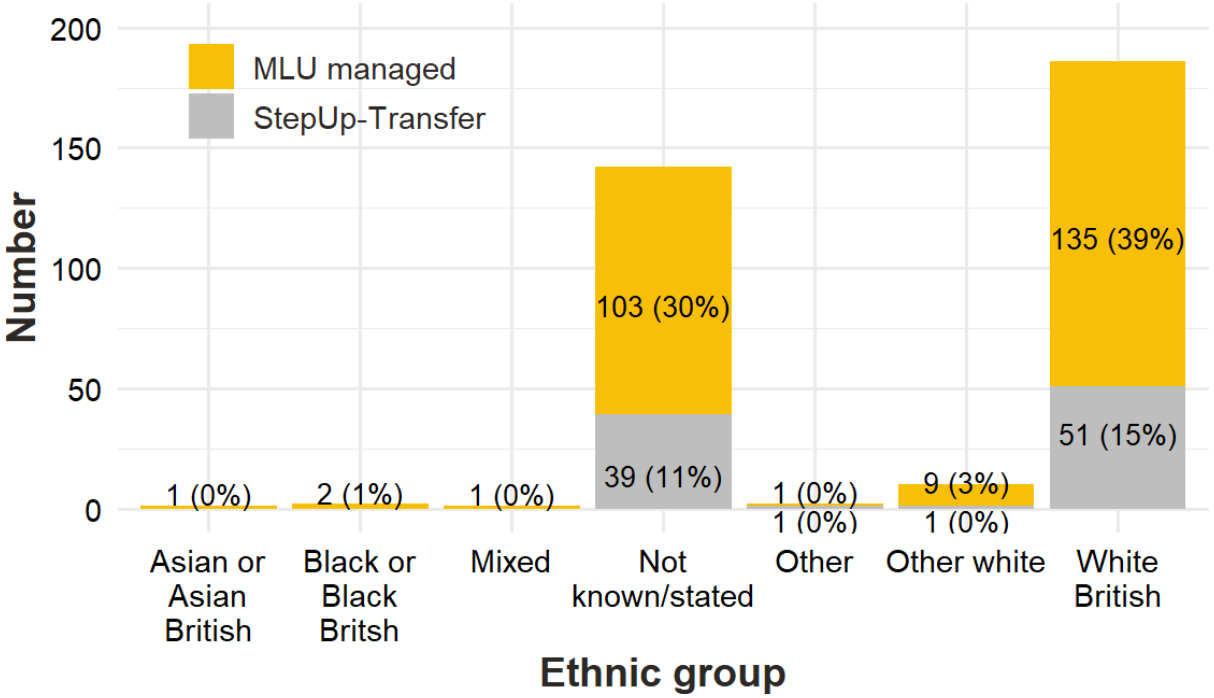


Figure 9: Ethnic group of people who used intrapartum services at the FMBUs during 2019/20

The map below highlights the place of residence of those that gave birth within the FMBUs during 2019/20:

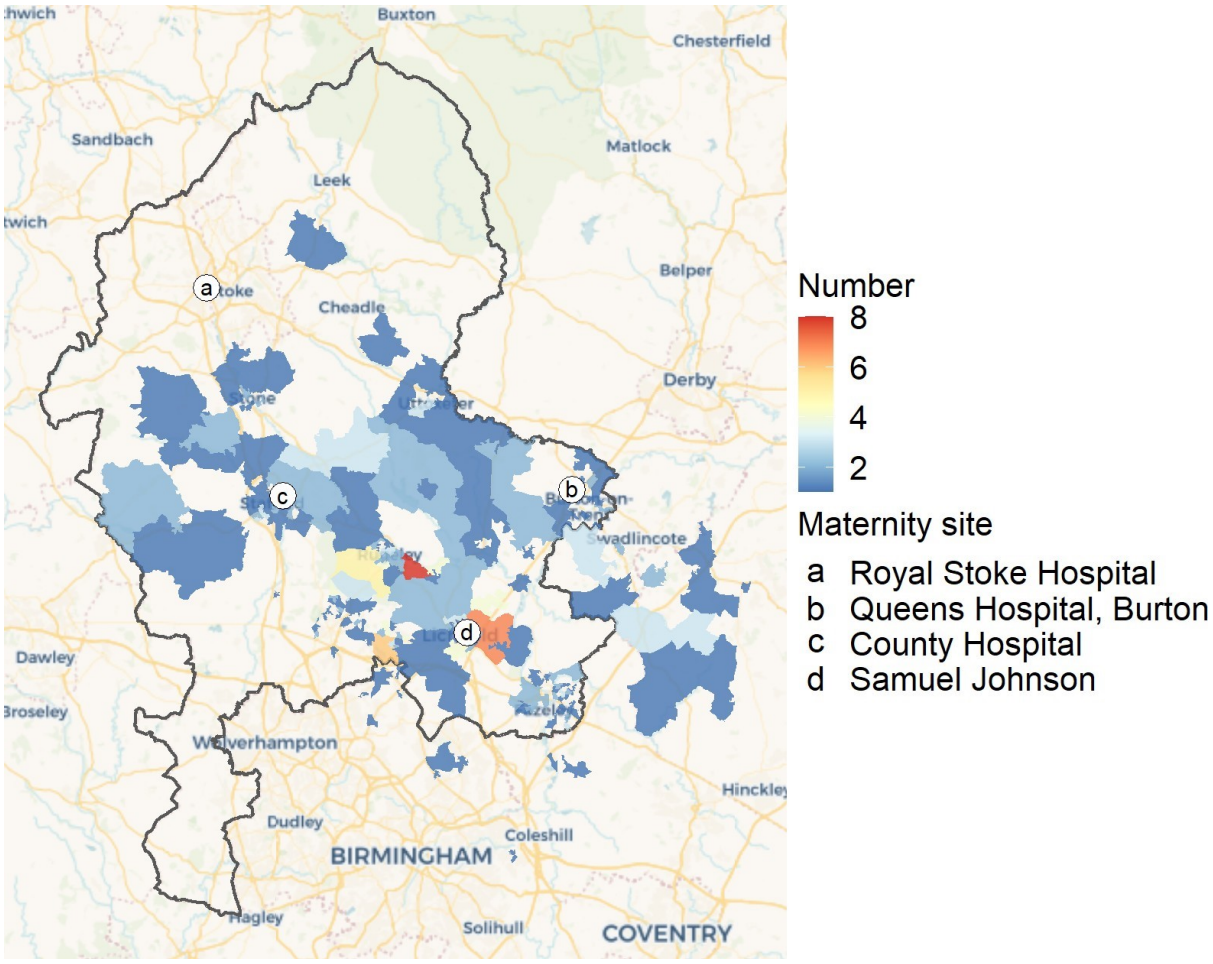


Figure 10: place of residence of people who used intrapartum services at the FMBUs during 2019/20

In contrast, the number of births within the consultant-led units and alongside midwife-led units/services for the year prior to the closure and in more recent years are included the table below.

Hospital	Birth Type	2019/20	2020/21	2021/22	2022/23	2023/24
Royal Stoke Hospital	Consultant-led	5,264	5,283	5,428	5,549	5,299
	Midwife-led	970	880	666	543	595
Royal Derby Hospital	Consultant-led	4,770	4,892	5,021	5010	4938
	Midwife-led	802	641	853	819	737

Queen's Hospital, Burton	Consultant-led	2,329	2,231	2,581	2,715	2,528
	Midwife-led	584	727	380	0*	0*

Table 5: Number of births within the acute units

*During 2022, midwife-led births were included within the consultant-led data at Queen's Hospital Burton due to a change in the way the overall data was electronically collated. This meant midwife-led and consultant-led births could only be disaggregated manually. The introduction of Badgernet, a new electronic maternity record, in June this year is expected to support the service to electronically capture the different pathways of births going forward.

Although the Trusts promoted the FMBUs, the number of births there continued to fall, and had dropped to less than 3% off all births across both sites at the time of the temporary closures as most low-risk women were choosing midwife-led births at the main hospitals instead.

It is unlikely that the number of births within the FMBUs would rise if they were to re-open due to the trajectory for the high-risk births as outlined within the Birthrate Plus® Reports.

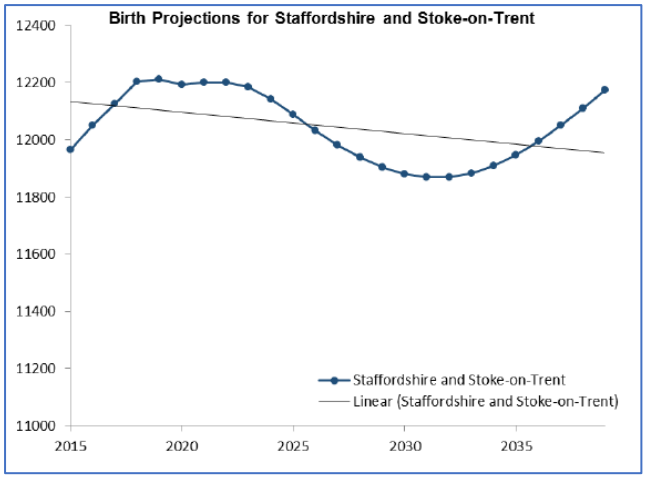
Consideration has been given the women choosing to give birth outside of the Staffordshire and Stoke-on-Trent area and whether the number of births at the FMBU would increase if these women chose to give birth within the two FMBUs. During 2023/24, an additional 121 women gave birth within neighbouring hospitals when compared to the number of women who gave birth in neighbouring hospitals during 2019/20 (Table 3 within 4.2). The data does not identify whether these are high-risk or low-risk women who may or may not choose to give birth within the two FMBU within Staffordshire and Stoke-on-Trent. Taking these numbers into account this would still not meet the minimum of 350 births per year that were recommended for an FMBU to be clinically and financially viable.

There were just over 10,500 births during 2023/24 within the Staffordshire and Stoke-on-Trent population. This is forecasted to fall over the next 10 years, before rising again after 2030. Some key assumptions are:

- Local demographic growth is assumed to be as per ONS demographic growth, of 0.39% for 2023/24. ONS population projections are utilised to ensure uniformity of approach across all platforms and programmes of work within the NHS. ONS calculations are complex and allow for a degree of housing growth and population in-flow/out-flow which aligns to the data included within district and borough locality plans, for example the growth within the Lichfield population due to local housing development. ONS population projections are

therefore the standard used in NHS statistical modelling and planning assumptions.

- Maternity projections:
    - based solely on gender and age band (see figures bottom right)
    - show that:
        - the 20-40-year-old female population is forecasted to have decreased by 0.12% during 2023/24.
        - each of the 5-year age bands demonstrate variability.



Age vs growth projections

20-24	-1.43%
25-39	-1.10%
30-34	+0.25%
35-39	+1.53%

Figure 11: birth projections for Staffordshire and Stoke-on-Trent

This expected fall in births over the coming years will also be accompanied by births that are taking place which are increasingly more complex. Developing and sustaining a culture of safety is one of the key themes within the three-year delivery plan and therefore it is key the ICS ensure appropriate services are in place to meet the changing needs of the population.

The Birthplace in England Research Programme (2022), coordinated from the National Perinatal Epidemiology unit, University of Oxford, identified that whilst midwife-led birth units appear to be safe and offer benefits to the mother, especially for low-risk mothers having a second or subsequent baby, for women having a first baby there is a high probability (36% chance) of needing to be transferred to an obstetric unit during labour or immediately after birth.

Skill mix and sustained competency of midwives is also a key safety factor to consider when birthing numbers are so low.

4.5 Workforce sustainability case for change

Staffing shortages in midwifery remain a challenge across the NHS with a shortage of just under 2,500 midwives across England (Royal College of Midwives, 5 April 2023). Recent investigations into maternity services have emphasised how important it is to maintain safe staffing levels in line with Birthrate Plus®.

One of the key themes within the three-year delivery plan for maternity and neonatal services focuses on workforce. NHS England's report acknowledges that the ambitions of the plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently services do not have the staff they need. As a result, Objective 5 within the delivery plan is to grow the workforce.

Birthrate Plus® workforce assessments have been completed for UHNM and UHDB with both Trusts Boards approving an increase in midwives to achieve the required midwifery staffing levels. This has been enabled through a combination of Ockenden funding and Trust investment. Recruitment campaigns have been undertaken at both Trusts and progress with recruitment has been made. Both Trusts have a recruitment trajectory to meet safe staffing requirements in line with Birthrate Plus®, by October 2024 and includes newly qualified international midwives and midwives acquired through the recruitment campaign and events.

The Birthrate plus® assessment completed for UHNM in July 2022 outlines the following baseline staffing requirements based on 25.99% uplift. The full Birthrate plus® assessment for UHNM is included in Appendix 01.

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Non-viable pregnancies • Escorted transfers out • Inductions of labour	83.57wte
Triage - BSOTS Model & additional hrs	13.17wte
Midwife Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite • Triage cases	12.15wte
Antenatal Ward - 305 • A/N Admissions • Inductions of Labour Postnatal Ward - 306 • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	78.23wte *(may Include MSWs postnatal care)*

• Postnatal Day Attenders	
Outpatients Services • Midwives/Specialist clinics • Midwife scan review clinics • Obstetric/Specialist clinics • Fetal medicine • Day Assessment Unit	8.75wte MWs 3.46wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional safeguarding FMBC – Stafford County • Obstetric clinics • Day Unit • Transfers out	 69.38wte *(may Include MSWs - postnatal care* 3.17wte*
Total Clinical WTE	**271.88wte RMs & PN MSW**

Table 6: UHNM midwifery staffing requirements identified within the Birthrate Plus® assessment

*As the FMBU was closed to births at the time of the assessment, the staffing calculation is based on antenatal and postnatal care only.

The Birthrate plus® assessment completed for Royal Derby Hospital in May 2021 outlines the following baseline staffing requirements based on 24% uplift. The full Birthrate plus® assessment for UHDB is included in Appendix 02.

Royal Derby Hospital **Annual Data 2020/21** • Total Deliveries = 5604 • Total Community Cases = 8062	
Clinical required	**WTE**
Delivery Suite • Births • A/N cases • Escorted transfers out • Non-viable pregnancies	 68.05wte (without IoLs) (71.82wte inc IoL)
Triage / PAU	18.05wte
Induction of labour activity	3.77wte

Midwifery Led Unit: • Births only • PN care & NIPE • Transfers to DS **small % women transferred to PN ward often for baby monitoring so included in ward staffing*	14.72wte
Ante Natal Ward: • A/N Admissions • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	7.37 57.35wte (*includes band 3 support staff)*
Outpatients Services • All Midwife Led Clinics • All Obstetric Led Clinics • Specialist Obstetric Clinics	9.75wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional hours for Safeguarding	77.01 (*includes band 3 support staff)*
Total Clinical WTE	**256.07wte**

Table 7: Royal Derby Hospital midwifery staffing requirements identified within the Birthrate Plus® assessment

The Birthrate plus® assessment completed for Queen's Hospital, Burton in May 2021 outlines the following baseline staffing requirements based on 24% uplift. The full Birthrate plus® assessment for UHDB is included in Appendix 02.

Queens Hospital Burton Annual Data 2020/21 • Total Deliveries = 2995 • Total Community Cases = 3792	
Clinical required	**WTE**

Delivery Suite • Births • A/N cases • Escorted transfers out • Non-viable pregnancies	36.08wte
Triage / MAU	13.89 wte
Induction of labour activity	2.04wte
Ante Natal Ward: • A/N Admissions • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	4.04 28.25wte (*includes band 3 support staff)*
Outpatients Services • All Midwife Led Clinics • All Obstetric Led Clinics • Specialist Obstetric Clinics	3.24wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional hours for Safeguarding	34.13 (*includes band 3 support staff)*
Samuel Johnson FMU • Births (total Care) • Transfers to Obstetric Unit • Triage cases • GTT Clinic & Anti D	**8.48***
Total Clinical WTE	**130.15wte**

Table 8: Queen's Hospital Burton midwifery staffing requirements identified within the Birthrate Plus® assessment

*Calculated based on antenatal and postnatal activity through the FMBU and birth activity from when the unit was open. To run the birthing services at the FMBUs and safely staff them with two midwives per shift 24/7, a minimum of 12.15 experienced midwives (whole-time equivalent) would be needed.

As of October 2023, both Trusts remained short of the budgeted establishment. UHNM had midwifery vacancies at 57.53 whole time equivalents (wte) and UHDB had vacancies at 41wte.

By March 2024, the vacancy position had significantly improved as a result of recruitments drives at both Trusts. At that time UHNM had a vacancy position of 25.03wte and UHDB has a vacancy position of 3wte. There are an additional 17 WTE funded as part of the maternity safety case and UHDB is utilising bank staff to fill these posts. The Trust has recently made the decision to appoint to these posts. Both Trusts continue to actively recruit to achieve the full midwifery establishment.

Both providers have developed a Continuity of carer plan which aligns to the personalised care and choice agenda and the National strategy. They involve ensuring the building blocks are in place for an effective sustainable approach to care for those known to be most at risk of poorer outcomes. The plans include:

- Ensuring workforce establishments align to Birthrate plus assessments and include provision for home births and enhanced continuity of carer models.
- Empowering staff to deliver personalised care by providing time, training, tools and information.
- Re-establishing the home birth service and strengthening this as a choice of place of birth.
- Developing and embedding the personalisation and choice agenda for all pregnant people regardless of risk to ensure they have care that takes into account their physical health, mental health, social complexities and choices.

Whilst safe midwifery staffing continues to be one of the ten safety actions within NHS Resolution CNST maternity incentive scheme a key action of Ockenden the Final Report (2022), the three-year delivery plan also places emphasis on the need to retain the workforce and invest in skills (objectives four and five).

Identifying and implementing ways to improve people's professional experience, and ensuring they have the skills and support they need, are key to staff retention and recruitment.

We must therefore ensure we are implementing staffing models that focus on the longer-term sustainability of the workforce by ensuring staff are working in environments that give them the required experience to not only safely maintain their skills but provides opportunities to grow and develop their skills.

Due to the low number of deliveries at the FMBUs, we must consider how we make the best use of such a scarce clinical resource at a time when the recruitment and retention of midwives is a challenge nationally. With such a low level of demand at these units, we must also consider how we support staff to develop their skills and have a fulfilling and sustainable career within the NHS.

5 Proposal development including patient, public and staff involvement

5.1 Introduction

Patient and public involvement is a priority for the Staffordshire and Stoke-on-Trent ICS. Patients, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of maternity services in Staffordshire and Stoke-on-Trent from the outset.

This section of the pre-consultation business case describes briefly:

- Phase one - the initial proposal development and the patient, public and stakeholder involvement that took place during 2019-20 as maternity services were considered as part of the wider Together We're Better transformation programme.
- Phase two – targeted maternity involvement during 2020 as part of the Together We're Better transformation programme.
- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement to understand whether there were any additional considerations about the future of maternity services.
- Phase four – Re-established proposal development process undertaken in 2023 along with public involvement to explore all possible proposals for future service provision.
- The ongoing engagement with local authority Health Overview and Scrutiny Committees.
-

Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of birthing services in Staffordshire and Stoke-on-Trent from the outset. The ICB, along with UHNM and UHDB, used this collective feedback to inform the development of the proposals and this pre-consultation business case and its proposal for the future of birthing services formerly provided at County Hospital Stafford and Samuel Johnson Community Hospital, Lichfield.

This process has been applied in line with the guidance *Planning, Delivering and Assuring service change for patients*[23], published by NHS England in 2018 and updated in May 2022.

[23] NHS Planning, assuring and delivering service change for patients, April 2018

The way in which the proposal for change has been arrived at will, if progressed, be exposed to scrutiny by local authority health overview and scrutiny committees (HOSCs), by patients, the public and other stakeholders, possibly by the courts and possibly by the Independent Reconfiguration Panel (IRP) if a referral is made to the Secretary of State.

It is important that when proposals are developed, a comprehensive range of perspectives is sought to identify the full range of service change solutions that could meet the stated objectives of the programme within available resources.[24]

There is no duty to carry forward to public consultation proposals that in the view of the commissioners are unrealistic, unviable or unsustainable.[25]

The objective of the options appraisal process was to develop proposals for the future of birthing services for women from Staffordshire and Stoke-on-Trent that, until March 2020, included low-risk birthing services at County Hospital and Samuel Johnson Community Hospital. The aim being that proposals that emerge from the process should:

- Fit with the national and local strategy for maternity services.
- Provide the highest quality service across all options for women.
- Make best use of workforce and financial resources and are fit with the overall estates strategy for the system.

Healthcare organisations have a statutory duty to ensure that individuals to whom current or potential future services are being or may be provided are *"involved in the development and consideration of proposals [for changes] where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them [at the point where the services are received by users]"*[26] and this has been taken into account throughout the development of proposals for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital.

Figure 1 in section one illustrates the process that the programme team have undertaken to support the development of proposals. The timeline was impacted by the pause for our systems response to COVID-19. The outputs from the involvement activity have provided valuable information and the options appraisal process included key stages where further patient, public and stakeholder feedback was used to shape and review proposals.

[24] p25, NHS Planning, assuring and delivering service change for patients, NHS England 2018

[25] R(Nettleship) v NHS South Tyneside CCG and Sunderland CCG [2020] EWCA Civ 46

[26] S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012

5.2 Phase one - Together we're better 2019

5.2.1 Proposal development 2019

The Staffordshire and Stoke-on-Trent system-wide Case for Change[27] set out the needs of the population, provision of health and care at that time and outlined the vision and aims for local health and care in the future.

Whilst developing the case for change a series of interdependency workshops took place to identify challenges and opportunities within and across each clinical programme. A standard approach was undertaken to identify a range of potential scenarios. These in turn were refined in a structured way through the options appraisal process.

To generate a theoretical longlist, the maternity programme considered the fixed points for their service, which included minimal staffing levels, interdependencies with other services such as primary/community care, benefits of co-location as well as the benefits and outcomes for patients. Therefore, it was agreed there would be no case for change in relation to other maternity services, other than the birthing services at the two existing FMBU's. The Case for Change also specifies the need to continue to provide a real choice of maternity care settings for women that meet their needs now and in the future. Such options must be safe, appropriate and high-quality and therefore consideration was given to the best and most viable ways to provide these options.

Key considerations also included volume (number of births at each site) and the number of transfers between site during or after labour.

This strategic view is the background to the development of proposals for the future of birthing services previously provided by at County Hospital and Samuel Johnson Community Hospital. The maternity specific elements outlined within the case for change were developed through the Sustainability and Transformation Partnership (STP) Maternity Programme Board, building on the NHS Long Term Plan.

A Clinical Advisory Group (CAG) for the transformation programme met four times in 2019/20. The CAG is an expert group of clinical leads from across the clinical programmes and organisations, GPs and Public Health clinicians, with the purpose of reviewing the clinical models in the transformation programme throughout the options appraisal process. Maternity services, as one of the elements in TWB, was included in their discussions.

In May 2019, the Case for Change was presented to the West Midlands Clinical Senate (WMCS). The Clinical Senate was of the view that the STP articulated a

[27] Case for Change, Together We're Better, 2019

credible case for change and the aspirational principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance.

In June 2019, the maternity case for change was presented to NHS England and NHS Improvement (NHSEI) alongside the clinical models for four other programmes that were part of the service change process at that point in time. They gave permission to hold engagement events in the summer of 2019.

In June 2019 Staffordshire and Stoke-on-Trent health and care system published its Case for Change document as part of its service transformation plan for services across the area. This set out the needs of the population, the current provision of health and care and outlined the vision and aims for local health and care in the future.

The case for change was articulated to the public during a 12-week listening exercise in summer 2019. During this exercise the ICB spoke to over 2,000 service users, staff and local communities about different health and care services, including maternity services. The ICB also held focus groups to gain in depth feedback on particular services.

5.2.2 TWB engagement 2019

In order to articulate the maternity case for change a range of materials were produced to inform stakeholders about the listening exercise in summer 2019 and to gather feedback. A mix of communication channels were used to raise awareness about the listening exercise and encourage participation. Information was also shared with stakeholders via the TWB monthly newsletter which was sent to MPs along with members of the public, the voluntary sector, Health Overview and Scrutiny Committee (HOSC) members and chairs, Chief Executives, providers and staff.

There was involvement with a number of organisations who could provide links to seldom heard groups and areas of health inequality including Local Equality Advisory Forum (LEAF), Healthwatch, Support Staffordshire (which provides county-wide support for the Voluntary, Community and Social Enterprise Sector) Burton YMCA, Burntwood Town Council and Staffordshire Sight Loss Association. The communications and engagement team worked with Assist in the North, and with Mind in East Staffordshire, asking for their support to promote the listening exercise across their members. A comprehensive stakeholder mapping exercise was undertaken and was reviewed throughout the engagement phase.

You can read more about our approach in our report of findings[28].

[28] Together We're Better Listening Exercise Report of Findings, 25 October 2019

5.2.3 Findings - TWB engagement 2019

Themes from the main involvement survey feedback in relation to respondents' experience

- Respondents tended to have positive experiences of maternity care services, with 26 (76%) respondents rating their experience as excellent or good, compared to six (18%) who rated their experience as poor or very poor.
- Respondents rating maternity care services as excellent or good highlighted the care and treatment by staff, while those rating neutral, poor, or very poor highlighted staff numbers, workload and working conditions.
- Key areas identified for improvement were staff numbers, workload and working conditions; maternity services in general; communication by staff and access, such as distance to hospital; the waiting list and appointments process and administration and information from healthcare providers.

Themes from the main involvement survey feedback

The top three themes for respondents rating maternity services as excellent or good were: General positive:

- Positive comment / all good / improved.
- Staff: care and treatment.
- Services: maternity services in general.

The top three themes for respondents rating maternity services as poor or very poor or having no opinion were:

- General negative: negative comment / experience.
- Services: maternity services in general.
- Staff: staff numbers / workload / working conditions.

The most frequently mentioned themes by respondent type for those rating maternity services as excellent or good were:

- Public: general positive: positive comment / all good / improved
- Staff: general positive: positive comment / all good / improved and staff: care and treatment.

The most frequently mentioned themes by respondent type for those rating maternity services as poor or very poor or having no opinion were:

- Public: general negative: negative comment / experience
- Staff: general negative: negative comment / experience.

Findings from this engagement exercise were shared with participants at options appraisal events for the public and one for staff on 5 November 2019, and technical

events on 15 October and 14 November 2019 for evaluators, including clinicians, observers, including a patient and public engagement (PPI) representative, and advisers including senior staff.

In addition, the report of findings from the engagement work was presented in a workshop for programme leads/clinical leads and shared by email offering them the chance to ask for any further information /clarity to inform the development of proposals. The Governing Body of Staffordshire CCGs formally received the report on 7 November 2019. A summary, public facing report of findings was published in February 2020[29]. Together We're Better also held workshops in Autumn 2019 to share the feedback from the listening exercise, to discuss the emerging models of care and to seek views on the desirable criteria.

5.2.4 Technical event 1

On 15 October 2019 a technical group consisting of clinicians, operational leads, strategic leads and communications colleagues considered the findings of the TWB listening exercise and defined essential criteria that proposals would have to meet (these criteria would be applied to any proposals within the transformation programme). These were:

- Clinical sustainability.
- Strategic fit.
- Meeting the needs of the population.

The group reviewed the proposals against these criteria. It was agreed at this event that the proposals should remain on the medium list. The previous sections of the pre-consultation business case give detail of the strategic fit, clinical sustainability and needs of the population that were taken into account during the technical event.

5.2.5 Deliberative events Oct/Nov 2019

Following the first technical event (15 October) and as part of the appraisal process for the whole transformation process, four deliberative events were held, one for patients and the public in each of the geographies of Staffordshire and Stoke-on-Trent; North, and South East and South West plus one event for staff:

- 24 October Port Vale football Club
- 28 October Lichfield, George hotel
- 30 October Stafford, Entrust
- 05 November Yarnfield, Stone (Staff only event)

The events covered the five service areas of urgent and emergency care, integrated community services, maternity care services, planned care services and mental health

[29] Together We're Better Listening Exercise, Report of Findings, October 2019

services. The vision, aims and partners involved in the Transformation Programme were outlined and the clinical case for change was presented. In addition, participants heard a summary of the feedback about maternity from the listening events held in Summer 2019. They were shown the clinical model for maternity services.

Benefit	Input	Output	Outcome
Improved experiences for women and their families	• System wide review of care delivery	• Increased access to maternity care	• Reduced stillbirths and neonatal deaths.
Improving patient access	• Development of maternity hubs	• Access to specialists roles throughout maternity.	• Improved continuity of care and carer, delivered closer to home.
Decreasing unwarranted variation in quality, safety and outcomes	• Meeting clinical standards in line with national standards set out in BB and SBLCB	• Provision of equitable choice	• Reduced stillbirths and neonatal deaths.
Solving workforce challenges	• Implementation of Birth Rate plus recommendations	• Appropriate workforce for current and future models of care	• Model of care will be in line with the national standards.
Improving efficiency	• Partnership working between CYP, public health and the NHS	• Integrated care	• Improved experience for women and their families.

Table 9: The expected benefits and outcomes for the maternity model of care

Participants were provided with data packs which provided demographic information, geographical information on service provision and activity level data.

They heard that, given the low number of births at each FMBU and the staffing challenges, there was a need to consider how best to re-provide services.

They heard that the proposals for provision of services, at that stage of the process, included:

- There is no case for change to consider changes to the provision of obstetrician-led services – therefore these would remain in place as they are within the geography.
- Alongside midwife-led units would be offered with obstetric-led units.
- We would look to enhance the home birth model – potentially with scope to consider a joint Staffordshire and Derby home births team.

- We would provide diagnostics and antenatal care at the hub level (community based)
- We would look to provide 'on demand midwife-led units' at hubs or freestanding midwifery birth units to allow women a choice of the equivalent of a home birth in a different setting – therefore a 24/7 midwife-led birthing model would not be offered at the existing FMBU sites.

Participants were asked three questions:

1. Is there anything we need to consider with the potential scenarios outlined for on demand maternity services?
2. Are there any locations missing that could be considered for an on-demand community midwife-led service?
3. What services could be integrated within community hubs?

.

We heard feedback on the following themes: access, staff, integration, patient care, services, demand, positivity around the model and support for particular groups. Only 6 % of respondents at this stage were maternity service users.

The feedback was presented and considered at the second technical event (14 November).

Following the deliberative event, it was agreed to undertake focused engagement with maternity service users, and this is described in section 5.3.

5.2.6 Technical event 2

On 14 November 2019 a further technical session was convened for evaluators and attended by advisors and observers. The evaluators were nominated clinicians and senior managers from across the system, in addition to workforce, estates, and quality representatives.

The evaluators received a report[30] on the outputs of deliberative events held in October and November and reviewed proposals against further essential criteria:

- Demand and capacity,
- Workforce sustainability, and
- Estates

Wide ranging discussions on these points included patient safety, management of risk, transfers of women during labour, home birthing service and staffing numbers.,

After these discussions, it was agreed that the proposals as they stood should remain on the medium list.

[30] Included in Appendix 03

5.3 Phase two – Maternity involvement 2020

Whilst the TWB listening exercise included the system case for change and the clinical model for maternity services across Staffordshire and Stoke-on-Trent, it was also important that more focused involvement activity was undertaken. In 2020, further involvement activities were undertaken and focus groups were held to talk in more detail about maternity services.

Six focus groups were held where maternity leads spoke to 25 new mothers, expectant mothers, people thinking about having a baby and staff who work in maternity services. 40 surveys were also completed. During these groups, leads shared the emerging models of care and sought attendees' views on the desirable criteria for evaluating proposals.

5.3.1 Findings – Maternity involvement 2020

During the 2020 involvement exercises, when asked about their experiences of maternity services, participants largely had positive experiences with healthcare staff – highlighting the good quality of care from community midwives, healthcare assistants, health visitors and paramedics.

Participants also highlighted areas for improvement, specifically:

- **Continuity of carer:** The need for improved continuity of carer to enable them to develop rapport with staff and avoid obtaining conflicting advice.
- **Communication:** The need for improved communication between services, as well as clearer explanations of processes and tests to avoid stress and anxiety.
- **Access to support services:** The need for improved access to breastfeeding support, mental health services and support for partners.
- **Medical records:** Issues with staff unable to access notes, information missing from notes and problems logging onto systems.
- **Access to services close to home:** The need to reduce travel and have services available locally, including access to home visits.

Participants were also asked to share their views on the clinical model and their considerations over where to give birth.

Most participants highlighted that the **safety** of both mother and baby was the main factor in deciding where to give birth. Some participants preferred to give birth at hospital to be reassured in case something went wrong. **Being close to home** and the available options and facilities (e.g. water birth, aromatherapy) were also taken into consideration.
The following factors were also highlighted:

- **Recommendations** from friends and medical professionals.
- **Health needs and requirements.**
- **Partners** being present throughout the birth.

- **Caring environment:** Participants wanted to give birth in a calm, less clinical environment and not feel medicalised.
- **Space, privacy and dignity:** One participant commented they didn't want to hear noise from other patients.

Many participants wouldn't consider a **homebirth** due to feeling unsafe and practical reasons, such as not having enough space and having to clean afterwards. Some participants felt they weren't informed about the option of a homebirth and that greater information and awareness would make them more likely to consider this option in the future.

Most participants would consider a **community birth** as they could be closer to home, have familiar staff, give birth in a less clinical environmental with more person-centred care. Other positive factors were easier car parking and opportunities for partners to be more involved.

Some participants said they weren't told about other available options such as community or homebirths, therefore they weren't offered a choice in where to give birth.

Participants were asked to share their views on the proposed desirable criteria that would be used to evaluate and score proposals for the future delivery of services across Staffordshire and Stoke-on-Trent.

Most participants agreed with the criteria and its domains and commented that this was a good idea.

However, the importance of **continuity of carer** before and after birth was raised again. Participants suggested this would help to improve communication between patients and medical professionals – avoiding any further issues. Participants also highlighted the need for greater access to breastfeeding and mental health support and for the clinical model to be implemented effectively.

The report of findings was shared with the TWB programme team and was incorporated into the evidence base for the options appraisal process. As the report was finalised during the Covid pandemic it was not published, as with other reports on the website. A full copy is included within Appendix 04.

5.3.2 The continuing process

In January 2020, technical events were held in relation to the other clinical areas subject to the TWB proposal appraisal process, the group were appraised of the process pertaining to maternity services in light of the interdependencies across programme areas.

The short list of proposals was shared with the Programme Board on 10 February 2020, and the Programme Board which included CEOs on 9 March 2020. A briefing paper was developed and circulated to all provider organisations to provide details of the proposals as they stood at that point in time ahead of progressing to the next stage of the business case development.

It should also be noted that a further workshop was held on 3 March 2020. The aim of this workshop was to develop the desirable criteria for all clinical programmes in the TWB transformation programme. This included examination of the proposals for the future of birthing services with discussion of what needed to be considered when deciding options.

The programme was then paused in March 2020 due to the response to the COVID-19 pandemic and re-deployment of staff to manage the response required across system partners to implement COVID-19 safe services and the vaccination programme.

5.3.3 Pause in engagement and involvement

COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for local birthing services.

During the pandemic we continued to have conversations with service users regarding the temporary service changes and that women would continue to be able to choose between a midwife-led birth or a consultant-led birth at both UHNM and UHDB.

5.4 Phase three – involvement in 2021

In Summer 2021 the involvement conversation was restarted by system partners, supported by TWB. It was recognised that services and people's experiences have had to adapt during the pandemic, and so further sense-check involvement activity took place during summer 2021 to understand any new context and to inform this pre-consultation business case.

The engagement sought to gather feedback on

- Experiences of maternity services in Staffordshire and Stoke-on-Trent, before and during COVID-19
- Whether respondents would choose a homebirth and why
- The proposed new continuity of carer and on-demand models of care.

The objectives of this work were to:

- Gather any further information needed to inform proposals for future service change.
- Sense-check the model of care and emerging proposals to inform the business case.

5.4.1 Maternity involvement 2021

The relevant stakeholders received briefings, bulletins and updates, including information sent to organisations' communications teams so that they could pass on the link to the survey and information about the events. Local MPs were kept up to date with regular briefings with the CCG accountable officer and the interim Integrated Care System (ICS) chief executive.

Engagement activity included a short survey available between 16 July and 15 August 2021 and two maternity workshops held on 16 July 2021 and 12 August 2021.

A midpoint review of the involvement took place in August 2021 to identify any gaps in the groups responding. The mid-point review identified that most respondents were white, with underrepresentation from the other groups, a higher proportion of responses were from those without a religion and those stating Christianity as their religion and very little representation from other religious groups. Most respondents were aged 30-39 with a low response from under 25s. There was a lack of representation of those with a disability or long-term condition and most responses have been received from the Stafford area and the North of the county. The Tamworth, Lichfield and areas around Stafford were underrepresented. Responses had been received from across all the IMD deciles. However, the areas of most deprivation could be targeted to gather more responses. Almost three in ten of those participating in the engagement were currently pregnant while over a quarter have recently given birth.

As a result of the mid-point review, it was agreed to continue the engagement activity as planned to ensure that those areas which were underrepresented to date were targeted.

Altogether, at the end of the engagement process, 240 responses were received to the survey and 28 people attended the engagement events.

5.4.2 Summary of responses - 2021 involvement

Prior to COVID-19, respondents told us they were well cared for in labour by supportive and "amazing" staff. Respondents also told us they were well cared for during pregnancy and after birth. Samuel Johnson Community Hospital was praised for its calming environment with respondents telling us staff were responsive and happy to talk through any concerns.

Respondents did however highlight a number of areas they felt required improvement.

- Better support for birth planning.
- Getting the right information to promote good choices at each stage of the journey.
- Being listened to and treated with respect.
- Receiving more help with breastfeeding.

- Consistent advice and seeing the same midwife.

We heard that things went well for many women - even during the especially challenging circumstances of COVID-19. Respondents shared stories about good, supportive care and positive experiences during pregnancy and labour.

COVID-19 restrictions meant that partners were often not able to be there during appointments, scans, or labour, and this made things much more difficult and sometimes distressing. Many women said they felt very lonely without their partner to support them.

Respondents told us that when planning where to give birth, they considered issues like the location of hospitals. For women who were keen to have a homebirth, it was still important to weigh up the distance to travel if additional or emergency care was needed. Some respondents wanted a homebirth because they felt they would be more relaxed at home and there would be no limitation on the time their partner could be there.

Respondents told us how important continuity of carer is and that being able to see the same midwife throughout their journey makes them feel more supported and less anxious.

Many liked the idea of the on-demand midwife-led units, although there were concerns about whether the staffing levels would be right, and whether a woman might arrive at the unit before the midwife.

Further detail is available in the full report of findings[31] on the ICB's maternity transformation webpage.

5.4.3 Supporting seldom heard groups - 2021 involvement

The communications and engagement team worked closely with the CCGs' Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

They ensured communications were accessible. The presentation slides at the engagement events and the questionnaire both included information about accessibility including a variety of opportunities to provide feedback, including attending the events, a survey, by phone or in writing.

The communications and engagement team built on relationships with the voluntary and community sector to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, they worked with trusted advocates, for

[31] PowerPoint Presentation (icb.nhs.uk)

example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that was approachable and understandable.

5.4.4 Technical event to review proposals

At a technical event held on 06 September 2021, a group comprising representatives of commissioners and providers from across the system including directors and/or leads for strategy and transformation, midwifery, communications and engagement and Healthwatch, reviewed comments from the Summer 2021 involvement and used this alongside their data to assess whether the proposals were viable.

The group received the report of findings and were asked to consider the new continuity of carer and on-demand models of care that were proposed prior to the pandemic.

Despite the easing of the lockdown restrictions, both UHNM and UHDB continued to report significant staffing pressures as a result of COVID and non-COVID related absences. Staff who were redeployed from the FMBUs during the first phase of the pandemic continue to be essential within the acute units, enhancing the senior midwifery presence and supporting Ockenden safety recommendations. As a result, it was made clear that the implementing the new models was dependent on achieving the full workforce establishment in line with Birthrate Plus®.

At this time the group agreed that implementation plans for the models would be developed that took into account the anticipated timelines for achieving the midwifery workforce establishment. To support the necessary development and workforce training, it was anticipated that the earliest the on-demand model of care could go live was during Winter 2021/Spring 2022.

5.5 Phase 4 - Options appraisal and public involvement 2023

5.5.1 Re-establishment of the options appraisal process

During 2022 it was anticipated that both Trusts would be in position to reinstate services either as per the clinical model of 2020 (pre-COVID) or through the implementation of an ‘on-demand model’. However, workforce challenges in relation to recruitment and retention of staff meant that neither provider was able to implement the pre-COVID 24/7 staffed model or a revised service offer. During this time, both organisations provided regular updates to the LMNS Board and correspondence was maintained with NHSE via the service change assurance routes.

Due to continued staffing pressures throughout 2022/23, both organisations informed the ICB in April 2023 they were not able to reinstate services as per the model of care considered in 2021.

In July 2023, the case for change on the future of birthing services at the FMBUs was presented to NHS England during a Stage 1 assurance meeting. No issues were raised by NHSE during the meeting and the feedback from NHSE was that the case was well presented with partners demonstrating a clear and robust understanding of the clinical model and the challenges the ICS is facing.

As a result, the ICB alongside system partners reinstated the service change process that was paused due to the pandemic and began to reassess proposals for the future of birthing services at County Hospital, Stafford and Samuel Johnson Hospital, Lichfield. Further work was undertaken to explore all possible proposals for future service provision. To develop the proposals, the ICS has taken steps including:

- Reviewing the earlier options appraisal process and findings from public involvement.
- Analysing the relevant data – including demographics, numbers of births at the different units, clinical complexity and equalities.
- Making sure our strategy for maternity is aligned with the national plans.
- Making sure we are considering the need for patient choice.
- Ensuring that any plans will promote equity for mothers and babies from black, Asian, and mixed ethnic groups and those living in the most deprived areas.
- Developing a case for change (submitted to NHS England in July 2023).
- Confirming a new clinical model.

5.5.2 Technical event September 2023

During a technical event in September 2023, clinicians identified and reviewed seven potential proposals for the future of birthing services at County Hospital and Samuel Johnson Community Hospital. Each proposal was re-assessed against the six criteria that were used in the previous options appraisal process. For the proposals to be viable, they needed to meet all the criteria. These were:

- **Clinical sustainability:** Does the scenario allow for clinical services and their interdependencies to be maintained in the geography?
- **Strategic fit:** Does the scenario align with national and local strategies, including making best use of current estate?
- **Meeting the needs of the population:** Does the scenario allow for appropriate services to meet population need, based on activity and geographical spread of these services?

- **Demand and capacity:** Is this a viable scenario given the level of activity, from a deliverability, capacity and safety perspective?
- **Workforce sustainability:** Is there a sufficient level of workforce to deliver the scenario?
- **Estates:** Is there sufficient time to implement the scenario? Is there sufficient space to deliver the scenario?

As the number of women with low-risk pregnancies is getting lower, consideration has been given to:

- whether it is viable to re-open the units
- whether it would make the best use of our workforce if we did, because the low number of births mean midwives will struggle to maintain their skills and competencies if they are based at an FMBU.

This was considered alongside how and when the home birth services – also for low-risk pregnancies only – can be reinstated on a permanent basis.

The tables below illustrate the pros and cons of each of the proposals for the future of birthing services that were considered during the technical event when assessing each of the proposals and presented to participants at the public facing deliberative event.

Advantages and disadvantages of the proposals

Reinstatement of birthing service at County Hospital and Samuel Johnson Community Hospital

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less travel for those living close to the units who are eligible to use the units and who choose to give birth there.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour, they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 10: Advantages and disadvantages of reinstating birthing service at County Hospital and Samuel Johnson Community Hospital on a 24/7 basis

Reinstatement of a single birthing service at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 11: Advantages and disadvantages of reinstating birthing service at either County Hospital and Samuel Johnson Community Hospital on a 24/7 basis

Implementation of a single birthing unit at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 12: Advantages and disadvantages of reinstating birthing service at an alternative site on a 24/7 basis

Implementation of an on-demand model at both FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running a 24/7 birthing unit. However, would likely need further recruitment beyond the current plans • Midwives maintain their skills – delivering more births at home and midwife-led units • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to Trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 13: Advantages and disadvantages of implementing birthing service at County Hospital and Samuel Johnson Community Hospital on an on-demand basis

Implementation of an on-demand model at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate birthing units. However, would likely need further recruitment beyond the current plans • Midwives maintain their skills – delivering more births at home and midwife-led units • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to Trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 14: Advantages and disadvantages of implementing birthing service at County Hospital or Samuel Johnson Community Hospital on an on-demand basis

Implementation of an on-demand model at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate birthing units. However, would likely need further recruitment beyond the current plans • Midwives maintain their skills – delivering more births at home and midwife-led units • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to Trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 15: Advantages and disadvantages of implementing birthing service at an alternative site on an on-demand basis

Permanent closure of birthing service at County Hospital and Samuel Johnson Community Hospital

Advantages	Disadvantages
• Women would continue to receive most of their antenatal and postnatal care within the units • Staff-to-patient ratios would be the same across all units • Midwives can support the homebirth services and midwife-led units • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days • Women who develop complications would no longer need to be transferred to a hospital unit during labour.	• There may be travel implications for women who are eligible to give birth at County Hospital or Samuel Johnson, who live close to the units and who would have chosen to give birth there. • Requires the reinstatement of homebirth services to ensure full patient choice is offered.

Table 16: Advantages and disadvantages of permanently closing birthing services at County Hospital and Samuel Johnson Community Hospital

As described earlier in this section, for the proposals to be viable, they needed to meet all essential criteria. Further detail on each of the criteria and the considerations when assessing each of the proposals against these criteria is outlined below.

- **Clinical sustainability:** Does the scenario allow for clinical services and their interdependencies to be maintained in the geography?
- **Strategic fit:** Does the scenario align with national and local strategies, including making best use of current estate?
- **Meeting the needs of the population:** Does the scenario allow for appropriate services to meet population need, based on activity and geographical spread of these services?
- **Demand and capacity:** Is this a viable scenario given the level of activity, from a deliverability, capacity and safety perspective?
- **Workforce sustainability:** Is there a sufficient level of workforce to deliver the scenario?
- **Estates:** Is there sufficient time to implement the scenario? Is there sufficient space to deliver the scenario?

Financial impact was not included within the essential criteria and instead is considered once viable options have been identified. Section 7.4 of this PCBC outlines the potential financial impact of reinstating services at the FMBUs on a 24/7 basis or through an on-demand model of care.

The technical group assessed each of the proposals against the essential criteria. A summary of the discussion is outlined below.

Proposal 1: Reinstatement of birthing service at County Hospital and Samuel Johnson Hospital

Clinical Sustainability
All present agreed the proposal does not meet the criteria as clinical services and their interdependencies cannot be maintained in the geography.

Strategic fit
It was noted that birthing services at the FMBUs would provide additional choice for women, however FMBUs do not provide continuity of carer in line with national and local strategies.

The group stated that birthing services at the FMBUs would be difficult to operationalise, manage and maintain, and they would divert resource from wider maternity services.

The Better Births Five Year Forward View for Maternity Care states that women must be offered the choice of home birth, midwife-led births and obstetric-led births, however it does not state whether midwife-led births should be within a freestanding unit. An alongside midwife-led unit provides the same service as a freestanding unit and therefore satisfies the choice requirements outlined within national strategies.
The group therefore agreed the proposal does not meet this criterion but noted that this proposal does provide an additional element of choice for the women in the relevant geographical areas.

Meeting the needs of the population
The group agreed that birthing services at the FMBUs may meet the needs of those women who wish to choose to birth within an FMBU and live local to the units. However, evidence suggests the majority of the population would not choose to give birth in an FMBU – only 0.72% (46) of the birthing population used the County FMBU in 2018.

The group discussed whether this proposal meets the needs of ethnic communities or those from deprived areas and whether more people would choose to birth in an FMBU if it was in a different location to support these populations. The group concluded that there is no intelligence to suggest that women outside of the current catchment area of the FMBUs would choose to give birth within either unit.

The group also noted that the reinstatement of these services does not meet the needs of the overall population due to the increasing clinical complexity/acuity and the low numbers of women eligible to give birth within an FMBU.

At UHNM 83.2% of women are moderate to high risk and 96.5% of women on the delivery suite are moderate or high-risk. Women from a more deprived area tend to have more comorbidities which will place them in a higher risk category.

Based on the above, the group agreed the proposal does not meet this criterion.

Demand and Capacity
Data shows that birthing services at the FMBUs are not utilised as demonstrated by the low activity which raises concerns about the long-term deliverability and sustainability of the service. The group agreed the proposal does not meet this criterion.

Workforce sustainability
The group highlighted that workforce challenges have meant that it is not currently possible to staff the units, and this position is unlikely to change.

Feedback gathered from staff who have worked at County FMBU was that they did not find the job satisfying due to the low level of activity within the unit. There are also concerns about de-skilling of staff. This in turn impacts on the recruitment and retention of staff to run the unit.

This proposal also results in inequality in provision due to the disparity in staffing ratios at the FMBUs compared to the hospital units.24/7 staffing at the units also means midwives can't support home births or other midwife-led units.

The group agreed the proposal does not meet this criterion.

Estates
The group agreed this criterion was met as there is sufficient and available space to deliver birthing services in an FMBU. However, it was noted that Trusts are having to subsidise the space as it is underutilised.

Proposal 2: Reinstatement of a single birthing service at one or other of the FMBUs
This proposal relates to the reinstatement of birthing services at one of the existing sites at either County Hospital or Samuel Johnson Hospital.

It was noted that maternity services are provided by two different providers and offering services from a single unit would mean the two services are amalgamated.

The group assessed the proposal against each of the hurdle criteria and agreed that the assessment does not differ from Proposal 1 as the issues highlighted for all criteria would be the same.

At this point it was noted that whilst assessing Proposal 1, the group did discuss whether offering birthing services within an FMBU at an alternative site would meet the need of the population. It was agreed the additional proposal to open birthing services at a single FMBU at an alternative site would be assessed against the hurdle criteria.

Proposal 3: Reinstatement of a single birthing service at an alternative site.
It was noted this is an opportunity to provide the FMBU service in an area with a different demographic, for example a higher proportion of diverse or deprived communities that may not access birthing services at the FMBUs in their current location.

The group noted that this would not be co-located with an acute site. It was also noted that Governance arrangements between the two providers offering the services within a single unit would be a significant risk.

The group stated that the workforce constraints identified within proposal 1 would remain irrespective of where a 24/7 FMBU is located, and these cannot be mitigated.

Whilst this may be offered in an alternative location and potentially increase access for a different patient demographic, the complexity and levels of acuity do not change and therefore there are a limited number of patients that would be eligible to give birth within these units. As highlighted within proposal 1, there is limited evidence to suggest that people who are eligible to birth in these units would choose to do so based on historic activity data.

The group noted the cost implications of identifying and setting up a new site.
Anecdotal evidence suggests that people typically want to birth where they have a connection to and feedback from patients is that they are reluctant to travel elsewhere.

All present agreed that due to the issues raised above, no hurdle criteria were met for this proposal including the estates criteria as this proposal relates to the identification of a new site.

Proposal 4: Implementation of on-demand at both FMBUs
This proposal would be subject to similar challenges as a 24/7 staffing model within birthing services at an FMBU.

Workforce constraints would not be mitigated with this proposal in line with the Birthrate plus reports.

As this is an on-demand service the group discussed whether the clinical complexity and low number of patients eligible for this service is less of a factor when looking whether the service meets the needs of the population as the service would be offered on an on-demand basis.

It was noted that offering an on-demand service is similar to having an effective well-staffed home birth service when managing the low-risk population.

Powys was identified as an example of where an on-demand model works well. However, this targets a low-risk population and there isn't a consultant led unit within the area.

It was noted that if there was a continuity of carer model in place with the correct workforce to carry out this model with a robust home birthing service, an on-demand service would work well for the low-risk population.

The group therefore agreed this proposal met the criterion of meeting the needs of the population.

It was noted that as the unit is not staffed 24/7 and the midwives need to travel to this unit, the risk of patients arriving at an on-demand unit before the midwife arrives and the potential to experience clinical complications cannot be discounted.

The group agreed the estates criterion was met as the sites are available however no further criteria were met for this proposal.

Proposal 5: Implementation of on-demand at one or other of the FMBUs
It was noted that clarification would be needed as to which provider would provide the staffing, or whether it would be a joint responsibility of both providers if this proposal were to be taken forward.

It was agreed the assessment against the hurdle criteria is the same as the proposal to implement on-demand at both sites with the exception of meeting the needs of the population due to the travel implications of having a single site across the entire Staffordshire and Stoke-on-Trent geography.

The group agreed to add implementation of on-demand at an alternative site as an additional proposal for consideration.

Proposal 6: Implementation of on-demand FMBU at an alternative site
The group stated that there would need to be an assessment of where to locate the alternative site to best meet the need of the population but as it currently stands, there is no evidence this service would be utilised.

The group agreed, all workforce constraints would remain with the added complication of staff working with a potentially isolated site. This proposal would also raise challenges with regards to the clinical governance if two providers are to jointly offer birthing services at a single FMBU.

The group agreed this proposal does not meet any hurdle criteria including the estates criteria as this proposal requires the identification of new site.

Proposal 7: Permanent closure of birthing service at County Hospital and Samuel Johnson Hospital
Clinical Sustainability
All present agreed the proposal meets the criteria as clinical services and their interdependencies can be maintained within the current acute sites.

Strategic fit

The group agreed this criterion is met as this proposal offers choice in line with national guidance although this is dependent on having a home birthing service in place.

Meeting the needs of the population
The group agreed this criterion is met and the proposal meets the needs of the overall birthing population due to the increasing clinical complexity/acuity and the low numbers of women eligible to give birth within an FMBU.

Demand and Capacity
The group agreed this criterion is met as this proposal is the most effective way of managing activity.

It was noted there had been comments previously regarding whether UHNMs activity modelling account for activity outside of North Staffordshire and Stoke-on-Trent.
UHNM confirmed that modelling was completed as part of the implementation of the TSA model and the shift of obstetric-led activity from County Hospital to Royal Stoke. As a result, the small shift in activity from the FMBUs into the midwife led units will not impact on the longer-term sustainability of the service with regard to demand and capacity.

Workforce sustainability
The group agreed this criterion is met in line with earlier discussions regarding recruitment and retention.

Estates
The group agreed this criterion was met as there is sufficient and available space to deliver the proposal and utilises estates in the most effective way.

The table below summarises the results of the assessment. All present were in agreement with the assessment against the essential criteria.

	Clinical sustainability	Strategic Fit	Meeting the needs of the population	Demand and capacity	Workforce sustainability	Estates
Reinstatement of birthing service at County Hospital and Samuel Johnson Hospital	No	No (but offers additional choice for women)	No	No	No	Yes
Reinstatement of a single birthing service at one or other of the FMBUs	No	No	No	No	No	Yes
Re-instate FMBU at alternative site	No	No	No	No	No	No
Implementation of on-demand at both FMBUs	No	No	Yes	No	No	Yes
Implementation of on-demand at one or other of the FMBUs	No	No	No	No	No	Yes
Implementation of on-demand at alternative site	No	No	No	No	No	No
Permanent closure of birthing service at County Hospital and Samuel Johnson Hospital	Yes	Yes	Yes	Yes	Yes	Yes

Table 17: Essential criteria assessment

The group were asked whether there were any other potential proposals for consideration and all agreed there were no other proposals to assess.

On assessing all proposals against the essential criteria, The Technical group recommended that only one proposal is viable, which is to make permanent the temporary closure of the birthing service at County Hospital and Samuel Johnson Community Hospital. The closure relates to five low risk birthing rooms (LDRP - Labour, Delivery, Recovery, Post-Partum) across the two sites (two at County Hospital and three at Samuel Johnson Community Hospital).

If the viable proposal were to be implemented, this would not directly impact the end-to-end pathway for maternity services. Women continue to be assessed throughout their pregnancy to check for any developing risk factors or complications, which may require a change of delivery options. Under this proposal, there would be no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the TSA (for UHNM).

5.5.3 Deliberative event

In December 2023, the ICB held an online event with women and stakeholders to discuss the proposal for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital.

The purpose of the event was to;

- Give an overview of the birthing services at the freestanding midwifery birth units (FMBUs) and the proposal for the case for change.
- Talk about how the proposal was developed and any challenges faced.
- Gather feedback from participants about their own experiences, and about the recommended proposal.

We worked with the Consultation Institute to design the methodology for this event. This recognised that the technical group had recommended only one viable proposal and as a result a scoring approach would not be appropriate. This event aimed to be open and transparent, sense-check the process so far and understand if there were any new considerations that would impact the viability of these, and any new proposals.

The group was recruited to form a balanced room of service users and carers, staff and seldom heard groups to discuss the process to date, the feedback received through previous engagement and assessment of each of the proposals.

16 people participated in the event. This included patients or members of the public, representatives from NHS Trusts and representatives from voluntary organisations and charities.

Those who attended received an information pack in advance on the event, explaining the background and challenges and the process so far. It included information on the findings from the 2019/20 and 2021 involvement events and information on the development of proposals.

At the deliberative event, those attending heard a recap of the process so far. They heard that new information or suggestions from the group would be included when the business case was finalised. All proposals that were considered were explained again, together with the view of the technical group that there is only one viable proposal.

Attendees at the deliberative event were asked a number of questions.
In answer to a question about whether they thought the proposal was a good solution; participants made the following points:

- Maintaining the competency and skills of midwives is important.

- Workforce challenges are a concern.
- Increased staffing should be a priority.
- Assurance that units are safe is the top priority.
- Homebirth option should be available for people who want that choice.
- Good proposal on basis that there's a community option to receive pre- and post-birth care – would not support closure of units if that option wasn't there.
- It's not ideal for everyone because of travel.

In answer to a question about any groups who they thought might be disadvantaged by the proposals, attendees highlighted the following groups:

- Disadvantaged groups, for example low-income families, migrants and new arrivals to the UK.
- People who have a long distance to travel, who live in rural areas or don't have access to a car.
- Those who need emergency services (for example: 999) need reliable services.
- Midwives currently working in Burton.

When asked whether there were any alternative proposals that should be considered, there were no alternative proposals to the service model identified, but participants wanted to ensure continuity of care and that that the homebirth service is available as an option.

During January – March 2024, we also conducted interviews with women who registered but were not able to attend the event to gather their feedback. We sent them the information pack to read in advance.

We interviewed three women, all of whom had given birth in the last three years and are local to the area. We asked them the same questions that were asked in the deliberative event and the feedback was largely in line with what we were told during the deliberative event. Respondents also told us the importance of being able to choose where to give birth, including a home birth option.

Further detail is available in the full report of findings on the ICB's maternity transformation webpage[32].

[32] Maternity transformation - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

5.6 Staff and clinical involvement

The development of proposals is in line with the process outlines within the Planning, Assuring and Delivering Service Change for Patients guidance.

A range of clinical colleagues and partners have been involved throughout the process including Trust and ICB clinicians (including Directors of Midwifery, Chief Nursing Officers, Chief Medical Officer, Heads of Midwifery and Community Midwives) maternity leads (including local maternity and neonatal system midwifes, maternity and neonatal independent sector advisor) quality leads and patient involvement leads across Staffordshire and Stoke-on-Trent and Derby and Derbyshire ICS.

Clinical colleagues have contributed to each of the Deliberative events described within Section 5 and supported with the development of proposals at each stage of the process. In addition, clinical teams were included within the stakeholder mapping and were invited to respond to the surveys and attend the public facing involvements that have been described within this PCBC.

Each of the report of findings includes a profile of participants and identifies whether participants work within the NHS or were representatives from voluntary organisations and charities.

When the services were temporarily closed in March 2020, staff who transferred from the FMBU's into the acute units were supported and upskilled as required. In some instances, upskilling was not required due to the rotational basis of the teams and the skills already acquired through working across different settings.

At UHNM, on transferring to Royal Stoke University Hospital, following the suspension of the FMBU services, there were three substantive Band 7 midwives that initially had a supernumerary period on delivery suite of two weeks followed by allocation to shifts where there was an addition band 7 to offer support and guidance.

At UHDB, affected staff had a 1:1 with their clinical lead and were able to choose their preferred place of work (i.e. the Royal Derby Hospital birth centre, the Queen's Hospital Burton labour ward, antenatal care or on an inpatient ward) All staff were supernumerary initially following the transfer and received in house training in their area of preference where this was required.
As the units remain closed, regular updates are shared with clinical teams through staff newsletters and briefings.

Throughout the assurance and governance stages we will continue to involve staff throughout the process. We will ensure that staff are involved in the consultation and a robust

communications plan will be developed to support any implementation plans once a final decision has been agreed.

5.7 Continuous involvement

A review of wider involvement activity, such as the ICB's surveys on their Joint forward Plan and the Integrated Care Partnership Clinical Strategy, was undertaken and feedback specific to maternity and neonatal care was collated to inform service transformation.

Joint Forward Plan engagement - The purpose of this engagement was to gather the views of the public on healthcare services across Staffordshire and Stoke-on-Trent. The feedback supported delivery of the Integrated Care System's (ICS) first Joint Forward Plan and the development for the future.

The engagement survey ran between Wednesday 21 June and Sunday 27 August 2023. It received 54 responses. Of these, three respondents provided feedback on maternity services. Respondents were asked how the ICS could improve people's use and experience of maternity or neonatal care. Of the three respondents, two (67%) stated that they, or their partner, have had experience of maternity or neonatal care in the last two years. These respondents were from the Cannock and South Staffordshire areas. These two respondents were also asked to rate a series of statements relating to maternity and neonatal care.

ICP Clinical Strategy engagement survey – One respondent (out of 39) provided feedback in relation to maternity services during the engagement activity relating to the ICP clinical strategy. The respondent highlighted that due to recent changes to digital technology, maternity services having online referrals and digital notes. It was not clear if this was viewed as a positive or negative experience for the responder.

Staffordshire and Stoke-on-Trent Maternity and Neonatal Voices Partnership (MNVP) has continued to actively seek feedback from service users through a number of sources whilst the FMBU birthing service and the home birthing service have been temporarily suspended.

The MNVP is currently reviewing how to engage and recruit maternity champions from seldom heard groups. This will further support a mechanism for reaching out to engage with women and families that we have not previously heard from.

The Maternity and Neonatal Independent Senior Advocate role also helps ensure the voices of women, birthing people and families are listened to, heard and acted upon by their maternity

and neonatal care providers when they have experienced an adverse outcome during their maternity and/or neonatal care.

5.8 Engagement with Health Overview and Scrutiny Committees

Overview and Scrutiny Committee responsibilities are outlined at the beginning of the pre-consultation business case. NHS commissioners kept the Staffordshire County Council Health and Care Overview and Scrutiny Committee up-to-date with information about the Together We're Better transformation programme as it progressed through 2019 and 2020. Information shared and discussed from 2021 onwards includes updates on wider maternity services across Staffordshire and Stoke-on-Trent, the situation regarding birthing services at County Hospital and Samuel Johnson Community Hospital and details of any patient and public involvement on these issues.

Key feedback to note is outlined in the table below:

Date	Committee	Outcome
09 Aug 2021	Staffordshire Health and Care Overview Scrutiny Committee	The Committee received an update report and presentation relating to the Temporary Closure of Free-Standing Midwife-led birthing Services. At the request of the Chair, the Lead Midwife Maternity Transformation Programme gave a brief overview of the Ockenden Review of maternity services at Shrewsbury and Telford Hospitals and of the Better Births Report published in 2016. The Lead Midwife provided an overview of the presentation and report relating to the temporary closure of freestanding midwife-led birthing units (FMBUs) at Samuel Johnson Community Hospital in Lichfield and County Hospital in Stafford which provided low risk care maternity services. Resolved: 1. That the report and presentation were noted. 2. That Committee requested further data about the trend for home births to be circulated. 3. That the final proposals would be considered by the Committee at a future meeting.

23 Sept 2021	Stoke-on-Trent Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee	The Committee received an update report and presentation on the temporary closure of free-standing midwife-led birthing services. The presentation was delivered by Alison Budd – Lead Midwife, Staffordshire and Stoke-on-Trent CCG and Jenny Fullard – Communications and Engagement Service Partner, NHS Midlands and Lancashire Commissioning Support Unit. Agreed – That the report and update be noted and any future updates to include details of the work being done to develop support for dads.
11 July 2022	Staffordshire Health and Care Overview Scrutiny Committee	The Chief Nursing and Therapies Officer and Lead Midwife for Maternity Transformation, at Staffordshire and Stoke-on-Trent, ICB provided an update on maternity services transformation, the temporary closure of free-standing midwife-led birthing services and an update on progress against recommendations of the Donna Ockenden report about failings at Shropshire and Telford Hospital. Resolved: 1. That Health and Care Overview and Scrutiny Committee receive the update report and request that ICS midwife staffing data be circulated to Health and Care O&S Committee Members for information.
17 October 2022	Staffordshire Health and Care Overview Scrutiny Committee	The Chief Nursing and Therapies Officer, ICS provided an update on the Ockenden Report and Maternity Services. She advised that a further report relating to maternity services was due to be published and actions from all reports would be taken into account when developing maternity services. The Lead Midwife for Stoke on Trent and Staffordshire ICS outlined the detail in the report. The first publication of the Ockenden Report had fifteen immediate and essential actions, the second publication outlined a further seven immediate and essential actions with further work lying beneath them. The report to Committee provided an update on the initial fifteen actions and outlined areas where there was still work to do.

		Resolved: 1. That Health and Care Overview and Scrutiny Committee receive the update report.
27 November 2023	Staffordshire Health and Care Overview Scrutiny Committee	Helen Slater, Associate Director for Transformation at Staffordshire and Stoke-on-Trent ICB and Karen McGowan, Associate Director Nursing, Quality & Maternity at Staffordshire and Stoke-on-Trent ICB presented the Maternity and Neonatal Services Update to the Committee. Resolved – That (a) the report be received, and the Committee comments be noted. (b) Staffordshire and Stoke-on-Trent ICB investigate the feasibility of an external audit of maternity services in Staffordshire. (c) the Committee receive an update on maternity services and on the Freestanding Midwife-led birthing Units
15 February 2024	Stoke-on-Trent Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee	The Associate Director Nursing, Quality and Maternity, Staffordshire and Stoke-on-Trent ICB, Karen McGowan and Director of Nursing – Maternity & Safeguarding, Lynn Tolley, attended the meeting to respond to questions from Committee members in respect of the report, which provided an update on Maternity and Neonatal Services within Staffordshire and Stoke-on-Trent. The report included areas of focus, responses to regulatory reports, areas to be commended as well as areas that need further support; the report also referenced the Ockenden Insight visit and NHS England's Three-Year Delivery Plan for Maternity and Neonatal Services, which was published in 2023. Agreed - That the Update on Maternity and Neonatal Services within Staffordshire and Stoke-on-Trent be noted and a further update would be shared with the Committee in June 2024.
13 May 2024	Derbyshire County Council Improvement	Tracy Burton, Deputy Chief Nurse and Claire Johnson, Lead Midwife introduced the report, which had been circulated in advance of the meeting, which provided an overview of the maternity services in Derbyshire for

	and Scrutiny Committee - Health	2023/24 and information on governance, assurance and safety of maternity services locally; this was accompanied by a presentation that highlighted the salient facts of the report regarding the maternity units at Chesterfield Royal Hospital (CRH) and University Hospitals of Derby and Burton (UHDB). **RESOLVED to** – 1) Review the contents of the report and note the actions taken to provide governance and assurance against the national maternity service recommendations and reports; and 2) Provide an update to Committee in 6-12 months time.
29 July 2024	Staffordshire Health and Care Overview Scrutiny Committee	Helen Slater, Associate Director of Transformation, Gina Gill, Transformation Programme Lead, Lynn Tolley, Assistant Chief Nursing & Therapies Officer and Jenny Brown, Lead Midwife for Maternity Transformation from the Staffordshire and Stoke-on-Trent ICB presented the Intrapartum services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield to the Committee. The Committee were reminded that the Freestanding Midwifery Birthing Units (FMBU) at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield, were suspended at the beginning of the pandemic to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton. It was reported that prior to the units closing on a temporary basis, 94 women gave birth at County Hospital in Stafford and 220 women gave birth at Samuel Johnson Community Hospital in Lichfield (2019/20 data).

		At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals, it was recommended at the event that there was only one viable proposal, which was to make permanent the temporary closure of the intrapartum birthing services at County Hospital and Samuel Johnson hospital. The Committee noted the following comments and responses to questions: • The Committee considered the proposal to undertake a 6-week public consultation and discussed that the consultation should be 12 weeks to allow the affected District and Borough Councils the opportunity to be a part of the consultation process. • The Committee requested to receive details of the reported 23% of Staffordshire residents giving birth outside of the area, and where they were giving birth. • 83% of birthing women were deemed to be a moderate of high risk in Staffordshire and Stoke-on-Trent. The Committee discussed that the 83% was County-wide and included Stoke-on-Trent which may not accurately reflect the individual Districts/ Boroughs within the County and there may be more eligible, lower risk pregnancies within the geographical remit of the FMBUs. • The West-Midlands Clinical Senate highlighted electronic notes and data sharing. The University hospitals at Derby and Burton had recently changed system to BadgerNet which was consistent with the notes from the Black Country Trusts for data sharing. It was reported that not all Maternity Trusts used BadgerNet so there were challenges in sharing data. • The Committee discussed the demographics and data used in the report was dated and would need to be updated due to ongoing and continued housing developments in the County.

		• Prior to the temporary closure of the FMBUs there were campaigns to increase the use of the service but there was little uptake. • There was an independent Maternity and Neonatal voices partnership across Staffordshire and Stoke-on-Trent which worked alongside the ICB. It was reported that Healthwatch worked alongside the partnership and Healthwatch would be involved in the consultation. **Resolved** – That (a) the report be received, and the Committee comments be noted. (b) the Committee recommend to the Staffordshire and Stoke-on-Trent ICB that: the period of consultation should be 12 weeks to allow more time for District and Borough Councils and other residents to be a part of the consultation process. the demographic data relied on in the report be updated due to ongoing and continued housing developments in the County. (c) the Committee requested to receive details on the reported 23% of Staffordshire residents giving birth outside of the area, and where they were giving birth. (d) the Committee consider further scrutiny of Intrapartum services previously provided at County Hospital and Samuel Johnson Community Hospital.
08 Aug 2024	Stoke-on-Trent Adult Social Care Health Integration and	Helen Slater, Associate Director of Transformation at Staffordshire and Stoke-on-Trent introduced the report which provides an update on the service change programme being undertaken on the future of intrapartum

	Wellbeing Overview and Scrutiny Committee	services at the Freestanding Maternity Birthing Units (FMBU) in the south of the county. These services were not utilised by Stoke-on-Trent residents historically however an update was provided as the service was available to all Staffordshire and Stoke-on-Trent residents prior to the temporary closure in March 2020. The FMBU services (births only) at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield, were suspended at the beginning of the pandemic to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton. However since the pandemic, significant staffing challenges in the maternity workforce had prevented both Trusts from being able to safely reopen these units. The Committee asked ICB colleagues to ensure that it was clear that services at the local hospitals would be unaffected by the proposal, and that an update was provided for the committee following consultation.
August 2024	Derbyshire County Council Improvement and Scrutiny Committee - Health	An update on service change process sent to Derbyshire County Overview and Scrutiny Committee for circulation to committee members.

Table 18: Health Overview and Scrutiny committee feedback throughout the process

6 Workforce analysis

6.1 Introduction

This section of the pre-consultation business case considers the potential workforce implications of the proposal. It looks at:

- The process used to develop the workforce plans.
- The impact on the workforce of the scenarios that have been considered. It analyses future workforce capacity and competency requirements and demonstrates sufficient staff supply and safe staffing levels.
- Examining measures taken to ensure future sustainability.

The workforce plans have been developed in line with Birthrate Plus® to ensure the appropriate number of midwives according to the clinical needs of the local maternity population. These have not been developed in response to this proposal, instead they have been developed for overall maternity services to ensure the Trusts have a fully established workforce by the end of 2024, with sustainable recruitments plans in place for the future workforce.

6.2 Process used to develop workforce plans

As described within this pre-consultation business case, the proposal would not introduce any new models of care and end-to-end pathways would not be affected if the proposal was to be implemented. The proposal would have no direct implications on staffing levels however workforce plans are described within the following section to demonstrate the longer-term workforce sustainability within overall maternity services and the actions that are taken to ensure safe staffing levels are met at all times. Staffing levels and workforce profiles will also be reviewed in accordance with Birthrate Plus® and MCoC requirements on an as required basis.

The workforce plans for maternity services consider several national drivers and are overseen by a robust governance structure within the Trusts and ICB.

Safe midwifery staffing features in many national documents relating to safe maternity care including:

- Birthrate Plus® (the only calculating tool endorsed by NICE)
- NICE Safe midwifery staffing for maternity settings (NICE guidance 2015; NICE pathway 2021)
- NHS England National Quality Board Safe Staffing documents (2018)
- Delivering Midwifery Continuity of Carer (MCoC) at full scale (2021) which acknowledges the need to undertake a Birthrate Plus® assessment to understand the current standard-model midwifery workforce required and following this through with recruitment.
- Strengthening midwifery leadership: a manifesto for better maternity care (RCM, 2019)
- NHS England Maternity Business assurance Framework (revised July 2021)

- Safe midwifery staffing was also at the forefront of 'the safety of maternity services in England Parliamentary Business July 2021.
- HSIB (2020) published a National Patient Safety, 'Delays to intrapartum intervention once fetal compromise is suspected' and recommended the introduction of a flow coordinator. UHNM also contributed towards the report.

Midwifery staffing was at the forefront of 'the safety of maternity services in England Parliamentary Business, July 2021. Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping women safe from avoidable harm.

Safe midwifery staffing continues to be one of the safety actions within the NHS resolution CNST maternity incentive scheme year 6, it features within the three-year delivery plan far maternity and neonatal services and is recognised by NICE as being vital to safety in maternity units (NICE guidance 2015; NICE pathway 2021).

Full Birthrate Plus® reviews were completed for each of the Trusts. Birthrate Plus®, is a national tool that gives the intelligence and insights and informs decision-making about safe and sustainable services needed to be able to model midwifery numbers, skill mix and deployment across all maternity services based on the complexity risk rating of women within each Trust.

Following a full review of their Birthrate plus® assessments, both Trusts approved business cases to increase the workforce establishment.

The planned growth within maternity services submitted as part of the business case at UHNM is shown below:

Phase	Job Title	Recurrent Funding source	Non recurrent funding	Start Date for UHNM Funding	Pay Band	WTE
Ockenden Funding Received in 21/22	Ockenden - Operational midwives	Ockenden funding in place from 21/22 RECURRENT		01/04/2022	6	3.26
	Ockenden - Training midwives			01/04/2022	6	3.26
	Ockenden - Consultant Obstetrician DCC PA's			01/04/2022	-	0.60
	Midwives - Newly qualified			01/10/2022	6	20.00
	Midwives - MAU triage			01/10/2022	6	2.14
	Maternity Support Workers			01/10/2022	4	5.60
STAGE 1 TOTAL						**34.86**
- Birthrate Plus® Compliance	Band 6 - Operational midwives	Recurrent funding requested through Business Case		01/01/2023	6	18.81
	Maternity Support Workers			01/01/2023	3	0.68
Specialist role	Maternal & New-born Screening Lead Midwife			01/01/2023	7	1.00
Pharmacy	Band 8a - Specialist Pharmacist Support			01/01/2023	8a	0.50
STAGE 2 TOTAL						**20.99**

Table 19: Approved establishment increase at UHNM

The planned growth within maternity services approved within business cases from 2021 onwards at UHDB is shown below:

Row Labels	Sum of £000's	Sum of WTE
Anaesthetics and Theatres - Additional sections	1,893	24.93
Medics - additional obstetric support	1,120	11.79
Midwifery - Birth rate plus staffing	957	17.38
Midwifery - Continuity of Carer	124	2.21
Midwifery - Governance	52	1
Midwifery - management	544	11.36
Midwifery - on-call	216	3.04
Midwifery - Sonography	134	3
Midwifery - specialist posts	177	3.8
Midwifery - training	297	0
Neonates	1,659	27.52
Theatres - Additional theatre support	300	7.76
Transitional Care	660	12.73
Grand Total	**8,132**	**126.53**

Table 20: Approved investments into maternity services at UHDB

Overall, the maternity workforce at both of these Trusts is showing a planned increase of 182.38 whole time equivalents.

6.2.1 System-wide governance

Maternity services are under intense scrutiny to provide significant assurance relating to how they are improving the safety of the care provided to mothers, babies and families following the publication of the reports of the University Hospitals of Morecambe Bay (2015), the East Kent Hospitals University NHS Foundation Trust enquiry (2021) and the Shrewsbury and Telford Hospital NHS Trust Ockenden Report (2022).

Following the publication of Ockenden the Final Report (March 2022) Trusts have been asked to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars, one of which being safe staffing levels.

The Royal College of Midwives (RCM) in March 2022 have additionally released their position statement on safer staffing;

- "Every woman in established labour should be cared for by at least one midwife.
- The Boards of NHS maternity providers are ultimately responsible for ensuring that there are, at all times, sufficient suitably qualified and competent midwives to provide women and babies with safe, compassionate, and high-quality care.
- Each Board should regularly review midwifery staffing levels and ensure that the maternity services budget covers the total cost of the midwifery staffing establishment.

> Midwifery staffing establishments should be regularly reviewed and monitored to ensure adherence to relevant guidelines and compliance with the recommendations of evidence-based workforce planning tools."

A robust governance structure is in place across the ICS to monitor and provide assurance on safe maternity staffing levels.

The midwifery staffing vacancy position is reported at a national level for each Trust through the PWR (provider workforce return) each month. The data for this is pulled from ESR based on the budgeted establishment. However, it includes data for all budgeted midwives throughout the organisation, not just those working clinically. Therefore, the figure quoted will not be representative of the actual clinical midwifery vacancy.

It does accurately represent the vacancies within the band 2, 3 and 4 roles. To have an accurate vacancy position, the senior team, ward managers and retention leads meet regularly with the Divisional finance lead to look at midwifery establishments numbers in every area to produce an accurate up to date position on a regular basis.

Workforce reports are compiled on a regular basis (at least quarterly) developed initially at ward/directorate level and reported through divisional governance, onto executive quality and safety oversight forums and then taken through Board level assurance and LMNS system wide assurance.

6.2.2 Safer staffing

The Birthrate Plus® tool has been utilised in both Trusts to identify the overall midwifery staffing requirements. The framework is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant(s) throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V) the lower the score the more normal are the processes of labour and delivery. The categories are described in the table below.

CATEGORY I Score = 6 This is the most normal and healthy outcome possible. A woman is defined as Category I [lowest level of dependency] if: The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring
CATEGORY II Score = 7 – 9

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.
CATEGORY III Score = 10 – 13 Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.
CATEGORY IV Score = 14 –18 More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.
CATEGORY V Score = 19 or more This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post- delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Table 21: Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

Together with the casemix, the number of midwife hours per patient/client category is included. This is based upon the well-established standard of one midwife to one woman throughout labour. In addition, extra midwife time needed for complicated Categories III, IV & V, is included to calculate the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, antenatal and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the locally agreed uplift (%) for absence allowances and for travel in community**.**

Based on 25.99% uplift, the overall maternity workforce requirements for UHNM are as shown in the table below:

Total Clinical WTE (including band B4 MSW's)	271.88
Non-Clinical	29.91
Clinical, Specialist, Management Total	301.79

Table 22: UHNM midwifery staffing requirements identified within the Birthrate Plus® assessment.

Based on 24% uplift, the overall maternity workforce requirements for UHDB are as shown in the table below:

Total Clinical WTE (including band B4 MSW's)	386.22
Non-Clinical	34.76
Clinical, Specialist, Management Total	420.98

Table 23: UHDB midwifery staffing requirements identified within the Birthrate Plus® assessment

The results are calculated based on three months case mix data and compared to previous reports to identify any changes in case mix and acuity and the resultant staffing requirements. Day-to-Day acuity in maternity is measured using the Birthrate Plus® intrapartum acuity app. This is reliant on 4 hourly data entries which identify any midwifery staffing needs and ensure safety for women and babies during this period.

The use of the acuity app is supplemented with daily safety huddles within each of the Trusts. During the safety huddle, representatives for the various areas within the maternity unit come together to give an accurate and readily available helicopter-level view of the whole unit. The huddles give all staff the opportunity to understand the workload within the unit, staffing and acuity and any potential or arising safety issues. The safety huddle board is updated throughout the day and supports the manager in planning the roster and allocation of staff.

Both Trusts anticipate reaching full midwifery workforce establishment by the end of 2024. While the mandate for implementing CoC by 2022 was removed by NHS England due to workforce challenges during the pandemic (see section 3), this was on the basis that Trusts review its implementation when it was safe to do so. At the heart of the model is the vision that women have consistent, safe and personalised maternity care and requires appropriate staffing levels to be implemented safely. Both Trusts are developing plans for implementing CoC for the most vulnerable groups of women now that there is a clear trajectory for reaching full staffing establishment (see sections 4.4 and 4.5).

Consideration of workforce sustainability has been central to the programme: longer term clinical and workforce sustainability enables the system to develop and grow a continuity of carer model during pregnancy, birth and beyond for those most vulnerable in the local community. Any current plans to implement CoC or expand this to further cohorts of women would be placed on hold if birthing services at the FMBUs were to be reintroduced due to the work that would be required to either recruit additional midwives or reconfigure the workforce.

6.3 Workforce impact for each scenario

As highlighted above, the proposal within this pre-consultation business case makes permanent the arrangements that have been in place since March 2020 when the units temporarily closed to births. As a result, there are no additional staffing requirements as a result of the proposal. However, a number of workforce challenges would be more challenging if birthing services were to be reintroduced at County Hospital and Samuel Johnson Community Hospital and these are described within this section.

6.3.1 Recruitment

A major challenge is the difficulty of recruiting and retaining staff. As described earlier in this pre-consultation business case, there is a national shortage of midwives and the Trusts have run large recruitment campaigns to recruit to vacant posts. These campaigns are ongoing with both Trusts aiming to reach full establishment by the end of 2024. A further increase or reconfiguration of the workforce would be required to reinstate birthing services at the FMBUs and historically, it has been difficult to these roles due to the factors described in the following two sections. In addition, at a national level we have been struggling with retention rates, where more midwives are leaving the profession than are joining; as a result, the Trusts have worked on their preceptorship programmes, as part of their retention strategy, in order to ensure that staff feel valued and remain working within the profession.

While the reinstatement of an on-demand model would not have the same recruitment pressures as the reinstatement of a 24/7 model, this would increase the workload within the community midwifery teams and likely require an increase in the community staffing establishment. The model would require an increase in the number of community midwives who are on-call at any given time which reduces their capacity to deliver antenatal and postnatal care. Teams would also need to consider how this may impact on home birth services that became operational in October 2024.

6.3.2 Training and Retention

Recruitment of midwives at both Trusts has been increased through the appointment of internationally educated midwives. However, support to complete OSCEs, gain PINS and then a minimum period of 12 weeks' supernumerary has meant this has not provided an immediate impact on safe staffing. In addition, a large proportion of the new recruits are newly qualified midwives or international midwives who enter 12-18 month preceptorship programmes on qualifying. The preceptorship programme is a period of structured support for newly registered midwives whilst they integrate into their new team and place of work. The programmes include rotation through antenatal, intrapartum and postnatal care to enable preceptees to gain extensive knowledge within the area they want to work. Positive preceptorship experience is reported to result in newly registered nurses, midwives and nursing associates having increased confidence and sense of belonging, feeling valued by their employer, and having greater professional and team identity. Effective preceptorship outcomes are also linked to improved recruitment and retention. The standalone nature of the FMBUs mean midwives are largely isolated whilst working within the unit with very limited clinical wrap around support. As such these units can only be staffed by experienced midwives to ensure preceptees are able to fully integrate into wider maternity services.

Retention midwives are in place within both Trusts (Two at UHDB - one at Royal Derby Hospital and one at Queen's Hospital, Burton and one at UHNM based at Royal Stoke Hospital) who are actively engaged with the workforce to support with recruitment and retention. Exit interviews conducted by retention midwives identify that key reasons for leaving are recruitment to roles in midwifery education and lack of core positions for midwifery staff. This is being reviewed as part of the workforce review.

There are regular reviews of the workforce skill mix to identify any gaps and provide training as appropriate, supported by clinical education midwives. All staff, including support staff have a training matrix including mandatory training (for example Practical Obstetric Multi-Professional Training - PROMPT) and where there are any gaps in available training the Trust source that training.

In May 2023, the Core Competency Framework Version 2 was released, and NHS England stated all Trusts must have a local training plan using a Training Needs Analysis (TNA) to include the six core modules of the CCFV2 and this training programme should run over a three-year period. The CCFv2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service. The Trusts training programmes have been developed to meet the requirements within the framework.

The Trusts monitor training guidance and best practice on an ongoing basis, including NHSEI and National Institute for Health and Care Excellence (NICE) guidance and provide appropriate training as required.

The Trusts also offer regular training workshops focussing on specialist clinical areas in addition to 'live' skills drills to test systems within clinical areas to improve safety and practice.
Staffing uplifts within the Birthrate Plus® assessments ensure teams can be offered dedicated time to complete their training and while Trusts maintain safe staffing within their units.

As the FMBUs managed a small number of low-risk births with very limited exposure to clinical complexities, there is also the risk that experienced midwives would be under-utilised and may struggle to maintain their competencies. They also are not exposed to the enhanced learning and training support that comes from working within an alongside unit.

6.3.3 Workforce interdependencies

During the options appraisal process, the clinical team outlined the following interdependencies for maternity services;

- Critical Care
- Anaesthesia
- Interventional radiology
- Emergency surgery for women
- Neonatal services

- Paediatric services
- Imaging
- Mental Health
- Pathology
- Gynaecology

These interdependent services have not been affected by the temporary closure of birthing services at the FMBU as both Trusts have continued to offer low-risk birth options within their maternity services and receive transfers/escalations into further care as required.

However, these services were not available within the FMBUs and the women or babies who required extra support were transferred via an ambulance to the acute hospitals. By centralising services on a single site it ensures women have access to timely emergency support. This also reduces the risk of a women having to be transferred in the later stages of childbirth, therefore reducing the potential for poorer experience of childbirth. As birth partners are not permitted in the ambulance, this may result in the mother feeling less supported and may also have a negative impact upon their birthing experience.

In addition, any babies born who need additional support would have closer access to a Neonatal Team at the main hospital sites, rather than a 'blue light' transfer to the hospital's neonatal unit.

Any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time. Centralising services reduces the risk of placing additional pressure on an already strained ambulance service.

6.4 Measures for workforce sustainability

Each Trust is carrying out a number of initiatives to ensure they have the workforce capacity for maternity services. This includes ensuring staff have the right competencies and skill mix.

6.4.1 Training and competencies for sustainability

The proposal under consideration assumes the reintroduction of the home birth services to ensure women have an alternative low-risk birth option. Both Trusts began booking women into the home birth service during their early pregnancy from April 2024 and as a result, refresher training for midwives was completed within both Trusts to prepare and upskill staff for the commencement of home birth services.

UHNM is currently in the process of providing in house training to all outpatient midwives. This comprises of a full day of training, focused on managing childbirth emergencies in a community setting. This is in addition to the Practical Obstetric Multi-Professional Training (PROMPT).

Following on from this, all community staff will work a supernumerary shift within an intrapartum area; preferably the birth centre with the purpose of consolidating learning and further

increasing confidence in preparation for offering and facilitating choices around home birth provision.

In addition, the Community staff are currently involved in multidisciplinary training with ambulance crew from West Midlands Ambulance Service (WMAS) on childbirth emergencies in the community to prepare for the reintroduction of the home birth service.

UHDB is currently in the process of providing in house training to midwives as required, including PROMPT mandatory training. The Trust is liaising with East Midlands Ambulance Service (EMAS) and WMAS to arrange joint in-house training. In addition, a one-day Babylife line Homebirth Emergency training is planned and will be taught jointly with the ambulance service. UHDB will undertake a skill gap analysis to identify staff that will need supported clinical supernumerary shifts in the midwife-led setting.

The home birth service will be configured in a more sustainable way going forward. It will form part of a mixed staffing model, midwifery resource to support complex birth and midwives to support universal care. In terms of universal care, midwife-led services and the home birth service will be staffed primarily by core birth centre midwives on shift, supported by community midwives who will be on call. Equally if activity is high in the birth centre community midwives on call would be expected to come in to support that activity. There will be a separate on call staff escalation by acute midwives to respond to peaks in activity for complex care. The proposed model ensures that staff are confident and competent to work in focused areas, as opposed to being expected to cover all, where historically it has been difficult to maintain skills due to the infrequency of exposure.

6.4.2 Recruitment and retention for sustainability

In terms of Trust level recruitment to support sustainability, proactive and successful recruitment campaigns have been completed and each Trust has lead midwifes for recruitment and retention in place to support the process. Midwifery recruitment and retention improvement plans have been developed which outline key actions that focus not only on reaching the required staffing establishment but reduce attrition with preceptees, offer support for staff to improve retention and ensure people feel valued within their roles.

The preceptorship programme at UHNM has seen great success with a 100% retention of the 2022 cohort. Some of the initiatives built into the preceptorship programme include*:*

- Strong onboarding process including afternoon tea, nights out and what's app group.
- Two-week induction including team building and orientation to the service.
- 6 weeks supernumerary time on top of induction.
- 4 protected nonclinical days for training and pastoral support.
- Allocated preceptor.
- Orange lanyard to identify preceptees. A successful way of ensuring good support.
- Opportunity to participate in Director of Midwifery fellowship.
- Enhanced financial package.

- Supportive package for preceptorship graduates with the Acorn scheme; new band 6's have an Acorn pin to identify them as junior staff members.

Initiatives have also been built into the Preceptorship programme at UHDB:

- Bespoke training packages for all newly qualifies midwives
- Students waiting for their PINS receive maternity specific mandatory training to support their transition to registrant
- Seven additional multidisciplinary / professional preceptorship days introduced, enhancing cross speciality learning and supporting the foundations of the preceptorship period.
- Maternity specific training days to support with skill development and wellbeing.
- All band 5 midwives now line managed by the retention leads to ensure a consistent approach, continuity whilst on rotation across the service and improving sickness, annual leave and wellbeing for each individual
- considering different ways of rotating across the service during the preceptorship period
- Supporting band 6 development packages
- Protected clinical supernumerary period for each rotation.
- Additional clinical support available if required via a bleep system

The development of the maternity support worker (MSW) workforce is key to the retention of MSW's and the improvement of maternity services. There are several opportunities available for support workers at UHNM to progress their career from entry level positions to entry on the NMC midwifery register. These include:

- Opportunities to take functional skills (Maths and English), NVQ level 2, & NVQ level 3
- Support of foundation degrees with a midwifery pathway to develop MSW's into B4 positions in the community, infant feeding, and education.
- Midwifery apprenticeships developing MSWs into midwives.
- Implementation of specialist MSW roles including:
    - Infant feeding
    - Substance abuse
    - Safeguarding
    - Bereavement
    - B4 community
    - Lead MSW for recruitment and retention.

- Celebration of MSW successes. One MSW has been nominated for and received a Chief Midwifery Officer award.
- Planned bespoke MSW training day to upskill the MSW workforce.

Developments for the maternity support worker workforce in UHDB includes;

- current workforce benchmarked against the national maternity support worker (MSW) framework, including 121 meetings with individuals to support career progression.

- Band 6 registered midwife and band 3 Maternity support worker appointed to support the benchmarking work.
- Applied for LMNS funding for a permanent band 6 RM and x2 Band 4 MSWs to support with bespoke training packages.
- Supporting Level 3 and Level 5 apprenticeship development for MSWs.
- Also supporting apprenticeship for MSWs to undertake midwifery training in Sept 24.
- Skills passports going through governance approval and should be ready for launch.
- Links with multiple academic providers to support with functional skills, and level 3 apprenticeship training to support different learning styles.
- Support from PLSU in the clinical area to help with assessments.
- Developing in house training for assessors to ensure a consistent approach.

At a system level, the ICS has been working collaboratively from a workforce perspective since 2017. Relationships have formed between NHS, local authority, ICB, primary care, social care and VCSE partners to tackle the workforce pressures at a system level.

Utilising the National People Plan, the Staffordshire and Stoke-on-Trent Interim People Plan 2022-23 and Beyond, prioritises workforce activities required to progress the ICS towards being a more integrated, inclusive, supportive system for our people. The People Plan prioritises working together to build compassionate and inclusive cultures, striving to affect positive change across the whole workforce, collaborating, widening participation, developing a broader talent pipeline and ensuring our workforce reflects our population.

The ICS is in the process of finalising our ICS Organisational Development (OD) Plan which intends to build on existing individual Organisation approaches to prioritising employee happiness and well-being in order to support improvements in engagement and experience efforts. Set within the strategic context of the NHS Long Term Workforce Plan, the Hewitt Review, the Fuller Stocktake, the NHS People Promise and The Future of HR and OD, it aims to cultivate a system wide culture of connection, collaboration and consistency with compassion, inclusion and belonging central to everything we do. The Plan will strategically shape our ICS Organisational Development approach and activities, guiding the focus for ICB Board Development and associated leadership and modelling of system culture and collaboration, as well as setting the scope and direction of agreed ICS strategic OD priorities. The Plan aims to identify and build on existing good practice, sharing learning, sourcing opportunities to scale, spread and innovate, in order to reduce duplication, whilst maximising efficiency.

Across the system, we have made significant progress to date in the areas of organisational development, equality, diversity and inclusion, staff engagement and talent and leadership. and staff engagement across their individual organisations. Health and Wellbeing and Positive Inclusive cultures are identified as collective priority areas of focus across providers. The OD action plan will identify areas of good practice that can be built upon, scaled and spread.
The infographic below sets out our ‘Journey to Work’ model which captures our long-term approach to engaging our communities; attracting and supporting local people into health and care volunteering, jobs and careers; and looking after people through the employment lifecycle.

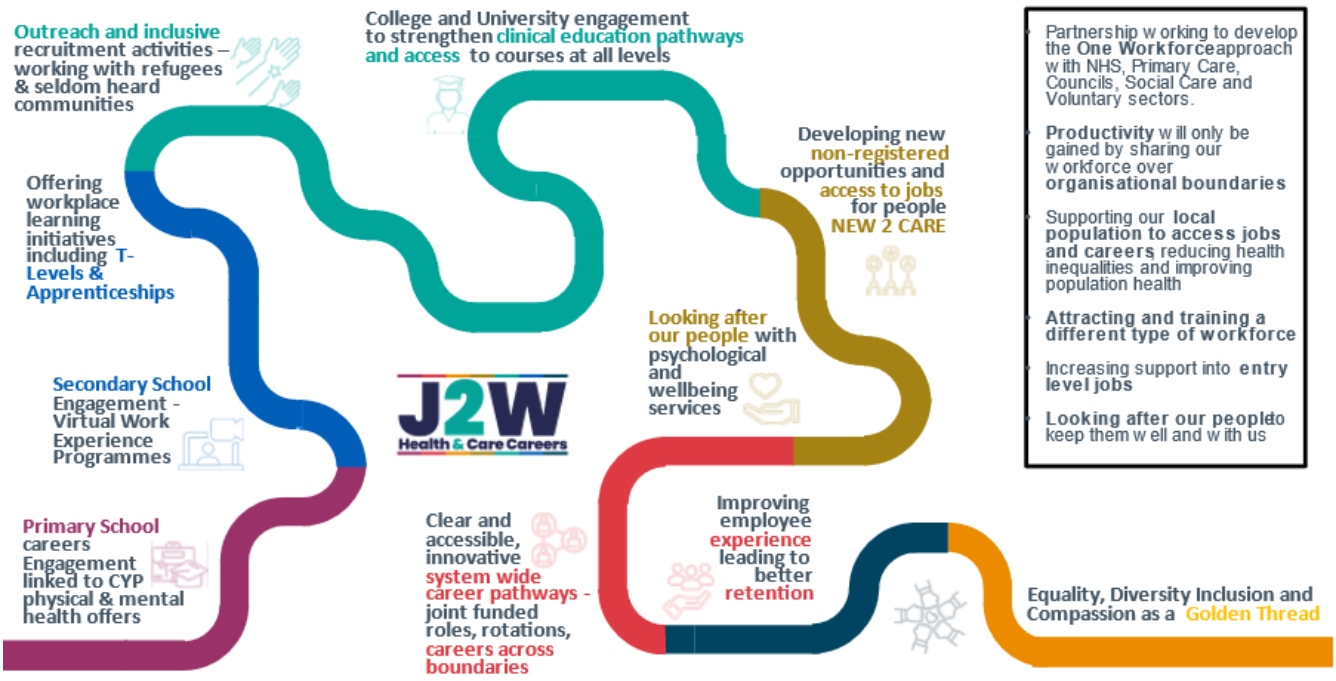


Figure 12: SSOT ICS 'Journey to work' model

7 Financial analysis

7.1 Introduction

This section describes the assessment of any financial impact of the proposal – making permanent the temporary closure of birthing services at County Hospital and Samuel Johnson Community Hospital.

The section includes:

- Staffordshire and Stoke-on-Trent ICB finances
- Trusts' baseline financial situation.
- Staffordshire and Stoke-on-Trent finance principles
- The impact of the proposals.
- Future prospects and funding.

The operating expenditure reflects the scale, nature and acuity of the women supported in the temporary model, by UHNM and UHDB within the acute sites and within the community. Inevitably of course, the current picture is different to that which existed prior to the temporary closure, and this section will demonstrate that.

True like-for-like comparisons are impractical as wherever based, maternity services required significant recruitment in order to reach the staffing establishment as identified within the Trusts Birthrate plus® reports. Nevertheless, this section will provide assurance that the proposal is sustainable within the overall financial plan for the Trusts and its commissioners and continues

to offer better value in financial terms than reverting to the pre-Covid model of a 24/7 staffed midwife-led birthing service at each unit.

7.2 Staffordshire and Stoke-on-Trent ICB finances

The Staffordshire and Stoke-on-Trent ICB estimated an underlying deficit of circa £200m before the pandemic and going into 2024/25 is circa £250m. Over the past year the system has implemented a financial strategy which has started the process of financial improvement. The system financial strategy alongside the system recovery plan has helped contain activity growth, also implemented double lock process for organisations to gain system approval for any business cases that deteriorate the underlying position.

Achieving financial sustainability is increasingly challenging and there will be significant control issues facing the system in the short and medium term, as partners work collaboratively to manage activity growth and reduce the underlying deficit. The system is working to maximise the significant opportunities for productivity improvements across all areas, which will be used to drive out the remaining deficit.

Maternity funding streams are within an overall block contract with providers. The contracts are not itemised on a line-by-line basis for each service therefore the allocation of resource to maternity activity is at the discretion of providers.

For intra-system providers (in area providers e.g. UHNM), the apportionment of resource allocations is split on a fair shares basis and growth applied accordingly within NHS guidelines. Any Ockenden funding is included within the ICB baseline funding, to which it is included in the block contract and ring-fenced for maternity services within UHNM.

For inter-system providers (out of area providers e.g. UHDB) For 2024/25, contract values for 2024/25 have been built up using the opening contract baseline (Exit 2023-24 recurrent contract value), any other known adjustments and then growth applied accordingly within NHS guidelines.

Each year transformation funding is allocated to Integrated Care Board LMNS partnerships with the purpose of supporting improvements in safe, personalised maternity and neonatal care.

High level objectives have been set out in NHS England » Priorities and operational planning guidance 2024/25 and all systems must continue to implement the NHS England » Three year delivery plan for maternity and neonatal services including meeting the key actions for systems identified in the planning guidance

Funding for maternity improvement comes in 3 main forms:

- Fair share allocation to support Three Year Delivery Plan Implementation including LMNS system leadership, safety and transformation.
- Funding for specific pilot projects which the system has agreed to take part in (Maternity bundle 2,3 & 4 where applicable)

- Funding relating to the Ockenden report which is for frontline maternity staff and is issued as a pass-through for provider Trusts :
    - Ockenden I: funding included in ICB core allocations from 2022/23 on a fair shares basis
    - Ockenden II: Maternity bundle 5 (Trust based allocations)
    - Ockenden III (as announced in Aug 2023) allocated within maternity bundle 1 (fair shares)

The LMNS was allocated a total of £3,371,000, the table below outlines the split of the allocation.

Summary	Allocation	Value
Maternity 1 **3 Year Delivery Plan Implementation** - Implementation funding including LMNS Capacity - Pre-term birth clinics and Maternal Medicine Networks - Perinatal Pelvic Health Services - Ockenden III workforce funding	SDF (recurrent)	£1,187,000
Maternity 2 Enhanced Continuity of Carer	Targeted	£196,000
Maternity 4 Independent Senior Advocate	Targeted	£90,000
Maternity 5 **Ockenden II Workforce** Bereavement Retention MSSW Improving Student Clinical Placement Experience Obstetric Leadership Capacity	SDF (recurrent)	£146,000
Initial funding for response to Ockenden included with ICB Baseline funding	Core ICB Allocations (recurrent)	£1,687,000
Maternal Mental Health LTP Maternity	SDF	£ 65,000

Table 24: SSOT ICB LMNS funding allocations 2023/2024

There are no associated costs with the proposal as described in the sections below and therefore it poses no risk to system finances.

7.3 UHNM and UHDB baseline financial situation

The table below provides the total operating expenditure (pay and non-pay) attributed to maternity provision at UHNM and UHDB, dating back prior to the temporary closure of birthing services in March 2020.

	2018/19 £,000	2019/20 £,000	2020/21 £,000	2021/22 £,000	2022/23 £,000	2023/24 £,000
County Hospital	1227	792	490	570	645	300
Royal Stoke Hospital	25,786	27,345	29,581	33,043	35,049	38,894

Table 25: Total maternity operating expenditure at UHNM April 2018 – March 2024

- This excludes fixed corporate overheads which may be attributable to the estate for a 'full absorption' expenditure view, but this is notional and variable based upon changing methodology over time and would be fixed in the medium term regardless of changes in operating models.
- The reduction in costing aligned to County Hospital in 2023/24 was due to the merging of the County Community Midwifery budget into a combined Midwifery team budget that is coded within the Royal Stoke Hospital Budget line.
- Expenditure includes any staff pay uplifts awarded.
- Medic cover is included within the expenditure for all years. These roles include support for Gynaecology however these costs cannot be disaggregated due to the dual nature of the Obstetrics and Gynaecology medical roles.

	2018/19 £,000	2019/20 £,000	2020/21 £,000	2021/22 £,000	2022/23 £,000	2023/24 £,000
Samuel Johnson Hospital	579	562	421	239	22	6
Sir Robert Peel Hospital	49	-1	0	0	0	0
Queens Hospital, Burton	10,278	10,161	9,812	10,462	11,261	12,085
Royal Derby Hospital	20,782	21,850	21,891	24,284	27,119	30,731
Cross site expenditure	799	1,040	1,139	1,432	1,440	2,316

Table 26: Total maternity operating expenditure at UHDB April 2018 – March 2024

- This excludes fixed corporate overheads which may be attributable to the estate for a 'full absorption' expenditure view, but this is notional and variable based upon changing

methodology over time and would be fixed in the medium term regardless of changes in operating models.
- Expenditure includes any staff pay uplifts awarded.
- Medic cover is included within the expenditure for all years. These roles include support for Gynaecology however these costs cannot be disaggregated due to the dual nature of the Obstetrics and Gynaecology medical roles.
- The decrease in budget at Samuel Johnson Hospital during 2022/23 and 2023/24 reflects a change in budget line where redeployed staff took up permanent posts within another role in the years following the temporary closure.

7.4 Impact of the proposals

The proposal makes permanent the temporary arrangements that have been in place since March 2020 when birthing services at County Hospital and Samuel Johnson Community Hospital were temporarily suspended. There are no additional staffing or estates costs as a result of the proposal however this section outlines the estimated costs associated with reestablishment of the clinical model as per March 2020 or as an on-demand service.

The required investment into maternity services overall, regardless of the service change process, means a direct comparison of the overarching cost of past and present models is not possible as this investment was required prior to the temporary closure of services to increase staffing levels to the required baseline.

The table below (also included within section 6.2) outlines the additional investment into maternity services at UHNM since 2021 to increase the midwifery workforce establishment to meet the workforce requirements as outlined within the Birthrate Plus® report.

Phase	Job Title	Recurrent Funding source	Non recurrent funding	Start Date for UHNM Funding	Pay Band	WTE	FYE
2021/2023							
Ockenden Funding Received in 21/22	Ockenden - Operational midwives	Ockenden funding in place from 21/22 RECURRENT		01/04/2022	6	3.26	(182,635)
	Ockenden - Training midwives			01/04/2022	6	3.26	(182,097)
	Ockenden - Consultant Obstetrician DCC PA's			01/04/2022	-	0.60	(92,372)
	Midwives - Newly qualified			01/10/2022	6	20.00	(946,362)
	Midwives - MAU triage			01/10/2022	6	2.14	(101,261)
	Maternity Support Workers			01/10/2022	4	5.60	(182,274)
TOTAL						**34.86**	**(1,687,000)**
2022/2023							
Birthrate Plus® Compliance	Band 6 - Operational midwives	Recurrent funding requested through Trust Business Case		01/01/2023	6	18.81	(890,054)
	Maternity Support Workers			01/01/2023	3	0.68	(21,055)
Specialist role	Maternal & New-born Screening Lead Midwife			01/01/2023	7	1.00	(52,881)

Pharmacy	Band 8a - Specialist Pharmacist Support		01/01/2023	8a	0.50	(31,494)
TOTAL					**20.99**	**(995,484)**

Table 27: UHNM midwifery staffing investment

The table below (also included within section 6.2) outlines the additional investment into maternity services at UHDB since 2021 to increase the midwifery workforce establishment to meet the workforce requirements as outlined within the Birthrate Plus® report.

Row Labels	Sum of £000's	Sum of WTE
Anaesthetics and Theatres - Additional sections	1,893	24.93
Medics - additional obstetric support	1,120	11.79
Midwifery - Birthrate plus® staffing	957	17.38
Midwifery - Continuity of Carer	124	2.21
Midwifery - Governance	52	1
Midwifery - management	544	11.36
Midwifery - on-call	216	3.04
Midwifery - Sonography	134	3
Midwifery - specialist posts	177	3.8
Midwifery - training	297	0
Neonates	1,659	27.52
Theatres - Additional theatre support	300	7.76
Transitional Care	660	12.73
Grand Total	**8,132**	**126.53**

Table 28: UHDB maternity services investment

This additional investment within each of the Trusts mean they are able to safely staff maternity services under the current operating model which mirrors the proposal within this pre-consultation business case.

The ICS has developed cost estimates for the reinstatement of birthing services at County Hospital and Samuel Johnson Community Hospital that would be required in addition to the above investment.

7.4.1 Staffing costs

The Birthrate plus® assessment completed for UHNM did not include the required staffing for birthing services at County Hospital as the service was temporarily closed at the time. These were not therefore, included within the business case to increase the staffing establishment. As a result, further investment would be required to reinstate these services in order to fund the additional midwives what would be needed to run birthing services at County Hospital.

The cost estimate for reinstating birthing services on a 24/7 basis at County Hospital is £1,091,704. This includes an increase of 12.15 wte Band 7 midwives to ensure there are 2 midwives present at a birth and 5.6 wte Band 2 admin support for the service within the hospital. This also includes any initial equipment costings.

Whilst the Birthrate plus® reports for UHDB included the births within the FMBU, the assessment was based on historic activity and did not reflect the required rota to staff the unit on a 24/7 basis. The Birthrate Plus® assessment included a requirement for 8.48 whole time equivalents to cover births within the unit and any transfers to obstetric care in addition to covering antenatal clinics. An increase of 3.67 wte band 7 midwives would be required to reach the minimum of 12.15 midwives to cover the births within an FMBU and to cover the rota for the unit to be staffed on a 24/7 basis. This would require an investment of £261,960 to fund the additional midwives that would be required. It is likely that an increase beyond 12.15 midwives would be required to cover the antenatal activity however this cannot be quantified as the Birthrate plus® assessment does not provide a breakdown of the staff required for each element of care within the unit.

Reinstatement of services on an on-demand basis would require the utilisation of the community midwifery team. A 24 hour on-call rota is currently in place with midwives supporting the alongside midwife-led and consultant-led units as required. Given the historic low demand and rising complexity within pregnancies, it is not clear that reinstating services on an on-demand basis would incur additional costs for the Trust. This would however require a reconfiguration of the teams to ensure there is adequate cover across all maternity services. If this proposal were to be implemented, additional costings associated to the reconfiguration would likely become apparent. Whilst it is not possible to quantify the impact, there would be cost implications if demand for birthing services at the FMBU were to increase as additional workforce would be required to maintain the long-term sustainability of home birth services and birthing services at the FMBU simultaneously.

7.4.2 Capital costs

Potential capital costs associated within the reinstatement of birthing services within the FMBUs have been identified by utilising the backlog maintenance figures for each of the sites.

The summary backlog figure for the FMBU at County Hospital, Stafford is included in Table 29 below which shows total of £1.3m less VAT, fees and risk (c40% in addition to the £1.3m).

	Physical Condition	Statutory Standards	Total
High	£0	£0	£0
Significate	£218,594	£26,488	£245,083
Moderate	£979,824	£1,577	£981,401
Low	£3,276	£0	£3,276
Total	£1,201,694	£28,066	**£1,229,759**

Table 29: County Hospital FMBU summary backlog position

The backlog figures outlined above are to bring the area to Condition B and does not take into account re-modelling or to create an area that is compliant with new non-retrospective legislation or recommendations from the Department of Heath technical standards and guidance for estates; the Health Technical Memoranda documents (HTM) and the Health Building Notes (HBN). This could be around £7m based on the costs for recent projects at County Hospital, to ratify these figures a feasibility study would need to be undertaken.

No additional capital costs or backlog maintenance has been identified for birthing services at Samuel Johnson Community Hospital with the exception of £16,200 for replacement equipment.

7.5 Staffordshire and Stoke-on-Trent ICS financial principles

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

These key principles are:

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

7.6 Future prospects and funding

The Staffordshire and Stoke-on-Trent (SSOT) Integrated Care System has agreed to meet a financial target to achieve a deficit of no more than £90m in 2024/25. Addressing the financial challenges and deficit within the system requires a multifaceted approach, combining immediate financial management strategies with long-term planning and investment in innovation and efficiency improvements. The system has recognised that it must develop a plan that returns the system to a sustainable financial position. Work on this medium-term plan is already underway and the milestone events have been agreed.

Looking further forwards, the financial model of all services will be kept under review to ensure the services not only remain safe and contemporary in terms of quality standards, and follow the national direction, but also that they offer value for money, compared against benchmarks, reference costs and other comparators. Workforce planning and building community capacity is essential.

8 Evaluation of proposals

8.1 Introduction

This section describes the evaluation of the proposals for the future of birthing services previously provided at County Hospital and Samuel Johnson Community Hospital. It includes:

- The Government's 'four tests' and bed test applied to service change.
- Quality, safety and clinical sustainability.
- Deliverability.
- Equality and health inequalities.
- Independent review of clinical model and proposal

The proposal for these services is:

- To make permanent the temporary closure of birthing services only at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

Antenatal and postnatal care would continue to be offered at the above locations.

8.2 The Government's four tests of service change and NHS England patient care test

NHS commissioners are required[33] to apply the tests of service change.[34] These include the Government's four tests of service change:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test.

This final test requires that local NHS organisations show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

[33] R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors [2013] EWHC 2381 & R (Cherwell District Council & Ors) v Oxfordshire CCG [2017] EWHC 3349 (Admin)
[34] p13, Planning, assuring and delivering service change for patients, NHS England 2018

- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The proposals for the services previously provided at County Hospital and Samuel Johnson Community have been developed in line with these tests.

8.2.1 Strong public and patient engagement

The IRP recommendation to the Lord Darzi report states that '*The IRP is also concerned about the number of overnight or full closures of services that were originally implemented as a short term solution due to staffing issues during the Covid-19 pandemic but still remain ongoing years later. These type of 'temporary reconfigurations' are prevalent among urgent treatment centres and freestanding midwifery-led birth units, restricting access to care and calling into question their long-term sustainability. The continuing uncertainty around the future of these services is unfair to patients and the NHS staff who work in them. It is important that NHS integrated care boards regularly review these ongoing temporary changes to address any concerns raised and to develop effective long-term plans in collaboration with their local system partners and the public*'.

Section five explains in detail the extensive public and patient engagement carried out whilst developing the options for the services previously provided at County Hospital and Samuel Johnson Community hospital. The section outlines engagement activity and plans, together with records of relevant meetings with stakeholders such as the Overview and Scrutiny Committee, and information about engagement with people from the nine protected characteristics and in areas of health inequality.

This section clearly outlines the review process undertaken prior to and throughout the period of the temporary closure to identify effective long-term plans for birthing services and the engagement with system partners and the public throughout the process.

8.2.2 Consistency with current and prospective need for patient choice

The NHS Choice Framework sets out patients' rights to choice in healthcare, where to find information to help choose and how to complain if choice isn't offered.

For maternity services this means women can choose to receive antenatal care from a midwife or from a team of maternity healthcare professionals, including midwives and obstetricians.

Women should also be able to choose whether to give birth at home with the support of a midwife, within a midwife-led facility with the support of a midwife or in a hospital with the support of a maternity team.

The choices available to women will be dependent on their clinical need. The table in Section 4.2 below provides a summary of the places in Staffordshire and Stoke-on-Trent that can be considered as part of a birth plan. Women will continue to be offered a choice of place birth, including the choice of a midwife-led birth, as recommended by the Birthplace Study (National

Perinatal Epidemiology Unit, 2011), Better Births and the National Institute of Clinical Excellence (NICE). Section four describes in detail the case for change for the future of birthing services that were previously delivered at County Hospital and Samuel Johnson Community Hospital in particular the consideration of both the workforce sustainability and the clinical sustainability of services.

Section five provides further detail on the feasibility of continuing to provide birthing services within an FMBU and the process followed to arrive at the single viable proposal for the future of services, including the criteria applied. The section explains the limitations of providing services within an FMBU and discusses the wider birthing choices available to women across Staffordshire and Stoke-on-Trent and the advantages of offering midwife-led births as an alongside model.

8.2.3 Clear, clinical evidence base

Section three explains the national commitment to ensuring maternity services are safer, more personalised and more equitable. As outlined within the three-year delivery plan, this ambition can only be achieved when services are delivered by skilled teams with sufficient capacity and capability. Section four outlines the rising complexity of pregnancies over recent years with more women presenting with comorbidities and requiring consultant-led care. This substantially reduces the number of women suitable for low-risk birthing services that were offered at County Hospital and Samuel Johnson Community Hospital. It is therefore essential that midwives are supported to develop and maintain their competencies to manage a more clinically complex workload and deliver high quality, safe care. This is particularly important given the national shortage of midwives.

Table 17 in 5.5.2 outlines the assessment of all proposals considered by the technical group. This highlighted a single viable proposal when considered against each of the six essential criteria which includes clinical sustainability and workforce sustainability.

The IRP recommendations to the Lord Darzi reports states that '*The IRP has also seen a shift to centralisation within the NHS justified as a clinical necessity and a means of resolving staffing issues, even when it presents a risk to access for patients and may negatively impact the patient experience, often with regards to travel, transport and ambulance conveyance times*.'

The information in Sections three and four and five references the strong evidence for centralising birthing services within the acute Trusts to meet the changing clinical needs of the population and ensure safe, high quality, and equitable services are offered to women. As highlighted within the quality impact assessment, making permanent the temporary closure of birthing services at the FMBUs also ensures midwives skills, experience and capacity are fully utilised in all areas of maternity care in order to support the delivery of key national requirements. Midwives rotate across both the low-risk and high-risk maternity units in line with demand rather than diverting resource to an underutilised unit.

Section 8.3 and 8.4 of this PCBC outline the assessment of any potential impact on access for women as a result of this proposal. As identified throughout this PCBC, the proposal reduces

the requirement for ambulance conveyances as centralising services means women and their babies have immediate access to additional support if required rather than needing to be transferred from an FMBU to an acute site in an ambulance.

8.2.4 Support for proposals from clinical commissioners

The maternity case for change was developed originally through the Sustainability and Transformation Partnership (STP) Maternity Programme Board, building on the NHS Long Term Plan. The Case for Change[35] sets out the needs of the population, the current provision of health and care and outlines our vision and aims for local health and care in the future.

In July 2023, a stage 1 assurance meeting took place. During the meeting, the ICS shared the current position of maternity services, the current case for change and clinical model ahead of undertaking the appropriate stages required within the NHSE service change process.

In April 2024, the Case for Change was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the ICS articulated a credible case for change and the principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. Further detail on the recommendations from the Clinical Senate and the ICSs response is included later in Section 8.6.

Detail of clinical involvement in the development of the proposals is detailed in Section five, including clinical involvement in technical events evaluating the proposals.

The ICB has ensured that neighbouring ICBs are aware of the process undertaken and have confirmation of support for the proposal outlined within the business case from Derby and Derbyshire ICB.

The business case will be subject to both NHSE and the Staffordshire and Stoke-on-Trent Integrated Care Board assurance and governance processes prior to a final decision being made.

8.2.5 Bed test

When looking at the bed test, bullet point one is the most relevant to this business case:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

There were no inpatient beds within the FMBUs at the time of the temporary closure. There were two labour, delivery, recovery and postpartum (LDRP) rooms at County Hospital and three at Samuel Johnson Community Hospital at the time of the temporary closure.

Activity modelling for low-risk eligible women within both acute Trusts has been completed using the Birthrate Plus® assessment. The activity modelling has been used to ensure the correct number of low-risk LDRP beds are available at each unit. UHNM have four designated

[35] Case for Change, Together We're Better, 2019

LDRP rooms at Royal Stoke University Hospital and Queens Hospital Burton have two designated rooms. This is ring-fenced capacity for low-risk births meaning that any increase in demand within other areas of maternity, for example an increase in inductions of labour, will not impact on the Trusts ability to offer low-risk, maternity-led care.

Whilst there are designated rooms for low-risk births within each hospital both sites have the ability to flex other delivery rooms to provide low-risk care as required. If additional capacity were required, women would be supported to have a midwife-led birth within available rooms on the consultant-led units.

The Birthrate Plus® reports for both Trusts demonstrate a continuing rise in maternal complexity, which means even fewer women are suitable for low-risk care currently than prior to the temporary closure of birthing services at the FMBUs. In addition, very few women chose to give birth at the FMBUs despite campaigns to promote the units. As described above, there is protected low-risk capacity within each of the Trusts. This protected capacity and the nature of low-risks births, i.e. that women and their babies do not require care on a ward or within the neonatal unit, means that low-risk births do not impact on the Trusts ability to provide care within other areas of overall maternity services.

Both Trusts are committed to retaining midwifery led birthing options for women on a low-risk pathway to ensure women have personalisation and choice.

Royal Stoke Hospital has 4 Midwifery led care (MLC) rooms which are close to the consultant unit with a very short transfer time if medical support is needed. This area is staffed by midwives and support workers and is protected capacity for low-risk births. There is also a birthing pool here. Whilst there are designated rooms for low-risk births within the midwife-led unit at Royal Stoke, additional capacity is available within the consultant-led unit. If additional capacity was required, women are supported to have a midwife-led birth within the consultant-led unit. Access to the Royal Stoke Midwifery Birthing Unit is monitored monthly through the Quality and Safety Oversight Forum through several balance measures.

Queens Hospital Burton has 2 birthing rooms identified for midwifery led care on the consultant birth centre and a birthing pool is available for use by women on an MLC pathway. This is protected capacity for low-risk births, but further rooms can be flexed to support low risk care as and when required. Women can also access the Royal Derby Birth Centre which is an alongside Midwifery Birthing unit which consists of 4 ensuite rooms and a birthing pool room. In Q3 24/25 22% of births at QHB were assessed as low risk in labour.

Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

QHB & UHNM have had no service suspensions or external diversions due to capacity over 2024/25.

The MNVP plan to work with UHNM and QHB to promote the midwifery led care birth options and plan to develop resources for birthing people.

As a result, there has been no operational impact as a result of the transfer of this activity to the main acute sites during the past four years and the proposal has no anticipated impact on the longer-term sustainability of the service.

8.3 Quality, safety and clinical sustainability

The case for change outlined earlier within this document articulated the system ambition to deliver high quality maternity services. A Quality Impact Assessment (QIA) has been completed for this service change (see Appendix 05).

The key quality impacts are outlined below:

- Consistent staff to patient ratios across sites removing the inequity in provision seen when the FMBUs were open.
- Women who develop complications would no longer need to be transferred to a hospital unit during advanced labour after already having travelled to an FMBU.
- Midwives' skills and experience are fully utilised in other areas of maternity care such as the alongside midwife-led units and within the home birth service. This also means they can support the delivery of key national requirements e.g. inductions of labour.
- FMBUs are for low-risk pregnancies only and the vast majority of the Staffordshire and Stoke-on-Trent maternity population (83%) fall into the moderate to high-risk category. Over time, even fewer women will fall into the low-risk category as data shows pregnancies are becoming more complex. As a result, the FMBUs do not meet the needs of the majority of the population.

Service specific quality reports are taken through both Trusts governance process. These reports begin at ward/directorate level, through divisional governance, onto executive quality and safety oversight forums and then taken through Board level assurance and LMNS system wide assurance. Key reports include progress reporting against national recommendations such as Saving Babies Lives and Ockenden, workforce and training position, any serious incidence and family experience.

Further detail on the quality reporting undertaken and the associated assurance and governance process within each of the Trusts is included within Appendices 06 and 07.
The Trust assurance processes include reporting through the Local Maternity and Neonatal System (LMNS) Partnership Boards. The Staffordshire and Stoke-on-Trent LMNS governance framework is illustrated below:

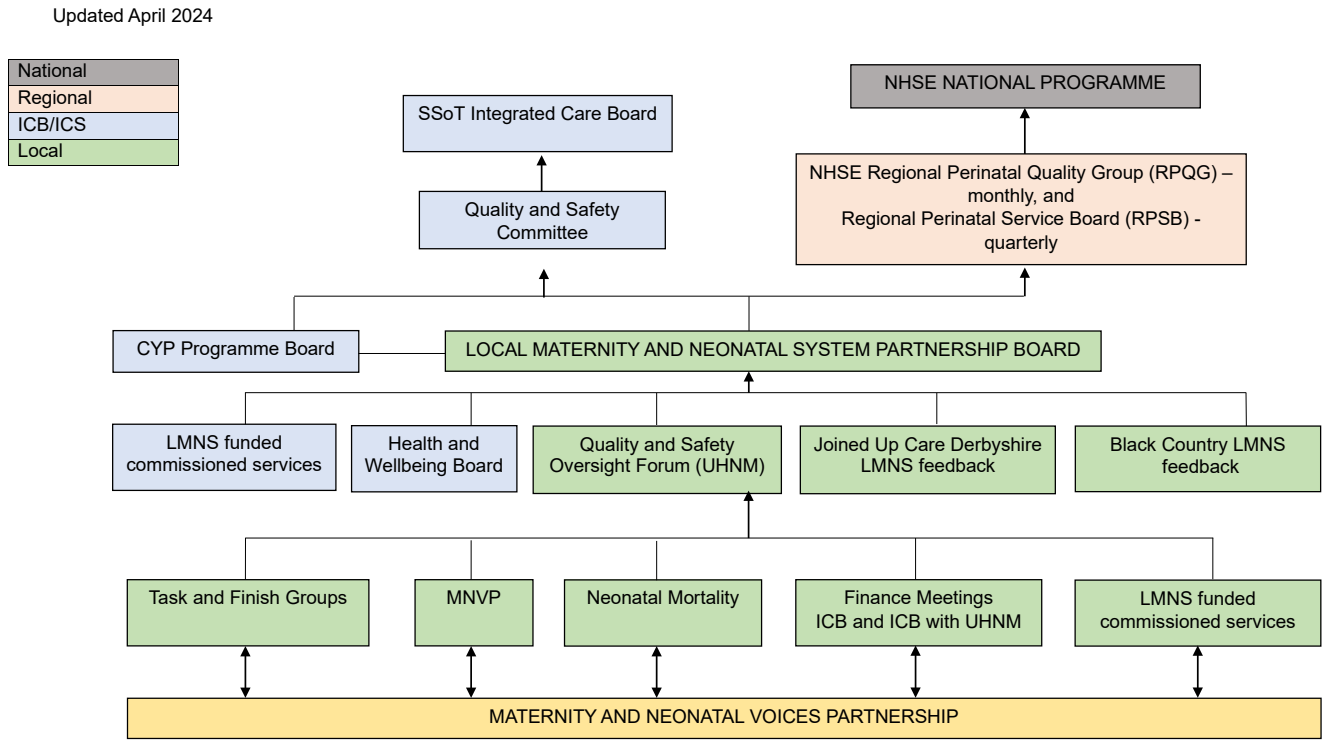


Figure 13: SSOT LMNS governance framework

8.3.1 Care Quality Commission (CQC) Inspection

The latest Care Quality Commission (CQC) inspection of maternity services at UHNM was in March 2023 and at UHDB in August 2023. As these were service specific inspections, services were inspected against two of the five domains – safe and well-led.

At UHNM, the service rating for safe moved from requires improvement to inadequate and moved from good in well-led to requires improvement. The overall rating for maternity services moved from good to requires improvement. The overall Trust rating is not affected and remains as requires improvement. The full report, published in June 2023 can be found within the maternity section here Royal Stoke University Hospital - Care Quality Commission (cqc.org.uk).

Following the inspection, a System Maternity Oversight and Assurance Group (SMOAG) was established in August 2023. The group was led by the SSoT ICB Chief Nurse and the Regional Chief Nurse. The group were accountable for gaining assurance for the delivery of the overall integrated quality improvement plan, and particularly progress against the actions being taken to address the CQC Section 29a conditions and the CQC actions which the Trust have been advised they must or should take to improve their maternity services. The group met monthly and reported to the LMNS Partnership Board and the ICB's quality and safety committee. Updates were included in the ICB report into the quarterly Regional Quality Group as a specific item.

The SMOAG was stepped down following the UHNM Rapid Quality Review meeting that was held with the national team, regional team, ICB, CQC, GMC, NMC, Maternity Safety Support Programme and UHNM on the 5th of April 2024. The Trust presented their progress against the CQC Action Plan, Maternity Incentive Scheme actions and any ongoing concerns or issues.

The Trust was commended for all the work they have achieved over the last year and the focus now should be on sustainability. The ICB was also praised for the pragmatic way in which it worked and supported UHNM. The ICB will continue with oversight locally through the LMNS QSOF and the data will be reviewed monthly through a Perinatal Quality Oversight pack that has been developed.

At UHDB, specifically Queen's hospital Burton the service rating for both safe and well led moved from requires improvement to inadequate. The overall rating for Queen's Hospital was not affected and remains as requires improvement. The full report, published in November 2023 can be found in the maternity section here Queens Hospital - Care Quality Commission (cqc.org.uk)

UHDB had recognised and acknowledged their challenges prior to the CQC inspection and sought additional support by requesting to join the Maternity Safety Support Programme earlier in the year. Immediate plans were put into place to address the issues raised by the CQC and the Trust track and report on their progress through their governance and assurance process.

On the 24 August 2023 the Care Quality Commission (CQC) inspected maternity services at UHDB

UHDB was issued with a notice of decision to impose additional conditions on the Trust's registration as a service provider in respect of regulatory activity at the Royal Derby Hospital site for maternity services under Section 31 of the Health and Social Care Act 2028.

On 7 September 2023 the Trust was issued with a notice of decision to impose a Section 29A warning notice for maternity services at Royal Derby Hospital (RDH) and Queen's Hospital Burton (QHB) sites.

On the 29 November 2023 the CQC reports for QHB and RDH were published detailing must and should do actions and an outcome of inadequate for safe and well led domains in maternity services for both sites were declared.

Neither Trust received recommendations to reinstate services at the FMBUs and no concerns were raised specifically regarding midwife-led services at Queen's Hospital Burton or Royal Stoke University Hospital.

8.4 Impact analysis

8.4.1 Equality Impact Assessment including health inequalities

An Equality Impact Assessment (EIA) was completed in August 2024 (see Appendix 08) which supports the proposal to make permanent the temporary closure of birthing services at the FMBUs.

The EIA identifies the protected characteristics of pregnancy and maternity as the most likely to be impacted. Whilst no negative or positive impacts were identified for other protected characteristics, this was identified following due consideration of the needs of the birthing population.

The impacts are as follows:

Age – Neutral Impact

Consideration has been given to teenage pregnancy rates as this population may have less access to private transport and there may be a travel impact if required to travel further to a birthing unit. The demographic data of those who accessed services in 2019/20 shows a very small proportion of those who accessed the FMBUs were aged under 20 years of age (2%) suggesting minimal impact on this cohort of women. Pregnancy rates broken down by area was subsequently reviewed to understand the impact for a particular locality.

A review of Staffordshire and Stoke-on-Trent demographic information highlights a higher rate of teenage pregnancies in Stoke-on-Trent when compared to the other localities and when compared to regional and national rates. The demographic data of those who accessed services in 2019/20 shows that there were no women who gave birth at either of the FMBUs. This may be due to the proximity of the alongside midwife-led units at Royal Stoke University Hospital. As a result, there is no impact expected for this cohort of women.

Within Derby (City), there is also a higher rate of teenage pregnancies when compared to other localities within Derbyshire and when compared to national rates. Less than 2% of women who accessed the FMBUs were from the Derby area suggesting minimal impact on this cohort of women. Furthermore, women from Derby travel further to reach the FMBU at either Samuel Johnson Community Hospital in Lichfield or County Hospital in Staffordshire than they would if accessing midwife-led services at Queen's Hospital in Burton suggesting travel time is not a factor for this cohort of women.

Disability – Neutral impact

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This also includes assessing any access requirements and communication needs. This is regularly reviewed at every contact during the pregnancy. Part of this assessment includes identifying where any protected characteristic, such as a long-term condition, means a pregnancy may fall into the high risk-category and women are counselled on a referral to consultant-led care. As such, this cohort of women would not be affected by the proposal as FMBUs manage low-risk pregnancies only.

Race – Neutral impact

The MBRACE-UK report about maternal and perinatal mortality shows worse outcomes for those from black, Asian and mixed ethnic groups and those living in deprived areas. The ICB utilised the demographic data of people who has historically used the units alongside the pregnancy and birth data for each of the localities from the Public Health England fingertips toolkit to complete this assessment. It is recognised that there are variances in outcomes for particular groups, for example those from black Asian and mixed ethnic groups and those living

in deprived areas (MBRACE-UK report). The service did not target these demographics specifically or address inequalities and the EIA did not identify any groups that would be disproportionately impacted by this proposal.

The demographic profiling within the travel analysis shows that the units were predominantly used by white British or white other ethnic groups who were not within the most deprived areas of Staffordshire and Stoke-on-Trent. Given the demographics of those that attended the FMBUs, it is likely that the reinstatement of services would create an inequality due to diverting resource from the acute sites and those that are identified as needing high-risk care.

Pregnancy and Maternity – Negative Impact
The women affected by this change will be pregnant and may need to travel further to an alternative low-risk unit. Further detail on the travel analysis is included in the section below.

8.4.2 Travel Impact analysis

Travel analysis was commissioned to understand the impact of the proposal on travel time. The analysis covered a range of scenarios:

Actual time: Time that women actually travelled from their home address to either County or Samuel Johnson.
Baseline: With County and Samuel Johnson still open and this situation is based on travel time to the nearest maternity site within Staffordshire (i.e. County, Samuel Johnson, Royal Stoke or Burton). This is assuming women travel to their nearest site, which is not actually the case as women have opted to travel further to use County and Samuel Johnson.
Scenario 1: All activity that would have happened at County or Samuel Johnson moves to the nearest site within Staffordshire, i.e. Royal Stoke or Burton.
Scenario 2: All activity that would have happened at County or Samuel Johnson moves to the nearest site, either within Staffordshire or to an external provider site if nearer.
Scenario 3: All activity that would have happened at County or Samuel Johnson moves to the nearest site within Staffordshire (i.e. Royal Stoke or Burton) or to a nearer external provider if the site has a midwife-led unit. In this scenario activity it is assumed that women will only travel outside of Staffordshire to attend an MLU if it is the nearest site, otherwise it is assumed they will travel to Royal Stoke or Burton.
Scenario 4: Deliberate reallocation of activity based on historic patient flows, including home births and taking into account travel times.

Additional analysis was completed to consider the impact of blue light transfers on total travel time for women who developed complications and were transferred to the main acute sites.

Within the travel analysis, scenario 4 takes into account the re-introduction of the home birth service and the patient flows during the temporary closure of birthing service at the FMBUs. It is likely this scenario represents the impact of the proposal more accurately than other scenarios and further detail is provided below. The full analysis is available at Appendix 09, including information about how the assumptions were made in deciding how potential women might travel and where they would be travelling from.

Within scenario 4, the average travel time would increase by around 8 minutes compared to Baseline or by 6 minutes compared to the actual travel time.

Women within Stafford are most affected by the proposals with travel time increasing by around 14 minutes compared to actual travel time. Within this scenario, the average travel time decreases in a number of areas as women are using alternative units that are closer to their home address.

Mitigating factors

While a number of women are affected by the additional travel time of approximately 6 minutes on average, the comparison of scenarios highlights choice of place of birth can be a factor over travel time as 25% of the cohort analysed chose to travel further to an FMBU rather than to their nearest maternity unit.

It is recognised that there may be an impact on those who were eligible to give birth at County Hospital or Samuel Johnson and who would have chosen to give birth there and therefore alternative options for low-risks births are offered to women (as outlined below). It is however noted that the proposal affects a relatively small number of births (around 344 per year) when compared to the overall number of births at UHNM and UHDB (around 15,033 per year)

Although the FMBU is temporarily closed to births only, all other maternity services have continued to operate during this time at the FMBU. This reduces the travel impact to intrapartum care only.

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact. Trusts began booking women into the home birth service during their early pregnancy from April 2024 which now means that women have the full range of low-risk birth settings to choose from.

Women and families have been kept regularly updated via the Maternity and neonatal voices partnership (MNVP) and both the Trust and ICBs Communications and Engagement Team regarding changes to the FMBU, home birth service and any other service changes to maternity.

As described within the QIA, where clinical complications arose during labour at an FMBU, women were transferred to acute sites during the advanced stages of labour. This would be in addition to the time already taken to travel to the FMBU from home. The proposal mitigates this risk of additional travel time, as births within low-risk settings at the acute hospitals would be transferred immediately without the need to transfer to a different hospital.

8.5 Deliverability

The initial temporary closure of birthing services at the FMBUs was unusual in that it was in response to the COVID-19 pandemic and services were temporarily suspended in March 2020.

As a result, the proposal described within this pre-consultation business case has been implemented and delivered in this way for over four years. During this four-year period, maternity services have developed in line with national reports and delivery plans, including those relating to the ICS digital strategy.

The proposal would not impact on the local health economy to plan for, and to respond to, a major incident - on call managers have access to SHREWD (Single Health Resilience Early Warning Data Base), a digital platform which provides a visual real time display of activity across our providers. Discussions have commenced between the Digital Midwives in UHNM and those responsible for SHREWD in the ICB, with a view to including induction of labour figures provided on the daily sitrep, but with more regular updates. The benefits of utilising SHREWD have been recognised by NHS England and other providers with an expectation that this will be extended across the region.

Capacity and demand modelling for maternity, including inductions of labour, is based on staffing capacity rather than physical bed capacity. Modelling has been completed using the nationally recognised Birthrate Plus assessment tool as described in Section 4. This is completed every three years to ensure there is sufficient staffing and takes into account both the local birth rate and the complexity of the caseload. Both Trusts have confirmed there is sufficient low risk capacity to meet current demand with ongoing recruitment programmes to maintain staffing levels in line with Birth Rate Plus. Both Trusts are in the process of re-running their Birthrate Plus assessments to support future workforce planning.

With regard to physical capacity, there are designated rooms for low-risk births within each hospital. This is ring-fenced capacity for low-risk births meaning that an increase in demand within other areas of maternity will not impact on the Trusts ability to offer low-risk, maternity-led care. Both sites have the ability to flex other delivery rooms to provide low-risk care as required. If additional capacity were required, women would be supported to have a midwife-led birth within the consultant-led units.

The information included within section four highlights the limited and reducing preference for birthing within the FMBUs in addition to the changing needs of the population (increasing complexity) who would not be suitable for low-risk care. The proposed model therefore is not only deliverable but supports the longer-term sustainability of services and ensures the ICS meets the needs of the population.

Information in Section five shows the advantages of the proposal and the report of engagement in this section illustrates the views of patients, the public and stakeholders.

The figures in the finance section (Section seven) show that the new arrangement for delivering these services for people as proposed within the business case is less costly than reinstating birthing services at the freestanding units. There are no capital requirements related to the proposal.

It is therefore clear that the proposal is deliverable.

8.6 Independent review of clinical model and proposal

8.6.1 Introduction

The West Midlands Clinical Senate review of proposals for birthing services previously provided at County Hospital Stafford and Samuel Johnson Community Hospital in Lichfield was commissioned by Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) Chaired by Dr Will Taylor, the review was carried out by a panel of 16 experts from the West Midlands Clinical Senate, most of whom are practicing clinicians. The review took place on 26 April 2024.

The purpose of the review is to offer external clinical assurance and focused on the birthing element of the maternity pathway and specifically, the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson Community in Lichfield. The clinical senate review and responses to the points raised in its recommendations form an essential part of the preparation for the stage two assurance checkpoint process as set out in NHS England's service change guidance: '*Planning, assuring and delivering service change for patients'*.

The report[36] contains five recommendations for the programme to consider. These are outlined below.

8.6.2 Clinical senate recommendations

Recommendation 1

The panel supports the ICB's proposal to make permanent the temporary closure of birthing/intrapartum service at the two FMBUs for intrapartum maternity care and reinstate the home birthing service.

Recommendation 2

The panel recommend that consideration is given to the different standards of birthing environment in place across the acute sites to ensure patients have a comparable high standard environment regardless of the birthing location.

Recommendation 3

The panel recommend that engagement with neighbouring ICBs at an LMNS level is widened to ensure that mothers receive equitable care during birthing and consider putting in place systems to ensure that all clinical notes are made accessible to those that need them in a timely manner.

Recommendation 4

[36] Midlands Clinical Senates - Our Published Work (midlandssenates.nhs.uk), June 2024

The panel recommend that the ICB works with the provider Trusts to fully develop and implement the home birthing service to ensure it is fully planned and understood to ensure safe delivery of babies at home. The panel was supportive of the workforce and operational/clinical model being led and developed by the staff in the services with oversight from senior midwives.

Recommendation 5
The panel suggest the ICB and provider Trusts give due consideration to the naming of the FMBUs to ensure the public are clear on what services will be available going forwards.

8.6.3 Programme response to recommendations

Recommendation	Programme response
Recommendation 1 The panel supports the ICB's proposal to make permanent the temporary closure of birthing/intrapartum service at the two FMBUs for intrapartum maternity care and reinstate the home birthing service.	Staffordshire and Stoke-on-Trent ICB along with UHNM, UHDB and Derby and Derbyshire ICB acknowledge the time and due diligence that the WMCS panel members took in reviewing the evidence submitted and the rounded discussion that took place in order for the panel to support the proposal.
Recommendation 2 The panel recommend that consideration is given to the different standards of birthing environment in place across the acute sites to ensure patients have a comparable high standard environment regardless of the birthing location.	UHDB will give continued consideration to ensuring a high-quality birthing environment is maintained and provides equity of access across acute sites. Standards will be monitored and maintained and capital funding will be sought when upgrades are required.
Recommendation 3 The panel recommend that engagement with neighbouring ICBs at an LMNS level is widened to ensure that mothers receive equitable care during birthing and consider putting in place systems to ensure that all clinical notes are made accessible to those that	This is a national issue which is specific currently for birthing people receiving post-natal care in Staffordshire but who have given Birth at University Hospitals Birmingham NHS Foundation Trust (UHB). University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) have introduced a new electronic maternity record, which will be the same one as that used at UHB and therefore all clinical notes will be electronically accessible. Staffordshire and Stoke-on-Trent ICB (SSOT) LMNS has arranged to meet with UHDB once implemented to review success. Whilst this hasn't been raised by University Hospitals of North Midlands

need them in a timely manner	NHS Trust as an issue within maternity services, the LMNS will scope this and ensure actions taken as required. Digital Maturity assessments and "What good looks like" benchmarking exercise has taken place with our providers. This formed the basis of their maternity digital strategy, which includes standardisation and interoperability. The SSOT LMNS works closely with Derby and Derbyshire ICB/ LMNS and Black Country ICB / LMNS as part of the wider maternity programme and will work with other ICBs at an LMNS level to understand any barriers to the sharing of clinical records in any cross-border patient flows. As an LMNS, we continue to be an active member of the regional digital maternity leadership network, and learning is shared widely across the system to help drive forward equitable care. As a system, we have continued to progress steps to Digitise, Connect and Transform. This aims to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. Our actions contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care and reducing digital inequity. The ICS digital teams are progressing our Electronic Patient Record programme focusing on interoperability and system-wide working. Our priority is now on the procurement process and embedding the identified solution.
Recommendation 4 The panel recommend that the ICB works with the provider Trusts to fully develop and implement the home birthing service to ensure it is fully planned and understood to ensure safe delivery of babies at home. The panel was supportive of the workforce and operational/clinical model being led and developed by the staff in the services with oversight from senior midwives.	Both providers have reinstated the offer of home birth commencing on the 1st April 2024 with home birth being offered to those who book from that date forward and those who fit the criteria. UHDB have undertaken multidisciplinary skills training, which is included within their PROMPT training days, which are also attended by paramedics at EMAS and WMAS. This facilitates working together around transfer women in practical scenarios. Additional bespoke home birth education is planned for August. Community midwives are also going through a process of reorientation with intrapartum birth settings to refresh their skills. Similarly, UHNM have held multidisciplinary skills training in home birth, including WMAS colleagues who have been attending training and updating in home birth, emergencies,

	and transfers. Community midwives are also going through a process of reorientation with intrapartum birth settings to refresh their skills. UHNM have commenced a staff Home Birth Working Group to support the service. Within the considerations of the working group we are including future plans for continuity of carer wherever possible. Home birth is included as an update at both LMNS Quality & Safety Oversight Forum and the LMNS Partnership Board and the ICB will oversee implementation through these forums.
Recommendation 5 The panel suggest the ICB and provider Trusts give due consideration to the naming of the FMBUs to ensure the public are clear on what services will be available going forwards.	The Trusts and ICBs will work collaboratively with their MNVPs to develop the appropriate signage for maternity services within County Hospital and Samuel Johnson Community Hospital.

Table 30: WMCS recommendations and system response

8.6.4 Conclusion/summary

This section outlines our responses in relation to the Government's four tests of service change and NHS England patient care test, outlines the impact assessment that have been undertaken as well as the recommendations produced by the West Midlands Clinical Senate in relation to proposals for birthing services previously provided at County Hospital Stafford and Samuel Johnson Community Hospital in Lichfield following their visit on 26 April 2024. These recommendations have been accepted and considered by the programme team who continue to work to address them. Information on the work undertaken and work being pursued is included in this pre-consultation business case.

9 Management and Governance

9.1 Introduction

This section of the pre-consultation business case:

- Explains the management and governance of the programme deciding the future of birthing services provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield until March 2020.
- Outlines the timeline and governance for sign off of the business case and the evaluation plan, together with the appropriate and agreed Health Overview and Scrutiny Committee arrangements.
- The programme risk register is explained together with any mitigations.
- Includes plans for appropriate engagement in the next stage, and this may include a public consultation. Throughout the process of developing the final proposal for the future of the services, there has been extensive public and patient, clinical, staff and stakeholder engagement.

9.2 Timeline and next steps

Legislation relating to NHS bodies changed on 01 July 2022, when the Staffordshire and Stoke-on-Trent Integrated Care Board took over health service commissioning responsibilities from the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. Governance for this programme transitioned seamlessly from the CCGs to the ICB.

This pre-consultation business case has been reviewed and approved for submission to the Staffordshire Integrated Care Board for consideration.

There will be continued liaison with the Staffordshire Health and Care Overview and Scrutiny Committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

If the Scrutiny Committee recommends further involvement, the ICB will decide what further appropriate public involvement is needed. A decision-making business case will be developed to reflect the outputs of that involvement activity and be presented to the Board of the Integrated Care Board for consideration and decision.

9.3 Next steps

The upcoming milestones and indicative dates for the process as it proceeds have been set out as:

Date	Milestone
October 2024	NHS England assurance

September/October 2024	Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee and Derbyshire County Council Improvement Scrutiny Committee - Health (status of programme and potential plans for involvement)
February 2025	ICB decision on whether to proceed with involvement
May - August 2025	Potential involvement activity
August - October 2025	Analysis of outputs from involvement activity
Autumn/Winter 2025	Develop decision-making business case

Table 31: Indicative programme timeline

9.4 Risk management

The programme has created a risk register, with appropriate mitigations. These have been reviewed and managed throughout the process.

9.5 Plan for consultation

The ICB is keen to ensure that we build on previous involvement activity and understand if there is any new or additional information that should be taken into consideration ahead of decision-making. Therefore, a draft consultation plan, draft consultation document and questionnaire is being developed which will be updated pending the outcome of NHSE assurance process and subsequent governance.

Scope of the work

This consultation activity will inform the decision-making about the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson Community in Lichfield.

Aims and objectives

If further involvement activity to gather views is required, the aims of this would be to take forward a twelve-week public consultation in order to:

- articulate the case for change and the single viable proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs).

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the proposal identified through the options appraisal process and wider involvement activity.
- reassure staff, service users, carers, carer representatives and other stakeholders about the scope of the proposal and the wider maternity clinical model.

- understand views about the process we have undertaken and the technical group's recommendation about the single viable proposal.

We will seek to understand people's views on the proposal, and in particular:

- if there are any proposals we have not considered to date.
- if there is any positive or negative impact that we have not already considered, if we decide to go ahead with this proposal.
- how we can support people if these changes are agreed.

The objectives of this work will be to gather any further information needed to inform the decision by decision-makers to meet our statutory duties. The full consultation plan is included in Appendix 10.

Key documentation

There will be three main documents which will act as the platform for the consultation activity:

- Consultation Plan. The plan includes surveys, online events, roadshow drop-in events and targeted engagement with specific demographics to ensure we hear from as many people as possible.
- Consultation document. Includes details of the case for change, the proposals, impact analysis, low risk maternity pathway, and details of the consultation process as supporting information.
- Survey. This will be developed in digital and print version, with support to complete these if required. Surveys and information will be made available in alternative formats as required.

In addition, this PCBC will be available on the ICBs webpage and all public facing documentation will be made available through various media outlets.

9.6 Implementation plan

Normally with a business case involving a move of services or a rebuild there would be an implementation timeframe, with metrics and an evaluation plan. However, this business case is recommending a single viable proposal for the future of birthing services. As outlined within the workforce section, both Trusts continue to recruit and retain their midwifery workforce through a range of training development opportunities to ensure that the current temporary arrangements are robust and resilient should the proposal be implemented on a permanent basis. As both Trusts are currently re-running their Birthrate Plus assessments with reports due during Q1 2025/26, this will be assessed to inform their ongoing workforce plans.

The current service provision through UHNM and UHDB would continue in place alongside the contracting, quality and, assurance measures that are already established via our LMNS partnership delivery and assurance arrangements see 8.3.

If during the formal public consultation, any additional proposals are identified, these would be reviewed against the essential criteria during a technical event and if these are deemed viable, implementation plans would be developed and taken into consideration through the process.

Following any formal implementation stage, the ICB will utilise both real time and process and outcome data to both monitor and drive improvements.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Strategic service change programme: Staffordshire and Stoke-on-Trent freestanding midwife-led birthing units (FMBUs)

November 2024

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Background

The Freestanding Midwife-led Birthing Unit (FMBU) services at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield, were suspended for births at the beginning of the Covid-19 pandemic. This was to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton.

Prior to the units closing on a temporary basis 94 women (8 per month) gave birth at County Hospital in Stafford and 220 women (18 per month) gave birth at Samuel Johnson Community Hospital in Lichfield (2019/20 activity). The units were staffed by midwifes on a 24/7 basis.

Whilst the initial closures were directly related to Covid 19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units. Throughout this period, the home birth services for both Trusts have had both fixed term and intermittent (in line with escalation) periods of suspension and are also currently closed. As staffing has increased, attempts have been made to reinstate the homebirth services and although currently suspended, both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024.

The Staffordshire and Stoke-on-Trent ICB, along with colleagues from the neighbouring Derby and Derbyshire ICB, have been working with the University Hospital of North Midlands (UHNM) and University Hospitals of Derby and Burton (UHDB) to outline the current position in relation to the FMBU's and the home birthing services provided by each organisation. All parties recognised that the ongoing closure under the temporary service change arrangements could not continue and began to consider the next steps regarding service change proposals for future maternity provision across Staffordshire and Stoke-on-Trent.

In July 2023, the case for change on the future of intrapartum services at the FMBUs was presented to NHS England during a stage one assurance meeting. No issues were raised by NHSE during the meeting and the feedback from NHSE was that the case was well presented, and partners demonstrated a clear and robust understanding of the clinical model and the challenges the ICS is facing. As a result, the ICB alongside system partners reinstated the service change process that was paused due to the pandemic and began to reassess proposals for the future of birthing services at Samuel Johnson Hospital, Lichfield and County Hospital, Staffordshire.

At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals. These were assessed against six essential criteria. During the event it was recommended that only one proposal is viable at this stage - which is to make permanent the temporary closure of intrapartum birthing services at County hospital and Samuel Johnson hospital.

Following the technical event, a deliberative event with women and key stakeholders was held online in December 2023 to discuss the proposal for intrapartum services previously provided at County Hospital and Samuel Johnson Hospital. Further involvement was carried out with women who registered but were unable to attend the event. A report of findings was developed by the Midlands and Lancashire Commissioning Support Unit (MLCSU) following the deliberative event and further involvement and was presented to the Maternity Service Change Steering Group.

The group formally received the report of findings and confirmed they were confident with the process that had been undertaken. The group was also asked to consider whether anything further needed to be considered within the business case considering the feedback received.

For complex service change commissioners should consider clinical senate advice. Clinical senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

In April 2024, the Case for Change and associated clinical evidence was presented to the West Midlands Clinical Senate. The Clinical Senate was of the view that the ICS articulated a credible case for change and the principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance. As such, the Senate supported the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs) at Samuel Johnson in Lichfield and County Hospital in Stafford.

Current position

The ICS is now finalising the Business Case that will be presented to NHS England during a stage two assurance meeting. The purpose of the business case is to outline the needs of the population and set out the case for change, describe the process we have followed and how we have involved key stakeholders and the public.

The business case will also describe the clinical model and potential benefits thereof and include an analysis of any financial or workforce implications relating to the proposal. Finally, the business case will set out how we will assure and potentially implement our plans if a decision is made to move forward. It is anticipated this will take place in September 2024.

At this point no decision has been made, and the business case will still need to undergo a robust assurance process and potential further involvement activity. This plan has been drafted to cover the period after the completion of the Business Case and the relevant corresponding governance steps required – it has been prepared in in case any further formal involvement activity is necessary. If required, any further involvement would include service users, staff, the wider public, and other stakeholders.

Scope of this work

This involvement activity will inform the decision-making about the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs) at Samuel Johnson in Lichfield and County Hospital in Stafford.

The proposal needs to be considered alongside the maternity clinical model, which is:

- No change to the provision of consultant-led services,
- No change to the Midwifery-led care offered at Royal Stoke Hospital and Queen's Hospital, Burton,
- Reintroduce and grow the homebirth services,
- Develop and grow a continuity of carer model for the most vulnerable in the county,
- No change to the antenatal and postnatal care at County Hospital and Samuel Johnson.

Aims and objectives

If further involvement activity to gather views is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the proposal identified through the options appraisal process and wider involvement activity since 2019,
- articulate the current position and the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs),
- reassure staff, service users, carers, carer representatives and other stakeholders about the scope of the proposal and the wider maternity clinical model, which is outlined above,
- understand views about the Business Case and the technical group's recommendation about the proposal detailed within it,
- review the views of the service users, carers, and carer representatives to date to inform our approach to involvement,
- inform decision-making, by listening to the views of:
    - people involved in the 2019 and 2021/22 engagement activity and others who were not involved at the time, to understand if there is anything new/additional that needs to be considered
    - service users and carers across Staffordshire and Stoke-on-Trent, but also targeting geographical areas that have experienced the temporary arrangements since the beginning of the Covid-19 pandemic
    - other stakeholders with views about the provision of maternity services.

We will seek to understand people's views on the proposal, and in particular:

- if there are any ideas we have not considered,
- if there is any positive or negative impact we need to plan for if we decide to go ahead with this proposal,
- how we can support people if these changes are agreed.

The objectives of this work will be to gather any further information needed to inform the decision by decision-makers to meet our statutory duties.

If further involvement activity to share information is required, the aims of this would be to:

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and outcome of the involvement activity since 2019,
- articulate the current position and the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs),
- communicate how the ICS strategic direction aims to meet the requirements of the national directives outlined in the 2024/25 priorities and operational planning guidance but also meets the need of our population, by:
    - empowering women, and their partners, by putting them at the centre of their care so they have the best support,
    - designing a service that supports women to access a team of midwives, who have worked with them to develop their own personal birth plan,
    - providing a network of places where women can choose to have their care, that are high quality and safe, have the right staff skill-mix and represent value for money,

- providing continuity of carer during pregnancy, birth and beyond to those most vulnerable in our community,
- making the best use of our staff, allowing them to work more flexibly and really get to know the women and families in their local communities,
- developing and sustaining a culture of safety which reduces inequalities in outcomes.

This vision, coupled with the ICS commitment in the Joint Forward Plan to ensuring that all activities in the maternity and neonatal programme will support achievement of the four themes of the National Delivery Plan is the strategic backdrop to the proposals for the future of the FMBUs.

Key messages

- We're committed to an open and transparent dialogue with service users, carers and carer representatives, staff, and partners.
- Women would continue to receive most of their antenatal and postnatal care within the units.
- Staff-to-patient ratios would be the same across all units.
- Midwives can support the homebirth services and midwife-led units.
- Midwives can fully utilise their skills and experience to support other areas of maternity care.
- Patients who develop complications would no longer need to be transferred to a hospital unit during labour.
- There may be travel implications for women who are eligible to give birth at County Hospital or Samuel Johnson Community Hospital, who live close to the units and who would have chosen to give birth there. (The continued increase in case mix complexity means that more women are presenting with comorbidities and therefore requiring consultant-led care, substantially reducing the number of women suitable for low-risk care)
- The proposal requires the reinstatement of homebirth services to ensure full patient choice is offered.

Key spokespeople

The following key spokespeople will be media trained and will act as spokespeople for the ICB, UHNM and UHDB.

Clinical spokespeople:

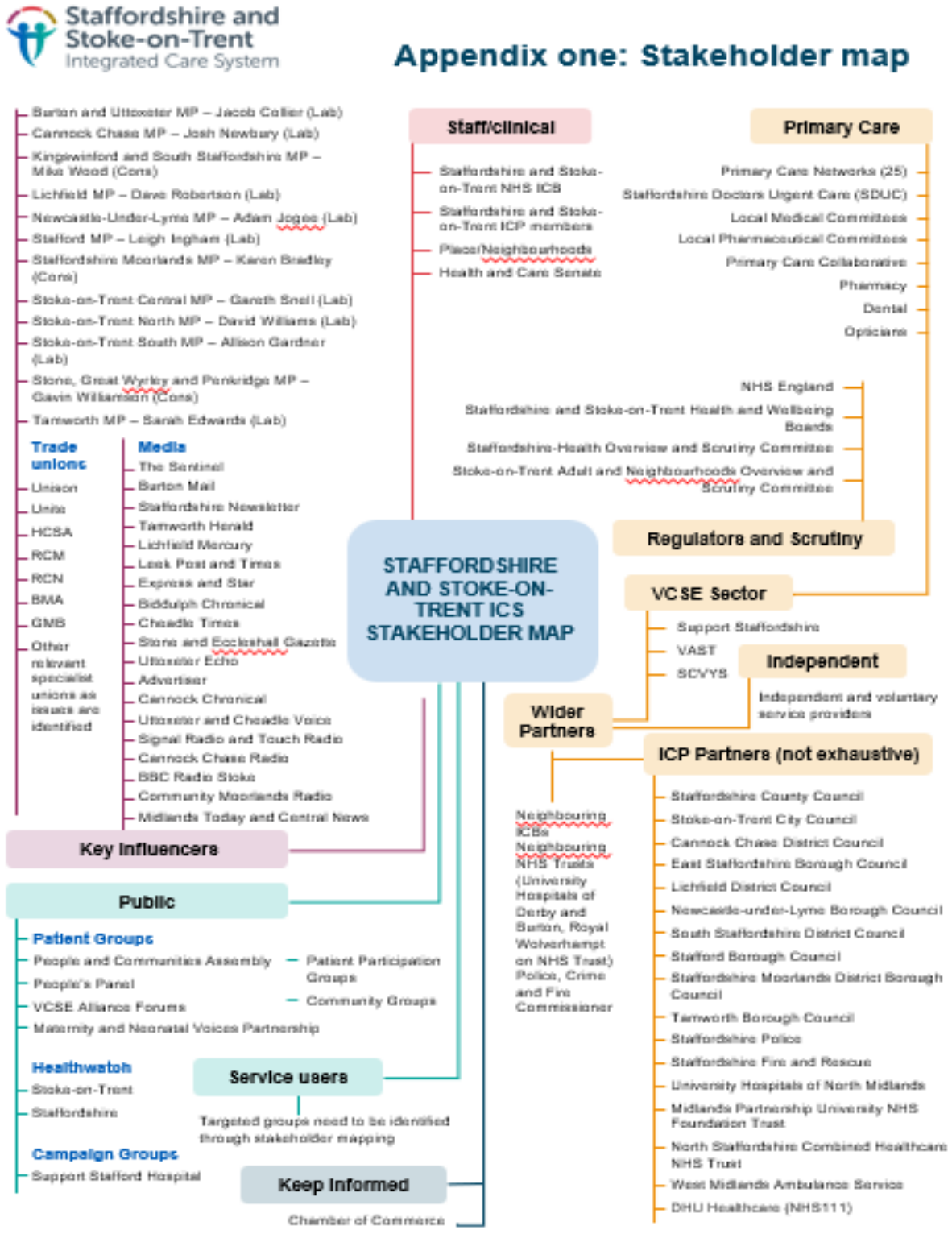
- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Heather Johnstone, Chief Nursing and Therapies Officer, ICB
- Alison Budd, Lead Midwife for Transformation Maternity Programme, ICB
- Sarah Jamieson, UHNM
- Sarah Noble, Interim Director of Midwifery, UHDB

Executive spokespeople:

- Paul Edmondson-Jones, Chief Medical Officer, ICB
- Heather Johnstone, Chief Nursing and Therapies Officer, ICB
- Helen Ashley, Director of Strategy and Performance, UHNM
- Guy Tuxford, Divisional Director for Women's and Children, UHDB

Key stakeholders

Our work to map stakeholders has been an iterative process throughout this programme of involvement activity and continues to be so. We have developed a comprehensive database of stakeholders. This is a live stakeholder management system which is updated as details change, and new or additional stakeholders are identified. This is the high-level stakeholder map.



Approach to involvement

Recognising that this phase follows involvement activity in 2019, 2021/22 and 2023, we will seek to build on the relationships already established and previous conversations with stakeholders as well as giving people who have not participated so far, the opportunity to have their say. We will continue to involve the Staffordshire Health Overview and Scrutiny Committee (OSC) in developing our approach to involvement and information activity.

This plan is an iterative document and sets out our initial thinking, subject to the views of the HOSC and the ICB Board. We have reflected on all previous engagement activity and are based on the recommendation of Staffordshire HOSC, we are proposing a 12-week consultation period. We believe this will give sufficient time for people to participate and provide an informed response – but is balanced against the demand on our clinicians and the potential for 'involvement fatigue'. A midpoint review will guide whether there is a need to undertake more targeted activity with certain groups and whether there is a need to extend this timeline.

We would be looking to launch a range of activities, including but not restricted to:

- Survey – To gather views about the proposal and understand if there is anything else that should be taken into consideration. The survey will also allow us to understand any potential impact of the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs). We would also seek to understand if there are any alternative considerations to this proposal that are viable
    - Traditional responses – In addition to our online survey, people will be invited to phone our Involvement Team or to send a survey to our freepost address to be received by the closing date. People can request a paper copy of the survey or can request support in completing the survey.
- Targeted engagement with service users, carers, carer representatives and other stakeholders via the Maternity and Neonatal Voices Partnership (MNVP).
- Offer a meeting with campaigners/campaign groups – To seek their views on the proposal, the impacts and the mitigations.
- Online meetings – Two meetings (one in working hours and one during an evening). These will include a presentation from the ICB, UHNM and UHDB and a series of breakout sessions to seek views on the proposal.
- Drop-in roadshow events – These would be face-to-face in the key towns of Stafford and Lichfield. They will be promoted through traditional media, digital channels and through stakeholder channels.
- Break-out rooms – These would be provided at both face-to-face and online events and meetings to allow space for one-to-one discussions or to support people requiring time away from the main meeting.
- Targeted focus groups/one-to-one interviews – We recognise that for some seldom heard groups, alternative channels may be needed. We will work closely with Healthwatch and the voluntary sector to identify existing community and voluntary groups that we can attend.

Provisional timeline

Milestone	Anticipated Date/Timeline
Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee Present Business Case outline to Staffordshire OSC	29 July 2024
Summary of assurance and governance process to Derbyshire County OSC members	July 2024
Summary of assurance and governance process to Stoke-on-Trent OSC members	08 August 2024
NHSE Stage 2 assurance meeting	2025 (TBC)
Return to Staffordshire OSC to confirm the approach to further public involvement (if not covered in July/August)	Follows on from above, TBC 2025
ICB Board for approval of Business Case and all recommendations for further involvement	TBC but likely 20 Feb 2025
Potential further involvement activity	Mon 5 May 2025 (owing to pre-election period w/c 17 March to 2 May)
Analysis of outputs from involvement activity	June to August 2025
Develop decision making business case	Summer/Autumn 2025

Communication channels

We recognise there is a need to keep people informed throughout this journey and will use the following channels to keep people informed:

Channel	Stakeholder	Frequency/timeline
Newsletters / intranet / team meetings, and dedicated focus groups	Staff	Monthly
Stakeholder bulletin – using existing bulletins through ICS UHNM and UHDB	Partners/other health and care professionals	Monthly

One-to-one virtual briefings/correspondence	MPs/Council Leaders/OSC	As required
Virtual briefings/targeted engagement	MNVP	Ongoing
Website – the dedicated website page will be updated to provide the latest information about the programme	All (including service users and public)	Ongoing
Media– we welcome the support of the media in helping us to deliver balanced information that will support patients to participate and share their views.	Media/public	We commit to providing regular and timely press releases that are written in plain language and, where appropriate, giving advance notice to reporters. We will launch an ongoing dialogue through the local media, including press releases, social media posts and radio interviews. We will respond to media enquiries in a timely manner, recognising the deadlines that reporters operate within
Social media – promotion of opportunities to have say	All	At key milestones
In-depth interviews with representatives or and members of seldom heard groups to gather people's experiences and views as appropriate	Service users / interested public and seldom heard groups (targeted engagement)	Ongoing
Workshops to be organised to gather people's experiences and views (as appropriate)	Service users/ interested public/seldom heard groups	TBC
Survey tool to seek feedback from people who cannot attend events	All	TBC

Communications and Engagement resources

We will develop a range of resources to support the planned involvement activity. The resources will support stakeholders who are interested in the subject matter and will be used as required and as appropriate. Resources could include but are not restricted to:

Public Information Products:

- Integrated consultation document and survey – online. Including videos or animations where applicable
- Printed consultation document and survey. Links to online resources provided to facilitate access to videos/possibly animations etc
- Summary consultation document
- Accessible consultation document and survey

Promotional Information Products:

- Website content (including the Business Case and further information)
- Handout flyer for events
- Poster to promote consultation and/or events. To include QR code to facilitate online access to materials. Translated posters to also be made available
- Videos/possibly animations
- Toolkit to support partners to promote on social media channels
- Press releases and media briefing
- Stakeholder updates (letters, emails and telephone scripts).

Event Products:

- Event registration form
- Event participation form, including demographic profiling questions
- Facilitator briefing notes and note-taking templates for events
- Presentations for deliberative online events
- Presentation for focus groups and voluntary sector events
- Voluntary sector collateral – presentation, facilitator booklet, and copies of printed promotional materials

Supporting seldom heard groups

An Equality Impact Assessment (EIA) will be produced that outlines the approach to involving seldom heard groups. We will work closely with the ICS' People and Communities Assembly and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

We will ensure our communications are accessible by:

- Writing in plain language
- Using visuals (including diagrams, animations and accessible documents)
- Providing access to other languages, other document formats (large print, Braille, etc) and British Sign Language (BSL) interpretation when needed
- Arranging events to be at various times and days of the week to maximise attendance
- Asking people if there are any reasonable adjustments needed when attending virtual events and offering alternative ways for people to share their feedback (for example by phone)
- Providing reasonable adjustment and support, for example using interpreters or offering smaller focus groups with existing networks where appropriate.

We will build on our relationships with the voluntary and community sector, to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, we will work with trusted advocates, for example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that is approachable and understandable.

Next steps

A detailed analysis report will be produced by MLCSU on the comments from the involvement activity; this will include a thematic breakdown of comments received and demographic analysis from participants, subject to them sharing this information.

These reports will be shared with the programme team to conscientiously consider the findings to inform the next steps and any decision-making resulting from the findings.

The proposals will be reviewed by the relevant governance routes within UHNM, UHDB and ICB (with statutory responsibility for decision making). The findings will be shared with the Staffordshire Health Overview and Scrutiny Committee for discussion. The full report of findings and a public summary will be published on our ICB website.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Birthing services at our freestanding midwife-led birthing units

DRAFT Consultation document

[Month] 2025

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What is this about?

The local NHS has been looking at **maternity services** in Staffordshire and Stoke-on-Trent. Our biggest priority is giving safe, high-quality care to women and babies throughout the maternity journey – making sure you are well looked after during pregnancy, during the birth, and in the first few weeks after your baby is born.

This document explains a proposal about the future of **birthing services** at two **freestanding midwife-led birthing units (FMBUs)**. These are at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield.

Both FMBUs currently provide antenatal and postnatal appointments. These services are **not** affected by the proposal, which is only about the services that support you when giving birth.

We are running a public consultation about the proposal, which will run for 12 weeks, from [add dates]. This is your chance to find out what change is being proposed and to tell us what you think.

See page 18 for details of how you can get involved – such as through our survey and by attending one of our events. This page also has more information about how NHS consultations work and our legal duties.

More information and accessible formats

As well as listening to your views, we want to keep you well informed – starting here.

- ✓ If anything in this document is hard to understand, an easy read version is also available You can find this online, or call us on 0333 150 3069 for a copy
- ✓ More information is available on our website – we include links throughout the document. See also ‘Find out more’ [on page X – to be added]
- ✓ If you can’t access the online information we mention, we can send you paper copies. Just call us on 0333 150 3069 and tell us what you need
- ✓ We can provide translated materials.

About us

We are NHS Staffordshire and Stoke-on-Trent Integrated Care Board. We are responsible for the health and care of 1.1 million people across the local area. We have been working with the two NHS trusts that provide the services that we are reviewing:

- University Hospitals of North Midlands NHS Trust (UHNM)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).

Our approach to improving maternity care

We know you may have worries about safety and quality in maternity care following recent national reviews.

Across the country, the NHS wants to make sure that maternity care is safe, that women are treated with care and respect, and that staff have all the skills and knowledge they need to give the best care.

The NHS Three-year delivery plan for maternity and neonatal services was published in March 2023, and our plans in Staffordshire and Stoke-on-Trent support its four main themes:

- Listening to women and families with compassion, which promotes safer care
- Supporting our workforce to develop their skills and capacity to deliver high-quality care
- Developing and sustaining a culture of safety to benefit everyone
- Meeting and improving standards and structures that underpin our national ambition.

These aims are at the heart of our approach to providing safe, high-quality care for you and your new baby. Read more about our local vision on page 11.

What birthing services are available locally?

Local and out-of-area maternity services are shown on the map below.

Maternity services map

Main hospital with consultant and maternity-led services

1. Royal Stoke Hospital, Stoke-on-Trent
2. Queen's Hospital, Burton

Freestanding midwife-led unit

3. County Hospital, Stafford
4. Samuel Johnson Community Hospital, Lichfield

Out of area services

5. New Cross Hospital, Wolverhampton
6. Good Hope Hospital, Sutton Coldfield
7. Walsall Manor Hospital
8. Heartlands Hospital, Birmingham
9. Birmingham Women's Hospital
10. City Hospital, Birmingham
11. Russells Hall Hospital, Dudley
12. Princess Royal Hospital, Telford
13. George Eliot Hospital, Nuneaton
14. Royal Derby Hospital
15. Solihull Hospital
16. Leighton Hospital, Crewe
17. Macclesfield District General Hospital

Hospitals in Staffordshire and Stoke-on-Trent

The two local hospitals where you can give birth are Royal Stoke University Hospital and Queen's Hospital, Burton. Each hospital offers two different types of maternity care:

Consultant-led units are run by senior doctors with full medical support on hand. For example, epidurals (a pain-relief injection) can be given, and there are maternity theatres if additional support or surgery is required. Both hospitals have antenatal and postnatal wards.

Midwife-led units are run by a team of midwives and are suitable only for low-risk pregnancies. They are designed to be a more relaxing environment. If you do need medical help during birth, you can be moved quickly to the consultant unit in the same hospital for specialist support.

Most babies are born in the consultant-led units in these hospitals.

Hospitals outside Staffordshire and Stoke-on-Trent

Women also choose providers outside of the county. In 2019/20, around 1 in 4 births for the Staffordshire and Stoke-on-Trent population were in hospitals outside of our local area.

Home births

Having your baby at home is an option for some women with low-risk pregnancies.

During the COVID-19 pandemic in 2020, the local trusts had to temporarily pause the home birth service. In the following years, staff shortages meant that it wasn't possible to get the service up and running again on a consistent basis.

However, since spring 2024, both trusts have been booking women into the home birth service. So, if you are assessed as having a suitable, low-risk pregnancy, you would be able to choose this option.

What makes a pregnancy low-risk?

- ✓ You are having one baby (not twins or triplets)
- ✓ Your general health, before getting pregnant, is good and there are no underlying complications due to long-term or chronic conditions
- ✓ You have been healthy and well all the way through pregnancy
- ✓ The birth takes place between 37 and 42 weeks, known as 'term'
- ✓ You go into labour naturally.

Freestanding midwife-led units

Freestanding midwife-led units (FMBUs) are places where women assessed as having **low-risk pregnancies** can choose to give birth. Freestanding means they are not in a bigger hospital with a consultant-led unit and access to additional medical support, such as anaesthetics. This makes them different from the midwife-led units at Royal Stoke and Queen's Hospital.

Our local FMBUs are at County Hospital, Stafford (run by University Hospitals of North Midlands NHS Foundation Trust) and Samuel Johnson Community Hospital, Lichfield (run by University Hospitals of Derby and Burton NHS Foundation Trust).

When the COVID-19 pandemic struck in March 2020, we had to stop providing the birthing services at County Hospital and Samuel Johnson Community Hospital. This was to make sure we had enough midwives to safely run the maternity units at Royal Stoke University Hospital and Queen's Hospital, Burton.

The closure was intended to be short-term. But the trusts have not been able to safely re-open the FMBUs for births because of a shortage of midwives – which has been a problem affecting the whole of England.

What services are offered at the local FMBUs now?

County Hospital	Samuel Johnson Community Hospital
✓ Base for community midwives	✓ Base for community midwives
✓ Antenatal clinics throughout pregnancy	✓ Antenatal clinics throughout pregnancy
✓ Routine ultrasound scanning	✓ Routine ultrasound scanning
✓ Postnatal care, including some specialist support services	✓ Postnatal care
× No birthing service at present	× No birthing service at present

What is the proposal?

The proposal is to make permanent the temporary closure of the birthing services at County Hospital and Samuel Johnson Community Hospital.

This does not mean we would stop providing all maternity services there. You would still be able to have your antenatal and postnatal appointments in these hospitals.

The proposal would not affect any services at Royal Stoke University Hospital or at Queen's Hospital in Burton.

Alongside the proposal, we would also:

- ✓ Maintain the home birth service throughout our local area, so that women with low-risk pregnancies have this option available to them.
- Work to put continuity of carer in place for women identified as most needing consistent support from the same team of midwives.

Why the proposal is needed

The number of babies born in the FMBUs was low

In the year 2019/20, before the temporary closure of the FMBUs, these were the total number of births in the units:

Location	Births (2019/20)
County Hospital FMBU	94 (about 8 each month)
Samuel Johnson FMBU	220 (about 18 each month)

Many more babies were born in the Stoke, Derby and Burton hospitals:

Location	Consultant-led units (2019/20)	Consultant-led units (2023/24)	Midwife-led units (2019/20)	Midwife-led units (2023/24)
Royal Stoke University Hospital	5,264	5,299	970	595
Royal Derby Hospital	4,770	4,938	802	737
Queen's Hospital, Burton	2,329	2,528	584	0*

* During 2022, midwife-led births were included within the consultant-led data at Queen's Hospital, Burton due to a change in the way the overall data was electronically collated. This meant midwife-led and consultant-led births could only be separated out manually. The introduction of Badgernet, a new electronic maternity record, in June this year is expected to support the service to electronically capture the different pathways of births going forward.

Not all women can choose to give birth in an FMBU. The units are only suitable if you have a low-risk pregnancy. Some women who choose midwife-led care also like the reassurance of being in a bigger hospital, with additional support close at hand.

Although the trusts promoted the birthing services at the FMBUs, the number of births there continued to fall.

It is likely that the number would fall further

Birthrate Plus® assessments at both trusts showed a growing number of high-risk pregnancies in the areas they serve. The reasons for this include women giving birth later in life, and lifestyle factors that can lead to conditions like diabetes and high blood pressure.

- An assessment carried out by **University Hospitals of North Midlands (UHNM)** in 2022 showed that just over 83% of women in their care had moderate or high-risk pregnancies
- An assessment carried out by **University Hospitals of Derby and Burton (UHDB)** in 2021 showed that just over 82% of all their births fell into the moderate or high-risk categories.

Birthrate Plus® assessments can only be completed for a particular Trust's area, not for an ICB population as a whole. However, applying the trends being seen at UHNM and UHDB, we can reach an estimate of the levels of low, and moderate or high-risk pregnancies for the local population. Staffordshire and Stoke-on-Trent would therefore expect 8,715 pregnancies each year to be moderate or high-risk, and 1,785 pregnancies to be low-risk.

More high-risk pregnancies mean fewer women would be suitable to give birth in one of the FMBUs.

Birthrate Plus®

Birthrate Plus is the national tool for calculating midwifery staffing levels. It helps maternity units work out how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.

What makes a pregnancy high-risk?

- ✓ You already have high blood pressure or diabetes
- ✓ You are going to have twins or triplets
- ✓ You are under 17 or over 35 years old
- ✓ A pregnancy-related health condition starts while you are pregnant, like high blood pressure (pre-eclampsia) or diabetes (gestational diabetes).
- ✓ You had problems in previous pregnancies, including going into labour or giving birth before 37 weeks.

Why would a low number of births at FMBUs be a problem?

Midwives' skills and experience – these units are recommended to manage at least 350 births per year, but the numbers locally were much lower and expected to fall further. Midwives working there may not experience enough births to keep their skills and competency at the right level.

Not making the best use of staff's time – to provide a round-the-clock birth service as before, the units must be staffed 24/7, with two midwives for every birth. A low number of births would mean that midwives' time and skills would be under-used. This is especially important when England as a whole continues to suffer a shortage of midwives.

Advantages and disadvantages of the proposal

Advantages

Safe, sustainable staffing levels for the maternity units at Stoke and Burton. Focusing our staff where the demand is highest would help us to provide the ongoing high-quality, safe and compassionate care that we all want.

Providing choice of home births and maternity-led care – with a low-risk pregnancy, you would still be able to choose to give birth in a more relaxed, less clinical setting. This could be in maternity-led care at Stoke or Burton, or a home birth (if assessment shows it's safe for you).

Reducing need for urgent transfer – if you had complications during labour at an FMBU, you would need an ambulance transfer to one of the acute hospitals. In 2019/20, just over one in three women (32.3%) giving birth at Samuel Johnson Community Hospital needed to be transferred to Queen's Hospital, Burton, and one in 10 women (10.3%) at County Hospital had to be transferred to Royal Stoke University Hospital.

Specialist support can be given much more quickly if you are already in a midwife-led unit at one of those hospitals, and it would avoid putting additional pressure on ambulance services.

Maintaining midwives' expertise – because of the high number of births, midwives at the bigger hospitals would experience a wide range of cases, ensuring their skills and expertise stay at the right level. Being based in the bigger hospitals also means new midwives have support from a wider team – which is important in giving recruits the right backing, help and encouragement as they develop their professional experience.

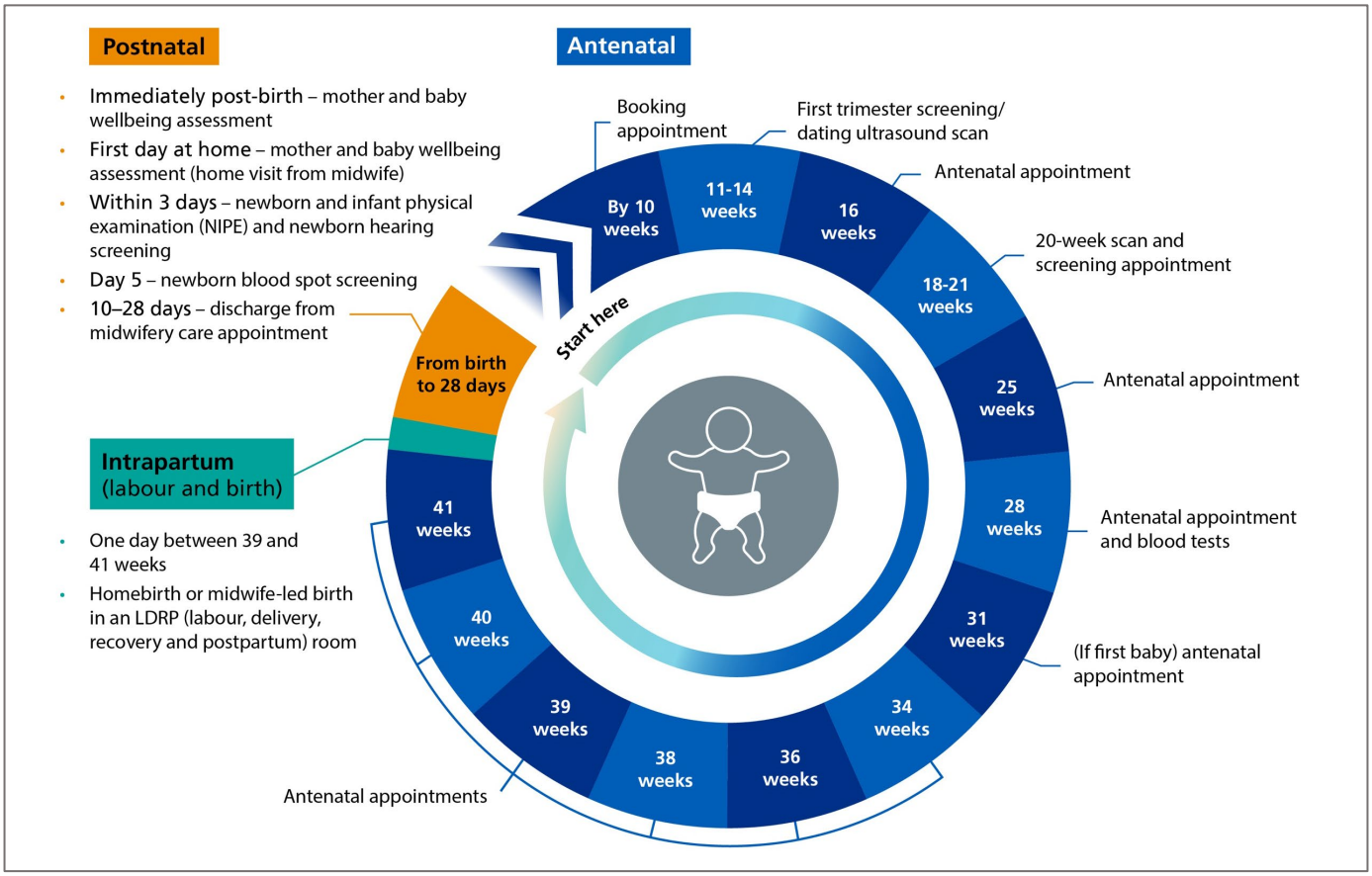
Locally, both trusts have successfully recruited more midwives. While this is great news, it's still vital that we deploy our staff in the way that makes the best use of their time, and gives them the varied experience they need to grow their skills – so they can provide the best care, and have the kind of fulfilling career that will encourage them to stay with the NHS.

Equity of care across the whole area – a lower number of births at the FMBUs meant on average, more midwife time per patient was given than at the Royal Stoke and Burton hospitals. The proposal would make the ratios the same across all units.

Antenatal and postnatal care would continue at the FMBUs, as well as in the community. The diagram below shows how most of the care received during and after pregnancy is either antenatal (**blue** – from booking appointment to labour) or postnatal (**orange** – from birth to 28 days).

Continuity of carer

By consolidating our workforce, we can work to provide continuity of carer – having support from the same team of midwives throughout pregnancy and after your baby is born – for the women who would benefit most from this kind of support. This would be women identified as particularly vulnerable, for example those with mental health support needs, or those experiencing deprivation.



Disadvantages

There may be **travel implications** for those women eligible to give birth at County Hospital or Samuel Johnson Community Hospital, if they live close by and would have chosen to give birth there.

We carried out a detailed analysis of how the proposal could impact travel time to birthing services, covering several scenarios. We did additional analysis of total travel time including urgent ambulance transfers from an FMBU to one of the main hospitals – which can happen if complications occur during labour or birth.

The analysis shows an impact on women who would be suitable to give birth at one of the FMBUs, and who would have chosen this option. Women living in Stafford would be impacted the most. For more detail, go to page 14.

How we have come to this proposal

Over several years, we have been having conversations about our maternity services with our patients and staff.

Developing our local vision

Our **local maternity and neonatal system (LMNS)** team has been leading conversations with our health and care partners – such as the trusts – to make sure we meet the needs of local people as well as the national aims for improving services.

Our **local vision** is to:

- Empower women, and their partners, by putting them at the centre of their care so they have the best support
- Design a service that supports women to access a team of midwives, who have worked with them to develop their own personal birth plan
- Provide a network of places where women can choose to have their care, that are high quality and safe, have the right staff skill-mix and also represent value for money
- Provide continuity of carer to the most vulnerable in our community during pregnancy, birth and beyond
- Make the best use of our staff, allowing them to maintain their skills, work more flexibly and really get to know the women and families they care for
- Develop and sustain a culture of safety which reduces inequalities in outcomes.

Working to tackle unequal outcomes

The MBRRACE-UK Report (October 2023) looked at deaths of women during and up to six weeks after pregnancy, between 2019 and 2021. It showed higher rates of deaths for women from black, Asian and mixed ethnic groups and those living in deprived areas.

We want to tackle the challenges that are leading to worse outcomes for mothers and babies from these groups. Every LMNS is working on an Equity and Equality Plan for how they will do this locally. We are funding an Equality, Diversity and Inclusion Midwife (as a pilot project) to support our work in this area.

Listening to the experiences of women and families

Our **Maternity and Neonatal Voices Partnership (MNVP)** listens and responds to the experiences of women and families.

A team of champions (volunteers who are local service users), the LMNS, midwives, neonatal nurses and doctors work together to review local maternity care and plan how to improve safety and experiences of the people who use these services.

The MNVP will seek out and listen to black, Asian, and mixed or other ethnic groups and those living in the most deprived areas, to make sure services are representative of the whole local population.

Options appraisal and public involvement

We have been having conversations with the public around maternity services, and options for change over several years – before the temporary closure of the birthing service at the FMBUs.

Timeline of options appraisal and public involvement

2019

Changes to maternity services were part of a wider 'Case for Change' in 2019. A listening exercise over 12 weeks that summer reached more than 2,000 service users, staff and local people. Their views were fed into an **options appraisal process** – where clinicians and other stakeholders review possible proposals by testing them against essential criteria.

2020

- **January and February:** Focus groups were held with expectant mothers and staff.
- **March:** The options appraisal process and involvement paused due to COVID-19.

2021

Further listening exercises to understand if any new feedback needed to be considered since the pandemic. We asked questions on home birth services and potential new continuity of carer and on-demand models of care. The on-demand model – which was proposed to replace midwives working 24/7 at the FMBUs – was in the pre-pandemic shortlist of options.

240 people responded to our survey and 28 people took part in the two online events we held. You can read about what they told us in the Report of findings and the Summary report of findings.

2023

Staffing pressures meant the trusts could not re-open FMBUs for births. The on-demand model previously considered was no longer viable (practical or possible).

- **July:** Case for Change submitted to NHS England.
- **September:** Options appraisal – technical event to review the evidence, consider all possible proposals for birthing services, and develop a shortlist of viable proposals.
- **December:** Deliberative event for public and staff to hear the proposal, share views and ask questions. The Report of findings from this event includes some interviews with women who wanted to take part, but couldn't do so.

2024/25

The actions below are part of the **governance process**. Before a consultation is launched, this is a process to check that we are doing things correctly – such as looking at all the evidence, looking at the impacts of any change, and meeting our legal duties.

- **April:** the West Midlands Clinical Senate (WMCS) visited the maternity units at Royal Stoke and Queen's Hospital. Later in the month, we held a meeting with the WMCS and presented our case for change.
- **October & January 2025:** We held stage 2 assurance meetings with NHS England.
- **February 2025:** Presentation of PCBC to ICB Board.

Options appraisal process in 2023

In September 2023, a technical group of clinicians and managers met to review a shortlist of five proposals, which was extended to seven proposals (listed below) during the meeting. To see the advantages and disadvantages identified for each proposal, refer to the appendix.

- Reinstating the birthing service at both FMBUs
- Reinstating a single birthing service at one or other FMBU
- Implementing a single birthing unit at an alternative site (which would need to be identified)
- Implementing an on-demand model at both FMBUs
- Implementing an on-demand model at one of the FMBUs
- Implementing an on-demand model at an alternative site (which would need to be identified)
- Permanent closure of birthing service at County Hospital and Samuel Johnson Community Hospital.

The technical group checked each proposal against six essential criteria – these set out the most important questions we need to answer about whether a proposal is going to work.

- **Clinical sustainability** – can we provide good, safe services in the long term?
- **Strategic fit** – is the service change in line with the health system's wider plans and aims?
- **Meeting the needs of the population** – would the service meet everyone's needs?
- **Demand and capacity** – are there enough people wanting to use the service and enough staff to provide the service?
- **Workforce sustainability** – do we have, or can we provide enough staff with the right skills to keep the service going in the long term?
- **Estates** – are the buildings and sites suitable?

Having worked through the proposals, the group found that only the single proposal set out on page 7 would be viable – meaning that it would be practical and possible to implement.

In December 2023, we held an online meeting for public and staff to hear the proposal, share views and ask questions. 28 people registered to join, 16 attended, and people who registered but didn't attend were contacted afterwards and offered one-to-one interviews to gather their feedback.

You can read the report of findings from this event on the ICB website.

Why is there only one proposal?

We follow the latest guidance from NHS England, Working in partnership with people and communities (October 2022), which includes NHS organisations' legal duties and responsibilities for working with people during public consultations. This explains (page 72) that "it is not appropriate to consult on options that are not genuinely under consideration or are **unviable or unrealistic**".

We can only consult on **viable** proposals – we are not allowed to, and would not want to, ask you to spend your time considering proposals that are not practical or possible for us to implement.

Impacts of the proposal

Financial impacts

The proposal doesn't lead to any additional staffing or building costs, whereas re-opening the birthing service at the two FMBUs would need recruitment of extra midwives.

Since 2021, significant funding has gone into maternity services at both trusts to make sure they could safely staff the maternity units at the two main hospitals – which has been achieved.

[add link to PCBC]

Equality impacts

We carried out an Equality Impact Assessment in August 2024 to see how the proposal could affect people depending on age, ethnicity and disability.

The assessment found neither a negative nor positive impact in these three cases, but there was a potential negative impact in terms of travel requirements (see below).

[add link to PCBC]

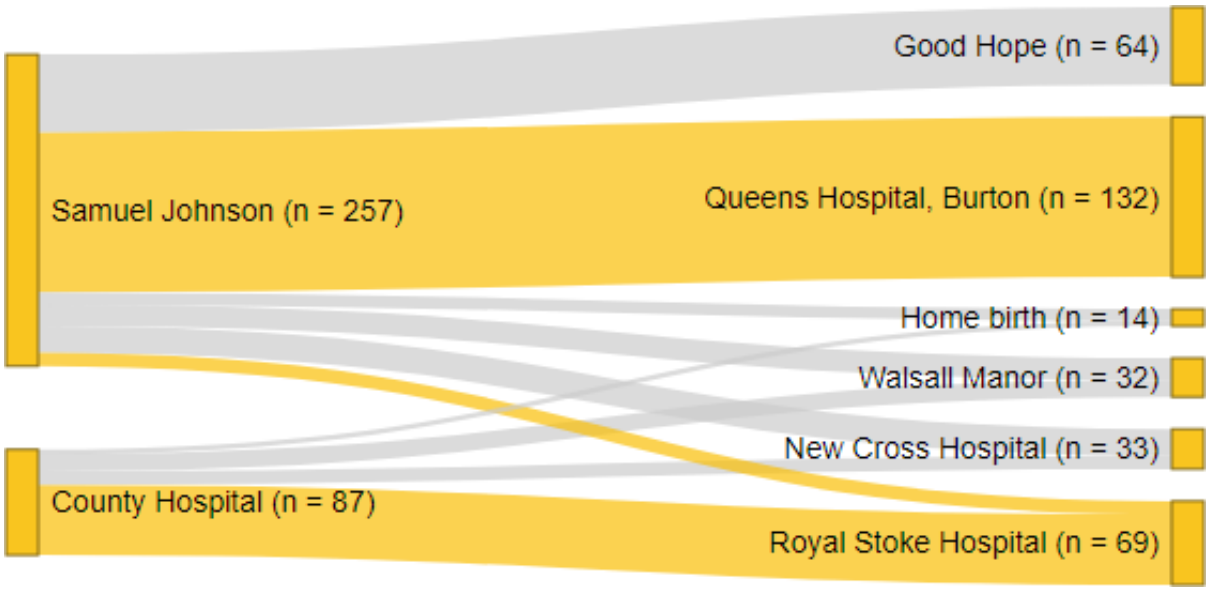
Travel impacts

We carried out a detailed analysis of how the proposal could affect the travel time to birthing services, covering several different scenarios. We did extra analysis of the total travel time for urgent ambulance transfers from an FMBU to one of the main hospitals – which can be needed when there are complications during the birth.

- **Actual time:** Time that women actually travelled from their home area to either County Hospital or Samuel Johnson Community Hospital.
- **Baseline:** With County and Samuel Johnson still open for births, this situation is based on travel time to the nearest maternity site within Staffordshire – either County, Samuel Johnson, Royal Stoke University Hospital or Queen's Hospital, Burton. This is assuming women travel to their nearest site, which was not always the case – in reality, some women decided to travel further to use County and Samuel Johnson.
- **Scenario 1:** All births that would have happened at County or Samuel Johnson, if open for births, move to the nearest site in Staffordshire – which would be Stoke or Burton.
- **Scenario 2:** All births that would have happened at County or Samuel Johnson move to the nearest site – either within Staffordshire or to an external provider site if nearer.
- **Scenario 3:** All births that would have happened at County or Samuel Johnson move to the nearest site (Stoke, Burton, or an external provider if the site has a midwife-led unit). In this scenario, it is assumed that women would only travel to a midwife-led unit outside Staffordshire if it was the nearest site, otherwise it is assumed they would travel to Stoke or Burton.

- **Scenario 4:** Re-allocation of births based on where people have actually given birth since the temporary closure of the birthing services at County and Samuel Johnson, including home births.

Scenario 4 is likely to represent the impact of the proposal most accurately. The diagram shows the births that would have happened at Samuel Johnson and County Hospitals 're-allocated' to hospitals within Staffordshire and Stoke-on-Trent (shown in **yellow**) and outside the area (shown in **grey** – home births included here).



In this scenario, the average travel time would increase by 6 minutes compared to the **actual travel time**, or about 8 minutes compared to the **baseline.** Women in Stafford would be most affected, with travel time increasing by around 14 minutes compared to actual travel time.

However:

- The proposal affects a small number of births (around 340 each year) when compared to the overall number of births in services provided by University Hospitals of North Midlands and University Hospitals of Derby and Burton across their sites (around 15,000 each year)
- With the home birth service fully available again, women with suitable low-risk pregnancies would have this option (with no travel), as well as the option of midwife-led care at one of the main hospitals
- There would be no impact on travelling for antenatal or postnatal care, as these services would not be affected by the proposal
- Urgent transfers from the FMBUs would no longer be needed. In 2019/20, just over one in three women (32.3%) giving birth at Samuel Johnson Community Hospital had to be transferred to Queen's Hospital, Burton, and one in 10 women (10.3%) at County Hospital had to be transferred to Royal Stoke University Hospital.

For more detail, please see the Pre-Consultation Business Case [add link] – or call us if you are not able to go online.

Meeting the tests of service change

We followed a tried and tested process to develop our recommendation. This includes making sure that it met the **five national tests** set out by NHS England (NHSE).

Full details of the five national tests can be found in these NHSE documents:

- Planning, assuring and delivering service change (see sections 5.1 to 5.4)
- Addendum to Planning, assuring and delivering service change (May 2022)

Strong public and patient engagement

We have run several phases of public engagement, which you can see in the timeline on page 12.

Need for patient choice

The NHS choice framework says: “Women should be able to choose whether to give birth at home with the support of a midwife, within a midwife-led facility with the support of a midwife, or in a hospital with the support of a maternity team.”

The proposal would offer this choice. While your choices for where to give birth depend on whether your pregnancy is assessed as low-risk or high-risk, the options of home birth, midwife-led care in hospital and consultant-led care would all be available in our area.

Clear clinical evidence base

We have worked with the trusts to make sure that the proposal is sustainable clinically and in terms of staffing. Our technical group reviewed the proposal against the six criteria shown on page 13, which include clinical and workforce sustainability.

The ICB has presented a pre-consultation business case to NHSE [add link]. This sets out the main reasons in the clinical case for change. A key factor is the growing number of complex pregnancies in our area, as shown by the Birthrate Plus® assessments carried out by both trusts (see page 8 for the numbers). This means that fewer women would be eligible to give birth in the FMBUs, because they would need to be in consultant-led care.

With this picture of growing numbers of higher-risk pregnancies, we want to make sure our midwives are supported to develop and maintain their skills to manage a more clinically complex workload and deliver high-quality, safe care.

Support from clinical commissioners

The ICB has worked closely with University Hospitals of North Midlands and University Hospitals of Derby and Burton throughout the options appraisal process. We have also kept the neighbouring ICBs informed. NHS Derby and Derbyshire ICB has confirmed their support for the proposal.

In April 2024, we presented the proposal to the West Midlands Clinical Senate, who also support the proposal. We held assurance meetings with NHS England in July 2023, October 2024 and December 2024.

[add link to WMCS review in PCBC]

Bed test

At the time of the temporary closure, there were no inpatient beds in the FMBUs. There were two rooms at County Hospital for labour, delivery, recovery and postpartum (LDRP), and three at Samuel Johnson Community Hospital.

We have modelled our proposals to make sure that the right number of low-risk LDRP beds would be available. There are four LDRP rooms at Royal Stoke University Hospital and two at Queen's Hospital, Burton. Both hospitals can use other delivery rooms to provide low-risk care as needed.

What is happening in this consultation?

[Consultation dates to be added]

About NHS consultations

Consultation is the process where:

- staff, patients, carers and other interested groups are given information about the work done so far, and any recommended proposal(s)
- the views of local people are gathered to inform decisions.

By law, the NHS must involve the public and local organisations when developing services or considering big changes to how they are provided. This legal duty is found in the NHS Act 2006, which was amended in the Health and Social Care Act 2012.

The Health and Care Act 2022 gives all health bodies a 'triple aim' duty. Together they must work for:

- ✓ better care for all patients
- ✓ better health and wellbeing for everyone
- ✓ sustainable use of NHS resources.

How can I share my views?

Complete our survey!

- You can do this online or ask us to send you a paper version
- An easy read survey is also available
- It's important to read this consultation document carefully before you answer the survey questions. There is an easy read version available in print or online.

[add links to survey, easy read survey and online easy read document]

Attend an event

- We'll be holding two online meetings – one during the day and one in the evening
- There will be a roadshow of drop-in events
- We're also arranging meeting with existing community groups.

We will add dates, times and venues of the online meetings and drop-in events on the ICB website. Please do keep checking in case there are any changes. If you don't have internet access, call us on 0333 150 3069 for details. [Add link to involvement page]

What will you do with my feedback?

We will analyse all the survey responses we receive, together with the feedback we gather at meetings and events. All the findings will be included in a report and published on the ICB website.

The ICB Board will consider the report alongside the clinical and financial factors that they also need to look at. Your feedback will help inform their final decision.

The results of public consultation do not represent a vote or a referendum over any proposals for change.

Who is running this consultation?

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) is legally responsible for this consultation. ICBs commission NHS services in their local area, from the NHS trusts and other bodies that provide them.

Who are we consulting?

Anyone who is interested can take part in this consultation.

To make sure we reach as many people as possible, we are working with:

- the Maternity and Neonatal Voices Partnership (MNVP) to engage with service users, families and carers
- Healthwatch and the voluntary sector to identify community and voluntary groups that we can attend.

Other ways to take part and keep in touch

If you have additional feedback you would like to share, you are welcome to send this to us by email or through our Freepost address [add address].

We will also be carefully monitoring social media during the consultation:

Tweet us **@staffsstokeicb**

Follow us on Facebook at **StaffsStokeICB**

If you would like regular updates on our work on Maternity, email us at **csu.involvement@nhs.net** and we will add you to the mailing list.

[To be added:

- ✓ Box with full list of information available online or which we can send out
- ✓ Translated alternative formats notice.]

Abbreviations and glossary

- **Antenatal care:** The care you receive while you are pregnant to make sure you and your baby are as well as possible.
- **Birthrate Plus® assessment:** The national tool used by the NHS for calculating midwifery staffing levels, based on data that has been collected over many years. It helps maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.
- **Clinical Senate:** Advisory bodies that bring together clinical leaders in an independent group to give expert clinical advice and guidance to all parts of the healthcare system.
- **Consultant-led care / unit:** Where the maternity service is run by consultant obstetricians – senior specialist doctors – and there is access to anaesthetics and neonatal (newborn) care. You would be advised to give birth in a consultant-led unit if you have a high-risk pregnancy.
- **Continuity of carer model:** A way of delivering maternity care so that women receive dedicated support from the same team of midwives through their pregnancy.
- **Freestanding midwife-led birthing unit (FMBU**): 'Freestanding' means it is not in a larger hospital alongside a consultant-led unit.
- **Local maternity and neonatal system (LMNS):** The partnership of maternity and neonatal service providers, local authorities and the MNVP (see below) who work together to transform maternity services for Staffordshire and Stoke-on-Trent.
- **Maternity-led care / unit:** Where the maternity service is led by midwives. Some maternity-led units are in larger hospitals that also have consultant-led units. A 'freestanding' unit (FMBU) would be in a smaller hospital or clinic without the consultant-led support. Maternity-led care is suitable if you have a low-risk pregnancy. It's preferred by some women because you can give birth in more relaxed surroundings and are less likely to have an intervention such as forceps or ventouse (vacuum delivery).
- **Maternity and Neonatal Independent Sector Advisor (MNISA):** This new senior role is being piloted to support women and families in England when they are involved in an investigation or complaint relating to their maternity care or their baby's neonatal care.
- **Maternity and Neonatal Voices Partnership (MNVP):** A group of service users, staff and other stakeholders, who listen to the experiences of women and families and identify where improvements are needed in maternity and neonatal care.
- **Neonatal unit:** Provides special care for ill or premature babies.
- **Options appraisal process:** A series of events that helps NHS boards decide the best way to change their services. Final decisions are not taken during the process – instead, it provides recommendations that help to inform a final decision.
- **Postnatal care:** The care given to a mother and baby for the first six to eight weeks after the baby's birth.
- **West Midlands Clinical Senate (WMCS):** See 'Clinical Senate'.

Appendix

The technical group considered seven proposals. **Only one was considered viable** – this is to make permanent the temporary closure of the birthing services at the FMBUs in County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield.

This appendix shows the seven proposals, with a table setting out the advantages and disadvantages of each.

Reinstatement of birthing service at County Hospital and Samuel Johnson Community Hospital

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less travel for those living close to the units who are eligible to use the units and who choose to give birth there.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour, they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Reinstatement of a single birthing service at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Implementation of a single birthing unit at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the units in the past. • 24/7 staffing of units means midwives can't support homebirths or other midwife-led units. • Due to low numbers of deliveries there is a possible under-utilisation of skilled, experienced midwives who cannot support in other areas of maternity care while working in the FMBU. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Implementation of an on-demand model at both FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less impact on staffing when compared to running a 24/7 birthing unit. However, would likely need further recruitment beyond the current plans. • Midwives maintain their skills – delivering more births at home and midwife-led units. • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Implementation of an on-demand model at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less impact on staffing when compared to running two separate birthing units. However, would likely need further recruitment beyond the current plans. • Midwives maintain their skills – delivering more births at home and midwife-led units. • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Implementation of an on-demand model at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered. • Less impact on staffing when compared to running two separate birthing units. However, would likely need further recruitment beyond the current plans. • Midwives maintain their skills – delivering more births at home and midwife-led units. • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women may arrive before the community midwife on-call, or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital. • This poses a governance risk to trusts who would be held accountable for incidents on the hospital premises. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Permanent closure of birthing service at County Hospital and Samuel Johnson Community Hospital

Advantages	Disadvantages
• Women would continue to receive most of their antenatal and postnatal care within the units. • Staff-to-patient ratios would be the same across all units. • Midwives can support the homebirth services and midwife-led units. • They can also fully utilise their skills and experience to support other areas of maternity care where there are national recommendations, for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days. • Women who develop complications would no longer need to be transferred to a hospital unit during labour.	• There may be travel implications for women who are eligible to give birth at County Hospital or Samuel Johnson, who live close to the units and who would have chosen to give birth there. • Requires the reinstatement of homebirth services to ensure full patient choice is offered.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 09

Report to:	**Integrated Care Board**						
Date:	**20 March 2025**						
Title:	Delegation of Specified Specialised Acute and Mental health Learning Disability and Autism Services						
Presenting Officer:	Paul Winter, Associate Director of Corporate Governance						
Author(s):	Kirsten Owen, Associate Director of Special Projects						
Document Type:	Report		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒	
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	YES					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	AAA Report – SpecComMarchUpdate. Acute Specialised Services Delegation Agreement (Appendix 1) Collaboration Agreement for the additional delegation of specialised acute and mental health learning disability and autism services (Appendix 2) Data Protection Impact Assessment (Appendix 3)						

(1) Purpose of the Paper:

The purpose of this paper is to provide an update to the integrated Care Board on the progress of phase two of the NHSE Delegated Commissioning programme of work and share the NHS England Briefing paper on the refreshed Delegated and Collaboration Agreement.

To request the Board approve the delegation of the additional Acute services and the range of Mental Health, Learning Disabilities and Autism Services.

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

(3) Implications:	
Legal / Regulatory	There may be an impact on a number of the ICB contracts with providers, to make reference to the new contracting arrangements for the delegated specialised commissioning acute services.
CQC / Patient Safety	Senior quality representatives are members of the specialised commissioning quality group regional meeting.

Financial (CFO-assured)	The financial implications relating to the delegated specialised commissioning services is managed at the regional CFO level. There is senior financial representation at the regional specialised commissioning finance and contracting subgroup.
Sustainability	NA
Workforce / Training	NA
Equality & Diversity	NA
Due Regard: Inequalities	
Due Regard: wider effect	

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The Delegation Agreement attached to this paper provides the particulars relating to the agreement between NHS England and Staffordshire and Stoke-on-Trent ICB

The Collaboration Agreement attached to this paper provides the arrangements that will apply between the ICBs and NHSE England in relation to the collaboration commissioning of specialised Services. The Agreement sets out the working arrangements with regards to, but not limited to: Lead Commissioner Arrangements, aligned commissioning arrangements, Joint commissioning arrangements, financial arrangements and governance arrangements.

Building on existing partnerships, there will be closer collaborative working between NHS England and ICBs on the commissioning of vaccination, screening and CHIS from April 2025. Responsibility for commissioning vaccination services and suitable elements of screening pathways and CHIS will be delegated to ICBs in April 2026, subject to governance and Secretary of State approval.

The ICB Specialised Commissioning Delegated Services Working Group, will report into this committee, the group includes all key ICB officers, who are the ICB representatives at the specialised commissioning operational groups, shown below:

- Midlands Acute Specialised Commissioning Group
- Mental Health Commissioning Group
- Specialised Commissioning Quality Group
- Finance and Contracting Group

The working group will be the coordinating group that will receive the updates for quality, finance, contracting and delivery, and the group members will provide relevant updates to Finance, Performance Committee and Quality Safety Committee.

There is further information and clarification around the duties with regards to potential litigation, whilst the transfer of the responsibility of claims and litigation was in the existing agreed delegation agreement, there is a concern that risk profile has changed with the inclusion of Specialised Mental Health, Learning Disabilities and Autism Services. We have asked for more clarity and NHSE have advised that they are drafting a briefing note which is due out shortly.

(7) Recommendations to Board / Committee:

- ☑ **APPROVE** the Acute Specialised Services Delegation Agreement (Appendix 1)
- ☑ **APPROVE** the Collaboration Agreement for the additional delegation of specialised acute and mental health learning disability and autism services (Appendix 2)
- ☑ **RECEIVE** and **NOTE** the Data Protection Impact Assessment (Appendix 3)
- ☑ **ASSURED** that the ICB has the relevant internal governance and reporting arrangements in place.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Report To:	Staffordshire and Stoke-on-Trent Integrated Care Board
Title	Delegation of Specified Specialised Acute and Mental health Learning Disability and Autism Services
Date of Meeting:	20/03/2025
Presenter:	Kirsten Owen, Associate Director of Special Projects
Author:	Kirsten Owen, Associate Director of Special Projects

Key Points for Discussion:

ALERT

Actions Update and Early Alerts: As part of the previously agreed, and new delegation agreement, the legal liabilities are delegated to ICBs, whilst this is not a new addition to the delegation agreement, with the expansion of the services delegated to include Mental Health, Learning Disabilities and Autism, there a potential small increase in the risk profile.

NHSE have provided a breakdown of cases nationally spanning the last 5 years, and senior officer are confident. The cases in the Midlands region are minimal and fall in the first instance to the Provider Collaborative responsible for the commissioning of the services.

We have been advised that any cases/claims either currently ongoing or future for the period prior to the 1st April 2025, will be covered under the existing arrangement and will be managed directly by NHSE.

As part of the specialised commissioning transition from NHSE sender/ receiver process discussions continue to take place with regards to the legal support function, aligned with the service transfer to take place in July.

The ICB Specialised Commissioning Delegated Services Working Group will keep a close to the detail around these new arrangements.

ADVISE

Early Advisories: The Delegation Agreement attached to this paper provides the particulars relating to the agreement between NHS England and Staffordshire and Stoke-on-Trent ICB

The Collaboration Agreement attached to this paper provides the arrangements that will apply between the ICBs and NHSE England in relation to the collaboration commissioning of specialised Services. The Agreement sets out the working arrangements with regards to, but not limited to: Lead Commissioner Arrangements, aligned commissioning arrangements, Joint commissioning arrangements, financial arrangements and governance arrangements.

Building on existing partnerships, there will be closer collaborative working between NHS England and ICBs on the commissioning of vaccination, screening and CHIS from April 2025. Responsibility for commissioning vaccination services and suitable elements of screening pathways and CHIS will be delegated to ICBs in April 2026, subject to governance and Secretary of State approval.

ASSURE

Assurances: The ICB Specialised Commissioning Delegated Services Working Group, will report into this committee, the group includes all key ICB officers, who are the ICB representatives at the specialised commissioning operational groups, shown below:

- Midlands Acute Specialised Commissioning Group
- Mental Health Commissioning Group
- Specialised Commissioning Quality Group
- Finance and Contracting Group

The working group will be the coordinating group that will receive the updates for quality, finance, contracting and delivery, and the group members will provide relevant updates to Finance, Performance Committee and Quality Safety Committee.

The working group will have an awareness of future proposed Delegation of other Specialised Commissioning service, such as vaccinations, screening and child health information services subject to governance and Secretary of State approval.

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

The paper supports the ICB in the delivery of several System ICB risks and Board Assurance Framework

- Responsive Patient Care – Elective
- Proactive Community Services
- Reducing Health Inequalities
- High Quality, Safe Outcomes

The ICB involvement and participation in the region specialised commissioning operational groups ensures that the ICB is able to proactively ensure that the services are commissioned to support our patients.

The PURPOSE of the Paper:

The purpose of this paper is to provide an update to the Strategic Transformation Commissioning Committee on the progress of phase two of the NHSE Delegated Commissioning programme of work and share the NHS England Briefing paper on the refreshed Delegated and Collaboration Agreement and the request from NHSE to sign the two agreements.

ICB (ICS) Policy Impacts:

N/A – The paper does not require a formal change in policy or procedure

The DETAILS of the Paper:

1 Introduction and purpose of the paper

1.1 ICBs were set up to work with all partners to create a system where decisions are taken as locally as possible, with frontline clinicians and professionals at the centre of driving change and supporting patients and communities having a say on how the changes are being proposed.

1.2 However, at the inception of ICBs a significant proportion of the populations care was managed outside of the ICS through NHSE as specialised services. Delegation means that ICBs will have decision making authority for a set specialised acute services and Mental health Learning Disability and Autism services in support of their local population.

1.3 On the 5th December 2024 NHS England Board approved the 11 Midlands ICB application for the delegation of the final specified specialised acute and mental learning disability and autism services to the Midlands ICBs.

1.4 ICBs received the first set of delegated specialised services in April 2024 and over the last 12 months have been working together and working in partnership with NHSE. The leadership experience this phased approached has afforded the midlands ICBs has been invaluable and has helped shape the new ways of working for the future.

1.5 Although responsibilities are delegated to individual ICBs, the delegation agreement requires ICBs to form a multi-ICB partnership. This is due to the larger population base required to safely and sustainably commission specialised services. Therefore, the Collaboration Agreement alongside the Delegation Agreement remains required.

2. What will ICB responsibilities after delegation be

2.1 Although NHSE will remain accountable to the secretary of state for the services, under delegation the responsibility for all decisions relating to the planning, design, quality, finance, and delivery, transfer to ICBs this includes:

- Decisions in relation to the commissioning and management of the delegated services
- Planning delegated services for the population, including carrying out needs assessments
- Undertaking reviews of delegated services in respect of the population
- Supporting the management of the specialised commissioning budget for delegated services
- Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate
- Such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 Whilst there will remain national specifications for Specialised Services, delegation provides the opportunity to ensure that planning is based on the needs of local populations, and that value is realised across pathways.

2.3 The responsibility for delivery of Specialised Services will sit collectively with the Muli-ICB partnership (East and West Joint Committees) this the multi-ICB arrangement is a formal requirement of delegation. Therefore, if a service in one ICB is having issues then is it the Muli-ICB partnership who will have oversight and the responsibility through the hosted Specialised Commissioning team to resolve.

3. The Integrated Commissioning Team

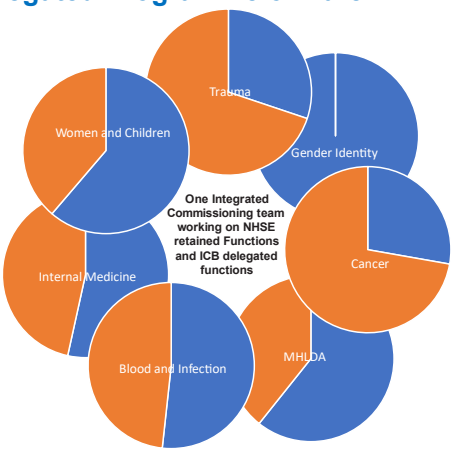
3.1 During 2024/25 the specialised commissioning workforce (including finance, quality, programme of care and contracting experts) remained employed by NHS England working on behalf of all 12 organisations. Having undertaken a formal consultation in Autumn 2024 the majority of the workforce will transfer to Birmingham and Solihull ICB as the employee host ICB in July 2025.

3.1 The team transferring to ICBs and the team remaining employed by NHSE however will continue to work together as one integrated commissioning team. This follows the principles of design set as the very early stages for the development of our collective operating model, including maximised opportunities and the skills of specialised staff and not cost the ICB or NHSE any more money.

3.2 In addition, whole pathways of care have not been delegated, individual service lines have therefore, it is essential to reduce fragmentation that services are planned, improved and delivered collaboratively. The diagram illustrates the percentage of services delegated and retained by programme of care. With the Orange segments being delegated services and the Blue segments being retained services.

Retained and Delegated Programme of Care

Orange Segments
Illustrating the percentage of the service lines that will be delegated to ICBs by programmes of care



Blue Segments
illustrating the percentage of the service lines that will be retained by NHSE by programmes of care

3.3 Led by 3 senior executives (Specialised Services Commissioning Director, Medical Director, Finance Director) the workforce will transfer under TUPE on the 1st July 2025. The team will work across all 11 ICBs reporting through the East Midlands and West Midlands Joint Committees.

3.4 The Birmingham and Solihull ICB are not the lead commissioner they are the workforce host ICB, there will be a separate agreement between the 11 ICBs to cover the hosting services which in summary will provide:

- The mechanisms to support payment of and corporate support functions for staff including office space and IT requirements.
- Line management and corporate support for the director level leadership team of the specialised commissioning function.
- Connectivity and the opportunity to provide corporate support around organisational development and training.

3.5 Complaints and Freedom of Information Requests are undertaken by the Specialised services team, there is no backlog of complaints with the annual level across the midlands being minimal with a total of 5 for 2024.

4. Mental Health Learning Disability and Autism (MHLDA)

4.1 The Specified Mental Health Learning Disability and specialised services commissioning responsibility will be delegated to ICBs from April 2025, these are delivered via the NHS-Led Provider Collaboratives as the delivery model.

4.2 NHS-Led MHLDA Provider Collaboratives take responsibility for local pathway delivery of a number of services lines within the specialised MHLDA portfolio. The Provider Collaboratives apply a population health approach across either an East or a West Midlands geography. ICBs under delegation will hold a contract an NHS Lead Provider. The Lead Provider is then responsible for the sub-contracting of its partners to support the range of services required for their cohort of patients, and with that they have day to day responsibility for the oversight and assurance of the delivery of these services, with robust governance arrangements in place to support escalation and decision making.

4.3 NHSE issued a new 2-year plus one contract for lead providers from April 2024, this was then duplicated to their sub-contractors.

4.4 There is a requirement for the 8 Lead Provider contacts to be held by a single ICB, therefore these 8 contracts will be held by the following ICBs as named coordinating commissioner, with all other ICB being named associate commissioners therefore they are not a lead commissioner, and governance will be through the East and West Joint Committee along with other specialised services.

4.5 In the East Midlands a single ICB will host the following four lead provider contracts on behalf of the five ICBs in the East Midlands:

Leicester, Leicestershire & Rutland ICB
- Adult Low & Medium Secure – Nottinghamshire Healthcare NHS Trust
- CYPMHS – Northamptonshire Healthcare NHS Trust
- Adult Eating Disorder – Leicestershire Partnership NHS Trust
- Perinatal Inpatient Services – Derbyshire Healthcare NHS Trust

4.6 In the West Midlands two ICB's will host the following four lead provider contracts on behalf of the six ICBs in the West Midlands:

Birmingham & Solihull ICB
- Adult Low & Medium Secure – Birmingham & Solihull Mental Health NHS Trust
- CYPMHS – Birmingham Women's & Children's NHS Trust

Staffordshire & Stoke-on-Trent ICB
- Adult Eating Disorder – Midlands Partnership University NHS Foundation Trust
- Perinatal Inpatient Services – Midlands University Partnership NHS Trust

5. Financial Risk Exposure, Rish Sharing and Pooling

5.1 For services delegated in 2024/25, a Finance and Contracting Subgroup and a Finance Working Group has been operating throughout 2024/25 where assurance of performance, reporting and planning has had full ICB engagement. These groups will continue to oversee financial governance into 2025/26 including oversight and engagement of the detailed planning process for existing delegated services and those to be delegated from April 2025. This group will also oversee financial due diligence in the run up to April 2025, once confirmed allocations have been received.

NHS England staff are developing 2025/26 financial plans for specialised services, ensuring full engagement with ICB finance staff through the Subgroup.

- ICB population-based allocations for all delegated services have been developed based on current contractual commitments.
- 2025/26 acute allocation baselines will be updated for all 2024/25 allocation adjustments, precommitments and variable activity levels. As such there will be no risk exposure from opening contract baselines for 2024/25.
- For mental health services, a full review of contracts with Provider Collaboratives was undertaken in Autumn 2024 to ensure ICB allocations were aligned to contractual commitments. Where available 2023/24 full year patient level activity was used to split services between ICBs in this exercise. There is no needs-weighted formula or convergence adjustments for mental health services. As with acute services, the basis of allocation means there will be no financial risk in opening ICB allocations.
- Finalisation of 2025/26 ICB allocations should be completed through January 2025 with a full ICB engagement session during February 2025.

- ICB delegated reserves were frozen during 2024/25, but these will be recreated in opening 2025/26 baselines. Retained reserves will be allocated to reflect additional delegation including mental health services.
- The majority of the specialised services contract is operated on a block basis so there is no financial exposure to activity variance.
- Elective activity is managed through the Elective Recovery Fund (ERF)which will be managed on the same basis as 2024/25 with contract values and allocations being adjusted for activity variances. These services were delegated in 2024/25 and there are no additional services linked to ERF in the proposed 2025/26 delegation. There will be a capping of financial allocations for elective activity in 2025/26 and NHS England are working with ICBs to agree appropriate baselines that reflect 2024/25 activity levels. Although the application of a cap to ERF payments does create a small level of risk for ICBs, there is no additional financial risk linked to the further delegation of services.
- There are a small number of variable services outside ERF arrangements that are managed locally within existing delegated services. Through 2024/25 these have been managed through a risk management framework to mitigate financial exposure at individual ICB. For 2025/26 opening allocations and associated contract values will be set at outturn to maximise resource availability for these services.
- Variable services will be capped in 2025/26. We are working with ICBs and providers to ensure that expected growth is understood and incorporated into any capped payment limit.
- There is a planning assumption that a contingency will be held to manage in year financial risk to mitigate the impact of variable service financial risks.

5.2 A risk management agreement was in place in 2024/25 to manage financial exposure of individual ICBs with all contractual payments managed by the finance team through the single joint Specialised Commissioning contract.

We do not expect these risk management arrangements to continue into 2025/26 due to the cap on variable activity payments. This will be confirmed with the Finance and Contracting subgroup in February 2025.

6. Governance & Decision Making

6.1 The Delegation Agreement is the legal mechanism for NHSE to delegate responsibilities to ICBs.

6.2 The Collaboration Agreement details how Multiple ICBs can effectively make joint decisions through the existing East Midlands and the West Midlands Joint Committees.

6.3 The Joint Committees will be supported by Tier 2 sub-groups who will manage financial risk sharing, quality oversight, contracts, and the commissioning reporting directly to the Joint Committees.

7. Due Diligence Process

7.1 The Due Diligence process undertaken has been the national safe delegation checklist through the working groups.

7.2 The due diligence domains are set below:

- **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in from 2025

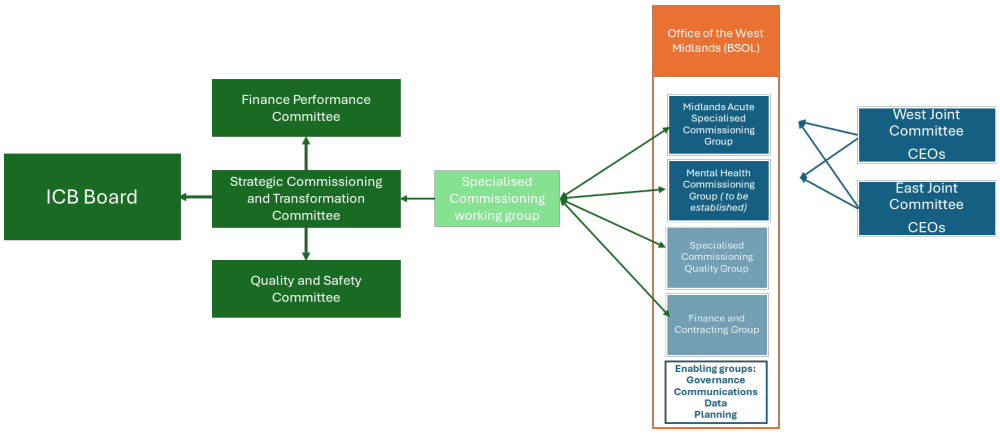
- **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
- **Resources** – staff capacity and capability and the ability to meet requirements for delegation as ICBs take on the commissioning role.

Staffordshire and Stoke-on-Trent ICB Governance Arrangements

The Strategic Commissioning and Transformation Committee, has the full oversight of the Delegation of Specified Specialised Acute and Mental health Learning Disability and Autism Services, this is supported by the Specialised Commissioning working group.

The Specialised Commissioning working group has membership from key ICB officers, who are the ICB representatives at the specialised commissioning operational groups.

- Midlands Acute Specialised Commissioning Group
- Mental Health Commissioning Group (currently being established)
- Specialised Commissioning Quality Group
- Finance and Contracting Group
- Enabling groups: Governance, Business Intelligence, Planning and communications



The working group will be the coordinating group that will receive the updates for quality, finance, contracting and delivery, and the group members will provide relevant updates to Finance, Performance Committee and Quality Safety Committee.

The working group will also have an awareness of future proposed Delegation of other Specialised Commissioning service, such as vaccinations, screening and child health information services and health and justice service, subject to governance and Secretary of State approval.

This committee will provide a regular coordinated update and assurance on delivery and performance to the ICB Board.

The DECISIONS to be Made – the Recommendations:

- ☑ APPROVE the Acute Specialised Services Delegation Agreement (Appendix 1)
- ☑ APPROVE the Collaboration Agreement for the additional delegation of specialised acute and mental health learning disability and autism services (Appendix 2)
- ☑ RECEIVE and NOTE the Data Protection Impact Assessment (Appendix 3)
- ☑ **ASSURED** that the ICB has the relevant internal governance and reporting arrangements in place.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 10

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

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

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

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in March 2025.

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

- Special Education Needs and Disability
- Urgent and Emergency Care
- Care Homes Diversional Therapy Pilot
- ICS Palliative and End of Life Quality Group
- Paediatric Dietetics
- Talking Therapies

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

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

Appendix A: Quality and Safety Report – Detail March 2025

1.0 Special Education Needs and Disability (SEND)

1.1 The ICS' System Quality Group received a presentation from the ICB's Designated Clinical Officer SEND on the key health focused activities and the progress in improving outcomes for Children and Young People 0-25 years with SEND across Staffordshire and Stoke-on-Trent. Provider roles in both Midlands Partnership University NHS Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust are continuing to strengthen the response to SEND operationally including the 6-week health advice; University Hospital of North Midlands NHS Trust (UHNM) is currently exploring whether a similar approach can be taken. The timeliness of Education, Health and Care (EHC) Needs Assessment within the statutory 6-week timescale has improved. Work is ongoing to develop and increase the reporting of advice requests. However, service demand and challenges across community paediatric services, both physical and mental health, are impacting on SEND. The ICB is updating the financial processes for children's continuing healthcare including consideration of personal health budgets.

2.0 Urgent and Emergency Care (UEC)

2.1 The ICB's quality leads, alongside senior staff at UHNM, have been reviewing the impact of any ambulance handover over eight hours delays on patients whose handover has been outside the hospital since April 2024. The learning – positive practice and harms – from January 2025 was presented at the ICS' System Quality Group. No immediate harm was identified in 90% of patients, time critical medication was recorded as being administered in the ambulance and timely mental health assessments were evidenced. Some pressure/moisture damage was identified; UHNM's tissue viability undertook a full review. Further, inconsistent documentation of the taking of fluids was identified as an improvement area.

2.2 The Health Services Safety Investigation Branch publish Safety Management: Accountability across organisational boundaries in February 2025. The investigation explores how patient safety is managed across different organisational boundaries such as multiple providers within an integrated care system. It is one of a series of investigations exploring safety management and whether the principles adopted in other industries may assist in the management of safety in health and care. The findings were discussed at the ICS's System Quality Group where it was agreed that partners will provide feedback to determine the next steps.

3.0 Care Homes Diversional Therapy Pilot

3.1 Following on from the success of the Diversional Therapy Programme, rolled out across the six older adult's wards at UHNM and benefits seen such as a reduction in falls, a pilot is in the process of being rolled out across two care homes within Staffordshire and Stoke-on-Trent. The pilot has support from UHNM, MPFT, both local authorities and the ICB. UHNM and the Care Home Intensive Support Team (CHIST) are working together to understand how the programme works at UHNM, what diversional activities are on offer and how CHIST can support the rollout of learning into the two identified care homes. The care homes were chosen following review of available system intelligence including falls data from WMAS and intelligence held by the local authorities. Both services are keen to be involved in the pilot and will be included in the regular task and finish meetings set up to monitor progress and address any queries. A baseline audit has been completed with both homes to understand the current activities on offer, training, staffing and falls information and an evaluation will be completed post pilot to understand its effectiveness for wider shared learning to maximise any opportunities found.

4.0 ICS Palliative and End of Life Quality Group

4.1 An ICS Palliative and End of Life Quality Group has been set up to connect partners and share best practice. Members include our local hospices, MPFT, UHNM and University Hospitals of Debry and Burton NHS FT. The inaugural meeting focused on falls and the deteriorating patient which was the topic selected by members. National and internal documents were shared across partners for learning and resource. Further, following the discussions hospices can now access the MiDOS for Care platform and the Social Care Academy as well as being invited to join the Regional Falls Group.

5.0 Paediatric Dietetics

5.1 Demand for Paediatric Dietetic services continue to outstrip current capacity across the system. This is coupled by inequity of service offer both from a community / inpatient perspective. Due to the small teams across providers and sickness levels, services remain fragile. Business continuity plans are in place and recruitment actions continue including locum usage. A service review being undertaken at a system level and interim actions in place whilst ongoing. Services continue to work in line with national guidance and a suite of resources have been made available. Further, feedback is being sought from referrers and service users/carers. The risk is being managed at the Children and Young People Portfolio Board and reported to the System Quality Group.

6.0 Talking Therapies

6.1 Staffordshire and Stoke-on-Trent NHS Talking Therapies (MPFT) has been chosen by NHS England as one of four talking therapies services in the country to spearhead a new programme aimed at enhancing how digital technology and innovation can more effectively support a patient's mental health recovery. The service will be adopting Virtual Reality (VR) technology as part of its psychological therapy offer after studies demonstrated that VR based therapy can be effective in treating phobias and anxiety disorders by creating a controlled immersive environment for the user. The aim of the pilot is to test effectiveness of technology on treatment periods and recovery rates.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 11

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**March 2025**
Reporting Committee:	**Quality and Safety Committee (QSC)**
Date of Meeting:	**12 February 2025 & 12th March 2025**
Meeting Quorate Y/N?	**Yes**
Presenter:	**Josie Spencer, Non-Executive Director & Committee Chair**
Author:	

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

Perinatal Quality Surveillance
The committee received an update on maternity and neonatal services accessed by women and babies from Staffordshire and Stoke-on-Trent. 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 underway with an action plan being developed.

The West Midlands Regional Clinical Genetics Service has served notice on the withdrawal of the low prevalence haemoglobinopathy screening practitioner service due to UHNM being classed as a high prevalence area. It has been confirmed this is part of the standard maternity tariff. The LMNS is supporting UHNM with a transition plan.

System Quality Group
The Committee received an overview of the System Quality Group (SQG) meeting that took place on the 7th of February with partners from across health, social care, and the wider ICS in attendance.

The Committee was alerted to three digital risks reported by UHNM which are impacting on clinical services and patient safety and experience. Assurance was provided on the actions being taken by the Trust. One recent Prevention of Future Deaths report relates to issues with shared notes at UHNM.

The Darwin Unit at NSCHT was placed in level 3 oversight by the West Midlands CAMHS Provider Collaborative at the end of December 2024. Assurance was given this should be stepped down soon due to actions being taken by the Trust.

ADVISE

Looked After Children Health Assessments
The committee received an overview of the current risk, compliance and progress against the recovery plan including ongoing challenges.

Since the paper had been written the risk score for Risk 1202 Looked After Children has reduced from 20 to 16 due to progress that has been made.

The committee were assured that:

- The position will continue to improve with the actions and mitigations put in place and this will be sustainable going forward

- Longstanding challenges relating to children not being taken to appointments and those bringing children to appointments having insufficient knowledge of their health needs are being addressed in partnership with both local authorities
- Work is being undertaken around a whole system service which should provide greater resilience.

Quality Impact Assessment
The committee received an overview of the QIA work programme and the actions being taken to ensure the ICBs statutory duty is fulfilled. The committee were informed of the eighteen QIAs completed within the period October 2024 to January 2025, eight of these were done so retrospectively. However, assurance was provided that actions are being taken to ensure completion of QIAs is embedded within governance processes.

ASSURE

Quality & Safety Committee Effectiveness Report 2024-25
The committee received the committee effectiveness report which provided the outcome from the self-assessment survey carried out in November and December 2024. The paper highlighted both positive aspects of the committee and areas for improvement.

The committee agreed the areas suggested for improvement would be reviewed outside of the meeting.

Safeguarding
The committee received an update and were assured on safeguarding activity across the system.

Thematic learning from reviews carried out in Quarter 2 and 3 will be the focus of health safeguarding collaborative audit and assurance work, with the first on domestic abuse due to be concluded in March 2025 and shared with the committee.

Continuous Quality Improvement (CQI)
The committee received an update and were assured on the work taking place across the system. The QI Network continues to be well attended. The total membership of the network continues to grow with 650 people now on the distribution list for these events. The network continues to expand and has grown by 58% in the last 12 months, an increase of 100 members on the last reported position with many of the new members joining from ICB's, primary care, care homes and social care. The ICB's Chief Nursing and Therapies Officer and the Associate Director – Quality Assurance and Improvement, have joined the NHS IMPACT ICB Network for Improvement. The network is aimed at ICBs to create dedicated time, space and attention to support the application of improvement across a system. The first meeting took place in January 2025 and was chaired by Dr Amar Shah – National Clinical Director for Improvement.

Perinatal Quality Surveillance
The committee received assurance there had been sustained improvement over a twelve-month period for induction of labour breach performance.

Health Inequalities: Future of NHS Vaccination and Immunisation Programmes
The committee received an update and were assured on the work taking place with regard to the delegation of responsibility for vaccination services from NHSE to the ICB with effect from April 2026.

The committee requested updates on any quality and safety impacts or concerns, although noted the Health and Care Senate would formally report to the ICB Board.

System Quality Group Terms of Reference
The committee **approved** the System Quality Group Terms of Reference. The ICB Board will need to ratify this decision.

Quality & Safety Committee Terms of Reference
The committee **approved** the Quality & Safety Committee Terms of Reference. The ICB Board will need to ratify this decision.

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

No SBAF report was presented this month.

(1) System & ICB Risk Registers

The Committee received and noted the System and ICB Risk Register Reports. For the ICS Risks there are **8 high scoring** risks; for the ICB Risks, there are **4 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 about the process for risks being transferred from the risk register to the issues log. It was agreed an update would be brought back to the committee.

The Committee:

- approved the addition of new risk 1444 demand for paediatric dietetic services outstripping current capacity coupled with inequity from a community/inpatient perspective, subject to the amendment of the current target date of 31st March 2025.
- Approved the addition of new risk 1446 lack of transparent data for Burton Urgent Care Harm reviews (ED)

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board or other Committees:

☑ The Quality & Safety Committee **approved** the System Quality Group Terms of Reference
☑ The Quality & Safety Committee **approved** the Quality & Safety Committee Terms of Reference

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 12

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**March 2025**
Reporting Committee:	**Staffordshire and Stoke-on Trent Health and Care Senate (Senate)**
Date of Meeting:	**13th February 2025**
Meeting Quorate Y/N?	**Yes**
Presenter:	**Paul Edmondson-Jones, Chief Medical Officer**
Author:	**Rachel Gallyot, Deputy Chief Medical Officer**

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 6th November 2024.

- There were 5 NICE TAs which were very specialised and were classified as RED, for prescribing in secondary care only.
- There were 2 ICB funded medicines, namely linzagolix, for symptoms of uterine fibroids, and relugolix, for treatment of prostate cancer, both of which were classified as AMBER-I for initiation in secondary care and then continuation in primary care.
- Cystine, for smoking cessation was classified as RED because smoking cessation services are provided by the Local Authority.
- Oral Nutritional Supplements (ONS) was a fast-track item approved by the Senate in December.

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

- The availability of cystine in Staffordshire, and not Stoke-on-Trent, creates health inequalities and Stoke-on-Trent Local Authority are reviewing their service.
- Tirzepatide for obesity will be presented to the IMOG, in March, and will be presented to the Senate at a future date.

The Senate **approved** the decisions summarised in the paper (a to c) detailed in the Committee Report and IMOG minutes from the meeting held on 6th November 2024.

2) Excluded Restricted Procedures (ERP) Policy including Evidence Based Interventions (EBI)

The paper was taken as read. Jackie Newman and Vanessa Weaver delivered a presentation to the Senate titled 'Excluded, Restricted Procedure Policy'. In response to questions/comments raised by the Senate, the following clarification points were made:-

- The focus of the strategy is sustainability, and the ERP Policy is already included in acute and Midlands Partnership Foundation Trust (MPFT) contracts and will be included in every single independent sector contract.
- The next stage will be engagement, to ensure that clinicians are aware of policy and understand the benefits. The portfolios will have ownership of the sections that relate to their clinical areas.
- A QIA was approved earlier in the week.

- With regard to mental health impact, for the cohort of patients who cannot afford private care, some of the items in the policy have caveats around deprivation and any differences in specialised characteristics.
- Not routinely commissioned means that there is not a blanket ban of any treatments and that an Individual Funding Request (IRF) application can be made, as there will be cases of exceptionality for consideration by an IRF panel.
- Items 1-3 were not in the previous ERP Policy and have been added, to ensure that the ICB is fully compliant with EBI regulations. Items 4-6 were already in the ERP policy, but the wording has been changed to provide clarity.

1. Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures.
2. Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children.
3. Angioplasty for PCI (percutaneous coronary intervention) in stable angina.
4. Removal of benign skin lesions.
5. Lumbar Discectomy.
6. Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis.

The Senate **approved** the review and the inclusion of the EBI criteria, into the ERP Policy, and acknowledged that the new ERP Policy has included all of the components, set out by GIRFT.

3) Asthma Improvement Adults (Sentinel Plus)

The paper was taken as read. Victoria Campbell, Consultant Respiratory Nurse at Midlands Partnership Foundation Trust, provided a verbal update regarding the Asthma Improvement Programme.

- The programme was previously presented to the Senate, as a proposed pilot, but now that the finance and impact assessments have been completed, a decision has been made to roll out as an offer to practices.
- The use of salbutamol (SABA) is quite high in Staffordshire and Stoke-on-Trent and the outcomes are not positive. Additionally, new asthma guidelines encourage a more steroid based treatment.
- The ICB and Astra Zeneca, a pharmaceutical company, will utilise a third party, Clinical Interface, to support pharmacist led assessment of people living with asthmas, with the aim of moving them onto a better treatment and reducing SABA use.
- Funding has been negotiated on a donation and grants basis, with Clinical Interface, so no money will be paid directly into the Integrated Care Board and the Integrated Care Board has no direct financial commitment.
- There will be learning opportunities from colleagues joining the assessments and support training will also be available.
- The report has been presented to the Respiratory Clinical improvement Group and all impact assessments have been completed.

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

- Some of the Senate members practices had worked with Clinical Interface and had had a positive experience.
- Wider support, education and mentorship is important and further education and work is planned. There is a considerable amount of work to be done with the acute trusts regarding the emergency portals.
- The asthma guidance is clear on prescribing for people with a new diagnosis so it is hoped that the use of SABA will decrease, as it should be initiated on fewer people.
- Health care professionals that have already done this work have experienced less patient resistance than expected and the more that they talk to the patients about it the more confident they become.
- The Governance Team were engaged with regarding the involvement of Astra Zeneca and the Commercial Sponsorship Policy has been followed. The QIA process has also been followed and there were no issues raised, in terms of equity of access, or any implication of it being supported by a commercial company.

The Senate clinically **approved** the Asthma Improvement Adults (Sentinel Plus Scheme) to roll out an offer to all practices.

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), November 2024 report; ☑ The Senate **approved** the review and the inclusion of the EBI criteria, into the ERP Policy ☑ The Senate clinically **approved** the Asthma Improvement Adults (Sentinel Plus Scheme) to roll out an offer to all practices.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 13

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

(1) Purpose of the Paper:

The purpose of this paper is to provide the board with a summary of performance, programme delivery and finance as received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). It outlines at a high level the current position of key system metrics and aligned programme delivery against the Integrated Care System (ICS) Annual Operational Plan and our month 10 finance position.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (I)	26/02/2025
System Finance and Performance Committee (S,D)	04/03/2025

(3) Implications:

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

Workforce / Training	As outlined in the body of the report.
Equality & Diversity	N/A
Due Regard: Inequalities	As outlined in the body of the report.
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report was discussed at the System Finance and Performance Committee (SFPC) on the 4th March 2025.

Performance

- Performance against the metrics set out as part of our Integrated Care System (ICS) Annual Operational Plan was presented.
- The drivers and actions reporting process was discussed, in particular that portfolios ensure that their mitigating actions remain dynamic rather than static. Within the Performance Overview, all metrics that are red (not to target) are provided with a focus. Each portfolio provides an update aiming to ensure that the committee and board receives an accurate reflection of ongoing actions and any new developments. If the actions remain the same this is stated.
- End of Life and Frailty will be a core component of the Community Transformation / Neighbourhood Health programme which will address the escalations made within the report.

Finance

- Following the receipt of funding to cover the planned deficit which was £90m at the start of the year, the plan is now to break even.
- Following on from the month 9 position remaining flat, the month 10 position continues to remain stable, and we have made further improvements to the level of unmitigated risk. At a system level we are reporting a year-to-date deficit position of (£30.5m), which is a £33.3m adverse variance against the revised plan (Month 9 variance to plan £32.8m). The year-to-date variance to plan sits within Integrated Care Board ICB) (£14.4m) and University Hospitals of North Midlands (UHNM) (£22.2m) with small surplus at Midlands Partnership University NHS Foundation Trust (MPFT) (£1.4m) and North

Staffordshire Combined Health Trust (NSCHT) (£2.0m). At month 10 the System has formally reported an increased surplus forecast of £2.4m at NSCHT (month 9 forecasted surplus of £1.2m) in line with their continuing run rate and efficiency delivery. This has been offset by a corresponding deficit in the ICB to maintain a nil net balance for the System.

- Given the increasing certainty as we move towards the year end and capture the benefits from the Investigation and Intervention (I&I) regime and Elective Recovery Fund (ERF) performance, the system has reduced the unmitigated risk to £30m which is an improvement from month 9 of £39m. This has been achieved through a combination of NSCHT increasing their forecasted surplus position, coupled with balance sheet flexibility at MPFT.
- Our capital reporting is on track with the forecast for operational capital and International Financial Reporting Standard **(**IFRS16) compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. We are currently working through our capital plans and allocations for 2025/26 in line with the guidance received and information regarding potential increased allocations.
- The reported system efficiency is now assessed to outturn at £180.4m, which equates to 88.8% delivery against the annual efficiency plan of £203.2m. We continue to work with the I&I team to identify any additional short-term opportunities and delivery plans for those are being worked up and implemented, many of which support delivery of opportunities set out in the Medium-Term Model.
- The system workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and are currently (end of January) 25,078. Within that we have achieved a reduction in agency equivalent to 206 working time equivalents (WTEs). Despite the pay controls of organisations having been reviewed both as a system and by the I&I team, there is a concern that since May the overall workforce numbers has risen each month.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Performance and Finance Report

20th March 2025

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

Overview

This report contains for discussion:

1. An overview of key performance in December 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 10 position.

Discussion from System Finance and Performance Committee (SFPC) on the 4th March to note:

Performance

- The drivers and actions reporting process was discussed, in particular that portfolios ensure that their mitigating actions remain dynamic rather than static. Within the Performance Overview, all metrics that are red (not to target) are provided with a focus. Each portfolio provides an update aiming to ensure that the committee and board receives an accurate reflection of ongoing actions and any new developments. If the actions remain the same this is stated.
- End of Life and Frailty will be a core component of the Community Transformation / Neighbourhood Health programme which will address the escalations made within the report.

Finance

- Following the receipt of funding to cover the planned deficit which was £90m at the start of the year, the plan is now to break even.
- Following on from the month 9 position remaining flat, the month 10 position continues to remain stable, and we have made further improvements to the level of unmitigated risk. At a system level we are reporting a year-to-date deficit position of (£30.5m), which is a £33.3m adverse variance against the revised plan (Month 9 variance to plan £32.8m). The year-to-date variance to plan sits within Integrated Care Board ICB) (£14.4m) and University Hospitals of North Midlands (UHNM) (£22.2m) with small surplus at Midlands Partnership University NHS Foundation Trust (MPFT) (£1.4m) and North Staffordshire Combined Health Trust (NSCHT) (£2.0m). At month 10 the System has formally reported an increased surplus forecast of £2.4m at NSCHT (month 9 forecasted surplus of £1.2m) in line with their continuing run rate and efficiency delivery. This has been offset by a corresponding deficit in the ICB to maintain a nil net balance for the System.
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Ctrl and click on any underlined text for further detail

Overview of Key ICB Performance December 2024 - Priorities 1 and 2

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

Urgent and Emergency Care

Category 2 Response target < 30m (January)	2m 24secs	▼
Accident & Emergency 4-hour wait (78% target by March 25) (UHNM) (January)	-0.2%	▲
Adult General & Acute (G&A) bed occupancy ≤92% (UHNM) (January)	1.0%	▲
Utilisation of Virtual Wards (target 80%) (ICB) (January)	-7.2%	▼
Ambulance Hours lost due to Handover delays > 15m (UHNM) (January)	+3230	▼
12 hour in Emergency Department Performance (UHNM) (January)	11.4%	▼

Mental Health, Learning Disabilities & Autism

Learning disability registers and annual health check (January)	1.3%	▲
Improve access to perinatal mental health services	-7.6%	▲
Improve access to Children and Young People Mental Health services	-8.6%	▲
Improve access to Transformed Adult Mental Health services (Nov)	-8.5%	▼
Access to a course of Talking Therapy	1.6%	▲
Mean week wait to start autism assessment (North: CYP)	62	▼
Mean week wait to start autism assessment (South: CYP) (Oct)	16	▼
Mean week wait to complete autism assessment (North: CYP)	71	▲
Mean week wait to complete autism assessment (South: CYP)	54	▼

Children & Young People (CYP)

Reduce CYP in residential care outside Staffordshire (November)	-15.7%	-
Reduce CYP in residential care outside Stoke-on-Trent (January)	0.8%	▲

Planned Care

Cost Weighted Activity. National published data. Position to October 2024	13.5%	▼
Elective Activity - Daycases (December)	-1.4%	▼
Elective Activity - Ordinary Elective (December)	-3.7%	▲
Elective Activity - Outpatient Procedures (December)	23.0%	▲
Elective Activity- Outpatient First Appointment (December)	11.8%	▲
% Outpatient attends for first appointments or follow-up appointments with a procedure	1.8%	▲
Reduction in Outpatient Follow-up against 2019/20 baseline (December)	28.5%	▲
Eliminate 65 week waits by September 2024 (December)	172	▼
Increase theatre utilisation (85% UHNM) (December)	2.5%	▼
Cancer 28-day Faster Diagnosis (77% target by March 2025) (December)	-1.5%	▼
Cancer 62-day pathways % seen within 62 days (target 70% by March 2025)	-4.5%	▼
Cancer non-specific pathway (December)	29.3%	▲
Community Bed occupancy rate (January)	2.9%	▲

Primary Care

Dental Activity delivered (Q2)	-1.6%	▼

Medicines Optimisation

Pharmacy First Provision – number of interventions (December)	4,066	▲

2 Improving access to high quality, sustainable primary care

Primary Care

General Practice Appointments	3.4%	▼
General Practice Appointments in <2 weeks (85% target)	6.6%	▲
Additional Role Reimbursement Scheme Full Time Equivalent (Q3)	12.0%	▼
Workforce: GP Full Time Equivalent (Q3)	4.7%	▲

Planned Care

Deliver increased diagnostic activity levels	-0.6%	▼
Patients that receive a diagnostic test within 6 weeks (target)	-17.1%	▼

Mental Health, Learning Disabilities & Autism

Recover the dementia diagnosis rate to 66.7% target	1.0%	▼

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 December 2024 - Priorities 3, 4 and 5

3 Delivering joined up proactive & preventative support & care

Mental Health & Learning Disabilities & Autism

Eliminating Out of Area Placements (Jan)	8	▲
Talking Therapy Reliable Improvement (67% target)	2.4%	▼
Talking Therapy Reliable Recovery (48% target)	0.3%	▼
Severe Mental Illness health checks (Q2)	2.3%	▼
Learning disability & Autism reliance on inpatient care (Adult) (January)	-4	▼
Learning disability & Autism reliance on inpatient care (CYP) (January)	2	-
Learning Disability and/or Autism Mortality Reviews (100% target) (January)	0.0%	▲

End of Life, Long-term Conditions and Frailty

Prevalence rate of Palliative care registers (January)	-0.2%	▼
Patients receiving all 8 care processes for Diabetes -Type 1 (cumulative to January)	2.7%	▼
Patients receiving all 8 care processes for Diabetes -Type 2 (cumulative to January)	2.7%	-
National Diabetic Prevention Programme - referrals (January)	1.0%	▲
National Diabetic Prevention Programme - commence (January)	36.5%	▲

Children & Young People

Reduce emergency admissions for epilepsy (flat activity)	-80%	▼
Reduce emergency admissions for asthma (flat activity)	-75%	▼

Maternity and Neonates

Stillbirth rate (UHNM only) (January)	1.9	▼
Neonate Mortality rate per 1000 (UHNM only) (December)	0.0	▼
Brain injury rate per 1000 (UHNM only) (December)	2.0	▼
The % of full - term babies admitted to a neonatal unit (UHNM only) (December)	4.2%	▲

Improving Population Health

Children and Young People vaccination uptake - MMR2 (Q3)	-0.1%	▲
Children and Young People vaccination uptake - Pertussis maternal vaccination (Q3)	7.3%	▲
Hypertension: Percentage of patients treatment to recommended age specific thresholds (Q2)	66.8%	▼
Cholesterol: Percentage of patients with QRISK 20% or more treated with lipid lowering therapy (Q2)	2.8%	▲

4 Delivering compassionate care of the frail and elderly

Urgent and Emergency Care

80% discharges on Pathway 0 (January)	-5.5%	▼
Discharges on Pathway 1 (January)	5.2%	▲
Discharges on Pathway 2 (January)	1.1%	▲
Reduce number of discharges on Pathway 3 to below 1% (January)	-0.9%	▼

Improving Population Health

Increase uptake of Flu vaccination (January)	2.2%	▲
Increase uptake of COVID vaccination (January)	-10.2%	▲

Integration

Prevent emergency admission Ambulatory care (Stoke-on-Trent) (Q2)	-26.3	▼
Prevent emergency admission Ambulatory care (Staffordshire) (Q2)	+1.1	▼
Improve access to fall service from A&E (Stoke-on-Trent) (Q2)	-36.7	▼
Improve access to fall service from A&E (Staffordshire) (Q2)	+80.9	▲
Discharge to usual place of residence (Stoke-on-Trent) (Q2)	+2.40%	▲
Discharge to usual place of residence (Staffordshire) (Q2)	-0.2%	▲

5 Supporting Care Home Residents

Urgent and Emergency Care

Achieve the 70% two-hour urgent community response standard (November)	+4.1%	▼

Medicines Optimisation

Structured Medication Reviews in last 12 months (Q3)	4.0%	▲

Integration

Admission to care homes	Annual	

Primary Care

% of Care Home Patients with ReSPECT Documentation	-4.7%	▼
% of Care Home Patients with a Personalised Care & Support Plan	62.8%	
Mean number of Multidisciplinary Team meetings per care home resident aged >18	-19.4%	▼

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

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 5 Care Home Admissions – now has become an annual metric: Q2 National Better Care Fund Reporting Template for Local Authorities has not included a figure for this metric in the latest publication and has defined the quarterly breakdown as "not applicable", with an annual target position.
- Priority 5 Percentage of Care Home Patients with a Personalised Care and Support Plan, shown performance in %. This is a new metric and has now replaced Percentage of Care Home Patients with a Personalised Care Plan, which has been reported previously. This change in methodology means the new metric is not comparable to plan or previous figures

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Accident & Emergency 4-hour Wait UHNM Latest unvalidated performance (January 2025) was 66.4%, up from 64.2% the previous month, and 3% better than the same period last year. 0.2% below plan and 10.6% below target.	1. Infection prevention and control (IPC) constraints within Emergency Department (ED) and the bed base are restricting patient flow out of ED either through discharge and onward movement to a ward. 2. Continued month-on-month increases in attendances at all locations other than Leek Hospital (7.25% growth in latest 3-month attendances at all sites versus the previous year), however, rate of increase for January 2025 was lower than experience during December 2024.	1. A new UHNM Urgent and Emergency Care (UEC) Improvement Plan is being developed which will include 5 workstreams that will support a whole hospital approach to improvement. 2. Additional senior decision maker cover within the ED department expediating decisions and onward flow through the acute. 3. Integrated Discharge Hub (IDH) portals in-reach team supporting identification and turn-around of patients from ED back to community settings.
	Virtual Wards (VW) Latest performance on 30th January 2025 was 74.8%, below plan for both occupancy and capacity. North – 67.1% South-East – 87.5% South-West – 54.3%	1. The positive increase in utilisation led to just a 0.48% variance from the target, equivalent to less than one patient. 2. Staff sickness impacted ability to complete first visits for patients entering onto a virtual ward as well as restricting increase in planned capacity within North sector	1. Appointment of a dedicated virtual ward practitioner at Queens Hospital Burton (QHB) to increase utilisation further. 2. Increasing staffing resilience including bank staff to support short term absence in conjunction with the ICS (Integrated Care System) People Hub.
	Ambulance Hours lost due to Handover delays >15 mins (UHNM) January 2025 was 6,866 hours, down 411 hours in December 2024 and 3200 hours above plan.	1. IPC constraints within the bed base restrict patient flow out of ED impacting ability to offload patients at times of high pressure. 2. IPC numbers significantly above expected volumes. 3. Continued high level of complex needs of patients arriving by ambulance and through ED front door mandating prioritisation of these patients over lower acuity attendances.	1. Continuing with the Test of Change – Overnight Integrated Care Coordination Centre (ICC) until 31st March 2025. Initial data suggests circa 80% of patients are being redirected away from emergency portals. 2. Supporting West Midlands Ambulance Service (WMAS) in their aim to deliver Call Before Convey during the overnight period via the ICC above to include all patients over the age of 18 and operational 24/7 to support alternatives to an ED conveyance. 3. Continued oversight and command and control arrangements within UHNM supported by the System Co-ordination Centre (SCC) to manage escalations and flow on a daily basis.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Proportion of patients spending more than 12 hours in Emergency Department at UHNM Latest unvalidated performance; 11.4% for January 2024, down from 11.7% in December 2024. In comparison the Midlands average, for January 2025 was 13%.	1. IPC constraints within the bed base restrict patient flow out of ED impacting ability to offload patients at times of high pressure. IPC numbers significantly above expected volumes. 2. Continued high level of complex patient needs arriving by ambulance and through ED front door mandating prioritisation of these patients over lower acuity attendances.	1. A new UHNM UEC Improvement Plan is being developed which will include 5 workstreams that will support a whole hospital approach to improvement. 2. System high intensity team (HIT) continue to work with twice weekly visits. Working in conjunction with UHNM clinical operational and medical teams to support implementation of learning via a Continuous Quality Improvement (CQI) approach. 3. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards (IPS), Ward Standard Work, Your Next Patient, Home Care is Best Care).

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Perinatal MH Services – 1,060 women had at least one contact with the service in the rolling 12 months to December 2024. This is 87 (7.6%) under the monthly trajectory (1,147) but continuing to increase month on month. The system is one of 19 ICBs in England that did not achieve the month 8 trajectory and is benchmarking at position 34th amongst 42 ICBs.	1. MPFT identified two technical issues causing their Mental Health Service Dataset (MHSDS) submissions to be lower than their locally reported activity. 2. Published data is currently around 77 below local data for the sub ICBs that MPFT serve.	Actions planned in **M8** continue: 1. MPFT corrected the technical issues and resubmitted previous months for the current financial year. This will impact on performance until 2023/24 is no longer included in the rolling 12 month calculation. 2. Additional Mental Health Investment Standard (MHIS) investment has been released to increase access but also to strengthen the current offer to meet Perinatal Quality standards and provide a reduction in time waiting for treatment; increased ability to provide care with infants up to 24 months of age; reduction in admissions to inpatient units; increase in the treatment interventions available. As this is based on recruitment to workforce the benefits may not be realised until later in the financial year.
	Improving Access to Children and Young People (CYP) MH Services – 14,900 CYP had at least one contact with community mental health services in the rolling 12 months to December 2024. This is 1,406 (8.6%) under the monthly trajectory (16,306) but an increase of 215 CYP compared to last month, the 4th month where an increase has occurred and higher than the same period last year (14,575). The system is one of 22 ICBs in England that did not achieve the month 8 trajectory and is benchmarking at position 28th amongst 42 ICBs.	1. North Staffordshire Combined Healthcare NHS Trust (NSCHT) reported a number of data capture issues, which have now been fixed locally (in the published dataset, their activity increased in December). 2. MPFT have indicated that they may not have sufficient eligible referrals, arising from the adoption of a Whole School Approach by Mental Health Support Teams (MHSTs) and Attention deficit hyperactivity disorder (ADHD) referrals being directed to the Community Paediatric Service, which are not reportable under the MHSDS. MPFT have also reported that some subcontractor activity may not be being flowed to the MHSDS. 3. Activity is lower than expected at 'Action for Children', partly arising from reduced referrals in 2023/24 and possibly also relating to missing Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) codes.	Actions planned in **M8** are reviewed and updated: 1. A CYP MH System Improvement Board development day was held on 6th February to agree a refocus on priorities in particular Access for 2025/26. There is a variance between the contacts in MHST's in North Staffs and Stoke in comparison to South that has been identified as a specific improvement action. The position in 2024/25 will not improve until a resubmission of data is allowed in May 2025. 2. NSCHT plan to resubmit 2024/25 in February 2025, however the full benefit won't be realised until 2023/24 is no longer included in the rolling 12 month calculation. 3. MPFT are continuing to review data capture and service configuration as part of a Performance Improvement Plan. 4. 'Action for Children' plan to submit missing codes. Awaiting an update on progress. 5. Increased investment into Child and Adolescent Mental Health Services (CAMHS) as result of refresh of the CYP MH Local Transformation plan in October 2024, however the benefits will not be realised until late in 2024/25 Quarter 4. 6. Two new Mental Health Support Teams have been recruited to commence in January 2025 however the benefits will not be realised until late in 2024/25 Quarter 4.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability and Autism (LDA)	Improving Access to Transformed Adult MH Services – 11,830 adults had at least two contacts with the service in the rolling 12 months to November 2024. This is 1,094 (8.5%) under the monthly trajectory (12,924). Lower than the same period last year (13,135). The system is one of 10 ICBs in England that did not achieve the month 8 trajectory and is benchmarking at 36th position amongst 42 ICBs.	1. NSCHT and MPFT are potentially under reporting, and/or underperforming. NSCHT reported an underperformance of 655 against their month 8 plan plus the published data is 260 under the locally reported data. Local data is awaited from MPFT to compare to the published dataset. 2. Changes Health and Wellbeing don't currently include adult activity in their MHSDS submissions.	1. NSCHT are looking into reporting improvements that will help support the service in understanding the underperformance. An initial meeting has been held to validate the services that are in scope for this measure in preparation for the targeted analysis and reporting improvements. 2. MPFT will be reporting on this metric as part of the contract reporting cycle, starting with the February report due around 22nd of the month. 3. Changes Health and Wellbeing plan to begin submitting adult activity in the May 2025 submission (for activity taking place in April 2025).
	Wait to commence Autism assessment, against quarter 3 target of 15 weeks (Nota bene (NB): national target = 13 weeks) • CYP North - mean wait of 77 weeks (102 last month) • CYP South - see note * Wait to complete Autism assessment, against quarter 3 target of 30 weeks (NB: national target = 26 weeks) • CYP North - mean wait of 101 weeks (100 last month) • CYP South - mean wait of 84 weeks (85 last month) * The mean waiting time for an assessment to start at MPFT in December was not available, due to a focus on patients with long waits for assessment completion. Many assessment starts are outsourced and this activity will be available end of January (February contract monitoring reporting cycle due around 22nd of the month).	1. Increasing demand remains as the main driver: since April 2024, the total number of children waiting for an autism assessment to commence increased by 14% at MPFT and by 32% at NSCHT. Caseloads (open referrals) have also increased by 2% at MPFT and by 13% at NSCHT.	In the short term the focus has switched to receiving and interpreting the national guidance and planning requirements for 2025/26. The following planned actions are on hold: 1. Interim improvement plan feedback collated in December 2024 and January 2025. Feedback to be used in workshop to review Learning Disability & Autism Programme (LDAP) workstreams. 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.
Children and Young People (CYP)	Reduce CYP in residential care outside Stoke-on-Trent – 77.1% of placements were outside Stoke-on-Trent in January 2025. 44.0% of the placements were within 20 miles of Stoke-on-Trent. Slightly above the same month last year (76.3%), and a little higher than last month (76.9%).	Driver identified remains: 1. Local Authority (LA) data for Stoke-on-Trent – as last month increasing numbers above the same month last year (which is the local target).	Planned action agreed previously remains in place: 1. Work is ongoing to reduce the overall number of residential placements in Stoke-on-Trent City 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.

Local Priority

Eliminate delays in access to treatment and long waits for care

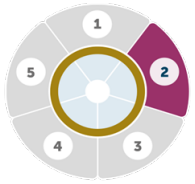
Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Planned Care	Elective (Inpatient) Activity - Ordinary Elective and Day cases In December 2024, there were 61 less Ordinary Elective spells than planned, and 195 less Day cases than planned.	1. Reduction in theatre capacity in independent sector (Rowley Hall Hospital), resulted in reduced activity in December. 2. UEC pressures continue to impact on elective procedures. Elective capacity has been converted to beds to support non-elective trauma cases. Cancellations have been clinically prioritised but included a small number of cancer surgeries during the system critical incident. 3. Winter pressures are expected to continue to impact in Quarter 4.	1. During periods of UEC pressures, clinical prioritisation is applied. Additional day case and outpatient appointment opportunities are being identified. Cancellations are subject to clinical oversight. Patients are rebooked as soon as possible. 2. Additional capacity is being utilised to mitigate, in the independent sectors providers.
	Reduce Outpatient Follow ups v 2019/20 level; In December 2024 there were 28.5% more attendances than the planned level (based on achieving a 25% reduction by March 2025).	1. In some cases, increased follow-ups are a result of treating patients with long waits on waiting lists. 2. Higher level of activity recorded in Independent Sector Providers (ISP) as more capacity available.	Actions planned in **M8** continue to drive performance improvement: 1. Work being undertaken to set a ratio of follow-ups within the Independent Sector contracts. 2. ICB working with providers to encourage Patient Initiated Follow Ups (PIFU).
	Eliminate 65 week waits by September 2024 - At the end of December 2024 there was 172 ICB patients waiting over 65 weeks (at all providers), against a plan of 0. • Out of 172 patients, 95 are at UHNM, and 59 at University Hospitals Derby and Burton (UHDB). • The latest forecast based on National Waiting Lists Data and provider returns, predicts that at the end of January there will be 170 breaches at UHNM (all commissioners) and 86 predicted at out of area providers (ICB patients).	1. Issues within particular specialities are a driver of the position. The specialties with highest numbers are Orthopaedics (49, with 24 at UHDB, and 19 at UHNM), Ear Nose and Throat (ENT) (25, with 23 at UHNM), and General Surgery (30, with 24 at UHNM). 2. Capacity in NHS providers, as well as Winter emergency pressures, continues to be an issue 3. High level of demand.	Actions planned in **M8** continue to drive performance improvement: 1. Additional workforce in place at UHNM for ENT and Orthopaedics. 2. Additional clinics taking place as well as weekend working. 3. Maximising outpatient appointments and day cases where overnight beds have been restricted due to Winter pressures.

Other Key Points Aligned to this priority
Community Services Waiting List: – At the end of December 2024, there were 22 patients waiting over 52 weeks for treatment in Community Services. All these patients were in Children and Young People Services (CYP). 19 patients in Dietetics, 2 in Community Paediatric Services and 1 in Audiology. ICB, MPFT and NHS England meet regularly to review performance and actions/progress are discussed.

Local Priority

Eliminate delays in access to treatment and long waits for care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Planned Care	Increase theatre utilisation at University Hospitals of North Midlands (UHNM) In January 2025 theatre utilisation was 72.5% at UHNM, against the target of 85%. UHNM are working towards 78% capped theatre utilisation target (which is a 4% increase on 2023/24). Progress has been made and at Quarter 2 2024/25 had reached 79%.	1. Performance has dipped due to Winter pressures and critical incident in Quarter 3 2024/25.	Actions planned in **M8** continue to drive performance improvement: 1. Focus is on patient cancellations (did not attends or unfit for surgery), looking at perioperative pathway transformation opportunities. 2. UHNM continue to maintain internal disciplines around booking processes and have resolved discrepancies between UHNM and Model Health data, which is now aligned.
Cancer	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded In December 2024, 75.3% of ICB patients (all providers), with an urgent cancer referral, were told they have Cancer, or Cancer is definitively excluded within 28 days (against an ICB target of 76.8%).	1. Performance in December for UHNM and UHDB was below 75% (73.6% and 73.5% respectively).	1. Weekly escalations following Patient Treatment List (PTL) meetings 2. Introduction of code Radiology Discharge If Normal (RDIN) for normal radiology investigations to remove patients from 62-day targets quicker. 3. Standardisation of templates for cancer navigators to inform patients of clock stops.
	Two Month (62-day) Wait from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment for Cancer In December 2024, 63.7% of ICB patients (all providers) on the Cancer 62 day pathway started treatment within 62 days. Performance at UHNM was 61.0% in December 2024, down from 69.4% in November 2024.	1. Drivers for reduction in performance include, surgical capacity and, diagnostic capacity for lung cancer.	1. Actions to improve 62-day combined performance include: increased surgical capacity, including seeking additional access to Shrewsbury and Telford (SATH) robot. 2. Use of RDIN coding (as for 28 day actions above).



Local Priority

Improving access to high quality sustainable primary care

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Primary Care	Additional Roles Reimbursement Scheme (ARRS) stands at 608.2 Full Time Equivalent (FTE) for December 2024, below the Quarter 3 Plan of 690.86 FTE. Plan and actual figures do not include additional GPs now included in the scheme.	1. Actual figures are based on National Workforce Reporting Service (NWRS) data and aligned to roles included in the 2024/25 plan, there are continued reporting discrepancies between these figures and ARRS claims. 2. For December 2024 data, NWRS is showing 608.2 FTE and the ARRS claims portal is much higher at 677.6 FTE, so a difference of 69.4 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 December 2024) shows budget utilisation at 97.9%. 3. Primary Care Networks (PCNs) are struggling or reluctant to recruit additional roles due to challenges with lack of clarity around funding for the PCN Contract past March 2025. 4. Performance at UHNM was 61.0% in December 2024, down from 69.4% in November 2024.	1. Primary Care Workforce Local Delivery Plan has been developed and dashboard developed to aid monitoring via Workforce Improvement Group (WIG). 2. Validation work is ongoing with individual PCNs where there is variation between claims and NWRS. The importance of accurate reporting was raised at the PCN Collaborative Meeting in January 2025 – presentation with validation recommendations shared following the meeting. PCNs with data discrepancies will be followed up by the Primary Care Team. 3. Letter from Secretary of State for Health (20th December 2024) recognised concerns and financial pressures facing general practice and provides reassures for recently qualified GPs employed via the ARRS scheme will continue to be supported through the scheme in 25/26. ARRS funding for other roles for 25/26 will be confirmed once contract changes released for 25/26.
Diagnostic waits and activity	The % of patients waiting within 6 weeks for a diagnostic test - at the end of December 2024 was 65.9%, against a plan of 83.0%. Number of diagnostic tests carried out in December 2024 was 48,630 against a plan of 48,930 (0.6% below plan). This is for the ICB patients at all providers. Performance against this metric in the NHS Oversight Framework remains in the lowest quartile, ranking 38 out of the 42 ICBs (November 2024 refresh (latest available)).	1. There has been an increase in demand for tests; UHNM have reported a 10.24% increase in GP referrals compared to 2022/23 2. At the end of December 2024, there were 11,510 patients waiting over 6 weeks for a test. The majority of these patients (9,386) were waiting for Non-Obstetric Ultrasounds.	1. Phase 2 pathways are in development for Urology and Musculoskeletal. Urology pathway will be presented at the May 2025 Health & Care Senate for approval. 2. Finalised process for transfer of patients from UHNM to Cannock Community Diagnostic Centre (CDC) for Non-Obstetric ultrasound (NOUS), with activity due to begin transfer from week commencing (w/c) 24th February. NOUS backlog is also being supported through additional training lists and registrar lists. 3. Endoscopy backlog at UHNM has been recovered and now focussing on sustainability with the mobile unit due to be removed in February.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Mental Health (MH) and Learning disability (LD)	Eliminating Out of Area Placements (OAP) - 9 active inappropriate adult acute mental health OAPs at the end of January 2025 (9 over plan). Two fewer than last month. 7 reported by MPFT and 2 NSCHT.	Drivers identified in **M8** remain in place: 1. Unavailability of suitable beds at MPFT and NSCHT. 2. A directive from NHS England (NHSE) mandating that mental health patients who are medically fit from a physical health perspective should not remain in acute hospitals or Accident and Emergency departments but must be transferred to inpatient mental health beds immediately has led to placing people out of area to ensure they are assessed appropriately.	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. 2. As an action from the System Performance and Finance Committee the Portfolio are reviewing the length of time patients are in Out of Area Placements prior to being repatriated to system beds, separately for acute/ Psychiatric Intensive Care Units (PICU) bed types.
	Reliance on inpatient care for people with a learning disability and/or autism (under 18 years of age) - 5 inpatients in January 2025, 2 over the quarter 4 plan (3), however one less than last month. Currently predicted to be 3 at year end.	Drivers identified in **M8** remain: 1. Case mix is becoming more complex. 2. The trend of late autism diagnosis in children is reported by NHSE as a national trend.	In the short term focus has switched to receiving and interpreting the national guidance and planning requirements for 2025/26. The planned actions are on hold: 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). 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.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
End of Life (EOL), Long-term Conditions and Frailty (ELF) **EOL** Programme Delivery Escalation	Prevalence rate of patients on palliative care registers to 1% In January 2025 there were 9,957 patients on a palliative care register. This equates to 0.83% of the registered practice population against a target of 1.00%.	Driver identified remains the same as in **M8:** 1. Pressures facing Primary Care and seasonal impact during summer period of Annual Leave.	Action planned in **M8** continues to aim to drive improvement in performance: 1. Training on Identification at End of Life will continue to be offered through the Staffordshire Training Hub, sessions are planned from October 2024 until July 2025.
	24/7 Advice Line Case for change has been presented at Clinical Senate and was supported from a clinical perspective.	Driver identified in **M8** remains: 1. Service currently delivered through Hospice funding. 2. Requirements to demonstrate need and source recurrent funding from April 2025.	1. Report presented at the Strategic Commissioning and Transformation Committee 5th February 2025. Approval to fund in 2025/26 aligned to Medium Term Plan. 2. Meeting took place 17th February with Hospice Chief Executive Officers (CEOs). 3. Implementation of the full 24/7 advice line service and alignment to linked ICC admission avoidance schemes.
LTC Programme Delivery Escalation	Pulmonary Rehabilitation (PR) contract in East and Southeast Staffordshire Current contract comes to an end 1st May 2025.	Driver identified in **M8** remains: 1. Current contract in place. Contract ends on 1st May 2025. Decision needs to be made on future delivery of service.	1. Report was presented (Part B) at the System Finance and Performance Committee on 7th January 2025. 2. Further work being undertaken with current provider and contracting team in relation to contractual arrangements for 2025/26.
Frailty - Programme Delivery Escalation	Frailty Programme Severe frailty service re-design Test of Change led by MPFT has been evaluated including an economic evaluation demonstrating impact and delivery of the project goals and national evidence/best practice. Frailty Programme: Scaling up of proactive falls projects.	Modelling of activity and financial assumptions to be worked through as part of the medium-term plan.	1. Development of Neighbourhood MDT (Multidisciplinary team) aligned to operational planning guidance and scheme outlined by MPFT aligned to Medium Term Plan. 2. Falls avoidance and response scheme reviews – rapid redesign and commissioning of services as part of Medium-Term Plan Community Transformation Programme.

Local Priority

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

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Maternity and Neonates **(at University Hospitals North Midlands only (UHNM))**	Brain Injury Rate - Monthly rate above the 2023/24 benchmark rate in December 2024.	1. The rate decreased to 2.0 per 1,000 in December 2024 with 1 reported Neonatal Brain Injury (Cooled) at UHNM; this rate is above the 2023/24 benchmark value of 0.0 in the same month. 2. Small numbers are derived from crude data. The Quarter 3 2024/2025 count (of 3) is less than the Quarter 3 2023/2024 count (of 4).	1. Work continues with UHNM to improve data quality and ensure verified data is received; at the latest Quality, Safety and Oversight Forum (QSOF) Theme 4 meeting (11th February 2025) it was agreed that UHNM will provide the data quarterly to ensure data quality checks are completed. 2. The Brain Injury rate will continue to be monitored through the QSOF on a monthly basis (which focuses on learning, themes identified and areas for improvement) with local intelligence supplementing the validated data.
	The proportion of full - term babies admitted to a neonatal unit, measured through the Avoiding Term Admissions into Neonatal Units (ATAIN) programme	1. A total of 21 babies admitted in December 2024, an increase on the prior month (of 19) and above the 2023/24 benchmark (same month) value of 17.	1. To monitor and analyse emerging themes and trends with the Business Intelligence team (using Provider data) and identify areas for further development and improvement with the Provider, for discussion and review in QSOF (date of next meeting in February 2025 to be agreed). 2. UHNM have introduced 'buccal 40% glucose' for the treatment of hypoglycaemia which should see a reduction in admissions; data will be monitored each month (from January 2025 onwards) and reviewed with the Provider in QSOF however the data is to be provided quarterly from 2024/25 Quarter 4 onwards.

Local Priority

Delivering compassionate care of the frail and elderly

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Discharges on Pathway 0 (ICB) - Performance in January 2025 deteriorated to 73.37% from 74.23%, which was 5.5% below plan. Current Year to date (YTD) position as of 31st January 2025: 76.55%	1. Continue to see increased acuity of admitted patients resulting in escalated requirements on discharge. 2. Discharge Facilitation 7-day workforce model continues to be delayed.	1. A new UHNM UEC Improvement Plan is being developed which will include a workstream dedicated to transformation of Pathway 0. 2. Consistent application and accountability monitoring of 5 key organisational policies (Rapid Handover, Internal Professional Standards, Ward Standard Work, Your Next Patient, Home Care is Best Care). 3. System high intensity team continue to work with twice weekly visits. Working in conjunction with UHNM clinical operational and medical teams to support implementation of learning via a CQI approach.
	Discharges on Pathway 1 (ICB) - Performance in January 2025 declined, rising from 20.91% to 21.98% which was 5.2% above plan. Current YTD position as of 31st January 2025: 19.34%	1. Discharge Facilitation 7-day workforce model delayed. 2. Workforce resilience waning due to increasing sickness and stress levels.	1. Integrated Discharge Hub (IDH) portals in-reach team supporting identification and turn around of patients from ED back to community settings. 2. System high intensity team (HIT) continue to work with twice weekly visits . Working in conjunction with UHNM clinical operational and medical teams to support implementation of learning via a CQI approach.
	Discharges on Pathway 2 (ICB) - Performance in January 2025 declined marginally, rising from 4.08% to 4.11% which was 1.1% above plan. Current YTD position as of 31st January 2025: 3.57%.	1. Risk aversion in support for patients with high-level residential requirements continues to be an issue.	Actions planned last month continue to aim to drive performance improvement. 1. System high intensity team continue to work with twice weekly visits. Working in conjunction with UHNM clinical operational and medical teams to support implementation of learning via a CQI approach. 2. Continue to work with Local Authority partners to ensure appropriate flow through the Discharge To Assess (D2A) bed base.

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

Improving Population Health (IPH)	Covid-19 vaccinations in >65 years eligible group: - 64.4% of the eligible group have received vaccination in January 2025, this is 10.2% below 2023/24 baseline of 74.6%.	• Covid-19 across all cohorts in autumn/winter 2025 is 12% lower than uptake last year with the over 65 year group seeing a 10.2% reduction in uptake this year.
		• This reduction in uptake is similar across the country and is down to a number of factors including
		  • reduced national awareness/communication campaigns for Covid-19 vaccines during the campaign period
		  • a perception that Covid-19 infections are not as much of a concern as in previous years due to repeated vaccinations and infections
		  • repeated Covid-19 vaccinations have reduced general uptake in the vaccine.
			1. Local campaigns have continued to press the importance of vaccination particularly in the over 65 year olds, to prevent serious infection and associated complications.
			2. Locally there will be a review to understand what improvements can be made for future campaigns. Key areas of focus will be:
			  • GP and Primary Care Network (PCN) Engagement: Encourage GP practices and PCNs to deliver targeted messaging to patients to boost vaccine uptake.
			  • 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.

Local Priority

Delivering compassionate care of the frail and elderly

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Integration	Emergency Admissions for Chronic Ambulatory Care Sensitive (ACS) Conditions (Staffordshire Local Authority) - Latest indirectly age standardised rate (quarter 2 2024/25) indicated 196.7 admissions per 100,000 population, 1 above plan.	1. Shortfall equivalent to 1 admission per 100,000 population not considered as significant underperformance	1. Increasing staffing resilience including bank staff to support Virtual Wards service capacity. 2. Expanded scope of analysis through Joint Commissioning Board involvement in Stoke Health and Wellbeing Board to include Acute ACS conditions, and replicate analysis for Staffordshire to address increasing numbers and deteriorating status of patients.
	Emergency Hospital admissions due to Falls in People aged 65 and over (Staffordshire Local Authority) - Latest directly age standardised rate (quarter 2 2024/25) indicated 442.9 falls per 100,000 population versus the annual plan figure 1,448. This is 80.9 above the quarterly equivalent plan figure.	1. Segmentation of activity for over 75 and over 85 years old patients has identified increased rates within specific districts where population has greater average number of co-morbidities. 2. Fall incidents within Care Homes continue to increase and now represent over 1/5 of all calls to WMAS for fall related incidents during 2024.	1. ICC and Acute Care at Home services have expanded activity and resource availability to support both Urgent Community Response (UCR) and Call Before Convey through WMAS to provide alternative Pathways and urgent emergency clinical attendance and treatment where appropriate. 2. Specific focus on Care Homes, with review of "top" sources under way. Contact to be made to discuss issues and reasons with guidance provided on alternative options where possible. 3. Additional "link-up" call service provided by Totally to bridge the gap beyond the end time of current clinical services.
	Discharge to Usual Place of Residence (Staffordshire Local Authority) - Latest Performance for quarter 2 2024/25 was 93.2%, 0.2% below plan.	1. Achievement rate shortfall not considered as significant underperformance over quarter	1. Full review of the D2A onboarding and off-boarding process to take place facilitating the development of an escalation and de-escalation matrix that will support future planning. This will reflect changes to patient complexity and seasonal impact on discharge destinations.

Other Key Points Aligned to this priority
Integration metrics: – Better Care Fund (BCF) Planning for 2025/26 is underway with changes to the metrics used to measure progress and impact. Future metrics will be Emergency Admissions per 100,000 population in over 65 years old, and proportion of patients discharged on their Discharge Ready Date.

Local Priority

Supporting Care Home Residents

Area	Under Plan or Target / Delivery Off track	Drivers of underperformance and programme delivery	Top 3 Planned actions provided by portfolio
Care Homes	Multidisciplinary Team Meetings (MDT) year to date to December 2024 are 19.4% below plan, delivering 6,114 meetings year to date, a shortfall of 1,506 MDT meetings.	1. Capacity of Community Teams and Primary Care is stretched to allow MDT meetings to take place across all locations. 2. Lack of clarity within practices around the appropriate coding of MDT meetings	1. Work with system partners to further refine the Enhancing Health in Care Homes (EHCH) Local enhanced services (LES) to compliment the Directed Enhanced Service (DES) and support the demand management system work. 2. Working with practices/Primary Care Networks (PCNs), clinicians within ICB and Business Intelligence to simplify coding 3. Review of PCN models to understand differences, what works well and sharing best practice. 4. Continuing with system partners under the Community Transformation umbrella to ensure alignment of teams. 5. Interface meetings established with MPFT and three localities to build relationships.
	The percentage of Care Home Patients with Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation remains below plan for December 2024, standing at 57.8% against the December plan of 62.5%, a shortfall of 369 patients with ReSPECT in place.	Drivers identified remain as reported in **M8**: 1. Challenges stemming from a shortage of MDTs taking place, limiting the ability to effectively conduct Advanced Care Planning discussions in a timely way. 2. Substantial variation identified between practices with ReSPECT plans in place.	1. Primary Care Team are contacting those PCN's furthest away from target to review EHCH delivery and identify risks & issues. 2. ReSPECT Programme is supported by the Quality Improvement Framework (QIF) with practices to increase uptake and reduce variation. Data has been shared with the End of Life (EoL) Team with low performing practices highlighted for review. 3. Practices continue to be encouraged to engage with the Digital ReSPECT Programme to increase the number of digital plans – 13 practices are now participating. 4. Staffordshire Training Hub are offering regular training on ReSPECT for GP's and Advanced Clinical Practitioners – next session arranged for 11th March 2025.
Care Homes Programme Delivery Escalation	The Care Homes Programme forms part of the Demand Management system collaborative for 2025/26.	Drivers identified remain as reported in **M8**: 1. Care Homes does not benefit from being aligned to a single Portfolio, which means that activities designed to support care home residents remain fragmented, with the potential for duplication and gaps. 2. EHCH has stalled and is waiting for further direction from the Demand Management Collaborative.	1. In the process of transitioning from a Demand Management system collaborative to a Community Transformation Programme as part of the Medium Term Plan developments. 2. Need to make sure that 25/26 projects are agreed as a matter of priority to support the productivity and efficiency agenda for the system. Key immediate focus areas identified: Pro-active/ Moderate/ Severe Frailty, Falls (Proactive and reactive), Care Homes (Support, training and escalation), High Intensity Users, Long Term Conditions (LTC) - Chronic Obstructive Pulmonary Disease (COPD), Pneumonia and End of Life. 3. Expect these projects to then move into the Provider Collaborative space for onward delivery and monitoring, whilst the longer term transformation programme focused on integrated neighbourhood teams runs in parallel.

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

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

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

2 — Improving access to high quality, sustainable primary care

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

TRAFFIC LIGHT KEY

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

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

4 — Delivering compassionate care of the frail and elderly

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

5 — Supporting Care Home Residents

Integration	
Care Homes System Recovery Programme	-

TRAFFIC LIGHT KEY

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
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▼	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

Finance Summary – Month 10

The following slides detail the aggregate financial position as at month 10. 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. Conversations have been held with Regional colleagues and we have proposed a year end control total deficit of £28m compared to the system breakeven plan, and we are awaiting their response. Until we get confirmation, we are required to formally forecast break-even, however we also report unmitigated risks which is our current view of the outturn position.

Following on from the month 9 position remaining flat, the month 10 position continues to remain stable and we have made further improvements to the level of unmitigated risk.

At a system level we are reporting a year-to-date deficit position of (£30.5m), which is a £33.3m adverse variance against the revised plan (Month 9 variance to plan £32.8m). The year-to-date variance to plan sits within ICB (£14.4m) and UHNM (£22.2m) with small surplus at MPFT (£1.4m) and NSCHT (£2.0m). At month 10 the System has formally reported an increased surplus forecast of £2.4m at NSCHT (month 9 forecasted surplus of £1.2m) in line with their continuing run rate and efficiency delivery. This has been offset by a corresponding deficit in the ICB to maintain a nil net balance for the System. .

Given the increasing certainty as we move towards the year end and capture the benefits from the I&I regime and ERF performance, the system has reduced the **unmitigated risk to £30m** which is an improvement from month 9 of £39m. This has been achieved through a combination of NSCHT increasing their forecasted surplus position, coupled with balance sheet flexibility at MPFT.

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

The system workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and are currently (end of January) 25,078. Within that we have achieved a reduction in agency equivalent to 206 WTEs. Despite the pay controls of organisations having been reviewed both as a system and by the I & I team, there is a concern that since May the overall workforce numbers has risen each month.

Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as system partners have significantly reduced plans to meet this allocation. We are currently working through our capital plans and allocations for 2025/26 in line with the guidance received and information regarding potential increased allocations.

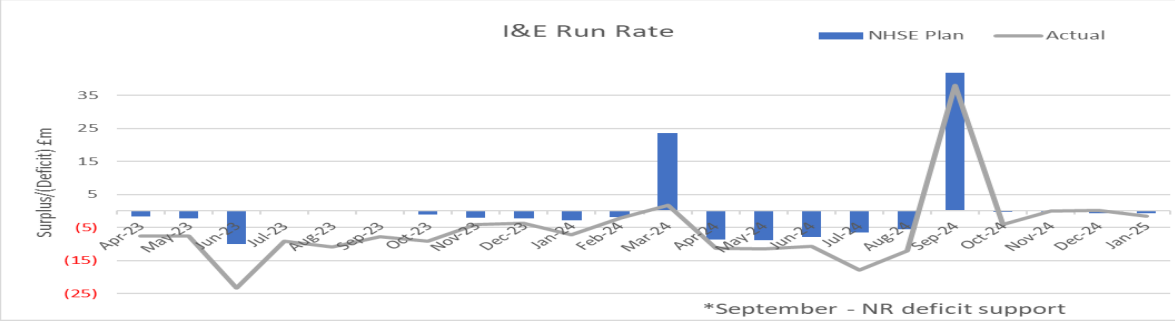
Month 10 Position

The System is reporting a year-to-date adverse position to plan of £33.3m against a revised YTD £2.7m surplus plan. The main drivers for the aggregate YTD position are efficiency slippage (£33.2m) and binding conciliation (£17.3m) with adverse impacts in CHC (£10.4m) and medical staffing (£6.2m). These are partially offset by other non-recurrent mitigations (£19.8m), ERF delivery (£11.5m) and Dental underspend (£4.4m).

Within the £33.3m there is a phasing mis-alignment between NHSE plan and UHNM which equates to £1.8m at Month 10, this will reduce monthly to no impact by year end.

System	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	4,298.3	4,338.3	40.0	3,858.8	3,889.8	31.0
Pay	(1,102.8)	(1,109.6)	(6.8)	(991.9)	(996.3)	(4.4)
Non Pay	(568.5)	(626.2)	(57.7)	(512.3)	(562.1)	(49.8)
Non Operating Items (exc gains on disposal)	(30.9)	(25.3)	5.7	(27.7)	(22.6)	5.2
ICB Expenditure	(2,593.4)	(2,607.8)	(14.4)	(2,323.5)	(2,338.3)	(14.8)
Total	2.7	(30.5)	(33.3)	3.4	(29.5)	(32.8)
			-0.8%			-0.8%

ICB	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Allocation	2,593.4	2,593.4	0.0	2,323.5	2,323.5	0.0
Expenditure	(2,593.4)	(2,607.8)	(14.4)	(2,323.5)	(2,338.3)	(14.8)
TOTAL ICB Surplus/(Deficit)	0.0	(14.4)	(14.4)	0.0	(14.8)	(14.8)
			-0.6%			-0.6%



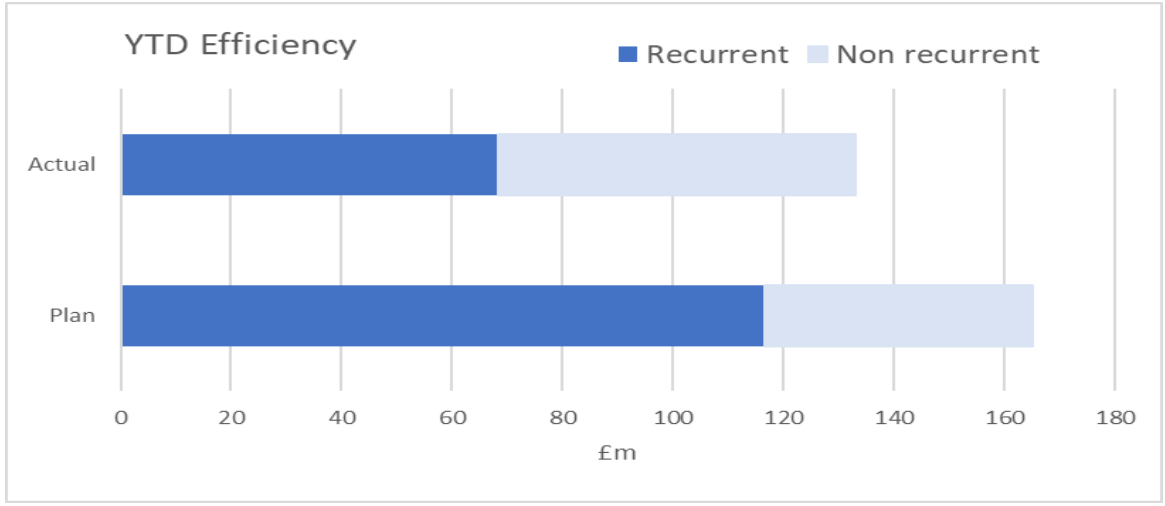
UHNM	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	984.5	1,019.8	35.3	886.3	916.1	29.7
Pay	(604.0)	(614.6)	(10.6)	(543.1)	(551.8)	(8.7)
Non-Pay	(348.3)	(396.8)	(48.5)	(314.1)	(356.5)	(42.4)
Non Operating Items (exc gains on disposal)	(30.8)	(29.1)	1.7	(27.7)	(26.1)	1.7
TOTAL Provider Surplus/(Deficit)	1.4	(20.8)	(22.2)	1.4	(18.3)	(19.7)
			-2.2%			-2.1%

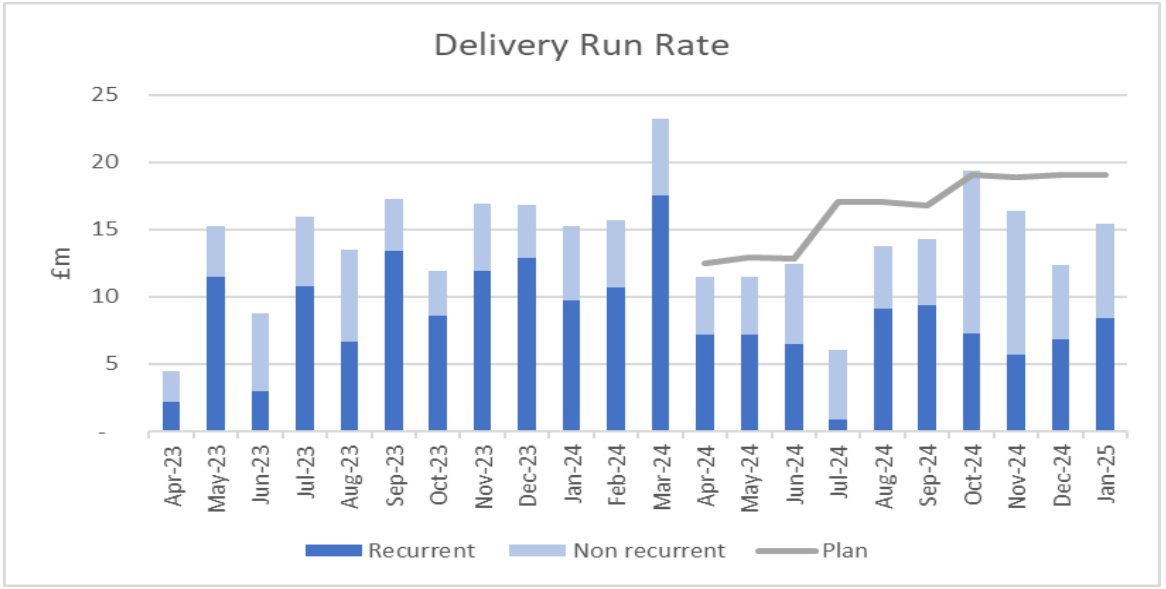
MPFT	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	578.8	584.6	5.9	521.3	524.7	3.3
Pay	(412.7)	(412.0)	0.7	(371.2)	(370.0)	1.2
Non-Pay	(165.8)	(174.5)	(8.7)	(149.1)	(155.8)	(6.7)
Non Operating Items (exc gains on disposal)	1.3	4.7	3.4	1.3	4.3	3.0
TOTAL Provider Surplus/(Deficit)	1.5	2.9	1.4	2.3	3.2	0.9
			0.2%			0.2%

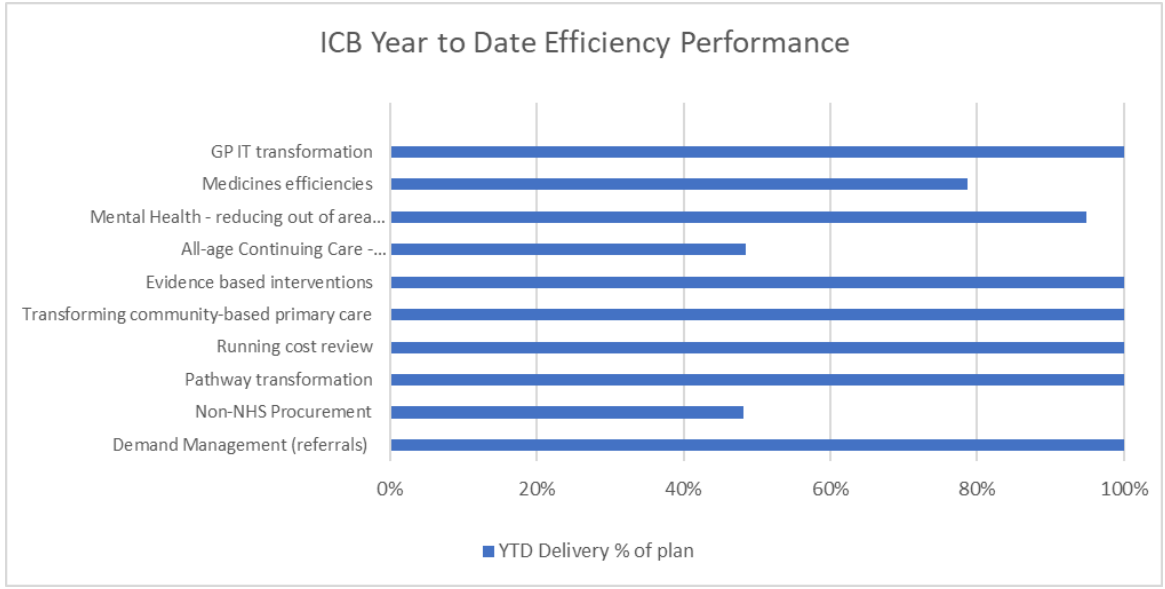
NSCHT	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	141.7	140.6	(1.1)	127.7	125.6	(2.1)
Pay	(86.0)	(83.0)	3.0	(77.6)	(74.5)	3.0
Non-Pay	(54.5)	(55.0)	(0.5)	(49.1)	(49.9)	(0.7)
Non Operating Items (exc gains on disposal)	(1.5)	(0.9)	0.6	(1.3)	(0.8)	0.5
TOTAL Provider Surplus/(Deficit)	(0.2)	1.7	2.0	(0.3)	0.4	0.7
			-1.4%			-0.5%

Efficiency

- The system efficiency programme totals £203.2m with £22.8m forecast shortfall. This is in line with last months reporting, with work on going to identify further schemes
- Forecast delivery equates to 88.8% delivery against the annual efficiency plan of £203m
- Year to date the system has delivered £133m of efficiency, this is £32.0m adverse against plan, which is largely at ICB (£19.1m) and UHNM (£13.0m)
- Recurrent schemes are £48.1m adverse at month 9. Key challenges remain to deliver the efficiency programme to meet the agreed deficit and within this, ensure the recurrent efficiency is met to not deteriorate the underlying position







Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 14

AAA Escalation & Assurance Report from Board Assurance Committee

Report To:	**ICB Board**
Date:	**20th March 2025**
Reporting Committee:	**Finance and Performance Committee Parts A and B**
Date of Meeting:	**4 March 2025**
Meeting Quorate Y/N?	**YES – both Parts**
Presenter:	**Megan Nurse, Non-Executive Director and Committee Chair**
Author:	**Debbie Everden, Business Manager**

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

PART A

Month 10 System Finance Report
At Month 10, at a System level we are reporting a year-to-date deficit position of £30.5m, which is a £33.3m adverse variance against the revised plan. Given the increasing certainty as we move towards the year end and capture the benefits from the I&I Regime and ERF performance, the System has reduced the unmitigated risk to £30m which is an improvement from £39m at Month 9. This has been achieved through a combination of NSCHT increasing their forecasted surplus position, coupled with balance sheet flexibility at MPFT.

Since the formal Month 10 reporting, there have been further improvements to the potential forecast outturn, and the latest forecast position is now a £28m deficit position and this has been agreed with the Regional Team as the position for the 2024/25 financial year.

The System workforce numbers (substantive + bank + agency) were 24,741 in March. Although these numbers dropped at the start of this financial year, they are now above the March 2024 numbers and as at the end of January are 25,078. Within that we have achieved a reduction in agency equivalent to 206 WTEs. 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. The Committee requested that future workforce reports provide greater clarity on the reasons for the variance to plan and the recurrent and non-recurrent elements so underlying issues can be identified; there should be consistency with the information presented to each organisations' Boards. The plan for 2025/26 needs triangulation between finances and workforce and the Committee was assured that this is being addressed by Executives across the System.

Our capital reporting is on track with the forecast for operational capital and IFRS16 compliant against the allocations. This is not without risk as System partners have significantly reduced plans to meet this allocation. The Committee was assured that all organisations will achieve their capital spend forecast for 2024/25.

The Committee acknowledged the System position at Month 10 and the net risk reported.

2024/25 System Recovery Programme
System Recovery Programme Update
The paper provided an update on the System Collaboratives and the plans underway to transition into the five programmes of work which underpin year one of the Medium Term Plan.

The Collaborative financial improvement forecast is £27.4m which is £26.9m adverse to plan for the year. The Committee considered the updates for the Collaboratives:
Continuing Healthcare - We continue to focus on agreeing the plans for 2025/26, against a benchmarking opportunity of c£77m. Leads have been confirmed, and they are reviewing the data and developing plans. This work will then be part of the ICB's Efficiency Programme for 2025/26 and be led by the ICB.

Demand Management - Plans are underway to transition the work of this System Collaborative into the Community Transformation Programme. We need to agree as a matter of priority which schemes will be moved into the Provider Collaborative for immediate delivery from 1 April 2025. We can then quantify what impact these schemes will have on the efficiency/productivity targets set for the in- System providers as well as out of area patient flows.

Contracts - We have delivered c£15m of ERF contribution to the System's financial position. The KPMG work continues and the first follow up opportunities continue to be scoped for any additional in-year delivery. Future models/options for MSK are being explored and this work will move into the Provider Collaborative space as required.

Clinical Value and Medicines - Financial delivery of the ONS project will continue into 2025/26 and be monitored through the Tough Choices Programme and the ICB Efficiency Programme. Work is underway to quantify the impact of the MRI and Vitamin D projects on provider efficiency/productivity targets. Clinical Value is one of the five programmes of work within the Medium Term Plan. A System-wide offer to providers, supported by the Clinical Senate, is currently under development and will be presented to the next Provider Collaborative Board.

<u>System Recovery Director Report</u>
System CIP delivery is now forecast to be £153m which is £4.2m favourable to plan. £11.9m of the green actions from the Recovery Plan have now been included within this forecast (with a further £9.4m of green actions included within the Collaborative position aligned to CHC). Inclusion of all green Recovery Plan actions would see the forecast CIP delivery increase to £158.2m, £9.4m favourable to plan.

Now that the I&I work has been completed, consideration has been given to how the work is taken forward with certain areas of work now taken up by the System and other areas of continuing support being considered and/or agreed.

The report provided an update on the Tough Choices workstream and in order to maintain momentum on the initial prioritised 21 schemes, further support has been agreed with the I&I Team from Deloitte. The additional support is based on an average 2-3 days per week over a 6 week period with the level of support reducing as the workstreams are embedded.

- The estimate of the savings ranges from a low estimate of £12.04m up a high estimate of £39.59m in 2025/26, with a larger full year effect in the following year. This figure is dependent upon pace of implementation and level of appetite on target savings once full impact assessment is undertaken.
- The SRO has identified individuals to lead each intervention and has requested a PID to be completed by the end of February 2025.
- Local individuals are to be identified to programme manage, coordinating the work of the leads for each intervention and tracking decision making, implementation and savings. For a transition period, Deloitte continue to provide this coordination.
- Regular updates on progress of decision making and implementation of the 21 phase 1 schemes will be provided.
- A second phase of consideration of further ideas will be undertaken, reviewing the list of items not prioritised in phase 1 and ideas gathered since that phase completed. Contribution of ideas from the System are welcomed.

The Committee acknowledged the ongoing actions and plans to support recovery of the System financial position, the current improved financial position against the Recovery Plan and the Investigation & Intervention support from Deloitte/Kingsgate.

System Performance and Programmes Report
The paper provided the Committee with an overview of performance and programme delivery at Month 9 against the ICS Operational Plan, key UEC metrics for out of System providers and metrics for Care Homes.

There has been some improvement in some of the high-level Urgent Care metrics against the priority to eliminate delays in access to treatment and long waits for care and A&E waiting time has improved significantly although remains below plan.

Cancer 62 days was in green consistently for the first 6 months of 2024/25, but has now turned to red again.

The Committee noted that for diagnostic wait and activity, the percentage of patients waiting within 6 weeks for a diagnostic test at the end of December 2024 was 65.9%, against a plan of 83.0%. Performance against this metric in the NHS Oversight Framework remains in the lowest quartile, ranking us 38 out of the 42 ICBs.

The Committee considered the104ww, 78ww and 65ww position for Staffordshire and Stoke-on-Trent and out of System providers.

The Committee was assured that for red rated items, the Portfolios provide dynamic mitigations which are included in the report.

The Committee noted the 3 escalations raised by the End of Life, Long-Term conditions and Frailty Portfolio, and 1 escalation on the Care Homes delivery programme. For Care Homes, the Committee noted that the planned actions have been reviewed and updated. The programme is now in the process of transitioning from the Demand Management System Collaborative to the Community Transformation Programme as part of the Medium Term Plan developments.

2025/26 Planning: National Planning Submissions and Local Timeline
The report outlined a summary of the headline submission made on 26 February covering activity, finance, workforce and productivity, the key milestones, and final submission expectations.

There are areas of non-compliance with national planning ambitions across most the areas which will need to be addressed collaboratively as a System to ensure a robust submission for the end of March. Key focus areas for the final submission were discussed in detail at the System Performance Group on 26 February and a set of priority actions over the next fortnight were agreed to ensure alignment between activity, capacity, workforce, and financial planning. Meetings will take place to firm up the assumptions with the aim of showing what it would take to deliver financial balance alongside the constitutional standards and ensure robust triangulation occurs between activity, finance and workforce and this will be completed by 17 March. A productivity tool kit has been issued by NHSE, this does not require submission but will be used internally to support plans.

We anticipate the outlined plans will not be sufficient to fully close the gap. As such, the System is committed to our work plan commenced under the I&I programme on Tough Choices and we will have this workstream fully developed by 14 March.

The Committee noted that Board assurance statements are required from all organisations in addition to the usual submissions.

An update on capital planning was also provided and it was noted that capital plans have been split into a series of tranches with different submission dates and processes for 2025/26. This means we are unlikely to conclude our capital position and associated risk until late May 2025.

PART B

Month 10 ICB Finance Report
The paper reported the current and projected financial position of the ICB for 2024/25. As previously reported, NHSE released funding equivalent to the £90m deficit plan agreed on 12 June 2024, enabling the ICB to set a breakeven plan for 2024/25.

At Month 10 the ICB reported a YTD deficit position of £14.5m adverse variance against the revised breakeven plan. This reflects a £0.3m improvement from a £14.8m deficit position at Month 9. Following clarity of the year end ERF income position and the CHC position improving once again, the ICB's risk position has now stabilised against the £19.9m targeted deficit. We feel confident of delivering this and Region have confirmed that this forecast position can be amended within reporting at Month11.

The Committee was assured that the ICB has received the cash draw down requested for the System so the risk for this financial year can be closed.

The ICB has received a further £17m allocation for 2024/25 and this will be allocated across the System.

The Committee acknowledged the ICB's risk position has stabilised at the 'most likely' (£19.9m deficit) position whilst our 'worst case' has become closely aligned with our 'most likely' position and that the ICB risk which was £66.4m at Month 4 has reduced to £19.9m.

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 of £84.6m of efficiency delivery for 2024/25, represents 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 understood that the £17.6m projected under-delivery is unacceptable and presents a key financial risk to the ICB both in-year and for 2025/26. The ICB is confident on all aspects of this forecast with exception to the £4.6m 'high risk' schemes within Continuing Healthcare. All KPIs are trending in the right direction, however the flow to the financial position is taking time to unwind and the Collaborative has been tasked to mitigate shortfalls by exploring all avenues.

The Committee acknowledged the £17.6m risk of efficiency under-delivery to the ICB's financial position and that the recovery actions being taken by the Recovery Director and organisation are having a positive impact on 2024/25 delivery. Notwithstanding the fact that we haven't achieved a break even financial position, the Committee acknowledged all the work that has taken place across the ICB regarding the efficiency delivery against a very challenging target.

2025/26 Budget Setting Update
The paper outlined to the Committee the latest ICB draft budget, key assumptions and risks to delivery.

The paper provided an update on the development of the ICB annual budget for the 2025/26 financial year and included a timeline based on final approval of the budget at the March meeting. However, the delayed release of the planning, operational and business rules guidance has resulted in an inability to produce full budgetary information for the Committee to take assurance at this point.

NHSE have issued allocations inclusive of £95m deficit support funding, subject to the System submitting a balanced plan (less a reduction of £11.6m to repay historic financial deficits accumulated by CCGs and the ICB). The draft ICB budget for 2025/26 reports a deficit position of £130m inclusive of £75m of core efficiency. Taking into consideration the deficit support funding is predicated upon a balanced plan, the ICB is including a £35m additional reduction to the plan and reported a balanced position within the 27 February Headline Submission to NHSE.

Regarding the efficiency target for 2025/26, the Committee discussed the importance of the Tough Choices work and ensuring this is delivered at pace.

Due to the delay in receiving the published guidance, the deadlines for approval of the final budget have had to be pushed back and so the Committee requests the ICB Board at the Seminar on 25 March agree the 'Go Live' budget of 1 April and the Final NHSE submission of 27 March.

ADVISE

PART A

NHSE Oversight

The Committee received the letter following the QSRM held on 30 January. This outlined the key points of discussion including the current areas of focus across the System, key challenges and positive progress made since the previous period. The letter stated that while improvements are being made, the ICS must increase the scale and pace of change to achieve financial sustainability and service transformation.

We are one of twelve Systems identified as high risk and therefore, there will be additional reviews with NHSE.

An outturn of a £28m deficit for 2024/25 has been agreed with NHSE. Significant improvements have been made since Month 4, but it was acknowledged that 2025/26 will be very challenging and we need to ensure that there is grip and control and pace and ambition to deliver the plan.

Investigation and Intervention Regime: Closedown Report

The report detailed the outcomes and recommendations of the Phase 2 Implementation of the I&I Programme. The programme focused on further refining and implementing measures across four key workstreams: Tough Choices, CHC, Workforce, and Productivity.

The report set out the financial impact delivered as well as a brief overview of the key results by workstream. It was noted that much of the implementation phase commenced in January 2025 (due to various delays, including data availability, the Christmas break, and the challenging operational position) and the programme has had insufficient time to deliver significant saving in-year with the majority of savings expected in 2025/26.

Key observations from the report were:

- Significant Savings Opportunities: The programme identified £41.4 – £72.3 million in potential savings with work underway to delivery these. Savings will primarily be realisable in 2025/26.
- Need for Continued Momentum: While implementation has commenced, maintaining momentum and focus is crucial to realising the full benefits and a structured programme will be required to deliver the sizeable benefits identified.
- Implementation Challenges: The report highlighted that the programme faced some delays in implementation due the need to secure stakeholder buy-in and engagement. Addressing these challenges will be crucial for future phases of the programme and having dedicated capacity and accountability will be essential.
- Mindset Change Required: The report emphasised the need for a System-wide mindset change, with full recognition, ownership, and engagement from key stakeholders in addressing the financial challenges faced by the ICS.

UEC Pressures/System Surge Plan Update

The paper provided an update on the management of ongoing System UEC pressures and an update to the System Surge Plan. The paper also provided an overview of recent audit work undertaken by NHSE with UHNM and the agreed next steps including the creation of a new UHNM UEC Improvement Programme.

Post the System-wide Critical Incident, the System has remained in a highly pressured position, with further surges in activity, however no further critical incidents have been called since the last update.

System-wide assessment of the Surge Plan highlights that the majority of capacity that was planned to be operational at this point is live and delivering against plan. The System Surge MDT forum (with

representation from all System partners) is continuing to oversee delivery of the plan and assess potential mitigations that can be brought forward or increased in order to address current pressures.

Key metrics agreed by Chief Operating Officers (COOs) were contained in the report and these continue to be monitored to support decision making in relation to escalation and de-escalation of actions and the incident status across the System. These are monitored daily and reported to the System Strategic Calls chaired by the ICB Chief Delivery Officer.

Following the initial System Critical Incident a full review including recommendations was presented to the UEC Board in January. A further review of the wider winter period to date is currently underway and will be approved via the UEC Board, ahead of presentation to both Staffordshire and Stoke-on-Trent Health Overview Scrutiny Committees with a formal lessons learnt event held in Spring 2025.

The Committee noted that the latest budget update as at 17 February showed that following the deployment of additional actions/mitigations, the current position remains £604k under forecast. This position has improved from the previous reported position by £67k driven predominantly by changes in providers' forecasted positions. All partners continue to record their costs in relation to winter and provide assurance on a fortnightly basis via their respective finances leads and through to the System Surge MDT and ICB Executives.

Better Care Fund (BCF) Review
The paper provided an update on the BCF review and outlined key findings, recommendations for the continuation or discontinuation of schemes and set out next steps, including the delegation of accountability in order to drive System-wide improvements and help meet national expectations.

The review involved a comprehensive, line-by-line assessment of the relevant schemes to analyse funding allocations and expenditure. Portfolio leads were required to complete a standardised template designed to facilitate evaluation against the BCF national conditions and outcome measures. This assessment, in conjunction with a cost-benefit analysis and consideration of strategic priorities and expertise within each Portfolio, informed decisions regarding whether services should be maintained, expanded, or discontinued. Additionally, the review aimed to enhance operational efficiencies by identifying opportunities for improved collaboration, reducing duplication, managing overspend, and strengthening the focus on priority outcomes. The findings will play a critical role in shaping future investments, ensuring that resources are utilised effectively to maximise benefits for our communities. This exercise has provided a foundation upon which to build our collaborative, strategic decision making. It is expected that further work will be required in 2025, including a second stage review of the BCF.

PART B

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.

Weight Loss Pharmacotherapy Roll-Out Project
The paper provided an overview of a future potential cost pressure due to a new NICE TA1026 relating to Tirzepatide (an injectable therapy for weight loss), NHSE guidance on priority cohorts for the next 3 years and the proposed model of delivery for the System. The amount of funding to be received from NHSE is currently unknown and the Board is asked to note that the implementation will cause a financial pressure to the ICS.

A further paper providing more detail on the financial costs will be presented to the next Committee meeting and health inequalities and ensuring the right cohort of patients is targeted will be discussed by the Quality and Safety Committee.

ASSURE

PART A

ICB Undertakings
The Committee received the latest dashboard showing performance against the Undertakings for information. Discussions throughout the meeting detailed how the ICB is working towards the Undertakings.

PART B

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

The Committee noted that the project is progressing in line with agreed deliverables and milestones, that there were no formal issues or risks that required escalation, and that activity is now increasing as the transition date approaches, weekly assurance check-point meetings are diarised with workstream leads and fortnightly updates presented to ICB Executive Team Meetings.

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

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

Policies Approved:

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

Decisions to be Escalated to ICB Board or other Committees:

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

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 15

Report to:	**Integrated Care Board**						
Date:	**20 March 2025**						
Title:	**People Culture and Inclusion Assurance Report**						
Presenting Officer:	Mish Irvine, Chief People Officer ICB						
Author(s):	Gemma Treanor, Head of ICS People Function Matthew Bewick, ICS Principal Workforce Information and Systems Manager						
Document Type:	Report		If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒	
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*		
Is the decision within SOFD powers & limits	**Yes / No**	NO					
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.					
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Any impacts on ICB Undertakings?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	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 via the 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:

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report outlines the current workforce position within SSOT. System level oversight and monitoring of people metrics, controls and performance against operational plan continues in partnership with NHS Providers. The current operating environment and financial position remains pressured, with additional scrutiny continuing in workforce reconciliation and oversight framework. The PCI Committee acknowledge the efforts and challenges facing organisational partners in contributing to the system recovery. The People elements are key to the operating plan delivery and recovery programme – at organisational and system level.

The following areas are detailed in the report:
- Workforce Assurance, Oversight, Metrics & Controls
- Workforce Challenges, Risks & Mitigations

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to: Note the workforce position, operating plan, risks and mitigations in place to address.

Staffordshire and Stoke-on-Trent Integrated Care System

ICS People Culture & Inclusion Performance and Assurance Report

SSOT ICB Board in Public

March 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 regular 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 Jan-25, workforce levels have exceeded the Mar-24 starting position by +358,7 wte and are 920.6 wte / 3.9% above planned position This is due to increases in the substantive workforce of +793 wte. Whilst decreases have been seen in both bank (-228 wte) and agency (-206 wte). Since Dec-24 position, the workforce has increased overall by +185 wte. This increase is largely driven by increases in substantive (+175.9 wte) and bank (+51 wte) whilst agency decreased slightly by -42 wte. From an agency perspective, our current position is 2.3% agency of total pay spend for FYTD24-25 and since Apr 24 we have remained been below Agency Spend plan as an overall system. For context, the Jan-25 Agency Spend is just £15k off being the lowest value in 12 months.
  - A more granular understanding of the reasons for increases and above planned position is currently being undertaken in partnership with Trusts – as discussed at the March Finance & Performance Committee.
  - Staff morale, health and wellbeing remain a high priority and current sickness absence levels are of concern, particularly during a period of significant operational pressure. Collectively, Jan-25 saw the second highest sickness rate in 24 months at 6.0% only surpassed by Nov-24 (6.2%) . Anxiety, Stress and Depression continues to be the largest single reason for sickness and accounts for 31% of all absence in Jan-25.

- 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: Employee Wellbeing/Retention; and slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage. Risks continue to be monitored and reviewed via the PCI Committee and Sub-Committees

- People, Culture and Inclusion **Programme delivery** is overall on track, with programmes and activity in place to address system challenges and risks.

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce Assurance, Oversight, Metrics & Controls

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

Staffordshire and Stoke-on-Trent Integrated Care System

- **NHS provider Total Workforce levels are significantly above plan by +921 wte**, this is predominantly driven by the UHNM position who are 707 wte above their own plan. However, from a **FTYD pay spend perspective this reflects an above plan position of 0.4%** (inclusive of substantive, bank and agency)
- **Total workforce has overall increased since Dec-24 by +184 wte** (+176 wte Substantive, +51 Bank and -42 Agency)
- **Total workforce for Jan-25 is +359 above the Mar-24 position** (+793 Substantive, -229 Bank and -206 Agency)
- Work is underway to continually improve the agency position in respect of utilisation and compliance of the NHSE policy rules, including price cap compliance.
- **In-Month sickness rate for Jan-25 is 6.0%,** for context the **Dec-24 rate was 6.2% which is the highest rate since Dec-22**. Current levels of sickness absence are significant and helping people to be well and supported at work remains a key opportunity.

- **Our combined bank and agency workforce equates to 7.7% of our total workforce**. This is **-1.9% lower** than the highest point in the past 12 months (Mar-24).
- **FYTD agency spend is -23.3% below plan** and positively is remaining static in terms of performance, despite operational pressures.
- **Agency spend is currently £2.2m which equates to 2.0% of total pay spend ; 1.2% below the reduced agency use measure of 3.2%** in FY24-25 (previously 3.7% FY23-24). The agency spend has decreased slightly since last month. For context Feb-24 position was 3.3% and the highest point in the last 12M.
- **Turnover rate is currently 8.4% (reduced from 8.9% in Dec-24),** which is currently the **lowest rate in the last 12 months** (and -0.7% below the highest rate in the last 12 months (Mar-24).
- **AfC appraisal rates currently 87.3% - currently +7.6% above the lowest point** in the last 12 months (Mar-24).

SSOT Workforce Variance to Plan by Provider NHS Trust (M10)

Staffordshire and Stoke-on-Trent Integrated Care System

	UHNM	MPFT	NSCHT
Total Workforce (wte)	+707 (+101 wte above establishment)	+166	+47
Substantive (wte)	+417	+284	+56
Bank (wte)	+269	-74	-14
Agency (wte)	+21	-44	+5
Reasons for Variation	- Substantive: NQN's, lower than planned turnover has led to increased staffing to plan. - Bank usage higher than planned due to vacancies, sickness, high numbers of 1-2-1 requirements. - Critical incident impact on work pressures, specifically in emergency portals.	- FYTD increased substantive staff due to recruitment to vacancies and new service acquisition, up until Nov-24 these increases have been offset by the decreases in temporary staffing. However, MPFT remains below planned pay spend. - Sickness absence increased from normal trend in Dec-24	- Increased substantive staff due to newly qualified staff on boarding.
Mitigating Actions	- Exec Led monthly assurance meetings to deep dive agency/bank use, vacancies, sickness, overtime, WLIs - Robust vacancy control in place - Divisional Finance and Control Groups, MDT approach in place, supported by Deloittes-Kingsgate	- Monthly analysis of temp staffing dashboards and performance against pay bill targets by Care Group - Quarterly workforce movement analysis and deep dive actions by People team - Robust Vacancy control in place, including regular review of approvals - Monitoring against the operational plan	- Exec level analysis of bank/agency use - Robust vacancy control in place

SSoT NHS Provider actual to plan position: Total +921 wte, substantive +758 wte, bank +181 wte, agency -18 wte

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce challenges, risks & mitigations through programme activity

5. Workforce - Risks, challenges and mitigation

The Risks and Challenge

People risks

The following risks are identified on the People Culture and Inclusion Risk Register:

- Agency usage and spend - risk under review to incorporate wider risks regarding workforce controls, temporary workforce
- Care Home and Home Care Workforce Capacity
- Ability to deliver the Local People Plan programmes, People Operating Model and Long Term Workforce Plan
- Employee Health Wellbeing and Retention
- Slowing of recruitment due to financial pressures, resultant increased vacancy control/ workforce controls e.g. temporary staffing usage
- Ability to deliver the Long Term Workforce Plan and create a sustainable future pipeline
- GP Collective action

A forensic review of risks is taking place during March to ensure the risks reflect the current position and those facing the System as we head into 2025/26. Mitigating action and solutions are developed and implemented by the Sub-Committees.

The System Board Assurance Framework ‘Sustainable Workforce’ also reflects the 2024/25 impact and controls, with quarter four review completed and to be signed off by the April Committee.

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.
- The 2024/25 PCI Annual Report is being finalised for approval by the April Committee and captures key achievements across the System
- The 2025/26 ICS People Delivery Plan is currently being finalised and will be approved by the PCI Committee in April. Work will commence over Summer 25 to develop a refreshed ICS People Plan, aligned to the Medium Term Plan, National 10 Year Plan and revised Long Term Workforce Plan.
- Establishment of the new Planning, Supply and Transformation Workstream and Sub-Committee is well under way with the remit and vision agreed. This Sub-Committee will operate in a similar way to the System Performance Group from a workforce lens – addressing planning and metrics challenges, identifying activities to improve our position and overseeing transformation programmes which support System priorities e.g. MTP, Provider Collaboratives.
- Organisations continue to address increased sickness rates and focussing on health and wellbeing of the workforce, with deep dives and targeted support in high-risk areas.
- Widening participation and access activities continue to be a key priority for delivery across the system, increasing access to health and care jobs from our local communities – aligned to IPH and Anchor employer models.
- The System OD plan launch took place on 10th March to agree priority actions, establish Sub-Committees and take forward the plan.

Staffordshire and Stoke-on-Trent Integrated Care System

People Metrics Appendices

- System Monthly Position
- System Trend
- Provider Summary

Staffordshire & Stoke-on-Trent NHS: January 2025

Staffordshire and Stoke-on-Trent Integrated Care System

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Workforce

Total Workforce
24,737 WTE
Currently +794 wte (May 24)

Substantive
22,884 WTE
Currently +861 wte (Feb 24)

Bank
1,558 WTE
Currently +138 wte (Oct 24)

Agency
335 WTE
Currently -206 wte (Mar 24)

Temporary Workforce
7.7%
Currently -1.9% (Mar 24)

Agency Spend
£2.2M (2.0%)
Currently -£1.6M (Mar 24)

Vacancies
2,249 wte (9.0%)
Currently -100 wte (Jul 24)

Joiners
265 wte
Currently +100 wte (Jun 24)

Leavers
118 wte
Currently -124 wte (Mar 24)

12 Month Rolling KPI's (%)

8.4% Turnover Rate
Currently -0.7% (Mar 24)

5.5% Sickness Absence Rate
Currently 12 Month High

93.9% Mandatory Training
Currently +0.7% (Feb 24)

87.3% AFC Appraisal Rate
Currently +7.6% (Mar 24)

76.7% Medical Appraisal Rate
Currently -8.2% (Mar 24)

Other Health and Care Workforce

SSOT ICB Workforce
341 WTE

Primary Care Workforce
3,490 WTE

Social Care Workforce
21,000 WTE

Dentistry Workforce
610 Headcount

Current Workforce Position: January 25

Staffordshire and Stoke-on-Trent Integrated Care System

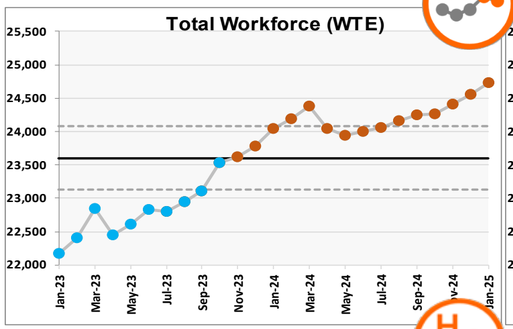
Staff in Post (Total Workforce wte)

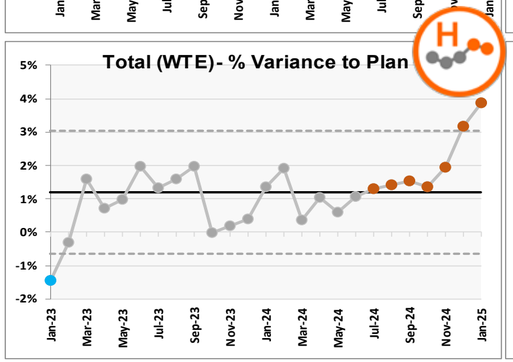
Jan 25: **24,737**

Position to Plan: **+921**

12M Change: **+695**

FYTD Change: **+359**





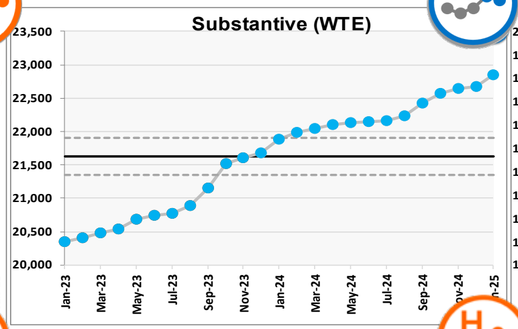
Staff in Post (Substantive wte)

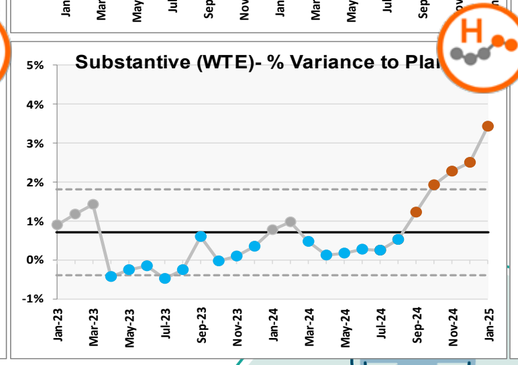
Jan 25: **22,844**

Position to Plan: **+758**

12M Change: **+964**

FYTD Change: **+793**





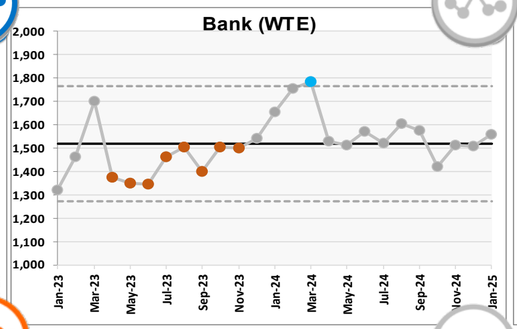
Bank Workforce

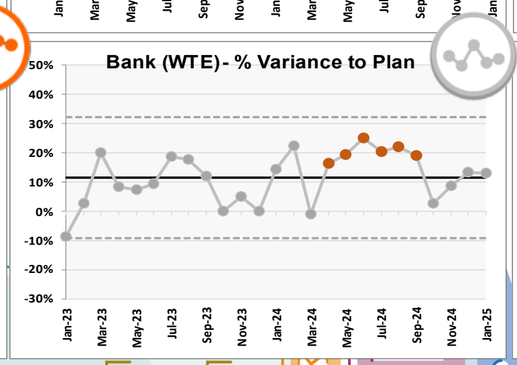
Jan 25: **1,558**

Position to Plan: **+181**

12M Change: **-98**

FYTD Change: **-229**





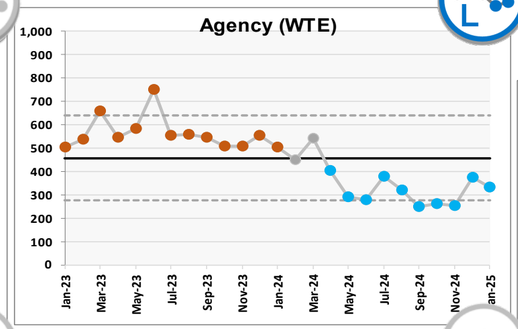
Agency Spend (% of total pay spend)

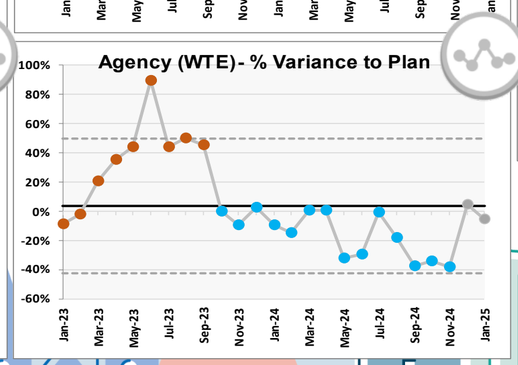
Jan 25: **2.0%**

Plan Position (FYTD): **-23 .3%**

12M Change: **-3.2%**

FYTD Change: **-3.2%**



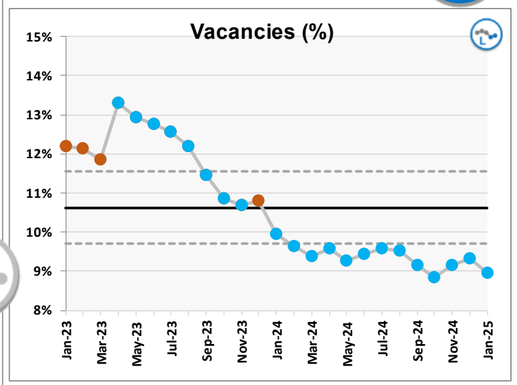


Vacancies (%)

Jan 25: **9.0%**

12M Change: **-1.0%**

FYTD Change: **-0.4%**



Actual vs Plan

Overall: +921 wte above plan
Registered Nursing: +318 wte above
Registered S,T&T: +100 wte above
Support to Clinical: +65 wte above
NHS Infrastructure: +296 wte above
Medical and Dental: +141 wte above

Actual vs Plan

Overall: +758 wte above plan
Registered Nursing: +288 wte above
Registered S,T&T: +84 wte above
Support to Clinical: +25 wte below
NHS Infrastructure: +260 wte above
Medical and Dental: +102 wte above

Actual vs Plan

Overall: +181 wte above plan
Registered Nursing: +23 wte below
Registered S,T&T: +16 wte above
Support to Clinical: +24 wte above
NHS Infrastructure: +44 wte above
Medical and Dental: +74 wte above

Actual vs Plan

Overall: -18 wte above plan
Registered Nursing: +7 wte above
Registered S,T&T: +1 wte below
Support to Clinical: +16 wte above
NHS Infrastructure: -8 wte below
Medical and Dental: -34 wte below

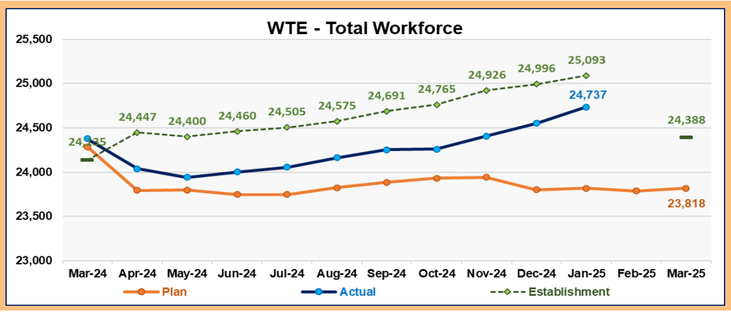
Vacancies

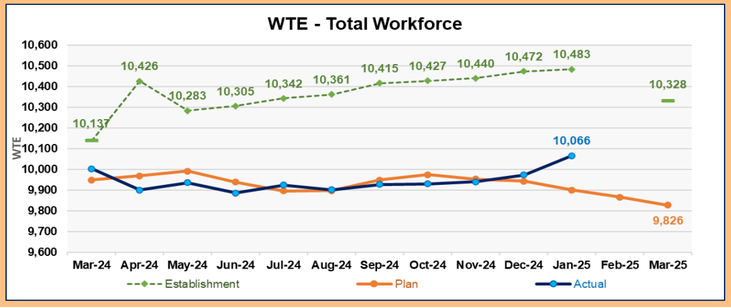
Vacancies total 2,249 wte (9.0%), which is +the second lowest level of vacancies in the system for the last 12 months (+ 61 wte more than lowest level of vacancies in system in the last 12 months (Oct 24)).

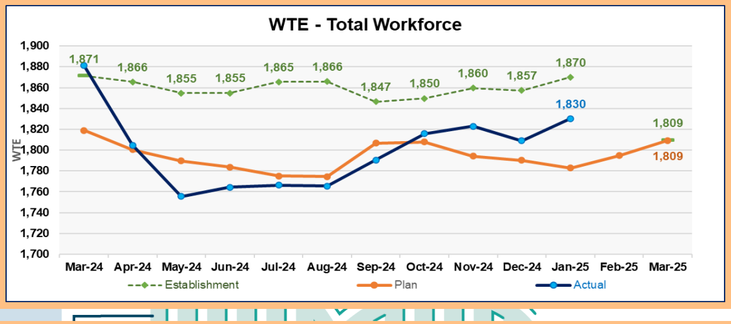
5. Workforce – FY24-25 Performance to Plan

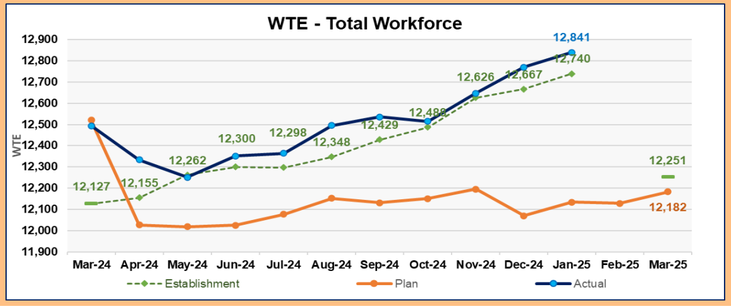
Staffordshire and Stoke-on-Trent Integrated Care System

	Total Workforce	Substantive	Bank	Agency
SSOT	31st Mar 24: 24,378 wte Jan-25: 24,737 wte FYTD Change: +359 wte / +1.5% Jan-25 Position to Plan: +921 wte / +3.9% above plan	31st Mar 24: 22,051 wte Jan-25: 22,844 wte FYTD Change: +793 wte / +3.6% Jan-25 Position to Plan: +758 wte / +3.4% above plan	31st Mar 24: 1,786 wte Jan-25: 1,558 wte FYTD Change: -229 wte / -12.8% Jan-25 Position to Plan: +181 wte / +13.2% above plan	31st Mar 24: 541 wte Jan-25: 335 wte FYTD Change: -206 wte / -38.1% Jan-25 Position to Plan: -18 wte / -5.1% under plan
MPUFT	31st Mar 24: 10,003 wte Jan-25: 10,066 wte FYTD Change: +63 wte / +0.6% Jan-25 Position to Plan: +166 wte / +1.7% above plan	31st Mar 24: 9,154 wte Jan-25: 9,440 wte FYTD Change: +286 wte / +3.1% Jan-25 Position to Plan: +284 wte / +3.1% above plan	31st Mar 24: 647 wte Jan-25: 515 wte FYTD Change: -132 wte / -20.4% Jan-25 Position to Plan: -74 wte / -12.6% under plan	31st Mar 24: 202 wte Jan-25: 110 wte FYTD Change: -91 wte / -45.3% Jan-25 Position to Plan: -44 wte / -28.6% under plan
NSCHT	31st Mar 24: 1,881wte Jan-25: 1,830 wte FYTD Change: -51 wte / -2.7% Jan-25 Position to Plan: +47 wte / +2.7% above plan	31st Mar 24: 1,732 wte Jan-25: 1,709 wte FYTD Change: -24 wte / -1.4% Jan-25 Position to Plan: +56 wte / +3.4% above plan	31st Mar 24: 113 wte Jan-25: 109 wte FYTD Change: -4 wte/ -3.6% Jan-25 Position to Plan: -14 wte / -11.4% under plan	31st Mar 24: 36 wte Jan-25: 13 wte FYTD Change: -23 wte / -64.9% Jan-25 Position to Plan: +5 wte / +67.1% above plan
UHNM	31st Mar 24: 12,494 wte Jan-25: 12,841 wte FYTD Change: +347 wte / +2.8% Jan-25 Position to Plan: +707 wte / +5.8% above plan Jan-25 Position to Establishment +101 wte above establishment	31st Mar 24: 11,165 wte Jan-25: 11,695 wte FYTD Change: +531 wte / +4.8% Jan-25 Position to Plan: +417 wte / +3.7% above plan	31st Mar 24: 1,026 wte Jan-25: 933 wte FYTD Change: -93 wte / -9.0% Jan-25 Position to Plan: +269 wte / +40.5% above plan	31st Mar 24: 303 wte Jan-25: 212 wte FYTD Change: -91 wte / -30.1% Jan-25 Position to Plan: +21 wte / +11.0% above plan









Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 16

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

Report To:	**ICB Board**
Date:	**20th March 2025**
Reporting Committee:	**Strategic Transformation & Commissioning Committee (SCTC)**
Date of Meeting:	**5th March 2025**
Meeting Quorate Y/N?	**YES**
Presenter:	**Mike Lawton**, Committee Chair
Author:	**Paul Winter**, Associate Director of Corporate Governance

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

This was the first meeting led by Mike Lawton, as Non-Executive Member (NEM) for the ICB. Committee Members wished to advise the ICB Board of a number of matters from the second meeting of the new Committee, for Board awareness and consideration, as follows:

SCTC Terms of Reference:

The TORs incorporate all changes discussed at the first couple of meetings and received by email outside of meetings. They also factor in offline Exec Director discussion outputs, to ensure there is clarity on where the committee sits and there is no duplication or gaps with other Board Assurance Committees' lead areas. The TOR were submitted for approval prior to Board Ratification; and will continue to evolve / be reviewed frequently over the next six months as this new Committee establishes itself.

2025/26 Planning Process Update:

The implications and messages for this committee were outlined by the Chief Transformation Officer; providing an overview of the ongoing process and the resource implications this presents to the ICB-ICS. This item also prefaced further, more detailed programme specific updates throughout the agenda, including interfaces with the Strategic Transformation Group programmes of work.

Pre-Consultation Business Case (PCBC) – Birthing Services:

The Committee received the full, detailed PCBC and numerous associated preparatory documents for the birthing services previously provided at County Hospital in Stafford & Samuel Johnson Community Hospital in Lichfield. The papers also describes the proposed approach to statutory public consultation, subject to Board approval, as outlined within a draft Public Consultation Plan appended.

In July 2023, our Case for Change on the future of intrapartum services at the Units was presented to NHSE during a Stage 1 assurance meeting. No issues were raised by NHSE and the feedback was that the case was well presented, with partners demonstrating a clear and robust understanding of the clinical model and the challenges the ICS is facing.

As a result, the ICB, alongside system partners reinstated the service change process paused due to the pandemic and began to reassess proposals for the future of birthing services at the hospitals. The service change programme has been conducted throughout in accordance with NHSE Guidance *Planning, Assuring and Delivering Service Change for Patients*.

In April 2024, the Case for Change / associated clinical evidence was presented to the West Midlands Clinical Senate; who supported the proposal to make permanent the temporary closure of the birthing / intrapartum service at the Units. In October 2024, a Stage 2 NHSE Assurance Meeting was convened.

Following this, and through subsequent discussions, NHSE have informally confirmed they are assured that our proposals meet the 5 Tests for Service Change, as well as other good practice; and are content for the ICB to proceed to consultation. We await the formal letter from NHSE.

ALERT (continued)

In line with NHSE recommendations, a series of amendments were made to the PCBC. Development of the Business Case has been through a robust process and activity undertaken meets the key legal requirements when proposing service change. Based on the involvement activity to date it is recommended that the ICB undertake a 12-week public consultation. The aims of this will be to:

- *Articulate the Case for Change and the single viable proposal to make permanent the temporary closure of the birthing service at the two Units;*
- *Inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the proposal identified through the options appraisal and wider involvement activity;*
- *Reassure staff, service users, carers, carer representatives and other stakeholders about the scope of the proposal and the wider maternity clinical model;*
- *Understand views about the process we have undertaken and the technical group's recommendation about the single viable proposal.*

The Consultation Plan outlines the process and methods used to conduct targeted engagement with service users, carers, carer representatives and other stakeholders; which includes a survey, structured online events and drop-in roadshow events.

The SCTC:

(1) Supported formal approval of the PCBC + appendices, the Consultation Plan & Document;
(2) Supported proceeding to public consultation on the single viable proposal;
(3) Supported a recommendation to be made to ICB Board to undertake that for 12 weeks.

ADVISE

Delegation of NHSE Commissioning Duties (Specialised Commissioning - Acute / MHLDA):
The Committee received a pre-Board update on the progress of Phase 2 of NHSE's Delegated Commissioning work programme. Including an NHSE Briefing Paper on the refreshed Delegation + Collaboration Agreements - the particulars between NHSE / SSOT ICB - where the NHSE request is for ICBs (Boards / Committees) to sign both. These set out the working arrangements with regards but not limited to: Lead Commissioner Arrangements ref. aligned commissioning / Joint Commissioning, financial and governance arrangements. The ICB Specialised Commissioning Delegated Services Working Group will report into this Committee, which includes all key ICB officers as ICB reps at the various, regional Specialised Commissioning operational groups that support the joint working arrangement.

The SCTC:

(1) Approved the Acute Specialised Services Delegation Agreement, the Collaboration Agreement for the additional delegation of specialised Acute & Mental Health, Learning Disability & Autism services;
(2) Received and noted an NHSE-created Data Protection Impact Assessment (DPIA); and
(3) Was assured that the ICB has the relevant internal governance and reporting arrangements in place.

BCF Review:
The Committee received an update paper - also discussed at F&P Committee given the timings - on the Better Care Fund (BCF) review for our ICS; outlining key findings, presenting recommendations for the continuation or discontinuation of schemes. Alongside some proposed next steps, including the delegation of accountability. The Review has identified key areas for investment, improvement, and strategic alignment with national policy. Ultimately, ICB Board's approval of the recommendations will ensure sustainable, integrated, and effective care delivery across our ICS. Our strategy is fully aligned with national priorities, ensuring that the BCF is effectively utilised to support integrated, proactive, and person-centred care that will drive system-wide improvements and help meet national expectations.

The SCTC:

(1) Discussed and agreed the recommendations made in this paper to enable commissioning teams to implement the decisions on continuing, completing further work or stopping funding for schemes;
(2) Noted the recommendations on further work and opportunities, including phase 2 of the BCF review, and supported their implementation, considering lessons learned in phase 1;
(3) Considered whether we have clear outcome measures and agreed how we define success for schemes that are to continue, including how overspends will continue to be monitored / mitigated.

ASSURE

System Transformation & Service Change Programme - Highlight Reports Update:

Maternity [also see "Alert" section for other elements of the report]
- PCBC amended following discussions with NHSE and submitted Jan-25.

UEC
- Report of Findings presented to UEC Board Jan-25 and Feb-25 discussion of the Planning Guidance (how this could impact UTC designation). A technical event meeting was postponed, to be re-convened in Mar-25 to plan a way forward.

UHDB Clinical Reconfiguration
- Planned clinical service review covering 8 clinical areas (T&O, Critical Care, Paeds, Maternity, Cardiology, Stroke, Haematology, Oncology) – UHDB's Programme Lead is meeting with the Deputy CMO to discuss arrangements for clinical engagement re. Cases for Change for each clinical area.

Community Transformation
- System workshops held Dec-24 / Jan-25, with the first Steering Group held Feb-25 to co-ordinate the work programme across Portfolios & Providers, aligned to NHSE's Neighbourhood Health programme. 8 schemes have been identified to develop in supporting a reduction in attendances / admissions in 25-26.

Primary Care Forum (PCF) Triple A Report – February Meeting:

(a) ***ALERT***
Confirmation has been received from NHSE that 'hard ringfencing' will be applied to Dental budgets. This confirms we will be left with liability on any overspends on Pharmacy & Optometry. Currently

forecasting breakeven on Optometry, with an overspend of £0.5m for Pharmacy; however, an allocation is expected which will hopefully provide a breakeven position.

(b) ***ADVISE***

Primary Care Financial Position (Month 10) = Non-Delegated Forecast Outturn (FOT) variance of £4.716m underspend // Medicines Management – FOT variance £3.069m overspend // Delegated General Practice – FOT variance of £0.016m overspend / Delegated Pharmacy, Optometry, Dental (POD) – FOT variance breakeven. The PCF noted the 2024-25 positions and the identified risks.

(c) ***ASSURE***

Service Development Fund (SDF) additional uplift funding was approved by the Forum – 13 training programmes contributing towards the Primary Care Workforce Local Delivery Plan. The proposal is to extend these to new delegates and continue to invest in the primary care workforce, encouraging new skills and retention within Staffordshire. The total cost of schemes is £218k. There is a proposal to use £200k to support a cardiovascular disease (CVD) pilot, which NHSE have launched.

Spirometry Underspend & Fractional Exhaled Nitric Oxide: FENO machines (for approval) – within budget, using a current underspend to deliver spirometry services with 100% population cover, per new NICE Guidelines for Asthma to fund 35 FENO machines at £2.7k each for the existing hubs to support the diagnosis and breathlessness pathway.

Fibricheck QIA (for approval) – now completed for this digital service to support the decision-making process, supporting the decision to let the Fibrecheck App contract come to a natural end, and not to recommission due to not enough evidence to support value for money.

Translation & Interpretation Spoken Languages Services Procurement (for approval) – PCF approved an extension, following a large amount of clarification questions received, and mindful of the pre-election period. This is a 7 month extension through a Direct Award Framework for these services; until 1st November 2025, while the procurement process is carried out.

System / ICB Risks & System Board Assurance Framework (SBAF):
No reports were shared for Committee oversight at this meeting – these will be due in April 2025.

Policies Approved:
No policies have yet been tabled to the Committee for approval, under Board-delegated powers.

Decisions to be Escalated to ICB Board:
The Committee agreed that the Terms of Reference were to be sent in full, for ratification by March Board, as this is a new committee. These are appended below for the purposes of achieving that.

TERMS OF REFERENCE
Strategic Commissioning & Transformation Committee (SCTC)

(1) Introduction

1.1 The Health & Care Act 2022 and associated Statutory Guidance set out a more joined-up approach to health & care, built on collaborative relations and using collective resources to improve the health and well-being of local areas.

1.2 The Integrated Care Board ('Board' or 'ICB') must ensure that it can effectively discharge its statutory functions and duties. This includes establishing committees of the ICB, to support the Board in the exercise any delegated functions, to help effective discharge of those.

1.3 The SCTC will help create an ICB Strategic Commissioning infrastructure which enables systemwide decisions to be well integrated with "Place" (Joint Commissioning Board / Local

Authority and Neighbourhood levels), supporting strategic collaboration between partners to address inequalities, improving outcomes and sustaining joined-up value for money services.

1.4 This will ultimately provide full opportunity for all responsible for planning, commissioning, and delivering health & care services to continue to build and maintain broader coalitions across all Partners to promote health & wellbeing, thus influencing the wider determinants of health.

(2) Delegated Authority

2.1 The Committee is established to enable Statutory Commissioning Duties decision-making, collaborating on Strategic Commissioning (including policy) matters and overseeing jointly agreed programmes of work to ensure their delivery. These TORs may only be changed with approval of the Board.

2.2 The Committee is a Non-Executive committee of the Board; and its members, including those who are not members or personnel of the ICB, are bound by the Constitution, Standing Orders, and other policies of the ICB.

2.3 The Board has delegated authority to the Committee, as set out in the Scheme of Reservation & Delegation and Delegated Financial Limits. These may be amended by Board from time to time. The Committee holds only those powers as delegated in these TORs.

2.4 Committee duties and responsibilities are set out in Section 4 and Appendix 1. Further may be delegated over time with the approval of the Board, following which these TORs will be updated.

2.5 The Committee will act in accordance with, and its decisions be informed by, ICB guidance, policies, and procedures. It must have 'due regard' to all Statutory Obligations the ICB is subject to, as set out in NHS Acts and ICB Governance documentation.

(3) Authority

3.1 The Committee is authorised by ICB Board to:

(a) *Investigate any activity within its TORs, seeking any information and commission any reports or remedial work deemed necessary from any employee or member of the ICB (who are directed to co-operate with any request made), to help fulfil its remit.*

(b) *Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if considered necessary to fulfil its functions (in doing so it must follow any procedures put in place by ICB for obtaining legal or professional advice).*

(c) *Create Task & Finish Groups as necessary (with memberships / TORs set in accordance with ICB's Constitution, Standing Orders, Scheme of Reservation & Delegation). The Committee does not have authority to delegate responsibilities delegated to it by Board to these; but may with the agreement of the Board establish sub-committees to assist with its responsibilities.*

(4) Purpose, Responsibilities and Core Duties

4.1 Operational duties will be driven by ICB-ICS objectives and associated risks: this will be kept flexible to adapt to new and emerging circumstances, priorities, etc.

4.2 The Committee is established to enable the ICB to exercise its statutory commissioning duties at System / Collaborative level in a lawful, simple, efficient way; to the extent permitted by ICB's Constitution and as part of the wider collaborative arrangements.

4.3 It shall support the development of Strategic & Collaborative Commissioning arrangements, supporting System (ICB-ICS) Portfolios, Place, & Provider Collaboratives, helping those to broker ICB commissioning decisions pertinent to their agendas, including:

(a) *The Committee will support ICB and NHS Partners to achieve through Collaborative Commissioning the agreed joint strategic aims, objectives, and deliverables of:*

i. *The Integrated Care Strategy produced by the Integrated Care Partnership: ICP.*

ii. *Staffordshire and Stoke-on-Trent Health & Wellbeing Boards (HWBBs) led Joint Local Health & Wellbeing Strategies and aligned Delivery Plans,*

iii. *Place Partnerships & Joint Commissioning Boards, to ensure coherence and alignment while delivering subsidiarity of those).*

4.4 In supporting the ICB to discharge its statutory commissioning duties and deliver strategic priorities at whole ICB / System level, the Committee will, in turn, be supporting ICB / our ICS with the achievement of the four core purposes of the "Quadruple Aim", including:

(a) *Day-to-day operational management of the delivery of ICB Statutory Commissioning Duties that support our strategic system-wide Transformation Agenda.*

(b) *In respecting sovereignty of extant arrangements (Forums / Boards, H&WBBs[1] etc), jointly exploring the implications of shared Transformation through Strategic Commissioning, without stifling ICB's or Partners' powers and authority.*

(c) *Co-ordination of the operational implications of transformation, by liaising with ICS Executive or ICB Board Assurance Committees on matters of significance, to ensure consistency.*

(d) *The development and implementation of ICB & System responses to Integrated Care Strategies / aligned plans required for Strategic Transformation of health & care services.*

(e) *The development of new Models / Pathways of care at strategic, whole-System level to inform Portfolio, Place and Provider Collaborative implementation, under subsidiarity.*

(f) *Taking all necessary steps to support delivery of ICB's / ICS's objectives by determining relevant actions to remediate any initiatives where intervention is resisted or contradicting agreed ways of working, agreeing how we support each other to mitigate any impacts.*

4.5 A full list of responsibilities is provided in Appendix One. In carrying these out, the Committee must have 'due regard' to the wider effect of its decisions on health & wellbeing / addressing health inequalities, the quality of services provided and efficiency in the use of resources.

(5) Membership and Attendance

5.1 The Committee has a broad membership, including those from organisations other than the ICB (until replaced by any substantive Joint Committee of all Partners). This is permitted by the ICB's Constitution and amendments made to the 2006 Act by the Health & Care Act 2022.

5.2 Members should be of a calibre to conduct core business, without having to take items back to their host organisation – unless the decision is a non-delegated matter from those, and required under local, non-ICB governance frameworks.

5.3 For example, those who are experienced in and knowledgeable of committee functioning, and ideally of Board-level decision-making level to effectively discharge Committee functions. Nominated Deputies may be proposed in advance to the Chair.

5.4 When determining the membership, active consideration will be made to diversity and equality:

- ICB Non-Executive Member (NEM): elected at the first meeting as Chair
- ICB NEM for Audit (as Vice-Chair)
- ICB Chief Transformation Officer and Chief Delivery Officer
- ICB Chief Finance Officer
- ICB Chief People Officer (workforce commissioning perspective)
- ICB Director of Corporate Governance (ICB governance perspective)

[1] The Committee will work in close partnership with both Health & Wellbeing Boards to ensure and to provide assurance to them that plans agreed by the Committee / its activities appropriately align with, and have full regard to Joint Local Health & Wellbeing Strategies / their assessments of needs, together with the Integrated Care Strategy; and that wider collaborative arrangements, including Place, support increasing integration & collaboration on planning & provision of services across the NHS, LAs, wider partners to deliver a joined-up approach to improving health & wellbeing and reducing inequalities.

- System Partner Exec Directors – Transformation / Strategy / Planning, as suited, from each[2]
- ICB Clinical Leaders – the Chief Medical Officer & Chief Nursing & Therapies Officer
- System Clinical Leaders – at a later stage, as suited, from each
- x2 Local Authority Leads – e.g. Directors of Public Health / Adult Social Care or equivalent
- x1 Primary Medical Care Lead – initially proposed as a GP 'Partner Member' on ICB Board
- If not any of the above, the x2 Place Board Chairs or Committee Leads
- If not any of the above, the Provider Collaborative Committee Chair or Lead
- If not the above, Portfolio Programme SROs
- A Voluntary Sector representative – tbc by VAST & Support Staffordshire

Note: the proposed membership is not exhaustive – it is fully expected to evolve over time.

5.5 Other individuals may be invited to attend all or part of any meeting as / when appropriate to assist with Committee discussions (but shall not be able to vote on any matter). For example, to co-opt other, ad hoc members as required from the following, when pertaining to specialist "deep dive" topics for discussion or to ensure 'Subject Matter Expert' input - Primary & Secondary Care, WMAS or Portfolios, Workstreams, System or Provider Collaboratives

5.6 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion.

5.7 The Chair will be responsible for agreeing the agenda with the Secretariat, and ensuring matters discussed meet the objectives as set out in these TORs.

(6) Frequency, Quoracy and Decisions

6.1 The Committee will meet monthly. Additional, exceptional meetings may take place as required. A minimum of two working days' notice shall be given by the Chair when calling an extraordinary meeting.

6.2 Quoracy will be 50% of ICB members present. The Committee may meet virtually when necessary and members attending using electronic means will count towards the quorum.

6.3 If any member has been disqualified from participating in an agenda item, by reason of a declaration of a conflict of interest, that individual shall no longer count towards the quorum.

6.4 If the Committee is not quorate then the meeting may proceed if those attending agree, with any decisions taken subject to offline or next-meeting approval by members not in attendance. Or the meeting may be postponed at Chair's discretion.

6.5 Decisions taken will be in accordance with ICB Standing Orders and will be by consensus. Unless the issue is so exceptional it requires a vote. Only members may vote; and each is allowed one vote. A majority will be conclusive on any matter. Where there is a split vote, or no clear majority, the Chair will hold a casting vote. The result will be recorded in the minutes.

(7) Conflicts of Interest

7.1 Members and all present shall satisfy themselves that all matters of ICB policy, systems and processes for the management of conflicts of interest, including gifts & hospitality / bribery, are upheld in all meetings.

7.2 This shall include abiding by the ICB Board-agreed COI Meetings Protocol, as well as ICB and NHS-wide policy. Reports relating to non-compliance will be shared with the Audit Committee.

(8) Etiquette, Behaviours and Conduct

[2] The Committee will work in close partnership with ICS and non-ICS NHS Partners to ensure it has equal focus on in-ICS and out-of-ICS matters.

8.1 All Members and Attendees will be expected to conduct business in line with the ICS Leadership Compact values and objectives of: *'Trust', 'Courage', 'Openness & Honesty', 'Leading by Example', 'Respect', 'Kindness & Compassion', 'System First', 'Looking Forward'*.

8.2 ICB members shall also always behave in accordance with the ICB's Constitution, Standing Orders and Standards of Business Conduct Policy.

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

(9) Accountability and Reporting

9.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. Actions shall be formally recorded by the Secretariat.

9.2 The Chair will provide assurance reports to the Board after each meeting, using Highlight & Escalation Reports, drawing to the attention of the Board any issues that require disclosure or further action, including when ratifying any Committee decisions made.

(10) Secretariat and Administration

10.1 The Committee shall be supported with a Secretariat, which will ensure that:

- The agenda and papers are prepared and distributed in accordance with ICB Standing Orders; having been agreed by the Chair with the support of ICB Governance leads if required.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- The Chair is supported to prepare and deliver reports to the Board.
- Actions are taken forward between meetings, and progress against those is monitored.

(11) Review

11.1 The Committee will formally review its effectiveness at least annually, using ICB Committee effectiveness tools and processes.

11.2 These TORs will be reviewed at least annually; and in its early, formative stages, more frequently (e.g. bi-annually) and as required by circumstances. Any proposed amendments will be submitted to the Board for approval (and will not be deemed operational until agreement has been confirmed).

Appendix One – ICB Board Delegations to the Committee: the Committee's Responsibilities

(1) Health & Care Strategy and Planning

(a) Providing strategic leadership and fostering collaboration across Partners to:

- Contribute to the development of System priorities, shaping key System-wide strategies / plans and future resource allocation approaches.
- Ensure the delivery of System or Provider Collaborative commissioning priorities and outcomes as may be set out in plans.
- Facilitate and oversee commissioning, service planning, delivery and transformation between Partners to drive integration and value for money.

(b) To support the ongoing development of System or Provider Collaborative arrangements to maximise benefits for the System in terms of driving integration and efficiency in how services are commissioned / delivered; giving regard to wider System arrangements.

(c) To establish robust relationships with the other ICB & System (statutory or non-statutory) decision-making bodies to promote integrated working and avoid duplication.

(d) To promote strategic alignment across decision-making by working with appropriate partners who deliver and commission services for the same population.

(2) Service Planning and Commissioning

(a) To lead the ICB's Strategic Commissioning work, ensuring compliance with relevant Statutory Obligations.

(b) To seek assurance that appropriate patient & public engagement / involvement is in place and best meets the needs of the population with regard to the development and design of services.

(c) To ensure Commissioning decisions achieve value for money, efficiency and effectiveness in the ICB-ICS sustainable use of resources, focus on cost reduction and achievement of efficiency targets.

(3) Service Delivery and Transformation

(a) To provide Strategic Leadership to facilitate collaboration of all Partners to ensure delivery of the Strategic Commissioning priorities and outcomes.

(b) Including oversight of Place & Provider Collaboratives Transformation activities, programmes and groups in locally implementing Strategic Commissioning outcomes and priorities set out in SCTC-overseen plans, as agreed for their roles and responsibilities.

(c) To oversee delivery of all System Transformation Programmes, by providing strategic direction, challenge, championing; and including the management of risks against delivery by receipt of exception reports and/or rectification plans, in support of their objectives, and as required.

(d) To have assurance oversight and review of Commissioning & Transformation risks / proposals for mitigation, aligned to the System-ICB Risk Register and System Board Assurance Framework.

(e) To resolve issues between programmes that need input / agreement of senior stakeholders to ensure success; by exceptions-monitoring of progress against objectives and benefits realisation metrics.

(f) To identify strategic integration opportunities between developed / delivered schemes; by taking an overview of & demonstrating compliance with strategic planning assumptions / documentation.

(g) To act as prime vehicle for ICB's statutory duties in involving / engaging the population.

(h) To assist the Audit Committee / IG, Data & Digital Group in the forward delivery of Programme-related Data & Digital transformation objectives.

(4) Population Health Management

(a) Providing strategic leadership and oversight to ensure:

- Commissioning activity and decision-making by Collaboratives, Places & Neighbourhoods is underpinned by data and intelligence.
- Data is shared to contribute to a single evidence base across the Collaborative.
- Assisting Health & Care Senate in ensuring that care models are collaboratively designed, tailored to local population need and evidence-based on effective interventions.
- The effective use of resources, value for money and improved outcomes for our population.

(b) To provide strategic leadership for the Population Health, Inequalities & Prevention programmes, and ensuring that decision making is aligned to relevant strategic documents.

(c) To oversee NHS services related to Health Inequalities, Prevention and Long-Term Conditions funding; ensuring that all decisions align with Joint Local Health & Wellbeing Strategies, Health & Wellbeing Boards, and the ICP's Integrated Care Strategy.

(d) To promote joint working arrangements with partners that embed collaboration in delivery.

(e) To promote integration of Place Partnerships to enable decisions to be made about allocation / sharing of resources and most suitable delivery models at Neighbourhood - PCN - Place level.

(f) To facilitate collaboration and sharing of best practice; and to ensure the breadth of views represented in these are reflected in decisions made.

(5) Links with other ICB Board Committees

(a) To support the Quality & Safety Committee (QSC) as Lead Committee, with any Quality Management implications arising from Commissioning or Transformation matters within its purview. By providing escalation & reassurance reports to QSC, for its lead scrutiny and oversight.

(b) To support the Finance & Performance Committee (FPC) as Lead Committee, with any Finance or Performance Management implications arising from Commissioning or Transformation matters within its purview. By providing escalation & reassurance reports to FPC, for its lead scrutiny and oversight.

(c) To support the Health & Care Senate as Lead Committee, in ensuring that all strategic, clinical commissioning of care models are collaboratively designed, tailored to local population need and have robust Clinical & Professional Leadership evidence on the most-effective interventions.

(d) Any decision of the SCTC that has an impact upon the Financial Position of the System or ICB must have prior consideration and prior approval by the FPC. This equally applies to the wider performance of System / Provider Collaboratives & Portfolios against ICB-ICS Operational Plan + Medium Term Plan matters, covered by FPC's own Terms of Reference.

(e) Through strategic oversight of Place, Portfolios & Provider Collaboratives, the SCTC will support the FPC with regard to its lead role in *Commissioning for Value* (under the plans & strategies it leads on). By reviewing in-year monitoring reports and assessment of delivery against plans within SCTC scope, it will provide a Strategic Commissioning perspective to FPC on where efficiencies could potentially be delivered through the Financial Strategy work belonging to the FPC.

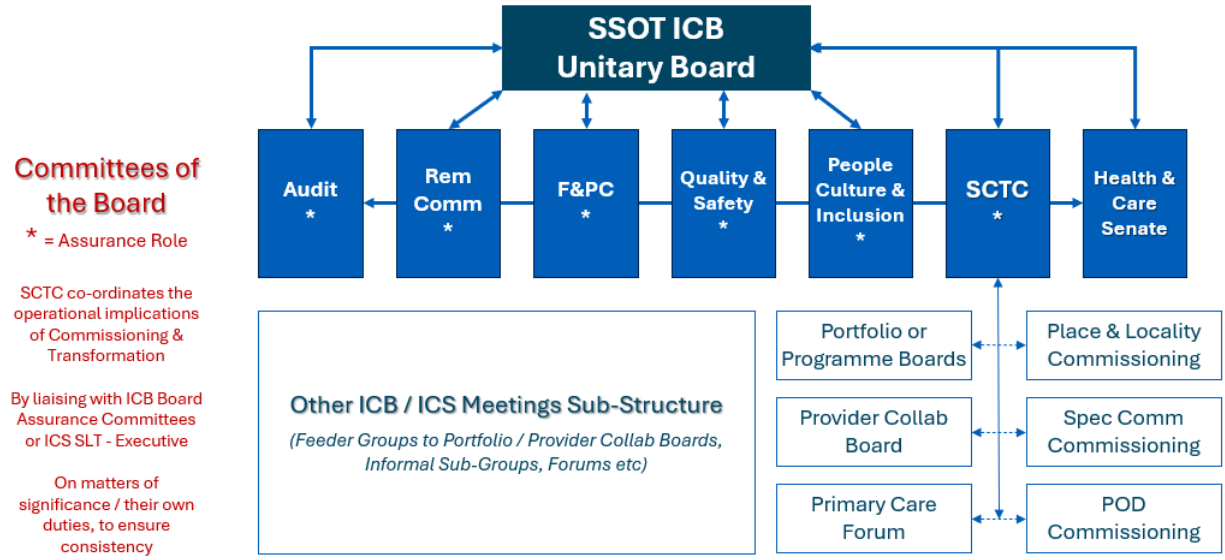
(f) SCTC shall have oversight of strategic Procurement & Contracting activity of the ICB, but it will also provide the necessary horizontal assurances to other Board Assurance Committees and up to Board, that all Provider Selection Regime (PSR) obligations have been conducted in a manner that meets ICB's Legal & Statutory Quality / Finance / HR obligations, whilst also delivering best value for patients and taxpayers. The SCTC must also specifically assure the FPC that any Procurement Decisions made are identified as falling within the available ICB-ICS financial envelopes.

***NB*: Interpreting Responsibilities**
Where there is any uncertainty about assigned responsibilities within this Committee's remit as a decision-making body within ICB's governance structure, including uncertainty about whether the matter relates to:

- ☑ *Determination by another Committee or other forum of the ICB*
- ☑ *A matter for wider determination within the ICS*

Then the matter will be referred to the ICB Director for Corporate Governance for consideration with the Audit & Governance Non-Executive Member (and Lead NEMs / Exec Directors as relevant), to determine where the matter or decision should be situated.

Where it fits – ICB Governance Structure & interfaces



NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Date of Approval: SCTC, 05.03.2025

Date of Review: 1st Review by 30th September 2025

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure 17

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

Report To:	**ICB Board**
Date:	**March 2025**
Reporting Committee:	**Audit Committee**
Date of Meeting:	**10th March 2025**
Meeting Quorate Y/N?	**YES**
Presenter:	**Julie Houlder**, Non-Executive Director
Author:	**Paul Winter**, Associate Director of Corporate Governance

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

After thanking the departing Committee Vice-Chair NEM (Megan Nurse) and our outgoing Internal Auditors: RSM (alongside welcoming their successors MIAA); Members wished to advise the ICB Board of a number of issues / Alerts from its latest meeting, for Board awareness and consideration, as follows:

System / ICB Risk Registers End-of-Year Review 2024-25:

The Committee noted some 'Early Alerts' in the reports presented: i.e. risks where there has been no change to the risk score in the last 6 months or more - 21 in total; many High Risk. As well as 8 risks that do not have any future actions identified in the latest updates. As a result, the Committee took a 'Deep-Dive' into the identified risk management process issues reported by the Governance Team, as follows:

As part of a "spring clean", the Governance Team will be undertaking a forensic review of the Registers with Risk & Action Owners throughout March. This will involve line-by-line review of each risk to assess:

- How the long a risk has been on either register;
- Is it still a risk, or is it now BAU and transferred to the local Issues Log;
- Review of actions / mitigations to date and whether these are working to achieve target scores & dates;
- Review of target scores & dates to make these more realistic / achievable;
- Enhancing the Risk Owners' Risk Appetites in line with ICB-ICS Risk Strategy available options;
- Discuss Directorate / Function / Team use of Issues Logs and how it can be used more proactively.

The Committee was concerned it potentially cannot be assured on the management of the 8 / 21 risks. The Governance Team will bring a further update to reassure the Committee once the review is complete, as part of bi-monthly reporting to all Board Assurance Committees in April 2025.

NHSE Investigation & Intervention Regime: Phase 2 Exec Summary Report:

The Committee welcomed the attendance of Deloitte LLP and Kingsgate colleagues, as assigned Auditors for the I&I / Undertakings work (see also ASSURE section for an Undertakings overview).

A report detailing the Phase 2 implementation of rapid cost improvement measures for SSOT ICB-ICS was presented for Committee oversight, notifying Members of the work programme focused on further refining / implementing measures across 4 key workstreams: **Tough Choices, CHC, Workforce, and Productivity**. The Committee wished to alert Board to Deloitte / Kingsgate's Key Observations:

(1) *Significant Savings Opportunities:* identified £41.4 – £72.3 million in potential savings with work underway to deliver these. Savings will primarily be realisable in FY25/26.

(2) *Need for Continued Momentum:* implementation has commenced but maintaining this is crucial to fully realising the benefits - a structured programme will be required to deliver the sizeable benefits.

(3) *Implementation Challenges:* the programme has seen some delay due to the need to secure stakeholder buy-in / engagement. Addressing these will be essential for future phases.

(4) *Mindset Change Required:* a system-wide mindset change, with full recognition, ownership, and engagement from key stakeholders in addressing the financial challenges faced by the ICS.

ALERT (continued)

NHSE Investigation & Intervention Regime: Phase 2 Exec Summary Report:

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

The Audit Committee wished to alert Board to it:

(1) *Having reviewed and endorsed the findings / recommendations outlined in the report;*

(2) *Agreeing on an Action Plan for implementing the recommendations, incl. timelines & responsibilities;*

(3) *Ensuring adequate resources are allocated to support the implementation process;*

(4) *Monitoring progress regularly and holding stakeholders to account for delivering expected outcomes.*

ADVISE

EPRR Annual Report and Policy:

The Committee received positive assurances on the ICB's annual EPRR (Emergency Planning Resilience & Response) Assurance Standards compliance position - the Annual Report - presenting the current position of EPRR priorities for approval, prior to being shared with ICB Board (itself a Standard).

The report demonstrated positive progress against EPRR workstream priorities, including maintained substantial compliance position against the EPRR annual assurance process; excellent engagement in training and exercising across all On-Call Managers; priorities for the year ahead to further enhance organisational / system resilience; alongside an overview of incidents for the 24-25 financial year, demonstrating our ability to respond well to various, multiple incidents across the ICB & System. The report also sets out progress on metrics showing positive Business Continuity management.

The Audit Committee wished to advise Board (who will ratify the same recommendations) to it:

(1) *Having noted the revised EPRR Team structure, and confirming that the ICB has put in place adequate resources to meets its roles and responsibilities with respect to EPRR / Business Continuity planning;*

(2) *Having noted the 2024 EPRR annual assurance compliance rating of substantial compliance;*

(3) *Having noted and supported the EPRR annual assurance 2025-26 priorities as listed;*

(4) *Having recommended for approval for onward presentation to the ICB Board in March 2025.*

Annual Committee Terms of Reference Review:

The Committee approved a number of required changes to the TORs, as follows:

- In light of the Committee's 2024-25 Committee Effectiveness Review outputs (discussed at the January meeting) and referencing a March 2025 Remuneration Committee paper, it is confirmed that all 5 NEMs, once fully recruited to, should be Members of the Audit Committee – with 2/5 set for the quoracy, thus allowing some flexibility in busy NEM diaries.
- To enhance this, the Audit Committee Business Cycle will factor in rolling deep-dives on the NEM Chairs lead Board Assurance Committees, as part of the Audit oversight role, with each NEM (and the Lead Exec for that committee) showcasing their own work programmes and activities.
- A small number of other minor changes were also approved (e.g. removal of a clause about referencing the ICB Meetings Charter that is no longer required for TORs);

Update to ICB Scheme of Financial Delegation (SoFD):

The Committee approved a small number of required changes to the SoFD, as follows:

- Proposed to take effect from 1st April 2025; to account for the impact on the approval process / hierarchy of in-housing the All Age Continuing Care (AACC) service from then. Ref 'Approval of Continuing Healthcare Packages' / 'Personal Health Budgets' / 'Section 117s' and amended financial expenditure levels for certain key AACC personnel.

ADVISE (continued)

Management's Assessment of Going Concern (basis for the Accounts):
During a previous Committee meeting it was requested that further assurances were sought on the ICB's approach to preparing its 2024-25 Annual Accounts on a going concern basis; in light of current year financial performance and future financial sustainability.

The Committee approved that ICB Management has correctly assessed that the ICB is a 'Going Concern' based on the rationale provided to it – after consulting the 2 primary sources of reporting guidance: the DHSC Group Accounting Manual (GAM) for 2024-25 and the Public Sector Financial Reporting Manual (FreM).

Internal Audit Progress Report 2024-25 and Draft Head of Internal Audit Opinion (HOIA):
The Committee received 2 reports from Internal Audit, as part of the Internal Audit Plan, relating to the Financial Efficiency Programme: Reasonable Assurance (x3 Medium priority recommendations and x1 Low); and the System Board Assurance Framework: Reasonable Assurance (x1 Medium, x5 Low).

The debrief report also contained positive assurance about the progress made against the Internal Audit Plan as a whole, and in tracking progress in the implementation of previous Internal Audit actions, where since the last meeting, 3 actions have been closed as implemented and requests received to extend the target dates for 3 further actions – noted and approved by Committee.

The draft HOIA was also received and noted / approved by Committee – providing positive reassurances that the ICB continues to have an "*adequate and effective framework for risk management, governance and internal control; [however work] has identified further enhancements to the framework to ensure it remains adequate and effective*."

As determined by x1 'Substantial Assurance' audits / x4 'Reasonable Assurance' audits conducted this year by RSM, alongside x2 advisory reports. Where RSM have not issued any 'Minimal' or 'Partial' opinion reports in 2024-25 to date; although in the audits shown as providing 'Reasonable' & 'Substantial Assurance', they have identified some areas where enhancements are required and in each of these cases, Management Actions have been agreed, the implementation of which will improve the ICB's Internal Control Environment.

External Audit Plan Proposal 2024-25:
The purpose of this was to provide Committee with the 24-25 Statutory Audit Plan to support the successful submission of the Annual Accounts within the prescribed NHSE deadlines. This audit approach was noted and received (approved) by the Committee and will now form the basis of Grant Thornton LLP interactions on progress against prior year recommendations, materiality assessments and *Value for Money* assessments planned over the coming weeks with lead ICB personnel.

ASSURE

Reviews of Single Tender Waivers (STW) Register and Losses & Special Payments:
The report outlined one new addition STW Register, about which the Committee was assured that the new item logged was in line with process.

There have been no new Special Payments or Losses confirmed in the latest reporting period.

Local Counter Fraud Service (LCFS) Draft Annual Report:
Discussion took place on how the outgoing LCFS provider RSM would liaise with the new, incoming provider MIAA; where the Committee was positively assured by the reported handover plans of both.

The report itself covers the work undertaken by the Counter Fraud Team during the current financial year, from 1st April 2024 to date. Providing details of the key messages and achievements in 2024-25, including a 'Green' Counter Fraud Functional Standard Return (CFFSR) rating, with 4 Local Proactive Exercises completed, 22 fraud alerts shared with ICB staff, and a review of awareness sessions offered to ICB staff.

Alongside receipt of the Fraud Risk Register – detailing all risks that have been reviewed in 2024-25 through LPEs, Internal Audit work and referrals. And an overview of LCFS investigation activity – of all referrals and NHS Counter Fraud Authority Intelligence Reports received; with details of fraud prevention figures and the Use of Resources – a summary of proactive and reactive resources in 2024-25.

ASSURE (continued)

ICB Governance – FOI & SAR Report:
The latest *Freedom of Information (FOI) Update Report* was received and the Committee assured that while there had been a further small number of breaches, due to long-term sickness in the team, some process issues and an increase in the number / complexity of requests, overall ICB compliance was still very positive. The Committee was updated on future work being planned to increase FOI training & awareness for ICB staff, to review the Root Cause factors resulting in breach or near breach; and an ongoing proposal to ICB Management to secure digital support software to further improve compliance.

The Committee was concerned about the significant growth Subject Access Requests, where 71 requests were received in the previous financial year and to date this financial year, the ICB has received 211 requests. The number of have increased exponentially in requests for maternity / birthing notes and GP records / medical records. Whilst the responses can be expedited quickly (as the ICB does not hold such), it is still a significant drain on the resources of the Governance Team workload to manage the statutory requirements pertaining to SAR responses.

The latest *Gifts & Hospitality Register* was presented, and the Committee assured about 1 addition, relating to hospitality received by a GP Clinical Lead working on behalf of the ICB.

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

ICB Governance Implementation Plan Overview:
The Committee received the draft 2025 Governance Implementation Plan as the final stage of the annual 'Governance & Partnerships Review' process. The Plan will help the Governance Team deliver the agreed outputs from the Review and the annual Board Assurance Committee Effectiveness Reviews.

Both have a sub-section with aligned deliverables that schedule the tasks for completion by the end of March. (Although several will be ongoing throughout the year, where these relate to future Board or Committee meetings, agendas, papers). The Committee approved the draft Plan; and was assured that it will ensure the necessary actions are implemented, with periodic updates to be provided on progress.

ICB Undertakings – Lead Committee Overview:
The latest Undertakings Dashboard was presented to assure the Committee; who were reassured by the process deliverables showing either as implemented, or currently well advanced / in train. The Committee also noted that further guidance (in the guise of a side letter) from NHSE had challenged the ICB to show that these analyses in support of the Committee's oversight role, should indicate the 'so what' outcome of a process, not just in creating the process itself. This principle is being factored into the future Undertakings analyses as part of the ongoing, separate ICB-NHSE assurance conversation.

[*Note: as covered in the ALERT section, the Committee received an update from representatives of Deloitte & Kingsgate to discuss the various internal controls going forward for I&I / Undertakings work.*]

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

No SBAF Report: this will be prepared and circulated for April (an offline route is proposed as the April meeting is dedicated to Accounts & Annual Report items).

System & ICB Risk Registers: [*see also ALERT section for more details*]
The Committee received and was assured on the System / ICB Risk Register Reports; while highlighting the static nature of many high-scoring risks and discussing those with no future actions identified.

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

The ***EPRR Policy*** – noted in the ALERT section, which was approved by Members.

Decisions to be Escalated to ICB Board:

- ☑ **To seek Board Ratification** of the Audit Committee-approved EPRR Annual Report + Policy;
- ☑ **To seek Board Ratification** of the Audit Committee-approved TORs;

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure 18

AAA Escalation & Assurance Report from Committees[1]

Report To:	ICB Board
Date:	20th March 2025
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	11th March 2025
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	N Walker, Project Lead (HR & Special Projects)

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

None discussed.

ADVISE

None discussed.

ASSURE

Refreshed Terms of Reference

- The Committee received a refreshed Terms of Reference for discussion and approval.
- The Terms of Reference have been updated following the review of Non-Executive Member roles and responsibilities, during which we identified that the Committee's Terms of Reference required a slight refresh regarding the Committee's role in Non-Executive Member pay and additional allowances.
- The changes provided are consistent with the ICB Constitution paragraph 3.15.2:
- *Remuneration for Non-Executive Members will be set by ICB Remuneration Committee, comprised solely of non-conflicted members added as further members to the committee such that the conflicted individuals could recluse themselves appropriately.*
- The Terms of Reference are also consistent with NHSE Integrated Care Board Chair & Non-Executive Member Pay and Guidance.
- The Committee approved the refreshed Terms of Reference.

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

Nothing to be added.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:
ICB Board are asked to ratify the Remuneration Committee's refreshed terms of reference. Please find the Terms of Reference enclosed.

Staffordshire and Stoke-on-Trent Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board

Remuneration Committee –Terms of Reference

1. Constitution

1.1 The Remuneration Committee (the Committee) is established by the Staffordshire and Stoke on Trent Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 The Remuneration Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. It is chaired by a Non-Executive Board Member other than the Chair or the Chair of the Audit Committee. But Non-Executive Members must recuse themselves where the Committee has been charged with determining the remuneration of Non-Executive Members. It may make decisions itself, rather than only making recommendations to the ICB Board. The remuneration of executives and Non-Executives is determined within national pay frameworks.

1.3 These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.4 The Committee is a subcommittee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Remuneration Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

2.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

3. Purpose

3.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. Please see Appendix 1.

3.1 In summary:

- Confirm the ICB Pay Policy including adoption of any national pay frameworks for all employees outside of Agenda for Change terms and conditions including senior managers/directors (including board members) and Non-Executive Members.

3.2 The Board has also delegated the following functions to the Committee:

This might include functions such as:

- Elements of the nominations and appointments process for Board members;
- Oversight of executive board member performance and appraisal.

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with the Staffordshire and Stoke- on- Trent ICB Constitution.

4.1.2 The Board will appoint the 5 Non-Executive Members as members of the Remuneration Committee.

4.1.3 The Committee will be supported by the Director of Corporate Governance and the Chief People Officer or nominated deputies

4.1.4 The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

4.1.5 When determining the membership of the Committee, active consideration will be made to diversity and equality issues.

4.2 Chair and Vice Chair

- The Chair of the Remuneration Committee will be the Non-Executive Member holding the portfolio
- The Vice-Chair will be Chair of Quality and Safety

4.2.1 In accordance with the constitution, the Committee will be chaired by an independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 Committee members may appoint a Vice Chair from amongst the members.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.3 Non Executive Board Member's Remuneration

4.3.1 The base pay and allowances of Non-Executive Members will be in line with NHSE Integrated Care Board Chair & Non-Executive Member Pay and Guidance.

4.3.2 In line with this Guidance the Chair may wish to exercise their discretion to award additional allowances for those working more than 3 days a month and taking on additional responsibilities. Any allowances made at the discretion of the Chair will be shared with the Remuneration Committee for information.

4.3.3 If a Non-Executive Member remuneration situation arises which requires divergence from the NHSE Integrated Care Board Chair & Non-Executive Member Pay and Guidance, the Remuneration Committee will delegate responsibility to a Remuneration panel consisting of:

- Two Non-Executive Director Chairs of the Board of the main provider partner organisations; one of whom shall assume the position of Chair;
- The Chair of the ICB
- Supported by The Director of Corporate Governance and the Chief People Officer

4.4 Attendees

4.4.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor (Chief People Officer) or their nominated deputy
- ICB Chief Finance Officer or their nominated deputy
- Chief Executive or their nominated deputy
- The ICB Director of Corporate Governance or their nominated deputy

4.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.3.4 No individual should be present during any discussion relating to:

- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

5. Meetings Quoracy and Decisions

5.1 The Committee will meet in private.

5.2 The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.3 The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.5 Quorum

5.5.1 For a meeting to be quorate a minimum of two of the Non-Executive Members **and** one of either the Chair or Vice Chair is required.

5.5.2 If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.5.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.6 Decision making and voting

5.6.1 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

5.6.2 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.6.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.6.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Responsibilities of the Committee

6.1 The Committee's duties are as follows:

6.1.1 For the Chief Executive, Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

6.1.2 For all staff:

- Determine the ICB pay policy (including the adoption of national pay frameworks such as Agenda for Change);
- Oversee contractual arrangements;
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

6.1.3 Possible additional functions that ICBs might choose to include in the scope of the committee include:

- Functions in relation to nomination and appointment of (some or all) Board members;
- Functions in relation to performance review/ oversight for directors/senior managers;
- Succession planning for the Board;

- Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR).
- The Remuneration Committee of the Integrated Care Board will also link with other system partners' Remuneration Committees where there are joint roles or joint transformational responsibilities

6.2 Non-Executive Member's remuneration cannot be determined by the remuneration committee if this committee's membership is entirely Non-Executive Board Members. A separate remuneration panel for Non-Executive remuneration will be convened in these circumstances.

7. Behaviours and Conduct

7.1 Benchmarking and guidance

7.1.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

7.2 ICB values

7.2.1 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

7.2.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2.3 Members of the remuneration committee will be ethical, transparent and act in line with the Nolan Principles.

7.3 Equality diversity and inclusion

7.3.1 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The minutes of the meetings shall be formally recorded by the secretary and a summary of these submitted to the Board.

8.3 The Remuneration Committee will submit a summary report to the Confidential Board following each of its meetings. Where reports identify individuals, they will not be made public and will be presented at part B of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

8.4 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

9. Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

10. Review

10.1 The Committee will review its effectiveness at every meeting as a standing agenda item and at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 21st July 2022

Date of first review: January 2023

Date of last review: 18th April 2024

Date of next review: April 2025

APPENDIX 1

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17-19 of Schedule 1B to the NHS Act 2006, which are set out below.

PART 2 - Further provision about integrated care boards
Paragraph 17

- (1) An integrated care board is a body corporate.
- (2) An integrated care board is not to be regarded
  (a) as a servant or agent of the Crown, or
  (b) as enjoying any status, privilege or immunity of the Crown.
- (3) An integrated care board's property is not to be regarded as property of, or property held on behalf of, the Crown.

Staff
Paragraph 18

- (1) An integrated care board may appoint employees.
- (2) Employees of an integrated care board are to be paid such remuneration and allowances as the board may determine.
- (3) Employees of an integrated care board are to be appointed on such other terms and conditions as the board may determine.
- (4) An integrated care board may pay or make provision for the payment of such pensions, allowances or gratuities as it may determine to or in respect of any person who is or has been an employee of the board.

Paragraph 19

- (1) An integrated care board may make arrangements for a person to be seconded to the board to serve as a member of the board's staff.
- (2) A period of secondment to an integrated care board does not affect the continuity of a person's employment with the employer from whose service the person is seconded.
- (3) In paragraphs 11 and 18 a reference to an employee of an integrated care board includes a person seconded to the board.
- (4) In paragraph 7(2) the reference to an employee of an integrated care board includes any of the following seconded to the board—
  (a) a person employed in the civil service of the State, or
  (b) a person employed by—
  (i) NHS England,
  (ii) an NHS trust established under section 25,
  (iii) an NHS foundation trust,
  (iv) a Special Health Authority performing functions only or mainly in respect of England,
  (v) the Care Quality Commission,
  (vii) the Health Services Safety Investigations Body,
  (viii) the Human Tissue Authority,
  (ix) the Human Fertilisation and Embryology Authority, or

(x) NICE.

- (5) The Secretary of State may by regulations amend this paragraph so as to provide that other references in this Act to an employee of an integrated care board include persons, or persons of a prescribed description, seconded to the board.