NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Thursday 18 April 2024

1.00pm-2.30pm

Via MS Teams

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

	Agenda Item	Lead(s)	Enc.	A/R/S/ D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	1.00pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 15 February 2024 and Matters Arising	Chair	Enc. 03	A		5-19
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		20
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	1.05pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	I	1.10pm	21-28
8.	EPRR Annual Report	PS/KW	Enc. 06	A	1.20pm	29-40
	System Governance and Performance					
9.	Quality and Safety Report • Quality Committee Assurance Report	HJ JS	Enc. 07 Enc. 08	S	1.30pm	41-44 45-47
10.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB/PS MN	Enc. 09 Enc. 10	S	1.40pm	48-59 60-67
11.	Board Assurance Framework	CC	Enc. 11	S	1.50pm	68-97
12.	CHC Proposal	HJ/PEJ	Enc. 12	A	2.00pm	98-112
13.	Operational Planning Update	PB	Enc. 13	S	2.10pm	113-139
	Any other Business					
14.	**Items notified in advance to the Chair**	All		D		
15.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.15pm	
16.	**Meeting Effectiveness**	Chair				
17.	**Close**	Chair			2.30pm	
18.	**Date and Time of Next Meeting** 16 May 2024 at 12.30pm held in Public – MPFT, St Georges, 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**.

NHS
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Stoke-on-Trent
Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2024-2025
INTEGRATED CARE BOARD (ICB)
AS AT 11 APRIL 2024

Kev
Declaration completed for financial year 2023/2024
Declaration for financial year 2023/2024 to be submitted

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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
1st April 2023	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 u11 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2023	Mr	Peter	Axon	CEO ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th April 2023	Mr	Chris	Bird	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim Chief Transformation Officer, NHS Staffordshire & Stoke-on-Trent ICB until 31.07.23. Substantive role - Director of Partnerships, Strategy & Digital , North Staffordshire Combined Healthcare NHS Trust (April 2023 - July 2023)	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (April 2023 - March 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) recorded on conflicts register.
2nd August 2023	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014-March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
26th July 2023	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.	
6th December 2023	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
3rd April 2023	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Charity Trustee of Royal British Legion Industries (RBLI) who are a UK wide charity supporting military veterans, the unemployed and people with disabilities (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
1st April 2023	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st April 2023	Dr	Paddy	Hannigan	Clinical Director for Primary Care	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Salaried GP at Holmcroft Surgery integrated with North Staffordshire Combined Healthcare Trust and contract responsibilities taken over by NSCHT (1st January 2020 - 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.
3rd April 2023	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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
4th May 2023	Mr	Chris	Ibell	Chief Digital Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
12th July 2023	Ms	Mish	Irvine	ICS Director of People	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	1. Trustee (NED) of the YMCA, North Staffordshire (July 2023 - ongoing)	Nothing to declare	(h) recorded on conflicts register.
21st April 2023	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Daughter in law volunteers as a Maternity Champion as part of the SSOT maternity transformation programme (2021 - ongoing) 4. Brother-in-law works for occupational health at UHNM (ongoing) 5. Step-sister employed by MPFT as Staff Nurse (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Local government employee (West Midlands region) and there are no direct or indirect interests that impact on the commissioning arrangements of the ICB (ongoing)	Nothing to declare	Nothing to declare		(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.
19th April 2023	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Renumeration Committee (September 2022 - ongoing)	1. Chair Acton Academy Governing Body, part of North-West Academies Trust (September 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
1st April 2023	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 - ongoing) 2. Membership of the Royal College of Nursing (RCN) (1978 - ongoing) Membership cancelled with effect from 30/11/2022 (declaration to be removed from the register in May 2023)	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing: redeclared 21.11.21)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th October 2022	Mr	Jon	Rouse	Local Authority Partner Member and CEO of Stoke City Council	Stoke-on-Trent City Council	1. Employee of Stoke-on-Trent City Council, local authority may be commissioned by the ICS (June 2021 - ongoing) 2. Director, Stoke-on-Trent Regeneration Ltd, could be a future estates interest (June 2021 - ongoing) 3. Member Strategic Programme Management Group, Staffordshire & Stoke-on-Trent LEP, may have future financial relationship with the ICS (June 2021 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Works shifts on Chebsey ward at MPFT (December 2022 - ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - 06 November 2023) (Declaration to be removed from register May 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th April 2023	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
1st December 2023	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 - ongoing	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - ongoing)	1. Chief Executive Coventry and Rugby GP Alliance (May 2022 - 31st August 2023) (Declaration to be removed from the register February 2024)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
17th May 2023	Mr	Baz	Tameez	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
3rd April 2023	Mr	Paul	Winter	Associate Director of Corporate Governance / ICB Data Protection Officer	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 Meeting HELD IN PUBLIC

Minutes of the Meeting held on Thursday 21 March 2024 12.30 pm - 2.30pm Via MS Teams

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✖	✓
Peter Axon (PA) Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✖	✓	✓	✖	✓	✓	✓	✓	✓
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✖	✓
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✖	✖	✖	✖	✖	✓	✓
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✖	✓	✓	✓	✓	✓
Chris Bird (CB) Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✖	✓
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✖	✓	✓	✖	✓	✓	✓	✓	✓
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✖	✓	✓	✓	✓
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	✓	✖	A	✖	✖	✖	✓	✓	✓	✖
John Henderson (JH) Chief Executive, Staffordshire County Council		✖	✖	✓								
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	✓	✓	✓	✓	✓	✖	✓	✓
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council					A	✓	✓	✖	✓	✓	✓	✖
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✖	✓	✓	✓	✖	✓	✓	✓	✓	✓
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands NHS Trust		✓	✖	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	✖	✖	✓	✓	✖	✖	✓	✓	✓	✖
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✖	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participant Members:												
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓	✖	✓	✖	✓	✖	✓
Baz Tameez (BT), Support Staffordshire		✖	✓	✓	✖	✖	✓	✖	✓	✓	✓	✓

Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alex Brett (AB) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✖						
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✖	✓	✓	✓	✓	✓	✓	✓	✓
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✖	✓	✓	✓	✓	✓	✓	✓	✓	✖	✓
Steve Grange (SG), Midlands Partnership University NHS Foundation Trust		✓	✓	✖	✓	✖	✖	✖	✖	✖	✖	✓
Helen Ashley (HA), University Hospitals of North Midlands NHS Trust			✓	✖	✖	✓	✖	✖	✖	✖	✖	✖
Claire Cotton (CC), University Hospitals of North Midlands NHS Trust		✓	✓	✖	✓	✓	✖	✖	✖	✖	✓	✖
Lynn Tolley (LT) Acting Chief Nurse and Therapies Officer, Staffordshire & Stoke-on-Trent ICB						✓	✓	✓	✓	✖	✖	✖
Richard Harling (RH) Staffordshire County Council								✓	✖	✖	✖	✖
Chris Sands (CS), Chief Finance Officer, Midlands Partnership University NHS Foundation Trust				✓				✓	✖	✖	✖	✖
Helen Dempsey (HD) Director of Finance & Performance, Staffordshire & Stoke-on-Trent ICB				✓					✖	✖	✖	✖
Mish Irvine, Chief People Officer, Staffordshire & Stoke-on-Trent ICB (People Directorate, Midlands Partnership University NHS Foundation Trust)				✓	✖	✖	✓	✓	✓	✓	✓	✖
Karen Webb (KWe), Deputy SRO Learning Disability and Autism, Staffordshire & Stoke-on-Trent ICB					✓						✖	✖
Katie Weston (KW), EPRR Strategic Lead, Staffordshire & Stoke-on-Trent ICB					✓						✖	✖
Jacqui Charlesworth, Deputy Finance Director, Staffordshire & Stoke-on-Trent ICB							✓	✓	✖		✖	✖
Rachel Gallyot, Staffordshire & Stoke-on-Trent ICB							✓				✖	✖
Becky Scullion, Director of Nursing Staffordshire & Stoke-on-Trent ICB										✓	✖	✖
Nicola Bromage, Staffordshire & Stoke-on-Trent ICB											✓	✖
Hayley Allison, Staffordshire & Stoke-on-Trent ICB											✓	✖
Neelam Bhardwaja, Stoke-on-Trent City Council												✓
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✖	✓	✓	✓	✓	✓	✓	✓

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting. DP advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP reminded member of the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and it guided the way they conducted business and he would return to that at the end of the meeting It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Neil Carr (Steve Grange attending) Pat Flaherty (Neelam Bhadwaja attending) and Jon Rouse.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 15 February 2024**	

	The minutes of the meeting held on 15 February 2024 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED** with the following amendments:- • DP was not in attendance at the March meeting • Remove "Interim" from BA's title • The meeting was chaired by JHo.	
5.	**Action Log**	
	There were no actions to review.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	Ian Syme 1**. Acute Care At Home (AC@H)** Mention is made in the 'Finance and Performance Committee Escalation Report' of workforce fragility within AC@H. I understand from NHS Board papers that AC@H has a 33% vacancy level at present. Any service having to carry that level of vacancies even with maybe bank workforce input most certainly cannot deliver envisaged services at requisite levels and will at the very minimum be overstretched. There are abundant examples nationally in the past that the quality and safety of overstretched services can deteriorate rapidly. (i) Given the above is there now enhanced monitoring of AC@H service very specifically as to the quality safety and expected outcomes for patients? If so could a flavour of such enhanced monitoring be given? (ii) What mitigations are being actioned to reduce what is a serious vacancy level within the AC@H service and provision? **Response:** *PS had previously briefed the Board on operational challenges. He stressed that the service is highly regarded regionally and recognised nationally, and they had dealt with the second highest numbers of calls from the ambulance service.* *Enhanced monitoring – a process for monitoring incidents, a new associate director role over the service, clinical framework excellence review has been taken by UHNM. We have an acute care at home board which has oversight of the overall system. There has been a specific* *Put in place over winter to reduce the gap is the dedicated support from people hub to support mutual aid across the system. Also agency staff support. Also had GP fed support for elements of the service delivery as well. MI added lot of work being done and there has been an improvement this month. We have the ICS people team supporting and got a regular baking pool. The service has also established workforce working group working on an action plan on how to attract and retain our workforce*. **2. Joint Forward Plan:** **Dentistry**: It would seem that despite ring fencing Staffordshire and Stoke-on Trent ICB Dental budget will be £9.9mill underspent 2023/24 which equates to a 14.9% underspend of the ICBs approx. £83mill dental budget. The dental underspend for all West Midlands ICBs 2023/24 is around £50mill.	

	The recently published Dental Recovery Plan (DRP) is very specific in that it will 'apply a firmer ringfence on NHS dentistry budgets for 2024 to 2025 so individual ICBs can seek to improve dental access'. The DRP also highlights the guidance to support Flexible Local Commissioning that was issued October 9th 2023. Mention within the ICBs Joint Forward Plan in today's ICB paper seems to imply a West Midlands Dental Strategy. (i) If there is to be a West Midlands Dental Strategy how can it be assured that such is NOT a 'One Size Fits All Strategy' and that individual ICBs enhanced ring fenced budgets maintain enough flexibility in their Dental Commissioning to address their specific populations needs? ***Response*:** *There is a national Dental Strategy and there will be a West Midlands Dental Strategy produced shortly. We will be using these, alongside the SSoT health equity audit which is imminently available and being done for every system, to develop a local implementation plan for our system. This will take into consideration the national dental recovery plan expectations and maximising opportunities. We recognise that that there is a clear national directive that there is a hard ring fence on dental budgets this year and we will work very closely with NHSE to obtain maximum flexibility with our budgets aligned to our local implementation plan.* (ii) Given the significant discrepancy in being able to access NHS Dentistry even within the ICS/ICB area how will the ICB publicly report its progress in eroding inequitable access to dental services in the ICS/ICB catchment area? ***Response:*** *Our local implementation plan will use the health equity audit to identify and set out plans to address inequitable access where possible. We will bring the plan through ICB board when this is available and we have committed to developing this in the first quarter of the financial year (Q1 24/25)*	
7.	**ICB Chair and Chief Executive Update**	
	DP referred to section 6.1 in the report and wished to confirm publicly that Heather Johnstone, Chief Nursing and Therapies Officer was back from her sickness leave and thanked Lynn Tolley and Becky Scullion who stepped up to cover while she was off. DP mentioned that David Rogers, Chair at NSCHT was stepping down and thanked him for all he had done to help to build a system wide approach during his time. DP mentioned that this was the last Board meeting for Dr Paddy Hannigan who was retiring. He had been a GP in the Stafford and surrounding areas for over 30 years and surrounding areas. Since 2013 he had a clinical Chair role in the CCG. So with over a decade he had played a clinical leader in the system, particularly for the covid vaccination and flu vaccination programmes. DP announced that on behalf of himself, the Board and the wider system, he thanked him for the leadership he had brought and the fact that he was not always seeking recognition for the impact it had made. He wished him all the best in his retirement. PH thanked DP for his kind words and stated that it had been a short 30 years and which had flown by. PA seconded the praise given to both David and Paddy. The words that came to mind for Paddy were professionalism and statesman. PA advised that the health inequalities item was very important given the pressure all systems were under. He added that they held a conference on Health Inequalities and	

	from that, they were finalising the Inequalities Strategy that would come to Board in due course. PA mentioned that, later on the agenda, they had the planning item for 2024/25; the progress they were making was gradual, but was challenging in terms of a finance and workforce point of view and making it all balance. He stated that it was a marathon not a sprint. However, he did state that they needed to acknowledge that they were taking on the legacy challenges that had been inherited from previous organisations. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
8.	**NHSE Specialised Service Delegation**	
	CB advised that NHS national policy required ICBs to work in collaboration with NHS England and other relevant partners regarding Specialised Services. The proposed delegation was a matter for each statutory ICB Board and would transfer the commissioning and monitoring of 59 specialised services to the ICB. CB added that the delegation would benefit the care provided to patients across care pathways, improve access and reduce inequalities by aligning commissioning responsibility to ICBs and enabling a whole population approach. Due diligence was set out in the report which had been completed to support the proposals and in particular amplified aspects of quality, finance and resources that were required to support a safe transition. ICBs across the Midlands have been working in partnership with NHS England to co-design an architecture to support delegation and continue to enable joint working on other retained services. CB advised that the Delegation Agreement was a nationally mandated document setting out the formal requirements of delegation which the ICB Board was invited to consider. The report concluded by describing the future governance arrangements via a Joint Committee together with topic specific sub-groups focussing on finance, quality and commissioning. CB confirmed that the Board was invited to review and approved the Delegation Agreement at today's meeting. He added that they would continue to work with NHSE on the next wave of delegations which were due to go live in 2025. DP thanked CB for identifying the link of our structure within our own ICB and asked if they were planning to review the committee structures to ensure that governance arrangements were in place. CB confirmed that on the terms of reference, they were involved and managing the opportunities. CB added that they were inviting the Board to consider the proposals around the delegations today and assured the Board that their scope in terms of governance was in place. CB also referenced that they were considering the TOR of the governance review which may impact on how they reflect on the governance arrangements in 2024/25. DP asked who was responsible for monitoring the risks on indemnity and liability. CB confirmed that there were some changes to the ICB scheme of delegations. He added that given the nature of the NHSE commissioning team, the collaboration agreement described how it would be routed through NHSE staff where appropriate. He stated that they would also include a review of specialised commissioning arrangements. JHo asked that when they look at TOR, to ensure that they did not forget the Audit Committee. She also asked for clarity that when they were allocated funding, was this over and above the normal allocations and she wanted to be clear on the scope in creating different ways of working for individual trusts and organisations. CB confirmed that they wanted to work with all the Chairs of all the committees and also at the point of the delegation, to enable visibility with a view that ICBs would bring forward pathway redesign to improve the way services were delivered. He added that NHSE had put some safeguards in with the ICB working separately with neighbouring systems.	

	SG stated that there was a lot happening here. The paper described some of the functions, but it would be helpful that some of mental health elements were at population level and in the context of the other stages of work. CB confirmed that was pertinent for the next wave of delegations, as they would bring in those areas of mental health. PB stated that a lot of the expenditure was sitting on the books of the Trusts which was linked this to the planning for next year. He added that there was a reasonable chance that the financial risk would be neutral and it was nationally agreed that the West Midlands would be one of the pilot regions and if there was any unexpected risk, we would be shielded. Financially it made sense to do this now and work closely with our providers where the majority of the spend sat. MN stated that it was important to note there were some difficult decisions ahead as well. CB responded that the nature of specialised provision would mean there needed to be a balance with access and specialisms at risk and there would be a degree of activity for come clinicians to maintain that level of specialism and their clinical competence. He added that they had a degree of services that were at risk as they did not have enough clinicians around those services. TS stated that from a member of public or patient perspective who did not see who bought their services, they just see their services being received. It was important that they involved the public and they had an opportunity to seek more from what the public want, which was better for them. The Staffordshire & Stoke-on-Trent ICB Board **APPROVED**:- • the delegation of the defined set of 59 specialised acute services to the ICB from 1st April 2024 • to delegate the final signature of the national Delegation Agreement to the Chair and Chief Executive of the ICB in the context of the collective ICB position across the Midlands region	
9.	**Joint Forward Plan**	
	CB thanked the planning team over the past months to get to this point with the Joint Forward Plan (JFP). He explained that the JFP 2024-2025 Update draft document followed on from the first JFP published in June 2023 and the expectation was that the plan would be refreshed yearly and published. CB reported that the National guidance published in December 2023 outlined that systems continue to have the same level of flexibility to determine how the JFP was developed and structured. However, the guidance and supporting materials indicated that they should pay particular attention to some of the statutory duties e.g. financial duties, duty to improve quality, as well as broader updates on areas such as workforce. The role of NHSE was outlined in the guidance as “providing support and guidance on the revision of the JFP” and to “review and comment on updated draft JFPs”. There was no formal assurance required from NHSE on the plan. CB advised that with the level of work and depth of detail outlined in the first JFP, they had chosen to develop an update which built on the ambitions set out in that plan. This update recognised progress over recent months and reflected the areas outlined in the national guidance. CB added that their long-term priorities had remained unchanged from the 2023/28 JFP and the updated plan was intended to be read as a companion piece to the full JFP. CB explained that they had updated on the challenges, the ongoing development of our Operating Model including the developing Communities Approach to Improving Health and Wellbeing Outcomes, prevention and targeting Health Inequalities. After the JFP was published some key national guidance and documents were published	

	and the local response to those was reflected in the update including the Delivery Plan for Recovering Access to Primary Care, delegation of key services from NHS England and the NHS Long Term Workforce Plan. CB pointed out that key additions had been made including updates around some of ICB statutory duties e.g., quality and finance, more detail on developing the wider infrastructure around Estates, Digital and Delivering a Net Zero NHS. The content had been developed with the full engagement and input of relevant leads from Staffordshire County Council and Stoke-on-Trent City Council. The approach to developing the JFP was discussed at the Stoke-on-Trent Health and Wellbeing Board (HWB) Development Session and the Staffordshire Health and Wellbeing Board. The JFP would be circulated to the Staffordshire Health and Wellbeing members after the ICB Board for final agreement, with the Chair having delegated authority to endorse the JFP and provide the statement of support on behalf of the HWB. CB confirmed that the JFP would be presented to the Stoke-on-Trent Health and Wellbeing Board on 27th March and to request the signed statement of support from the HWB. CB added that the approach to developing the JFP was also discussed with NHSE and a draft of the JFP was shared on 4th March. They gave positive feedback on the ICB's openness, good engagement and constructive collaboration with the regional team. However, areas where they felt the JFP could be strengthened have been addressed but they were minor changes rather than wholesale change. He added that other feedback received already from our Local Authorities and other system partners had also been addressed where appropriate. CB reiterated that the publication of this JFP update for Year 2 (2024/2025), was just the continuation of their journey and they would continue to hold conversations with local partners, people and communities to inform future iterations of the plan. PA thanked everyone who had contributed to the development of the plan. He stated that it spanned the distance between the ICP and the in-year delivery document. PA referred to the piece around community transformation which was articulated within mental health and LDA arena and stated that this was a big opportunity over the next couple of years. SG commented that the JFP captured the vision and commitment to the population and offered his services to do a second read across the provider plans, so that all providers could have co-ownership across their strategic plans. JHo agreed that a read across would be helpful, but also reiterated the challenging nature of the finances over the next 12 months. She also agreed that it was a big opportunity and it was realistic to publish. MN added that it was a well written document but reiterated on the section about the finances and the how that would impact on the rest of the ICB ambitions. CB stated that they were required to publish by the end of March and he and PB would give some thought around recovery and delivery of the transformation within the JFP as they needed to be able to do both recovery and bring forward opportunities. The Staffordshire & Stoke-on-Trent ICB Board:- • **NOTED** the development of the final draft of the Joint Forward Plan, with the caveat that a fully designed document will be developed for the 6 April publication date with the caveat that that the final would be by 6 April. • **AGREED** delegated approval to the ICB Chairman, David Pearson and ICB Chief Executive Officer, Peter Axon for sign-off by allowing for any final feedback from the Health and Wellbeing Boards	
10.	**Intelligence Strategy**	

	CI acknowledged the work that Colin Fynn had done over the last the months on the Intelligence Strategy. CI explained that the strategy set out the vision of where they wanted data, business intelligence infrastructure and capability to be in order to support delivery of the ambitions set out in the Integrated Care Strategy and Joint Forward Plan. In order to start realising the benefits of operating as a system they needed to effectively use their combined data and intelligence to enhance the care of the service user, improve the efficiencies of the system, predict and create interventions for Population Health Management and innovate new ways of improving health and care. Utilising data meant effective data-management, appropriate data sharing governance, robust digital infrastructure, digital skills pathways and a shared operational framework. The data and intelligence strategy set out the national and local drivers for change, the goals and benefits of implementing the strategy and how they had worked with system partners to develop the strategy. The five main local goals and benefits of delivering the strategy cover: 1. Creating a data centric culture and workforce 2. A unified data warehouse 3. Governance and information governance processes 4. Intuitive reporting and Insight 5. A virtual ICS-wide intelligence function CI reported that they had followed an iterative development process to continuously collate feedback and refine ambitions to ensure the strategy represented and was accepted by leaders across the ICS. The ICB had co-ordinated engagement with the wider NHS Intelligence Community throughout development of the strategy and they had undertaken direct engagement with stakeholders and NHSE Regional Leads. CI added that as it progressed through delivery and implementation, the strategy would be supported by a range of discussion papers to ensure that work across the digital, intelligence and population health management work programmes of the ICS did not sit in isolation of each other. CI explained that the next steps for the strategy would include:- • Prioritising a Programme Manager, allocated by the Digital Team, to develop an incremental, multi-year delivery and transformation plan by end-H1 2024/25 • As with the Intelligence Strategy, continue to ensure alignment with all the key stakeholders across the system/providers/region to support the design and delivery of key workstreams • Define a detailed roadmap outlining milestones, deliverables, dependencies, and timelines against which progress can be tracked MN supported the proposal and asked if they were moving fast enough to deliver on the ambitions they had. CI confirmed that they could move at a greater pace as the informatics structure was already in situ. However, they needed to free up assets and be optimistic that they could make good headway. SL supported the proposal and felt it was about driving through significant changes which linked to the point MN made, particularly with scarce resources. His concern was regarding the people at the other end once that data was there, how that data was produced and having the data in a way which it could be easily interpreted in a plain English way. He asked if the resources were right there to carry this forward and also have the resources at the other end to interpret the data. CI responded that they needed to be able to get to a point to embed the use of analytics within their day-to-day processes so that as and when people were engaging patients in their care they	

	would be using information and making decisions based on that evidence and it would be done in a simple way. PA asked if they were going far enough in terms of the combined opportunity on virtual ICS wide intelligence systems. CI agreed that would be something that they would have to discuss and it would require the buy in of sovereign organisations. PH stated that this was important piece of work and it was also important to recognise culture around the use of data and it was quite a challenge in the way they had used data in the past. He felt there was a lot of work to do with clinicians on how they change that culture on the use of data and how they move forward with that. They needed to ensure they brought those two together and not let them go on parallel tracks. CI agreed that it would not be driven solely on a digital and technology perspective, it had to be hand in hand with clinicians. CI confirmed that it was evolving and there was a significant business change element that they needed to go through. The Staffordshire & Stoke-on-Trent ICB Board **APPROVED** the implementation of the ICS Data & Intelligence Strategy.	
11.	**Quality and Safety Report**	
	HJ took the report as read, but highlighted the following:- HJ gave some positive news regarding the application and progress in relation to continuing healthcare which was working well and they had seen a number of notable improvement over the last few months on the patient experience and journey. The Risk Register was reviewed in detail and they added a new risk in relation to surgical termination of pregnancy services on the back of an unexpected closure of service in Stafford and Stoke-on-Trent. Maternity LMNS – Good progress had been made in response to CQC improvement actions, including reducing vacancies and training compliance. Induction of Labour breaches had reduced following the re-opening of the Transitional Care Unit at Royal Stoke University Hospital, resulting in increased bed capacity and the ability to admit women the night before. The assurance process had been revised to support focussed discussions with UHNM midwives at the Quality and Safety Overview Forum meeting. WMAS had now received their CQC report and had been rated as good overall and continue to be rated as outstanding for caring. The Staffordshire & Stoke-on-Trent ICB Board: • **RECEIVED** the report and sought clarification and further action as appropriate • **WERE ASSURED** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System**.** • **RATIFIED** the decisions of the Quality and Safety Committee with regards to the Quality Impact Assessment Policy update	
12.	**Finance and Performance Report**	
	Finance PB noted the good performance in Primary Care and Maternity and the improvements made in end of life in terms of the number of people who die where they wanted to. PB gave an overview on the finances at Month 9 which was forecasting a year end deficit of £91.4m which was in line with the plan agreed with NHSE. He added that all	

	of the deficit sat with the ICB, but they would be working closely across the system to manage the costs and they were still on track to delivery that. **Performance** PS reported that the for latest reporting week, Category 2 ambulance response times had improved to 30 minutes which was within the national target. The Board were aware of the national ask in 4 hour improvements in emergency departments during March. Previously they were running at 63% and had now seen an improvement to just over 69%. PS reported that they had made decision to maintain all surge capacity beyond the Easter period but were developing a de-escalation plan and capacity plan for the year ahead to match the curve that was expected. During April they were also having system learning events reflecting on winter as they had done previously and those findings would be presented through to FPC. Urgent care – subject to a national UEC board assurances in terms of how the System Coordination Centre operated, they had just been notified that they had been award 100% compliance. With regard to the Ambulance service and the CQC report, he stated that there would be an independent review carried out in terms of demand and capacity for ambulance services across the whole WMAS footprint. Planned Care – the recovery of 78 week waits has been challenging because they had further industrial action during February, but they were looking to eliminate 78 week waits by the end of April. PS reported that they were now within their tolerance for backlog clearance for cancer patients for the year, which was a real improvement and had seen it reduced from over 500 last summer to 240 now. MN confirmed that FPC had a good conversation around system planning and ensuring that sufficient resource was aligned to recovery. MN also highlighted some positive news on medicines optimisation work which was forecast to deliver between £4.2 and £6m costs savings for 2023/24. The Staffordshire & Stoke-on-Trent ICB Board • **NOTED** the headlines, escalation and exceptions highlighted • **NOTED** the year-to-date deficit position and efficiency delivery. • **TOOK ASSURANCE** from the conversations taken at F&P Committee.	
13.	**2024/25 Planning**	
	PB reported that they submitted their first operational plan flash submission to NHSE on 27th February which focused on operational performance measures for urgent and elective care, the overall NHS system financial position and headline data around workforce. He confirmed that the operational plan submission guidance, technical and narrative had not been published by NHSE and the next operational plan submission was 21st March 2024. Since the 24th January system event, they had progressed the recovery plan through discussions across a wide range of system leaders. System Directors of Strategy had set out the approach to defining our plans and they had agreed the six system	

	collaboratives for recovery, identified SRO's and started to scope the outcomes and projects to deliver the outcomes. **Finance Submission** PB reported that, at the end of February, a submission was made for a system deficit of £179m which was masked by significant use of money from the balance sheet The System agreed CIP efficiency targets of 3.44%. However, the centre felt that was not an acceptable plan to get to break even. Yesterday, they had a further challenge from NHSE and were asked to do better, but there was some positive feedback that all of the organisations were joined up and working well together. PB reiterated that they still had a lot of work to do. **Workforce** MI stated that the position was collaboration and each organisation were clear that patient safety was paramount. She advised that they were putting in a submission today as a draft and would continue to work collaboratively to see how they could safety reduce the workforce where appropriate. She stated they were complex from a workforce position but they were they were transparent and learning from each where they could, to make sure that they have all the grip and control in place to get to a better position. **Performance** PS advised that, for the submission today, they would be showing their intention to meet the improved ED target to meet the cancer 62 day standard. They have done significant work in terms of activity and long waits and will be indicating that by September 2024 that they could clear all 65 ww which would include taking advantage of productivity opportunities. However, he reiterated that the only risk was that there would be continued IA over the next 6 months. PS stated that it was a good plan operationally that was well triangulated across the system with finance and workforce. PB confirmed that they were developing the shape of the recovery plan which was looking good and it would build on the learning from the current year. He added that the Provider Collaborative was the mechanism in which they would deliver the whole pathway improvement. PB confirmed that they would ensure that they needed to look at the future and improve services that would make a difference down the line. PB explained that they needed to do things at pace and deliver improvements. They have been working on six improvements over the last few weeks:- Continuing Health Care (CHC) – an established system collaborative already and would continue to take that forward. Children and Young People (CYP) - needs to be given full prominence Over 65s – putting in a single point of access and reduce the number of patients that go into the secondary care sector. Back office – working collectively across the system rather than working in silos. Medicines and clinical value – putting clinicians in a place where they could collectively look at the types of services we provide and put them through a test to see which ones had most value. Contracts – The system spends £175m on contracts outside of the NHS, many of which could be in housed. PB reiterated that they did not think it was possible to get to balanced position in-year. JHo commented that this was a good model which had been proven on the collaboration on CHC. She stated that was a lot of work and asked if there was the	

	capacity and workforce to work on those at the same time. PB confirmed that they were working through that and would come back to the Board with a precise proposal in due course. The Staffordshire & Stoke-on-Trent ICB Board:- • **NOTED** the operational plan flash submission • **NOTED** the timeline for our first operational plan submission • **NOTED** the progress made around the recovery plan • **NOTED** the wider high level planning timeline	
14.	**ICB Budget Setting**	
	PB advised that the draft planning guidance inclusive of allocations on the 16th February 2024 and they were confident to recommend an interim budget to the Board so the organisation could fulfil the ICB's statutory duty of having a budget in place from the 1st April 2024 NHSE guidance stated that "the achievement of financial balance, while maintaining the quality of healthcare provision, was a legal requirement for all systems. The organisations within each system had a duty to co-operate in the delivery of system objectives. Further, when a system overspends against its allocation for the year, spending must be restricted elsewhere to make sure that overall the NHS remains within its spending limits". PB explained that as a result of the proposed (£179.0m) deficit system financial plan in 2024/25 of which the ICB contributed (£48.6m), it was a statutory duty to break even that we were not meeting. Therefore they did not have the authority to spend more than the allocation, at this stage they required approval so that spending could continue in April. Following the formal draft submission on the 22nd March it was expected that NHSE would require the system to operate within a more stringent control environment. The ICB fully expected the level of deficit to be heavily challenged by external stakeholders and further regulatory action had commenced and therefore this initial budget was subject to change. PB added that System provider contracts had been set following the IFPS methodology and principles which have been established for a number of years. The system agreed on an interim basis to redistribute the underlying deficit equally across the system during the planning process. The internal efficiency target was set at 3.44%/£57.3m of the ICB's cost base following the agreement by System CFOs, a 5.3% efficiency of controllable expenditure. The principles and draft targets had been signed off by budget managers and approved by the Finance & Performance Committee. The efficiency target would be subject to a further stretch target following further regulatory action. As well as informing the Board of the draft plan submission to NHSE on the 22nd March, ratification from the Board was sought for the 2024/25 Budget following approval and recommendation by the Finance and Performance Committee, recognising that this was indicative and subject to change in line with the submission of the final plan at the end of April 2024. The Staffordshire & Stoke-on-Trent ICB Board • **APPROVED** – the provisional budget to be set based on the submitted financial plan of a (£48.6m) deficit, recognising that this is subject to change following enhanced regulatory scrutiny following the 22nd March submission.	

	• **APPROVED** – Purchase orders to be raised aligned to the draft budgets set out within this paper	
15.	**People Culture and Inclusion Report**	
	MI advised that over the past 12 months, in line with the workforce plan, there had been a growth in substantive workforce in our System which had a positive impact on care quality, morale and use of temporary high cost workforce. The National Long Term Workforce plan outlined a significant increase in workforce numbers required in 15 years to ensure safe staffing levels. However, the financial challenge our System required the ICB to carefully consider the workforce models that were implemented to ensure maximum productivity was achieved by flexible teams doing tasks that were appropriate to their competency level. They would continue to innovate and create new roles to support the skill mix which drew on the wider community by being inclusive and retain their valuable existing highly skilled workforce. The following areas were detailed in the report: - Current workforce position - Operational Workforce Plan - People risks - People Programme priorities - People, Culture and Inclusion Programme delivery JHo mentioned that the PCI Committee did acknowledge the sudden passing of Paul Draycott. They also agreed to the strengthening of governance between the committee and the People Collaborative and there was an excellent discussion around inclusivity and the Too Hot to Handle report. JHo asked that Board keep a focus on inclusivity together with quality and finance. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the reports.	
16.	**ICB Constitutional changes required by NHSE**	
	TS advised that NHSE had asked ICBs to make amendments to their Constitutions at the next opportunity and the Board were asked to review and agree to the amendments for changes to the Constitution; and to note the suggested process for confirming their approval by NHSE. The Staffordshire & Stoke-on-Trent ICB Board **APPROVED** that: • **ALL** the mandated NHSE changes are made forthwith to the Staffordshire & Stoke-on-Trent ICB Constitution, as outlined in Section 2.3 of the Briefing Note; • A letter from the ICB Chair is then sent, alongside the updated Constitution (enacting the above), to the NHS Regional Director	
17.	**Freedom to Speak Up (FTSU) Report**	
	TS explained that the FTSU report detailed the key activities that the Guardians had undertaken during August 2023 to date and there was also a copy of the workplan which set out core activities to be undertaken during the coming year. The Guardians have had regular catch-up meetings with the Chief Executive, Director of Governance, Non-Executive Director and also link in with HR. TS added that a three year strategy was being developed which would be presented to Execs, the People, Culture and Inclusion Committee and the Board when finalised.	

	The report also sets out the numbers of contacts the Guardians had received, along with outcomes. TS thanked Shabana Mahmoud and Tracey Revill for their work on the report. MN commented that the authors should be noted down with their titles as FTSU Guardians and she felt it would be helpful to see more details on the contacts made from GP practices. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the paper was presented for information.	
18.	**Committee Assurance Reports**	
	Audit Committee The report was taken as read with no further questions. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the reports.	
19.	**Any Other Business**	
	No other items of business raised.	
20.	**Questions from the floor relating to the discussion at the meeting**	
	Ian Syme In the Spec comm presentation there was mentioned of a West Midlands pilot – is there a timeframe for that as he had helped someone go through a process of appealing rejection of access to a specialised service with an individual funding request and ended up in the Supreme Court. What is the situation with regard to exceptionality individual funding requests and does it sit with the ICB or wit the West Midlands Pilot. ***Response**:* *CB confirmed that the IFRs were set out in the Collaboration Agreement and he agreed to email Mr Syme separately on that.* *CB clarified the language with regard to the pilot and explained that the delegation proposals that the board considered earlier were not a pilot, they were for the transfer of delegated commissioning responsibility to the ICB from April 2024. CB referred to Section 14 of the Delegation Agreement which confirmed that IFR would be retained by NHSE and the ICB would support that process.* Maternity services have improved considerably at Royal Stoke. What is the situation at Queen's Hospital Burton as there are Staffordshire women who use that hospital. ***Response**:* *HJ responded that they work closely with the UHDB maternity cell and she would be more than happy to have a more detailed conversation offline. She assured the board that they work closely with both UHDB and Derbyshire ICB to ensure that patients from Burton and Staffordshire as a whole get a high level of care.* **Amanda Griss** I understand the contract to Opcare for recommissioning of the orthotic service to one single provider, is worth £13 million. How much money has this saved you compared to previously using 3 providers for South Staffs, Stafford & Stoke-on-Trent? Why has the orthotic service previously provided by the three NHS providers for, now been recommissioned to a private company?	

	***Response**: PS stated that he did not have all the contract detail to hand, but confirmed that they went through a full procurement process last year. Opcare were previously the provider in the North and would now also be the provider in the south east and south west. PS agreed to confirm offline more of the detail.* When start reconsulting with patients and *public on the recommissioning of services?* ***Response**: TS confirmed that the ICB has an ongoing responsibility to work with all patients and members of public. If there was any issue in respect of a single contract, then they would respond to that offline.* **David Jones** In the 1960's at the North Staffs Royal Infirmary a project got underway to provide what we could call 'computerise health care based on a National vision of electronic integration; or using today's terminology this could be an 'intelligence strategy'. After 60+ years we have a lot of tools but no comprehensive electronic integration. I don't see this changing … as our aspirations and emerging technologies change, we ought to be investing as much as possible in applications of systems which provide direct patient benefit (you may even call this piecemeal application) and, yet, make sure that these appropriately integrate as necessary based on technology, etc available at the time. All I ask is that, when the ICB is looking at the emerging Intelligence Strategy, they bear in mind the history and these points. ***Response**: CI confirmed that the product itself was called "patients know best" – which provides much improved interaction from residents with their health care information. He added that there are significant improvement and the point made around integration are very important, but equally there were hundreds of IT systems and they were working actively to try to simplify that and reduce that down to make it more accessible for patients.* The were no further questions received from the floor.	
21.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact.	
22.	**Close**	
	There being no further business, the Chair closed the meeting.	
23.	**Date and time of Next Meeting**	
	18 April 2024 at 1.00pm held in Public – via MS Teams	

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

Date of Meeting 18/04/2024

Open Actions

Reference Number	Meeting Date	Agenda Item	Agenda No	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
				THERE WERE NO ACTIONS FROM THE MEETING HELD ON 21 MARCH 2024			

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

(1) Purpose of the Paper:

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

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

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

7.0 Vaccinations

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
N/A	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions

CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	N/A for the report
Workforce or Training	N/A – no specific training implications; workforce matters are inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

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

1.0 System and general update

1.1 Primary Care

93 practices have signed up to the Modern General Practice Transition Funding. This funding is available to support the aims of the Recovering Access to General Practice Delivery Plan and tackle the 8am rush. It will support patients to know on the day they contact their practice, how their request will be managed.

The PCN Network DES for 2024/25 has been released and shared with PCNs and General Practice.

GP registration service target reached and exceeded – 69 (48%) practices signed up

Primary Care Winter Programme – activity delivered between 4/12/23 and 24/3/24:

Multi-Disciplinary winter hubs

Target: 41,664
Actual: 41,899
Average utilisation: 86%
DNA rate: 6%

Practice level additional appointments

Target: 40,730
Actual: 38,376*
DNA rate: 3%
*There is a lag in practice reporting, therefore this figure is expected to increase

1.2 NHS England Specialised Services Delegation 2024/24 and 2025/26

At the meeting of the Integrated Care Board (ICB) Board on 21 March 2024, the Board approved a recommendation to 'approve the delegation of 59 specialised acute services to the ICB from 1 April 2024'. This decision was made on an in-principle basis pending confirmation of the collective ICB position across the Midlands.

All 11 ICB Boards across the Midlands region have approved the delegations. On that basis, the Delegation Agreement has been signed and returned to NHS England.

The delegations came into force on 1 April 2024 and the ICB is now responsible for the commissioning of these additional services. The arrangements articulated in the Collaborative Agreement and Operating Framework, previously shared with ICB Board members, will now apply.

Looking forward, the NHS England Board, at their meeting on 28 March 2024, have approved a final list of services that are considered suitable and ready for delegation from April 2025. This represents a further 25 service lines including children and young people's inpatient mental health services, eating disorder services and adult secure mental health services in addition to a further range of specialist acute services. As we move through 2024/25, the ICB will work collaboratively with relevant provider colleagues to establish appropriate transition plans building on the arrangements established through the Agreement and Frameworks agreed for 2024/25.

1.3 Fit and Proper Person Test

Our response to the mandatory requirements for ICBs regarding the "Fit and Proper Person Test": FPPT is currently being finalised for our ICB Leadership and Board. The ICB's Governance and HR Teams have created a new Standard Operating Procedure to help ensure that the new regime is applied appropriately across our Leadership tiers. With identified process steps outlined for both Teams and utilising the support of MLCSU colleagues.

This will help us embed a smooth application of FPPT alongside other aligned validation processes, encompassing Chair / CEO, Executive and Non-Executive Appraisals; and referencing NHSE's new Leadership Competency Framework (just recently launched) and their emerging Board Appraisals Framework (due in September 2024).

We have agreed that the FPPT process will apply to all on the Board, and selected others regularly in attendance. Which includes our System 'Partner Members', acknowledging their own internal FPPT or equivalent processes owned by their Host Employers, to gain all the relevant assurances that way.

The final elements of the integrated process are currently nearing completion for all individual FPPT assessments, aligned to appraisals for 2023-24. ICB / CSU personnel are currently finalising the relevant assessment documents and ensuring the final actions are completed, in order to help the ICB Chair make the required final "Attestation" via a report to be presented to May's Board meeting.

1.4 People team

1.4.1 Operational planning and workforce controls

There is continued partnership working with Provider Trust Chief People Officers and Workforce Planning leads, and finance and activity colleagues, to deliver the 21 March operational plan workforce elements. Additional granular analysis and reconciliation work is underway with providers to support the further submission in May 2024. In addition, there is ongoing support and oversight of workforce controls and submission of returns relating to agency, bank and vacancy position for NHS providers.

1.4.2 2023 NHS Staff Survey Results

The 2023 NHS Staff Survey results were recently published, and the results show that the Integrated Care System (ICS) were the highest scoring system in the region. The system has also achieved higher scores or remained the same in all areas.

Trusts are currently analysing the results at a local level and developing plans to address areas for improvement. At a system level, additional actions will be identified to take forward the results and deliver improvements, in addition to activities underway within existing workstreams / projects, as follows:

- Reporting and governance around successes and improvements via ICS People, Culture and Inclusion Committee
- Steering/working groups leading detailed analysis and work with partners to identify additional actions e.g., Retention, Employee Experience and Health and Wellbeing, Leadership and Talent, Equality, Diversity, and Inclusion (EDI).
- In addition to Provider level actions, specific system activities already underway include an ICS Organisational Development Strategy, Leadership programmes and approaches, targeted NHS Occupational Health offers, system approach to Sexual Safety Charter & training, Retention including flexible working programmes and system EDI development.

1.4.3 Apprenticeships

Cohort six of the system wide rotational Health Care Support Worker Apprenticeship have successfully completed their assessment day. Over 100 applications were received, with six apprenticeship placements being secured across the acute and community health care settings.

Cohort four of the programme are currently completing their end point assessments with over half already securing a job or further education placement in a health or social care setting.

The scheme has successfully supported over 58 apprentices to date on the programme, gaining valuable experience and skills in a range of health and care environments across our system.

1.4.4 Education, Training & Development (ETD)

The ETD Steering Group continues to grow from strength to strength under the leadership of Ann-Marie Riley (University Hospitals of North Midlands NHS Trust (UHNM) Chief Nursing Officer), delivering the education and training priorities set out in the Long-Term workforce Plan and our local Joint Forward Plan. Priority workstreams for the group include clinical education and placements; system training and development opportunities, career development and progression, higher apprenticeships, student pipeline and funding, student experience and retention and widening participation.

Colleagues from across the system are leading working groups to take forward these priorities, and will consider the opportunities for collaboration, digital/technology and innovation.

2.0 Finance

At month 11, at a system level, we are reporting a £68.9m adverse variance against plan. The adverse position drivers are consistent with prior months across Continuing Health Care (CHC) and prescribing inflationary pressures, slippage on efficiency programmes, the ongoing retention of escalation beds due to urgent and emergency care (UEC) demands throughout the financial year. Our original break-even plan included a number of upside assumptions. Unfortunately, a number of these assumptions have not come to fruition and last month we notified regional and national teams as part of the financial reset return of a forecast out turn of £91.4m. All organisations are increasingly confident of delivering their risk adjusted forecast and managing the residual risks. However, the position includes risks around the fixed and variable aspects of ERF, and we hold firm on our assumptions and bills related to overperformance associated to UEC, (NELs and A&E attendances) amounting to £5.3m. On this basis, as a system, we still believe that a deficit of £91.4m is our most likely position.

3.0 Planned Care

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

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

Current position is as follows:

104-week waits: One patient breached at the end of March at University Hospitals of North Midlands NHS Trust (UHNM), due to the patient being removed from their waiting list following transfer to Nuffield North Staffs. The transfer didn't follow standard operating procedures and the patient was not tracked through. UHNM have offered a date in March, but the patient has requested to be treated in April with a To Come In (TCI) date of 9 April. There are no further 104-week breaches predicted. There were zero breaches at the end of March for patients who are outside of the system.

78-week waits: For patients waiting beyond 78 weeks for treatment, the number of breaches across the system at the end of March was 94 (79 at UHNM and 15 at Medefer). The forecast position for the end of April is 14 (11 at UHNM and 3 at Medefer), with a forecasted position of 0 for May. As previously reported the ICB does continue to track long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System. In the latest unvalidated data (31 March), there are 19 patients waiting over 78 weeks outside of the system, 12 are on the admitted part of the pathway, all of which are at University Hospitals of Derby and Burton (UHDB), and 7 are on the non-admitted part of the pathway, of which 6 are at UHDB. UHDB are on Tier 1 elective oversight and are subject to weekly monitoring by NHS England.

65-week waits: Good progress is being made overall on the 65-week-wait cohort. Numbers have continued to improve since the start of the financial year. The total cohort at the start of the financial year was 37,000, and as of 25 February the cohort size was c1,900.

As of 3 April, there were 911 breaches at the end of March (866 at UHNM, 7 at Nuffield and 38 at Medefer), with a forecasted position for the end of April of 836 breaches (818 at UHNM and 18 at Medefer). The forecasted position for May is 897 (883 at UHNM and 14 at Medefer). However, work is continuing to reduce these further. For providers outside of the system, in the latest unvalidated data (31

March) the potential cohort of patients who could breach 65 weeks if not treated, by the end of March is 364 patients, 213 of these are on the admitted part of the pathway and 151 on the non-admitted pathway.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) have seen a continued steady reduction in the 62-day backlog since September but did see an increase during December. As of 31 March the 62-day backlog was at 222, this is compared to 274 as at 3 March.

The 104+ day backlog also saw an increase during December. As of 31 March, the 104+ day backlog was at 79 this is the same as the position on 3 March. There had been a steady reduction from the beginning of January, but there has been a slight increase between 3 March and 24 March, with a reduction seen again as of 31 March.

The position of 28-day faster diagnosis standard for cancer has seen a steady improvement since November but did see a slight decline in January. November position was 65%, December position was 70%, January position was 67%, February position was 75% and March current provisional position is 77%.

4.0 Urgent and Emergency Care (UEC)

Four-hour performance in March reached 70.24%, up 6½ percentage points from 63.7% during February, as specific focus was placed on addressing Emergency Department (ED) performance. This was assisted by near-perfect performance at Haywood, whilst Leek Hospital and the Eye Clinic reported no breaches during the month. When comparing overall ED performance to the same period last year, March 2024 was up 3 percentage points on March 2023. This increased performance was achieved in the face of a 9% overall increase in attendances at University Hospitals of North Midlands NHS Trust (UHNM), which when accounting for the shorter month for February, translated into 15 extra patients per day. When compared to March 2023 the increase in patients was equivalent to 27 more patients per day through March 2024.

Twelve-hour performance improved with a reduction to 8.6% from 9.5% which kept UHNM in the 2nd quartile regionally. Royal Stoke Hospital was primarily responsible for this improvement with a 1½ percentage point improvement over the previous month and the best performance reported for the site of the last 6 months. When compared to the same period last year, March 2024 was 1.9 percentage points better off. County Hospital continued to feel the impact of increased Acuity with a minor deterioration in performance from 3.2% to 3.5%.

Long Length of Stay (LoS) performance reported increasing 7+, 14+ and 21+ day levels towards the end of the month. Specifically, within the 14+ LoS cohort the level increased to 26.3% during the month, which was the highest it had been for 11 months resulting in a 2023/24 average of 23.9%.

Category 2 performance through March saw increased pressure through the start of the month, with a degree of improvement seen through the second half of the month. The latest 4-week average of 36m 35s, whilst remaining above the 30-minute target position, saw the system move up to 22nd out of 42 nationally and remain at 4th out of 11 regionally.

Medically Fit for Discharge (MFFD) rose slightly during March with patient acuity impacting patient pathways for periods during the month, primarily at Royal Stoke although County Hospital was not immune to variation. The KPMG Test of Change has now concluded with the outputs and recommendations being picked up in Workstream 2 within the non-Elective Improvement Programme.

COVID-19 bed numbers continued to reduce through March, ending the month at 30 beds, down from 69 the previous month. This reported the lowest number for the end of March since COVID-19 was identified and is following the pattern of reduction reported during 2021, which led to three months of consistently

low figures. COVID-19 bed occupancy at Burton Hospital also reported at the lowest March level since reporting began, with consistent single digit figures reported since the middle of the month. With figures indicating reduced COVID-19 in the community, Staff absences due to COVID-19 also fell with 0.2% or fewer staff absences across the system during the month being due to COVID-19. Flu continued to pose issues during March, with rising numbers at the start of the month reversing the previous trend for reduction, however, by the 2nd week, numbers were trending downwards again. Infection Prevention Control (IPC) concerns relating to diarrhoea and vomiting (D&V) remained consistent through March, removing a proportion of beds form the bed base and showing no signs of abating as of the end of the month.

5.0 Key figures for our population

		Last 3 to 4 months in current financial year				Same month in previous financial year		Latest month v same month in previous financial year		
		Nov-23	Dec-23	Jan-24	Feb-24	Jan-23	Feb-23			
*	111 calls received	32,553	40,198	37,000	34,894		29,179	5,715	19.6%	↑
	Percentage of 111 calls abandoned	6.3%	7.1%	13.0%	12.5%		4.5%	8.1%	180.4%	↑
	A&E and Walk in Centre attendances (UHNM)	19,592	19,877	20,461	19,593		17,923	1,670	9.3%	↑
	A&E and Walk in Centre attendances (other providers)	17,348	17,303	17,367	17,291		15,091	2,200	14.6%	↑
	Non elective admissions (UHNM)	7,637	7,638	8,140	7,592		6,536	1,056	16.2%	↑
	Non elective admissions (other providers)	5,964	5,744	6,682	6,545		5,032	1,513	30.1%	↑
	Elective and Day Case spells (UHNM)	7,272	6,431	7,685	7,579		6,491	1,088	16.8%	↑
	Elective and Day Case spells (other providers)	8,869	7,411	8,426	8,242		7,595	647	8.5%	↑
	Outpatient procedures (UHNM)	5,912	4,707	4,915	5,203		4,390	813	18.5%	↑
	Outpatient procedures (other providers)	9,619	7,530	9,742	9,415		7,024	2,391	34.0%	↑
	GP Appointments (all)	562,056	466,525	596,636	558,380		488,735	69,645	14.3%	↑
**	Physical Health Community Contacts (attended)	140,675	122,865	143,115	128,825		122,545	6,280	5.1%	↑
**	Mental Health Community Contacts (attended)	46,465	37,150	47,370		46,330		1,040	2.2%	↑

Most datasets are subject to change following refresh

*NHS 111 - latest month is provisional and subject to change
**Physical and Mental health contacts - latest month is provisional and subject to change and both datasets are sometimes one month behind the other datasets depending upon timing of publication

The comparison with the same month the previous financial year is the same month for most measures, apart from measures that lag one month behind. The month being compared is indicated by the absence of dark grey shading.

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

6.0 Quality and safety

6.1 NHS IMPACT (Improving Patient Care Together)

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach which aims at creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities. The ICB have undertaken the initial self-assessment to identify the areas of focus with which to develop the organisational capacity, capability and infrastructure support delivery of clinical and operational excellence. The Associate Director of Quality and Assurance, Lee George, is leading the development of the action plan to take this forward.

6.2 Mental Health and Learning Disability and Autism Inpatient Quality Transformation Programme

In February 2023 the new national Mental Health and Learning Disability and Autism Inpatient Quality Transformation Programme was launched. As part of this transformation programme new Mental Health Host and Home guidance has been developed to support the ICBs to meet the requirements of oversight and support arrangements which are fit for purpose

across CQC registered independent providers that are providing specialist mental health inpatient care in non-secure specialist mental health inpatient settings to all age adults who do not have a diagnosis of Learning Disability or Autism. Staffordshire and Stoke-on-Trent ICB Quality and Nursing team have volunteered to be part of the pilot and will be instrumental in providing feedback at a regional and national level which will support further development of the processes required to undertake this important aspect of the transformation programme.

7.0 Vaccinations

7.1 Measles, Mumps and Rubella Vaccinations (MMR)

Due to increased incidence of measles in areas of the West Midlands, there is a focus on increasing MMR vaccination rates, including the evergreen offer for anyone who had not received one or two doses in accordance with the recommended schedule. There has been an increase in vaccination activity during the start of 2024 with weekly activity for MMR1 58% higher than the previous year and MMR2 32% higher, as based on weekly NHS England activity data from early March 2024. Targeted MMR clinics were held within Stoke-on-Trent in March with further pop-up clinics running during April.

7.2 COVID-19 vaccinations

The Spring COVID-19 campaign will offer a booster vaccine to all those aged 75 years and over, residents within older age care homes and anyone aged six months and over who are immunosuppressed. Care home vaccinations will start on 15 April with all other cohorts from 22 April 2024. There are an estimated 147,000 eligible individuals; the national predicted uptake for Spring will be around 58%. In total there are 109 COVID-19 vaccination sites – 24 Primary Care Networks (PCNs) and 85 pharmacies in addition to the targeted vaccination team operated by Midlands Partnership University NHS Foundation Trust (MPFT).

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:	**18 April 2024**					
Title:	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report**					
Presenting Officer:	Phil Smith - Chief Delivery 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.				
Appendices:	NA					

(1) Purpose of the Paper:

The purpose of this report is to provide the Integrated Care Board with a comprehensive overview of the ICB arrangements in place for Emergency Preparedness, Resilience and Response (EPRR); confirm the annual assurance position for 2023 of substantial compliance, and outline the action plan in place to maintain this compliance rating for 2024; 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)	22/02/2024
ICB Audit Committee (A)	04/03/2024

(3) Implications:

Legal or Regulatory	ICBs are legally required to have suitable arrangements in place to place for major incidents and events that might diversely impact on statutory or essential ICB functions or on the sustained delivery of commissioned health services, 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 or Patient Safety	Nil
Financial (CFO-assured)	Nil

Sustainability	Nil
Workforce or 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 Board 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 Board 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 Board 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 EPRR priorities to the Integrated Care Board for approval and ratification. The report demonstrates positive progress against EPRR workstream priorities, including an uplift of two compliance levels from 2022 to substantial compliance against the EPRR annual assurance process in 2023; 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 from June 2023 to present, demonstrating an ability to respond to incidents across the ICB and system.

(7) Recommendations to Board / Committee:

Recommendation 1: Board are asked to 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 2023 EPRR annual assurance compliance rating of substantial compliance.

Recommendation 3: Board are asked to note and support the EPRR annual assurance 2024/25 priorities as listed in section 5.

Emergency Preparedness, Resilience and Response (EPRR)
Annual Report to the Integrated Care Board – 2023-24

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. This work is referred to in the NHS as EPRR.

2. Purpose

2.1 The purpose of this report is to provide the 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 2023 and predicted rating for 2024, including an update on EPRR priorities for 2024;
- 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. The EPRR function is an example of matrix working, with delivery of the EPRR agenda undertaken across multiple directorates, and across the Integrated Care System to enable collaborative working.

3.2 The EPRR resource is detailed below, noting the addition of the Portfolio Director for Delivery and Improvement from the reported 2022 position.

Position	Role	Post Holder
Executive Director Lead / Accountable Emergency Officer (AEO)	Accountable Emergency Officer (AEO) and Executive Director who has the statutory responsibility for EPRR delivery.	Phil Smith
Portfolio Director – Delivery and Improvement	Director level deputy for the Executive Director Lead as required.	Hayley Allison
Associate Director for UEC and EPRR	Associate Director Lead for UEC Operations and EPRR deputising for the EPRR Director Lead / Portfolio Director as required	Kate Farrow
EPRR Strategic Lead	EPRR Lead responsible for delivery of EPRR functions against the work programme. The EPRR Strategic Lead will also lead on the annual Core Standards self-assessment for the ICB and for assurance of the Core Standards returns by NHS service providers.	Katie Weston
SCC/EPRR Support Manager	EPRR Support Manager who will be responsible for supporting the EPRR Strategic Lead in delivery of the EPRR work programme.	Yasmin Sharif
Emergency Planning CCU (Civil Contingencies Unit) Link Officer	Emergency Planning Link Officer from the CCU, providing advice and support on multi-agency emergency planning matters, whilst supporting internal arrangements as required, including training, exercising, planning arrangements, and debriefing.	Karen Poyser
On-Call Staff	The organisation maintains a 24/7 response capability at a strategic (gold) and tactical (silver) level. These roles are held by competent experienced post holders at VSM/Band 9, and Bands 8d/8c respectively. These individuals can deliver incident response to any incident affecting the system through training and exercising appropriate to their role.	
Directorate 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 Business Continuity Recovery Teams	Each Team (for Business continuity purposes) has identified a business continuity recovery team that will lead the recovery process and support the Directorate Leads for business continuity.	

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

3.4 This role has been assigned within the Chief Delivery Officer function, with the roles and responsibilities of the AEO as set out in the 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.

3.5 Recommendation 1 - Board are asked to 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 **2023 Core Standards compliance** – as reported to Audit Committee, SSOT ICB was rated as substantially compliant following the 2023 self-assessment and confirm and challenge process.

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	7 ↑	1 ↓	0
Command and Control	2	2 ↑	0 ↓	0
Training and Exercising	4	4 ↑	0 ↓	0
Response	5	4 ↑	1 ↓	0
Warning and Informing	4	4	0	0
Cooperation	6	6 ↑	0 ↓	0
Business Continuity	10	9 ↑	1 ↓	0
Total	**47**	**43 ↑**	**5 ↓**	**0**
Overall self-assessment:	**Substantial Compliance**			

4.5 Of the eleven ICBs in the Midlands region, four were substantially compliant, including SSOT ICB, with four ICBs achieving partial compliance, and three ICBs achieving non-compliance.

4.6 The system was rated as partially compliant overall, noting the upward movement in compliance by the ICB, MPFT, and NSCHT, and downward movement by UHNM, Totally Group, and EMED Medical. Good actions plans are underway to address areas of non-compliance across the system.

4.7 Regionally there has been an improvement in position from 2022, albeit slower than anticipated due to industrial action. Regional forecasts suggest this will continue into 2024.

4.8 Recommendation 2 – Board are asked to note the 2022 EPRR annual assurance compliance rating of substantial compliance.

5. EPRR Assurance 2024/25 Priorities

5.1 Building upon the focus of establishing robust and scalable frameworks for EPRR policy and response arrangements to enhance organisational resilience and compliance, the 2023 priorities of establishing good business continuity management systems and processes, and developing training and competent on-call teams were achieved.

5.2 This will continue to be a priority for 2024, ensuring individuals have opportunities to embed learning through exercise opportunities and sharing of experiences, and through the further development of business continuity arrangements.

5.2 Areas for improvement have been identified through the EPRR assurance process, predominately in the domains of risk assessment and management, and supply chain resilience of commissioned providers, and will form the focal points of the 2024, alongside risk-based response arrangements identified across the system and local resilience forum.

5.3 Risk assessment and risk management will be a key focus to ensure the risk management process becomes more mature, with risks raised by Central Government, NHS England, the Local Resilience Forum, and Providers underpinning EPRR priorities. The new NHSE regional risk management framework will be utilised across EPRR to support this.

5.4 EPRR will also seek to work closely with commissioning and procurement teams to support robust supply chain resilience arrangements which can be utilised during tender processes to assess the resilience of commissioned service business continuity arrangements.

5.5 The ICB EPRR team held a system EPRR away day in February 2024 to enhance the system EPRR community, sharing expertise, learning, and collaboration opportunities, identifying where provider collaboration and matrix working could be explored across EPRR priorities to build a system approach to EPRR.

5.6 Following the system EPRR away day, the Local Health Resilience Partnership (LHRP), chaired by the Chief Delivery Officer, and Director of Public Health for Staffordshire County Council, has identified work programme priorities within response arrangements such as mass countermeasure distribution, evacuation and shelter arrangements, and mass casualty response arrangements.

5.7 The 2024 EPRR annual assurance standards have been set and are being worked through by the EPRR Strategic Lead with an aim to maintain substantial compliance for 2024. The ICB self-assessment will be submitted at the end of August.

5.8 Recommendation 3 – Board are asked to note and support the EPRR annual assurance 2024/25 priorities 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, 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 UHNM 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.

- Business continuity incident declaration – 31 October 2023
- Critical incident declaration – 30 January 2024
- Critical incident declaration – 13 February 2024

6.4 NSCHT Harplands Hospital A&T Unit Electrical Safety Issue – Business Continuity Incident – 20 July 2023

Concerns raised relating to electrical safety on the Assessment and Treatment unit at Harplands Hospital. 2 patients relocated to another ward whilst investigations were carried out. No impact to the wider hospital. Confirmed safe by specialist engineers.

6.5 UHNM Careflow System Outage – Business Continuity Incident – 31 July 2023

Outage of the Careflow system due to planned upgrade work for security and functionality which failed due to infrastructure issues. Some impacts experienced due to the need to update records manually.

6.6 MPFT Switchboard Failure – Business Continuity Incident – 19 August 2024

Complete loss of internet and systems connected via the internet across all sites. All telephones were unavailable, however internal bleeps and red phones remained functional. Issue identified as potential power issue at Stafford Data Centre. No impacts to inpatient care.

6.7 UHNM Emergency Department Leaking Domestic Hot Water Pipe – Business Continuity Incident – 24 October 2023

Leaking domestic hot water flow pipe identified above an emergency department bay, with a risk of pipe burst and flooding. Water isolated to enable repair, with patients relocated and intelligent ambulance conveyance put in place. Works completed with minimal disruption.

6.8 MPFT Connectivity Outage – Business Continuity Incident – 27 October 2023

Impacts across NASSTAR and Staffordshire Health Informatics Services due to hardware issues. Impacts felt across multiple sites.

6.9 UHDB Power Outage at Sir Robert Peel Hospital – Business Continuity Incident – 22 November 2023

Loss of electrical power to large areas of the hospital due to damage to a major electrical cable. Impacts across heating, hot water, and some lighting. Repair completed and power restored later the same day.

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 2023-24, demonstrating an ability in the organisation to respond and support the ICS while delivering the EPRR work programme:

7.3 *NHS Industrial Action - November 2022 to present.*

Following Agenda for Change Unions accepting the terms of the government pay offer, and the Royal College of Nursing not successfully reaching mandate for an extension for action to December 2023, NHS industrial action from June 2023 to present has been by the BMA and HCSA Unions for Junior Doctors and Consultants. Robust system plans and arrangements are in place to respond to this. BMA Junior Doctors achieved an extension to the mandate for Industrial Action to September 2024. The BMA Consultants have recently accepted a pay offer from the Government and have ended their Industrial Action.

Since June 2023, the system has responded to nine periods of extended NHS industrial action.

7.4 Royal Stoke Patient Decontamination – 20 April 2023

A patient self-presented to Royal Stoke requiring decontamination and treatment following an incident.

7.5 Potters 'Arf Marathon – 11 June 2023

Heatwave conditions impacted the Potter's 'Arf Marathon in Hanley with several participants requiring medical treatment. A multi-agency debrief took place to identify lessons and recommendations, and the learning is being adopted into event safety advisory group processes to enable early notification of events such as this to Trusts and the ICB.

7.6 Shrewsbury and Telford Hospital (SaTH) Power Outage – 22 June 2023

The ICB were made aware of a critical incident declaration at SaTH due to a power outage and loss of the site generator, impacting maternity services. The ICB and UHNM supported with ambulance diverts / transfers to UHNM.

7.7 Storm Babet – 19 October 2023

The ICB supported preparedness for Storm Babet following Met Office weather warnings and an Environment Agency issued amber flood warning for Staffordshire and Stoke on Trent.

7.8 Motorsports Event – County Showground – February 2024

Several patients presented to County Hospital following an event at Stafford County Showground. A multi-agency debrief has been requested to identify learning.

7.9 Operation Lazurite – October 2023 to present

The ICB is supporting NHSE and the Ministry of Defence (MOD) in an operation to relocate 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 is supporting the provision of health care services at the site in Staffordshire to appropriately manage any presenting initial health needs, reducing the impact on local NHS services. System partners are aware and supporting as required.

7.10 Outbreaks – Staffordshire wide – undeclared incidents

The ICB and system have responded to several outbreaks across SSOT, including a number of measles outbreaks, a case of C.Diptheria within asylum accommodation, cases of adulterated heroin in the local drug networks, and a flu outbreak at a care home. The ICB outbreak

management documentation and system memorandum of understanding for outbreak management between relevant health partners has supported response, and a measles pathway is in production to support measles specific outbreak response.

7.11 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.

7.12 Walley's Quarry health impacts – ongoing

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 odours on health and wellbeing. The ICB continues to represent the system at the Walley's Quarry SCG chaired by the 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. This response has been ongoing for over 3 years. In 2023, a short-term GP led Healthline in 2023 was stood up to support public concerns around accuracy of monitoring data.

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 Gold and 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 procured and delivered by the CCU as part of the Partnership Service Level Agreement and assigned CCU Link Officer.

8.4 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.

8.5 Key highlights of training in 2023/23 include:

- 100% of On-Call Managers have attended EPRR and UEC introduction training prior to starting On-Call.
- 100% of 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 to support the provision of tactical and strategic advice to On-Call Managers during incidents.
- Uptake of the monthly on-call development sessions has been excellent, with all On-Call Managers actively participating in discussions.
- A training needs analysis and training record is in place for all On-Call Managers to support tracking of their development.
- On-Call Managers are encouraged to raise further areas of development and actively contribute suggestions to training and exercise schedules where areas are identified.
- 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.
- The EPRR Strategic Lead undertook business continuity management system training in line with the relevant ISO standards with UHNM's EPRR Team to support development of ICB business continuity arrangements.

8.6 Attendance at exercises has increased through 2023/24, however the EPRR team will continue to encourage this going forward.

8.7 Upcoming training for the EPRR team includes multi-agency gold incident command training with the College of Policing for the Associate Director of UEC Operations, and Public Inquiry training for the Chief Delivery Officer and EPRR Strategic Lead should the ICB be asked to join a public inquiry.

9. Exercises Completed during 2022-2023

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 2023/24 is listed below:

Exercise	Type	ICB Participants
Incident Response Exercise – DDICB – 25 September 2023	Tabletop exercise held by Derby and Derbyshire ICB and ICS to test response arrangements and consideration of cross-border engagement with SSOT ICB/ICS/	EPRR Strategic Lead
Exercise Fortitude – 24 October 2023	Tactical and strategic tabletop exercise scenario to test the multi-agency response to a fictitious low sophistication terror attack at Port Vale Football Club, with engagement at tactical and strategic coordinating groups, and coordination of NHS response via Local Health Strategic Command.	Silver and Gold On-Call Managers, EPRR team, Communications team, UEC System Coordination Centre Commander.
Exercise Morse Code – 22 November 2023	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.

Measles Exercise – 31 January 2024	Tabletop exercise to review the Staffordshire and Stoke on Trent outbreak management memorandum of understanding and outbreak response pathways with a focus on Measles management.	EPRR/CCU Link Officer, Consultant in Public Health, Head of Clinical Business, Infection Control Team, Primary Care, and System partners.
Cyber Crisis Simulation Exercise – 08 April 2024	Tabletop exercise to consider the system identification, response to, and recovery from a system wide cyber-attack. Facilitated by NHS England Digital.	Digital/Cyber/IT specialists, Senior Stakeholders, Clinicians, EPRR, Primary Care, and Communications.

9.3 Upcoming exercises include an ICB incident response exercise for On-Call Managers (date tba), and a multi-agency incident exercise 'Exercise Raven' on 16 May 2024.

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 Silver or Gold on call if an incident should occur and participation in exercises is a crucial part of this.

10. Conclusion and Recommendations

10.1 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.

10.2 Board are therefore asked to note the arrangements in place as described within this report and consider and approve the recommendations as outlined:

- Recommendation 1: Board are asked to 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 2023 EPRR annual assurance compliance rating of substantial compliance.
- Recommendation 3: Board are asked to note and support the EPRR annual assurance 2024/25 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

Report to:	**Integrated Care Board**					
Date:	**18 April 2024**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Heather Johnstone, Chief Nursing & Therapies Officer					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail April 2024					

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

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	13/03/2024
Click or tap here to enter text.	Click or tap to enter a date.

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The paper summarises the items received by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in March 2024. The Committee fulfilled its role as defined within its terms of reference. Where appropriate, actions and oversight arrangements are identified within Appendix A.

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

- Deep Dive Discussions
- Updates from System Partners (from SQG)

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report and seek clarification and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail April 2023

1. Deep Dive Discussions

1.1 The ICB's QSC continues to schedule bi-monthly deep dives, where focused discussion on areas of interest and the impact on the quality and safety of services can take place. In March 2024 deep dive discussions took place with a focus on Safeguarding Children, and Children in Care. Members of the ICB's safeguarding team attended the committee and outlined governance structures, key workstreams, learning from safeguarding reviews and areas of key focus including a system wide approach to calculating health assessment compliance using statutory guidance and development of a system wide dataset and dashboard for Children in Care.

1.2 Looked After Children who do not receive an Initial or Review Health Assessment in statutory timescales are at risk of having unmet health needs which can have a detrimental impact on their physical and emotional wellbeing, in both the short term and long term as they transition into adulthood. The current compliance for Staffordshire and Stoke-on-Trent is 7% and 11% respectively against a target of 85% within statutory timescales; this does not include children placed out of area. Delays in the completion of Initial Health Assessments will also impact on decisions made for children who are being considered for adoption and the timescales for court proceedings. This not only impacts on their physical and emotional wellbeing, but their plans for permanency. This issue has been discussed at the Children and Young People Project Board and a working group has been set up to provide a better understanding of the issues and offer some short- and long-term resolution. Discussions have also been held with NHS England – Midlands' Associate Director for Safeguarding to share the challenges, understand the regional position and learn from any areas that have developed solutions to these challenges.

2. Updates from System Partners (from SQG)

2.1 Staffordshire County Council (SCC)

2.1.1 To support the transition from the NHS Serious Incident (SI) Framework to the Patient Safety Incident Reporting Framework (PSIRF), meetings are taking place with care home providers with the aim of providing advice and guidance on how to manage and respond to patient safety incidents under the new direction. Until transition care homes are still able to report serious incidents into the ICB to be logged on STEIS (Strategic Executive Information System). Five care home providers who cover a mix of national groups and smaller independent providers are actively involved in PSIRF conversations with the ICB.

2.2 University Hospital of North Midlands NHS Trust (UHNM)

2.2.1 UHNM's Head of Nursing attended SQG to present an update on the Trust's journey implementing the John Hopkins Activity and Mobility Program. Phase 1 has seen the launch of Johns Hopkins Activity and Mobility Programme on eight adult inpatient wards across UHNM. Including six wards in older adults' unit and one fractured neck of femur ward at Royal Stoke University Hospital and the older adults ward at County Hospital. All wards now have diversional therapist(s) who have been key members of the implementation team. These new roles are being piloted for one year with the aim to get patients up and out of bed to prevent deconditioning syndrome which happens with prolonged bed rest and the associated loss of muscle strength.

2.3 Healthwatch

2.3.1 Healthwatch Staffordshire advised that they have received an increased number of calls about lack of NHS dentistry appointments available, particularly the lack of appointments available for children. Healthwatch Staffordshire also advised that they have received some positive feedback where some dentists are now offering NHS appointments.

2.4 Primary Care

2.4.1 There continues to be a delay with the ICB receiving updates on complaints relating to GP practices and upheld by NHS England. The ICB's Primary Care team remain in frequent contact with the Office of the West Midlands to support the receipt of updates.

2.5 Staffordshire and Stoke-on-Trent ICB

2.5.1 A substantial number of residents in South Staffordshire access healthcare at providers outside of Staffordshire. In these instances, Staffordshire & Stoke-on-Trent ICB is an associate to the contract held by another ICB and work in partnership with partners to collaboratively support quality improvements for our residents. The ICB's Quality Leads have long established working relationships with NHS Birmingham & Solihull ICB, NHS Black Country & West Birmingham ICB & NHS Derby & Derbyshire ICB. Where there has been CQC inspection activity the ICB has been notified and received updates on any improvement actions identified. Further, our Local maternity and neonatal system (LMNS) routinely receives updates on the quality and oversight of maternity services at The Royal Wolverhampton NHS Trust and University Hospitals of Derby & Burton NHS FT.

2.5.2 The latest NHS Oversight Framework 2023-24 segmentation levels were published by NHS England in March 2024. The segmentation is based on a quantitative and qualitative assessment of the five national and one local priority themes contained within the NHS Oversight Framework including an assessment of the quality of care, access, and outcomes. The segmentation levels for our main NHS providers are as follows:

Inter-System Providers	
Midlands Partnership University NHS Foundation Trust	2
North Staffordshire Combined Healthcare NHS Trust	1
University Hospitals of North Midlands NHS Trust	3
Intra-System Providers	
The Royal Wolverhampton NHS Trust	3
University Hospitals of Derby & Burton NHS Foundation Trust	3
West Midlands Ambulance Service University NHS Foundation Trust	2

2.5.3 The ICB have instigated a "Step in process" for Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) reviews due to deteriorating performance. A business case to support the ICB to fulfil its statutory obligations related to LeDeR and ensure robust and timely learning is being developed. Currently the back log of cases for review (35) goes back to August 2023. The ICB have advertised LeDeR bank reviewer role (8 appointed and currently undertaking onboarding process). Further, thirteen nurses within the ICB are training to undertake reviews and senior reviews; a small number of reviews by have already commenced.

2.5.4 There is an increasing number of people waiting over 18 weeks for a wheelchair and a corresponding increase in service user feedback. The ICB has worked with the provider to strengthen their quality governance arrangement including updating the duty triage guidelines to include reprioritisation and clinical harm review. Further, MPFT have also shared best practice and learning to support and inform these updates. A joint communications strategy for service users and key stakeholders is in place including referrer groups multi-disciplinary teams.

2.5.5 Ofsted have published the Stoke-on-Trent special educational needs and disabilities (SEND) are inspection report, which also included alternative provision jointly run by the city council and ICB. The inspection highlighted some areas of excellent practice as well as five key areas for improvement which will be assessed by the local area partnership before a refreshed improvement plan is published.

2.5.6 The ICB and MPFT are piloting a joint SEND Improvement Lead to support and share duties with the current Designated Clinical Officer. This commenced in September 2023. To date, the role has been able to demonstrate positive impact in terms of proactively planning training, allowing operational teams to have a closer link for queries, providing a greater understanding and scoping of how the agenda will become embedded in MPFT, and enhanced links between the local authorities and MPFT.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure No: 08

Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 10th April 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Board Assurance Framework	The Q4 BAF was received in full by the Committee for oversight of all BAF risks. Consideration will be given to revised target dates for BAF 1, 2, 5, 6 and 7 in the 2024/25 BAF. The committee agreed the Q4 risk scores, and assurance assessments were an accurate reflection of the position and noted the changes set out in the report.	
Risk Register	The committee received the Risk Report. The committee were assured in relation to the report and noted the risk owner for Risk 1238 Paediatric Audiology is now Heather Johnstone with Becky Scullion as action owner.	
Urgent & Emergency Care Communications & Involvement Plan	The committee approved the Communications & Involvement Plan in relation to Urgent Treatment Centres.	
Looked After Children Health Assessments	The report provided an update on the current performance in completing Initial Health Assessments (IHA) and Review Health Assessments (RHA) for looked after children, the impact on this cohort of children and the work being undertaken. The performance against these targets is significantly off track and not likely to be redressed in the short term. Additional actions were being developed and further resources would be needed to support improvement and to ensure a sustained improvement trajectory. The Committee noted the update and supported plans for system service redesign.	Given the lack of assurance the Committee asked for a recovery plan to be submitted to its next formal meeting including an agreed harm review process to support the long waiters. In addition, the Committee requested a review of submitted business cases and clarification of

		the approval process that needs to be followed to secure funding.
Paediatric Audiology Improvement Programme	The report provided an updated position regarding Staffordshire and Stoke-on-Trent's response to the National Paediatric Improvement Programme. The Committee noted the risks and issues identified and mitigations which support a system response. The Committee were assured that actions are in place to improve the quality and safety of Paediatric Audiology Services.	
ICS ReSPECT Policy	The Committee approved the ICS ReSPECT Policy subject to approval of the supporting Quality Impact Assessment (QIA). This approach was approved by exception given the need to formalise the policy which had been developed to support providers in aligning their ReSPECT Policies to promote standardisation of best practice and facilitate effective and safe movement of individuals within Staffordshire and Stoke-on-Trent.	
All Age Continuing Care Service Specification	The Committee approved the All Age Continuing Care Service Specification. For the work to progress this approval was given by exception subject to sign off of the supporting Quality Impact Assessment (QIA) which is due for consideration within the next working week.	
Health Inequalities	The report provided an update on the progress made in developing an ICS Health Inequalities Strategy. The Committee noted the progress being made towards co-production of a Staffordshire and Stoke-on-Trent Health Inequalities Strategy.	
ICB Patient Safety Partner Involvement Policy	The Committee approved the ICB Patient Safety Partner Involvement Policy	
Safeguarding Policies	The Committee approved the following safeguarding policies which had been updated to reflect changes in statutory guidance. • Safeguarding Children & Young People Policy • Managing Safeguarding Allegations Against Staff Policy • Safeguarding Children & Adults Supervision Policy • Safeguarding Training Policy • Adult Safeguarding Policy	
Health Safeguarding & Looked After Children Strategic Oversight Group Terms of Reference	The Committee approved the Health Safeguarding & Looked After Children Strategic Oversight Group Terms of Reference.	
Safeguarding Adults	The report provided highlights and exceptions in	

& Children Report	relation to safeguarding adults and children. The Committee were assured in relation to key quality assurance, improvement and patient safety activity being undertaken.	
Working with People and Communities	The report provided an update on the work being undertaken to engage and communicate with people and communities across Staffordshire and Stoke-on-Trent. The Committee were assured the ICB has measures in place to fulfil their duties to engage with local populations across Staffordshire and Stoke-on-Trent	
Local Maternity & Neonatal System (LMNS)	The report provided an update on maternity and neonatal services in Staffordshire and Stoke-on-Trent as well as specific activities from local providers of maternity and neonatal services. The Committee were pleased to see the number of improvements that had been made and were assured in relation to key quality assurance, improvement and patient safety activity being undertaken.	
Infection Prevention & Control	The report provided an update on Health Care Associated Infections (HCAI) against NHSE thresholds and IPC activity. The Committee were assured in relation to the update provided.	
System Quality Group	The report provided an overview of the System Quality Group (SQG) meetings held on the 1st of March 2024 and 5th April 2024 with partners from across health, social care, and the wider ICS in attendance. The Committee were assured in relation to the key work areas set out in the report. The Committee noted the progress of the Quality Strategy Dashboard and looked forward to receiving the first quarters report in due course.	
Quality Oversight Dashboard	The Quality Dashboard 2023/24 was presented as at Month 11 (February 2024). The Committee noted the Quality Dashboard and supported the realignment of metrics to ensure efficient reporting.	
ICB Patient Safety Incident Response Framework (PSIRF) Policy	The Committee received the draft PSIRF Policy for review and comment. The Committee noted the contents of the policy which will be returned to the committee for approval in June 2024.	

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee.

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

(1) Purpose of the Paper:
The purpose of this paper is to provide a summary of performance and finance report received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC).

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (D)	27/03/2024
System Finance and Performance Committee (S)	02/03/2024

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report contains:

1. An executive summary of performance across our One Collective Aim, Urgent and Emergency Care (UEC), Tackling Backlogs (Planned Care), Diagnostics, Cancer, General Practice/Primary Care, Prevention and Health Inequalities, Children and Young People (CYP), Mental Health and Learning Disabilities.
2. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operating plan
3. Escalations presented and considered at SFPC, along with exception reporting against our One Collective Aim and 4 system priorities.
4. An overview on finance at month 10 which is forecasting a year end deficit of £91.4m.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Note the headlines, escalations and exceptions highlighted
2. Note the M11 summary and year-to-date deficit position.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Finance and Performance Report

ICB Board 18th April March 2024

Prepared by the Transformation Delivery Unit and

ICB Finance & Intelligence Team

Overview

The report was presented at the Finance and Performance Committee (F&PC) on 2nd April 2024.

This report contains:

1. An executive summary outlining key headlines and escalations.
2. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operating plan.
3. Exception reporting against our One Collective Aim and 4 system priorities.
4. A finance summary including a month 11 position

Ctrl and click on any underlined text for further detail.

Executive Summary – Headlines (1/2)

Headlines	Points to note
One Collective Aim	• February data shows a 6.25% decrease in Category 2 incidents over the previous month. This is 8% up on the same period last year with the 3-month average also reported 8% higher than last year. • Category 2 response continued to be pressured throughout January and into February with the Februarys mean time at 48 minutes, improved from January. • Category 3 incidents decreased 6.1% against the previous month but were 39.5% up on the same month last year. • Acute Care at Home are working with WMAS to facilitate the validation of Category 2 calls as part of the daily calls. • Call Before Convey is now formalised as business as usual.
Urgent and Emergency Care (UEC)	• 4hr Emergency Department (ED) performance at University Hospital of North Midlands (UHNM) has declined to 63.7% from the previous month (64.1%) primarily due to reductions in performance at County Hospital due to load sharing, and Type 3 sites reporting increased breaches. Performance is less than that of the same month last year (by 2.5%) and continues to report below plan for 2023/24. Additional Daily monitoring of 4hr Emergency Department (ED) Performance is in place with NHSE targeting breach reduction in support of achieving the 76% target by the end of March 2024. • ED Attendances in February decreased by 4% on the previous month but were up 8.3% on the same month last year. • 12hr Performance reported at 9.5%, 1.2 percentage points above the average for 2023 but down on the previous month by an equivalent amount. • Medical outliers have reduced to 8, 5 in surgery and 3 in network, which is a continued improved position from earlier in the month when 22 medical outliers were reported. Elective capacity has not been affected by medical outliers. • There is currently a site reconfiguration review underway at UHNM linked to the new elective hub between April and August which will mean a temporary reduction in bed capacity, returning to 1336 from August.
Tackle Backlogs (Planned Care)	• Eliminating 104+ and 78+ week waiters (ww) remains a system focus; two patients remain in the 104+ ww category at ICB level in January and 128 in the 78+ ww category. • UHNM have exceeded monthly targets in 52+ ww. • 65+ ww at UHNM have decreased slightly in January but remain over 1000. As at w/e 03/03/24 65+ ww are greatest in Gastroenterology (263) and Respiratory Medicine (189).
Diagnostics	• ICB Diagnostic performance against the 7-core test plan (of 78.3% of patients to be seen in <6 weeks in January) was 75.8%, the ninth consecutive month below plan. • The activity count increased in all [7] tests, by 5,028, with the greatest increase in Computed Tomography (CT) (of 2,365). The plan was exceeded in Magnetic Resonance Imaging (MRI) and Gastroscopy only.
Cancer	• The latest UHNM position (w/e 03/03/2024, weekly recovery pack) reports the Cancer 62-day backlog has decreased to 274. • The ICB 28-day faster diagnosis pathway saw 69.7% of patients told within 28 days (across all providers), below the plan of 76.8% in M10 and below the national standard of 75%. The percentage of Lower Gastrointestinal (GI) referrals with a FIT result was 82.3%, has exceeding the plan of 65.1% in January by 17.2%. The number of referrals and the number with a fecal immunochemical test (FIT) test in January have both increased (by 10% and 11.6%, respectively). • The 104-day Cancer backlog at UHNM (w/e 03/03/2024, weekly recovery pack) has decreased across February and early March to 79; this total remains below the revised trajectory (of approximately 95 for this period). Largest backlog is in Colorectal (38) and Urology (21).

Executive Summary – Headlines (2/2)

Headlines	Points to note
General Practice/Primary Care	• GP appointments for January 2024 exceeded the monthly plan by 101,532 appointments (20.5%) and remains well above plan overall for 2023/24. • Community Pharmacist Consultation Service (CPCS) referrals from General Practice exceed the overall Year To Date (YTD) target by 490 referrals (April 23 to January 24). No new data is available since the move to Pharmacy first on the 31st January 2024. • Additional Roles Reimbursement Scheme (ARRS) FTE and budget utilisation continues to increase.
Prevention and Health Inequalities	• National objective is to increase the percentage of appropriate patients on lipid lowering therapies; the national target of 60% has not been met in January 2024 with 57.0% achieved. The percentage is trending upwards.
Children and Young People (CYP)	• Reduce the emergency admissions for Long Term Conditions (LTCs), including diabetes, epilepsy and asthma in the under 18-year-old population. In January, emergency admission rates in the under 18-year-old population were below the equivalent period in 2019/20 for asthma and diabetes, but above for epilepsy. • The YTD rates of asthma and diabetes admissions were below the equivalent period in 2019/20, whilst the rate of epilepsy admissions increased (an additional 15 admissions).
Mental Health and Learning Disabilities	• Inappropriate adult acute Out of Area Placement (OAP) bed days are over the plan (of zero) by 185 this year, to December. System Performance Group (SPG) have agreed revisions to the Psychiatric Intensive Care Unit (PICU) pathway which will align corporate and clinical aspects of the pathway to ensure there is collective visibility across the entire pathway. It is expected this will improve OOA utilisation going forward. • Autism assessment waits for Children and Young People (CYP) increased by one week at Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT). The 27-week median wait in January is double the plan (of a 13 week wait) at MPFT and 18 weeks above the plan (of 20 weeks) at NCSHT. The Task and Finish Group have mapped the pathways, and expect automated reporting in April, validation in May to then support evidence-based improvement plans. • Access to NHS Talking Therapies increased in January.

Ctrl and click on any underlined text for further detail.

Overview of key underpinning deliverables

Children and Young People / Maternity

- Design and Implement Long Term Conditions Programme:
  - Asthma
  - Epilepsy
  - Diabetes
- Implement Children with Complex Needs Project
- Implementation of the national delivery plan for maternity and neonatal care

Planned Care, Diagnostics & Cancer

- Ongoing implementation of Patient Initiative Follow Up (PIFU)
- Trajectory for eliminating 65 week waits delivered
- Meeting 85% /theatre utilisation
- Meeting 85% day case utilisation
- Introduce Community Diagnostic HUBs
- Optimal use of lower GI 2 week pathway

Improving Population Health

- Systematic implementation of the Core20 approach
- Implement NHS Long Term Plan prevention programmes
- Utilise population health management techniques

Urgent and Emergency Care

- Implement Capital Investment Case
- 76% of patients seen within 4 hours in A&E
- Bed occupancy 92% or below
- Full review and priority setting for virtual wards.
- Development of a fully integrated Single Point of Access.
- Deliver a fully integrated discharge "hub"

Mental Health, Learning Disability and Autism

- Improve the crisis pathways including 111 and ambulance response
- Undertake a Psychiatric Intensive Care Unit (PICU) Options Appraisal
- Minimise waiting times for autism diagnosis
- Improving Access to Talking Therapies
- Increased number of people with a Serious Mental Illness (SMI) having annual physical health check

Primary Care

- % Appointments within 14 days of booking
- Patient Experience (GPPS & FFT positive responses)
- Deliver Additional Roles Reimbursement Scheme (ARRS) – Budget utilisation %
- Direct Patient Care FTE per 10,000 pop. vs. National
- Digital Pathways
- GP Referrals to Community Pharmacy Consultation Service (CPCS).
- Deliver recovery of dental activity (UDA's)

End of Life, LTCS and Frailty

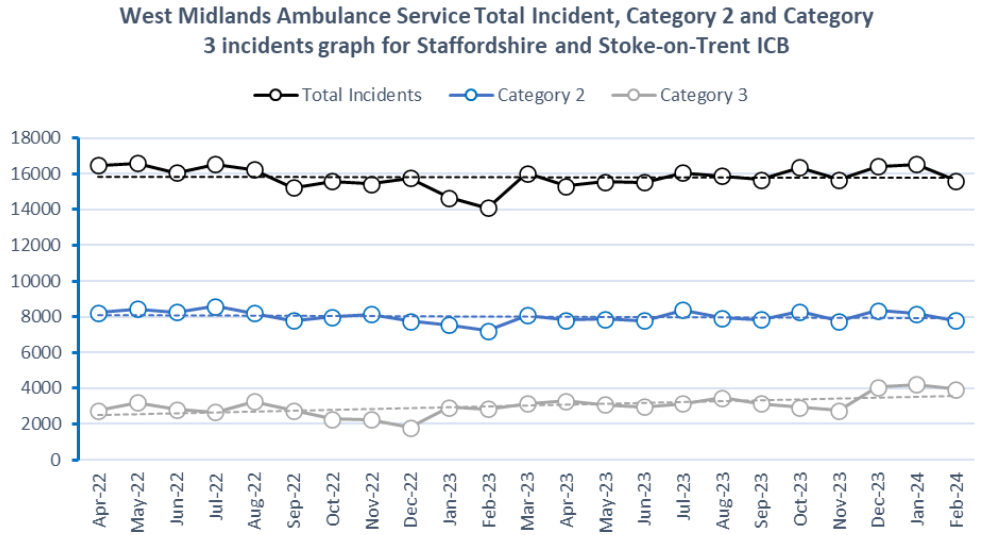
- The creation of a Palliative End of Life Care (PEoLC) strategy
- Identification of Patients in the last 12 months of life recorded on Palliative Care Registers in Primary Care
- The creation of a Long Term Conditions (LTC) strategy
- Transformation programme around Cardiovascular (CVD), Respiratory and Diabetes
- Delivery of the frailty strategy

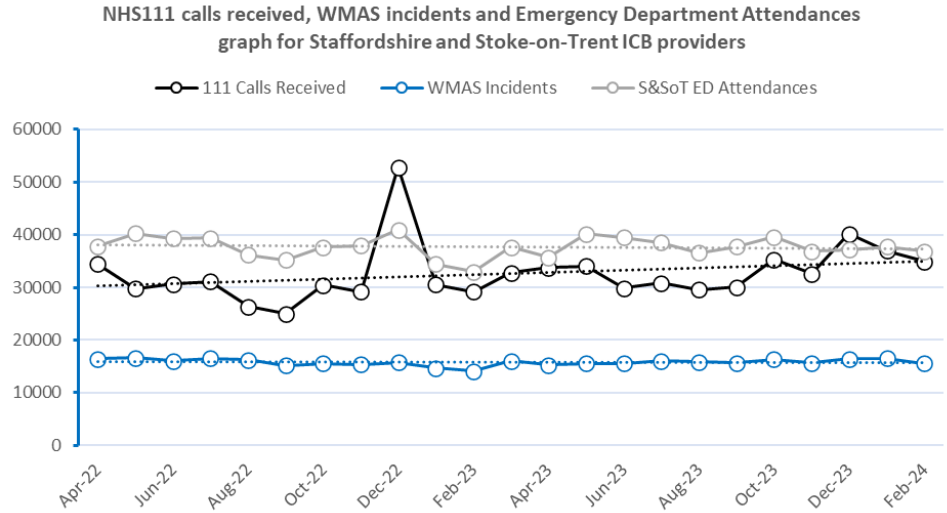
TRAFFIC LIGHT KEY:

- On track
- Behind schedule but mitigations should improve in year position
- Mitigations identified but unlikely to improve position in year
- Complete
- Measure of success under review by the portfolio

Our One Collective Aim

One Collective Aim	Points to note
Reduce the number of Category 2 and 3 ambulance calls *The data provided here are the incidents derived from calls to West Midlands Ambulance Service (WMAS) for our ICB only.* *Charts run from April 2022.*	• WMAS data for February indicates a 6.25% decrease in Category 2 incidents over the previous month, which equates to 4 incidents fewer per day in February. This is 8% up on the same period last year with the 3-month average also reporting 8% higher than last year. Breathing problems, Medical, and Chest Pain symptoms continue to account for almost 50% of calls for the month but whilst there were reductions across all 3 for the month the reduction in Chest Pain calls was minimal • Monitoring against contractually agreed trajectories for Category 2 Response saw the latest 4-week average of 38m 51s placing us 6th out of 11 in the Midlands region, and 27th out of 42 nationally. • Category 3 incidents decreased 6.1% against the previous month but were 39.5% up on the same month last year. Whilst most other symptoms reported reductions Mental Health, Medical Minor and Abdominal Flank Pain symptoms all showed increases • The total number of 111 calls answered during February 2024 fell by 4.6% on the previous month but were 8.9% higher when compared to the same month in 2022/23. • Call Before Convey is now formalised as business as usual. Call levels have dropped slightly; daily communications via WMAS and the System Control Centre have been initiated to remind crews.





Please note: A WMAS incident could have multiple calls and not all incidents result in a conveyance.

Our 4 system priorities (1)

System Priority	Key points this month or actions and observations for the coming months
1. Urgent & Emergency Care **Focus on prevention, hospital avoidance and appropriate and timely discharge**	• In hospital – Industrial Action taking place in February had minimal impact on Ambulance Handover delays with reducing time lost for 3 out of the 4 weeks. County Hospital performance continues to report below expected levels impacting on overall Trust performance. • Emergency Department – Twice daily System Calls supporting 4-hour performance focus and gaining the assurance that clear processes are in place for early escalation of partner support to prevent breaches. System Control Centre (SCC) escalation regionally to Out of Area (OOA) delays to improve flow. • Weekly long length of stay reviews continue (for patients over 30 days stay currently excluding paediatrics and rehab). • Discharges - KPMG Test of Change (TOC) ensured the same level of support was maintained across the 4 initial wards with the TOC focused on pre-noon discharge and standardised working. Trust 'manual' for discharge to educate and standardise processes in progress as part of workstream 2. KPMG have completed week 6 of 8 weeks support with output to be managed via Non-Elective Improvement Plan (NELIP) workstreams. • Surge Plan Summary - Assessment of Trust wide deficit is -30 against plan of -28 with all acute planned capacity open. Focus remains on maximising alternative pre-hospital pathways and improving Simple and Timely (S&T) discharges. Above plan actions included MPFT standing up 35 spot purchase D2A beds, Outpatient Antibiotic treatment (OPAT) over performance and continuing System support with Acute Care at Home (ACAH). Focus over the next few weeks includes bank holiday planning and subsequent de-escalation, whilst the System has a lesson learnt event on the 17th April. • A plan to integrate Your Next Patient into Community Hospitals has been agreed and will begin with a view to improving patient flow. • Plans to deliver a fixed number of handovers per hour have been replaced by proactive management of offloads based on arrival patterns. Internal rapid handover protocol has been agreed by Execs subject to amendments • Plans to reduce DTAs in ED and urgent referral pathways, including professional standards, and agreed timelines for medics to see patients are ongoing in workstream 2 of NELIP. Numbers have significantly reduced resulting in the process transferring to business as usual.
2. Tackle Backlog (Planned Care) **Backlog reduction**	• UHNM are achieving the Patient Initiated Follow Up (PIFU) target, but this is not resulting in a reduction in follow-ups to the national target. Analysis of new to follow up ratio's (January 22/23 compared to January 23/24) shows 19 specialities (of 55, 34.5%) having a greater first to follow-up ratio and 36 with a reduction (65.5%). • 65+ week waits at UHNM were 1,084 in January, above the plan of 565. Monthly reductions are not in line with the plan. • 78+ week waits; increased to 128 at UHNM in January's monthly data. A total of 81 are forecast for the end of March and 16 are forecast at the end of April (latest forecast reported w/e 11th March). • 104+ week waits: Two at UHNM in January's monthly data. UHNM forecast for there to be no 104+ ww at the end of March and April (latest forecast reported w/e 11th March). • Diagnostic activity was below plan in January (across the 7 core tests) by 3.6%. MRI and Gastroscopy the only tests to exceed the plan. The percentage of patients seen in <6 weeks (at 75.8%) decreased (from December) and was below the monthly plan (of 78.3%). Performance has declined month on month since October 2023. • The 28-day faster diagnosis standard (FDS) was below plan and below the National Standard of 75% in January, at both UHNM (67.0%) and across the ICB (69.7% for all Providers).

Our 4 system priorities (2)

System Priority	Key points this month or actions and observations for the coming months
3. General Practice / Primary Care **Ensuring that residents have appropriate, timely and equitable access to services**	• GP appointments for January 2024 exceeded the monthly plan by 101,532 appointments (20.5%) and remains well above plan overall for 2023- 24. • The January 2024 Did Not Attend (DNA) rate was 4.2% - a decrease of 0.6% from December, in-line with previous seasonal trends. • The number of completed referrals to Community Pharmacist Consultation Service (CPCS) from General Practice remained stable for January 2024.The overall YTD target is being exceeded by 490 referrals (April 23 to January 24). No new data is available since the move to Pharmacy First on the 31st January. • Winter programme - extension agreed for schemes originally due to end on 31st March to include two weeks into April to support the Easter surge period. • The Scheduled Units of Dental Activity (UDAs) increased during January 2024, but remains below the contracted number. The ICB is impacted by corporate contract UDAs and the regulatory changes required to enact this have not yet gone through parliament. Draft dental strategy (expected publication April 2024), Health Equity Audit (expected March/April 2024) to be aligned with national dental recovery plan to formulate a local implementation plan. • Additional Roles Reimbursement Scheme (ARRS) stands at 490.9 Full Time Equivalent (FTE) for January 2024 and remains below plan however the FTE is expected to further increase as PCNs continue to deliver their revised plans. Monthly underspend is reducing, year to date (April to January) shows utilisation at 88.0% of the cumulative budget.
4. Complex Individuals **Improving access to high quality and cost-effective care for people with complex needs, which requires multi-agency management.**	Mental health: • Access to Children and Young People (CYP) community mental health services has dropped by over 1,200 contacts (rolling 12-months) so far this year, from 14,735 in April to 13,440 in January. North Staffordshire Combined Healthcare NHS Trust (NSCHT) identified an issue with their submissions and plan to resubmit the data for the current financial year. • The Dementia diagnosis rate at 71.9% in January, continues to exceed the national target of 66.7%. • Access to NHS Talking Therapies increased positively in January. However, Year to Date (YTD) performance is 29% below the [YTD] trajectory. • The number of people with Severe Mental Illness (SMI) having an annual physical health check in Q3 was 27% below the Q3 plan target of 6,092 (a shortfall of 1,637 patients). The ICB current position equates to 73% delivery compared to the Midlands regional average of 74%. An action plan to address data quality issues in reported performance and variation in Severe Mental Illness (SMI) physical health checks across general practice has been developed and shared with the Mental Health & Learning Disabilities and Autism Portfolio Learning Disabilities: • Patients with Learning Disabilities and Autism (LD&A) with an Annual Health Check (AHC): the February position is 69.9%, which is positively above plan (67.9%.)

Finance Summary

Following the H2 planning process being completed, a revised control total of £91.4m deficit was agreed by NHS England. As a result, the system has been allowed to move its forecast outturn to reflect this deficit.

All organisations are increasingly confident of delivering their risk adjusted forecast and managing the residual risks. On this basis, as a system, **we still believe that a deficit of £91.4m is our most likely position**.

The position includes risks around the fixed and variable aspects of Elective Recovery Fund (ERF), and we hold firm on our assumptions and reject bills related to overperformance associated to Urgent and Emergency Care (UEC), (Non-Elective admissions (NELs) and Accident and Emergency (A&E) attendances) amounting to £5.3m. These bills have been disputed on the basis the claim is outside the contracting guidance regarding the fixed element of the contract being based on provider cost base. Finally, forecast does not include any provision for band 2/3 retrospective payments as reported in prior months.

At month 11, at a system level we are reporting a year-to-date deficit position of £92.5m, which is a **£68.9m adverse variance** against the £23.7m deficit plan (Month 10 –year to date deficit £90.4m; variance to plan £69.5m). The year-to-date variance to plan sits within the ICB (£65.1m) and UHNM (£4.0m) with NSCHT and MPFT slightly better than plan. The main drivers behind this variance remain consistent with prior months, being:

- Continuing Healthcare (CHC) and prescribing costs being over and above the inflationary assumptions used within the system plan submission (£49.1m)
- Slippage on efficiency programmes within the plan (£12.8m)
- Retention of escalation beds longer than initially planned due to the ongoing UEC demands within the system (£7.0m)
- Other adjustments offsetting, including allocation clawback and programme underspends

Our capital plan remains overcommitted as expected, although mitigations have brought the overcommitment down significantly, we have an overspend regarding Project Star which are known to region and pressure in International Financial Reporting Standard 16 (IFRS 16) which we are managing as a system. Further detail on capital is set out in the quarterly capital update.

Month 11 Position

The general themes driving our financial position are CHC inflation & volume challenges, inflation in excess of plan in primary care prescribing and efficiency under-delivery. There are internal plans being developed and work ongoing to review the CHC challenges the system continues to face. Strong emphasis to close the efficiency gap remains, see the following slide.

	Month 11			Month 10		
	£m			£m		
System	Plan	YTD	Variance	Plan	YTD	Variance
Income	4,046.7	4,095.1	48.4	3,681.4	3,720.7	39.3
Pay	(1,102.2)	(1,094.9)	7.3	(1,000.8)	(991.9)	9.0
Non Pay	(570.2)	(637.9)	(67.7)	(518.7)	(576.9)	(58.1)
Non Operating Items (exc gains on disposal)	(26.3)	(18.0)	8.3	(23.9)	(16.4)	7.5
ICB/CCG Expenditure	(2,371.6)	(2,436.8)	(65.1)	(2,159.8)	(2,225.9)	(66.2)
Total	(23.7)	(92.5)	(68.9)	(21.8)	(90.4)	(68.5)
			-1.7%			-1.8%

	Month 11			Month 10		
	£m			£m		
ICB	Plan	YTD	Variance	Plan	YTD	Variance
Allocation	2,347.6	2,347.6	0.0	2,136.8	2,136.8	(58.1)
Expenditure	(2,371.6)	(2,436.8)	(65.1)	(2,159.8)	(2,225.9)	0.0
TOTAL ICB Surplus/(Deficit)	(24.0)	(89.2)	(65.1)	(22.9)	(89.1)	(66.2)
			-2.8%			-3.1%

	Month 11			Month 10		
	£m			£m		
UHNM	Plan	YTD	Variance	Plan	YTD	Variance
Income	976.0	1,022.1	46.1	886.9	926.8	39.9
Pay	(602.2)	(608.8)	(6.6)	(546.5)	(551.6)	(5.1)
Non-Pay	(347.4)	(395.0)	(47.6)	(316.3)	(357.8)	(41.5)
Non Operating Items (exc gains on disposal)	(25.6)	(21.5)	4.1	(23.3)	(19.5)	3.7
TOTAL Provider Surplus/(Deficit)	0.7	(3.3)	(4.0)	0.8	(2.1)	(2.9)
			-0.4%			-0.3%

	Month 11			Month 10		
	£m			£m		
MPFT	Plan	YTD	Variance	Plan	YTD	Variance
Income	571.4	577.2	5.9	519.6	523.3	3.7
Pay	(414.1)	(400.8)	13.3	(376.2)	(362.9)	13.3
Non-Pay	(160.1)	(181.9)	(21.8)	(145.4)	(164.5)	(19.1)
Non Operating Items (exc gains on disposal)	2.5	4.8	2.4	2.3	4.4	2.1
TOTAL Provider Surplus/(Deficit)	(0.3)	(0.6)	(0.2)	0.3	0.3	0.0
			0.0%			0.0%

	Month 11			Month 10		
	£m			£m		
NSCHT	Plan	YTD	Variance	Plan	YTD	Variance
Income	151.8	148.2	(3.6)	138.1	133.8	(4.3)
Pay	(85.9)	(85.3)	0.6	(78.1)	(77.4)	0.7
Non-Pay	(62.6)	(61.0)	1.7	(57.0)	(54.6)	2.4
Non Operating Items (exc gains on disposal)	(3.2)	(1.4)	1.9	(2.9)	(1.3)	1.7
TOTAL Provider Surplus/(Deficit)	(0.0)	0.5	0.5	(0.0)	0.5	0.5
			-0.3%			-0.4%

NHS
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Integrated Care Board

Enclosure No: 10

Board Committee Summary and Escalation Report

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

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
System Recovery Programme 2024/25	As previously reported, the 6 System Collaboratives and SROs have been agreed and work has started to scope the aims and ambitions and additional staffing resources needed. A high level programme plan to support the establishment of the System Collaboratives. Urgent work needs to take place to clarify what we can achieve in each of the System Collaboratives. To address this, an urgent SPG meeting is taking place on 3 April.	Progress in completing the Project Implementation Plans for the 6 System Collaboratives needs to be accelerated. Work has begun to develop the timeframe for achieving a System 'breakeven' position. This will be brought to the May Committee for discussion.
21 March Operational Planning Submission Overview	The paper provided an overview of the draft Operational Planning submission made to NHSE on 21 March 2024, focused on activity, workforce and finance. Weekly flash reports will be submitted with the final submission taking place on 2 May. Regarding the financial submission, following the national escalation meeting on 14 March, the System revised the financial deficit position and submitted an aggregate deficit of £139m (before technical adjustments). In addition, the System reported c£44m unmitigated risk within the financial returns. This leaves us well short of the expectation set by the national CFO of a 'material improvement from the 2023/24 outturn of £91m'. The reduction in the deficit has been driven by:	All NHS Members of the Committee outlined their view that achieving a System deficit of £139m in 2024/25 will be a very significant challenge which is not fully mitigated. Further work is taking place to refine the activity submission, in particular targets around '4 hour' A&E waits and elective 65 week waits.

	• Increasing the System efficiency ask to 4% of gross expenditure for all organisations • An estimated upside from revised NHS inflation figures • An estimate of cash out of £15m from the System Recovery Programmes, initially allocated against CHC.	
System Recovery Programme 2023/24	The paper provided an update on performance against the overarching metrics for the System Recovery Programme. The Committee noted the following escalations: • There is real System commitment to getting the Single Point of Access right and prioritising its mobilisation during Q2. However it will require a robust digital infrastructure, which will require investment. A further discussion on the investment required will take place at the next SPG meeting. • We are entering an important phase of evaluation for many of the recovery projects sitting in the E.L.F. Portfolio, which will determine whether/how they are taken forward in 2024/25. The Committee noted that a closure report will be completed to identify the successes delivered in 2023/24 and the learning that we need to take into 2024/25.	Board to note that the ambition to achieve a 'Single Point of Access' will require improvements in the digital infrastructure.
Integrated System Performance and Programmes Highlight Report	The Committee noted the Month 10 performance position against the key metrics in the Operating Plan. The Committee received escalations from the Portfolios and in particular noted the following: • WMAS data for Category 2 incidents indicates breathing problems, medical, and chest pain symptoms continue to account for almost 50% of calls for the month • The Scheduled Units of Dental Activity (UDAs) increased during January 2024, but remains below the contracted number • Autism assessment waits for CYP have increased. An	

	action plan has been agreed to improve performance, but it will take time before improvements are seen.	
Elective Care/Elective Recovery Plan	The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position. The report also provided details on the long-waiters who receive elective care outside of the Staffordshire and Stoke-on-Trent System. The Committee noted: • The good progress made in respect of 65ww breaches with an improvement of c1,200 patients since 11 February. • For the 78ww cohort, there were 81 breaches at the end of March.	Five patients breached 104ww at the end of February at UHNM / Medefer. A review is undertaken for every breach. There is a forecasted position of zero breaches for April. Outside the System, there were 2 104ww breaches at the end of February. A revised route to zero by the end of April for 78 week cohort has been developed but includes risks for 16 patients.
System Finance Month 11 Report	At Month 11, we are reporting a year-to-date deficit position of £92.5m which is a £68.9m adverse variance against the £23.7m deficit plan. The revised control total of a £91.4m deficit as agreed by NHSE is still believed to be the most likely position. Our capital plan remains overcommitted as expected (further details were provided in the Capital Update Report). Although mitigations have brought the over- commitment down significantly, we have an overspend regarding Project Star (Region are aware) and pressure in respect of IFRS16.	The position includes risks around the fixed and variable aspects of ERF but does not include any provision for Band 2/3 retrospective payments which could have a significant impact.
System Transformation and Service Change Update	The paper provided the monthly overview of the clinical areas included within the System Transformation and Service Change Programme and the latest version of the monthly service change return to NHSE. Key updates for the Committee focused on Urgent Treatment Centres, maternity and the Cannock Transformation Programme.	The ICB is waiting for RWT to share their strategic ambitions for the future of Cannock Chase Hospital. This will inform the future plans for the wider primary care estates plan. A short-life contract has been agreed to resume MRI scanning provision in the Cannock area. Discussions regarding the long-term solution for MRI provision in Cannock are continuing. A strategic meeting is being set up with colleagues from Primary Care, MPFT and Community Estates to discuss long term plans for Primary Care and GP provision in Cannock.

Urgent Treatment Centre Designation	The paper detailed the proposal for the three standalone UTCs for Staffordshire and Stoke-on-Trent to be designated and outlined the current gaps and risks against the national UTC principles and standards (specification).	The Committee noted and approved the process to develop the timeline for submission of evidence to NHSE for approval.
Integrated Community Hubs – Outline Business Cases	In January 2020, a Decision-Making Business Case (DMBC) was approved by the CCGs' Governing Bodies but the development of the Hubs was paused during Covid. Due to changes in the NHS capital regime and a worsening financial position nationally, it would not be practical or affordable to progress all four hubs simultaneously so MPFT has worked with local stakeholders to determine a preferred phasing of the developments and the Outline Business Cases (OBC) for capital funding for Stoke South and Staffordshire Moorlands Integrated Care Hubs were presented to the Committee. There will be a funding request made to NHSE as MPFT no longer have the capital resource limit but there will be a cost pressure to the System of c£1.5m together with a revenue impact of c£200k per case. The Committee approved both OBCs for submission to NHSE and requested the work up of Final Business Cases (FBCs).	The Longton OBC is revenue cost neutral, subject to the System recognising the cost of additional activity from the site. The Leek OBC has a net revenue cost of £1.5m. The FBCs will be required to identify the net revenue cost by the utilisation of these facilities to support the delivery of the System recovery, therefore creating a revenue neutral solution for the System.
System Surge Winter Plan Update	The report provided an assessment against the plan, the mitigations and escalated risks. The Committee noted the following escalations: • Rapid Social Care and Care Home Support schemes are under-delivering against plan, with limited referrals and usage to date • Golden Park EoL beds remain underutilised, the service is to cease at the end of March (with closedown arrangements in place for admitted patients) • Acute Care At Home workforce remains fragile although some recruitment has taken place.	
ICS Capital Update	The paper provided an update on the current main capital schemes developments from the work of the	Discussions are continuing with NHSE on the phasing of capital allocations to support the

	Capital Investment Group and the draft plan for 2024/25. The Group are maximising the capital resource available to the System and we have a current over-commitment of £3.3m. We are working closely with Region to mitigate the pressures. The Committee noted that the Joint Capital Resource Utilisation Plan (JCRUP) which is normally published from 1 April each financial year has been deferred by NHSE to 30 June. This will be shared at the June Committee meeting. The Committee noted that the System is in discussion with NHSE regarding the CDC and timelines on mobilisation.	mobilisation of the Stoke Community Diagnostic Hub.
System Risk Register	There are 27 risks on the System Risk Register of which 16 are high scoring (12 and above) and there are 9 medium risks and 2 low risks. The Committee approved: • The addition of new Risk 1294: System Surge Capacity De-Escalation • The closure of Risk 1216: Mobilisation of System Surge Capacity • The closure of Risk 1170: Totally PLC Sustainability • The closure of Risk 1234: Acute Care at Home Workforce and Capacity Pressures • The closure of Risk 1232: UHDB Winter Pressures • The closure of Risk 1170: Urgent and Emergency Clinical Assessment Service (CAS) • The increase in risk score from 10 to 15 for Risk 1180: NHS Provider Licence • The increase in risk score from 9 to 12 for Risk 1286: Direct booking into Primary Care from NHS 111 • The reduction in risk score from 12 to 9 for Risk 1217: Responsive Elective Care - reduction and clearance of long waiters (104, 78 and 65ww) • The reduction in risk score from 16 to 8 for Risk 1233: UHNM/MPFT NHS 111 Booking System (EDDI)	

	The Committee has good sight of the top risks for finance, performance and transformation.	
Quarter 4 2023/24 BAF Update	The report set out the refreshed Board Assurance Framework (BAF) for Quarter 4 for 2023-24. The Committee noted the changes from Q3 and that work is now being progressed to set the System BAF for the 2024/25 as the strategic objectives from 2023/24 have not changed.	
PART B		
ICB Efficiency 2023/24 Performance	The paper reported on the achievement against the 2023/24 efficiency plan. The Committee took assurance from the remedial actions taken by the organisation against the plan with a year-end forecast over-delivery of £3.1m against a previously reported (£30.0m) prior to implementation of the Recovery Plan. The Committee was pleased to note the achievements of the programme particularly that CHC efficiency delivery is now forecasted to over-deliver the £21.4m target by £1.4m in-year with a recurrent full year effect of £44.5m. The Committee noted that the final Prescribing PMD data is not yet available but the risk of an adverse movement is minimal.	The Efficiency Oversight Group will continue into 2024/25. Project Initiation Documentation is now being produced at pace to support the 2024/25 programme, with the challenge to the organisation to submit PIDs for review by 5 April and to be approved prior to scheme implementation. FPC will continue to receive a monthly report on efficiency performance.
ICB Finance Report (Month 11)	The paper reported an ICB year-to-date deficit position of £89.2m against a planned deficit of £24m, creating an adverse variance to plan of £65.1m. The ICB continues to be confident in delivering the £91.4m deficit forecast subject to successful settlement of NHS contract risks.	The Committee approved the ICB's Month 11 forecast position of a £91.4m deficit.
ICB 2024/25 Interim Budget	Following approval of the 2024/25 £48.6m deficit interim budget at the last Committee meeting, improvements of £25.8m have now been included and further work will continue until the final submission on 2 May. A draft deficit budget of £22.8m was submitted to NHSE on 21 March.	The Committee approved the budget improvements set out within the paper whilst noting the level of risk and the steps being taken to mitigate this.
ICB Procurement Operations Group Highlight Report	The paper reported the key activities being co-ordinated by the Procurement Operations Group and	The Committee approved the award of the Tier 3 Gynaecology contract following

	in particular the actions being taken to ensure the ICB is able to implement the new Provider Selection Regime Regulations. The Committee • Noted the update on Provider Selection Regime and endorsed that the principles from 2023/24 continue for 2024/25 including the approach to recording and audit of ICB Decision Making Records • Approved the award of the Tier 3 Gynaecology contract in line with the recommendations following the conclusion of the open market procurement • Noted the updates within the open procurement programme, including action to address the clinical risk on the ICB Risk Register relating to MRI services for patients in Cannock.	the conclusion of the open market procurement.
Caseload of Individual Placements Quarterly Review	The paper provided an overview of the current bespoke funding arrangements including support packages that are jointly funded with the Local Authorities The Committee noted that significant work is underway in terms of S117 and Transforming Care (TCP) and work is ongoing to collate an overview of all cohorts in receipt of joint funding via health and social care at place level to support further development opportunities.	
Single Tender Waiver – Optum Accelerate Programme	Following a discussion under the Medicines Optimisation Update item at last month's Committee meeting, negotiations have taken place with Optum regarding a service to deliver medication switches at scale and pace. Their model is based on a gain share arrangement whereby their fee is a proportion of the savings made. The programme is in two parts, an initial pilot phase and, subject to success criteria being met, a roll-out across the wider System.	The Finance and Performance Committee approved the contract with Optum to deliver up to £5m savings in prescribing efficiencies.
Primary Care Forum Report	In order to have governance oversight, the Committee received a summary report of the meeting that took place on 12 March. This reported on the discussions on Primary Care finances, General Practice and Pharmacy, Optometry &	The Committee noted the ongoing work to mitigate the risks regarding the contract termination notice at the Gordon Street Surgery.

	Dental (POD).	
ICB Risk Register Report	There are 13 risks on the ICB Risk Register of which 8 are high scoring (12 and above) and there are 4 medium risks and one low risk. The Committee approved the following new risks: • Risk 1285: Ambulance dispatches from the incoming NHS 111 provider • Risk 1288: Mental Health Investment Standard (MHIS) 2023/24 • Risk 1294: System Surge Capacity De-Escalation The Committee approved the increase in risk score from 9 to 12 for Risk 1286: Direct booking into Primary Care from NHS 111. The Committee approved the closure of Risk 1216: Mobilisation of System Surge Capacity as no further escalation capacity is to be opened as the System moves out of Winter/Surge.	
All Age Continuing Care (AACC) Arrangements	The Committee discussed the options presented in the report, and agreed with the recommended hybrid approach.	This report is being presented to the April Board meeting with the approval of the Committee.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions that took place at the Committee. Specific risks are highlighted above, and in the FPC Risk Register.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 11

Report to:	**Integrated Care Board**					
Date:	**18 April 2024**					
Title:	**Quarter 4 2023-24 Board Assurance Framework (BAF) Update**					
Presenting Officer:	Claire Cotton, Director of Governance					
Author(s):	Tracey Revill, Interim Deputy Head of Governance					
Document Type:	Report					
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☒	**Assurance (S)**	☒
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	NO				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	BAF Report					

(1) Purpose of the Paper:

The enclosed report sets out the refreshed Board Assurance Framework (BAF) for Quarter 4 2023-24 for approval. The Q4 BAF has been presented at Execs and SLT, no further comments have been received.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Finance and Performance Committee	02/04/2024
Quality and Safety Committee	10/04/2024

(3) Implications:

Legal or Regulatory	UK Corporate Governance Codes and Controls Assurance Audits. BAF completion is a key component of the ICB's Risk Management Strategy.
CQC or Patient Safety	There are no implications for CQC or other regulators
Financial (CFO-assured)	Managing financial risks will help mitigate Financial Management Concerns
Sustainability	Managing 'Greener NHS' risks will help mitigate Sustainability Concerns
Workforce or Training	There are no workforce training implications resulting from this paper
Equality & Diversity	Not applicable in relation to the BAF
Due Regard: Inequalities	Not applicable in relation to the BAF
Due Regard: wider effect	Not applicable in relation to the BAF

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why Not applicable in relation to this report.* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Not applicable in relation to this report.
	QIA	☐	☐	☒	*If N, why Not applicable in relation to this report.* *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Not applicable in relation to this Report

(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 enclosed report sets out the refreshed Board Assurance Framework (BAF) for the final Quarter 4 for 2023-24. The BAF has been structured around eight key strategic risks, previously agreed by the Board, which threaten the achievement of the Strategic Ambitions set out within the ICP strategy and has been mapped accordingly. The BAF has also been circulated to People, Culture and Inclusion committee members as there is no meeting in April 2024.

The Board is asked to note the following:
• Risk scores for BAF 1, 5, 6 and 7 have remained the same as the previous quarter and have not achieved the target score within the timeframe; consideration should be given to revised target dates for the 2024/25 BAF
• There has been a reduction in risk for BAF 2 and BAF 3 although BAF 2 has not achieved the target score within the timeframe; again, consideration should be given to revised target dates for the 2024/25 BAF
• All assurance assessments have remained the same as reported in quarter 1
• BAF 8 has seen a reduction in risk score and this is now in line with the target score and timeframe

The business cycle for presentation of the BAF has been reviewed at the request of the committees and the BAF will be presented to the committees and board the month following the quarter end, any updates received following the close-down of the BAF will be presented in a slide to the committee.

Work is now being progressed to set the System BAF for the 2024/25 BAF as the strategic objectives from 2023/24 have not changed.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to Receive the BAF and consider whether the Q4 risk scores and assurance assessments are an accurate reflection of the position, noting the changes above and that the BAF will be presented at committees and board the month following the quarter end.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board

Board Assurance Framework (BAF)

Quarter 4 2023/24

1. Introduction and High Level Overview

Situation

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

Background

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

To develop the ICB BAF for 2023/24, strategic risk 'headlines' were identified by lead directors in February 2023. In doing this, they brought forward six risks from the 2022/2023 BAF, although each has been reviewed and amended to reflect the current position. Two additional risks were also identified for inclusion (BAF 3: Proactive and Needs Based Community Services and BAF 7: Improving Productivity).

Those 'headline' Strategic Risks were approved by the Board April 2023 and it was agreed that the first full BAF would be presented in July 2023 and quarterly thereafter.

The BAF is a dynamic, ever evolving document which has and will continue to be developed and improved in terms of format and function throughout 2023/24 and beyond.

Assessment

	**BAF 1: Responsive Patient Care (Urgent and Emergency)** • Risk level has remained at High 20 during quarter 3 and quarter 4 and has not yet achieved the target risk score by the planned date • Of the 6 actions identified, 3 are delayed and 3 are on track • In the top 5 system risks
	**BAF 2: Responsive Patient Care (Elective)** • Risk level has reduced for the first time during the year to High 12 although has not yet achieved the target risk score by the planned date • Of the 5 actions identified, 2 are complete, 1 is on track and 2 are delayed • In the top 5 system risks
	**BAF 3: Proactive Needs Based Community Services** • Risk level has reduced for the first time in the year to High 15 and remains on track to achieve the target risk score by planned date • Of the 8 actions identified, 6 are complete and 2 are on track
	**BAF 4: Reducing Health Inequalities** • Risk level has remained at High 20 through the year although the target date for reduction is not until March 2028 given the nature of this risk • Of the 7 actions identified, 4 are complete and 3 are on track
	**BAF 5: High Quality, Safe Care Outcomes** • Risk level has remained at High 16 for the year and has not yet achieved the target risk score by the planned date • Of the 3 actions identified, all are on track • In the top 3 system risks
	**BAF 6: Sustainable Finances** • Risk level has remained at High 20 for the year and has not yet achieved the target risk score by the planned date • Of the 3 actions identified, all are complete • In the top 3 system risks
	**BAF 7: Improving Productivity** • Risk level has remained at High 16 during quarter 3 and quarter 4 and has not yet achieved the target risk score by the planned date • Of the 3 actions identified, 1 is complete and two are on track • Assurance rating has reduced from acceptable to partial during the quarter
	**BAF 8: Sustainable Workforce** • Risk level has reduced to High 16 for the first time during the year and is now in line with the target • Of the 4 actions identified, 3 are on track and 1 is delayed • No 1 in top system risks although is scored higher for the ICB than for providers

Recommendations

Committees are asked to:

- Consider whether the Quarter 4 Risk Scores and Assurance Assessments are an accurate reflection of the position

- Consider whether the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance
- Note that further work is to be undertaken on Committee Business Cycles to ensure full alignment with the BAF

Additional Information

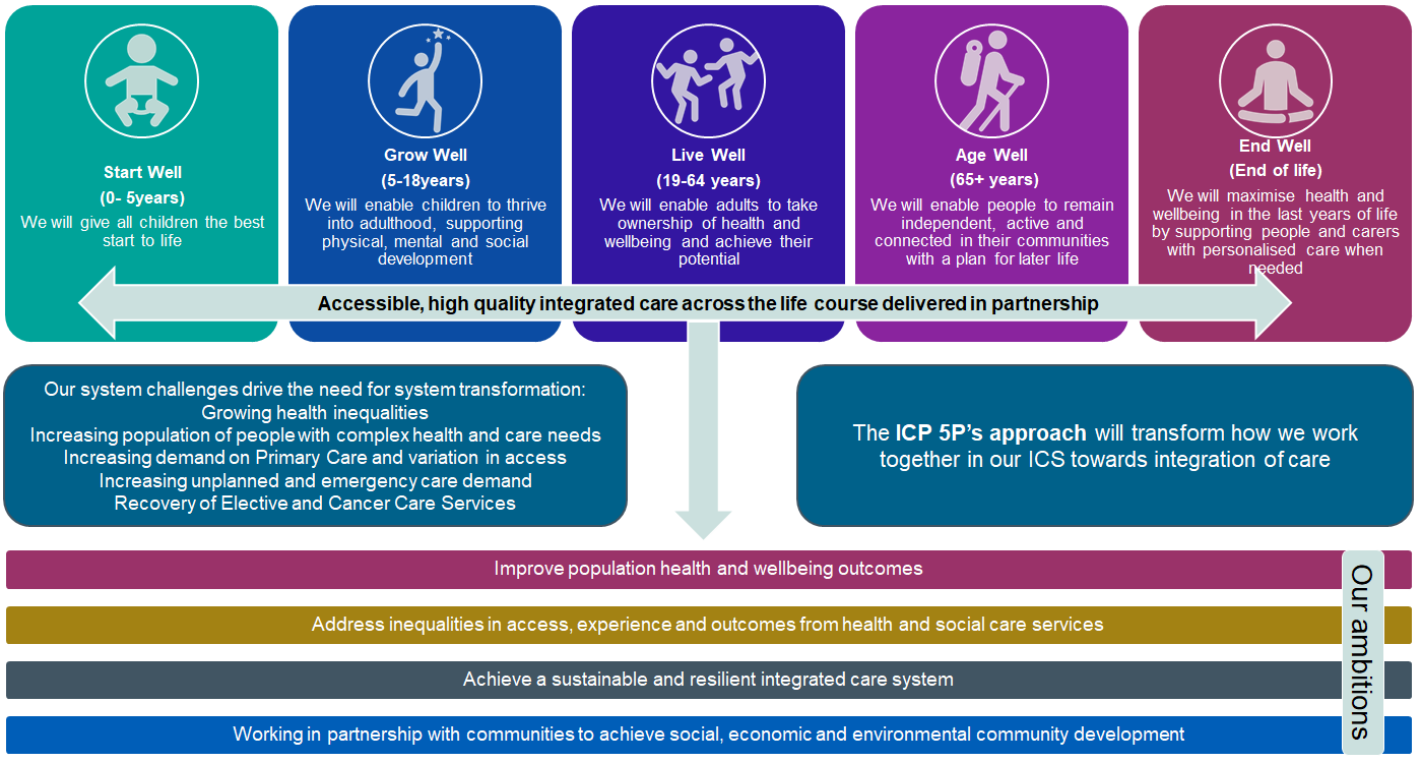
- The BAF can be viewed on SharePoint: Q4 ICB BAF 2023-24 - UPDATED.docx (sharepoint.com)
- The following tables set out the keys used within the BAF for Action Plans and Assurance Assessment Ratings

BAF Action Plans – Key to Progress Ratings	
Complete / BAU	Action completed, now business as usual
On Track	Improvement on trajectory, on track, or completed
Problematic	Delivery remains feasible, actions not completed, awaiting further interventions
Delayed	Off track / trajectory / milestone breached. Recovery plan required.

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

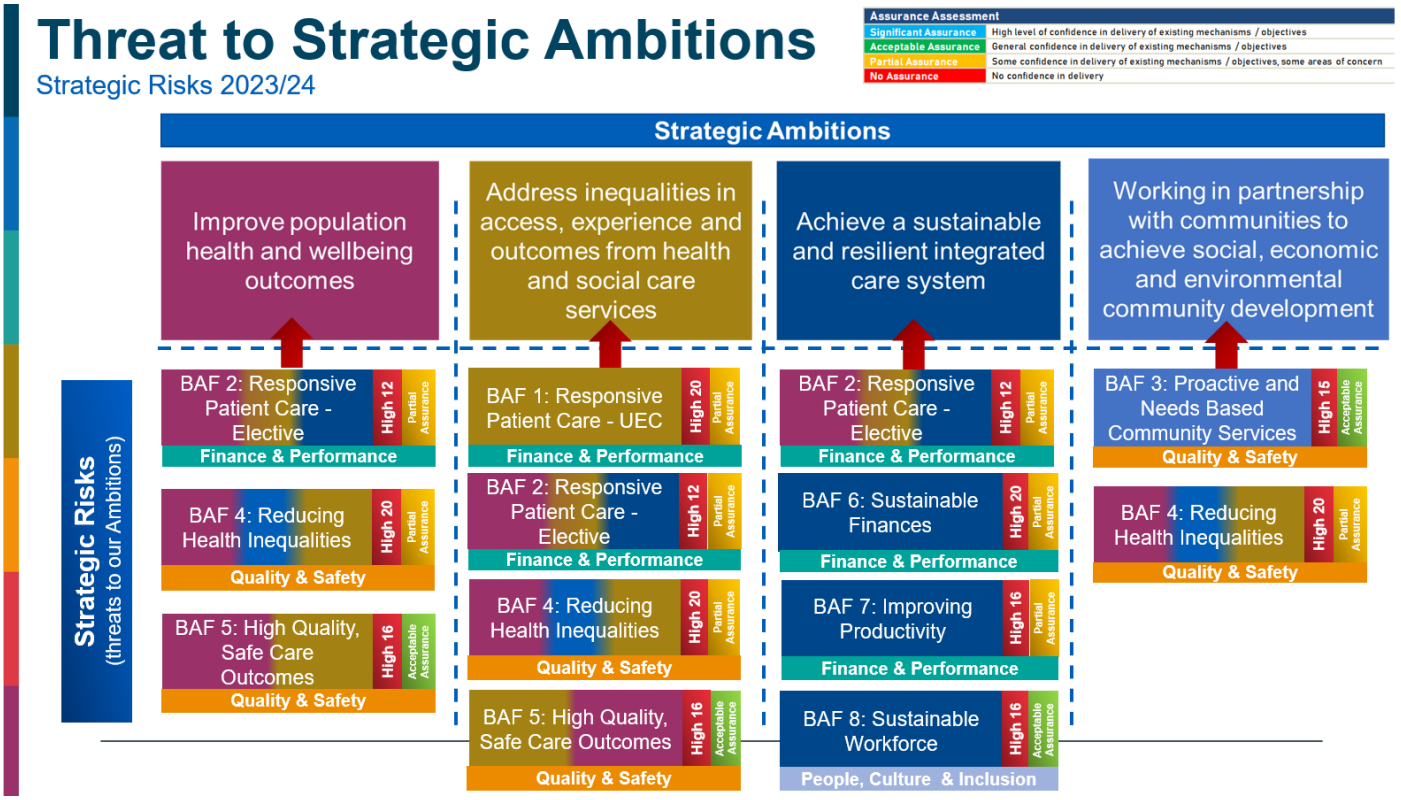
2. Strategic Framework

The Strategic Ambitions identified within the BAF form part of the Strategic Framework within the ICP Strategy.



3. Board Assurance Framework on a Page

This provides a high-level overview of our BAF, setting out the Strategic Risks which pose a threat to our Strategic Ambitions, overlaid with Quarter 4 Risk Scores, Assurance Ratings and Responsible Committees.



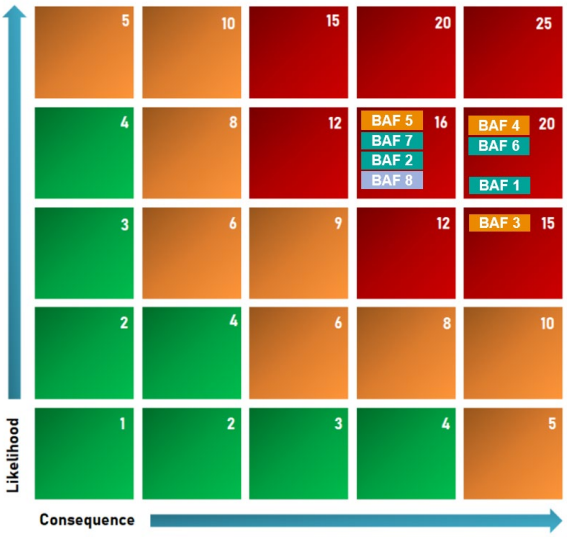
4. Summary Board Assurance Framework – Risk Movement

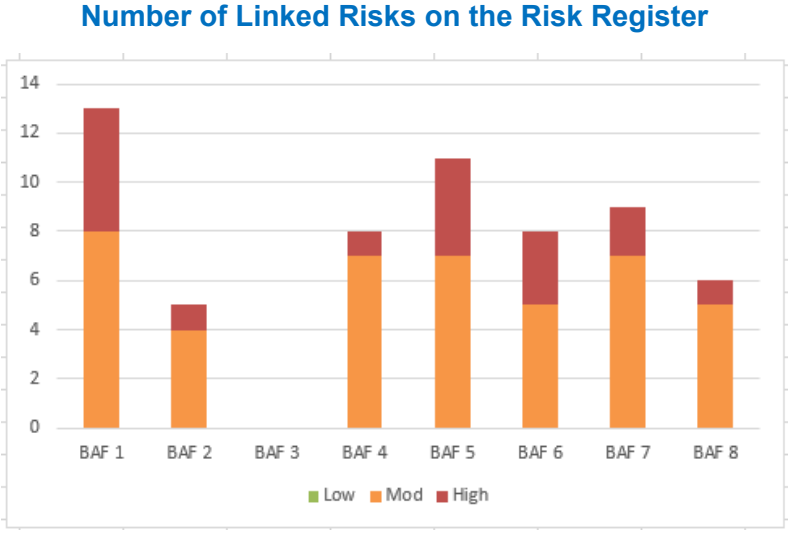
The below summary demonstrates the movement of risk scores throughout 2023/24 as they progress towards their target, along with their assurance rating, summary action plan based on BRAG criteria and threat to ambitions:

- Risk scores for BAF 1, 5, 6 and 7 have remained the same as the previous quarter and have not achieved the target score within the timeframe; consideration should be given to revised target dates for the 2024/25 BAF
- There has been a reduction in risk for BAF 2 and BAF 3 although BAF 2 has not achieved the target score within the timeframe; again, consideration should be given to revised target dates for the 2024/25 BAF
- All assurance assessments have remained the same as reported in quarter 1
- BAF 8 has seen a reduction in risk score and this is now in line with the target score and timeframe

No.	Strategic Risk Title	Q1			Q2			Q3			Q4			Target				Risk Change	Assurance Assessment	Action Plan	Threat to Ambitions
		L	C	S	L	C	S	L	C	S	L	C	S	L	C	S	Date				
BAF 1	Responsive Patient Care - Urgent & Emergency Care	3	5	High 15	3	5	High 15	4	5	High 20	4	5	High 20	3	5	High 15	31/01/2024	→	Partial Assurance	3, 3	SA2
BAF 2	Responsive Patient Care - Elective	5	4	High 20	5	4	High 20	5	4	High 20	4	3	High 12	2	3	Mod 6	31/03/2024	↓	Partial Assurance	2, 2, 1	SA1, SA2, SA3
BAF 3	Proactive and Needs Based Community Services	4	5	High 20	4	5	High 20	4	5	High 20	3	5	High 15	2	4	Mod 8	31/03/2026	↓	Acceptable Assurance	2, 6	SA4
BAF 4	Reducing Health Inequalities	4	5	High 20	4	5	High 20	4	5	High 20	4	5	High 20	2	2	Low 4	31/03/2028	→	Partial Assurance	3, 4	SA1, SA2, SA4
BAF 5	High Quality, Safe Care Outcomes	4	4	High 16	4	4	High 16	4	4	High 16	4	4	High 16	3	3	Mod 9	31/03/2024	→	Acceptable Assurance	3	SA1, SA2
BAF 6	Sustainable Finances	4	5	High 20	4	5	High 20	4	5	High 20	4	5	High 20	4	3	High 12	31/03/2024	→	Partial Assurance	3	SA3
BAF 7	Improving Productivity	4	4	High 16	3	4	High 12	4	4	High 16	4	4	High 16	3	3	Mod 9	31/03/2024	→	Partial Assurance ↓	2, 1	SA3
BAF 8	Sustainable Workforce	4	5	High 20	4	5	High 20	4	5	High 20	4	4	High 16	4	4	High 16	31/03/2024	↓	Acceptable Assurance	1, 3	SA3

5. Strategic Risk Heat Map and Linked Risks





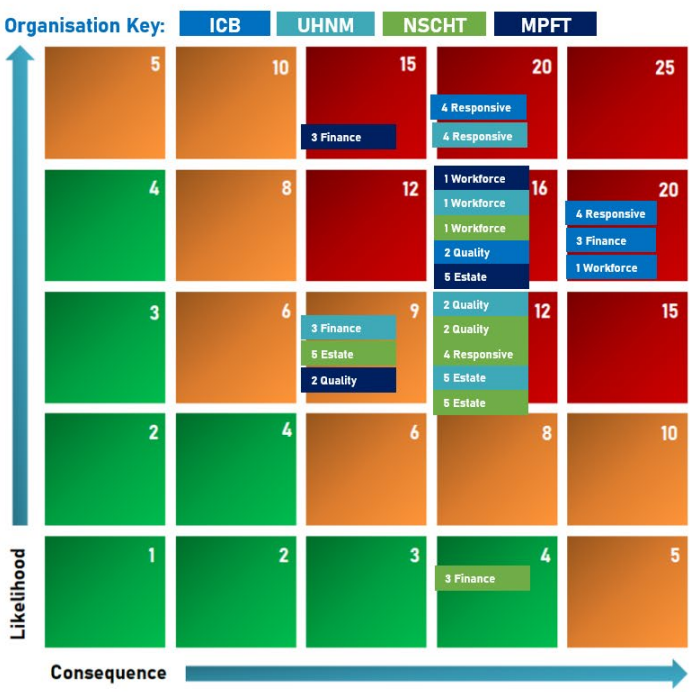
Finance & Performance Committee | Quality & Safety Committee | People, Culture & Inclusion Committee

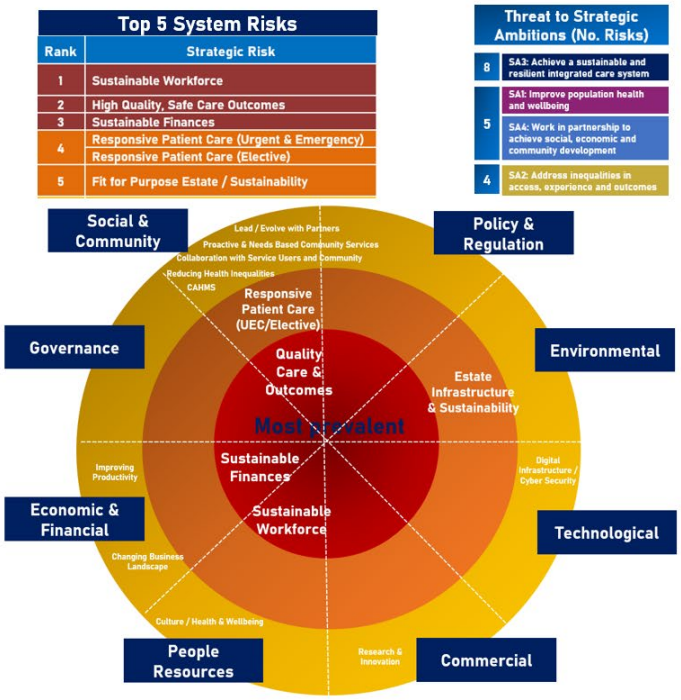
6. System Strategic Risk Map (Q3 Risks)

The below 'System Strategic Risk Map' represents the mapping of strategic risk across the system and has been refreshed for quarter 3 BAF data. This identifies our 'Top 5 System Risks' based on their prevalence in BAF's across the system which are displayed in the below risk matrix, by organisation.

The Risk Radar displays these risks against a range of risk categories, which, whilst not previously used within our BAF, are nationally recognised and used in models of best practice.

A key observation made through the Governance and Risk Network is that there is variation in risk scores for the same risk across the system; most notably that 'Workforce' risk is scored higher by the ICB than the providers. This should be taken into consideration when developing the System BAF (SBAF) for 2024/2025.





The full mapping of strategic risks across the system is displayed below including those that are not within the 'Top 5'; risks which are only present in 1 or 2 BAF's across the system are listed below from 6 – 12.

System Risk – Mapping of SSOT ICS Strategic Risks from Board Assurance Frameworks (Quarter 3 23/24)									
Rank	Strategic Risk	ICB	UHNM	NSCHT	MPFT	SA1	SA2	SA3	SA4
1	Sustainable Workforce	20	16	16	16			●	
2	High Quality, Safe Care Outcomes	16	12	12	9	●	●		
3	Sustainable Finances	20	9	4	15			●	
4	Responsive Patient Care (Urgent & Emergency)	20	20	8			●		
	Responsive Patient Care (Elective)	20				●	●	●	
5	Fit for Purpose Estate / Sustainability		12	9 12	16			●	
6	Reducing Health Inequalities	20	20			●	●		●
7	Digital Transformation / Infrastructure / Cyber Security		12		20 15			●	
8	Leadership, Culture & Values (including EDI) / Staff Health and Wellbeing		12		12 6			●	
9	Proactive & Needs Based Community Services	20							●
10	Improving Productivity	16						●	
11	Collaboration with / Feedback from Service Users, Carers & Communities			12		●			●
	Lead / Evolve Relationships with Partners			12					●
	Changing Business Landscape				12			●	●
12	Research & Innovation		9			●			

7. Board Assurance Framework (BAF)

BAF 1: Responsive Patient Care – UEC

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions		
Cause (likelihood)	**Event**	**Effect (Consequences)**
If the Urgent and Emergency Care (UEC) system does not have sufficient capacity across the entire pathway to meet demand and support flow	Then should demand outstrip capacity, there will be pressure points within the UEC system	Resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance

SA1	Improve Health and Wellbeing Outcomes	
SA2	Address inequalities in access, experience and outcomes from health and social care services	✓
SA3	Achieve a sustainable and resilient integrated care system	
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk			
Committee:	Finance & Performance	**Lead Director:**	Chief Delivery Officer

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	3	3	4	4	3	31/01/24	The tolerance is set at 15, the consequence of not having capacity in the UEC system will inevitably result in domino effect where patients are not able to timely access the urgent and/ or emergency care they require. The biggest risk is having long waits for emergency ambulances.
Consequence	5	5	5	5	5		
Risk Level	High 15	High 15	High 20	High 20	High 15		

Rationale for Risk Score and Progress Made in the Quarter:

Within Q4 there have been challenges with flow in the UEC System resulting in an increase in ambulance handover delays which has subsequently impacted our average category 2 response time. The 23/24 average currently sits at 41 minutes 11 seconds (as of w/e 3rd March 23). As part of Surge Planning, we have built our plans using the SSOT bed model. The SSOT predicted bed model demonstrates that the SSOT system always requires a level of escalation open, this is due to historically not having sufficient core capacity. The bed model utilises a robust evidence base and is supported by all partners. The Surge Plan has been through all partner organisational Boards for sign off and it is well recognised that there is an expected bed deficit throughout all Q3 and Q4 in 2023/24. As part of the Surge Plan, the system has a System Escalation Plan in place, which received formal sign off through the UEC Board on the 13th of December 2023. The System Escalation Plan outlines the system's agreement and commitment to manage risk during times of pressure.

The plan was built to mitigate the bed deficit to agreed manageable levels, however, due to staffing constraints of registered and qualified staffing groups in UEC and late confirmation of funding aligned to the Local Authority bid process, a delay was experienced in some schemes onboarding. March had an expected planned -1 deficit, given removal of expected EOL hospice provision, the best-case scenario has been adjusted to -10 bed deficit. As of 8th March 179/190 acute beds/acute bed equivalent mobilised, including capacity above plan, taking medicine deficit to -12.

As part of the national operational plan SSOT had submitted a Short Form Business Case to the national team to increase the Royal Stoke acute bed capacity by 45 beds to meet demand during 23/24 peak surge. The additional bed capacity was imperative to the delivery and compliance of the national operational plan. Whilst further core capacity has opened by baselining escalation capacity, the modular build remains incomplete and has not been available to support 23/24 surge.

	Q4 22/23	Q4 23/24	Q4 variance on previous Year (Q4)
4hr ED Performance	65.80%	64.50%	-2.0%
12hr ED Performance	9.40%	10%	+4.3%
Hours Lost due to Ambulance Handovers*	7792	10055	+29.0%
Category 2 Response Times**	00:31:00	00:49:27	+59.5%

4-hour ED performance has seen a refreshed focus towards achieving 76%, and 12 Hour ED performance remains a key priority focus area within Tier 2 reporting, surge planning and the UEC Improvement Plan.

The UEC Portfolio recognises that the UEC Improvement plan required an in-year refresh within the In-Hospital programme given the expected benefits of the plan were not coming to fruition. The plan has been refreshed and continues to form part of the wider system UEC plan, which will be carried forward and evolve as part of 24/25 planning.

Q4 has brought significant challenges due to peaks in demand and IPC pressures. During this period we have seen 2 instances of Critical Incident for UHNM. Across the whole of 23/24 we have had 13 periods of industrial action. Whilst the surge plan has operated well in bringing additionality in capacity for the system, we have not achieved enough to reduce/eliminate delays. For this reason the target risk score has not been achieved.

Key Controls Framework	
Key Controls:	• Daily System Control Centre & Daily System Calls Daily • Regional Capacity Calls attended by System Control Centre • System UEC Priority Plan/Operational plan – the system has agreed a 7-point focused plan to drive improvements across the UEC system. As part of the national operational plan SSOT has submitted a Short Form Business Case to the national team to increase the Royal Stoke capacity by 45 beds to meet demand during 23/24 peak surge • System UEC 23/24 Surge Plan has been developed through a multidisciplinary approach and has been signed off through an extension governance route including all partner organisational Boards. • System Control Centre – The SCC was mobilised in December 22 and remains in place. The SCC proactively manages the daily capacity and demand across the system and leads daily system COO calls to manage pressure • System Escalation Plan –the refreshed system escalation plan has been developed with system partners. Following consultation with regional NHSE colleagues, the UEC Board signed off the revised System Escalation Plan on 13th December to ensure there is an appropriate framework for managing risk and escalation across the ICS • System UEC Strategy – whilst outlining longer term plans of improvement, the UEC Strategy development ensures that the UEC Portfolio has a clear vision for UEC development, any in year improvements will be striving to meet the improvements set out in the long-term System UEC Strategy • ICB F&P Committee + System Performance Group –These groups are tasked with being assured on delivery, and offer good-strength controls into the decision-making processes, supporting the other principal controls outlined. Surge reports monthly to these forums.

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q1**	**Q2**	**Q3**	**Q4**
1st Line (Organisation)					
2nd Line (System)	System Performance Report to Finance & Performance Report to F&P Committee and ICB Board				
	Monthly updates to System Delivery Group				
	Monthly updates to Finance and Performance Group				
	Monthly update to System Performance Group				
	Monthly update to Finance and Performance Committee				
	Fortnightly SLT update				
	Surge Plan Assurance by: • UEC Board • CYP Programme Board • UEC Clinical Advisory Group • Finance & Performance Committee • UHNM Trust Board • Clinical Senate • SOTCC Operational Business Meeting • MPFT Trust Board • SCC Health & Care SLT • Staffordshire Health OSC • System Quality Committee • ICS People, Culture & Inclusion Committee				
3rd Line	Tier 2 UEC Improvement framework – exec weekly oversight				
	Surge Plan Assurance				

(External / Independent)	NHS England - Surge Plan Assurance Template				
	NHS England Regional Assurance Visit				

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

Gaps in Control or Assurance

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

- Residual Bed Capacity gap
- Workforce deliverability across all areas of UEC pathway
- Industrial action
- Surge beyond the predicted peak
- COVID restrictions applied in Care Home market
- Unforeseen demand due to major incident
- Individual organisation risk management

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	23/24 Surge Plan to be agreed ICB Board	Agreed trajectory to increase capacity	Chief Delivery Officer	18/11/23	Surge Plan developed. There remains a residual bed gap.	
2	National capital bid submission for increased G&A capacity	45 additional acute beds available at RSUH	Chief Delivery Officer	01/12/23	Funding agreed, however due to delay in approval the additional beds through the modular build will not be available for 23/24. On the 1st December, there was an increase in the beds above core to demonstrate increased bed base.	
3	Delivery of System UEC Improvement Plan against trajectory	Achieve Operational Plan requirements Bed occupancy – 92% Cat 2 response – 30 mins	Chief Delivery Officer	31/03/24	Delivery underway. Improvements have been seen, however off track in line with trajectory.	
4	System Escalation Plan	Plan to cover risk arising from • Bed capacity gap • Surge beyond predicted peak • Covid restriction in Care Homes	Chief Delivery Officer	30/10/23	Agreed and signed off by UEC Board 13th December following consultation with NHSE regional colleagues	
5	Industrial action	There are plans in place to deal with each incidence of industrial action	Chief Delivery Officer	31/03/24	This remains a risk as the level and frequency of the industrial action are unknown	
6	Workforce deliverability across all areas of UEC pathway	Overarching workforce plan, underpinned by workstream & service level plans including transformation, supply, training and OD	Chief Delivery Officer/ Chief People Officer	31/03/24	In progress and improved since Q3. Approach to workforce plan agreed, scoping underway within workstreams and services to identify workforce requirements, risks and plans to mitigate	

No. Linked Risks on Risk Register		
Low (1-4)	Mod (6 – 10)	High (12 – 25)
0	8	5

BAF 2: Responsive Patient Care – Elective

ICS	✓
ICB	✓

Risk 2 Responsive Patient Care – Elective		
Cause (likelihood)	**Event**	**Effect (Consequences)**
If the system fails to deliver on the specific expectations set out in the 23/24 (and earlier) planning guidance relating to waiting time recovery	Then waiting times will not reduce in line with national expectations	Resulting in potential patient harm and reputational damage to the ICS in addition to a potential claw-back of ERF funding

SA1	Improve Health and Wellbeing Outcomes	✓
SA2	Address inequalities in access, experience and outcomes from health and social care services	✓
SA3	Achieve a sustainable and resilient integrated care system	✓
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk

Committee:	Finance & Performance	**Lead Director:**	Chief Delivery Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	5	5	5	4	2	31/3/24	The tolerance to failing to deliver against this risk should be low- as underachievement will have a knock-on effect to subsequent milestones. All efforts must therefore be focussed on delivery.
Consequence	4	4	4	3	3		
Risk Level	High 20	High 20	High 20	High 12	Mod 6		

Rationale for Risk Score and Progress Made in the Quarter:

- As a system we have effectively utilised Independent Sector capacity to support clearance of long waits.
- UHNM have not delivered on the original milestones associated with 104 and 78 week waits but have seen 13 periods of Industrial Action throughout 23/24 and 3 Critical Incidents which impacted on elective activity delivery
- However, despite this - progress has been made in reducing the 104, 78 and 65ww cohorts, with an expectation that we will achieve zero 78s by the end of April 2024, and an expectation that 65ww will be cleared by September 2024
- On this basis, the risk score has improved but not achieved the year-end target.

Key Controls Framework

Key Controls:

- Weekly tier 1 accountability meetings with NHSE
- 23/24 operational plan delivery and reporting
- Portfolio performance steering group (reporting to portfolio Board)
- Weekly meetings in place to ensure maximisation of independent sector capacity and tracking of long wait patients
- Regular monitoring backlogs of Staffordshire and Stoke-on-Trent patients in other systems to ensure equitable access to recovery milestones.
- Portfolio Board oversight of plans to monitor utilisation of additional capacity
- Weekly meeting with UHNM to review specialty level challenges, to support transfer of long-waiters to alternative providers. Including focus on rescheduling/reprioritising listed patients to achieve the milestones.
- UHNM improving productivity through GIRFT review and best practice adoption
- NHS-E supporting provision of mutual aid monitored through weekly meetings
- Opening of tier 3 community Gynae service in Stafford & Cannock (~40% acute activity)
- New Independent Provider is supporting long waits in Gastro-Colorectal and other medical pathways
- Review of core capacity and demand across the system

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Organisation)	Weekly performance updates via tier 1 meeting providing ”live” sitreps against trajectory and mitigations				
2nd Line (System)	System Performance Report to Finance & Performance Committee & ICB Board				
3rd Line (External / Independent)					

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

Gaps in Control or Assurance

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

- Workforce deliverability across challenged specialties
- Capacity plans in some specialties to meet demand – ICB team to maintain focus on development of appropriate community capacity to direct patients to the most appropriate setting through commissioning and contracting of additional provision
- Industrial action impact – need to fully understand impact of Industrial action in elective cancellations which compromises delivery of ambitions.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1.	Opening of tier 3 community Gynae service in Stafford & Cannock (~40% acute activity)	Reduce demands on UHNM to enable recovery	Chief Delivery Officer	30/06/23	Service was open to referrals in July and new clinics in operation in August. To increase referrals information to be shared at GP Engagements.	
2.	Harmonised Tier 3 gynaecology service to be procured.	Reduce demands on UHB and UHDB supporting recovery	Chief Delivery Officer	01/07/24	SSOT procurement plan is being development and will be published in November.	
3.	Extension of Community Dermatology contract to cover East Staffs	Reduce demands on UHDB supporting recovery	Chief Delivery Officer	31/10/23	Proposal discussed at POG and supported by FPC. UHDB undertaking impact assessment and therefore not yet agreed. Community provider costs still under negotiation	
4.	Commissioning Virtual Outpatient services - Gastroenterology	Reduce demand on UHNM and reduce UHNM Backlog	Chief Delivery Officer	31/10/23	Proposal discussed at POG and supported by FPC. Single tender waiver approved; Contract signed and service is live	
5.	Ophthalmology: IS providers contracted to deliver the SSOT Cataract pathway	Reduce costs within the system and ensure informed patient choice is delivered	Chief Delivery Officer	31/10/23	Contracts have been signed by 3 of the 4 providers.	

No. Linked Risks on Risk Register

Low (1-4)	Mod (6 – 10)	High (12 – 25)
0	4	1

BAF 3: Proactive and Needs Based Community Services

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If we do not have the capacity and capability to assess the needs of the population to develop targeted, proactive services	Then services will remain reactive and won't meet the needs of the population or change outcomes	Resulting in an increasing demand for health and care services and widening health inequalities

SA1	Improve Health and Wellbeing Outcomes	
SA2	Address inequalities in access, experience and outcomes from health and social care services	
SA3	Achieve a sustainable and resilient integrated care system	
SA4	Working in partnership with communities to achieve social, economic and environmental community development	✓

Responsibility for Risk

Committee:	Quality and Safety	Lead Director:	Chief Medical Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	4	4	3	2	31/03/26	Risk tolerance is moderate (8). The consequence of not mitigating this risk and moving to a more proactive needs-based community model of care is that our system will remain reactive and reliant on services, particularly secondary and urgent and emergency care. This will not meet the needs of our population, will challenge the sustainability of services and is not in line with our strengths-based strategy for our population.
Consequence	5	5	5	5	4		
Risk Level	High 20	High 20	High 20	High 15	Mod 8		

Rationale for Risk Score and Progress Made in the Quarter:

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

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

Delays to Digital and PHM Programmes regards the secondary use of data has led to a review of the PHM programme to scale, spread and sustain a PHM approach across SSOT at all levels.

The programme has continued to work with our partner (Optum) to influence the culture of the system and has established plans to commence work on a PHM Culture Compact. The biggest difficulty remains IG and data sharing which, although they have solutions, continue to provide significant challenge. Work is ongoing around the necessary DPIA and CAG applications in order that we can share data for secondary use. There is a planning meeting face to face with Optum in final 2 weeks of Q4 to set the strategy and work programme for 24-25 – we are expecting to see a step change in delivery and that we will start to recover some ground lost in 23-24.

During Q3 the PHM Programme undertook an options appraisal and procurement exercise to enable bulk extracts of GP data into a linked dataset. Procurement has concluded, the contract has been awarded and mobilisation commenced in Q4. It is expected that data extraction implementation will commence in Q1 of 24-25 which will be a significant step forward.

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

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

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

Health Inequalities Strategy now complete in draft, with a multi-agency group to support, and this will now progress through IPH Board, ICB Execs, H&WB Boards, ICB Board and through to ICP for the June meeting. There is a supporting Financial Strategy that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme into the VCSE through localities/neighbourhoods.

A significant amount of preparatory work has taken place in 2023-4, with anticipated delivery being a little slower than was hoped or envisaged. This is due to the significant challenges posed by IG and data sharing agreements, workforce challenges in the ICB and across the ICS compounded by diversion of effort to support BAU in year and the recovery programme. However, progress has been made and foundations have been built which should pay dividends in 2024-25. Thus, while recognising that the target of a risk level of 8 has not been achieved, it is felt that the solid foundations that have been laid and the steady progress that has been made justify a slight upgrading of the score from Q1-3 (at 20) down to 15 for Q4 due to a small change in the likelihood score.

Key Controls Framework	
Key Controls:	• PHM Partner contracted to support scale, spread and sustain of PHM approach for SSOT • Portfolio governance heavily partnership based with District/Borough Council (community) leadership in role of CE Sponsor • People and Communities is one of the 5P's of the ICP Strategy • Place Development Boards have agreed the construct of 'Place' • IPH Team (manage the implementation of the PHM Programme to scale, spread and sustain a PHM approach across SSOT) • IPH Portfolio Programmes (cross working to ensure health inequalities and preventative actions are considered during intervention design) • Other Portfolios (matrix working with other portfolios to design interventions and deliver transformational change) • H&CS (provides a system health and care viewpoint on any PHM processes being implemented and interventions being designed) • IPH Portfolio Board (provides strategic oversight and is the portfolio aligned with this risk) • ICP (has ICS partnership wide oversight) • Establishment of IPH Portfolio Board • Defined scope of IPH Portfolio and all incumbent programmes and projects • CSU Procurement guidance to ensure procurement exercise is robust • Report procurement exercise outcome to ICB EWT • Procurement completed and contract awarded and being mobilised. • Locality/Neighbourhood plans/proposals well-articulated and co-produced. • HI Strategy complete in draft and will be formally endorsed by June at ICP Board

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q1**	**Q2**	**Q3**	**Q4**
1st Line (Organisation)	**IPH Team Meetings** MS Planner reviewed to assure programme actions are on track for delivery (weekly)				
2nd Line	**Quality & Safety Committee** IPH Portfolio Progress update provided to assure committee of progress (bi-monthly)				
	F&P IPH elements of Quarterly Stocktake to provide assurance against LTP and 1YOP delivery				
3rd Line (External / Independent)	**Regional HI Programme** IPH Portfolio Progress Reports for progress assurance against LTP				
	Regional Prevention IPH Portfolio Progress Reports for progress assurance against LTP				
	NHSE IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery				

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

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score or to improve adequacy of assurance?
• Data and Information Governance issues regards the sharing of data for the purpose of secondary use • Formalising arrangement regards Place and localities

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	Establishment of IPH Portfolio Board	Additional control through governance	Chief Medical Officer	30/06/2023	First IPH Portfolio Board was held on 26/06/2023.	
2	Defined scope of IPH Portfolio and all incumbent programmes and projects	Additional control through governance and clarity of scope	Chief Medical Officer	30/06/2023	IPH Portfolio Blueprint approved at first Portfolio Board meeting on 26/06/2023.	
3	Develop HI Strategy	Additional control through shared strategy for SSOT	Chief Medical Officer	31/03/2024	Strategy now complete in draft and will progress through various Boards before ultimately going to ICP Board in June.	
4	Establishment of PHM Steering Group	Additional control through governance	Chief Medical Officer	31/07/2023	PHM Programme Plan reviewed and now being led out by PHM Culture Compact whilst Data and IG issues are resolved.	
5	Develop a detailed plan to scale, spread and sustain a PHM approach across SSOT	Additional control to manage progress and delivery	Chief Medical Officer	31/07/2023	PHM Programme Plan developed and reviewed to enable progress in areas not constrained by Data and IG issues	
6	Resolve data and information governance issues regards GP data extraction	Additional control through secure and legal basis to extract data	Chief Medical Officer	30/11/2023	Procurement completed and contract awarded and being mobilised.	
7	Work with the Digital Programme to resolve data and information governance issues regards the sharing of data for the purpose of secondary use	Additional control through secure and legal basis to use data	Chief Digital Officer	31/03/2024	Working with Digital Programme, section 251 being reviewed	
8	Co-develop plan to implement localities with Partners	Additional Control	Chief Medical Officer	31/03/2024	Locality/Neighbourhood plans/proposals well-articulated and co-produced.	

No. Linked Risks on Risk Register

Low (1-4)	Mod (6 – 10)	High (12 – 25)
0	0	0

BAF 4: Reducing Health Inequalities

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If we are unable to work together as an integrated care system across organisation and sector boundaries	Then we will have less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent	Resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced

SA1	Improve Health and Wellbeing Outcomes	✓
SA2	Address inequalities in access, experience and outcomes from health and social care services	✓
SA3	Achieve a sustainable and resilient integrated care system	
SA4	Working in partnership with communities to achieve social, economic and environmental community development	✓

Responsibility for Risk

Committee:	Quality & Safety Committee	Lead Director:	Chief Medical Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	4	4	4	2	31/03/28	Tolerance is low (4) as reducing health inequalities and working in partnership impacts on 3 of 4 SO's.
Consequence	5	5	5	5	2		
Risk Level	High 20	High 20	High 20	High 20	Low 4		

Rationale for Risk Score and Progress Made in the Quarter:

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

The Improving Population Health Portfolio has been established (June 2023) and is now meeting quarterly. Partner have agreed the delivery structure of the portfolio as ICB Delivery (to meet NHS statutory requirements in partnership), ICP Strategy Development (to turn the ICP Strategy into reality with the 5Ps across the Life Course, underpinning strategies and development of Place/localities), and ICS Transformation (to find and engage system-wide support around shared priorities and joint endeavours).

Key to improving health inequalities of the SSOT population is the development of Place and localities in partnership. Through PHM led discussions at both Staffordshire and Stoke-on-Trent Place Development Boards, there is now agreement of the localities that make-up the two Place's aligned with UTLAs:

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

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

Health Inequalities Strategy now complete in draft, with a multi-agency group to support, and this will now progress through IPH Board, ICB Execs, H&WB Boards, ICB Board and through to ICP for the June meeting. There is a supporting Financial Strategy that uses the full £4.1M allocation to drive forward change in inequalities through a clear investment programme into the VCSE through localities/neighbourhoods.

A significant amount of preparatory work has taken place in 2023-4, with anticipated delivery being a little slower than was hoped or envisaged. This is due to the significant challenges posed by IG and data sharing agreements, workforce challenges in the ICB and across the ICS compounded by diversion of effort to support BAU in year and the recovery programme. However, progress has been made and foundations have been built which should pay dividends in 2024-25. Thus, while recognising that the target of a risk level of 4 has not been achieved, it is felt that although the solid foundations that have been laid and steady progress that has been made , it is too early to justify an upgrading of the risk score at this stage, given that the target of 4 is to be achieved by 2028.

Key Controls Framework	
Key Controls:	• ICP Strategy approved with a focus on 5P's across the life course which all centre on reducing health inequalities across SSOT • Place Development Boards have agreed the construct of 'Place' • ICB impact assessment and business case templates include consideration of HI • IPH Team (manage the implementation of the HI Programme to reduce inequalities across SSOT) • IPH Portfolio Programmes (cross working to ensure work to reduce health inequalities is led by intelligence) Other Portfolios (matrix working with other portfolios to design interventions and deliver transformational change) • H&CS (provides a system health and care viewpoint that will always consider HI impact) • ICP (has ICS partnership wide oversight) • Clarity of governance and delegated authority to Place and Portfolio • Defined scope of IPH Portfolio and all incumbent programmes and projects • Bi-monthly assurance reporting to Quality & Safety Committee (accountable for BAF 4) • Procurement for GP Extraction Tool complete, contract awarded and being mobilised. • Locality/Neighbourhood plans/proposals well-articulated and co-produced. • HI Strategy complete in draft and will be formally endorsed by June at ICP Board

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q1**	**Q2**	**Q3**	**Q4**
1st Line (Organisation)	**IPH Team Meetings** MS Planner reviewed to assure programme actions are on track for delivery (weekly)				
2nd Line	**Quality & Safety Committee** IPH Portfolio Progress update provided to assure committee of progress (bi-monthly) IPH Portfolio – Health Inequalities Deep Dive				
	F&P IPH elements of Quarterly Stocktake to provide assurance against LTP and 1YOP delivery				
3rd Line (External / Independent)	**Regional HI Programme** IPH Portfolio Progress Reports for progress assurance against LTP				
	Regional Prevention IPH Portfolio Progress Reports for progress assurance against LTP				
	NHSE IPH elements of Quarterly System Review provided to assure progress against LTP and 1YOP delivery				

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

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score or to improve adequacy of assurance?
• Maintaining stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners • Shared understanding and development of delivery vehicles that ICP Strategy priorities can be owned • HI Strategy (developed using same approach as that taken for the ICP Strategy)

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1	Continued ICP Strategy engagement plan to maintain stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners	Additional Control	Chief Medical Officer	31/12/2023	Continuous engagement plan to be formalised – delivery moved to Q4 to take reflect progress and formalisation of Place and localities	

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Due Date**	**Quarterly Progress Report**	**BRAG**
2	Clarity of governance and delegated authority to Place and Portfolio to ensure a shared understanding and development of delivery vehicles that ICP Strategy priorities can be owned through	Additional Assurance	Chief Executive	30/09/2023	Portfolio TOR finalised and approved on 27/6/23. PHM led discussions at Place have resulted in the agreement of 12 localities aligned with SSOT UTLAs.	
3	Establishment of IPH Portfolio Board	Additional Control	Chief Medical Officer	30/06/2023	First IPH Portfolio Board meeting held on 27/6/23.	
4	Defined scope of IPH Portfolio and all incumbent programmes and projects	Additional Control	Chief Medical Officer	30/06/2023	IPH Portfolio Blueprint approved at first Portfolio Board on 27/6/23.	
5	Develop HI Strategy	Additional Control	Chief Medical Officer	31/03/2024	Strategy now complete in draft and will progress through various Boards before ultimately going to ICP Board in June.	
6	Develop a detailed plan to reduce HI across SSOT	Additional Control	Chief Medical Officer	31/07/2023	Detailed and costed plan based on HI Strategy has been co-developed and endorsed at IPH Board.	
7	Co-develop plan to implement localities with Partners	Additional Control	Chief Medical Officer	31/03/2024	Locality/Neighbourhood plans/proposals well-articulated and co-produced.	

No. Linked Risks on Risk Register		
Low (1-4)	**Mod (6 – 10)**	**High (12 – 25)**
0	**7**	**1**

BAF 5: High Quality, Safe Care Outcomes

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If we cannot maintain high quality, equitable & safe patient care	Then we will be unable to maintain high standards of quality and safety and deliver our statutory quality duties	Resulting in actual or potential harm to patients, loss of reputation, intervention from regulators and increased costs associated with poor standards of care

SA1	Improve Health and Wellbeing Outcomes	✓
SA2	Address inequalities in access, experience and outcomes from health and social care services	✓
SA3	Achieve a sustainable and resilient integrated care system	
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk

Committee:	Quality & Safety Committee	Lead Director:	Chief Nursing & Therapies Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	4	4	4	3	31/03/24	Tolerance is moderate (9) as the system will prioritise quality & safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures
Consequence	4	4	4	4	3		
Risk Level	High 16	High 16	High 16	High 16	Mod 9		

Rationale for Risk Score and Progress Made in the Quarter:

All areas progressing well, but some challenges remain across the system:

- There has seen a reduction of Maternity Induction of Labour (IOL) breaches at UHNM as they have increased the use of their inpatient beds for IOL.
- Both UHNM and UHDB have significantly reduced their vacancy rates following successful recruitment campaigns in 2023. UHNMs Neonatal Unit is now also fully staffed with a business case for an increase in medical staffing approved.
- Following site visits to both Derby and Burton Maternity Units the CQC published a final report which included a s29a notice for both sites. UHDB have produced a Maternity Improvement Plan and continue to receive support via the Maternity System Support Programme (MSSP) and UHNM by the monthly System Maternity Oversight Assurance Group.
- The planned FMBU due diligence event was undertaken in December 2023. The next step in the process will be at the West Midlands Clinical Senate FMBU Panel Meeting in April 2024. Both UHNM and UHDB have made a commitment to re-establish the Home Birthing Service at the end of Q4 to support choice. UHNM have stated they will start to book women in from the 1st April 2024.
- Additional 0.6wte Midwife post aligned to the Maternity Transformation Programme has been appointed, and commenced in post in March 2024.
- The Quality Strategy has been approved at Board with a delivery plan has now been approved by Quality and Safety Committee.
- Patient Safety Incident Response Framework (PSIRF) has been launched and is in the process of being embedded within our NHS providers. Further work is being undertaken with our care home providers and Primary Care to align processes.
- The ICB has now received 3 alerts which require system oversight and assurance. Progress has been made over the last quarter to achieve the expected outcomes with the collaborative approach utilised to implement the necessary changes within local Paediatric Audiology services seen as an exemplar by the regional and national NHSE teams.
- Quality concerns have been raised regarding 4 contracts (Termination of Pregnancy Service, LeDeR, Wheelchairs & Community Eye Care) contract negotiations and service pathway development along with mitigations are in place to support address the issues.
- The QIA policy and process has been approved at SQG and ratified at QSC. The refreshed process builds upon feedback and learning undertaken over the last 12 months.
- The number of Initial Health Assessments (IHA) and Review Health Assessments (RHA) completed within agreed timescales remains below the compliance target, additional clinical capacity is currently being sought by UHNM and MPFT to assist with a reduction in the current backlog.

Key Controls Framework	
Key Controls:	• Quality Impact Assessment agreed and implemented (Policy and Procedures) • ICS Quality Strategy with agreed outcomes • Quality features as an enabler to all portfolios and all have allocated quality links • Quality Improvement Group/network established and sharing best practice • System Maternity Oversight and Assurance Group meeting • Local Maternity and Neonatal Service Partnership Board and Quality and Safety Oversight Forum (sub-group) and attendance at relevant internal UHNM meetings • Strong maternity transformation plan • Established system wide Safeguarding arrangements – Second Stage of Provider collaborative agreed and first meeting has taken place • Portfolio groups/boards or other meetings • CQC and LA information sharing meetings • Health watch attendance at SQG • Reporting to and attendance at NHSE meetings • Nursing Home Quality Assurance and Improvement Group (NHQAIG) – system partner attendance • Care Home quality framework monitoring • LeDeR group including system partner attendance and shared learning as well reporting into LDAP board • PSIRF training has been agreed using a system wide approach with plans approved at ICB Board Additional training sessions have been made available to the system • Health Economy Infection Prevention meeting as well as weekly informal IPC Leads meetings • Midlands IPC BAF • Health Safeguarding and Looked after Children Forum • Independent hospital quality quarterly assurance meetings • Bronze, silver and gold cell meetings – Paediatric Audiology Improvement Programme • Contract quality review meetings • Progress report and impact received by CYP and QSC regarding RHA & IHA delays • Patient Safety Notification process in place within the ICB

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
1st Line (Organisation)	Monthly Quality and Safety Assurance report to ICB Board				
	Bimonthly Assurance paper and Chair Update from QSC to ICB Board				
	Bi-Monthly LMNS report to QSC				
	Bimonthly Assurance paper from SQG to QSC				
	Monthly Assurance papers to SQG				
	Bimonthly Safeguarding Adults & Children Report to QSC				
	Bi- Monthly People & Communities Assembly to QSC				
	Quarterly QIA Assurance report to QSC				
	Quarterly LeDeR Assurance Report to SQG				
	Bi-Monthly Assurance report to QSC - Paediatric Audiology Improvement Programme				
	Assurance report re: IHA/RHA received by QSC (Ad hoc or included in Safeguarding report)				
2nd Line (System)	Monthly Provider Update/Assurance reports to SQG				
	Quarterly Nursing Home Quality Assurance & Improvement Group Report to SQG				
	Bimonthly Patient Safety & Serious Incident Report to SQG (which will be replaced with PSIRF report as it becomes more established).				
	Quarterly Soft Intelligence/Complaints report to SQG				
	Monthly Provider CQRM Quality & Assurance reports				
	Monthly Provider Update and Assurance report to SaSoT LMNS Partnership Board				
	Monthly Provider Update and Assurance reports to Staffordshire and Stoke-on-Trent Integrated Care System Health Safeguarding Forum				

	Monthly Provider Update and Assurance report to SaSoT SMOAG				
	Deep Dive Report SQG & QSC (ad hoc)				
	Infection Prevention Control (Health Economy Group) Update/Assurance report to QSC				
	Monthly Assurance report to SQG - Paediatric Audiology Improvement Programme				
	Monthly CQRM meetings escalation report to SQG				
3rd Line (External / Independent)	Quarterly Update and Assurance report to Regional Quality Group – NHSE led				
	CQC Assurance Reports (across all providers)				
	Monthly NOF Assurance Report (UHNM)				
	Quarterly System Review Meeting Assurance Report				
	Quarterly NOF Assurance Report (NSCHT/MPFT)				
	Monthly update/assurance report to NHSE regional/national Paediatric Audiology Improvement Silver & Gold cells				

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

Gaps in Control or Assurance

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

- Mitigations in place to support business continuity within TOP service however requires a longer-term resolution to provide stability and address accessibility
- LeDeR performance has dropped requiring step in action by the ICB monitoring of progress against trajectory will take place within QSC whilst decisions are made regarding the future of the contract.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	Develop a collaborative Quality Strategy that meets ICS requirements and NHSE guidance	Additional Control	Chief Nursing & Therapies Officer	31/11/23	Delivery Plan is in development expected to begin delivery against plan in Q1 (24/25)	
2	LMNS Board and maternity team continue to drive up improvements in maternity services including clarity on all aspects of the choice agenda.	Additional Control	Chief Nursing & Therapies Officer	31/03/24	Maternity services at UHNM & UHDB have seen an improving position against recruitment targets. Home Birthing service due to be recommenced across SSOT in Q4. UHNM have confirmed they will commence booking women from home birthing service in April 2024. Due diligence process continues regarding the future of FMBUs in SSOT Further (joint) Lead midwife post appointed to and commenced in post to ensure full time cover of this essential role. IOL improvements continue and embedding.	

3	Establish strong systems and processes and reduce duplication of effort in portfolio working on quality	Additional Control	Chief Nursing & Therapies Officer	**31/07/24**	**Quality is established and embedded as part of the MDT approach across the majority of portfolios with ongoing work to support the remaining as they mature.**	

No. Linked Risks on Risk Register		
Low (1-4)	**Mod (6 – 10)**	**High (12 – 25)**
0	**7**	**4**

BAF 6: Sustainable Finances

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If financial pressures are not controlled	Then we will not achieve our statutory financial duties	Resulting in financial intervention from the NHSE including reduced local discretionary decisions, reduced opportunities to apply for additional funds, impact on services and waiting lists

SA1	Improve Health and Wellbeing Outcomes	
SA2	Address inequalities in access, experience and outcomes from health and social care services	
SA3	Achieve a sustainable and resilient integrated care system	✓
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk

Committee:	Finance & Performance	Lead Director:	Chief Finance Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	4	4	4	4	31/03/24	Tolerance is high (12) as costs related to maintaining patient safety and workforce issues may cause additional financial demand.
Consequence	5	5	5	5	3		
Risk Level	High 20	High 20	High 20	High 20	High 12		

Rationale for Risk Score and Progress Made in the Quarter:

The Financial Plan for 2023/24 was a break-even plan but we defined it as high risk and required best case outcome in terms of a range of assumptions. A number of the risks have crystalised and we are now reporting that the System will not achieve financial balance in 2023/24. At month 10 the System are forecasting hitting the revised control total of a £91.4m deficit, as reported to NHSE. Target score has not been achieved due to the financial challenges faced by the System.

A System-wide Recovery Plan is being designed for 2024/25. The risk will be rolled forward into 2024/25 and the target score will be reviewed following escalation meetings with NHSE and final submission of the plan.

Key Controls Framework

Key Controls:

- System Financial Plan agreed
- Recovery Plan agreed
- Monthly monitoring of the delivery of all efficiency plans by the TDU across the system
- Reporting on progress through System Performance Group and Finance and Performance Committee
- Monthly budget holder meetings to ensure delivery remains on track
- Weekly meeting of System Chief Finance Officers
- Weekly System/IFP finance deputies meetings held to support System meetings
- System CFO meeting
- System Senior Leadership Team meeting

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Organisation)	Monthly System finance reports articulating risk / mitigations				
2nd Line (System)	System Finance Report to Finance & Performance Committee				
	Monthly Recovery Programme report to F&P Committee				
	System Performance Report to Finance & Performance Committee				
3rd Line (External / Independent)	Value for money assessments completed by external auditors				N/A
	Internal audit review of efficiency programme				N/A

	PwC reviewing grip & control of financial management			N/A	N/A

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

Gaps in Control or Assurance

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

- The Financial Plan is a best-case scenario and consequently the System is working towards a Financial Plan for the year to ensure all risks are understood and mitigated wherever possible.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	Agreed System Recovery Plan to be implemented and overseen by System Performance Group (Recovery Board)	Improvement to financial trajectory	Chief Finance Officer	31/03/24	Reported to System Finance and Performance Committee and SPG.	
2	At M6 a number of the risks identified in the financial plan have crystallised. Outturn plan to be agreed with regulators	Agreement to a deliverable outturn	Chief Finance Officer	31/12/23	System Finance and Performance Committee in January 2024	
3	Notified regulators of the likely financial outturn of £141m deficit which has been improved to £91m deficit as a result of the Recovery Plan. We are awaiting feedback from the national team as to whether this is an acceptable outturn.	Agreement to a deliverable outturn	Chief Finance Officer	31/01/24	Reported to System Finance and Performance Committee and SPG.	

The Financial Plan is a best-case scenario and consequently the System is working towards a Financial Plan for the year to ensure all risks are understood and mitigated wherever possible.

No. Linked Risks on Risk Register		
Low (1-4)	Mod (6 – 10)	High (12 – 25)
0	5	3

BAF 7: Improving Productivity

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If the ICB and provider partners are unable to develop/deliver recurrent productivity gains in 2023-24 which will be needed to help address our recurrent deficit of c.£160m	Then we will fail to achieve the operational improvements which underpin our performance targets and fail to deliver the recurrent efficiency requirements which underpin delivery of our statutory financial target of breakeven	Resulting in financial intervention from the NHSE including reduced local discretionary decisions, reduced opportunities to apply for additional funds, impact on services and waiting lists

SA1	Improve Health and Wellbeing Outcomes	
SA2	Address inequalities in access, experience and outcomes from health and social care services	
SA3	Achieve a sustainable and resilient integrated care system	✓
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk

Committee:	Finance & Performance	Lead Director:	Chief Finance Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	3	4	4	3	31/03/24	Productivity improvement is an essential ingredient of the System plan and so a lower risk appetite target has been set.
Consequence	4	4	4	4	3		
Risk Level	High 16	High 16	High 16	High 16	Mod 9		

Rationale for Risk Score and Progress Made in the Quarter:

Target score has not been achieved as Trusts are still working through their productivity plans for 2024/25. It has been agreed by SPG that work on productivity will be delegated to providers. Progress has not yet been reviewed at SPG or Finance and Performance Committee and consequently the higher likelihood of this risk occurring is currently assessed. The Finance and Performance Committee received an update from UHNM on the Trust's approach to productivity improvement at its meeting in August 2023, and took assurance that actions are underway to continually improve productivity in the delivery of acute services.

Key Controls Framework

Key Controls:

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

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Organisation)	Monthly System finance reports articulating risk / mitigations				
	Responsibility for acute productivity improvement to be taken forward by UHNM. Progress to be reported to System Finance and Performance Committee.				
2nd Line (System)	System Finance Report to Finance & Performance Committee				
	System Performance Report to Finance & Performance Committee				
	Productivity Report to System Performance Group				
3rd Line (External / Independent)	Value for money assessments completed by external auditors			N/A	N/A
	Internal audit review of efficiency programme			N/A	N/A

Assurance Assessment

Significant Assurance	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable Assurance	General confidence in delivery of existing mechanisms / objectives	

Partial Assurance	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	✓
No Assurance	No confidence in delivery	

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score or to improve adequacy of assurance?
• The national team look at productivity through an acute lens. The System will need to widen this to include all other elements of productivity.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1	Finance and Performance Committee to conduct a more detailed review of the productivity work undertaken by UHNM	Additional Assurance	Chief Finance Officer	31/07/23	Responsibility for acute productivity improvement to be taken forward by UHNM. Progress to be reported to System Finance and Performance Committee.	
2	Finance and Performance Committee to review progress over the reminder of the financial year	Additional assurance	Chief Finance Officer	31/03/24	To be reported to the Finance and Performance Committee quarterly.	
3	Financial framework paper for 2024/25 is being discussed at the Finance and Performance Committee on 2 January 2024. This proposes a greater focus on productivity in both the acute sector and other parts of the health system.	Additional assurance	Chief Finance Officer	31/03/24	Progress to be reported to Finance and Performance Committee	

No. Linked Risks on Risk Register		
Low (1-4)	**Mod (6 – 10)**	**High (12 – 25)**
0	**7**	**2**

BAF 8: Sustainable Workforce

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If we are unable address the current national shortfall of staff in health & social care in Staffordshire and Stoke-on-Trent	Then there is a risk of increased vacancy rates in key services	Resulting in insufficient capacity to deliver current services, transformation & the Winter Plan and further increase staff sickness & burnout

SA1	Improve Health and Wellbeing Outcomes	
SA2	Address inequalities in access, experience and outcomes from health and social care services	
SA3	Achieve a sustainable and resilient integrated care system	✓
SA4	Working in partnership with communities to achieve social, economic and environmental community development	

Responsibility for Risk

Committee:	People, Culture & Inclusion	Lead Director:	Chief People Officer

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Target	Target Date	Risk Tolerance Statement
Likelihood	4	4	4	4	4	31/03/24	Tolerance is high (16) in recognition of the workforce pressures and financial position in health & social care. It may not be possible to secure a robust future pipeline, retain people in the current climate and deliver the demand within the workforce constraints. The work programmes will focus on reform, collaboration, productivity, maintaining safe staffing levels, and developing operational & innovative approaches to reduce the impact.
Consequence	5	5	5	4	4		
Risk Level	High 20	High 20	High 20	High 16	High 16		

Rationale for Risk Score and Progress Made in the Quarter:

In Qtr. 4 the risk level has reduced from 20 to 16 in view of the following:

- Deep dive undertaken at January 2024 PCI Committee, underpinned by work with partners to review and map organisational level risks and scores to system. Further review and approval of revised risks and scores at the March 24 Committee
- The risk register reflects the current System People context, partner organisation risks and scores
- All risk scores are currently 16 or under.
- The landscape and workforce position has changed since the overarching risk was identified. The risk is being tackled via targeted programmes of work, interventions and collaborative work at system and organisational level with evidence of an improved position in several areas including vacancies, retention and sickness. Additionally, the Education training and development workstream is making significant progress in developing approaches to strengthen the future pipeline.
- Increased scrutiny and processes introduced, driven by national requirements and system financial deficit including agency usage and spend, vacancies, system financial deficit, and productivity.
- Overall delivery of the ICS People Plan and Long-Term Workforce Plan is led by the ICS People Function and programme delivery across all schemes is currently on track. The plan covers several schemes and programmes which seek to improve supply, retention, the experience and health & wellbeing of the workforce, belonging and our approach to OD, culture and leadership. The system EDI agenda is a crucial element of the plan and all programmes.

Key Controls Framework

Key Controls:

- A number of strategies and plans provide direction and a framework including ICS People Plan and strategic delivery plan, ICS Operational Workforce Plan Awaiting publication of National Long Term Workforce plan published - translated locally and plans reviewed to respond to the ambitions and targets.
- ICS People Hub and Reserves - contingent workforce
- ICS People Team members of COO call/process in operation during incidents and significant pressure periods. Robust escalation process in place for contingent workforce and mutual aid.
- Systems scrutiny around recruitment activity and agency spend in line with the operational workforce plan and financial strategy – inc vacancy control review group with NHS partners
- System CPO Forum and joint CPO/CFO forum to align, agree and work in partnership

	• System CPO and CNO forum • System People report to system FS&P and SPG • System Workforce Planning Group including collaboration on strategic, portfolio and operational planning • System Resourcing and Recruitment Groups • System Education, Training and Development Group – strategy, and delivery plans on track • System Retention Steering Group, strategy and delivery plans on track • System OD Plan development on track • System Leadership and Talent Steering Group, strategy and delivery plans on track • System EDI Group and programmes on track • NHSE support and review meetings • NHSE funding to support workforce solutions and programme delivery

Assurance Map					
Defence Line	**Sources of Planned Assurance**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
1st Line (Organisation)	**Trust People Committees (Review and assurance)** • People Metrics, Key performance indicators and assurance reporting • People Risk Register and Board Assurance Framework				
2nd Line (System)	**ICS People Culture and Inclusion Committee** • People Metrics, Key performance indicators and assurance reporting presented • Deep drive review of high scoring risks driving the BAF risk – January 2024				
	ICB Board • ICS People Culture and Inclusion Committee highlight report • People Deep dive planed for February 2024				
	FPC • People Metrics Report presented including agency, vacancies and staffing position				
	SPG • People Metrics Report presented including agency, vacancies and staffing position				
3rd Line (External / Independent)	NHSE - Quarterly System Review - People Metrics and KPI report presented to assure progress against Operational plan, JFP and LTWP				
	NHSE – Regional Workforce Transformation and Development teams • Quarterly review meetings to report and assess the progress of workforce development funding spend • Monthly review meetings for national/ regional programmes (including T-Levels and retention) to assure progress of programme activity and funding				
	NHSE - Monthly Provider Workforce Return and Agency reporting				
	NHSE • Monthly Provider Workforce Return and Agency reporting				

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

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score or to improve adequacy of assurance?
• Capacity to meet additional reporting requirements from NHSE • Workforce development funds limited from NHSE and other sources to support innovative future workforce supply solutions and programmes. High level local data and intelligence analysis against the long-term workforce plan projections.

Further Actions (Additional Assurance or to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Outcome of Action**	**Lead Director**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1	Collaboratively review and update the ICS People Plan in line with the National Workforce Strategy	Additional Assurance	Chief People Officer	31/03/2024	• National Long-Term Plan translated locally, • Identified priority activities to address the immediate and future workforce risks in line with the local JFP • Commenced work on compiling annual report to reflect on 2023/24 activities • Commenced partner committee • Identified 2024/25 priorities	
2	Establish CPO and CNO/CMO forum to join up and agree actions to address critical workforce challenges	Additional Assurance	Chief People Officer	31/03/2024	CPO and CMOs to agree collaboration focus and alignment of activities. CNO and CPO discussions ongoing.	
3	Horizon Scanning for alternative workforce development funding sources	Additional Assurance	Chief People Officer	31/03/2024	No additional funding secured in Q4. Continue to source alternatives but a risk heading into 2024/25 and ability to deliver additional WFD activities	
4	Further mapping and alignment of long term workforce plan trajectories against the local position and our gap.	Additional Assurance	Chief People Officer	31/03/2024	Further data and intelligence analysis underway to understand the local position and projections Work ongoing to map professional group requirements and implications locally	

No. Linked Risks on Risk Register		
Low (1-4)	**Mod (6 – 10)**	**High (12 – 25)**
0	**5**	**1**

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 12

Report to:	**Integrated Care Board**					
Date:	**18 April 2024**					
Title:	**All Age Continuing Care Arrangements Proposal**					
Presenting Officer:	Paul Edmondson-Jones and Heather Johnstone					
Author(s):	Kirsten Owen, Associate Director of Special Project and Nat Cotton, Head of Integration					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☒	**Assurance (S)**	☐
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

The purpose of the paper is to share with the Integrated Care Board the available commissioning options for the All Age Continuing Care Service, the challenges with the range of funding cohorts covered under this heading the complexity of the shared arrangements and the restrictions regarding the procurement routes.

This paper brings together the legal advice received from Mills and Reeve, the Executive Director debate in February, and highlights the continued legal and statutory responsibilities of the ICB, whilst identifying risks and mitigations. Finally, the paper proposes recommendation which has been supported by Staffordshire and Stoke on Trent Integrated Care Board (ICB) Executive Directors and the Finance and Performance Committee.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Executive Directors (formal)	21/03/2024
Finance and Performance Committee	02/04/2024

(3) Implications:

Legal or Regulatory	The ICB holds statutory duty of eligibility for All Age Continuing Care (AACC) and its associated service. The ICB is held to account for this by NHSE. It is imperative that the legal frameworks as discussed in this paper are upheld, if they are not there is significant legal and regulatory risk for the ICB. The recommendation will support

	close and responsible working with providers to ensure safe and effective delivery of the AACC programme of work.
CQC or Patient Safety	The recommendation in this paper will enable application of frameworks in a more efficient and timely manner with less duplication. It will enable improved adherence to statutory and regulatory frameworks due to improvements to quality, experience, and safety of care.
Financial (CFO-assured)	The recommendation in this paper will in turn ensure significant financial recovery and efficiency. This has oversight of the CFO. Where current expenditure is above or below planned levels, actions will be taken to aim to ensure this is managed within the overall allocation for the financial year including CIP.
Sustainability	The recommendation will also enable a more sustainable All Age Continuing Care (AACC) service across the Staffordshire and Stoke on Trent Integrated Care System. All relevant ICS partners have a collective responsibility to manage patient care and safety in line with National Framework Standards. Relevant system partners are consulted with for all service improvements.
Workforce or Training	This recommendation is expected to improve recruitment and retention of workforce and provide further training opportunities across system partners and the Integrated Care System this will further enhance quality of care and patient experience, in turn minimising risk. The AACC team ensures that all workforce decisions are taken with a clear understanding of the impact that any changes will have on its workforce.
Equality & Diversity	This recommendation is expected to improve and encourage equality, diversity and inclusion, this will help make it more successful. Keeping employees happy and motivated. Prevent serious or legal issues arising, such as bullying, harassment and discrimination, this applies to workforce and the population we serve.
Due Regard: Inequalities	The AACC programme of work is expected to improve and support the system to address inequalities in a fair and equitable manner with opportunity to ensure more funding for addressing inequalities overall through efficiency and financial recovery.
Due Regard: wider effect	The application, delivery, and success of the AACC programme of work will enable improvements to quality, experience, and safety of care for the population we serve in turn resulting in improvements in quality of life for individuals. This will also apply to workforce involved in supporting this work programme. With motivated, empowered and satisfied workforce, aiding recruitment, retention and overall well-being for all.

(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:

Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) formally served noticed on 20th November 2023 to Midlands and Lancashire Commissioning Support Unit (MLCSU) on the services provided in relation to All Age Continuing Care (AACC) this includes:

- Continuing Health Care (CHC),
- Funding Nursing Care (FNC)
- Fast Track (FT),
- Non CHC including:
  - Continuing Care (CC),
  - Acquired Brain Injury (ABI),
  - Section 117 (S11),
  - Joint funded (JF),
  - Non CHC complex cases,
- Personal Health Budgets (PHBs).

The 12month notice period runs until 30th November 2024.

The commissioning arrangements for services under the Personalised Healthcare (PHC) contract between the SSOT ICB and MLCSU is complex, complicated, and multi-faceted. The majority of the services listed above are regulated and governed through National Frameworks or legislation, however Acquired Brain Injury and Non CHC complex cases, have been determined locally and jointly within the Staffordshire and Stoke-on-Trent system.

The paper provides detail with regards to various elements of All Age Continuing Care services, such as referral management, clinical assessment, reviews etc, and who currently delivers these elements, this includes MLCSU, local authorities or can be part of providers core services.

Following legal advice from Mills and Reeve, which ruled out the Provider Selection Regime (PSR) direct award there were four options remaining, due to the limited resource and considerable compressed time window a full open procurement option was also ruled out.

This left three options; undertake a PSR Most Suitable Provider (MSP) route, inhouse all services, or a hybrid model, between in-housing services and undertaking the PSR MSP route. Due to the complexity of the commissioning elements associated with this contract, it is recognised that one size will not fit all and therefore a hybrid solution was the recommended suitable option.

There are national frameworks that govern how CHC/ FNC/ fast track and Personal Health Budget services are delivered, and it makes sense that these services would be best sat within a community and or mental health trust to ensure an integrated offer led by clinicians and practitioners that are already involved in the individuals care plan.

With regards to S117 and Joint Funded, these fall under completely different legislation and the LAs currently act as the lead commissioner, they source, procure and contract manage provision for this cohort. Childrens and Young Peoples Continuing Care and non CHC complex cases are covered by locally agreed policies and quite often include tripartite arrangements with Local Authorities and other key stakeholders.

Due to the complexities around the S117, JF, CYPCC and non CHC complex cases, we are proposing that these services are initially in housed while new joint working arrangements are developed between the ICB and LAs and the wider emerging collaboratives.

The paper includes the recommendation from the Executive Directors, Finance and Performance Committee and includes detail with regards to: approach, risk, mitigations, and timeline.

(7) Recommendations to Board / Committee:

The recommendation is that the ICB apply the hybrid approach outlined in section 5.7.

- Undertake an MSP for all elements of CHC, FNC, and ABI service delivery as outlined in the service specification, which would include Personal Health Budgets, as would improve efficiency and the quality-of-service delivery by keeping these together.

- ICB to inhouse the S117, joint funded, CYPCC and non CHC (MH) elements from the MLCSU with a plan to work with the local authorities to develop future joint arrangement during 2025/26.

AACC Options paper and recommendation

1. Introduction

1.1 Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) formally served noticed on 20th November 2023 to Midlands and Lancashire Commissioning Support Unit (MLCSU) on the services provided in relation to All Age Continuing Care (AACC) this includes:

- Continuing Health Care (CHC),
- Funding Nursing Care (FNC)
- Fast Track (FT),
- Non CHC including:
  - Continuing Care (CC),
  - Acquired Brain Injury (ABI),
  - Section 117 (S11),
  - Joint funded (JF),
  - Non CHC complex cases,
  - Personal Health Budgets (PHBs).

1.2 The 12month notice period runs until 30th November 2024.

2. Background

2.1 The current commissioning arrangements for services under the Personalised Healthcare (PHC) contract between the SSOT ICB and MLCSU is complex, complicated, and multi-faceted.

2.2 Several of the above services are commissioned in line with national guidance whereby the ICB is the statutory organisation responsible for delivery, as detailed below:

- **CHC, FNC and FT -** The National Framework for NHS CHC, FNC and FT guidance sets out the principles and processes to be applied by ICBs as the statutory organisation responsible for delivery. https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care
- **Personal Health Budgets –** The NHS England Guidance on the legal rights to have a personal health budget (PHB) and personal wheelchair budgets supports ICBs to meet their duty to ensure eligible groups of people benefit from the legal right to have a PHB. This includes people eligible for CHC, CC and people eligible for after-care services under section 117 of the Mental Health Act. https://www.england.nhs.uk/publication/guidance-on-the-legal-rights-to-have-personal-health-budgets-and-personal-wheelchair-budgets/
- **Childrens Continuing Care –** The Children and Young People's continuing care national framework identifies the process for ICBs in assessing, deciding and agreeing continuing care for children with complex health needs. https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework
- **S117 –** Section 117 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) places a joint legal duty on Integrated Care Boards (ICBs) and Local Authorities (LAs) to provide (or arrange for the provision) of after-care for individuals who have been detained under specified sections of the Act once they leave hospital. These bodies are known collectively as the "responsible after-care bodies".

2.3 All of the above patient cohorts are underpinned by either national guidance, framework or legislation that provide clear guidance and expectation of how care should be commissioned and by who. The remaining cohorts as detailed in section 1 have been locally determined by

the system and in essence have been contract varied into the MLCSU contract on top of CHC which has created the umbrella term used locally as PHC.

2.4 When considering further commissioning arrangements, the ICB should take due care and diligence to ensure that any proposed amendments are in line with the relevant national guidance, framework and legislation to ensure that it remains safe within its constitution and statutory duties.

2.5 The services delivered by the MLCSU under the current contract is detailed in Table 1:

Table 1

Personalised Care Services specification elements	CHC	Fast Track (Home care)	ABI	S117	None CHC (MH)	Joint Funded	CYP Continuing Care
Referral management							
Clinical assessment							
Reviews				Joint		Joint	
Case management				Joint		Joint	
Quality assurance - provision		Joint					
Personal Health Budget		N/A	N/A	N/A	N/A	N/A	
Care brokerage							
Market Management		Joint					
Administration - Financial systems							
Appeals / retrospective applications				N/A		N/A	
Court of Protection				Joint		Joint	

Key:

- MLCSU contract
- MPUFT (operational delivery but core provision sits in MLCSU contract)
- LA
- Core Services (MPUFT/ NSCHT)

3. Challenge

3.1 The current service specifications for the delivery of CHC including Adult NHS Continuing Health Care including fast track, adult NHS funded nursing Care (FNC), children and young people continuing care, ABI and personal Health Budgets), is not fit for purpose, there are several gaps in provision, and they required refreshing to cover these gaps and with the development of the new system collaborative.

3.2 The ICB has a mechanism to implement PHBs for a range of cohorts but recognises there is more to do. The ICB existing PHB Policy in place, requires an review and refresh to ensure robust governance processes are in place to enable safe decision making when consideration a PHB. As part of this programme of work, a PHB audit has been agreed to take place in Q1 of 2024/25 by internal audit with a focus on the whole PHB process, including focus on assessment quality and capturing benchmarking and good practice so findings and recommendations can be included (where appropriate) within the PHB Policy review and refresh.

3.3 The AACC service specification is being refreshed as part of the system collaborative, the ICB is leading the development although due to clashing urgent priorities it has been difficult to get people together, however work is progressing offline and through email, the final service specification will be presented to the Quality and Safety committee in April 2024.

3.4 The NHS England directions remain in place that the ICB is not able to delegate its statutory duty of Adult NHS Continuing Health Care including fast track, adult NHS funded nursing Care (FNC), children and young people continuing care, the 2024 NHSE Statutory Guidance forbids delegation of this to any organisation.

3.5 The ICB can either deliver the service internally or commission a provider to deliver elements of the service on our behalf, although the ICB remains accountable and responsible.

3.6 Currently the dedicated AACC ICB team (3 WTE) focus on the delivery of the ICB statutory duties, this includes being points of escalation internally and externally particularly to MLCSU and the provider collaborative, along with the financial management and performance management of the contract. In addition to this there is part time support from the Head of Integration, the Associate Director of special projects and the Head of Programme Finance for AACC.

3.7 Subject to discussion of the available options, if a decision was made to run any type of procurement process this will be time consuming both from preparing the documentation and undertaking the due diligence process.

4. Strategy

4.1 The 2024/2025 Vision for the Staffordshire and Stoke on Trent AACC service:

"The AACC service is timely, personalised, efficient, safe, fair, and equitable. Applied through smaller, integrated 'place' working arrangements that will follow our shared approach, in line with the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, July 2022. With the opportunity to be flexible, creative, and innovative to meet the specific needs of the different populations served".

4.2 The AACC Vision for 2024/2025 aligns to the strategy of Staffordshire and Stoke on Trent Integrated Care System (ICS) Partnership.

5. Options

5.1 Mills and Reeve, (the ICB commissioned legal partner) has provided expert advice when considering the options available to the ICB for the commissioning arrangements and delivery of the specified services referred to in section 1 of this paper:

5.1.1 PSR direct award

5.1.2 PSR Most suitable provider procurement

5.1.3 In-house

5.1.4 PCR – full procurement

5.1.5 Hybrid approach

5.2 **Direct Award –** The Provider Selection Regime (PSR) guidance permits NHS bodies to justify using a direct award via three individual routes (A, B and C) as described below: https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/

- **Process A:** Can be used where there is realistically only one possible provider of the service, for example 999 ambulance services.
- **Process B:** Can be used where there is patient choice of a provider and or any provider who meets the requirements can be awarded a contract.

- **Process C:** Can be used to continue with an existing provider where the ICB is satisfied that the incumbent is delivering the contract to a satisfactory standard.

5.2.1 To ensure that the ICB acts in line with PSR, process C would be the only option that the ICB could consider however this is not deemed a realistic or appropriate option as the current contract is not compliant or delivered in line with the contract. On this basis, the option to Direct Award has been ruled out.

5.3 **Most Suitable Provider (MSP)** under MSP, the ICB can award a contract to a provider(s) which, after taking key points into consideration deems the most suitable for the contract, this option can be used for both short-term and long-term contracts.

5.3.1 The ICB can only use MSP where it believes it can identify the most suitable provider(s) considering 'likely providers' and all information available at the time. To enable this to happen, pre-market engagement activity is strongly advised. Like with a full open procurement, if utilising MSP the ICB will still need to notify the market of its intention to use this process notice on the Find a Tender Service (FTS). The ICB would then need to wait 14 days after the publication before going ahead and identifying potential providers with reference to Key Criteria and Basic Section Criteria. The ICB can contact any potential providers if further information is required. From those potential providers identified, the ICB would then identify the most suitable provider, publish a notice of intention to award and then subject to no representations being made by unsuccessful providers a contract can be awarded at the end of the standstill period.

5.3.2 This option is like an open procurement under PCR however does reduce the timescale considerably, a fully developed service specification is required for this option.

5.4 This process can also be used for a "mixed procurement" which combine both health care and non-health care services. The nature of this service there is a mixed of both clinical and administrative services, the clinical and administrative services are so closely aligned the need to ensure that these are combined into a single service is to ensure efficiency, reduce handoffs and improve quality.

5.5 **In House –** many other ICBs over the last few years have decided to in house CHC and similar services due to the lack of grip and control experienced when commissioning from another Provider. This would provide certainty to the MLCSU staff regarding new employer arrangements and minimise the risk of a depleted workforce.

5.5.1 There are many opportunities with in-housing the services as it would enable the ICB to have grip, control, and assurance in the delivery of services that it is ultimately held to account for. It should be noted that this is not the ideal long-term solution due to the strategic direction of working in a localised 'place' environment with opportunity of minimal duplication and more efficiency but if chosen it could provide the opportunity for short term whilst the system coproduces a robust service specification for the future.

5.5.2 The biggest challenge in this instance would appear to be an increase in the ICB headcount however, this is not the case. Staff would sit as part of programme costs rather than running cost allocation, therefore not counted.

5.5.3 This would be a streamlined process within the short timescales before the current contract ends in November 2024. There are no risks in terms of PSR with this option.

5.6 **PCR Full Procurement** - The Public Contract Regulations 2015 competitive tender process involves advertising the contract opportunity, inviting interested suppliers to submit bids, and evaluating those bids based on specified criteria to select the most suitable supplier. It aims

to ensure transparency, fair competition, and value for money in public sector procurement while adhering to legal requirements and promoting efficiency.

5.6.1 A full procurement process under the Public Contract Regulations 2015 can take between 9-12 months to conclude.

5.6.2 Due to the termination notice, the ICB would not be able to conduct a robust PCR full procurement and undertake the service transfer in the period left on the contract.

5.7 **Hybrid (In-house & MSP)**

5.7.1 Due to the complexity of the commissioning elements associated with this contract, it is recognised that one size will not fit all and therefore a hybrid solution enables a more flexible, localised, and personalised option.

5.7.2 Table 1 describes the components and functions delivered by the current provider for each of the patient cohorts, this is helpful as it enables the ICB to look at a wide range of options when considering longer term commissioning arrangements.

5.7.3 For example, the referral management, assessment, review, and case management functions would be more appropriately led within a community and or mental health trust. This will ensure an integrated offer led by clinicians and practitioners who are already involved in an individual's care plan. Similarly, the system has already started to explore opportunities to streamline processes and workforce in the best interests of the population and to drive efficiencies, this has been demonstrated through the implementation of the End of Life (EOL) pathway currently led by the Palliative Care Coordination Centre (PCCC).

5.7.4 Personal Health Budgets will be included as part of the Continuing Care service specification for Continuing health care and the service will manage the delivery and management of personal health budgets for these individuals.

5.7.5 This hybrid option supports the creation of a single point of access for all EOL referrals led by a high specialised clinically workforce to assess, provide, review and case manage in line with national guidance.

5.7.6 S117 after-care provision however falls under completely difference legislation and the LAs currently act as the lead commissioner, they source, procure and contract manage provision for this cohort. This option enables opportunity for alternative consideration and system working in support of ongoing transformation and quality improvements in particular relation to efficiency and experience for the population by temporarily in-housing this element whilst further developing and maturing proposals.

5.7.6.1 The function commissioned by the MLCSU via the ICB contract is the back-office administration of payment for the ICB contribution to the care package and to support annual reviews.

5.7.6.2 There is opportunity to consider if this provision could be streamlined if led and commissioned in its entirety via the LAs. This could be supported through a robust Section 75 (S75) Agreement between the ICB and LA.

5.7.7 The complexity with the S117 after care provision would mean the ICB needing to undertake additional procurements (which could be run concurrently alongside the main procurement) to enter formal commissioning arrangements with the LAs, this may over complicate the process.

5.7.8 Expansion of Personal Health Budgets the ICB is working on refreshing the Personal Health Budget Policy during 2024/25 with a view of expanding the current scope of the existing policy to include S117, CYP with an EHCP)

5.7.9 It is sensible that this element of the team is in housed initially to the ICB to further support the further transformation and development of new joint working arrangements between the ICB and LAs. The same principals discussed in relation to S117 applies for jointly funded cases and the ongoing and future transformation of this cohort. There is still work to do to further develop and mature this to a point of future options in relation to an additional MSP.

5.7.10 The ICB has considered at length the methodology and rationale to conclude the following recommendations on those services to in-house and has sought subject matter expert advice when doing so. The following rationale may help to describe the factors that have been considered when coming to this conclusion:

- **Court of Protection** - The Mental Capacity Act (MCA) was introduced in 2005 as a legal framework to protect people who were unable to make decisions for themselves. In 2007 following a European Human Rights Court (EHRC) ruling, the Deprivation of Liberty (DoL's) legislation was introduced to provide a safeguard for all adults (over 18 years) subject to the MCA to ensure any action taken did not breach the persons Human Rights under the Human Rights Act (HRA) (1999). This required a legal authorisation process for any person subject to the MCA who was deprived of their right to liberty (article 5 of the HRA). To breach a person's article 5 rights without a legal authorisation is unlawful. In 2007, it was considered the MCA and DoL's only applied to people in hospitals and care homes, and the authorisation process, for most people was granted by the Local Authority (LA). 2021 further changes were made to the MCA and DoL's legislation which will see once enacted, ICB's given the legal authority to grant deprivation of liberties. This was scheduled to be introduced in 2023 but has been delayed until early next year. Depriving a person of their liberty without a legal authorisation in place is unlawful, and if challenged, the ICB could face a legal penalty and risk significant reputational damage. Whilst it is recognised that the application of the MCA is everyone's business and all staff when completing assessments for individuals should be fully trained and competent to do so, the court of protection application process is complex and specialist in its nature with a limited workforce available nationally to meet demand. As the role of the ICB having legal authority to grant deprivation of liberties in the future and this being a non-delegated task it is recommended that this is best met by the ICB.

- **Childrens Continuing Care (CCC)** – it is recognised that there is a national framework for the application of CCC however this is different to CHC as it is not nationally defined, and policy is agreed through local determination cross the NHS and LA. There is also a differential point in terms of the determination of eligibility and full funding as eligibility does not equate to full NHS funding in the same way as adults CHC as education, children's social care and parental responsibility still have a role to play. On this basis and due to the complexities described it is proposed that this service is in-housed initially whilst potential new joint working arrangements are explored and developed between the ICB and LAs and the wider emerging collaboratives.

- **NHS CHC Appeals and Retrospective Reviews –** this element does form part of the National Framework for NHS CHC, FNC as referred to in section 2.2 of this report. It does form part of the overall MLCSU contract however the function is separate to the main CHC service. There are strict criteria in place

to determine eligibility to raise an appeal or retrospective review in line with NHSE guidance, there is also close working relationships with NHSE colleagues due to the interdependency of Independent Review Panels which falls under the responsibility of NHSE. This is a service that requires robust oversight, case management and leadership due to the financial, legal, and reputational risk to the ICB if not applied correctly.

- **Non-CHC complex mental health** – the principle funding arrangements for this service is similar to S117 after-care and joint funded packages of care although there is no defined legislation, framework or guidance. This arrangement is in place to support individuals who have been assessed and have needs over and above core commissioned services but who have been assessed and deemed not eligible for NHS CHC. Often these are individuals who have been detained informally via Section 2 of the Mental Health Act and are therefore not eligible for S117 after-care however in most circumstances have the same level of needs. Due to the similarities, it is proposed that this element forms part of the in-house provision managed by the ICB whilst further new ways of working is established with system partners.

5.7.11 The ICB will need to develop a small management team to include clinical, operational and contract management expertise and experience to safely manage the application of the proposed MSP and in-house elements detailed within the paper in line with NHSE guidance and relevant legislation. This is important as the ICB is ultimately held to account by NHSE for AACC which will continue post MSP.

5.7.12 Table 2 below provides an overview of the services and components that could form part of in-house and current MSP provision.

Personalised Care Services specification elements	CHC	Fast Track (home care)	ABI	S117	None CHC (MH)	Joint funded	CYP Continuing Care
Referral management	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Clinical assessment (excluding eligibi	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Reviews	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Case management	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Quality assurance - provision	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Personal Health Budget	MSP	MSP	MSP	In-house	N/A	N/A	In-house
Care brokerage/ contracting	MSP	MSP	MSP	LA already	N/A	N/A	In-house
Market Management	MSP	MSP	MSP	LA already	N/A	N/A	In-house
Administration - Financial systems	MSP	MSP	MSP	In-house	In-house	In-house	In-house
Appeals / retrospective applications	In-house	In-house	In-house	N/A	N/A	N/A	N/A
Court of Protection - process	In-house	In-house	In-house	In-house	In-house	In-house	N/A

6. Timescales and Governance

6.1 There is a three-stage process.

6.1.1 Stage 1 the ICB governance to make a final decision, recommendation.

6.1.2 Stage 2 the procurement route and ICB governance

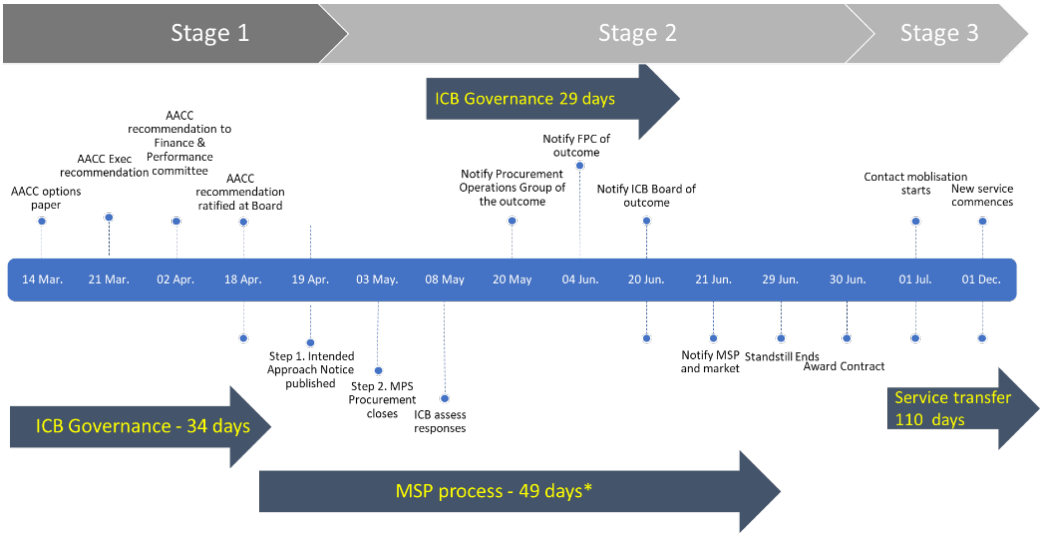
6.1.3 Stage 3 mobilisation of the new contract including TUPE and digital solution.

6.2 Then following the Executive Director meeting the recommendation of the future model of AACC services will need to be presented to Finance and Performance Committee for agreement.

6.3 This will then be presented at the ICB Board meeting for ratification of the decision.

6.4 Ideally the ICB will then have the required paperwork to issue a notice to the market of its intended approach.

6.5 The timeline for a Most Suitable Provider approach, if runs smoothly without objection can be concluded in 28 days, the ICB will need to take the recommendation through a formal decision-making route of the Finance and Performance Committee and due to the value of the contract the ICB Board.



7. Risks

7.1 The timeline outlined in figure 1, is incredibly tight and resource capacity has been flagged as an issue. There is currently no dedicated team currently working solely on the AACC procurement approach, transfer of the CSU contract, service transfer or contract mobilisation. Holidays, sickness, or a challenge to the procurement approach could delay the process and risk a safe transfer of the service.

7.2 CSU have advised that their TUPE transfer process can take up to six months, the ICB projected timeline takes in to account the various governance, and procurement stages and would conclude on/ around the 20th June, resulting in only a five month TUPE transfer window. We would need to discuss with the CSU the option to extend the existing contract for a further month to ensure a staff transfer of the staff to a new provider.

7.3 Delays in the senior decision making regarding the procurement process and final outcome, will further exacerbate this.

7.4 Delivery of ongoing financial recovery and the delivery of saving may be reduced during the MSP and contract handover period. To date we have been able to achieve an in-year improvement based on the month 11 forecast of £19m has been achieved, the importance of this continuing is paramount and therefore specific project support to this work is essential.

7.5 Loss of ICB organisational memory and experience is a risk that has been mitigated through the alignment of support by the Head of Integration it is important that this support continues to mitigate and further risk due to other team members not having this time in post.

7.6 There could be a perception that one provider would have dominance within the CHC system collaborative.

7.7 Procurement resource, Most Suitable Provider was introduced in January 2024, this new approach to procurement is untested within the ICB, and by our CSU procurement specialists, and the lack of experience and understanding in this process could add delay to the process.

7.8 These risks are presented with mitigating actions in appendix 1.

8. Recommendations

8.1 The recommendation is that the ICB should take the hybrid approach outlined in section 5.7. This means:

8.1.1 Undertaking an MSP for all elements of CHC, FNC, and ABI service delivery as outlined in the service specification, which would include Personal Health Budgets, as would improve efficiency and the quality-of-service delivery by keeping these together.

8.1.2 ICB to in-house the S117, joint funded, CYPCC and non CHC (MH) elements from the MLCSU with a plan to work with the local authorities to develop future joint arrangement during 2025/26.

April 2024

Risk and mitigations

Risks	Mitigations
The timeline outlined in figure 1, is incredibly tight and resource capacity has been flagged as an issue. There is currently no dedicated team currently working solely on the AACC procurement approach, transfer of the CSU contract, service transfer or contract mobilisation. Holidays, sickness, or a challenge to the procurement approach could delay the process and risk a safe transfer of the service.	Develop an ICB task and finish group with the relevant experts around procurement, contract mobilisation and programme management. Executive agreement with regards to prioritisation of tasks to free up resources.
CSU have advised that their TUPE transfer process can take up to six months, our projected timeline takes in to account the various governance, and procurement stages and would conclude on/ around the 20th June, resulting in only a five month TUPE transfer window.	Discuss with the CSU the option to extend the existing contract for a further month to ensure a staff transfer of the staff to a new provider
Delays in the senior decision making regarding the procurement process and final outcome.	Exec agreement to protect time in order to make and reach speedy decision making.
Leadership, management and oversight to plan, mobilise and enact the proposed changes will require dedicated management resource for ICB business as usual processes around eligibility, supporting the elements that are proposed to be in-housed and developing options for future models, associated procurements and robust contract management, the way that the NHS, specifically ICBs contract management services has changed significantly over the last three years which makes it difficult to hold providers to account through contractual levers such as Key Performance Indicators (KPIs) and Service Development Improvement Plans (SDIPs). The resource to undertake this function within the ICB is limited and therefore this would be a risk that should be considered.	Develop robust contract management expectations during the contract mobilisation stage. The ICB will need to develop a small management team to include clinical, operational and contract management expertise and experience to safely manage the application of the proposed MSP and in-house elements detailed within the paper in line with NHSE guidance and relevant legislation. This is important as the ICB is ultimately held to account by NHSE for AACC which will continue post MSP.
Delivery of ongoing financial recovery, the delivery of saving is reduced during the MSP and contract handover period. We have been able to achieve an in-year improvement based on the month 11 forecast of £19m.	Ensuring that financial recovery work continues. Oversight from the small management team described above also.

Loss of ICB organisational memory and experience before the service is transferred over to the new provider and the in-housing arrangements have been enacted.	Supporting the transfer of knowledge and experience over a period of contract mobilisation
There could be a perception that one provider would have dominance within the CHC system collaborative.	This would be for the system collaborative to manage.
Procurement resource, Most Suitable Provider was introduced in January 2024, this new approach to procurement is untested within the ICB, and by our CSU procurement specialists, resulting in a lack of experience which could delay the process.	Not rushing the PSR MSP process and allowing the scope to ensure due process is being followed. Use our procurement experts and requesting support and assistance from the national team on any potential queries

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:	18 April 2024					
Title:	**2024/25 Operational Planning Update**					
Presenting Officer:	Paul Brown – Chief Finance Officer					
Author(s):	System Leads					
Document Type:	Business Plan	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	2024/25 Operational Planning Update					

(1) Purpose of the Paper:
The attached update provides the board with a summary of progress to date on 2024/25 operational planning. The slides were used as part of ongoing discussions within the ICS and formed the basis of the 2024/25 Operational Planning Update meeting with NHS England (NHSE) on 10th April 2024.

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

(3) Implications:	
Legal or Regulatory	Constitutional requirements around national performance targets.
CQC or Patient Safety	None directly arising based on the content of this report.
Financial (CFO-assured)	Finance implications are outlined in the body of the report.
Sustainability	None directly arising based on the content of this report.
Workforce or Training	Workforce implications are outlined in the body of the report.
Equality & Diversity	None directly arising based on the content of this report.
Due Regard: Inequalities	None directly arising based on the content of this report.

Due Regard: wider effect	None directly arising based on the content of this report.

(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?		☐	☐	☒	

(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:

On 21st March 2024 we submitted our draft operational planning submission to NHS England (NHSE), which focused on narrative and numerical submission across operational performance measures for the overall NHS system financial position and workforce. The position submitted is summarised in the attached report attached along with the areas we have discussed with NHSE including the progress made around the 6 system collaboratives for recovery.

Since the previous update to the board the national planning guidance has been published. Many of the objectives and actions are similar to those set in 2023-24 or effectively delay recovery targets which have been missed nationally. The final operational plan submission is 2nd May 2024 and the System's submission will be covered in an update to the May Board.

The system is committed to a local narrative system operating plan which builds on the national planning submission with more detail on local deliverables – both in terms of the recovery collaboratives and the broader operational priorities. This will be completed in May and brought to the System Finance and Performance Committee for review and then to the June ICB Board meeting.

The attached report is designed to summarise progress as at the date of a meeting with NHSE, on 10th April 2024.

(7) Recommendations to Board / Committee:

1. Note the attached slides
2. Note the progress made around the recovery plan
3. Note the publication of the national planning guidance
4. Note the timeline for the final operational plan submission

Staffordshire and Stoke-on-Trent Integrated Care System

2024/25 Operational Planning – Update

ICB Board - 18th April 2024

Headlines

Finance

- The Expenditure run rate is planned to **be flat year on year** for the first time for Staffordshire and Stoke-on-Trent since at least 2019.
- High levels of activity on-going to work up the **System Collaboratives**. They will be critical to delivering the in-year efficiency ask as well as closing the unfunded bed gap and providing longer term recovery measures
- All organisations working to develop **recurrent efficiency plans.**
- **Non-recurrent mitigations** reviewed alongside **unpalatable opportunities** to improve the deficit.

Workforce

- Excluding TUPE, workforce is **now flat year on year** for the first time
- Enhanced **workforce controls** have been enacted

Activity and Performance

- Forecasting clearance of **65 week waits** by September.
- **Cancer Faster Diagnosis Standard (FDS) and 62 days pathway** will be compliant on both measures in May submission.
- **Cost Weighted Activity** System level performance is currently 104.4% for 24/25. Focus on seeking to improve this.
- **A&E 4hours** - seek to deliver 78% by March 2025.
- **Diagnostics** - will likely achieve 95% in multiple modalities early in 2024/25 but will continue to be challenging in a couple of modalities without further investment.

Executive Summary

- The 2023/24 plan was propped up with a significant non-recurrent support, consequently a system recovery programme was agreed and launched in June 2023. Initially that focused on CHC, which will deliver £67m of the £109m target in 24/25. Recognising that this would not be enough to eliminate the system deficit, in the autumn we agreed an expanded recovery programme that introduces a further 5 system collaboratives.
- The recovery plan delivers a mix of secondary care activity reduction, improved productivity and cash-out. We have targeted a reduction in NEL activity to eliminate the 85-bed gap. Those areas that will achieve cash-out need more time to deliver as the savings will come from contract repatriation and back office that needs to be beyond that already included in CIP, and so require a transformational approach, and in some cases the development of local services before repatriation can commence.
- The flash submission on 29th February outlined a financial deficit of £179m, built on an assumed efficiency of 3.44% of total spend. It was made clear to us in feedback that we needed to do better. We were asked to look specifically at enhanced pay and non-pay controls. We were also asked to look at improving the volume of elective work, and consequently the level of ERF generated.
- We consequently agreed to increase cash-out CIP to 4% (equating to 6.3% of RRL) underpinned by additional workforce controls and the need to hold vacancies. We also took a further assumed improvement from the recovery of £15m into the plan and have improved our planned ERF performance. These actions led to a deficit of £139m that was submitted on 21st March. About half of the CIP is classified as high risk and we are working on PIDs to de-risk the plan and to ensure that as much of the CIP as possible is recurrent.
- This deficit is currently spread across all 4 system organisations. We agreed that it needed to be shown this way so that the implication of getting to breakeven can be shown by each organisation. Once we have an agreed plan, the sharing of this deficit will be revisited.
- Our workforce has grown since 2019/20, including over the past year, however we are still below establishment. Our strategy is to drive up productivity from this workforce. We are still finalising workforce plans, but after the application of the increased CIP to workforce budgets, we expect there to be a reduction in the planned headcount for Staffordshire NHS posts
- MPFT have confirmed a £7m improvement through additional CIP and there are a few smaller allocations that could lead to an improvement. We are expecting to reduce the deficit in the next iteration to be below £130m, but to go further would require service reductions. We would appreciate a conversation about these choices.
- We have started to model the impact of the 24/25 plan on the medium term. In the 24/25 plan we have flat costs, and so growth and efficiency are eating into the underlying deficit. Our modelling shows that if this strategy were maintained, we could return the system to break even in 3 years. However we recognise that this is not leading to a financial plan in 24/25 that is acceptable.

We welcome the opportunity of this escalation conversation, to discuss the issues and the shape of an acceptable solution.

Clinical Engagement and Risk

- From the outset we have been clear that our plan for 24/25 will be one that is owned across the system.
- Our Health and Care Senate is comprised of membership from across the system and has supported in the development of this plan.
- The Senate is integral to the design and delivery of the recovery solutions.

Health and Care Senate

- This is a system group with representation of clinicians from across the system.
- The Senate has been clear that we must 'cut our cloth' according to resources.
- This must be done safely, and all decisions need clinical support.

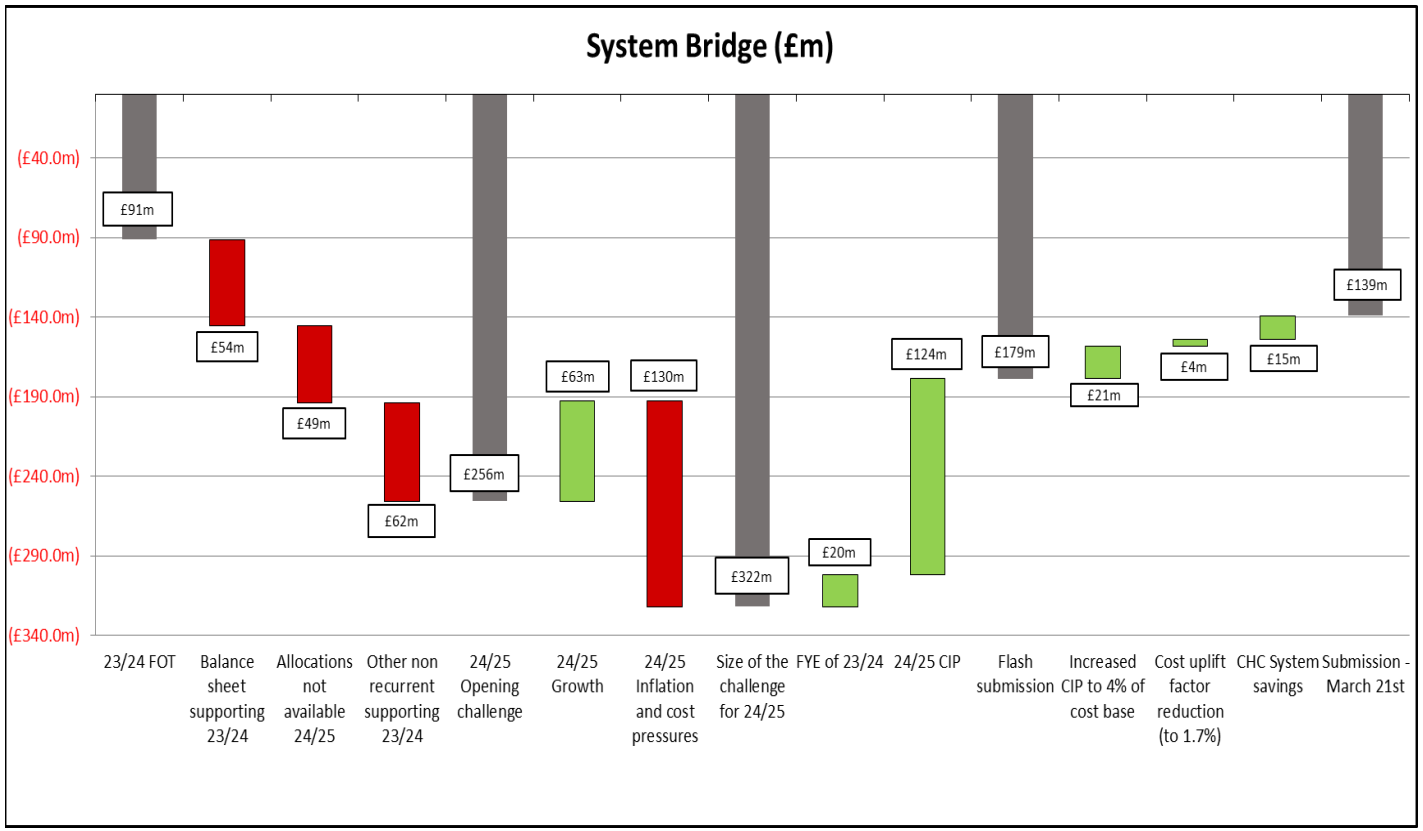
Recovery Programme

- The Senate has recognised that there is evidence of significant opportunity.
- We over-prescribe care, and this is not leading to better outcomes.
- The Senate is leading one of the recovery workstreams that seeks to address this opportunity.

Staffordshire and Stoke-on-Trent
Integrated Care System

Financial Position

Reminder - the construct of the financial plan of £138m deficit



- The system is expecting to post a deficit of £91m in 2023/24
- A large amount of balance sheet support, use of allocations not available next year and other non-recurrent support reduced the deficit we would have otherwise posted
- Expected cost pressures and inflation for 24/25 outstrip growth
- The current level of CIP in the plan eats into some of that underlying pressure, but is not enough to achieve system financial balance

The bridge shows that we have significantly improved our underlying position from the opening challenge of £252m to the latest plan of £139m – by c£110m.

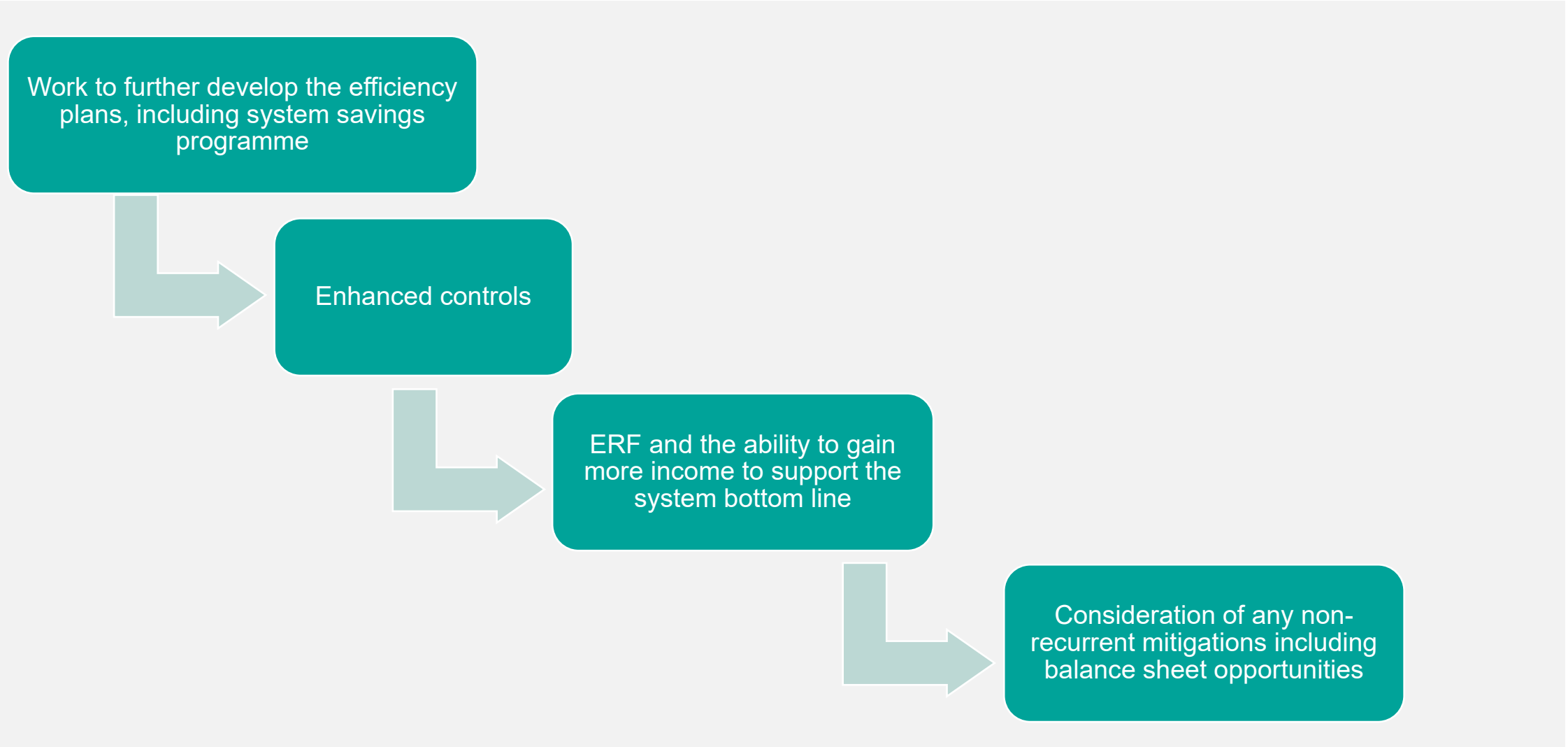
How the Financial Plan has been developed

- The system developed its outline financial plan in January, based on an individual organisational build using draft inflation assumptions, a reasonable proxy for the income and allocation based on notified allocations and expectations around ERF, SDF and out of system income.
- At this point all organisations committed to an equal efficiency target of 3.44% of total expenditure. This led to a collective system gap of c£175m on which the deficit was shared in line with our IFP contract principles. It should be noted that this is a reapportionment process and in no way impacts on the total deficit of the system.
- On receipt of the draft planning guidance, we updated our inflation and allocation assumptions which resulted in small deterioration to the collective deficit to £179m which was the deficit reported in the Flash Return in February.
- Following the escalation meeting on 14th March, we made three adjustments to the deficit –
    1. we took a stretch system saving of £15m into the ICB,
    2. we made a high-level estimate of the impact of the CUF (£3.9m) again which was held in the ICB,
    3. all organisations increased their efficiency target to 4% of total spend.
- These changes resulted in the £138m collective deficit submitted shown in the table below.

SSOT 2024/25 Planning:	ICB	UHNM	MPFT	NSCHT	Total
Submission (21st March)	(£22.8)	(£78.2)	(£30.6)	(£6.9)	(£138.6)

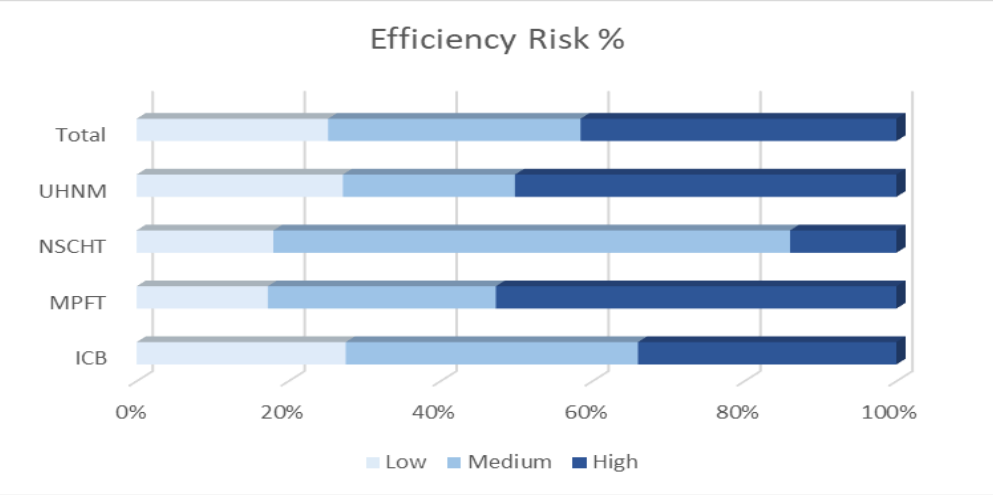
- The express agreement of all CEOs is that the principles of the IFP are retained into 2024/25 and as such, once the final deficit is agreed, and appropriate reapportionment of the deficit will be enacted. Again, this is a reapportionment process and in no way impacts on the total deficit of the ICS.

Progress since the 21st March Submission



The construct of the efficiency programmes

- The system has set a very challenging efficiency plan, this is 4.0% of total cost base which equates to 6.3% of RRL
- Once adjusted for costs where we cannot access efficiencies i.e. our influenceable expenditure this grows 5.2% of total cost base and equates to 8.0% of RRL.



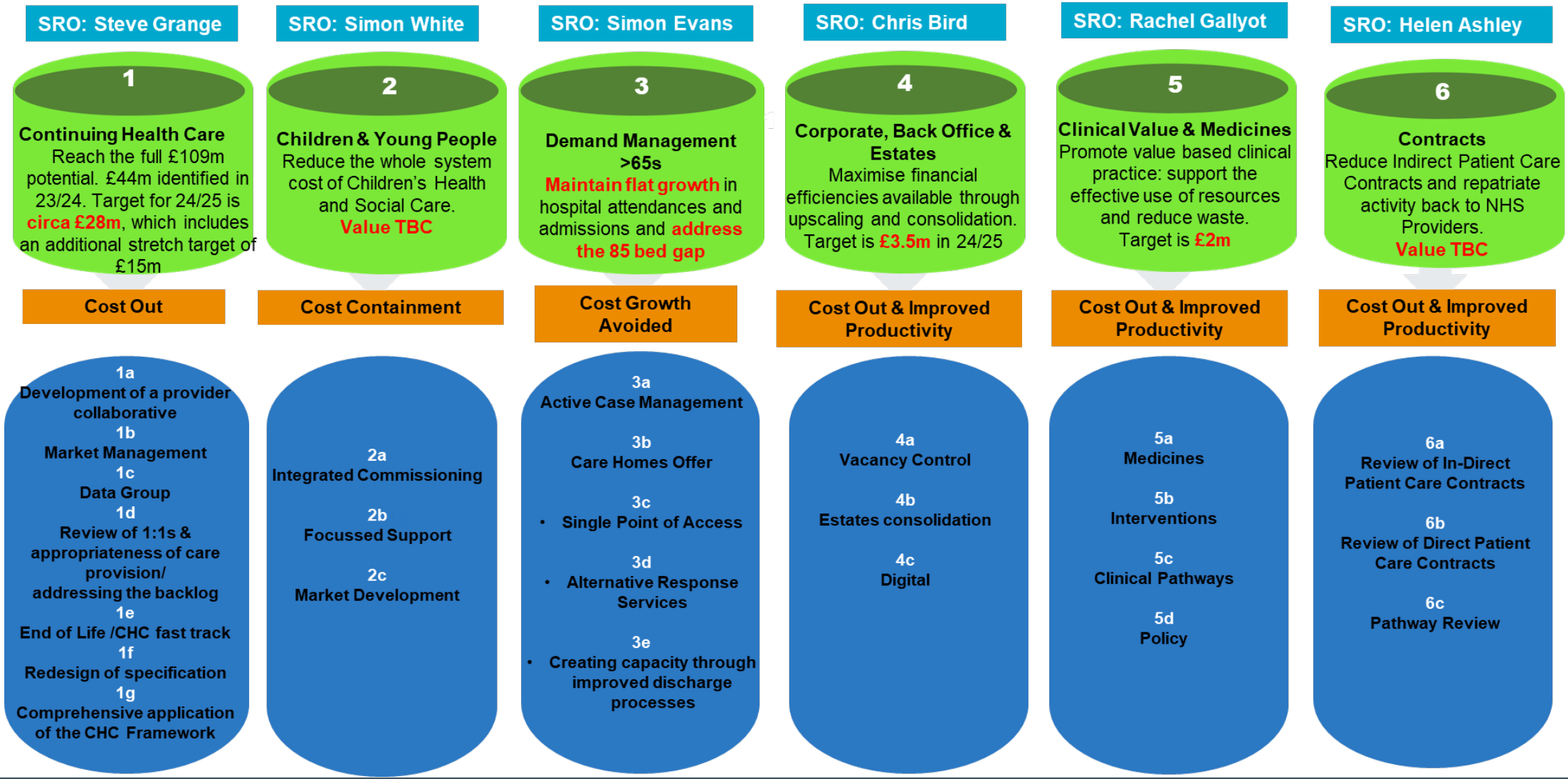
Efficiency Theme	ICB	MPFT	NSCHT	UHNM	Total
All-age Continuing Care - Commissioning/Procurement	27,623				27,623
Demand Management (referrals)	11,629				11,629
Income - Non-Patient Care		84		2,000	2,084
Income - Private Patient		924			924
Non-NHS Procurement	6,900				6,900
Non-Pay - Corporate services transformation			100	1,239	1,339
Non-Pay - Digital transformation		312	100		412
Non-Pay - Estates and Premises transformation		583	300	2,964	3,847
Non-Pay - Medicines efficiencies	13,608			1,000	14,608
Non-Pay - Procurement		4,374		7,105	11,479
Non-Pay - Service re-design		72	1,670	8,880	10,622
Pathway transformation	8,931				8,931
Pay - Agency - reduce the reliance on agency		1,897		1,700	3,597
Pay - Corporate services transformation				1,550	1,550
Pay - Establishment reviews		6,992	590	10,755	18,337
Pay - Service re-design		13,736	1,540		15,276
Running cost review	3,273				3,273
Other	7236	313			7,549
Unidentified		836	700	9,207	10,743
Total	**79,200**	**30,123**	**5,000**	**46,400**	**160,723**

With a large amount of risk inherent within the existing plans and status of scheme development, the ICS feels there is currently no scope to go significantly further without impacting on service outcomes.

- We set out the impact on staffing levels to deliver breakeven on slide 15.

Recovery and System Savings – 6 Collaboratives

- We have set out 6 system collaboratives which will support recovery.



Six System Collaboratives - process to end of May

The system is committed to delivering material recurrent impact through the creation of the 6 system collaboratives. We have learned a lot from the CHC collaborative which was developed in the Autumn of 2023 and are bringing learning into the 5 new collaboratives.

The next steps are

- We will continue to build on the successes on CHC as we construct the system's new operating model and broaden the scope of the work beyond our initial focus on the very high-cost cases for our elderly and frail patients. This forms a key part of the stretch opportunity of £15m factored into the 21st March deficit position.
- By the 2nd May planning submission we will have finalised activity and finance reductions for each Collaborative and built our reporting dashboard.
- Learning from CHC was the need for dedicated resource to lead the work programme and we have already commenced and internal recruitment process on the 8th April, offering12 months secondments advertised across the system. We recognise the need to agree backfill arrangements where necessary, but the intention is not to add to the cost base.
- Our SRO and Senior Programme Managers will establish appropriate matrix teams and co-ordinate enabling functions input: TDU, finance, quality, digital, governance, planning, Portfolio Teams, comms and engagement.
- We have a System Leaders Event on 15th April where we will bring the Teams supporting the Collaboratives together with the System Executive Teams to gain Executive endorsement for the Collaborative's initial priorities and address any underlying concerns. This will enable the finalisation of the detailed project plans by no later than 31 May, but in many cases sooner.

Enhanced Controls

- In Autumn 2023, the ICB in agreement with NHSE commissioned an independent review into the 2023/24 Recovery Plan and the "Grip and Control" within the system. The report was generally positive about the levels of control already in place, and where opportunities to enhance controls were identified these have been enacted.
- System oversight is achieved through the System Performance Group that ensures that controls are fully implemented and escalates to the system CEO group if necessary. Implementation is scrutinised by System Finance & Performance Committee. Oversight of these controls will be checked by Internal Audit and reported to system Audit Committee
- In addition, each organisation has reviewed its pay and non-pay controls coming into 2024/25 in recognition of the collective financial position. Key organisational changes are summarised below

MPFT

- Electronic system for vacancy control to introduce consistency and to support visibility, control and reporting
- Developed a Quality Impact Assessment to be incorporated into the electronic vacancy control process
- Workforce targets are being set for each Care Group and corporate as part of the 24/25 planning which reconciles with finance
- Working with Care Groups on top areas of agency spend both in terms of value and length of time, and focussing specialist recruitment resource at these areas, as well as supporting new ways of working
- We have reviewed delegated limits and reduced CFO sign off from £20K to £10K

UHNM

- Not commit to any new expenditure unless it is for a critical safety issue.
- Immediately scrutinise internal process to ensure effective vacancy and expenditure controls to give Boards and wider system partners, assurance that no further commitments are now made. Including reviewing live adverts and interviews which may already be scheduled.
- Prepare an options appraisal for every non-clinical vacancy with a cost greater than £80,000 per annum. This options appraisal should clearly examine how through partnering or other arrangements system overheads can be reduced. These processes must withstand peer scrutiny.

NSCHT

- Bank & Agency – Tighter controls on use of bank and Agency within Divisions including targets for Bank and agency reductions.
- Enhanced reporting on Bank and Agency costs to Execs & F&R.
- Exec review of all current vacancies within the Trust
- Exec to authorise all vacancies via establishment control process.
- Senior Finance team to review and authorise all requisitions over £15k

ICB

- Reduced delegated limited for contract sign off to £20k for the CFO
- Further strengthened vacancy controls including the establishment of the exec panel to review all vacancies.
- This process is delivering a 30% reduction in ICB headcount by 2025/26.

Elective Recovery Fund, Contract Risks and Scope to go further

ERF in system

- UHNM are modelling the total capacity available to deliver additional ERF.
- Currently the assessment is that this sitting alongside the CIP requirement, means there is no opportunity for further upside.

ERF out of system

- The system is significantly disadvantaged by the fact that ERF benefits at Burton flow to Derbyshire and Cannock flow to Black Country.
- All additional activity is paid for at tariff so there is no upside.

Contracts

- Out of system providers are requesting additional payments for activity growth. The most material is Black Country which is up to £50m. We also have significant claims from UHDB and UHB.
- This is not included in the current plan.
- In summary out of system contracts represent a significant risk and there is no likelihood of upside

Consideration of further non-recurrent opportunities

	Max Value	Most Likely	Considerations
Re-purposing of health inequalities funding to cover existing initiatives	£4.1m	£1.5m	The ICB has not attributed a savings target to the HI allocation which is a possibility. Should the 4% be applied this would contribute c£160k to the savings planned. In addition, there are a number of material value adding VS contracts for which we would be looking to disinvest but could retain through using the HI allocation
Review BCF and discharge contingencies to ensure maximum VFM	£2.0	£1.0	Work with LA partners to ensure the BCF and Discharge funds are directly contributing to productivity and best use of resource. This will include a review of national design rules and grant conditions to prompt a comprehensive analysis
24/25 SDF slippage – total SDF received is £38m	£3.8m	TBC	Looking at all SDF within the ICB and the providers to assess any potential for non-recurrent release. Risk is that most SDF is pre-committed through prior notification from NHSE national programmes
Capitalisation of revenue costs and release of balance sheet flexibilities	-	-	System is confident that all reasonable costs are capitalised. Capital allocation is already fully committed with priority schemes so no existing flexibility even if an opportunity was identified. Balance sheet flex is playing a material part of delivery of 23/24 but all partners have reviewed balance sheet opportunities, and these are already played into the plans.
Align & enforce restricted and excluded procedure policies with neighbouring systems	TBC	TBC	This is a priority workstream within the Contracts system savings programme. Main benefit will be seen in waiting list reduction rather than finances through freeing clinical time
Delegated Primary Care – Dental Firm ring fence in guidance	£5m	£3m	We would welcome the opportunity to discuss with NHSE
No reinvestment of MHIS efficiency delivery on contracted elements (CHC & prescribing)	£10m	£1m	System recognises the imperative of MHIS for planned services. There is however an opportunity where there is reduced spend due to demand (eg prescribing) or effective delivery of efficiency eg package price negotiations to bank those in-year savings. We would welcome the opportunity to discuss with NHSE. In addition, we would welcome the opportunity to discuss the value of the MHIS audit (£140k) and whether this can be decommissioned.
Limitation of choice	TBC	TBC	Consideration of restricting choice where sufficient capacity exists within the system.

What it would take to get to break even in 2024/25

- We have completed modelling which assesses the workforce impact required to take the providers in the system to breakeven.
- Whilst this is indicative analysis it shows the extent workforce impact would bring our teams below safe staffing levels.

WTE	UHNM	MPFT	NSCHT	Total
WTE in plan	12,054	10,320	1,801	24,175
WTE reduction required	1,537	638	137	2,312
% WTE reduction required	13%	6%	8%	10%

- The equivalent ask of the ICB will require termination of a very high proportion of our third sector contracts for organisations such as hospices and our voluntary sector partners, who are key to our admissions avoidance and health inequalities work across the system.
- This level of workforce reductions would have a profound effect on our ability to deliver safe services.
- We do however recognise the challenge, that the allocations (cash) will not be available to support the workforce currently employed.

We would welcome a conversation on whether Regulators would support seeing staffing levels reduced in line with the available budget.

Update on the Net Risk position

- Within the planning submission on 21st March, we included £44m of net risk, summarised below. We are working to mitigate as many of those risks as possible.

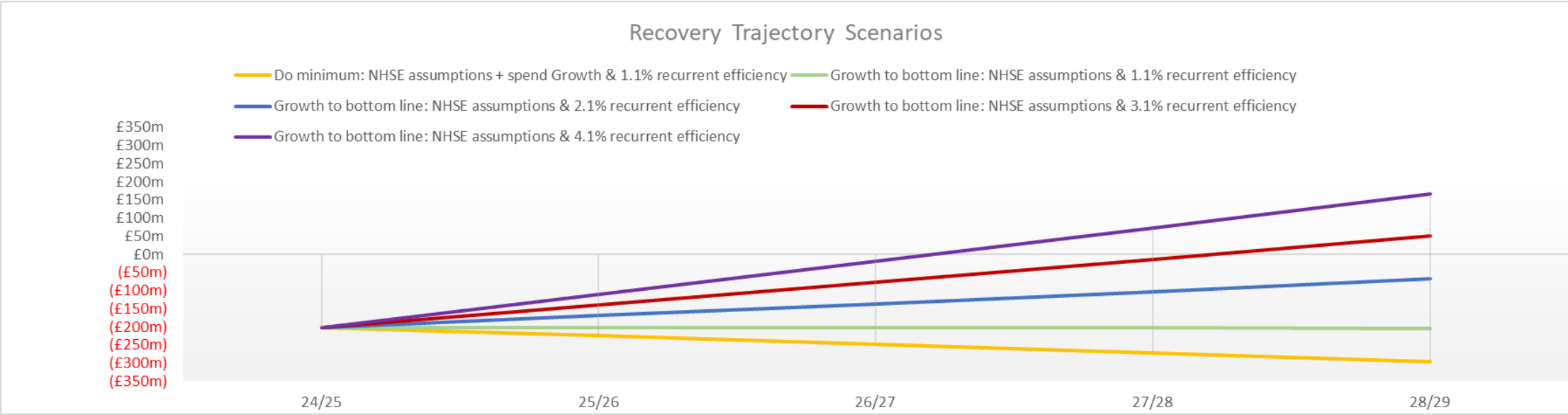
Risks and Mitigations	UHNM £m	MPFT £m	NSCHT £m	ICB £m	Total £m
(Risks)/(Offsets to benefits):					
Additional cost risk (capacity, pressures, winter, COVID)	(8)	(6)	0	(15)	**(29)**
Additional cost risk (inflation)	(3)	(1)	0	0	**(4)**
Efficiency risk	(23)	(7)	(3)	(6)	**(39)**
Income risk (excl. ERF)	0	(1)	0	0	**(1)**
Total Risks	**(34)**	**(15)**	**(3)**	**(21)**	**(73)**
Mitigations/benefits:					
Additional cost control or income (excl. ERF)					
Efficiency mitigation	17	6	0	0	**23**
Non-recurrent mitigation	3	0	3	0	**6**
Mitigations not yet identified	0	0	0	0	**0**
Total Provider Net Risk (excluding ERF)	**20**	**6**	**3**	**0**	**29**
Net Risk	**(14)**	**(9)**	**0**	**(21)**	**(44)**

Emerging risks not currently reflected in the plan

- The impact on interest receivable and PDC of sharing the deficit rather than holding in the ICB books - £3.4m
- UEC contractual challenges from Black Country providers. The risk based on PbR is £16m, the providers have collectively notified a £50m claim for additional funding.
- Band 2/3 equal pay claims (value yet to be quantified).

Route to sustainable financial balance

- We are already working through the impact of 2023/24 outturn and 2024/25 into the system medium term financial model.
- As the bridge earlier shows, the level of efficiency in the current 2024/25 plan is making in-roads into the underlying position.
- The model below assumes that we continue with the approach taken in 2024/25 of holding costs flat, with historically high levels of efficiency.
- The purple line assumes that all CIP is delivered recurrently. If so we could return the system to break-even in 2026/27.
- More realistically, the red line would allow for up to1% of that CIP to be non-recurrent, in which case financial balance would be achieved in 2027/28.



Staffordshire and Stoke-on-Trent
Integrated Care System

Workforce

Operational Workforce Plan – FY24-25 - 21st March Submission

FY 2023-24

- In Oct-23 a reconciliation activity was completed to understand the rational for workforce levels increasing back to FY19-20. This enabled an understanding of the rationale for the workforce movements and the direction of travel (fig 1).
- In FY23-24 we planned for further substantive increases of +855.1 wte (+4.3%, fig 2). As at Feb-24, the actual growth has been significantly higher, resulting in an increase of 1,495 wte since Mar - 2023 7.9%).
- In Dec 2023, a review of the operational plan was completed, which resulted in an adjustment to the workforce plan, agreed at system and shared with NHSE (fig 3).

FY 2024-25

- The FY24-25 operational plan submitted in March results in a substantive increase of +359 wte (+1.6%), from Mar-24 to Mar-25.

Staff Groups – Substantive WF Movement

- Reg Nursing, Midwifery & HV's: +231 (+3.7%)
- Reg/Qual Sci, Therapeutic & Staff: +28 wte (+0.9%)
- AHPs: +16 wte (+1.1%)
- Reg/Qual Healthcare Scientists: +0.7 wte (+0.2%)
- Support to Clinical staff: +80 wte (+1.2%)
- NHS Infrastructure Support: -2 wte (+0.9%)
- Medical & Dental: +22 wte (+1.3%)

Provider FY24-25 Plan – Substantive

- MPUFT: +273 wte (+2.4%, fig 4)
- NSCHT: +53 wte (+3.2%, fig 5)
- UHNM: +33 wte (+0.3%, fig 6)

Fig 1) Reconciliation

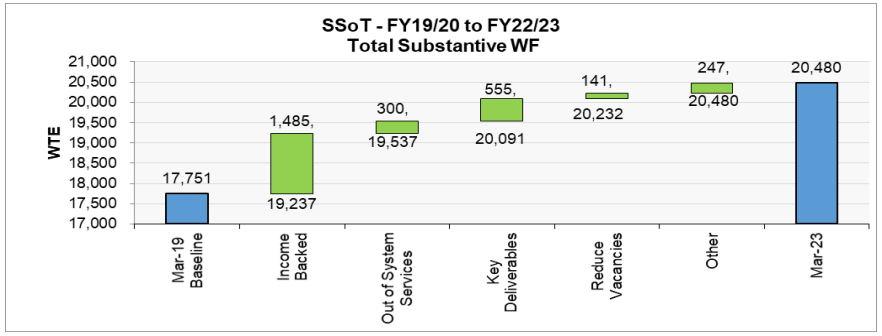


Fig 2) FY23-24 Ops Plan

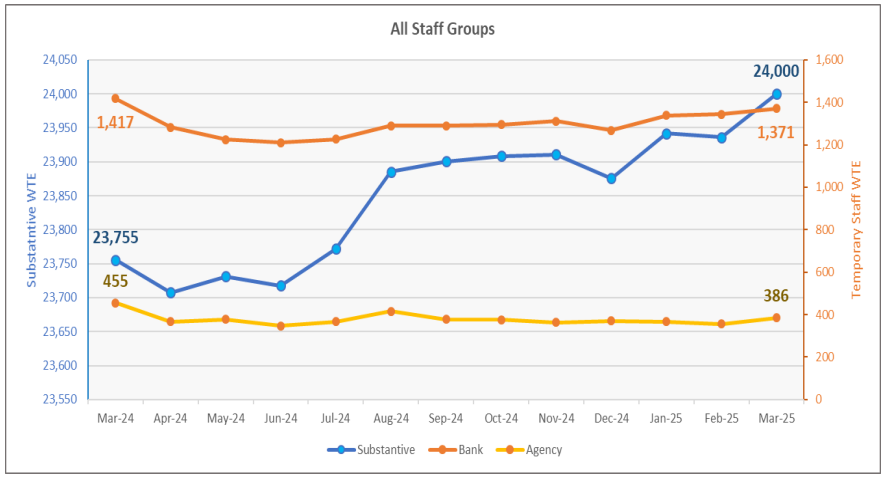


Fig 3) SSoT FY24-25 Plan

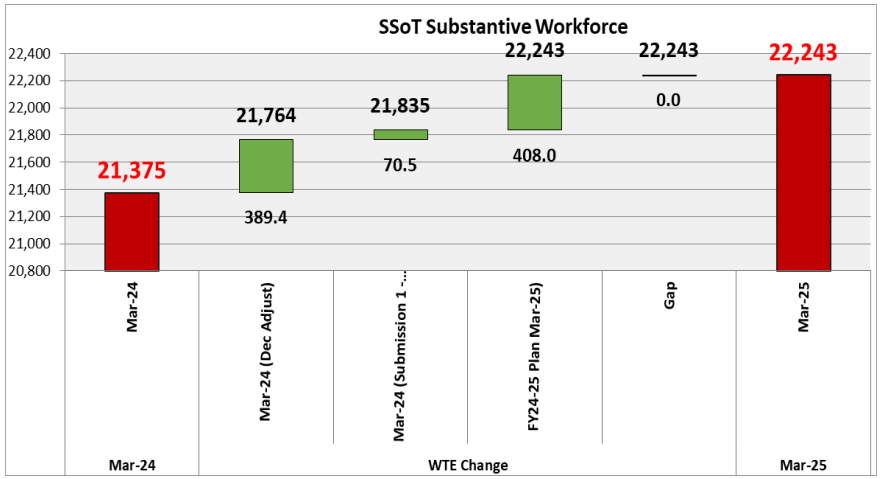


Fig 3) MPFT FY24-25 Plan

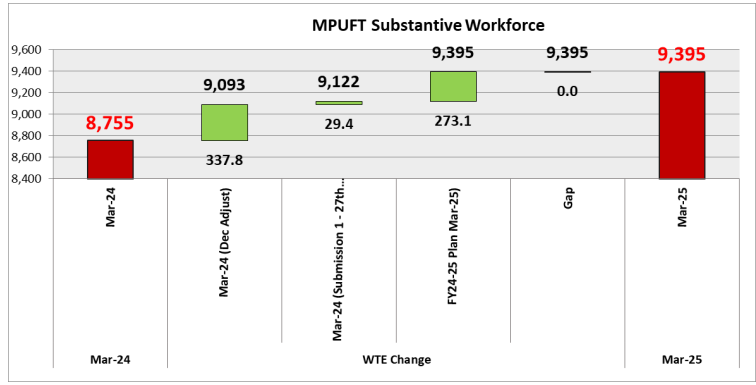


Fig 4) NSCHT FY24-25 Plan

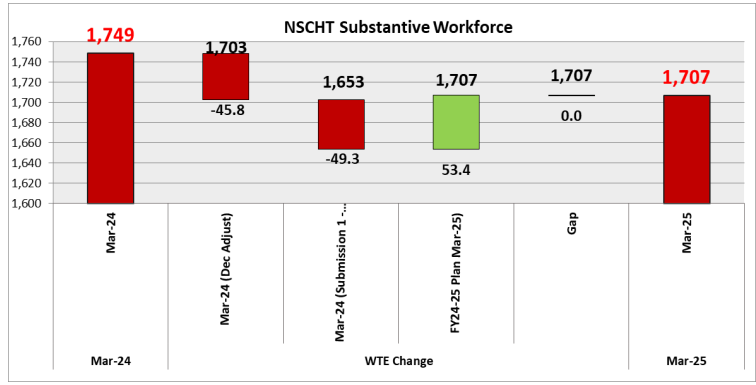
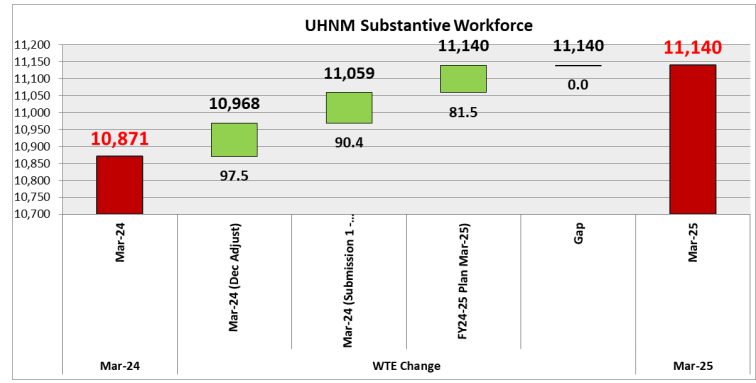


Fig 4) UHNMFY24-25 Plan



FY22/23 to FY23/24 Workforce Reconciliation

Purpose

- Understand the additionally of the workforce and the rationale for increase – as requested from 20th March NHSE Escalation meeting attended by CPO's
- Enable a level of workforce information which can be linked to activity and performance

Scope

- Providers to determine local approach to their reconciliation aligned to this overarching guidance; applied down to Specialty/Department/Ward/Team level.
- To cover the start period of Apr-22 to Mar-23 and Apr-23 to Mar-24, i.e. 31st March baseline for respective years to 31st March end position for full 12-month period.

Timeframe

- NHSE have mandated this ask to be shared alongside operational plans – Thursday 2nd May 24. The deadline for this specific activity is Thursday 25th April, 1 week after workforce plans are shared to system, and 1 week prior to submission to NHSE. Enabling a slightly extended period after ops plans have been shared.

Reconciliation Factors

- Overall categories to remain consistent with bridging activity completed in Oct-23, namely: 1) Income backed, 2) Out of system services, 3) Key deliverables, 4) Reduced vacancies, 5) Other. This enables comparison back to previous recon activity back to FY19/20 if required.
- The above categories will remain with the below sub-categories to enable a more detailed understanding of the workforce increase drivers:

Reconciliation main category	Sub-category	
Income backed	• TUPE in/out • Service/Ward opening/closure • Mental Health Investment Standard (MHIS) • Primary Care System Development Funding (SDF) • Elective Recovery Fund (ERF) & waiting lists	• Community Diagnostic Centres (CDC) • Winter resilience • Capital Projects • Better Care Fund
Out of system services	• Namely MPFT – services to footprints other than SSoT (STW)	
Key deliverables	• Investment/disinvestment • Efficiency measure • Safer staffing – nursing	• Safer staffing – Ockenden • Cleaning and infection control standards • Digital & Technology
Reduce vacancies	• Recruitment to establishment	
Other	• Only used if absolutely necessary – if a new category, judgement should be applied as a collective in the categories above	

- The above examples are not extensive, and there will be examples of workforce movements which will need to be considered throughout the process, being shared and agreed as a collective for adoption.
- BAU - Going forward this will be an ongoing exercise – frequency to be determined in conjunction with providers (monthly/quarterly)

Staffordshire and Stoke-on-Trent
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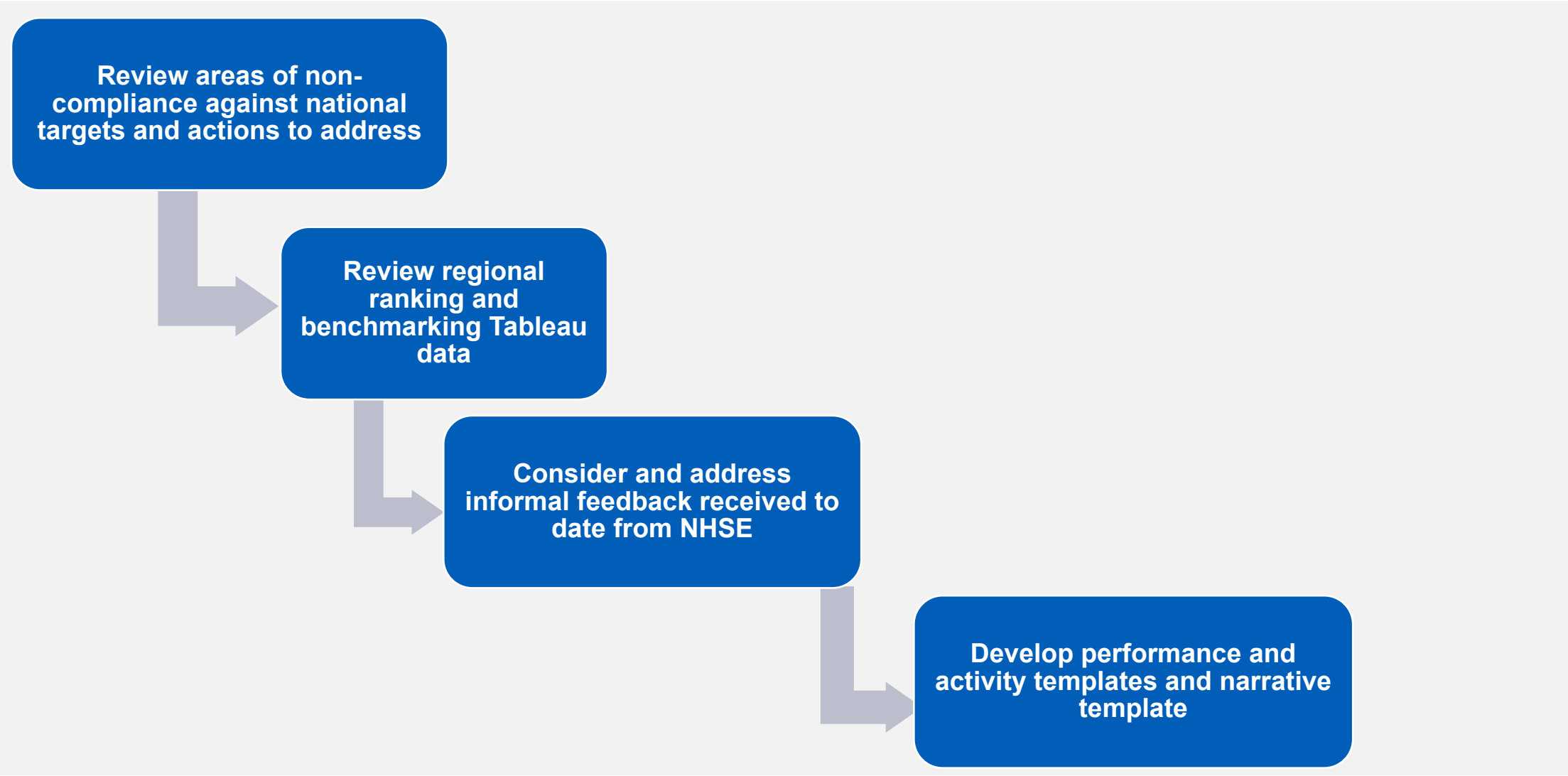
Activity, Performance and Productivity

Expectations for the 2 May Submission – Activity and Performance

- We are working through the following as system partners:



Capacity and operational issues to manage

- The submission on 21st March was at a point in time, with further modelling carried out since.
- We are continuing to work with finance and workforce colleagues to ensure reconciliation between plans as they develop ahead of the next submission.
- Note: The draft submission also included indicative UHDB data from a system position and has since been refreshed with their final submission.

Anticipated direction of plan from 21st March submission

- **65 week waits** – We are now in a position where we are forecasting clearance of 65 week waits by September in line with planning guidance. We anticipate all but respiratory and gastro clearing earlier.
- **Cancer Faster Diagnosis Standard (FDS) and 62 days pathway** - Utilising the actual plans for UHDB the ICB will be compliant on both measures in May submission. Delivery is reliant on securing Cancer Alliance bids which we are awaiting notification of.
- **Cost Weighted Activity –** System level performance is currently 104.4% for 24/25. Full reconciliation to 19/20 undertaken. Focus on seeking to improve this further ahead of the next submission – looking to unlock further WLI opportunity and productivity gains. However, this needs to be done in a controlled way with finance (ERF income) and workforce (potential temporary staffing impact).
- **A&E 4hours wait** - Following 6.5% improvement between February and March 2024 at UHNM we are building plans to continue this momentum and seek to deliver 78% by March 2025.
- **Diagnostics** – DM01 will likely achieve 95% in multiple modalities early in 2024/25 but will continue to be challenging in a couple of modalities without further investment.

Productivity Examples

- All system providers are committed to the delivery of improved productivity and already have examples of where productivity improvements are in place.
- There are broader underpinning areas of longer-term development including completing the NHS IMPACT self-assessment to support ongoing application of best practice in the design and delivery of improvement programmes that include tackling flow, safety, productivity.

Next Steps and Conversation at Escalation Meeting