NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 17 November 2022 12.45-15.00

Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford, Staffordshire, ST18 0BF

[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** **Quoracy** **Conflicts of Interest**	Prem Singh Prem Singh	Verbal Enc. 01 Enc. 02	 S	12.45	 3 4-5
2.	**Minutes of the Meeting held on 22 September 2022 and Matters Arising** **Action Log** Progress Updates on Actions	Prem Singh Prem Singh	Enc. 03 Enc. 04	A D	12.50	6-15 16-17
3.	**Questions submitted by members of the public in advance of the meeting**	Prem Singh		D	12.55	
4.	**Staffordshire and Stoke-on-Trent Staff Story**	Alex Brett	Enc. 05	D	13.00	18-25
	Strategic and System Development					
5.	**ICB Chair and Chief Executive Update**	Prem Singh/ Peter Axon	Enc. 06	D	13.15	26-31
6.	**Winter Plan**	Phil Smith	Enc. 07	A	13:25	32-41
7.	**ICS Oversight Framework**	Paul Brown	Enc. 08	A	13.40	42-48
	System Oversight and Governance					
8.	• **System Performance and Finance Report** • **Financial Strategy Update** • **Ambulance Delays Report** • **Quality and Safety Update Report**	Paul Brown Phil Smith Heather Johnstone	Enc. 09 Enc. 10	S S S	13.50 14:00 14.10	49-91 92-100
	Assurance Reports from Committees of the Board					

9.	• **Finance and Performance Committee Report** • **Audit Committee Report** • **People, Culture and Inclusion Committee Report** • **Quality and Safety Committee Report**	Megan Nurse Julie Houlder Shokat Lal David Pearson	Enc. 11 Enc. 12 Enc. 13 Enc. 14	S S S S	14:20 14:25 14.30 14.35	101-107 108-110 111-114 115-117
	Any other Business					
10.	**Items notified in advance to the Chair**	All		D		
11.	**Questions from the floor relating to the discussions at the meeting**	Prem Singh			14.40	
12.	**Meeting effectiveness**	Prem Singh				
13.	**Close**	Prem Singh			14.50	
14.	**Date and Time of Next Meeting** 19 January 2023 at 14.00.					

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
Staffordshire and
Stoke-on-Trent
Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2022-2023
INTEGRATED CARE BOARD (ICB)
AS AT 08 NOVEMBER 2022

Kev
Declaration completed for financial year 2022/2023
Declaration for financial year 2022/2023 to be submitted

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

Date of Declaratio	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*
10th October 2022	Dr	Buki	Adeyemo	Mental Health Provers' Partner Member and Interim 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.
19th October 2022	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 (2019 - present) 4. North Staffordshire Local Medical Committee Member (2009 - ongoing) 5. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 6. Director North Staffordshire GP Federation (2019 - ongoing) 7. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 8. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. Accurx Ltd Pilot site for digital services (ongoing) 3. Redmoor Healthcare Digital Health Consultant (adhoc consultant) (ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a principal partner of Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke on Trent (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. Redmoor Healthcare - no longer claiming expenses or speaker fees from them.
1st July 2022	Mr	Peter	Axon	Interim Chief Executive Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim CEO, NHS Staffordshire & Stoke-on-Trent ICB until November 2022. Substantive role - CEO, North Staffordshire Combined Healthcare NHS Trust (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) interest recorded on the Conflicts Register.
17th August 2022	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	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (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 July 2022	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	(h) recorded on conflicts register.
20th October 2022	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	MPFT	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.
1st July 2022	Ms	Alexandra (Alex)	Brett	Chief People Officer	Midlands Partnership NHS Foundation Trust/ Staffordshire & SoT ICS	Nothing to declare	1. Chief People Officer for MPFT and member of the People Committee for the STW ICS (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on ICB conflicts register.
4th October 2022	Mr	Neil	Carr OBE	Community Services Partner Member and CEO of MPFT	Midlands Partnership 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.	
1st July 2022	Dr	Paul	Edmondson-Jones	Chief Medical 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 July 2022	Mrs	Deborah (Debbie)	Everden	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
4th October 2022	Dr	Paddy	Hannigan	Clinical Director (Strategic Portfolio Lead)	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) 2. Works occasional Extended Access sessions for GP First Ltd (ongoing) 3. Practice is a member of Stafford Town Primary Care Network (ongoing)	Nothing to declare	Nothing to declare	1. Practice is a member in GP First Ltd (GP Federation) (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.
21st June 2022	Mr	John	Henderson	Local Authority Partner Member and Chief Executive Staffordshire County Council	Staffordshire County Council	1. Chief Executive Staffordshire County Council - 2015 - date. No direct financial relationship with the ICS, but SCC commissions services from NHS providers who are members of the ICS. (May 2015 -	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.

Date of Declaratio	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*
1st July 2022	Mrs	Julie	Houlder	NED / Chair of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner/Director - Elevate Coaching Ltd (October 2016 - ongoing) 2. Associate - Charis Consultancy (January 2019 - ongoing) 3. Director/Chair of Finance and Performance - Windsor Academy Trust (January 2019 - ongoing)	1. Non-Executive Director /Chair of Audit and Assurance-Derbyshire Community Health Trust (October 2018 - ongoing) 2. Non-Executive Director/Chair of Audit/Vice Chair - George Elliot NHS Trust (May 2016 - ongoing) 3. Chair Sir Josiah Mason Trust (2014 - ongoing) 4. Director/Chair of Finance and Performance - Windsor Academy Trust (January 2019 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register
1st July 2022	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
1st July 2022	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 Heartlands Hospital (ongoing) 2. Step-sister employed by MPFT as a nurse (ongoing) 3. Brother-in law works as an Occupational Health Nurse for Team Prevent at UHNM (ongoing) 4. Daughter is marketing executive for Voyage Care (LD and community service provider in Staffordshire) (August 2020 - ongoing) 5. Daughter-in-law volunteers as a maternity champion as part of the maternity	(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 July 2022	Mr	Shokat	Lal	NED / Chair of People Culture and OD Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st July 2022	Ms	Megan	Nurse	NED/Chair of Finance and Performance Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Mental Health Act Panel member, MPFT. (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association (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
1st July 2022	Mr	David	Pearson	NED / Chair of Remuneration Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Elected Councillor for Bagnall Parish Staffordshire Moorland (2005 - 30th June 2022) Retiring from this post 30th June 2022	1. Non-Executive Chair Land based College linked with Chester University (2018 - ongoing) 2. Membership of the Royal College of Nursing (RCN) (1978 - ongoing)	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	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.
1st July 2022	Mrs	Tracey	Shewan	Director of Communications and Corporate Services	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (ongoing) 2. Sibling is a registered nurse with MPFT (ongoing) 3. Daughter has commenced a student paramedic at 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.
1st July 2022	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 July 2022	Mrs	Josie	Spencer	NED / Chair of Quality and Safety Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Managing Director Josie Spencer Consultancy (November 2021 - ongoing)	Nothing to declare	1. Interim Chief Executive Coventry and Rugby GP Alliance (May 2022 - November 2022)	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
1st July 2022	Mr	Prem	Singh	Chair - Staffordshire and Stoke on Trent ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Chair of Derbyshire Community Health Services NHS Foundation Trust (November 2013 - ongoing) 2. Independent Coach (October 2021 - ongoing)	Nothing to declare	1. Spouse holds position of Chief Executive at Rotherham, Doncaster and South Humber NHS Foundation Trust (June 2015 - 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 July 2022	Mrs	Sally	Young	Director of Corporate Governance	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

Integrated Care Board Meeting
IN PUBLIC

22 September 2022
1.00pm-4.17pm

Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford, ST18 0BF

Members:	**01/07/22**	**18/08/22**	**22/09/22**
Prem Singh (PS) Chair, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Peter Axon (PA) Interim Chief Executive Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Paul Brown (PB) Chief Finance Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	x	✓
Phil Smith (PSm) Chief Delivery Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Sally Young (SY) Director of Corporate Services, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	x
Alex Brett (AB) Chief People Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Chris Ibell (CI) Chief Digital Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Heather Johnstone (HJ) Interim Chief Nursing and Therapies Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓
Chris Bird (CB) Interim Chief Transformation Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
David Pearson (DP) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Julie Houlder (JHo) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Megan Nurse (MN) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Shokat Lal (SL) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓
Josephine Spencer (JS) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Jon Rouse (JR), City Director, City of Stoke-on-Trent	x	x	✓
John Henderson (JH) Chief Executive, Staffordshire County Council	✓	x	✓
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire and Stoke-on-Trent Integrated Care Board		✓	✓
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire and Stoke-on-Trent Integrated Care Board		✓	Via Teams
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands	x	✓	x
Neil Carr (NC) Chief Executive, Midlands Partnership NHS Foundation Trust		✓	✓
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓

In Attendance:	01/07/22	18/08/22	22/09/22
Charlotte Woodcock (CW) Operational Lead the Staying Well Service, Midlands Partnership Foundation Trust			✓
Helen Ashley (HA) Director of Strategy and Transformation /Deputy Chief Executive, University Hospitals of North Midlands NHS Trust	✓		✓
Jane Chapman (JC) Head of Governance, Staffordshire and Stoke-on-Trent Integrated Care Board			✓
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Tracey Shewan (TS) Director of Communications, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓
Dr Steve Fawcett (SF) Medical Director, Staffordshire and Stoke-on-Trent Integrated Care Board			✓
Helen Slater, Head of Transformation, Staffordshire and Stoke-on-Trent Integrated Care Board		✓	✓
Gina Gill (GG) Senior IFR/Improvement Manager, Staffordshire and Stoke-on-Trent Integrated Care Board			✓
Professor Zafar Iqbal (ZA) Associate Medical Director Public Health, Midlands Partnership NHS Foundation Trust			✓
Dr Amit Arora (AA) Associate Medical Director, Midlands Partnership NHS Foundation Trust			✓
Jenny Fullard (JF) Communications and Engagement Service Partner, NHS Midlands and Lancashire Commissioning Support Unit	✓	✓	✓
Richard Caddy (RC) NHS Midlands and Lancashire Commissioning Support Unit		✓	✓
Debbie Everden (DE) Executive Assistant, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓

		Action
1.	**Welcome and Apologies**	
	PS welcomed attendees to the ICB Board meeting. PS advised that this 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. PS advised that the Leadership Compact document was included in the Board papers as a reminder that meetings should be conducted in accordance with the agreed principles. The meeting was quorate. Apologies were received from Sally Young and Tracy Bullock (Helen Ashley attending).	
2.	**Conflicts of Interest Register**	
	No additional conflicts of interest were declared. PS requested that the Register include the role of the Partner Members on the Board. The Integrated Care Board: • Noted the Conflicts of Interest Register	**SY**
3.	**Minutes of the previous meetings**	
	The minutes of the meetings held on 1 July 2022 and 18 August 2022 were approved.	
4.	**Action Log**	
	The action log was updated.	
5.	**Questions submitted by members of the public in advance of the meeting**	

	No questions had been submitted from the public in advance of the meeting.	
6.	**Staffordshire and Stoke-on-Trent Resident Story**	
	CB presented the item and advised that the Staying Well Service was an excellent example of partnership working. The service focusses on prevention and helps residents maintain good health and avoid admission to hospital. Charlotte Woodcock, Operational Lead for the Staying Well Service, presented slides on the work with residents with mild to moderate levels of frailty. JHo asked whether patients' families could refer to the service and also how the outcomes are quantified. CW advised that referral pathways are being examined so that patients and carers can make referrals. Health confidence scores, patient surveys and case studies are being examined together with outcomes for frailty across the System. DP asked whether the service covered residents with cognitive impairment and CW confirmed that they work alongside the Memory Service to offer services on mainlining health and cognition to residents with early memory problems and also their family members or carers. DP asked if there were any plans to expand into an educational role within care homes and CW advised that there were no imminent plans but any education that could take place in the community PE-J asked whether the service could be made available in Stoke-on-Trent where there are community lounges. There is work taking place around Better Health Staffordshire and social prescribing in place through GPs and he asked how the work could be joined up to achieve greater impact. CW advised that they were working with colleagues in the north to look at sharing good practice. JR commented that it was a fantastic service and we should have a shared ambition to have a service of this quality across the whole of Staffordshire. SL asked if engagement was taking place in all areas of the community particularly with people who didn't have English as their first language and if there was data available to show emerging patterns related to frailty and the link to particular professions. CW advised that this work has started and although the service was available for over 55s it was being accessed by residents in their 70s and 80s. it was being examined whether people are developing frailty later due to prevention work taking place and whether this is physical frailty or cognitive. Work was going to take place in the community particularly with faith groups to reach all residents. PS commented that the opportunity to work at community/Place level should be embraced and we need to include people who are self-referred. The challenge for the System was delivering what is needed here and now and also carrying out prevention work to ensure people are not admitted to hospital in the future. The Integrated Care Board: • Thanked CW for the presentation and thanked her and her colleagues for their work • Noted the content of the presentation and the work that is being undertaken by the Staying Well Service.	
7.	**BAF and Risk Register**	
	PS commented that for items which have already been scrutinised by Committees, the Board only needed to focus on the key issues. PA presented the papers and advised that the BAF and Risk Register were important documents but were still work in progress given the recent establishment of the ICB. PW presented the Risk Management Strategy and advised that work on this had taken place with System governance leads. It was planned to consolidate the Risk Register and BAF into	

	one report. PW advised that the strategy had been approved by the Audit Committee and was being presented to the Board for ratification. Regarding the Risk Register which included risks of 16 and above, JR questioned the consistency with the scoring as there were no risks relating to urgent and emergency care and requested that this is examined. He commented that the Register was very important and the Board should use the Risk Register to inform future agendas e.g. cyber security. PA commented that further work was taking place on the Register and agreed that urgent and emergency care should be included together with workforce and these areas would be included when the Register was next presented to the Board in November. He agreed that management and mitigation of risk was an important task for the Board to undertake. JHo advised that the Audit Committee would retain oversight of the work and would recommend areas of strategic work to be presented to the Board. HA commented that it would be useful to useful to check against the Providers' Risk Registers to ensure consistency. PW advised that there is a pan-Staffordshire Governance Group which examines risks to ensure alignment and avoid duplication. JC presented slides on the strategic objectives which were based on the ICB's quadruple aims. She advised that there would be a Board development session on strategic risk and risk tolerance in October and the full report linking strategic objectives, controls and assurances would be presented at the November meeting. PA commented that the BAF should link to our strategic objectives. The draft ICP Strategy would be completed by the end of December and the current objectives were interim until this had been finalised. HA questioned the inclusion of People as a strategic objective and AB advised that the risks identified by the People, Culture and Inclusion Committee do need to be included and further work regarding this would take place. The Integrated Care Board: • Approved the Risk Management Strategy • Noted the Risk Register • Agreed to review the strategic objectives outside the meeting and provide comments.	
8.	**Clinical Policy Alignment**	
	PE-J introduced the paper and GG presented slides detailing the process so far and the current position for the harmonisation of the eligibility criteria for the following areas: • Assisted Conception • Hearing Loss in Adults • Male and Female Sterilisation • Breast Augmentation and Reconstruction • Removal of excess skin following significant weight loss PE-J summarised the proposals and their impacts. It was confirmed that Quality Impact Assessments and Equality Impact Assessments had been carried out. JS advised that the proposals had been scrutinised at the Quality and Safety Committee meeting. They were assured and recommend approval by the Board. SL queried the outcome of the engagement with the public and requested that future communications are clear. GG advised that there are mitigations to cover the impacts and a strong communications process in place. Any patients already on a waiting list would have the procedure honoured. PS commented that it was important to note that these proposals were not financially motivated but were clinically driven and provided improvements in the services.	

	The Integrated Care Board: • Was assured that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders • Considered the financial consequences and the risks relating to the recommendations • Approved the recommendation to decouple assisted conception from the wider policy alignment programme and develop an interim aligned assisted conception policy • Approved the recommendations for the four other clinical areas.	
9.	**ICB Chair and Chief Executive Update**	
	PS stated that we and the nation were deeply saddened by the passing of Her Majesty, Queen Elizabeth II. On behalf of the NHS Staffordshire and Stoke-on-Trent Integrated Care Board and the wider system, we express our deepest condolences and our thoughts are with the Royal Family at this very sad time. PS advised that he had attended the Quarterly System Review Meeting with Executives and Board Partner Members and National Health Service England (NHSE) had commended the System on the very positive meeting. He advised that PE-J had delivered a presentation on Population Health Management. PA advised that the Secretary of State had made an announcement regarding funding for Primary Care and Health and Social Care and our challenge was to use this appropriately to ensure capacity and the winter requirements are met. He stated that there will be challenges over winter but there will be opportunities and we need to also focus on prevention and the needs based agenda. Regarding the Constitution, PA advised that latest iteration was broadly supported across the System and had been submitted to NHSE for final approval. PS commented that the funding announcements provided the opportunity to be innovative but workforce was a major concern. AB advised that included in the Secretary of State's announcement was a call for volunteers to support the NHS. JR advised that at the Stoke-on-Trent City Forum there would be a launch of the Stronger Together Through Winter Programme. This was a multi-agency approach to support vulnerable residents and there would be the opportunity for volunteers to work in their communities to assist with this. He commented that the funding was welcome but there were a lot of things the System will need to do collectively to get through the winter challenges. PS commented that it was important to share data and knowledge to reach residents who are isolated. BA commented that as well as recruiting new staff we need to ensure that existing staff are retained and that we look after their wellbeing. AB advised that all NHS organisations have signed up to be foster friendly employers. The Integrated Care Board: • Noted the ICB Chair and Chief Executive Report.	
10.	**Delegation of Services from NHS England to ICB Boards**	
	PA presented the paper and advised that this detailed the emerging relationship with West Midlands ICBs to operate together regarding the delegation of Primary Care and some specialised commissioning services from NHSE. PA advised that work was on-going and any final proposal would be presented to the Board for approval. PS commented that there needed to be the appropriate delegation of resources to carry out the tasks and PA advised that this is emerging as the NHS Operating Plan is finalised but did form part of the conversations.	

	JR commented that we would want some of the specialised functions delegated down to ICB level and PA advised that this would be taken into account when working through the proposals. The Integrated Care Board: • Approved the Terms of Reference and noted the expectation that these will be reviewed as delegation arrangements progress through into 2023/24 • Noted the commissioning framework and noted (as part of the Terms of Reference for the Committee) that it is for the Committee to determine the most appropriate arrangements for each activity and/or function.	
11.	**ICB Memorandum of Understanding with NHS England**	
	PA presented the paper and advised that this latest iteration described the relationship between the ICB and NHSE and the oversight responsibilities of the ICB. MN commented that how the Committees fit in regarding the governance arrangements was important and PA agreed. The Integrated Care Board: • Approved the October 2022 NHS England Memorandum of Understanding with Staffordshire and Stoke-on-Trent ICB.	
12.	**Healthier Ageing And Frailty Strategy Implementation Update**	
	NC introduced the item and thanked JR for chairing the earlier work on the strategy. He advised that we have over 250,000 residents over the age of 65 and we need to address the issues to ensure demand on urgent and emergency care services doesn't increase. He advised that the strategy had been socialised in all part of the System and ZA commented that we have the opportunity through the ICS to realise the ambition to improve healthy life expectancy. ZA presented slides on the programme detailing the priorities and next steps. AA advised that Staffordshire and Stoke-on-Trent was progressive in this area and we have a lot of projects in place. He advised that in producing the strategy, there had been a lot of clinical engagement and workshops attended by the public and voluntary sector. PH advised that he had been involved in the Primary Care and Digital elements of the strategy and the challenge was applying a limited resource in the most effective way. The data and algorithms can assist with identifying the patients most likely to benefit and they can be directly approached. PSm requested alignment with the work of the Urgent and Emergency Care (UEC) Board regarding piloting of some of the opportunities highlighted in the presentation. DP commented that the involvement of the voluntary sector would assist with capacity and AA stated that there were positive on-going relationships and he was confident of their assistance. JHo asked how communication would be managed so that residents as they age can discuss their needs with their families. AA advised that early intervention is key and there is a digital educational element to the programme including inter-generational work. PB commented that given the long-term financial challenges, working together on frailty and long-term conditions was paramount. He asked if the projected figure of patients with long-term conditions was inevitable or if any action could be taken to reduce this. ZA advised that with a strong preventative approach there is lot we can do particularly regarding hypertension, diabetes and the progression of respiratory conditions. PE-J commented that the four impacts of frailty are on the acute hospital, on mental health services, on social care and on families. We need to consider non-clinical predictions such as housing and isolation. With advanced care planning, individuals can indicate how they could like their care going forward; this could also include social care.	

	The Integrated Care Board: • Thanked ZA and AA for the presentation and thanked them and their colleagues for the work on the strategy • Requested that a workshop is held to establish actions and priorities and the results presented to the Board in spring 2023 • Noted the Healthier Ageing And Frailty Strategy Implementation Update.	**NC**
13.	**ICS Oversight Framework**	
	PB presented the paper and advised that this has been previously discussed at System meetings and would be discussed further at future meetings. One of the ICB's main roles was to oversee the quality and performance of the System and to provide assurance to NHSE. He advised that the ICB wanted to be facilitative rather than a regulator but would have to consider intervention as a last resort. PS commented that the statutory responsibilities of the ICB were out of our control but how we execute these was important. The Oversight Framework was developed to avoid us being hierarchical but we do need to deliver as a System and be collectively held to account. He suggested that some Committees could be socialised with Non-Executives from Providers to ensure alignment. The Integrated Care Board: • Noted the ICS Oversight Framework paper • Noted that a further update would be presented to the November Board meeting.	**PB**
14.	**System Performance and Finance Report**	
	PB advised that the financial position is challenging but we compare favourably with other Systems. We had a planned deficit of £28.6m but we were requested by NHSE to get to break even. To achieve this we had to make some nationally agreed assumptions e.g. no inflation impact, no Covid impact. There are inflation costs and costs relating to Covid in the hospitals and in Primary Care so a predicated gap of £20m is forecast and within the ICB, Continuing Healthcare (CHC) is a driver for this. A System efficiency target of 4.2% has been set and we are at 85% of delivery of this target. PB advised that the regulator has requested a break even position and the Chief Finance Officers are working to achieve this. If break-even is achieved for two consecutive years then the CCGs' legacy debt of £300m will be written off. PSm advised that we achieved the 104 week waits target by the end of Quarter 1 and the focus was now on eradicating all 104 week waits including the complex patients by the end of September. We are ahead of trajectory for the 78 week waits; there is a national requirement to eradicate these by March 2023 so we need to ensure there is capacity built in during winter. Additional work is being carried out to utilise the independent sector and to identify efficiencies in the pathways. There have been significant backlogs for patients awaiting cancer treatment mainly for colorectal and skin. There have been improvements in the last 3 or 4 weeks with additional capacity put in place to ensure referrals received are appropriate and support is being provided by NHSE nationally and regionally. PSm advised that the urgent and emergency care pathway continues to be challenging; ambulance handover delays are an issue nationally and additional funding has been received together with support being provided by the national and regional teams. Actions being taken include working closely with the community teams that support the ambulance service so that where possible patients can be treated in their own home, ensuring that patients that present at A & E are treated efficiently and by the right teams, carrying out estates work to expand the A & E department and examining the balance of risk across the Trust and the wider System.	

	PSm advised that all partners are engaged in the development of the Winter Plan and this will be presented to a future Board meeting. JR commented that the report should contain a table to show performance against the core standards and the trajectory and this would provide transparency for the public. PS commented that the key areas and not every metric should be included. MN advised that the data including the trajectories is examined at the Finance and Performance Committee. The Integrated Care Board: • Noted the System Performance and Finance Report.	**PB/ PSm**
15.	**Quality and Safety Update Report**	
	HJ presented the report. She advised that The Woodhouse would no longer be a unit providing support for people with mental health and learning disabilities and, therefore, we are finding alternative accommodation for patients; the majority are out of area patients. After the building work has been completed, The Woodhouse until will re-open as a neuro-behavioural unit and be known as Moorlands Neuro Centre. Regarding maternity, HJ advised that there have been challenges over the last few weeks. The backlog of inductions has now significantly reduced. HJ advised that yesterday a letter was received from NHSE removing the formal target for continuity of care and she advised that this would provide flexibility to be able to make local improvements but the workforce challenges continue. HJ advised that the Serious Incident Framework is being replaced by the Patient Safety Incident Response Framework and has to be implemented by September 2023. PE-J asked how we can be assured that the level of care at The Woodhouse has improved and how the CQC will manage the transition. HJ advised that as host commissioner, we work closely with the CQC. We are not making any assumptions regarding the commissioning of the service in the future and if necessary a quality oversight process will be set up. The Integrated Care Board: • Was assured in relation to key quality and safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System and ratified the decisions made by the Committee under delegated authority as follows: o Approval of the Quality and Safety Committee Terms of Reference o Approval of the System Quality Group Terms of Reference o Approval of the Interim QIA Subgroup Terms of Reference o Approval of the System Patient Safety Specialist Network Terms of Reference	
16.	**ICB Board Development Programme**	
	AB presented the outline framework and advised that a programme of support for the Board would be externally commissioned. The programme would cover how the Board discharges its statutory duties, behaviours and leadership competencies. JR recognised that this work is important but questioned if more time should be focussed on preparing for delivery. The Board should use scenarios to problem solve and draw out strengths and weaknesses. PS commented that strongly aligned leadership supports improvement and delivery. AB advised that the current proposal was fairly broad and non-specific as the intention was for the Board to co-create the programme. PA commented that the best OD work is practical as this builds relationships and ensures a practical set of outputs.	

	PB commented that the leadership was reasonably well aligned and the challenge was getting information down through the organisations. The portfolios will allow work to be undertaken in a different way and he questioned if there could be a System OD programme. AB agreed and advised that an early iteration of a System Plan was in place and further work was taking place on this. PS commented that with bringing in an external provider there was the risk of having a ready-made product which wasn't appropriate so asked that AB co-create the programme. It should include tangible, practical elements and enable alignment with the System to deliver on the portfolios. HA asked if the portfolio approach is taken, whether the colleagues involved in those portfolios would then be invited and she agreed with PB that teams needs to be brought into the conversation to enable them to deliver. PA commented that we are reliant on individuals and each organisation to collectively deliver our objectives and we can develop the ICSs' concepts as we evolve the work programmes. CB commented that some of our teams work well in partnership and questioned what we can learn from them and whether the reverse mentoring concept could be included. The Integrated Care Board: • Approved the ICB Board Development Proposal and requested that AB co-create the programme to include the elements discussed • Noted the proposal to source a delivery Partner	
17.	**Assurance Reports from Committees of the Board**	
	PS advised that this was the first time these reports had been presented to the Board. He commented that they were very informative and showed the quality of the work being undertaken by the Committees. <u>Finance and Performance Committee Report</u> MN advised that the Committee was assured that all partners are working together on the financial challenges outlined and are continuing to discuss CHC costs and activity. She commented that the Primary Care deep dive was very informative and would be useful when the strategy is developed. She advised that the Intelligence Fixed Payment System paper was being presented to System Committees for approval. <u>Audit Committee</u> JHo advised that there were no items for escalation to the Board. She queried if the reports should be earlier on the agenda so if any items are to be escalated the discussions could be focussed on these. <u>People, Culture and Inclusion Committee</u> SL commented on the challenges regarding workforce planning and that this would be the focus of the Committee. The workforce metrics data from the different organisations is being examined for trends and the impact of the work on retention and recruitment. <u>System Quality & Safety Committee</u> JS advised that the focus is being shifted from the oversight of the performance of Trusts to the wider System transformation, health inequalities and prevention work. The Terms of Reference were agreed but further discussions with partners about the approach is needed and discussions are taking place regarding the attendance of Trust Safety and Quality Non-Executives. The Integrated Care Board: • Aside from the limited assurance regarding Maternity Services took assurance regarding the reports provided and the discussions that took place at the Committees.	
18.	**Any other Business**	

	No matters were raised.	
19.	**Questions from the floor relating to the discussions at the meeting**	
	Mention is made of a 'robust' plan to reduce ambulance handover delays. When will this 'robust plan' with trajectories for reduction be made public and also when will the North Bristol model (with any modifications) and implementation be made public? PSm advised that the plan focussed on avoiding unnecessary admission and expanding the Emergency Department space. National support is being received and funds allocated. Daily monitoring takes place with escalations when necessary. Regarding the North Bristol model, this is a 'push' approach where each hour patients are moved to wards rather than wait for an identified bed to keep flow moving through the hospital. This only works to an extent so a whole System approach is needed and we are examining balancing the risk across all partners and looking at other areas of best practice. HA commented that the North Bristol model considers the risk to all patients with the patient on a ward being at less risk than the patient still waiting for an ambulance to respond. PSm advised that a more detailed report on ambulance delays would be presented to the next Board meeting. What are the 'problems' (highlighted in the Systems Review letter) with induction of labour and what has been mobilised to improve such? HJ advised that the Quarterly System Review letter referred to the pressures. If women are due to be induced but there are insufficient midwives then there has to be a safely managed 'queue'. There has been a workforce challenge meaning there has not been enough staff to safely induce and manage all the other maternity activity. Support had been given to UHNM to obtain alternative providers to provide safe induction of labour for women who could not wait any longer. A regional escalation criteria has been developed to ensure standardisation and prioritisation across all providers. HJ advised that the numbers were now at normal levels but this would continue to be monitored. Further to the above 2 questions how is the ICB monitoring the efficacy of the above improvement plans and reporting publicly on such? PB advised that further work on the metrics and dashboard is taking place and relationships across the System to collectively manage performance are being formed particularly though the System Performance Group with scrutiny provided by the Finance and Performance Committee.	**PSm**
20.	**Meeting Effectiveness**	
	PS reminded Board members of the Leadership Compact and Members agreed that the meeting had been conducted according these principles.	
21.	**Date and time of next meeting**	
	17 November 2022 at 1.00pm. Newcastle Suite, Stafford Education and Enterprise Park, Stafford, ST18 0BF	

Integrated Care Board - Action Plan

Date	Item	Agenda Item	Action	Action Owner	Update	Due Date	RAG
18.08.22	5.	Inpatient Mental Health Services previously provided at the George Bryan Centre/Questions from members of the public	The MPFT transport policy and the mapping work to be completed and included as part of the submission to NHSE. Transformation Team to present to a future meeting of the Board following assurance meeting with NHSE.	NC PE-J	15.09.22 MPFT have shared the travel document and this has been submitted to NHSE ahead of the assurance process. **Action closed.** Travel analysis and mapping is part of the technical impact assessment work undertaken and included in the business case appendices. The mapping has been refined for inclusion in the formal involvement documentation submitted to NHSE. NHSE Assurance meeting will take place 21 September 2022 and the team will present back once the report from NHSE is received.	By submission date of 21 September Provisional date of October 2022. 22.09.22 A positive meeting with NHSE has taken place ahead of the formal assurance panel. A report will be presented to the November Board meeting. 17.11.22 Awaiting confirmation of NHSE meeting date. A report will be presented to the January Board meeting.	
22.09.22	2.	Conflicts of Interest Register	The Register to include the roles of Partner Members.	SY		17.11.22 Amendments to the Register made. **Action Closed.**	
22.09.22	12.	Healthier Ageing And Frailty Strategy Implementation	A workshop to be held to establish actions and priorities and the results	NC		April 2023	

		Update	presented to the Board in spring 2023.				
22.09.22	13.	ICS Oversight Framework	A further update to be presented to the November Board meeting.	PB		17.11.22 On the agenda. **Action closed.**	
22.09.22	14.	System Performance and Finance Report	Future reports to contain a table to show performance against the core standards and the trajectory.	PB/PSm		17.11.22 Information included in the performance report. **Action closed.**	
22.09.22	19.	Questions from the floor relating to the discussions at the meeting	A detailed report on ambulance delays to be presented to the November Board meeting.	PSm		17.11.22 On the agenda. **Action closed.**	

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**Staff Story – Adil, Health Care Support Worker Apprentice & CASE STUDY: A system approach to apprenticeships in Staffordshire and Stoke on Trent ICS**

Meeting Date:	17th November 2022

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Mish Irvine		Megan Page

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	N

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**	**X**	**Assurance - S**		**Information-I**	**X**

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Video presented at ICS People Programme Board	12/10/23	D/I

Purpose of the Paper (Key Points + Executive Summary):

Over the last 3 years the ICS People Function Team has worked with partners across the ICS to increase participation in health and care careers from young people in schools and from deprived and seldom heard communities. This was driven by the ICS's role as a 'cornerstone employer'– with social responsibility across the local footprint – while also supporting broad routes to growing the system's future workforce.

When looking to recruit our 3rd cohort in 2021, we wanted to ensure our apprenticeship scheme provided equal opportunity for all and engaged seldom heard communities for feedback.

This valuable engagement highlighted that individuals from seldom heard communities may not have the qualifications to help them start their career in health and social care. We wanted to change this in our practices and made adjustments to our apprenticeship scheme with our education provider partners. For Cohort 3, the scheme has focussed on accessing and engaging with hard to reach communities and individuals from deprived backgrounds. Engagement with staff networks, community groups and faith leaders has provided a wealth of insight into those groups accessing and understanding roles and routes into health and care careers. The team has adapted the programme

and the recruitment process to ensure inclusivity and diversity across the programme. Our scheme is still evolving now to ensure we can support all individuals, especially those that think it may not be an option for them.

Since then, the ICS People Function have been awarded Employer of the Year for the West Midlands round of the Apprenticeships National Awards 2022 and are finalists for the National Awards. After this success and recruitment being undertaken for a 4th Level 2 Health Care Support Worker Cohort; we would like to share one of our apprentice's journey.

Adil is a Level 2 Health Care Support Worker Apprentice, who came to the UK as a refugee.

Adil left his homeland at 15 because of threats of death. He travelled alone through 14 different countries to come to the UK, the journey took him almost a year to complete.

Adil was previously living in the YMCA in Stoke-on-Trent and had enrolled on a Traineeship Programme at Stoke-on-Trent City College which was focussed on health and social care roles. After receiving support from the YMCA and the College, he joined our Apprenticeship Programme in January 2022.

Stoke on Trent City College asked Adil the following questions upon completing his Traineeship:

How did the traineeship benefit you?

"If it wasn't for the traineeship I wouldn't be where I am now. I am finally doing something I love and I'm on the right path, working towards the career I want. It's also helped me to become more confident in myself and being in the workplace, as well as developing my Maths and English skills. English is not my first language but I have come a very long way from talking to professionals and my peers on the course."

Did the work experience help you to make the right decision about your future?

"Yes, definitely – a month of work experience opened my eyes and made it clear to me that this is what I want to do. I was on a Stroke Ward for my work experience, it was challenging but I enjoyed every second of it. Now on the apprenticeship, I get the opportunity to experience many different wards and environments

How do you feel about your future now compared to before the Traineeship?

"I feel that I am now on the right path, I knew that I always wanted to work for the NHS but I didn't know how to get there. I was feeling a little bit lost before but my tutors gave me the support and guidance I needed to get where I wanted to be."

Do you think the traineeship was the right option to get you ready for work?

"Yes, I do. It was the best decision for me to get onto the right path. It gave me an insight into the work environment and what to expect. It helped to build my confidence and opened up an opportunity for me."

Would you recommend the traineeship course and the college?

"I would definitely recommend it, you get out what you put in. Especially if you are like me, wanting to get into work and find what's right for you. I didn't feel committed to studying on a full-time course as I am a more practical person. I didn't have a job or much experience at the time so it was the right course for me and the college gave me the support I needed to progress. Now on the apprenticeship I earn whilst I learn."

Adil shares his journey and thoughts on the apprenticeship so far, as well as his future aspirations in his career conversation video.

[Please read the attached case study for further information and background on the Apprenticeship Pathway Scheme]

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

N/A

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
N/A

Implications:	
Legal and/or Risk	N/A
CQC/Regulator	N/A
Patient Safety	N/A
Financial – if yes, they have been assured by the CFO	N/A
Sustainability	N/A
Workforce / Training	N/A

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a)		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	**N/A**
2b.	What was the outcome from the System QIA Panel? (N/A)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N/A**	**N/A**
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **N/A**		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	**N/A**
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	**N/A**
Recommendations / Action Required:			
The Integrated Care Board is asked to: Listen to Adil's story and experience and encourage Trusts and partner organisations to continue to support the apprenticeship scheme via vacancies and placement opportunities.			

CASE STUDY: A system approach to apprenticeships in Staffordshire and Stoke on Trent ICS (People Function)

Region: Midlands

ICS: Staffordshire and Stoke on Trent

Key contacts in the ICS: Mish Irvine, ICS Associate Director of People, mish.irvine2@mpft.nhs.uk;

Summary:

- Staffordshire and Stoke on Trent ICS are committed to widening participation of its population in Health and Care roles.
- There are a number of programmes in place to support this, however this case study will focus on their System wide Health and Care Apprenticeship and Apprenticeship Levy Share scheme which are now in year 3 of delivery.
- As part of Cohort 3, the System have focused on expanding their remit to reach under-represented communities and also make the Apprenticeship accessible to those without the traditional GCSE results via Traineeships.

What was the aim? How was the work developed and implemented?

Over the last 2-3 years the ICS People Function Team has worked with partners across the ICS to increase participation in health and care careers from young people in schools and from deprived and seldom heard communities. This was driven by the ICS's role as a 'cornerstone employer'– with social responsibility across the local footprint – while also supporting broad routes to growing the system's future workforce.

Two of the initiatives included:

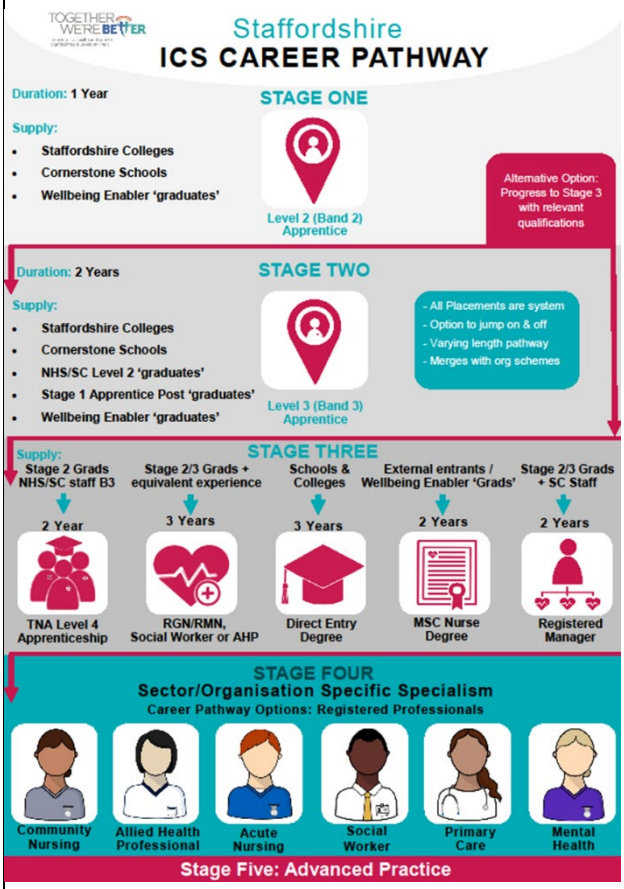
1) **Rotational apprenticeships across the ICS**

The Staffordshire and Stoke on Trent Health and Care ICS Career Pathway was developed by the ICS People Function Team in 2019 in order to tackle the following challenges for the system workforce:

- An ageing population within the workforce and subsequent potential lack of workforce capacity within 5-10 years.
- High vacancy rates currently within health and social care in nursing, domiciliary care and social care roles.
- Reduced Student Nursing numbers due to the academic requirements and financial outlay associated with this degree.
- High attrition from nursing degrees and newly qualified band 5 nurses due to lack of understanding of the nature of the role; which would be improved if candidates had an opportunity to test the workplace in a supportive placement prior to committing.
- To have a workforce that has knowledge of how system organisations work together and in turn develops relationships to improve partnership working.

- To develop a transient workforce that is adaptable and has the skills to work across the sector when required to do so.
- Educate young people regarding the plethora of potential careers with the health and social care sector and allow them to make an informed career choice.
- More recently; the impact of COVID-19 on workforce capacity has highlighted the need to future proof the health and care workforce in Staffordshire, especially in Care Homes.

The aim of the pathway was to give young people a clearly defined vocational pathway from school into a registered profession that does not require them to participate in full time education after 18 or pay University course fees. The pathway is mutually beneficial as the candidates add clinical value within each placement and have a robust knowledge of the system on graduation from the scheme (summarised in **Figure 1**).



Over the course of the programme, the team have worked with different partners in the ICS – including acute, mental health and community trusts, the local skills council, local authorities – to agree a joint approach to developing people from the local communities to step into health and care careers through rotational apprenticeships.

All partners agreed to provide funding and support for apprenticeship placements to enable apprentices to move through organisations and pathways, and gain experience working in different settings – including placements in primary care, hospitals and the community. This includes a robust pastoral support package to help apprentices going through the programme, including clinical support, mentoring and coaching.

For Cohort 3, the scheme has focussed on accessing and engaging with seldom heard communities and individuals from deprived backgrounds. Engagement with staff networks, community groups and faith leaders has provided a wealth of insight into those groups accessing and understanding roles and routes into health and care careers. The team has adapted the programme and the recruitment process to ensure inclusivity and diversity across the programme. A Traineeship programme was introduced to support entry into the scheme for those individuals who do not hold the necessary qualifications for the apprenticeship scheme. An Outreach Advisor role was also recruited to, to help increase engagement with seldom heard communities and to potentially encourage them to join the scheme. There are future plans in place to employ a number of clinical facilitators from across the system, to enhance the support that is already in place.

Challenges included: engagement and partnership with providers to convince them of the benefits of investing in a system-wide rather than organisation-based apprenticeship programme; finding places for each of the apprenticeship placements in different settings.

Enablers included: building relationships and trust between different ICS partners over time to buy into this approach; meeting with Ethnically Diverse, Differently abled and LGBTQ staff groups across the ICS to understand how to engage with these communities, to encourage wide reach of the apprenticeship programme and uptake from all communities; articulation of each organisation's social responsibility role in supporting the wider local community even where there may be no immediate direct benefits to each individual organisation; having a dedicated team and resource to support organisations and apprentices; evaluating the effectiveness and impact of the programme.

The programme currently covers healthcare support worker role apprenticeships, but the ICS is exploring expanding to Allied Health Professionals and Pharmacy roles.

2) **Apprenticeship Levy sharing across the system**

The team facilitated conversations between different NHS organisations in the ICS and worked with partners such as Skills for Care, Care Home and Hospice managers and education providers to develop a scheme to share unspent levy funds which would have otherwise been lost.

Large system employers committed to sharing some of their unspent apprenticeship levy funding to support smaller providers to recruit apprentices, including in social care and the independent sector. As a result, organisations across the system are working together to support workforce development and secure supply across key pathways in true partnership.

Challenges included: not being able to access as much training as other employers, or not being able to develop staff or get them released.

Enablers included: relationship building between partners to articulate benefits of the approach; encouraging partnerships and sharing across specific pathways e.g. Cancer services, Acute provider and hospices; robust process and systems to support sharing.

What were the results?

1) **Rotational apprenticeships across the ICS**

- The ICS is currently supporting 10 apprentices within the scheme, across 4 cohorts. In the most recent cohort 2 of the successful candidates are refugees and 4 are young workers under the age of 18.
- Apprentices have gained valuable experience in different health and care settings to support their studies and experience.
- Placement providers across Community, Mental Health, General Practice and Care Homes have reported the value and positive impact the apprentices have had whilst on their placements and during the rotations. The Apprentices gain valuable insight into health and care pathways in order to share learning and practice across providers.

- 44 apprentices have been recruited since the scheme was created with 70% of these remaining in Health or Social Care or pursuing higher level qualifications.

2) Apprenticeship levy sharing across the system

- The ICS providers have collectively supported 80 new applications across Staffordshire and Stoke on Trent in 2021 whilst supporting their own apprenticeship programmes - totalling £1.4m utilised in levy sharing for over 300 Apprenticeships. The scheme has supported an increase in much needed entry level routes into health and social care careers, supporting the overall aims to strengthen the supply pipeline.

What were the learning points and what would your advice be to other ICSs?

1. By working with system partners and independent providers, the system has created a really strong foundation enabling a 'One Workforce' and becoming an anchor employer.
2. Engage with as many people and providers as possible, spend the time understanding the barriers and tweaking any programmes to help increase engagement and inclusivity.
3. Backing from the People, Culture and Inclusion Board is crucial.
4. Present the 'what's in it for them' case, outline the benefits and the value it will add to them and the population
5. Don't under estimate the support that is required for these groups, ensure there is comprehensive clinical and pastoral support in place

Want to know more?

- *Together we're better* ICS Health and Care Apprenticeship Programmes (video and video)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**06**

Title:	Chair and Chief Executive Officer Report

Meeting Date:	17 November 2022

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Prem Singh, ICB Chair and Peter Axon, ICB Interim Chief Executive Officer		Peter Axon, ICB Interim Chief Executive Officer

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	N

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**	**X**

History of the paper – where has this paper been presented		
	Date	A/D/S/I

Purpose of the Paper (Key Points + Executive Summary):
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 & General Update** **2. Finance** **3. Planning and performance** **4. Quality and safety** **5. COVID-19**

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
This report covers a range of risks on the Risk Register.

Implications:	
Legal and/or Risk	The report outlines key updates from the Chair and CEO.
CQC/Regulator	
Patient Safety	
Financial – if yes, they have been assured by the CFO	
Sustainability	
Workforce / Training	

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The Board will need to consider this statutory duty and how we reduce these.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1** • **Stage 2**	**N/A**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • Note the updates in the report.			

1.0 System and general update

1.1 Industrial Action Update

Trade unions representing NHS staff have advised the Secretary of State for Health and Social Care that they are in dispute over the 2022/23 pay award. Several unions are balloting or have signalled their intention to ballot their NHS members to take part in industrial action.

The NHS is preparing for any potential industrial action so there is minimal disruption to patient care and emergency services can continue to operate as normal. Although the negotiations are for the Government to lead on, at a local level it is vital that constructive relationships with trade unions and staff representatives are maintained and that the employment rights of staff during industrial action are respected.

A range of preparedness sessions are taking place during November to prepare for the outcome of the ballots at this stage.

1.2 ICB Consultation on Proposed Structures

After extensive engagement with staff, the consultation will end on 11 November. The Executive Team met on 2 November to review all the feedback so far and have agreed to push back the release of the structures by a week to enable ringfence interviews or vacant post interviews to take place. The structures will now be released on 12 December. The focus of the emerging structures remains on ensuring that portfolios play a central role in delivery of our strategic ambitions, whilst ensuring that enabling functions are equally prominent.

1.3 Shortlisted as Inclusive ICS of the Year

We have been shortlisted in this year's Midlands Inclusivity and Diversity Award Scheme (MIDAS) for the Inclusive ICS of the Year Award. The winners will be announced in a virtual ceremony on 18 November.

Our system was recognised for its ambition around inclusion and in particular the bold progress being made on race inclusion. We want to extend, and improve, what is delivered to local people by creating anti-racist, compassionate and inclusive healthcare. We do this, not just through words, but by taking impactful action to Lead, Educate and Act Now on Inclusion.

Through our pioneering System Equality Network for Race Inclusion and Cultural Heritage (ENRICH) we have listened to our ethnic diverse workforce and will continue to do so.

2.0 Finance

The ICB remains committed to its aim to break-even this current financial year. To help the system remain financially sustainable and, in a position to develop services and address health inequalities in the future, the Chief Finance Officers (CFOs) are working collectively to develop a system financial strategy. This will chart the steps we need to take to create a balanced financial plan in 2023/24 and beyond. Further details will be shared once the plan has been agreed.

3.0 Planning and performance

3.1 Operational Planning

Release of the national operational planning guidance relating to the Joint Forward Plan (JFP) and 2-Year Operating Plan has been delayed until after the fiscal announcements. As an ICB

we have commenced preparatory work, in advance of the guidance being released, to co-ordinate our approach across a range of work including the ICP Strategy, the Workforce Strategy and the work of the portfolios.

In October the system completed a stocktake of the wider system deliverables against our 2022/23 operational plan. The exercise assessed progress to identify any areas 'at risk' of non-delivery. The piece of work will be repeated in Quarter 3 and Quarter 4 and will inform the development of our JFP and two-year operating plan.

Following submission of the 2022/23 Operating Plan the system continues to closely monitor activity versus planned performance, highlighting key areas of risk and supporting actions through to the Finance and Performance Committee. Key areas of risk focused on workforce, increasing Covid-19 cases, the urgent care pathway and elective recovery.

3.2 Elective Waits (104 week waits and 78 week waits)

At present, UHNM are under tier 2 reporting with NHSE, with patient level circumstances being reviewed daily. The breaches are a combination of patient choice (where earlier dates have been offered at alternative providers) or down to complexity/Illness. The position is improving week on week.

Nuffield Health are working to support UHNM so no patients will be waiting over 78weeks by the end of March 23. New choice guidance has also been issued by NHSE, which outlines when and how a patient can be moved to watchful waiting.

3.3 Cancer

On 17 October the urgent skin Teledermatology pilot went live between UHNM and HealthHarmonie. This means all referrals will be received, and triaged, with high quality images. At the start of October, the Lower GI referral hub went live at UHNM. This has already reduced the waiting list as all referrals now include FIT test results to help make triage more efficient.

3.4 Diagnostics

Pressure is being felt due to staffing sickness and high DNA rates in Endoscopy. Recovery plans are in place for the top 5 contributors, with the biggest pressure in non-obstetric ultrasound and a new outsourced provider has been procured to support this.

3.5 Urgent and emergency care and System Winter Plan

During September, call volumes for NHS 111 were significantly down on previous months due to an issue with the national IT platform. Within the reported numbers, the abandonment rate reduced, whilst the percentage of calls triaged by a clinician increased.

As part of the national direction for ambulance handover delays, the Ambulance Task and Finish Group is reporting weekly on the position at Royal Stoke University Hospital. They have experienced fluctuating numbers daily, however, overall numbers remained high.

To support pathway flow and free up capacity within the emergency department 'Your Next Patient' has been implemented. 30+ minute delays have reported lower numbers since the scheme was initiated at the end of September, however, 60+ minute delays continue to be high and will continue to be targeted within the plan. Whilst it is recognised that there remain unacceptable delays, the Task and Finish Group has noted the improving position.

Pressures within the Emergency Department (ED) continued through October. There was the highest number of individual attendances in recent years (402), as well as a reduction in the

number of patients seen for assessment within 15 minutes. For those patients attending Royal Stoke, and not being admitted, the average wait in the ED is below 6 hours.

Workforce recruitment, retention and absence continues to be identified as a risk to the Winter Plan, although there has been a slight reduction in absence through sickness.

3.6 Key figures for September for our population:

- 35,115 attendances at A&E and Walk in Centres
- 13,874 episodes of planned care (elective and day case)
- 11,919 outpatient procedures
- 475,404 people seen by GPs

4.0 Quality and safety

4.1 Quality Strategy

A draft of the Quality Strategy has been shared at the ICB Quality and Safety Committee. The strategy has been co-produced with system partners, who will continue to progress this work. This strategy will underpin a shared commitment to quality across the ICS to ensure quality permeates everything we do. This could be from the way we jointly plan, commission, and deliver care, to the way we work collaboratively to drive improvement and innovation.

To enable us to provide high quality and safe services for all, we will not only focus on quality assurance but also quality improvement. Quality will be collectively owned, and its challenges managed across the system.

4.2 Clinical upskilling pilot

Over the past month, the cohort of nurses, who will be attending the clinical upskilling programme, have been recruited. The inductions and training days have been established and it has been confirmed that the nurses will be released one day a month in November and December to familiarise themselves with their upcoming placements, before the programme begins in the new year.

5.0 COVID-19

The COVID vaccination Autumn programme is continuing at pace within SSOT. 298,535 Autumn booster vaccinations and 5,373 primary vaccinations have been given since September. Currently 584,464 registered patients within SSOT eligible for a COVID Autumn booster – 50.3% of these have received their vaccination. Overall, SSOT is doing favourably against national and regional uptakes.

6.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

Prem Singh, ICB Chair

Peter Axon, Interim ICB Chief Executive Officer

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**07**

Title:	**Staffordshire & Stoke-on-Trent ICB System Winter Plan**

Meeting Date:	17 November 2022

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Phil Smith, Chief Delivery Officer	Y	Ashleigh Shatford, Tom Bailey

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Dr Steve Fawcett/Clinical Senate	Y

	Action Required (select):									
Ratification-R	**X**	**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**		

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Clinical Senate	13/10/2022	A
Urgent and Emergency Care (UEC) Board	19/10/2022	A
System Performance Group	26/10/2022	A
MPFT Trust Public Board	27/10/2022	A
Finance and Performance Committee	1/11/2022	A
Staffordshire County Council Senior Leadership Team	1/11/2022	A
Stoke-on-Trent City Council Operational Board	8/11/2022	A
UHDB Trust Public Board	8/11/2022	I
UHNM Trust Public Board	9/11/2022	A
Quality Committee	9/11/2022	A
North Staffordshire Combined Healthcare Trust Public Board	10/11/2022	

Purpose of the Paper (Key Points + Executive Summary):

The ICB System Winter Plan has been developed in collaboration with all System partners with the intention of providing a clear approach to navigating the operational demand pressures forecast during the remainder of the financial year. The plan is presented in three primary component parts;

- **System Capacity Plan**

  Containing details of all schemes (including those funded by the ICB, system partner organisations and via received NHSE winter monies equating to £10.8m) designed to provide increased capacity over the winter period, the impacts of those schemes, timescales and funding source(s).

- **System Escalation Plan**

  Outlining the triggers and escalated actions to be taken during periods of increased system pressure. The Escalation plan is designed to minimise and mitigate risk by balancing risk across the system.

- **System Workforce Plan**

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

In addition, the Winter Plan contains appendices relating to Bed Modelling, Finance, Monitoring arrangements and the system Communications plan.

The Winter Plan has been developed via a Multidisciplinary Team (MDT) approach, ensuring that all system partners are sighted on activities, initiatives and mitigations planned across the system. This level of collaboration and engagement is designed to ensure that action taken to address issues in one part of the system do not negatively impact upon another.

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

In addition, the Winter Plan has been presented at all constituent partner organisations Board meetings and senior leadership forums to ensure review, comment and sign-off from all system partner organisations and respective non-executives.

Information is contained outlining financial considerations relating to the Capacity Schemes. The Winter Plan contains spend trajectories and costing information for each of the capacity schemes – both those funded by the ICB or partner organisations and those funded via NHSE winter monies.

All ICB financial spend has been presented to CFOs and taken forward via appropriate governance (System Performance Group and the Finance and Performance Committee) to ensure that it is modelled in line with SFIs and approved accordingly.

Note: the plan is an evolving document and will be under constant review in order to ensure that Winter Plan activities, decisions and mobilisation of schemes and initiatives best meet system-wide need during periods of winter escalation.

The full plan is available on the website:

https://staffsstoke.icb.nhs.uk/~documents/route%3A/download/482/

Is there a potential/actual Conflict of Interest?	N
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
There are a number of risks associated with the winter plan and UEC. These are being routinely reviewed by the system MDT and Winter Steering Group and will uploaded on to the corporate risk register.

Implications:	
Legal and/or Risk	System-wide risk relating to non-delivery of Winter Plan
CQC/Regulator	All providers are CQC registered.
Patient Safety	Quality involvement throughout development of plan – Quality & Safety Committee to receive, review and approve plan to mitigate risks.
Financial – if yes, they have been assured by the CFO	Spend commitments approved by CFO in advance – linked to Winter Plan initiatives and schemes. Additional funding received from NHSE with appropriate assurance and reporting mechanism in place (via Board Assurance Framework)
Sustainability	Risks relating to de-escalation and ensuring NHSE funded schemes are stood down in timely fashion added to Risk Register.
Workforce / Training	Workforce risks managed via System Workforce plan & escalated via Risk Register.

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a)		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**Y**	**22/11/ 2022**
2b.	What was the outcome from the System QIA Panel? TBC		

2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1 01/11/2022** • **Stage 2 in progress**	**Y**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **N/A**		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Winter plan presented to Trust Public Boards, ICB Public Board and other forums for NED and public engagement. Communications plan in place to proactively engage with patients and public regarding initiatives and contingency planning.***	**Y**	
5.	Has a Data Privacy Impact Assessment been completed? ***In process***	**Y**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: **Ratify the decision of the Finance and Performance Committee and confirm approval of the System Winter Plan.**			

1. Introduction

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

This includes; University Hospital North Midlands (UHNM) Midlands Partnership Foundation Trust (MPFT), North Staffordshire Combined Healthcare Trust (NSCHT), Staffordshire County Council, Stoke-on-Trent City Council and University Hospitals of Derby and Burton (UHDB). The Royal Wolverhampton Trust (RWT) have been sighted on all aspects of the System Winter Plan and development discussions have been held with the Deputy Chief Operating Officer and other colleagues to ensure awareness and collaboration on key aspects. Engagement with provider partners that serve the ICS population but sit within other ICSs has been carried out to ensure a joined-up approach and to factor in relevant considerations from partner organisations.

The Winter Plan is presented within three distinct comprising parts, namely; the System Demand and Capacity Plan, System Escalation Plan and System Workforce Plan. An overview and summary of these component parts of the Winter Plan is included within this paper.

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

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

- UHNM Public Board meeting (9 November)
- North Staffordshire Combined Healthcare Trust Public Board meeting (10 November)
- MPFT Public Board meeting (27 October)
- Stoke-on-Trent City Council Operational Board Meeting (8 November)
- Staffordshire County Council Senior Leadership Team (1 November)
- UHDB Trust Public Board (8 November)
- System Clinical Senate (13 October)
- ICB Urgent and Emergency Care Board (19 October)
- ICB System Performance Group (26 October)
- ICB Finance and Performance Committee (1 November)
- ICB Quality Committee (9 November)
- ICB Public Board (17 November)

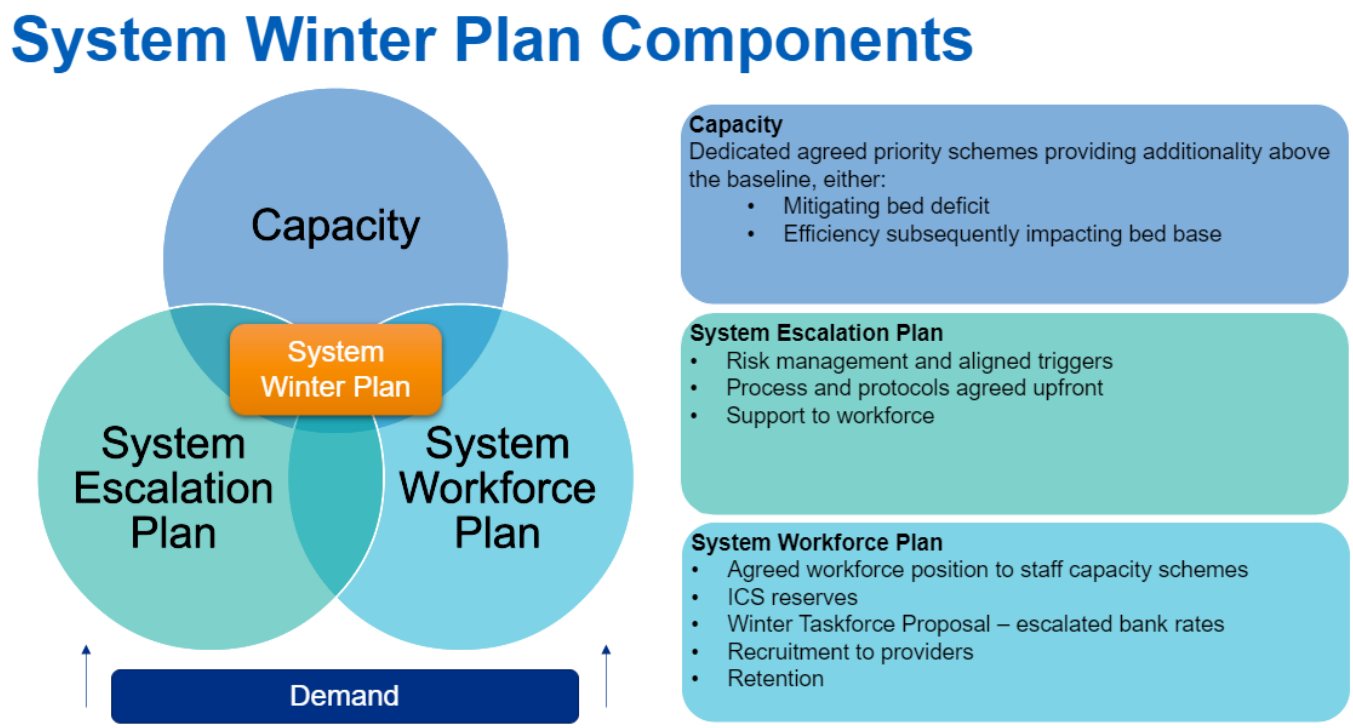
The Winter Plan is a ‘live’ document and will be under constant review to ensure that all activities and decisions are made to enhance the system response to the forthcoming winter period.

A Risk Register is in place to ensure that all Risks are assessed holistically and addressed via system-wide action. The Winter Plan Risk Register feeds into the ICS Corporate Risk Register and is updated weekly, via the Winter Plan System MDT and Steering Group forums.

2. System Winter Plan Components

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

Figure 1:



System Capacity Plan

The System Capacity Plan is split into two parts; described as "Additionality" and "Enabling". Underpinning the System Capacity Plan, extensive bed modelling has been undertaken to ensure that mitigations and schemes/initiatives developed and mobilised are proportionate to the levels of demand expected this winter. The Plan has been able to close the expected bed deficit, albeit delivery is dependent on the availability of workforce to deliver. This is a significant risk detailed on the risk register.

PWC have been commissioned by the system to provide a functional bed model that factors in system demand from previous years, levels of flu and Covid-19 infections and demand, the system bed base, patient flows, community bed base, virtual wards, ambulance conveyance information, staffing levels, elective demand and activity and other contributing factors.

Bed modelling undertaken both by ICB and Trust colleagues, and that undertaken by PWC, is based upon data and assumptions relating to; non-elective demand returning to pre-pandemic (2019/20) levels, the impact of Covid-19 and Flu peaking simultaneously and during periods of increased non-elective demand – to enable the system to prepare for a 'worst case' scenario and to mitigate accordingly. The bed modelling also takes into account the mandated and increased levels of elective and cancer activity to be carried out this winter – to address the backlog of need and comply with the Elective Recovery Fund.

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

Within the System Capacity Plan, “Additionality” plans are those that are designed to directly create and/or increase capacity within the system, be that as a result of mobilisation of additional resources (e.g. acute beds) or by creating additional capacity via improving patient flow through the Urgent and Emergency Care (UEC) system (e.g. Discharge to Assess beds).

“Enabling” plans are those that are designed to provide vital initiatives or schemes to mitigate the increased demand seen through winter. These include initiatives which are more akin to business as usual (and as such included within system financial totals already) such as vaccination programmes, community pharmacy provision and mental health improvement schemes.

A summary of the Capacity schemes is provided in Appendix 1

System Escalation Plan

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

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

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

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

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

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

The impending mobilisation of an ICS System Command Centre (SCC) as outlined in the NHS England “Going further for winter” letter of 20 October 2022.

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

System Workforce Plan

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

The plan details additional workforce numbers required to support each scheme, actions being taken to recruit/supply this additional workforce (including provider and system level activities), workforce risks and mitigations.

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

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

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

3. Summary and Next Steps

The Staffordshire and Stoke-on-Trent ICS System Winter Plan will continue to be evaluated and evolved according to need as we move through the winter period. The Winter Planning process has been closely aligned to the System Ambulance Handover plan and associative workstreams and will remain as a concurrent process to ensure synergies and coalescence with other system priorities.

To ensure appropriate review, oversight, scrutiny and management throughout the winter period, a weekly System Winter Plan Steering Group will be formed from the end of November (building upon the MDT meetings already in place). Chaired by the ICB Chief Delivery Officer, with representation from senior system leaders, this forum will continually re-evaluate schemes and utilisation of resources across the system, taking proactive decisions regarding the deployment of resource to mitigate winter pressures and other events/incidents.

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

4. Recommendation

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Appendix 1 – System Capacity Plan

Title	Summary	Impact	Funding Source
Virtual Wards	Introduction of a targeted 130 Virtual Ward beds	Equivalent 30 Beds	NHSE Monies
Enhanced UCCC/ CRIS	WMAS to be part of proactive admission avoidance MDT to reduce ambulance dispatch and conveyance	TBC	No additional funding
Enhance UCCC/ CRIS - Falls	Falls Pick Up service – to provide increased capacity to attend falls related calls in the south of the county.	Reduced wait time for WMAS response. Reduced variation and gaps in service provision.	NHSE Monies (Separate non-winter funding bid)
Staffordshire Fire Service – Falls Response Service	Falls response service to calls in Staffordshire and Stoke for patients who have had a fall requiring no medical intervention but require being lifted.	Responses within 2 hours	NHSE Monies (Separate non-winter funding bid)
System Frailty Decision Unit MDT	Introduction of dedicated eight trolleyed space area to turnaround or navigation patients supported by acute frailty, acute therapists, community nursing, and social care. System to reconvene re staffing model post TOC	Reduction of 12 admissions per day (c14 Beds)	NHSE Winter Monies
Acute Winter Escalation Beds	Identified winter escalation capacity available for use	W7 = 14 Beds	UHNM Winter Monies
		WD123 = 25beds	UHNM Winter Monies
		*WD80/81 = 34beds	*NHSE Winter Monies
D2A Spot Purchase	Spot purchase of average 40 additional D2A beds across the system	Equivalent 17 Beds	NHSE Winter Monies
Cheadle D2A	Opening of 40 additional Cheadle D2A beds	Equivalent 17 Beds	MPFT Winter Monies
Therapy Enhanced Discharge	Acute therapy bridging service designed to expedite complex discharges.UHNM/MPFT agree to holding support.	5 Beds	UHNM Winter Monies
Provider Of Last Resort (POLR) Capacity	Due to market fragility with social care we are currently over relying on Home First to bridge the gap for care packages via POLR. Increase of 1900 hours across winter to support the Home First pathway. Will go where need is between Stoke LA and County LA, MPFT will hold the ring. NOTE: County LA is mobilising an in-house Care service to take Provider of Last Resort (POLR) activity from Home First. The scheme is not due to go live until 1st April 23, but may be capable of being used earlier.	TBC	NHSE Winter Monies
UHNM Non-Elective Improvement Programme	Improvement work implementing new ways of working and developing internal efficiencies supported by PWC bed model	13 Beds Reduced LoS	UHNM Winter Monies
WMAS	Extended Hospital Ambulance Liaison Officer cover at RSUH.	Reduce extended ED waits.	ICB System Funding
ERS (Patient Transport Services)	Increase capacity across acute sites in SSOT with clear outcomes for delivery. Priority for ED and emergency portals to support admission avoidance. Will need to map in additional community capacity too.	Reduce failed discharges, support increased flow.	ICB System Funding
Primary Care	Respiratory Access Hub. 7 day access. Modelled for 22 weeks	3312 F2F appointments per week additional	ICB System Funding

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

"Enabling" Schemes

Title	Summary	Funding Source
Primary Care	- Seasonal Vaccination Programme	Funded through baseline
	- Increase 111 Direct Booking	
	- Proactive QIF prioritisation	
	- Community Pharmacy Provision	
Vocare (111)	Increase in call handlers behind 111. Positive trajectory throughout year.	Contract baseline
UCCC/CRIS – Care Home Education	Suite of initiatives designed to educate and support Care Homes and CH staff	Contract baseline
Health Navigator	Proactive support to patients identified at risk of hospital admission	Contract baseline
Deterioration Patients Network	To support Care Homes with managing extreme frailty	
End of Life	Palliative Care Coordination Centre (PCCC) pilot relating to provision of Dom. Care for pts at EoL utilising free Hospice at Home capacity across the county. A shared care approach has been agreed across all providers.	
	Proposed that pathway is extended from 2 to 12 wks – inc. Proactive management to reduce admissions of EoL pts and those with plans in place.	
(Further work in discussion)	Associative reduction in Comm. Nursing input and admin requirements	
	PCCC also scoping further work at RSUH; Douglas Macmillan assessing improved access to hospice beds for UHNM pts via link to Track & Triage.	
	Exploring similar links/scheme with Katherine House Hospice at County hospital & St Giles hospice	
System Workforce Plan	Campaigns to support reservists pool increasing and people hub transition into capacity schemes	ICB System Funding
Communication plan	In development	
Mental Health	Urgent Care model for Crisis Care/All Age Access to support anticipated increased demand due to associated winter pressures (cost of living/economic crisis, COVID, health inequalities, etc.)	NHSE Mental Health Winter monies
	VCSE contracts in place including Crisis houses	
	Emotional support helpline available during evenings & weekends	
	Increased access to Rapid MH support through community lounges in Stoke and ARRS practitioners linked to primary care.	
	Procurement of an out of hours service working alongside CRHT focused on hospital avoidance - provision will go live in October, expected to support 30 services users per week outside of core working hours.	
	Targeted partnership working with LAs relating to MFFD patients & care packages/placements	
	Discharge pathway expansion for adults and older adults including dementia	NHSE Mental Health Winter monies
	Temporary expansion of discharge pathway to support early discharge into the community with additional resource (October 2022 - March 2023):	£191,911
	- Mental Health Nurses	
	- Financial Wellbeing advisor	
	- Housing officer	
	- Additional recovery workers	
	Unplanned Care - Mental Health - Adult and Older Adults	
	Additional Support workers to support unplanned activity in Community Teams	
	Financial Wellbeing support for service users in crisis	
	Financial wellbeing advisor to support (October 2022 - March 2023)	
	Other	
	Warm Places - Working in partnership with Borough councils to create warm places to support vulnerable groups and prevent the escalation to clinical teams	

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**08**

Title:	**ICS Oversight Framework**

Meeting Date:	17 November 2022

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Brown, Chief Finance Officer	Y	

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	N

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**	**x**	**Assurance - S**		**Information-I**	

History of the paper – where has this paper been presented		
	Date	A/D/S/I
System Performance Group	31.08.22	D
Senior Leadership Team	01.09.22	D
Finance and Performance Committee	06.09.22	D
ICB Board	22.09.22	D
Senior Leadership Team	27.10.22	D

Purpose of the Paper (Key Points + Executive Summary):

At an early meeting of the ICB Board we recognised that the creation of the ICB would bring a fresh dynamic to system oversight, and agreed that we need to do some work together to discuss that dynamic and develop a solution that will be right for us. Through the discussion it was clear that we are all committed to the development of vibrant Places and to the development of the Provider Collaborative model, whilst recognising that national expectations that the ICB will provide system oversight is a potential conflict with our aim to be a system facilitator. We agreed that the system leaders should be asked to think through these tensions and to develop a proposed way forward.

The attached paper summarises the outputs from the work that has taken place and seeks Board support for the proposed way forward.

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

N/A

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Strategic Objective 3 – Sustainable services for the taxpayer The draft ICB Board Assurance Framework and related risks are being discussed at an ICB development session. Risk 103: Underlying deficits from 2023/24: Without the delivery of robust system saving schemes, there is a risk that the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position (i.e. a financial deficit from 2023/24), in line with the operating and planning framework.

Implications:	
Legal and/or Risk	Yes risk of not delivering sustainable services for the taxpayer
CQC/Regulator	The regulator has delegated the performance management of the ICS to the ICB and will hold the ICB to account
Patient Safety	None
Financial – if yes, they have been assured by the CFO	Achievement of financial plans
Sustainability	Yes relating to use of resources
Workforce / Training	None

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **Inequalities will be considered as part of the performance management process that is agreed upon, following this work.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **n/a**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients **The paper has been discussed with system partners in the Leadership Group, at the System Performance Group and the ICB F&PC.**	**Yes**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**No**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • **Endorse the proposed guiding principles and the compact for system oversight.**			

Staffordshire and Stoke-on-Trent Integrated Care System

Performance Management in the ICB

Update to ICB Board

Introduction and Agreement Sought

- In one of our first meetings as a newly formed Integrated Care Board, we discussed the changing shape of performance oversight in the system.
- We recognised the change that the creation of the ICB would bring to the dynamic of system oversight, and agreed that we need to do some work together to discuss that dynamic and develop a solution that will be right for us. Through the discussion it was clear that we are all committed to the development of vibrant Places and to the development of the Provider Collaborative model, whilst recognising that national expectations that the ICB will provide system oversight is a potential conflict with our aim to be a system facilitator. We agreed that the system leaders should be asked to think through these tensions and to develop a proposed way forward.
- Discussions have now taken place with CEOs in the Senior Leadership Team, where we worked through some scenarios to test out how we could work. One scenario was around an escalating problem with ambulance waits and A&E pressures and a second scenario involved a problem with CAMHs services that crossed portfolios and Place. These exercises helped tease out the crunchy issues of performance oversight and improvement that would need to be overcome.
- Discussions also took place at the System Performance Group and System Finance & Performance Committee.
- Following this work, there is a broad level of consensus to the shape of the approach we need. We agreed that we'll need to test this out with some 'real world' situations and then return to it in about 6 months, and then at that time maybe make some adaptions.
- The key outputs are some guiding principles and a compact for oversight, which are attached. These will be used to frame the approach we take to dealing with the performance issues we encounter. The Board is asked to endorse this approach and to agree to revisit the arrangements in six months time.

Guiding Principles

The approach will be based on strong collaborative working across partners to understand the needs of the system and put the system priorities first. Partners will monitor quality and performance collectively, hold each other to account, identify problems, and act together. The system will only be as strong as the sum of its parts. It requires the right collaborative behaviours, and the systems and processes to support those behaviours.

This will demonstrate to NHSE that the ICS can be trusted to manage and resolve its own issues. Initial guiding principles will be as follows:

- Further embed a system culture of openness, transparency and trust
- ICB acts as enabler and facilitator
- The whole system manages performance collectively
- Delegation where possible

These principles have been developed to support the system's overall Leadership Compact values and have been colour coded accordingly.

A new compact for oversight

Principle	The ICB commits to:	All partners and providers commit to:
Further embed a system culture of openness, transparency and trust	The ICB will trust providers to raise issues where required. The ICB will not ask questions (unless data or intelligence indicates an issue). The ICB will not use any information provided by any provider against them.	Providers will raise risks and issues with the ICB as soon as they occur. Providers will share all relevant data and information with the whole system. Providers will actively and consistently engage with the ICB and its Committees.
ICB acts as enabler and facilitator	The ICB will try to resolve problems by bringing partners together. The ICB will not get involved in operational management as long as providers are open and share information. If things are not going right, the ICB will intervene.	Providers will put the system first, collaborate and work together to solve problems. All partners will do what they say they will, and do their utmost to deliver solutions. Partners will work with the ICB if things are not going right and the ICB has to intervene.
The whole system manages performance collectively	The ICB will not hold individual organisations accountable for issues. The ICB will hold all partners as well as the ICB itself accountable. The ICB will provide constructive and appropriate challenge to the system and will not tolerate poor behaviour. The ICB will always invite providers to oversight meetings with NHSE and present a collective front.	Providers will take accountability for delivery collectively. If one organisation fails, all are accountable. If one provider is struggling, all providers will work together to find a solution. Providers will provide constructive and appropriate challenge to each other and not tolerate poor behaviour. Providers will always attend oversight meetings with NHSE and present a collective front.
Delegation where possible	The ICB will encourage Places and Provider Collaboratives to take on duties around performance management.	Partners and providers commit to helping Place and Provider Collaborative to mature.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**09**

Title:	Finance and Performance Update

Meeting Date:	17 November 2022

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Brown Chief Financial Officer	Yes	Finance, Planning and Intelligence Directorate

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	No

	Action Required (select):								
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**	✓	**Information-I**	✓

History of the paper – where has this paper been presented		
	Date	A/D/S/I
System Performance Group	26/10/2022	D
Finance and Performance Committee	1/11/2022	D

Purpose of the Paper (Key Points + Executive Summary):

The purpose of this report is to summarise the key financial and operational performance issues for the ICB Board. The report focusses on three key areas:

- Financial performance at the system level
- Urgent care
- Planned care, cancer and diagnostics
- Mental Health
- Primary Care

Finance

- The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) agreed a plan to break even over the financial year after flagging a number of risks. We continue to flag a risk of £20m to the achievement of this plan, however the CFOs collectively are of a view that break-even may still be feasible. A detailed year-end forecast is being developed across the system and next month we will be taking a view as to whether we will continue to forecast break-even.

- Nationally we understand that many ICBs are struggling to get to a break-even, and if we were to achieve this we believe that we would be in a minority. Our relatively strong position is down to a culture of transparency and collective working between all system partners, and a huge amount of hard work by our operational and clinical colleagues who are mainly managing within their budget.
- Whilst there is still a long way to go to deliver balance in 2022/23, our attention is switching to the medium term. We believe that our relatively strong position is because we got ahead last year and had both the provider level savings and system savings worked up, developed and implemented before the start of the financial year. We need to be in that same place next year. Consequently the CFOs have collectively developed a draft Financial Strategy, which is attached as Appendix 1. Over the next few months CFOs are working with clinical, operational, workforce, strategic and digital teams to ensure that the financial approach is fully integrated with other system strategies

The Staffordshire and Stoke-on-Trent ICB Financial Strategy has been provided as an additional appendix. The strategy:

- Sets out a framework for keeping the system in financial balance.
- Seeks to create a culture where resource deployment is undertaken at a system level with a focus on clinical outcomes
- Is realistic about workforce availability and suggests a focus on retention of the people we have and replacing high agency use with substantive
- Recognises the opportunity to eliminate waste and increase activity within the current physical and people capacity – productivity improvement
- Defines the role of organisations and portfolios in this task and seeks to empower clinical leaders to find the best clinical models.
- Sets a timeframe and process for this work, recognising that the financial outlook is currently very uncertain.

Performance

- Covid-19 cases are increasing and this is likely to add to the existing pressures across the system, including high bed occupancy and staff sickness/self-isolation. The system will continue to monitor and respond to these trends.
- Handover delays remain an issue with the volume over 60 minutes at 30.1% of all handovers well over the national target of 2%. The Royal Stoke site remains a significant challenge in terms of ambulance handover delays, and is one of 12 sites receiving national oversight and support to improve.
- The elective waiting list is continuing to grow limiting the ICB ability to meet and maintain elective recovery targets. 52+ week waits and 78+ week waits have decreased in M5 across the ICB, however 104+ week waits have shown an increase.
- The 28 day waits (faster cancer diagnosis standard) remains below the 75% standard with performance for August at 58.5%
- Appointments in General Practice activity for August 2022 exceeded the monthly plan by 36,788 appointments, increasing the monthly total to 108.5% of plan.
- IAPT is 75.5% below the plan, equating to 6129 contacts.

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
• **Risk No 068 –** Finance - there is a risk that the ICB does not achieve break even in the current period 2022/23. • **Risk No 103 –** Performance - Ambulance handover delays at RSUH are significant and of national concern. In an attempt to support the issue, the winter plan proposals may be brought forward. The risk is that the capacity is open ahead of need and there become limited options at time of super surge need.

Implications:	
Legal and/or Risk	Monitoring performance is a statutory duty of the ICB.
CQC/Regulator	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Financial – if yes, they have been assured by the CFO	The report provides a headline summary of finance and the financial strategy developed by the CFO with system partners.
Sustainability	N/A
Workforce / Training	The finance strategy is realistic about workforce availability and suggests a focus on retention of the people we have and replacing high agency use with substantive.

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a)		
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4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

- Note the contents of the Finance & Performance report and the Staffordshire and Stoke-on-Trent ICB Financial Strategy.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Report to the ICB Board on Finance and Performance

ICB Board Meeting – 17 November 2022

Executive Summary

The purpose of this report is to summarise the **key financial and operational performance issues for the ICB Board**. We are continuing to develop the performance dashboard which now includes mental health and primary care, the next step is to include community services and social care.

Headlines

Finance

- The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) agreed a plan to break even over the financial year after flagging a number of risks. We continue to flag a risk of £20m to the achievement of this plan, however the CFOs collectively are of a view that break-even may still be feasible. A detailed year-end forecast is being developed across the system and next month we will be taking a view as to whether we will continue to forecast break-even.
- Nationally we understand that many ICBs are struggling to get to a break-even, and if we were to achieve this we believe that we would be in a minority. Our relatively strong position is down to a culture of transparency and collective working between all system partners, and a huge amount of hard work by our operational and clinical colleagues who are mainly managing within their budget.
- Whilst there is still a long way to go to deliver balance in 2022/23, our attention is switching to the medium term. We believe that our relatively strong position is because we got ahead last year and had both the provider level savings and system savings worked up, developed and implemented before the start of the financial year. We need to be in that same place next year. Consequently the CFOs have collectively developed a draft Financial Strategy, which is attached as Appendix 1. Over the next few months CFOs are working with clinical, operational, workforce, strategic and digital teams to ensure that the financial approach is fully integrated with other system strategies

Performance

- **Covid-19** cases are increasing and this is likely to add to the existing pressures across the system, including high bed occupancy and staff sickness/self-isolation. The system will continue to monitor and respond to these trends.
- **Handover delays** remain an issue with the volume over 60 minutes at 30.1% of all handovers well over the national target of 2%.
- The elective waiting list is continuing to grow limiting the ICB ability to meet and maintain elective recovery targets. **52+ week waits and 78+ week waits** have decreased in M5 across the ICB, however **104+ week waits** have shown an increase.
- The **28 day waits (faster cancer diagnosis standard)** remains below the 75% standard with performance for August at 58.5%
- **Appointments in General Practice** activity for August 2022 exceeded the monthly plan by 36,788 appointments, increasing the monthly total to 108.5% of plan.
- **IAPT** is 75.5% below the plan, equating to 6129 contacts.

Supplementary information

Financial Position – Year to date

The general themes driving our financial position remain constant as previous months. These include: workforce vacancies, offset by CHC price & volume challenges and efficiency under-delivery. We continue to operate with a favourable run rate position than expected due to a continuation of non recurrent favourable items falling into the position. Strong emphasis to close the efficiency gap remains, see following slide.

The improvement in the YTD position was mostly driven by increased income for the pathology alliance at UHNM.

We're addressing the on-going payment issues with our local authorities, if successful will close the deficit reported within North Staffordshire Combined Healthcare.

ICB	Month 6 Plan	Month 6 YTD	Month 6 Variance	Month 5 Plan	Month 5 YTD	Month 5 Variance
Allocation	1,119.9	1,119.9	0.0	911.4	911.4	0.0
Expenditure	(1,119.9)	(1,119.6)	0.3	(911.4)	(911.5)	(0.1)
TOTAL ICB Surplus/(Deficit)	0.0	0.3	0.3	0.0	(0.1)	(0.1)
			0.0%			0.0%

System	Plan	YTD	Variance	Plan	YTD	Variance
Income	1,964.1	1,985.7	21.6	1,615.1	1,620.3	5.3
Pay	(524.3)	(527.6)	(3.3)	(436.8)	(429.6)	7.2
Non Pay	(296.8)	(315.8)	(19.0)	(247.2)	(262.0)	(14.9)
Non Operating Items (exc gains on disposa	(15.8)	(15.1)	0.7	(13.2)	(12.7)	0.5
ICB/CCG Expenditure	(1,119.9)	(1,119.6)	0.3	(911.4)	(911.5)	(0.1)
Total	7.3	7.6	0.3	6.5	4.5	(2.1)
			0.0%			-0.1%

UHNM	Month 6 Plan	Month 6 YTD	Month 6 Variance	Month 5 Plan	Month 5 YTD	Month 5 Variance
Income	486.8	499.4	12.6	405.8	409.2	3.4
Pay	(286.6)	(287.8)	(1.1)	(238.8)	(234.4)	4.4
Non-Pay	(183.5)	(195.9)	(12.4)	(152.8)	(163.5)	(10.8)
Non Operating Items (exc gains on disposa	(12.9)	(12.5)	0.4	(10.7)	(10.5)	0.3
TOTAL Provider Surplus/(Deficit)	3.8	3.2	(0.5)	3.5	0.8	(2.7)
			-0.1%			-0.7%

MPFT	Plan	YTD	Variance	Plan	YTD	Variance
Income	283.3	288.8	5.4	236.2	235.5	(0.6)
Pay	(196.7)	(197.1)	(0.4)	(163.9)	(160.5)	3.4
Non-Pay	(81.5)	(84.5)	(2.9)	(68.0)	(68.8)	(0.8)
Non Operating Items (exc gains on disposa	(1.3)	(0.9)	0.4	(1.1)	(0.8)	0.3
TOTAL Provider Surplus/(Deficit)	3.8	6.3	2.6	3.2	5.5	2.2
		0.0	0.9%			1.0%

NSCHT	Plan	YTD	Variance	Plan	YTD	Variance
Income	74.1	77.7	3.6	61.7	64.2	2.4
Pay	(40.9)	(42.7)	(1.8)	(34.2)	(34.8)	(0.6)
Non-Pay	(31.7)	(35.4)	(3.7)	(26.4)	(29.7)	(3.3)
Non Operating Items (exc gains on disposa	(1.6)	(1.7)	(0.1)	(1.3)	(1.4)	(0.1)
TOTAL Provider Surplus/(Deficit)	(0.2)	(2.2)	(2.0)	(0.2)	(1.7)	(1.5)
		0.0	-2.6%			-2.4%

ICB performance – Urgent Care – Month 5

- **A&E 4-hour target performance** remains challenging for all acute providers locally and nationally, although performance has improved slightly for all of our six providers this month (August).
- **12-hour trolley breaches** have reduced at four of the main providers across the system with UHNM seeing a particularly large decline from 665 in July to 346 in August. Increases have been seen at UHDB and the Dudley Group.

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	YTD	Change on last month	YTD monthly trend
A&E 4 Hour Performance (% seen in <4 hours)	University Hospitals North Midlands	95%	62.9%	62.8%	62.3%	63.4%	64.9%	63.2%	▲	
	University Hospitals Derby & Burton	95%	62.0%	64.2%	61.7%	62.4%	63.0%	62.7%	▲	
	The Royal Wolverhampton	95%	76.8%	79.5%	78.9%	80.4%	80.5%	79.2%	▲	
	University Hospitals Birmingham	95%	54.7%	54.6%	53.2%	49.8%	52.7%	53.0%	▲	
	The Dudley Group	95%	80.3%	74.7%	74.0%	75.6%	75.9%	76.1%	▲	
	Walsall Healthcare	95%	73.9%	72.3%	72.5%	72.4%	73.9%	73.0%	▲	

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	YTD	Change on last month	YTD monthly trend
A&E 12 Hour Trolley Breaches	University Hospitals North Midlands	0	878	390	555	665	346	2834	▼	
	University Hospitals Derby & Burton	0	432	388	256	333	348	1757	▲	
	The Royal Wolverhampton	0	30	20	30	194	130	404	▼	
	University Hospitals Birmingham	0	271	211	552	749	525	2308	▼	
	The Dudley Group	0	31	79	49	67	90	316	▲	
	Walsall Healthcare	0	6	10	1	35	13	65	▼	

Ambulance Handover Delays

- The Royal Stoke site remains a significant challenge in terms of ambulance handover delays, and is one of 12 sites receiving national oversight and support to improve.
- Ambulance handover delays are a symptom of the capacity and flow challenges throughout the health and care system, therefore a whole-system improvement response is required to address the issue.
- A Weekly Task and Finish group is in place, chaired by ICB CEO Peter Axon with membership from local health and care partners.
- Improvement Plan in place with multi-stakeholder actions agreed. This is complimentary to the winter plan.
- Key action areas are set out below:

1) Alternative Pathways
Maximising usage and opportunity for treatment in care settings other than ambulance/ED based

2) Pre-ED Cohorting
Enabling rapid offload of ambulances in order to release crews

3) Post ED Cohorting
Utilising capacity throughout the acute footprint in order to balance risk and decongest ED

4) Post Hospital Cohorting
Minimise MFFD levels so only those patients who medically require an acute bed remain in UHNM.

5) Clinical Risk Ownership
Ensuring that clinical risk is managed across the acute footprint and wider system

6) Escalation Triggers and OOH
Ensure pro-active management of UEC pathway weekdays and enhance OOH support

Key impacts to date:

- During October ambulance handover delays (in excess of 30 minutes) at Royal Stoke have reduced by 29.8%.
- Our Community Rapid Intervention Services are working closely with WMAS to identify up to 20 patients per day who can be treated by community based teams rather than requiring an ambulance / hospital conveyance. There is scope to further improve on this.
- Estates work to expand the Emergency Department Footprint in Royal Stoke is concluding in early November, supported by national funding.
- UHNM has implemented the Your Next Patient flow model in response to the national learning from North Bristol.
- Revised discharge targets for Royal Stoke have been implemented, with each part of the pathway closely managed through daily system calls.
- Provider of Last Resort usage in Stoke has reduced by 500 hours per week, resulting in improved flow through Discharge to Assess Services.

ICB performance – Urgent Care – Month 5

Ambulance handover delays

- The total number of Handovers decreased in September (by 370, 7.5%), with an associated rise in the volume of handover delays above 60 minutes (354, 34.6%).
- Handover delays remain an issue with the volume over 60 minutes at 30.1% of all handovers well over the national target of 2%.
- Handover delays of within 30 minutes decreased in September (by 542, 19%) resulting in a position significantly below the target of 95%

	Indicator	Target	Period / Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD to current month	Y/E (Actual/FOT)	YTD monthly trend
Ambulance	Ambulance handovers @ UHNM (all Patients at UHNM)		Handover count	4,784	5,263	4,990	4,669	4,944	4,574	29,224	58,448	
		2%	Handover delays of over 60 minutes	1,400	874	1,495	1,561	1,022	1376	7,728	15,456	
			% over 60 minutes	29.3%	16.6%	30.0%	33.4%	20.7%	30.1%	26.4%	26.4%	
		65%	Handover delays of under 15 minutes	1226	1439	1212	1016	1285	1056	7,234	14,468	
			% under 15 minutes	25.6%	27.3%	24.3%	21.8%	26.0%	23.1%	24.8%	24.8%	
		95%	Handover delays of under 30 minutes	2386	3294	2551	2173	2843	2301	15,548	31,096	
			% under 30 minutes	49.9%	62.6%	51.1%	46.5%	57.5%	50.3%	53.2%	53.2%	
	Response Standards	Increase	Category 1 mean	00:09:25	00:08:32	00:08:58	00:09:08	00:08:54	00:09:01			
		Increase	Category 2 mean	01:28:01	00:40:26	01:01:39	02:11:07	00:43:06	01:03:22			

ICB performance – Planned care activity – Month 5

Elective Activity

- Elective Ordinary Spells, Day Cases and Outpatient Procedures and all below the volume in 2019/20.
- Outpatient attendances are over 2019/20 activity levels (first 13%, follow up 6%), both increasing in M5. National target is to reduce FUP by minimum of 25% against 2019/20 activity.

Diagnostics

- **Diagnostic performance** against the national ambition has not been met during August, however activity has increased by 6.7% compared to July. In August, 61.4% of patients were seen within 6 weeks against the constitutional target of 95%, a decline from 66.1% in July; this decline [in performance] is due to a 6.3% decrease in the number of patients seen in less than 6 weeks, from a wating list that increased by only 0.9%.
- **Activity** has increased in all tests bar gastroscopy and echocardiography. Year to date, only 80.2% of 19/20 activity is being delivered, across all tests. However, diagnostic activity has increased in all tests bar gastroscopy and echocardiography.
- There is planned investment into diagnostic facilities to increase capacity.
    - YTD UHNM are currently delivering 27% less diagnostic activity than in 19/20, delivering slightly less (0.4%) activity in M5 (than in M4).

	2019/20					2022/23					YTD 1920 v YTD 2223				Y/E (Actual/FOT)		
Indicator	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Apr-22	May-22	Jun-22	Jul-22	Aug-22	19/20	22/23	% Var	YTD monthly trend	19/20	22/23	Below 19/20?
Elective Ordinary Spells	1,537	1,770	1,663	1,751	1,613	1,213	1,409	1,441	1,331	1,331	8,334	6,725	-19%		19,137	16,140	Yes
Day cases	12,887	13,222	12,309	13,665	12,486	10,843	12,464	12,207	12,077	12,305	64,569	59,896	-7%		152,523	143,750	Yes
Outpatient procedures (Cons Led)	13,708	14,216	13,744	15,297	13,588	9,616	11,240	10,424	10,393	10,920	70,553	52,593	-25%		164,216	126,223	Yes
Outpatient first attendances without a procedure (Cons Led)	26,313	27,224	25,683	28,824	24,826	23,180	27,870	26,689	25,543	26,321	132,870	129,603	-2%		317,277	311,047	Yes
Outpatient follow-up attendances without a procedure (Cons Le	43,191	45,665	42,944	48,318	42,218	38,206	44,402	41,517	38,800	40,619	222,336	203,544	-8%		535,884	488,506	Yes
Diagnostic Tests (Specific 7 Tests)	37,950	39,669	39,235	40,563	37,767	29,625	32,536	30,406	31,850	32172	195,184	156,589	-20%		458,445	375,814	Yes

ICB performance – Planned care waiting lists – Month 5

Long Waits

- **52+ week waits** have decreased in M5 to 8,883 across the ICB, focussed at UHB and in the Independent Sector Providers.
- **78+ week waits** have decreased in M5 to 1,340 across the ICB. While the decrease is small (80) it's seen across all providers again this month.
  - As of 9th October, unvalidated data shows a decrease to circa 1,252 78+ week waits for our patients across all Providers.
  - UHNM were requested to submit a revised planning trajectory for 22/23 to get them to zero by March 2023.
- **104+ week waits** have increased in M5 to 84 across the ICB. UHNM record an increase [from 44] to 53, UHDB and RWT report zero again this month, UHB report an increase [from 3] to 17 and out Independent Service providers also report an increase [from 5] to 11 this month. The breaches at UHNM are a combination of patient choice (where earlier dates have been offered at alternative providers) or down to complexity/Illness.
  - At UHNM 104 week waits have increased in Trauma and Orthopaedics (from 23 in M4 to 30 in M5) and in General Surgery (from 15 in M4 to 18 in M5). At UHB the focus in 104 week wait increases is in Urology (from 1 in M4 to 5 in M5) and Trauma and Orthopaedics (from 0 in M4 to 3 in M5).
  - As of 9th October unvalidated data reports 75 patients waiting more than 104 weeks.
- **GP referrals** into acute services (YTD) for outpatient appointments are above pre-pandemic levels by 4%.
- **28 day waits (faster cancer diagnosis standard (FDS))** performance for August is 58.5%, remaining below the 75% standard and decreasing on July, but only by 0.1%. This is due in part to an increase in the number of patients receiving a diagnosis (up by 202 July) and an increase in the number of patients receiving a diagnosis in 28 days, which increased by 348 in August.
  - The FDS has improved at UHNM to 52.9% (Aug position) from 51.7% (July position) – with Breast, Lung, Sarcoma, Upper GI, and Gynae Screening all having achieved the standard.

	2019/20					2022/23					YTD 1920 v YTD 2223				Y/E (Actual/FOT)		
Indicator	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Apr-22	May-22	Jun-22	Jul-22	Aug-22	19/20	22/23	% Var	YTD monthly trend	19/20	22/23	Below 19/20?
RTT - admitted, completed	5,423	5,794	5,427	6,076	5,440	4,143	5,107	5,004	4,801	4,755	28,160	23,810	-15%		66,046	57,144	Yes
RTT non-admitted, completed	21,951	23,159	21,735	24,049	21,320	19,410	22,194	20,723	20,294	22,375	112,214	104,996	-6%		268,666	251,990	Yes
Incomplete Pathway - Total Waiting List	85,296	86,968	87,398	89,266	90,289	144,518	146,503	148,018	150,901	150,022	90,289	150,022	66%		88,982	161,858	No
Incomplete Pathway - 52+ Weeks	0	1	1	0	0	8,415	8,550	8,498	8,920	8,883	0	8,883			11	9,829	No
Incomplete Pathway - 78+ Weeks	0	0	0	0	0	2,041	1,828	1,488	1,420	1,340	0	1,340			0	0	No
Incomplete Pathway - 104+ Weeks	0	0	0	0	0	445	235	64	59	84	0	84			0	0	No
GP and other (non-GP) referrals first consultant-led outpatients	35,448	36,394	34,198	37,420	33,230	34,894	38,797	36,348	36,202	37,130	176,690	183,371	4%		406,751	440,090	No
Cancer 28 days FDS - Total Patients Diagnosed	1,510	1,945	1,858	2,015	2,723	4,564	5,017	4,653	5,139	5,487	10,051	24,860	147%		33,199	59,664	No
Cancer 31 day Treatments	539	524	523	591	526	521	534	602	564	608	2,703	2,829	5%		6,672	6,790	No

ICB Level Summary – Primary Care

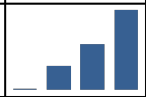
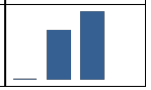
- The first table outlines performance against key metrics submitted as part of the 2022/23 planning round. The only updated data available for Q2 is in relation to PHBs and appointments in General Practice. Validated data for extended access has also been included.

Performance against 2022/23 plan

Metrics		Q1			Q2			YTD	Y/E (Actual/FOT)
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22		
Personal Health Budgets	% to Plan - Count	125.8%			112.6%			112.6%	96.2%
Social Prescribing Referrals	% to Plan (FTE PCN Network)	105.3%						105.3%	105.3%
Social Prescribing Referrals	% to Plan (Social)	92.7%						92.7%	92.7%
Personalised Care and Support Planning	% to Plan	48.5%						48.5%	48.5%
Extended Access Appointment Utilisation	% to Plan	102.7%						102.7%	102.7%
Appointments in General Practice	% to Plan	99.4%	114.6%	93.5%	98.8%	108.5%		102.7%	96.2%

- The second table outlines specific metrics escalated from the portfolio that were not part of the 2022/23 planning submission but where national targets are in place.

Performance against target

Indicator	Target	Q1			Q2	YTD	Y/E (Actual/FOT)	Change on previous period	Monthly trend
		Apr-22	May-22	Jun-22	Jul-22				
Total number of social prescribing referrals (quarterly)	*3,365*	3,121				3,121	3,121	n/a Quarterly	
Learning Disabilities annual health checks (quarterly targets)	*Q1 Target 12.29%, Q2 Target 18.7%*	3.30%	7.48%	11.67%	17.83%	17.83%	55%	n/a Cumulative	
Antimicrobial resistance: total prescribing of antibiotics in primary care	0.871	0.989	1.003	1.008		1.003	1.095	↑	

Data Sources: Social Prescribing Referrals – Local Extract for IIF Reporting (accessed via Aristotle), Appointment in General Practice – Appointments in General Practice data collection (NHS Digital)
Extended Access – Local reports - Extended Access Returns, PHB – Direct from the PHB Support Officer, Personalised Care and Support Planning – CSU Aristotle report. *Time Period: Note the data is subject to a 2 month 'lag' for validation and delivery by NHSE. This is normal process.*
Y/E Actual/FOT: Estimated by applying the current YTD monthly average to the entire financial year

Metrics by Exception

- **Appointments in General Practice**: Appointment activity for August 2022 exceeded the monthly plan by 36,788 appointments, increasing the monthly total to 108.5% of plan. The 2019/20 monthly baseline for appointments was 40,4638. The actual number of appointments in M5 was 47,0805, which is 66,167 appointments above the 2019/20 baseline (an increase of 16.4%). In M5 70.1% of appointments were face to face, which is 17.2% below the 2019/20 baseline of 87.3%.

- **Extended Access:** 2022/23 Q1 Extended Access delivered 102.7% of the plan across Q1 22/23, equating to 940 extra appointments [across the quarter].

- **Annual Health Checks:** Q1 published data was marginally under target (11.67% completed, target 12.29%). Provisional data for September continues to be falling marginally under the monthly trajectory (29.34% completed, target 31.0%).

- **Antimicrobial resistance:** Latest data for June 2022 shows antimicrobial resistance: total prescribing of antibiotics in primary care remains above the 0.871 target and has been increasing month on month. Although the trend looks unfavourable, the overall level of prescribing of antimicrobial drugs currently is less than for the same period during 2019/20 (pre-covid year has been chosen as an appropriate period for comparison). However, primary care prescribing of antimicrobial remains high compared to national target and national average value.

Mental Health Summary

Metrics		Q1
Total access to IAPT services	% to Plan	23.2%
Estimated diagnosis rate for people with dementia	Variation to plan (in rate)	1.4%
	% to Plan - Numerator	103.6%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Variation in rate	-0.5%
	% to Plan - Numerator	120.4%
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Variation to Numerator	18
	% to Rate (% variance to plan)	8.4%
People with severe mental illness receiving a full annual physical health check and follow up interventions	% to Plan	112.4%
Women Accessing Specialist Community Perinatal Mental Health Services	% to Plan	85.4%
Access to Individual Placement and Support Services	% to Plan	97.0%
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	% to Plan	93.9%
First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral	% to Rate (% variance to plan)	4.6%
	% to Plan - Numerator	207.3%
Access to Children and Young People's Mental Health Services	% to Plan	75.2%

Data Source: Validated performance data NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.

Q1 performance summary

- IAPT is 75.5% below the plan, equating to 6129 contacts.
- The CYP routine rate variation (below plan) pertains to 6 cases and urgent rate variation (above plan) pertains to 18 cases.
- Perinatal Mental Health service access is below plan by 52 contacts.
- Access to Individual placement and support services is at 97% of the plan at Q1, by 26 contacts.
    - The year end target is usually exceeded and the underperformance is only slight therefore it is of little concern at the moment. Performance against this target will be monitored.
- Overall access to core community mental health (CMH) services is below plan by 690 contacts.
- Access to mental health services for children is delivering 75.2% of plan which is a shortfall of 4,898 contacts. However the service continues to exceed the national ambition target set by NHSE of 14,505 contacts per month.

Risks	Actions
All breaches of access standards have an exception report as part of contractual mechanisms in order to monitor any risk.	
Risk to achieving **IAPT** access standard	• IAPT referrals remain below target due to the impact of Covid, we continue to promote extensively and there has been an improvement over the months. • Implementation of IAPT bus to target under represented groups and areas with poor transport links. • New website and digital promotion to increase online self-referral (including NHS Talking Therapies links). • Use of digital devices for older adults to overcome barriers to access.
Risk to achieving **Adult Community Mental Health** access standard	• The community MH transformation programme continues to develop at pace, with new pathways being embedded around Adult Eating Disorder and Self Harm. • The new voluntary community sector providers that have been commissioned have now commenced delivery and are now receiving referrals, this will increase the number of contacts over the next few months to ensure the target is achieved.

Appendix 1

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

System 2023/24 Financial Strategy

Introduction

This financial strategy….

- Has been developed collectively by the CFOs of the system
- Has been discussed and supported at System Finance & Performance Committee
- Aims to provide a framework to the money. CFOs are strongly of the view that we want our clinical leaders to own and support the way forward

So we appreciate the chance to discuss this at the system Health & Care Senate. We would appreciate:

- Feedback from the Senate on the direction set
- Advice on how we can position this – we know that finances will be difficult but we want to create positive energy and a desire to make the money go further, as opposed to a sense of ‘doom and gloom’. How can we collectively achieve that sense?
- A discussion on how we reach into the providers and also penetrate primary care. The opportunities are there if we can work across the pathway - how do we actively get clinicians from across the system on board?

Executive Summary

This Financial Strategy has been developed collectively by system CFOs working with their executive colleagues.

- The strategy sets out a framework for keeping the system in financial balance.
- Seeks to create a culture where resource deployment is undertaken at a system level with a focus on clinical outcomes
- Is realistic about workforce availability and suggests a focus on retention of the people we have and replacing high agency use with substantive
- Recognises the opportunity to eliminate waste and increase activity within the current physical and people capacity – productivity improvement
- Defines the role of organisations and portfolios in this task, and seeks to empower clinical leaders to find the best clinical models.
- Sets a timeframe and process for this work, recognising that the financial outlook is currently very uncertain.

Context – what this financial strategy is aiming to do

This strategy aims to empower our clinical leadership team. We want to help the system unlock finance, to enable change and improvement:

The aim of the system is to provide the best health and social care for our 1.1m residents.

The goal of integrated care means that we focus on the patient pathway, and not the organisation.

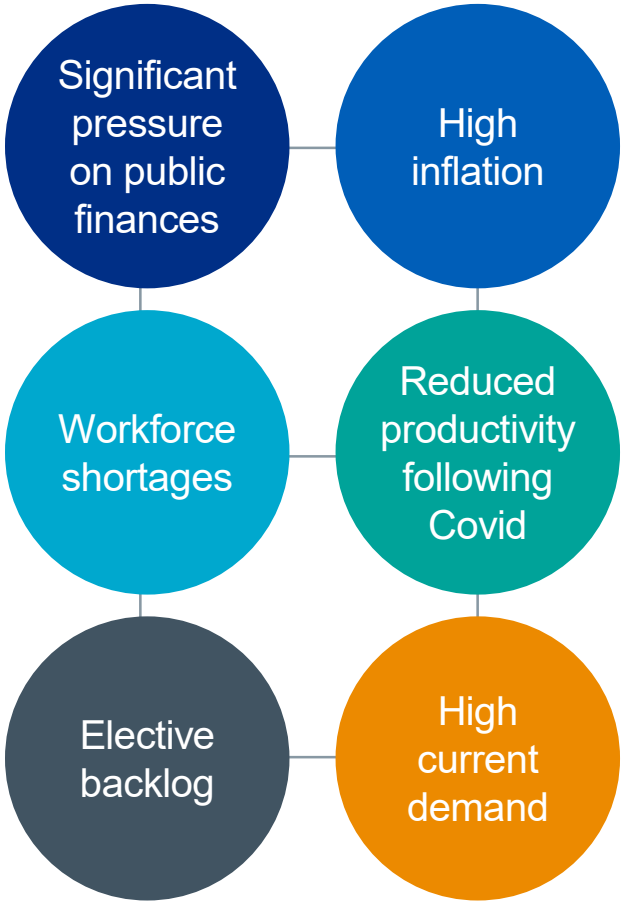
This means that the money is a system resource and needs to be targeted to where it can have the biggest impact.

This financial strategy is an enabler of this goal. It depends on full transparency on where we spend our money.

The underpinning principle is that we focus on clinical need and priority.

And from that, the best financial solutions will emerge.

The National Picture



So we're dealing with:

- A very uncertain outlook, with significant pressure on public finances
- A real chance that funding for the NHS will be negative after inflation
- Ever higher expectations on quality and access at a time of increased operational pressure
- A significant backlog to address, alongside very high demand.

Given this uncertainty:

- We need to plan to be the best we possibly can
- If we wait to find out exactly how much money we have, and what we're required to do, it will be too late to get things in place for April
- So we need this strategy now. We need to be realistic about the money and ensure we're the most productive we can be within the money we have. We need to stay positive and to look at the opportunities to stretch the money as much as we can, by working collectively with the Staffordshire and Stoke-on-Trent £.

Background

The system has a long history of deficits, and starts with an accumulated deficit of £300m.

In the past two years, a combination of extra money for Covid alongside a successful system financial savings programme, has led to break-even.

In 2022/23 we have a plan to break-even - there are some challenges to achieve this.

However the underlying deficit from the pre-Covid period remains.

We are working very well collectively, and there is full transparency and openness in the financial position. We fully intend to retain these strong working relationship and build further on them.

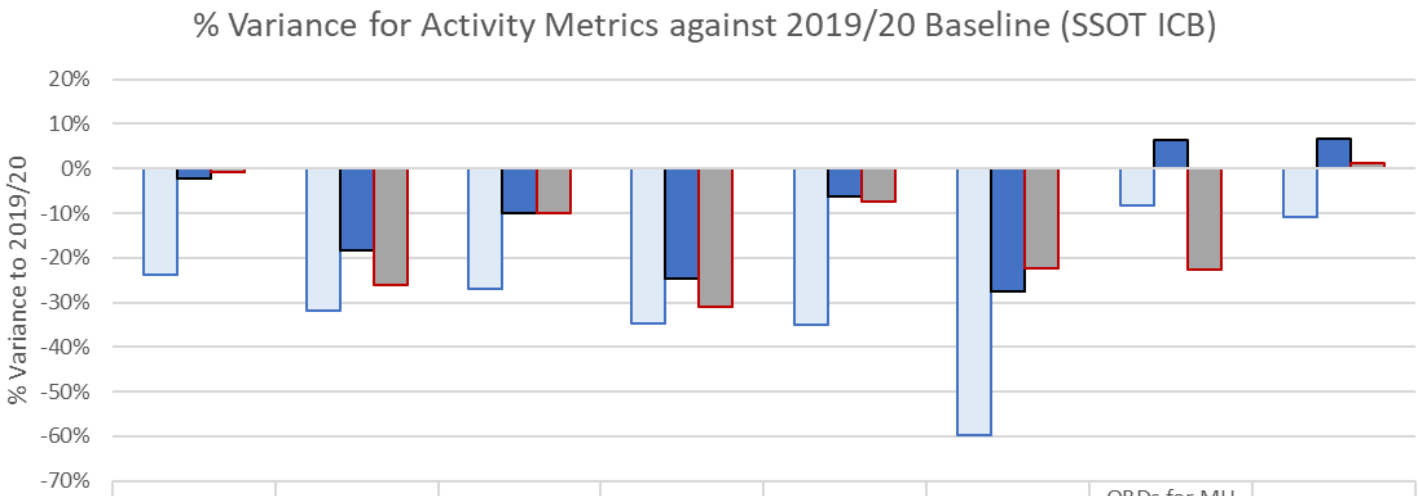
- The national and local context is very strained and we face:
  - Current cost of living crisis across all service provision
  - Workforce shortages
  - Pressures on urgent care are intense
  - Supply and demand challenges within social care
  - Waiting lists are at an unprecedented level
  - Mental health services are stretched
  - The social care sector is in crisis and the local supply chain struggles financially and with retention of skills
  - Ever higher expectations from patients and the public for better health and social care
- Taking into account the above our existing financial strategy is insufficient to bring us back to a financially sustainable position. It has helped us establish some system control, but transformation is needed to ensure a sustainable future
- This strategy describes how we will achieve that sustainable future for the local health and social care system.

System Agreement to this Strategy

- This approach has been developed collectively by the system CFOs and their teams.
- We have attempted to create a strategy that is ‘doable’. Too many financial plans of the past were theoretical and so had no chance of ever being implemented. We want this to be equally owned by the system and our clinical and operational colleagues.
- Given the size of the financial challenge, we very much recognise that this strategy will be a very difficult one to deliver. Consequently this is a draft of the strategy that we will publish in March, as the framework for 2023/24 and beyond. We are producing this now to set out a timeline to work with colleagues on the plans for 2023/24, to allow a sufficient amount of time for schemes to be developed and implemented ahead of the next financial year.
- It will be a collective and consultative process. We can only achieve this if we do it together. Therefore this approach will be discussed at organisational Committees and Boards, system meetings and specifically with the Health and Care Senate. The final strategy will therefore be one with strong clinical and operational support to the approach.
- The timeline for this work is shown opposite.

The Current Financial Strategy

Our current strategy is named '**flat activity, flat cash**'. The focus on avoiding acute activity growth has had some success and alongside the work of providers to hold costs flat, has led to a more stable financial situation for the system. The table below summarises this for the key metrics selected by the Health and Care Senate.



	ED Type 1 Attends	Short Stay NEL Admits	OBDs for NEL Admits	28 Readmissions	Referrals via ERS	MSK Elective Activity	OBDs for MH Patients in Acute	Primary Care Consultations
20/21	-24%	-32%	-27%	-35%	-35%	-60%	-8%	-11%
21/22	-2%	-18%	-10%	-25%	-6%	-28%	6%	7%
22/22	-1%	-26%	-10%	-31%	-7%	-22%	-23%	1%

Some conclusions:

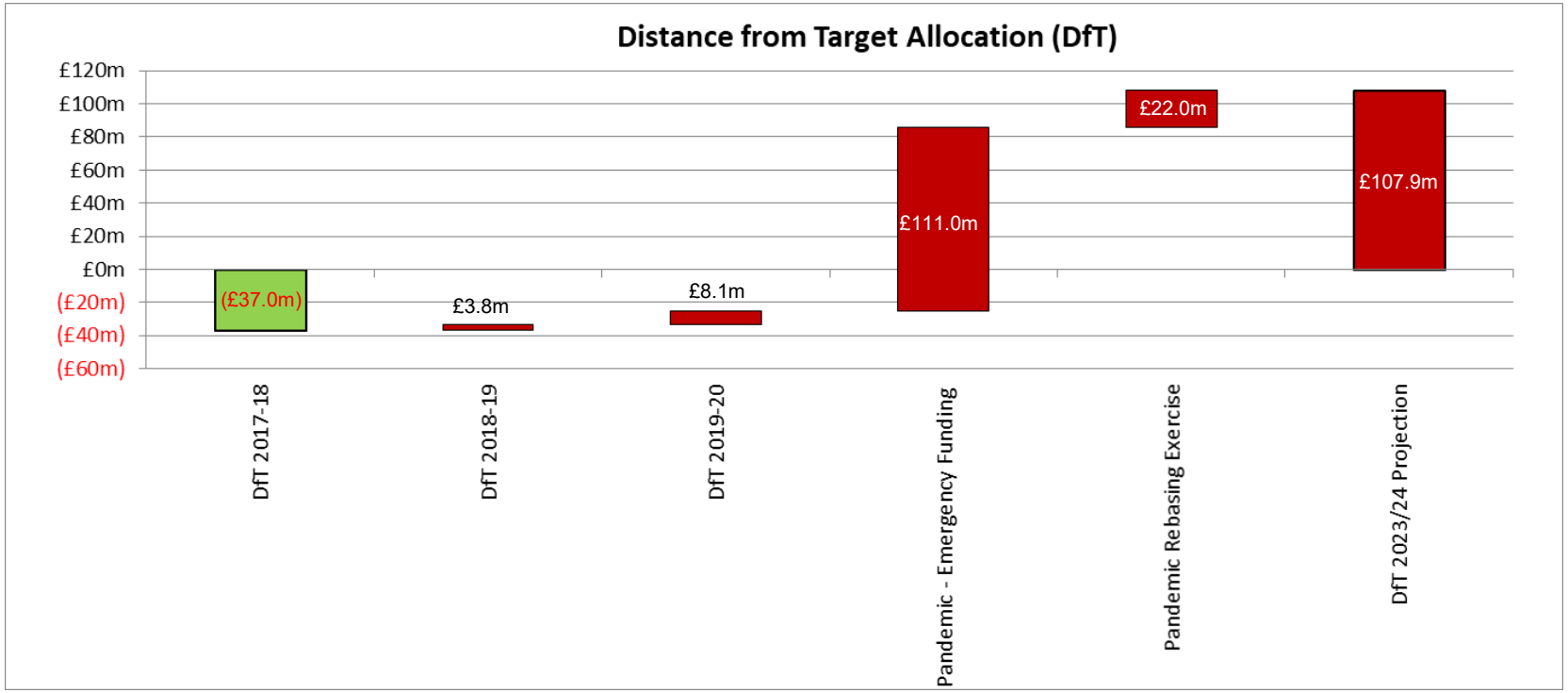
- We need to continue with the system focus on managing demand so that the patients are referred to the appropriate pathway
- The strategy is fundamentally sound, but needs some refinement to recognise the challenges of the system and the complexity of what we are dealing with
- The narrative for the strategy 'flat activity, flat cash' was not owned by everyone so we should build a new narrative that all partners own
- We should continue to keep it simple so that there is strong understanding of the collective goal.

Outlook for growth

Pre-pandemic our system operated with a structural deficit. We received less than our fair shares allocation by c£37m pa. As such, growth received was favourable.

However, resulting from the emergency framework imposed throughout the pandemic, the system received c£130m additional funding to reflect the cost base at that time, plus growth to deal with Covid. This takes us materially above our target allocation.

A 'convergence policy' has been implemented centrally to bring systems back to their fair share of allocation within a set period. The impact being our growth is projected to be reduced.

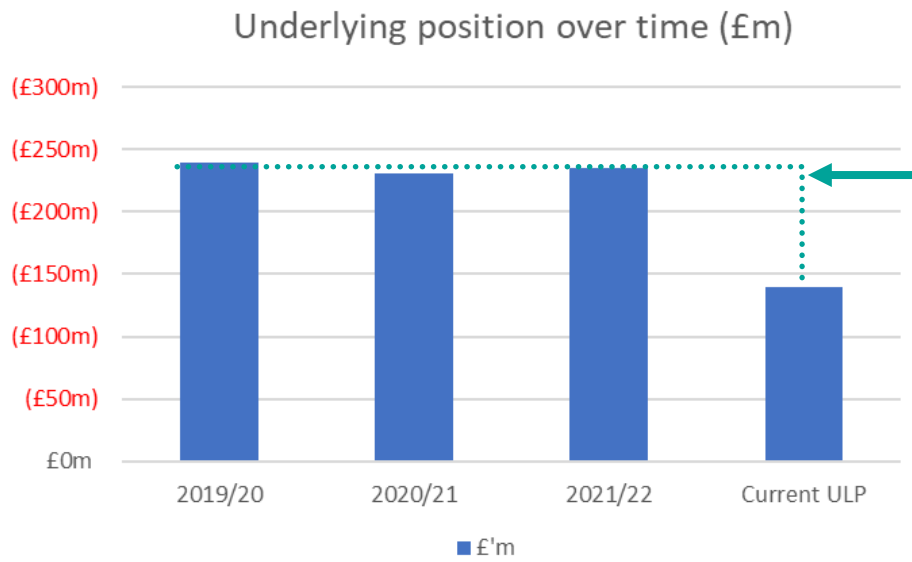


Our Underlying Position

Our current position (2022/23) is a forecast gap of £20m. However, this position is significantly masked by non-recurrent resources. For example, we have money allocated for the Elective Recovery Fund and the Strategic Development Funding that is not all being used for those purposes, and so is supporting the bottom line.

The additional growth received during the Covid period has helped reduce the underlying deficit. In the years up until Covid this underlying deficit was more than £230m, but this narrowed to about £140m in recent years. Over the past year we have managed to ensure that the position does not deteriorate, but we remain with a challenge of about £140m that will surface as soon as the non-recurrent resources are consumed.

This is shown in the chart below:



The emergency financial framework imposed at the start of the pandemic resulted in £111m additional funding.

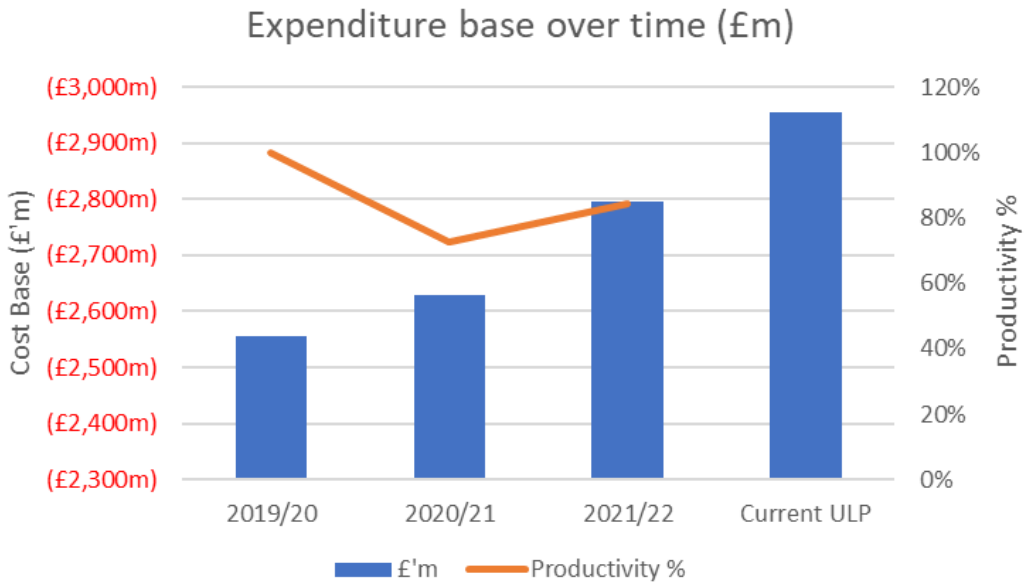
This impacted our system by moving from a position of £30m underfunded to c£80m above 'target allocation' and therefore subject to the national **convergence policy.**

Conclusion:

2023/24 and beyond are going to be some very challenging financial years as the non recurrent resource we have, that is supporting the current year, falls away.

The Opportunity for Improved System Productivity

The response to Covid was to fund the NHS at the pre-Covid cost level and then increase funding further to allow the NHS to cope with the pandemic. As costs rose, activity fell due to the constraints of operating within the restricted capacity due to social distancing and higher levels of staff sickness.



As slide 6 shows, there has been some recovery of output since lockdown. But we're still not seeing any significant levels of activity over that from three years ago. And yet costs have risen markedly in that time. Consequently productivity has fallen. The chart below shows that this recovered to 80% in 2021/22, but clearly that still leaves a very significant opportunity if we can get back to pre-pandemic levels of productivity or better.

Conclusion:

- People are working incredibly hard, and a strategy of increased productivity needs to be sensitively articulated
- But the conclusion is clear, that we have a significant opportunity to increase activity without further increases in cost
- This has to be about working smarter, eliminating unwarranted variation and using digital opportunities.

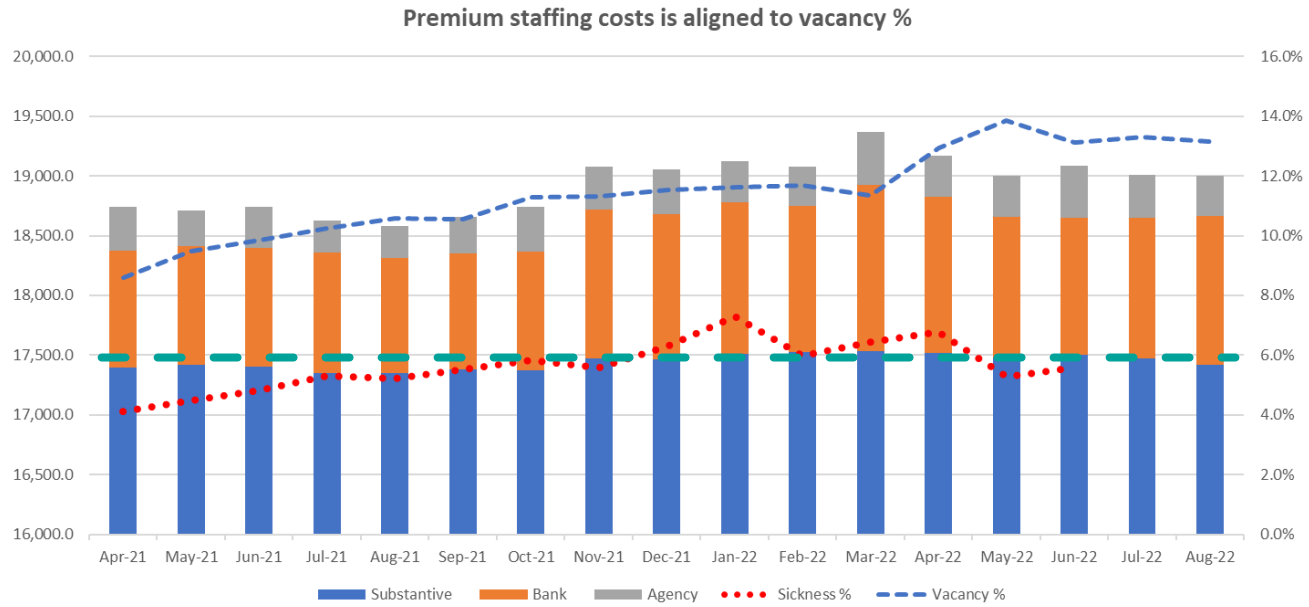
We need to Connect this Financial Strategy to our People Strategy

About three quarters of what we spend is to employ people. People are our greatest asset, and they are a scarce resource. The financial strategy needs to define our approach to workforce if we are to articulate a coherent approach to achieve financial targets.

The previous slide confirms that our cost base has increased. This is because we now spend more on people. But as a system, those people are not generating additional activity.

In 2022/23 we set out to increase the workforce by 700 people. In fact, the workforce is about the same as before as we have lost as many as we recruited. Whilst recruitment overseas and increases in training posts are planned, realistically this is not going to change much going forward.

We are also spending too much on agency staff. A focus on recruiting more than we lose in order to reduce the agency cost could mean that we save money on the workforce in totality, and create a more sustainable workforce supporting better continuity of care.



Some conclusions:

- Planning on increasing the net number of staff in post is not a realistic aim.
- We need to generate more activity from the current establishment to get back to pre-Covid levels of productivity, whilst recognising that low levels of workforce is contributing to the challenge
- If we can recruit at a higher rate than staff leave, but do that within current establishments, we would have a stronger workforce and save money from spend on agency.

Size of the Challenge and Inflation

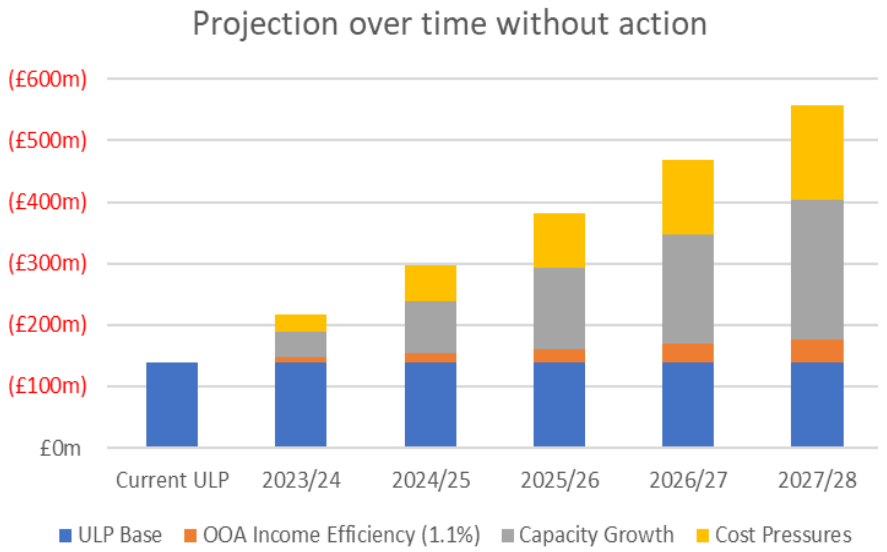
The challenge

Our financial strategy needs to address both the current underlying deficit of £140m, and the costs that (without action) would continue to rise.

The 'Do Nothing' scenario makes the following assumptions:

- Our underlying deficit of £140m has been signed off by all partner organisations
- Cost pressures have been included at 1% pa of total cost base – this is a reasonable estimate of cost increases we can expect to see over the strategic period
- Out of area (OOA) income has had a 1.1% efficiency applied at source to match the 2022/23 financial model (c1/3 of total income)
- Demand growth has been assumed at 2% - this is the historic rise of acute activity that we experienced before the past few years pre-Covid

This is the scale of the challenge we face, shown on the chart opposite.



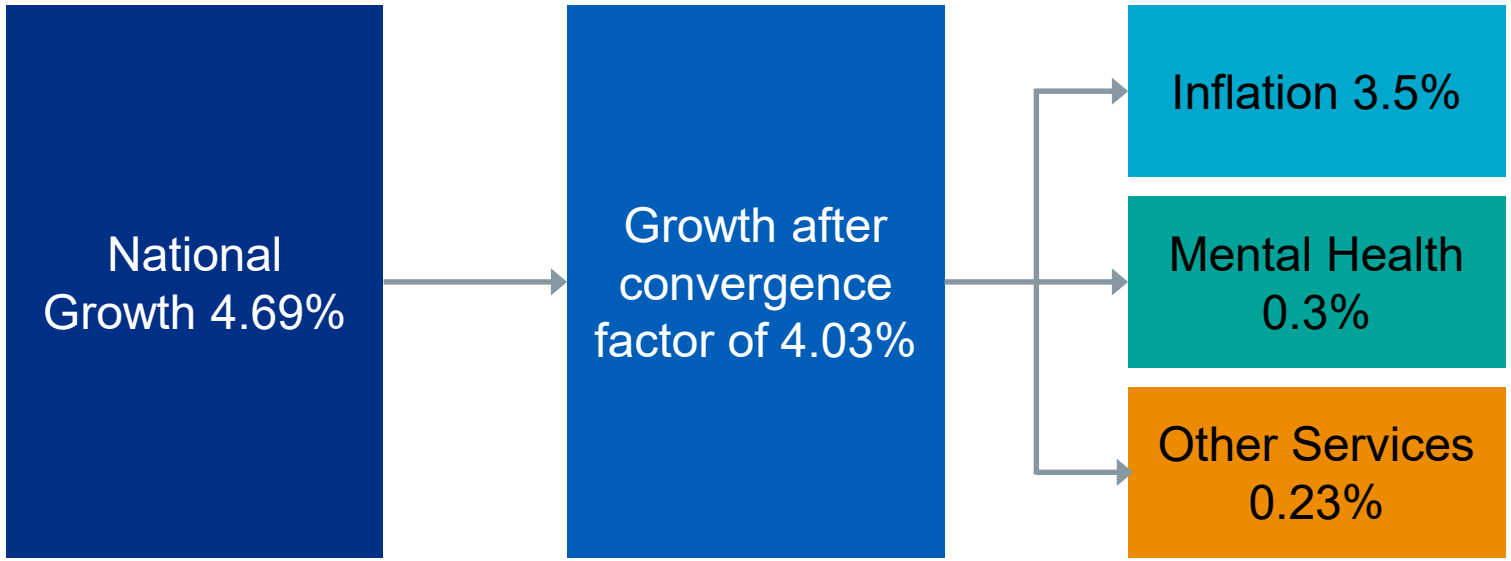
Inflation

We have also carefully considered the impact of inflation, which is a major concern for the public sector and the economy more generally. Predictions vary, but all show costs outrunning public sector growth. This is a cost that we cannot control. If unfunded, it would lead to very significant service cuts. In this plan, going forward we have decided to plan on an assumption that further inflation is funded. This is the best case, but is what has happened in all previous years. It emphasises that as a minimum we should be living within our means before the inflationary impact.

Income

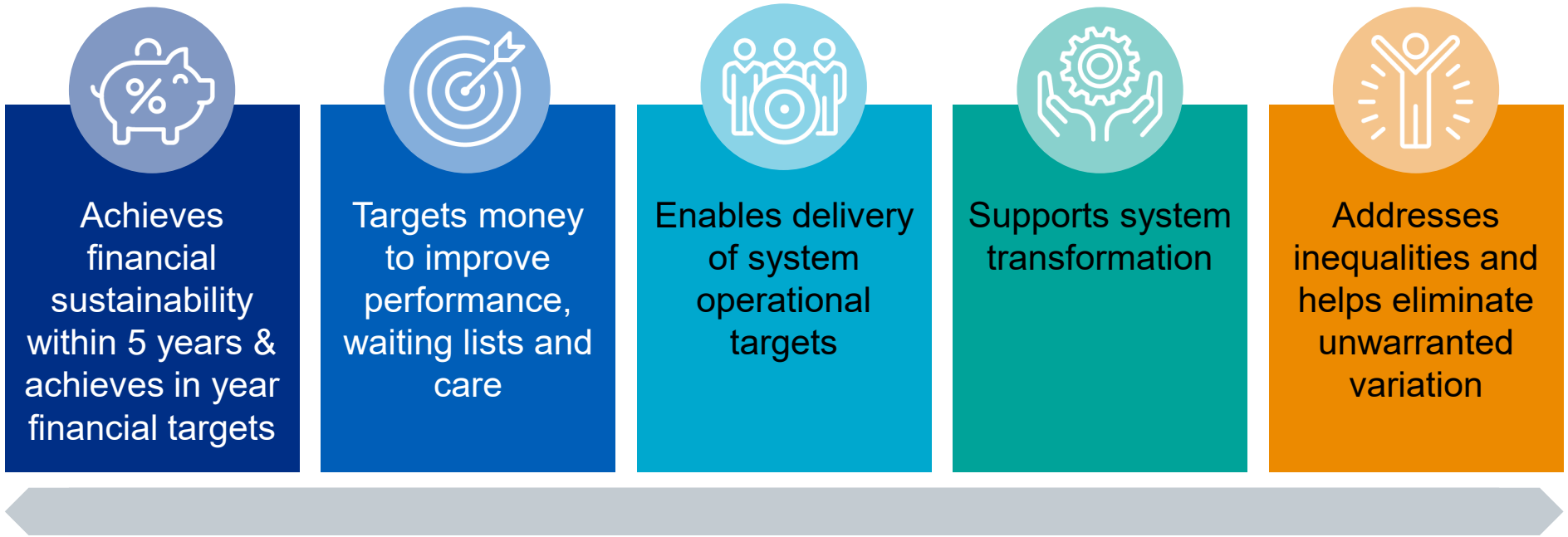
We have explained that due to the system being above ‘fair shares’ funding levels, we can anticipate reduced growth. The chart below summarises our key planning assumptions.

Because of the system’s relative position to ‘fair shares’ most of the uplift we get will go to cover inflation. Creating a ‘flat cash’ situation for the medium term:

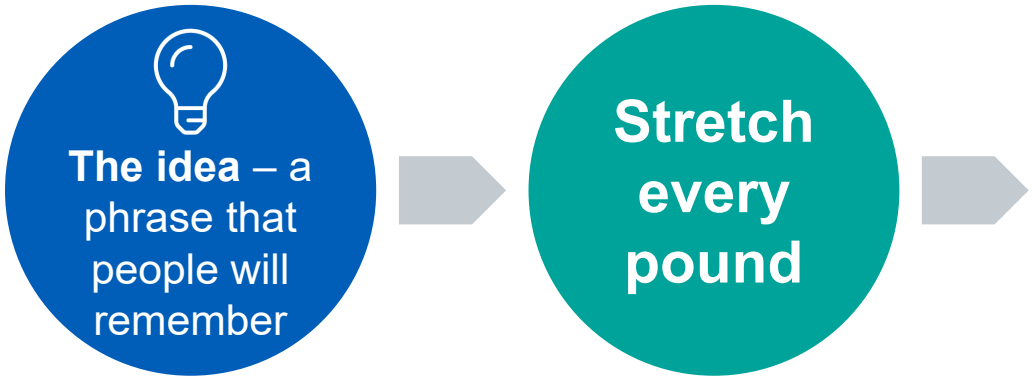


Principles for the Strategy

The Financial Strategy needs to balance longer and shorter term objectives. We need to keep the system in financial balance, as otherwise clinical services and patient care suffers from the knee-jerk responses that would have to follow. We need to address the inequalities our population experience and we need to address the priorities for health. We propose a strategy centred on five principles:



Strapline for the 2023/24 financial strategy



Because:

- We can't influence how much we get. But we can make each SSOT £ go further
- We need to ensure that financial plans are clinically focussed and owned
- Working together across the patient pathway opens up opportunities to improve care within this fixed envelope
- Focus on doing more with the resources we have now – as opposed to cutting costs
- Every pound of new spend has to be covered by saving a pound somewhere else
- Portfolios to have clear targets and to be empowered to deliver improvements from that framework.

The Proposed 23/24 Financial Strategy

Goals

- Increase the proportion of the workforce employed substantively
- Increased activity through the existing physical and clinical capacity to address backlogs – using digital and other means so that this also improves the quality of the clinician's experience
- Portfolios encouraged to 'stretch every pound' to address priorities
- Targeted system activities to make savings and get more for the SSOT pound
- Eliminate the underlying deficit over time
- Find non-recurrent solutions to keep the system on track in the intervening years.

We do this by

- Reducing unnecessary NEL attendances through interventions that keep people at home
- Better flow – more timely discharge through use of Out Of Hospital interventions / social care / etc.
- New pathways – alternatives to improve the patient journey / digital first
- Eliminate unwarranted variation
- See more patients through the existing clinical capacity – repatriate spend on IS etc.
- Better value from enabling functions e.g. more efficient use of estate, reduced internal transactions.

A six-step plan

6. Repatriate
Replace use of Independent Sector for electives, MH placements with in-house capacity

5. Manage Activity
Integrated care models so that more pathways take place outside of the acute sector

4. Savings
2% cash out to cover cost pressures and the convergence factor

1. Capacity
Other than specific targeted additional funding (eg TIF) capacity will be static

2. Workforce
Broadly, workforce establishment will be the same – but more staff in post and fewer agency

3. Productivity
More activity through the existing capacity

System Efficiency

	Modelled ask per annum					
Organisational Requirement:	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Savings		62	66	70	73	78
Savings % (cost base)		-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
Transformation Requirement:	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
System Savings e.g. Estates & VW		10	0	0	0	0
Repatriation		10	0	0	0	0
Activity Management		42	44	45	47	49
Total Transformation		62	44	46	48	49
Transformation % (cost base)		-2.0%	-1.3%	-1.3%	-1.3%	-1.3%
Total		124	110	116	121	127
Total % (cost base)		-4.0%	-3.3%	-3.3%	-3.3%	-3.3%
Total % (RRL)		-5.7%	-4.8%	-4.9%	-4.9%	-5.0%
Non Recurrent:	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
BAU NR Gain		33	33	33	33	33
Total		33	33	33	33	33
Total % (cost base)		-1.1%	-1.0%	-0.9%	-0.9%	-0.8%
Total % (RRL)		-1.5%	-1.5%	-1.4%	-1.3%	-1.3%
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Total Ask		**157**	**143**	**149**	**154**	**160**
Total Ask % (Cost Base)		-5.0%	-4.3%	-4.3%	-4.2%	-4.1%
Total Ask % (RRL)		-7.2%	-6.3%	-6.3%	-6.3%	-6.3%

Conclusion:

- This model is realistically the best level of efficiency we think we could achieve. We now need to test out viability with operational and clinical colleagues
- Total efficiency is 5% of which 2% would need to be cash savings or cost pressures mitigated. Whilst very challenging, this is likely to be the minimum acceptable position for our system
- There are also sizeable system financial challenges to meet, that the portfolios will need to lead
- In conclusion CFOs recommend that this model is now tested across the system.

Going Further

This is a tough ask, but…

- The model leaves us with a gap that would have to be filled non-recurrently
- And assumes that inflation is fully funded – clearly a best case assumption
- So it is possible that we may be asked to do more
- And if so, we need to be ready to explain whether we could, and if so what shape that solution would look like.

So we also need to consider our options for reducing some services:

- This is clearly not at all what we would want to do, but we would need to be prepared to explain the implications
- In doing this, we should ask the system to advise on any areas where this could be done, and the impact
- And maybe this could help in those services where we are short of people, so maybe concentrating workforce on a smaller number of services might have some benefits?
- The proposal is to ask each Portfolio to advise on options for making a further 1% or 2% saving in terms of service reductions. These would only be adopted in a scenario where inflation was underfunded and we felt as a system that we had no other option.

Method of Delivery

System Support for the Strategy

This strategy will only deliver if all system partners, including LAs are on board.

Organisations lead on creating viable financial models

Organisations employ the clinicians and support staff and deliver the care, so need to be content that the financial model will deliver

Portfolios lead on system action to recycle the money

The opportunity for transformation comes from working across the pathway and Portfolios can unlock inter-organisational opportunities. It is recognised that there may have to be some ‘invest to save’ to deliver these benefits

Focus on portfolios

	Portfolio	Action for activity and output	Action on money
1	Prevention	• Identify schemes that address inequality • Identify options for reducing future demand for urgent or elective care	• Growth allocated as per national allocations • Money recycled to address priorities
2	Urgent Care	• Flat or reduced IP activity • Reduced LOS to free up capacity • Increased community / primary care / OOH activity • Reduce number of MFFDs	• Flat cash (inflation funded)
3	Planned Care and Cancer	• Increase activity to 19/20 levels + at least 4% • Reduce waiting times for elective and cancer • Improve theatre productivity • Reduce referrals for surgery	• Flat cash (inflation funded) • Repatriate IS money for reinvestment in system capacity
4	Maternity and Children	• Acute activity flat, increased OOH provision • Improved use of capacity	• Flat cash (inflation funded) • Respond to Okenden
5	Underlying conditions and Frailty	• Reduce average number of interventions per patient with LTC / frailty	• Flat cash (inflation funded)
6	Mental Health and LDA	• Improved use of acute capacity • Increase in OOH activity	• Baseline + MHIS
7	Primary Care	• Plan for an increase of 2% attendances • Flat levels of onward referral	• Baseline + mandated contract uplift
8	Enabling Functions	• Increased level of service with same money	• Flat cash (inflation funded) • Cash releasing savings from estate

Modus Operandi for the delivery of this financial strategy

Clinical excellence with the system money allocated to where it will have the greatest effect

Organisations manage cost pressures and CIPs	Portfolios plan activity and system savings	Health and Care Senate oversees clinical models	Leadership leads transformation / improvement

- CFOs operate as a single team
- One financial model with complete transparency
- Finance teams support organisations, the portfolios, the Health and Care Senate and the leadership team to stretch the money and focus on the best clinical solutions

Actions and Next Steps

Over the next 8 weeks:

- This financial strategy to be discussed at System Performance Group, System F&P, Trust Board F&Ps and with the Clinical Senate
- Portfolio leads to design the system PIPs for the delivery of the system savings
- Trust teams to lead on the development of the efficiency and productivity improvement work
- System People team to develop the workforce solution
- System COOs to design the operational response to the plan
- System strategy leads to agree the system strategy and operating plan within these defined resources
- Activity modelling to take place – there are some services (eg cancer) where demand management will not be possible so plans will need to be triangulated
- Workforce plans to be developed to underpin the solutions
- In the run in to Christmas, stock take where we are and test against national requirements.

Over the period from January to March 2023:

- Refine the strategy and develop into a comprehensive system approach to stretch the SOST £
- Publish the final system Financial Strategy

Appendix A – Calculation of likely growth

Income Growth	2022/23	2019/20	2018/19	2017/18
RRL Growth	4.69%	5.37%	2.63%	2.15%
Committed Growth:				
Tariff	(2.80%)	(3.80%)	(2.10%)	(2.10%)
Inflation top up	(0.70%)			
Uncommitted Growth	1.19%	1.57%	0.53%	0.05%
Convergence	(0.66%)	n/a	n/a	n/a
Net Growth	0.53%	1.57%	0.53%	0.05%

Appendix B – How our cost base is modelled

	Current ULP	2023/24	2024/25	2025/26	2026/27	2027/28
ULP Base	-140	-140	-140	-140	-140	-140
OOA Income Efficiency (1.1%)		-7	-14	-21	-29	-37
Capacity Growth		-42	-86	-131	-178	-228
Cost Pressures		-29	-58	-89	-121	-154
Total	-140	-217	-298	-381	-468	-558

Appendix C – Our agency opportunity

Organisation	FoT	YTD (Month 5)	Premium	Total FoT Opportunity
University Hospital of North Midlands	19,673	8,197	25%	4,918
Midlands Partnership NHS FT	14,390	6,399	25%	3,598
North Staffordshire Combined HC	4,462	2,212	25%	1,116
Total	**38,525**	**16,808**	**25%**	**9,631**

Opportunity to realise	
50%	**4,816**

Appendix D – Our productivity opportunity

PBR Activity and Costs (based on 22/23 Tariff) 2019/20 v 2022/23

Staffordshire & Stoke on Trent ICB, All Providers

Point of Delivery	2019/20		2022/23 FOT		Cost Variance (£m)		Avtivity Variance	
	Cost (£m)	Activity	Cost (£m)	Activity	Var	% Var	Var	% Var
1st Outpatient	£45.7	236,734	£34.1	177,384	-£11.6	-25%	-59,350	-25%
Follow Up Outpatient	£34.8	383,254	£22.6	259,356	-£12.1	-35%	-123,898	-32%
Outpatient Procedure	£28.6	169,588	£25.2	149,686	-£3.3	-12%	-19,902	-12%
A&E Attendances	£60.4	401,136	£59.7	401,191	-£0.8	-1%	55	0%
Daycase	£89.9	109,649	£80.4	99,110	-£9.5	-11%	-10,539	-10%
Elective	£72.3	15,857	£61.9	13,409	-£10.4	-14%	-2,448	-15%
Emergency	£257.3	112,317	£239.0	91,032	-£18.2	-7%	-21,285	-19%
Non Elective	£42.0	12,872	£38.6	11,318	-£3.4	-8%	-1,554	-12%
Total	**£630.9**	**1,441,407**	**£561.6**	**1,202,486**	**-£69.3**	**-11%**	**-238,921**	**-17%**

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**10**

Title:	**Quality and Safety – Update Report**

Meeting Date:	**17th November 2022**

Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Heather Johnstone – Chief Nursing and Therapies Officer	Y	Nursing and Quality Heads of Service

Clinical Reviewer:	Clinical Sign-off Required Y/N
N/A	N

	Action Required (select):									
Ratification-R		Approval -A		Discussion - D		Assurance - S	X	Information-I		

History of the paper – where has this paper been presented		
	Date	A/D/S/I
This paper is a combination of those corresponding papers presented and discussed the at Quality & Safety Committee		S

Purpose of the Paper (Key Points + Executive Summary):

This paper is intended to provide assurance to the ICB in relation to the key quality matters.

These include:

Routine updates from subgroups including System Quality Group, Continuous Quality Improvement, the Local Maternity and Neonatal System Board and the Quality Impact Assessment Subgroup.

Current System Quality Matters including:

- Moorlands Neurological Centre
- Ivetsey Bank
- Ambulance Service ED Waits and Delays
- Infection Prevention and Control

Quality Assurance and Improvement of ICB and ICS developments including:

- System Winter Plan
- Quality Strategy
- Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services
- Voluntary Community Social Enterprise Sector (VCSE)
- Inpatient Mental Health Services (South-East Staffordshire) - Communications and Improvement Plan

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
No conflicts of interest were identified.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks are collated from all partners and presented and discussed at the meeting.

Implications:	
Legal and/or Risk	Risks identified and discussed within the agenda
CQC/Regulator	Discussed as appropriate and against the relevant organisation, as appropriate
Patient Safety	All key areas in response to system assurance for patient safety have been identified within the report
Financial – if yes, they have been assured by the CFO	Potential financial implications on the quality of services across the system due to restoration and recovery
Sustainability	N/A
Workforce / Training	Many current quality issues relate to workforce matters including areas where gaps in workforce present ongoing challenges.

Key Requirements:	
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? The report relates to key quality assurance, quality improvement and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) N/A

		Y/N	Date
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

Be assured in relation to key quality assurance, quality improvement and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Members are asked to receive this report and seek clarification and further action as appropriate.

Quality and Safety Committee (QSC) report to the Integrated Care Board – November 2022

1. Introduction

This report is intended to summarise the key discussion points from the November 2022 meeting, to highlight any additional relevant emerging quality matters and to provide assurance to the ICB that quality is being monitored and improved in partnership across the system.

2. Quality Risks on the Register

Risks relating to Quality and Safety were discussed at the Quality and Safety Committee with a recommendation to merge the maternity risks into one overarching risk as well as cross reference with other directorate risks to ensure they are all aligned.

3. Sub-Group Updates

3.1. System Quality Group (SQG)

The Group met on 4th November 2022. System partners provided updates on key areas of work within their specific organisations. A summary of the discussions has been presented to the Quality and Safety Committee. Key points including:

- Updates from all System partners except for NSCHT, UHDB, Stoke -on-Trent City Council, Health Education England and the CQC.
- UHNM highlighted workforce pressures within maternity as well as the fluctuating numbers of induction of labour and how this was being addressed. There will also be a review of maternity services at UHNM in response to the Independent Inquiry in East Kent.
- Healthwatch have re-instated their 'Enter and Review' programme and there has been CQC visits on 2nd and 3rd November to MPFT premises in Shropshire and Staffordshire following staffing concerns. MPFT themselves are reviewing mental health in-patient facilities and restrictive practices and re-instating a Quality visit programme.
- 15 ICB nurses are being supported to refresh clinical competencies as part of an Upskilling Pilot, who will be part of a system wide response in times of pressure.
- Health care professionals are working together to support Asylum Seekers expected to arrive in Stoke on the 4th or 5th November.
- The ICB QIA process is being developed and progressed via a recent workshop. Work will also include exploring with wider system partners how to reduce duplication.
- There were no formal escalations, however it was noted attendance is not always consistent.

3.2. Continuous Quality Improvement (CQI)

The CQI subgroup continues to meet monthly and review current projects, scope new requests and identify how best to build improvement capacity and capability into the system. Updates are as follows:

- Complex Hospital Discharge (North) – work has been presented to the UEC (Urgent and Emergency Care) Board and work continues to consolidate and share learning across the UHNM footprint prior to community roll out from early 2023.
- System savings Quality Improvement (QI):

  - Falls Redesign – closed following discussion with the TDU.
  - Community Rapid Intervention Service (CRIS) – agreement to put any new QI work on hold. No further support requested currently.
  - Planned Care (MSK) – workshop facilitated to share outcomes from a mapping exercise against the National Best Practice guidance. No further support requested at this point.
- Further embedding Quality Improvement in Primary Care – a number of initiatives have been implemented including sharing of national resources across PCNs, training and development incorporated into academic programmes, and ICS primary care bulletins.
- Community equipment – scoping exercise is in place to identify areas for improvement which will have the greatest benefit.

3.3. Maternity and Neonatal Services

The Local Maternity and Neonatal System (LMNS) Board continues to monitor all aspects of maternity quality and safety, including services provided out of area and the findings from all matters incorporated into the work of the LMNS Board.

Workforce challenges remain an issue affecting the ability to provide safe maternity staffing in line with Ockenden recommendations and risks are mitigated by moving staff to areas of greatest need, primarily the consultant units on the delivery suites. The freestanding midwife led units in Lichfield and Stafford remain closed for births and home births are intermittently suspended in line with local escalation levels.

The high number of women who require their labour inducing (IOL) and subsequent backlog continues to impact on capacity within Maternity services. An Improvement project has now been established in collaboration with UHNM, LMNS and NHSE with the aim to develop an IOL pathway that promotes choice and positive experiences for women and families, whilst developing a service that meets operational demands to reduce the need for escalation for mutual aid.

Work continues across the region, led by our Chief Nursing and Therapies Officer, to standardise the escalation criteria for maternity to enable regional agreement on actions to support improvements in maternity access. Maternity data is discussed on the daily COO (Chief Operating Officer) calls in case of future escalations requiring on call support. In addition, the SITREP data is being scrutinised by the ICB on a daily basis and actions taken on early indications of issues, particularly increasing backlogs of IOLs. A Rapid Quality Review meeting has taken place between the ICB, UHNM and NHSE in line with the National Quality Board guidance, to discuss the current maternity concerns and to gain further assurance in relation to how the Trust are managing the risks.

<u>Independent investigation into Maternity and Neonatal services in East Kent</u>

This month the long-awaited report of the independent investigation of East Kent Maternity and Neonatal services was published. The investigation reviewed 202 cases which occurred between 2009 and 2020 and concluded that the outcome could have been different in 97 of those cases. In total 45 of the 65 baby deaths reviewed might have been prevented with different care.
It describes how those responsible for the provision of maternity and neonatal services failed to

ensure the safety of women and babies leading to suboptimal care and poor outcomes. The report also highlights an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards when they sought answers to understand what had gone wrong. It highlights grossly flawed teamworking among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating findings.

The full report will be taken through the LMNS Board and the local response will be provided to the ICB at the next public Board meeting:

Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)

3.4. Quality Impact Assessments (QIA)

A paper was presented to the QSC providing an overview of the QIA work to date and next steps. The Committee were advised that the ICB's Interim QIA Subgroup met three times during September and October 2022; all seven QIAs reviewed were 'approved'. A (virtual) QIA Workshop took place on 25th October 2022 to consider the ICB's statutory responsibility, strengths, weaknesses, opportunities, and threat (SWOT) analysis of the former CCGs' approach and peer comparisons. There was good engagement and energy from all workshop attendees, where it was agreed that the emphasis of the ICB's future process should be on ensuring consistency and proportionality. A follow up workshop is scheduled for 22nd November 2022. Meetings with system partners to discuss a system-wide approach to QIAs that supports collaboration and reduces duplication but retains individual organisations governance processes, are being reconvened.

4. Current System Quality Matters

4.1. Moorlands Neurological Centre (formally The Woodhouse)

The Woodhouse name has, in line with their proposed change of business, been changed to Moorlands Neurological Centre. They advise that all current arrangements and transfer plans for the existing cohort will remain the same.

Five patients remain at the Moorlands Neurological Centre with all but 2 having placements. The remaining patients' placements are being managed by GOLD system calls within their own placing system and meetings are undertaken weekly with the Quality Team as Host Commissioner and NHSE.

4.2 Ivetsey Bank (formally Huntercombe)

A recent SKY news item and article in The Independent newspaper have raised concerns from last year regarding the management of young people at The Huntercombe Hospital (now Ivetsey Bank). NHSE Specialised commissioning and more recently Birmingham Women's and Children's Hospital who lead the Provider collaborative, take the formal lead in quality surveillance, however the ICB Quality and Safeguarding teams work very closely with them in monitoring quality and safety. The organisation has completed its action plan following last year's CQC Inadequate rating and a CQC inspection visit has recently taken place. The draft report is awaited and the ICB will continue to work closely with the lead organisations and the Ivetsey

Bank team to sustain improvements. Currently there are 32 patients, 11 of these have a Learning Disability and/or autism (LD/A). Staffordshire and Stoke on Trent currently have 4 residents in the hospital, none of these have a LD/A diagnosis.

4.3 Ambulance Service ED waits and delays

Ambulance handover delays continue to be a challenge across the system but particularly at the UHNM Royal Stoke University Hospital (RSUH). Long waits to offload at RSUH are also resulting in frequent delays in all categories of calls to WMAS. UHNM continue to undertake harm reviews on a sample of patients who experienced ambulance handover delays; to date no significant harm has been identified. WMAS continue to report serious incidents. Any serious incidents reported that are directly attributed to ambulance delays are subject to a thematic review with input from the ICB's Clinical Quality Improvement Manager. The CQRM, hosted by Black Country ICB, being held in December 2022 will be focussing on the outcomes from thematic reviews.

4.4 Infection Prevention and Control (IPC)

Providers across the system report a plateauing of Covid-19 outbreaks which reflects the regional picture as reported by the NHSE IPC team. Outbreaks are expected to remain at a similar level as winter months approach, resulting from increased indoor activity and community control no longer being in place. Healthcare providers continue to use risk assessments to support safe practice and enhance National IPC requirements when Covid-19 rates are noted to be increasing, including the reintroduction of face masks within patient facing areas in line with winter planning guidance from NHSE.

Influenza cases continue sporadically across Providers though not resulting in outbreak situations. An outbreak coinciding with a Covid-19 outbreak has now resolved. Providers across the system continue to encourage staff vaccination, concerns have been expressed regarding vaccine apathy. Adult social care report good vaccine uptake amongst care home residents.

MPFT continue to support the provision of antivirals, where required, for contacts of confirmed Avian influenza at the request of the UK Health Security Agency (UKHSA), with systems in place to also support swabbing, in line with guidance. No further outbreaks have been reported to IPC. Antivirals have been issued to staff managing disposal of birds having confirmed Avian influenza.

Monkeypox cases are noted to have slowed nationally with 3 cases reported across the UK during the week 24th –31st October. One case reported in London, one in North West and one in Yorkshire and Humberside regions. Zero cases were reported in 6 of 9 regions during this timeframe, including the West Midlands.

IPC services have supported colleagues across the system with advice and management of asylum contingency accommodation to ensure appropriate and timely intervention in promoting the health and wellbeing of those arriving in the area.

5. System Winter Plan

Prior to the System Winter Plan being received at Board for decision, the QSC received a paper demonstrating that had been developed in collaboration with all system partners and the plans – system capacity, system escalation and system workforce – that underpin it. System Medical and Nursing Directors are working collaboratively to agree thresholds and finalise a system escalation plan to mitigate the impacts for patients of enhanced winter pressures. Harm review

processes are also in place as part of the quality assurance approach across the system. The QSC were assured that the process undertaken was robust and supported the recommendations.

6. Quality Strategy

A draft Quality Strategy has been designed based upon National Quality Board Guidance and requires local system ambition adding. This was shared with the Quality and Safety Committee. A system group, involving leads from partner organisations, will support this work to progress at pace to enable prompt approval and implementation of the strategy.

7. Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services

A paper was presented to the QSC providing an overview of the governance arrangements for system oversight of the quality and safety of mental health, learning disability and autism inpatient services. The paper outlined the ICB's systematic quality assurance approach and how system partners work collaboratively to identify early warning signs of emerging issues or impacts including escalation processes.

The ICB has well-established arrangements in place to provide oversight of the quality and safety of these services, building upon the Host Commissioner Guidance published by NHS England in January 2021. It should be noted that the decision was made in 2021 to extend all areas of the oversight described by NHS England to all people placed in an inpatient service with mental health illness, learning disability and/or autism in Staffordshire and Stoke-on-Trent. Clinical Quality Review Meetings and Quality Standards Assurance Visits schedules are in place for Midlands Partnership NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust.

8. Voluntary Community Social Enterprise Sector (VCSE)

A Staffordshire and Stoke-on-Trent VCSE is being developed in accordance with national requirements and local ambitions. It will mirror the ICB and Place structures and is expected to be in place by April 2023. A Memorandum of Understanding (MoU) is being produced following a workshop with system partners earlier in the year and will clearly support the development of the ICS' relationship with the sector, and how the work will progress through the ICS Development Framework. There is a plan to present the final MoU to the QSC December meeting.

9. Inpatient Mental Health Services (South East Staffordshire) – Communications and Involvement Plan

The transformation programme for inpatient mental health services in South East Staffordshire has progressed significantly since the involvement activity in the autumn of 2021. The programme is now in the assurance phase with planning for potential public involvement in 2023. Work to support that activity is underway, supported by a Communications and Involvement Plan, setting out the approach being taken with regards to communication, engagement and involvement and the rationale for those actions. The plan is due to be shared with relevant stakeholders over the coming months and will continue to be updated as a live document.

10. Summary

In summary, the ICB Quality and Safety committee received the papers for assurance, discussion and information. These were well received and generated healthy discussion, which provided assurance that the challenges and risks that the system are dealing with are being managed to minimise harm to patients.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	4th October, 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Performance Report	Exception report focused on primary care, elective, cancer, urgent and emergency care, and mental health. Continuing concern regarding ambulances with delays showing a YTD position 300% above the 19/20 baseline. National support is continuing to assist with reducing delays. Performance against National Elective Recovery activity Ambitions, percentage to plan, has decreased across most indicators. 104+ week wait elimination will be very challenging but the system is working to achieve from end of October. 78+ week waits have decreased however in line with trajectory.	Challenges and plans regarding ambulance service to be discussed in more detail in November F&P. WMAS representation at F&P to be taken forward. Adult social care performance to be included in future reports. Cancer diagnostics continues to be a challenge. Investment into diagnostic facilities planned to increase capacity. Cancer Tele-dermatology business case for urgent skin referrals agreed which will reduce skin care backlogs.
Finance Report	The Committee received an update from each organisation regarding their current financial position. In a challenging environment, Trusts felt they had sufficient mitigants to still meet their Plan, although these are non-recurring, leaving the system with substantial challenge for 2023/24.	. Continued commitment to deliver year end breakeven position if possible, however net risks after mitigations suggest most likely outturn deficit of £20m driven by continuing covid19 costs; inflationary pressures above plan; recurrent efficiency shortfall.

	CHC remains a challenge for the ICB with a risk of £9.1m which is currently unmitigated. System outturn deficit risk of £20m continues to be flagged. Local authorities reported a significant financial challenge in year, and for 23/24. 48% of all System Saving PIPs are still in initiation phase, with all PIPs in Frailty Portfolio in initiation. Update on SSOT System Saving metrics evidenced significant achievement in meeting flat activity targets, with a full year effect forecasted financial difference of -£68.5m.	Deep dive into CHC activity / costs underway and will report to the November committee. F&PC to monitor progress of Portfolio PIPs.
Portfolio Deep Dive – Mental Health	Presentation of KPIs and mental health system performance dashboard, together with mental health priorities 2022/23; overview of community mental health transformation and provider collaboratives. Highlights include: mental health response vehicles to be in operation Q3 23/24; 8 MHSTs in place, rising to 12 by 23/24; gambling harm clinic established in Stoke-on-Trent; crisis cafes in development and 2 crisis houses in operation.	Key challenges include: workforce recruitment and retention; rise in number and complexity of referrals; neurodevelopmental provision; IAPT referrals below prevalence levels; variation across PCNs; estate provision. Opportunities for improvement around multi-agency working and crisis pathways, and review of commissioning priorities to deliver greater alignment.
Transformation Update	Presentation on progress against major transformation programmes including Urgent Treatment Centres, Community Diagnostic Centres, Inpatient Mental Health Services and Freestanding Maternity Birthing Units Update includes a helicopter view of all programmes and timelines to support forward planning	Revised ToR for Strategic Transformation Board have been developed and will be shared at next FPC
Winter Plan – Additional	Additional funding request for	Additional funding of £2.647m

Funding	unfunded schemes. Impact of schemes will be to: reduce ED waits; improve hospital flow; support admission avoidance; and mitigate workforce risks. Push on rapid access to respiratory care.	approved by F&PC (net pressure of £0.947m). Workforce is the highest risk. This risk is not fully mitigated. Further work underway regarding escalated bank rates which is likely to have financial implications. Full Winter Plan to come to November F&PC and ICB Board.
Approach to Strategy and Planning	Overview of approach to the development of the ICP Strategy, ICB Joint Forward Plan and 2 Year Operational Plan. Strategy will set ambition for our system and population and will build on JSNAs and HWB Strategies. High level with suite of supporting strategies. Forward and Operational Plans will be driven through the Portfolios.	Significant engagement across system is planned to produce the Strategy and Plans. F&PC will have oversight, with ICB Board sign off.
PART B		
ICB finance report – month 5	YTD position at M5 has improved to a deficit of £0.131m, however this does not represent an improved expenditure run rate, and year end deficit of c£9m is anticipated without corrective action. Forecast is shown as breakeven because a variance has not yet been agreed with NHSE, however the risk is not currently mitigated.	Work continues on areas of mitigation: stronger grip on CHC costs; agree slippage in other areas; review reserves to identify slippage against allocations. Board to be aware of risk to breakeven position.
ICB Procurement and Contracting Programme	114 contracts valued at £1.2bn due to expire in 2023. Procurement to proceed for 5 contracts which are currently in progress. Other specified contracts and grants should be continued on current terms for a further 12 months to allow a review as part of a wider transformation programme.	Continuation of significant number of contracts and grants for 12 month period to allow time for broader transformation programme to be developed. Procurement Oversight Group to be established. ICB Contracting and Procurement Strategy to be reviewed. Training programme to be delivered for ICB Executives and key staff involved in procurement.
Single Tender Waivers	Single Tender Waivers	Committee recommend approval to

	approved for non-contracted activity for high volume independent providers in relation to cataract surgery.	Board.
Acute Visiting Services for South Staffordshire	AVS service in South-West and South-East Localities to be extended until 31st March 2023, with further option to extend until September 2023 to allow time for the re-procurement of a newly commissioned Acute Visiting Service covering the whole of South Staffordshire.	Committee approved contract extensions, and recommended Option 2 to Board (AVS service for the whole of South Staffordshire) for future commissioning.

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

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Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	1st November, 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Performance Report	Key risks highlighted include: workforce due to sickness and vacancies; decline in MFFD performance; ambulance handover delays at RSUH are significant; 62 and 104 day cancer backlogs are continuing to increase; elective waiting list is continuing to grow; diagnostic performance is at 80.2% of 19/20 performance; high levels of patient acuity in psychiatric ICU negatively impacting on out of area placement bed days.	System working to deliver ambulance delay improvement plan, CRIS staff based in WMAS hub for 3 day pilot yielded significant benefits. Future long term implementation is being considered. Pathway specific task and finish groups being established to address backlogs in elective care. Business case for Community Diagnostic Centre in SoT due to be submitted in December. Cannock Chase bid has been approved. Tamworth bid with the national team.
Finance Report	No change to October position regarding individual organisations. System outturn deficit risk of £20.5m continues to be flagged. System delivered 83% of planned efficiencies, with £9.1m shortfall. 40% of efficiencies delivered through demand management. Recurrent efficiencies remain a challenge. Limited progress on moving forward 'in development' PIPs.	December committee will receive clear position on whether likely to achieve breakeven 22/23.

System Winter Plan and Ambulance Handover Plan	Committee reviewed and approved system winter capacity plan, escalation plan, workforce plan. Plan developed with all partners. Escalation plan places focus on system solutions to minimize and mitigate risks across system. Workforce plan focus on recruitment, retention and enhanced bank rates. WMAS Executive representation at committee for this item.	Plan also to be approved by ICB Quality Committee and at Board level at MPFT, UHNM, NSC, UHDB and November ICB. Risks: workforce supply due to vacancies, sickness and turnover; uncoordinated escalation action taken in isolation; resilience of care homes; UHDB capacity impact on SSoT; ambulance handover delays at RSUH; de-escalation of services by end March. Mitigation plans in place / being developed.
Draft Financial Strategy	Discussion on approach and focus of new system Financial Strategy.	Broad engagement across system to develop plans and refine the strategy before final sign off in March 2023.
Continuing Healthcare (CHC) Deep Dive	Detailed report into overspends in CHC providing assurance regarding governance and actions to mitigate challenges and risks.	Progress against action plan to be monitored by committee.
22/23 System Delivery Plan Q2 stock take	Progress report against 219 key deliverables. 21 deliverables 'at risk' of non-delivery, majority of these sit in UEC and Maternity portfolios.	
Workforce Update	Discussion on progress, key risks and mitigants in relation to system workforce plans. Workforce targets in the Operational Plan and Agency Spend targets are not being met.	
ICP Strategy and Joint Forward Plan Update	Update on work to develop the ICP Strategy and Joint Forward Plan and 2 Year Operational Plan.	
System Transformation and Service Change Update	Update on transformation programme. NHSE Assurance panel for inpatient mental health services previously provided at George Bryan Centre, scheduled for 30th November.	Further update to FPC following NHSE feedback session

PART B		
ICB finance report – month 6	Forecast is shown as breakeven because a variance has not yet been agreed with NHSE. At month 6 we continue to face a deficit risk of c£9m.	Focus on reducing CHC expenditure run rate and agreeing savings to other budgets to compensate. Board to be aware of ongoing risk to breakeven position.
Continuing Health Care – specific case	Discussion regarding complex CHC case.	Committee approved the recommendations subject to a clarification note which has since been issued

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

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Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Sally Young/Paul Brown
Date:	7th November 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Management	Following agreement of the ICB's strategic priorities, the committee received a verbal update on the progress to produce the ICB BAF. There was also considerable discussion regarding the latest Risk Register. It should be noted that there is good alignment within the system as this work is being co-ordinated by the System Risk Group.	Further work is required to improve risk definition, form of reporting, consistency in rating and ownership of risks. System risks will be shared with the Audit Committee members and agreed with System Chief Executives before the BAF is presented to the Board in December.
Financial Policies/Scheme of Delegation	Audit Committee agreed that delegated authority should be given to Finance and Performance Committee as proposed for: Single Tender waivers up to £2m Contract Awards up to £10m: Contract over-payments up to 5%: Revenue Expenditure over £2m: Consultancy expenditure and Business Cases up to £5m. There was considerable discussion around these proposals in the context of Internal Audit findings around procurement internal controls. The Committee were however satisfied that these are being adequately addressed and that the principles of devolved delegation should be supported.	The Board can take assurance from the discussion at the Committee and the proposed levels of delegation are commended for approval.
Lease Car VAT Refunds	A paper was considered regarding the outcome of a recent HMRC consideration of Lease Car VAT refunds on payments. It was agreed that SSOT employees with Lease Cars should receive the benefit of the decision in line with other Trusts.	Audit Committee felt that this report should be referred to Remuneration Committee for information only.
Final Audit Report for the CCG's 2021/22 and Q12022/23	Grant Thornton presented their final report for the CCGs for 2021/22. There are no matters of concern to be highlighted to the ICB regarding their Value for Money review which covered	Grant Thornton has created capacity to audit the CCG Accounts for Quarter 1 2022/23 and this work is now in hand.

	financial sustainability, governance and improving economy, efficiency and effectiveness	
Internal Audit update	A Progress report from RSM was discussed and some changes to the implementation dates for audit recommendations were agreed. Three Internal Audit Reports were received. Financial Feeder Systems (Substantial), Key Financial Controls (Reasonable) and Procurement and Single Action Tenders (Reasonable) Most discussion was centred on the findings around procurement and single action tender waivers. The Committee were assured that changes to the Procurement Policy, increased training, improved contract management and the embedding of "no PO no pay" arrangements will address the issues discussed.	Management have agreed implementation dates for all the Audits completed. Board is asked to note the concern expressed by the Committee that vacancies were cited for the reasons of non-implementation of audit recommendations by due dates in the Serious Incident and Medicine Management teams. This will be referred to the Quality and Safety Committee.
Counter Fraud Update	RSM presented their latest update report and progress in delivering each element of their plan including a detailed update on active cases. There were 4 active cases, 1 now closed and 1 referral which has not resulted in any further action. RSM also presented their Referral and Single Action Tender Benchmarking Reports.	Considerable work is being undertaken to promote the Anti-Fraud Education week 14th to 19th November.
Governance	The Committee received and discussed the latest FOI Report, Losses and Compensations and Single Action Tenders.	At its next meeting the Committee has invited the ICB's Payroll supplier to the meeting to discuss errors in pension deductions
Extension of Internal and External Audit Contracts	Both Internal and External Audit Contracts have the option for a two - year extension to the contracts. A proposal was considered and agreed in principle to extend both contracts	Commercial conversations will now follow with Grant Thornton and RSM.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee and specifically recommend the proposed financial delegations attached for approval.

Scheme of Financial Delegation Summary

- The Scheme of Financial Delegation's (SoFD) purpose is to provide clear instruction as to the financial approval authority of nominated officers/committees of the ICB.
- It was agreed at Audit Committee in July 2022 that a revised SoFD would be presented for revisions within the first six months of the ICB to ensure that approval limits were commensurate with the needs of the business.
- Primarily the changes proposed relate to the ICB Board delegating financial authority to the Finance and Performance Committee (summary contained in the table in the body of the slide).
- Other changes simply reflect the changes in job titles agreed since the formation of the ICB

Delegation of Financial Authority from ICB Board to Finance & Performance Committee

Description	Current FPC Approval Limit	Proposed FPC Financial Limit
Approving Single Tender Waivers	£0	Up to £2m
Awarding Contracts	£0	Up to £10m
Approving Contract Over-performance	£0	Up to 5% of contract value
Approving Individual Revenue Expenditure	£0	Over £2m
Approving Consultancy/Agency Expenditure	£0	Unlimited
Approving New/Additional Investment Business Cases	Up to £1m	Up to £5m

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Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal
Executive Lead:	Alex Brett
Date:	14.09.2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	Story of an ICS Health and Care Apprentice, their journey into a career in Health and Care, receiving support via a Traineeship programme https://youtu.be/sFWcJw4GMd0	To be shared as part of the ICB Board
People Culture and Inclusion Governance	Members and Chair noted the work undertaken to transition the Committee to a formal subcommittee of the ICB Board Risk register reviewed and now included in the ICB risk register. People Culture and Inclusion Programme delivery assurance report was noted by the Committee.	Risk register to be included in ICB register
People Metrics	People Metrics noted by the Committee, acknowledging the reduction in sickness but an increase in turnover in line with national figures. From the WRES data, it was noted that the BME workforce representation is lower than regional and national levels however we are excelling in disparity of the non-clinical lower AfC bandings. Committee acknowledged a significant improvement in the metrics provided and the progress made towards understanding the system workforce position. Future	Partners agreed to work together where appropriate and possible to develop workforce solutions which address the challenges. Specific projects & actions in progress within the People and OD, Leadership And Inclusion Programmes including Retention, Recruitment, Health and Wellbeing and Staff Psychological wellbeing hub. To be discussed and addressed via People Culture and Inclusion Programme Boards

	reporting and metric development was outlined.	
Workforce Supply and Winter Planning	Approach to Winter planning and supply outlined. Workstreams to address the supply issues include ICS Reserves, escalated bank rates, recruitment to providers and staff retention	Committee requested this be a standing agenda item through the winter period
Operating Plan	The Committee noted the operating plan projections and current position. Assurance could not be given re meeting Operational Plan target in year due to potential lack of workforce supply however mitigations in place to support this.	Ongoing agreement of partners to work in collaboration to increase workforce supply and share workforce data to enable targeted initiatives in relevant service areas. Committee requested this be a standing agenda item
Agency	The Committee noted the ICS agency spend and performance. Assurance could not be given re meeting the agency ceiling in year due to lack of workforce supply and subsequent clinical risk.	Ongoing agreement of partners to work in collaboration to reduce agency spend at system level. Ongoing work with region
ICS Retention Programme	ICS Retention programme update provided along with the proposal for the next phase. The committee noted Retention is a significant issue but also a solution for the supply risks.	To link with the OD, Leadership, HWB and Inclusion Programmes Committee requested this be a standing agenda item
Primary Care and GP Workforce	Members noted the contents of the Fuller report and local GP workforce position. The Committee was assured that the system has in place several schemes and initiatives being driven forward collaboratively to support our General Practice workforce.	No action or escalation required

Risk Review and Assurance Summary
The People Culture and Inclusion Committee noted the significant challenges in workforce supply, achieving the workforce growth and the Agency reduction target. The Committee is assured that the action and solutions are in place to address the challenges, and continue to be developed in collaboration with system partners

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Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal
Executive Lead:	Alex Brett
Date:	09.11.2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	Story of a High Potential Scheme Graduate, Sarah Jeffery. Sarah shared her experience of this innovative and inclusive scheme and how she has grown as a leader as a result.	Story to be shared with next ICB Board
People Culture and Inclusion Risks	Risks noted and discussed by the Committee. It was acknowledged that the workforce risks are a golden thread throughout the system. Members were assured that the risks are being managed and addressed within organisations and collectively at system level through People Plan delivery.	Included in ICB Risk Register
People Metrics and Assurance	People Metrics were discussed and it was acknowledged that the system position remains challenged. The Committee acknowledged the programme activity within the People and OD, Leadership And Inclusion Programmes to address the workforce challenges, however the metrics are still. The Committee recognised it was maturing well in its approach to governance and Assurance.	To be discussed and addressed via People Culture and Inclusion Programme Boards
Social Care Workforce	Skills for Care and	Social Care workforce to feature

	Staffordshire County Council Colleagues presented a summary of the State of Adult Social Care sector and workforce report. SCC updated on the progress of their Workforce strategy, developed in partnership with system colleagues. The Committee acknowledged the significant challenges across the sector and the importance of integrating planning and action across NHS and Social Care	regularly, in an integrated way, at the PCI Committee Proposal for January PCI Committee Staff Story to focus on Social Care The ICB Board is asked to note the significant challenges to Social Care workforce
Workforce Planning	The current Operating Plan position was highlighted and noted. The winter planning process was discuss and the Committee was assured by the process followed to develop the workforce plan and implement. Workforce planning and challenges were highlighted across Maternity and Learning disability and Autism.	No action or escalation required
Staff experience and Looking after our People	The ICS retention programme highlights were presented to the committee with a summary of Phase 1 and Phase 2 activities. National funding received to appoint an ICS Retention lead.	Regular PCI Committee agenda item. Update on Phase 1 evaluation and outcomes requested at the next PCI Committee.
Culture and Leadership	An overview of the HPS scheme and Scope for Growth programmes provided. It was acknowledged that the second HPS scheme was about to launch, with 60+ applications from across the system	No action or escalation required

Risk Review and Assurance Summary

The People Culture and Inclusion Committee noted the significant challenges in workforce supply, achieving the workforce growth and the Agency reduction target. The Committee is assured that the action and solutions are in place to address the challenges, and continue to be developed in collaboration with system partners

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Board Committee Summary and Escalation Report

Report of:	ICB Quality & Safety Committee
Chair:	David Pearson
Executive Lead:	Heather Johnstone
Date:	9 November 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register	The current highest risks are related to Maternity Services. The detail of these were discussed within the agenda. . In addition, there is piece of work led by governance to align the Quality & Safety risks with others within the ICB risk register All quality and nursing risks have collective and organisational actions in place to mitigate risk	The Committee reviewed the risks. Maternity risks require merging prior to the next Quality & Safety Committee.
ICB Quality and Safety Committee Terms of Reference	The ICB Quality & Safety Committee approved 2 changes within the quoracy to ensure health only related discussions are not delayed by LA colleagues not being able to attend	
System Quality Group	The ICB Quality and Safety Committee received an assurance paper with the exceptions from across the system. The second meeting went well, but there were at least 3 system partners who did not attend. This was highlighted to system partners in the Committee to ensure full contribution to this core meeting.	The specific relevant exceptions are included in the Quality report presented to the ICB.
Quality Strategy	Draft Quality Strategy was presented for comment.	

	System partners attending the committee demonstrated their commitment to collaboratively develop the quality strategy and attend a workshop in December 2022.	
Sub-Group Updates 1. Local Maternity & Neonatal Services (LMNS) 2. QIA 3. Continuous Quality Improvement	1. The Committee received the updated position of the LMNS following actions agreed from its last meeting in October 2022. Pressure within the system continues and daily sit reps are received within ongoing monitoring of the situation in close liaison with staff at UHNM. 2. The QIA report provided an overview of the Quality Impact Assessments (QIA) work to date and next steps, demonstrating progress toward a system wide QIA process. 3. Update paper demonstrated the work being undertaken within the CQI Sub-Group.	1. Daily monitoring continues in partnership with UHNM. There has also been an escalation meeting under the new Rapid Quality Review Process with Trust and NHSE. This has confirmed the actions that the system is taking to support the Trust and a joint action plan will be developed.
Papers received for assurance 1. Quality & Safety of Mental Health, Learning Disability & Autism Inpatient Service 2. Inpatient mental health Services (South East Staffordshire) Communities and Involvement Plan 3. System Winter Plan	All papers received for assurance. 1. Recognition of the system's current proactive approach to quality and safety of mental health, learning disability & autism inpatient services, which has also been recognised externally. However, further discussions with MH NHS and non NHS providers will progress and enhance this work further. 2. The committee received the communications and involvement plan, setting out the rationale and approach to communications, engagement and involvement activity for the development of inpatient mental health service (South East Staffordshire). 3. The Committee received the winter assurance plan presentation for recommendation to approve.	3. The Quality and Safety Committee reviewed and supports the recommend approval of the System Winter Plan.

Papers received for information 1. Staffordshire & Stoke-on-Trent Voluntary Sector Alliance Development		

Risk Review and Assurance Summary
The ICB is requested to note there continues to be challenges related to the provision of maternity services at UHNM. It is also asked to receive assurance that the risks are known, mitigations are in place and their action plans will continue to be closely monitored. This will be overseen by the CNO and the ICB Quality and safety Committee in partnership with UHNM.