NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 18 January 2024

12.30pm-2.30pm

Stoke City Council, Council Chamber, Civic Centre, Glebe Street
Stoke-on-Trent ST4 1HH

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

	Agenda Item	Lead(s)	Enc.	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	12.30pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 21 December 2023 and Matters Arising	Chair	Enc. 03	A		5-21
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		22
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	12.32pm	
7.	Community Story – Bala Sankarasubbu		Enc. 05	I	12.40pm	23-24
	Strategic and System Development					
8.	ICB Chair and Chief Executive Update	DP/PA	Enc. 06	D/I	12.55pm	25-32
9.	PWC Report on Financial Recovery Plan and Grip & Control	PB	Enc. 07	D/I	1.10pm	33-99
	System Governance and Performance					
10.	Quality and Safety Report	BS	Enc.08	S	1.25pm	100-104
11.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB/PS MN	Enc. 09 Enc. 10	S	1.35pm	105-117 119-124
12.	2024/25 Planning	PB	Enc. 11	S	1.50pm	125-138
13.	Freedom to Speak Up Policy	TS	Enc. 12	R	2.00pm	139-156
	Committee Assurance Reports					
14.	Audit Committee	JHo	Enc. 13	S	2.15pm	157-159
15.	People, Culture and Inclusion Committee	SL	Enc. 14	S	2.10pm	160-172
	Any other Business					
16.	**Items notified in advance to the Chair**	All		D		
17.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.20pm	
18.	**Meeting Effectiveness**	Chair				
19.	**Close**	Chair			2.30pm	
20.	**Date and Time of Next Meeting** 15 February 2024 at 1.00pm held in Public – via Microsoft Teams					

ICS Partnership leadership compact

Trust

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

Courage

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

Openness and honesty

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

Leading by example

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

Respect

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

Kindness and compassion

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

System first

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

Looking forward

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

NHS
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Stoke-on-Trent
Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2023-2024
INTEGRATED CARE BOARD (ICB)
AS AT 08 JANUARY 2024

Kev

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

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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
1st April 2023	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2023	Mr	Peter	Axon	CEO ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
6th April 2023	Mr	Chris	Bird	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim Chief Transformation Officer, NHS Staffordshire & Stoke-on-Trent ICB until 31.07.23. Substantive role - Director of Partnerships, Strategy & Digital , North Staffordshire Combined Healthcare NHS Trust (April 2023 - July 2023)	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (April 2023 - March 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
2nd August 2023	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014-March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
26th July 2023	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.	
3rd April 2023	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Charity Trustee of Royal British Legion Industries (RBLI) who are a UK wide charity supporting military veterans, the unemployed and people with disabilities (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
6th December 2023	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
1st April 2023	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st April 2023	Dr	Paddy	Hannigan	Clinical Director for Primary Care	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Salaried GP at Holmcroft Surgery integrated with North Staffordshire Combined Healthcare Trust and contract responsibilities taken over by NSCHT (1st January 2020 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.

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

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

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Minutes of the Meeting held on Thursday 21 December 2023 1:00 pm - 3.30pm Via Microsoft Teams

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

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓			
Alex Brett (AB) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✖						
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓	✖	✓	✓	✓	✓	✓			
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✖	✓	✓	✓	✓	✓	✓	✓			
Steve Grange (SG), Midlands Partnership University NHS Foundation Trust		✓	✓	✖	✓	✖	✖	✖	✖			
Helen Ashley (HA), University Hospitals of North Midlands NHS Trust			✓	✖	✖	✓	✖	✖	✖			
Claire Cotton (CC), University Hospitals of North Midlands NHS Trust		✓	✓	✖	✓	✓	✖	✖	✖			
Lynn Tolley (LT) Acting						✓	✓	✓	✓			
Richard Harling (RH) Staffordshire County Council								✓	✖			
Chris Sands (CS), Chief Finance Officer, Midlands Partnership University NHS Foundation Trust				✓				✓	✖			
Helen Dempsey (HD) Director of Finance & Performance, Staffordshire & Stoke-on-Trent ICB				✓					✖			
Mish Irvine, Chief People Officer, Staffordshire & Stoke-on-Trent ICB (People Directorate, Midlands Partnership University NHS Foundation Trust)				✓	✖	✖	✓	✓	✓			
Karen Webb (KWe), Deputy SRO Learning Disability and Autism, Staffordshire & Stoke-on-Trent ICB					✓							
Katie Weston (KW), EPRR Strategic Lead, Staffordshire & Stoke-on-Trent ICB					✓							
Jacqui Charlesworth, Deputy Finance Director, Staffordshire & Stoke-on-Trent ICB							✓	✓	✖			
Rachel Gallyot, Staffordshire & Stoke-on-Trent ICB							✓					
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✖	✓	✓	✓	✓			
Kay Johnson (KJ), Executive Assistant, Staffordshire & Stoke-on-Trent ICB					✓							

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting. DP advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP reminded member of the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and it guided the way they conducted business and he would return to that at the end of the meeting It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Simon Fogell.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 16 November 2023**	

	The minutes of the meeting held on 16 November 2023 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
5.	**Action Log**	
	There were no actions to review.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	No questions were received from members of the public in advance of the meeting.	
7.	**ICB Chair and Chief Executive Update**	
	DP mentioned that he had received requests for a general briefing to be available for partners in the system and had agreed to provide. DP gave his thanks for the efforts of everyone involved in terms of their involvement in the Urgent and Emergency Care (UEC) and Industrial Action over the last few months. PA reported that planning work was well set for this year's activity and was in progress and they were in a decent position in terms of UEC. For the medium to long term, he acknowledged that they had significant financial pressures and that the key was to focus on that here and now, but also to have equal focus on the proactive agenda. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
8.	**Decision-Making Business Case (DMBC) for the long-term solution for Inpatient Mental Health Services previously provided at the George Bryan Centre**	
	It was noted that MN and NC reported conflicts of interest in this item and would withdraw from the discussions and would not have a formal vote on the Board decisions. CB recognised that they were inviting the Board to consider a significant recommendation which was reflected in the extent of material that was published with the DMBC, associated appendices and report of findings on the public consultation exercise. It was noted that the latest reports build on previous decisions taken by the Board, notably the Pre-Consultation Business Case which was approved at the meeting of the Board in January 2023. In supporting the Board navigate the material they had developed a set of slides which drew particular attention to some key elements. CB advised that he and HS would take the Board through an overview of the background and outlined the outcome of, and responses to, the public consultation exercise. CB reiterated that there were important procedural elements that were needed to ensure were covered as part of the governance requirements when considering major service change. CB confirmed that the presentation did not replace the DMBC but would act to draw emphasis to specific elements:- • To demonstrate compliance with national service change guidance – Planning, Assuring and Delivering Service Change (PADS) • Alignment with national and local strategy • Share process, outcomes of and responses to public consultation	

	CB advised that the decision-making responsibility for service transformation, under the Health and Social Care Act, is held by the Staffordshire and Stoke-on-Trent Integrated Care Board. CB explained that The George Bryan Centre (GBC) was a facility providing inpatient mental health services to people living in SE Staffordshire: The West Wing had 19 beds for adults aged 18 – 65 with severe mental illness (SMI) The East Wing had 12 beds for adults aged 65 and over with SMI and/or dementia. Following a fire in February 2019 all patients on the West wing were safely transferred across to St Georges Hospital in Stafford. The East Wing was closed shortly afterwards on safety grounds. An enhanced community service had been established and continued to offer support to the local communities. CB felt it was important to note that the patient profile for services at GBC usually had low-risk/less complex needs: • Just 1 in 4 patients from the areas around the GBC went there if they needed a hospital stay • More seriously ill patients went to St George's Hospital, Stafford / other specialist settings • Sometimes GBC patients were transferred to St George's Hospital as it was better able to meet their needs CB ran through the chronology of events and actions undertaken since January 2023 when they last presented to Board. They worked very closely with colleagues at the Staffordshire HOSC, ultimately they decided the proposals should not be considered as major service change and opted not to be formally consulted. However, the ICB agreed to proceed with a public consultation to ensure all views were taken into consideration prior to decision making. The 6-week public consultation ran from 9 February to 23 March 2023, which included a midpoint review and the production of the report of findings and development of the DMBC. CB reminded members that prior to the PCBC coming to Board in January 2023, the clinical model had been assured by the West Midlands Clinical Senate and compliance with national guidance was assured through NHSE. It was noted that the report of findings had been presented to ICB Quality & Safety Committee and the Finance & Performance Committee, who concluded that all elements of due process had been followed and the final report could be presented to Board. CB advised that diagram 1 of the Business Case outlined the full service change process they had been through and demonstrated the alignment of those proposals with national and local strategies. He reported that clinical evidence showed that most patients get the best outcomes if mental healthcare was provided in the community, rather than in a hospital. Getting the right support and treatment, while living in their usual home with loved ones close by, gave people the best chance to recover and stay well. For older adults with dementia, clinical evidence suggested that hospital stays did not help due to the increased risk of losing their independence.	

	Prior to, and since the fire, MPFT had invested to enhance community mental health services. CB explained that Section 2.2 of the DMBC outlined the alignment to local and national strategy in more detail and reminded members that the PCBC included a statement of support from Ben Richards, Chief Operating Officer NSCHT, in his capacity as SRO for the ICS Mental Health, Learning Disabilities and Autism Portfolio. CB added that an important feature of the changes introduced since 2019, which was proposed to continue as part of the recommendations to Board, was the enhanced community model. For patients experiencing mental ill-health this was provided through a range of improvements including - access to care – mental health helpline, self-referral or Mental Health practitioner in primary care; Personalised care – considering wider determinants that impact on mental health as well as treatment of the symptoms of Mental Health; Integrated working – across professionals, teams and organisations and Crisis support For support to older adults, the enhanced model included Dementia & Memory services; Home Treatment; Hospital Avoidance; Crisis Support and Coordination of other support services, including signposting for further information & advice, or services that offer support and company CB advised that the ICB public consultation, approved by the Board and supported through legal advice and NHSE, detailed one viable proposal which was to maintain the 18 beds at St Georges as per the temporary service model they had in place now for in patients with severe mental illness, supported by the community service for SMI and dementia. That proposal would provide Improved clinical safety, because of the range of specialist staff and facilities at St George's Hospital; Sustainability in terms of staffing as it was easier to recruit and keep staff at a bigger specialist hospital; Improved patient care and outcomes because of the range of therapies and interventions available on site and Enhanced community services which would mean more people could be cared for in the community, supporting long-term wellbeing and independence. CB handed over to HS to give an overview of the 6 week public consultation. HS confirmed that the public consultation was planned and delivered in line with national guidance, good practice and the statutory 'Duty to Involve' and was underpinned by the Gunning Principles. The consultation was launched on 9 February 2023 and ran for 6 weeks until 23 March 2023. She added that alongside the MLCSU, who ran the consultation on behalf of the ICB, they commissioned Support Staffordshire as a delivery partner, as it was recognised that they were able to reach communities who might not engage directly with the NHS for example specific minority ethnic groups, people in the most deprived areas, men aged 65 and over and people involved in substance misuse In preparation for the consultation, a range of promotional activities were identified which included traditional stakeholder messaging as well as utilising social media. HS advised that the Communications and Involvement section of the full report of findings provided detailed information on how they reached and involved people. She added that to support the consultation, a range of documents were developed in both hard copy and online, to ensure they shared consultation information in the most	

	accessible ways. There were a range of resources available via the ICB website such as short animations and case studies. Throughout the consultation, they held two online events, Support Staffordshire engaged with 81 respondents in addition to those the ICB engaged. HS explained that during the consultation, they collated information regarding the demographics of people who completed the survey or who participated at events. Although the consultation was carefully promoted, the number of people who took the opportunity to respond was lower than anticipated but the detail of comments was rich and informative. 32 respondents were users of mental health services and 50 respondents were carers. Participants were asked if they had used either St George's or the GBC. For both sites there was a mixture of positive and negative feedback regarding the facilities and staffing model. HS stated that it was important to note that 49 (45%) respondents were from the most deprived areas. **Clinical Model for Severe Mental Illness** HS reported that the survey feedback on the clinical model and the enhanced community model for supporting people with severe mental illness and the responses. They recognised the negative comments were higher in number than the positive and also the concerns such as access, suitability of the model for all and the sustainability of staffing such a model. HS advised that during the engagement sessions with specific communities, participants were asked to what extent they thought the care model was a good one. In response, the most frequently mentioned themes were: • Consider the need for better mental health support locally (12 / 36%) • Access and in practice, whether the pathway was as smooth as described in the model (5 / 15%); • Health and wellbeing – Considering the negative impact a lack of community support has on patients and their families (5 / 15%); • The care model was good (5 / 15%). **Clinical Model for Dementia** HS reported for the survey feedback on the clinical model and the enhanced community model for supporting people with dementia and the responses, the positive comments outweighed the negative but the responses also reflected the impacts such a model had on carers. She advised that during the engagement sessions with specific communities, participants were asked to what extent they thought the care model was a good one. In response, the themes most frequently mentioned were: • Health and wellbeing – Being close to home was better for patients with dementia than being in a hospital (7 / 21%) • General – The new care model was good (6 / 18%) • Safety – Concern over the safety and security of patients with dementia (for example, lack of supervision in community) (5 / 15%) **Consultation responses – the proposal** HS outlined the survey responses in relation to the proposal to make permanent the temporary service change of maintaining the 18 beds for severe mental illness at the St Georges site in Stafford supported by the enhanced community offer.	

	She advised that the responses were predominantly negative, with concerns around travel in relation to the time it would take to visit a loved one if the carers lived in the South East area, the impact of the cost of travel, particularly those from disadvantaged backgrounds and they recognised that a proportion of respondents did come from deprived areas. During the engagement sessions with specific communities, participants were asked to what extent they thought the proposal was a good one. In response, the themes most frequently mentioned were: • General – The proposal is not a good solution (for example, unrealistic) (5 / 17%) • Access – Concern over the location of the services (for example, too far to travel from some parts of Staffordshire) (4 / 14%) 3 • Cost and efficiency – Concern over the lack of hospital beds to meet demand (3 / 10%) **Impact on Groups** As outlined in both care models and the proposal, the top themes in feedback emphasised negative impacts for older people, those with dementia, carers, family members and visitors **Travel** HS advised that one of the survey question was: To what extent are you concerned about travel for visitors under this proposal? 46 people responded and HS outlined the concerns and feedback from respondents on how the ICB could support carers if they had difficulty with travel. These included to consider providing transport for visitors (11 / 39%) and consider the need to align visiting times with public transport timetables (6 / 21%). Other suggestions included flexible visiting times, volunteer drivers, and keeping the café open during visiting times. **Use of Technology** Within the consultation respondents were asked about the use of digital technology. Whilst digital technology could provide support for patients and carers to keep in contact during an in-patient's stay, there was a benefit of having face to face contact to aid recovery and the notion that nothing can replace the benefit of a hug. **Carers** HS reported that although the survey did not ask a specific question about impacts on carers and families, they had received feedback on this topic in answers to many other survey questions (on the clinical models, impacts on groups, and travel and technology). HS proved a selection of comments that were received:- Feedback on Clinical Model – "Community care puts more responsibility on family and friends. This may not be in everyone's best interest." Feedback on the Proposal – "Many families would be unable to afford travel" "Chronic and aged carers" [would be disadvantaged] Feedback on questions about travel and use of technology – "To get to Stafford is a 60 mile round trip for our most vulnerable people." "Many visitors are older or do not drive."	

	"This [use of technology] relies on friends and family having internet access at home and not everyone has access, particularly those supporting someone which dementia who may be older themselves." **Technical Group** – report of findings. The one viable proposal remains. HS advised that the full report of findings was reviewed in June 2023 and the group concluded there were no proposals outlined within the consultation feedback that had not been considered previously, however the technical group were keen to ensure that the prominent themes outlined within the feedback were explored further and all impacts were reviewed again in light of these. Therefore, one viable proposal remained – making permanent the temporary change and maintaining inpatient mental health services at St George's Hospital. It was agreed that impact assessments would be updated to reflect the feedback and any mitigations and to progress to a decision-making business case (DMBC). HS reported that MPFT's mitigations were outlined in the Quality Impact Assessment and Equality Impact Assessment and had been signed off through the ICB governance process. MPFT had developed a Standard Operating Procedure (SOP) to support people on low income and following the consultation the SOP had been revised to increase the payment per mile and eligibility criteria. The enhanced community mental health offer for people who could be cared for without an admission would provide a service in that person's usual place of residence. This had been recognised as a positive impact for people with disability, removing any barriers to access for the patient or carer. It was also a positive impact for age, as for people with dementia (which impacted more on people over 65 years old), the transformed and enhanced community offer would ensure they could receive appropriate care, in their usual place of residence where possible. HS added that in addition to the travel impacts, the technical group took into consideration the impact on patients and carers and how the ICS could provide support, some of this was built on support developed during Covid-19. However, through the digital programme there was a range of support offered via the MPFT clinical and support teams HS advised that feedback received during the public consultation about the need for greater support for carers, with participants noting that carers may require greater support, particularly out of hours, that peer support could be useful and that some carers struggle to access carer's allowance. The ICB recognised for those carers supporting loved ones with dementia a wealth of information would be shared at time of diagnosis but MPFT and partners were looking at range of ways to ensure information was accessible and timely:- • Hospital Avoidance team, which included older adult specialists and offered phone calls and home visits. Carers could call for help in a crisis • A new home sitting service to support carers who needed a break during the evening or at weekends • Working with the Alzheimer's Society to support patients and carers post-diagnosis • Improving partnerships with system partners such as Staffordshire County Council to improve and join up care for dementia patients and carers • Developing a 'message in a bottle', which was kept in the fridge and contained useful information for patients and carers. This was expected to be implemented in April 2024 • Providing accessible information on their website – MPFT were currently working with parents and carers to look at simplifying the language used	

CB gave a summary of the proposal :-

- Make permanent the temporary change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer
- Aligns with national and local policy
- Centralised site more sustainable in terms of workforce and clinical safety
- Improved care and access to crisis support and specialist services for patients
- No capital resource required, and no adverse impact on the revenue position

DP referred to Section 11.2 which was helpful regarding ongoing change and the governance arrangements it recommended that the monitoring arrangements were enacted and that if the decision was taken today by the Board that these be brought back to future meetings. He also referred to Robert Peel and ask if the model of care had been put into place, whether it was on schedule and that Tamworth would receive that enhanced location.

HS confirmed that Cherry Orchard was one of the centres that would support the enhanced clinical model and that it was on plan.

JS understood the impact on patients around the new enhanced model and asked what would that look like. Nicky Bromage answered that prior to 2019, they had a lot of feedback from those who had loved ones with dementia and the services were not in place to help with the people with those needs. She added that since the change to enhanced models, they have put in additional staff to help with those patients. JS then asked how sustainable the model was. NB confirmed that the roles were far more attractive, notwithstanding the workforce challenges through the NHS.

JHo referred to the assurance around the consultation process and the improved and enhanced community model and asked what would have been the likelihood of getting capital funding and what would happen to the building.

CB confirmed that the capital allocation was fully allocated for the year. He added that the estate was out of scope of this consultation and the question of that estate would be for MPFT as the owner of that asset.

HS advised that they worked closely with a third party to fine tune some aspects of the consultation and sought advice from the Consultation Institute who reviewed the business case before finalising it.

JR stated that he had no problem with the model for severe mental illness in adults but was concerned about the dementia and care at home and they would lose those specialist beds. He asked that they, as a Board, could agree to take a full review of those EMI review portfolio leads.

NB confirmed that the beds at St George's would still take patients with dementia if needed. The response around keeping people safe in their homes, she added that the enhanced model would provide that and they would also welcome to do that with social care.

BA commented that as it stood now, it was currently going through Frailty Group and it was important to have joined up care and taking it into the Mental Health Portfolio.

JR felt assured about the dementia and care at home, but had not had a satisfactory answer for the EMI review on portfolio leads.

	PF stated that they needed to understand about the ongoing monitoring and receive feedback on the decisions that they made. PF commented that they knew where there was a lack of capacity at acute level and he would like a reflection down the line that this had been achieved and what they want it to achieve, in perhaps in 6-12 months' time. BA stated that the work they had done at NSCHT was key to people with dementia and was to ensure they had the right placement. She felt that when they came back in 6 months' time, it would demonstrate the great care that had provided. JA regarding those that need further care, he hoped that the enhanced care was not just to one area but it would be included where it was needed elsewhere. There no questions received from the public. The Staffordshire & Stoke-on-Trent ICB Board **UNANIMOUSLY APPROVED** the recommendation to make permanent the temporary change and maintain inpatient mental health services at St George's Hospital, supported by an enhanced community service offer.	
9.	**Interim Aligned Assisted Conception Policy**	
	PEJ advised that involvement work for the Clinical Policy Alignment programme (previously known as Difficult Decisions) began in 2020. This looked at five procedures, including Assisted Conception. The policies for these five procedures were different in some areas. PEJ explained that the former 6 CCGs, now the Integrated Care Board (ICB) began to work together more closely and it became obvious that the policies for excluded and restricted procedures were different in some areas and they needed to align those policies across Staffordshire and Stoke-on-Trent. Some of the exclusions and restrictions had also not been reviewed for some time. The aim was to make them the same for everyone PEJ confirmed that the ICB Board made decisions for the other four procedures and these were presented to the Overview and Scrutiny Committee (OSC). PEJ gave some background as to why they were looking at the CPA interventions via public involvement. He confirmed that these areas had been through CPAG and had either fallen below the threshold or the CPAG recommendation was to commission against eligibility criteria (Hearing Aids). The CCGs at the time noted that further work was required to understand any potential impact on patients prior to aligning these policies and therefore it was agreed that public, patient and stakeholder involvement would be undertaken to shape proposals that would inform the future commissioning policy in line with the Integrated Care Board's Duty to Involve. PEJ confirmed that while they were developing the proposals for assisted conception services, the Women's Health Strategy was published which promised a review of fertility provision across England. The strategy did not say whether ICBs would need to implement mandated access criteria, but it intended to initiate a review of geographic variation, address inequities of provision and remove any non-clinical criteria that are in place. He added that the strategy did not provide an estimated timeline for any policy mandates. However, a review of current NICE guidance had been initiated with expected publication in November 2024	

PEJ advised that in September 2022, the ICB agreed to separate assisted conception from the Clinical Policy Alignment programme and pause further work on the long-term proposals until further guidance is released and instruct the Chief Medical Officer to ensure that an interim aligned Assisted Conception policy was developed while they awaited further guidance from the national review of service provision.

Following approval of recommendations at the ICB Board meeting, the project team, working with clinicians, began to review the current policies and develop a draft interim aligned policy.

Once updated guidance was received from the national review, they would look to see whether the interim policy needed to be changed in any way

PEJ reiterated that the scope of the review was to align criteria that was different. This was an interim policy while awaiting further guidance and a review of the policy in its entirety would be completed once further National Guidance was received.

GG gave an overview of the process that was undertaken. It was noted that there would be an implementation period if the policy was approved. She reiterated that the technical group formally received the report of findings following the feedback, considered whether any further involvement was required and reviewed the initial proposals that were included in the policy that was released through the involvement to understand if any changes to the proposals were required.

Involvement Plan
GG confirmed that the identification of key groups was based on the 2018 Equality Impact Assessment (EIA) for the full transformation programme and a gap analysis was carried out in 2021 on all the involvement to date. This was done to provide a sense-check of whether they were meeting involvement best practice and guidance:

- The two pieces of equalities work identified key groups with protected characteristics that we should proactively engage with if a service change was proposed. For assisted conception we have identified these groups as
- People aged 35–45
- LGBTQ+ with a focus on the Trans community and single-sex couples
- The working well and the working unwell
- Ethnic minority groups.

GG advised that the involvement activity included:

- More than 150 stakeholders were contacted;
- Information leaflet and accessible leaflet created;
- Online surveys open for 3 weeks with 96 responses to the main survey and 11 responses to the accessible survey - 107 responses in total
- Involvement promoted through social media
- Online events on 15 March, afternoon with 2 participants and 20 March, in the evening with 5 participants

Summary of findings
GG confirmed that they had received both negative and positive feedback.

When considering the impact of the draft interim policy, most respondents (102 / 95%) said it would have a negative, or very negative impact, on themselves or others.

The key reasons given for this negative response were:

- the impact of reducing the number of cycles and embryo transfers offered would be negative
- reducing the number of cycles offered goes against NICE guidelines

	• the policy excludes specific groups, like same-sex couples, single women and patients with low Anti-Müllerian Hormone (AMH) • participants felt the policy was discriminatory/unfair • the policy is not in line with other organisations' / NICE guidelines. Participants also said they needed a greater understanding of the draft interim policy, asking for more information around the types of embryo transfer available and how changes will be made in line with NICE guidance The increase in age limit was considered positive by some survey respondents. Survey respondents and event participants made several suggestions about how to avoid negative impacts. The most frequently mentioned suggestions were: • providing the number of cycles in line with NICE guidelines • making sure that the policy is inclusive and fair • providing more cycles of IVF treatment • ensuring the policy does not discriminate against certain groups, like same-sex couples, single women and patients with low AMH The biggest theme that came across was increase in cycles and embryo transfers. GG confirmed that a formal response letter was received from Fertility Network UK who expressed concerns about the following five points: • The provision of only one embryo transfer – for example, they cited concerns about the ethical implications of creating embryos that will not be funded for transfer • The limit of 12 months' storage – they said this was the lowest they had seen offered by an ICB • The proposal not to commission donor eggs – they requested an explanation of the proposal, noting that donor eggs were previously commissioned by four of the CCGs for women with some specific conditions • The proposal not to commission treatment for single infertile women – the concerns were that this was not in line with the Women's Health Strategy (WHS) or with UK government policy, which encourages single women to adopt children • The proposal for same-sex couples – there was an objection that the proposed policy was not in line with the WHS guidance, and that the requirement for single-sex couples to have had six cycles of self-funded donor insemination/IUI during the previous 12 months was not reasonable, as the timeframe was too short. Summary of the proposals and associated impact: GG reported that there were a number of proposed changes listed within the paper where there was no anticipated impact on activity. GG highlighted the areas where there was an impact on activity within the presentation. The proposed number of cycles would result in a decrease in provision in Stoke-on-Trent regarding the number of cycles and the number of embryo transfers. For gamete and embryo storage, the original proposal was 1 year storage but during the technical group the recommendation was amended to 3 years after consideration of feedback recognising that people may need additional time to consider their options. The change to the upper age limit in North Staffordshire is expected to lead to an increase in number of cycles per year for that area. The recommendation to commission donor eggs for certain clinical indications within Stoke-on-Trent and North Staffordshire is also expected to increase the number of cycles per year in those areas. GG confirmed the next steps:-	

	The ICB would maintain our dialogue with NHS England about developments from the Women's Health Strategy for England and the national review of fertility services When the Women's Health Strategy review of fertility services was completed and when NICE has released further guidance (expected by the end of 2024), the ICB would review the interim policy for assisted conception, which may include further scoring by the ICBs CPAG, to see if it needed to be changed in any way. The ICB would make any necessary changes to the interim policy if they received nationally mandated directives before the NICE guidance was published The Board were asked to: • **BE ASSURED** that a robust process had 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. • **NOTE** the anticipated financial impact relating to the recommendations • **APPROVE** the recommendation to implement the draft interim aligned assisted conception policy across Staffordshire and Stoke-on-Trent JR felt that he had a difficult dilemma in terms of the policy and was disappointed that there was no reflection as to why Stoke-on-Trent had a different policy. The reason is poverty and people who could not afford private treatment. PEJ agreed that there were inequalities across Staffordshire & Stoke-on-Trent. He added that it would be an interim aligned policy that includes a levelling up in other aspects of the policy. PEJ confirmed that when the interim policy is reviewed, equitable access will be looked at as part of this process. JA supported the alignment and felt it was a step forward. JS commented that the NICE review in 2024 would be helpful and supported extending the age group and embryo storage period in the meantime. JHo acknowledged the work being done and asked if it was possible to look at what else was offered elsewhere in the country. PEJ reiterated that it was incredibly different across the country and that was why the Women's Health Strategy had been published which includes the statement about addressing variation across boundaries. GG confirmed that treatment would be honoured for people who have already completed all primary and secondary care investigations and been accepted into tertiary services under CCG policy. Embryo storage would remain at 12 months for these patients. **Questions from the public** <u>Ian Syme</u> *I fully appreciate that the 'Interim Assisted Conception Policy' seeks to align disparate policies within the ICS/ICB.* *A demographic informing the policy is understandably age.* *Earlier this month December 2023 the Human Fertilisation & Embryology Authority (HFEA) published the "Ethnic Diversity data in which Disparities in Treatment Outcomes for those from Ethnic Minorities are Identified" and also Access disparities that are suffered by BAME women.* *Some of the data in that HFEA report are very disquieting.*	

	A particular stark statistic amongst many within the HFEA report was that whilst during the last couple of years NHS funding for assisted conception has decreased for all ethnic groups such funding has decreased the most' proportionately, for Black patients. *The HFEA report emphasises the urgent need for decisive and long lasting actions to dramatically improve treatment outcomes and access for Black Asian and Ethnic Minority patients.* *How is the whole system ICS/ICB now going to ensure that this policy and its implementation and any successor policies will significantly improve access and treatment outcomes for individuals as identified in the HFEA report and how will such be transparently publicly reported?* PEJ confirmed that the interim aligned policy was equal in terms of the opportunities of everyone person in our community, however, equitable access needs to be reviewed and will be through the Integrated Care Partnership strategy. The Staffordshire & Stoke-on-Trent ICB Board: • **WERE 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. • **NOTED the anticipated financial impact relating to the recommendations.** • **ALL MEMBERS APPROVED** the recommendation to implement the draft interim aligned assisted conception policy across Staffordshire and Stoke-on-Trent with the exception of Jon Rouse, who abstained.	
10.	**ICB Quality Strategy**	
	LT advised that the Staffordshire and Stoke-on-Trent ICB three year Quality Strategy was developed by ICB and NHS partners and described quality aims for next three years. It was presented and approved at the Quality and Safety Committee (QSC) in November 2023 and was being presented to the ICB Board for ratification. She added that an associated delivery plan would be taken to the QSC for approval in February 2024 and would come to the ICB Board meeting in March 2024 for ratification. LT confirmed that the Quality Strategy would also be added to the ICB public-facing website page. JS thanked LT, the Quality team and Provider colleagues for the work they had done in producing the Quality Strategy. She confirmed that the QSC would be taking a close look at the delivery plan at their meeting in February. JHo asked if there would be alignment following the CQC report. LT confirmed that would be reviewed. The Staffordshire & Stoke-on-Trent ICB Board **RATIFIED** The ICB Quality Strategy.	
11.	**Quality and Safety Report**	
	LT reported that the System Maternity and Oversight Assurance Group was established and included representatives from the Maternity and Neonatal Voices Partnership and Care Quality Commission. All UHNM's maternity improvement actions had been aligned to each of the 4 themes and 12 objectives in the Three-Year Maternity and Neonatal Delivery Plan 2023. Therefore, rich discussions about	

	innovation and improvements could be had that met the requirements in the action plans, supporting RAG rating and the implementation of the actions in a meaningful way seeing significant improvement. LT advised that the Care Quality Commission (CQC) inspected the maternity service at Queens Hospital Burton and Royal Derby Hospital as part of their national maternity services inspection programme. Following CQC visits to the Derby and Burton sites in August 2023, the final report was published on 29th November 2023, confirming that the Safe and Well-led domains and overall service has been rated Inadequate. She added that further Section 29A warning notices have been issued. She confirmed that the ICB received regular updates from the Derby and Derbyshire ICB Chief Nurse and the Local Maternity and Neonatal System forums and groups LT advised that the ICB's Chief Medical Officer had now taken on the role of Director of Infection Prevention and Control (DIPC). The ICB's IPC leads continue to support system wide working, with weekly IPC meetings including representations from all NHS IPC teams, GP Practice Nurse Facilitators and wider partners which allowed early recognition of any issues or concerns and also allowed close working to support and enhance service delivery across the region. LT reported that NHSE had conducted a national Paediatric Audiology Hearing Service Review, which identified significantly high risks specific to Visual Reinforcement Audiometry (VRA) and Auditory Brainstem Response (ABR) testing within UHNM and MPFT services. Therefore, joint NHSE and ICB peer review site visits took place in November 2023. In response, a system 'Bronze Cell' had been established (meeting weekly) with the ICB's Chief Medical Officer, supported by the Director of Nursing – Quality Assurance and Improvement and the Patient Safety Specialist, assuming the SRO/Lead Clinician role. She added that progress had been made to deliver the immediate actions required and work was underway to review clinical outcomes following VAR and ABR tests with external clinicians to ascertain the level of risk and impact upon children who had received hearing tests. LT confirmed that the UKAS Accreditation process would commence over the coming months JR referred to the Safeguarding Adults & Children OFSTED report with the key multi-agency guidance which mandated them to move to multi-disciplinary team working and reiterated that this was now a must do and was not an option. PA confirmed that he and DP were considering how they could provide support in this area. The Staffordshire & Stoke-on-Trent ICB Board **RECEIVED** the report and sought clarification and further action as appropriate and **WERE ASSURED** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System**.**	
12.	**Finance and Performance Report**	
	PB reported that at Month 7, at a system level, they were reporting a year-to-date deficit position of £75.5m, which was £60.7m adverse variance against the £14.7m deficit plan (Month 6 –year to date deficit £66.4m; variance to plan £52.7m). The general themes driving the current financial position were: - • Continuing Health Care inflation and volume challenges, • Inflation in excess of plan in primary care prescribing • Efficiency under-delivery. In November, all Integrated Care Systems were required to review their 2023/24 financial positions and provide a budget refresh. In doing this, it was considered the	

	most likely impact of the recovery plan actions as well as a detailed review of all commitments for the remainder of the financial year. Through this process, as a system the ICB have indicated a most likely position of a £91.4m deficit. Further discussions were anticipated with NHSE on this position throughout the remainder of December and into January. PS presented the headlines and escalations around Urgent and Emergency Care (UEC) performance. PS updated on the positive performance around access targets in primary care and the percentage of appointments within 2 weeks from time of booking, being above the Primary Care Network (PCN) Investment & Impact Fund (IIF) higher threshold (>90%) for September 2023. For Long Term Conditions (LTC) diabetes, epilepsy and asthma emergency admission rates for under 18-year-olds in September were below the same period in 2019/20. PS reported that access to Specialist Perinatal Community Mental Health Services continued to improve following a range of actions put place earlier in 2023. PS advised that the operational pressures were linked to winter, which started in November and resulted in longer ambulance delays. However, he added that it should be noted this was ahead of where we were last year. Any ambulance waits over 8 hours were now subject to national escalation. The ICB were locally committed to as short a time as possible back stop within 7 hours in the system and were looking to implement a dynamic implementation tool and had also put a System Control Centre in place. PS added that the Junior Doctors industrial action had a significant impact on urgent care and electives and they were now preparing for further industrial action in January. It was also anticipated that flu would surge in the early part of January. DP agreed that this was a very difficult time and a very difficult set of challenges. JHo stated that it was useful to hear the escalation process and the back stop. She asked how quickly was the response back to someone who may be in A&E. She also asked for an update on pharmacy and primary care colleagues. PS confirmed that the rapid ambulance handover calls was a live discussion within the silver and gold command structure. PS advised that primary care and pharmacy staff would be fully in place during this period and they were working with the hospitals and primary care support team. TS stated that it was important that they alerted the public as to what services were available for them and the ICB would keep promoting that through their social media and website. TB added that norovirus was also on the increase. She confirmed that they wholly supported the eradication of the long waiters and they would be making a statement around zero tolerance. DP thanked PS for his leadership with the collaboration of all partners. MN gave an overview from the Finance and Performance Committee. She reported that the Committee had a positive review of the double lock process and noted a number of positive actions on the Recovery Plan and asked for further information on Virtual Ward roll out in the South West and Care Home projects in light of the and red RAG status	

	The Committee had also approved three system business cases and welcomed the robust discussion and challenge that had taken place at SPG.	
13.	**Any Other Business**	
	No other items of business raised.	
14.	Questions from the floor relating to anything heard during the meeting not relating to items 08 and 09	
	Ian Syme ***Winter Surges 2023/2024*** *Has the System now received all resources (ie monies) for Winter Surges 2023/2024 or is it expected more resources will be forthcoming.* PS confirmed that this year, the monies were allocated in three key pots and the Tier 2 monies were linked to oversight and escalation. He was working closely with local authority partners on a small amount of £200k which had been allocated to the system. ***Maternity*** *Earlier via Quality and Safety Report it was mentioned that the UHNM Maternity service has significantly improved.* *Queens Hospital Burton provide Maternity Services to Staffordshire Women and babies. What is the state of play at Burton re improvements and can a flavour of the improvements if any at Burton please be given?* LT confirmed that the improved areas picked up from the Burton site were around training and leadership DP thanked all NHS staff for the work they had been doing throughout the year and wished everyone a healthy 2024. DP also congratulated Buki Adeyemo on securing the substantive post as Chief Executive Officer for North Staffordshire Combined Healthcare Trust. The were no further questions received from the floor.	
15.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact.	
16.	**Close**	
	There being no further business, the Chair closed the meeting.	
17.	**Date and of Next Meeting**	
	18 January 2024 at 1.00pm in public in Stoke City Council, Council Chamber, Civic Centre, Glebe Street, Stoke-on-Trent ST4 1HH	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Date of Meeting 18/01/2024

Open Actions

Reference Number	Meeting Date	Agenda Item	Agenda No	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
				THERE WERE NO ACTIONS FROM THE MEETING HELD ON 21 DECEMBER 2023			

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 05

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

(1) Purpose of the Paper:
To inform the ICB Board about the local work to improve the outcomes for women locally

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

(3) Implications:	
Legal or Regulatory	N/A for the report
CQC or Patient Safety	N/A for the report
Financial (CFO-assured)	N/A for the report
Sustainability	N/A for the report
Workforce or Training	N/A for the report
Equality & Diversity	N/A for the report
Due Regard: Inequalities	N/A for the report
Due Regard: wider effect	N/A for the report

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

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	☐	BAF5	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	BAF6	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	BAF7	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	BAF8	Sustainable Workforce	☐

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

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

To receive the presentation and consider if the ICB's work plans are coordinated and aligned with work happening locally.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

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

(1) Purpose of the Paper:

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

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

1. System and General Update
2. Finance
3. Planned Care
4. Urgent Care
5. Key figures from our population
6. Quality and safety
7. COVID-19

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

(3) Implications:

Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

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

1.0 System and general update

1.1 Delegation of NHS England Specialised Commissioning to ICBs

At their meeting in December 2023, the national NHS England (NHSE) Board, supported the delegation of some specialised services to Integrated Care Boards (ICBs) in three regions: East of England, Midlands and Northwest England with effect April 2024 and subject to ICBs own governance arrangements.

As with the delegations of Pharmacy, Ophthalmology and Dentistry (PODs), NHS England will retain legal responsibility for all services, both delegated and non-delegated. ICBs will become operationally responsible for 59 specialised services from April 2024 with a further 29 services scheduled for delegation in April 2025. The services in scope of delegation are predominantly acute-based services but from April 2025 do also include specialist mental health and learning disability services currently delivered through regional provider collaboratives.

Delegation readiness is assessed via a Pre-Delegation Assurance Framework (PDAF) – all 11 ICBs in the Midlands developed a joint submission with NHSE region in September 2023. This has led to the national NHSE Board determining that ICBs in the Midlands have category 1 delegation status – i.e., without conditions – barring a requirement to ensure that delegated specialised commissioning allocations are spent only on specialised commissioning services. This is a variable condition and will be managed through NHSE region with relevant ICBs.

The Delegation model will be a threefold layer of governance; Delegation Agreement (between NHSE/ICBs), Collaboration Agreement (between ICBs) and a Hosting Agreement (between NHSE, Birmingham and Solihull ICB and other ICBs in Midlands). This is a very similar model to that used for the delegation of Podiatry, Ophthalmology and Dentistry services; governance colleagues from across the Midlands have been devising these documents.

There will be a lot of focussed effort in the run up to delegations across key areas such as finance, quality, planning etc. The ICB is actively engaged in the regional programme structure to support a smooth transition.

Detailed updates have been presented to the ICS Provider Collaborative Board for the past six months and that will also extend now to include Finance and Performance in February and March as well as summary updates in subsequent Chair and CEO Board reports leading to a formal proposal at March Board to consider delegation.

1.2 New Year Honours list

Congratulations to everyone from Staffordshire who received an honour in the King's New Year Honours List. The honourees include:

- **Chandra Kanneganti, GP at Goldenhill Medical Centre, Stoke-on-Trent who was awarded a CBE for service to General Practice.**
- **Abi Brown, Councillor and lately Leader, Stoke-on-Trent City Council, and Deputy Chair, Local Government Association, for services to Local Government.**
- Elaine Hutchings, for services to the community in Lichfield, Staffordshire during COVID-19.

In addition, Karen Bradley, Conservative MP for Staffordshire Moorlands, was appointed a Dame Commander of the Order of the British Empire on 29 December in the 2023 Political Honours for public and political service - these special honours are awarded outside the New Year and Birthday Honours.

1.3 General Practice Winter Schemes

The Integrated Care Board (ICB) has commissioned two schemes from General Practices for winter 2023/24, which are Additional Appointments in General Practice and Multi-Disciplinary Primary Care Hubs, which together aim to deliver circa 5,000 additional appointments per week.

1.3.1 Additional Appointments in General Practice

Practices are funded to deliver additional appointments to their individual populations over a period of 17 weeks to help address the challenges described above. This will deliver an additional 2,370 general practice appointments per week.

1.3.2 Multi-Disciplinary Acute Primary Care Hubs

Groups of Primary Care Networks (PCNs) are working together to provide same day access to urgent Primary Care at a hub level, supporting their community through joint working. The hubs can flex the referral criteria in response to pressures observed by the system or NHSE guidance e.g., respiratory. Hubs also provide direct booking access for 111 during weekends.

1.3.3 December Performance

The December activity reported so far is as follows:

Scheme	Target appointments (December)	Total appointments offered (December)	% utilisation	% DNAs	RAG Rating
Additional appointments in General Practice	2370	7927	100%	2%	
Multi-Disciplinary Acute Primary Care Hubs	2604	10,172	83%	5%	
Total	**19,896**	**19,899**			

1.4 People

A need to ensure the right people, with the right skills, are in the right place at the right time to provide high quality care, whilst improving outcomes and experience. Staffordshire and Stoke-on-Trent continue to be under significant financial challenge and in an environment of unprecedented Industrial Action. Affordability of current establishment, of which any recruitment will contribute to the Staffordshire and Stoke-on-Trent financial deficit, in the backdrop of a national requirement to increase capacity in priority areas including Urgent and Emergency Care (UEC), Elective and Mental Health to contribute to system recovery.

The NHS England (NHSE) Long-Term Workforce Plan (LTWP) is expected to impact the system workforce levels required in the future; it outlines the biggest training increases/recruitment drive in history but also an ongoing programme of strategic workforce planning. Based on the NHSE LTWP (Jun-23) which models that the expected workforce increases nationally, when applied proportionately to Staffordshire and Stoke-on-Trent, equates to potential increases of between 5,200 to 6,800 whole time equivalent (WTE) (increase of between 22.8% to 30.1%). We are modelling the impact of the NHSE LTWP at a local level with providers and anticipate a social care workforce plan also to be shared soon.

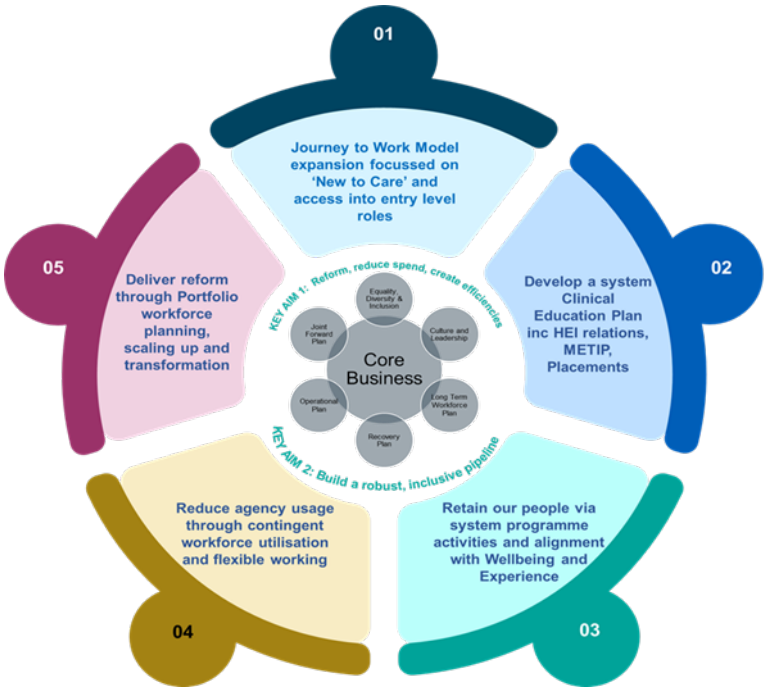
In 2024-25, integrated planning will be essential to reduce demand on services where possible, including but not limited to; ensuring that the current workforce is effectively utilised and what transformation is needed to deliver this. Productivity will be key, alongside improving access routes, i.e. apprenticeships, retention, medical expansion and reform, clinical expansion and reform (non-medical).

1.4.1 People Programme Priorities 2024/25

Given the current challenge, a shift in focus for the Integrated Care System (ICS) People function is necessary, to support the achievement of the system priorities and recovery in 2024/25. A review of

delivery plans associated with the Long-Term Workforce Plan, programme work and core business, has been undertaken and activities realigned to support the financial framework and operating plan aims.

The key principles and aims of this approach will be to reduce spend, increase reform and create efficiencies, where possible, working smarter not harder.



Continued focus on collaboration and scaling, transformation, productivity, helping our local population access entry level routes into health and care careers, securing our future pipeline and clinical and professional engagement. As a system, we are continuing to develop good practice approaches in respect of people programme activities. An example of which being reflected in the system being shortlisted for the Widening Participation Recognition Award with Further Education (FE) Week and The Associate of Employment and Learning Providers (AELP) Apprenticeship Awards 2024, for the system wide rotational Health Care Support Worker Apprenticeship Scheme.

1.5 CEO Retirement

We would like to take this opportunity to note Tracy Bullock's decision to retire in June this year. We thank Tracy for her contribution to system and UHNM leadership since her arrival in April 2019. Amongst other roles, over recent years Tracy has led the system Provider Collaborative Board which has played a key role on the development of our approach to joint working across the system. There will of course be more opportunities to thank Tracy, but for now and on behalf of the system, thank you!

2.0 Finance

At month eight, at a system level, we are reporting a £62.7m adverse variance against plan. The adverse position drivers are consistent with prior months across Continuing Health Care (CHC) and prescribing inflationary pressures, slippage on efficiency programmes, the ongoing retention of escalation beds due to urgent and emergency care (UEC) demands throughout the financial year. Our original break-even plan included several upside assumptions. Unfortunately, a number of these assumptions have not come to fruition and last month we notified regional and national teams as part of the financial reset return of a forecast out turn of £91.4m. All organisations are increasingly confident of delivering their risk adjusted forecast and managing the residual risks. However, we still need c£3m to secure the position, and whilst we are confident that this can be covered by the improving CHC run rate, to go further at this stage is not possible. On this basis, as a system, we still believe that a deficit of £91.4m is our most likely position.

3.0 Planned Care

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

The Integrated Care Board (ICB) and system partners continue to address the backlog of patients on the elective waiting list with the ambition of treating all those waiting more than 65 weeks by the end of March 2024, in accordance with the national planning guidance. However, despite progress being made the rate of improvement has been impacted by the ongoing Industrial Action by both junior doctors and consultants.

Significant work has been undertaken to eradicate 104-week breaches. There were two patients who breached 104 weeks at the end of December at University Hospitals of North Midlands NHS Trust (UHNM). One was due to custom equipment being needed and will be treated in January, the other was

due to capacity; they are forecasted to breach at the end of January. It is hoped that the system will have no further 104-week breaches from February.

For patients waiting beyond 78 weeks for treatment, the number of breaches reported across the system at the end of December was 130 (117 at UHNM and 13 at Nuffield), the forecast position for the end of January is 101 (94 at UHNM and 7 at Nuffield) but a continued focus is required to ensure that we reduce this further.

Good progress is being made overall on the 65-week-wait cohort. Numbers have continued to improve with the potential cohort of patients breaching 65 weeks by the end of March now standing at circa 5,400, this is compared to over 37,000 at the start of the financial year. The number of patients forecasted to be waiting beyond 65 weeks for treatment at the end of January is 1,612 (1,562 at UHNM, 49 at Nuffield and 1 at Ramsay) and the current forecasted position for February is 1,719 (1,658 at UHNM, 60 at Nuffield and 1 at Ramsay). Work is ongoing to ensure appropriate support is given to reduce these numbers further.

To accelerate delivery of the 65-week-wait target, NHS England issued a letter on 4 August asking that systems challenged themselves to ensure that all patients within the 65-week-wait cohort had received their first outpatient appointment by the end of October. UHNM has flagged this target wouldn't be met and have completed their analysis to identify which specialties would deliver on the ask and which would not. As of 31 December, there were 1,247 patients in total who still require a first outpatient appointment, 367 already have one booked from January and 880 were still without an appointment booked. The two main specialties without appointments booked are Neurology (559) and Gastro (272).

As a result of Industrial Action, we had seen an increase in the 78-week-wait cohorts for Staffordshire and Stoke-on-Trent patients awaiting treatment from providers outside our system, this has now started to improve. The number has decreased from 102 as of 26 November to 68 as of 17 December. Similarly, Staffordshire and Stoke-on-Trent patients greater than 65-week-waits outside our system has seen a reduction from 1,069 as of 26 November to 890 as of 17 December.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) has seen a continued steady reduction in the 62-day backlog since September but has seen an increase during December. As of 31 December, the 62-day backlog was 381 against a revised trajectory of 389. This has been an improved position since the end of October, where the backlog was 427 against a revised trajectory of 430. The 104+ day backlog has also seen an increase during December; as of 31 December, UHNM has reported 110 breaches against a fair share's trajectory of 78. This is a reduction from 130 as of 29 October. The total Patient Treatment List (PTL) volume has continued to reduce, and as at this week (31 December) it is currently at 3,176, compared to 3,783 at the end of October.

The position of 28-day faster diagnosis standard for cancer has again improved with a projected performance of 66.3% for November. UHNM has drafted a forecast to improve performance against the FDS metric – to a point of achieving 79% against the standard by March 24, with the national target being 75%.

4.0 Urgent and Emergency Care (UEC)

Unvalidated four-hour performance, whilst continuing to be challenged, only slipped by 0.4 percentage points in November, and is reporting a full 8.5 percentage points higher than the same period last year. We continued to see sustained levels of breaches within Minor Injury Unit (MIU) activity whilst overall attendances in these units remained below the 23/24 average. In comparison to last year, MIU attendances were down 18%, and this in conjunction with the 85% reduction in four-hour breached within these units mitigated the potential reduction on performance.

12-hour unvalidated performance reported as 9.4% for December, 0.2 percentage points down on November. The mean for the calendar year has increased slightly to 8.5% whilst the week ending 31 December showed improved performance over the Christmas weeks reporting at 8.1%. This remains significantly higher than the desired 2% target.

Long Length of Stay (LoS) performance reported little variation over November with each of 7+, 14+ and 21+ proportions shifting by less than 0.4 percentage points. When compared to December 2022 each of

the time bands is reporting an improvement of approximately 2 percentage points, the equivalent of 25 days per day through the month.

Category 2 performance through December, whilst challenged, was better than the regional planned position for the month and the average performance for last week of the month was 50 minutes compared to over three hours for the same period in 2022. However, October and November performance has detrimentally impacted our ability to finish 23/24 at the 30-minute expected average. This has been delivered whilst receiving over 700 more conveyances to the University Hospitals of North Midlands NHS Trust (UHNM) emergency department sites in December compared to December 22, representative of a 17.5% increase in activity.

Medically Fit for Discharge (MFFD) has marginally decreased at Royal Stoke Hospital, whilst County Hospital showed improved performance in the second half of the month. Both remain below the assumption made within the predictive bed modelling tool as part of the system surge plan.

COVID-19 bed numbers at UHNM continued to rise through December peaking at 136 just after Boxing Day, before reducing by 20 at the end of the month. Increases were also reported in bed numbers in our Community Hospitals: 23 at the end of the month. COVID-19 related staff absences continued trending upwards whilst overall absences also increased reflecting the latest flu surveillance report, which indicated the seasonal surge has begun. Flu bed numbers increased as cases within the community rose, with UHNM reporting 28 beds occupied at the end of the month. This is likely to increase as we reach the peak period as modelled by NHS England in the next fortnight.

Finally, during December there has been a significant increase in calls going through Acute Care at Home (AC@H) in December (2299), a 25% increase on November which is the 2nd highest number since we began reporting it in April 22, only behind the 2402 from last December.

5.0 Key figures for our population

		Aug-23	Sep-23	Oct-23	Nov-23
*	**111 calls received**	29,579	30,021	35,316	32,553
	Percentage of 111 calls abandoned	8.2%	5.8%	5.7%	6.3%
	A&E and Walk in Centre attendances (UHNM)	19,573	20,502	21,360	19,591
	A&E and Walk in Centre attendances (other providers)	16,968	17,284	18,303	17,337
	Non elective admissions (UHNM)	7,424	7,463	7,947	7,655
	Non elective admissions (other providers)	5,498	5,563	5,953	5,971
	Elective and Day Case spells (UHNM)	6,872	6,592	7,168	7,310
	Elective and Day Case spells (other providers)	8,117	7,858	8,416	8,645
	Outpatient procedures (UHNM)	4,931	5,021	5,229	5,904
	Outpatient procedures (other providers)	8,312	8,428	8,925	8,494
	GP Appointments (all)	506,811	580,922	621,388	562,056
**	**Physical Health Community Contacts (attended)**	128,840	129,825	138,610	
**	**Mental Health Community Contacts (attended)**	43,590	42,225	46,070	

**NHS 111 - latest month is provisional and subject to change*

***Physical and Mental health contacts - latest month is provisional and subject to change and both datasets are sometimes one month behind the other datasets depending upon the publication dates*
Most datasets are subject to change following refresh

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

6.0 Quality and safety

6.1 Workforce Race Equality Standards (WRES)

Members of the Chief Nursing and Therapies (CNTO) team are participating in the ICS Workforce Race Equality Standard (WRES) Champion and Sponsorship training which aims to ensure that people's voices are heard, and actions are taken to reduce the differential experiences based on race and ethnicity. The Sponsor and Champion roles are designed to drive real change and improve the lives of our people to reduce barriers and increase equity across our system. This visionary program is designed to bridge the experience and outcome gaps between black and minority ethnic staff and their white counterparts within the NHS. With a mission to cultivate a new generation of leaders who are passionately dedicated to addressing and advocating for racial equality issues within the healthcare system.

7.0 COVID-19

7.1 COVID Vaccinations:

The main phase of the COVID-19 autumn/winter 2023/4 programme came to an end on 15 December with small numbers of vaccination clinics continuing to target harder to reach populations or to address areas of inequality. All activity COVID-19 vaccinations will end on the 31 January 2024.

Total COVID vaccinations given = 275,247 (as at 5/1/24)

Staffordshire and Stoke-on-Trent is the third highest performing system within the region at 52.4% of eligible individuals vaccinated this autumn.

7.2 Flu Vaccinations:

Total Flu vaccinations given = 367,266 (as at 5/1/24) which is 52.4% of eligible individuals vaccinated.

Highest vaccination activity within region for Staffordshire and Stoke-on-Trent. All school flu immunisations have now been completed with some additional catch-up clinics being held in early January for anyone unable to be vaccinated during school clinics.

8.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

David Pearson, ICB Chair

Peter Axon, ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 07

Report to:	**Integrated Care Board**					
Date:	**18 January 2024**					
Title:	**PWC Report on Financial Recovery Plan and Grip and Control**					
Presenting Officer:	Paul Brown, Chief Finance Officer					
Author(s):	PWC					
Document Type:	Report					
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	NO				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:						

(1) Purpose of the Paper:
To share the findings and recommendations from the PWC external review into the Recovery Plan and grip and control.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group/Turnaround Board	20/12/2023
Finance and Performance Committee	02/01/2024

(3) Implications:	
Legal or Regulatory	Failure of the ICS to achieve its financial duty to remain within its resource limit
CQC or Patient Safety	None specifically identified pertaining to this report
Financial (CFO-assured)	Risks to delivery of the plan signed off by the ICB Board have been identified in the report
Sustainability	Delivery of the financial plan and effective implementation of the IFPS are key to supporting the longer-term plan for financial sustainability
Workforce or Training	None specifically identified pertaining to this report
Equality & Diversity	None specifically identified pertaining to this report

Due Regard: Inequalities	None specifically identified pertaining to this report
Due Regard: wider effect	None specifically identified pertaining to this report

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

In response to the deficit, the ICS was required by NHS England to commission an independent assessment from PWC to comment on the robustness of the Financial Recovery Plan (FRP) and underpinning Cost Improvement Plans, and also review and comment on the cost control structures in place across key areas of pay and non-pay spend.

The report provides detailed feedback and recommendations on:
- the Financial Recovery Plan
- Pay controls
- Non pay controls

Detailed organisational level feedback is also provided.

The ICB accepts the main findings and through the ongoing development of the monitoring of the recovery will implement the system level controls. Each organisation is now considering its response to the detailed assessment and will report back on those through their own governance arrangements

(7) Recommendations to Board / Committee:

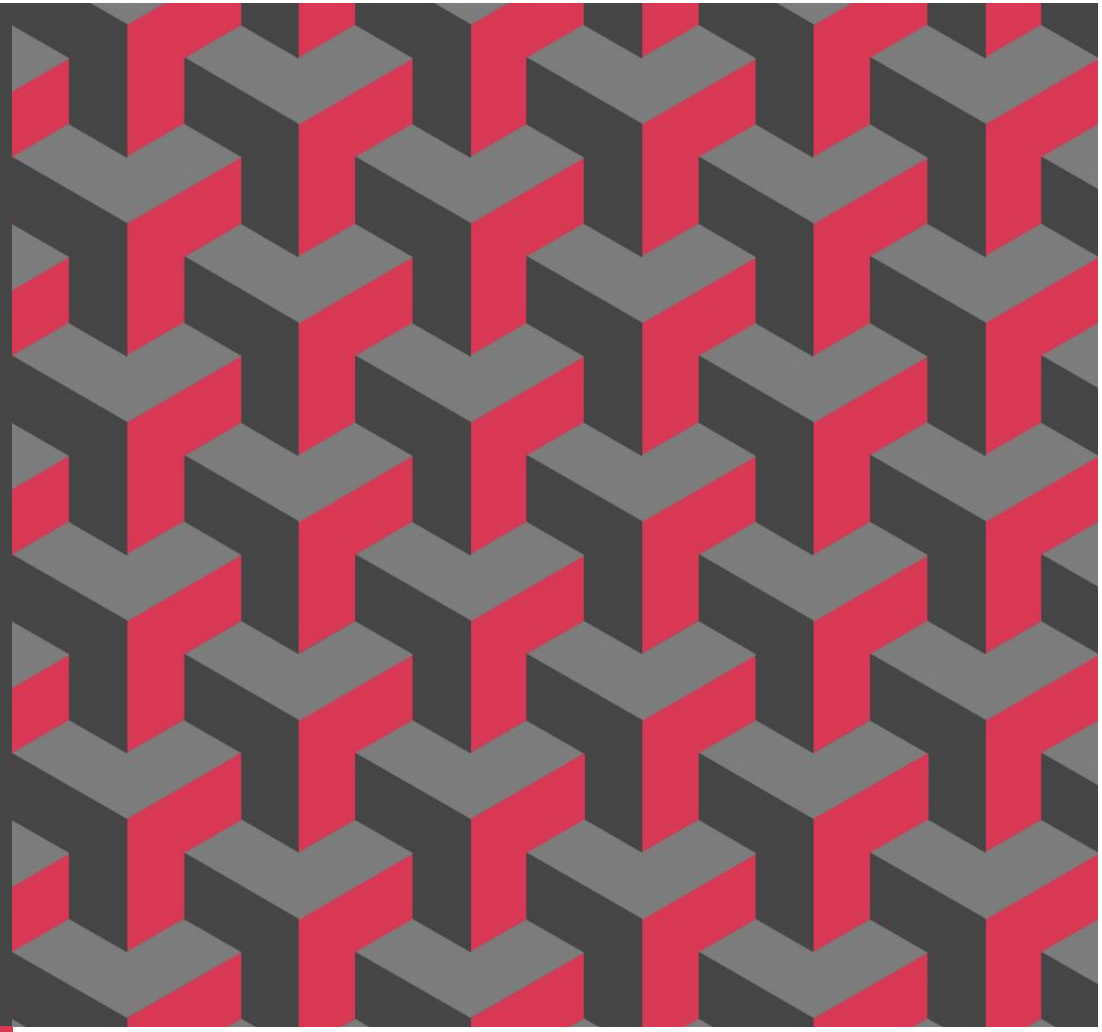
The Integrated Care Board is asked to:
Note the findings and additional recommendations of the independent assessment.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board (SSoT ICB)

Financial Recovery Plan and Grip and Control Review across the NHS Staffordshire and Stoke-on-Trent Integrated Care System (SSoT ICS)

Strictly Private & Confidential

December 2023



pwc

Paul Brown
Chief Finance Officer
NHS Staffordshire and
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New Beacon Building
Stafford Education and
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Weston Road
Stafford, ST18 0BF

Dear Paul

We report on NHS Staffordshire and Stoke-on-Trent Integrated Care System (the "ICS") in accordance with our agreement dated 14 November 2023 (see Appendix 4).

The ICS consists of three providers (the "Providers"), the Integrated Care Board ("the ICB") itself and other system partners. The Providers included within the scope of this review are Midlands Partnership University NHS Foundation Trust, North Staffordshire Combined Healthcare NHS Trust and University Hospitals of North Midlands NHS Trust.

This report has been prepared in connection with our review of the ICS's Financial Recovery Plan and cost control measures in place at the ICB and the Providers across key areas of pay and non-pay spend. Our fieldwork was conducted between 14 November 2023 - 01 December 2023.

We draw your attention to important comments regarding the scope and process of our work, set out on page 10.

Save as described in the agreement or as expressly agreed by us in writing, we accept no liability (including for negligence) to anyone else or for any other purpose in connection with this report, and it may not be provided to anyone else.

Yours faithfully

David Morris

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Contents

Section 1

Executive Summary: Review at a glance

Executive summary: Review at a glance (1/2)

1 Context, scope and approach of this review

Staffordshire and Stoke-on-Trent Integrated Care System ("SSoT ICS" or "the ICS") includes the SSoT Integrated Care Board ("SSoT ICB" or "the ICB") and the three providers University Hospital of North Midlands NHS Trust ("UHNM"), Midlands Partnership University NHS Foundation Trust, ("MPFT") and North Staffordshire Combined Healthcare NHS Trust ("NSCHT"). **The ICS originally submitted a breakeven plan for FY23/24 which highlighted significant risks to delivery.** Many of the risks have since materialised and the in-year position has significantly deteriorated. In October 2023, the ICS was forecasting a **revised deficit of £141m without any further recovery actions (**noting the unmitigated risk was £75m at plan stage)**.** The ICS has reported that the significant drivers of this deficit include inflationary cost pressures, an unfunded bed gap, industrial action and increased CHC costs. As of M7, the System had a deficit of £75.5m, £60.7m adverse to plan. See page 9 for further background.

In light of this, and in agreement between NHS England and SSoT ICS, we have been asked to undertake a rapid three week assessment to **comment on the robustness of the ICS's Financial Recovery Plan (FRP) and underpinning cost improvement plans, and also review and comment on the cost control structures in place at the ICB and the Providers across key areas of pay and non-pay spend.**

We have undertaken the review through a mixture of document review including (but not limited to) the FRP, supporting financial / bed modelling information, key grip and control process documents / forms. We have also made our assessments via a number of meetings with key stakeholders and observing a mix of corporate and clinical vacancy panels where they are implemented. This review has not included financial analysis of pay, non-pay or savings identified.

2 The FRP was developed cross system and there is good buy-in to the recovery actions. It is focussed on delivering sizeable improvements to CHC but focus should now be given to developing costed in-year actions to further mitigate the financial challenge

The FRP was developed from Summer 2023 (final document reviewed was dated October 2023) and identifies seven key workstreams as areas of focus for recovery. Key performance indicators have been set out for each workstream, however these **have not all been costed in detail and phased to mitigate the £141m financial challenge** nor have improvement trajectories been finalised or action owners identified.

It should be noted that the plan has been **developed collaboratively between key stakeholders, with significant system engagement events** in co-creating the document. System partners we engaged with felt that they played a role in the development of the plan. It will be important to **continue this level of engagement and collaboration** as further underpinning detail is developed across the ICS to support the **recently revised plan submission of £91m deficit** (submitted to NHS England during the course of this review).

In developing the FRP, System partners have **intentionally focussed on identifying financial opportunities to address the key drivers of the deficit**. Potential savings have been identified for CHC totalling £109m, however a risk of double count has been highlighted in the assumptions. These savings opportunities have not yet been phased, although actual savings delivered are being tracked month on month. We understand that the bed modelling recovery actions have not been costed to date, as they are designed to bridge the bed gap, as opposed to releasing cash. We note that over and above the financial challenge being addressed by the FRP, additional efficiencies of £181m have been targeted within organisations.

The FRP would benefit from more financial analysis and **further detail of the immediate actions** required to address the in-year challenges. This could include the focus on grip and control measures which has not formally been included or monitored as part of the FRP governance.

3 The Continuing Health Care (CHC) workstream is a key component of the FRP and would benefit from additional capacity to release savings in year

Continuing Health Care (CHC) has been identified by the ICS as a significant driver of the deficit as a result of the increase in average cost, total cost, length of time and volume of care packages. As such, increasing grip and control of the CHC packages is a key component of the FRP that could materially change the run rate and improve the position in year.

Since July 2023, there has been an **increased focus on reducing CHC** via a number of proactive interventions including both the immediate 1:1 reviews whilst also tightening the criteria for both eligibility into the CHC pathway and the assessment criteria in the package of care reviews.

This approach is **clinically led to make sustainable change** and should result in changes in year from the 1:1 assessments and longer term behavioural changes in the way patients are assessed and packages of care are provided.

Whilst savings have been identified and achieved year to date, **the programme could be accelerated further with additional, dedicated resource.** This would be in addition to the resource agreed at F&PC on 5 December 2023 for a 6 month pilot within the Fast Track workstream.

4 Recovery governance could be improved with enhanced reporting and tracking of actions, to drive the pace and accountability of delivery

A weekly recovery programme meeting was established in September 2023 as an operational group to provide regular focus on the recovery actions. This feeds into the more strategic monthly System Performance Group / Turnaround Board, which ultimately reports into the Finance and Performance Committee which holds the decision making powers. This **governance and reporting structure is in-line with our expectations** and common with other organisations in a financial recovery situation.

These forums would **benefit from more granular reporting** as well as improvements to the progress update templates to provide **more visibility and greater assurance of recovery workstream delivery and benefits realisation.** For example, supporting narrative for any missed milestones / actions that will impact the scheme delivery. We understand that an issues log including milestone status has been recently introduced.

We understand that the System Recovery Dashboard metrics are being developed at present. Additional resource should be provided to urgently progress this to support the tracking of any in year financial and non-financial benefits. This will **promote greater transparency of progress, highlight any risks / blockers and support increased accountability from Project Leads.**

Executive summary: Review at a glance (2/2)

5 All organisations across SSoT have a level of cost control with some variation in the efficacy and maturity of these measures. Some have been recently re-introduced and therefore need time to embed to enable the realisation of in-year benefits

All organisations across SSoT have a level of “grip and control” mechanisms now in place, however some of the controls have been implemented as recently as November 2023. There has been **varying practice between and even within organisations** with grip and control measures having been introduced either as part of good practice within usual financial management, as a response to the self assessment checklist, or through other triggering events such as the introduction of new supporting systems or processes.

While a number of mechanisms have been implemented and we have **observed some good practice**, given the heightened focus on the in year financial position, we have **identified incremental improvements** that can be made across the System as follows:

- variation in the maturity and efficacy of controls across organisations should be addressed;
- outstanding controls should be implemented / made consistent across organisations; and
- pace could be brought to the embedding and refinement of existing controls.

It is important to note that given the varying scale and complexity of organisations within the ICS, controls and level of scrutiny required should be tailored to yield the most benefits without creating significant additional administrative burdens.

On the following pages (12 and 13), we have summarised the key themes identified across pay and non-pay controls. More detailed observations and recommendations by organisation are set out in section 4 (pages 20 to 50).

6 A rapid review of business cases should be undertaken to assess the actual benefits realised vs those planned to ascertain those which could be stopped or delayed to achieve in-year savings

The ICS has implemented a “double lock” approval process, whereby any business cases approved by providers are also reviewed and scrutinised by the System collectively. We observed that the **business case approval process was subject to robust challenge** at the System Performance Group (SPG), with pertinent queries raised by system partners, for example seeking alternative solutions / what could be stopped where investment is being sought in addition to that currently planned.

Whilst the initial approval process is robust, we understand that the System does not currently conduct any benefits realisation processes on the approved business cases. We recommend that a **benefits realisation methodology should be defined at SPG** and that a rapid review is undertaken to ascertain those investments which could be stopped or deferred to realise in-year benefits. The benefits realisation process should be established to understand and **track the return on any money invested** with the associated KPIs / non-financial benefits within the business case on an on-going cycle. This should be connected with the Transformation Delivery Unit (TDU) to enable the quantification of any additional efficiency impacts linked to support the recovery actions within the FRP.

This benefits realisation process could be extended to include the vacancy panels and temporary staffing reviews. This could also be coordinated by local PMOs and supported by the TDU to enable the quantification and **reporting of any run rate impacts from the increased or decreased requirement of temporary staffing**. Where vacancies are rejected, the decreased establishment should also be recorded.

7 There are a number of next steps which should be prioritised by the ICS which could improve the in-year financial position

The FRP would benefit from the development of more granular plans for each workstream, setting out the expected financial impact, key milestones and actions with associated owners. **The plans should then be monitored via enhanced reporting through the financial recovery governance structure in place, including finalisation of non-financial delivery metrics and a dedicated approach to monitoring benefits to evidence improvements in year.** There needs to be a heightened focus on actions that can take place, and have an impact, between now and the end of the financial year, in order to help address the immediate financial challenge that the system faces. Additionally, we would recommend that the System closely monitors the underlying position, including any deterioration, such that further mitigating actions can developed and implemented. We have detailed our findings and recommendations in relation to the FRP further in sections 2 and 3.

We recognise that there are some areas of good practice in the grip and control measures in the System, however we have also identified a number of areas for improvement. There remains variation in the maturity and efficacy of controls across organisations which should be addressed, outstanding controls which are yet to be implemented, and opportunities for organisations to bring more pace to the embedding or refinement of existing controls. Further details of our recommendations adhering to specific controls for specific organisations are outlined in sections 2 and 4.

We have summarised four priority actions overleaf in terms of immediate next steps for the ICS to consider. We also recommend that lessons learned from the development of the FRP, including the review of drivers of the deficit and assessment of grip and control measures, should be factored into the 2024/25 planning rounds.

Key recommendations for the Board to consider

We have highlighted the key recommendations for the ICB to consider below which will support the urgent action to further extend and embed all grip and control mechanisms and provide more granular in-year detail to further develop the FRP as outlined in our At A Glance. We recognise that we have made very detailed recommendations on individual controls later in this report, but wanted to highlight the four points below that we believe the respective Boards should consider. The intention is to be helpful to the Boards, so you can consider this report and take steps to support the system to create and sustain a strong control environment and support the in year delivery of recovery actions.

1 Finalise the benefits realisation plans for the Recovery Workstreams

- **We recommend that each workstream should finalise their non-financial delivery metrics and associated costed financial phasing for each element in their recovery plans.** This should include monitoring and a benefits realisation approach supported by the TDU.
- A phased approach and evidence in financial / non-financial metrics will provide the Executive team and NHSE with confidence that improvements are demonstrated in year.

2 Undertake a rapid review of business cases to identify any in-year savings

- **The ICS should undertake a rapid review of approved business cases with significant investment to validate the anticipated impacts and assess whether there are any opportunities to pause or disinvest. This process will yield any in-year savings opportunities.**
- Consideration should be given to unpalatable ideas within an MDT team to fully assess any anticipated impacts before committing to any actions that may inadvertently affect the operational position or quality / equity of care provided.

3 Implement recommended enhancements to grip and control

- **We recommend that each organisation takes forward the recommended improvement actions to enhance the efficacy and consistency of controls within their organisation and across the system.**
- An organisation that has strong Grip and Control can demonstrate key enablers including:
  - a strong Executive leadership team to drive through action
  - clarity and consistency of its controls
  - ongoing engagement of key stakeholders both internally and externally

4 Enhance system level reporting to support visibility and drive delivery

- **System governance reporting should be enhanced to provide more granular reporting to enable tracking of delivery. Progress updates should include specific dates, as well as narrative explanation for any missed milestones and what mitigations are in place.**
- The financial recovery reporting should also include benefits realised through grip and control measures. Workforce metrics should be considered collectively alongside the results of vacancy panels. For example, expanding the MPFT workforce dashboards and using data to enable better scrutiny and decision making.

Section 2

Summary of the grip and control and FRP review

Background and scope

Background

Staffordshire and Stoke-on-Trent Integrated Care System ("the System" or "the ICS" or "SSoT ICS") services over 1.1million people in the North Midlands region. The System includes the following providers within the scope of this review:

- Staffordshire & Stoke-on-Trent Integrated Care Board ("the ICB")
- University Hospitals of North Midlands NHS Trust ("UHNM")
- Midlands Partnership University NHS Foundation Trust ("MPFT")
- North Staffordshire Combined Healthcare NHS Trust ("NSCHT")

The System is experiencing significant financial challenge, which we were advised was first escalated in August 2023. Following national escalation meetings, this resulted in a revised planned deficit of £141m being submitted in October 2023. This was following an original breakeven plan with £75m of unmitigated risk. The System has identified that the deterioration of the position in year has been driven by:

- Excess inflation, largely within CHC and prescribing (£50m);
- Increased number of patients requiring CHC, with increased complexity of packages;
- Industrial action resulting in increased use of temporary staffing;
- Inability to close winter escalation beds, creating an unfunded bed gap.

To note, the revised submission of the £141m planned deficit was in the context that the ICB agreed to implement £181m efficiencies required to deliver the plan at c.8.2% of RRL.

The operational and financial recovery programme developed by the System is now being implemented and has started to deliver benefits. This paired with additional funding for Industrial Action, changes to the Elective Recovery Fund and relaxation of requirements for some previously ring-fenced funds has allowed the System to resubmit their in year plan of a £91m deficit (in November 2023).

As of M7, the System had a deficit of £75.5m, £60.7m adverse to plan.

Scope of our work

In light of the deficit submission, and in agreement between NHS England and SSoT ICS, PwC have been asked to undertake a rapid three week assessment in reviewing documents, processes, meeting with individuals and observing key meetings to:

a) Comment on the robustness of the ICS's Financial Recovery Plan (FRP) and underpinning cost improvement plans, including:

- Context including the ICB's understanding of challenges faced and strategic plan looking ahead
- Granularity of supporting financial information
- Milestone plans and timescales for delivery
- Stakeholder engagement
- Risk assessment and mitigations
- Interdependencies (including links to quality and operations)
- Governance and accountability arrangements for delivery of the FRP

b) Review and comment upon:

- The cost control structures in place at the ICB and the Providers across key areas of pay and non-pay spend, including but not limited to:
  - vacancy control systems
  - temporary staff controls and authorisation processes
  - procurement spend control systems
- The quality of financial management information produced at a system level to support decision making and compliance with cost control systems

An overview of the approach

In order to support financial recovery within Staffordshire and Stoke-on-Trent ICS, a review of their Financial Recovery Plan (FRP) and their Grip and Control mechanisms was performed. Outlined below is an overview of the approach we took to conduct a rapid review across the System. The review has been undertaken on the information that has been made available to us, with the aim of identifying opportunities for strengthening the FRP and Grip and Control help address the financial challenge faced in the System. The stages below formed the basis of our rapid review:

Document review

We have reviewed the System's Financial Recovery Plan and details of the key underpinning recovery schemes through documents provided by the ICB and providers. We have reviewed key programme delivery documentation around the FRP to understand the underpinning governance of the plan.

For cost control measures, in the first instance we have reviewed the providers and ICB self assessment of the controls submitted to NHSE. Following this, we have received corresponding documentation to support the operation of these controls, as well as any other relevant control operated in the System.

We have put particular focus on controls that fall into the following categories:

- Vacancy control
- Temporary staffing governance
- Internal temporary staffing and authorisation controls
- External / agency authorisation controls
- Procurement and spend

See appendix 3 for document review log.

Discussion and Observation

Follow up meetings were held with various stakeholders, including Executives, representing Finance, People / Workforce / HR and Procurement to discuss their role in achieving financial recovery in the System.

These key meetings discussed:

- Key underpinning actions supporting the FRP
- Governance forums supporting the delivery of CIP
- NHSE grip and control checklist and further controls in place.

Where possible, we also observed controls in practice to understand how the controls have been implemented to find further opportunities to strengthen controls if required.

Further supplementary information was requested from the providers and the ICB to evidence controls in place and provide an opportunity to share examples of good practice system wide.

See appendix 2 for engagement meeting log.

PwC view

We have provided key recommendations based on our experience of how to enhance and increase the robustness of the FRP. We have explored best practice to ensure delivery of the key actions identified.

Leveraging the insight from the NHSE checklist, discussions, sample supplementary materials and our experience we have formed our view on the maturity of organisation's current grip and control measures.

The view considers the efficacy of the controls; as well as strengths, opportunities and any upcoming planned enhancements where relevant.

The scope of this review has not included undertaking any detailed analysis or validation for example of workforce data, bed modelling, or CHC trajectories. Our work has been limited to document review, discussions with key stakeholders and observation of key forums during three weeks of field work.

System wide view and recommendations

The review has been undertaken across the ICB and three providers in scope, in order to be collated into a single Staffordshire and Stoke-on-Trent ICS FRP and Grip and Control report.

The report includes:

- A view on the effectiveness of controls across the System - highlighting areas of good practice or learning where they exist and gaps identified.
- Recommendations for the enhancement of grip and control mechanisms.
- A view on the composition and delivery of the FRP, actions taken to date and supporting governance.
- A summary of overarching next steps for the System to consider and action.

Financial Recovery Plan Summary

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

The FRP could be enhanced through an increased focus on in year actions and benefits realisation

The Financial Recovery Plan has been collaboratively developed between key stakeholders in the SSoT ICS. There were significant system engagement events in developing and co-creating the document and the System partners we engaged with felt that they played a role in the development of the plan. The FRP is widely recognised and understood which is a sign of positive collaborative across the system. In developing the FRP, System partners have intentionally focussed on identifying financial opportunities to address the key drivers of the deficit, with a particular focus on CHC.

The document sets out the financial challenge of £141m vs the original planned breakeven position and identifies seven key recovery workstreams, which are in addition to the £181m of targeted efficiencies. Key performance indicators have been identified for each, however critically not all of the workstreams have not been costed up in terms of their financial impact.

We note that since the production of the FRP, the System has increased its focus on the in year actions required as noted within NHSE resubmission process. Further decisions are required regarding workforce controls in year to seek System agreement and assessment against any associated clinical and operational risks.

We recommend that through the recovery governance structures in place that system partners revisit the actions in the FRP to ascertain what can be further accelerated and what new actions can be taken to improve the position. This should include consideration of the provision of staff to the CHC workstream and further detailed costings within the pay opportunities of not replacing leavers and reducing any bank / agency spend safely.

In addition to this the monitoring of delivery of the FRP actions could be enhanced through more granular supporting programme management information, including:

- The addition of action / milestone owners for the key actions and milestones, in addition the relevant sections could be split into the workstream highlight reports to enable more granular reporting
- Fully developed non-financial KPIs, with phased trajectories, with regular reporting streams identified
- Fully developed financial phasing, linked to the milestones and non-financial KPIs

The TDU may also benefit from implementing check and challenge stages within the programme lifecycle, run and monitored by the TDU. This would give colleagues a chance to ensure that the projects are delivering the identified benefits and provide a platform to rapidly agree remedial actions or close down the programme where deemed necessary.

Control category	Opportunity for enhancement	Complexity to implement	Priority controls for enhancement or implementation
Financial Recovery Plan			
Context and understanding of challenges faced and strategic forward plan	🟠	🟠	• Further analysis and documentation of the System's underlying position within the FRP or supporting documentation to provide additional context on the actions identified to mitigate the drivers of the deficit.
Granularity of supporting financial information and benefits realisation	🔴	🟠	• Rapid analysis and confirmation of financial and non-financial KPIs and trajectories, linked to key milestones / actions, to provide a clear route to cash out or run rate reducing savings. • Rapid review of business cases and establishment of a benefits realisation methodology to include the impact on substantive and temporary staffing controls / panels
Milestone plans and timescales for delivery	🟠	🟠	• Update the FRP recovery workstream highlight reports to include key actions / milestone owners and mandate updates at the recovery leads meeting twice monthly (instead of once).
Stakeholder engagement and ownership	🟢	🟢	• Continue to engage with stakeholders in key submissions / document creation.
Risk assessment and mitigations	🟠	🟢	• Continue to monitor risks from the supporting FRP governance meetings and feed into SPG / F&PC. • Additionally, expand the risk log into a governance log that contains risks, issues, actions, decisions and interdependencies log to document all key items throughout the workstream updates, giving opportunity to course correct if workstreams are not delivering benefits as planned.
Interdependencies (including links to quality and operations)	🟠	🟢	• (As noted above re: the documentation of interdependencies) • Continue the close link with the Chief Delivery Officer in support of the bed modelling as workstreams 2-6 start to deliver productivity and LoS reducing / admission avoiding benefits.
Governance and accountability arrangements for delivery of the FRP	🟠	🟢	• (As noted above re: updating of the FRP highlight reports and benefits realisation)
Impact assessments undertaken	🟠	🟢	• Implement regular reporting on the impact assessments undertaken, any gaps and continually challenge workstream leads as to whether any actions have changed that could benefit from a re-assessment to ensure that all impacts are carefully considered throughout the programme.

Pay controls review summary

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

There are opportunities to enhance the control of substantive and temporary pay costs to ensure these are appropriate

Organisations across the system indicated that they have implemented a wide range of pay controls, however the challenging pay expenditure position across trusts and average growth in pay expenses year on year suggest that there are opportunities for further enhancement. The details of the enhancements within this report align with what we would anticipate a System in financial turnaround to be operating.

All organisations demonstrated controls in place for the approval of vacancies (though not all via a formal VCP process as NSCHT operates virtual approval through Trac). In MPFT and UHNM, vacancy control panels (VCPs) are in operation, some have been established for some time whilst others are newly established (generally the corporate vacancy panels which were largely implemented in September - November as a response to the requests of NHSE in this matter). We observed 2xVCPs at MPFT, 2xVCPs at UHNM. We observed good practice at the vacancy panels with Executive leadership and robust challenge for the posts. A key point of note is that there are no vacancy freezes in place across the system currently, although we also note that the ICB are reviewing this possibility and have only recently ended their vacancy freeze which was in place until September 2023.

A critical factor in the system's ability to improve its financial position is through the strength of temporary staffing governance and controls. NHSE have set a target of 3.7% of % agency spend of total pay. The M6 YTD actual was 4.2% across the system (3.2% for MPFT, 5.2% for NSCHT, 4.8% for UHNM). UHNM and MPFT could demonstrate that they had associated governance (SFIs and sign off limits e.g. Executive sign off for rates over 50% of the cap and over £100 for Medics), through largely virtual or divisionally devolved management as opposed to physical panels. At the point of writing, we have not received the same information for NSCHT. In terms of rate cards, UHNM adhere to the agreed West Midlands Collaborative rate card for Medics to avoid competing with neighbouring organisations for medical staff.

In regards to governance, reviews of bank and agency data takes place, but this is monthly as opposed to the NHSE weekly recommendation. A key point of good practice can be highlighted within the system as MPFT have recently developed a workforce dashboard which gives greater transparency regarding key workforce metrics such as sickness, vacancies / recruitment, temporary staffing (bank and agency), etc. This is an excellent example of how data-driven insights can have impact on performance as MPFT's average % agency spend as at M1 was 3.57% of total pay, this has reduced to 2.55% in M6 and it is forecast to be below 2% by the end of the financial year. System collaboration in the use of a dashboard in this manner and increased frequency of review could seek to reduce the agency spend through closer monitoring.

Providers shared that they also collate lists as part of their routine monitoring of temporary staffing regarding the highest earners and longest agency staff being utilised. In MPFT, they have plans in place to remove these agency workers through various strategies, and in UHNM they have asked the divisions to develop agency reduction trajectories in line with nursing vacancy decreases, though this will have a time of overlap due to people being supernumerary when they initially commence in post and until sufficiently trained. UHNM are the only trust within the System to have banned off-framework agency, while the trusts that continue to use off-framework have authorisation processes in place with Executive Leads and are only used in exceptional circumstances.

Pay control review findings overview

There are examples of good practice and innovation in the System, which should be shared such as the MPFT workforce dashboard that could be leveraged to support system-wide strategic workforce planning.

Control category	Opportunity for enhancement	Complexity to implement	Priority controls for enhancement or implementation
Pay			
Vacancy control	🟠	🟢	• Review of vacant positions explore whether these can be: removed, changed, scaled up to system level, skill-mixing, or made as a secondment/bank role. Supported with a benefits tracking process to be implemented. • Agree on plans to reduce any associated temporary staffing spend • Consider temporary recruitment freezes • Monthly establishment reports to be instated with budget holders expected to provide clear rationale for any over-establishment or WTE increases with exit strategy in place • Ensuring ESR and the ledger are reflective of the active establishment within organisations • Introduce the use of the temporary staffing data (bank and agency dashboards) within VCPs to assist in the articulation of vacancies and set trajectories for agency reduction in line with recruitment • Ensure the vacancy control panel outputs are aligned to the cessation of any backfill arrangements (i.e. rejected / frozen recruitment requests should then not be backfilled via bank / agency).
Temporary staffing governance	🟠	🟠	• Support the expansion of the MPFT dashboard model into other trusts and at a System level to support agency reduction targeted schemes and strategic workforce planning • Regular (weekly) interrogation of temporary staffing trends
Internal temporary staffing and authorisation controls	🟠	🟠	• Additional scrutiny to be applied in regards to departments that are overspent on pay budgets in relation to pay append approval processes and potentially revise authorisation limits e.g. through senior workforce team attendance at divisional / care group / directorate panels • Continue with efforts to recruit to the staff bank to displace agency workers
External / agency authorisation controls	🟠	🟠	• Implement a systematic process to prospectively review shift information to both increase temporary staffing governance / oversight and make positive interventions in regards to staffing levels in managing bank, agency and safe staffing across trusts.

Non-pay controls summary

Opportunity for enhancement	
●	**High** - clear opportunities to accelerate or increase financial benefits
●	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
●	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
●	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
●	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
●	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

There are opportunities across the System to enhance non-pay controls with a particular focus on drug expenditure and medicines optimisation

While pay represents the majority of spend across the System, there are still opportunities available to enhance non-pay controls. At M6, non-pay expenditure for the trusts sits at £401m, £39m adverse to plan. This is driven by:

- £114 at MPFT, £13m adverse to plan
- £40m at NSCHT, £500k favourable to plan
- £248m at UHNM- £27m adverse to plan

Non-pay controls have good coverage across the system and there are examples of good practice, however there are further opportunities to embed and enhance these.

Collaboration through the North Midlands and Black Country Procurement Group (NMBCPG) has allowed for efficiency in UHNM and NSCHT, however there is still scope for further collaboration with the ICB and MPFT, allowing for further economies of scale and increased buying power to be achieved.

The System operates a ‘No PO, no Pay’ policy, where expenditure incurred should not be paid unless accompanied by a PO which has secured appropriate approval in line with the SFIs and procurement processes. Retrospective POs are still prevalent in UHNM (127 in Q2, although this was only 1% of total POs), and these are reported quarterly in the Audit Committee paper, highlighting control weakness in this area.

Governance is clearly outlined in the SFIs and appropriate approval for contract levels are defined. This is set out in policy documents but has also been built in to the eREAF system used by the NMBC Procurement Group. It is clear across the system that appropriate approval mechanisms are in place and are being adhered to.

The entire System has performed a thorough line by line expenditure review, requiring budget holders to assess if / how the expenditure relates to an ICB statutory duty or directly supports a national or local system plan priority, allowing for the identification of cost savings.

Due to resource constraints, there is lack of pace in horizon scanning. This should be prioritised due to the risks that arise from the dynamic drug environment e.g. new switches identified and potential NICE recommended high cost drugs entering the market, resulting in additional expenditure.

Non-Pay control review findings overview

There are examples of strong controls in operation, which should be shared across the System. For example, the ICB has performed a through line by line expenditure and contract review allowing for the identification of savings of £9.18m. For those lines that required more information in the summer, they have continued to be taken forward in the Efficiency Oversight Meeting, to ensure completeness.

Control category	Opportunity for enhancement	Complexity to implement	Priority controls for enhancement or implementation
Non-Pay			
No PO, No pay	●	●	• Implement robust processes to monitor breaches of No PO, No pay, as defined in the SFIs, to ensure that patterns can be tracked and non compliance can be reduced
Governance and approvals	●	●	• Explore further collaboration within the NMBC procurement group for the ICB and MPFT, including the onboarding of the eREAF system to automate approvals
Expenditure review and contract management	●	●	• Explore further collaboration within the NMBC procurement group for the ICB and MPFT, to allow for increased efficiencies through economies of scale as well as stringent contact management processes.
Drug expenditure and medicines optimisation	●	●	• Focus on horizon planning with pace to ensure risk around drug expenditure can be quickly responded to

Section 3

Observations and Recommendations on the System's Financial Recovery Plan

Financial Recovery Plan (1/5)

Opportunity for enhancement	
●	**High** - clear opportunities to enhance FRP governance and / or delivery of the FRP
●	**Medium** - rapid further exploration recommended to confirm opportunities to enhance FRP governance and / or delivery of the FRP
●	**Low** - limited actions recommended

Complexity to implement	
●	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
●	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
●	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

The FRP was developed between July - October 2023. The **plan was developed collaboratively by the System leaders and key stakeholders** at two engagement events held in July and September 2023. The **July event focussed on the development of the 2024/25 System plan and transformation programme**. The follow up **event in September centered around the financial challenge and the FOT of £141m was shared to contextualise the scale of the position and requirements to mobilise the recovery actions at pace**, leads of the "big ticket" items held stands to share progress on their workstream mobilisation to date. The feedback from this event was **support for the recovery workstreams and commitment to the delivery**. The TDU (Transformation Delivery Unit) has allocated a lead for each of the recovery workstreams to support the project management. The seven workstreams were then broken down into 16 projects and 24 delivery products which are now monitored by the Weekly Recovery Programme Meeting, which then flows into the System Performance Group and finally the Finance and Performance Committee.

FRP theme	Observations	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Financial and operational sustainability	• The financial recovery plan is very much focussed on addressing the drivers of the deficit (increased costs in CHC and bridging the bed gap) to support the financial and operational position. • We note that there is a System Performance Group / Turnaround Board and the plan references the £181m of efficiencies within the organisations to be delivered in year. However the FRP could provide further detail on typical turnaround actions that we would expect to see in a financial recovery plan. The plan would benefit from a refresh and focus on in year activities.	The System would benefit from the review and inclusion of further in year, run rate reducing improvement schemes such as the below. We note that some of the schemes area already in place such as: • Increased scrutiny on substantive recruitment via control panels / local processes • Agency reduction plans for all agency users There are further "unpalatable" items that the ICB could consider such as the items below. It should be noted that they could impact morale / operations across the System and would need to be carefully reviewed in QIA / EIA panels: • Reinstating car parking charges for staff / patients / both • Removal of funding for staff training / courses • Deferral of the approval of business case approvals until 2024/25 • Enhancements to the "double lock" process whereby business cases can only be presented if an agreed ROI of savings are presented	●	●	1-2 months	ICB and Trust CFOs
Drivers of deficit	• The FRP does not contain detail of the underlying position and whilst the key challenges that the System are facing are cited, in terms of the aging population, increased cost and volume in CHC, inflationary pressures in prescribing, etc. further analysis on the underlying position could be provided to contextualise and understand the challenges faced at the start of the year.	• Addition / addendum to the FRP of the underlying position to contextualise the challenges seen within the System. • In addition the System could benefit from conducting pay spend reviews from 19/20 to understand the key changes in staffing compared to activity levels. This could support decision making at the organisational VCPs.	●	●	1-2 months	ICB finance team
Ownership and stakeholder engagement	• We have seen true collaboration and system working in the SSoT system and this is evidenced in the financial recovery plan. It is very much written from a System perspective and does not read as an amalgamation of individual plans. • However, it is also very difficult to understand the individual organisations roles in delivering the FRP.	• Confirm the split of the recovery actions between the organisations and the accountable owners for each workstream. This would support the TDU in tracking the delivery of the big ticket recovery items and wider ownership of the recovery actions.	●	●	1-2 months	TDU

Financial Recovery Plan (2/5)

Opportunity for enhancement	
	High - clear opportunities to enhance FRP governance and / or delivery of the FRP
	Medium - rapid further exploration recommended to confirm opportunities to enhance FRP governance and / or delivery of the FRP
	Low - limited actions recommended

Complexity to implement	
	High - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

FRP theme	Observations	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
"Big ticket items" - CHC	• The FRP is structured with seven themed areas and two additional projects. There are underpinning products for delivery, which are reported to impact on the financial recovery plan. • The key costed component of the systems FRP is limited to CHC. The volume, LoS and cost of the care packages within CHC has grown exponentially over the last few years (c.25% growth year on year since 2021/22). Through increased grip and control of the contract, the assessments and timely reviews there is clearly a valid opportunity to take contribute to financial recovery. However the savings outlined within the current FRP (£109m) have been costed as a 'best case scenario'. In reviewing supporting programme management materials predicted financial savings (cost out) to the value of £10.6m is expected to be delivered in year, the FYE aim is £109m. • Following discussions during our review, it is understood that the savings will not be genuine CIP / cash out, but a run rate reduction from the forecast outturn position prior to the recovery actions. Whilst the savings cannot be released as a CIP due to the overspend YTD, they should materially impact the financial position at year end and support a reduction in the planned deficit. Part of this is already being factored in to the resubmission of the financial outturn position. • The main rate-limiting factor in delivering the financial savings at significant pace in year is the staffing capacity constraints in overall programmatic support in the workstream, in undertaking the assessments and working through the backlog of reviews.	• Information to support financial recovery plan would benefit from being more granular with regards to the forward looking plans, in the same way that it is monitored at a granular level for actual savings (e.g. by individual package of care / care home). Greater modelling against the workstreams within CHC to develop trajectories in line with when costs will be taken out of the system would be beneficial now that they are more cohesively formed. It would be helpful to ensure this accounts for the available capacity to drive forwards the work plan to ensure that savings projections are realistic. • With regards to the work streams that are contributing to the in year financial improvement in year, we would recommend that they remain in Amber until the ICB receives confirmation of the payments / costs are avoided at year end. • The workstream would benefit from additional capacity both from a clinical perspective to undertake the patient reviews and from a project management perspective to support the management of the workstream e.g. providing more of a project management approach to the 1:1 reviews workstream with regards to a detailed action plan week on week linked to a trajectory of savings to support the operational meetings (albeit we recognise that the operational nature of the meetings may impact this). The additional capacity would be over and above the resource in the 6 month pilot to the Fast Track workstream agreed at F&PC on 5 December 2023. • We understand that the workstream are reviewing the service specification and within this, will be supporting an increase in reviews where appropriate. A sample and comparison of review timeframes to create a set of principles would be encouraged to ensure that individuals are regularly reviewed and opportunities for potential step down are assessed in a more timely manner. • Whilst we recognise that the workstream is currently focussed on the patient reviews and the implementation of the eligibility / package of care review panels, additional savings could be realised within pathway reviews e.g. the Acquired Brain Injury (ABI) pathway. Additional resource to specifically review the packages of care for patients on the ABI pathway could support the appropriateness of the care provision, potentially releasing efficiencies via lower costs of packages. A longer term action would be to review the pathway in its entirety, to support the sustainability of any savings made.			3-6 months	Project leads

Financial Recovery Plan (3/5)

Opportunity for enhancement	
🟠	**High** - clear opportunities to enhance FRP governance and / or delivery of the FRP
🟡	**Medium** - rapid further exploration recommended to confirm opportunities to enhance FRP governance and / or delivery of the FRP
🟢	**Low** - limited actions recommended

Complexity to implement	
🟠	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟡	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

FRP theme	Observations	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Bridging the bed gap	Six of the seven big ticket items relate to savings in bridging the bed gap, these do not have any financial savings attached to them. From conversations with colleagues and the Chief Delivery Officer at the ICB we note that these are not included within the bed modelling due to an agreement that the recovery actions would support the reduction in required capacity and the 2023/24 bed modelling. The teams are optimistic that the impacts from the items will impact the bed modelling for Winter 2024 however they have not yet seen any trajectories or phasing to confirm this.	• The project groups supporting the schemes that will result in operational improvements should complete detailed milestone / action plans and associated KPIs that will detail when the effects of the interventions will be anticipated to impact the bed modelling at UHNM. • The bed modelling should then be updated in the 2024/25 planning process and this should reduce the identified reliance on IS beds or additional beds being opened in the escalation wards at RSUH / the County Hospital.	🟡	🔴	3-6 months	Project leads for recovery actions 2-7 as referenced in the FRP
Granularity of supporting financial information	There is currently a lack of financial information supporting six of the seven big ticket items relating to bridging the bed gap. This has intentionally not been included to date as these workstreams are designed to reduce year on year growth initially. Ultimately the savings will be delivered via a combination of: • Closure of winter / escalation wards • Reduced temporary staffing • Reduced on-pay spend on the wards	• Define the “tipping point” for the bed reducing / productivity schemes early on in the development process to confirm the point at which they would be able to move into cash releasing. This should be part of the milestone / action plan and this should include engagement from the financial teams to provide an early indication of the areas of budget that could be released when this happens. For example, WLIs, agency spend, additional sessions, etc.	🔴	🟡	3-6 months	Phil Smith
Content of the plan and going further	Many of the items within the plan are focussed on bridging the bed gap. We would typically expect to see additional elements within an FRP to generate cost-out, for example the inclusion of medicines optimisations transformation programmes and review of services / contracts across the system for opportunities to deliver services at scale (e.g. shared services). In relation to medicines optimisation the scope of the workstream in the financial recovery plan is focussed on supporting the bed gap through quicker discharge however this is not cash releasing and there is the opportunity to do more in terms of medicines optimisation across the ICS to drive further savings e.g. management of non medical drug expenditure (Stoma care and nutritional supplements), de-prescribing within primary care and patient pathway planning. In regards to assessing opportunities to operate at greater scale, we recognise that some of this exists with e.g. the North Midlands procurement collaborative containing 2/4 organisations from the patch, however there is a broader opportunity to map out back office functions and make an assessment whether some can be delivered at scale for a greater cost efficiency e.g. procurement all under North Midlands collaborative instead of ICB and MPFT outlier - also other opportunities e.g. alignment of people functions, analytical resources, business intelligence, estate management, or other standard back office functions.	• Through Medicines Optimisation Leads group, develop a transformation plan for Medicines optimisation transformation, with the intention of transforming the way the services are currently delivered and generating cost-out opportunities. • Undertake an assessment of back office services to identify opportunities to deliver at scale (subject to full business case and assessments within each department)	🟡	🟡	3-6 months	TDU

Financial Recovery Plan (4/5)

Opportunity for enhancement	
🟠	**High** - clear opportunities to enhance FRP governance and / or delivery of the FRP
🟡	**Medium** - rapid further exploration recommended to confirm opportunities to enhance FRP governance and / or delivery of the FRP
🟢	**Low** - limited actions recommended

Complexity to implement	
🟠	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟡	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

FRP theme	Observations	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Governance and accountability arrangements for delivery of the FRP	• The reporting we have reviewed (weekly recovery programme meeting and the system performance group) contains status updates on the big ticket items. The reporting contains some good updates with regards to key metrics, achievements to date and some context for Amber / Red RAG ratings. However it can be quite difficult to understand in this format and this rationale is not provided consistently.	The reporting would benefit from being broken down into categories of updates, for example: • Progress in the past 2 weeks • Plan for the next 2 weeks • Key milestone / KPI achievements linked back to the overarching programme gantt • Any support / escalation required If the project is RAG rated Amber / Red - there should also be an inclusion of the planned “pathway to Green”	🟡	🟢	1-2 months	TDU
Savings and savings trajectories	• The FRP contains high level savings against the CHC items which are set to be realised partly in year (from 1:1 reviews and changes to eligibility panel and care review panel processes) and in the future financial years. • The wider workstream savings (either financial or bed savings) are modelled on targeted of % increase / decreases. However this recognises that at this point the reviews and changes within the System had not yet started to reap benefits, noting that the CHC workstream have now started to record savings made. Linked to this, whilst the KPI dashboards are being developed at present, there are currently no projected financial / non-financial trajectories to show the savings over time. Whilst there are good KPIs identified within the project summaries and within recent SPG reporting, the improvements are not phased and not all metrics include baseline measures, targets or actuals YTD.	• The project teams would benefit from having phased non-financial KPIs with a starting baseline and monthly targets / actuals. The phasing of these should be linked to key milestones / actions to link the incremental increases. We understand that this is currently in development and drafts have been shared at the SPG. • There should also be an inclusion of the financial trajectory linked to achievement of the non-financial KPIs, with associated budget / account codes where possible. We understand that this is currently underway within the CHC workstream.	🟡	🟡	3-6 months	All project leads, supported by the TDU
Risks / issues	• There are eight risks that have been identified on the risk register at the time of writing. Risks are articulated clearly and the scoring appears to be consistent with expectations with a tracking of the trends and how the current risk scores have increased / decreased over time. We note however that the residual risk scores in most cases are not impacted therefore suggesting that the associated actions and mitigations are not supporting the control and management of the risk. Also there are no risk or action owners outlined within the risk register. • We have observed evidence of risks being cited through both the System Performance Group and Finance & Performance Committee structure R121 on the delivery of the plan and R113 regarding CHC cost pressures. Showing that there is oversight of the key risks affecting the financial recovery plan and financial position.	• Risk owners and action owners to be applied to promote the accountability in reducing risks • Review of mitigating actions and ensuring that actions noted are intended to control the risk (even if not to bring down the overall score) it could be helpful to utilise a risk management technique to identify how the risks are being treated e.g. the 4Ts - tolerate (the risk remains at the same score and is to be tolerated), Treat (mitigating actions are in place to bring down the impact / likelihood of the risk), Transfer (transfer the risk to another party) and terminate (risk to be closed upon completion of mitigating action)	🟡	🟡	1-2 months	TDU

Financial Recovery Plan (5/5)

Opportunity for enhancement	
High	**High** - clear opportunities to enhance FRP governance and / or delivery of the FRP
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to enhance FRP governance and / or delivery of the FRP
Low	**Low** - limited actions recommended

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

FRP theme	Observations	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Interdependency mapping	• Whilst we have not seen a map of interdependencies in the form of a traditional log / matrix, this is covered in practice at the Weekly Recovery Programme meeting whereby all recovery workstream leads attend and discuss the actions they are undertaking. This is the main update forum from the workstream leads to the TDU, intentionally to promote the cross workstream updates and to support the identification and mitigation of any duplications or dependencies.	• Whilst the updates at the Weekly Recovery Programme meeting will be helpful, there is a risk that individuals could miss vital updates if they are unable to attend. A shared log on MS teams that all leads could access and update would be beneficial to confirm the audit trail of any dependencies. This will be particularly important as the pace of the programme increases.			1-2 months	TDU
Impact assessments	• We understand that the TDU have recently undertaken a review of the existing QIAs (Quality Impact Assessments) relating to the recovery workstreams and documented this in an update to the Weekly Recovery Programme meeting, although from the report it was unclear as to how recently the QIA was undertaken. The intention is for the TDU to submit any remaining QIAs for the workstreams to the Quality and Safety Committee for review and approval which is in line with our expectations. • At the point of writing, it has not been confirmed if a similar process has been undertaken for EIAs (Equality Impact Assessments) and DPIAs (Data Protection Impact Assessments)	• Confirm the dates of when the existing QIAs were undertaken for the recovery workstreams and if there have been material changes in scope / savings associated, resubmit through the process • Confirm if the same process has been undertaken for the EIAs and DPIAs and undertake this at pace if this is outstanding.			1-2 months	TDU
Business case process	• We note that the System has self imposed the double lock process to review and approve business cases at both an organisation and System level collectively. We observed this in practice at the System Performance Group and noted a substantial discussion regarding the risks of not approving the business case, clinical / operational considerations and the wider financial picture. SPG then made a recommendation to F&P Committee whereby the business cases were approved. • Whilst the approval process contains robust challenge, we understand that the ICB does not currently conduct any benefits realisation processes on approved business cases (either for the ICB or System as a whole).	• Define a monitoring and benefits realisation methodology at SPG to monitor the desired / actual impact set out in the business case, compared to investment made. This benefits realisation methodology should be connected with the TDU to enable the quantification of any productivity impacts impact linked to the recovery actions within the FRP.			1-2 months	TDU & System CFOs

Section 4

Observations and recommendations on grip and control

Section 4a - Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Observations and recommendations on grip and control

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

ICB - Pay Controls (1/2)

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Vacancy Control	• A vacancy freeze was in place (until September 2023). Following this, a vacancy panel was established as part of the Executive team meeting to scrutinise vacancy control forms (which detail the reason for the request, funding for the post and additional information) to approve/deny the request. • However in November 2023, due to the ICB's financial situation, they decided to revisit this to strengthen their approach. • All Directors were instructed to remove 30% from their budgets prior to being able to recruit. We have been made aware that the intention is to introduce a 'first line decision-making panel' for posts up to 8B, and a further Executive-level quality assurance panel. It has been reported that the intent is to support this approach with line manager justification questions and agreed decision-making criteria, to ensure consistency. The ICB have shared these documents in draft form, which we understand are currently being agreed with the Executive team.	*ICB* • Explore the use of Trac to digitise the justifications questions and ensure a robust audit trail for decision making in the VCP approvals process. • Continue with plans to implement new vacancy control processes. *Potential additional system controls* • The ICB may wish to consider implementing an additional layer of governance such as a Consistency and Scrutiny panel arrangement that sits above the trusts for e.g. corporate vacancies above a certain banding. • This consistency and scrutiny panel may also consider the number of approvals / rejections that the trusts' vacancy control panels are making to ensure there is parity across the patch and that panels are working effectively, possibly utilising the recently shared NHSE weekly controls spreadsheets as a central data source to provide additional scrutiny			1-2 months	Mish Irvine

Temporary Staffing Governance
 	
and
 	
External / agency controls and authorisation processes
	• There are no formal controls in place to support external / agency appointments. All appointments are subject to the NHSE regulations e.g. business case if they are an A&C (Admin & Clerical) role and for the purposes of time-limited projects. Agency workers are reviewed on a case-by-case basis by the CEO and CFO for approval.	*ICB*
		• Whilst recognising that the usage is minimal, the ICB could increase rigor by implementing formal principles regarding agency usage e.g.:
		  ○ Centralised oversight mechanism for agency spend
		  ○ Regular audits to identify patterns, trends and potential skills gaps across the system
		  ○ Foster collaboration with trusts i.e. if resources can be shared as opposed to making temporary appointments
		  ○ Cap on agency usage
		• Establishment of a formal panel that reviews all agency expenditure (or a formal agenda item). The request forms would support with a robust agency request process, detailing e.g. the rationale for the request, the quality / service need for the support, confirmation that the post will support the financial challenges e.g. linked to CIPs, business cases and detailing the ROI
		Potential additional system controls
		• Look to support the expansion of the MPFT dashboard model into other trusts and at a System level to support agency reduction targeted schemes and strategic workforce planning
		• Conduct a staffing vs. productivity review at scale across the system
					1-2 months	Mish Irvine

ICB - Pay Controls (2/2)

Opportunity for enhancement	
	High - clear opportunities to accelerate or increase financial benefits
	Medium - rapid further exploration recommended to confirm opportunities to release financial benefits
	Low - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	High - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Internal temporary staff controls and authorisation processes	• It was noted that secondments are agreed by the Executive team and are tracked by HR.	• No recommendations identified.			N/A	N/A

ICB - Non-Pay Controls (1/2)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Procurement and spend control systems - No PO, No Pay	• The ICB operates a 'No PO, No Pay' control through the use of its Oracle Financial Ledger. The system has been configured such that relevant creditor invoices cannot be registered on the system without quoting a valid PO number. • The ICB currently do not have any formal monitoring of late POs or breaches to the policy, despite the SFIs stating that all retrospective approvals should be reported. • The ICB regularly hold training exercises with budget holders explaining the importance of purchase orders and the role purchase orders play in implementing a control environment. This training is delivered in person each year and relevant materials ares uploaded onto the intranet page for staff to access and to support wider communication within the organisation. • The ICB have an average of 98% compliance with the Better Payment Practice Code (BPPC) across NHS and Non-NHS Invoices.	• Continue to operate the control, and should continue to deliver regular training on why the control is important. Ensure training is delivered to new joiners if out of line with the annual training cycle. • Formalise a mechanism for the monitoring of breaches of the control to ensure that there are not patterns in non compliance.	Medium	Low	1-2 months	Lee Squire
Procurement and spend control systems - Approvals and governance	• The ICB has moved from outsourcing its P2P and O2C back office functions to the MLCSU, to having in house staff to perform these functions. They still outsource specialist and technical support to the MLCSU. The ICB are not currently a part of the NMBC procurement group and are not involved in the programme board. • Currently non-pay expenditure follows the ICB SFIs with approval limits delegated to budget holders. Under the existing SFIs up to £1k can be approved by a Band 6 (if a budget holder) and up to £10k by Band 8a and £25k by 8b.	• Consider the adoption of the eREAF system used by NMBC procurement group to allow for automatic application of the control and approval process. • Explore the potential for the ICB to become a part of or share further functions with the NMBC Procurement Group. • To rapidly review the SFIs across the group and reduce the current spending approval limits delegated (for instance, reducing the value individuals can commit to or raising authorisation rights up the hierarchy) recognising the scale of the financial challenge faced.	Low	Medium	1-2 months	Lee Squire
Procurement and spend control systems - Expenditure and supplier review	• The ICB has performed a thorough line by line expenditure review, requiring budget holders to assess if / how the expenditure relates to an ICB statutory duty or directly supports a national or local system plan priority, to determine if it was necessary expenditure that could be reduced or withdrawn. This review identified total cost savings of £9.16m, of which £4.78m will impact in year. • A number of budget lines required further information for a formal recommendation to be made. These contracts are now assessed in the Efficiency Oversight meeting that reports into the Finance & Performance Committee. • The ICB have also performed a robust contract review, using a detailed checklist outlining key lines of enquiry around value for money and commissioner insight, to assess whether contracts should be renewed or reduced.	• Continue to perform regular expenditure reviews to ensure regular scrutiny is applied and any CIP identification is achieved through the Efficiency Oversight Meeting. • Continue to use the contract review template to ensure contracts are continually subject to scrutiny. • Consider the expansion of the exercises undertaken at the ICB (and the checklist) with organisations within the System that have not yet performed the same review. • Explore the possibility of further collaboration with NMBC procurement group to achieve potential savings through sharing large contracts and utilising advanced buying power through large scale procurement.	Low	Low	1-2 months	Lee Squire

ICB - Non-Pay Controls (2/2)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

Procurement and spend control systems - Drug expenditure and Medicines Optimisation	• There is a medicines optimisation group at a System level that reviews all opportunities to reduce medicine spend, led by Chief Pharmacist Mark Seaton. The team are progressing well against their targets of 90% uptake in biosimilar switches (90% of switches achieved) and switching from IV to oral antibiotics (83% update in last quarter audit). However the financial benefits realised from these switches are currently not tracked.
	• The Pharmacy Leadership Group (PLG), that meets fortnightly, has recently been re-established and therefore surrounding governance and terms of reference are not finalised. The PLG has the aim to cover horizon scanning and business planning, medicines safety assurance and medicines governance, allowing for the identification of potential cost savings and identification and mitigation of any potential risks. There is currently no formal agenda, however terms of reference have been defined. Core membership includes Chief pharmacists in the system, as well as representatives from the local authority and Keele University.
		• Implement a mechanism to track the savings realised from the release of beds through the switch of antibiotics from IV to oral, this will then be able to feed into the operational bed planning.
		• Continued regular review of biosimilars and focus on horizon scanning to maximise benefits as new switches are approved and lead in times for the switches are reduced as far as possible.
		• Finalise the governance surrounding the PLG to ensure that meetings are action focussed, minutes are documented and pace is driven into the development of CIP and transformational schemes.
		• Work with the System to consider further transformational pharmacy schemes, for example:
		  ○ Work to identify problematic patient pathways involving medicines and/or high cost drugs to consider if there is alternative treatment that can be delivered out of hospital to reduce bed blocking
		  ○ Assessment of non medical drug expenditure (e.g. Stoma care and nutritional supplements) to identify potential wastage
		  ○ De-prescribing in primary care to ensure that there is reduced wastage. Efficiencies can also be realised if patients are given over the counter options (which is cheaper than prescribing).
					1-2 months	Mark Seaton

Section 4b - Midlands Partnership NHS Foundation Trust

Observations and recommendations on grip and control

MPFT - Pay Controls (1/5)

Opportunity for enhancement	
🟠	**High** - clear opportunities to accelerate or increase financial benefits
🟡	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🟠	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟡	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

Vacancy Control (1/2)	• A new vacancy control process was authorised in October 2023, with the full implementation taking place in early November 2023. To note, this was already in place within three care groups (for a number of years) and the new process was rolled out more widely to the Stoke and Staffordshire Care Group and Corporate areas from 10th November.
	• Example terms of reference for the vacancy panels in place were shared for the SSoT and Childrens and Families Care Group vacancy panels which we reviewed and were in line with our expectations regarding VCP governance.
	• Clinical, additional clinical services, estates and ancillary have been defined as exempt from the new vacancy justification process and are considered via the usual care group vacancy approval processes. All A&C posts are required to be approved by a financial accountant. If the A&C posts are based within the care group they are subject to the care group vacancy panel process, whereas if they are corporate they are required to be sent to a weekly corporate vacancy panel that is scrutinised by the CPO, CFO and DoN.
	• The Trust has a vacancy control electronic form in place (on Sharepoint) which prompts key questions regarding displacement of agency, impact of the post to be recruited to (e.g. performance / quality), sustainability (changes considered regarding the way the Team works / is rostered to cover the duties within existing resources and or opportunities for sharing resource with other teams). However given the recent introduction of this form, it is has not been possible as yet to obtain back end data to report on the vacancies requested to date, but the workforce / intelligence teams are working on the reporting element at present as they are aware that they will need to report on its effectiveness within the Trust / ICB.
		• Review vacant positions that have been vacant for more than six months to understand current staffing arrangement and explore whether these can be: removed, changed, scaled up to system level, put through a skill mix assessment, made into a secondment role if short term. Benefits tracking process to be implemented regarding any benefits delivered as a result of this.
		• Implement a monthly review of all vacant posts with the intention of freezing / removal of posts or updating the establishment as required. To support this, divisional budget managers could receive a monthly establishment report and be expected to provide clear rationale for any over-establishment or WTE increases with an exit strategy in place.
		• Continue with VCP processes across the Trust. Given the decentralised nature of the VCP process that has been established for Clinical, additional clinical services, estates and ancillary posts, consider this approach to ensure consistency across the VCP process.
		• Consider alignment of VCP processes (documentation) across the Trust to achieve greater visibility, oversight and collation of management information related to VCPs, this could be delivered through different options:
		  ○ a) Transition Care group VCPs to using the Sharepoint form process which would provide a more streamlined process and greater oversight across the Trust to the Executive Board.
		  ○ b) Build additional questions into the tracker for the care groups with established vacancy panels to provide evidence of the scrutiny / challenges that we have observed within the meeting e.g. clinical risks, safety risks, links back to vacancies, establishment structures, considerations to fixed term vs. substantive recruitment, etc. With regards to panels that do not use the sharepoint form, create a log to capture any risks and actions raised through the VCP process are captured centrally for recording purposes
			🟡	🟢	1 - 2 Months	Alex Brett and Angie Astley

MPFT - Pay Controls (2/5)

Opportunity for enhancement	
	**High** - clear opportunities to accelerate or increase financial benefits
	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Vacancy Control (2/2)	• We observed the Children and Families Care Group vacancy panel meeting and noted that there was a weekly vacancy tracker in place to highlight the posts for review and support discussions. The tracker contained reference to the post, recruiting manager, WTE, Perm / Temporary and whether funding was in place. From the meeting we observed that the care group has a robust level of challenge within this process, connecting the posts requested with the associated operational and service risks, and assessed the requests operationally with thorough consideration, for example: supervision arrangements, backfill arrangements for internal only secondment etc. that were required. Whilst this meeting was supported by a tracker, it did not contain an area within the spreadsheet / prompts to provide evidence of the scrutiny / challenges that we have observed within the meeting. There was also slight confusion over a service manager post from the previous week which although authorised, had not been formally approved on Trac, thereby causing a slight delay to recruitment. There were no A&C posts for scrutiny in the panel we observed, only a retire and return post, so we cannot comment on whether the new A&C vacancy process (sharepoint form) was followed. • We observed the Corporate vacancy panel for A&C posts. The panel process is supported by a sharepoint form (this is a new process that was launched in November for Stoke and Staffordshire Care Group and all corporate / A&C vacancies, which differs to the process used for clinical roles in the care divisions whom already had established VCPs in place which we observed). The Sharepoint form was updated in real time detailing the discussions that took place at the panel to ensure there is a full audit trail and avoids manually emailing papers and feedback e.g. reasons for deferring the post due to further information required. We observed good engagement from Executive leads on the panel (CFO, CPO and Chief Nurse), robust challenge regarding clarity of funding attachments, banding queries (i.e. why a post was a particular band and the rationale being given) and the need to confirm with other colleagues prior to formal approval (HIS shared service posts that are for a system-wide shared service that MPFT hosts). A longer term bank post was also brought to the panel we observed, to ensure that there was scrutiny and this was the only one of the five posts that was approved, the remaining were referred back for further clarifications from the hiring managers following the discussions within the panel. • We noted that there are different processes in place across the Trust to support the VCP process and both are effective. However the audit trail (due to the use of everything in a sharepoint form) is stronger and more streamlined with the new process that has been developed. There would also be benefits to gain in having a Trust-wide reportable view of vacancy panel activity. • We were advised that all corporate posts that were vacant more than three months were reviewed and challenged as part of 2023/24 budget setting and that the Trust intends to review all vacant posts as part of 2024/25 budget setting.	• Introduce the use of the temporary staffing data (bank and agency dashboards for care divisions) within VCPs to assist in the articulation of vacancies with the aim to set trajectories for agency reduction in line with recruitment • To ensure the vacancy control panel outputs are aligned to the cessation of any backfill arrangements (i.e. rejected / frozen recruitment requests should then not be backfilled via bank / agency). • To define a monitoring and benefits realisation methodology to accompany the panel. It is recommended that the panel is supported by a dashboard which monitors requests considered at panel, decisions taken and wider trends to identify if mitigating action is required and to support ongoing refinement. The benefits realisation methodology should be connected with the joint working group across HR and Finance to enable the quantification of the run rate impact.			1 - 2 Months	Alex Brett and Angie Astley

MPFT - Pay Controls (3/5)

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Temporary Staffing Governance	• As at M7 pay spend YTD actuals were £8m under budget compared to the YTD plan. • Temporary staffing expenditure is reported monthly to the Finance & Performance Committee and off-framework/over cap shift information is reported monthly to the MPFT People Committee for scrutiny. • Medical and Dental expenditure is signed off by Medical Director and Chief People Officer. Nursing expenditure is overseen by Chief People Officer with devolved responsibility to the Associate Director. • MPFT's average agency spend of total pay between M1-6 was 3.14% against an NHSE target of 3.7%. There has also been a reduction month on month; as at M1 the total agency spend was 3.57% of total pay, this has reduced to 2.55% in M6 and it is forecast to be below 2% by the end of the financial year. • Temporary staffing demand equates to on average 1,571 shifts per week for inpatient services. Bank fill is averaging at 75% fill, agency is accounting for around 20% of fill and around 5% of shifts remain unfilled. • The DoF and CPO work together to retain a grip on temporary staffing and vacancies to ensure a coordinated approach between finance and HR through a regular working group between the departments, ensuring relevant updates to Finance & Performance Committee, the People Committee and joint representation on the corporate VCP. • MPFT have developed workforce dashboards which give greater transparency regarding key workforce metrics in the workforce summary dashboard such as sickness, vacancies / recruitment and a detailed temporary staffing dashboard. Whilst the substantive workforce dashboard has been developed and in use for some time, the bank and agency dashboard is newly established in November and being rolled out at present, however this is a brilliant example of how data-driven insights can have impact on performance. This is supported by the governance through the Directorates Management Group (DMG) and this forum will then decide which other trust forums should be cited on the data in regards to the supporting governance. The Trust is keen to rollout the dashboard to care groups so they have greater insight into their workforce data down to departmental / ward level.	• Implement a regular (ideally weekly) interrogation of bank and agency trends and spend to support further proactive intervention within particular care divisions (e.g. Other care group as Agency as % of Temporary Staff by FTE has been at 100% since May 23 and Off-framework Agency as % of Total Agency by FTE usage in Childrens and Families care group (increases from Jul-Sept in usage peaking at 39.78% in Sept and ensuring the downwards trend continues and ensuring they're following the associated non-framework agency controls). • Include the bank & agency summary dashboard as part of the suite of KPIs that is shared through the workforce governance routes including the People Committee and at care group level to support the interrogation of temporary staffing usage. • Implement a systematic process to prospectively review shift information for substantive, bank and agency planned staff numbers against bookings (e.g. a week in advance) and make positive interventions in regards to staffing levels in managing safe staffing and agency reduction. The implementation of this process / tool would be based on the ward establishment and safe staffing levels reviewing the supply and demand of the care group or department. This would be coupled with a robust governance structure that would provide a platform for confirm and challenge of future shift data at ward level.	🟢	🟠 *Amber due to the third recommendation	1 - 2 Months	Alex Brett and Angie Astley

MPFT - Pay Controls (4/5)

Opportunity for enhancement	
	High - clear opportunities to accelerate or increase financial benefits
	Medium - rapid further exploration recommended to confirm opportunities to release financial benefits
	Low - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	High - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Internal temporary staff controls and authorisation processes	• In MPFT, CPO authorisation is required for all enhanced / additional payments and overtime for Band 8A and above. However anything below this is approved by the operational service lead / line manager, with KPI reports available to monitor. Audits with regards to the highest earners in overtime are not completed within the temporary staffing team, but the finance team and this has been recently reinstated as part of the Trust's Director Management group. It was however highlighted that very little overtime exists and primarily shifts are advertised via the bank. • Interims and secondments are tracked centrally and are managed utilising a suite of e-forms and this process is primarily managed within the payroll team in the payroll team. It was reported that ESR is used for tracking secondment end dates. • It was reported that shifts are automatically sent to the bank once the roster has been finalised and there is a proactive promotional programme that the Trust is running 'Project Synergy' which has included the recent implementation of a weekly payroll for bank to increase incentivisation. • Targeted efforts have been implemented to increase the effectiveness of the MPFT bank (average bank as a % of temp staff increased from 67.43% in April 23 to 76.07% in October) we were advised that the key things completed by the temporary staffing team to achieve this have been: recruitment efforts, active chasing / calling of bank workforce to fill shifts and developing a greater understanding of the demand.	• Continue to monitor the pay spend / approval controls e.g. using the bank and agency dashboard to interrogate and track trends and rationale in actual spend. • Continue with efforts to recruit to bank to displace agency workers. As this decreases, shift to an increased focus on the reduction of overtime where possible. • As per previous recommendation, implementing a tool / process to prospectively review shifts could reduce the amount of temporary staff required where the Trust meets planned staffing levels.			N/A	N/A

MPFT - Pay Controls (5/5)

Opportunity for enhancement	
●	**High** - clear opportunities to accelerate or increase financial benefits
●	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
●	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
●	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
●	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
●	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

External / agency controls and authorisation processes	• The Trust utilises non-clinical agency, however we were advised that the NHSE business case processes are complied with where this is applicable.
	• Agency authorisation forms are required for agency requests and this must be authorised by the relevant budget holder and senior financial business partner. The request would then be sent to temporary staffing to source from the bank in the first instance. If the temporary staffing team are unable to fill the shift via bank, they will seek CPO / Medical Director or nominated deputy approval to source the agency worker. Secondary approval would be required if the agency worker identified were to be above the capped rates or off-framework (from the CPO / Medical Director or deputy).
	• We were advised that MPFT only use substantive and bank staff for admin and estates workers, demonstrating compliance with the NHSE control recommendations.
	• For inpatient wards, agency is automatically approved and therefore does not require an additional layer of authorisation for agency. It was reported that there is an approximate 98% shift fill rate with c.13% of the fill from agency and the remaining from the bank.
	• For all other areas, an e-form (Part 1 form) is required to be completed to support agency authorisation. This is currently a manual process, however the Trust is looking to implement an end-to-end system to manage the governance and approval process for agency request forms. This would improve efficiency as it would be a less manual process, less time intensive and this would reduce the risk of human error.
	• We note that there are some retrospective approvals for non-framework agency workers, however these were reported as being very infrequent and only in times of unplanned / short notice shortages e.g. sickness / emergency leave on the day. In addition to this, the Trust's policy is that off-framework requests require pre-authorisation by the Associate Director of People.
	• The Associate Director of People links closely with the recruitment and retention team to highlight areas where there is significant agency usage to develop a recruitment strategy. Care groups are also challenged on long term / frequent usage and need to provide a compelling case for continued use. Current areas of continued use are: geographically challenging areas e.g. South of England and prisons. The Trust is also currently in discussions with the South of England collaborative bank and NHSP to understand if there are supplementary solutions that can be provided to reduce off-framework agency usage.
	• The Trust has a mastervend contract in place with Medacs that they use to source and fill agency shifts, typically at a more competitive price.
	• Breaks are accounted for in the booking system, however managers have the ability to override the system and have the option to pay breaks. This is reconciled weekly due to the requirement to lock down shifts for weekly payment.
	• There is no current set trajectory for reducing interim locum spend.
		• Implement a policy to seek to eliminate retrospective agency authorisation for all agency shifts e.g. via a silver / gold command / out of hours structure and / or Executive level authorisation of this control.
		• Consider a panel or sign off requirement for non-urgent agency / off-framework / long term temporary staffing cover similar to the VCP e.g. as we have observed within the Corporate Bank request at VCP on Friday 01/12/2023.
		• Use the bank and agency workforce dashboard to identify trends in agency and measure the success of the agency controls in place at the Trust
		• Implement additional budgetary controls on departments in relation to agency spend e.g. define a cap on agency usage within particular departments e.g. X number per week, £ per week - ensuring these are realistic based on establishment and historic requirements.
		• Consider the application of additional scrutiny that are using additional agency that is not in line with other care divisions e.g. Shropshire Care group. The additional measures of scrutiny would include:
		  ○ Weekly agency reviews with senior workforce colleagues
		  ○ Weekly reporting of agency reducing actions e.g. recruitment actions, use of bank staff, overtime, etc.
		  ○ Implementation of a process / tool to prospectively review shifts which could reduce the amount of temporary staff required where the Trust meets planned staffing levels
		• Consider setting a trajectory for reducing interim locum spend.
			●	●	1 - 2 Months	Alex Brett and Angie Astley

MPFT - Non-Pay Controls (1/2)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Procurement and spend control systems - No PO, No Pay	• MPFT operate a manual 'No PO, No Pay' Policy, which is known by suppliers. Failure to provide a PO number on invoices will result in no payment, ensuring records are complete. This is quoted on the POs raised by MPFT, and the team regularly share updates to the supply chain regarding this policy. • For FY22/23, there were 100 breaches (retrospective) of 'No PO, No Pay', which were reported to the audit committee, with the majority occurring in the Medical Directorate. • MPFT have an average of 95% compliance with the Better Payment Practice Code (BPPC) across NHS invoices, however only 93% Non-NHS Invoices, falling below the 95% target.	• Whilst it is reported that MPFT uses EProc (an automated Procurement System) the Trust could consider the adoption of the eREAF system used by NMBC procurement group in the longer term to further collaborate across the System. • Work to understand why the medical directorate has a higher number of retrospective POs, to identify gaps and reduce non compliance. • The Trust should increase their control over BPPC to meet the 95% threshold for non-NHS invoices, to ensure that no late payment interest arises.			1-2 months	Nick Alexander
Procurement and spend control systems - Approvals and governance	• MPFT are not part of the NMBC procurement group, however still attend board meetings where the key risks and areas of progress are discussed. • Robust procurement processes are in place and supporting governance aligned to SFIs and SoD. We were advised that all contracts go through a Reg 84,(1) of the Public Contracts Regulations 2015 that requires every Contracting Authority to create a written report for most procurements. The Regulation 84 document ensure that contracts upon conception or renewal are market tested or tendered and ensure appropriate scrutiny is applied.				1-2 months	Nick Alexander
Procurement and spend control systems - Expenditure and supplier review	• All contracts are subject to scrutiny and the team have to conform with governance outlined in MPFT's SFIs and SoD when undertaking an activity. • MPFT performed a line by line review of 1500-3200 contracts to identify cost savings, and hold a monthly meeting to review these contracts. Currently no CIP as been identified as everything mobilised has requirement / justification. • Dedicated Category Managers review all spend as well as attend ICB collaborative working groups to streamline efficiency gains across all trusts. In addition, the Trust are mobilising ATAMIS that will support the identification of savings opportunities across trusts.	• Continue to regularly review their contracts through the Procurement Care Group / Directorate reps to ensure that local contracts are continually subject to scrutiny and re-assessed in line with any changes in requirement or performance. • Continue to explore efficiency gains through the ICB led collaborative working groups that the Trust is already well linked in to and signed up to via an MOU.			1-2 months	Nick Alexander

MPFT - Non-Pay Controls (2/2)

Opportunity for enhancement	
	High - clear opportunities to accelerate or increase financial benefits
	Medium - rapid further exploration recommended to confirm opportunities to release financial benefits
	Low - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	High - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

Procurement and spend control systems - Drug expenditure and Medicines Optimisation	• MPFT has performed a deep dive into drugs expenditure including monitoring and reporting on prescribing practice and benchmarking at prescriber level. The use of non branded generic drugs in the Trust is embedded in their processes. They have started to have meetings with finance representatives from Care Groups to identify and monitor potential savings.
	• MPFT continue to work with the System on their medicines optimisation strategy. The ICS Pharmacy Leadership Group meets weekly to discuss CIPs in relation to drug expenditure and medicines optimisation. This group is fairly well established and has been meeting for around 3 months.
	• MPFT have a monthly prescribing forum which is used to discuss risks to efficiency realisation, as well as discuss more transformational schemes to help further cost savings and mitigate risks e.g. additional prescribing.
		• Progress work with Primary Care at pace to understand and mitigate the risks associated with the GP prescribing moving into MPFT to reduce any increase in costs in year.
		• Continue to liaise with care groups in order to further identify potential savings and review pathways to instigate transformational initiatives.
		• Work with the System to consider further transformational pharmacy schemes, for example:
		  ○ work to identify problematic patient pathways involving medicines and / or high cost drugs to consider if there is alternative treatment that can be delivered out of hospital to reduce bed blocking
		  ○ assessment of non medical drug expenditure (e.g. Stoma care and nutritional supplements) to identify potential wastage
					3-6 months	Andrew Campbell

Section 4c - University Hospital of North Midlands NHS Trust

Observations and recommendations on grip and control

UHNM - Pay Controls (1/7)

Opportunity for enhancement	
	**High** - clear opportunities to accelerate or increase financial benefits
	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Vacancy Control (1/2)	• The vacancy position at UHNM is 8.98% as at M7 2023. As at 31/10/23 15.43% of medical and dental posts were vacant (an increase from 09/23 of 10.66%), 10.27% of registered nursing posts vacant (an improvement compared to 09/23 - 12.96%) and 6.65% of all other staff groups vacant (an increase compared to 09/23 - 5.68%). • The Trust have advised that they have undertaken a fishbone (cause & effect) analysis of their key challenges and developed a number of countermeasures and actions. This includes the development of a retention plan and education for hiring managers e.g. managers role in undertaking career conversations. • VCPs, SOPs and process flows have been developed, however these are newly established in some areas e.g. the Corporate VCP was established in w.c. 20/11/2023. We observed the Corporate VCP on 28/11/2023 and from the meeting we observed that there was significant Executive representation and oversight within the panel with the Executive lead for each area presenting the post, a robust level of challenge within this process around fixed term vs. permanent positions, the risk of not recruiting was discussed as well as questions regarding the potential to scale up posts to a System level. However the meeting was only scheduled for 15 minutes therefore leaving limited time on the agenda without the risk of overrunning. These meetings are also not formally minuted due to the pace required but decisions / requests for further information are captured within Trac. • For other divisions (e.g. Estates, Facilities and PFI and Network Services), VCPs have been established for quite some time. We were advised that that offline vacancy approvals still take place via Trac but if there are any questions these can be brought to the VCP. Attendance and actions were recorded to capture the agreements. We noted that of the evidence that was shared regarding VCP approvals, not all of the approved posts had leavers documented, suggesting increases in establishment. An example of this would be from documentation from a Risk and Compliance board meeting on 25/07/2023 whereby 2 posts (a Band 2 Admin support and Band 6 Catering Manager) were approved for the County with no leavers detailed.	• Review vacant positions that have been vacant for more than six months to understand current staffing arrangement and explore whether these can be: removed, changed, scaled up to system level, put through a skill mix assessment, made into a secondment role if short term. Benefits tracking process to be implemented regarding any benefits delivered as a result of this. • Implement a monthly review of all vacant posts to understand routes to recruitment and a reduced trajectory of bank / agency reliance (where applicable). We are aware that agency reduction trajectories linked to substantive recruitment are being developed / agreed and a supporting governance structure to review this monthly is being implemented at present. • We observed that budget managers receive a monthly establishment report within Network Services, if this is not already in place across other divisions then this should be implemented. All budget managers should be expected to provide clear rationale for any over-establishment or WTE increases with exit strategy in place. • Continue with VCP processes across the Trust and consider approach to ensure consistency in approach across the VCPs, given the decentralised nature of the VCP process that has been established across divisions. • Ensure that risks and actions raised through the VCP process are captured centrally for regular review. • Introduce the use of the temporary staffing data (e.g. bank and agency dashboards for care divisions) within VCPs to assist in the articulation of vacancies with the aim to set trajectories for agency reduction in line with recruitment			1 - 2 months	Jane Haire

UHNM - Pay Controls (2/7)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Vacancy Control (2/2)	• We observed the Network Services VCP, it was highlighted that finance is the first stage of approval and the VCP process was coupled with a strong and clear grip on the monthly establishment reports. We observed robust challenge related to future service redesign (and therefore rejection of a post which was requested as permanent) and also within the context of wider staffing and establishment. We found this approach to be very robust and are keen to highlight this as an example of good practice. That being said, we have not been able to corroborate that this level of scrutiny also happens across the other divisions. • The Trust were keen to utilise their own vacancy system (Trac) to support the VCP process for central functions, in a bid to reduce reliance on manual forms, and to support information governance by minimising the risk of e.g. missing documents. The system outlines the key approval questions regarding the impact on services if rejected, funding for the post, vacant posts (and impacts of this), opportunities for redeployment and whether the post is hard-to fill. The Trac system is used to record decisions and progress or reject the vacancy. Following the panel the Recruitment Team update Trac and where vacancies are not approved the team either reject fully or return the vacancy to draft, which in turn notifies the hiring manager. • In the Vacancy SOP it outlines that the divisional vacancy approval processes requires four stage authorisation, which takes place as part of the panel (we observed this in action within the Network Services VCP): ○ 1. Divisional Finance Manager ○ 2. Associate Director / Director ○ 3. Professional Head ○ 4. Divisional HR / People Business Partner / Deputy • An acuity review takes place bi-annually to ensure staffing levels are satisfactory and drives potential investment cases for additional capacity requirements.	• To ensure the vacancy control panel outputs are aligned to the cessation of any backfill arrangements (i.e. rejected / frozen recruitment requests should then not be backfilled via bank / agency). • To define a monitoring and benefits realisation methodology to accompany the vacancy control process. It is recommended that the panel is supported by a dashboard which monitors requests considered at panel, decisions taken and wider trends to identify if mitigating action is required and to support ongoing refinement. The benefits realisation methodology should be connected with the Finance & Performance Committee and the agency trajectory meetings to enable the quantification of the run rate impact. • Undertake an audit of divisional agency panels to assess the consistency of approach and robustness as compared with the Network services VCP observations.			1 - 2 months	Jane Haire

UHNM - Pay Controls (3/7)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Temporary Staffing Governance	• The total number of bank and agency shifts requested on a monthly basis is approximately 21-22,000, with an average bank fill between M1-M7 of 54% and an average agency fill between M1-M7 of 19.5%. Given the high number of vacancies in this area, the majority of agency shifts are Medical and Dental (M&D) with over 9% of all M&D shifts being filled by agency in October. • Monitoring of agency spend takes place on a monthly basis across the Trust in the Finance and Performance Committee. For nursing, it was confirmed this is also reported to Board as part of the Quality Performance Report. • The CPO and CFO (and teams) intend to provide a further intervention with the divisions to develop fully rounded plans for vacancies, temporary staffing and staff management at a divisional level (this may also include procurement and reviewing employment contracts for long term locums etc). The intention of this is to develop trajectories for improvement, they have recognised that this will be a challenge within some areas where reductions in agency may not be possible due to a variety of drivers and pressures such as hard-to-fill areas, however they will take a keen interest in understanding the drivers and have a clear justifications as to why agency cannot be reduced, and work closely to audit the division and their actions taken (e.g. when division last went out advert, how many applications were received and e.g. focussing on substantive recruitment). • The Trust are keen to develop a quarterly report that reviews agency spend in comparison with vacancies as the vacancy rate has now decreased (particularly for nurses) and therefore the Trust are anticipating a reduction in agency usage. To note, the temporary staffing team are working with divisions to develop trajectories for their planned agency reduction. • Every 2 months, the medical workforce group reviews the total spend on bank and agency. Discussions in this forum cover job planning, performance, and non-productive activity that can be reduced. • For nursing, shift requests vs fill rate is monitored weekly and the triangulation of safecare (for the impact of patient acuity on staffing requirements) is completed daily. All divisions and the staff bank attend this daily staffing meeting to determine if staff can be redistributed. There is a cap in the Allocate system, which can be overridden if additional capacity is required (due to high acuity) with the authorisation of the division • 21.5% headroom is budgeted headroom for ward nursing covering: sickness, planned leave, study leave, parenting leave (including carers leave).	• Continue with plans for finance / workforce teams to meet with divisions to drill down into greater detail on vacancies, bank agency and key drivers. Continue to agree and monitor the trajectories for improvement with associated timelines and the monthly reviews to assess progress and mitigate slippage if required. • Consider expanding the nursing weekly monitoring of fill rates to other areas to support a weekly centralised oversight mechanism for agency spend, possibly through a dedicated team or committee responsible for monitoring, analysing, and controlling agency usage across different care divisions to support proactive interventions. • Develop workforce dashboards / reporting (similar to MPFT) which gives greater transparency regarding key workforce metrics such as sickness, vacancies / recruitment, temporary staffing etc. and define governance routes for workforce reporting, ensuring that the information contained within the dashboard is supported by a robust action plan and accountability structure to an executive committee. • Utilise dashboard information to enable strategic workforce planning to anticipate and address staffing needs proactively. This can help reduce reliance on agency staff by ensuring that the trust has the right mix of permanent employees. • Implement a systematic process to prospectively review shift information for substantive, bank and agency planned staff numbers against bookings (e.g. a week in advance) and make positive interventions in regards to staffing levels in managing safe staffing and agency reduction. The implementation of this process / tool would be based on the ward establishment and safe staffing levels reviewing the supply and demand of the care group or department. This would be coupled with a robust governance structure that would provide a platform for confirm and challenge of future shift data at ward level.			3 - 6 months	Jane Haire

UHNM - Pay Controls (4/7)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Internal temporary staff controls and authorisation processes	• We were advised that secondments are managed by the divisions, and the workforce information team issue reminders of secondment end dates to line managers to ensure that they are terminated on the system and no dual / overpayments are made. • Once ward managers have locked down the rosters (average of 4.2 week ahead of shift being worked for nursing) the roster shifts become available for bank workers. Additionally with health roster and employee online, even if an agency worker is booked, the shift will show as available to bank staff and if staff then apply for the shift, the workforce team can amend / cancel the Agency in place of this. • Pay spend approvals such as WLIs, TIs, overtime or enhanced payments are signed off by divisional budget holders. A WLI request form and SOP process is in place with set expectations around authorisation, reporting and monitoring. Controls for Junior Doctors are in place via the Rostering system to ensure that there is not an overlap between WLI and contracted shifts. For Consultants that are not on the rostering system, checks are completed at a divisional level when booking any WLIs / TIs / additional activity to ensure that consultants are not being scheduled WLIs when they are currently working, however there is no central oversight mechanism for this currently. • It was reported that there is also very little overtime for A&C, most additional hours are directed through the admin bank, which is bookable via the Locum on duty app. This is the same system used to book bank shifts for medical staff. • We did not receive confirmation of scrutiny on frequent overtimes areas / earners. • Bank rates for Medics are comparable to the West Midlands agency rate card, this has been signed off by the UHNM Executive committee, however this could be viewed as a cost pressure given that they are in excess of the NHSE recommended rates.	• Conduct regular audits of bank and agency data across a number of variable e.g. shifts time of day, holiday periods, time of the month, etc to identify patterns and trends for improvement that can be utilised in future planning. In our experience this supports the development of agency reduction plans, which we understand are being developed at present. • Additional controls to be implemented with divisions to ensure appropriate management of WLI and additional clinics with Consultants. We have previously seen trusts implement a process whereby every WLI shift needed to be pre-approved at divisional level by a divisional director and then was subject to scrutiny and review at a monthly financial performance review meeting. Whilst this may not be required at UHNM, additional scrutiny could be applied. • Additional scrutiny to be applied in regards to departments that are overspent on pay budgets in relation to the divisional pay spend approval processes and potentially revise authorisation limits. • Continue with efforts to recruit to the staff bank to displace agency workers. • Work towards rostering 6 weeks in advance of the shift being worked to give the best chance of filling shifts via bank before having to go out to agency. • Report monthly on top overtime areas and transition where possible to bank shifts to mitigate additional costs (for nursing as medics are already through the bank).			1 - 2 months	Jane Haire

UHNM - Pay Controls (5/7)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
External / agency controls and authorisation processes (1/3)	• In M1 2023 total % of shifts filled by agency was 15.92%, in M7 2023 it has increased to 20.15% • For the first six months in 2023/24 the agency expenditure of £15.8m is 4.8% and therefore above the target rate of 3.7% • Rotas and rosters are managed centrally, standard rota templates are set with appropriate staffing levels. Only in circumstances when the gaps cannot be filled, will the Trust go out to agency. • There are agency control processes that differ for all staff groups. Where Medical / dental roles are in breach of the agreed rate card they are signed off by the Medical Director and Clinical Director. In the Nursing SOP it states that agency shifts are requested by the matron and signed off by the Director of Nursing or Head of Nursing (or silver command for out of hours shifts). • It was reported that health roster is set up to automatically deduct breaks; there is the ability to override this, but the Trust's rota coordinators review this regularly to ensure they are deducted as expected. • There is a ban on non-framework agency in place that is largely adhered to, with the exception of SHS in Theatres and we were advised that there is an improvement plan in place for this to cease by the end of the year. • As previously noted, work is underway to develop fully rounded plans for vacancies, temporary staffing and staff management at a divisional level with the intention to reduce agency spend where possible. • We spoke with the NWS division, who confirmed they are currently triangulating establishments with agency requests e.g. if they are fully established or have unused hours within the roster data then using this to support rationale for denying requests and working with ward managers to explain this position and the collective need for agency reduction. It was stated that as the agency position improves the intention is to further target and strengthen the bank and overtime controls, though some additional work is required to gain clarity on the roster data to support the interrogation of overtime.	• Introduce a consistent panel / sign off requirement for non-urgent agency / off-framework / long term temporary staffing cover similar to the VCP. Implement a benefits realisation mechanism to measure the success of this pay control and provide assurance within the Trust and ICS. • Implement additional budgetary controls on departments in relation to agency spend e.g. define a cap on agency usage within particular departments e.g. X number per week, £ per week - ensuring these are realistic based on establishment and historic requirements. • Regain control within Theatres nursing regarding transition from off-framework to on-framework, and eventually look to bank. Explore internally within the Trust via: skills review e.g. with international nurses that have Theatre experience, expressions of interest from other internal staff (who may be currently placed in Trust areas that are easier to backfill with bank) to upskill in Theaters and targeted recruitment and attraction campaigns. • Look at developing a workforce dashboard model to support the agency reduction targeted schemes and plans in development. • Rapid review of the data quality and provision to Divisional teams with regards to overtime recording on the rostering system to support further pay spend reduction plans			3 - 6 months	Jane Haire

UHNM - Pay Controls (6/7)

Opportunity for enhancement	
🟠	**High** - clear opportunities to accelerate or increase financial benefits
🟡	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🟠	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟡	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
External / agency controls and authorisation processes (2/3)	**<u>Nursing:</u>** • In M1 2023 total % of nursing shifts filled by agency in comparison to total shifts requested was shifts filled by agency was 9%, in M7 2023 it has increased to 14.6% (overall requests increased by 411 shifts from M1-M7). • Divisions have their own controls around agency, budgets and processes. The ward manager completes an agency approval form which is signed off by the matron and divisional team lead. This is then sent to the temporary staffing team and the Trust's mastervent (Day Webster) for fulfilment. • Non-framework agency usage is banned in nursing however it has recently come to the Trust's attention that there is non-compliance with this from the Theatres division. Off-framework SHS usage that has primarily been driven by the surge in demand for recovery and limited capacity for scrub nurses and ODPs (though noting that there has also been some band 2 agency usage). We were advised that a plan is in place to pull the management back into the temporary staffing team and that this is expected to be back on framework by the end of the calendar year. • For agency, a master vend is in place - the main challenges are within worker-led markets e.g. oncology, renal where the teams may need to go to other agencies to fill shifts. • Breaks are automatically deducted as the roster system has been coded to do this. If breaks are not taken on shift, this requires a countersignature from the nurse in charge to confirm this.	• Implement a systematic process to prospectively review shift information for substantive, bank and agency planned staff numbers against bookings (e.g. a week in advance) and make positive interventions in regards to staffing levels in managing safe staffing and agency reduction. The implementation of this process / tool would be based on the ward establishment and safe staffing levels reviewing the supply and demand of the care group or department. This would be coupled with a robust governance structure that would provide a platform for confirm and challenge of future shift data at ward level.	🟡	🟡	3 - 6 months	Jane Haire

UHNM - Pay Controls (7/7)

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
External / agency controls and authorisation processes (3/3)	**Medical:** • In M1 of 2023 the total percentage of Medical and Dental shifts filled by agency in comparison to total shifts requested was shifts filled by agency was 32%, in M7 this has increased to 45.5% (although note that the overall requests increased by 50 shifts from M1-M7). • For medics, no additional sign off is required to convert from a bank to an agency shift (MP1 form required for both), as the demand template is already signed off. In the Locum appointment procedure it states that all locum requirements out of normal working hours must be discussed with the Site Manager and Senior Manager On-Call, whereas in hours it is agreed by the Clinical Director / Directorate Manager / nominated lead clinician. • It was reported all Medics and AHs are paid through Direct Engagement to maximise efficiencies and all on-framework spend. • Recently the Trust has commenced a long-term locum review. It is currently in the process of re-testing the market and interrogating usage on an individual basis. • The Trust aligns with West Midlands Collaborative rate card. **A&C** • All A&C agency spend is for specific projects (generally IT) e.g. LIMS and O365 workers. UHNM reported (and this was confirmed by ICB CPO) that the Trust does not use any off-framework A&C staff.	• Reinforce divisional requirement to comply with agreed governance in regards to agency sign off requirements - i.e. no retrospective sign off for medics out of hours and mechanism in place to support compliance e.g. via a silver / gold command / out of hours structure and / or Executive level authorisation. • Prospective agency authorisation / additional sign off requirement for all Medics agency shifts required possibly via a Silver / Gold command / out of hours structure if required and Executive level authorisation of this control • Continue with long term locum review and re-testing the market to determine whether greater value can be achieved.	*(As per the previous page)*	*(As per the previous page)*	*(As per the previous page)*	*(As per the previous page)*

UHNM - Non-Pay Controls (1/2)

Opportunity for enhancement	
High	High - clear opportunities to accelerate or increase financial benefits
Medium	Medium - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	Low - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	High - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	Medium - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	Low - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Procurement and spend control systems - No PO, No Pay	• UHNM have the 'No PO, No Pay' control linked to the e-Procurement system eREAF, ensuring that all invoices have a valid PO, and thal all POs are raised prior to raising the invoice. • Breaches relating to late and retrospective POs are reported to the Audit Committee. The Q2 audit committee report has identified 127 instances of SFI breaches in relation to late POs, representing 0.65% of total purchase orders. Of these 127 single tender waivers, 11 exceeded £100k. The total contract value of these breaches is £20.0m. • Following a breach, Supplies and Procurement Department will continue to contact all Budget Holders breaching the Trust SFIs informing them when a breach has occurred and request further details regarding the breach, as well as consider what measures have been taken to address the breach. Additional training in relation to the control processes is also offered. • UHNM have an average of 98% compliance with the Better Payment Practice Code (BPPC) across Non NHS invoices, however only 90% across NHS Invoices, falling below the 95% target.	• To consider key themes of areas with non compliance and breaches and investigate key gaps that need to be closed. For example, assess if late POs are more frequent during certain times of year or in certain divisions, to put in additional measures to help target the non compliance. • Continue the regular reporting of the compliance with no PO no pay from a volume and value perspective, as well as requesting team to enable proactive intervention if required. • The Trust should increase their control over BPPC to meet the 95% threshold, to ensure that no late payment interest arises.			1-2 months	Nathan Joy-Johnson
Procurement and spend control systems - Approvals and governance	• The employment of the eREAF system in the NMBC procurement group means that the relevant approval process is applied to contracts based on their size. Approval authorisation levels are clearly outlined in the SFIs. Each layer of approval is required for the contract to be progressed, ensuring relevant scrutiny is applied. • UHNM and NSCHT are part of the NMBC procurement partnership agreement, hosted by UHNM. The NMBC procurement board meet every 2 months to discuss performance and savings, actions and risks. Actions are appropriately documented within an action log and discuss at the following Board meeting.	• Continue to operate grip and control around the approvals of contracts.			1-2 months	Nathan Joy-Johnson
Procurement and spend control systems - Expenditure and supplier review	• The work plans for UHNM identify numerous proactive price and contract renegotiations the work plan indicates a CIP / cost avoidance total of £1.3m to date that is in implementation. • Additionally, it was reported that Trust have recently adoption the Atamis procurement system and this will support increased contract management and oversight across the Trust and NMBC group. The Atamis system will increase contract visibility and increase the potential to leverage collective buying power and further realise efficiencies within the NMBC.	• Continue to perform regular contracts and expenditure reviews to increase the CIP within the workplan identified YTD.			1-2 months	Nathan Joy-Johnson

UHNM - Non-Pay Controls (2/2)

Opportunity for enhancement	
	**High** - clear opportunities to accelerate or increase financial benefits
	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Procurement and spend control systems - Drug expenditure and Medicines Optimisation	• UHNM are part of the System on their medicines optimisation strategy. The ICS Pharmacy Leadership Group meets weekly and discussed CIPs in relation to drug expenditure and medicines optimisation. This group is fairly well established and has been meeting for around 3 months (albeit the Pharmacy leads are have been meeting in other forums in addition to this e.g. IMOG). • There has been a deep dive into drugs expenditure including monitoring and reporting on prescribing practice and benchmarking at prescriber level. There has also been an increase in reported usage of biosimilars. • The transfer from oral to IV antibiotics has also reported compliance over the 60% target, supporting bed capacity at the Trust. • The Trust have already taken additional measures to stop prescribing self-care drugs and dressings. • As part of the medicines management, divisional business analysts are provided with the drug spend data which they can then filter by ward and division to review areas of high spend YTD. This allows them to investigate key variances at divisional level.	• Continued collaboration at a System level to support horizon scanning and early adoption of switches as they are communicated. • Maintain or look to increase the oral to IV antibiotics volumes YTD, particularly given winter pressures. • There is opportunity for the Trust Chief Pharmacist / Pharmacy team and the DBAs / finance to work in greater collaboration to review the drug spend data, trends and key outliers of increase activity / cost to identify any opportunities to further current CIP plans. Additional governance should be implemented and a cadence for meeting, together with reporting via the divisions into the PMO as part of the CIP plans would support the increased collaboration.			Ongoing	Sue Thomson

Section 4d - North Staffordshire Combined Healthcare NHS Trust

Observations and recommendations on grip and control

NSCHT - Pay Controls (1/4)

Opportunity for enhancement	
🟠	**High** - clear opportunities to accelerate or increase financial benefits
🟡	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🟠	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟡	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

Vacancy Control	• Vacancies are added to Trac which has an in-built business case process (i.e. how the role fits with the workforce plan, risk factors if not approved, etc) and sign off process. Approvals are required by recruiting manager, divisional manager, people and finance business partner. The establishment is not managed within ESR at NSCHT, it is all managed by the finance leads, and therefore the finance approval ensures that the vacancy request does not exceed the agreed establishment. There is no standard vacancy panel process as such (a panel was in place pre-COVID however given the low number of vacancies and the nature of them i.e. like-for-like replacements, this was stood down. Therefore challenge and discussions related to vacancies take place virtually (over email correspondence) prior to approval in Trac.
	• It was reported that the establishment control panel is chaired by Director of Workforce and according to the SOP this takes place if requests meet the criteria detailed e.g. long term locum / agency, medical staffing posts, changes outside of AfC or medical / dental T&Cs, etc. Full detail can be found in the NSCHT SOP. For changes to be approved the MD, Director of Workforce, DoN and DDoF must unanimously agree. However it was reported that the approvals largely take place via virtual correspondence as and establishment control panel meetings only take place if they are required i.e. cannot be agreed offline.
	• Of the vacancies within the Trust, it was reported that very few are corporate vacancies. The Trust is currently in discussion with the ICB in regards to approval / review of these posts.
	• We were advised that an analysis of corporate and clinical vacancies (that have been vacant for 6 months or longer) was recently reviewed by the CFO and COO. This resulted in a small number of WTEs to be removed and contribute to the Trust CIP, though we were advised that this has not been actioned yet. The Trust are now starting to look across at all vacancies to triangulate with demand to see whether any additional opportunities are available.
		We recognise the scale and nature of the services provided at NSCHT are very different to their ICB provider counterparts and therefore whilst there are opportunities to strengthen controls, these must be assessed in line with the Trust's judgement regarding available capacity to support this. **This applies to recommendations on all pages.**
		• Increase vacancy control scrutiny and auditability, this could be through a number of potential options:
		  ○ a) introduction of a standard VCP that considers all posts (e.g. not just at 8b or above)
		  ○ b) ensure all comments regarding queries on vacancies goes and shared via the Trac system
		  ○ c) develop a vacancy tracker process which captures all of the challenge and scrutiny applied in a central shared log (i.e. to move away from emails and provide a single source audit trail of approvals / discussions / challenges discussed)
		• To add further questions into the Trac form to increase scrutiny, particularly:
		  ○ Confirmation that the post is within the current establishment / budget
		  ○ Whether there would be another way of delivering this posts
		  ○ If the post is a like for like post then confirmation of the date of the current leaver
		• To ensure the vacancy control process outputs are aligned to the cessation of any backfill arrangements (i.e. rejected / frozen recruitment requests should then not be backfilled via bank / agency / overtime).
		• To define a monitoring and benefits realisation methodology to accompany the vacancy control process. It is recommended that the panel is supported by a summary report that monitors requests considered at panel, decisions taken and wider trends to identify if mitigating action is required and to support ongoing refinement. We understand that the Trust have communicated the intention of this, but we have not seen any outputs during our review.
			🟡	🟢	1-2 Months	TBC

NSCHT - Pay Controls (2/4)

Opportunity for enhancement	
●	**High** - clear opportunities to accelerate or increase financial benefits
●	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
●	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
●	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
●	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
●	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observtions specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Temporary Staffing Governance	• The average number of agency hours used since M1 2023 is 35,235, in comparison to 110,002 bank hours. Both have remained reasonably consistent from M1-M7 2023. • The YTD pay expenditure was reported at under budget in M7 by £0.7m and M6 by £1.1m in the ICB's Finance and Performance Committee. • Agency spend is reported through the Finance and Performance Committee and People Committee monthly. Safer staffing is reported through the Quality Committee monthly and gives an indication of the bank and agency trends, though not financial in focus. Where there are outliers / hotspots in agency spend detected these are discussed and worked through into action plans where applicable. • It was noted that bank spend is not currently reported to any of the committees. • The weekly monitoring of shift requests and fill is work in progress. It was reported that regular roster reviews are in place on a cyclical basis across the Trust, all in-patient areas have been reviewed, but other areas across the Trust are awaiting review. • Regular establishment reviews take place across the Trust to assess the establishment in line with safer staffing levels, there is one remaining area in the Trust to review. The panel considers: Long-term Locum cover / Long term agency requests (12 months plus), Band 8b / VSM and above posts, all Medical Staffing posts (including Primary Care), permanent, fixed term or bank post in which the proposed salary or contractual arrangements sits outside of established AFC banding / NHS Medical and Dental T&Cs, increasing or decreasing total establishment which changes the service banding / skill mix, a typical worker requests e.g. alternative / new agency suppliers, honorary contracts, employment hosting arrangements or SLAs within the Integrated Care System that have an impact on workforce. As per the policy it is not required in relation to the below establishment changes for any roles at AFC 8B banding or below. • The sign off of shifts to go out to bank can be issued by the shift sister. To escalate this to an agency shift a form is required to be completed detailing the reasons it is required and the actions that have been taken to cover the shift prior to the request. This form is completed by the service manager and must receive Executive level approval prior to going out to agency.	• Inclusion of bank spend and trends within monthly committee reporting to supplement information and support greater interrogation of temporary staffing profile and trend analysis. • Work with the Trust matrons regarding devolving safer staffing responsibilities, accountability and governance structures to for safe staffing. Coupling this with initial support to understand the reports and the actions they are expected to complete in relation to them • Develop a workforce dashboard (similar to MPFT) which gives greater transparency regarding key workforce metrics such as sickness, vacancies / recruitment, temporary staffing (bank and agency), etc. and define governance routes for workforce reporting, ensuring that the information contained within the dashboard is supported by a robust action plan and accountability structure to an executive committee. • Utilise dashboard information to enable strategic workforce planning to anticipate and address staffing needs proactively. This can help reduce reliance on agency staff by ensuring that the trust has the right mix of permanent employees. • Implement a systematic process to prospectively review shift information for substantive, bank and agency planned staff numbers against bookings (e.g. a week in advance) and make positive interventions in regards to staffing levels in managing safe staffing and agency reduction. The implementation of this process / tool would be based on the ward establishment and safe staffing levels reviewing the supply and demand of the care group or department. This would be coupled with a robust governance structure that would provide a platform for confirm and challenge of future shift data at ward level.	●	●	3-6 Months	TBC

NSCHT - Pay Controls (3/4)

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Internal temporary staff controls and authorisation processes	• Overtime and enhanced payments are pre-authorised by the ward managers. For Medics enhanced payments are authorised by the Associate Director and Clinical Directors (or Executive Directors) • The Trust does not currently undertake an analysis of the top 10 overtime earners, however they did report that there are very little amounts of overtime used within the Trust. • It was reported that secondments are tracked within the roster, posts end dates are added to the system therefore ensuring there is limited risk of an overpayment. • The Trust are regularly recruiting to the bank, they have a large number of unregistered HCAs but struggle to recruit registered nurses and we were advised that the promotion of bank staff is always offered over agency • The roster is programmed to automatically deduct breaks, ensuring the Trust is only making payments in line with time worked. • Many of the current Nursing registered roles are currently supernumerary. The Trust previously had a policy that for 3-6 months new nurses would be supernumerary, they have recently changed this to transitioning out of the supernumerary position earlier, providing that they can demonstrate competence.	• Additional scrutiny to be applied in regards to any departments that are overspent on pay budgets in relation to pay spend approval processes and potentially revise authorisation limits • Continue with efforts to recruit to the staff bank to displace agency workers, particularly within registered nursing • As per previous recommendation utilising the process to prospectively review shifts could reduce the amount of temporary staff required where the Trust meets planned staffing levels. • Consider further reduction of the supernumerary training period for new registered roles, coupled with training and development support to enable sign off as competent.	🟠	🟢	1-2 Months	TBC

NSCHT - Pay Controls (4/4)

Opportunity for enhancement	
🔴	**High** - clear opportunities to accelerate or increase financial benefits
🟠	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
🟢	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
🔴	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
🟠	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
🟢	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
External / agency controls and authorisation processes	• There is significant off framework expenditure for Nursing and non-clinical - Nursing all relates to Darwin. This is due to a specific requirement, and there are plans to work with the Local Authority regarding this. The Trust has worked with procurement to negotiate better terms with Thornbury. • The majority of agency Doctors are now working via Direct Engagement (DE) and all Doctors are from framework agencies. • If the current trend of Medical agency expenditure continues for the remainder of the year, the Trust will spend around £2.26m, a reduction of c. £200k compared to 22/23. • In 2022/23, the Trust spent £2.45m on medical agency which was similar to the prior year of £2.489m. • Non-clinical off-framework agency has previously been used, these are very rare cases (it was reported the last instance of this was when a service TUPE transferred into the Trust and had existing agency staff supporting). • Month 7 YTD expenditure on agency is £2,921k; which is over the YTD agency target by £925k. 25% of agency costs to date were incurred in the Community directorate, with 43% in Specialised and 16% in Acute and Urgent Care, the remainder related to Primary Care and Corporate areas. • As mentioned, to escalate a shift to go out to agency, a form detailing the reasons for the shift and the actions that have been taken to cover the shift prior to the request is required to be completed by the service manager and be approved by an executive. This is the same process to authorise off-framework agency use. • Like the top overtime earners, there is no regular monitoring or transition plans for the conversion / transition of the longest serving, highest paid agency workers in the Trust. However we note a review of the longest serving agency medics in October 2023. The majority of the longest serving medics are consultants and the majority of their rates are reportable as they exceed the £100 cap. • During COVID, the Trust brought in an agency pool of both registered and unregistered roles (3x registered and 3x unregistered for the early and late shift everyday). These were pre-booked agency workers that were set up in the Roster and allocated their working area on the day of the shift in line with staffing requirements (e.g. to cover unplanned leave such as sickness). The Trust reported that they fear teams have grown reliant on this model and whilst they have now ceased the use of the unregistered roles, they still maintain the registered agency pool workers. There are some alternative options that the Trust could consider dependent on appetite. • Due to the current demand and supply of medics within the specialised nature at NSCHT, the Trust is unable to comply with the West Midlands Collaborative agency rates.	• Ban on non-framework usage or increased controls around usage where appropriate. • Implement additional budgetary controls on departments in relation to agency spend e.g. define a cap on agency usage within particular departments e.g. X number per week, £ per week - ensuring these are realistic based on establishment and historic requirements. • As per previous recommendation utilising the process to prospectively review shifts could reduce the amount of temporary staff required where the Trust meets planned staffing levels. • Regular monitoring of longest serving, highest earning agency workers and a supporting plan of action agreed to transition from the use of these workers. • Either removal of the agency pool (if determined safe to do so) or replacement of the agency workers with either bank or overtime work (either completely or for a defined period of time until there is such assurance across the Trust that the pool is no longer required). • Improve compliance with standardised West Midlands Collaborative agency rate card where possible. Exceptions to rates should be made only in exceptional circumstances and we would recommend these flow through to an Executive Lead for oversight and independent challenge. If exceptional rates are authorised a log of these should be retained and work undertaken to exit these as soon as possible.	🔴	🟠	3-6 Months	TBC

NSCHT - Non-Pay Controls (1/2)

Opportunity for enhancement	
High	**High** - clear opportunities to accelerate or increase financial benefits
Medium	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
Low	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
High	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
Medium	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
Low	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner
Procurement and spend control systems - No PO, No Pay	• The approach to not apply the 'no PO no pay' control was endorsed by the Audit Committee in September 2021, due to some areas of spend being excluded from the control. However given the financial situation across the System this has now been approved to be implemented in the October 2023 Audit Committee, and will go live from January 2024. • NSCHT have an average of 90% compliance with the Better Payment Practice Code (BPPC) across NHS invoices (currently 93% at M7) and Non-NHS invoices (currently 94% at M7), falling below the 95% target.	• Continue regular reporting of the compliance with no PO no pay from a volume and value perspective, as well as requesting team to enable proactive intervention if required. • Continue to implement actions supporting the increase in BPPC compliance to ensure that no late payment interest arises.	Medium	Low	1-2 months	TBC
Procurement and spend control systems - Approvals and governance	• The main procurement function at NSCHT is currently managed by UHNM as part of the NMBC procurement group, therefore the assessment of procurement controls shown on page 42 is applicable to NSCHT. At M5 around £7m of spend was outsourced to NMBC. • NSCHT have monthly procurement and finance meetings as a forum to discuss progress on key projects and upcoming projects as a point of escalation for risks. There is an agenda for these meetings however they are not minuted.	• Confirm that the procurement and finance meeting actions, risks and mitigations are logged. If this is not in place to date, start capturing from the next meeting to support the regular reporting into NSCHT committees and the NMBC group governance.	Low	Low	1-2 months	TBC
Procurement and spend control systems - Expenditure and supplier review	• We understand that NSCHT have completed a line by line contract review, with total value of £18.6m, the output of this and quantified CIP value is not yet confirmed at the point of writing. • As at September 2023 NSCHT have reported a review of their underspent non-pay budgets with a total saving identified of £81k, our understanding is that this has not been undertaken through all directorates to date. • Noting the collaboration with the NMBC procurement group, NSCHT still control 75% of their non-pay spend (based on M5 data). However a large proportion of this is driven by patient placements. Since April 2021, the Trust have managed complex learning disability and mental health patients in private provider settings on behalf of the whole ICS. A lot of the contracts were inherited and the Trust have been systematically increasing the grip and control through TCP / Project86. There has been investment of training and education on the new procurement process, delivered with the CSU, this has included the formalisation of contracts with providers, regular meetings between operational and finance teams to ensure forecasting / reporting is correct and a targeted focus from clinical teams in assessing the most appropriate community placements. The improved controls and appropriateness of the placements are resulting in a reduction, within complex care, of the number of service users of (8.4%) and total cost (14.3%) from 22/23-23/24. The FOT for TCP is still increasing albeit not at the same rate prior to the integration with NSCHT.	• Confirm the financial savings associated with the contract review undertaken to date. • Extend the non-pay reviews conducted to date for all directorates and corporate areas. Systematically re-review this throughout the financial year. Additionally, all areas of non-committed / discretionary spend could be included for review within this to maximise the savings potential. • Continue to manage the complex care patient placement contracts to ensure the most appropriate level of services are being delivered.	Medium	Low	1-2 months	TBC

NSCHT - Non-Pay Controls (2/2)

Opportunity for enhancement	
●	**High** - clear opportunities to accelerate or increase financial benefits
●	**Medium** - rapid further exploration recommended to confirm opportunities to release financial benefits
●	**Low** - control appears to be operational and limited opportunities for enhancement available or considered longer term

Complexity to implement	
●	**High** - Significant coordination across trusts required, including engagement with NHSE and / or external suppliers
●	**Medium** - Coordination within trusts required to implement; limited engagement outside of trusts and with external suppliers
●	**Low** - Minimal levels of additional planning required, minimal stakeholder engagement

Non-Pay control	Observations specific to organisations (where applicable)	Recommendations	Opportunity for enhancement	Complexity to implement	Timescales	Proposed owner

Procurement and spend control systems - Drug expenditure and Medicines Optimisation	• NSCHT have made biosimilar switches where possible however there is less opportunity in the Trust due to its size and range of services. Some of the switches have been delayed due to supply chain issues and the availability of drugs.
	• All inpatient prescribing is overseen by NSCHT's pharmacy group, with all drug procurement through UHNM.
	• The Trust use electronic systems for gathering of prescribing data and to provide insights and analyse trends. Insights produced are then discussed in various forums such as:
	  ○ Medical clinical efficiency group
	  ○ CIP workshops
	  ○ Adhoc direct engagement with the directorates
	• Collaboration within the Trust is supported with pharmacist being aligned to each directorate to continually work to identify CIP.
	• NSCHT currently have ePrescribing implemented for their inpatients, but the current software does not have the capability to do this for outpatients. The implementation of ePrescribing is believed to promote efficiencies in clinical time, mileage and paper costs and this is being quantified at present.
		• Continue to work closely with directorates to identify medicines optimisation CIPs.
		• Focus on System wide horizon planning to mitigate risks within the drug spend environment.
		• Rapidly quantify the impact of the ePrescribing and, if savings are as anticipated, share the findings across the ICS.
			●	●	1-2 months	Helen Sweeney

Appendices

Glossary, engagement log and key information list

Appendix 1

Glossary

Glossary

Appendix 1 | Glossary

	Reference
Staffordshire and Stoke-on-Trent Integrated Care System	SSoT ICS
Staffordshire & Stoke-on-Trent Integrated Care Board	SSoT ICB
Integrated Care System	ICS
Integrated Care Board	ICB
University Hospitals of North Midlands NHS Trust	UHNM
Midlands Partnership University NHS Foundation Trust	MPFT
North Staffordshire Combined Healthcare NHS Trust	NSCHT
National Health Service England	NHSE
Financial Recovery Plan	FRP
Grip and Control	G&C
Length of Stay	LoS
Continued Health Care	CHC
All Age Continuing Care	AACC
Full Year Effect	FYE
Transformation Delivery Unit	TDU
North Midlands and Black Country	NMBC
Standing Financial Instructions	SFIs
Commercial Medicines Unit	CMU
Strategic Finance Group	SPG
Finance and Performance Committee	F&PC
Vacancy Control Panel	VCP
Multidisciplinary Team	MDT
Human Resources	HR
Cost Improvement Programme	CIP
Key Performance Indicators	KPIs
National Institute for Health and Care Excellence	NICE
Forecast Outturn	FOT
Quality/Equality Impact Assessment	QIA / EIA

	Reference
Return on Investment	ROI
Data Protection Impact Assessments	DPIA
Chief Executive Officer	CEO
Chief Finance Officer	CFO
Chief People Officer	CPO
Better Payment Practice Code	BPPC
Pharmacy Leadership Group	PLG
Admin & Clerical	A&C
Year to date	YTD
Director of Finance	DoF
Deputy Director of Finance	DDoF
Directorates Management Group	DMG
Full time equivalent	FTE
Electronic Staff Record	ESR
Scheme of Delegation	SOD
Purchase Order	PO
Divisional Business Analyst	DBA
Network Services	NWS
Director of Nursing	DoN
Whole Time Equivalent	WTE
Healthcare Assistants	HCA

Appendix 2

Engagement log

Stakeholder engagement log (1/3)

Appendix 2 | Engagement log

Outlined below is a summary of key stakeholder engagement sessions held, the insights which were considered as part of the preparation of this report. Observed pay controls are highlighted in light red.

Organisation	Date	Meeting	Organisation attendees (title*)
ICB	16 Nov	ICB recovery plan and financial planning discussion	Helen Dempsey (Director of Planning)
ICB	17 Nov	Introductory meeting	Alex Robinson (Head of TDU)
ICB	20 Nov	Medicines Optimisation and Drug Expenditure Controls overview	Mark Seaton (Chief Pharmacist)
ICB	20 Nov	Recruitment and Temporary Staffing Grip and Control review	Mish Irvine (Interim CPO)
ICB	22 Nov	Procurement Controls	Lee Squire (Head of Procurement)
ICB	22 Nov	CHC Delivery Meeting	Multiple Attendees
ICB	24 Nov	Bed Modelling walk through	Phil Smith Thomas Bailey
ICB	30 Nov	CHC Finances	Pam Rodgers
ICB	4 Dec	Sharing initial findings	Paul Brown (ICB CFO) Helen Dempsey (ICB Director of Planning) Deborah Everden

Stakeholder engagement log (2/3)

Appendix 2 | Engagement log

Outlined below is a summary of key stakeholder engagement sessions held, the insights which were considered as part of the preparation of this report. Observed pay controls are highlighted in light red.

Organisation	Date	Meeting	Organisation attendees (title*)
System	15 Nov	CFO Meeting (observed)	Paul Brown (ICB CFO) Eric Gardiner (NSCHT CFO) Chris Sands (MPFT CFO) Mark Oldham (UHNM CFO) Helen Dempsey (ICB Director of Planning)
System	16 Nov	AACC FASG	Pam Rodgers Claire Underwood System CHC Leads
System	23 Nov	CHC Collaborative Group	Multiple Attendees
System	24 Nov	Weekly Recovery Programme Meeting	Multiple Attendees
System	16 Nov	CHC 1:1 Workstream	Multiple Attendees
System	16 Nov	Private ICB Board	Multiple Attendees
System	29 Nov	System Performance Group	Multiple Attendees
System	5 Dec	Finance and Performance Committee	Multiple Attendees
MPFT	16 Nov	Meeting with MPFT Finance Team	Laura - DDoF Marianne Cleeve - head of accounting and assurance Glen - head of financial management - focused on the care groups
MPFT	17 Nov	CHC Project Management meeting	Mark Hayward
MPFT	20 Nov	CHC Project Management meeting	Kelly Mandley
MPFT	22 Nov	Exec Introductory Meeting	Chris Sands (CFO) Alex Brett (CPO) Marianne Cleeve
MPFT	23 Nov	Vacancy Update Call	Multiple Attendees
MPFT	27 Nov	Procurement Controls meeting	Nick Alexander- Head of Procurement Marina Poultney - Head of Creditors/Debtors Marianne Cleeve
MPFT	30 Nov	Agency Controls Discussion	Angela Astley Jenny Williams
MPFT	30 Nov	Medicines Optimisation and Drug Expenditure Controls overview	Andrew Campbell (Chief Pharmacist)

Stakeholder engagement log (3/3)

Appendix 2 | Engagement log

Outlined below is a summary of key stakeholder engagement sessions held, the insights which were considered as part of the preparation of this report. Observed pay controls are highlighted in light red.

Organisation	Date	Meeting	Organisation attendees (title*)
MPFT	1 Dec	Vacancy Control Panel	Chris Sands (CFO) Alex Brett (CPO) Angel Astley Liz Lockett
MPFT	6 Dec	Sharing of initial findings	Chris Sands (CFO) Alex Brett (CPO)
NSCHT	16 Nov	NSCHT Introductory meeting with Finance	Kimberli McKinley (DDoF)
NSCHT	24 Nov	NSCHT Introductory meeting with Execs	Eric Gardiner (CFO) Buki Adeyemo
NSCHT	4 Dec	Medicines Optimisation and Drug Expenditure Controls overview	Helen Sweeney (Chief Pharmacist)
NSCHT	5 Dec	Sharing of initial findings	Eric Gardiner (CFO)
NSCHT	5 Dec	Temporary Staffing meeting	Lisa Arnold Zoe Grant
NSCHT	6 Dec	Temporary Staffing meeting	Kerry Smith
UHNM	22 Nov	Executive Introductory Meeting	Tracy Bullock (CEO Mark Oldham (CFO) Jane Haire (CPO) Jonathan Tingham (DCFO) Simon Evans (COO)
UHNM	28 Nov	Procurement Controls meeting	Nathan Joy-Johnson (Head of Procurement NMBC)
UHNM	28 Nov	Executive Team Meeting - Weekly Review of Central Functions Vacancies	Multiple Attendees
UHNM	30 Nov	Nursing Agency Controls meeting	Carol Lloyd-Bennett
UHNM	30 Nov	Medical Agency Controls meeting	Diane Poulson
UHNM	30 Nov	Medicines Optimisation and Drug Expenditure Controls overview	Sue Thomson (Chief Pharmacist)
UHNM	7 Dec	Sharing of initial findings	Mark Oldham (CFO) Jane Haire (CPO)
UHNM	7 Dec	Divisional Vacancy Panel	Multiple Attendees

Appendix 3

Key information list

Key information list (1/2)

Appendix 3 | Key information list

The following documentation and supplementary information has been reviewed and considered as part of the preparation of this report.

Organisation	Key information
ICB	Controls Assessment (NHSE Submission)
	ICS Development Plan
	SSOT ICB Prime Financial Policies
	SSOT ICB Scheme of Financial Delegation
	SSOT ICB Standing Financial Instructions.pdf
	System Recovery Plan
	Finance and Performance Committee Papers
	SPG Meeting Papers
	Process for Double Lock
	Executive Workshop Events for FRP- Slides and Agenda
	Procurement Ops Group Papers
	Line By Line Expenditure Review
	System PMO SPG: Agenda, Minutes, Risk Register, Status Report
	Bed Modelling Papers
	Workforce Deep Dive Papers
	Underlying Position Papers

Organisation	Key information
UHNM	CIP Data
	Terms of Reference
	Meeting Papers
	CIP Governance Papers
	Financial and CIP Delivery Reports
	Vacancy & Agency Governance
	Temporary Staffing Rate Cards
	Longest Serving/Highest Paid Agency Data
	Standing Financial Instructions
	Scheme of Delegation Reservation of Powers to the Board
	UHNM Workplans (Procurement CIP)
	Audit Committee Papers

Key information list (2/2)

Appendix 3 | Key information list

The following documentation has been reviewed and considered as part of the preparation of this report.

Organisation	Key information
MPFT	Temporary Staff Authorisation Process Flow Chart
	2024-25 financial planning approach
	Vacancy Justification Form MPFT
	Authorisation Limits
	Business Justification Form
	CIP Data
	F&P Agenda/Minutes
	M6 Financial Report
	Financial Sustainability Report
	Governance Impact Assessment
	MPFT Investment Policy
	Joint Impact Assessment Tool (EA QIA)
	NHS Authorisation Levels - Temporary Staffing
	Scheme of Delegation Reservation of Powers to the Board
	Standing Financial Instructions
	Standing Orders
	Temporary Staffing fill rates

Organisation	Key information
MPFT	Vacancy Control Process Information
	ESR Self Service Standards Report
	Temporary Staffing Dashboard
	SSoT Vacancy Control Panel ToR
	Controls Assessment (NHSE Submission)
	Audit Committee Papers
	FEG Report (Procurement CIP Delivery)
	Reg 84 Document (Procurement)
NSCHT	Sustainability Report
	Off Framework Agency Information
	Medical Agency Staffing Update
	Standing Financial Instructions
	Scheme of Delegation Reservation of Powers to the Board
	CIP Papers
	M7 Finance Report
	Agency & Bank trend
	Audit Committee Papers

Appendix 4

Contract

Contract (1/3)

Appendix 4 | Contract

The engagement contract is detailed below.

Crown Commercial Service

Call-Off Order Form for RM6187 Management Consultancy Framework Three (MCF3)

Provision of Consultancy Services

To

NHS Staffordshire and Stoke-on-Trent Integrated Care System

From

PricewaterhouseCoopers LLP

–

Framework Schedule 6 (Order Form Template and Call-Off Schedules)

Order Form

CALL-OFF REFERENCE:	**A001**
THE BUYER:	NHS Staffordshire and Stoke-on-Trent Integrated Care System
BUYER ADDRESS:	New Beacon Building, Stafford Education and Enterprise Park, Weston Road, Stafford, ST18 0BF
THE SUPPLIER:	PricewaterhouseCoopers LLP
SUPPLIER ADDRESS:	PricewaterhouseCoopers LLP, 7 More London Riverside, London, SE1 2RT
REGISTRATION NUMBER:	OC303525
DUNS NUMBER:	733367952
SID4GOV ID:	SQ-XTSV59U/1

For the purposes of this agreement, the Buyer means NHS Staffordshire and Stoke-on-Trent Integrated Care System, as host organisation of the partnership organisations (within the NHS) forming NHS Staffordshire and Stoke-on-Trent Integrated Care System ("the ICS"), as follows: University Hospital of North Midlands (UHNM) NHS Trust, North Staffordshire Combined Healthcare NHS Trust, Midlands Partnership University NHS Foundation Trust, University Hospitals of Derby and Burton NHS Foundation Trust and West Midlands Ambulance Service University NHS Foundation Trust.

APPLICABLE FRAMEWORK CONTRACT

This Order Form is for the provision of the Call-Off Deliverables and dated 03 November 2023

It's issued under the Framework Contract with the reference number RM6187 for the provision of management consultancy services.

Contract (2/3)

Appendix 4 | Contract

The engagement contract is detailed below.

CALL-OFF LOT(S): Lot 7: Health, Social Care and Community

CALL-OFF INCORPORATED TERMS

The following documents are incorporated into this Call-Off Contract. Where numbers are missing we are not using those schedules. If the documents conflict, the following order of precedence applies:

1. This Order Form including the Call-Off Special Terms and Call-Off Special Schedules.
2. Joint Schedule 1 (Definitions and Interpretation) RM6187
3. The following Schedules in equal order of precedence:

   - **Joint Schedules for RM6187 Management Consultancy Framework Three**
     - Joint Schedule 2 (Variation Form)
     - Joint Schedule 3 (Insurance Requirements)
     - Joint Schedule 4 (Commercially Sensitive Information)
     - Joint Schedule 10 (Rectification Plan)
     - Joint Schedule 11 (Processing Data)

   - Call-Off Schedules
     - Call-Off Schedule 1 (Transparency Reports)
     - Call-Off Schedule 3 (Continuous Improvement)
     - Call-Off Schedule 5 (Pricing Details)
     - Call-Off Schedule 20 (Call-Off Specification)
4. CCS Core Terms (version 3.0.10)
5. Joint Schedule 5 (Corporate Social Responsibility) RM6187

No other Supplier terms are part of the Call-Off Contract. That includes any terms written on the back of, added to this Order Form, or presented at the time of delivery.

CALL-OFF SPECIAL TERMS
None

CALL-OFF START DATE:	**13 November 2023**
CALL-OFF EXPIRY DATE:	**8 December 2023**
CALL-OFF INITIAL PERIOD:	**4 weeks**

CALL-OFF DELIVERABLES

See details in Call-Off Schedule 20 (Call-Off Specification)

Contract (3/3)

Appendix 4 | Contract

The engagement contract is detailed below.

For and on behalf of the Supplier:		For and on behalf of the Buyer:	
Signature:		Signature:	
Name:	David Morris	Name:	Paul Brown
Role:	Partner	Role:	Chief Finance Officer
Date:	14/11/2023	Date:	14/11/2023

Call-Off Schedule 20 (Call-Off Specification)

This Schedule sets out the characteristics of the Deliverables that the Supplier will be required to make to the Buyers under this Call-Off Contract.

The Services

NHS Staffordshire and Stoke-on-Trent Integrated Care System ("the ICS") consists of three providers (the "Providers"), the Integrated Care Board ("the ICB") itself and other system partners. The Providers included within the scope of this review are Midlands Partnership University NHS Foundation Trust, North Staffordshire Combined Healthcare NHS Trust and University Hospitals of North Midlands NHS Trust.

In Phase 1, the Supplier will:

a. Review and comment on the robustness of the ICS's Financial Recovery Plan (FRP) and underpinning cost improvement plans and how these are scrutinised at the ICB. The assessment will consider key areas of the FRP, anticipated to include:

- Context including the ICB's understanding of challenges faced and strategic plan looking ahead
- Granularity of supporting financial information
- Milestone plans and timescales for delivery
- Stakeholder engagement
- Risk assessment and mitigations
- Interdependencies (including links to quality and operations)
- Governance and accountability arrangements for delivery of the FRP

b. Review and comment upon:

- The cost control structures in place at the ICB and the Providers across key areas of pay and non-pay spend, including but not limited to:
  - vacancy control systems
  - temporary staff controls and authorisation processes
  - procurement spend control systems
- The quality of financial management information produced at a system level to support decision making and compliance with cost control systems

c. Produce a short PwC branded report summarising the findings as well as providing recommendations for improvement. These recommendations will include ideas for immediate short term control measures which might deliver results for FY23/24.

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Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**18 January 2024**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Becky Scullion, Director of Nursing – Quality Assurance and Improvement					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail January 2023.					

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

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	13/12/2023
Click or tap here to enter text.	Click or tap to enter a date.

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

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

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The paper summarises the items received by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in December 2023. The Committee fulfilled its role as defined within its terms of reference. Where appropriate, actions and oversight arrangements are identified within Appendix A.

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

- Deep Dive Discussions
- Health Inequalities
- Updates from System Partners (from SQG)
- Portfolio Quality Updates

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

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

Appendix A: Quality and Safety Report – Detail January 2023

1. Deep Dive Discussions

1.1 The ICB's QSC continues to schedule bi-monthly deep dives, where focused discussion on areas of interest and the impact on the quality and safety of services can take place. In December 2023 deep dive discussions took place with a focus on i) Safeguarding Adults and Children, and iii) System Recovery Plans. Members of the ICB's safeguarding team attended the committee and outlined governance structures, key workstreams and learning from safeguarding reviews. QSC members also discussed system recovery plans and the importance of quality impact assessments including identifying appropriate quality assurance metrics to monitor, as early warning indicators, the impact of recovery plans on the quality of the service.

2. Health Inequalities

2.1 The ICB's Deputy Chief Medical Officer provided QSC with an update against Board Assurance Framework 3: Proactive and Needs Based Community Services and 4: Reducing Health Inequalities to provide assurance regards progress against planned activities and to escalate any risks or issues relating to quality and/or safety appropriately.

2.2 Committee members were provided with an update regarding the 'foundations' being put in place to support SSOT reducing health inequalities e.g., strategy, population health management, research and innovation, organisational and locality partnerships. A working group has been set up to support the development of the Health Inequalities Strategy and it was agreed that it would be presented to QSC in April 2024. Further discussions included spotlight areas and an overview of progress against statutory health inequality workstreams (Core20).

2. Updates from System Partners (from SQG)

2.1 Staffordshire County Council (SCC)

2.1.1 As part of the Deteriorating Patient Network, a review of the 'Care Home Resource Pack' is being is progressed, supported by the ICB's Nursing and Therapies Team. This is a resource pack that was circulated to care homes and contains guidance, information and supporting tools for care home staff to support the recognition of the deteriorating patient. Information contained in these packs also includes the soft signs of deterioration, common conditions including dehydration, urinary tract infections and gastroenteritis. The Resource Pack is accessible to all care staff via the MiDoS for Care platform.

2.2 Midlands Partnership University NHS Foundation Trust (MPFT)

2.2.1 It was reported that pressures in the heart failure service remain. The service is prioritising urgent referrals, but this is having an adverse effect on routine waiting times. System partners are working together to communicate the situation and review pathways and workforce models. A Consultant Cardiologist commenced secondment and is supporting the recovery process. Harm reviews are completed for patients on caseload where potential harm has been identified, learning implemented following harm reviews.

2.3 University Hospital of North Midlands NHS Trust (UHNM)

2.3.1 It was reported that the Trust continue to progress with work promoting the prevention of deconditioning and harm free care. The Trust have been collaborating with John Hopkins Hospital (Baltimore USA). Phase 1 of the John Hopkins Programme went live on 1st November 2023 and will see assessment of activity and mobility, mobility goal setting and daily recording of highest level of mobility for patients in the West Building, ward 225 and ward 15.

2.4 North Staffordshire Combined Healthcare NHS (NSCHT)

2.4.1 It was reported that the Trust continue to progress moving away from the Care Programme Approach for community mental health services. Face to face training is being rolled out throughout community adult and older persons teams, supported by the introduction of new care planning standards, outcome measures and patient aids which allows patients direct access to their care plan via an 'app'.

2.5 Healthwatch

2.5.1 Healthwatch Staffordshire advised of a number of deep dives that they are undertaking; 'Access to Primary Care', 'Root causes of good and poor teenage mental wellbeing and health outcomes when you've been in care as a child' and 'Being a Seldom Heard/LGBTQI+ patient/resident in the health and care system'. As well as sharing patient experiences aligned to the ICS' 7 portfolio areas.

2.6 Primary Care

2.6.1 An update was provided about Care Quality Commission (CQC) inspection ratings. Within Staffordshire and Stoke-on-Trent there are 8 practices rated as Outstanding, 129 rated as Good, 9 rated as Requires Improvement, 1 rated as Inadequate and 1 not rated. Practices rated as Requires Improvement or Inadequate are provided with intensive support with their CQC actions plans and improvement areas by the ICB Primary Care team and in some instances the GP Support Team. The ICB's Primary Care team follow the Quality Stages Standard Operating Procedure which details the necessary actions/intervention required to be undertaken with practices.

2.7 Staffordshire and Stoke-on-Trent ICB – Quality Assurance and Improvement

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

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

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

2.7.3 As part of their Strategy for Special Provision, Staffordshire County Council approved the new model of Enhanced Assess, Plan Do, Review (EAPDR) and Staffordshire Enhanced District Inclusion Support model (SEDIS). Focus regarding health includes ensuring appropriate school interventions are carried out with timely referrals and involving health teams who provide support creatively to prevent capacity issues in services. The SEDIS model will 'go live' in September 2024. The Stoke-on-Trent Special Educational Needs and Disability (SEND) Strategy is currently being refreshed and is due to be published in the Summer of 2024. The Strategy will identify a set of shared priorities and clear outcome measures that will form the road map for SEND in Stoke-on-Trent.

2.7.4 The ICB's Director of Nursing – Quality Assurance and Improvement is leading the system response to the Medicines and Healthcare products Regulatory Agency (MHRA) National Patient Safety Alert (NatPSA/2023/013/MHRA) advising of regulatory changes for oral valproate medicines from January 2024. A system group has been set up to coordinate the implementation of the new regulatory measures in providers.

4. Portfolio Quality Updates

4.1 Primary Care

4.1.1 The ICB's Nursing and Therapies and Primary Care teams are working closely to support transition to the Patient Safety Incident Response Framework (PSIRF), this will include encouraging GP Practices to use the Learn from Patient Safety Events (LFPSE) service which is the successor to the previous National Reporting and Learning System (NRLS). The LFPSE is a new national NHS service for the recording and analysis of patient safety events that occur across all care settings to help make care safer. One of the major objectives of LFPSE was to make it more suitable for use across all healthcare settings as the NRLS, was originally designed for use primarily within secondary care, where local risk management system (LRMS) software is common, which created a barrier to primary care participation. This new online service has been designed for use by staff anywhere healthcare is delivered by organisations registered with an ODS code. This includes general practice, community dentistry and community optometry. The LFPSE introduces improved capabilities for the analysis of patient safety events occurring across healthcare and enables better use of the latest technology to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 09

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

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

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (D)	27/12/2023
Finance and Performance Committee (S)	02/01/2024

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

Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

The report was presented at the Finance and Performance Committee (F&PC) on 2nd January 2024 with a detailed discussion around 4 key points:

- The ongoing fragility of the Acute Care at Home service which has resulted in the workforce risk being increased from 16 to 20 on the ICB Risk Register.
- The removal of all non-allocated SDF funding from the Learning Disabilities and Autism Programme, as per NHSE guidance. The committee discussed in detail the Quality Impact Assessment that had been completed alongside this and noted the risks that had been identified, which had very few mitigations. The Committee asked for regular updates on this via the Mental Health and LD&A Portfolio Report
- The fact that this month, 5 out of the 7 Portfolios had raised escalations, which is the highest number since the Portfolio Reports were introduced in April 2023. It was agreed that for future reports, the Committee needs a summary slide which easily captures whether these escalations are being managed appropriately or whether no solutions have been identified to date.
- The financial outturn for 2023/24 and the forward look to planning for 2024/25.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to: Note the exceptions highlighted in the report.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated System Performance and Programmes Highlight Report

ICB Board Meeting 18th January 2024

Executive Summary for ICB Board

This report contains:

1. An executive summary outlining key headlines and escalations.
2. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operating plan.
3. Exception reporting against our One Collective Aim and 4 system priorities.
4. A finance summary including a month 8 position and an update on efficiency delivery.

The report was presented at the Finance and Performance Committee (F&PC) on 2nd January 2024 with a detailed discussion around 4 key points:

- The ongoing fragility of the Acute Care at Home service which has resulted in the workforce risk being increased from 16 to 20 on the ICB Risk Register.
- The removal of all non-allocated SDF funding from the Learning Disabilities and Autism Programme, as per NHSE guidance. The committee discussed in detail the Quality Impact Assessment that had been completed alongside this and noted the risks that had been identified, which had very few mitigations. The Committee asked for regular updates on this via the Mental Health and LD&A Portfolio Report
- The fact that this month, 5 out of the 7 Portfolios had raised escalations, which is the highest number since the Portfolio Reports were introduced in April 2023. It was agreed that for future reports, the Committee needs a summary slide which easily captures whether these escalations are being managed appropriately or whether no solutions have been identified to date.
- The financial outturn for 2023/24 and the forward look to planning for 2024/25.

Headline Summary

Headlines	Points to note
One Collective Aim	• WMAS data for November indicates a 6.2% decrease in Category 2 incidents over the previous month, which equated to 17 incidents fewer per day. Category 3 incidents, whilst 22% up on the same period last year, are showing a decrease of 5.6% on October. Covid has been on a reducing path for most of the month, and Flu showing signs of returning to the later impact of 2017/18 and 2018/19 seasons. Breathing problems as Category 2 incidents fell by 9.2% on the previous month and were 11.7% down on the previous year. Falls in Medical and Chest Pain incidents also contributed to a reduction. Overall trend for Category 2 is stable whilst Category 3 is trending downwards over the last 4 months
Urgent and Emergency Care (UEC)	• 4hr ED Performance has tracked below the 23/24 mean of 68% for nine continuous weeks fluctuating between 60% and 67% during this period. County Hospital has seen a large drop in performance over this time due to demand. 12hr Performance has also reported above the 23/24 mean or 8.1% for the last 10 weeks with 2 points exceeding the expected upper levels. During this period performance has varied from 8.9% to as high as 11.8%, the highest since the first week of January 23. The reduction in performance through October was far more than expected levels and as such the ability to end the year at the 30-minute average target has been severely compromised. Category 2 Response times have deteriorated significantly but currently remain in line with Operational Plan forecasts.
Tackle Backlogs (Planned Care)	• Eliminating 104+ and 78+ week waiters (ww) remains a system focus; One patient remains in the 104ww category in the ICB and 186 78+ ww as at w/e 10th December. UHNM continue to exceed monthly targets in reducing 65+ and 52+ ww (at ICB level).
Diagnostics	• Performance against the 7-core test plan (of 79.1% of patients to be seen in <6 weeks in October) was 77.2%, the sixth consecutive month below the plan. Activity count increased in six of the seven tests, of these six the plan was exceeded in Gastroscopy and MRI. Activity in Flexi Sigmoidoscopy reduced when compared to last month.
Cancer	• The number of patients whose treatment started after 62 days (at UHNM in month) is below plan in October and in November (provisional) data. • The ICB 28-day faster diagnosis pathway saw 66.3% of patients told within 28 days (across all providers), below the plan of 73.2% in M7 and below the national standard of 75%. Data The percentage of Lower GI referrals with a FIT result remains below plan, unchanged from last month. However, the number of referrals this month and the number with a FIT test have both increased by 15.8%.
General Practice/Primary Care	• Access targets in primary care are on track and delivering as expected against plan. The % of appointments within 2 weeks from time of booking (within the 8 appointment categories) remains above the Primary care network (PCN) Investment & Impact Fund (IIF) higher threshold (>90%) for October 2023.
Prevention and Health Inequalities	• The national objective to increase the percentage of appropriate patients on lipid lowering therapies; the national target of 60% has not been met in October 2023 with 55.4% achieved.
Children and Young People (CYP)	• Reduce emergency admissions for Long Term Conditions (LTC), including diabetes, epilepsy and asthma in the under 18-year-old population. The admissions rates remain below the equivalent period in 2019/20.
Mental Health and Learning Disabilities	• Inappropriate adult acute Out of Area Placement (OAP) bed days, over plan by 150 this year so far. Several issues have been identified, one of which is a gap in female Psychiatric Intensive Care Unit (PICU) beds. A local PICU options appraisal is being developed to go through ICB governance in Q4. • Autism assessment waits for CYP increased by one week at Midlands Partnership Foundation Trust (MPFT) and by two weeks at North Staffordshire Combined Healthcare Trust (NSCHT). • Access to Specialist Perinatal Community mental health services continues to increase. However, the rate of increase has slowed down over the last few months and meeting the Q3 target may prove challenging.

Ctrl and click on any underlined text for further detail.

Escalation Summary

Headlines	Escalation detail
One Collective Aim	• Additional capacity within Primary care as part of Surge planning available and being utilised to support redirection. • Within 111 Surge Management has been implemented with periods of offline time suspended. Consolidation is being utilised where appropriate and being monitored throughout the course of the working day. Call validation has been increased to 2 hours during periods of high volume with focus on Community Rapid Intervention Service (CRIS) utilisation to reduce ambulance call out and support admission avoidance.
Urgent and Emergency Care (UEC)	• The Ambulatory Clinical Decisions Unit (ACDU) is now open and functional to eight large reclining chairs. Utilisation continues to be under target and will have been impacted by pressures over the last fortnight including the extreme congestion of the department which led to UHNM being placed on standby for a Critical Incident. • Emergency Care capacity increase of two additional treatment rooms has been reassessed and brought forward to give an anticipated completion date of 17th December to support the post-Christmas Day pressures seen last year. Additional Medical staff, funded for winter, placed on the late shift to ensure utilisation of this additional capacity. • The System Surge (Winter) Plan expects December to have a bed deficit of -24. The true capacity gap was assessed to be -80 across the Trust with -71 in RSUH Medicine. 143 acute beds/equivalents have been stood up.
Planned Care	• The underlying 78ww position is improving, however UHNM are currently forecasting (with Industrial Action (IA)) 124 78ww breaches in December and 94 in January 2024 (as at w/e 18th December, from the UHNM weekly forecast). Without the IA impact, the expectation would be close to zero. UHNM are achieving the PIFU (Patient Initiated Follow Up) target, but this is not resulting in a reduction in follow-ups to the national target. Analysis of new to follow up ratio's (October 19/20 compared to October 23/24) details a declining ratio in 23/24 compared to 22/23 and 21/22. In October 23/24, eight specialities from 29 (27.5%) have an improved first to follow up ratio, compared to October 22/23.
Efficiency Programme	• We continue to report an in-year deficit position of £91.4m. A review of the system's 'grip and control' has just been completed by Price Waterhouse Coopers and we are currently reviewing their findings and recommendations.
Programme Highlight Reports	• The Urgent Care portfolio have escalated four points including Acute Care @ Home Workforce issues, the surge position and capacity gaps and challenges with the Emergency Department Digital Integration De-mobilisation, which will affect our ability to designate Urgent Treatment Centres. • The Mental Health & Learning Disabilities portfolio continue to escalate the risk regarding the removal of Learning Disability & Autism non-recurrent development monies (SDF Funding). The Quality Impact Assessment has noted significant risks. • The Planned Care portfolio have escalated two points including the unknown impact at present of the forthcoming industrial action. • The End of Life, Long Term Conditions and Frailty portfolio have escalated the delays in bringing the End of Life accelerated beds and the 24/7 advice and guidance service online to support surge. These are also referenced in the System Recovery Programme update • The Primary Care portfolio have escalated 4 points including an increasing demand for appointments & prescriptions, and the impact of recent network outages

Ctrl and click on any underlined text for further detail.

Overview of key underpinning deliverables

Children and Young People / Maternity

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

Planned Care, Diagnostics & Cancer

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

Improving Population Health

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

Urgent and Emergency Care

- Implement Capital Investment Case
- 76% of patients seen within 4 hours in A&E
- Bed occupancy 92% or below
- Full review and priority setting for virtual wards.
- Enhance provider collaborative offer to include the Clinical Assessment Service.
- Deliver a fully integrated discharge "hub"

Mental Health, Learning Disability and Autism

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

Primary Care

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

End of Life, LTCS and Frailty

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

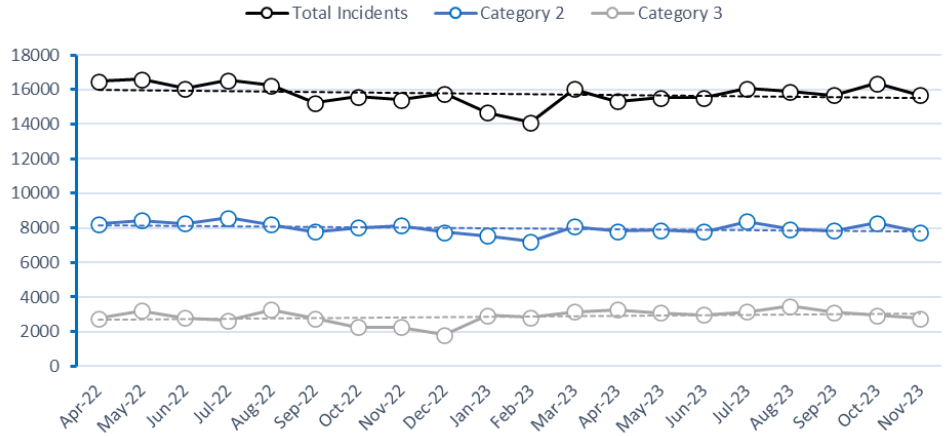
TRAFFIC LIGHT KEY:

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

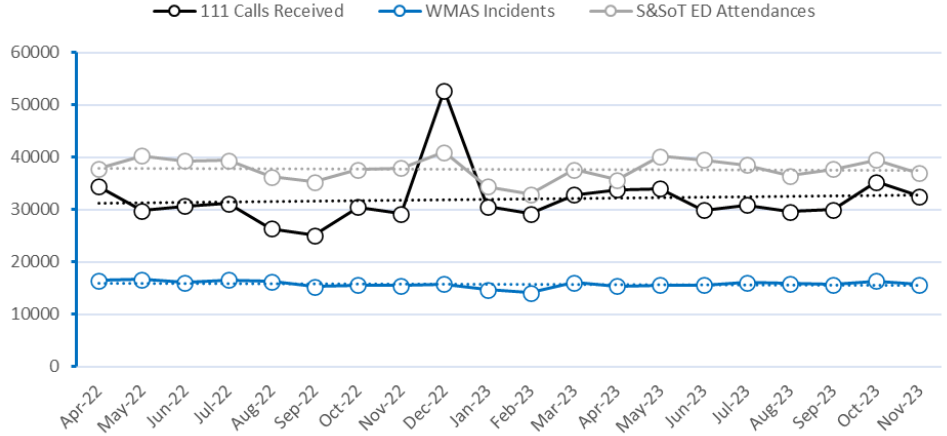
Exception reporting against our One Collective Aim

One Collective Aim	Points to note
Reduce the number of Category 2 and 3 ambulance calls *The data provided here are the incidents derived from calls to West Midlands Ambulance Service (WMAS) for our ICB only.* *Charts run from April 2022.*	• WMAS data for November indicates a 6.2% decrease in Category 2 calls over the previous month, which equates to 17 incidents fewer per day. • Category 3 calls, whilst 22% up on the same period last year, are showing a decrease of 5.6% on October. With Covid on a reducing path for most of the month, and Flu showing signs or returning to the later impact of 2017/18 & 2018/19 seasons, breathing problems as Category 2 incidents fell by 9.2% on the previous month and were 11.7% down on the previous year. Falls in Medical and Chest Pain incidents also contributed to the reduction • Emergency Department (ED) Attendances through November reduced by 8.2%, down to the lowest volume since April 2023 and recording levels 3.5% below the same month last year. • The total number of 111 calls during November 2023 decreased by 7.8% on the previous month but was 11.6% higher when compared to the same period of 2022/23, a change of equivalent to 89 and 78 calls per day, respectively. • UHNM are in segment 3 of the NHS Oversight Framework with 5 exit criteria in place in relation to UEC with challenged performance in Ambulance Handover Delays and > 12-hour waits undergoing continual monitoring to gauge progress. • Monitoring against contractually agreed trajectories for Category 2 Response times continues with the latest 4-week average of 51m 26s significantly above the 30-minute target, placing us 4th out of 11 in the Midlands region. Performance in October – November was off trajectory and has compromised the ability to end the year at the 30 minute average target.

West Midlands Ambulance Service Total Incident, Category 2 and Category 3 incidents graph for Staffordshire and Stoke-on-Trent ICB



NHS111 calls received, WMAS incidents and Emergency Department Attendances graph for Staffordshire and Stoke-on-Trent ICB providers



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

Exception reporting against our 4 system priorities

System Priority	Key points this month or actions and observations for the coming months
1. Urgent & Emergency Care **Focus on prevention, hospital avoidance and appropriate and timely discharge**	• In hospital – The 4hr A&E performance target at UHNM deteriorated by a further 0.8 percentage points to 64.4% for November, 1.4 percentage points higher than the same period last year. The number of patients waiting 12+ hours (~65/day) reduced by 10% in November and was 3.9% below the same period last year. • Surge – The Bed occupancy rate in November increased by 0.4% to 91.9% from October, reflective of the pressures being managed. • The Ambulatory Clinical Decisions Unit (ACDU) is now open and functional to eight large reclining chairs. Utilisation has been under target for the first week but will be improved as the model and pathways are embedded. • Call before you Convey in conjunction with WMAS has gone live and we are awaiting initial data to review outcomes. • Emergency Care capacity increase of two additional treatment rooms has been reassessed and brought forward to give an anticipated completion date of 17th December to support the post-Christmas Day pressures seen last year. UHNM has implemented a five-strand approach to ensuring pre-Christmas discharges sufficient to generate required capacity to ensure the circumstances leading to the Critical Incident declaration last Christmas are not repeated. • Surge Planning – The System Surge (Winter) Plan expects December to have a bed deficit of -24. The true capacity gap was assessed to be -80 across the Trust with -71 in RSUH Medicine. 143 acute beds/equivalents have been stood up.
2. Tackle Backlog (Planned Care) **Backlog reduction**	• Follow-up attendances are at a higher level of activity than planned this month. Achieving the national target of a 25% reduction is challenging and remains the focus of outpatient transformation schemes. • 65+ week waits at UHNM were 979 in October better than the plan of 1,145. However, the pace has been impacted by Industrial Action. • 78+ week waits 101 were at UHNM at w/e 10th December (weekly recovery pack). Eliminating 78+ week waiters remains a challenge, as UHNM forecast 124 at the end of December and 94 at the end of January (latest forecast w/e 18th December). • 104+ week waits: 1 across the ICB as at w/e 10th December. At UHNM the forecast (with Industrial Action) for there to be one 104+ ww in December and none in January (latest forecast w/e 18th December). • Diagnostic activity was below plan in October (across the 7 core tests) by 3.2%, MRI and Gastroscopy the only tests to exceed the plan again. The percentage of patients seen in <6 weeks (at 77.2%) increased (from September) but was below the monthly plan (of 79.1%). • The latest UHNM position (10th December) shows the [Cancer] 62-day backlog has dropped to 355, below their revised trajectory of 371. • The 104-day Cancer backlog at UHNM continues to decline and has decreased to 101 (as at w/e 10th December); this total remains below the revised trajectory (of approximately 120 for this period). • The 28-day faster diagnosis standard (FDS) was below plan and below the National Standard of 75% in October, at both UHNM (66.6% and across the ICB (66.3% for all Providers)). • UHNM are in segment 3 of the NHS Oversight Framework with 8 exit criteria in place in relation to High Proportion of Urgent Cancer waits and High volume of Long Waits > 78 weeks.

Exception reporting against our 4 system priorities

System Priority	Key points this month or actions and observations for the coming months
3. General Practice / Primary Care **Ensuring that residents have appropriate, timely and equitable access to services**	• The October 2023 Did Not Attend (DNA) rate was 5.8% - a decrease of 0.8% from September, in-line with previous seasonal trends. • The Scheduled Units of Dental Activity (UDAs) increased in October but remains below the contracted number. A delay to the ability to rebase UDAs is an issue in terms of timeframes to lever change to dentistry provision. The ICB is impacted by corporate contract UDAs. Nationally contract changes to allow unilateral re-basing of UDAs within the contract term have been proposed however there will be a delay to the implementation of the changes as the regulatory changes required to enact this have not yet gone through parliament and it may take another 12 months. A delay to the ability to rebase UDAs is an issue in terms of timeframes to lever change to dentistry provision. • Additional Roles Reimbursement Scheme (ARRS) stands at 460.4 Full Time Equivalent (FTE) for October and remains below plan however the FTE continues to increase month-on-month.

4. Complex Individuals
 	
Improving access to high quality and cost-effective care for people with complex needs, which requires multi-agency management
	• Continuing Healthcare (CHC) – Tackling CHC costs and improving patient pathways remains a priority for the system and is discussed in more detail in the System's Recovery Programme. The projects remain on target to deliver an in year savings of £17m (which has a full year effect of £43m) and a new CHC Fast Track pathway went live on 4th December.
	• Access to Children and Young People (CYP) community mental health services has dropped over 1,000 (rolling 12-month) this year so far, from 14,735 in April to 13,610 in October. North Staffordshire Combined Healthcare NHS Trust (NSCHT) is working with the NHSE (NHS England) to explore/investigate root causes of the unexpected decline, including NSCHT data quality and methodology applied in NHSE's calculation.
	• The Dementia diagnosis rate at 72.3% in November, continues to exceed the national target of 66.7%.
	• Learning Disabilities & Autism –
	  ○ Patients with Learning Disabilities and Autism (LD&A) with an Annual Health Check (AHC): the November position is 44.2%, below Q3 target trajectory. Staffing changes and departures of LD Champions impacted adversely on performance. Actions, including increasing staffing capacity are taken to improve performance trajectory.
	  ○ the removal of LDA SDF funding remains a significant challenge for the portfolio. The QIA has identified the following risks & issues:
	  • Continued delay to waiting times for adults as well as poor access from Black Country Partnership Trust for Autism diagnostic waiting times
	  • Likely to lead to a loss of confidence in the system from parent carer group
	  • Reduction in the ability to pump prime local working at Place to reduce health inequalities
	  • Reduction in the ability to share learning and to seek solutions to premature death across the system
	  • Increase of CYP and adults in crisis leading to further trauma and significant increase to care costs
	  • Crisis situations will continue without learning opportunities
	  • inability to transform the key working offer in line with National Best Practice

Finance Summary

At month 8, at a system level we are reporting a year-to-date deficit position of £79.5m, which is a £62.7m adverse variance against the £14.7m deficit plan (Month 7 –year to date deficit £75.5m; variance to plan £60.7m). The year-to-date variance to plan sits within the ICB (£59.9m) and UHNM (£3.2m) with NSCHT and MPFT slightly better than plan.

The main drivers behind this variance remain consistent with prior months, being:

- CHC and prescribing costs being over and above the inflationary assumptions used within the system plan submission (£33.6m)
- Slippage on efficiency programmes within the plan (£15.3m)
- Retention of escalation beds longer than initially planned due to the ongoing UEC demands within the system (£7.0m)
- Industrial action throughout the financial year, which impacted UHNM over and above plan (£3.9m
- Adverse planning assumptions including delegated budgets (£2.9m)

All organisations are increasingly confident of delivering their risk adjusted forecast and managing the residual risks. However, we still need c£3m to secure the position, and whilst we are fairly confident that this can be covered by the improving CHC run-rate, to go further at this stage is not possible. On this basis, as a system, we still believe that a deficit of £91.4m is our most likely position. We will endeavour to improve upon this, but we want to offer a position that we will deliver rather than put in an aspiration that we won't.

The position includes risks around the fixed and variable aspects of ERF, and we hold firm on our assumptions. It is also worth noting that the £91.4m does not include any impact for further strike action or any provision for band 2/3 retrospective payments. Following the revisions to the support worker (CSW) band 2 and the clinical support worker higher level (CSWHL) band 3 matching profiles, all providers are needing to assess any impact of this on their pay bills. Whilst this process is at an early stage, it is expected that this could have a significant impact and our providers may need to provide for both the recurrent impact and any back pay due in their 2023/34 accounts.

Our capital plan remains overcommitted as expected, although mitigations have brought the overcommitment down significantly, we have an overspend regarding Project Star which are known to region and which we are managing as a system.

Month 8 Position

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

	Month 8			Month 7		
System		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	2,951.9	2,977.7	25.9	2,573.4	2,590.7	17.3
Pay	(797.8)	(786.6)	11.2	(697.1)	(691.0)	6.1
Non Pay	(414.6)	(460.4)	(45.8)	(362.5)	(401.2)	(38.7)
Non Operating Items (exc gains on disposal)	(19.1)	(13.2)	5.9	(16.7)	(11.7)	5.1
ICB/CCG Expenditure	(1,737.1)	(1,797.0)	(59.9)	(1,511.8)	(1,562.4)	(50.5)
Total	(16.8)	(79.5)	(62.7)	(14.7)	(75.5)	(60.7)
			-2.1%			-2.3%

	Month 8			Month 7		
ICB		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Allocation	1,716.4	1,716.4	(45.8)	1,492.2	1,492.2	(38.7)
Expenditure	(1,737.1)	(1,797.0)	0.0	(1,511.8)	(1,562.4)	0.0
TOTAL ICB Surplus/(Deficit)	(20.8)	(80.6)	(59.9)	(19.7)	(70.2)	(50.5)
			-3.5%			-3.4%

	Month 8			Month 7		
UHNM		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	708.9	736.7	27.8	620.2	635.9	15.7
Pay	(434.9)	(437.9)	(3.0)	(379.8)	(382.4)	(2.6)
Non-Pay	(253.0)	(284.1)	(31.0)	(221.1)	(247.7)	(26.5)
Non Operating Items (exc gains on disposal)	(18.6)	(15.5)	3.1	(16.3)	(13.6)	2.6
TOTAL Provider Surplus/(Deficit)	2.4	(0.8)	(3.2)	3.1	(7.8)	(10.9)
			-0.4%			-1.7%

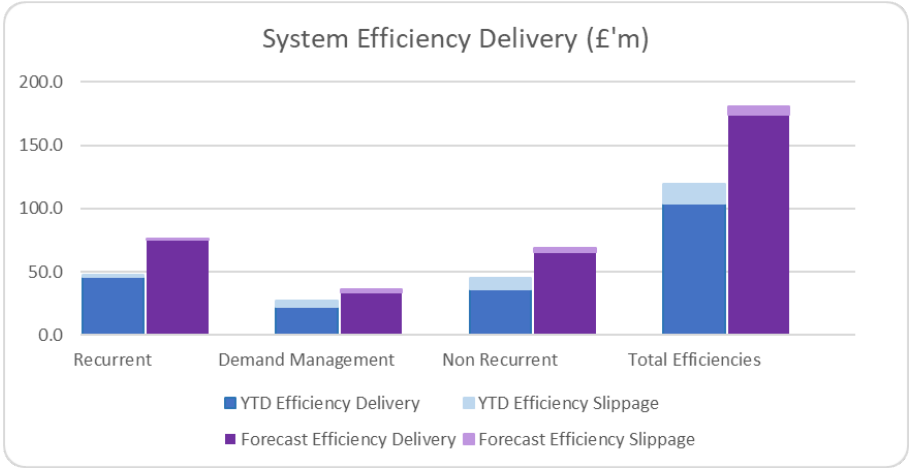
	Month 8			Month 7		
MPFT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	416.1	415.4	(0.6)	364.2	367.9	3.7
Pay	(300.4)	(286.9)	13.5	(262.7)	(254.6)	8.0
Non-Pay	(115.9)	(130.4)	(14.6)	(101.3)	(114.0)	(12.6)
Non Operating Items (exc gains on disposal)	1.8	3.5	1.6	1.6	3.0	1.4
TOTAL Provider Surplus/(Deficit)	1.6	1.6	0.0	1.8	2.3	0.5
			0.0%			0.1%

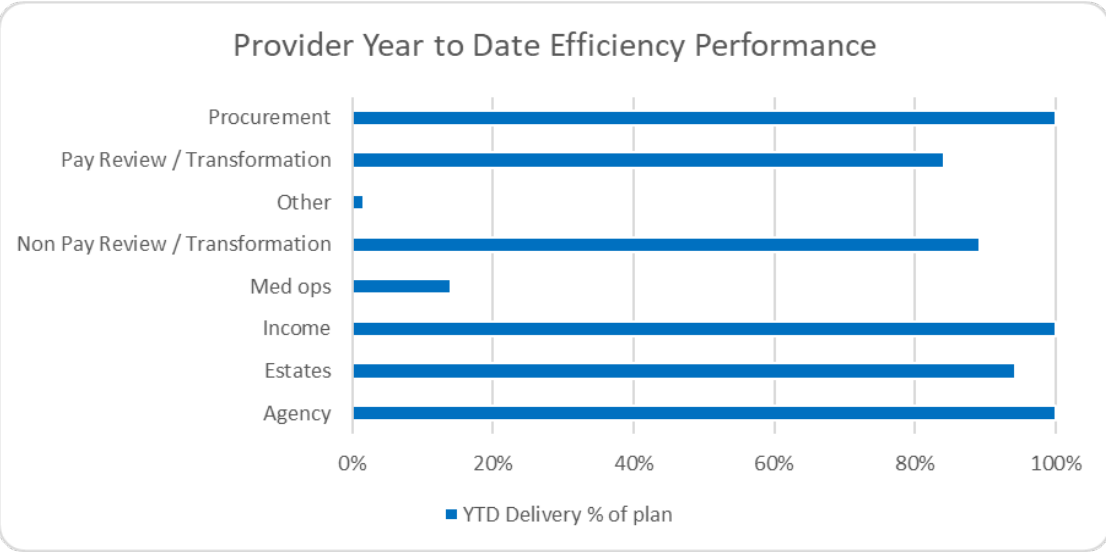
	Month 8			Month 7		
NSCHT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	110.6	109.2	(1.3)	96.8	94.7	(2.1)
Pay	(62.5)	(61.8)	0.6	(54.6)	(53.9)	0.7
Non-Pay	(45.7)	(45.9)	(0.2)	(40.0)	(39.6)	0.5
Non Operating Items (exc gains on disposal)	(2.4)	(1.1)	1.2	(2.1)	(1.0)	1.0
TOTAL Provider Surplus/(Deficit)	0.0	0.4	0.4	0.1	0.2	0.2
			-0.3%			-0.2%

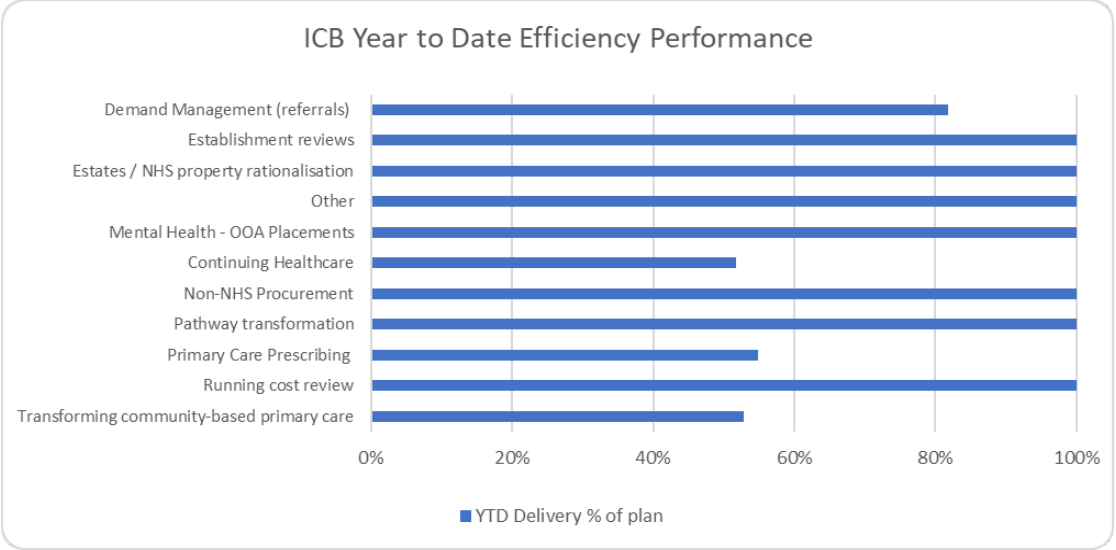
Efficiency Delivery

- **The system has delivered £104m of efficiency as of November 2023, 87% of plan.** Forecasts project the system reduced to £6.5m behind their total efficiency plan by year end, and there remains a level of risk within this forecast due to the size of the efficiency target within the plan.

- Key challenges remain to deliver recurrent efficiency within the current environment. We are currently forecasting a **£3.3m shortfall of recurrent schemes at year end.** All organisations have been ramping up assurance of FYE delivery into 2023/24 and the previously identified actions continue.







NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure No: 10

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	2 January 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Risk Register	There are 24 risks on the System Risk Register of which 16 are high scoring (12 and above) and there are 8 medium risks. The Committee approved: • The increase in the score from 16 to 20 for Risk 156: Acute Care at Home Workforce and Capacity Pressures • The increase in the score from 12 to 16 for Risk 130: Risk of financial failure at Stoke-on-Trent City Council • The reduction in the score from 12 to 6 for Risk 126: Reinforced Autoclaved Aerated Concrete (RAAC) • The reduction in the score from 16 to 9 for Risk 097: Cost of Living Impact. The Committee agreed that Risk 112: Industrial Action be re-worded to ensure all the different aspects are included e.g. finance, planned care, quality and safety. It would be presented to all relevant Committees but Finance and Performance Committee would be the lead Committee. The Committee has good sight of the top risks for finance, performance and transformation.	Workforce and capacity issues in the Acute Care at Home service are impacting upon a number of services.
Integrated System Performance and	The Committee noted the Month 7 performance position against the key	

Programmes Highlight Report	metrics in the Operating Plan. The Committee noted the significant challenges in Urgent and Emergency Care, Planned Care, Diagnostics and Cancer performance. There is continued pressure on Psychiatric Intensive Care Beds within the system and a local PICU options appraisal is being developed to address this. Autism assessment waits for CYP increased by one week at Midland Partnership FT and two weeks at North Staffordshire Combined HT. Access to specialist perinatal community mental health services is improving, but meeting the Q3 target will be challenging. Access targets are on track in General Practice and emergency admissions for Long Term Conditions for Children and Young People remain below the equivalent period last year. Five Portfolios highlighted risks to the Committee, these included delays in opening up the additional End of Life beds and 24/7 advice service and risks regarding removing SDF money for Learning Disability and Autism services. The Committee will consider how to better consider Portfolio escalations in future meetings.	
Planning Update	The paper provided an update on the 2024/25 System Plan Priorities which seek to strengthen the links between the ICP Strategy, the Joint Forward Plan and the Operational Plan. The proposed priorities have been shared in several forums including the Health and Care Senate, Provider Collaborative Board, System Planning Task and Finish Group and with a wide range of partners from across the System. The feedback was included in the report and reflected in the latest iteration of the priorities presented for approval by the Committee.	
Elective Care/Elective Recovery Plan	The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position noting that despite progress being made, the rate of improvement has been significantly hampered by industrial action.	Two patients have breached 104ww at UHNM. One is due to very specialist equipment being required and treatment is due to take place in January. The second long wait patient is due to a process issue and an investigation is underway regarding this breach.

	The report also provided details on the long-waiters who receive elective care outside of the Staffordshire and Stoke-on-Trent System. The Committee noted that: • Nuffield are incurring long wait breaches as a result of patients being transferred there late on the treatment pathway. Therefore, Nuffield have currently put a hold on any further transfers until the New Year with the exception of foot and ankle patients where they still have capacity. • For 65ww, work is ongoing to identify the specialties where performance is not currently assured to allow appropriate support to be given. • NHSE have requested that a refreshed route to zero for the 78ww cohort is provided following the non-achievement of the previous plan to clear by the end of October. Detailed focus on 78ww will be taking place at the Tier 1 meeting to be held on 11 January.	
PwC Report on Financial Recovery Plan and Grip and Control	In response to the deficit, the ICS was required by NHSE to commission an independent assessment from PwC to comment on the robustness of the Financial Recovery Plan and underpinning Cost Improvement Plans, and also review and comment on the cost control structures in place across key areas of pay and non-pay spend. Their report provides detailed organisational level feedback and additional recommendations.	The report is being presented to this Board meeting. Individual organisations will produce and monitor their actions in relation to the report, with a system-wide overview presented to this Committee.
System Finance Month 8 Report	At Month 8, we are reporting a year-to-date deficit position of £79.5m which is a £62.7m adverse variance against the £14.7m deficit plan. The System is no longer going to achieve a forecast breakeven position and a supplementary return detailing a £91.4m deficit System forecast has been submitted to NHSE. Capital is forecasted as expected however medium-term challenges remain and require national monies to achieve plan.	A deficit of £91.4m is believed to be our most likely position. However, we still need c£3m to secure the position and are fairly confident that this can be covered by the improving CHC run-rate. There is a need for the System to deliver on the Recovery Plan in order to reduce the run rate deficit. The position includes risks around the fixed and variable aspects of ERF but does not include any impact for further

		strike action or any provision for Band 2/3 retrospective payments which could have a significant impact. We have received a claim from RWT for over £7m of additional contract payments that we will be challenging.
ICS 2024/2025 Financial Framework	CEOs have asked that clinical and operational leaders lead the work on identifying solutions to live within the financial resources available to the System. The document described the financial framework within which we will be operating and the areas requiring a clinically-focussed approach in order to address the financial challenge. The Committee discussed the causes of reduced productivity and the need to include consideration of back office services in this work.	The paper is being presented to all partner Finance Committees and will frame the conversations at the next System Leadership meeting on 24 January.
System Recovery Plan Update	The paper provided an update on how the System Recovery Programme is being implemented. The Committee noted the escalations that were discussed at the System Performance Group meeting on 20 December and that a summary of actions agreed will be taken back into the weekly System recovery meeting.	The Admission Avoidance and Care Homes priorities remain the most challenged areas, with a majority of red rated key deliverables.
System Business Cases	As part of the double lock process, the following Business Cases were discussed in detail at SPG on 20 December: • Additional recurrent investment in the Medical, ANNP and AHP workforce in Neonatal Services • Recurrent investment in the Medical, Sonographer and robotic assistant workforce for Obstetrics and Gynaecology Services • Pharmacy Workforce Resource Requirement to support the current Medicine Division in-patient bed base and activity The Committee noted that the three Business Cases had been approved by the UHNM Trust Board on the grounds of patient safety. SPG found the case for investment was compelling but given the financial outlook, if these investments were supported then the System would need to find further savings to cover them.	The Committee agreed with the need for additional investment (£1.1m full year costs in each case) in the Neonatal and Obstetrics Business Cases, but given no sources of funding were identified, the Committee requested that the System Chief Executive Group consider the options. UHNM have agreed to undertake further work on the Pharmacy Business Case to consider the impact of cash releasing benefits.

Draft Staffordshire & Stoke-on-Trent Green Delivery Plan and Quarterly Green Plan Update	The paper provided the quarterly update to the Committee on the delivery of the Green Agenda, funding opportunities and progress on the development of the update to the Green Delivery Plan. The Committee noted the significant progress which has been made since the previous report.	
ICS Capital Update	The report updated the Committee on the current main capital schemes developments from the work of the Capital Investment Group. The Committee noted: • There are many strategic outline cases currently in motion to secure national funding for schemes • The Group are maximising the capital resource available to the System and have a current over commitment of £3.3m. This risk is being mitigated. • The escalation from the System Capital Group regarding governance arrangements following the decision made by the Urgent Care Board on the designation of 3 UTCs which cannot be delivered within the current capital constraints.	
System Surge Winter Plan Update	The report provided an assessment against the plan, the mitigations and escalated risks. The Committee noted the good flows around discharge in the period leading up to Christmas and the positive agreement of an Ambulance Escalation Policy. Escalations included level of additionality provided by Hospice beds; Golden Park Step Up beds delays due to Acute Care At Home capacity.	
ICS Oversight Framework Update	The Committee received for information the letters following the UHNM Provider Review Meeting with NHSE and the ICB on 7 December, the ICB SRM meeting on 5 December and MPFT and NSCHT Provider Oversight Meetings with the ICB on 8 December.	
Finance and Performance Committee Annual Work Schedule	The paper detailed the Committee's proposed annual business cycle.	

PART B		
Transformation Programmes Update	The paper provided the monthly overview of the clinical areas included within the System Transformation and Service Change Programme. Key updates for the Committee focused on maternity, the Cannock Transformation Programme and Urgent and Emergency Care – UTC Designation.	
Risk Register	There are 7 risks on the ICB Risk Register of which 4 are high scoring (12 and above) and there are 3 medium risks. There have been no new or closed risks or changes to risk scores since last month's report.	
ICB Efficiency Performance	The paper reported on the achievement to date and the remedial actions being taken to manage any gaps in the delivery of the ICB's 2023/24 efficiency programme.	The Committee was pleased to note the improvement in the forecast outturn from £11.8m in Month 7 to £3.3m this month. The Committee noted the areas of focus for 2024/25 in particular the plan to widen the scope of the CHC recovery plan to Mental Health packages which are the highest cost to the ICB.
ICB Finance Report (Month 8)	The paper reported an ICB year-to-date deficit position of £80.4m against a planned deficit of £20.6m, creating an adverse variance to plan of £59.4m. The ICB's element of the System £91.4m deficit position submitted to NHSE is a £97.4m deficit which is challenging but believed to be achievable. The key risks to the position are ERF allocation and contract agreements. We continue to adopt a formal forecast of break-even for the year, following NHSE forecasting protocols, and are anticipating imminent release of guidance allowing the ICB to move the risk position into the formal forecast.	FPC approved the ICB's Month 8 forecast position of breakeven and noted the level of unmitigated risk being reported.
ICB Procurement Operations Group Highlight Report	The paper reported the key activities being co-ordinated by the Procurement Operations Group and in particular the actions being taken to ensure the ICB is able to implement the new Provider Selection Regime regulations.	
Delegation of Specialised Services from NHSE to ICBs	The paper provided an update on the delegation of Specialised Services to the ICB from April 2024.	The Committee will receive information and assurance reports throughout the delegation process.
Caseload of Individual	The paper provided an overview of	

Placements Quarterly Review	the current bespoke funding arrangements including support packages that are jointly funded with the Local Authorities.	
Primary Care Forum Report	In order to have governance oversight, FPC received a summary report of the meeting that took place on 2 December. This reported on the discussions on Primary Care finances, General Practice and Pharmacy, Optometry & Dental (POD).	The Committee noted although the in-year financial position for Delegated General Practice is on track, the underlying position is a significant deficit. Due to dental funding associated with clawbacks being utilised to support ICB deficit positions, schemes developed for improving access to dental care will not be able to proceed.

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

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 11

Report to:	**Integrated Care Board**					
Date:	**18 January 2024**					
Title:	**Planning Update ICB Board**					
Presenting Officer:	Paul Brown – Chief Finance Officer and Chris Bird - Chief Transformation Officer					
Author(s):	Planning Team					
Document Type:	Report		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix 1: Planning Update ICB Board					

(1) Purpose of the Paper:
To provide an overview of 2024/25 System Operational Plan Priorities A high-level summary of the national planning guidance that has been received to date An overview of the aims of the system event taking place on the 24th January and the broader next steps in planning, including a revised provisional timeline.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Plan Priorities only - System Planning Task and Finish Group	23/11/2023
System Plan Priorities only - System Finance and Performance Committee	02/01/2024

(3) Implications:	
Legal or Regulatory	System Plan Priorities are central to the ICB meeting its legal duty to plan local services to improve health and reduce inequalities. ICBs have a legal responsibility to deliver operational planning priorities and to produce and annually refresh Joint Forward Plans.
CQC or Patient Safety	The system Plan Priorities, and operational plan priorities (especially priorities for Urgent & Emergency Care (UEC), Elective Care and Primary Care Recovery), are key areas that CQC monitor as part of the their regulatory framework, particularly in terms of effective, responsive and well-led services.
Financial (CFO-assured)	A sustainable financial plan is central to the proposed Operational Plan Priorities set out in the System Plan Priorities

Sustainability	Sustainability is a theme which runs throughout the system operating plan.
Workforce or Training	The system operating plan has multiple workforce and training requirements within it, which will also be monitored by the People Committee
Equality & Diversity	Optimising health and wellbeing and ensuring fair and equal access for all is an overarching principle of the ICP Strategy and national planning ambitions.
Due Regard: Inequalities	Making best use of resources and targeting those in greatest need, or with greatest ability to benefit is an overarching principle set out in the ICP Strategy.
Due Regard: wider effect	System Plan Priorities will support broader social and economic development

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

1. 2024/25 Operational Plan Priorities

The report contains the 2024/25 System Operational Plan priorities as approved by System Finance and Performance Committee on 2nd January 2024.

2. National planning guidance

Key messages from the national planning guidance published and what is yet to be published covering the
a) Letter on operational planning for 2024/25 key messaged
b) Guidance on developing the Joint Forward Plan (JFP) for 2024/25
c) Guidance on developing joint capital resource use plans 2024/25 and supporting resources
d) Finance Guidance and Allocations 2024/25

Yet to be published;
a) 2024/25 Operational Planning Guidance and Technical submissions
b) Confirmed timelines for submissions.

3. Next steps

Focus remains on achieving, or if possible improving upon, the approved £91.4m system deficit, line with

the system commitment at the recent escalation meetings.

In terms of 2024/25, we are currently finalising the financial framework within which we will be operating, and some of the issues that need to be worked through. We will start to work this up through the system meeting on 24th January 2024 with the objective of this session being to pave the way for our clinical leaders to help us work through our priorities and options.

A summary of what we have done so far in relation to the planning round and next steps including a revised provisional timeline is also outlined.

(7) Recommendations to Board / Committee:

1. Note the 2024/25 Operational Plan Priorities approved by SFPC on 2nd January 2024
2. Note the summary of the national planning guidance
3. Note the next steps around the System event on 24th January and the broader planning next steps.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

2024/25 planning round

ICB Board Meeting 18th January 2024

Executive Summary for ICB Board

This report contains:

1. An overview of the 2024/25 System Operational Plan Priorities
2. A high level summary of the national planning guidance that has been received to date
3. An overview of the aims of the system event taking place on the 24th January and the broader next steps for planning

ICB Board are asked to:

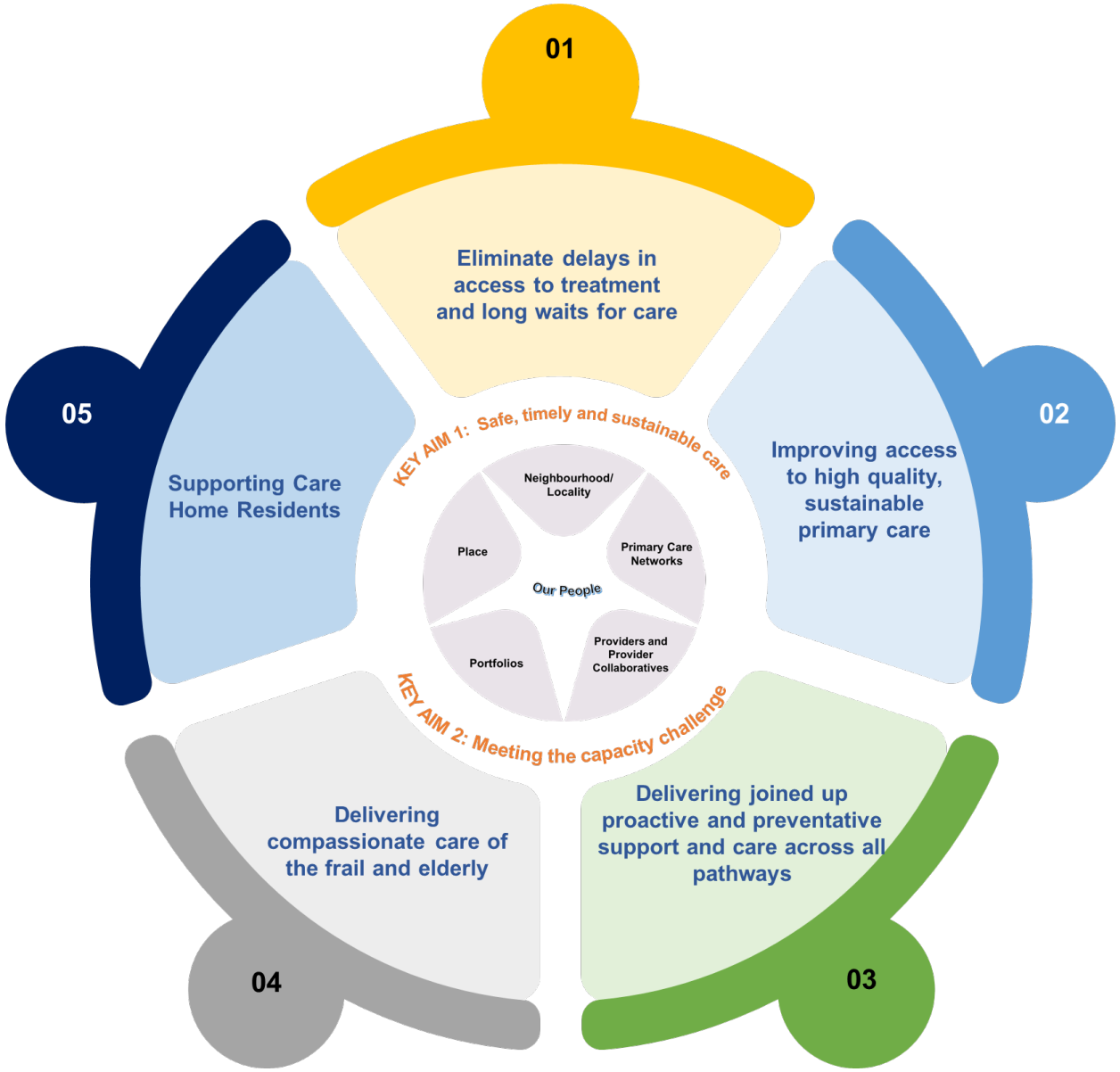
1. Note the 2024/25 Operational Plan Priorities approved by SFPC on 2nd January 2024
2. Note the summary of the national planning guidance
3. Note the next steps around the System event on 24th January and the planning next steps, including a revised provisional timeline.

NHS
Staffordshire and Stoke-on-Trent Integrated Care Board

System Operational Plan Priorities 2024/25

Context to the 2024/25 Operational Plan Priorities

- We have set out **5 high level operational plan priorities (the What)** for 2024/25.
- Although numbered these are not set out in priority order. They are a built from the priorities set in the "triangle" last year and priorities emerging either as part of the financial recovery programme or as the result of pieces of other work throughout the year eg the over 75 PHM assessment.
- The rationale for each will be outlined in the overarching operational plan narrative.
- These are wrapped around 2 key aims for us all in ensuring we have safe, timely and sustainable care, and meeting the capacity challenge.
- The priorities are aimed at being broad enough to make these relevant to all portfolios, providers and partners.
- There has been good engagement from a wide range of partners across the system. The main work has been on reviewing and reflecting the feedback on the wording, rather than any change to the priorities.
- Each portfolio has already set out their draft high-level priorities for 2024/25 which will underpin delivery of the system level priorities alongside those of our system partners/providers. These will continue to be progressed and prioritised over the coming weeks supported by the system executive event on 24th January.



The What

"make Staffordshire and Stoke-on-Trent the healthiest places to live and work"

Integrated Care Partnership Strategy

Five P's

These are the five things we need to change if we are going to make a difference

Improving health and wellbeing

People and communities
working with people and communities to empower them to build healthy, supportive and thriving neighbourhoods

Personalised care
holistic, integrated care designed around personal needs and preferences

Personal responsibility
working with individuals to empower them to make healthy choices and manage their health and wellbeing as an active partner

Prevention and health inequalities
promoting healthy decision making, optimising health and wellbeing and ensure fair and equal access for all

Productivity
making best use of resources and targeting those in greatest need, or with greatest ability to benefit

Underpinned by Population Health Management (PHM)
improve population health outcomes through intelligent decision making.

Achieved Through

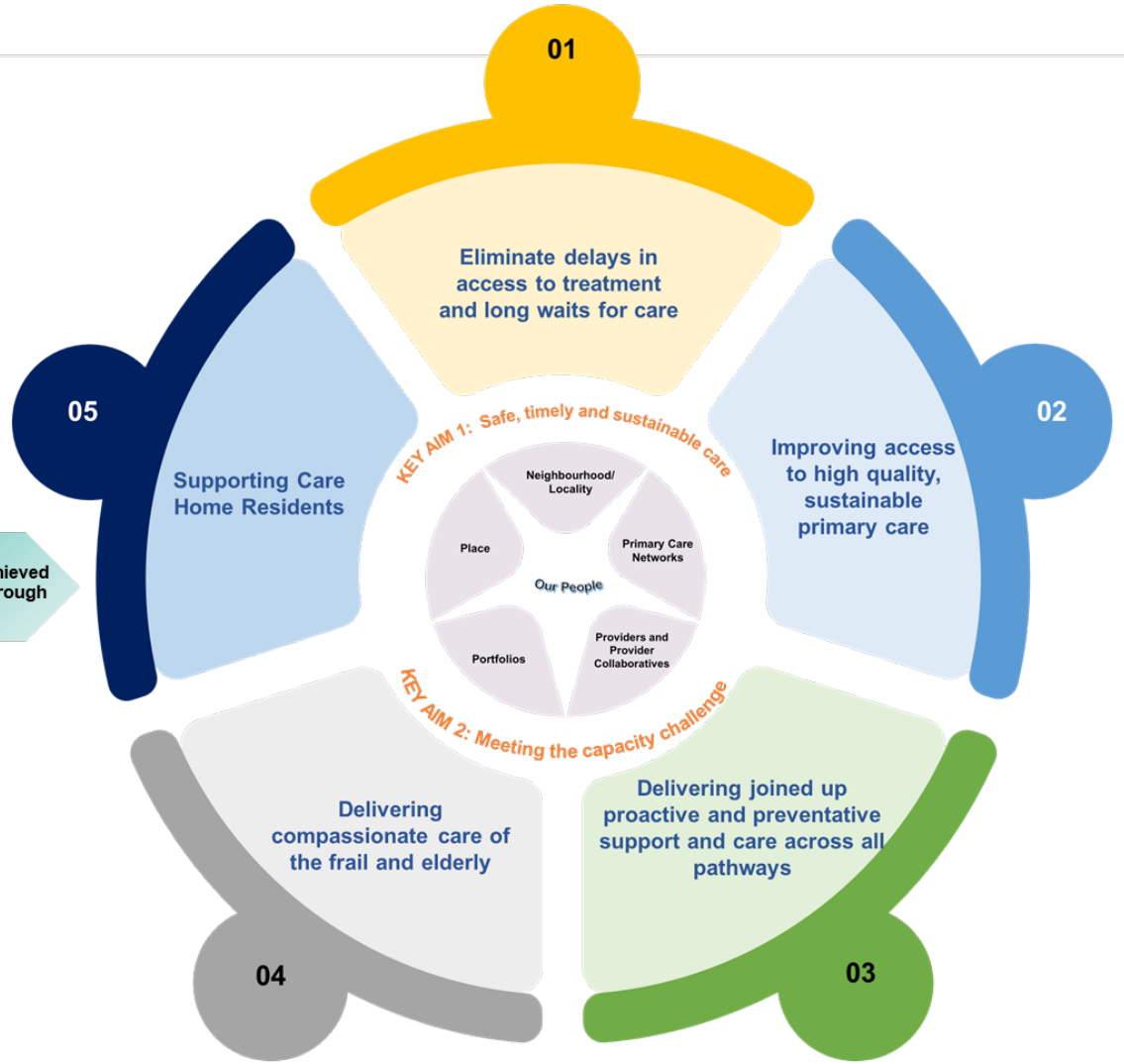
Joint Forward Plan (JFP)

Outlines our collective priorities over the period 2023 to 2028. It addresses the four core purposes of an ICS

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

Achieved Through

System Level 2024/25 Operational Plan Priorities



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National Planning Guidance

Joint Forward Plan and 2024/25 Operational Planning

National Planning Guidance Key Messages

Documents and guidance published to date include:

- Letter on **operational planning** for 2024/25 key messaged
  - Not wait for national guidance to start operational planning for next year.
  - Priorities and objectives set out in 2023/24 national documents will not fundamentally change the 2024/25 approach.
  - Continue to target a reduction in the cost of temporary staffing.
  - Have a standard set of metrics to track productivity alongside operational level service delivery.

- Guidance on updating the **Joint Forward Plan (JFP)** for 2024/25
  - There are no fundamental additions to the guidance nor anything that has been removed, compared to the guidance published in 2022/23.
  - The guidance does not require any change to our agreed approach to refreshing the JFP, which has been already set out for our boards and committees.

- Guidance on developing **joint capital resource use plans** 2024/25 and supporting resources
  - Outlines requirements for developing joint capital resource use plans (JCRUPs).
  - Systems have the flexibility to determine the scope for their JCRUP's but as a minimum should describe how capital is contributing to ICB's priorities and delivering benefits to patients and health care users.

- **Finance Guidance** and Allocations
  - The overall financial framework will remain consistent, including the payment approach used to support financial recovery.
  - Financial allocations for 2024/25 have already been published and system plans will need to achieve and prioritise financial balance.

Yet to be published:

- 2024/25 Operational Planning Guidance and technical submissions delayed
- Timeline for NHSE focused technical submissions - early indications that drafts will still be required for end of February and that plans need to be published by the end of the financial year (by the 1st of April 2024)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

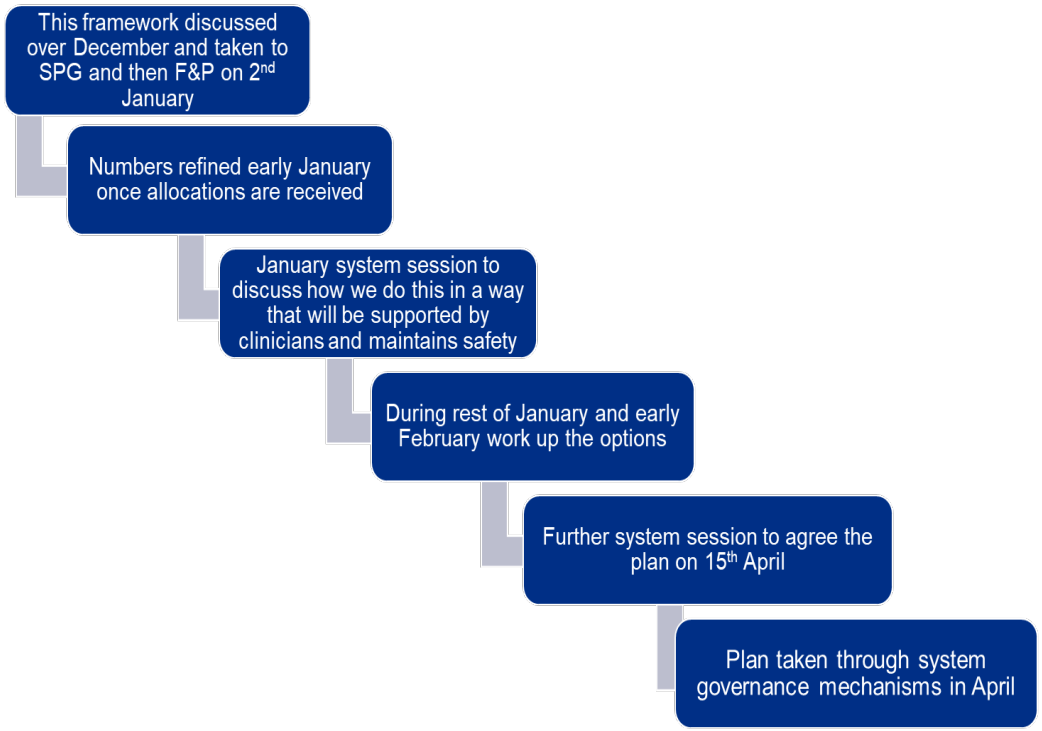
Next Steps

System Meeting , Joint Forward Plan and 2024/25 Operational Planning

System Meeting Aims and Objectives

Framework for 2024/25

- Chief Executive Officers (CEOs) have asked that clinical and operational leaders to lead the work on the choices that we face as a system.
- We are finalising the framework within which we will be operating, and some of the issues that need to be worked through. We will start to work this up through the system meeting scheduled for 24th January. The objective of the session is to pave the way for our clinical leaders to help us work through our priorities and options.
- We have framed the likely size of the challenge and some of the options we have. We need to be clear that the plan for 2024/25 will not compromise safety. All schemes/proposals to have QIA/EQIA/ Health inequality impacts as part of standard practice.
- We also need to explain that there are unlikely to be any new funds for investment, and therefore planning needs to be about how we deliver within the current financial envelope. The outlook is that inflation is likely to be higher than originally planned, and this will utilise the growth we can expect.
- We need to plan on the capacity we have now and find ways of delivering the priorities safely from that allocation.



Operational plan and JFP - What we have done so far and next steps

What we have done so far

- System operational plan priorities developed and approved at SFPC
- Summarised national guidance for system leads.
- Outlined the framework for 2024/25
- Portfolios have set out their draft operational priorities and delivery plans for 2024/25.
- NHS providers have commenced their internal operational planning which will be aligned with system level plans support working with provider planning, analytical, workforce and finance leads.
- A draft strawman of the JFP setting out proposals for content refresh to include
  - areas where national guidance was written after the JFP was published such as the three-year delivery plan for maternity and neonates, the Primary Care Access Recovery guidance and the long-term workforce plan.
  - system development to support delivery including place/neighbourhood/locality; provider collaborative development.
  - strategic approach and programmes coming out of the 24th January system event..
  - digital maturity including addressing inequity and inequalities and supporting net zero objectives.

Next Steps

- Continue to work with portfolio / leads / providers
  - to develop operational plan priorities and delivery plans for 2024/25 which will also inform the JFP.
  - progress activity, finance and workforce technical elements and trajectories
- Linking in with regional analytical team around the triangulation tool.
- Finalise the JFP strawman.
- Sharing both narrative plans as they develop, with our partners including the two local Health and Wellbeing boards (Joint Forward Plan) and Overview and Scrutiny Committee (Operational Plan).

Proposed Planning Timeline – Key Dates

Develop plans → Sign off – Committees and Boards

January 2024

Early January
Finance numbers refined once allocations are received

19 January
Second drafts of delivery plans to inform Ops Plan and JFP narrative

24 January
System Workshop 4

January to early February
Continue to work up finance options

31 January – provisional date
First working drafts of Activity, Workforce and Finance

February 2024

9 February
Papers due Staffs Health & Wellbeing Board (JFP update)

14 February – provisional date
Second working drafts of Activity, Workforce and Finance

22 February – provisional date
Interim NHSE submission

28 February
Papers due Stoke Health & Wellbeing Board (JFP update)

28 February
Papers due SFPC

March 2024

5 March
SPFC (papers due 28th February)

7 March
Staffs Health & Wellbeing Board (papers due 9 Feb – JFP)

11 March
ICB Board papers due

20 March – provisional date
Final Operational Plan 2024/25 & JFP

21 March – provisional date
Final NHSE submission deadline

21 March
ICB Board (papers due 11 March)

27 March
Stoke Health & Wellbeing Board (papers due 28 Feb – JFP)

April 2024

6 April
Publication of 2024/25 Operational Plan and JFP

15 April
System Workshop 5

- The timeline is currently being worked through with activity, workforce and finance to agree internal submission milestones.
- Dates for the Staffordshire and Stoke-on-Trent Health and Wellbeing Boards have been included in the timeline to show the sign off points for the JFP.
- Dates for the Overview and Scrutiny panels are still being confirmed and will be added to the timeline once confirmed to take the Operational Plan through.

Key

- All unknown or provisional dates are highlighted in yellow pending guidance publication or system agreement.

First and second drafts of local outputs | Final versions of local outputs | First draft NHSE submission | Final version NHSE submission

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 12

Report to:	**Integrated Care Board**					
Date:	**18 January 2024**					
Title:	**ICB & GP Freedom To Speak Up (FTSU) Policy**					
Presenting Officer:	Tracey Shewan					
Author(s):	Tracey Revill					
Document Type:	Policy		If Other: Click or tap here to enter text.			
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☒	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	ICB & GP FTSU Policy					

(1) Purpose of the Paper:

The ICB has two Freedom to Speak Up Guardians and it has been agreed that one of the ICB's Guardians will act as FTSU Guardian for the general practices in South Staffordshire, whilst practices in the North of the area have this service via the federation, they can also approach the ICB's guardian as this is offered to all practices within the Staffordshire and Stoke-on-Trent ICB.

The attached policy has been updated to include general practice.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Execs	01/08/2023
PCI Committee	13/09/2023

(3) Implications:

Legal or Regulatory	The ICB is legally required to have a Freedom to Speak Up Guardian and to provide support for general practices in their area.
CQC or Patient Safety	Freedom to speak up allows colleagues to raise concerns around patient safety and/or their working environment.
Financial (CFO-assured)	There is no financial impact as the role is undertaken as part of the individual's current role.
Sustainability	Monitoring of cases raised by general practice will be undertaken with the guardian and Senior Director responsible for FTSU to ensure maintaining workload is sustainable.

Workforce or Training	The guardians have undertaken all necessary mandatory training to carry out the role and all staff are required to also undertake training on ESR.
Equality & Diversity	FTSU is for all regardless of ethnicity / gender etc.
Due Regard: Inequalities	Reviewed and not considered applicable
Due Regard: wider effect	Reviewed and not considered applicable.

(4) Statutory Dependencies & Impact Assessments:

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

(5) Integration with the BAF & Key Risks:

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

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

ICBs will need to have routes for speaking up by 30 January 2024. The ICB has already had this in place for some time and have produced the policy in line with the guidance provided by the National Guardian's Office (NGO). The ICB should also consider providing speak up routes for all staff in primary care. Staffordshire and Stoke-on-Trent ICB have two FTSU Guardians and it has been agreed that one of the ICB's guardians will provide a route for speaking up to support general practice.

The policy that was approved in July 2023 has been updated to reflect this change and notes the inclusion for general practice.

(7) Recommendations to Board / Committee:

The ICB Board is asked to ratify the attached policy, which was approved by the People, Culture and Inclusion Committee on the 13th September 2023.

Freedom to Speak Up Policy (Whistleblowing/Raising Concerns)

Policy Number	FTSU/01
Version:	3.0
Name of originator/author:	MLCSU HR Team / ICB FTSU Guardian
Name of responsible committee/individual:	People Culture and Inclusion
Date approved:	13th September 2023
Date issued:	01 November 2023
Review date:	01 November 2026
Date of first issue	01 November 2023
Target audience:	All ICB Employees, Directors, Non-Executive Directors, temporary Staff, Contractors & Practices and Primary Care/GP Practices

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
	Ethnic Diverse Group (EDG)	27/01/2023
	General Purpose Resources Group	13/02/2023
	Staff Engagement Group (SEG)	23/02/2023

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
People, Culture and Inclusion Committee for approval	13/09/2023
ICB Board for Ratification	
Signed off by Exec team	August 2023

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
1.0	First version	August 2022	MLCSU
1.1	Revised First version in line with National Guardian Framework	February 2023	T Revill
2.0	Final Approved Policy	July 2023	T Revill
3.0	Policy updated to include GP Practices	August 2023	C Nokes-Lawrence/T Revill

IMPACT ASSESSMENT = available on request

	Stage	Complete	Comments

CONTENTS

1.0 Introduction

This policy is designed for all ICB employees and GP Practices, to raise any concerns they may have in a confidential and safe environment. The ICB welcomes individual concerns being raised so they can be addressed and enables the ICB the opportunity to make improvements.

The ICB is aware however, that some practices have their own FTSU arrangements, but this option is also open to all of our practices to ensure there is equal access for all.

The ICB will have a focus on how we can improve the culture and the experience of our staff and will adopt the National Guardian's values below:

2.0 Speak Up – we will listen

2.1 Speaking up about any concern you have at work is really important. A relevant concern can relate either within the workplace or externally, in relation to danger, risk, malpractice or wrongdoing which affects others.

2.2 This may be a specific concern regarding some danger, fraud or other illegal or unethical conduct that affects others, how the organisation delivers its services or how it affects patient services. It is vital that you know how to speak up as it will help us to keep improving the working environment for our staff and services for all patients.

2.3 You may feel worried about raising a concern and we understand this - but please don't be put off. In accordance with our duty of candour, the organisation is committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

3.0 What concerns can I raise?

3.1 You can raise a concern about risk, malpractice, or wrongdoing you think is harming the service we provide or commission. Just a few examples of this might include (but are by no means restricted to):

- unsafe working conditions
- inadequate induction or training for staff
- suspicions of fraud (which can also be reported to the counter-fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying).
- failure to comply with legal obligations
- damage to the environment
- unsafe patient care
- lack of, or poor, response to a reported patient safety incident

3.2 Remember that all employees and workers, including clinical and non-clinical registered professionals within the NHS have a duty to report a concern under the circumstances set out in this policy. If in doubt, please raise it.

3.3 Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

3.4 This policy should not be used to raise concerns of a personal nature for example complaints relating to a management decision or matters of individual conscience where there is no suggestion of wrongdoing, but an employee or worker is, for example, required to act in a way which conflicts with a deeply held belief. These matters should be dealt with using the relevant alternative procedure, for example, the Grievance Procedure.

There is not right or wrong way in which to raise a concern and staff are encouraged to raise their concern. It may be that the concern raised could be looked at under another process, this will be discussed with you at the time. You may wish to raise your concern in the first instance, with someone you have a trusted relationship with, e.g. your line manager or another colleague and ask them to raise it on your behalf as you may wish to remain anonymous going forward.

4.0 Feel safe to raise your concern

4.1 If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment, victimisation, ostracising or ignoring you as a result of raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. If you think you are in this situation, seek advice and support. If your concerns remain unresolved, seek advice and escalate your concerns. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

4.2 Provided you are acting honestly it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

5.0 Confidentiality

5.1 We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously,

without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

All concerns raised regardless of whether open or anonymous will be treated confidentially and not discussed outside of the process or with anyone not involved in any necessary investigation.

6.0 Who can raise concerns?

6.1 Anyone who works (or has worked) in the NHS, GP Practices, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

7.0 Who should I raise my concern with?

7.1 In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager. However, where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

7.2 If raising it with your line manager does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

- A member of the ICB Executive Team.
- The Freedom to Speak Up Guardian - this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation or if necessary, outside the organisation.

  The ICB has two Guardians who are:

  Tracey Revill, Interim Deputy Head of Governance;
  tracey.revill@staffsstoke.icb.nhs.uk Guardian for the ICB and General Practice; and
- Shabana Mahmood, Medicines Optimisation Pharmacist:
  Shabana.mahmood@staffsstoke.icb.nhs.uk Guardian for the ICB
- Tracey Shewan, Director of Corporate Governance, is the ICB's Director for Freedom to Speak Up; tracey.shewan@staffsstoke.icb.nhs.uk and Shokat Lal is the ICB's Non-Executive Director for Freedom to Speak Up; shokat_lal@sandwell.gov.uk and you can also raise any concerns with either Tracey or Shokat.
- There is also a dedicated Freedom to Speak Up inbox where you can raise concerns; FTSUconfidential@staffsstoke.icb.nhs.uk
- If, as part of your role in the ICB, you have to visit another organisation across the system where you identify freedom to speak up concerns you can either, report these to the ICB Freedom to Speak Up Guardian or that organisation's own Freedom to Speak Up Guardian.

7.3 The ICB would welcome individual practices to have FTSU Champions to help support the FTSU Guardian and act as a channel for the practice to approach for support.

7.4 If you remain concerned after this, you can raise your concerns through the:

National Director: Transformation and Corporate Operations in the capacity of NHS England's appointed Freedom to Speak Up Guardian via the email: england.voicingyourconcerns@nhs.net

.

7.5 All these people have been trained in receiving concerns and will give you information about where you can go for more support.

7.6 If for any reason you do not feel comfortable raising your concern internally, you may raise concerns with external bodies, listed on page 8.

8.0 Advice and support

8.1 Details of the local support available to you can be obtained by contacting MLCSU's People Services Team on mlcsu.people@nhs.net or contacting the Freedom to Speak Up Guardian.

8.2 However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

9.0 How should I raise my concern?

9.1 You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

9.2 You can raise your concern anonymously via our E-form, see Appendix D, the link for the form; Raising Concerns (office.com)

Anonymous concerns that are raised directly to the Freedom to Speak Up Guardian or Champion are required to be recorded for national monitoring and will be available on the Freedom to Speak Up section on the ICB intranet.

9.3 Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

Please be aware that if you raise your concern anonymously, the ICB will not be able to provide you personally with any updates or outcomes. However, any anonymous concerns will be available on the ICB intranet.

10.0 What will we do?

10.1 We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns and will respond in line with them (see Appendix B).

10.2 We are committed to listening to our staff, learning lessons and improving patient care and the services we commission. On receipt the concern will be recorded, and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

If you raise a concern, you should expect to:

- Be treated fairly
- Feel listened to and have your concerns taken seriously
- Have access to incident reporting mechanisms such as Datix or other local system for reporting adverse events, or near misses

- Receive timely and constructive feedback, including actions taken to resolve your concern.

The person you have spoken to:

- Should thank you for speaking up and listen carefully
- Maintain your confidentiality
- Tell you what they are going to do
- May need to investigate your concern
- Will decide on the most appropriate action to take
- Communicate what action has been taken maintaining confidentiality if required.

11.0 Investigation

11.1 Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based and will produce a report that focuses on identifying and rectifying any issues and learning lessons to prevent problems recurring.

11.2 We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

11.3 If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

11.4 Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

12.0 Communicating with you

12.1 We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

13.0 How will we learn from your concern?

13.1 The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

13.2 Equally, concerns raised regarding the working environment, which has an impact on a member of staff will be looked into and where it identifies any issues these will also be monitored to ensure any necessary changes are made and lessons learnt will be shared.

14.0 Monitoring and Review

14.1 This policy and procedure will be reviewed annually by Human Resources in conjunction with operational managers and Trade Union representatives. Where review is necessary due to legislative change, this will happen immediately.

14.2 Implementation and operation of this policy will be monitored on an annual basis by the ICB Leadership Team and People Services.

15.0 Equality

15.1 In applying this policy, the organisation will have due regard for the need to eliminate unlawful discrimination**,** promote equality of opportunity**,** and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

16.0 Data Protection

16.1 In applying this policy, the Organisation will have due regard for the Data Protection Act 2018 and the requirement to process personal data fairly and lawfully and in accordance with the data protection principles. Data Subject Rights and freedoms will be respected, and measures will be in place to enable employees to exercise those rights. Appropriate technical and organisational measures will be designed and implemented to ensure an appropriate level of security is applied to the processing of personal information. Employees will have access to a Data Protection Officer for advice in relation to the processing of their personal information and data protection issues.

17.0 Raising your concern with an outside body

17.1 Alternatively, you can raise your concern outside the organisation with:

- **NHS England (NHSE)** for concerns about:
  - i how NHS trusts and foundation trusts are being run
  - ii other providers with an NHS provider licence
  - iii NHS procurement, choice and competition
  - iv the national tariff
  - v primary medical services (general practice)
  - vi primary dental services
  - vii primary ophthalmic services
  - viii local pharmaceutical services
  - ix Education and training in the NHS.

- **Care Quality Commission** for quality and safety concerns

- **NHS Counter Fraud Authority** for concerns about fraud and corruption.

18.0 Making a 'protected disclosure'

18.1 There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of 'prescribed persons', similar to the list of outside bodies on page 7 & 8, who you can make a protected disclosure to.

18.2 To help you consider whether you might meet these criteria, please seek independent advice from:

www.speakup.direct, which is free, independent and confidential advice service available to all staff and contracted workers within health and social care. While the helpline cannot investigate concerns, it can provide invaluable advice on whether your concern is indeed whistleblowing and talk you through the process to ensure it is followed correctly. The helpline is also able to advise on how you can escalate the concern with a prescribed body if needed.

Telephone: 08000 724 725.
Web: www.speakup.direct/contact-us/

Protect (formerly known as Public Concern at Work).
Protect is a charity that provides free, confidential legal advice to people who are concerned about wrongdoing at work and not sure whether, or how, to raise their concern.

Web: https://protect-advice.org.uk/

Email: https://protect-advice.org.uk/contact-protect-advice-line/

APPENDIX A - Process for Raising and Escalating a Concern

Step One
If you have a concern about a risk, malpractice, or wrongdoing at work, we hope you will feel able to raise it first with your line manager. This may be done verbally or in writing.

Step Two
If you feel unable to raise the matter with your line manager for whatever reason, please raise the matter with the local Freedom to Speak Up Guardian.

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- Treat your concern confidentially unless otherwise agreed.
- Ensure you receive timely support to progress your concern.
- Escalate to the board any indications that you are being subjected to detriment for raising your concern.
- Remind the organisation of the need to give you timely feedback on how your concern is being dealt with.
- Ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step Three
If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact an alternative member of the ICB Leadership Team.

Step Four
You can raise concerns formally with external bodies.

APPENDIX B – Route for raising a concern

You have a concern that you would like to raise

Speak to your line manager or senior manager for early resolution

I want to raise my concern anonymously

You don't feel able to raise your concern with your line manager or senior manager

Raise concern via Freedom to Speak Up Guardian/Champion. Access the Freedom to Speak Up Policy

Fill out the FTSU form, which can be obtained; [insert link]

Your concern is logged formally with details of the concern raised. You can request that your name is not used if you do not wish for it to be used during any investigations.

The concern is reviewed by the Guardian to determine action to be taken and with consultation with others as required.

An investigation is undertaken by a nominated appropriate person with involvement from the Guardian. Timescales will be agreed. You will be kept updated on progress.

If you are raising your concern anonymously, please be aware that it will not be possible to provide feedback to you, but data will be recorded to map any lessons learnt or areas of trends

The investigation report and findings are reviewed. An action plan will be put in place to address any actions identified in the report and feedback will be provided back to the person raising the concern.

The ICB encourages anyone with any concerns to report them, you will be thanked for raising your concern, it will be treated confidentially, unless otherwise agreed, your concern will be acted upon, you will be kept informed. You **will not** suffer any detriment as a result of raising your concern this will not be tolerated by the ICB.

APPENDIX C - Raising Concerns Record Form

The organisation is committed to achieving the highest possible standards of service for the benefit of patients, employees, service users and visitors. Where standards are not as expected, we want to learn and welcome the opportunity to address issues as early as possible and make improvements swiftly.

The organisation is committed to ensuring that, in accordance with the Public Interest Disclosure Act 1998, individuals raising concerns will be protected from detrimental or unfavourable treatment and victimisation.

Stage 1 – To be completed by the manager receiving the concern

Date concern raised / disclosed	
Recipient of concern: • Name • Job Title • Email address • Contact telephone number	
Details of how the concern was received: (e.g. by email, call, meeting, letter etc.)	
Does the person(s) raising the concern agree to reveal their identity?	Yes / No
If Yes, person's / persons' details • Name • Job Title • Organisation • Department / Team • Email address • Contact telephone number	
If Yes, obtain signature	*Signed*:
Nature and type of concern (the wording of which should be agreed by both the individual raising the concern and the manager receiving the concern	
Outcome of initial discussion (to include details of triage and if required referral to alternative more appropriate policy or senior member of staff)	

Details of any relevant litigation relevant to this concern (e.g. breach of Data Protection Act)	

Stage 2 – To be completed by the Investigating Officer

Investigating Officer's details: • Name • Job Title • Email address • Contact telephone number	
Acknowledgement letter sent to the individual who raised the concern to include expected timescale for completion by the Investigating Officer	Yes / No
Case brought by professional/ worker group *e.g. Allied Health Professional, Medical, Registered Nurses, Administrative, Estates/Ancillary, other*	
Element of concern, *e.g. patient safety/ quality, worker safety/wellbeing, bullying/ harassment, inappropriate attitude/ behaviours, detrimental treatment as a result of speaking up*	
Details of agreed actions, including dates.	
Findings – what has been identified as the principal causes of the concern(s)?	
Is the concern(s) justified?	Yes / No
Suggestions for Improvements/Changes to Policy or Procedure, including the Freedom to Speak Up Policy and Procedure.	
Do you think improvements are justified?	Yes / No

If yes, how in your opinion may procedures /systems/ policies be reasonably amended?	
Are there changes that outside agencies/suppliers could make?	Yes / No
If Yes, what changes do you recommend/suggest?	
Results of investigation to person(s) raising concerns provided by letter	Date:
Outcome reported to FTSU Guardian	Date:
Any additional information/Lessons Learnt	

APPENDIX D – "E-Form" for raising an anonymous concern

If you wish to raise any concerns, but do not wish to be identified, you can raise your concerns anonymously.

We have created an E-Form to enable you to raise anything you think needs looking into, to do this please follow the link below

Click Here

Please note that raising a concern anonymously will mean that the ICB will be unable to provide any feedback or outcomes to you.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure No: 13

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Tracey Shewan/Paul Brown
Date:	8th January 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Procurement Policy	An update was given on the work being undertaken to revise the Procurement Policy. This will lead to greater transparency around decision making.	The draft will be reviewed by Finance and Performance Committee In February and will be approved by Audit Committee outside of the formal meeting structure to ensure timely adoption of the policy.
EPRR Annual Assurance	The latest EPRR assessment demonstrates substantial compliance with all criteria and demonstrates the considerable work to improve and maintain EPRR arrangements.	
Risk Management	The Committee received the latest Corporate Risk Register distinguishing between system and ICB risks. All risks have been seen and scrutinised by each committee. The Three Bells reporting mechanism is working well. There was a good discussion around the number of high -level risks and those risks which have not moved despite mitigations.	Work has been done on Committee Business Cycles to ensure timely review and scrutiny of the BAF before being reported to Board. An action was agreed to recommend to Committees to review these risks to identify if additional mitigations are required. This was Jane Chapman's last Audit Committee meeting before her retirement and the Committee would like to thank and acknowledge the significant work Jane has been involved in strengthening Risk management and government arrangements more generally.

Finance	The **Final Accounts timetable** was agreed with some minor additions. **Single Tender waivers** were scrutinised with discussion around the cost of Out of Area placements.	The timetable was agreed in the context of proposed changes to meeting dates of the committee. An additional separate meeting with a single Final Accounts agenda item was agreed in April 2024. Following approval by the Audit Committee, the Accounts will be recommended to Board at it's June 2024 meeting.
Counter Fraud	RSM presented their latest update report and progress in delivering each element of their plan including a detailed update on active cases. A further 2 new referrals have been received.	
Internal Audit	There were two reports received. **Efficiency Savings.** This was phase 2 of a review of arrangements to support the identification, delivery, and monitoring of efficiency savings. The review received **reasonable assurance** with a series of medium priority recommendations to be delivered by March 2024 to strengthen arrangements in 2024/25. RSM had been asked to review POD commissioning arrangements as this is i) the first time there have been collective arrangements ii) these arrangements are hosted iii) there was a real risk of disconnect identified. The review received **reasonable assurance** but recognised these are evolving arrangements. Recommendations which will improve reporting arrangements are being implemented.	Both Internal Audit reports were referred to Finance and Performance Committee but the Board is asked to note the additional burden this will place on an extremely busy committee. This issue will be discussed as part of the Development session on today's agenda on the outcome of the Governance Review.
Governance	**Gifts and Hospitality**. The latest register was received for review. **Freedom of Information-** The Board can take assurance around the process for receiving and responding to FOI requests. **Information Management-**A verbal report was received, and no issues of concern were raised. **Meeting Dates 2024/25** As previously reported to the Board, revised meeting dates for the Committee were agreed. **Audit Procurement arrangements** were discussed and agreed for External Audit and a system procurement for Internal Audit provision	Further work is going to be undertaken to use the triangulated data set out in the FOI in other Forums with a view to understanding concerns and improving communication and services.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee. In particular the Committee approved the amendments to the Scheme of Reservation and Delegation.

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Integrated Care Board

Enclosure No: 14

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal, Non Executive Director
Executive Lead:	Mish Irvine, Chief People Officer
Date:	Wednesday 10th January 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	The Committee heard from the ICS Staff Psychological Wellbeing Hub Service Manager, Richard Bagnall, who described the service offered to the whole Staffordshire and Stoke on Trent workforce. Richard provided an overview of the services offered including conversations, workshops and signposting to support and counselling services. The Committee also heard from a service user who shared their experiences of the Hub and how they benefited from the support offered. Committee members welcomed the update on the Hub and the positive feedback around what a difference the Hub has made to individuals across the system. YouTube video link: https://youtu.be/wFWUas6qKWw	
Strategic People, Culture and Inclusion Update	Committee members received an update regarding the 'System and Financial context for People' which included the current context regarding planning, risks, Workforce Controls, and People Programme Priorities. - The Financial Framework was shared and committee members were updated on the underlying challenge, how the system is addressing and responding to the challenge, considering the workforce impact and risks associated. - The Committee was provided an update on the current Operational Workforce Plan position and also advised that the 2024/25 Planning guidance is yet to be released nationally, however planning preparation is underway locally. Workforce Controls focussed on delivering a reduction in costs, Agency usage and Vacancy Control are currently in place as a	

	result of the financial position and the PWC rapid assessment. - A review of delivery plans associated with the Long Term Workforce Plan, programme work and core business has been undertaken and activities realigned to support the financial framework and operating plan aims. The key principles and aims of this approach will be to: Reduce spend, increase reform, create efficiencies. The Committee acknowledged the risks associated with delivering Operational Plans and Long Term Workforce Plan against the financial position. The Committee was assured that the People programmes were focussed on supporting the Financial position, Recovery, Grip and Control, whilst ensuring delivery of the Long Term Workforce Plan and People Plan. *Appendix 1: Strategic People Update*  Appendix 1_Strategic People Update_ICB Bc	
Portfolio / Profession/ Provider spotlight	System Recovery Plan: Committee members received an overview of the Recovery Plan, noting the particular emphasis around the workforce elements. They were assured by the fact the ICS People team have been fully embedded into the process for delivery of the programmes within the plan.	
People Culture and Inclusion Programme Assurance	Members received a high level summary of the People Culture and Inclusion Programme activities and assurance regarding delivery and progress. The Committee was assured that the programmes were we on track and being monitored via the People Collaborative Board. Committee members welcomed the proposal to review the assurance reporting and to reflect the updated People Programme focus.	
People Culture and Inclusion Risk Deep Dive	Committee members noted that there are nine risks on the Risk Register of which, five are high scoring (12 and above) and four medium risks (5-10). The total number of risks have reduced from ten since the last report. The Committee also noted the People Risks Review document which outlined the assessment and mapping exercise undertaken via the People Collaborative Board to support the deep dive into risks at the Committee.	

	Committee members reviewed the current risks and scoring, and alignment to current workforce challenges and organisational risks; Risk appetite and considered Risks vs Issues. The Committee agreed the risks should reflect the current System and Financial context for People and that the mitigation reflected should be strengthened to include all system and organisational activities.	
ICB Board Deep Dive – People	The Committee discussed and agreed the approach to the ICB Board Deep Dive scheduled for February.	
PCI Committee Review	Agreement reached by members to hold a review and development session for the Committee in March 2024. The session will bring Executive and Senior leads together from across the system to focus on profile, membership, relationships and engagement with other Committees and Portfolios – in line with eh governance review already ongoing within the ICB. The Committee agreed to CPOs taking forward recommendations and to design the session.	Attendance required at the PCI Committee Review Session being held in March 2024

Risk Review and Assurance Summary

The following points were highlighted by the Committee:

- Review of People programme activities in line with system and financial context
- Risks associated with delivering Operational Plans and Long Term Workforce Plan against the financial position
- People Risks Deep Dive undertaken with clear actions regarding review and mitigation agreed
- Workforce metrics, risks and interdependencies to be discussed in depth at ICB Board

NHS
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Enclosure No: 14

Appendix 1

Current Workforce Position – September 2023

Staffordshire and Stoke-on-Trent Integrated Care System

Vacancy (%)	Staff in Post (substantive wte)	Bank Usage (% of total staff)	Agency Usage (% of total staff)	Turnover (%)	Sickness (%)
Sep 23	Sep 23	Sep 23	Sep 23	Sep 23	Sep 23
11.6%	21,121	6.1%	2.3%	9.6%	5.2%
Sep 22	Sep 22	Sep 22	Sep 22	Sep 22	Sep 22
12.0%	19,824	6.6%	2.1%	11.7%	6.0%
12 Month Change	12 Month Change	12 Month Change	12 Month Change	12 Month Change	12 Month Change
-0.4%	+1,297	-0.6%	+0.2%	-2.1%	-0.8%

Vacancy

- Our vacancy position has periodically improved since the highest 12m position which was in Apr-23 (currently 400 wte lower).
- Supporting interventions are in place, e.g. SSoT system bank, system wide retention programme, new roles, to ensure impact of vacancies is minimised.

Staff in Post & Ops Plan

- Total workforce is currently above operating plan by +387 wte, due to being over plan for bankand also agency.
- **However total workforce remains below the budgeted establishment (Mar-24) by -567 wte**
- Winter plan adjustments will be reflected from Nov23.

Bank Usage

- SSoT to reduce reliance on agency.
- Bank workforce is currently above plan by +150 wte predominantly in Registered Nursing and Support to Clinical.
- Have a system wide agreement on escalated bank rates, evidence demonstrates positive impact will be repeated this year.

Agency Workforce

- Agency spend is currently 0.6% above 3.7% target (agency of total pay spend).
- Areas of sustained use relate to medical and registered nursing.
- Work is underway to ensure full compliance with the agency rules.

Turnover

- Turnover is an improved position.
- Significant activity is underway at system level to continually address the levers that impact retention. Including a clear understanding of the data position and enabling flexi-working and flexi retirement options for staff.

Sickness

- Sickness is an improved position.
- Activity is underway to support the health and wellbeing improvement offer.
- Oversight of sickness in the forthcoming months Q3 and Q4 will be critical.

Staffordshire and Stoke-on-Trent Integrated Care System

Strategic People Update

Financial Recovery, Operating Plan, workforce Controls (Vacancy and Agency), LTWP 2024/25 delivery

Mish Irvine, Helen Conway, Gemma Treanor

Helen Dempsey

System and Financial context for People

Planning:
- Operating plan 2024/25
- Joint Forward Plan (inc ETD duty)
- Recovery plan - Acute Care at Home, CHC, CHIST, EOL, IDH

Grip & control:
- PricewaterhouseCoopers rapid assessment.
- Reducing costs
- Agency spend and usage reduction
- Increasing bank
- Vacancy Control
- Workforce growth and reconciliation
- Productivity & efficiency

SSOT People risks:
- Grip and Control, Financial Deficit
- Agency usage and spend
- Workforce growth required (Operational Plan and LTWP) and supply pipeline
- Registered workforce availability and pipeline
- Employee Health Wellbeing and Retention
- Industrial Action

NHS Long Term Workforce Plan –

7 Priorities:
- **Clinical expansion** (inc. nursing and midwifery and enhanced and advanced practice)
- **Apprenticeships** (inc. apprenticeship funding approach)
- **Medical expansion and reform** (inc. shortened undergraduate courses, increase in clinical placements)
- **Retention** (inc. nursing staff, locally employed doctors & SAS doctors)
- **Clinical reform** (inc. shortened courses, new roles/skill mix)
- **Medical reform** (inc. accelerating shift to generalism)
- **Productivity** (focused on the workforce-specific actions that contribute to productivity)

Staffordshire and Stoke-on-Trent Integrated Care System

Operating Plan

Helen Conway

Current position and challenge

Staffordshire and Stoke-on-Trent Integrated Care System

Current position, FY23-24 leading into FY24-25:

- Leading in to FY24-25 operational planning, we know/need:
  - **System deficit is sizeable** in FY23/24, however all partners are committed to the 'Financial Framework for 24/25 plan' which details that we won't compromise safety.
  - **Unlikely to be any more funds and need to plan within our financial envelope.**
  - Plan needs to be developed within the capacity we have now, within financial assumptions agreed by all to deliver the priorities safely.
- In **Dec-23 the operational plan (as submitted to NHSE May-23) was adjusted** to reflect the revised operational plan for the period Nov-23 to Mar-24. As off Nov-23 the budgeted establishment is 24,177 wte. The majority of this adjustment to plan relates to commissioner based funding activity. Our total actual workforce in post was 23,618 wte (substantive, bank & agency) which is 559 wte below establishment, and 37 wte above planned staff in post.
- In parallel, **PWC have reviewed our workforce controls, which has confirmed appropriate controls are in place**, not withstanding some opportunities for improvement – action planning/delivery in progress.

The challenge (FY24-25):

- A need to **ensure the right people, with the right skills, are in the right place at the right time** to provide high quality care, improved outcomes and a better experience for all, therefore the opportunity.
- **Affordability of current establishment**, any recruitment will contribute to financial deficit but will follow QIA process in vacancy control to ensure we offset clinical risk and potential for agency cost increases (see workforce controls)
- **NHSE requirement to increase capacity** in priority areas (e.g.. UEC, Elective, MH)
- **NHS Long-Term Workforce Plan** (Jun-23) is expected to potentially impact the system with increases in the range of 5,200 to 6,800 wte based on national modelling under the domains of 1) Train, 2) Retain, and, 3) Reform. It outlines the **biggest training increases/recruitment drive in history** but also an ongoing programme of strategic workforce planning. SSOT will evaluate our position to skill mix the registered roles where appropriate and increase training number for non-registered roles/career pathways.
- In FY24-25 integrated planning will be essential to:
  - Where possible reduce demand on services, including but not limited to, what potentially stops.
  - Ensure that the current workforce is effectively utilised and what transformation is needed to deliver this – Productivity will be key.

FY24-25 Operational Planning – For agreement & consideration

- Application of integrated planning principles.
- Baselines revised in Dec-23 for Mar-23 plan to form the basis for plan.
- Opportunity for further considerations to be discussed/raised at this stage.

Staffordshire and Stoke-on-Trent Integrated Care System

SSOT Long Term Workforce Plan

Gemma Treanor

SSOT Long Term Workforce Plan Delivery 2024-26

Staffordshire and Stoke-on-Trent Integrated Care System

Existing plans and delivery of activities were mapped against the National Long Term Workforce Plan, with gaps identified and plans reviewed in Summer 23. To further support and deliver the reduction in spend and reform required across the system, the SSOT plan has been reviewed and specific areas identified for delivery in the next 6 – 12 months (highlighted in blue) and set out in the following infographic.

TRAIN

- Medical and Dental education
- 'New 2 Care' – entry level and access into health and care careers
- Engage seldom heard communities
- Reduce International Recruitment
- Clinical Education / training commissions (METIP)
- Grow Education provider partnerships
- Clinical Placement Capacity
- Alternative training / education models
- Trainee pipeline intelligence & planning
- Alternative workforce development funding sources
- Apprenticeship reform and expansion

RETAIN

- Health and Wellbeing offers
- Staff Psychological and Wellbeing Hub long-term funding
- Experience & wellbeing data and intelligence
- Employee Value proposition
- Expansion of Flexible Working practice inc e-rostering
- Equality, Diversity & Inclusion activities
- Health Inequalities focus in activities
- Culture, Leadership and Talent activities
- Digital Staff Passport

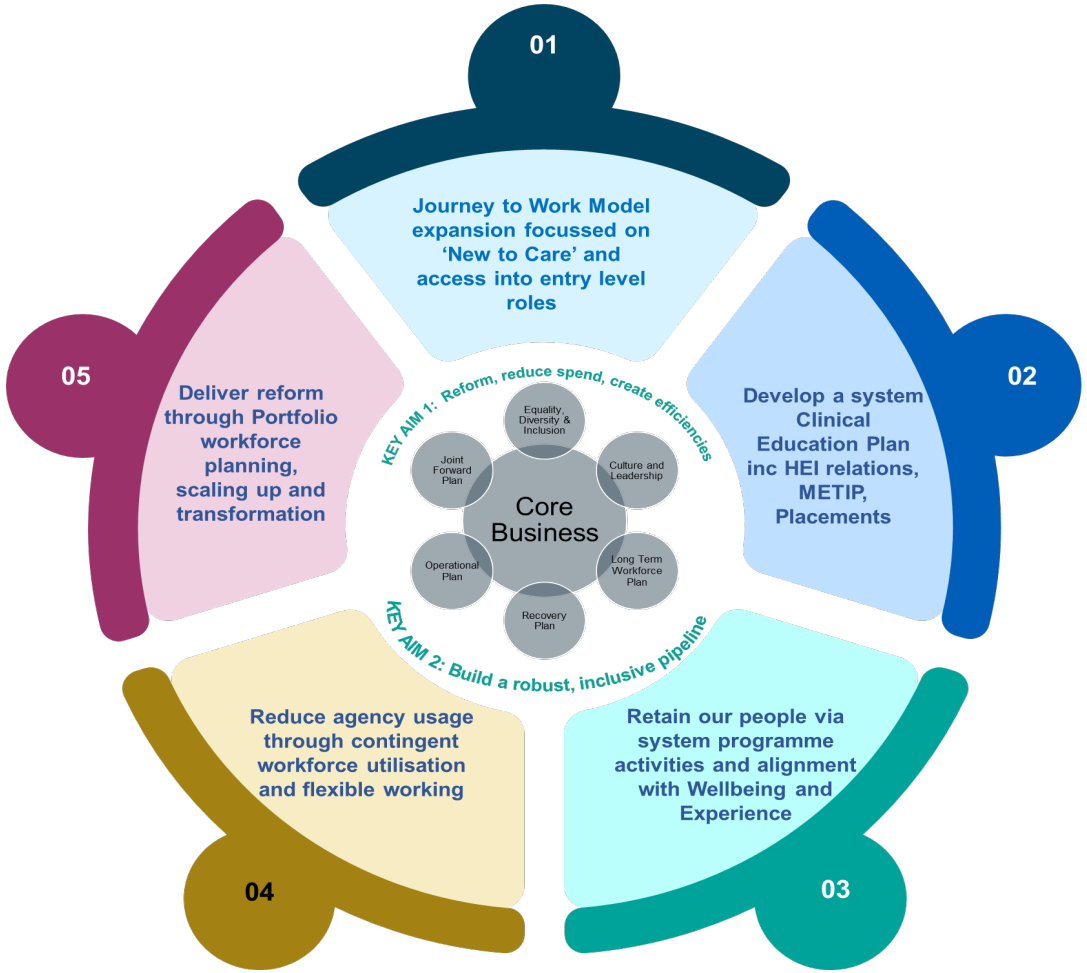
REFORM

- Reduction in agency – linked to flex working, supply and e-rostering
- Increase contingent workforce
- Delivery of ICS People Digital Plan: Upskilling workforce; Attraction of digital workforce; Future workforce for digital and AI
- Delivery of People Services at Scale
- Engage Professional bodies
- ICS Portfolio workforce planning
- Transformation inc new roles & skills
- Cultural and Leadership for reform
- ICS career pathway & rotational offers

SSOT People Priorities 2024/25

2024/25 Operational Plan Priorities

2024/25 People Programme Priorities



Next Period Actions January – June 2024

- Long Term Workforce Plan growth review with Professional Group data / intelligence collation and mapping
- Professional group focused workshops to determine local pipeline position and activities, inc unregistered an skill mix
- Implementation of professional outcomes - delivery of highest risk / challenging area plans
- Commence delivery of identified projects to deliver reform e.g. Clinical placement, Delivering people Services at Scale
- Continued Provider/Partner mapping to identify opportunities to align activities at system level
- Delivery and monitoring through established working and steering groups
- Oversight, monitoring and review via ICS People Collaborative Board
- Regular review of activities in line with changing system and financial position