NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 19 October 2023
1.00pm-3.00pm
Via MS Teams

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

	Agenda Item	Lead(s)	Enc.	A/R/S/ D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	1.00pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 21 September 2023 and Matters Arising	Chair	Enc. 03	A		5-14
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		15
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	1.05pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	D/I	1.20pm	16-25
8.	System Recovery Plan	JC	Enc. 06		1.35pm	26-49
	System Governance and Performance					
9.	Quality and Safety Report	LT	Enc. 07	S	1.55pm	50-54
10.	Finance & Performance Report • Finance & Performance Committee Assurance Reports	JC/PS MN	Enc. 08 Enc. 09	S	2.15pm	55-67 68-74
	Committee Assurance Reports					
11.	People, Culture and Inclusion Committee	SL	Enc. 10		2.35pm	75-76
	Any other Business					
12.	**Items notified in advance to the Chair**	All		D		
13.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.45pm	
14.	**Meeting Effectiveness**	Chair				
15.	**Close**	Chair			3.00pm	
16.	**Date and Time of Next Meeting** 16 November 2023 at 12.30pm held in public via MS Teams					

ICS Partnership leadership compact

Trust

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

Courage

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

Openness and honesty

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

Leading by example

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

Respect

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

Kindness and compassion

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

System first

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

Looking forward

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

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 10 OCTOBER 2023

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

Note: **Key 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. (h) recorded on conflicts register.
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	1. Non-Executive Director and minority shareholder of Infinite Me Primary Health Care, Ireland.	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.
3rd April 2023	Ms	Alexandra (Alex)	Brett	Chief People Officer	Midlands Partnership NHS Foundation Trust Staffordshire & Stoke-on-Trent ICB Shropshire, Telford & Wrekin ICB	Nothing to declare	1. Chief People Officer- Midlands Partnership NHS Foundation Trust (June 2019 - ongoing) 2. Chief People Officer - Shropshire Telford and Wrekin ICB (April 2023 - 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.
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.
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.
4th April 2023	Mr	John	Henderson	Chief Executive	Staffordshire County Council	1. Salaried Employment as CE of Staffordshire County Council. (May 2015 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mrs	Julie	Houlder	Non-Executive Director Char of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner of Elevate Coaching (October 2016 - ongoing)	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) (Non-Executive since October 2018) 2. Non-Executive George Eliot NHS Trust (May 2016 - ongoing) 3. Director Windsor Academy Trust (January 2019 - ongoing) 4. Associate Charis Consultants Ltd (January 2019 - ongoing)	1. Owner Craftykin Limited (July 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register

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

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 September 2023 12:30 pm-2.20pm Newcastle Room, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

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) Interim 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) Interim 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		✓	✖	✓	✓	✓						
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	✖	✖	✓	✓						
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✖	✓	✓	✓	✓						
Present:												
Sally Young (SY) Director of Corporate Services, Staffordshire & Stoke-on-Trent ICB		✓										
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓						
Baz Tameez (BT), Staffordshire Healthwatch		✖	✓	✓	✖	✖						
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		✓	✓	✖	✓	✓						

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
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		✓	✓	✖	✓	✓						
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, 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					✓	✖						
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 the 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 welcomed Pat Flaherty to his first meeting. DP reinforced the importance of the Leadership Compact document which was included in the Board papers as a reminder that meetings should be conducted in accordance with the agreed principles. It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Alex Brett, Jon Rouse, Tracy Bullock (Helen Ashley attending), Heather Johnstone (Lynn Tolley attending) and Baz Tameez.	
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 20 July 2023**	
	The minutes of the meeting held on 20 July 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**	
	David Jones	

	When changes are made to service provision, how is their impact assessed relative to your mandated and statutory obligations. For example, one of your statutory obligations is to 'tackle inequalities in outcomes, experience and access'. If any proposed changes result in significant reduction in access by a particular community, then what level of change would be allowed and how will that community be involved and/or notified? *CB responded: Generally, we would expect it to be around a change to range of services available or the geographical location from which those services were delivered and the process follows a structured methodology. So that would include the outline in the case for change, clinical oversight of those proposals and an assessment on the impact on patients and communities using those services. Depending on the scale of the proposed change, we may work alongside the local authority scrutiny colleagues. We may also work with NHSE and we may have to conduct a formal consultation. We do have statutory obligations such as the equality impact assessment and where there are issues identified through those reviews, we are required to give regard to how we can mitigate those impacts which would be included in the final proposals that would go through our committee and board structures as well as the individual provider organisations own corporate governance processes.* *TS added: We have our broader engagement and involvement which we do with the public. The ICB has formal statutory obligations to involve the public in any significant service change. And when that happens, we use various mechanisms such as our People & Communities Assemblies, as part of our strategy, to help us reach those communities.* **Ian Syme** <u>Mental Health (MH)</u> The ICB has previously reported that Female MH Patients needing MH inpatient services have had to be placed Out Of Area due to demand/capacity issues locally. Is this still the case and if so how many ICB area Female MH Patients are at present placed Out Of Area? *CB noted that across Staffordshire & Stoke-on-Trent there are very low numbers of inappropriate out of area placements. Currently, we have two and in both cases they are female patients who we have had to be placed in neighbouring systems because of a lack of capacity of Psychiatric Intensive Care Units (PICU). There was a review conducted by the Provider Collaborative earlier this year that identified a gap in relation to female PICU beds across the West Midlands and ICBs are required to submit a draft plan by March 2024 to localise and realign Mental Health & Learning Disability Autism inpatient services over a three year period and we will be working with the Provider Collaborative to take their findings into those local plans.* <u>Agenda Item 10 Enc 09 Finance & Performance Report.</u> <u>Page 65 of 86</u> (i) Disparity in Virtual Ward utilisation between North and South - Could this be clarified please. What are the dimensions of this disparity and what has been as yet identified as the main drivers of this disparity? *PS confirmed that virtual wards are central to the EUC recovery plan and locally. They will be an increasing part of plans to tackle winter this year. The model we have in the north is more mature than the one in the south. The north was led by UHNM with three pathways ways acute, frailty COPD and acute monitoring. The South is led by UHDB which covers acute frailty pathway working. We are working up capacity in the north . and the latest figures are 57% in north and around 33% in south.*	

	Page 66 of 86 (ii)General Practice/Primary Care No additional funding provided first GP Winter Surge I appreciate that such is external funding. It is however astonishing that a key area of Care delivery has been exempt from additional Winter Surge funding. Could a flavour as to how 'Portfolio' will be resolving within current allocations Winter Surges within Primary Care? *CB stated that the proposal was developed to invite GP to provide more capacity through the winter period. This was outlined in the paper of the financial challenge we are in.* *PH we hear in the press that you cannot get a GP appointment, but there have been over 6m appointments in general practice in Staffordshire and Stoke-on-Trent. We recognise that we need to provide additional capacity. We are moving from GP partnership model to a workforce model. The flexibility to absorb surge has diminished and we would seek to commission more accessibility. Last year we bought 7% increase in same day activity. Delivered in a hub model. We are seeking to run the same model this year.* *TS reiterated that we are in a Pre-Election Period and may need to take some questions to the end of the meeting.*	
7.	**ICB Chair and Chief Executive Update**	
	DP congratulated Support Staffordshire for their achievement of the Volunteer Centre Quality Accreditation demonstrating the quality of their offer and impact in supporting local Voluntary, Community & Social Enterprises across Staffordshire. The Accreditation was awarded for three years and was provided following independent assessment of a portfolio of evidence provided against a set of criteria based around the Five Functions of Volunteer Centres. DP felt it was important to acknowledge the recent Lucy Letby case. He advised that in response to the verdict in the trial of Lucy Letby, NHSE had stated that they were committed to doing everything possible to prevent anything like this happening again and were already taking decisive steps towards strengthening patient safety monitoring. The ICS were ensuring that national and regional recommendations were acted upon. The Quality and Safety Committee was also ensuring that bespoke discussion and action was occurring as required. He relayed some of the next steps being taken nationally and locally were: - • Patient Safety Incident Framework (PSIRF) – JS and HJ were working on this • Fit and Proper Person Framework will start this month and involve all members of the board and they will make sure that those initiatives were implemented robustly. • Freedom to Speak Up – The ICB have Tracey Shewan as Exec lead and Shokat Lal as Non-Executive Director together with a network of champions across the organisation. DP made the Board aware of an important document that had been released by NHSE which was the Sexual Safety and Healthcare Organisational Charter. The Charter identifies 10 initiatives that organisations should sign up to. He added that the People Committee would be looking at this in detail and he was keen to sign up to this on the NHSE website to ensure they were in agreement with the contents of the Charter. DP acknowledged the following awards across the system:- • The ICB had been nominated for the Nursing Times Award	

	• HSJ Safety Awards – winners of the primary care initiative were MPUFT for psychological therapy service and UHNM for the Care Excellent framework. UHDB were also finalists for the Urgent Care Safety initiative of the year. PA gave an update on the current position they were facing at the moment. From a financial point of view, they were facing significant pressures and coupled with the elective backlogs and UEC were under extreme pressure together with the industrial action at the moment. Winter was around the corner and covid was still present, but they were embarking on a vaccination programme. PA reiterated that this put stress and pressure on individuals and they needed to reflect on the work that everyone was done across the system. However, he felt confident that they would manage those pressures going forward. He noted that they had put a number of building blocks in place: 1. How UEC teams were working together breaking down barriers and focusing on the patient journey. He felt heartened on how they had come together to work in a better way. 2. Recovery programme had been developed to address the money pressures and he was delighted with the effort and energy by everyone. 3. Provider Collaborative arrangements, led through TB had built the foundations for that piece to move into the next phase. JHo felt it important to mention that they were meeting in pubic and the reports that were received by the Board were a summary of what the Assurance Committees had scrutinised. She therefore felt that it would be useful to have the key people data that supports the performance within that report. PA agreed that they would make sure the various measures on the people agenda can be included in future. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
8.	**System Recovery Plan**	
	PB reported the financial position at M4 was a deficit of £48m, which was a £34m variance and confirmed that most parts of the country were seeing a variance to plan. Into M5 that variance had continued. He added that they were required to report breakeven, but had explained to NHSE that they would not achieve that. The Recovery Plan was important so that they could right size our services as we move into 2024/25. PB stated that they had seen an increase in Continuing Healthcare: CHC. As a system they have examined the pathways of patients in CHC. The recovery plan was focused on making it better for the people in Staffordshire and Stoke-on-Trent. It was noted that the ICB spend more on CHC per head of population compared to all other systems in the country. However, this could be sorted if they work as a system on the pathway. PB gave an example of a patient and his pathway through CHC. PB reiterated that they should feel positive about this plan as it would make things significantly better for the population. The plan was focused on seven areas. The main area was CHC and Lorna Clarson had done work on the ages 75+ cohort and ways to provide better care for that cohort. They were addressing where patients do not need to be admitted to hospital in the first place. A lot of patients come from the Care Home sector and they were looking at End Of Life: EOL care; focusing on frailty and those who fall. There are 32 specific projects. Collectively those metrics mean fewer in hospital stay.	

	He confirmed that the recovery plan was going to System Performance Group and they were holding another system event on Friday 29th October to agree how they deliver those benefits that they know are achievable. It had been an achievement for the system to come together and make the lives of our patients better as well as saving money. NC confirmed that the collaborative working was exceptional; they asked CEOs to put their most senior people onto these issues. They were working a whole system effectively. He added that the CHC group was led by TB and was pivotal to ensuring that the left hand and right hand were connected. All organisations have put senior people forward and the group was working to a detailed action plan and would have a coordinated approach to share with CEOs in the next 2-3 weeks. DP asked where prescribing fitted into the discussions on the seven big ticket items. PB confirmed that prescribing was a strand and they have appointed Mark Seaton as Lead Pharmacist. He had established a group of pharmacists across the system and includes partners in Derbyshire in that group. Medicines continues to be looked at and forms part of the ICB primary care use of medicines within the Trust. JA commented on medication prescribing in primary care. Along with the agenda around prevention and PHM, a lot of Long-Term Conditions: LTC sit within primary care and the cost of drugs had gone up. He added that they need investment for the future and preventing hospital admission, strokes, heart attacks. They were investing in the future of the workforce and the future of people in the community to prevent those diseases that would have an impact. JHo thanked PB and NC for bringing this report to life and reiterated that it was an excellent opportunity to showcase collaborative working. She added that it was bringing forward things in the portfolios at pace. She stated that there was a lot of work to improve the lives of individuals with a saving at the end of it. MN reiterated the amount of work that had taken place in developing the Recovery Plan and that it had been driven across the system. On the Big Ticket 7 – they could now drive forward on these which were for making life better for patients in Staffordshire and Stoke-on-Trent. PA agreed this was why the ICS had been developed in the first place. The Provider Collaboratives and collective working together to get things in a different place. PA also stated this was about ensuring the recovery work bring connotations of money and it was about how we support our population in a proactive and supportive way and therefore spend less money on the reactive side of healthcare. NC reiterated that if anyone was entitled to a service, they would receive that service. They know that there were a lot of people who did not need that level of service and that money could be saved. In EOL, LTCs and frailty, they have done a lot of work with ‘deep-dives’, they have the size and data and they know what was making a difference. This would no doubt prevent admissions into hospital. He added that the support they have had from Lorna Clarson and Rachel Gallyot et al had been exceptional. DP agreed that this had been an exceptional piece of work. The Staffordshire and Stoke-on-Trent Integrated Care Board **WERE ASSURED** and **NOTED** the progress of the System Recovery Plan; **NOTED** that the final Plan would be submitted for approval to the October Finance and Performance Committee meeting and then to the ICB Board for ratification	

9.	**Quality and Safety Report**	
	LT reminded member that the Quality and Safety Committee: Q&SC was now meeting bi-monthly and they had their first 'deep-dive' in August which covered Harm Reviews. They also looked at Maternity services and the new 3 year delivery plan and how they were linking in with the Maternity Action Plans. Following the CQC visit to MPUFT for Psychiatric Intensive Care Units (PICU), they found that further improvement were to be made. The Quality Team were doing joint visits with the CQC on progress of those improvements. UHNM Maternity and Neonatal services – following the CQC report they have set up a self-assurance group co-chaired by Chief Nursing and Therapies Officer of the ICB with oversight from NHSE. Those actions plans were being revisited and strengthened. On 7 September the team visited UHNM, they spoke to staff and asked if they felt they were able to speak up and it was recognised that the staff they spoke to were motivated and acknowledged their leadership team and their want to get things right. LT reported that there were two policies that came to Q&SC for approval and required ratification by the Board. • Safeguarding Children and Young People Policy • Safeguarding Training Policy. JS added that we moved into a new approach to Quality Improvement Assessments which was now a slicker process to get things properly looked at an earlier point than previously. She mentioned the continuous quality improvement work that was ongoing and they have over 300 staff across the system training in the continuous quality improvement methodology and given the pressures on services this is a significant achievement for the system.. DP referred to the Maternity oversight and assurance group and asked if all staff would get their voice heard. LT confirmed that they have their own system within the Trust. With regard to the vacancy numbers reduced DP noticed that was an innovative piece of work. LT agreed that their overall Maternity was closing the gap and looking at innovative ways to increase their workforce. JHo commented that the two reports showed how much work was being done in the committees. She gave her concerns regarding negative press around all staff working in maternity which causes a lot more work to report against and asked if the CQC ratings were impacted by the rating to report on governance or looking at the element of safety. LT responded that the CQC were still reporting against their regulatory areas of quality. The ICB were working with UHNM using the 3 year delivery plan that had four themes and linking all the action plans into one. MN referred to section 4.2 in the report and the conference that took place in July around learning from the lives and deaths of people with a Learning Disability and Autistic people. There were several positive themes that came out of that conference and in particular and she asked about the areas where further work was needed and were they doing the things that were needed. LT confirmed that they have good engagement with system partners, but DNAR has been there a long time, there was so much focus on LeDer at the moment and they would see improvement. The Staffordshire and Stoke-on-Trent Integrated Care Board**:** • **RECEIVED** the reports and sought clarification and further action as appropriate.	

	• **WERE ASSURED** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.
	• **RATIFIED** the decisions of the Quality and Safety Committee with regards to the:
	  ○ Safeguarding Children and Young People Policy
	  ○ Safeguarding Training Policy	

10.	**Finance and Performance Report**	
	PB confirmed that he covered the finance headlines in the first item. PS reported that the continued periods of industrial action remained a challenge in all aspects of delivery across the system. Particularly across planned and urgent care there had been significant impact in terms of the planning for those periods and the actual response to activity that had to be stood down or delivered in a different way. Electives and Backlogs remain in Tier 1 (T1) which was a national escalation focused on the UHNM position. They have been on a strong improvement path from UHNM and he had seen the evidence that demonstrated that the industrial action was severely limiting the progress there. In August, they predicted that all 78 week waiters would be seen by end of September, but the industrial action during that period meant that they had 177 in August. They had also seen an increase in patients waiting 78 weeks at other providers, notably at UHDB were around 40 at the end of July and had increased to 89 in August. PS stated that the T1 national support embedded within UHNM in terms of how they were managing activity were ensuring that they got the greatest productivity possible out of the theatres and making sure they were managing and validating the lists in the right way. There is a particular focus in line with the national ask to look at any patient who would breach 65 week wait by the end of March and ensure that they have had a first outpatient appointment by the end of October. Urgent and Emergency Care remains in Tier 2 which was regional escalation oversight and reported that they have had some strong overall progress with the delivery of the Urgent Care Improvement Plan, notably that the Integrated Discharge Hub went live in September. There had been a significant spike in acuity which was linked to the heat wave in September, but those pressures had improved. PS confirmed that the System planned and responded well to the industrial action the previous day. Primary Care and Virtual wards – the focus for winter was building in the learning from last year and ensuring escalation was appropriate and timely. He added that all partners had a role in managing surge and the plan would come to Board in November for final ratification. PS concluded that they were also looking at other innovative schemes using Voluntary Sector etc. MN highlighted the finance & performance assurance reports from the August and September meetings. There were two items that she referred to from September; the direct award of the contract for NHS Community Services in East Staffordshire where the Finance & Performance Committee recommended for the Board to ratify the direct	

	award for 18 months commencing on 1 October; She then referred to a discussion that the committee had on a Business Case for centralised repeat prescriptions management system which would be piloted in Burton and Lichfield subject to positive Quality, Equality and Data Protection Impact Assessments and delivered in partnership with the Primary Care Networks: PCNs. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the reports for information and **RATIFIED** the decisions made at the Finance & Performance Committee.	
11.	**Assurance Reports from Committees of the Board**	
	Audit Committee It was noted that there was a change in frequency of the Audit Committee meetings to 4 + 1 and would require an Extraordinary Meeting of the Board in June 2024. JHo confirmed that the discrepancy reported for the 6 CCGs in 2021/22 for the Mental Health Investment Standard had now been rectified. JHo highlighted that the Value for Money assessment reflected the risk associated with the achievement of breakeven financial position for 2023/24. The Staffordshire and Stoke-on-Trent Integrated Care Board **APPROVED** the change in frequency of the Audit Committee meetings **People, Culture and Inclusion Committee** SL felt that the staff story from Isuda who had completed a level 2 healthcare support apprenticeship was a great example of some of the workforce planning issues they had addressed. He added that they had detailed discussions around the Surge Plan and the ICS Recovery Plan. They also looked at the implications around workforce, and many colleagues had spoken about workforce planning issues. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
12.	**Any Other Business**	
	No other items of business raised.	
13.	**Questions from the floor relating to the discussions at the meeting**	
	Ian Syme Units of Dental Activity (UDA) - Are there any plans to be brought forward to get on some degree of track for people to access NHS dentists. *CB confirmed that the executive summary of the performance reported a shortfall of 38% in Q1. This was attributable to a difficult April, but this has improved since then. They were now at 82% delivery and unvalidated in month 5 we will get to 90%. This was discussed with MPs this week, and he has met with the Local Dental Committee to formulate an Action Plan. This will be brought through the F&P Committee in the next couple of months.* The were no questions received online.	

14.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact. We heard a lot about "System First" from presentations today.	
15.	**Close**	
	The Chair closed the meeting at 14:05	
16.	**Date and of Next Meeting**	
	19 October 2023 at 1:00pm in public	

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

Date of Meeting 19/10/2023

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)
2023-24/003	20/07/2023	Questions from the public	14	TS to write to Ian Syme with a detailed response to the question raised around 75-year-old and older admissions following the Deep Dive session into the EOL framework and frailty.	26/09/2023	TS	**UPDATE**: Needs assessment to be conducted by the end of September and End of Life Framework deep dive to be shared. **COMPLETE: Response shared on 26/09/2023**
2023-24/004	20/07/2023	Questions from the public	14	TB to correspond with Ian Syme information in relation to work being undertaken by the Medical Director in relation to re admissions from virtual wards/beds.	16/11/2023	TB	**Update 22/08/2023** - Work is still ongoing in relation to virtual wards. When complete it can be shared.

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:	**19 October 2023**					
Title:	**Chair and Chief Executive Officer Report**					
Presenting Officer:	David Pearson, Chair, and Peter Axon, Interim CEO					
Author(s):	David Pearson, Chair, and Peter Axon, Interim 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, although item 1.2 may have some Greener NHS implications
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:

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

1.0 System and general update

1.1 Workforce

1.1.1 Midlands and Lancashire Commissioning Support Unit (MLCSU) Transfer

Staffordshire and Stoke-on-Trent Integrated care Board (ICB) has recently concluded part of their Commissioning Support Service review that commenced in September 2022. The ICB wanted to explore the service provision in the context of the requirements of the newly formed ICB and wider system workings of the ICS, to consider an alternative contract format going forward, allowing the ICB to have the flexibility to scale down or up services in response to the developments of system working.

A key principle of this review was “generally, where a service is better delivered at scale, due to specialised skills/technical delivery this should remain at scale however, where a service requires a high level of localisation and personalisation this would be better delivered by the ICB, and the service should be in-housed”. Following a review of each service, the ICB have in-housed the following teams:

- GP Digital Programme management Team
- Equality, diversity, and inclusion team
- Contract management team
- Business intelligence team
- Finance team
- Communication and Engagement team

37 colleagues transferred from MLCSU to the ICB on the 2 October and we welcomed our new colleagues at an in person induction and welcome event at Stafford Hub on the 2 October.

1.1.2 Staffordshire and Stoke-on-Trent Workforce Summit: Aiming Hire and Higher

118 leaders from across Staffordshire and Stoke-on-Trent attended our first ever System wide Workforce Summit: 'Aiming Hire and Higher'. Attendees included both clinical and operational leaders from the breadth of our footprint: NHS Trusts, Local Authorities, Voluntary Sector, Primary Care, Social Care, Education Providers, NHS England.

The aim of the Summit was to collectively find solutions to our biggest workforce related challenges in Staffordshire and Stoke-on-Trent and how we will meet the ask of the NHS Long Term Plan, as well as ambitions of Primary Care and Social Care. A panel of high-profile representatives from nursing, medical, social care, Allied Health Professionals, workforce, and education gave an overview of the challenges faced in their worlds and then took some thought-provoking questions from delegates.

Throughout the day, there was a real sense of System partners wanting to come together to collaborate and a recognition of the power of working collectively. The team are in the process of evaluating the day and arranging a follow up event November, with the aim of developing System wide action plans.

1.2 Walleys Quarry

Since March 2021, a multi-agency response to issues relating to Walleys Quarry landfill site has been in place to support communications, environmental monitoring and regulation, and public health advice and services. The ICB represents the local health system at the Strategic Coordinating Group, following the expert advice around public health and health protection of the UK Health Security Agency and Director of Public Health.

On 5 October 2023, the Environment Agency published concerns about the accuracy of their hydrogen sulphide monitors around the Walleys Quarry landfill site. The multi-agency partnership cannot therefore rely on this data to assess the risk to people’s health. The risk of long-term health problems is likely to be

small but cannot be excluded at this stage, and we know that some people continue to experience short term health effects. All health partners continue to recommend that all appropriate measures are taken to reduce the off-site odours from the landfill site, to reduce the health impacts experienced in the local community and maintain concentrations in the local area to levels that we can be confident do not pose long term risks to health.

In response, the ICB, alongside the GP Federation and Local Medical Committee established a resident's health advice line to offer advice by health professionals for residents with health concerns related to the issues from Walleys Quarry, provide information and signposting to services. The health advice will run until Monday 16 October 2023. The ICB will continue to support the multi-agency partnership in responding to the issues relating to the site to support the local community.

2.0 Finance

At month 5, at a System level we are reporting a year-to-date deficit position of £58.6m, which is a £45.0m adverse variance against the £13.6m deficit plan (month 4 –year to date deficit £48.7m; variance to plan £34.1m). The drivers behind this adverse position are slippage on efficiency programmes, the ongoing retention of escalation beds due to urgent and emergency care (UEC) demands, continued health care (CHC) and prescribing inflationary pressures, alongside the Industrial Action that has taken place across the year. Whilst we are still reporting a forecasted breakeven position, we have completed a thorough review, assessing the run rate, the remaining plan and the risks and mitigations, concluding as a System that we no longer think we can hit a breakeven position at year end as the risk incorporated into our financial plan are realising within the year-to-date 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 is being hampered by the ongoing Industrial Action by both junior doctors and consultants.

Significant work has been undertaken to eradicate 104-week breaches. One patient breached 104-weeks at the end of September at University Hospitals of North Midlands NHS Trust (UHNM) but there are plans in place to treat the patient during October. Therefore, it is hoped that the system will have no further 104-week breaches.

For patients waiting beyond 78-weeks for treatment, the number of breaches across the system at the end of September was 207 (188 at UHNM and 19 at Nuffield). The forecast position for the end of October is now 161 (154 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 c15,000; this is compared to over 37,000 at the start of the financial year. This is ahead of trajectory, but it is becoming clear that some specialities are making much better progress than others. Work is ongoing to identify the specialties where performance is not currently assured to allow appropriate support to be given.

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. University Hospitals of North Midlands NHS Trust (UHNM) has completed their analysis to identify which specialties will deliver on the ask and which won't. As of 1 October, there are 4,224 patients in total who still require a first outpatient appointment, 1,140

already have one booked before 31 October, 371 have one booked after 31 October and 2,713 are still without an appointment booked.

As a result of Industrial Action, we have seen an increase in the 78-week-wait cohorts for Staffordshire and Stoke-on-Trent patients awaiting treatment from providers outside our system. The number has increased from 105 as of 27 August to 134 as of 24 September. Similarly, Staffordshire and Stoke-on-Trent patients in the 65-week-wait cohort awaiting treatment outside our system has been static over the last two weeks at around 2,500.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) has previously reported a continued steady reduction in the 62-day cancer backlog. As of 1 October 2023, the 62-day backlog demonstrated a deterioration and was 495 against a revised trajectory of 466. The 104+ day backlog has reduced to 143 against a fair shares trajectory of 78, as at 1 October. The total Patient Tracking List (PTL) volume remains stable at 4,122; it is slightly higher due to seasonal demand.

The position of 28-day faster diagnosis standard for cancer has again improved with performance at 72.6% and the September milestone of 70% was achieved and is on track to deliver the national target of 75% by March 2024.

4.0 Urgent Care

4.1 Operations and Delivery

Four-hour performance continues to be a significant area of focus for University Hospitals of North Midlands NHS Trust (UHNM), which has maintained at approximately 70% since April; the latest 6-week average reporting as 70.1%.

Twelve-hour performance has been maintained below the mean for calendar year again reporting as 7.8% for September. However, performance has been relatively flat since April and requires improvement to achieve the 2% target.

Long length of stay (LOS) performance has maintained a positive step change with continued strong performance regionally, and both 14+ and 21+ numbers reporting below pre-pandemic levels.

Cat 2 performance rose above the 30m standard in line with other systems regionally, however, better performance placed Staffordshire third out of 11 regionally, and sixteenth out of 42 nationally during the latest week.

Medically Fit For Discharge (MFFD) on the Royal Stoke Hospital site has seen a steady 19% reduction over the last three weeks whilst County Hospital has shown little change.

Increasing COVD-19 bed numbers at both Royal Stoke and County Hospital has placed pressure on demand for beds, with 133 patients in beds during the first week of October and 124 staff off sick with COVID-19.

The 111 provider announcement has been delayed due to extension of the standstill period. Standstill, as it stands, is expected to end at midnight on 9 October.

System Surge Plan is currently working through system governance process. Collective system process has been recognised. The plan remains as high risk due to bed deficit position remaining at -24 during the peak of December/January. Due to plan mobilisation timeframes and October and November present as high risk with deficit bed positions of -38 and-39 respectively.

5.0 Key figures for our population

		May-23	Jun-23	Jul-23	Aug-23
*	111 calls received	34,043	29,849	30,868	29,579
	Percentage of 111 calls abandoned	7.0%	8.0%	5.3%	8.2%
	A&E and Walk in Centre attendances (UHNM)	21,465	21,052	20,696	19,573
	A&E and Walk in Centre attendances (other providers)	18,718	18,522	17,880	16,952
	Non elective admissions (UHNM)	7,599	7,637	7,600	7,744
	Non elective admissions (other providers)	5,680	5,636	5,746	5,513
	Elective and Day Case spells (UHNM)	7,114	7,075	6,687	6,887
	Elective and Day Case spells (other providers)	7,761	8,438	8,012	7,952
	Outpatient procedures (UHNM)	4,659	4,674	4,306	4,908
	Outpatient procedures (other providers)	8,825	8,997	9,043	9,134
	GP Appointments (all)	492,079	523,955	500,967	506,811
**	Physical Health Community Contacts (attended)	134,775	136,955	132,625	128,320
**	Mental Health Community Contacts (attended)	46,615	48,060	44,590	

**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 Maternity and Neonatal Independent Senior Advocate

As reported in May 2023, the Ockenden report includes an Immediate and Essential Action (EIA) that, 'Maternity services must ensure that women and their families are listened to with their voices heard', and specifically that:

- Trusts must create an independent senior advocate role which reports to both the Trust and the Local Maternity and Neonatal Systems (LMNS) boards, and
- The independent senior advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

The Integrated Care Board (ICB) successfully recruited to this post and Mel Mears started in post on the 17 July 2023. Since that time, she has invested significant energy in getting to know maternal and neonatal stakeholders; building relationships and getting to know the area.

Mel was one of two people asked to join the National Steering Group for the pilot and has provided valuable insight from her former role as a Neonatal Nurse and Trainer. The project is currently paused whilst they review the aims of the pilot and produce necessary documentation. Mel's input is clearly valued as some of the things she has commented and advised on are appearing in the national documentation.

Mel is providing significant support to the national team and hopefully will be able to provide that local input into our mothers, babies and families in Staffordshire and Stoke-on-Trent in the very near future. Monthly updates are provided to the Local Maternity and Neonatal System Partnership (LMNSP) Board.

7.0 COVID-19

COVD-19 and Flu vaccinations are continuing with excellent early activity data. The accelerated programme is supporting sites to vaccinate as many eligible individuals as possible prior to 31 October 2023. There are now around 100 COVD-19 vaccination sites offering COVID-19, together with flu wherever possible.

7.1 Vaccination data

- Total COVID-19 vaccinations given = 85,356 (as at 2/10/2023)
- Staffordshire and Stoke-on-Trent is the highest performing system within the region at 18.64% of eligible individuals vaccinated this autumn (other systems 9.58-16.88%).
- Staffordshire and Stoke-on-Trent has the top performance in region for % uptake in healthcare workers, 65–79-year-olds, those at risk, and those aged 5-11 and at risk.
- Care home resident vaccinations are at 36.8%. There are many planned visits in w/c 2 October and w/c 10 October, so this is expected to improve over the coming weeks.
- Total Flu vaccinations given = 126,959 (as at 2/10/2023)
- Second highest flu vaccination activity within region for Staffordshire and Stoke-on-Trent.
- Specialist Assessment and Intervention Service (SAIS) teams have seen a good early start showing the highest vaccination events in schools compared to other systems within the region.

Uptake Performance by ICS and JCVI Cohorts

Data Source: https://ppds.palantirfoundry.co.uk/workspace/report/ri.report.main.report.ddd85e37-b488-4b8b-8210-1babb57099e2/edit

Uptake by AW23 Cohorts – As at 2nd October

Data Correct as at 02/10/23

AW23	England	Midlands	BSOL	BC	CW	Derby	HW	LLR	Lincs	Nhants	Notts	STW	SSOT
1: Care Home Residents & Residential Care Workers	39.2%	39.8%	34.2%	20.4%	52.3%	34.9%	44.8%	31.0%	48.4%	36.6%	48.9%	★ 56.2%	36.8%
2: Healthcare Workers	8.3%	7.5%	4.7%	4.8%	7.2%	9.4%	8.6%	8.6%	8.1%	7.0%	7.3%	8.9%	★ 9.5%
3: Social Care Workers	8.6%	8.3%	6.3%	6.3%	10.3%	9.8%	9.3%	★ 11.5%	6.8%	8.4%	6.9%	7.0%	8.9%
4: 80+	23.8%	23.5%	20.9%	18.2%	★ 27.0%	25.0%	26.9%	25.7%	23.4%	23.7%	19.5%	20.9%	26.4%
5: 75-79	25.9%	25.7%	22.5%	19.8%	29.1%	27.3%	27.4%	27.3%	25.2%	27.3%	21.6%	23.0%	★ 30.5%
6: 70-74	22.1%	21.5%	19.6%	15.2%	25.0%	23.4%	21.8%	24.1%	19.0%	22.8%	18.3%	17.3%	★ 27.7%
7: 65-69	17.0%	16.8%	14.5%	10.8%	20.3%	18.1%	18.0%	18.1%	16.4%	17.4%	13.4%	13.4%	★ 22.5%
8: At Risk	5.3%	5.2%	3.7%	3.0%	5.9%	6.3%	5.5%	5.8%	5.7%	5.8%	3.9%	4.3%	★ 8.1%
9: 12-15 At Risk	0.7%	0.6%	0.6%	0.6%	0.3%	0.6%	0.7%	0.5%	★ 1.0%	0.3%	0.7%	0.4%	0.5%
11: 5-11 At Risk	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	★ 0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	★ 0.1%

7.2 Regional update

COVD-19 surveillance data from pillar one and two testing, and reporting of COVD-19 hospital admissions, reveals a relatively stable position but we are starting to see seasonal increase as we head into autumn and winter, with gradual increase in hospital admissions who are COVD-19 positive.

Positively we are not seeing the same numbers of people requiring Intensive Treatment Unit (ITU) beds or mechanical ventilation due to COVD-19 compared to 2020/21 and 2021/22.

We have observed an increase in COVD-19 positive admissions and staff sickness absence due to COVD-19 at Royal Stoke University Hospital compared to County Hospital and Queens Hospital Burton with local reporting indicative of higher circulation in North Staffordshire and the Stoke-on-Trent area. Without systematic mass testing in the community this is hard to confirm.

Some non-specific community indicators suggest that reports of respiratory symptoms are stabilising or declining, however, this may not be related to COVD-19 and due to other winter respiratory illnesses for example RSV.

Incidence of positive tests on pillar one polymerase chain reaction (PCR) tests and hospitalisation increased during August and into early September, but this appears to have plateaued.

UK Health Security Agency (UKHSA) continue their investigation into the variant BA.2.86 to inform risk assessment on transmissibility, ability to evade vaccine immunity and the virulence (transmission and severity of symptoms).

At this point UKHSA's view is that the overall COVD-19 situation nationally and regionally remains stable, and we are not seeing a significant increase like that observed with delta and omicron variants.

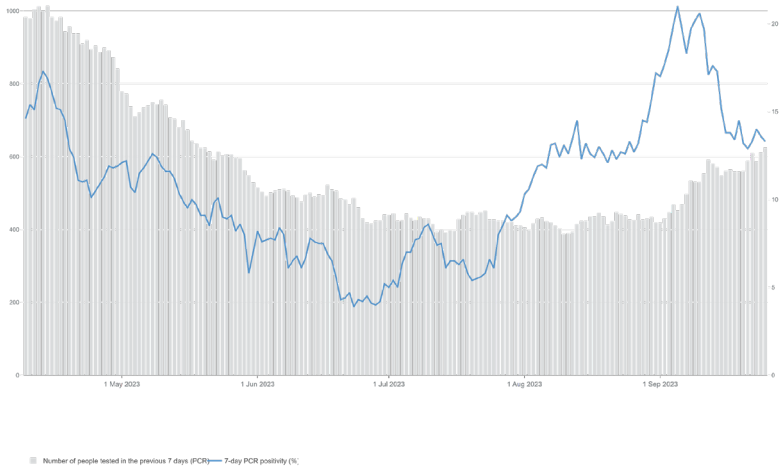
Influenza A/B and RSV reports remain low, as do laboratory reports of Norovirus. Weekly reporting of winter pressures indicators by UKHSA (acute respiratory infections and infectious intestinal diseases reports) will commence from Thursday 12th October.

7.3 Regional Data

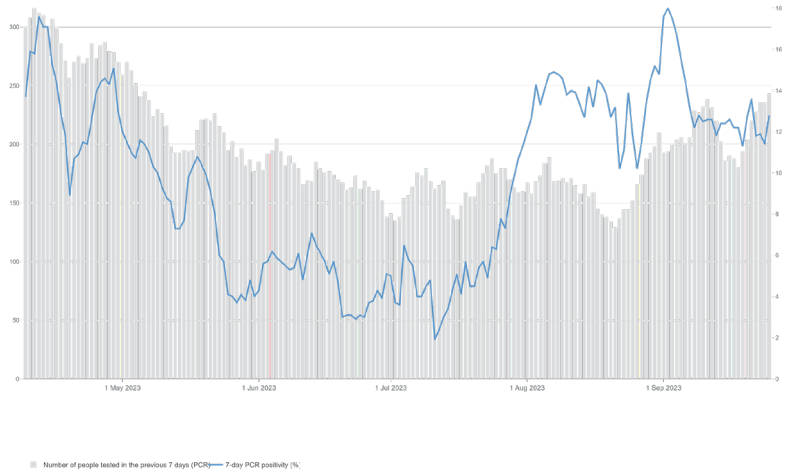
The below graphs show the number of people receiving a PCR test during a one-week period, and % having at least one positive PCR during the same one week period. The data is taken from https://coronavirus.data.gov.uk/.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Staffordshire County Council:

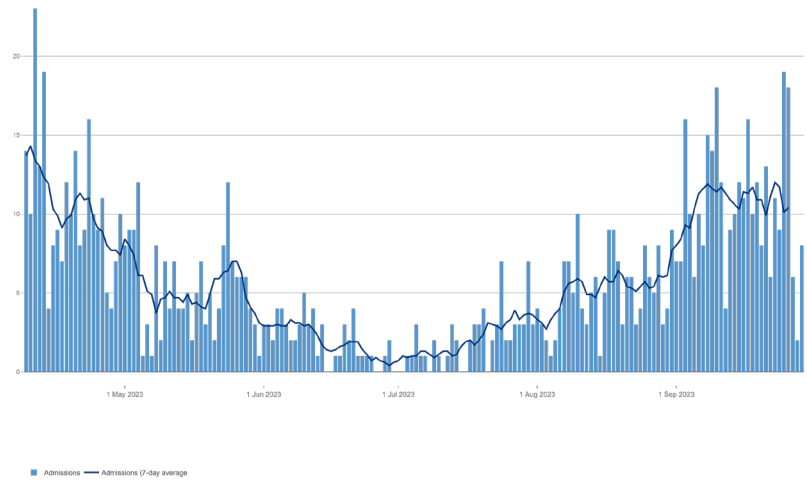


Stoke-on-Trent:

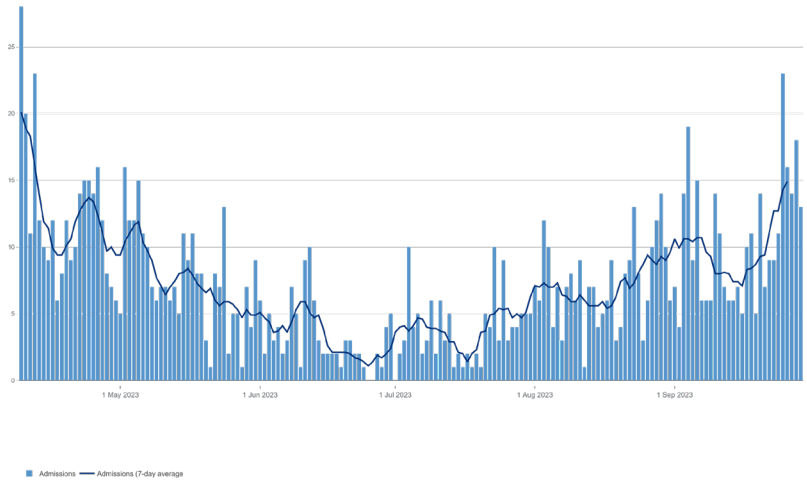


The graphs below show the daily total numbers of COVD-19 patients admitted to hospital over a seven-day average for admissions. The data is taken from https://coronavirus.data.gov.uk/.

University Hospitals of Derby and Burton NHS Foundation Trust:



University Hospitals of North Midlands NHS Trust:



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, Interim ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

Report to:	**Integrated Care Board**					
Date:	**19 October 2023**					
Title:	**System Recovery Programme**					
Presenting Officer:	Jacqui Charlesworth – Director of Operational Finance					
Author(s):	Paul Brown – Chief Financial Officer					
Document Type:	Report					
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* The document sets out that without further action, the NHS partners in the system face a deficit of £141m				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This paper describes the approach being taken to establish our System Recovery Programme.

The approach described has been developed through conversations with the ICB Executive Team, Chief Executives and senior leaders from across a range of ICS partners, as well as through discussions with the NHSE Regional Team.

The Recovery Programme was agreed at the System Performance Group meeting on 27 September and at the System Executive event held on 29 September. It was approved at the Finance and Performance Committee meeting on 3 October.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (D)	27/09/2023
Finance and Performance Committee (A)	03/10/2023

(3) Implications:

Legal or Regulatory	A significant breach of our statutory duty to break even.
CQC or Patient Safety	The Recovery Programme is intended to help mitigate financial risks, quality risks and performance risks.
Financial (CFO-assured)	Improved ability to meet the financial plan that the ICB and ICS has set for 2023/24, and to enable longer-term financial and clinical sustainability.

Sustainability	Sustainability is a theme which runs throughout the Recovery 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	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* Impact Assessments will form part of the specific project approach as required. *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* Impact Assessments will form part of the specific project approach as required. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Involvement activities will form part of the specific project approach if required.

(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:

Going into 2023/24 we knew that the financial challenges would be immense. Most significantly, we have seen excess inflation (inflation above that funded through allocations), continuation of the trend of recent years where patients requiring Continuing Health Care (CHC) has grown, there have been unforeseen costs of industrial action and further pressures on the acute and mental health care sector. These pressures are mirrored within the Local Authorities who are also experiencing financial challenge.

We also continue to see high rates of admission in our 75+ population from care homes, with rates of re-admission highest in the housebound cohort, and increases of length of stay in this age group, along with high rates of emergency department attendance and admission in our End of Life (EoL) patients.

Our analysis demonstrates that we have a strong grip on our cost base. We need to retain this grip and control, but this alone will not return us to financial sustainability because we are not taking the cash out savings that we need, whilst we are also incurring the unbudgeted costs of excess inflation and growth in the costs of CHC and prescribing.

We have concluded that without further action, the NHS partners in the system face a collective deficit of £141m for 2023/24, coupled with a deterioration in our underlying position (ULP) to £237.7m.

System Actions:
At the System Executive event held on 14 July, we agreed to the need to focus on the Continuing Health Care (CHC) issue and care for patients aged over 75. Over the summer work took place at pace, and the recovery plan is the culmination of that work.

The System Recovery Plan outlines the context and why we need a recovery programme. We set out the “Big

Ticket 7" themes and we will focus on covering Management of CHC, Integrated Discharge, Admission Avoidance, Care Homes, Falls, Severe Frailty and End of Life and the underpinning projects. The opportunities and impact from these projects on our financial position, our patients and modelling of the potential bed savings and financial opportunities from CHC are also outlined.

The programme of recovery projects will support improving care pathways for patients and also positively impact on the financial position for 2023/24 and beyond. It will reduce the 2023/24 projected deficit down from the forecast £141m (which we will be agreeing with Regulators in the next few weeks) and it will have gone a significant way in terms of addressing our underlying problem. We have set ourselves the target to save £100m from CHC in a full year, which if achieved would mean that we spend closer to the average across the Region. However, there is long lead in time before we see that full year effect, and unfortunately it is too late for this to eliminate the outstanding projected deficit that we face.

We have proposed a robust programme management approach to ensure we deliver at a rapid pace and to provide assurance to our Statutory Boards, the Integrated Care Partnership (ICP) and to our Regulators with respect to our collective grip and control in terms of recovery. The plan outlines our approach to programme management, the workstreams and governance wrapped around the work including the role of our clinical leadership teams, digital, people and governance.

We plan to deliver these improvements through our developing provider collaborative arrangements and delivery teams at project level. The System has agreed to come together to work across the care pathway, and so the provider collaborative is the ideal vehicle.

Our immediate focus now is to assure that we deliver these improvements at pace. Once the recovery is underway, we will start the next stage of planning to address the remaining gap that we face for 2024/25 and beyond.

Discussions with NHS England are on-going about the 2023/24 outturn. We have been clear that even with these measures, it will not be possible to achieve a break even position, however, these measures will reduce the deficit from the £141m. We will update Finance and Performance Committee on the year end projection and the discussion with NHS England, and this will be reported back to the Board at a future date.

This recovery plan was supported at a System event held on 29 September and then approved by System Finance and Performance Committee on 3 October. We are now seeking ratification by the Board.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Take assurance from progress being made
2. Ratify the decision of the Finance and Performance Committee to approve the Recovery Programme.

Staffordshire and Stoke-on-Trent Integrated Care System

System Recovery Programme

v10 – 6th October 2023

Contents

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Appendices

Click on the boxes to jump to that page.

Executive Summary

- The system has **achieved financial balance for the last three financial years**. Two of these were during the COVID19 period when there was more money, and so the task of achieving financial balance was much more straightforward. In the year to March 2023 however, financial challenges returned, and it was only due to the close system working that took place, that we were able to land balanced positions for all system partners, something that many systems were unable to do.
- Going into 2023/24 we knew that the **financial challenges** would be immense. In the previous year, we had been able to utilise reserves that we had accumulated and so we had a significant amount of non-recurrent support, that we used to prop up the position. However, as we approached the current financial year, we signalled a significant gap that needed to be addressed.
- After much conversation and thought, we decided to plan for a break-even position in 2023/24, recognising that it is our statutory duty to do so. In agreeing to this plan, we signalled clearly to all parties that it would require a best-case outcome across a range of assumptions.
- Unfortunately, that best case scenario has not played out. Most significantly, we have seen **excess inflation** (inflation above that funded through allocations) of £50m. We've also seen the continuation of the trend of recent years where patients requiring **Continuing Health Care (CHC) has grown markedly**. In addition, there have been unforeseen costs of **industrial action** and further pressures on the acute and mental health care sector. These pressures are mirrored within the local authorities who are also experiencing financial challenge.
- This document sets out that without further action, **the NHS partners in the system face a deficit of £141m.**
- However, the likelihood of a financial deficit was recognised immediately after the plan was agreed, and the system has now held two events where we've come together to look at options for approving the position.
- At the most recent of these system conversations held on 14th July, we agreed to the need to focus on **CHC and our over 75 population in particular.**

Executive Summary (2 of 2)

- We agreed **seven key themes** to focus our efforts on, with the goal of improving the care pathway for patients over 75 and those requiring CHC, because the evidence shows that the higher levels of intervention are not only costing more, they're leading to the deterioration in the outcome for many of these patients. We have agreed a set of enablers covering clinical leadership, digital, people and governance.
- We've spent the summer working on the **detailed projects** to underpin this approach. Collectively these projects improve the care pathway for people aged over 75, with the aim that many more people receive that care outside of the acute setting, and without the need for ongoing continuing healthcare. We have set ourselves the target to save £100m from CHC in a full year, which if achieved would mean that we spend closer to the average across the region. However, there is long lead in time before we see that full year effect, and unfortunately it is too late for this to eliminate the outstanding projected deficit that we face.
- This **recovery programme will impact positively** on the financial position in 2023/24 and beyond. It will reduce the 2023/24 projected deficit down from the forecast £141m – we will be agreeing a position with Regulators in the next few weeks – and it will have gone a significant way in terms of addressing our underlying problem and gives us a fighting chance of developing a better financial plan for next year.
- We plan to deliver these improvements through our developing **provider collaborative arrangements**. The system has agreed to come together to work across the care pathway, and so the provider collaborative is the ideal vehicle.
- We have considered **a range of other measures** that would save money, but these have been discounted since they would harm patient safety or compromise delivery of statutory services
- Our immediate focus now is to assure that we **deliver our projects at pace**. Once the recovery is underway, we will start the next stage of planning to address the remaining gap that we face for 2024/25 and beyond.
- This projection would mean a significant breach of our statutory duty to break even and so the position and the planned recovery is being discussed with Regional and National colleagues.

Financial context and why we need a Recovery Programme

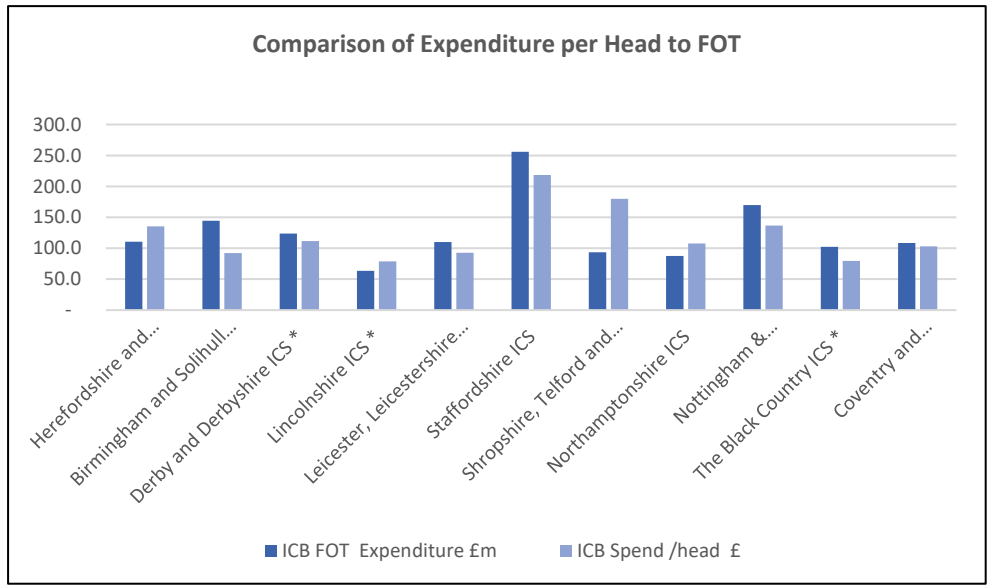
Throughout the planning round for 2023/24 a material level of financial risk was flagged

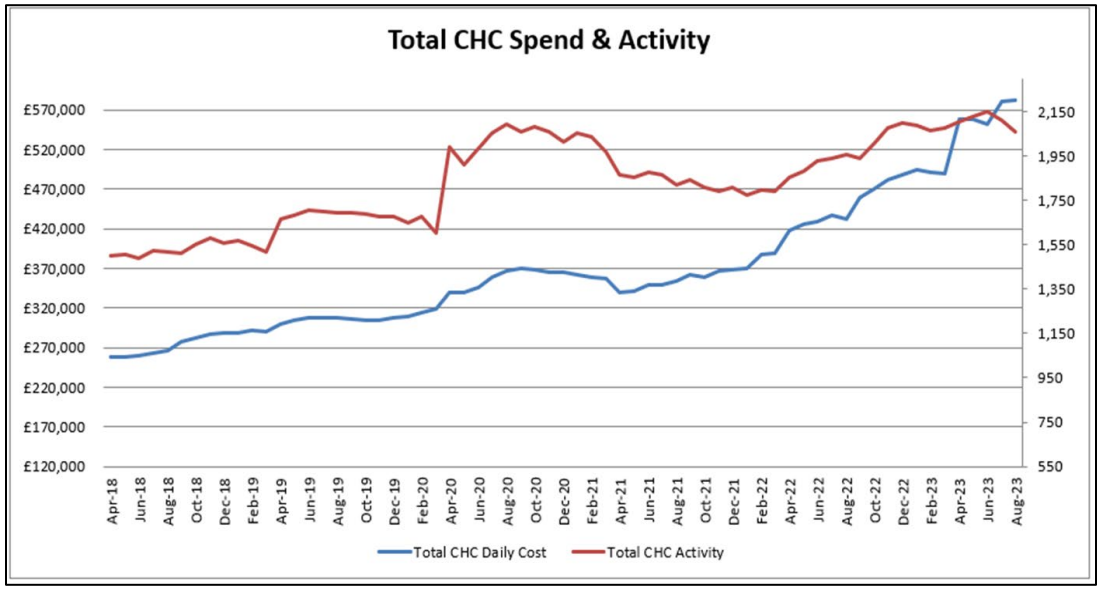
- As a system we agreed to plan for a break-even position in 2023/24, recognising that it is our statutory duty to do so. In agreeing to this plan, we signalled clearly to all parties that it would require a best-case outcome across a range of assumptions. Unfortunately, that best case scenario is not playing out.
- Most significantly, we have seen
  - excess inflation within continuing healthcare (CHC) and prescribing of £50m.
  - the continuation of the trend of recent years where patients requiring CHC has grown markedly and with more complex packages being assessed. These pressures are mirrored within the local authorities who are also experiencing financial challenge.
  - there have been unforeseen costs of industrial action and further pressures on the acute and mental health care sector. Due to the Urgent and Emergency Care (UEC) pressures we have been unable to close the "Winter" escalation beds in line with plan.
- This is detailed in the The Financial Context and Rationale section.

We have concluded that without further action, the NHS partners in the system face a collective deficit of £141m for 2023/24, coupled with a deterioration in our underlying position (ULP) to £237.7m.

- However, the likelihood of a financial deficit was recognised immediately after the plan was agreed, and the system has now held two events where we have come together to look at options for approving the position.
- Our analysis demonstrates that we have a strong grip on our cost base. We need to retain this grip and control, but this alone will not return us to financial sustainability because we are not taking the cash out savings that we need, whilst we are also incurring the unbudgeted costs of excess inflation and growth in the costs of CHC and prescribing.
- A robust programme management approach is required to ensure we deliver at a rapid pace and to provide assurance to our Statutory Boards, the Integrated Care Partnership (ICP) and to our Regulators with respect to our collective grip and control in terms of recovery.

Continuing Health Care Context: The system is a major outlier in terms of the costs we incur on CHC





- The graphs above show our current position at Month 5 on CHC spend. As at month 5 the full year forecast spend is circa £256m before the actions set out in the recovery plan. This has increased from £196m in 2022/23.
- The system was a high spender on CHC before COVID.
- During COVID costs increased but were covered by the Hospital Discharge Fund.
- Since COVID costs have continued to rise from this high base, even faster than other systems. We think that there are two major factors in this:
    1. The market, particularly in the city of Stoke-on-Trent, is constrained and this has allowed Care Homes to rise prices faster
    2. The arm's length nature of the Midlands and Lancashire Commissioning Support Unit (MLCSU) means that the assessors have no 'skin in the game'. There is always pressure from patients, relatives and staff to discharge patients to the best CHC packages, and this has fuelled some of the local cost growth we have seen
- All this has led to a situation where the system is a major outlier in terms of costs, with pathways that in some cases lead to patients losing functionality and independence. There is clearly the chance to improve patient's lives and reduce cost at the same time.
- Further detail is provided in the CHC Analysis of Forecast Expenditure and Case Mix section.

Population Context: Our over 75's population

- Population Health Management analysis suggests higher use of resource by our over 75 population when looking at attendances, admissions, re-admissions and length of stay. The evidence shows that the higher levels of intervention are not only costing more, but they are also not leading to the best outcome for many of these patients.

The over 75s are 10% of the total local population (120,026) but account for 21% of A&E attendances

Nearly half of over 75s A&E attends convert to an admission

32,898 have had at least 1 ED Attendance in last 12 months

18,246 have had at least 1 non-elective admission in the last 12 months

By 2043 the population is estimated to grow in the 65-79 age group by 14% and in the 80+ age group by 64%.

Admissions

Highest rates of admission from

1. nursing home residents (732 per 1000 residents)
2. followed by the housebound (700 per 1000 residents)
3. then residential home residents (637 per 1000 residents)

- Men living in these settings are more likely to be admitted than women

Common reasons for admission

- Urinary Tract Infection (UTI)
- Pneumonia/Lower respiratory tract infection /COVID/ Exacerbation of COPD
- Acute Kidney Injury (AKI)
- Tendency to fall
- Fractured neck of femur

- Risk of emergency admission increases with age, male sex and multimorbidity

Re-Admissions

Rates of readmission were

- highest in housebound
- then by nursing home residents

- Re-admissions are higher in those with multiple co-morbidities and men with multiple co-morbidities

Common reasons for re-admission

- UTI
- COVID/pneumonia/exacerbation of COPD/Lower respiratory tract infection (LRTI)
- AKI
- Falls
- Cellulitis

- Risk of readmission increased with age, male sex, multimorbidity

Length of Stay

A number of clinical conditions increased the risk of having a prolonged length of stay (LoS)

This is regardless of the reason for the admission.

Increases in LoS

- Palliative care - 5.8 day increase
- Epilepsy - 4.6 day increase
- Osteoporosis - 2.4 day increase
- Congestive heart failure - 2.1 day increase

Chronic Conditions

- Diagnosis of epilepsy 2.4 times more likely to have an emergency admission for any reason (not necessarily related to their epilepsy)

- Patients who had a combination of multiple comorbidities and stroke were 4 times more likely to have emergency admissions
  - Congestive Heart Failure (3.3x)
  - Epilepsy (3.0x)
  - Peripheral arterial disease (2.7x)

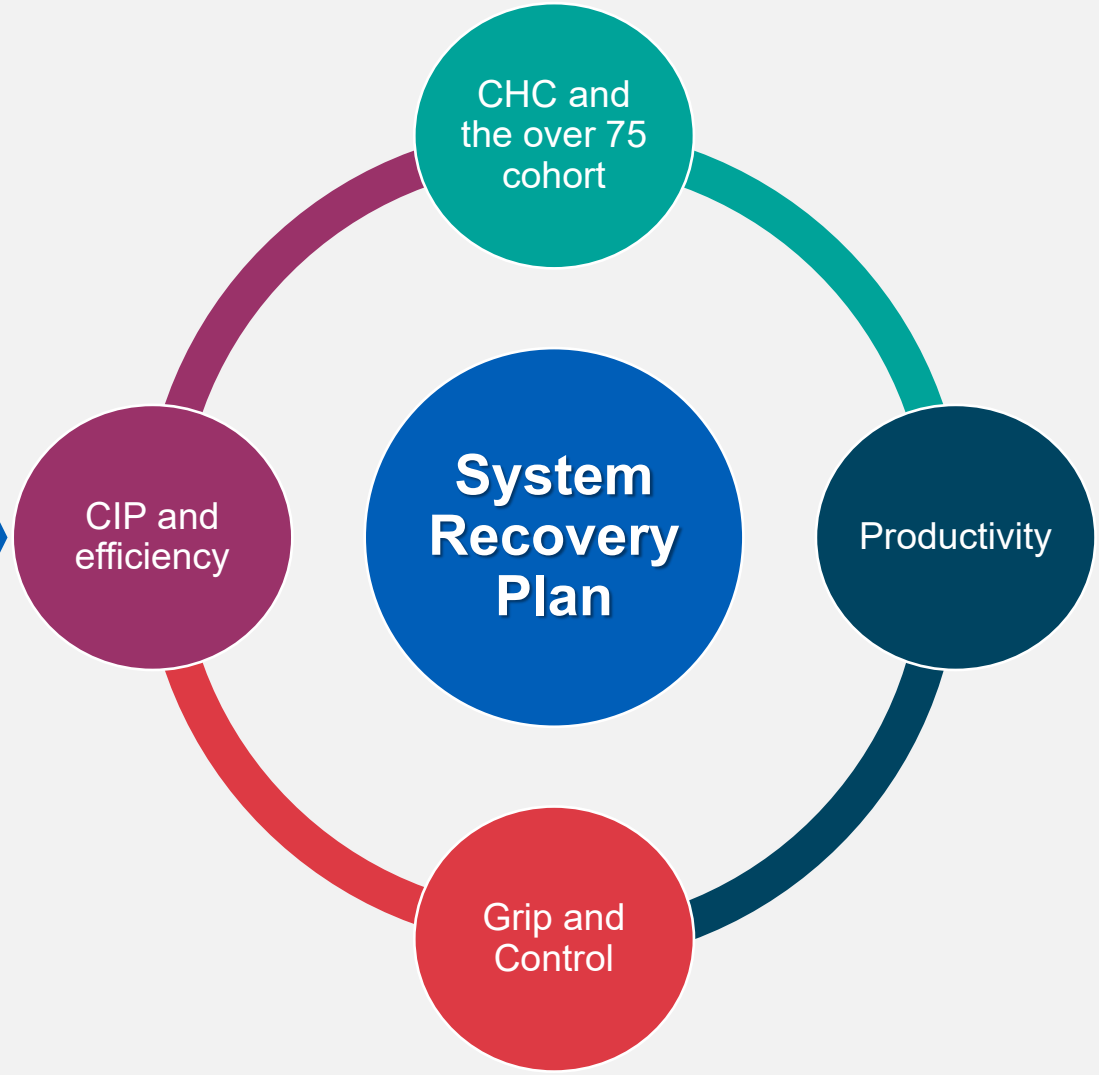
- Multi-comorbidities (4 or more chronic conditions) were 2.5 times more likely to have multiple emergency admissions (compared to the population with no chronic conditions)

- We have agreed seven key themes to focus our efforts on, with the goal of improving the care pathway for patients over 75 .

Shape of the Financial Recovery Plan

Recovery will be achieved by maintaining control, driving higher levels of efficiency and better productivity, in addition to this new focus.

The system recovery plan builds on the operational plan and seeks not to replicate existing narrative on efficiency and productivity.

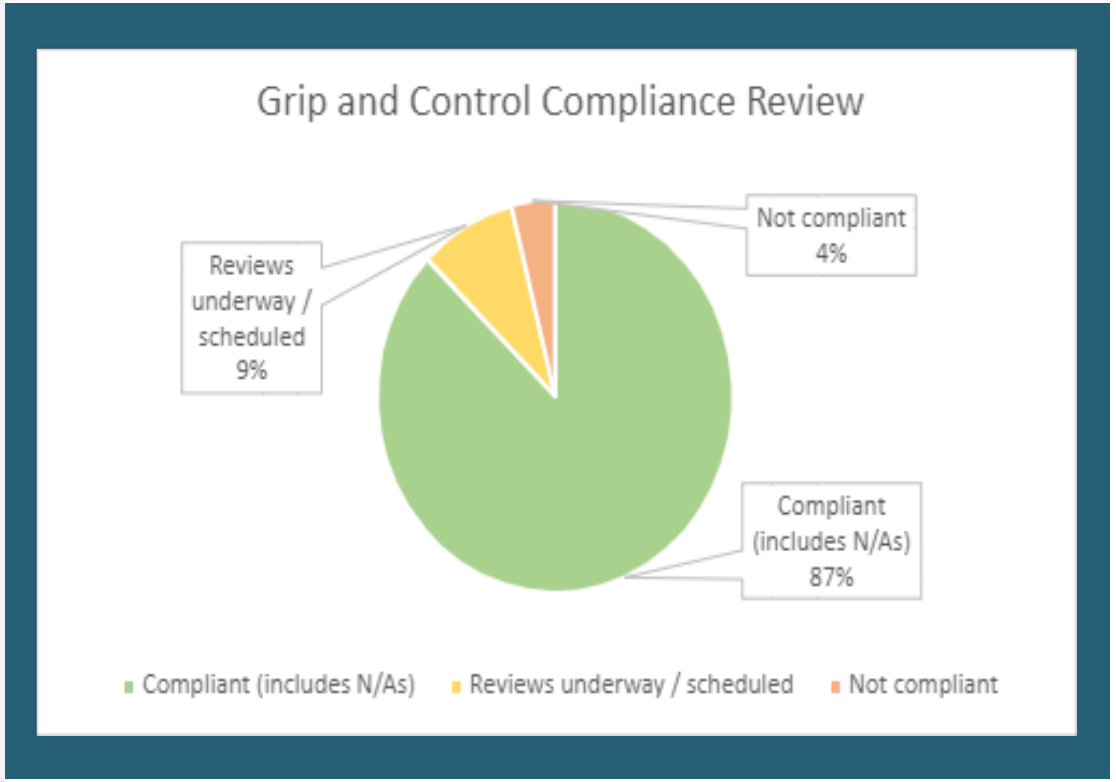


- CHC and the over 75 cohort – seven themed Big Ticket areas embedded in a Provider Collaborative model.
- Productivity – faster throughput and better use of beds, theatres and clinical capacity.
- Grip and Control – an ICS wide approach to vacancy and agency spend and the control of procurement.
- Cost Improvement (CIP) and efficiency – delivering the £181m 2023/24 target recurrently.

Grip and Control

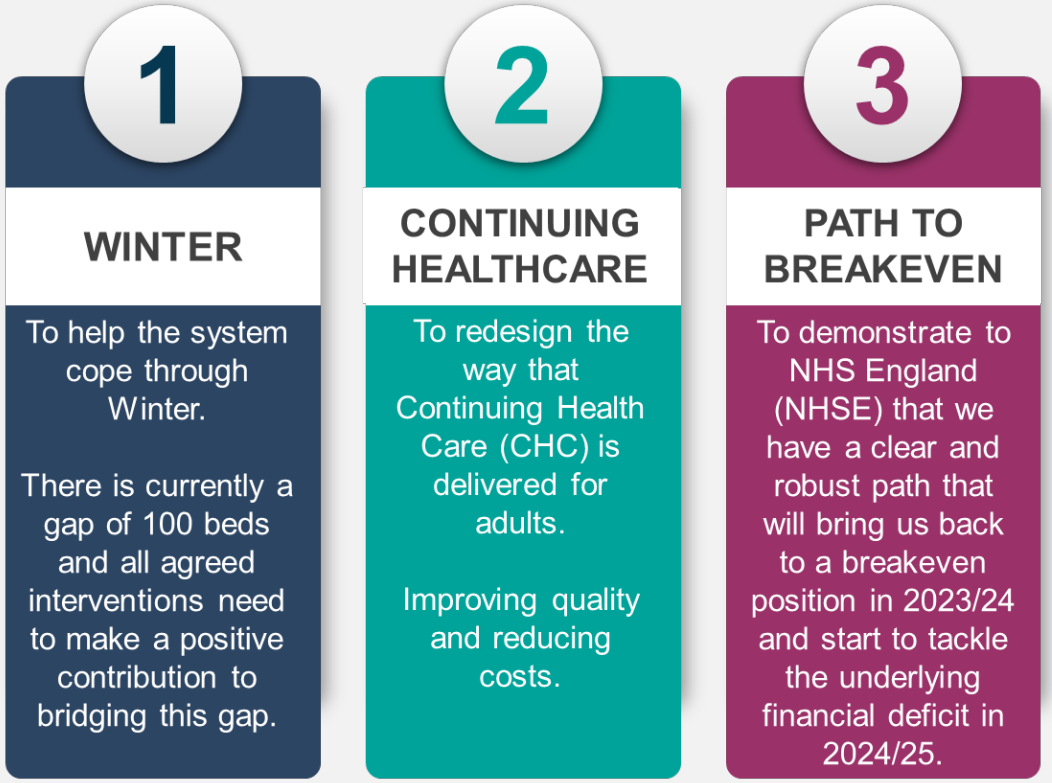
Our system has controls in place to avoid cost growth and to optimise finance sustainability, through strong governance process and internal controls.

- **System risk register** – the system collates and captures all risks impacting on performance and finance. Ensuring early visibility and any remedial actions plans can be implemented.
- **System double lock and risk share** – the system has implemented a double lock, which ensures all investments (including capital) that negatively impact the underlying position of the system require the governance route through System Performance Group onto System Finance and Performance Committee.
- **Grip and control** – the system has conducted the assessment of the NHSE list of pay and non-pay controls. The system is fully compliant with 87% of the controls and is working through the detail and impact of the remaining controls, providing an action plan to implement where possible.
- **Agency controls** – the system has implemented the NHSE process to ensure ICB approve all cases before onwards approval by NHSE where applicable. We are on target to meet the national target of containing the agency bill to 3.7% of the payroll and have good level of usage of framework rates.



Three Key Objectives of the Recovery Programme

- In developing this Recovery Programme, we have made sure that we are ensuring capacity to cope with winter, whilst dealing with the CHC challenge and setting a pathway to breakeven.



The Recovery Programme is built around

- Big Ticket 7 Recovery Themes and Projects
- It is underpinned by
  - A clear understanding of our financial position and the drivers of the deficit
  - Delivery teams at project level and provider collaborative level
  - Broader enabling work focused on clinical connectivity, digital, people, medicines, estates, ICB payroll and procurement
  - A set of project summaries
- Governance and programme management arrangements are set out in more detail in the appendices.
- Further detail on the underpinning areas is available in the appendices or by clicking on any underlined text.

The ‘Big Ticket 7’ System Recovery Themes

Theme	Focus (further detail is available in the Project Summaries)	KPI to be achieved by March 2024 (further detail is available in the metrics dashboard)
01 Management of CHC	• Transfer management of CHC to Midlands Partnership University Foundation Trust (MPFT). • North Staffordshire Combined Healthcare NHS Trust to retain management of Project 86 and Transforming Care Partnership. • MPFT to manage Midlands and Lancashire CSU staff. MPFT to align CHC with Discharge to Assess (D2A) and through the provider collaborative, when formed, to align with the rest of the pathway	• Review of 1:1’s to ensure the appropriate and least restrictive care option for individuals • Reduce cost run rate by £100m • More appropriate placement of patients in CHC to support improved outcome
02 Integrated Discharge Hub	• Implement the IDH with support from all stakeholders through Integrated Discharge Steering Group	• Improve the ratio of simple to complex discharges from 70:30 to 80:20
03 Admission avoidance	Implement the three remaining measures agreed by the admissions avoidance table: • Turbo charge end of life programme and link into care planning for elderly and frail people • Single point of access for admissions avoidance, to cover support for clinicians as well as development of rapid response services • Repository for information and sign posting both to support clinicians and also create empowered citizens • Universal offer to care homes • Professional development work to help manage clinicians to manage risk	• Reduce the number of +75-year-olds attending A and E.
04 Care Homes	Care Home Task Force to be established across Primary Care and with Local Authorities. Prioritise the use of existing resources e.g. digital. Two key objectives will be: 1. Ensure that all care home residents have a compassionate care plan 2. Ensure a rapid and compassionate response to incidents / deterioration of care home residents	• Reduce the number of overall attendances and zero LoS attendances at A&E • Reduce the number of admissions from care homes
05 Falls	Identification of those most at risk of falls and implementation of integrated support.	• Reduce number of patients admitted following a fall
06 Severe Frailty	Identification of severely frail patients and increase in the number with completed anticipatory care plans	• Reduce number of severely frail patients admitted to hospital
07 End of Life	Implement 24/7 integrated response for EOL patients	• Reduce the number of patients dying in acute secondary care settings

Our Projects and Metrics (1)

- Over the summer we have developed the **7 'big ticket' theme areas** plus medicines optimisation, Children and Young People and Estates into more detailed projects, all with leadership, deliverables and metrics. These detailed project summaries are included in the appendices and are summarised below.

Project	Interventions	Underpinning Metrics to Deliver the KPI
01 Management of CHC	• Review of 1:1's to ensure the appropriate and least restrictive care option for individuals • Changes to the market pricing structure • Improving the experience and timeliness of support for individuals who are end of life and eligible for fast track. • Addressing the existing backlog of CHC reviews to ensure appropriate care that meet the assessed needs of individuals	1. Reduction in the average LOS for Fast Track patients to 12 weeks or less 2. Reduction in fast-track discharge turnaround times 3. Reduction in fast-track bed based CHC costs
02 Integrated Discharge Hub	• Fully deployed IDH model • Implement a Virtual Wards Step Down pathway at County Hospital* • Expand Pathway 1.0 for patients who can be discharged home with a support package from the voluntary sector / use of personalised health budgets	1. Improve the number of discharges on Pathway 0 to 80% 2. Reduce the number of readmissions within 30 days and within 48 hours to 12% or less 3. Decrease the number of admissions to Pathway 3 to 1%
03 Admission avoidance	• 12hr / 7 days a week Single Point of Access - development of 3 triage point process - routine assessment, urgent assessment, emergency assessment • Acute Care @ Home	1. Consistently meet or exceed the 70% 2-hour UCR standard 2. Reach 80% utilisation of virtual wards

04 Care Homes	• Implement improvements to the Enhanced Health in Care Homes Local Enhanced Service (LES) to include RESPECT, Comprehensive Geriatric Assessments and Care Planning with a view to
	  ○ Improve the number / proportion of care home residents with a recent clinical review
	  ○ Improve the number / proportion of care home residents with an End Of Life plan
	• Implement a 24/7 single point of contact to a rapid community response to crisis service
		1. Reduce Care Home Admission Rates
		2. Number of patients in a Care/Nursing Home
		3. Number of patients on a Palliative Care Register
		4. Increase number of patients with ReSpect documentation
		5. Number of patients on a EOL Care Plan
		6. Number of patients with a Personalised Care Plan

Our Projects and Metrics (2)

Project	Interventions	Underpinning Metrics
05 Falls	• Improved referral pathway between Emergency Departments and Specialist Falls Teams	1. Increase in number of referrals from A and E to specialist falls service 2. Reduction in the number of subsequent falls for patient cohort
06 Severe Frailty	• Develop an outcomes framework to support the Care Homes LES • Prioritise the implementation of active case management in South Stoke, Leek and Newcastle	1. Reduction in admission for those identified as severely frail within the target group 2. Increase in number of targeted patients with assessments completed 3. Increase in number of targeted patients with plans in place 4. Increase in number of targeted patients with EOL/ReSPECT plans in place
07 End of Life	• Increase in patients identified as EoL on GP registers with improved MDT management • Offer of 18 additional hospice beds and 200hrs domiciliary care to support urgent and emergency care flow • Implementation of a 24/7 advice line • Implementation of a Virtual Ward • Better integration and co-ordination of existing pathways	1. Increase percentage of patients in the last 12 months of life recorded on palliative care registers. 2. Reduction in the percentage of people with 3 or more emergency admissions in the last three months of life. 3. Growth in the percentage of people dying in their usual place of residence. 4. Reduction in proportion of PEoLC admissions in out of hours period.

- We have agreed that the ICS wide work on **Medicines Optimisation and Estates** would continue with a focus on generation of cash-out savings and be monitored through the recovery plan. The main medicines programme is set out within in existing CIPs which deliver the £189m original savings therefore this is only referring to additional schemes picked up since September

Project	Interventions	Underpinning Metrics
Estates	• Voids and Disposals • Utilisation of Estate • Leases • Solar PV (link to admissions avoidance through the Warmer Homes initiative)	1. To deliver recurrent financial savings against current level of voids. 2. Further metrics to be agreed via the project team.
Medicines Optimisation	• Biosimilar Switch usage and uptake (Dependent on biosimilar and provider organisation)	1. 90% uptake within 12 months of launch.

Further detail on each project is available in the appendices or by clicking on the project title.

Provider Collaborative and System Partnership

01 Management of CHC

A Provider Collaborative Partnership is being established to own and drive **Project 1**.

The collaborative will be led by MPFT bringing key partners together from across the ICS to enable the collective delivery of agreed interventions.

The collaborative will connect into the Provider Collaborative Programme as it evolves and develops.

04 Care Homes

A System Partnership Group is being set up to own and drive **Project 4.**

This group will be led by the Local Authorities. It will bring together key partners together from across the ICS to agree and enable the collective delivery of agreed interventions.

The form this group will take is yet to evolve.

02 Integrated Discharge Hub | **03 Admission avoidance** | **05 Falls** | **06 Severe Frailty** | **07 End of Life**

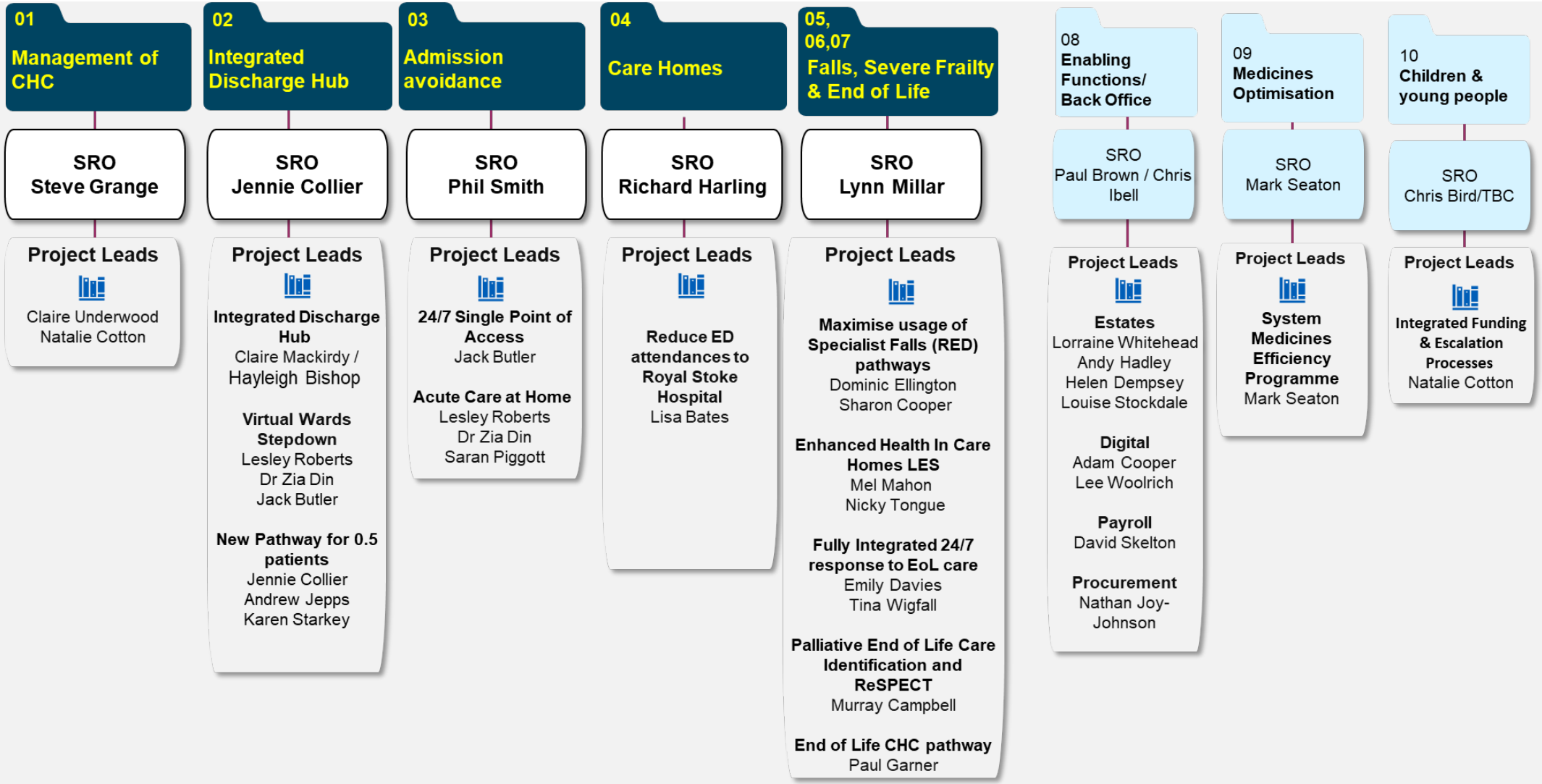
The further 5 Projects are led and **delivered through the ICS Portfolio structure** and are priority areas of focus within their delivery plans.

The co-dependencies between the Projects/Portfolios and Enablers have been identified and worked though.

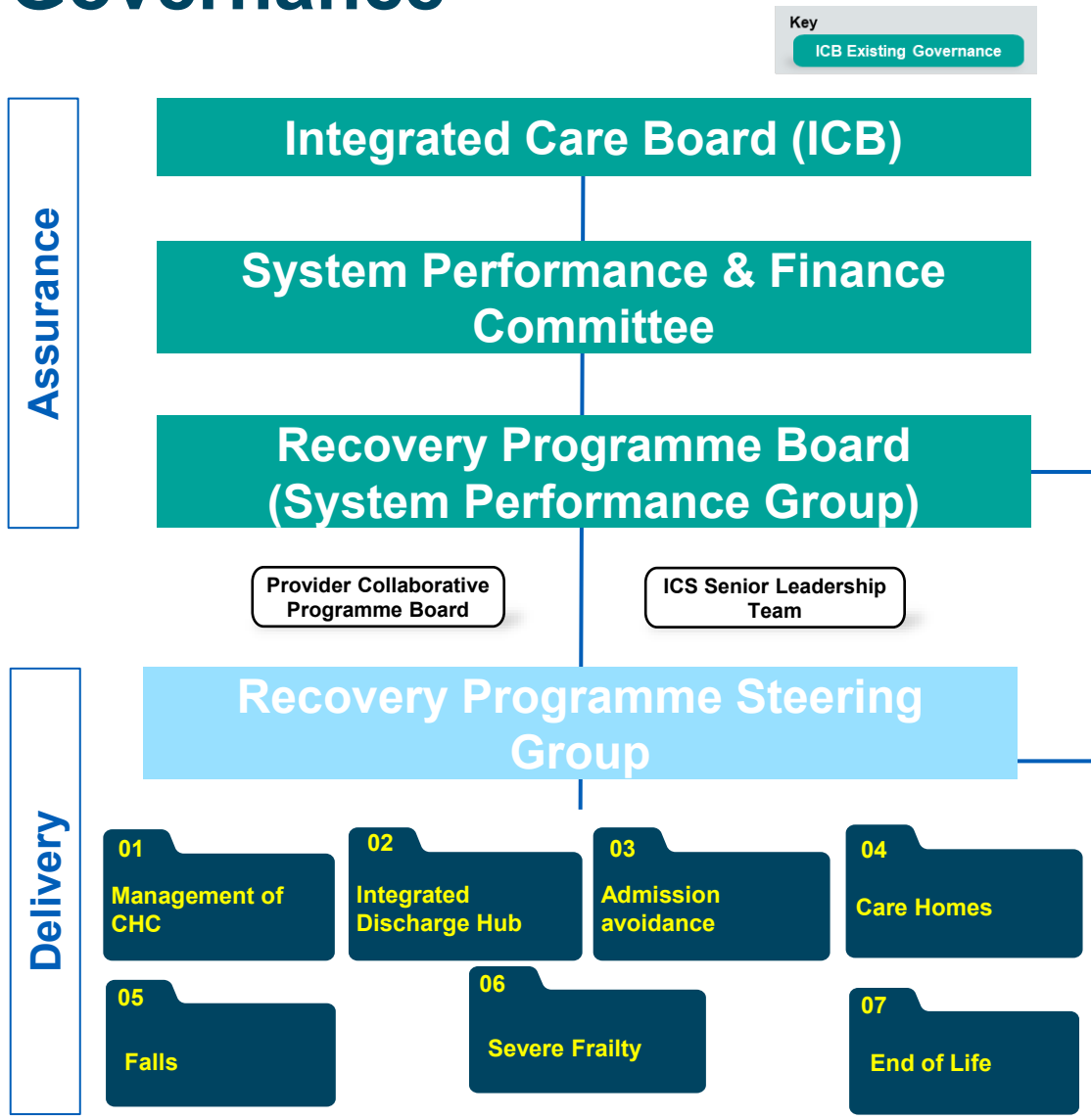
The Provider Collaborative Programme Board is a provider partnership operating as a vehicle for the development of provider collaboration, discussion, joint decision making and resolution of any barriers to delivery. The programme will support the collaborative form as it evolves

Delivery Teams at Project Level

- Each project has a nominated Senior Responsible Officer (SRO's) and project leads as outlined.
- SRO's will be accountable for the delivery of their project interventions and metrics.
- SROs will meet monthly to agree actions that interplay between projects and to focus down the issues that need discussion at the System Performance Group (SPG)
- As a system we will be accountable for the impact on the number of people admitted to acute hospital.



Recovery Programme Governance



Principles:

- Uses **existing governance** where possible with clear lines of accountability
- Clear differentiation between the Steering Group (delivery) and the Programme Board (assurance)
- The Recovery process will be supported by the Transformation and Delivery Unit (TDU) as the system PMO.
- The Provider Collaborative Programme Board and ICS Senior Leadership Team will be key in unblocking any delivery issues.

Aim:

- Receive **assurance** against delivery of the programme
- Receiving escalations and ensuring immediate actions are agreed and taken

Focus:

- Performance against plans and their impact on agreed metrics, unblocking any barriers to ensure pace

Aim:

- Monitor **delivery** of the System Recovery Programme
- Identify any **blockers** that require escalation

Focus:

- **Project management** and delivery against agreed milestones
- Holistic **clinical review** of recovery programme and supporting clinical connectivity

Clinical Review and Connectivity

Clinical Risk Group

Aim:

- Risk tolerance, identification and recommendations in support of system recovery

Focus:

- Assessment of recovery clinical risks and mitigations
- Connecting the recovery programme to H&C Senate

Health and Care (H&C) Senate

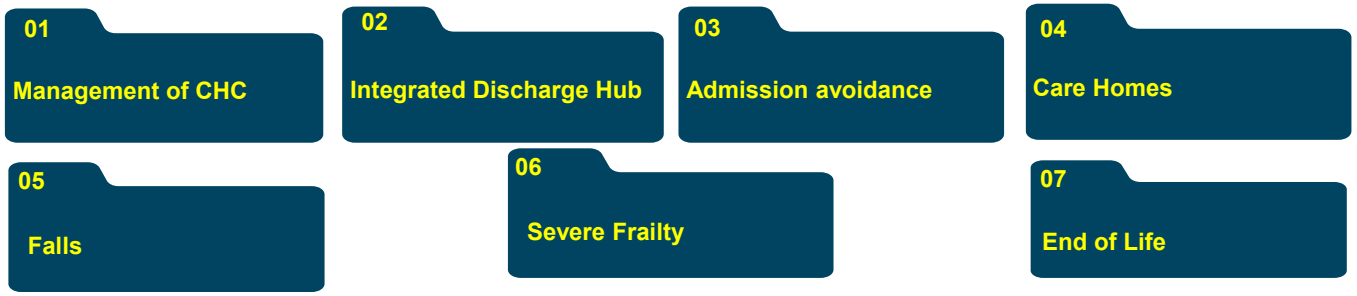
Aim:

- Clinical oversight and scrutiny of system recovery and clinical risk

Focus:

- Connecting system clinical strategy and recovery
- Clinical recommendations to the ICB

Recovery Programme Steering Group



Clinical leadership, review and connectivity across health and social care is paramount to our Recovery Programme.

Principles

- Support the Recovery Programme Steering Group with a **holistic clinical review** of the recovery programme
- Escalation to the **Clinical Risk Group** and **H&C Senate** where required.
- Assessment and identification of recovery clinical gaps **and clinical support at project level**
- Provide **clinical leadership, connectivity** and scrutiny of the system recovery programme.
- Support clinical connection between the recovery themes and projects and the **wider system**

Proposed assumptions and impact on bed savings of projects (1)

- The table below and on the next slide outline the potential UHNM bed saving at peak December 2023. There is further opportunity to impact on bed savings for our wider acute providers outside the ICB footprint.
- Senior Responsible Officers and Project leads will be accountable for the delivery of their project metrics, as a system we will be accountable for the impact on the number of people admitted to acute hospital.
- The delivery of these improvements would close the remaining bed gap and ensure that further escalation costs can be avoided.
- Reduced numbers of inpatients will also lead to some reduction in those requiring CHC on discharge. The table below outlines which of the 7 projects will contribute to the bed gap.
- The potential savings are calculated based on the assumptions shown. There is the possibility of a double count across some of these headings. The bed saving numbers will be worked through in more detail with system partners to test and check out the assumptions.
- The rationale for bed modelling is that projects will impact on all ages not just the 75+ population with opportunities for some projects identified in the 65+ age group.
- Further detail on the underpinning numbers is provided in the appendices.

Project	Assumptions	Potential UHNM bed saving at peak Dec 23
03 Admission avoidance	• Focus on 75+ excludes activity where post code is Care Home • Monitor A&E attends of cohort against previous 12 months as baseline • Assume 10% reduction in attendances of cohort • Emergency admissions conversion ratio of 42.89% based on 22/23 Emergency admissions at 6 main acutes • Volume of occupied bed days saved based on applied reduction of attends with an average length of stay of 10.6 days, derived from 22/23 emergency admissions • Potential Bed Saved Impact calculated from volume of admissions saved multiplied by average length of stay and divided by calendar days in the month • Potential Total Beds Saved by Main 6 local Acutes and UHNM as a subset	45

Proposed assumptions and impact on bed savings of projects (2)

Project	Assumptions	Potential bed saving at peak Dec 23
04 Care Homes 06 Severe Frailty	• Based on Post Code of Care Home and age 65+ represent Care Home residents • Monitor A&E attends of cohort against previous 12 months as baseline • Assumed initial 20% reduction in attendances of care homes patients with further modelling to be worked through with SRO to identify further stretch opportunities and agreement on phasing, based on start date of project interventions • Emergency admissions conversion ratio of 48.57% based on 22/23 Emergency admissions at 6 main acutes • Volume of occupied bed days saved based on applied reduction of attends with an average length of stay of 7.9 days, derived from 22/23 emergency admissions • Potential Bed Saved Impact calculated from volume of admissions saved multiplied by average length of stay and divided by calendar days in the month with further modelling to be worked through with SRO to identify further stretch opportunities and agreement on phasing, based on start date of project interventions • Potential Total Beds Saved by Main 6 local Acutes and UHNM as a subset • Includes the impact of Severe Frailty project 6.	15
05 Falls	• Focus on 65+, admitted for an overnight stay where Trauma is the primary Diagnosis and Fall as the Secondary Diagnosis • Use of BCF metric also monitoring falls across the population • Monitor against a baseline of previous 12 months • Assume emergency admissions reduced by 4% • Volume of occupied bed days saved based on applied reduction of attends with an average length of stay of 13.9 days, derived from 22/23 emergency admissions • Potential Bed Saved Impact calculated from volume of admissions saved multiplied by average length of stay and divided by calendar days in the month • 6 Local Providers Potential Bed Saved Impact • Potential Total Beds Saved by Main 6 local Acutes and UHNM as a subset	3
07 End of Life	• Focus on 65+, emergency admissions at coded with a discharge destination of Death in Hospital • Monitor against a baseline of previous 12 months • Assume emergency admissions reduced by initiatives to impact • Volume of occupied bed days saved based on reduction of admissions through initiatives assuming a patient within the last 12 months of life has 5 admissions with a length of stay of 34 days, therefore assumption is a 5/34 providing an average episode length of stay of 6.8 days. • Potential Bed Saved Impact calculated from volume of admissions saved multiplied by average length of stay and divided by calendar days in the month • Potential Total Beds Saved by Main 6 local Acutes and UHNM as a subset	6
Total	**Cumulative Impact of metrics on bed position**	**69**

The Financial Opportunities from CHC

- Given that **we spend c£100m more per capita than most systems**, the opportunities are vast. Some of this is about better control on the process, and the evidence is growing that we have started to flatten the growth curve, then there is the opportunity from the impact of the other 6 elements of the recovery plan, which will result in fewer people being eligible for CHC in the first place.
- The table below shows that the **target run rate improvement of £100m is** potentially feasible. However, there is an element of cross over as some of the high-cost patients for example, are on 1 to 1 or multiple packages. The figures shown below are likely to be the maximum achievable, but we should aim for the best return possible:

Action	Assumptions	Potential saving
Future growth avoided	The 2023/24 financial plan assumes that there is further growth over the remainder of 2023/24. The control measures already in place could avoid that growth	£20m
One to one packages	The number and the cost of one-to-one packages offered has increased significantly and there is scope to reduce this. Further detail on the working assumptions is available in the appendices by clicking here.	£14m
Fast Track	The average length of stay of fast track over the target of 12 weeks is currently 36 weeks. It should be offered when end of life is expected within 12 weeks. This cohort of patients should be on FNC care until they reach that EOL status. Further detail is available in the appendices by clicking here.	£6m
High-Cost patients	We define high-cost patients as those costing more than £3,000 per week. This cohort has increased from 410 last year to 457 at the moment, with the average cost per patient rising from £145k to £239k. Those costing more than £7k pw (£364k pa) has increased from 29 to 40 in the year. Many of these are mental health or Learning Disability patients. If we returned to the level of last year and held the cost increase at 5%, that would release £44m.	£44m
Numbers of CHC patients	The recovery plan is reducing the number of over 75-year-old cohort coming into hospital in the first place. This will lead to a smaller number eventually being deemed eligible. If we could reduce eligibility by 10% it would release a further £25m.	£25m
Total	**There is the possibility of a double count across some of these headings. The total calculated is therefore an optimistic scenario, but we should aim to achieve it to bring the system back into line with other systems.**	**£109m**

Financial Impact and Next Steps

Summary of the impact of the financial measures underway

- Prior to this financial recovery we were already looking to improve the run rate. Action underway is:
  - Non-recurrent measures to address recurrent slippage in the providers (£13m);
  - The marginal benefits of additional Elective Recovery Fund (ERF) income arising from over-target delivery of elective activity within our in-system providers of (£10m)
- This recovery plan will contribute in three ways
  - It seeks to deliver as much a part year effect of the £109m opportunity as possible. Given the nature of CHC with patients often on care packages for many years, the impact will take some time to work through. However, we expect at least £20m of part year improvement as a result of this programme
  - The volume of +75 year olds coming into the acute sector will reduce, which will reduce the risk of further escalation cost, and potentially could reduce the costs we have built into the forecast
  - Additional benefits from the system's medicines project are expected to yield c£2m
- This will not be enough to deliver the break-even plan. Achieving break-even is a statutory duty that we would be failing, and so we will require conversations with regulators. Further options for cutting cost need to be considered and the impacts assessed and discussed.

What this means for 2024/25 and the longer term

- Failing to achieve financial targets in 2023/24 is a serious matter. We think we will be far from alone across the country, but this is not a pattern we can allow to set in.
- The positive aspect is that we are launching a programme now that will have a large full year effect for 2024/25. That narrows the gap we are facing for the coming year.
- However, this will not be enough. We are going to need either a large CIP for next year or further system savings. CFOs have discussed this, and we think that it will need to be a blend of these two things.
- Consequently, there are two next steps that we are asking to be supported by the system executive and then by the system Finance & Performance Committee:
  1. **Approve these actions, recognising that this will improve the 2023/24 outturn but not eliminate the deficit**
  2. **Support the development of the 2024/25 financial plan that builds on this work and seeks to achieve a balanced financial plan for the coming year**

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:	**19 October 2023**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Lynn Tolley, Director of Nursing – Maternity and Safeguarding					
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 October 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.	13/09/2023
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 at the meeting held on 13th September 2023 and the System Quality Group at the meeting held on 1st September 2023. The Committee fulfilled its role as defined within its terms of reference. Where appropriate, actions and oversight arrangements are identified within Appendix A.

A number of key programmes of work were discussed and the paper is intended to provide assurance to the ICB (Integrated Care Board) in relation to:

- Risk Register
- Working with People and Communities
- Health Inequalities
- Local Maternity and Neonatal System
- Continuous Quality Improvement
- Quality Impact Assessment
- Quality Dashboard
- Midlands Partnership University NHS Foundation Trust

(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 October 2023

1. Risk Register

1.1 The Quality and Safety Committee (QSC) received the risk register for assurance. No new quality risks have been added. Risk 115, Looked After Children Initial/Review Health Assessment (IHA/RHA) compliance, was discussed and acknowledged as a shared system risk. Since the QSC, system partners have agreed improvement actions to enable accurate and timely reporting, risk stratification of the case load to enable clear articulation of the risk, short term introduction of waiting list initiative and agreement for a long-term redesign. Further, NHS England have signposted the ICB to other systems to explore if any best practice/initiatives can be implemented locally.

2. Working with People & Communities

2.1 The ICB's approach to engagement is shaped by the Working with People and Communities Strategy and the core principals of engagement that were developed with the public. Overseen by the People and Communities Assembly, engagement activities held with patients and the public, partners and staff include:

- Engagement launched to support development of a system-wide policy for Continuing Healthcare.
- Completed targeted stakeholder mapping for three portfolios: Population Health Management, Children and Young People and Learning Disability and Autism. This included a stakeholder mapping session with the People and Communities Assembly.
- Launched engagement with partners and the public on the Quality and Safety Strategy.

3. Health Inequalities

3.1 The ICB's 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. Improving Population Health Portfolio Boards have been held in June and September 2023 and work is ongoing to understand and establish Place Boards in both Staffordshire & Stoke-on-Trent.

3.2 A deep dive into Health Inequalities took place in October 2023.

4 Local Maternity and Neonatal System (LMNS)

4.1 All providers continue to report operational pressures around workforce, however, there are positive recruitment programmes in place and proactive action is being taken to attract midwives into the Trusts working towards birth rate plus establishment. NHS England have released additional funding for obstetrics and neonatal medical staff. This will support the initiative to ensure obstetric teams can provide key aspects of care and serve to support the significant challenge with Neonatal Consultant absences.

4.2 The ICB undertook an Ockenden assurance visit to University Hospital of North Midlands NHS Trust (UHNM) Royal Stoke University Hospital in September 2023. Full findings are being shared with UHNM, however, despite the immense pressure maternity staff are under, they were complimentary of the leadership team. NHS England also commented on the significant improvements that have been made since the previous visit in April 2022. This has been verbally fed back to the Trust. Healthwatch Staffordshire and Healthwatch Stoke-on-Trent are planning to undertake a joint enter and view visit to the maternity and neonatal unit at UHNM in November 2023. NHS England Regional Chief Nurse will also be visiting on 9th November 2023 to look at the new Maternity Assessment Unit/Triage, a key action from the CQC section 29A warning notice.

4.3 The second System Maternity Oversight and Assurance Group took place with UHNM on 4th October 2023 following publication of the CQC report in June 2023. The meeting demonstrated that the Trust are making positive progress, including the official opening of the Maternity Assessment Unit and Triage area.

4.4 UHDB are part of the Maternity Safety and Support Programme in a voluntary capacity and currently awaiting the draft report from a CQC visit to both hospital sites in August 2023. Derby and Derbyshire ICB have shared initial feedback and commencing actions whilst awaiting the report.

5. Safeguarding Adults & Children

5.1 The Provider Collaborative for Safeguarding has now moved into the next phase of implementation and workstreams have been established to take the work forward across the system. The ICB's Director of Nursing – Maternity and Safeguarding has taken on the role of Senior Responsible Officer.

5.2 The ICB's safeguarding team responded to the Working Together to Safeguard Children consultation. The government were seeking views on how best to strengthen effective multi-agency help, support, safeguarding and child protection across the system.

5.3 Work continues in partnership with the Improving Population Health Portfolio in progressing the ICB's scale of readiness in line with the Serious Violence Duty. The Serious Violence Strategy is currently being refreshed and the formulation of a Violence Reduction Health Link Lead post is in process to work across the Integrated Care System, supported by grant funding through the Violence Reduction Alliance.

6. Continuous Quality Improvement (CQI)

6.1 NHS IMPACT (Improving Patient Care Together) has been launched to support all NHS organisations, systems, and providers at every level, including NHS England, to have the skills and techniques to deliver continuous improvement. The ICB and Core NHS Providers provided an initial baseline response to their approach at the end of August 2023. System partners have agreed to share submissions with each-other at the CQI Subgroup and consideration has been given to how the ICS can demonstrate progress against each of the 5 domains within the framework.

6.2 System partners are co-producing system-wide quality improvement training resources for people with lived experience to enable them to better engage and help shape improvement work across the ICS.

6.3 The ICS Quality Improvement Network continues to be well received with 60 people attending the most recent event on involving the people that matter in improvement work (Stakeholder Analysis), with a 12% growth in membership from last quarter.

7. Quality Impact Assessment (QIA)

7.1 The inaugural QIA Panel was held in August 2023 and three QIAs were presented including the Inpatient Mental Health Services Decision-Making Business Case. Following the meeting, to support a continuous improvement approach, a debrief was held and improvement actions have been put in place with a view of enhancing the efficiency of the panel whilst also to enabling the ICB to deliver its statutory responsibility.

7.2 Work continues to be undertaken to socialise the policy including 'lunch and learn' sessions which receive positive feedback. Feedback from these sessions has informed updates to (i) the ICB's Front Cover sheet to Committees and Boards, and (ii) the QIA template formatting and inclusion of prompts/considerations. In addition, a standard operating procedure has been produced to ensure consistency of approach, support resilience and provide business continuity.

7.3 Health system partners continue to work to explore system approaches that support collaboration and ensure that the system understands cumulative quality impacts aligned against system portfolio areas.

8. Quality Dashboard

8.1 QSC received the quality dashboard 2023/24 month 4 (July 2023) for information. The quality dashboard focuses on traditional measures of quality reported as part of the business cycle. As the system implements the Patient Safety Incident Response Framework and portfolios' delivery system priorities, the dashboard will evolve and reflect current system intelligence focusing on system-based approaches to learning, outcomes and health inequalities complementing the ICB's Quality Strategy.

9. Midlands Partnership University NHS Foundation Trust (MPFT)

9.1 The Care Quality Commission (CQC) have published their latest inspection into acute wards for adults of working age and psychiatric intensive care units. The CQC report confirms that satisfactory progress has been made against the section 29A warning notice, which as a result has been lifted. The report also sets out additional improvements which have been included within MPFT's existing action plan. The service remains rated as inadequate as the CQC revisit in June 2023 was not intended to result in a re-rating. The Trust's overall rating of good remains unchanged.

9.2 The ICB continues to work in partnership with MPFT and Shropshire, Telford and Wrekin ICB. The ICB continues to join MPFT's assurance spot check visits in collaboration with the Trust to identify if actions are embedded. The ICB's Designation Nurse (Adult Safeguarding) is a member of the Trust's Sexual Safety Working Group. Updates are reported by MPFT monthly to the System Quality Group.

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:	**19 October 2023**					
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:	Click or tap here to enter text.					

(1) Purpose of the Paper:
The purpose of this paper is to provide a summary of performance and finance received at 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)	27/09/2023
Finance and Performance Committee (S)	03/10/2023

(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.
Financial (CFO-assured)	The report provides a headline summary of the financial position. Failure of the ICS to achieve its financial duty to remain within its resource limit
Sustainability	None specifically identified pertaining to this report
Workforce or Training	None specifically identified pertaining to this report
Equality & Diversity	N/A
Due Regard: Inequalities	Click or tap here to enter text.

Due Regard: wider effect	Click or tap here to enter text.

(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 3rd October with discussion around the headlines and escalations. In particular, F&PC discussed:

- The Elective Recovery Fund threshold and Cost weighted activity target which has been reduced nationally based on the impact of industrial action.
- The Remedial Action Plans (RAPs) issued to Totally (NHS111 and GP Out of Hours) due to a decline in performance. The ICB have utilised contractual mechanisms to monitor delivery. The RAPs have not met satisfactory standards to provide assurance around delivery. The Urgent Care Portfolio are leading on managing this.
- Delivery against our "One Collective Aim" to reduce the number of Category 2 and 3 ambulance calls. Category 3 calls increased for the second consecutive month. The level of impact seen during 2023/24 on this objective will be linked to the growth of alternative pathway offers.
- The year-to-date deficit position of £58.6m, which is £45.0m adverse to plan at month 5 submitted to NHS England. Net risk is now materially worse than the £75m within the plan. After thorough review and discussions, we have concluded as a system that we no longer think we can hit a breakeven position at year end. A recovery programme is in place as a system to reduce the run rate deficit which was discussed as a separate agenda item.
- The capital forecast is as expected however medium-term challenges remain and require national monies to achieve plan.
- A large decrease in agency usage in July compared to June, mainly due to a decrease at University Hospital of North Midlands (UHNM). Within our system return for month 5 our forecasted agency spend is no longer in breach of our agency cap. The continued overuse of agency and bank staff is partly down to the retention of escalation beds longer than initially planned due to the ongoing urgent care demands as well as ongoing Industrial Action.

(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

Report to the ICB Board on Performance and Finance

ICB Board Meeting – 19 October 2023

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 5 position and an update on efficiency delivery.

The report was presented at the Finance and Performance Committee (F&PC) on 3rd October with discussion around:

- The Elective Recovery Fund threshold and Cost weighted activity target which has been reduced nationally based on the impact of industrial action.
- The ICB have utilised contractual mechanisms with remedial action notices issued to Totally (NHS111 and GP Out of Hours) due to concerns around performance. The Remedial Actions Plans have not met satisfactory standards to provide assurance around delivery. The Urgent Care Portfolio are leading on managing the risks and impact across the system.
- Category 3 calls increased for the second consecutive month impacting on delivery against our “One Collective Aim” to reduce the number of Category 2 and 3 ambulance calls. The level of impact seen during 2023/24 on this objective will be linked to the growth of alternative pathway offers.
- The year-to-date deficit position of £58.6m, which is £45.0m adverse to plan at month 5 submitted to NHS England. Net risk is now materially worse than the £75m within the plan. After thorough review and discussions, we have concluded as a system that we no longer think we can hit a breakeven position at year end. A system recovery programme is in place to reduce the run rate deficit which was discussed as a separate agenda item.
- The capital forecast is as expected however medium-term challenges remain and require national monies to achieve plan.
- A large decrease in agency usage in July compared to June, mainly due to a decrease at University Hospital of North Midlands (UHNM). Within our system return for month 5 our forecasted agency spend is no longer in breach of our agency cap. The continued overuse of agency and bank staff is partly down to the retention of escalation beds longer than initially planned due to the ongoing urgent care demands as well as ongoing Industrial Action.

Headlines Summary

- One Collective Aim - Category 2 calls show a 5.4% reduction on the previous month. Category 3 calls increased for the second consecutive month, rising by 10% on July, and 6% on the same month last year. Increases in falls and abdominal flank pain were the primary reasons for the increase.
- Urgent and Emergency Care (UEC) - Emergency Department (ED) Attendances have fallen for the third month and are 3.3% down on the previous month, but 3.3% up on the same period last year. Virtual Ward (VW) bed capacity is increasing in line with the trajectory however utilisation still remains challenged in the South East and the South West. North utilisation is currently over the 80% target.
- Tackle Backlogs (Planned Care) - Eliminating 104+ and 78+ week waiters (ww) has been impacted by industrial action, but downward trends are still evident. 104ww are below 5 across the ICB. At UHNM improvements have been made in 65+ and 52+ week waiters, currently each of these cohorts of patients is ahead of the plan.
- Diagnostics – Performance against the 7-core test plan (of 77.3% of patients to be seen in <6 weeks) was 71%, the third consecutive month below the plan. However, activity increased in five of the seven tests, when completed to last month. MRI and Gastroscopy were the only tests to have above plan activity this month.
- Cancer - The number of patients whose treatment started after 62 days (at UHNM in month) increased to 138, from 119 last month – directly impacted by the Industrial action (IA). The 28-day faster diagnosis pathway saw 72.1% of patients told within 28 days, above our local plan (69.1% in M4) but below the national standard of 75%.
- General Practice/Primary Care – Full time equivalent (FTE) numbers recruited into Additional Roles Reimbursement Scheme (ARRS) roles continue to increase month-on-month but remains below plan. Dental – Units of Dental Activity (UDAs) are increasing but are below the contracted number by YTD (by 211,101). The ICB are working with NHSE to understand the impact of in year commissioning changes.
- Complex individuals – Complex patient dashboard in development.
- Efficiency Delivery – The system cannot collectively deliver breakeven and, without additional action our deficit will be £141m. A series of recovery programmes have been identified and we are in the process of evaluating the financial impact (in year and recurrent) with a view to having a revised forecast outturn agreed for reporting at month 6.

Click on any underlined text for further detail.

Escalations Summary

- One Collective Aim – Category 2 calls reduced below 50% of the call volume for the first time since December 2022. Category 3 calls increased replacing 2/3 of the space created and occupied 21.8% of the call volume for August, the highest proportion since July 2021. Further analysis is required to identify if the projects within the system recovery plan are responsible for the reduction in Category 2, however the overall increase in Category 3 may be artificially skewed by what was an extremely pressured month both regionally and nationally.
- Urgent and Emergency Care – Focussed work by teams at UHNM and Acute Care at Home to identify suitable patients for Virtual Ward beds resulted in increased occupancy alleviated pressure within the system. Additional schemes to address/mitigate potential bed gap have been requested as further funding is being made available. There are NHS111 and General Practitioner (GP) out of hours performance issues, both have been issued with remedial notices. Remedial Plans submitted by the Contractor (Totally) have not met satisfactory standards and the issue was escalated to the F&PC in line with the contractual process. The Committee will be kept up to date on the risks and actions.
- Planned Care - The underlying 78ww position is improving however, UHNM are currently forecasting 104 78ww breaches in September. Without Industrial Action impact the expectation would be close to zero.
- General Practice/Primary Care – No additional funding has been provided for the General Practice Winter surge plan. Portfolio will need to resolve within current allocations.
- Complex Individuals – The performance indicators for Oliver McGowan training will not be met by 31st March 2024, however this is not unexpected, and a plan is in place for delivery over a three-year period. There are a small number of complex Young People requiring bespoke solutions not yet available in the market. Discussions are underway with a range of providers, with visits planned in some areas.
- Efficiency Delivery – We are working with the Regional Finance Director to prepare for national escalation.

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% day case /theatre 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
- Increased number of people accessing Improving Access to Psychological Therapies (IAPT) services
- 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

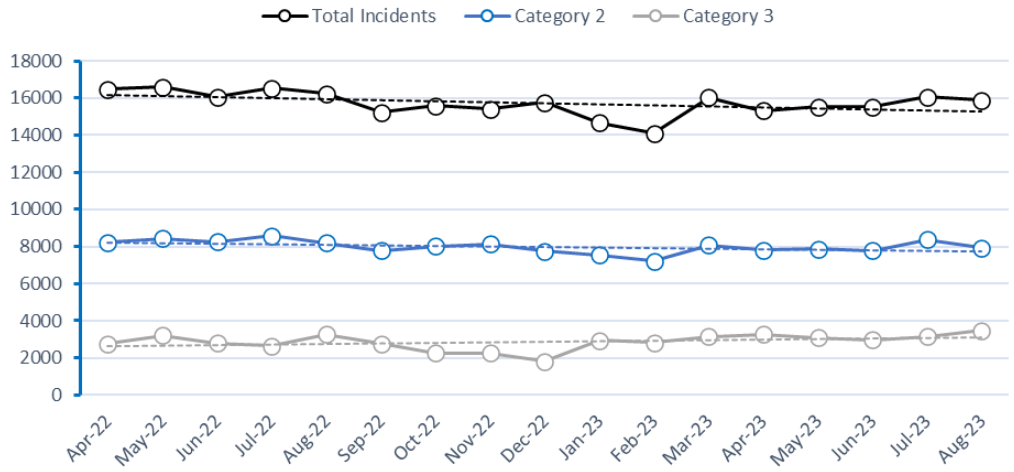
TRAFFIC LIGHT KEY:

- On track
- Deliverable behind plan, but mitigations in place to try and improve the position
- Behind plan and no mitigations identified as yet to improve position in year
- Complete
- Measure of success under review by the portfolio

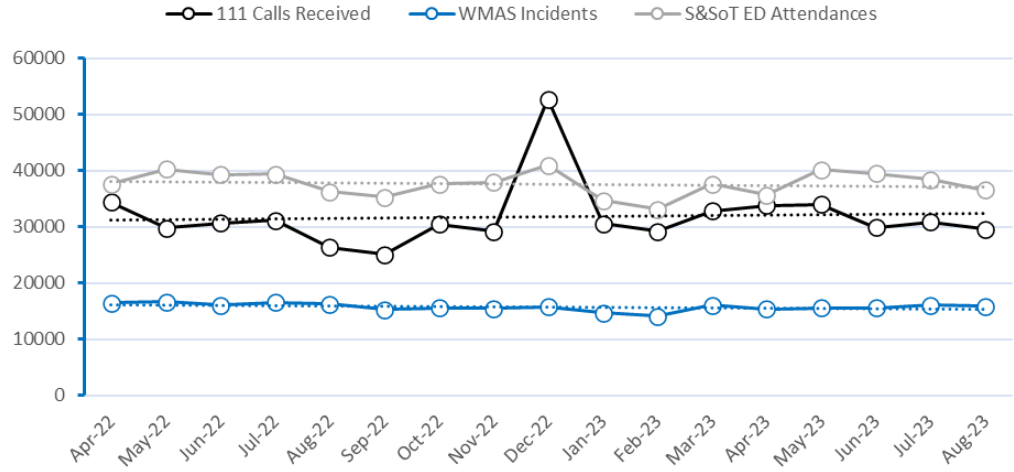
Exception reporting against our One Collective Aim

One Collective Aim	Key markers for success this month, actions and 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.*	• Category 2 calls show a 5.4% reduction on the previous month whilst Category 3 calls increased for the second consecutive month, rising by 10% on July, and 6% on the same month last year. • Most of the reduction within Category 2 calls can be attributed to calls designated as Medical or Breathing Problems. • Falls continue to be the largest proportion of Category 3 calls reported with over 21% of the total number in August, however increases were also seen in calls relating to Concern for Welfare and Abdominal Flank Pain.
	• Whilst Emergency Department (ED) Attendances have fallen for the third consecutive month, there were more attendances in August than the corresponding month last year. • The total number of 111 calls during August 2023 increased by 12.3% when compared to the same period of 2022/23, not repeating the reductions seen through August and September last year.
	• University Hospitals of North Midlands (UHNM) continue in Tier 2 of the national support mechanism, with continual monitoring against all Exit Criteria to gauge progress. • Monitoring against contractually agreed trajectories continues with Category 2 Mean Response times remaining below 30 minutes through the end of August 2023.

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



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**	• EDDI – (111 online and telephony bookings into ED) to be decommissioned on 30.09.2023 – extension being discussed but not confirmed – minimal impact anticipated due to flow through ED. Escalation is that Staffordshire and Stoke On Trent (SSOT) will not meet one of national mandates. • Remote monitoring solution for Virtual Ward Docobo ends 31/03/2024 – digital monitoring solution needs to be identified, recommendation and procurement ahead of March 2024 to continue delivering Virtual Wards. • In hospital – recognition of deterioration of 4hr and 12 hr performance up to July at UHNM. A Quality Improvement methodology is in place and will be escalated for action if improvement not seen by the end of October 2023. • Surge – Residual bed gap (with mitigations) currently stands at -24 beds – mitigations work ongoing with Frailty and Care Homes. Visibility of the Better Care Fund and system Financial Position required. System wide financial position including the position of the local authorities remains a challenge to developing plans. • The Royal Stoke University Hospital (RSUH Non-Admitted (NAD)/County Hospital Performance & Escalation Recovery Cell meetings continue with a focus on capacity and demand, standard work, and the engagement of senior medical colleagues. • UHNM Frailty Strategy including a focus on a newly implemented Frailty Same Day Emergency Care (SDEC) targeting a 30% reduction in admission of 75+ has now commenced with initial work underway to release senior geriatric resource to support front door turnaround.
2. Tackle Backlog (Planned Care) **Backlog reduction**	• 65+ week waits at UHNM were below plan in July (1,219 against a plan of 1,539). Decline has been lessened by the IA. • UHNM have remained stable in 78 week waits despite continued Industrial Action. However, Eliminating 78+ week waiters remains a significant challenge, 185 are forecast for the end of September across the ICB, 179 at UHNM. • 104+ week waits number 3 across the ICB (as at w/e 3rd September) and are forecast to be zero in September and October. • Diagnostic activity was below plan in July (across the 7 core tests) by 6.3%, MRI and Gastroscopy the only tests to exceed the plan. The percentage seen in <6 weeks (at 71.0%) increased (on June) but was below the plan (of 77.2%). • The number of patients whose Cancer treatment started after 62 days at UHNM increased in July to 138, but was below the plan of 162. From the latest UHNM position (w/e 10th September) the 62 day backlog is increasing (due in part to the IA) and is now 541, above their revised trajectory (of 491). • The 104 day cancer backlog (latest UHNM position (w/e 10th September)) has Increased to 153 but remains below the UHNM revised trajectory. • The 28 day cancer faster diagnosis standard (FDS) was above plan in July at both UHNM and across the ICB (for all Providers) but below the National Standard of 75%.

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 number of appointments within General Practice remains above plan for July 2023. • The % of appointments within 2 weeks from time of booking (within the 8 appointment categories) is above the Investment and Impact Fund (IIF) lower threshold (>85%) and has increased above the higher threshold (>90%) for June and July 2023. Sub-ICB comparison shows 4 out the 6 SSOT Sub-ICB locations are in the highest performing quartile nationally for this indicator. • July 2023 Did Not Attend (DNA) rate at 4.4% - lowest value since September 2022. • Additional Roles Reimbursement Scheme (ARRS); the full time equivalent (FTE) continues to increase month-on-month with July 2023 at 441.6 FTE, but remains below plan. A proportion of ARRS roles are currently not reported in the National Workforce Reporting Service (NWRS). Local data from the ARRS Claims portal suggests the FTE stands at 570.0 which exceeds the plan target for Q2.
4. Complex Individuals **Improving access to high quality and cost effective care for people with complex needs, which requires multi-agency management**	• All Age Continuing Care (AACC) is one of the key priorities for the ICS which focuses on a range of patient cohorts with complex needs including those with severe frailty and end of life. We spend significantly more per head than other systems on care packages. In July 2023, it was decided that a system approach would be applied through providers collaborating together to produce the way forward. Whilst the scope of the collaboration of providers evolves, the ICB continues to deliver against the four priority areas derived from the CHC Transformation Plan. All patients are safe and cared for and it is important to highlight that within all of this work that personalisation, patient experience, and safety are upheld with paramount importance at all times: 1:1 Reviews, Fast Track Pathway (including 48 hour discharge target), Backlog of 3 and 12 month framework reviews and Continuing Healthcare (CHC) verification of eligibility. • Access to NHS Talking Therapies saw an increase in June however the Q1 target of 7,367 was not met but July saw an increase on June; actions being taken to increase referrals appear to be working. • Access to Children and Young People (CYP) community mental health services was below the Q1 plan (by 4.6%) and the value for July also below the Q2 plan (by 9.5%). • The Dementia diagnosis rate continues to exceed the national target (by 4.9% in July), however it is below the plan stretch target [in July]. • Learning Disability Annual Health checks data for August shows performance at 23.6% - marginally below plan. • Palliative and End of Life 24/7 advice line phase one has been agreed to support people and professionals in sign posting patients. This is an excellent example of a provider collaborative working across a system. Phase two will look to triaging and coordinating patients from July 2024. • Long Term Conditions – the Chief Pharmacist has joined the End of Life Care, Long Term Conditions and Frailty (E.L.F) team to develop a comprehensive LTC strategy. This will be completed by December 2023 and ratified through the E.L.F board on the 15th December 2023.

Finance Summary

- At month 5, at a system level we are reporting a year-to-date deficit position of £58.6m, which is a £45.0m adverse variance against the £13.6m deficit plan (Month 4 –year to date deficit £48.7m; variance to plan £34.1m). We understand that this is currently one of the biggest variances across the Midlands Region, although we believe this may partly be driven by phasing of efficiency.

- The year-to-date variance to plan sits within the ICB (£33.4m) and UHNM (£11.7m) with North Staffordshire Combined Healthcare Trust (NSCHT) and Midlands Partnership Foundation Trust (MPFT) remaining on plan.

- The main drivers behind this variance remain consistent with prior months, being:
  - Slippage on efficiency programmes within the plan (£16.5m)
  - CHC and prescribing costs being over and above the inflationary assumptions used within the system plan submission (£15.2m)
  - Retention of escalation beds longer than initially planned due to the ongoing UEC demands within the system (£6.2m)
  - Industrial action in April, June, July and August, which impacted UHNM £3.4m over and above plan (£3.4m)

- In month we have had further costs within UHNM as a result of Industrial Action, with the net impact of this in August estimated to be £1m. Whilst we have seen signs of improvement in relation to the run rate of CHC costs in recent months, this has been offset by a further worsening of the run rate of costs within prescribing. This increased level of cost within prescribing is a national issue, with up to 95% of the cost increases appearing to be cost growth as opposed to activity growth. We understand that the prescribing inflation pressure is being experienced across all ICBs within the Midlands.

- We have completed a thorough review at month 5, assessing the run rate, the remaining plan and the risks and mitigations. We have concluded as a system that we no longer think we can hit a breakeven position at year end. We submitted a net risk at the planning stage of £75m which assumed a material level of mitigations. As at month 5 many of those mitigations have fallen away, whilst the risks remain real and at a similar level. We have worked through a set of recovery actions which were presented at F&PC on 3rd October and will be presented at ICB Board in October as a separate agenda item. We have meetings scheduled in month with the Regional Director to go through the position so for month 5 we are holding at £75m net risk, however we need to flag that the position is now materially worse than this.

- Capital reporting is on track with what was expected the capital plan was submitted for 2023/24. There are overspends regarding Project Star which are known to NHS England and which we are managing as a system.

Month 5 Position

- The general themes driving our financial position are CHC price & 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 continuing healthcare (CHC) challenges the system continues to face. Strong emphasis to close the efficiency gap remains, see the following slide. There is also a phasing alignment of Elective recovery funding (ERF) / Service Development Funding (SDF) against allocation receipts compounding the in month position.
- As well as the recurrent problems above, there was also a deterioration to the year-to-date position due to further industrial action in August, along with a continued increase in growth within prescribing which is an issue being faced nationally. During all strikes that have so far taken place we made a decision as a system to try and maintain usual activity levels and take on the additional costs required to make this happen.

	Month 5			Month 4		
System		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	1,840.5	1,849.9	9.4	1,482.3	1,485.7	3.4
Pay	(493.8)	(492.9)	0.9	(393.7)	(389.8)	3.9
Non Pay	(258.8)	(284.1)	(25.3)	(206.7)	(225.3)	(18.6)
Non Operating Items (exc gains on disposal)	(12.0)	(8.5)	3.4	(9.6)	(7.1)	2.5
ICB/CCG Expenditure	(1,089.6)	(1,123.0)	(33.4)	(886.1)	(911.3)	(25.3)
Total	(13.6)	(58.6)	(45.0)	(13.7)	(47.8)	(34.1)
			-2.4%			-2.3%

	Month 5			Month 4		
ICB		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Allocation	1,071.5	1,071.5	(25.3)	868.4	868.4	(18.6)
Expenditure	(1,089.6)	(1,123.0)	0.0	(886.1)	(911.3)	0.0
TOTAL ICB Surplus/(Deficit)	(18.1)	(51.5)	(33.4)	(17.6)	(42.9)	(25.3)
			-3.1%			-2.9%

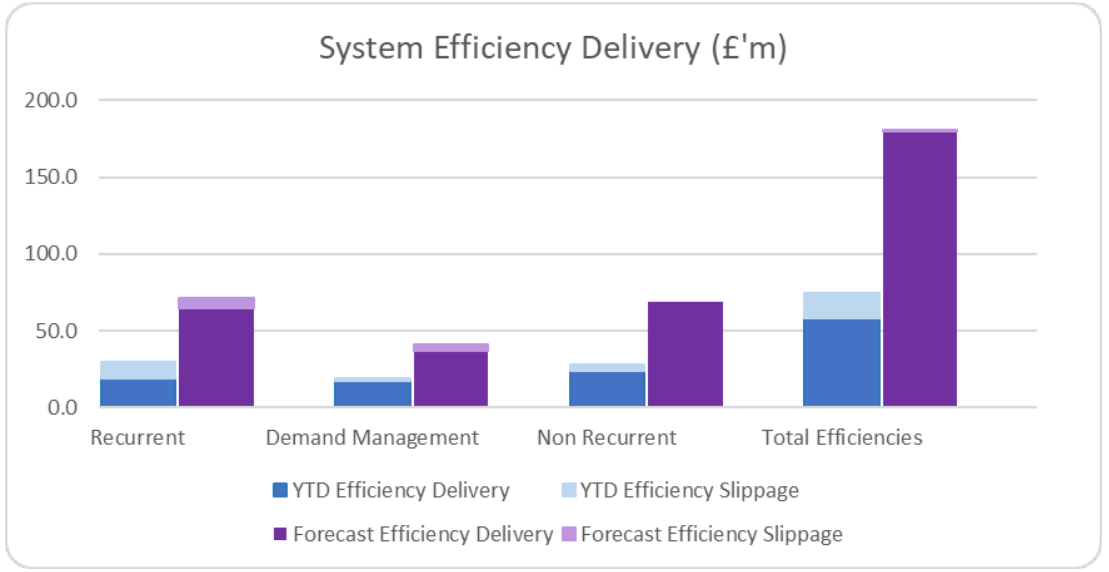
	Month 5			Month 4		
UHNM		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	439.3	449.9	10.6	351.5	355.6	4.1
Pay	(267.2)	(273.9)	(6.7)	(213.8)	(215.6)	(1.8)
Non-Pay	(157.6)	(175.0)	(17.4)	(125.7)	(138.3)	(12.6)
Non Operating Items (exc gains on disposal)	(11.6)	(9.8)	1.8	(9.3)	(8.0)	1.3
TOTAL Provider Surplus/(Deficit)	2.9	(8.8)	(11.7)	2.7	(6.3)	(9.0)
			-2.6%			-2.5%

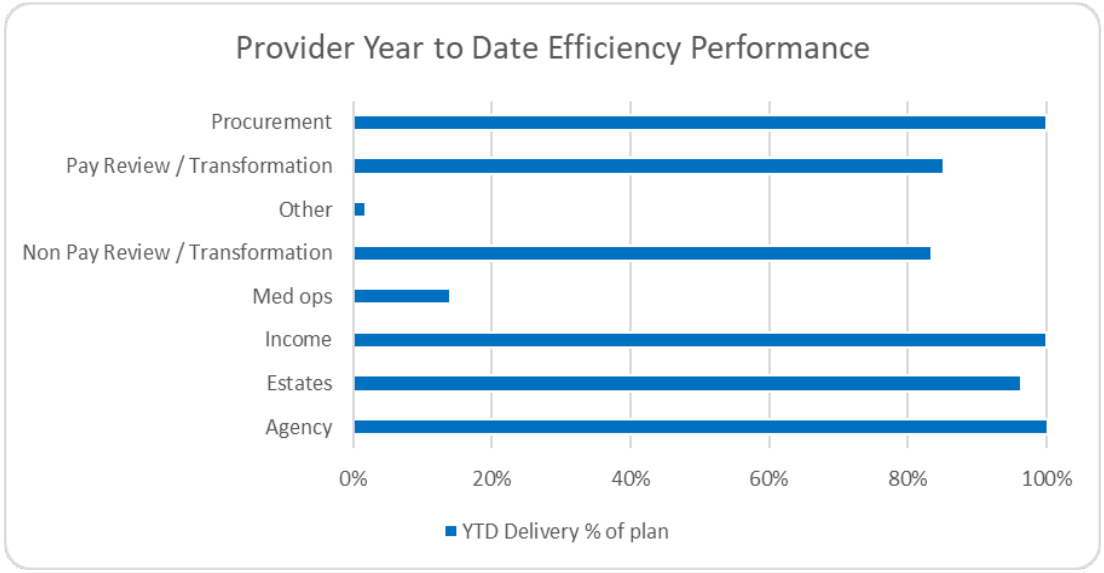
	Month 5			Month 4		
MPFT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	260.4	261.2	0.8	207.1	207.6	0.4
Pay	(187.6)	(180.8)	6.9	(149.0)	(143.8)	5.2
Non-Pay	(72.5)	(81.1)	(8.6)	(58.0)	(64.3)	(6.3)
Non Operating Items (exc gains on disposal)	1.1	2.1	1.0	0.9	1.7	0.8
TOTAL Provider Surplus/(Deficit)	1.4	1.5	0.1	1.1	1.2	0.1
			0.0%			0.1%

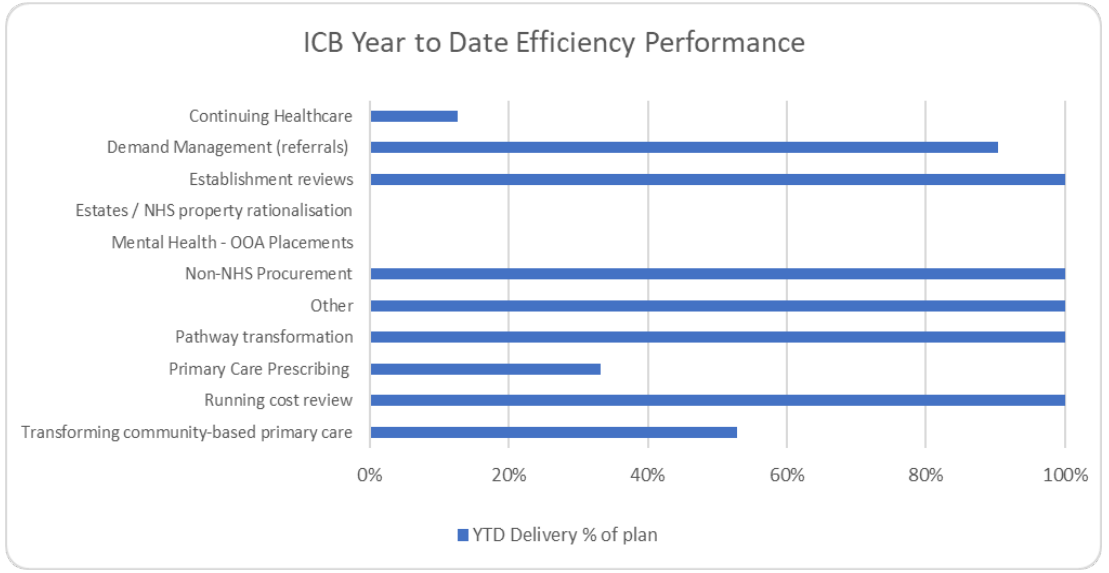
	Month 5			Month 4		
NSCHT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	69.2	67.3	(2.0)	55.3	54.1	(1.2)
Pay	(38.9)	(38.2)	0.7	(30.9)	(30.4)	0.5
Non-Pay	(28.7)	(28.1)	0.6	(23.0)	(22.7)	0.3
Non Operating Items (exc gains on disposal)	(1.5)	(0.8)	0.7	(1.2)	(0.8)	0.4
TOTAL Provider Surplus/(Deficit)	0.1	0.2	0.0	0.1	0.2	0.0
			0.0%			0.0%

Efficiency Delivery

- The system has delivered £57.9m of efficiency as of August 2023, 78% of plan, which is an 3% increase on last months delivery levels. Forecasts project the system will recover most of this position by year end, although there is a high 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 £10.6m shortfall of recurrent schemes at year end. All organisations have been ramping up assurance of a delivery into 2023/24 and the previously identified actions continue.







NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	3 October 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Risk Register	There are 27 risks on the System Risk Register of which, 21 are high scoring (12 and above) and there are 6 medium risks. The Committee approved: • The addition to the register of new Risk 151: Phasing out of the Emergency Department Digital Integration by NHSE • The closure of Risk 104: Scheme De-escalation Plans • The increase in risk score from 16 to 20 for Risk 123: Underlying Deficits from 2023/2024 • The reduction in risk score from 20 to 16 for Risk 133: Responsive Elective Care – Long Waiters (104, 78 and 65w). The Committee has good sight of the top risks for finance, performance and transformation.	
Integrated System Performance and Programmes Highlight Report	FPC noted the Month 4 performance position against the key metrics in the Operating Plan and welcomed the continued development of the Performance and Programmes report. The Committee received the report which contained: • Key headlines and escalations • An overview of programme delivery and exceptions • A placemat that demonstrated high level key metrics and deliverables within the	Board to note that Remedial Notices have been issued to Totally regarding performance issues with NHS 111 and GP out of hours services. The remedial plans submitted have not met the satisfactory standards and further work is ongoing between the ICB and the contractor. A further report will be brought to the November FPC meeting.

	2023/24 Operating Plan • Exception reporting against our One Collective Aim and 4 System priorities. The paper included a detailed set of appendices providing more information on: • Portfolio Programmes Highlight report • Efficiency Delivery Plan • National NHS objectives 2023/24 Performance. The Committee discussed the documents in the report relating to NHS111 and GP out of hours performance issues. Remedial Plans submitted by the Contractor have not met the satisfactory standards requiring escalation to FPC in line with the contractual process.	
Elective Care/Elective Recovery Plan	FPC receives monthly reports on elective long waits to provide additional focus and assurance regarding System performance and recovery. The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position. The expected target of zero 104 week waiters by the end of September wasn't achieved due to Industrial Action. This is now expected to be zero by the end of October. The report provided details on the long-waiters who receive elective care outside of the Staffordshire and Stoke-on-Trent System.	Actions relating to data quality continue to be addressed and the System is now reporting a more consistent position on long-waiting patients. The target to clear all 78ww by the end of September has become significantly more difficult due to industrial action. There continues to be good progress on the reduction of the 65ww cohort. However, UHNM are reporting concerns in some specialties and a detailed report at specialty level is being prepared.
System Finance Month 5 Report	At Month 5, we are reporting a year-to-date deficit position of £58.6m which is a £45m adverse variance against the £13.6m deficit plan. The Committee noted that the System is no longer likely to achieve a forecast breakeven position; having the System Recovery Plan in place will reduce the run rate deficit. The main drivers for this position are: • Slippage on efficiency programmes within the plan (£16.5) • CHC and prescribing costs being over and above the inflationary assumptions used within the System plan submission (£15.2m). Whilst we have seen signs of improvement in relation to the run rate of CHC costs in recent months, this has been	The Committee would like to highlight the deficit position at month 5 and level of risk within the plan. The net risk is now materially worse than the £75m within the plan, demonstrating the size of the challenge and need for the System to deliver on the Recovery Plan.

	offset by a further worsening of the run rate of costs within prescribing • Retention of escalation beds longer than initially planned due to the ongoing UEC demands within the System (£6.2m) • Industrial action which has impacted UHNM £3.4m over and above plan. Capital reporting is on track with the expectations when we submitted our capital plan for 2023/24. We have overspends regarding Project Star which are known to Region and being managed as a System.	
System Recovery Plan	The System Recovery Plan outlined the context and need for a recovery programme. It confirmed that the 7 areas of focus will be Management of CHC, Integrated Discharge, Admission Avoidance, Care Homes, Falls, Severe Frailty and End of Life and the underpinning projects. The opportunities and impact from these projects on our financial position, our patients and modelling of the potential bed savings and financial opportunities from CHC were also outlined. Appendices to the paper detailed projects and metrics supporting each theme. The Recovery Programme will reduce the 2023/24 projected deficit down from the forecast £141m and have a significant effect on our underlying problem. The plan outlined the approach to programme management, the workstreams and governance wrapped around the work including the role of our clinical leadership teams, digital, people and governance. Delivery will be through developing provider collaborative arrangements and delivery teams at project level.	The Committee approved the final Recovery Plan, which will come to Board for ratification. An escalation meeting with NHSE will take place on 11 October. Board to note the Committee's appreciation of the intensive work that has taken place over the summer to develop and gather support for the Plan, including the System Executive event on 29 September.
System Surge Winter Plan	The paper set out the System approach to mitigating the impacts upon all facets of the UEC system during periods of increased demand, specifically during the forthcoming winter period. The three core principles of the System approach are: • The System Capacity plan • The System Escalation plan	FPC approved the System Surge Winter Plan for ratification by the ICB Board. Board to note additional risk in October and November due to mobilisation. FPC will receive a monthly highlight report on Winter

	• The System Workforce plan The Plan covers the whole system, but the acute section focuses on UHNM and is based upon bed modelling predictions and the need to minimise impact on elective recovery. FPC approved £2.8m to support additional appointments in General Practice.	Planning delivery and spend.
Social Care Report	The paper provided information on the CQC's new regulatory powers to undertake independent assessment of local authorities' delivery of the statutory duties set out in Part 1 of the Care Act 2014. The CQC has released a framework that they intend to use for assessments. This comprises four themes and nine quality statements and Local Authorities will be rated as "Outstanding", "Good", "Requires Improvement" or "Inadequate". The paper provided details of the self- assessments completed by Staffordshire County Council and the City of Stoke-on-Trent in preparation for the assessment framework for Local Authority Assurance.	It is proposed that a Social Care report is presented to FPC bi-annually with the next report being presented in February 2024.
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 the development of the Business Case regarding Freestanding Midwifery Birth Units, Community Diagnostic Centres, the Cannock Transformation Programme and Urgent and Emergency Care – UTC Designation.	The Decision Making Business Case regarding East Staffordshire Inpatient Mental Health Services has been delayed due to the Tamworth By-election.
Digital Update	The quarterly update provided details of key achievements and a briefing for the Committee on the challenges, benefits and next steps for Integrated EPR.	
Intelligence Strategy	The paper provided assurance to the Committee on the progress of the development of a System Intelligence Strategy. The Strategy sets out the vision of where we want our data, business intelligence infrastructure and capability to be, in order to support delivery of the ambitions set out in our ICP Strategy and Joint Forward Plan and how we are meeting all national legislative requirements now and in the next 5 years.	
ICS Oversight	The Committee received for	

Framework Update	information the oversight letter following the UHNM Provider Review Meeting with NHSE and the ICB on 22 August.	
PART B		
Risk Register	The Committee reviewed the 7 risks on the ICB Risk Register of which 3 are high scoring (12 and above) and 4 are medium risks. The Committee approved the increase in risk score from 20 to 25 for Risk 121: Delivery of the 2023/2024 Financial Plan as it is now considered unlikely that breakeven can be achieved in 2023/24.	
ICB Finance Report (Month 5)	The paper reported an ICB year-to-date deficit position of £55.9m against a planned deficit of £19.5m, creating an adverse variance to plan of £33.4m. The net risk of £75.6m identified in the planning process was reliant on a number of assumptions regarding improvements to the run rate through further efficiency/CHC reductions; these mitigations have yet to impact the run rate. Prior to the agreement to the System Recovery Plan to be implemented from 1 October, the ICB faced a risk adjusted deficit of £117.6m for 2023/24, coupled with a deterioration in our ULP to £169.6m. The Recovery Plan measures will reduce the projected deficit and work is taking place with the recovery teams on the impact and to deliver the improvements. It was recommended that we continue to adopt a formal forecast of break-even for the year, following NHSE forecasting protocols, but continue to discuss with Region the point at which we move from a net risk position into a revised forecast outturn.	FPC approved the ICB's Month 5 forecast position of breakeven and noted the level of unmitigated risk being reported.
ICB Efficiency Performance	This 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 noted that current projections suggest a £69.6m efficiency delivery against the £93.1m plan; this variance represents a £1.7m improvement in forecast from Month 4.
ICB Procurement Operations Group Highlight Report	This paper reported the key activities being co-ordinated by the Procurement Operations Group. The Committee: • Supported the modification for an additional 6 months' provision to 3 contracts for the	

	Acute Visiting Service that were due to end on 30 September • Supported and endorsed the adoption of the proposed Due Diligence Questionnaire with an update to the ICB Procurement Policy, ahead of final approval at Audit Committee • Approved a Single Tender Waiver for £1.2m at Priory Group for a complex patient that is not covered within the system's TCP arrangements.	
Adult ADHD Position Update	The paper provided an update on the response to the level of activity and cost the ICB continues to incur as a result of Patient Choice, a contract awarded to a private provider, and the pathways put in place with MPFT and NSCHT and the emerging gap around prescribing under shared care.	NHSE is establishing a Task and Finish Group to oversee work across the Region on ADHD. Further work will take place on the SSoT ADHD pathway and continued communication with GPs. Work to take place on redesigning the Adult Autism and Diagnosis pathway.
Integrated Community Equipment Service (ICES)	The paper presented to the Committee: • Described the aim and objectives of the ICES • Provided an update on the completion of the contract novation • Provided an overview of current performance, activity and finance (2023/24) • Set out the details of future options for the service and recommended that these are discussed further at a meeting of the System Performance Group.	
Children and Young People's Mental Health Local Transformation Plan	The paper outlined the progress to date relating to the development of a refreshed version of the Staffordshire and Stoke-on-Trent Local Transformation Plan (LTP) for CYP Mental Health. This Plan acts as an anchor document for all CYP plans over the next 3 years.	The Committee approved the refresh of the annual Children and Young People's Mental Health Transformation Plan to enable publication on the ICB website which is an NHSE mandate.
Primary Care Access Recovery Plan	The paper provided the Committee with a progress update regarding the development of the Primary Care Access Recovery Plan. ICB's are required to develop a system-level pan for recovering access to primary care, which includes Primary Care Network action, funding and outcomes expected.	It is proposed that the plan will be presented to ICB Board in November with a further update presented in February or March 2024.
Primary Care Forum Report	In order to have governance oversight, FPC received a summary	Board to note that the Outwoods development in

	report of the meeting that took place on 12 September. This reported on the discussions on Primary Care finances and efficiency delivery, General Practice and Pharmacy, Optometry & Dental (POD).	Burton has been 'unpaused' by NHSE and a business case needs to be completed to allow the project to proceed. The Primary Care Centre element will receive around £8m to be spent by 31.3.25. Discussions are underway between the ICB, UHDB and Staffordshire County Council. Further report to come to FPC.

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.

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Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee (Part B)
Chair:	Shokat Lal, Non Executive Director
Executive Lead:	Alex Brett, Chief People Officer
Date:	Wednesday 13th September 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Q1 Workforce Report	Committee members received the workforce report for quarter one. This provided data around workforce size, sickness, leavers and statutory and mandatory training. Members noted the most common reason for sickness as stress / depression, the report does not differentiate between whether this is work or home related but they were assured by support the ICB has in place such as all the work being done around Freedom to Speak Up.	
Q1 Equality Diversity and Inclusion Report	Committee members received the quarter one Equality, Diversity and Inclusion report.	
Carbon Literacy – Addition to Statutory and Mandatory Training	Committee members discussed the possibility of adding a module around Carbon Literacy to the Statutory and Mandatory training catalogue. Committee members acknowledged this was in support of the NHS green plan and the work being done around sustainability but were concerned about the additional impact on staff due to the number of statutory and mandatory training modules that have been introduced. It was agreed that the leads for sustainability would meet with the CPO and lead NED for this work to discuss further.	
Finance Training and Development Policy	Committee members approved the updated Finance Training and Development Policy.	
Vacancy Control and Secondments Process	Members received an update in relation to the vacancy control process noting that there will be a vacancy control panel going forward, which will scrutinise every vacancy prior to recruitment and recruitment to fixed term / secondments will be done over a phased approach.	
Freedom to Speak Up Report	Members of the committee were assured by the report noting that these roles are more critical than ever given	

	recent events within the NHS. Committee members agreed to receive a report on a six monthly basis.	
HR Policies for Approval	The Committee approved the following: • Guidance Document – Supporting Employees with a Terminal Illness • Freedom to Speak Up Policy	

Risk Review and Assurance Summary