NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 18 May 2023
12.30pm-2.30pm
Newcastle Room, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

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

	Agenda Item	Lead(s)	Enc.	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact • Quoracy • Conflicts of Interest	Chair	Enc. 01 Verbal Enc. 02	S	12.30pm	1-4
2.	Minutes of the Meeting held on 20 April 2023 and Matters Arising	Chair	Enc. 03	A		5-14
3.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		15
4.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	12.35pm	
5.	Community Story		Enc. 05	I	12.40pm	16-18
	Strategic and System Development					
6.	ICB Chair and Chief Executive Update	DP/PA	Enc. 06	D/I	12.55pm	19-26
	System Oversight and Governance					
7.	Board Assurance Framework	CC	Enc. 07	A	1.05pm	27-33
8.	Quality and Safety Report	HJ	Enc. 08	S	1.15pm	34-54
9.	22022/23 Finance & Performance Report	PB	Enc. 09	D	1.25pm	55-68
10.	2023/24 Planning Update • Operating Plan • Financial Plan	PB	Enc. 10	R	1.35pm	69-130
11.	ICB Purpose, Vision and Mission and Statements	AB	Enc. 11	R	1.50pm	131-140
	Committee Assurance Reports					
12.	Quality & Safety Committee	JS	Enc. 12	S	2.00pm	141-143
13.	Finance and Performance Committee	MN	Enc. 13	S	2.05pm	144-148
14.	People, Culture & Inclusion Committee	SL	Enc. 14	S	2.10pm	149-151
15.	Audit Committee	JHo	Enc. 15	S	2.15pm	152-154
	Any other Business					
16.	**Items notified in advance to the Chair**	All		D		
17.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.20pm	
18.	**Meeting effectiveness**	Chair				
19.	**Close**	Chair			2.30pm	
20.	**Date and Time of Next Meeting** 15 June 2023 at 1.00pm in public – 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
Staffordshire and
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 12 MAY 2023

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

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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company.
1st April 2023	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing)	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.
3rd April 2023	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014-March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	No action required
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
3rd April 2023	Ms	Alexandra (Alex)	Brett	Chief People Officer	Midlands Partnership NHS Foundation Trust Staffordshire & Stoke-on-Trent 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.
4th October 2022	Mr	Neil	Carr OBE	Community Services Partner Member and CEO of MPFT	Midlands Partnership NHS Foundation Trust	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.	
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	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
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
1st April 2023	Ms	Mish	Irvine	Associate Director of People	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

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*
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.
19th April 2023	Ms	Megan	Nurse	NED	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	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	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 Communications and Corporate Services	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
4th April 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 - 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) interest recorded on the conflicts register
#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
1st April 2023	Mr	Baz	Tameez	Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
3rd April 2023	Mrs	Sally	Young	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

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

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

Staffordshire and Stoke-on-Trent Integrated Care Board

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

Thursday 20 April 2023
1.00pm-3.00pm
Newcastle Suite, 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		✓										
Sally Young (SY) Director of Corporate Services, Staffordshire & Stoke-on-Trent ICB		✓										
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		✓										
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		✓										
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓										
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓										
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓										
John Henderson (JH) Chief Executive, Staffordshire County Council		✖										
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓										
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 Foundation Trust		✓										
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✖										
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓										
Baz Tameez (BT), Staffordshire Healthwatch		✖										
Present:												
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, 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
Eric Gardiner (EG) Chief Finance Officer, North Staffordshire Combined Healthcare NHS Trust		✓										
Claire Cotton (CC)												
Gill Hackett (GH) Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓										

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Board meeting. DP advised that this was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP advised that the Leadership Compact document was included in the Board papers as a reminder that meetings should be conducted in accordance with the agreed principles. It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Jon Rouse, Buki Adeyemo (Eric Gardiner attending), Paul Winter and Baz Tameez. Before the meeting commenced, DP announced that it was Sally Young's last Board meeting. After 19 years of service to SSOT system she has made the decision to retire. He stated that it had been great to have her steady hand and values in place as the ICB formed last year. The Board thanked her for everything she had done during the period from July last year to get the ICB established.	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 16 March 2023**	
	The minutes of the meeting held on 16 March 2023 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED**.	
5.	**Action Log**	
	Actions were noted on the actions log.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	No questions had been received in advance of the meeting.	
7.	**ICB Chair and Chief Executive Officer Report**	
	DP recognised the publication of the Hewitt Report and receipt of that report. He stated that they now await the Government's response to that review. DP confirmed that they had processes in place to consider the findings of that report.	

	DP thanked all front-line staff across the system. He added that it has been another challenging period and was grateful to the workforce during that time. DP advised that the Joint Forward Plan was due to be published on 30 June 2023 and there would be further engagement planned in late May/early June prior to it ging through Health and Wellbeing Boards before being presented at the ICB Board meeting in June for approval. It was noted that the Integrated Care Partnership Strategy was published on 31 March which would work over the next five years to improve services for the communities of Staffordshire & Stoke-on-Trent. DP pointed out that several of the SSOT System Partners had been identified and shortlisted for various awards as part of the Health Service Journal (HSJ) Awards. On Finance for 2022/23 and subject to audit, the system had delivered a breakeven position and DP thanked PB and the CFOs and their teams across the system for the way this had been handled for 2022/23. PA reiterated the thanks for the hard work to land the ICP strategy which was available on the ICB website. PA stated that the Population Health Management (PHM) programme had taken another step forward following a successful procurement exercise and announced that Optum would be partners in providing the digital support. This now meant that better care and support could be tailored for individuals, design more joined-up and sustainable health and care services and make better use of public resources. Local health and care services could then design new proactive models of care which would improve health and wellbeing today as well as in future years. PA advised that the Operating Plan was on the agenda for later in the meeting. However, as it stood at the moment, it was challenging, but deliverable and achievable. PA's final point was on the Hewitt Report. He stated that it was an important document around the fundamental role of the ICB going forward. It touched on vital points and issues that they needed to work on. He confirmed that the Board would discuss this in more detail at the OD session in May. JHo highlighted the importance of having the ICP Strategy as an overarching strategy and asked where all the strategies sat and how they would contribute towards the ICP strategy. PA confirmed that the front cover sheets for all papers linked to each of the strategies and key expectations that would then link directly to the ICP Strategy. CB suggested that perhaps the JFP would give them that space to do this and use that schematic set out in the JFP. MN welcomed the improvements on cancer performance at UHNM and elective care. She confirmed that the F&P Committee monitored the performance of UHNM and care for residents in the ICB area. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
8.	**Living my best life with Autism: SSOT Strategy for Autistic Children, Young People and Adults 2023-2026**	
	CB advised that this strategy was a high-level strategic document that set out the vision and intentions for improving life in Stoke-on-Trent over the next three years for autistic	

	children, young people and adults. He added that it took a whole life course approach to improving outcomes from childhood into adolescence, adulthood and older age. CB reported that the ICB focus was in: • Supporting young people in preparing for adulthood. • Creating better physical and mental health and social care outcomes for people living more actively in their local communities. • Generating greater satisfaction for people using services and their carers He confirmed that it has been developed in partnership with partners and stakeholders and was a joint strategy with the City Council and the ICB. It had been through all the committees and, subject to approval today by the Board, it would go to City Council for approval implementation. CB explained that 1% of the population in Stoke-on-Trent were estimated have autism. However, there was a high level of overlap between people with autism and people with mental health. He detailed the extensive engagement in developing the strategy. In terms of oversight there would be an overview plan with a link back to the Autism Partnership Board. CB confirmed that the Strategy would be launched in May following the election. JR stated that this was an all-age strategy. It identifies some of the challenges that are faced. He added that the most important challenge was to ensure as many people with autism could fulfil their lives in the communities. He stated that he had an autistic daughter and therefore knew the barriers and challenges that were faced and he hoped that through this strategy they could do something different in Stoke-on-Trent to remove those barriers and all people with autism could fulfil their potential. DP commented that this document told the story through the lens of a service user and congratulated the team that had put this together. He asked if there would be a parallel strategy in Staffordshire. CB confirmed that the Staffordshire strategy had been developed pre-ICB days and both strategies took their time period to 2026. JHo felt that it was a good, clear document and welcomed the seventh additional local theme and that parents and carers would be able to see a clear path. HJ welcomed this strategy. However, she felt it was not clear whether people could have been missed already and should they be actively finding people who could benefit from this strategy. JR confirmed that they would ensure that went into the delivery plan. He agreed that those people had a right to the correct diagnosis. He added that there was a role in general practice and in employers to support and champion neurodiversity in the workforce and helping them to get right diagnosis and get the most from their lives as well. The Staffordshire and Stoke-on-Trent Integrated Care Board **APPROVED** the ICB Board 'Living my best life with Autism - Stoke-on-Trent Strategy for Autistic Children, Young People and Adults 2023 - 2026' to be published and implemented	
9.	**General Practice Five Year Forward Strategy**	
	CB thanked Sarah Jeffery as Portfolio Director for Primary Care, Paddy Hannigan as Clinical Lead as well as MN and JHo as non-exec directors, for their input on this strategy. He explained that the strategy aimed to continue its vital contribution to the health and wellbeing of the population and outlined the direction of travel for general practice in terms of how they would support its sustainability and development as well as playing a key role as a partner in the ICS.	

	CB stated that it was an ambitious document which would • Improve outcomes in population health and healthcare • Tackle inequalities in outcomes experience and access • Enhance productivity and value for money • Help the NHS support broader social and economic development PH stated that the strategy was a continuation of what had happened over the years. And he hoped it would take things forward for general practice and patients. JA welcomed the strategy and echoed the elements within it. He would like to encourage the system to work collaboratively as stated in the Fuller Report which had a latitude around collaborative working. JS fully supported the documents. Primary Care was in a difficult place and they needed to work hard with the 143 practices and PCNs going forward with this strategy. SF commented that there was mention in terms of access with a digital platform and stated that it should include the full access and that it was not intentionally excluded. JA reassured the Board that digital poverty and exclusion was in the forefront of their thinking. He confirmed there was a lot of collaborative work done around the system and was the engine room of care delivery. He commented on the work within the Peoples Directorate and suggested they should expand working with higher education establishments and engage with schools and other establishments to make it sustainable for the long term. CB agreed that technological development had a place in the service. He confirmed that 69% of appointments were face to face. JR welcomed the strategy. However, he felt there was a gap around continuous improvement, benchmarking, use of data exchange of best practice etc. He therefore hoped there would be a focus on driving continuous improvement. AB commented on the workforce development piece. She confirmed that it was very much in their thinking with educational institutions and they were working with the new Deans in the region on how the ICB could think differently in terms of workforce development, particularly in primary care. CB stated that they had a positive attribute of delivery but there was some variation and there was a role for the ICB to publish data back to PCNs and drive that improvement. JA referred to digital poverty and stated that it allowed primary care to take closer care of patients that were naturally at home. He assured the Board of the QI sub-committee was very much a new theme in general practice and training. He added that continuous improvement was mandated by the CQC and was in its early stages. DP thanked all those involved in developing the document. The Staffordshire and Stoke-on-Trent Integrated Care Board **SUPPORTED** and **APPROVED** the general practice strategy	
10.	**2022/23 PSED Equality Diversity and Inclusion Annual Report**	
	AB confirmed that the PSED Equality Diversity and Inclusion Annual Report it was already on the ICB's website in draft as it was a statutory duty of the ICB to publish it. She added that they would form an EDI action plan going forward.	

	The Board noted the work on neurodiversity and AB confirmed that they were actively working on this as well as the other protected characteristics. SL also confirmed that this was a legal responsibility. However, he would like to see more around delivery and stated that it would be good to put some targets and measures towards this for both the Board and the public to see the direction of travel in more detail. AB agreed that this was one of the recommendations and was part of the action plan and she would bring this back to the Board to assess. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the PSED report and **APPROVED** the report to be confirmed as the final version on the ICB website (currently in draft but compliant with the deadline)	
11.	**Board Assurance Framework (BAF)**	
	SY explained that the paper presented a review of the strengths and weakness of the BAF used in the first year of the ICB and was followed by the full BAF, updated by the risk owners for the final quarter of the 2022/23 financial year. SY explained that there were some inconsistencies within the report for the close down of the objectives, but detailed a review of the work to date and suggestions for improvement. In addition, the BAF development had been recognised as a good example of system working which the Risk and Governance Group had presented to the North-West ICBs and would be developed by the Good Governance Institute as a case study on the subject of system risk, for HFMA. CC gave an overview of the BAF for 2023/24. JHo confirmed that the Audit Committee's role was to give assurance to the Board. She acknowledged the hard work this year and felt that they were in a very strong position. She added that they needed to approve the strategic risks and acknowledged the three lines of assurance. MN felt it was very positive overview. She stated that if the Board agreed the BAF set out, she presumed that the risks could be changed or altered going forward. SY agreed that this was a dynamic document and they would be able to incorporate extra work or take something away if needed. CC agreed this was a real document and if there was something missing, they could take the opportunity to change it with a continual check and review. PA thanked CC and others involved in the process in developing the BAF. He commented that now they had the ICP Strategy etc. in place, they could see it all coming together. The Staffordshire and Stoke-on-Trent Integrated Care Board **DISCUSSED** the report and **APPROVED** the recommendations for improving the 2023-24 BAF Report and formally approving the 8 risks contained within the report.	
12.	**Quality and Safety Report**	
	HJ took the report as read and highlighted the following issues. HJ advised that UHDB were fined for failing to pride safe care and treatment to a patient and causing them avoidable harm following an incident on 15 July 2019. She confirmed that this was a Staffordshire patient and assured the Board that they were working to maximise the opportunity to learn from this incident.	

	At UHB following concerns raised in December 2022 relating to patient safety, leadership, culture and governance, three independent reviews had been commissioning focusing on:- • Patient safety and governance (Bewick Review) - commissioned by NHS Birmingham and Solihull ICB and overseen by an experienced senior independent clinician, Professor Mike Bewick, former NHS England Deputy Medical Director. • Well-Led review of leadership and governance – in conjunction with NHSE, using an established methodology. • Culture - commissioned externally by UHB's Interim Chair and incorporating findings from the above reviews. WMAS – the CQC carried out an unrelated review of WMAS during November 2022. The full report was published on 15 March and she confirmed that there was nothing that the Quality Team we were not aware of or already dealing with. She assured the Board that they would continue to do the ongoing improvement work. Ivetsey Bank Hospital remains closely supported by the Provider Collaborative at Birmingham Women's and Children's NHS Foundation Trust with 2 further issues identified for escalation. There has been publication a three-year single delivery plan for Maternity and Neonatal care was published on 30 March 2023 and sets out how the NHS would make maternity and neonatal care safer, more personalised and more equitable for women, babies and families. The plan was framed around 4 high level themes: • listening to women and families with compassion • supporting our workforce • developing and sustaining a culture of safety, and • meeting and improving standards and structures that underpin the national ambition HJ reported that since the report had been written there were two further items that she wished the Board to be aware of:- 1. She acknowledged that MPFT had been awarded university status. 2. UHNM had been awarded NHS Plus Quality Awards for international recruits. JS confirmed that she has nothing further to escalate to the Board from the Quality & Safety Committee. The Staffordshire and Stoke-on-Trent Integrated Care Board • **RECEIVED** the report and sought clarification and further action as appropriate • **WERE ASSURED** in relation to key quality assurance, quality improvement and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.	
13.	**2022/23 Performance and 2023/24 Plan**	
	PB briefed the Board on the key points for **Finance** • PB confirmed that all system partners had closed down the finance and all had delivered a break-even position for 2022/23. This would then go through Audit and back to Board once the audit had been completed. It was understood that nationally many ICBs were struggling to achieve break-even. • Pressures were increasing in both CHC and primary care prescribing however mitigations had been identified PSm briefed the Board on the key points on **Performance**	

	• Pressures in Urgent and Emergency Care remained in line with January; flu, RSV and Covid admissions continued to decline. • Ambulance handover delays of over 60 minutes reduced by 41%. As of to day 90% reduction of hand over delays. • The national target to eliminate 78+ week waits by March 2023 will not be achieved. As at w/e 12 March 901 breaches are recorded. • As at w/e 12 March 71 104+ week waits are recorded. As set out in the CEO report. We have moved into tier 1 oversight approach and will build a clear path to ensure that there were no 65 ww by March 2024. • In Cancer, 89.2% of patients were seen within 2 weeks (national standard is 93%). • GP appointments, Social Prescribing referrals and Learning Disability Annual Health Checks were on track to achieve their year-end targets. PSm confirmed that they held a learning event at the end of March and the outcome of that was being used to form the planning for the year ahead. PB confirmed the main points on the **NHSE Activity Submissions** • UEC – Complaint • Planned Care – Partially compliant • Workforce - Compliant • Finance – Not compliant PB briefed the board on the key points on the **2023/24 Operational Plan** He confirmed that a first draft of the 2023/24 one-year plan based on work to date with leads and portfolios had been developed and shared with feedback required by 19 April. Completion was on course and was being presented to SPG the following week and would be coming back to the Board in May. PB advised that there was an escalation meeting to meet the National Team to talk through where they currently were. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
14.	**Freedom To Speak Up (FTSU)**	
	SY updated the Board on the work for Freedom to Speak Up (FTSU), with the arrangements that had been put in place to support members of staff to speak up regarding any concerns they had in relation to the ICB. She confirmed that the ICB were committed to providing support to anyone who wished to raise any concerns and to assure them that anything they raised was treated in the strictest confidence and with their consent and that they would not be treated any differently in any way. SY added that contained within the papers was the new NHSE Freedom to Speak Up Policy that all Trusts were asked to adopt by January 2024. She asked the Board for approval to assign one of the NEDs to be the lead NED for Freedom to Speak Up and to agree that a further Freedom to Speak Up Guardian, who was not in an Executive role, was nominated They had also expanded the mandatory training to staff to include three new modules focused on freedom to speak up. DP confirmed that there was complete agreement from the Non-Executive Directors to assign an NED to that role.	

	The Staffordshire and Stoke-on-Trent Integrated Care Board • **Ratify** the Freedom to Speak up Policy and support the ongoing work for speaking up • **APPROVED** the proposal to assign one of the NEDs to be the lead NED for Freedom to Speak Up • **AGREED** that a further Freedom to Speak Up Guardian, who was not in an Executive role, be nominated.	
15.	**Assurance Reports from Committees of the Board**	
	Quality and Safety Committee Dealt with as part of the previous business. Finance and Performance Committee Dealt with as part of the previous business. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the Committee Assurance Reports.	
16.	**Any Other Business/Close**	
	No other business	
17.	**Questions from the floor relating to the discussions at the meeting**	
	Mr Ian Syme **1.** A question regarding children, young people, eating disorders, routine cases, national standard yet again not attained. What are we talking about here? Is there a national standard that doesn't apply to the ICB or is it national, or does the ICS ICB area have not been attaining the routine cases of eating disorders - could I have clarification on that please and if it is the responsibility of our area, how are we going to get back on track of attaining the standard? *CB responded:* *There are two measures for timeliness around CYP with eating disorders. Routine cases, and then there are urgent cases. With the routine cases, there is a national target of 95% of routine cases need to be seen within four weeks. We are currently projecting that will be about 76/77% and will be falling slightly short. They tend to be very low patient numbers here. You often find that one or two patients makes a significant difference to the to the percentages as the reporting. We do then review each breach and we know within the breaches we have got that the delay over 4 weeks is because there has been a conversation between CAHMS and the eating disorder service to make sure that the patient is on the right Pathway. The reported level of performance is below the national target. Each of those reviews are reviewed at the point the breach occurs.* *CB referred to the planning submission for the 2023/24 operational plan there are a range of mental health measures where we have submitted green plans against all of those with the exception of IAPT and there is a particular set of reasons why that is the case linked to some national issues. CB confirmed that going forward, they did expect to be achieving the national standards*. **2.** With regard to Q&S Report and safeguarding and looked after children's situation where children are not receiving timely reviews of their health assessments. Will whatever the outcome of your investigations be reported publicly? *HJ responded:* *Historically what we have reported has been near compliance with the required rate. However, in last month's board report, we highlighted a significant drop in the compliance data which when we looked at it does not tally with the data that our two local authorities*	

	hold. It is essential that we fully understand the correct position and I am exploring this at the moment with colleagues across the other ICBs. While the majority of chief nurses have got a similar problem, we are doing a collective piece across the region to look at how we can make sure there is a standardisation of that data and a standard understanding. When we have done that piece of work and confident that we know exactly what the position is, whether that be a more positive one or whether it is not, we will report that back as part of the normal quality and safety process. It will go through the safeguarding forums, through the quality and Safety Committee and then come up to Board once we know the full outcome. **3.** Section 42 timescales backlogs – I have looked at Derbyshire as I can't find anybody else's practice guidance and they talk about 24 hours within receiving an inquiry or the next working day there will be either actions or clarification and we've got timescales for Section 42. What kind of time lapses are happening and with safeguarding? If looked after children are resident, never mind where they have come from but are resident in care. Who leads on safeguarding for those individuals resident and care in Staffordshire and who is responsible for safeguarding Staffordshire residents placed outside the Staffordshire Stoke-on-Trent area and how do you coordinate the safeguarding situation? *HJ covered a brief response, but offered to have a conversation outside of the meeting to go into more detail.* *The Section 42 enquiries are for safeguarding adults. In terms of the standards, it is less of an issue about meeting our own standard but more of an issue about the fact that historical practices have led to a place where quite a lot of the Section 42 work that comes our way probably should not. So again, we are redefining the responsibilities and trying to understand who does what to make sure that the limited capacity that we have got within the safeguarding team and the ICB is appropriately and correctly used to undertake the health aspects of any such enquiries.* *With regard to the looked after children and who makes sure that the well-being of the looked after children is overseen and it depends on who has placed them. If health has placed them, health become the corporate power and take no responsibility and if social care have then social care will, although it is much more complicated than that.* *From a health point of view, we pick this up through the Health Safeguarding Forum, which is just being revisited to make it a more formal subcommittee of the Quality and Safety Committee with a link through me to the Safeguarding Children's Boards in both Staffordshire and Stoke on Trent and make sure that the communication is there and that we are highlighting any concerns in respect of any aspect of the looked after children's agenda.* Ian Syme asked for outside communication on these for extra clarification.	
18.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact and closed the meeting at 3.00pm	
19.	**Date and of Next Meeting**	
	18 May 2023 at 1.00pm via Newcastle Room, Beaconside Conference Centre, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF	

DATE	ITEM	AGENDA ITEM	ACTION	ACTION OWNER	UPDATE
24/04/2023			THERE WERE NO ACTIONS RAISED FROM THE MEETING ON 26 MAY 2022		

DUE DATE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**Community story: Integrated Medicine Management - what could it look like?**

Meeting Date:	18 May 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Tracey Shewan, Director of Communications and Corporate Services		Imogen Crouch-Hyde, Communications and Engagement Manager

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

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

Purpose of the Paper (Key Points + Executive Summary):
This presentation is about Andrew's community pharmacy and how he and his team go the extra mile to support their local community.

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

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

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

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

Recommendations / Action Required:
The Integrated Care Board is asked to: Listen to Andrew' story and consider his suggestions from more integration across the system.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**06**

Title:	**Chair and Chief Executive Officer Report**

Meeting Date:	18 May 2023

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

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

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

Purpose of the Paper (Key Points + Executive Summary):
This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent system that are not reported elsewhere on the agenda. Specifically, the paper details a high-level summary of the following areas: **1. System & General Update** **2. Finance** **3. Planning and performance** **4. Quality and safety**

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

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

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

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The Board will need to consider this statutory duty and how we reduce these.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1**	**N**	

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

1.0 System and general update

1.1 NHS Agenda for Change Terms and Conditions of Services (TCS).

The NHS Staff Council trade unions have confirmed the outcome of their individual ballots. They recommended that the pay offer made to them by the government should now proceed to be implemented. Employer representatives noted the individual trade union positions and endorsed the recommendation of the NHS Staff Council trade unions. NHS Employers will be publishing new pay scales for 2022/23 and further resources to support the implementation of the offer.

1.2 BBC Make a Difference Awards

The Integrated Care Board's Learning Disability and Autism team have been shortlisted as finalists in the 'Together' category at BBC Radio Stoke's Make a Difference Awards 2023. The team were nominated by the Pegis parent carer forum, who said of the team, "They have moved away from their office and engaged with the community, truly listening to what people with lived experience say. Whilst listening, they are reflecting on their practice and building a service and community which will support our loved ones". In addition, the Homeless Healthcare service, commissioned by the Integrated Care Board, in partnership with Stoke-on-Trent City Council and Newcastle-under-Lyme Borough Council, has been shortlisted as a finalist in the 'Community Group' category. The awards ceremony will be held on 16 September.

2.0 Finance

The system was able to deliver a small surplus for 2022/23, which is a slight improvement on the forecasted breakeven position. This is subject to any material audit issues emerging. Nationally we understand that many Integrated Care Boards (ICBs) struggled to get to a break-even position. The 2023/24 Operating Plan, supported by the finance, activity and workforce plans, was submitted to NHS England on 4 May. Work by all four system partners resulted in improvements to the individual plans and the plan was submitted with a system-wide breakeven position, with net risks totalling £76.2m. Work will continue into the new financial year to further develop the efficiency plans and mitigate the risks, which underpin the current plan.

3.0 Planning and performance

3.1 Elective care

Elective Waits (104, 78 and 65 week waits (ww)): As reported last month, University Hospitals of North Midlands (UHNM) is now in tier 1 reporting with NHS England (NHSE) for Elective care. Weekly meetings take place between the Trust, the Integrated Care Board (ICB) and NHSE. Long- waiters continue to be a challenge for the system.

At the end of April, the number of patients breaching the 104 week wait position was 50; the forecast position for the end of June is 16. The number of patients breaching the 78 week wait at the end of April was 586; the forecast for the end of May is 389.

Mutual aid from external providers is still being offered by the Royal Orthopaedic Hospital and work is ongoing in supporting patients to take up this offer. This work is being supported by the national Getting It Right First Time (GIRFT) team. Elective activity cancellations due to Industrial Action and issues relating to insourced providers have hampered efforts over recent weeks, however the latter issue has now been resolved. Following constructive meetings with a range of

independent sector providers, additional capacity has been sourced for the remainder of the financial year to support clearance of the 65 week wait cohort. This has generated sufficient confidence for the system to submit a compliant plan to NHSE to have zero 65 week waits by the end of March 2024. Work within the Trust to improve theatre throughput and productivity is showing early signs of improvement.

Cancer performance: University Hospitals of North Midlands (UHNM) continues to make good progress on cancer care delivery, but a deterioration in 62-day standard performance has resulted in further scrutiny. However, there is still confidence that the Trust will achieve the "fair share" allocated target.

Diagnostics: The system has submitted a business case for a large community diagnostic centre in Stoke-on-Trent and feedback on this is awaited. There are ongoing pressures in a range of diagnostics, including endoscopy and echocardiology. Both are being mitigated through the insourcing of additional capacity at University Hospitals of North Midlands (UHNM). The impact will be closely monitored as trajectory in these diagnostics does not currently deliver the requirements of the system.

3.2 Urgent Care

Operations:

- 111 have performed well this month. The Emergency Department (ED) and Ambulance validation has been in place at all times.
- There has been good progress with ambulance delays, including the lowest recorded number, in the last 16 months, for patients waiting over an hour to be handed over.
- At Royal Stoke there was a 61% reduction in patients waiting over an hour to be handed over. At UHNM, 93.42% of patients waited less than an hour. This is an improvement on the 88.82% that was recorded in March.
- A COVID-19 spike at the beginning of April impacted on patient flow and meant a number of beds had to have Infection Prevention and Control (IPC) restrictions.
- There has been a reduction in 12-hour breaches from the 2009 in March, to 1409 in April.
- PoLR (Provider of Last Resort) had reduced to five by the end of April, and zero at the beginning of May.
- On average in April there were 35 complex discharges daily from University Hospitals of North Midlands (UHNM).
- Despite both Industrial Action and Bank Holidays this month, the system has performed well. The system approach and collaborative working has proved to be a success.

Delivery:

- The system continues to work collaboratively to ensure that surge capacity is deployed appropriately for periods of increased demand; arrangements for the May Bank holidays are in place.
- System partners are working with Integrated Care Board (ICB) colleagues to ensure timely de-escalation of capacity, with a Senior Responsible Owner (SRO) level forum convened to ensure timely de-escalation of currently open bed capacity, while ensuring adequate resource to safely meet increased demand. Regular reporting regarding de-escalation and surge capacity will be imminently commenced to provide oversight and ensure coordinated management of resource.

- The system Urgent and Emergency Care (UEC) Strategy development work continues, with Integrated Care Board (ICB) leads undertaking engagement and development work with key system forums.
- Underpinning the Urgent and Emergency Care (UEC) Strategy is the new UEC governance structure, sitting under and reporting into the UEC Board. This continues to embed with all sub-groups and workstreams, providing monthly highlight reports to the UEC Board. The System Delivery group has been refreshed and now meets monthly, with extraordinary meetings as required.
- Work continues on the seven-system high impact programme areas with good system engagement and initial progress observed.
- System work continues regarding the future provision of Urgent Treatment Centres (UTCs) with a follow-up system technical event to be held on May 25. The follow-up event seeks to build upon the progress made across the system and to refine proposals with additional data, information, and intelligence. All system partners will be represented and agreed recommendations and outputs will be collated, with a final briefing paper circulated after the event.
- A Short Form Business Case, completed with input from system partners to secure capital funding for an additional 45 General and Acute (G&A) beds at the Royal Stoke site has been completed and submitted to NHSE. The capital scheme represents a key mitigation within the system Urgent and Emergency Care (UEC) Recovery plan to provide additional capacity during Winter 2023/24. Accelerated work has been completed to ensure that timelines are adhered to, but there remains a risk regarding mobilisation of the capacity, which is being closely monitored and expedited where possible.
- The Delivery Team continue to work with West Midlands Ambulance Service (WMAS), the Black Country Integrated Care Board (ICB) (host commissioners), region and system partners with regards to the Category 2 response time trajectory. A revised submission has been made following consultation with ICBs across the West Midlands.
- Planning for the Integrated Discharge Hub implementation proceeds at pace. A whole system engagement event, hosted by University Hospitals of North Midlands (UHNM), takes place on 24 May. The Integrated Discharge Director post is out for recruitment.
- Concerns remain around the regional 111 model that is going out for tender with regards to increase finance, workforce and touch points for patients. The team continue to work through the proposal and have escalated to regional colleagues.
- Relationship building with interdependent portfolios continues and requires further work to build an infrastructure of mutual support, accountability and delivery.

3.3 Key figures for our population:

	Dec-22	Jan-23	Feb-23	Mar-23
* **111 calls received**	52,748	30,580	29,179	31,860
Percentage of 111 calls abandoned	35.0%	8.3%	4.5%	14.0%

	A&E and Walk in Centre attendances (University Hospitals of North Midlands (UHNM))	22,180	18,739	17,923	20,545
	A&E and Walk in Centre attendances (other providers)	18,862	16,006	15,271	17,090
	Non elective admissions (UHNM)	7,038	6,958	6,527	7,878
	Non elective admissions (other providers)	5,383	5,479	5,034	5,722
	Elective and Day Case spells (UHNM)	5,955	6,828	6,494	7,960
	Elective and Day Case spells (other providers)	6,653	7,782	7,611	8,544
	Outpatient procedures (UHNM)	3,848	4,213	4,390	4,549
	Outpatient procedures (other providers)	6,441	7,763	7,014	7,854
	GP Appointments (all)	469,981	520,189	485,869	557,712
**	**Physical Health Community Contacts (attended)**	121,165	136,805	122,545	137,205
**	**Mental Health Community Contacts (attended)**	37,120	46,330	42,450	

All datasets subject to change - latest months are often refreshed and can therefore change

**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 can sometimes be one month behind the other datasets*

4.0 Quality and safety

4.1 LeDeR – Health Passport Campaign

On 27 February 2023, the Health Passport Campaign went live across all our social media pages for a one-month period. The Health Passport was a key action from our Learning Disability Mortality Review (LeDeR). It arose during COVID-19 when individuals with Learning Disabilities were becoming increasingly unwell and conveyed to acute settings without their usual support

and those who knew them best. The Health Passport is pre-populated with the individual's preferences and includes subjects such as communication, medications, carer details as well as favourite food, pastimes, and usual strategies employed for managing anxiety, etc. The campaign was supported by an animation and a short video which raises awareness of the Health Passport and a suite of documents including easy read leaflets, posters and flyers.

Access to on-line resources can be found via the following link.

The initial evaluation from NHS Midlands and Lancashire Commissioning Support Unit (MLSCU) showed us that the campaign has been extremely successful in terms of outreach, comments, links to the site etc. Further evaluation will take place and all learning will be shared.

The Health Passport and other successful initiatives will be celebrated at the LeDeR conference planned for June 2023.

4.2 Maternity Independent Senior Advocate

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 ICB has successfully recruited for this post with an expected start date at the end of June.

4.3 Multi-Vitamins in Pregnancy

The universal provision of multi-vitamins in pregnancy has been successful locally. As well as being provided by midwives, the vitamins are also available at the 0-19 clinics, Family Hubs and Children's Centres. Midwives that may be working from these clinics are able to make use of these supplies as well and this has helped raise awareness of how pregnant woman can access these for free.

The next stage is to further improve the awareness of the vitamin drops for children. This is not a universal scheme but is via the Healthy Start Scheme. Locally, there is work to improve the uptake of vitamins for families who are eligible.

5.0 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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**07**

Title:	**Board Assurance Framework -update**

Meeting Date:	18 May 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Sally Young/Claire Cotton	**Y**	**Jane Chapman**

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

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

Is the Board being asked to make a decision/approve this item? No			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

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

Purpose of the Paper (Key Points + Executive Summary):
The paper provides the Board with a brief update on the development of the BAF risks, identifies the BAF Risk Owner and Lead Committees with responsibility for providing assurance to the Board. The paper also sets out the annual cycle for Committee and Board presentation of future reports.

Is there a potential/actual Conflict of Interest?	**No**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/A	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
All risks link to one or more BAF risks

Implications:	
Legal and/or Risk	BAF forms a key part of the Risk Management Strategy

CQC/Regulator	Considered and N/A
Patient Safety	BAF Risk 5
Financial – if yes, they have been assured by the CFO	BAF Risk 6 & 7
Sustainability	BAF Risk 7&8
Workforce / Training	BAF Risk 8

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**No**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1** • **Stage 2**	**No**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **The paper does not propose a change to patient services or staff conditions**		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**No**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**No**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: **Be assured that the process for the BAF risk management in on track to provide quarterly Committee / Board reporting.**			

1. Introduction

A development and engagement process has been undertaken with the Executive Team and the Board to develop the Board Assurance Framework (BAF) for 2023/24. This resulted in an outline framework which identified eight broad strategic risk themes which pose a threat to the four Strategic Ambitions, which were approved by the Board in April 2023.

Upon agreeing those strategic risk themes, it was recognised by the Board that the framework would then need to be developed into a full BAF outlining risks, controls, assurances and actions (appendix 1) and that a quarterly development / review and reporting process would be initiated. During May 2023, this process has commenced.

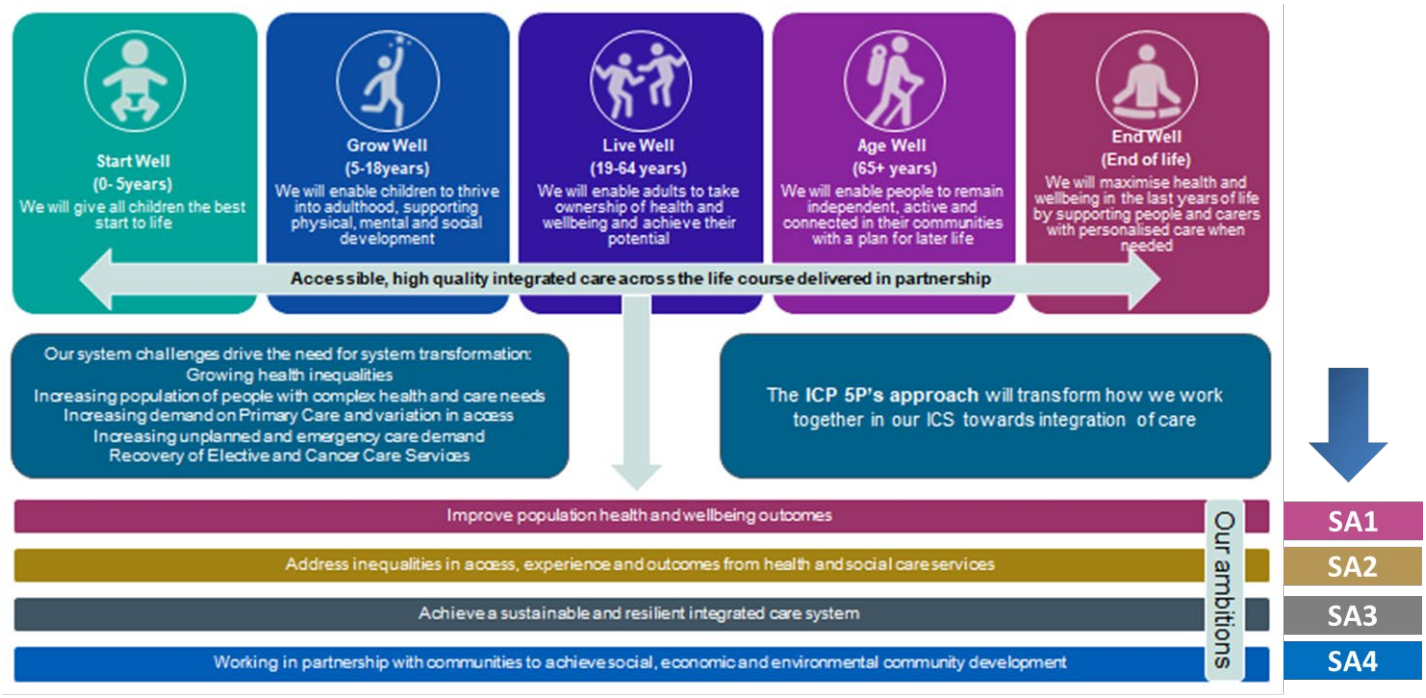
This paper sets out the initial outputs of that work, which to date has focussed on confirmation of Executive Leads and responsible Committees, articulation of risk descriptions and mapping to Strategic Ambitions. A timetable for quarterly reporting to the Board and its Committees has also been developed.

The content of the BAF will be subject to regular review, with opportunity throughout the course of the year to refine as the process becomes embedded and matures.

2. Strategic Ambitions

The four Strategic Ambitions (set out below) have been agreed as part of the ICP Strategy. Each strategic risk within the BAF has been mapped to one or more of the Strategic Ambitions to which it threatens the achievement of. The BAF will enable the Board to understand the potential impact on those Strategic Ambitions, along with the controls and assurances in place and the gaps to be addressed.

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



3. Responsibility for Risk

Whilst the ICB retains responsibility for the risks associated with the BAF, they will seek assurance from the Lead Committees and the Audit Committee will have responsibility for oversight of the process. The risks will be managed by the Lead Director and their team.

4. Overview of Initial BAF Development

The table below draws together the initial outputs of developing the BAF, as described above.

Strategic Risks, Mapping and Responsibly										
BAF No.	Risk Description			Strategic Ambition				Responsibility	
	Cause	Event	Effect	SA 1	SA 2	SA 3	SA 4	Exec Lead	Responsible Committee
BAF 1	Responsive Patient Care – UEC								
	If the UEC system does not have sufficient capacity across the entire pathway to meet demand and support flow	Then demand may outstrip capacity and there will be pressure points within the UEC system	Resulting in poor outcomes and experience for patients and increased pressure for our workforce		●			Chief Delivery Officer	Finance & Performance Committee
BAF 2	Responsive Patient Care – Elective								
	If the system fails to deliver on the specific expectations set out in the 23/24 (and earlier) planning guidance relating to waiting time recovery	Then waiting times will not reduce in line with national expectations	Resulting in potential patient harm and reputational damage to the ICS in addition to a potential claw-back of ERF funding	●	●	●		Chief Delivery Officer	Finance & Performance Committee
BAF 3	Proactive and Needs Based Community Services								
	If we are unable to work together as an integrated care system across organisation and sector boundaries	Then we will have less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent	Resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced				●	Chief Medical Officer	Finance & Performance Committee
	Reducing Health Inequalities								

BAF 4	If we are unable to work together as an integrated care system across organisation and sector boundaries	Then we will have less (or no) impact on reducing health inequalities of the population of Staffordshire and Stoke-on-Trent	Resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced	●	●		●	Chief Medical Officer	Quality & Safety Committee
BAF 5	**High Quality, Safe Care and Outcomes** If we cannot maintain high quality, equitable & safe patient care in the event that staffing, investment and training are maintained	Then we will be unable to deliver safe, sufficient services and will be unable to reduce inequalities	Resulting in actual harm to patients and service users	●	●			Chief Nursing & Therapies Officer	Quality & Safety Committee
BAF 6	**Sustainable Finances** If financial pressures are not controlled	Then we will not achieve our statutory financial duties	Resulting in financial intervention from the NHSE including reduced local discretionary decisions, reduced opportunities to apply for additional funds, impact on services and waiting lists			●		Chief Finance Officer	Finance & Performance Committee
BAF 7	**Improving Productivity** If the ICB and provider partners are unable to develop/deliver recurrent productivity gains in 2023-24 which will be needed to help address our recurrent deficit of c.£160m	Then we will fail to achieve the operational improvements which underpin our performance targets and fail to deliver the recurrent efficiency requirements which underpin delivery of our statutory financial target of breakeven	Resulting in financial intervention from the NHSE including reduced local discretionary decisions, reduced opportunities to apply for additional funds, impact on services and waiting lists			●		Chief Finance Officer	Finance & Performance Committee
BAF 8	**Sustainable Workforce** If we are unable address the current national shortfall of staff in health & social care in Staffordshire & Stoke-on-Trent	Then there is a risk of increased vacancy rates in key services	Resulting in insufficient capacity to deliver current services, transformation & the Winter Plan and further increase staff			●		Chief People Officer	People, Culture and Inclusion Committee

			sickness & burnout						

5. Annual BAF Reporting Cycle 2023/24

The Governance Team will be working with Lead Directors to agree the calendar of business and the related business cycles for 2023/24. The table below sets out the proposed reporting cycle for the BAF during 2023/24.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Committees	June 2023	September 2023	December 2023	March 2024
Board	July 2023	October 2023	January 2024	April 2024

In the same way as done for 2023/24, the engagement process for development of the 2024/25 BAF will then commence during February / March 2024.

Appendix 1 – BAF 2023/24 Template

BAF 1: [Strategic Risk Title]

ICS	✓
ICB	✓

Risk Description and Impact on Strategic Ambitions

Cause (likelihood)	Event	Effect (Consequences)
If	Then	Resulting in

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

Responsibility for Risk

Committee:		Lead Director:	

Risk Scoring and Tolerance

Quarter / Score	Q1	Q2	Q3	Q4	Appetite (Target)	Target Date	Risk Tolerance Statement
Likelihood							
Consequence							
Risk Level							

Rationale for Risk Score and Progress Made in the Quarter:

xxx

Key Controls Framework

Key Controls:	• xxx

Assurance Map

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Organisation)		●	●	●	●
2nd Line (System)					
3rd Line (External / Independent)					

Assurance Assessment

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

Gaps in Control or Assurance

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

•

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

No.	Action Required	Outcome of Action	Lead Director	Due Date	Quarterly Progress Report	BRAG
1						
2						

No. Linked Risks on Risk Register

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**08**

Title:	**Quality and Safety Report**

Meeting Date:	18 May 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Heather Johnstone – Chief Nursing and Therapies Officer	Y	Cath Marsland - Associate Director of Quality and Patient Safety Lee George - Associate Director of Quality Assurance and Improvement Karen McGowan - Associate Director of Nursing and Quality Claire Underwood – Associate Director for Safeguarding and Director for Continuing Healthcare

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
This paper is a combination of those corresponding papers presented and discussed at the Quality and Safety Committee. There was no System Quality Group this month due to a clash with the long bank holiday weekend.		S

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

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

Updates from the System Partners

Current ICB updates include:

- Safeguarding
- ICB Quality Strategy
- Quality Impact Assessments (QIA)
- CHC Policy
- Soft Intelligence Process – Standard Operating Procedure (SOP)
- Nursing Home Quality Assurance and Improvement Group (NHQAIG) Terms of Reference (TOR)
- PSIRF Implementation Group
- Patient Safety Specialist (PSS) Network

Updates on quality issues within the Portfolios

Other System Quality Matters by Exception:

- Continuous Quality Improvement (CQI)
- Industrial Action
- Infection Prevention and Control

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

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks aligned to these areas of work are submitted as a separate agenda item and discussed fully at the Quality Safety Committee

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

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	N	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		

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

Recommendations / Action Required:

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.
- Ratify the decisions in relation to:
  - Items approved at the Quality Safety Committee:
    - Quality and Safety Committee Terms of Reference
  - Items approved at the System Quality Group:
    - Soft Intelligence Process Standard Operating Procedure (SOP)
    - Nursing Home Quality Assurance and Improvement Group (NHQAIG) - Terms of Reference

Quality and Safety Report to the Integrated Care Board – May 2023

1. Introduction

The purpose of this report is to provide assurance to the Integrated Care Board regarding quality matters whilst also providing a summary of the discussions and emerging issues raised at the key quality forums, System Quality Group and Quality and Safety Committee throughout May 2023.

2. Quality Risks on the Register

There are a number of risks on the register related to care homes and allocated to different directorates. It was agreed that representatives from the relevant directorates will work together to review them all and open/close risks as appropriate. No new quality risks have been reported.

3. Board Assurance Framework (BAF)

Quality Safety Committee received and accepted the Q4 BAF report, noting that progress has been made in terms of recruitment increasing midwife establishments and clear escalation plans in place, however recognising that there continues to be challenges.

4. QSC Terms of Reference

The Terms of Reference (TOR) (appendix 1) were agreed in October 2022 with a 6-month review date. In keeping with this committee members agreed that the TOR continued to reflect the purpose, aims and functions of the committee. The key proposed change was to change the frequency of the formal meeting to bi-monthly and using the intervening time to focus on developments and specific quality issues. It was agreed that space would be reserved at each monthly meeting, to be able to approve papers as appropriate. The recommended changes were approved by the Committee and await ratification by the Board.

5. Updates from System Partners

5.1 Midlands Partnership University NHS Foundation Trust (MPFT)

The final report from the CQC visit to the Trust in November and December 2022, is awaited following return of the draft report following a factual check. Actions continue to be implemented. The Trust has been awarded university status from Keele in recognition of the research undertaken by the organisation.

Positive feedback continues from the Staff Survey where MPFT have been rated as the top mental health community trust in the region.

5.2 North Staffs Combined Healthcare NHS Trust (NSCHT)

NSCHT work closely with system partners to support children and young people requiring specialist mental health care. All agreed there is a need to consider how as a system we develop a stronger emphasis upon identifying and supporting our young people, carers and families as early as possible to improve outcomes. It has been proposed that all stakeholders will link through the CYP portfolio to maximise learning from recent experiences, identify and close the gaps that exist within our current pathways. The Chair recognised the impact of these cases, not only on the individual and their families/carers but also on other patients and the staff providing the care, for which they were thanked.

Project Chrysalis, a project to eradicate dormitories and minimising ligature risks across NSCHT estate, has been delayed by 10 to 12 weeks following challenges with water temperatures in the areas where patients will be transferred to allow the work to continue. The operational and estates team are working together to agree further actions and timelines to support completion of the project.

5.3 Staffordshire County Council (SCC)

Regulatory ratings for Staffordshire care services continue to improve and are consistently ahead of regional and national figures. Further improvements are expected with an increase in nurse capacity following a recruitment campaign.

The Staffordshire Workforce Strategy for children's and adult's services, co-produced and endorsed by the ICB People Function, health, social care and education providers, has been launched. An academy model is being scoped with care home intelligence to support the identification of skills gaps and the development of a clinical leadership programme.

5.4 Primary Care

A GP surgery has been rated as 'Requires Improvement' following a CQC inspection in December 2022. An action plan has been submitted to the CQC and the Primary Care team are providing learning on themes from Requires Improvement practices.

Data to support the NHSE GP Access Recovery Plan shows there are an additional 1,000 appointments. The Primary Care team are working with Healthwatch on a Deep Dive into access, which will include public communication campaigns and liaison with regional groups in order to share the learning. At the QSC it was confirmed that the plan has now been launched

5.5 NHS England

Workforce, Training and Education are currently focusing upon 3 areas of work; a Midwifery Safe Learning Environment Charter developed from the findings of the Midwife National Review, the GMC National Training Survey and the NETS (National Education and Training Survey) for all learners in the workforce. The latter closed with 39,856 responses across the 7 regions of England with the midlands recording a high response of 9,566.

Work is progressing to support the development and roll out of a number of key mental health and Learning Disability strategies within the prison service.

5.6 Healthwatch Staffordshire

Health watch have supported the gathering of soft intelligence from residents within care homes. regarding their views on the care they receive. Initial themes indicate a need to consider increasing the range of activities made available to residents in particular outside of the care home environment, and concerns regarding access to dentistry services which tallies with information received via the Nursing Home Quality Improvement and Assurance Group. It was agreed further discussions in regard to access to dentistry services will be discussed later in the year.

6. ICB Updates

6.1 Safeguarding

6.1.1 Domestic Homicide Reviews (DHRs)

Work is underway to capture the child's lived experience of domestic abuse and detail this in DHRs of the future. This is an action from the Domestic Abuse Delivery Group following the implementation of the Domestic Abuse Act and the victim status of children.

6.1.2 Liberty Protection Safeguards (LPS)

The Government has announced that work on the Liberty Protection Safeguards (LPS) guidance will be paused for the life of the current Government. Advice from NHS England is to continue with the improvement work that has come about because of this change in legislation with Deprivation of Liberty Safeguards (DoLs) and Court of Protection applications and with application of the Mental Capacity Act.

6.1.3 Multi Agency Safeguarding Hubs (MASH)

The current operating practice of MASHs in Staffordshire and Stoke on Trent are undergoing review and redesign to ensure best, safest and most efficient practice to ensure prevention of harm and protection of all citizens. The Integrated Care Board Safeguarding Team and health partners are aligned to and working with this from a system perspective, engaging with Police and Local Authority colleagues and partners.

6.2 Quality Impact Assessment (QIA)

Following approval at the Committee and ratification at the ICB Board in February 2023, the ICB's updated QIA Policy came into effect on 1st March 2023. Work has been undertaken by the Quality Assurance & Improvement team to socialise the new policy including raising awareness, launching a suite of documents (Frequently Asked Questions, best practice example, QIA template) on the ICBs Intranet and News (IAN) QIA landing page and the delivery of training sessions which have received positive feedback.

To ensure a consistent and proportionate approach, the new policy has introduced screening criteria to determine the appropriate governance sign-off level (Gateway Control) this will facilitate quicker and simpler decision making but maintain the focus on further review of the quality impact of higher risk decisions. The process is being used to support the current line-by-line review of the ICB's expenditure. Further, health system partners are working in partnership to i) explore how a system approach that supports collaboration, reduces duplication, and retains individual statutory organisations' QIA governance processes could be put in place to support system transformation, and ii) ensure that the system understands cumulative quality impacts aligned against system priority (portfolio) areas.

6.3 CHC Policy

The Integrated Care Board (ICB) does not currently have an agreed Continuing Healthcare (CHC) policy, this leaves the organisation reliant on the utilisation of the NHS Continuing Healthcare Framework when making decisions which consequently means the organisation can be at risk of challenge. Many other ICBs have functioning CHC Policies and these have been utilised as a benchmark when developing a Staffordshire and Stoke-on-Trent ICB CHC Policy. The CHC policy will set out the ICB's commissioning intentions for the provision of care in relation to patient choice and allocation of funds for individuals who have been deemed eligible for NHS CHC funding. The policy will acknowledge the importance of patient choice balanced with consideration of financial constraints on the ICB and wider ICS and the need to provide services that are fair and equitable.

A briefing update paper has been presented to Quality and Safety Committee on the 10th May 2023 to provide an overview of the proposed policy contents and timescales for development and ratification.

6.4 Soft Intelligence Process – Standard Operating Procedure (SOP)

The ICB has a process for the collection of soft intelligence from across the system including primary care providers. Soft intelligence is defined as information that does not fall into the complaints, incidents, serious incidents, or safeguarding categories and which provides valuable intelligence about patients' experiences and safety. It can be both positive and negative.

The information collated from these reports is essential in the triangulation of quality for all those in receipt of healthcare. A Standard Operating Procedure (SOP), produced to define the processes for collecting, managing, and reporting soft intelligence, was approved by members of the group with agreement to review in 6 months.

The ICB has recently been congratulated by NHSE for the production of an excellent document which complements the Quality Improvement work going forward.

6.5 Nursing Home Quality Assurance and Improvement Group (NHQAIG) - Terms of Reference (TORs)

The purpose of the NHQAIG is to ensure the safety and wellbeing of residents in care homes with nursing provision and providers with residents in receipt of NHS funded care. Partners work closely through an established governance process to provide strategic oversight and share intelligence.

The Terms of Reference were submitted following a planned annual review. There were very few changes, namely updates in titles since commencement of the ICB and inclusion of members who attend to present specific expert reports. The Terms of Reference were approved with no changes.

6.6 PSIRF Implementation Group

The group is well attended with excellent partner engagement and seen regionally as a front runner. This has been demonstrated by securing funding for 144 people and the first cohort of 20 to commence training in May 2023.

6.7 Patient Safety Specialist (PSS)Network

The request for PSSs from the NHSE, are a significant ask, and often assigned to existing Heads of Safety or similar roles. The ICB Chief Nurse established the network initially and ToRs were produced 6 months ago. Following discussion at SQG and agreement between key stakeholders it has been decided that the Network meetings would pause to allow for the implementation of PSIRF throughout autumn to allow the process to be embedded. Once achieved the focus of this meeting will shift to re-establishing and refreshing the TOR the Patient Safety Network.

7. Portfolio Updates

7.1 Planned Care, Cancer & Diagnostics

Since the portfolio structure went live in December 2022, the Quality Assurance & Improvement team have been made to feel valued members of the extended multi-disciplinary (matrix) team supporting the Planned Care, Cancer and Diagnostics portfolio. Members of the Quality Assurance & Improvement team have actively engaged in weekly team meetings, timeouts, Planned Care Board and System Summits supporting the portfolio. The Quality Assurance & Improvement team have provided subject matter expertise, advice, and insight to champion quality as a central principle supporting system transformation, review of service specifications, contact line by line review and procurement. Work is underway, with system partners, to consider how to demonstrate and celebrate a system learning culture, continuous quality improvement and implementation of best practice through reporting.

7.2 Primary Care

The Primary Care work currently falls into 2 workstreams. The Primary Care Forum which continues to have an oversight of General Practice, and following the move to ICBs on 1st April 2023, Delegated Commissioning for Pharmacists, Optometrists and Dentists (PODs). The former continues in a similar vein, pre portfolios, with Quality input to the relevant discussions. The latter is still evolving with ongoing discussions with Birmingham and Solihull ICB to understand the roles and responsibilities of each ICB on a daily basis and developing a working relationship with CQC who provide ratings for Dentists and are only able to visit 10% (300) dentists a year.

7.3 End of Life, Frailty & Long-Term Conditions

Weekly meetings continue, to understand the scope of the work. Discussions to date have primarily focused on understanding the 23 contract lines, with regards to establishing the timescales for each contract, many of which (the hospices primarily) are grants, and the required finance arrangements, i.e. Purchase Order arrangements, etc.

Members of the Quality Team have been allocated re: End of Life, and Long Term Conditions and Frailty, and starting to get involved in the detailed work of the portfolio, e.g. reviewing the specs for Lymphoedema care in the community. Good working relationships are being established within the portfolio with good attendance from the respective directorates.

7.4 Children, Young People & Maternity

7.4.1 NHSE Three-year delivery plan for maternity and neonatal services

Following publication in March 2023, the LMNS (Local Maternity and Neonatal Services) are reviewing the plan to better understand the roles and responsibilities for all those involved in maternity and neonatal care. The delivery plan is aligned to the ICS funding allocation and brings together all the actions and standards for improvement contained within the Maternity Transformation Programme. The plan provides guidance on how to implement the improvements, who is responsible and how to measure success. The ICB LMNS Board has asked that a delivery plan is developed, in partnership with providers and service users and population focused and will feedback next steps in June 2023.

The ICB are undertaking a review of all services which closed on a temporary basis at the start of the COVID-19 pandemic. The two Freestanding Midwife led units at County Hospital and Samuel Johnson hospital form part of this review. A service change programme will be established to work with system partners to assess the long-term viability of the units.

7.4.2 Maternity and Neonatal Voices Partnership (MNVP as

A review of the MNVP provision in Staffordshire and Stoke-on-Trent has been completed and is due to go to the ICB Executive Team in May. It describes the next steps required in order to bring the model in line with National recommendations.

8. Other System Quality Matters by exception:

8.1 Continuous Quality Improvement (CQI)

The CQI Sub-group continues to meet monthly reviewing current projects, scoping new requests and identifying how best to build improvement capacity and capability within the system. The recent addition of Staffordshire County Council's Change Team has added a new dimension to the discussions within the group and this has established new opportunities for learning and sharing. The CQI work programme continues to support a range of projects including Complex Hospital Discharge and Community Equipment. Work is in development exploring how CQI can be built into the priority programmes of work and how this might be best supported and

collectively resourced based on the testing of two suggested ways of working. The QI Network continues to be well received with 59 people attending the most recent event on measurement, with a 14% growth in membership from last quarter. System partners and people with lived experience are co-producing QI training resources to better enable people with lived experience to engage and be involved with Quality Improvement Projects across the ICS.

8.2 Industrial Action (IA)

System partners have implemented agreed plans and worked collaboratively to deliver ongoing services during the recent industrial action by the RCN and Junior Doctors. Trusts commented on the many planning meetings, picket lines, and the continued work of staff to ensure patients were safely cared for in both in-patient units and the community, and whilst maintaining good staff relationships. It was recognised that the RCN may ballot again and strikes could continue until Christmas. It is also anticipated that information will be going out to Consultants imminently on a possible planned IA. As previously, ICS partners will continue to work closely and support each other should these come to fruition. The Chair expressed thanks to all system partners and the support they had shown to each other.

8.3 Infection Prevention and Control (IPC)

The updated Infection Prevention and Control Board Assurance Framework was published by NHSE in April reflecting wider IPC review rather than the Covid-19 focus of earlier versions. The framework is for use by all involved in care provision in England to support compliance with IPC expected standards. The framework provides an assurance structure against the National Infection Prevention and Control Manual, and The Health and Social Care Act 2008; code of practice on the prevention and control of infections.
The IPC leads will continue to work together to ensure a system wide support system in adoption and implementation of this framework.

Systems are also working together to minimise and resolve issues regarding delays in receipt of laboratory results following the introduction of new IT systems supporting the laboratories at UHNM. Issues within Primary care had already been under investigation due to delayed results, but wider issues have been identified with other providers and escalated appropriately.

Appendix One

NHS Staffordshire and Stoke-on-Trent Integrated Care Board Terms of Reference Quality and Safety Committee

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Appendix One :NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Terms of Reference
Quality and Safety Committee

1. Introduction

1.1 The Quality and Safety Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 The primary function of the Quality and Safety Committee (the Committee) is to provide assurance to the Staffordshire and Stoke-on-Trent ICB in relation to the quality, safety, experience, and outcomes of services across the entire health economy. By ensuring that quality is a focus in all our stated aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development

1.3 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.4 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2. Constitution and Authority

2.1 The Committee is a non-executive chaired Committee of the Board and its members, including those who are not members of the Board or ICB staff, are bound by the ICB's Constitution Standing Orders (the Standing Orders) and other key policies of the ICB. The Committee has no executive powers, other than those delegated in the Scheme of Reservation & Delegation (SoRD) and specified in these TOR. The Committee is authorised by the Board to:

- Investigate any activity within its TOR, including oversight of assigned Risk Management and Board Assurance Framework (BAF) activities within its lead responsibility area.

- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined.

- Commission any reports it deems necessary to help fulfil its obligations.

- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if considered necessary to fulfil its functions (in doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice).

- Create 'Task & Finish' sub-groups to take forward specific programmes of work as considered necessary by members – the Committee shall determine the membership and TOR of any such sub-group in accordance with ICB's Constitution, Standing Orders and SoRD (Scheme of reserved delegation), but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Committee will comply with the Standing Orders, Standing Financial Instructions and SoRD, other than for any exceptions agreed by the Board.

2.3 Committee duties will be driven by ICB objectives and associated risks – an annual programme (cycle) of committee business will be agreed by Members before the start of each financial year, however, this will be kept flexible to adapt to new and emerging circumstances, priorities or risks.

3. Purpose of the committee

3.1 The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

3.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

3.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit and escalate concerns in a proportionate and timely fashion.

4. Aims and Function

4.1 The Quality and Safety Committee has been constituted in terms of its scope, responsibilities and membership to facilitate the ICB meeting its four fundamental purposes to:

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience, and access
- **Enhance productivity** and value for money
- Help the NHS support broader **social and economic development**

4.2 The Quality and Safety Committee as a committee of the ICB Board will have a remit which encompasses two primary areas of responsibility:

4.3 First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. The Committee will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

4.4 The committee will have a strong focus on the partnership agenda and will work with all associated subgroups to support the ICS to bring partners together on approaches that can't be achieved by a single organisation alone.

4.5 In addition to the prime responsibilities identified above:

- It shall ensure that through a collaborative approach to quality, system partners discharge their statutory duties in relation to the achievement of continuous quality improvement at both system and place level.

- It shall pro-actively challenge and review delivery of continuous quality improvement expectations against the NHS Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes, including any National Reports and enquiries agreeing any action plans or recommendations as appropriate.

- It shall, in partnership with the wider system, work to drive improvements in the health and well-being of all local communities including working at a place-based level, not just with those people known to be users of services.

- It shall review Quality issues impacting on the Staffordshire and Stoke-on-Trent System. It will provide all key partners with greater clarity and detailed information about the impact and underlying performance of key services.

- It will provide one Quality exception report that will assure the system (Integrated Care Board) and (if required) each statutory board of delivery against all Key Quality Indicators and any emerging risks and concerns using common quality and performance data.

- It will lead the establishment of system level relationships with all regulatory bodies including NHSE, CQC etc. ensuring that regulatory bodies play a key role in ensuring this system oversight.

- It will also establish and maintain system level relationships with professional leadership bodies such as the General Medical Council, Nursing and Midwifery Council and Health and Care Professionals Council and other associated bodies as required.

5. Membership and Attendance

5.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members and two Executive Members of the Board. Other Members are as listed below.

- Non Executive Director - Chair of Quality & Safety Committee (Chair)
- Non Executive Director (Vice Chair)
- ICB Chief Nursing and Therapies Officer (or nominated deputy)
- ICB Chief Medical Officer (or nominated deputy)
- ICB Director of Nursing – Maternity & Safeguarding
- ICB Director of Nursing – Quality Assurance & Improvement
- ICB Chief Finance Officer
- ICB Chief Transformation Officer
- ICB Director of Corporate Governance
- ICB Governance Representative
- Directors of Public Health (Staffordshire County Council & Stoke-on-Trent City Council)
- Provider Trust Chief Nurses (or nominated individual) from UHNM, NSCHT, MPFT, UHDB
- NHSE
- Patient Representation to be considered

5.2 Additional relevant subject experts and other representatives may be invited to attend meetings to present on specific work eg service transformation, children's services, safeguarding.

5.3 Committee members must appoint a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed with power to make decisions and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

5.4 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5.5 These may consist of or include persons other than Members or employees of the ICB. In order to best meet the next clause, these non-ICB Members should ideally be of a suitable calibre to conduct core business without having to continually take items back to their host organisation. (Unless the decision is a non-delegated sovereign matter of that partner organisation required for their decision).

5.6 Members will together possess between them knowledge, skills and experience to effectively discharge the functions of the ICB, including any requisite technical or specialist issues pertinent to ICB business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

5.7 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these TOR.

5.8 Attendees

- Only Members as described above shall have the right to attend Committee meetings unless it is agreed to meet in public for part or all of the agenda to be transacted. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter.

- The Chair (or Vice Chair) may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

6 Frequency, Quoracy and Decisions

6.1 The Committee will meet 6 times a year; with arrangements and notice for calling meetings reflecting those as set out in ICB Constitution Standing Orders for Board meetings. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

6.2 In accordance with ICB Constitution Standing Orders, the Committee may meet virtually when necessary; and members attending using electronic means will be counted towards the quorum.

7. Quorum

7.1 For a meeting to be quorate, the Chair or Vice Chair must be present, plus the ICB Chief Nursing and Therapies Officer or ICB Chief Medical Officer (or their nominated deputy), one provider representative and one Local Authority representative.

7.2 For decisions that exclusively impact on health for the meeting to be quorate, the Chair or Vice Chair must be present, plus the ICB Chief Nursing and Therapies Officer or ICB Chief Medical Officer (or their nominated deputy), and one provider representative.

7.3 If any Member has been disqualified from participating in an item on the agenda, by declaration of a Conflict of Interest, then that individual shall no longer count towards the quorum. If a quorum has not been reached, then the meeting may still proceed if those present agree. However, no binding decisions may be deemed as fully taken by the meeting until confirmed by all Members via offline 'virtual' methods outside of the meeting and before the next scheduled one.

8. Decision Making and Voting

8.1 Decisions will be taken in accordance with the ICB Constitution Standing Orders. The Committee will ordinarily reach its conclusions by consensus. When this is not possible the Chair may call a vote. This provision should though be seen as an exception to normal, routine decision-making.

8.2 Only Members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

8.3 Mirroring provisions set out within the Standing Orders, if an urgent or emergency decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct such business on a 'virtual' basis through the use of telephone, email or other electronic communication.

9. Responsibilities of the Committee

9.1 The Committee's detailed duties and core responsibilities are itemised within Appendix One.

9.2 Matters delegated to the Committee by the Board (and as also defined by / covered within the SoRD) are also itemised within Appendix One.

10 Declarations & Conflicts of Interest

10.1 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10.2 The Committee and all Members or Attendees present shall fully and continuously satisfy itself that all matters of ICB policy, systems and processes for the management of conflicts (including gifts & hospitality and bribery) are upheld in all meetings.

10.3 For the avoidance of doubt, any additional national or statutory policy requirements shall also guide the Committee's processes and procedures. This shall include sending any reports relating to non-compliance with ICB policy and procedures to the ICB Audit Committee.

11. Etiquette, Behaviours and Conduct

11.1 ICB Values

- All Committee Members and Attendees will be expected to conduct business in line with the ICB's stated values and objectives.

- Committee Members and those attending shall always behave in accordance with the ICB's Constitution, Standing Orders and Standards of Business Conduct Policy.

11.2 Equality and Diversity

- All Members must demonstrably consider the Equality and Diversity implications of any or all decisions they make. Attendees will also be required to uphold the Equality Act and Public Sector Equality Duty in any of their engagements with the Committee.

12. Integrated Care System Compact and ICB Meetings Charter

12.1 In addition to the items noted in section 8.2, all Members and Attendees will be expected to adhere to the separate Integrated Care System (ICS) Partnership Leadership Compact key principles of 'Trust', 'Courage', 'Openness & Honesty', 'Leading by Example', 'Respect', 'Kindness & Compassion', 'System First' and 'Looking Forward'.

12.2 Similarly, all will be required to respect and apply the ICB Meetings Charter, which shall codify all of the above and help with the logistics / practicalities of running an ICB meeting in line with the Constitution and Standing Orders.

13. Accountability and Reporting

13.1 The Committee is accountable to the ICB (Board) and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings shall be formally recorded by the secretariat and submitted to the Board in accordance with the Standing Orders.

13.2 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

13.3 The Committee will provide the Board with an Annual Report, timed to support finalisation of ICB Annual Accounts and Annual Report (Governance Statement section). The report will summarise its conclusions from the work it has done during the year, specifically commenting on:

- The fitness for purpose, completeness and 'embeddedness' of the BAF and Risk reporting obligations of the Committee within the ICB's organisational context.
- The integration of governance arrangements to underpin the 'Quadruple Aim' and Core Purposes of an ICB-ICS as detailed.
- The appropriateness of the evidence that shows how the Committee is helping the ICB in fulfilling its regulatory requirements
- The robustness of the processes behind the Committee's decisions.

13.4 The Committee will receive scheduled assurance reports from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

14. Secretariat and Administration

14.1 The Committee shall be supported with a secretariat function, which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with ICB Standing Orders; having been agreed by the Chair with the support of the relevant ICB Executive and Governance lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Maintenance and reporting of the committee Conflicts of Interest Register (with the ICB Governance Lead).
- Good quality minutes are taken and distributed in accordance with ICB Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Actions are taken forward between meetings and progress against those actions is monitored.

15. SUB-COMMITTEES

15.1 The Committee may delegate responsibility for specific aspects of its duties to sub-groups or other working groups. The Terms of Reference of each such sub-group or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

15.2 Any sub-groups or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

15.3 Sub-groups will include:

- Health Safeguarding (Children and Adult) Forum
- Patient Assembly
- VSCE Alliance
- System Quality Group
- Staffordshire and Stoke-on-Trent Local Maternity and Neonatal Partnership Board
- Staffordshire and Stoke-on-Trent IPC Group
- Quality Improvement Network
- Portfolio Boards – exceptions relating to quality as required
- QIA Subgroup
- Improving Population Health ICS Portfolio Board (Health Inequalities)

Additional subgroups may be added as the ICB evolves.

15.4 In addition, from time to time the Committee will receive exception reports relating to relevant system wide groups.

16. Review

16.1 The Committee will review its effectiveness at least annually.

16.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments will be submitted to the Board for approval (and will not be deemed as operational until that agreement has been confirmed).

Appendix One

1. Committee Responsibilities and Duties

1.1 Quality Assurance and Improvement

a) Provide the Integrated Care Board with assurance that services are of a high quality, safe, effective, and provide patients and carers with positive experiences of care with an emphasis on outcomes not performance.

b) Ensure that quality assurance data and information is used to inform commissioning decisions and drive improvements in quality.

c) Have oversight of the process and compliance issues concerning incident themes and any incidents being reviewed under the new Patient Safety Incidents Response Investigation Framework (PSIRF) and are informed of all Never Events with subsequent learning and mitigations.

d) Have effective and transparent mechanisms in place to monitor mortality with clear and robust learning from deaths (including coronial inquests and PFD report)

e) receive reports and information relating to how the ICB is fulfilling its responsibility in relation to the strategic aim of tackling inequalities in experience, outcomes and access.

f) A clear process for informing the key partners of any escalation or sensitive issues.

g) Seek and consider assurance on the quality performance of NHS organisations in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.

h) Ensure processes are in place to interpret and implement local, regional and national policy (e.g. Quality Accounts, Safeguarding etc.) and provide assurance that policy requirements are embedded in services.

i) Working with system partners, take action where required to investigate any quality, safety or experience concerns and to ensure that a clearly defined escalation process is in place, taking action to ensure that improvements in quality are implemented where necessary. Where appropriate to include liaison with appropriate external bodies such as the CQC.

j) Ensure that statutory obligations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver the statutory functions of all NHS Organisations and system partners.

k) Receive and scrutinise independent investigation reports relating to system safety issues and agree any further actions.

l) Oversee the development of System Wide quality indicators and other relevant quality indicators linked to the quality aspects of the NHS contract.

m) Oversee the development of the Quality Dashboard to report summary quality metrics in line with local and national reporting requirements.

n) Monitor Key Performance Indicators (KPIs) relating to system quality ensuring a strong focus on outcomes.

o) Receive exception reports from the appropriate system partner's Board (or equivalent) and System Quality Group which highlight areas of concern and the actions being taken.

p) Identify areas of risk to the quality and safety across the system and support the appropriate Delivery Board to manage these risks.

q) Support the establishment and operation of a system wide Quality Impact Assessment process and subgroup to ensure that the full impact of system wide decisions is identified and action taken to mitigate that risk and receive feedback after action to ensure impacts do not have a detrimental effect.

r) Where necessary instigate System-wide recovery Action.

s) Establish and maintain strong links with the Clinical Senate and Assemblies ensuring regular two-way communication in respect of key quality improvement and other associated activities.

t) In partnership with other groups such as the Clinical Senate, identify areas for targeting Continuous Quality Improvement work across the system, engaging with all system partners and feeding into the CQI Subgroup.

u) Agree appropriate methodology/methodologies to undertake Continuous Quality Improvement activity:

- Receive reports and updates on system wide improvements.
- Work in partnership with all parts of the system to extend continuous quality improvement activity and ensure it is embedded in systems and processes utilised across the ICS.
- Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report).

v) To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities.

These terms of reference are intended to ensure clarity of role and function for the SQSC in its current form, operating within current structures. As such they will be subject to regular review and amendment with further work to finalise once the ICS is formally established.

Date of Approval:

Date of Review:

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**09**

Title:	**Finance & Performance Report**

Meeting Date:	18 May 2023

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

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
Finance and performance committee	02/05/23	D/S/I

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

The purpose of this report is to provide an update for the ICB Board on the key financial and operational performance issues.

Key points on **Finance**

- The system has submitted a breakeven position for 2022/23 in line with plan. The detailed accounts remain subject to audit at this point.
- As reported through the year, there were a number of areas of escalating spend and the achievement of break even position was largely achieved through non-recurring mitigations, leaving the system with a substantial challenge for 2023/24. Details for the 2023/24 financial position are covered in the planning update.

Key points on **Performance**

- Pressures in **Urgent and Emergency Care** remained in line with February. Staffing shortfalls impacted significantly across all areas at the end of March.
- The national target to eliminate **78+ week waits** by March 2023 has not been achieved. However it is worth noting that waits of over 65, 78 and 104 weeks are decreasing.
    - As at w/e 16 April 3,032 65+ breaches are recorded.
    - As at w/e 16 April 653 78+ breaches are recorded.
    - As at w/e 16 April 54 104+ week waits are recorded.
- In **Cancer,** 92.0% of patients were seen within 2 weeks (national standard is 93%).
- In **Diagnostics**, 104.5% of 19/20 activity was delivered in February, the first month exceeding 100%.
- The number of **GP appointments** and **Learning Disability Annual Health Checks** are on track to achieve the year end targets.

The ICB Board is asked to discuss and note the contents of this report.

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

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

- BAF Strategic Aim '(3C) (**Risk 961**) - Support the delivery of system financial balance by 2025/26'. (BAF submissions being reviewed by ICB Board and are subject to change)
- **Risk 001** - Underlying deficits from 2023/24: If the system saving schemes do not deliver the financial strategy, the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position, in line with the operating and planning framework.
- **Risk 068** – Finance: there is a risk that the ICB does not achieve break even in the current period 2022/23, resulting in additional cost pressures in 23/24.
- **Risk 111** – If continued delays to ambulance handovers are incurred and sustained, or levels increased there will be significant pressures placed onto ED, ambulance crews and the wider UEC system resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time and associative issues.

Implications:	
Legal and/or Risk	Monitoring performance is a statutory duty of the ICB.
CQC/Regulator	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Financial – if yes, they have been assured by the CFO	The report provides a headline summary of 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 / Training	None specifically identified pertaining to this report

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Report to the ICB Board on Finance and Performance

ICB Board Meeting – 18 May 2023

Executive Summary

The purpose of this report is to summarise the **key financial and operational performance issues for the ICB Board**.

Headlines

Finance

- The system was able to stay on track and deliver a year end breakeven position for 2022/23, subject to audit sign off. We were able to utilise our mitigations to offset the ongoing impact of further CHC and prescribing deterioration and the inevitable impact of addressing the operational pressures experienced with high levels of flu and covid admissions and high levels of staff sickness.
- Despite achieving a break even position for 2022/23, we recognise this was largely achieved via mitigations which are likely non-recurring, leaving the system with a substantial challenge for 2023/24.

Operational Performance by Exception

- ***Please note that validated data for March confirming final year end position will be available during the third week of May.***
- ***This summary contains updated RTT positions for March using the latest available operational information.***
- In March, the pressure in the **Urgent and Emergency Care system** remained in line with February. Whilst flu and RSV continued to decline Covid admissions increased in-line with regional patterns resulting in requirements for IPC restricted areas. Staffing shortfalls impacted significantly across all areas (at the end of March) due in part to increased illness and ongoing Industrial Action.
- **65+ week waits**: the most recent ICB level data (w/e 16 April) shows a steady decline in the number of patients waiting; of 3,032 patients as at 16 April compared to 3,326 in February and 3,619 in January.
- The national target to eliminate **78+ week waits** by the end of March 2023 has not been achieved. The number is declining however; as at 16 April 653 ICB patients were waiting more than 78 weeks.
- **104+ week waits** have also decreased; 54 patients were waiting over 104 weeks as at 16 April compared to 74 at the end of February.
- **Diagnostics:** In February 104.5% of 19/20 activity was delivered (the first month 100% has been exceeded) - 83.7% year to date.
- **Cancer waiting times**: 92.0% of patients have seen within 2 weeks (against the 93% national standard).
- Performance against the **Cancer 28 Day Faster Diagnosis Standard** in February was 73.3% (national standard is 75%), a year to date high.
- **Primary care:** The number of GP appointments and Learning Disability Annual Health Checks are on track to achieve the year end targets.
- **Mental Health**: Inappropriate out of area bed days at ICB level decreased from 160 bed days in Q2 to 120 in Q3, however the total remains significantly above the plan (of 60 bed days). Current demand exceeds the bed base available due to high levels of patient acuity and a limited number of female beds. Plans to secure additional bed capacity with independent hospitals have been delayed.

Supplementary information

Financial Position – Year end

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

ICB	Month 12 £m Plan	Month 12 £m YTD	Month 12 £m Variance	Month 11 £m Plan	Month 11 £m YTD	Month 11 £m Variance
Allocation	2,323.9	2,323.9	0.0	2,075.6	2,075.6	0.0
Expenditure	(2,323.9)	(2,323.4)	0.5	(2,075.6)	(2,080.1)	(4.6)
TOTAL ICB Surplus/(Deficit)	0.0	0.5	0.5	0.0	(4.6)	(4.6)
			0.0%			-0.2%

System	Month 12 £m Plan	Month 12 £m YTD	Month 12 £m Variance	Month 11 £m Plan	Month 11 £m YTD	Month 11 £m Variance
Income/Allocation	4,010.7	4,159.3	148.7	3,621.7	3,670.5	48.8
Pay	(1,059.5)	(1,161.6)	(102.1)	(969.7)	(982.9)	(13.2)
Non Pay	(595.6)	(645.0)	(49.4)	(545.3)	(582.5)	(37.2)
Non Operating Items (exc gains on disposal)	(31.6)	(28.4)	3.2	(29.0)	(26.1)	2.9
ICB/CCG Expenditure	(2,323.9)	(2,323.4)	0.5	(2,075.6)	(2,080.1)	(4.6)
Total	(0.0)	0.9	0.9	2.1	(1.1)	(3.3)
			0.0%			-0.1%

UHNM	Month 12 £m Plan	Month 12 £m YTD	Month 12 £m Variance	Month 11 £m Plan	Month 11 £m YTD	Month 11 £m Variance
Income	973.7	1,058.1	84.4	892.4	923.5	31.1
Pay	(582.1)	(635.3)	(53.2)	(532.4)	(539.4)	(7.0)
Non-Pay	(365.8)	(397.6)	(31.8)	(335.3)	(361.5)	(26.2)
Non Operating Items (exc gains on disposal)	(25.8)	(25.2)	0.6	(23.6)	(22.7)	1.0
TOTAL Provider Surplus/(Deficit)	(0.0)	0.0	0.0	1.2	(0.0)	(1.2)
			0.0%			-0.1%

MPFT	Month 12 £m Plan	Month 12 £m YTD	Month 12 £m Variance	Month 11 £m Plan	Month 11 £m YTD	Month 11 £m Variance
Income	565.0	614.2	49.2	518.0	528.5	10.6
Pay	(395.9)	(432.1)	(36.2)	(362.6)	(364.1)	(1.5)
Non-Pay	(166.4)	(181.5)	(15.1)	(152.0)	(160.7)	(8.7)
Non Operating Items (exc gains on disposal)	(2.6)	(0.3)	2.4	(2.4)	(0.5)	1.9
TOTAL Provider Surplus/(Deficit)	0.0	0.3	0.3	1.0	3.3	2.3
			0.0%			0.4%

NSCHT	Month 12 £m Plan	Month 12 £m YTD	Month 12 £m Variance	Month 11 £m Plan	Month 11 £m YTD	Month 11 £m Variance
Income	148.1	163.1	15.1	135.7	142.9	7.2
Pay	(81.5)	(94.3)	(12.8)	(74.7)	(79.5)	(4.7)
Non-Pay	(63.4)	(65.8)	(2.5)	(58.1)	(60.3)	(2.2)
Non Operating Items (exc gains on disposal)	(3.2)	(2.9)	0.3	(2.9)	(2.9)	0.0
TOTAL Provider Surplus/(Deficit)	0.0	0.1	0.1	(0.0)	0.2	0.2
			0.1%			0.1%

Urgent Care – Ambulance delays

	Indicator	Target	Period / Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD to current month	Change on previous period	Y/E (Actual/FOT)	YTD monthly trend
Ambulance	Ambulance handovers @ UHNM (all Patients at UHNM)		Handover delays of over 60 minutes	1,400	874	1,495	1,561	1,022	1,376	1,717	1,567	1,606	1,003	595	843	15,059	▲	15,059	
			Variance to 19/20	1,390	857	1,442	1,472	992	1,342	1,656	1,506	1,301	923	542	764				
			Handover delays of over 30 minutes	2,398	1,969	2,439	2,496	2,101	2,273	2,566	2,374	2,368	1,935	1,385	1,858	26,162	▲	26,162	
			Variance to 19/20	2,080	1,540	1,828	1,348	1,445	1,586	1,689	1,471	802	775	551	997				
			Handover delays of over 15 minutes	3,558	3,824	3,778	3,653	3,659	3,518	3,636	3,629	3,507	3,629	3,281	3,673	43,345	▲	43,345	
			Variance to 19/20	1,360	1,299	1,057	367	861	607	386	277	-428	85	46	877				
	Response Standards (WMAS - all responses) Times in hh:mm:ss	00:07:00	Category 1 mean	00:09:25	00:08:32	00:08:58	00:09:08	00:08:54	00:08:59	00:09:29	00:09:39	00:10:17	00:08:53	00:08:57	00:08:46	00:09:13	▼		
			Time variance to 19/20	00:02:17	00:01:22	00:01:46	00:01:51	00:01:43	00:01:26	00:01:53	00:02:14	00:02:32	00:01:27	00:01:30	00:01:12				
		00:18:00	Category 2 mean	01:28:01	00:40:26	01:01:39	01:11:06	00:43:06	00:59:25	01:35:21	01:05:13	02:25:40	00:34:06	00:28:45	00:30:08	01:04:37	▲		
			Time variance to 19/20	01:14:55	00:27:47	00:47:48	00:56:58	00:29:32	00:45:44	01:20:54	00:49:39	02:08:47	00:21:03	00:14:48	00:14:38				
	Time Lost		Hours lost in total (Handover)	3,800	2,264	3,572	4,116	2,728	3,178	4,532	3,921	4,839	2,498	1256	1817	38,521	▲		

Ambulance Activity

The data on this slide is for the West Midlands Ambulance Service (WMAS), and reflects the service's responses across their area of operation. The 'Time Lost' line is the total time WMAS lost to Handovers (UHNM).

- During March WMAS received 22,749 calls (734 per day) which resulted in 16,039 assigned incidents. This is an increase on February (19,409 calls or 693 per day).
- The category 1 [mean] response time improved slightly in March but remains above the 7 minute target; this was in spite of an increase in the count of Category 1 incidents, from 1,583 in February to 1,780 in March, a rise of 197 or 12.4%.
- The category 2 [mean] response time increased in March and remains above the 18 minute target. The category 2 incident volume rose on the total in February, from 7,209 to 8,078 (in Mar), an increase of 869 or 12.1%.
- Although March saw an increase in 60 minute + handover delays from what was a much improved figure in February; the March position represents an overall downward (improving) trend comparative to most of the current year. At Royal Stoke there was a 40.9% increase in March from February (242 patients), whilst County Hospital reported an increase of 6 patients.
- At Queens Hospital Burton the proportion of ambulance conveyances arriving through EMAS reduced from 25.8% in February to 23.3% in March, although the average arrivals per day for the month increased slightly to 47.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Urgent Care - Performance against NHS Constitutional Standards

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Change on previous period	Trend
A&E 4 Hour Performance (% seen in <4 hours)	University Hospitals North Midlands	95%	62.9%	62.8%	62.3%	63.4%	64.9%	66.0%	64.0%	62.9%	55.2%	63.1%	66.6%	67.1%	63.3%	▲	
	University Hospitals Derby & Burton	95%	62.0%	64.2%	61.7%	62.4%	63.0%	62.5%	61.0%	61.3%	55.9%	61.9%	59.9%	60.7%	61.3%	▲	
	The Royal Wolverhampton	95%	76.8%	79.5%	78.9%	80.4%	80.5%	79.3%	79.1%	73.5%	70.1%	76.8%	76.4%	75.4%	77.1%	▼	
	University Hospitals Birmingham	95%	54.7%	54.6%	53.2%	49.8%	52.7%	52.1%	52.1%	51.1%	49.9%	54.7%	47.6%	51.0%	52.0%	▲	
	The Dudley Group	95%	80.3%	74.7%	74.0%	75.6%	75.9%	75.0%	74.8%	72.5%	68.4%	75.1%	73.9%	68.9%	74.0%	▼	
	Walsall Healthcare	95%	73.9%	72.3%	72.5%	72.4%	73.9%	74.5%	70.6%	72.8%	69.7%	74.4%	77.7%	73.5%	73.0%	▼	

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	Change on previous period	Trend
A&E 12 Hour Trolley Breaches	University Hospitals North Midlands	0	878	390	555	665	346	695	1028	947	1289	1039	690	906	9428	▲	
	University Hospitals Derby & Burton	0	432	388	256	333	348	394	785	323	872	648	867	641	6287	▼	
	The Royal Wolverhampton	0	30	20	30	194	130	100	208	84	487	101	89	113	1586	▲	
	University Hospitals Birmingham	0	271	211	552	749	525	775	1384	1233	1830	1493	1279	1356	11658	▲	
	The Dudley Group	0	31	79	49	67	90	95	129	20	67	56	26	30	739	▲	
	Walsall Healthcare	0	6	10	1	35	13	14	63	91	259	148	125	265	1030	▲	

- Constitutional targets around 4 hour performance and 12 hour trolley breaches continue to be a challenge.
- Performance against the 4 hour target in March was similar to February at our main 3 providers.
- The number of 12 hour trolley breaches increased in March at 5 out of 6 providers.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Planned care activity – Month 11

Indicator	YTD 1920 v YTD 2223			Y/E (Actual/FOT)	
	19/20	22/23	% Var	19/20	22/23
Elective Ordinary Spells	17,938	15,235	-15%	19,137	16,620
Day cases	142,459	134,287	-6%	152,523	146,495
Outpatient procedures (Cons Led)	154,626	126,104	-18%	164,216	137,568
Outpatient first attendances without a procedure (Cons Led)	295,468	307,917	4%	317,277	335,909
Outpatient follow-up attendances without a procedure (Cons Led)	496,556	489,481	-1%	535,884	533,979
Diagnostic Tests (Specific 7 Tests)	428,377	358,647	-16%	458,445	391,251

Elective Activity

- In February, activity against plan has **increased** across three indicators:
  - Elective Ordinary Spells increased to 96% of plan, the highest volume this year.
  - Elective Day Case activity increased to 99.7% of plan, again the highest volume this year.
  - Outpatient procedure activity increased to 91.9% of plan.
- Consultant led outpatient first attendances **decreased** in February to 110.2% of plan, but remain above the targeted volume against 19/20.
- Outpatient follow ups remain above plan – an adverse position. The year to date position is a forecasted 14.8% surplus to the plan at year end.

Diagnostics

- Diagnostic activity increased again, by 14% from January to February, and was the highest in-month activity recorded so far in 2022/23 at 93% of the plan. However year to date activity is 16% below this point in 2019/20.

*Note: The current Year End FOT is set to be **below** the 19/20 FOT for the above indicators (with the exception of outpatient follow-up attendances). This indicates that activity must increase for Elective Ordinary Spells, Day Cases, Outpatient and Diagnostics if the 2019/20 volume [target] is to be met.*

Planned care and Cancer – Month 11

	YTD 1920 v YTD 2223			Y/E (Actual/FOT)	
	19/20	22/23	% Var	19/20	22/23
RTT - admitted, completed	62,064	54,353	-12%	66,046	59,294
RTT non-admitted, completed	249,406	241,278	-3%	268,666	263,212
Incomplete Pathway - Total Waiting List	91,125	148,229	63%	88,982	152,413
Incomplete Pathway - 52+ Weeks	0	8,792		11	9,946
Incomplete Pathway - 78+ Weeks	0	1,017		0	1,011
Incomplete Pathway - 104+ Weeks	0	74		0	0
GP and other (non-GP) referrals first consultant-led outpatients3	381,591	404,062	6%	406,751	440,795
Cancer 28 days FDS - Total Patients Diagnosed	30,102	56,296	87%	33,199	61,414
Cancer 31 day Treatments	6,039	6,413	6%	6,672	6,996

Updated RTT position as at 16 April (data is weekly)

- 52+ week waits: 9,465 across all providers, of which 5,010 are at UHNM and 315 at the Independent Sector providers. The ICB and UHNM totals have increased since 12 March. Increases are driven by the 65+ and 78+ wait bands.
- 65+ week waits: 3,032 across all providers, of which 1,894 are at UHNM and 38at the Independent Sector providers. The ICB and UHNM totals have reduced since 12 March, although they remain on an upward trend overall.
- 78+ week waits: 653 across all providers, of which 569 are at UHNM. Of these, 8 waits are on the 2 week wait pathway, 530 routine and 31 urgent.
- The **forecast** at UHNM (trust-wide) is for 369 patients to be waiting >78 weeks at the end of April without Industrial Action impact and 498 patients with Industrial Action impact.
- There are currently no patients forecasting to breach 78 weeks at the 2 Independent Sector providers. *Please note this data is not a final position and will change.*
- 104+ week waits: 54 across all providers, (50 are at UHNM, 2 at UHDB, 1 at UHB and 1 at another NHS provider). The ICB total remains on a downward trend.
    - UHNM **forecasts** 24 patients to be waiting >104 weeks by the end of April without Industrial Action impact and 498 patients with Industrial Action impact.

Date Source: SUS and Performance data published by NHSE. Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, as published by NHSE. This is normal process.
Y/E Actual/FOT: When year end actual position is yet available, estimated FOT is used: RTT waiting list FOTs are calculated using linear regression; Other metrics are derived by applying the current YTD monthly average to the entire financial year.

Primary Care Summary

Appointments in General Practice

Indicator	Currency	Q1			Q2			Q3			Q4		YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23				
Appointments in General Practice	Count	423,294	484,394	448,258	455,173	470,805	501,940	571,228	556,735	469,981	520,189	485,869	5,387,866	5,917,885	▼	
	% to Plan	99.4%	114.6%	93.5%	98.8%	108.5%	93.3%	100.3%	99.6%	103.1%	106.1%	111.8%	102.2%	103.9%	▲	
	% to 19/20	99.6%	111.1%	108.8%	97.5%	116.4%	105.1%	104.9%	116.3%	112.7%	109.4%	114.5%	108.6%	110.1%	▲	

- Year to date the ICB is delivering 102.2% of the plan (66,982 more appointments than 19/20).
- Activity remains above that delivered in 2019/20, for the seventh consecutive month.
- The year end plan is forecast to be exceeded by 1.4%, although some impact may be seen due to Junior Doctor strikes affecting capacity in training practices (29% of GP WTEs in the ICB are Junior Doctors).

Metrics by Exception – Performance against Target

Indicator	Targets / Variance	Q1			Q2			Q3			Q4			YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23				
Total number of social prescribing referrals (cumulative)	*Cumulative target Q1: 3365, Q2: 6730, Q3: 11,780, Q4 16830*	3,103			6,692			9,991			16,786			16,786			
Learning Disabilities annual health checks (quarterly targets, cumulative data)	*Targets: Q1 12.29%, Q2 31.0%, Q3: 49.8%, Q4: 75%*	12.0%			29.4%			50.0%			80.7%			80.7%			
Antimicrobial resistance: total prescribing of antibiotics in primary care	0.871	0.989	1.003	1.008	1.013	1.019	1.013	1.013	1.024	1.073	1.103			1.103	1.088	▲	
	Variance to 19/20 (rate)	-0.063	-0.046	-0.037	-0.033	-0.027	-0.034	-0.032	-0.019	0.023	0.057			0.057		▲	

- Referrals to **Social Prescribing**; the position has improved in March (Q4) with the total cumulative number of referrals at 16,786 – only 44 below target.
- **LD Annual Health Checks** data is cumulative; provisional data for March (Q4) reports that 80.7% of eligible patients received a health check.
- The **Antimicrobial Resistance** rate increased in January and remains above the target set for our ICB.

Data Source: *Appointment in General Practice – Appointments in General Practice data collection (NHS Digital). Y/E Actual/FOT calculated using the 3 year cumulative average*
NHS Digital *- "Appointments in General Practice (experimental statistics). This is an experimental dataset and the full supporting information should be taken into consideration when interpreting activity in General Practice. Appointments are also affected by widespread variations in working methods (e.g. patient choice, preference, demographics), appointment recording, seasonality and number of working days services are available"*

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			Q4		YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23				
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days - ICB level	Count	15			160			120					295	393	▼	
	% to Plan	8.3%			133.3%			200.0%					98.3%	109.3%	▲	
	% to 19/20 (count)	12.0%			66.7%			88.9%					59.0%	61.0%	▲	
	Provider wide actual - NSCHT*	0			115			20					135	180	▼	
	Provider wide actual - MPUFT*	565			885			675					2,125	2,833	▼	
Access to NHS Talking Therapies (formerly IAPT)	Count	6,025			5,935			6,630			2,060		20,650	26,245		
	% to Plan	75.5%			70.9%			76.6%					73.9%	77.6%	▲	
	% to 19/20 (count)	116.4%			110.4%			120.1%			69.9%		113.7%	120.8%		
Estimated diagnosis rate for people with dementia	Count	10,157			10,476			10,586			10,506	10,725	10,725	10,881	▲	
	% to Plan (numerator)	102.8%			105.2%			105.8%					106.3%	107.9%	▲	
The proportion of CYP with ED (**routine** cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <4 weeks	78.3%			77.8%			80.0%					80.0%	80.7%	▲	
	Variation to plan (rate)	-0.5%			0.5%			-6.2%					-6.2%	-14.2%	▼	
	Variation to 19/20 (rate)	-13.9%			-13.7%			-14.4%					-14.4%		▼	
	Variance to National Target (95%)	-16.7%			-17.2%			-15.0%					-15.0%		▲	
The proportion of CYP with ED (**urgent** cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <1 week	91.7%			98.1%			97.9%					97.9%	100.6%	▼	
	Variation to plan (rate)	8.3%			13.9%			7.9%					7.9%	0.6%	▼	
	Variation to 19/20 (rate)	-0.6%			-1.9%			-2.1%					-2.1%		▼	
	Variance to National Target (95%)	-3.3%			3.1%			2.9%					2.9%		▼	

Metrics by Exception

- **Out of Area bed days** (at ICB level) remain above plan in Q3, by 200% - 120 bed days to a plan of 60. Current demand exceeds the bed base available due to high levels of patient acuity and a limited number of female beds. Females are more likely to be affected because there are no female-only hospitals within Staffordshire.
  - **note that Provider data includes all patients not just SSoT and is rounded by NHSE to the nearest 5 and must be used as an indicative guide only.*
- Access **to IAPT** Services is forecast to over perform against 2019/20 at year end but under perform against plan.
- **CYP eating disorder** service for **routine** cases variation to the plan is 6.2% below the Q3 plan value. The National target has not been met again but we were closer to the target in Q3 then in Q2.
- The **CYP eating disorder** service for **urgent** cases - the percentage of patients seen waiting less then 1 week: we continued over performing 95% national target, by 2.9% in Q3, with a small drop (0.2%) from Q2. We also over performed our achievement made in 2019/20.

Data Source: Performance data published by NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.
Note re. CYP eating disorders (ED) data; the source is the initial cut of the data direct from NHSE/D and remains consistent (as a source) across the financial year. This may not match the published data as that is often subject to change and has a time lag.

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			Q4		YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23				
People with severe mental illness receiving a full annual physical health check and follow up interventions	Count	3,697			3,801			3,976					3,976	4,104	▲	
	% to Plan	112.4%			102.5%			87.5%					87.5%	73.8%	▼	
	% to 19/20 (count)	141.1%			149.1%			149.6%					149.6%	152.7%	▲	
Women Accessing Specialist Community Perinatal Mental Health Services	Count	310			455			530			565	595	595	659	▲	
	% to Plan	86.8%			84.6%			72.5%					67.6%	73.5%	▼	
	% to 21/22 (count)	96.9%			98.9%			91.4%			90.4%	89.5%	89.5%	93.5%	▼	
Access to Individual Placement and Support Services	Count	345			460			550			595	625	625	682	▲	
	% to Plan	156.6%			104.4%			83.2%					77.4%	77.4%	▼	
	% to 19/20 (count)	328.6%			270.6%			224.5%			212.5%	211.9%	211.9%	209.8%	▼	
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Count	10,560			11,040			10,995			10,815	10,625	10,625	11,094	▼	
	% to Plan	93.9%			97.7%			96.9%					92.3%	96.4%	▼	
	% to 21/22 (count)	102.5%			111.6%			107.7%			106.0%	103.5%	103.5%	106.3%	▼	
Access to Children and Young People's Mental Health Services	Count	14,885			14,945			14,845			14,905	14,845	14,845	14,981	▼	
	% to Plan	75.2%			74.8%			73.2%					73.2%	74.1%	▼	
	% to 21/22 (count)	121.9%			114.4%			108.4%			106.6%	103.6%	108.4%	103.4%	▼	

Metrics by Exception

- Severe Mental Illness (SMI) annual health checks – There is no new data as the metric is reported quarterly.
- Perinatal Access – Q4 to date shows a surge in the number of contacts, however the volume is only 89.5% of that in 2021/22.
- Access to Individual Placement and Support Services - Q4 to date shows a surge in the number of contacts during February, the 19/20 count exceeded.
- Overall Access to Core Community Mental Health Services (for Adults with SMI) reports a slight drop in February but a count above that in 2021/22.
- Access to Children and Young People's MH Services reports a slight drop in February but a count above that in 2021/22.

Notes:

- *(*) Where metrics do not have a FOT they either do not have a plan or they are a combination of monthly data and quarterly plans therefore it is not possible to generate a linear forecast*
- *Overall Access to Core Community Mental Health Services for Adults and Older adults with Severe Mental Illnesses and Access to Children and Young People's Mental Health Services continue to be impacted by the move to ICBs. NHS Digital are working on getting the data for August and September into next month's publication of the MHSDS.*
- *Published First Episode Psychosis treatment data is currently withheld because the data has yet to be released by NHS Digital in a usable format (being only available at Sub-ICB level and rounded to the nearest 5/ suppressed where values fall below 5).*

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**10**

Title:	**Planning Update**

Meeting Date:	18 May 2023

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

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Yes			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
System Performance Group	26/04/23	D/S/I
Finance & Performance Committee	02/05/23	D/S/I

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

The purpose of this report is to seek ratification of the 2023/24 One Year Operational Plan and to appraise the Board of the material changes made to the technical plan submissions 4th May.

Key points on the **2023/24 Operational Plan**

- The plan sets out a collective goal and priorities agreed in February by the executive teams of all statutory organisations.
- The plan has been developed collectively with system partners to cover both local and national priorities
- It describes the key focus as agreed at the system planning event on 13 February to reduce category two and three ambulance calls and how all of our portfolios will contribute to this goal.
- It highlights the need to come together behind two significant system initiatives over the year around admission avoidance and discharge, which will help us address the challenges of delivering high quality care and addressing our significant underlying financial challenge.

Key points on the **2023/24 National Planning Resubmission**

- A break-even system plan has been submitted to NHSE, following ratification by system CEOs and the Finance and Performance Committee. It was noted that there is very significant risk associated with the delivery of this break-even position, and that the National and Regional teams had been fully appraised of the level of risk.
- The collective efficiency plan requirement has increased to 7.4%.
- The March submission indicated that there would be 800 patients waiting more than 65 weeks by the end of March 2024. Since that point the system has developed a plan to reduce these 65-week waiters to zero by March 2024.
- There have been no material workforce changes between submissions.

The attached operating plan was discussed with all system partners at the May meeting of the Finance and Performance Committee and was approved by that Committee. It is now brought to the ICB Board for final approval.

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

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
BAF Strategic Aim '(3C) (**Risk 961**) - Support the delivery of system financial balance by 2025/26'. (BAF submissions being reviewed by ICB Board and are subject to change)
Risk 001 - Underlying deficits from 2023/24: If the system saving schemes do not deliver the financial strategy, the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position, in line with the operating and planning framework.
Risk 111 – If continued delays to ambulance handovers are incurred and sustained, or levels increased there will be significant pressures placed onto ED, ambulance crews and the wider UEC system resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time and associative issues.
Industrial Action is the biggest risk for our long waiters. **Risk 112** - If Industrial action continues there will be periods of additional pressure placed upon the system due to staffing cover and contingency arrangements resulting in increased instances of patient harm, increased system capacity issues, compromised staffing ratios and the need for enhanced contingency measures.

Implications:	
Legal and/or Risk	None specifically identified pertaining to this report
CQC/Regulator	None specifically identified pertaining to this report
Patient Safety	None specifically identified pertaining to this report
Financial – if yes, they have been assured by the CFO	The breakeven financial plan to be submitted on 4th May to be signed off by the ICB Board have been identified in the report
Sustainability	None specifically identified pertaining to this report
Workforce / Training	None specifically identified pertaining to this report

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	

1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • Approve the 2023/24 One Year Operational Plan • Note the submission of a breakeven financial plan for 2023/24 and the associated risks • Note the activity resubmission and the improved compliance with national targets			

2023/24 Operational Plan and Planning Update

Paul Brown – Chief Finance Officer

Overview of the Operational Plan

- The 2023/24 One Year Operational Plan summarises national and system priorities, and how, across ICB delivery and enabling portfolios, and partners we will deliver them across the ICS. We have worked in partnership across the system to co-produce this one year plan for 2023/24.
- It builds on the Integrated Care Partnership (ICP) Strategy, the Health and Wellbeing Strategies, wider partner strategies and plans that focus on our local population and forms the first year of the Joint Forward Plan.
- It sets out our key priorities as a system for 2023/24 and how we will measure our success.
- It draws out key actions from across the system, these actions come from a mixture of:
    - The local system priorities as agreed at our system workshop on 13th February
    - The 31 national planning objectives and 50 national actions
    - Ongoing National Long Term plan 2019 commitments and other national guidance and frameworks
- The plan describes in particular the need to come together behind two significant system initiatives over the year around admission avoidance and discharge which will help us address the significant underlying financial challenge.
- Specific actions and metrics are part of the plan which will allow executives to stay on top of the detail and the System Finance and Performance Committee will scrutinise progress.
- A public facing summary of the document will be produced and published on the ICB website.
- A draft version of the plan was shared with the ICB Finance & Performance Committee, the System Performance Group (SPG) and system partners to arrive at this final version. The ICB Finance & Performance Committee recommended the approval of the plan on 2nd May 2023.

The ICB Board is asked to approve the 2023/24 One Year Operational Plan.

2023/24 Financial plan update

- The Finance & Performance Committee approved a system plan with a deficit of £39.4m after applying £40m of stretch improvements to the plan in March.
- We were then asked to make further improvements and to identify a pathway to breakeven.
- Following discussion with the national leadership team at the NHSE regional escalation meeting on 26th April the CFOs recommended to the CEOs that we should move to a system plan to break-even.
- We have increased our efficiency plans in moving to a breakeven position. At the end of March, we had an efficiency target which equalled 5.5% of our RRL, which has now increased to 7.4%. The detail around these efficiency plans is still being worked through.
- We consider this to be an upside plan and whilst we do not have confidence that we can deliver it in full we are committed to trying to achieve it.
- This recommendation was supported by the CEOs and the Finance and Performance Committee and we have submitted a balanced financial plan for all four organisations within the system.

2023/24 Activity Ambitions

- In the March 2023 planning submission the ICB demonstrated compliance across a range of metrics, however there was non-compliance on the reduction in specific waiting list numbers.
- Whilst progress has been made, there remain continuing areas of risk and non-compliance:

65 week waits

- The March submission indicated that there would be 800 patients waiting more than 65 weeks by the end of March 2024. Since that point the system has developed a plan to reduce these 65-week waiters to zero by March 2024.
- Industrial Action is the biggest risk for our long waiters. This was a specific area of discussion at the NHSE escalation meeting on 26th April.

Improve category 2 ambulance response times

- In March West Midlands Ambulance Service (WMAS) submitted a non-compliant regional trajectory to improve category 2 ambulance response times to an average of 30 minutes across 2023/24. The WMAS plan only achieves 44 minutes against the target of 30 minutes.
- Discussions are ongoing with the host commissioner (The Black Country) and the NHSE regional team in relation to the current trajectory. We will be looking to set local stretch targets which we can monitor each month.

Summary of Planning Trajectories and Activity Ambitions

The summary below outlines the main compliant areas across planned care, cancer, diagnostics and urgent care:

- 76% of patients seen within 4 hours by March 2024
- Reduce adult general and acute (G&A) bed occupancy to 92% or below
- Deliver the system-specific activity target-the cost-weighted target (103%)
- Increase productivity and meet 85%-day case and 85% theatre utilisation target
- Reduce the number of patients waiting more than 62 days to commence cancer treatment
- Meet the 28-day faster diagnosis standard by March 24 (75%)
- Increase the number of patients with suspected cancer on a non-site-specific pathway
- Increase percentage of Lower GI cancer referrals with an accompanying Faecal Immunochemical Test (FIT) result
- Increase percentage of patients receiving diagnostic tests within 6 weeks in line with ambition to achieve 95% by March 2025
- Deliver increased diagnostic activity to meet the ambitions with elective and cancer recovery plans

Staffordshire and Stoke-on-Trent Integrated Care System

2023/24 Operational Plan

Foreword

Our role as an Integrated Care Board (ICB) is to help bring partners together to integrate our approach to improving health and care services for our local population. We have made positive strides towards that goal this year, but there is much more to do. This Operational Plan for 2023/24 marks another step towards that aspiration of an integrated working environment where the focus of us all is on the best health and social care for our residents.

The document sets out our key priorities as a system for 2023/24 and how we will measure our success. The document aims to draw out key actions from across the system, delivered through the Portfolio structure we have created. The plan does not duplicate issues that are covered within the business plans of NHS providers, local authorities or other partners: instead it aims to distil the key system level actions that are planned for this year.

We have co-created a common understanding of the behaviours expected of our leaders, supported by a compact to ensure mutual accountability between individuals and organisations. The leaders of the organisations within the Integrated Care System (ICS) have agreed to adopt the System Leadership Compact which is outlined further in this document. These behaviours have supported the development of this plan, and I am grateful to my CEO colleagues and their teams for the way that they have engaged in the development of this first system plan.

Working with all our partners across the system, we want to improve the lives of people living across Staffordshire and Stoke-on-Trent now and in the future. We want to do this while restoring inclusively our services to pre-COVID levels, eliminating long waits to access services, and reducing unwarranted variation in our services. Alongside this, we will work to embed service changes which have proved beneficial to our people and communities – including our populations at neighbourhood level. We have a strong foundation to build on, but we know we need to continually look for new ways to strengthen our networks and adapt our communications, engagement, and operational delivery – to enhance our understanding of the needs of our diverse population.

The context for this plan is a very challenging financial and operating environment. The plan sets out a collective goal and priorities agreed in February by the executive teams of all statutory organisations. It describes the need to come together behind two significant system initiatives over the year, which will help us address the significant underlying financial challenge.

Collectively we need to come together to meet this challenge, and keep the system in a sustainable financial position which will enable our work to enhance the quality and sustainability of our services.

Peter Axon
ICB Chief Executive Officer

System 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.**

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The purpose of the one-year Operational Plan 2023/24

- The purpose of this plan is to summarise national and system priorities, and how we will deliver them across ICB delivery and enabling portfolios, providers and partners
- We have worked in partnership across the system to co-produce this one-year operational plan for 2023/24
- This one-year operational Plan reflects national and system priorities and builds on the Integrated Care Partnership (ICP) Strategy, the Health and Wellbeing Strategies, wider partner strategies and plans that focus on our local population
- It forms the first year of the Joint Forward Plan and acts as a delivery mechanism for the ICP Strategy
- The actions outlined in this document have been developed at a point in time, and are based on a range of current assumptions
- This is a working document that we will use throughout the year. It will allow us to track progress and to hold one another to account
- This plan and the how, is underpinned by a more detailed outline of deliverables across each quarter. The underlying high level detail for each portfolio is available from each lead.
- The document and the underlying detail categorises deliverables so that it is clear where the responsibility for delivery sits – at System, Provider, Place, Primary Care Network (PCN) or Portfolio. This enables appropriate governance for decision making and to monitor delivery. Specific actions and metrics are part of the plan and the System Performance Group will allow executives to stay on top of the detail and System Finance and Performance Committee will scrutinise progress.

Key achievements in 2022/23

Over 2022/23, we built on our system-first approach to the leadership of our system. There have been many successes where we were able to make much more progress working collectively – that would have been impossible working in single organisations. These include:

- System Chief Operating Officers (COOs) led the system through a very challenging winter period and maintained services despite disruption due to industrial action. We ended the year in a much stronger place within our urgent and emergency care (UEC) pathways and ambulance waits, although clearly we still have a long way to go.
- System Chief Finance Officers (CFOs) led the system to delivering the third consecutive year of financial balance with all organisations achieving financial balance. CFOs worked as a team to collectively manage risk and to develop a medium-term Financial Strategy focussed on addressing the underlying deficit.
- System Directors of Strategy (DoS) were integral in the partnership approach to developing our plans during 2022/23. They have ensured that plans are devolved into their respective organisations, both leading and contributing to the design and approach of system planning.
- Our ICS People Collaborative approach has continued to develop over time with health and social care partners. It is mature and effective in collectively tackling our workforce challenges and has been a key enabler to delivery during 2022/23.
- Chief Nursing Officers and quality leads have worked collaboratively to develop a framework and a set of mutually agreed quality principles. Our teams work collaboratively to identify early warning signs of emerging issues or impacts.
- Our System Clinical and Professional Community have delivered, along with organisational operational teams, a range of work.

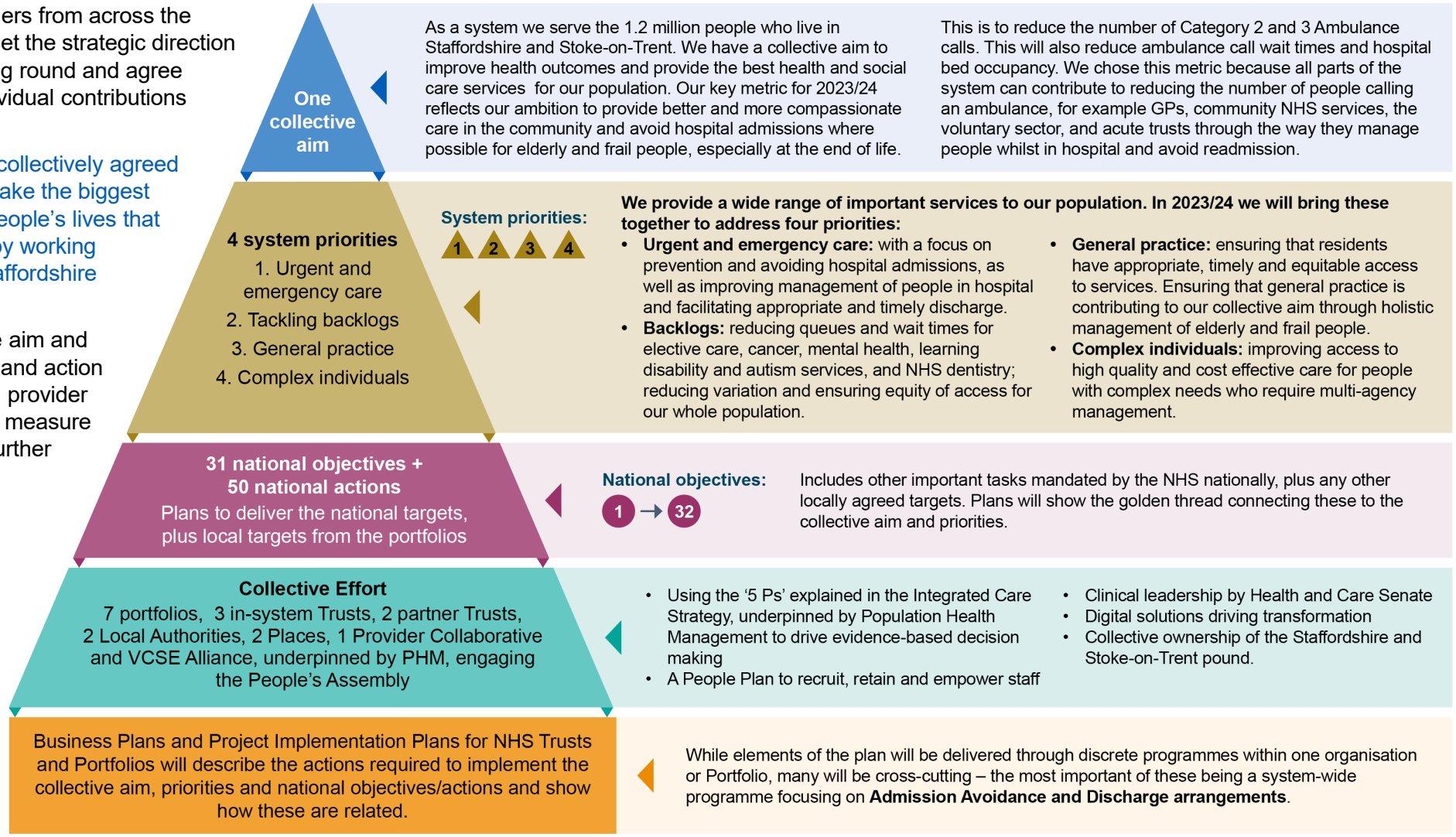
This includes:

- the System Winter Plan to deliver enhancements to a number of schemes, including expansion of the Community Rapid Intervention Service (CRIS) to include a two-hour Urgent Community Response service, Community Falls Response services and expansion of our virtual wards offer
- making progress in recovering our elective waiting time performance during 2022/23, against an ongoing high level of COVID-19 infection, patient acuity, capacity constraints in social care, and workforce availability
- making good progress in reducing the backlogs of patients waiting 62 days or more for cancer treatment
- improvements across primary care, specifically face-to-face GP appointments, where Staffordshire and Stoke-on-Trent is the second-highest performing ICB in the region
- achieving transformation across mental health and learning disabilities the ICS has operated a comprehensive Mental Health Programme which has delivered a large number of improvements.

In developing the 2023/24 Operational Plan, we have reflected on the lessons learned in addressing the challenges over the last 12 months in both setting our local priorities and also in how we use our portfolios, places, provider collaboratives and our broader partners to set ourselves up for the delivery of those priorities in the next 12 months.

The system plan on a page for 2023/24

- CEOs and system leaders from across the ICS came together to set the strategic direction for the 2023/24 planning round and agree organisational and individual contributions to that.
- As a system, we have collectively agreed the priorities that will make the biggest positive difference to people's lives that can be best achieved by working across the whole of Staffordshire and Stoke-on-Trent.
- We have one collective aim and each priority, objective and action is aligned to a portfolio, provider or partner. How we will measure delivery of is outlined further on in this plan.
- The key aim is to reduce the number of Category 2 and 3 ambulance calls.
- The system plan on a page has been agreed and signed off with our partners, Integrated Care Partnership and Integrated Care Board.



Our approach to developing our priorities

- This one-year plan reflects national and system priorities and builds on the ICP Strategy, the Health and Wellbeing Strategies, wider partner strategies and operating plans that focus on our local population
- The principles of our approach are illustrated in the diagram (our 'Hopper Model') which shows how the converging parts of our vision, ambitions and priorities will be delivered by working together to improve health outcomes and provide the best health and social care services for our population
- We used this hopper to create this plan that clearly defines the system objectives for the year ahead and apply those tasks to the appropriate part of the system – Trust, Provider Collaborative, Portfolio.

Informing our ambitions and priorities
We have used feedback, information, data & best practice to gain insight into the needs of our changing population, through JSNAs, engaging with our local people, existing partner plans ensuring alignment with national targets & priorities

1

A single vision for the future
We want people to live well, stay healthy and independent for as long as possible, accessing health and care services that meet people's needs '*making Staffordshire and Stoke-on-Trent the healthiest places to live and work*'.

2

Integrated Care Partnership (ICP) Strategy
To achieve this vision we have developed an ICP Strategy which sets out our long-term ambitions at different stages of life: Start well, grow well, live well, age well and end well

3

Joint Forward Plan & Annual Operating Plan 2023/24
Our Joint Forward Plan sets out our key priorities of how we will work together over the next 5 years to deliver our ambitions. Our Annual System Operating Plan 2023/24 sets out our current priorities for this year

4

Our operating principles & commitments
We will deliver all of the above against a set of operating principles and commitments of how we will work together, these include our 5Ps.

5

How we will deliver our ambitions & priorities
We will deliver our ambitions and priorities through a range of vehicles set up to work at the level and scale required to make the biggest impact these include: Provider Collaborative, Place, Portfolios, PCNs and Providers

Icons on this slide designed by Freepik

Our system-wide approach for pathway redesign

Our goal: We need to design models of care which help our patients and residents follow seamless care pathways and which remove unnecessary delays and duplication. In turn, these pathways need to help maximise the time our workforce spend in delivering care. Being successful in both of these aims will help us address the need for financial savings.

Our approach: One of the biggest challenges facing all systems is supporting the care of our frail elderly and those with long-term conditions. Our Continuing Healthcare (CHC) costs have increased by £50m, which is a cash-cost to the system. Our local authority partners are facing similar pressures in terms of funded social care placements. The demand for care currently outstrips the supply, resulting in lack of choice for our most vulnerable population and unsustainable pressure on our workforce in the care home sector. We know that some of these CHC and social care costs may be avoidable if patients are not admitted in the first place or, when they are, they are discharged with alternative home support packages. We know from evidence that patients degenerate if their discharge process is inadequate, and a large number of these people end up with a lifetime of dependency. Working together on admissions and discharges as two joined-up projects, we can positively impact on the quality of lives of our population. This will also have a positive impact on managing the demand for beds in the already constrained care home and positively impact on the finances. **So we propose two transformational projects for pathway redesign this in 2023/24:**

1. Admission avoidance

A system team to join current work programmes and services together, to significantly reduce the number of admissions, with a focus on frailty and older people. This to include all five system Trusts and local authorities, with capacity from the ICB.

2. Discharge

An enhanced focus on connecting hospital discharge with CHC projects, D2A/Home First, Domiciliary Care services and social care. This will include all five system Trusts and local authorities, with capacity from ICB. Enhancing the integrated discharge model will support this overall aim.

Existing projects and services grouped and linked if appropriate to one of the two system transformation projects.

Acute Care at Home Provider Collab (Step up and Step down)	Same Day GP Access End of Life Programme	Proactive Frailty: Healthy Ageing, Falls Prevention and Mild Frailty	Reactive Frailty: Moderate and Severe	LTC Programme 111 MH Response	Integrated Discharge Team	Continuing Healthcare End of Life Programme	Home First Discharge to Assess	Discharge Medicine Service	Project 86 (Complex MH)

Portfolios: To identify resource, to work into the appropriate transformation project, to work in a multi-organisation team, and to deliver the agreed metrics.

Prevention actions

The case for a system-wide focus

1. Admission avoidance

- We need to reduce unnecessary hospital admissions for our frail elderly population through effective proactive interventions as well as providing rapid support at home when they become sub-acutely unwell. This requires the provision of effective out-of-hospital services including virtual wards, remote care systems and other community teams. Our focus should be on keeping people within their own homes – reducing the often negative impact of hospital admission. People almost universally prefer to avoid hospitals where possible – and we need to be able to offer them that choice
- Care and treatment in the usual place of residence is preferable – if safe to do so with an appropriate care model in place. We know that admitting elderly people via busy emergency departments can shorten their lives, and is often a poor experience
- There are still people who are at the end of their life being escalated into hospital who have clearly indicated they want their care at home, and an enhanced community offer will help ensure their wishes are met
- Avoiding unnecessary admissions will play an important part in improving our capacity to discharge people effectively.

Benefits

- One system-wide operationally led project would reduce avoidable emergency admissions, improve the quality of life for people with long-term and acute conditions and their families, and would reduce pressures on cross-system resources. A key focus will be on older frail people for whom alternative services are a better route to maintaining their independence and quality of life, as well as being a much lower cost
- The focus will be to help clinicians access the existing services that we already have in place
- This will be established as a six-month task that will aim to reduce the number of people receiving their urgent care in the hospital setting.

The case for a system-wide focus

2. Discharge

- We know all parts of the system either rely on or contribute to effective discharge arrangements and we spend monies in every organisation on aspects of facilitating discharge. We know that most people want to leave hospital and, where possible, return to possible living in their own homes. Many of these people are in the last 1,000 days of life, so we need to be able to get them home as swiftly as possible. Improving discharge pathways will improve people's lives and support their carers
- As a system, we need something big to get behind where there is a realistic opportunity to improve outcomes and simultaneously take out unnecessary costs. We know that too many people are being admitted to a hospital bed and then become deconditioned. Many are not discharged on a timely basis, and as a system we appear to discharge more people into bed-based care rather than getting them home. We also have rising numbers requiring expensive CHC packages / social care compared to peers, with many remaining dependent on the health and care system for the rest of their lives. We should be striving to restore independence for our population
- This cohort of people are cared for across acute, community and social care elements our system, and this is where there is evidence of duplication of effort and a risk of gaps between services
- We know we have implemented step-down services like virtual wards which are not being used to their full potential.

  We need to understand why this is the case and how those services need to be changed to maximise their impact/productivity. We need to engage with clinicians across the system to make the most of the opportunity that virtual wards and telehealth offer our population.

Benefits

- The system aim should be for one system-wide, operationally-led project that would improve the lives of people (largely the elderly or those with complex needs), who are ending their lives in a state of dependency with the opportunity to reduce inefficiencies, remove duplicated effort and ultimately take costs out of the CHC and social care
- To critically review all aspects of discharge processes and support through a structured approach to redesign a seamless pathway. This needs to maximise the impact of services commissioned through the Better Care Fund as well as by local authorities and the NHS, and should address unwarranted variation within the system in terms of access to service offers
- We will set this up as a six-month task, that will deliver cash out from CHC and social care later in 2023/24, but more importantly lead us to a better 2024/25 and beyond.

How we will deliver the plan

- All portfolios have identified the actions that they need to address in 2023/24. These actions come from a mixture of:
  - 31 national objectives and 50 national actions
  - Ongoing national Long Term Plan 2019 commitments
  - National guidance and frameworks not published as part of the 2023/24 planning guidance
  - Other locally determined actions to address system priorities of providers, local authorities and our broader system partners
  - Where actions are the responsibility of one of the statutory organisations, the governance arrangements of that organisation will apply and the ICB will take assurance from those governance mechanisms
  - Where actions require several organisations to be involved, the ICB governance mechanism applies and decisions and monitoring occurs at the system level
  - Each slide indicates which national objectives the portfolio will deliver or which local priority they will contribute to using a circle or a triangle. Example:

  - A list of the national objectives is provided on slide 54.
  - The plan is underpinned by a more detailed outline of objectives/ deliverables across each quarter. The link to the detail of each Portfolio plan is available from each lead.

- We are keen to build on the successes of 2022/23 by being a lot more rigorous in our assessment of delivery. The system Programme Management Office (PMO) and the Transformation Delivery Unit (TDU) will coordinate the monitoring of all tasks and metrics. Exceptions will be discussed and corrective action agreed at System Performance Group, then scrutinised at System Finance and Performance Committee
- We will deliver our ambitions and priorities through a range of vehicles that have been set up to work at the level and scale required to make the biggest impact on improving population health and wellbeing in Staffordshire and Stoke-on-Trent. These include:
  - **Provider Collaborative:** Enabling workstreams as the delivery vehicle for transformation at scale to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers
  - **Place:** Aligning with our local authorities where at scale is required with multiple partners
  - **Portfolios:** Bringing delivery and local transformation together
  - **Primary Care Networks (PCNs):** PCNs build on existing primary care services and enable more resilient delivery of primary care in local neighbourhoods, and the integration of health and care services
  - **Providers and Partners:** Provider organisations will focus on local service change when this is required to drive change and efficiency and includes a range of providers in an advisory capacity.

Summary of what we will deliver

- The place mat demonstrates at a high level, objectives, metrics and deliverables of the System Plan
- This is underpinned by Business Plans and Project Implementation Plans for NHS trusts. Through Portfolios, we have described the actions required to implement the collective aim, priorities and national objectives/actions and show how these are related.

PORTFOLIO	Children and Young People / Maternity	Planned Care, Diagnostics & Cancer	Improving Population Health	Urgent & Emergency Care	Mental Health, Learning Disability and Autism	Primary Care	End of Life, LTCS and Frailty (ELF)
	• Deliver the key NHS Long Term Plan ambitions for a strong start in life for children and young people • Implementation of the national delivery plan for maternity and neonatal care	• Deliver the goals for elective recovery in planned, cancer and diagnostics	• Embed measures to improve health and reduce inequalities	• Recovery of Urgent and Emergency Care Services	• Deliver the key NHS Long Term Plan ambitions	• Deliver the vision outlined in the Fuller Stocktake and make it easier for people to contact a GP practice	• Deliver the Ambitions for Palliative and End of Life Care national framework • Deliver the key NHS Long Term Plan ambitions supporting people to age well • Deliver the NHS Long Term Plan prevention priorities
NATIONAL OBJECTIVES	13 14	6 7 8 9 10 11 12	27 28 29	1 2 3 4	19 20 21 22 23 24 25 26	5 15 16 17 18	
SYSTEM PRIORITIES	1 3 4	1 2	1 2 3 4	1 2	1 2 3	1 2 3	1 2
KEY METRICS / DELIVERABLES	• Design and Implement Long Term Conditions Programme (Diabetes, Epilepsy and Asthma) • Implement Children with Complex Needs Project • Implementation of the national delivery plan for maternity and neonatal care	• 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 2ww	• Systematic implementation of the Core20 approach • Implement NHS Long Term Plan prevention programmes • Utilise population health management techniques	• 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”	• Improve the crisis pathways including 111 and ambulance response • Undertake a PICU Options Appraisal • Minimise waiting times for autism diagnosis • Increased number of people accessing IAPT • Increased number of people with SMI having annual physical health check	• Deliver ARRS recruitment • Implement digital solutions to provide enhanced remote care to people. • Deliver recovery of dental activity • Implement POD Delegation	• The creation of a PEoLC strategy • Identification of Patients in the last 12 months of life recorded on Palliative Care Registers in Primary Care • LTC strategy • Transformation programme around CVD, Respiratory and Diabetes • Delivery of the frailty strategy

PEOPLE & COMMUNITIES | PERSONALISED CARE | PERSONAL RESPONSIBILITIES | PREVENTION & INEQUALITIES | PRODUCTIVITY

Staffordshire and Stoke-on-Trent Integrated Care System

Our Portfolios focus for 2023/24

Bringing delivery and local transformation together

- Our Portfolios are aligned to eight key focus areas: Urgent and Emergency Care; Planned care including cancer and diagnostics; End of Life, Long-Term Conditions and Frailty; Primary Care; Mental Health, Learning Disabilities and Autism; Children and Young People and Maternity; Improving Population Health
- Each Portfolio has an agreed set of senior leadership roles including an Executive Sponsor, a Senior Responsible Officer (SRO), a Portfolio Director and a Clinical Director.

Urgent and emergency care

- We are working in partnership with our provider organisations across including University Hospitals of North Midlands NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust, Midlands Partnership University NHS Foundation Trust, Staffordshire County Council, Stoke-on-Trent City Council, West Midlands Ambulance Service, East Midlands Ambulance Service, Midlands and Lancashire Commissioning Support Unit, North Staffordshire Combined Healthcare NHS Trust and other key providers including primary care and the third sector. Our revised governance structure fully reflects this
- Provision of services has been extremely challenging. Our population have experienced significant delays in accessing urgent and emergency care, with our hospitals unable to meet the required A&E waiting time standards. Across the country, ambulance handover delays have reached critical levels – leading to considerable delays for people waiting in the community – especially for our Category 2 and 3 patients
- As a system, we have worked together to co-produce and agree local plans to develop the capacity required to deliver UEC recovery. These plans feed into our more detailed local UEC plans. In developing our short, medium and longer term strategy for UEC, we have focussed on seven priority areas for 2023/24 which are fully aligned to the 2023/24 national UEC Recovery Plan. The focus is to ensure consistent simplified delivery and our plans are be focused on provider collaboration where appropriate.

Our commitment

"We recognise that people in our catchment areas deserve the best quality urgent and emergency care, as close to home as possible, and as swiftly as possible. Our work through the UEC Board aims to offer people rapid access to assessments and treatments, whether they are being looked after in their home, in primary care, by paramedics or in the hospital. We intend to make use of the full range of technology to manage the needs of people, ranging from traditional one-to-one appointments to virtual consultations and wearable devices to monitor vital signs without leaving their home."

Matthew Lewis, SRO

Our high level key measures for urgent and emergency care

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Recovery	Improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25.	76.2%	72.0%	79.7%	77.5%	75.6%
	Reduce adult general and acute (G&A) bed occupancy to 92% or below*.	91.7%	90.6%	90.6%	90.6%	90.6%
Pre-hospital	Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard.	84.4%	85%	85%	85%	85%
	Reach 80% utilisation of virtual wards at a minimum by the end of September 2023.	35%	63.9%	70.9%	75.5%	86.2%
Post-hospital	Improve number of discharges on Pathway 0 to 80%.	72%	76.4%	77.6%	78.8%	80%

* Subject to successful capital investment for additional beds

Urgent and emergency care 2023/24 deliverables

1 2

- Deliver the wide ranging actions set out in National UEC Recovery Plan 1 2 3 4
- Deliver the system UEC Delivery seven-point plan pre-hospital, in hospital and post-hospital 1 2 3 4

- Progress capital investment business case for 45 additional beds at Royal Stoke University Hospital – essential to close the peak capacity gap in winter 2023/24
- Full review and priority setting for virtual wards
- Work with interdependent strategies and programmes e.g. primary care, mental health, end of life, long-term conditions and frailty
- Full review of the access programme with a view to enhancing provider collaborative offer to include the Clinical Assessment Service
- Work with UHNM on the UEC improvement programme to improve acute hospital flow, and deliver the 76% emergency department standard, the 92% occupancy target and improve ambulance handover delays
- Deliver a fully integrated discharge "hub" with a single operational tasking structure and physical co-location
- Improve the discharge profile and targets and achieve a consistent seven-day service.

Staffordshire and Stoke-on-Trent UEC next steps

Pre-hospital

- **Frailty and end of life pathways** – regional benchmarking and pathway development – Steve Grange/ Lynn Millar
- **Acute care at home (ACAH)** – Unscheduled Care Coordination Centre, virtual wards and Urgent Community Response delivery – Paul Bytheway / Jennie Collier

B C G H I J

In hospital

- **Acute hospital flow** – acute front door, portals and navigation, and base ward discharges – Paul Bytheway

A C

Post-hospital

- **Integrated discharge hub review** – complex pathway integration – Paul Bytheway / Sam Merridale
- **P0 optimisation** – P0:P1 and 2 benchmarking and improvement
- **Discharge profile and targets** – consistent 7 day service – Paul Bytheway / Jennie Collier

E F G

System bed capacity and demand – strategic alignment and implementation – Paul Bytheway / Jennie Collier / Ashleigh Shatford

A C D

Planned care including cancer and diagnostics

- Despite improvements in 2021 and 2022 compared to the first year of the pandemic, the number of electives and outpatient attendances currently being carried out is still well below pre-pandemic levels
- All providers of planned care continue to work towards recovery of elective and day case activity; people continue to be triaged for potential referral to the Independent Sector and other NHS trusts
- Building on both the operational planning guidance and also the NHS Triple Aim, the Planned Care, Cancer and Diagnostics Portfolio has two main aims: recovery and transformation for 2023/24 and beyond
- The ICB shows a similar profile to the national one, with a large increase in the numbers of people on the referral to treatment (RTT) waiting lists and a corresponding decrease in performance against the 18-week target
- Additionally, the number of people waiting over 52 weeks for treatment and over six weeks for diagnostics has increased. We will continue to build on the progress made in reducing the number of people waiting over 104 and 78 weeks for their surgery.

Our commitment

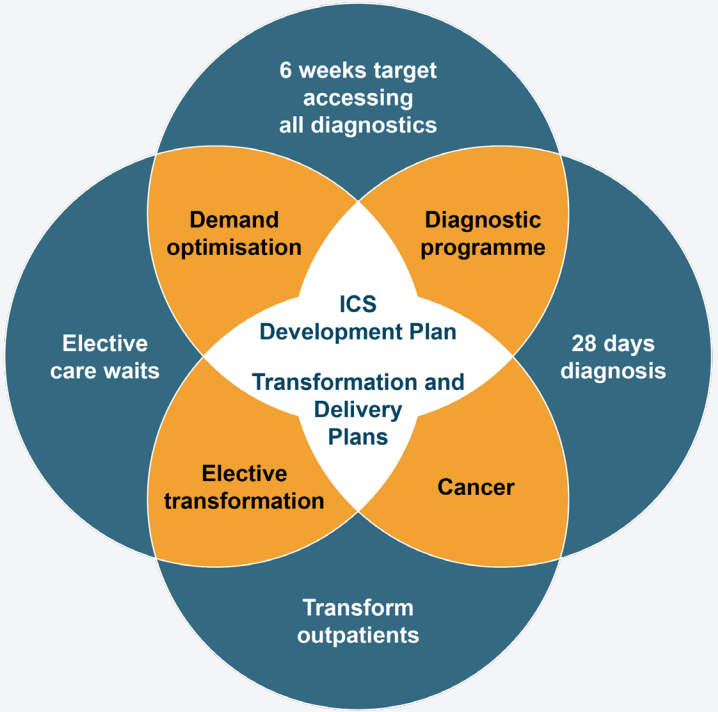
"From a planned care perspective, the ICS continues to focus on the delivery of two overarching objectives – the recovery of capacity to levels that meet or exceed that in existed pre-COVID in order to eliminate long waiting times, as well as the transformation of patient pathways in order to promote the use of alternatives to traditional outpatient and surgical interventions.

"Continued focus on access and reporting of diagnostic services will ensure the delivery of cancer pathways and the ability of primary care clinicians to deliver care in the most appropriate settings."

Helen Ashley, SRO

At ICB level as at 2 April 2023:

- **8,966** people were waiting more than 52 weeks, compared to 8,213 people in the same week in 2022 (w/e 03/04)
- **588** people were waiting more than 78 weeks, compared to 2,001 people in the same week in 2022 (w/e 03/04)
- **44** people were waiting more than 104 weeks, compared to 613 people in the same week in 2022 (w/e 03/04).



Planned care 2023/24 deliverables

1 2

- Eliminate waits of over 65 weeks 6
- Aim to reduce outpatient follow-ups
- Deliver the system-specific elective activity target (103%) 7
- Increase productivity and meet the 85% day case and 85% theatre utilisation expectations
- Referral and intervention management
- Outpatient transformation

- We will support the reduction of 65-week waits through ongoing validation and review of long waiters. ICS partners will collaborate to ensure all available capacity is used to clear backlog of patients waiting for treatment. This will include the use of mutual aid from providers external to the system and the ICS will work with people to take up the offer of treatment. The ICS will make full use of the NHS 'Choice' agenda to ensure people can receive timely treatment
- We will aim to deliver an appropriate reduction in outpatient follow-ups through continuing to provide improved access to primary care services, increasing the diversion rate of outpatient attendances and exploring opportunities through reinvigoration of the system Demand Management Group
- We will deliver the system-specific elective activity target and create additional outpatient activity through driving the implementation of the Patient Initiative Follow Up (PIFU) work to support a personalised care model
- The ICS will implement GIRFT recommendations and improve and maintain theatre productivity and other efficiency measures.

Our high level key measures for planned care

Objective	Baseline	Year 1 (2023/24) Q1	Q2	Q3	Q4
Eliminate waits of over 65 weeks for elective care by March 2024.*	2,267 (Dec 2022)	2,925 *1,680*	2,140 *1,272*	1,199 *750*	0 *0*
Aim to deliver a reduction in OPFU in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024.	520,688 (2019/20)	132,081	136,761	135,834	136,344
Deliver the system-specific elective activity target 103%.	103%	103.9%	103.2%	103.0%	103.0%
Increase productivity and meet the 85% day case and 85% theatre utilisation expectations.**	System submission compliant	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory	UHNM internal trajectory

*ICB level trajectories are shown for 65-week waits first, with UHNM trajectories shown underneath in italics
**System submission is compliant. Current UHNM performance achieves 85% overall.

Cancer and diagnostics 2023/24 deliverables

1 2

- Increase the percentage of people that receive a diagnostic test within six weeks 8
- Deliver increased diagnostic activity and capacity 9
- Meet national standards to reduce the number of people waiting over 62 days 10
- Meet the faster diagnosis standard 11
- Increase the percentage of cancers diagnosed at stages 1 and 2 12

- Continue to improve diagnostic test wait times and activity levels through improved used of existing capacity. In 2023/24, we have planned to deliver 20% more diagnostic test activity than 2019/20 – maximising the pace of roll-out of Community Diagnostic Centres (CDCs)
- We will build on the progress made to improve performance against cancer standards through:
  - Supporting capacity expansion – especially diagnostic capacity at pathway pinch-points
  - Ensuring as many two-week wait skin referrals as possible are accompanied by high quality images to enable remote triage and maximise discharge / Straight to excision without outpatient appointment
  - Ensuring optimal use of lower GI two-week wait referrals by diverting FIT negative patients to alternative pathways where clinically appropriate
  - Promote more consistent primary care initiated “straight to test”.
- Promote and maximise use of non-site specific referral pathways
- Support an increase in the percentage of cancers diagnosed at an early stage through:
- Targeting communities with poorer outcomes to increase awareness of cancer symptoms and importance of cancer screening programmes
  - Expand the Targeted Lung Health Check Programme into south Staffordshire.
- Use the Midlands Cancer Screening Dashboard to inform targeted interventions that improve screening uptake, address late-stage diagnosis and health inequalities.

Our high level key measures for cancer and diagnostics

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Diagnostic recovery	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.	65.60% (Oct 2022)	69.13%	75.64%	76.58%	78.56%
	Deliver increased diagnostic activity levels.	470,585 (2019/20)	133,856	143,026	143,225	143,170
Cancer recovery	Reduce the number of patients waiting over 62 days (UHNM).**	740 (Dec 2022)	170	148	124	102
	Meet the 75% cancer faster diagnosis standard by March 2024 (UHNM).	57.62% (Dec 2022)	67.49%	70.77%	75.46%	79.98%
	Meet the 28 day waits faster diagnosis standard 75% (ICB).	62.67% (Nov 2022)	68.53%	71.36%	75.16%	78.76%
	Increase the number of patients with suspected cancer seen on a non-specific pathway following GP referral or referral from another service (ICB).	24 (Oct 2022)	83	109	123	140
	Increase the percentage of lower GI suspected cancer referrals with an accompanying FIT result (ICB).	62% (Oct 2022)	71.97%	90.91%	84.77%	94%

** At the point of publication of this plan, regional and national discussions are ongoing in relation for an improved trajectory of 62 day waits – so these numbers may change. In addition, the diagnostic recovery target is set for March 2025, the figures above show the trajectory for the first year only 2023/24.

End of life, long-term conditions and frailty

Palliative and end of life care

We aim to help meet peoples' wishes, including their preferred place of care and death which requires consistent effective identification, care planning and for rapid processes for discharge to be in place. This requires close working between inpatient team and the community-based services including local authorities, voluntary and community sector, pharmacy, the ambulance service and our local hospices.

Long-term conditions

Existing plans include developing Clinical Improvement Groups to provide strategic overview of the system, and developing a strategy to improve the health outcomes and quality of life for all those living with or at risk of cardiovascular disease (CVD), diabetes and respiratory conditions. CVD and respiratory conditions are also explicitly referenced in the ICP Strategy – focused on how we reduce premature deaths from them.

Frailty

We aim to delay the onset of frailty and slow down its progression. Care of older people will be more streamlined to make our pathways more collaborative, integrated and patient-centred – reflecting five key areas of our Frailty Strategy: Prevention and Healthy Ageing, Mild, Moderate and Severe Frailty, and Proactive Falls Prevention.

Our commitment

"Our Portfolio is committed to high-quality, person-centred care pathways and culture. Using outstanding leadership, clinical governance and culture which will be used to drive and improve the delivery of high-quality person-centred care for our end of life, long-term conditions and frailty pathways. We aim to drive the prevention agenda forward using a coproduced, multiagency approach backed with sound data and future modelling which will enable us to predict demand and meet the needs and aspirations of our population. We will ensure this is supported with high standards of transformation methodologies and planning oversight which will be delivered and assured through a full Portfolio governance approach. Ensuring the right partners at the right times are at the helm of everything we do and that people are at the heart of the Portfolio. "

Steve Grange, SRO

Our high level key measures of success for end of life, frailty and long-term conditions

	Objective	Baseline
PEoLC	Identification of patients in the last 12 months of life recorded on Palliative Care Registers in primary care increased from 0.5%.	0.5% 2021/22 and mid-Mar 2023
Long-term conditions	Enrol 85% of those referred for pulmonary rehabilitation (PR) with stable COPD within 90 days.	N/A
	Ensure 70% of patients enrolled for PR go on to complete the programme and have a discharge assessment.	N/A
	Eight care processes – increased offer rollout to diabetes patients.	Only 37.7% reach, based on 2021/22 data
	Patients with >20% increased chance of CVD treated with statins.	Only 57.4% reach, based on 2021/22 data
	AF – 10% increase screening/identification (Pulse Check).	Baseline 32% mid-March 2023
Frailty	10% increase in the number of people with severe frailty who have a completed ReSPECT document and an Anticipatory Care Plan.	Based on performance end of 2022/23, the baseline is 5,714 using: • Unique views on SCC adult social care webpages: 3,723 • Unique views of Staffordshire Connects adult homepage: 1,641 • CHPs: 348 • Mild frailty digital self-management of risk: baseline 0 (new offer) • MECC digital self-completion: baseline 0 (new offer)
	90% completion rate of the Clinical Frailty Scale (Rockwood) for each moderately frail patient assessed as part of Staying Well Service and Facilitated Admission Avoidance Scheme.	N/A
	10% increase in the number of people accessing self-help and support under prevention service offer, Staffordshire County Council service adult social care webpages, Staffordshire Connects and community health partnerships.	5,714, based on performance end of 2022/23
	HN service offer to identify 2,000 patients at risk of hospital admission with a 5% reduction in the cohort	Pilot showed a 26% reduction in the cohort, but that has many caveats

End of life, long-term conditions and frailty 2023/24 deliverables

1 2

- Drive improvement in Palliative and End of Life Care (PEoLC) framed by the National Ambitions, including the new legal duty (Health and Care Act 2022)
- Deliver the outcomes for patients and carers which are described in the National Ambitions for PEoLC
- Develop a comprehensive Long-Term Conditions Strategy
- Agree a healthy ageing and prevent/delay Frailty Plan.

Palliative and End of Life Care (PEoLC)

In response to the six National Ambitions and the statutory duty on ICBs to commission PEoLC, the programme of work for 2023/24 will include:

1. Developing comprehensive PEoLC Needs Assessment identifying key demographics, inequalities, baseline, current performance and predictive modelling
2. Developing a strategy for Palliative and End of Life Care. This is expected to include:
   - 24/7 access including a Co-ordination and Advice Line
   - Access and availability of palliative care medication
   - Improving identification of people in the last year of life, the number and quality of Respect Plans completed
   - Workforce and training.

Long-term conditions

During 2023/24, a refresh of the current programme structure and approach will take place. To support this, we will:

- Develop a comprehensive Long-Term Conditions Strategy, reflecting the ambitions of the NHS Long Term Plan. We will use a population health management (PHM) approach to improve health outcomes, reduce health inequalities and reduce disease progression in cardiovascular disease, diabetes and respiratory.

This will be scoped against national guidance including the NHS Long Term Plan and in conjunction with other Portfolios to ensure that all interdependencies are identified and considered as part of the strategy development.

Concurrently the Portfolio will continue to focus on actions within the following projects:

- Improving uptake of the eight care processes
- Improving care of foot ulcers and reducing amputation rates caused by diabetes
- National Diabetes Prevention Programme
- Case finding and accurate diagnosis of chronic obstructive pulmonary disease (COPD)
- Improving access to pulmonary rehabilitation.

Frailty

During 2023/24, we will:

- Develop a healthy ageing and prevent/delay Frailty Plan
- Implement the Loneliness Reduction Plan
- Agree and roll out the system-wide Outcomes Framework.

Primary care

We have set out a strategy for the next five years to deliver the vision for General Practice. During 2023/24, we implement year one of our strategy.

Our population will experience:

- More integrated, personalised and flexible care
- An equitable offer of general practice provision
- Reduced variation in care, services and outcomes
- Empowerment to self-care.

The ICB will:

- Work in partnership on the existing programmes to tackle the challenges around recruitment and retention of the workforce and addressing workload pressures
- Provide consistent training and development, as well as health and wellbeing initiatives, to support our workforce
- Support general practice to have a strong and consensus voice locally and within the system
- Integrate actions from the four building blocks in the Fuller Stocktake into our existing eight enabler programmes.

Our commitment

"This is an exciting time for primary care. The ICB will soon publish a General Practice Strategy developed in partnership with GPs and sets a shared ambition to improve access, experience and outcomes for our population. This will sit alongside the ICB taking on delegated responsibility for other elements of primary care including dentistry, pharmacy and optometry. This means for the first time the service planning and delivery of all aspects of primary care will be together in one place and offers huge opportunities for us to better reflect the needs of our local populations".

"At the same time, we have ambitious plans for building on the great work of our Medicines Optimisation team to increase their profile across the ICS and offer a tangible demonstration of the value they have to offer in improving services to our communities."

Chris Bird, Chief Transformation Officer

Our high level key measures for primary care

			Year 1 (2023/24)			
	Objective	Baseline	Q1	Q2	Q3	Q4
Access	Deliver more appointments in general practice by the end of March 2024.	5,917,885 (FOT)	1,369,269	1,444,707	1,613,923	1,359,691
Workforce	Deliver Additional Roles Reimbursement Scheme (ARRS) recruitment against 26K additional roles by March 2024.	388.70 (FOT)	451.73	503.67	555.60	608.17
	GP WTE (working towards national 6K target) by March 2024.	680.9 (Feb 23)	682.57	677.43	672.28	667.87
Dental activity recovery	Recover dental activity towards pre-pandemic levels.	1,908,485 (Year to end Jan)	469,462	469,462	469,462	469,462

Primary care 2023/24 deliverables

1 2 3

- Improve access to the right primary care services 5
- Deliver more appointments in line with the national trajectory 15 16
- Continue workforce and recruitment to Additional Roles Reimbursement Scheme (ARRS) and WTE GP roles 17
- Implementation of the Fuller Stocktake
- Support recovery of backlogs across the system (including dental) 18

- We will build on the programme of work already started to improve access and deliver more appointments in general practice by end of March 2024 evidenced through the quarterly trajectory in place for 2023/24. Practices will be supported with digital solutions including advanced telephony solutions, online consultations, video consultation, messaging and booking solutions, GP Connect (allowing NHS111 to book into GP appointment books) to provide enhanced remote care to people
- We will continue to focus on increasing workforce numbers, with more GPs and general practice nurses recruited and retained and a further increase of additional roles to compliment the general practice skill mix
- We will implement the vision of the Fuller Stocktake report focusing on a population health management approach through the building of integrated neighbourhood teams, same day urgent access, prevention and personalised care
- We will review and implement the recommendations from the national general practice access recovery plan when this is published focusing initial recovery actions on:
  - The POD Joint Commissioning Groups (West Midlands) which have set contracts with all dental providers (units per quarter) to recover backlogs in dental activity
  - Recovery of mental health performance around supporting dementia diagnosis and SMI annual physical health checks.

Medicines optimisation 2023/24 deliverables

1 3

- Enhance service provision through community pharmacy to improve access to healthcare in primary care 5
- Reduce overprescribing in general practice 30
- Reduce the carbon impact of medicines
- Reduce the risk of microbial resistance to antibiotics used in primary care
- Reduce the risk of harm to people from medicines

- The Community Pharmacist Consultation service will improve access to primary care by referring people requiring advice and treatment for certain minor illness conditions from a GP practice to a community pharmacist, ensuring that people have access to the same levels of care, close to home and with an emphasis on self-care. This will be evidenced through the quarterly trajectory in place for 2023/24
- Population health management data relating to prescribing trends in primary care shows that the ICB has high level of polypharmacy. Clinical pharmacists employed in general practice will support teams to conduct structured medication reviews in people aged 65 and over with eight or more prescription items including care home residents who also tend to be on multiple drugs
- Of all the medicines, inhalers used in asthma and COPD contribute the most to carbon emissions in the environment. The ICB Medicines Optimisation team has produced guidance on choice of inhalers. Practices will be supported to implement this guidance in 2023/24
- Last year, 83% of practices completed audits on antibiotic prescribing and identified areas for improvement with regard to managing volume of prescribing and meeting NICE recommendations on choice and appropriate dosing of antibiotics. During 2023/24, practices will be supported to implement interventions targeted at areas requiring improvement.

Our high level key measures for medicines optimisation

			Year 1 (2023/24)			
	Objective	**Baseline**	Q1	Q2	Q3	Q4
Access	Referrals to Community Pharmacist Consultation service from all relevant sources (general practice and NHS 111).	24,210 (general practice Apr 2022-Mar 2020) 7,351 (NHS 111 Jan 2021-Oct 2022)	7,427	7,569	10,749	8,513
Overprescribing	% of structured medication reviews conducted in general practice.	Based on % delivery of 20,429 SMRs	15%	40%	70%	100%
Carbon impact	Inhalers with low carbon impact as a percentage of all inhalers (based on prescriptions dispensed).	44.94% (per quarter)	44.94 %	45.44 %	45.94 %	46.44 %
Clinical Audit	Number of patient case notes reviewed as part of clinical audit programme on prescribing.	Target 80% of maximum of 9,045	0	2,412	4,824	7,236
Antibiotics (AMR)	Number of antibiotic prescriptions per weighted patient (known as STAR-PU) per year.	Current 12-month rolling average is 1.123	= or < 1.161	= or < 1.161	= or < 1.161	= or < 1.161
Cost	% of CIP delivered.	80% target	20%	40%	60%	80%

Mental health, learning disabilities and autism

- We know that the pandemic has had a significant impact on mental health, and this is now compounded by the cost-of-living crisis. Mental health demand and acuity is high as a direct consequence of the COVID-19 pandemic – with national predictions for mental health needs to remain at elevated levels for some time to come
- Much work has been undertaken over recent years to transform services and this will continue through the delivery of our plans in 2023/24.

The vision for mental health, learning disabilities and autism is to ensure older people, adults, young people and children feel supported whether they find themselves in need of help in crisis or to maintain their day-to-day mental health and wellbeing.

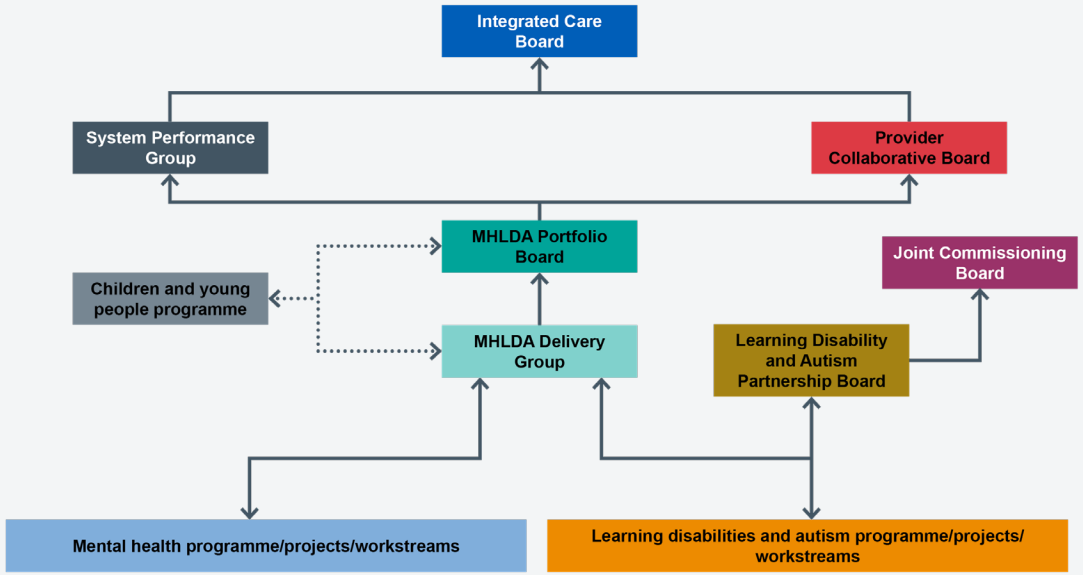
- We work in an integrated and collaborative way to ensure mental health is given equal priority to physical health needs and people receive the help and support they need closer to home and family
- By bringing together leaders from all local partners, we will continue to raise the profile of mental health in our system and enable new models of support to be developed, delivered by a wide range of partners
- The Mental Health, Learning Disability and Autism Portfolio brings together local commissioners, providers, regulators, the voluntary sector and other local stakeholders to identify, test, agree and implement the optimal solution of mental healthcare services for the local health and care economy
- We recognise that our plans need to be linked with the work of a range of other Portfolios (e.g. children and young people and urgent and emergency care), and that there are interdependencies across the ICB.

Our commitment

"As a system, we are well on our journey to make mental health, learning and disability and autism everyone's business. Over the coming year, we will operationalise our investment in perinatal mental health, mental health ambulance provision and children's autism services, while still progressing our community mental health transformation and transforming care (for people with a learning disability) programmes to deliver effective care for our population. The impact (and challenge) that comes with the wider implementation of the Oliver McGowan training programme is not to be underestimated, both in terms of the operational challenges it will create but also in raising understanding across the whole health and social care system."

Ben Richards, SRO

Mental health, learning disabilities and autism Portfolio



Mental health 2023/24 deliverables

1 2 3

- Improve access to mental health support for children and young people 19
- Increase the number of people accessing IAPT treatment, perinatal mental health services and supported by community mental health services 20 21 23 24
- Work towards eliminating inappropriate adult acute out of area placements 22
- Improve the crisis pathways including 111 and ambulance response

- We will continue to seek to increase the number of people accessing Talking Therapies (IAPT) treatment to populations that will benefit from interventions, including those who are currently under-represented, increasing opportunities for liaison with physical health pathways, and combining psychological treatment with employment support
- In collaboration with our maternity providers and maternity Portfolio, we will increase access to perinatal mental health services recruiting in line with indicative 2023/24 workforce profile and contribute to the delivery of the Local Maternity and Neonatal System (LMNS) Equity and Equality Action Plan by understanding and improving equalities of access
- We will continue to work towards eliminating inappropriate adult acute out of area placements during 2023/24 by completing demand and capacity work and appraising and implementing our options for PICU
- We will co-create the long-term vision and service model to localise and realign inpatient services and improve therapeutic inpatient care and repatriating service users with complex rehab needs
- Working collaboratively with the UEC Portfolio, we will improve the crisis pathways for all ages, including 111 and ambulance response through agreed processes with our 111 provider, outlining the call flow process of people in crisis calling NHS 111 and the national procurement of mental health response vehicles (MHRVs).

Our high level key measures for mental health

			Year 1 (2023/24)			
	Objective	Baseline	Q1	Q2	Q3	Q4
Out of area placements	Work towards eliminating inappropriate adult acute mental health out of area placement (OAP) bed days.	160	0	0	0	0
IAPT access	Increase the number of adults and older adults accessing IAPT treatment.	7,579.5	7,367	7,509	7,650	7,792 (30,318 Year-end)
Adult mental health	Achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services.	11,241 (2022/23 Q1)	10,934	11,513	12,093	12,678
Perinatal access	Improve access to perinatal mental health services.	760	304	608	912	1,216
CYP access	Improve access to mental health support for children and young people through increasing the number of under-18s supported through NHS-funded MH services.	16,300.5	15,154	15,800	16,600	17,648
SMI physical health checks	Number of people with SMI having annual physical health check.	3,695 (2021/22)	3,967	4,587	5,282	6,268
Dementia	Recover the dementia diagnosis rate to 66.7%.	69.4% (Feb 2023)	74.99 %	75.67 %	76.57 %	75.74 %

Learning disabilities and autism 2023/24 deliverables

- Make learning disabilities and autism everyone's business to ensure equal access and reasonable adjustments are considered across all services
- Increase the rates of annual health checks 25
- Improve and minimise waiting times for autism diagnosis
- Reduce reliance on inpatient care for both adults and children 26
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs)

Our plans are arranged around six workstreams to deliver against the priorities for learning disability and autism:

1. Identification – primary care actions to establish baselines at PCN, Place and ICS level and undertake Health and Wellbeing roadshows. This will support us to increase the number of annual health checks and quality of their impact
2. Place – housing provision and home in the local community. Making education, employment and life more accessible and inclusive
3. Universal services – dentists, opticians and wider preventative services are accessible to all with reasonable adjustments
4. Dedicated care and support – to develop a joint independent sector market with health and social Care that is fit for purpose
5. Community services – secondary mental health services for people with a learning disability and autism
6. Inpatient settings – appropriateness, with the right care locally supporting timely discharge, reducing reliance on inpatient care where appropriate. Physical conditions and mental wellbeing are both part of this workstream.

- Across the ICS, we will also improve understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing through the roll out of the Oliver McGowan mandatory training.

Our high level key measures for learning disability and autism

	Objective	Year 1 (2023/24) Baseline	Q1	Q2	Q3	Q4
Learning disability registers and annual health check	75% of people with learning disability (aged 14+) have a completed annual health check.	80.7% (FOT)	13%	32%	53%	75%
Autism Assessments to begin within 13 weeks (average)	Minimise waiting times for autism assessment (MPFT CYP).	13 weeks	13	13	13	13
	Minimise waiting times for autism assessment (Black County adults).	60 weeks	60	60	50	45
	Minimise waiting times for autism assessment (NSCHT CYP).	50 weeks	50	40	20	13
	Minimise waiting times for autism assessment (NSCHT adults).	50 weeks	50	50	40	35
Reliance on inpatient care for people with a learning disability and/or autism	The number of adults who are in inpatient care for a mental health disorder.	15 ICB 15 NHSE	12 14	12 14	12 14	12 14
	The number of under-18s who are in inpatient care for a mental health disorder.	3	3	3	3	3
Learning Disability and/or Autism Mortality Review	100% of LeDeR reviews are undertaken within six months of notification of death.	100%	100%	100%	100%	100%

Children and young people and maternity

- We are committed to delivering better health outcomes for children and young people (CYP) in our community through the vision set out. This is also explicitly referenced in the ICP Strategy – focused around giving children the best start to life and setting them on a course of improved life-long health and wellbeing
- As an ICB, we work with NHS, local authority and voluntary and community organisations. The plan is not designed to replace other more detailed plans that may exist operationally. It is a high-level over-arching plan to outline system priorities for CYP.

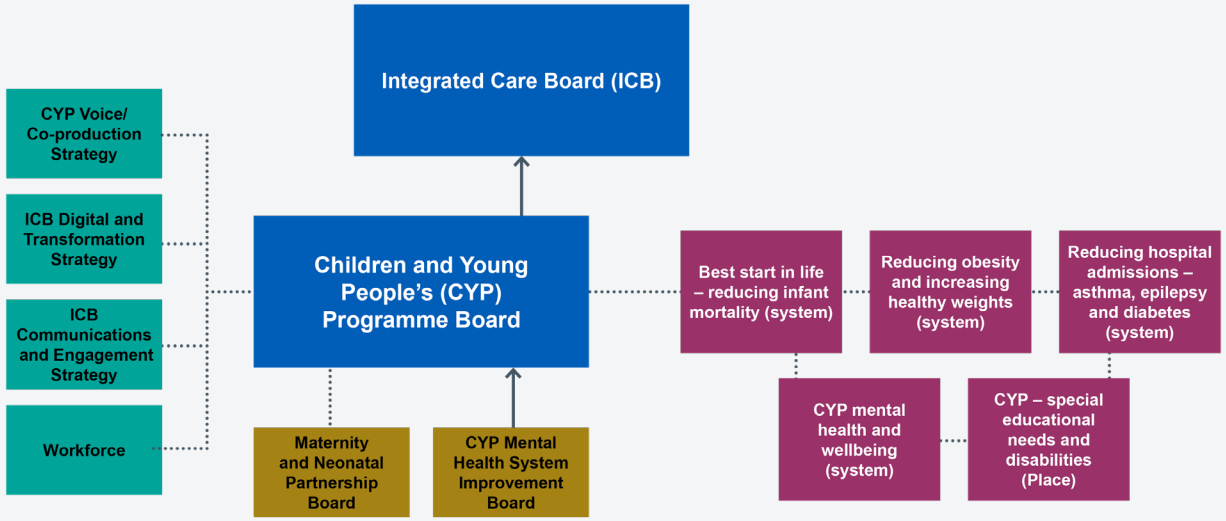
The vision for children and young people is to ensure that children are healthy and happy. They will be motivated, and we will support them to make informed choices about healthy and safer lifestyles.

- There is a clear shared ambition to work with local people, communities, and staff to improve the health and wellbeing of our children and young people, using our collective resources much more effectively. We want to see children, young people and families who are supported to start, grow and live well
- We will utilise **Core20PLUS5** to review system level inequalities for CYP
- The CYP programme has developed a plan across the system to set the direction for children and young people and co-ordinate activity that sits under each of the priority areas. The CYP programme board will provide the governance for the Children's ICS Delivery Plan. This is a relatively newly established group, with members from a wide range of organisations
- We recognise that our plans need to be linked with the work of a range of other Portfolios (e.g. Mental Health and UEC), and that there are interdependencies across the ICB.

Our commitment

"We are putting the health and wellbeing of our children and young people at the heart of the work of our ICS. We are determined that our kids get the best start in life, including high quality maternity services. By engaging with children and young people, we will develop programmes that meet their priorities. We have already identified early priorities such as reducing infant mortality, improving mental health and reducing obesity. We want to provide superb care close to home for children with relatively common conditions such as asthma, diabetes and epilepsy, so they don't need to go into hospital as often. And we will also ensure that we support children with complex needs to the best of our ability, joining up their care and helping them to thrive within their communities."

Jon Rouse, CEO Sponsor for CYP



Children and young people 2023/24 deliverables

1 3 4

- Improve the survival rates of babies and young children to reduce infant mortality
- Increase the number of children able to achieve and sustain a healthy weight
- Reduce avoidable hospital admissions in relation to asthma, epilepsy and diabetes
- Improve pathways and support for children and young people (including those with complex needs) by enjoying good emotional wellbeing and positive mental health and so that they can fulfil their potential.

- We will work with our partners to develop and implement a systematic approach to infant mortality surveillance and governance and raise awareness of the key risk factors associated with infant mortality
- Opportunities will be identified within existing commissioned services (health visitor, school nursing, family weight management) to promote healthy lifestyle and opportunities to utilise the National Child Measurement Programme (and its data) more effectively
- We want CYP and families to be more confident in managing their asthma. We will support this through the implementation of the national asthma bundle. The Asthma Friendly Schools (AFS) programme will be piloted and a community-based clinic for emergency department discharges in relation to asthma commenced
- Children's asthma is one of the Portfolio Provider Collaborative projects
- The roll out of the national epilepsy and diabetes bundle will continue and a gap analysis undertaken against the bundle of care
- A dedicated space for children and young people will be developed on the ICS website
- During 2023/24, we will support children with complex needs with the help they need so that they can fulfil their potential by exploring an improved and integrated, multi-disciplinary response. We will identify local stakeholders and scope existing provision with an aim to identify gaps in service provision and designing solutions to meet any gaps.

Our high level key measures for children and young people

Objective	Year 1 (2023/24)				
	Baseline	Q1	Q2	Q3	Q4
Reduce hospital admissions for diabetes (flat activity).	52.9	52.9	52.9	52.9	52.9
Reduce hospital admission for epilepsy (flat activity).	83.6	83.6	83.6	83.6	83.6
Reduce hospital admission for asthma (flat activity).	197.1	197.1	197.1	197.1	197.1
Reduce numbers of CYP in residential care outside the ICS geography.	Data flows being established through discussion with CEO sponsor.				

- Baseline measure is 2019/20 admission rate per 100,000.
- In relation to reducing hospital admissions and for the purposes of reporting, 2019/20 data has been used as a baseline measurement.
- National sources of data indicate that there are specific areas of focus where, compared to nationally benchmarked figures, we are below average. Through the programmes of work, we will be looking to make improvement to align with benchmarked figures during 2023/24.These include:
  - Infant mortality rates – Staffordshire and Stoke-on-Trent
  - Obesity rates – Staffordshire and Stoke-on-Trent at Reception age, and Stoke-on-Trent at Year 6.

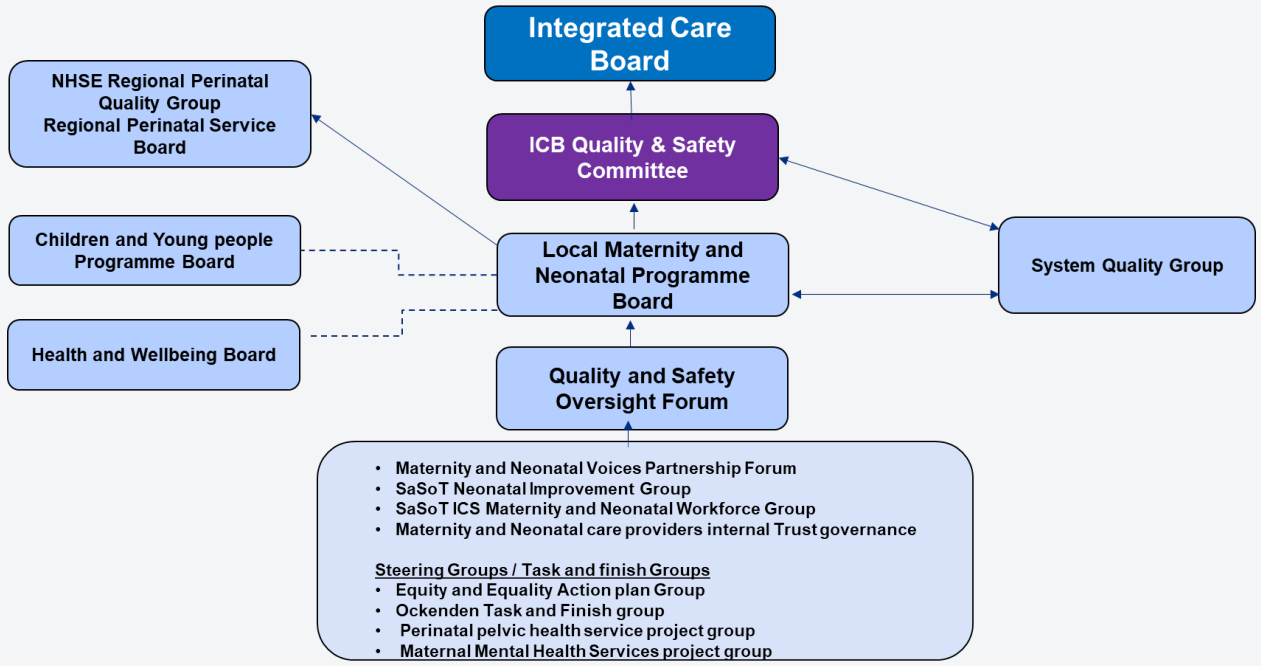
Maternity and neonate

- Despite the challenges created by the pandemic, the Local Maternity and Neonatal System (LMNS) have continued to develop a system approach to maternity and neonate care, identifying where we can make a positive change to our services and improve care for our women/birthing people, babies and their families
- We continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable
- On 30 March 2023, NHSE published a three-year Single Delivery Plan for maternity and neonatal services that:
  - sets clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care
  - brings together actions from the final Ockenden Report, the report into East Kent, the NHS Long Term Plan and Maternity Transformation Programme deliverables
  - has input from services users, frontline colleagues, system leaders and national stakeholders, including a new working group led by the Royal Colleges.
- The plan will help shape our action plans going forward
- We recognise that our plans need to be linked with the work of a range of other Portfolios. This diagram recognises how we work across partners and Portfolios.

Our commitment

"The local maternity and neonatal system remain committed to bringing together all partners, including users of these services, to work to ensure high quality, safe services for mothers and their babies. We are equally committed to ensuring that we take every opportunity to learn from high profile maternity investigations such as Ockenden to avoid reoccurrence in local services. We will listen to our families to support the implementation of the single delivery plan at a local level ensuring local arrangements remain relevant to local need."

Heather Johnstone, SRO Maternity Transformation Programme



Maternity and neonate 2023/24 deliverables

- Implementation of the national single delivery plan for maternity and neonatal care
- Listening to, and working with, women and families with compassion
- Growing, retaining, and supporting our workforce with the resources and teams they need to excel 14
- Developing and sustaining a culture of safety, learning, and support 13
- Standards and structures that underpin safer, more personalised, and more equitable care
- Benchmarking and development of a single delivery plan.

The three year Single Delivery Plan for maternity and neonate care will form the basis of our work programme during 2023/24. We will work together as maternity and neonate services with wider partners as appropriate to embed and deliver the required actions. The ICB will support and monitor the delivery of these requirements through the 12 identified objectives aligned to the four themes within the plan:

Theme 1: Listening to, and working with, women and families with compassion

Objective 1 – Care that is personalised; Objective 2 – Improve equity for mothers and babies; Objective 3 – Work with service users to improve care

Theme 2: Growing, retaining, and supporting our workforce with the resources and teams they need to excel

Objective 4 – Grow our workforce; Objective 5 – Value and retain our workforce; Objective 6 – Invest in skills

Theme 3: Developing and sustaining a culture of safety, learning, and support

Objective 7 – Develop a positive safety culture; Objective 8 – Learning and improving; Objective 9 – Support and oversight

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

Objective 10 – Standards to ensure best practice; Objective 11 – Data to inform learning; Objective 12 – Make better use of digital technology in maternity and neonatal services.

Theme	Progress measures	Year 1 (2023/24)				
		Baseline	Q1	Q2	Q3	Q4
1	• Implementation of perinatal pelvic health services and perinatal mental health services in place • NHS Mental Health Dashboard – number of women accessing specialist perinatal mental health services • Proportion of maternity and neonatal services with UNICEF BFI accreditation.	The national single delivery plan outlines how success against each theme will be determined. The high level key measures for Maternity and Neonates are in development to support and reflect system delivery against the four themes.				
2	• Establishment, in-post and vacancy rates for obstetric anaesthetists, sonographers, allied health professionals and psychologists • Annual census of maternity and neonatal staffing groups • Assess retention through monitoring staff turnover, sickness rates and NHS Staff Survey results on experience and morale.					
3	• Results from the NHS Staff Survey, National Education and Training Survey, GMC National Training Survey.					
4	• Local implementation of Saving Babies' Lives Care Bundle v3 using a national tool • Proportion of births at less than 27 weeks, at trusts with on-site neonatal intensive care • Avoiding term admissions into neonatal units (ATAIN) programme measurement of the proportion of full-term babies admitted to a neonatal ward • Overview of the progress of maternity services via a periodic digital maturity assessment of trusts.					

Improving Population Health

Improving population health across the life course

The life course approach recognises that at different stages of life, people have different physical, mental health and social needs. This evidence-based approach allows us to look at what each organisation can contribute to improve the health and wellbeing of the population at different stages of life.

Offering high quality services from conception to death, targeted to those who need it most or have the greatest potential to benefit, will make a significant difference to people and communities in Staffordshire and Stoke-on-Trent.

Population Health Management (PHM)

PHM will help us to understand the health and care needs of our population both now and in the future. We will do this by looking at lots of different health and care data, using intelligence and evidence to make decisions on the different services we need to provide and where to act and react to local needs.

Health Inequalities

This approach will be central to all we do, ensuring we focus efforts on the best ways to support our communities, and ensuring there is as little variation (inequity) as possible in services. Our objectives for health inequalities are set out overleaf.

Prevention

An integrated approach will focus on preventing illness through improved access to preventative services. We will work with people and communities to achieve environments that promote health and wellbeing. We will work together to understand and address the factors that put people at risk.

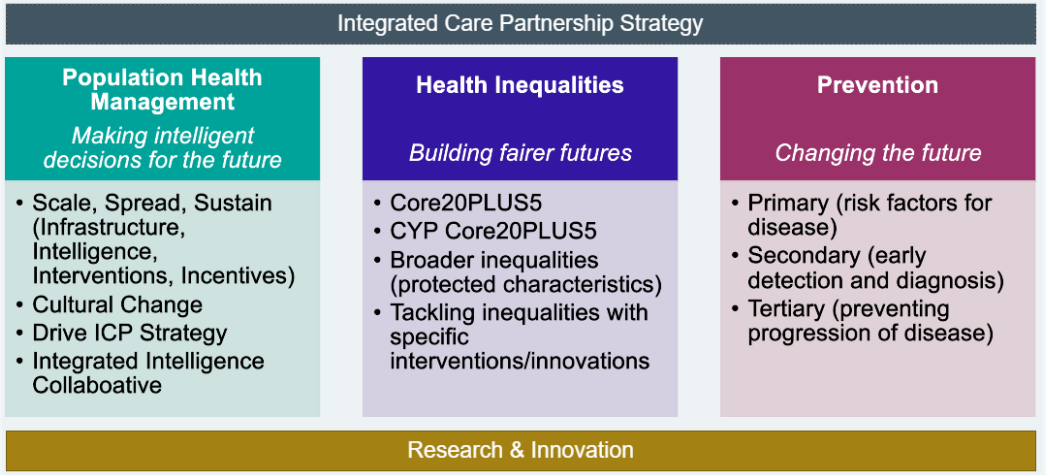
We will focus on delivering personalised care, empowering people to take personal ownership and self-manage such conditions in the community. This will enable people to live well, independently from care, for as long as possible.

Our commitment

"We want to make sure that everyone in Staffordshire and Stoke-on-Trent has a fair opportunity to live a good life. Looking at some of the inequalities that we know still exist is simply not good enough, and many of these can only be addressed by partners working together. Improved health and wellbeing will be achieved through better support and high-quality services, but also through preventing people from becoming unwell and supporting them to live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them".

"Working together is the fundamental principal behind the Staffordshire and Stoke-on-Trent Integrated Care Partnership, building on our collective resources and making better use of shared learning and experience. Our residents need to be an equal part of that partnership and we look forward to working with them to achieve our ambition of making Staffordshire and Stoke-on-Trent the healthiest place to live and work."

Dr Paul Edmondson-Jones, Chief Medical Officer



Health inequalities 2023/24 deliverables

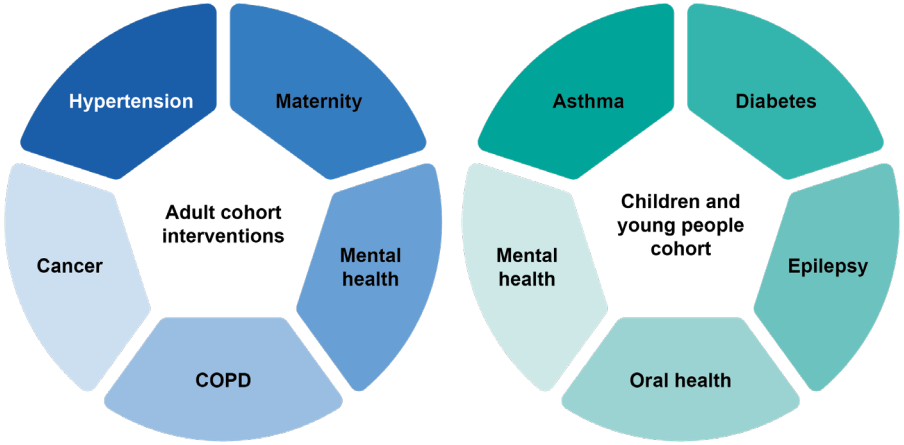
1 2 3 4

- Restore NHS services inclusively
- Mitigate against digital exclusion
- Ensure data sets are complete and timely
- Strengthen leadership and accountability
- Systematic implementation of the Core20 approach.

27 28 29

- Our plans and deliverables reflect the NHS England operational planning guidance national inequalities priorities to: Restore NHS services inclusively, Mitigate against digital exclusion, Ensure data sets are complete and timely, and Strengthen leadership and accountability.
- The systematic implementation of the Core20 approach will start with PLUS5 Groups identified for both adults and children. We will utilise the Core20Plus5 Tailored Support Offering covering connectors, collaborative, ambassadors and trajectories to develop and mobilise our work to take forward the national inequalities priorities and Core20plus5.

Core20PLUS5 – adults, children and young people



Restore NHS services inclusively	• Delivery of ICS Elective Recovery Plan with specific objectives enabling inclusive recovery • Undertake health impact assessment against Elective Recovery Plans • Establish Board-level reporting on health inequalities in elective care patient treatment lists • Use population health management approach to prioritise elective and cancer care waiting lists • Identify and agree high impact action plan from Midlands Decision Support Unit paper on evidence-based intervention.
Mitigate against digital exclusion	• Deliver the ICB Digital Transformation Strategy • Strengthen links with existing programmes in the ICS on digital inclusion with local authorities • Use research and innovation programme to understand barriers to digital inclusion and innovate on new approaches to digital tools for health and care.
Ensure data sets are complete and timely	• Improve data quality towards creating a 'single version of the truth' through the One Health and Care Record, ICS population health management programme and existing programmes of work in ICP partner organisations • Undertake engagement with frontline clinical and administrative staff to understand barriers to capturing accurate data on protected characteristics within services • Embed reporting on inequalities data completeness within ICS governance arrangements • Develop and use the integrated intelligence collaborative to facilitate data sharing between organisations to underpin a strong population health management approach with high quality linked data sets.
Strengthen leadership and accountability	• Establish a network of 'Inequalities Senior Responsible Officer' roles in ICP partner organisations • Develop a programme of reporting on health inequalities to ICS governance arrangements • Maintain a system-wide Health Inequalities Group • Establish a Health Inequalities and Prevention Network and training offer within the ICS • Undertake ICS development programme to strengthen the ICP commitment to health inequalities agenda and support development of a strong ICS programme • Use the Healthcare Inequalities Improvement Planning Matrix across Portfolios and programmes to inform inclusive planning of delivery.

Prevention plans 2023/24 objectives

- Implement NHS Long Term Plan prevention programmes
- Embed prevention across all portfolios
- Utilise population health management techniques to target prevention programmes
- Empower people to take personal ownership
- Self-management of conditions.

- Prevention remains important for people living with long-term illness and we will focus on delivering personalised care, empowering people to take personal ownership and self-manage such conditions in the community. This will enable people to live well, independently from care, for as long as possible.
- Prioritising prevention reflects the growing evidence supporting resources being shifted 'upstream' for people as well as health and care services. There is broad support for this approach in both our communities and workforce.
- We will utilise population health management techniques to target prevention programmes to those with greatest capacity to benefit and address health inequalities.
- We will use the ICP Strategy and Joint Forward Plan to embed prevention across all of our portfolios towards improving future population health and care outcomes.

We will implement NHS Long Term Plan prevention programmes across the ICS, including a focus on:

- Development of tobacco dependence treatment services in all inpatient and maternity settings
- Evidence-based (PH48/NG92/PH26) smoking cessation offer available for at-risk populations, inpatients, pregnant women and for those with severe mental illness (SMI)
- Improve uptake of lifestyle services, Diabetes Prevention Programme, low calorie diets, the new Digital Weight Management Programme and digitally supported self-management services
- Restore diagnosis, monitoring/management of hypertension, atrial fibrillation, high cholesterol, diabetes, asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23
- Develop improvement of optimal Alcohol Care Teams in hospitals with the highest rates of alcohol dependence-related admissions
- Weight management – implementation of T3 and T4 services
- Continue to adopt culturally competent approaches to increasing vaccination uptake.

Staffordshire and Stoke-on-Trent Integrated Care System

The implications for our resources

Workforce

- Approach to planning: Shared vision based on the NHS People Plan and NHS People Promise, developed and informed by collaboration and historical delivery.
- Transformation: Implementation and introduction of new roles. In the long-term, drive approaches to develop supply opportunities through career pathways.
- Key recruitment activities: Continue to understand 'hard to recruit' and hotspot areas and subsequent interventions to address, be an 'employer of choice'.
- Retention: Significant focus on retention challenges and mitigations to support retention initiatives, including improvement on-boarding, flexibility and career development.
- Health and wellbeing: Continue to strengthen existing support available to staff to help them be well at work.
- Temporary staffing: Oversight of temporary staffing usage and plans to continue to support identification of improvement opportunities to decrease reliance where possible.
- Key risks and issues: Challenges remain in relation to supply and retention and specific shortages in specific areas of the workforce.

The above is underpinned by support and implementation at scale to ensure opportunities for duplicity are maximised across the system.

Our commitment

"We continue to build on our collaborative approach towards delivering the National guidance for ICB People Functions to support a sustainable 'One Workforce', linked to our People Promises, focusing on priorities to:

- Inform and insight: Informing and actively shaping workforce supply (partnership with Health Education England)
- Transform and collaborate: Ensuring the transformation activity is understood and incorporated, where new roles or development to existing workforce is required, at scale
- Maintain and improve: Ensuring we maintain and improve wellbeing and mitigate the retention risks within our ICS
- Equity: Ensuring the impact of the above addresses the areas of highest need from a population health/reducing health inequalities perspective."

Alex Brett, Chief People Officer

People Plan priorities:

- **Supporting the health and wellbeing of all staff**
- **Growing the workforce for the future and enabling adequate workforce supply**
- **Supporting inclusion and belonging for all, creating a great experience for staff**
- **Valuing and supporting leadership at all levels, and lifelong learning**
- **Leading workforce transformation and new ways of working**
- **Educating, training and developing people and managing talent**
- **Driving and supporting broader social and economic development**
- **Transforming People services and supporting the People profession**
- **Leading coordinated workforce planning and intelligence**
- **Supporting system design and development**

Workforce

Looking forward

To tackle the workforce challenges and close the gaps is a vast undertaking. The ICS People Function is key for the system working together to strengthen the offer to our existing workforce, attract and support more people from our local communities into careers in health and care, and create a robust pipeline of trained and skilled people to deliver quality treatment and care to our population.

Our ICS People Collaborative approach, developed over time with health and social care partners, is mature and effective in collectively tackling these workforce challenges. Below highlights the way we have and will continue to work together to transform the way we recruit, retain and develop our workforce:

- Embedding 'One Workforce' approach, driven and owned across organisational boundaries
- Creating the right cultural environment for people to thrive, focusing on civility and safe working ethos, embedding inclusive cultures underpinned by equality and diversity
- Integrated workforce planning and transformation, aligned to national and system priorities and portfolios, including design of new staffing models and roles to deliver care differently
- Further development of the national HPMA award-winning ICS People Hub and Reserves to provide a contingent flexible workforce at system level
- Development of an ICS New to Care Academy – attracting, training and supporting our local population into entry level roles and career pathways across health and care
- Implementing and embedding the Journey to Work concept with partners, communities, education to build a robust offer of support to increase our pipeline, create opportunities for everyone and ensure our workforce is representative of our local population
- Strengthening our outreach work with refugee, seldom-heard and deprived communities to support and develop people into careers in health and care
- Expanding Widening Participation activities across all our partners including Cornerstone, T-Levels, traineeships, apprenticeships, workplace learning
- Developing our ICS Education, Training and Development Strategy with our education providers, addressing our collective challenges including clinical placement capacity, future pipeline and transforming course offers
- Provide the workforce with the tools and skills to enable digital transformation and to support our population in building their digital skills for self-care and prevention.

ICS People Function

Programme activity

ICB Chief People Officer	ICB Chief People Officer	NSCHT Chief People Officer	UHNM Chief People Officer	ICB Chief People Officer	NSCHT Chief People Officer
Workforce supply – recruitment and retention	**Workforce transformation and future pipeline**	**Equality, diversity and inclusion (EDI)**	**Staff experience, health and wellbeing**	**System culture and collaboration**	**Leadership and talent**
ICS People Hub and Workforce Cell Reserves Retention programme System recruitment including international recruitment New to Care Academy Redeployment	Portfolio workforce, planning and transformation Programme delivery – e.g. vaccinations, virtual wards Health Education England funding – including METIP Journey to work – including schools engagement and outreach Education, training and developments – including clinical placements Widening participation – including ICS apprenticeships, workplace learning ICS Strategy – e.g. digital, green	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Staff networks Differently-abled buddy scheme Inclusion School EDI training and development – including New Futures, Comfortable Being Uncomfortable with Race and Difference	Staff insights – cross-cutting Staff Psychological Wellbeing Hub Wellbeing resources and events Occupational Health	Delivered by Strategic Organisational Development (OD) Lead and OD Collaborative PCN OD programme OD cultural diagnostic System OD activities	High Potential Scheme Coaching and mentoring – including collaborative, reverse Exec and Senior Leader development – including System Connects, Alumni Scope for Growth career conversation tool

Underpinned and supported by

Clinical Senates	Clinical/social groups	Workforce planning	People metrics	Operating Plan	Joint Forward Plan	Financial Strategy

Finance

"Our system is collectively committed to delivering our financial duty of living within the financial resource made available to us and this commitment is set out within our Financial Strategy.

Our Financial Strategy is centred on our view that the optimum financial solutions come from the best clinical models. We enter the 2023/24 planning period with a high level of financial challenge, but with an explicit commitment by all partners to deliver a path to financial sustainability.

Our Financial Strategy describes a clear six-step plan, which has clinical and operational buy in, and we can already demonstrate successes in key areas. We recognise the need to make tough decisions and bear down on unwarranted variation and improve productivity."

Paul Brown, Chief Finance Officer

Context	• System achieved breakeven in 2022/23 • System plan is a **breakeven** for 2023/24 • Significant risk in getting breakeven – unmitigated value £83m and further risks where mitigations are currently being assessed.
Goal	• National expectation is that systems will achieve break-even and break-even remains our goal, notwithstanding the risks identified above • Tackle the underlying deficit during the year so that we enter the 2024/25 planning period in better shape • Reward for getting there, since this would be the second consecutive year of system breakeven since COVID, is that the system legacy debt of £300m would be written off.
Actions	• Whole system to undertake a line-by-line review and agree costs that can be removed, to support in-year balance and contribute towards the elimination of the underlying deficit • Agreement to a 'Double Lock' mechanism so that no part of the system takes decisions that would mean missing 2023/24 financial target or worsening the underlying position • 2023/24 target achieved and underlying deficit eliminated through four actions: organisational grip (delivery of organisational positions), system oversight on system stretch, the line-by-line and a transformational focus on discharge and CHC.

Delivering the Financial Plan

- The system has agreed the following key actions to continue our focus on the financial position.

- Revisit all workforce plans to maximise the opportunities to reduce reliance on temporary staff and cut premium costs and ensure that growth in workforce delivers improved productivity or addresses key delivery targets
- Deliver a CHC Recovery Plan which arrests the escalation and seeks to reverse the growth in care costs. This will include the development of ambitious plans, jointly with our local authority colleagues to stimulate and manage the care market
- Ensure we maximise all possible efficiencies in both primary and secondary care in terms of prescribing and drugs costs, such as the urgent implementation of biosimilar switches
- Collectively work with our community trust and local authority partners to ensure that investment in the Better Care Fund and discharge funding, is directed at services which make a tangible contribution to delivery, especially in terms of admission avoidance for the frail elderly and timely discharge arrangements from acute settings
- Develop the efficiency plans, increasing the proportion that are delivered through recurrent schemes.

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

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

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

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

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

3. Productivity
More activity through the existing capacity

Staffordshire and Stoke-on-Trent Integrated Care System

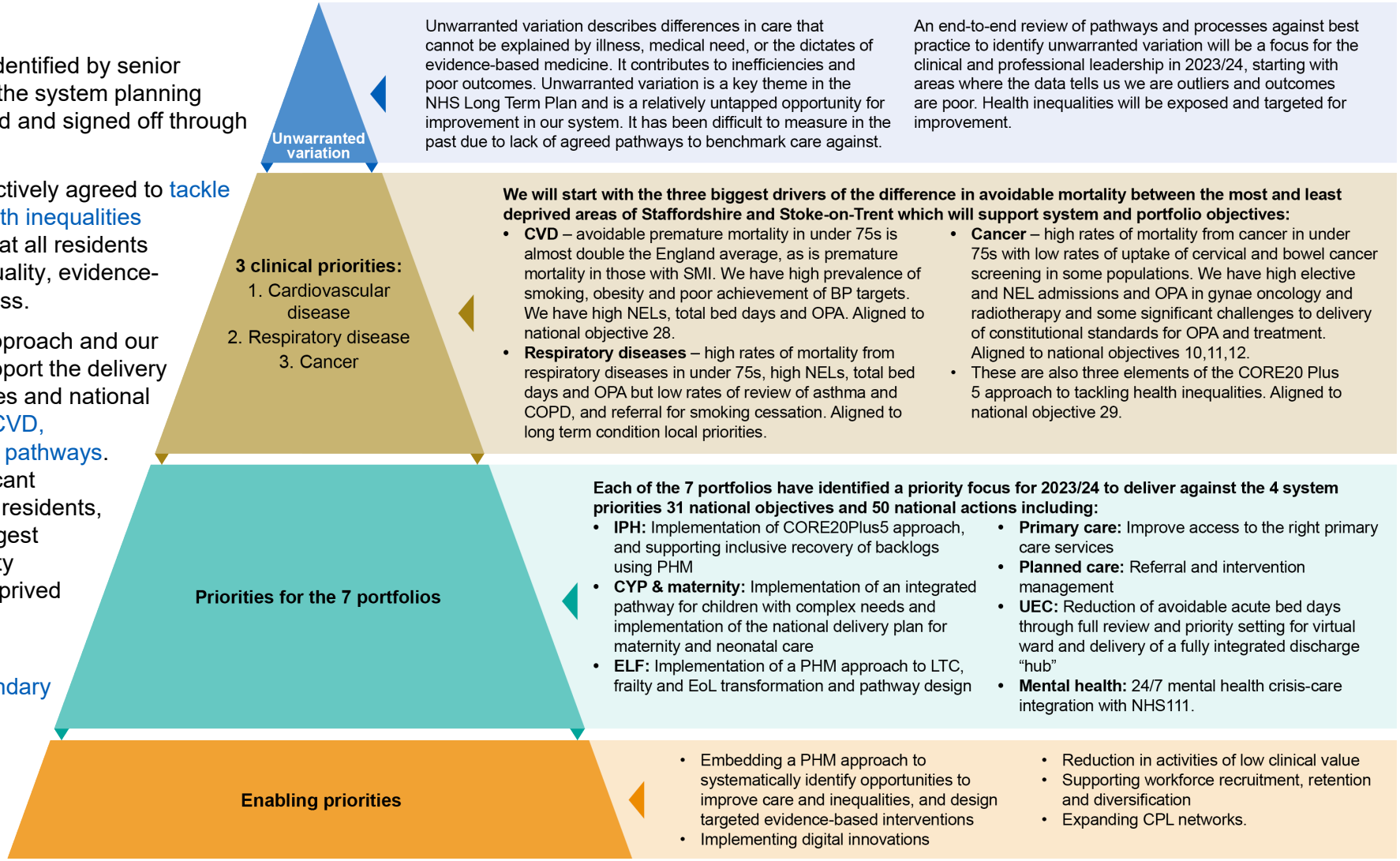
Annex A - Our enablers to success

There are a series of enablers to delivery, outlined in the following slides, which include:

- Clinical and Professional Leadership in each portfolio. Our clinical leads through the clinical senate have set our their priorities
- Understanding current, and predict future health and care needs (population health)
- Broader enabling functions and programmes
- Our provider collaborative programme

Clinical and professional leads (CPL) focus for 2023/24

- The focus areas were initially identified by senior clinicians and professionals at the system planning summit 2023/24, and developed and signed off through the Health and Care Senate.
- As a CPL community, we collectively agreed to tackle unwarranted variation and health inequalities because we strongly believe that all residents have the right to expect high quality, evidence-based care with equitable access.
- As CPL leads, our collective approach and our three clinical level priorities support the delivery of the high level system priorities and national objectives through a focus on CVD, respiratory disease and cancer pathways. These conditions cause significant premature mortality across our residents, and are responsible for the biggest difference in premature mortality between our most and least deprived communities.
- We will also focus on the opportunities for primary, secondary and tertiary prevention and Identifying and tackling health inequalities.



Population health management (PHM)

The vision for the programme is to enable, implement and embed a population health management approach to help us understand current, and predict future health and care needs, so that together we can improve outcomes, reduce inequalities, improve use of resources and engage our community appropriately.

Embedding population health management will:

- deliver integrated health and care that is underpinned by intelligent decision-making using data on our population's health and care needs
- use data to understand risk and protective factors, enabling us to target resources to those at increased risk of poor health outcomes or with greatest potential to benefit from care
- identify inequalities in access, experience, and outcomes of care to inform improvements to care pathways so that we offer high quality inclusive care
- proactively target preventative interventions and services to those identified as being at higher risk of illness or adverse events, for example infant mortality or emergency hospital admission.

Population health management programme key areas

Infrastructure

- Organisation and human factors
- Digital infrastructure and maturity
- Information governance process
- Vision

Intelligence

- Advanced analytical tools
- Analyses and actionable insight
- Alignment of multi-disciplinary analytical and improvement teams
- Development of a cross-system ICS intelligence function

Interventions

- Care model design and delivery
- Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle
- Person-centred care
- Community wellbeing voluntary and third sector

Incentives

- Population health based contracting and payment models
- Workforce development and modelling
- Enabling governance

Continuing healthcare 2023/24 deliverables

- We know that the pandemic has had a significant impact on the delivery of continuing healthcare (CHC) – both in terms of performance and finance. This was due to the temporary suspension of the CHC Framework for six months between March and August 2020
- Although the system achieved the closure of the deferred backlog of assessments for individuals with care while the suspension was in place via COVID monies, the impact and aftermath to return to business as usual has and continues to be a significant challenge
- The service has consistently underachieved the NHS England Quality Premium Standard of >80% of Decision Support Tools completed within 28 days throughout 2022/23
- During Q3 of 2022/23, we were the third highest ICB nationally in terms of CHC eligibility rates which stand at 30% against an average of 23%, and there has been a visible and sharp increase from October 2022 onwards. The ICB was also the 12th highest across the country in terms of Fast Track eligibility
- A CHC Action Plan has been developed and approved by the ICB Finance and Performance Committee. The Action Plan will be subject to detailed monitoring throughout 2023/24.

"Our CHC position offers significant challenge and will be a real area of focus for us throughout 2023/24 as we work to deliver a return to a clinically and financially sustainable service model. This will involve a wholescale review of the CHC service, including interdependencies with other pathways and models of care. Our ability to work in partnership as a system will be the key to success in ensuring we are able to secure improvements in quality, efficiency and effectiveness."

Chris Bird, Chief Transformation Officer

Our high level key measures for continuing healthcare

		Year 1 (2023/24)			
Objective	**Baseline**	Q1	Q2	Q3	Q4
Reduction in the number of patients in D2A requiring a full DST to be completed.	The baselines are in development to then build quarterly targets from.				
Reduction of the overdue CHC backlog to 10% of the caseload.					
Reduction in costs for CHC packages and placements					

During 2023/24, we will focus on:

1. Engaging with the market to develop a financial sustainable commissioning process for both the market and the system that maintains good quality and safe care to our population.
2. Working with system partners to review current CHC discharge processes to ensure delegated decision making is in line with the Framework and Regulations, whilst maintaining flow within the urgent care system by supporting discharge within the set parameters and principles agreed for CHC.
3. Developing a robust and transparent CHC Policy that articulates the ICB's intentions to provide CHC-funded services to those eligible.

Quality

Our commitment

"Our system is collectively committed to delivering our statutory duty for quality through a programme of quality assurance and improvement activity. This commitment includes recognition that we are jointly accountable for quality. Our emerging Quality Strategy describes the systems and processes that exist to ensure that we not only continue to monitor the quality and safety of health and care, but that we also strengthen our links to the quadruple aims for ICBs whilst responding to emerging best practice. Our commitments are intended to ensure our population can access high quality, safe care and that if things go wrong ,they can be assured we will listen, learn and change practice."

Heather Johnstone, Chief Nursing and Therapy Officer

- Our partners play a vital role in providing oversight of the quality of care provided, and in creating and sustaining a culture of openness, learning and continuous improvement
- The emphasis has shifted from provider-based reporting to system-level. Agreement on common risks and areas of concern are a core part of the quality approach and are underpinned by the explicit expectation that all members of the Quality and Safety Committee share accountability for the quality of services and for driving required improvements
- System partners work collaboratively to identify early warning signs of emerging issues or impacts. Where routine quality and safety monitoring, soft intelligence and other forms of feedback and review highlight areas of concern the ICB's Nursing and Quality team, alongside other system professionals, undertake additional quality assurance activities including (but not limited to) announced and unannounced visits (including evenings and weekends), deep dives into data, and focussed reviews. In the event that these highlight further areas of concern or a lack of plan to address identified concerns, the escalation process outlined within the National Quality Board guidance is followed
- To enable the system to provide outstanding quality services for all, our shared vision and underpinning quality framework include both quality assurance and continuous quality improvement (CQI). In line with the guidance set out by National Quality Board, our approach to CQI is focused on developing capacity and capability to practice quality improvement (QI), support the embedding of QI in all levels of change, nurturing a learning culture, and sharing best practice
- Partners have worked collaboratively to develop a framework and a set of mutually agreed principles. As the system matures and the CQI continues to grow, there are a number of areas that we will be looking to strengthen. These will include the development of an ICS CQI training offer and the further embedding of CQI within Place, Provider Collaborative and ICB delivery Portfolios
- A core principle at the heart of CQI is putting the people we serve at the centre of change. The ambition is that through the growth and embedding CQI further across the system that we can also move towards co-production being our default approach to involvement within CQI and the ICS.

Digital

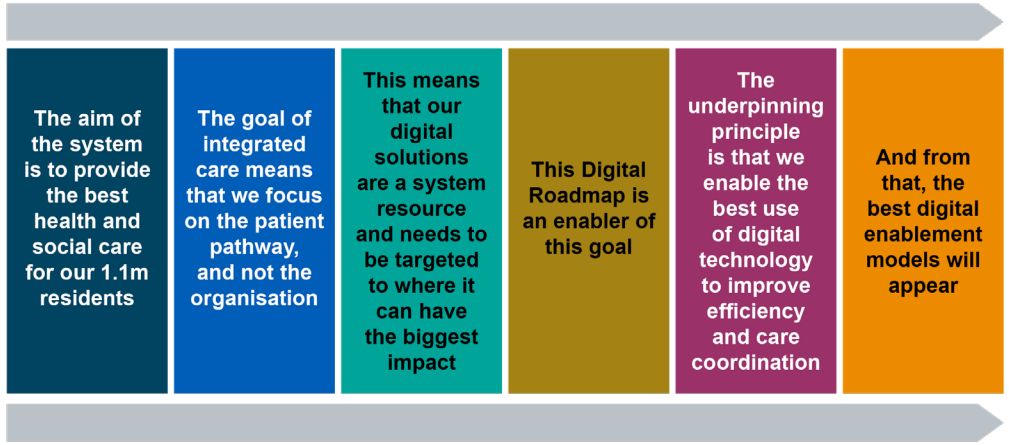
Our commitment

“From a resident’s perspective, it is critical that each of us can engage digitally when accessing health and social care services, providing a seamless care journey, underpinned by accurate and up to date information. We shouldn’t have to repeat the same information every time we see a new health and care professional. From a health and care provider perspective, information needs to be accessible at the point of care so that safer and better decisions can be made about people’s care.”

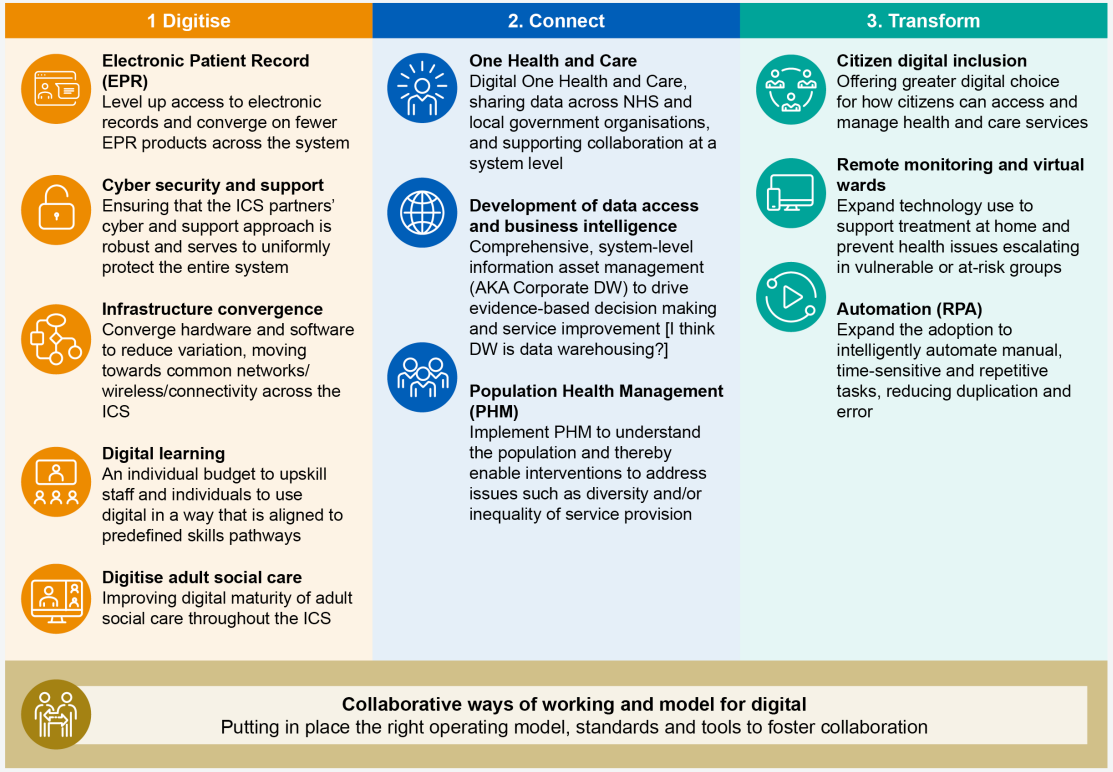
Chris Ibell, Chief Digital Officer

Our Digital Roadmap

The ICB Digital Roadmap aims to empower our care providers and recipients of care to make the most of the benefits full digital enablement can deliver. The Digital Roadmap has been developed collectively by system stakeholders.



Our digital initiatives for 2023/24 are aligned with national aims, local need, and our collective ICS goals and ambitions to digitise, connect and transform.



Provider collaborative projects

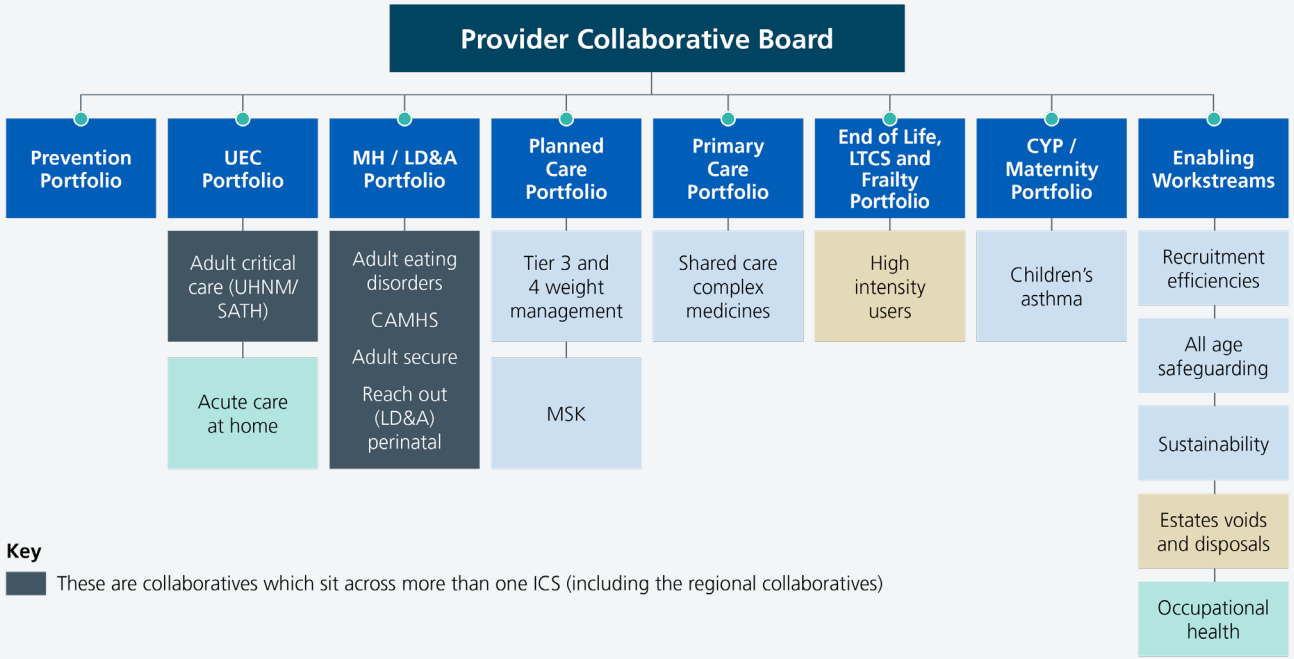
1 2 3

- The Provider Collaborative approach has an Executive Sponsor and is developing well across the majority of our system portfolios and enabling workstreams as the delivery vehicle for transformation at scale
- A Programme Board meets monthly with Executive representatives from acute providers, community providers, Place, ICB, local authority and general practice. A Board Work Programme has been agreed to enable the delivery of the ICS Advanced Design features and will be revised when the Provider Collaborative Maturity Matrix is finalised
- Our approach has been developed against a set of design principles (see the next page)
- A Development Framework to support emerging provider collaborations has been tested and is in place, reflecting the design principles, system priorities and the ICS Advanced Design features
- The Provider Collaborative Board both oversees the developing collaboratives and those collaboratives which we are apart of outside of our system including Lead Provider Collaboratives, e.g. mental health and Provider Partnerships
- During 2023/24, we will focus on a range of projects across our portfolios. The TDU will work with the Provider Collaborative Programme Director to ensure consistency of approach for all provider collaborative projects through the project lifecycle road map.

Our commitment

"Collaboration between providers in and outside of our system has always taken place and we have a good track record of effectively working in partnership. Over the next 12 months we will continue to focus on working at scale to properly address unwarranted variation and inequality in access, experience and outcomes across wider populations. This will also help us to improve resilience in our services and ensure that specialisation and consolidation occur where this will provide better outcomes and value. We will work alongside our system Portfolios, Place and enabling workstreams to identify further opportunities to collaborate whilst mobilising our collaboratives in development."

Tracy Bullock, Executive Lead



Place

Our commitment

"We are committed to working in partnership with our system colleagues in establishing the two Place-based Partnerships – Stoke-on-Trent and Staffordshire. Through these partnerships, we will create an engine room of collaboration between organisations so that we can better Through these arrangements we will better plan and deliver health and care services focussed on improving health and wellbeing."

Chris Bird, Chief Transformation Officer

- We have a two Place model aligned with our upper-tier local authorities (Stoke-on-Trent City Council and Staffordshire County Council) which has been agreed by all system partners developing the governance to continue to provide system oversight to Place
- System agreed Place model will focus on integrated commissioning, with both local authorities having integrated health and social care teams. Both local authorities shared their visioning papers based on the Integration White Paper. The ICB is pulling together a bridging document identifying areas of alignment and difference, and the ICB proposes bringing the paper together for one overarching view, to be presented to CEOs for discussion and agreement in mid-September
- Programme governance for the development of Place was agreed by all system partners, and the operational and steering groups first met in September 2022. Initial Place Executive meetings were held in early October. This structure will be in place on an individual basis
- Priorities for Place were identified and agreed as care homes, learning disabilities and autism, transitions/preparation for adulthood, dementia and S117. Work programmes have commenced to develop the approach to these areas feeding into the Place Executive Groups. These programmes contribute to the delivery of system and national priorities and objectives
- Full review of the Better Care Funds to support further areas of integration with the aim of transparency across aligned services in the first year to support discussions regarding full integration. Alignment meetings between Place and Provider Collaborative leads commenced to ensure that close working is achieved and the developing models complement each other, and interdependencies are identified and acted upon
- Continuing to work with Staffordshire County Council to determine and define the roles of the Districts and Borough Councils in the Place arrangements. Developing formal agreements for working across Place where needed, e.g. standardising discharge processes to ensure consistent model
- An emerging difference in approach to Place between the local authorities which continues to be discussed and developed to ensure that the Place offer is consistent for our population recognising local need wherever possible
- Development of governance to continue to provide system oversight to Place
- The ICB is fully committed to delegation where it makes sense, recognising that full system buy-in is required and that a robust process needs to be followed.

Personalised care 2023/24 objectives

- The NHS Long Term Plan places a commitment for ICBs and wider ICS partners to roll out personalised care to its population
- Personalised care is also a key enabler to managing demand for urgent and unplanned care services through individuals, families and carers taking a more proactive, preventative approach to health and wellbeing through forward health and care planning and self-care management
- We will do this through the ongoing development of strengthened relationships between individuals and professionals across the health and care system
- We will take learning from the areas of system change and embedded personalised care approaches achieved through the Memorandum of Understanding (MOU) foundations
- Population health management will be a driver to achieve better experience and outcomes for individuals that is based on what matters to people, individual circumstance, challenges and assets to enable everyone to have the opportunity to lead a healthy life.

Our commitment

"We have a unique opportunity to transform the way health and social care services are designed and delivered in Staffordshire and Stoke-on-Trent. Working with partners, we want to rebuild new and improved services in a different way to ensure they address inequalities and better support individuals, families and communities now and in the future."

Chris Bird, Chief Transformation Officer

Our high level key measures for personalised care

		Year 1 (2023/24)			
Objective	**Baseline**	Q1	Q2	Q3	Q4
Promote and offer personal health budgets for people with a legal right to have in priority local cohorts.	2,556	2,588	2,620	2,652	2,684
Increase the number of personalised care support plans (PCSPs) for identified cohorts in line with the PCSP model.	62,268	63,046	63,824	64,602	65,380
Delivery of increased referrals to social prescribing link workers (or other equivalent PCI trained professionals).	24,646	24,954	25,262	25,570	25,878

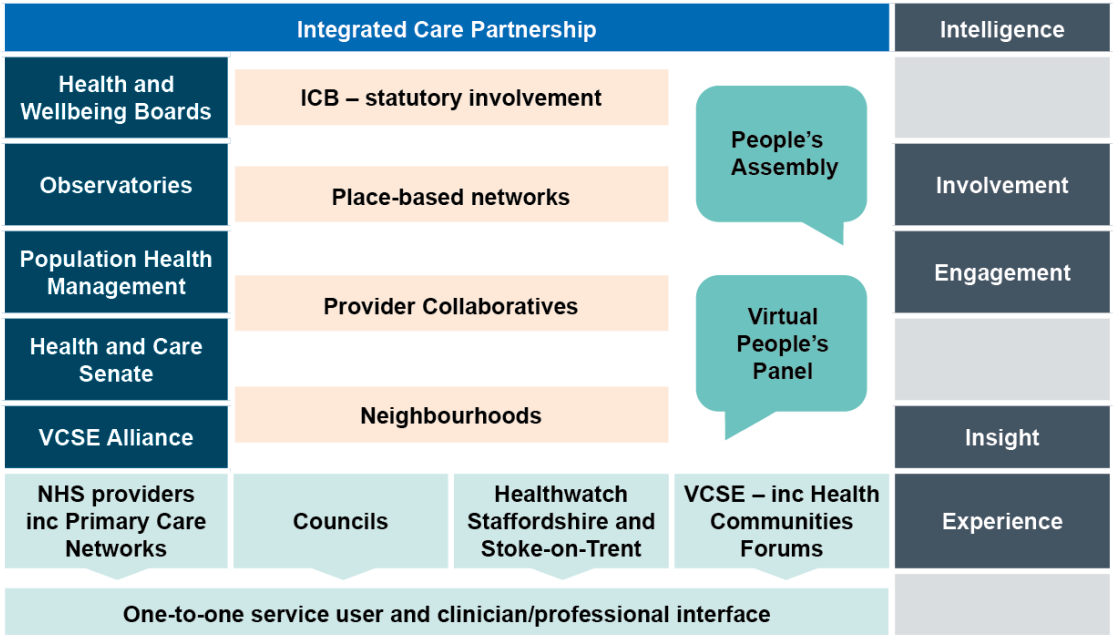
During 2023/24, we will continue to focus on:

- Further developing and embedding the areas of good practice delivered and achieve through the personalised care MOU, Partnership Agreement and Expansion Funds
- Develop an ICS Personalised Care Strategy to embed the approach of the comprehensive model for personalised care in existing Portfolio areas, Provider Collaboratives and Place.

Working with people and communities

- Transitioning to a new way of working as an integrated care system has given us a unique opportunity to reset our relationship with people and communities to one where people are treated as active partners in their own health and wellbeing rather than passive recipients of services
- Working together, we are in a stronger position to achieve the four key aims of the ICS by engaging with the public to understand barriers and opportunities and using that insight to collaboratively build social assets and services that will help to tackle inequalities, improve outcomes in population health, and enhance productivity and value for money
- Our Working with People and Communities Strategy recognises and values the benefits of a community-focussed approach and builds on established relationships and best practice already being delivered by partners and communities across Staffordshire and Stoke-on-Trent
- Our People and Communities Assembly will help to shape and assure the ICB and its partners on our approach to working with people and communities and continually monitor diversity and inclusivity to ensure greater input by people who experience the greatest inequalities
- The Assembly advises the ICB on how best to meet its legal duties to involve, acting as a critical friend, but also holding the ICB to account. It will also help to review and update our Working with People and Communities Strategy as the ICS matures and evolves, supporting the vision to make Staffordshire and Stoke-on-Trent the healthiest place to live and work.

Emerging Stakeholder Framework



Strategic transformation and service changes 2023/24

- Service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, and/or the geographical location from which services are delivered
- In addition to our operational transformations, we have a small number of strategic transformation programmes where our focus for 2023/24 requires wider community engagement to manage the change
- The Portfolios are supported by our System Transformation function to manage those significant service changes. The table on the right summarises the key actions.

Programme and portfolio	Key actions for 2023/24
Inpatient mental health services (IMHS) *Mental Health, Learning Disabilities and Autism Portfolio*	• Technical Group to receive report of findings 9 June 2023 • Following receipt of the report of findings, to begin development of the Decision Making Business Case (DMBC) and reviewing impact assessments • Share report of findings with the Staffordshire Health Overview and Scrutiny Committee • Papers to be developed and submitted to take report of findings through ICB governance process (September 2023).
Urgent and emergency care (urgent treatment centre designation) *Urgent and Emergency Care (UEC) Portfolio*	• Further technical session to take place May 2023 • Briefing paper to be shared following the technical events • Stage 1 NHS England assurance check point meeting to take place • West Midlands Clinical Senate desktop review of proposals • Integrated impact assessments developed • Travel impact analysis • Governance process to be developed (multiple providers) and signed off • Business case to be developed and taken through approved governance routes.
Cannock transformation programme *Primary Care, UEC, Planned Care Portfolios*	• Planning application to be submitted early March 2023 – delayed until April 2023 • Agree lease arrangements for accommodation to house service offer • Completion of feasibility study to confirm location for Alliance Medical mobile MRI scanner • Completion of UEC specification, costs of service provision and potential procurement route.
Maternity *Children and Young People and Maternity Portfolio*	• Communications and involvement plan to be developed • Stakeholder mapping conducted • Bi-weekly maternity meeting to be established • Service change programme office to be established.
Community Diagnostic Centres (CDCs) *Planned Care Portfolio*	• Implementation plans for University Hospitals of Derby and Burton and Royal Wolverhampton NHS Trust CDCs to be assured via Planned Care Portfolio Board • (North CDC) Implementation Group to be established reporting into the Planned Care Portfolio Board and Strategic Transformation Group.
Assisted Conception *Planned Care Portfolio*	• Technical Group to receive report of findings May 2023 • Following receipt of the report of findings, revise the draft interim policy and reviewing impact assessments • Share report of findings with the Staffordshire Health Overview and Scrutiny Committee • Take report of findings and interim policy through ICB governance process.

Staffordshire and Stoke-on-Trent Integrated Care System

Annex B
Assurance on delivery and 31 National Objectives

We will deliver our ambitions and priorities through a range of vehicles that have been set up to work at the level and scale required to make the biggest impact on improving population health and wellbeing in Staffordshire and Stoke-on-Trent.

Delivery

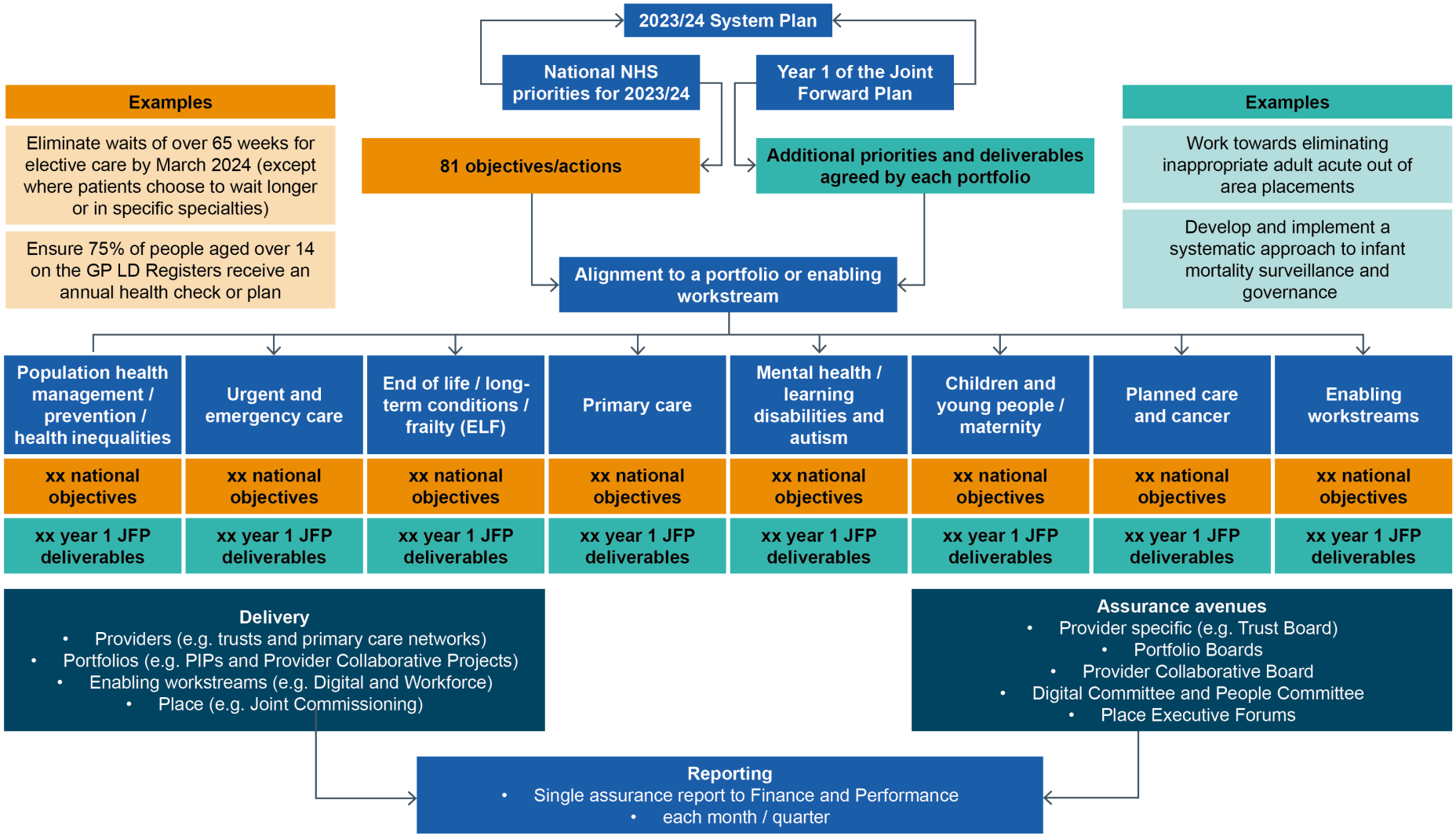
Assurance on delivery

- As partners, we will undertake a continuous appraisal of the position, performance, and delivery of the key priorities and goals set out in the 2023/24 plan
- All system leaders need to be collectively assured that there are mechanisms in place to demonstrate compliance against the 2023/24 System Operating Plan
- The System Operating Plan is made up of a range of quantitative and qualitative objectives and actions which will need to be delivered either through a provider specific activity or a system-led transformation programme. Often there is a clear interdependency between these two types of activity that needs to be managed for an objective to be delivered
- The challenge for the ICS/ICB is to bring these different approaches together into a single view of performance.

How will we make this happen?

- Each national and local objective is aligned to one of the portfolios or enabling workstreams which make up the delivery architecture for the system
- We have identified which deliverables are specific to individual providers and which deliverables require a system approach
- We will use existing assurance mechanisms to demonstrate compliance, e.g. Statutory Trust Boards and Portfolio Boards. Any gaps will be escalated to Executive Leads who attend the System Performance Group in the first instance
- Progress will be reported to the ICB's Finance and Performance Committee, who will take overall responsibility for the delivery of the 2023/24 System Operating Plan
- A flow chart of how this should work in practice is set out on the next page.

Assurance on delivery



National objectives		Portfolio
1	Improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024/25	UEC (Slide 16)
2	Improve Category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	
3	Reduce adult general and acute (G&A) bed occupancy to 92% or below	
4	Consistently meet or exceed the 70% two-hour urgent community response (UCR) standard	
5	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access (DA) and setting up local pathways for direct referrals	Primary Care (Slide 23)
6	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Planned Care (Slide 18)
7	Deliver the system-specific activity target (agreed through the operational planning process)	
8	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Diagnostics (Slide 19)
9	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	
10	Continue to reduce the number of patients waiting over 62 days	Cancer (Slide 19)
11	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	
12	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	
13	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Maternity (Slide 31)
14	Increase fill rates against funded establishment for maternity staff	
15	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	Primary Care (Slide 23)
16	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	
17	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	
18	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	
19	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS-funded services (compared to 2019)	Mental Health (Slide 26)
20	Increase the number of adults and older adults accessing IAPT treatment	
21	Achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services	
22	Work towards eliminating inappropriate adult acute out of area placements	
23	Recover the dementia diagnosis rate to 66.7%	
24	Improve access to perinatal mental health services	
25	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	Learning Disabilities and Autism (Slide 27)
26	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults, and no more than 12–15 under-18s with a learning disability and/or who are autistic per million under-18s are cared for in an inpatient unit	
27	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March	IPH (Slide 33)
28	Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20% on lipid lowering therapies to 60%	
29	Continue to address health inequalities and deliver on the Core20PLUS5 approach	
30	Deliver a balanced net system financial position for 2023/24	Finance (Slide 38)
31	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Workforce (Slide 36)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**11**

Title:	**ICB Purpose, Vision, and Mission and statements**

Meeting Date:	18 May 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Alex Brett, Chief People Officer	Y	Caroline Nokes-Lawrence Head of ICB People, OD and Inclusion

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

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

Is the [Committee]/[Board] being asked to make a decision/approve this item? N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N	n/a	**Decision's Value / SOFD Limit**	N/a

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
Staff Time Out Session	17.01.23	D
Executive Directors	14.03.23	D
Task and Finish Group	15.02.23 10.03.23	D
Non Executive Directors meeting	09.05.23	D

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

Since the ICB was established last year, and following the management of change, work has been underway to commence the drafting of the Purpose, Vision and Mission statements. Full engagement across the workforce has taken place, with staff invited to share their feedback on wording, and the importance of the contents of each of the statements. The final versions (appendix 1) will be communicated widely, and staff will be able to embrace the statements alongside the Leadership Compact.

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

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

Implications:	
Legal and/or Risk	None identified
CQC/Regulator	None identified
Patient Safety	None identified, however it is good practice for patients to understand the ethos and values of the ICB within the statements
Financial – if yes, they have been assured by the CFO	None identified
Sustainability	N/A
Workforce / Training	The workforce have been fully engaged in owning and being part of the discussions around the content of the statements, which create a sense of belonging within the ICB and the wider system partners

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

3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**Y**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

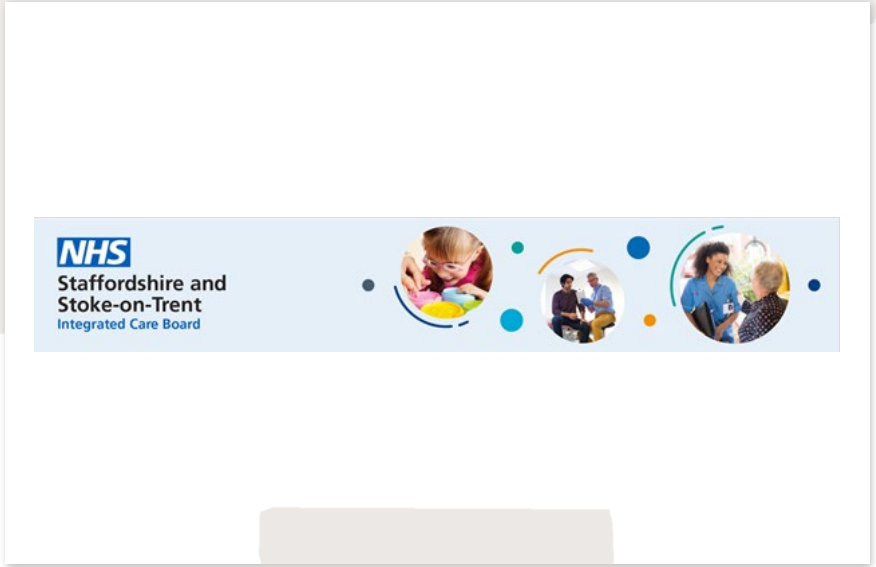
Recommendations / Action Required:

The Integrated Care Board is asked to:

i) Receive the final versions of the ICB Purpose, Vision and Mission statements for ratification

ii) be assured that the statements will be widely shared and communicated so that they can be owned by the workforce and recognised throughout the Staffordshire and Stoke-on-Trent ICS, alongside the Leadership Compact

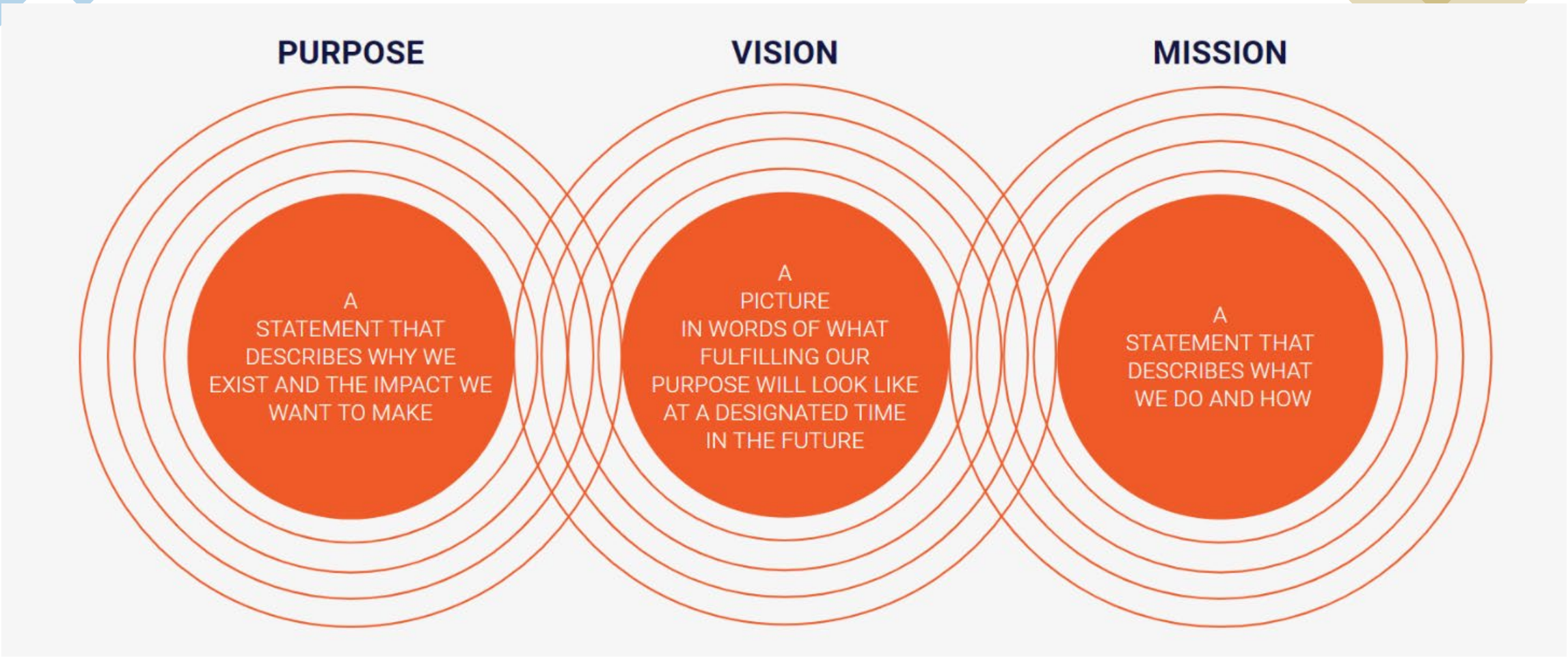
ICB Purpose, Vision and Mission



Focus of the Staff Time Out session on 17th January 2023, asking for feedback from staff via break out groups and padlet

Resulted in the set up of a Working Group with representation from each directorate - meeting on 15th February

'You said, we did' discussion in the Working Group, on what the ICB Purpose, Mission and Values should be, based on feedback


PURPOSE
A STATEMENT THAT DESCRIBES WHY WE EXIST AND THE IMPACT WE WANT TO MAKE
VISION
A PICTURE IN WORDS OF WHAT FULFILLING OUR PURPOSE WILL LOOK LIKE AT A DESIGNATED TIME IN THE FUTURE
MISSION
A STATEMENT THAT DESCRIBES WHAT WE DO AND HOW

Engagement

- All staff – Time Out session
- Staff Engagement Group
- Working Group
- Directors and NEDs

ICB Purpose

- *Leading collaboratively and strategically we will achieve safe care, wellbeing and experiences, for all of our residents and communities*

ICB Vision statement

- *Our vision is simple: We will **work** together to ensure the best possible outcomes for our patients, residents and communities, within a culture of **respect, trust** and **support***

ICB Mission Statement

- Enabling effective delivery across organisational boundaries to improve outcomes and reduce inequalities in population health and health care

- Creating innovative, safe, and high quality care for citizens and our communities, that we are all proud of

Staffordshire & Stoke-on-Trent System 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 & 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.

Respects

- 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 & Compassions

- 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 & Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking Forward

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 10th May 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Board Assurance Framework (BAF)	The full BAF for Quarter 4 was received, which had been updated by the BAF Risk Owners. There are six BAF risks, BAF Risk three "Strategic Objective, Better Quality for all Patients and Service Users" and BAF Risk 6 "Reducing Health Inequalities" are overseen by the Quality & Safety Committee. Both risks have remained static throughout the nine-month period of the BAF. The high level BAF risks for 2023-2024 were agreed at the April Board and the reporting arrangement confirmed. The Quality & Safety Committee will receive the Q1 BAF report in July	
Risk Register	The Committee received the Risk Register for discussion and assurance. The following three risks were confirmed as the Committees highest level risks. Risks Risk: 108; Ivetsey Bank (Independent Hospital): Risk 114; Children and Young People placements for complex behaviour: Risk 115; Looked After Children Initial Health Assessment/ Review Health Assessment (IHA/RHA). The Committee also asked for a review of risks related to Care Homes to ensure they filly reflected the current risks relating to access, capacity and price.	To seek further assurance around the mitigations and timely resolution of these issues a "Deep Dive" of CYP risks will be scheduled for later this year.
QSC Terms of Reference	The Quality &Safety Committee (QSC) Terms of Reference were formally agreed in the October 2022 QSC meeting. As agreed, they have been reviewed at 6 months and a few amendments have been made with the proposal that the meeting will be held bi-monthly: This proposal was agreed by the Committee to be recommended to the Board. There was a further proposal to utilise the intervening months for transformation / deep dive sessions. It may be suitable to invite Provider NED S&Q Chairs to these sessions. Further discussion on this issue will take place on the 5th of June. In addition, the Committee requested further work on a standard Q&S dashboard be undertaken.	The Board will be asked to ratifythe revised TOR in June
Continuing Health Care (CHC) policy	The Committee received a summary paper is to advise members of the development of an NHS CHC	

update	policy which shall be presented to the Committee in July.	
Local Maternity & Neonatal System	Oversight and assurance of maternity and neonatal services continues to be delivered via the LMNS (Local Maternity and Neonatal System) Quality and Safety Oversight Forum (QSOF), which is held monthly and well attended by providers within Staffordshire and Stoke-on-Trent ICS and neighbouring ICSs. The Committee was assured in relation to key quality assurance, quality improvement and patient safety activity relevant to maternity and neonatal services.	
Quality Strategy Update	The Committee was informed that progress had stalled due to partners not being able to engage in the process. The Committee therefore were not assured that the required progress would be made in the previously agreed timeframes.	The Committee requested this matter be resolved and an update received at its next meeting.
Continuous Quality Improvement	This Committee received full assurance from the quarterly update of the CQI Sub-Group: Key issue of note: • NHS Impact has published a review of CQI with a set of recommendations that include the development of national improvement board, a consolidated approach to improvement and the development of a leadership programme. •The co-production of system-wide QI Training resources for people with lived experience to enable them to engage and help shape System QI Projects. • Work is underway with the TDU to embed CQI thinking within the design of system projects. • The QI Network continues to be well received with 59 people attending the most recent event on measurement, with a 14% growth in membership from last quarter	
Quality Impact Assessment	The report to the Integrated Care Board (ICB) Quality and Safety Committee gave an overview of the Quality Impact Assessments (QIA) work programme. Following approval at the Committee and ratification at the ICB Board in February 2023, the ICB's new QIA Policy came into effect on 1st March 2023. There was full assurance that the new policy was now embedded and working well.	
System Quality Group	The System Quality Group (SQG) met on 5th May 2023 with partners from across health, social care, and the wider ICS in attendance. Intelligence, identification of opportunities for improvement and concerns/risks to quality were discussed to enable ongoing improvements in quality of care and services across Staffordshire and Stoke-on-Trent. The group has an extensive work programme, but the Committee wished for further assurance on the safety and quality impacts around Dentistry should be received in due course.	A deep dive will be scheduled for Quarter 3 around the POD delegations with particular attention being paid to access to dentistry.

Risk Review and Assurance Summary

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

Staffordshire and Stoke-on-Trent Integrated Care Board

Board Committee Summary and Escalation Report

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

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register	The FPC Risk Register is now split into ICS risks (Part A) and ICB specific risks (Part B). FPC approved the closure of 5 risks relating to 2022/23. Ambulance handover delays risk was reduced to 20. FPC requested new risks to be developed re: non compliance of ambulance category 2 response times; and elective care waiting times. 3 new risks have been added to the FPC register. The Committee has good sight of the top risks for finance, performance and transformation.	
Performance Report	The report provided detail on performance against key targets and levels of activity. Key points are outlined in the performance report to Board so are not repeated here. Additional challenges due to strike action were acknowledged. Questions focused on 111 abandonment rate; cancer waiting list and backlog; diagnostic performance.	
Elective Care/Elective Recovery Plan	FPC will receive monthly reports on elective long waits to provide additional focus and assurance regarding system performance.	FPC has previously highlighted that SSoT did not achieve the national expectation regarding 104ww and 78ww. A compliant plan for zero 65ww by the end

	FPC discussed the latest data on Staffordshire patients waiting over 78 weeks; the key areas of work being undertaken to mitigate the position; and UHNM data for 65-week waiters (ww), 78ww and 104ww for the week ending 23.04.23. The report also contained information on the route to zero and the trajectory. UHNM have been placed into tier 1 scrutiny, and work is ongoing to close the gap including: an external review of data quality processes at UHNM; changes to theatre utilisation; support from independent sector providers; and national support from the Get it Right First Time team.	of March 2024 has now been submitted.
ICS Finance Report	The Committee noted: • A financial position of breakeven was delivered for 2022/23, subject to audit sign off • Our workforce position is an improving picture with an upward trend, although the use of agency has risen as anticipated in recent months due to winter pressures • Capital is forecasted to achieve plan however medium-term challenges remain.	The Board is asked to note the formal reporting of an ICS 2022/23 breakeven delivery.
Planning Update • Operating Plan • ICS Planning Update	Systems with non-compliant plans are required to resubmit their plans on 4 May and the paper updated the Committee on progress since the 30 March Plan submission specifically: • the route to submitting a breakeven position from a £39.4m deficit • The level risk and efficiencies incorporated into this breakeven plan • The proposal for a 'double lock' process to be introduced to manage and control the system position collectively • Activity compliant plan with exception of 65 week waits and improvement to category 2 ambulance response times	The Committee approved the System Operating Plan for 2023/24 and recommend to the Board that it ratifies this decision. The Board is to note that at the April meeting, FPC approved a system plan with a deficit of £39.4m, which was after applying £40m of stretch improvements to the plan. Work on implementing those stretch measures is ongoing. NHSE requested that we identify further improvements and a pathway to breakeven. Work was undertaken by CFOs and supported by CEOs resulting in a breakeven plan being presented to the national team at an escalation meeting on 26.04.23. The Committee supported the submission of a balanced

		financial plan and acknowledged the significant risk and 'best case' approach that has been taken. The March submission indicated that there would be 800 patients waiting more than 65 weeks by the end of March 2024. The system has now developed a plan to reduce these 65-week waiters to 398, with further work ongoing in May to find solutions to the balance.
Stoke Community Diagnostic Centre Business Case	In line with the national development of Community Diagnostic Centres (CDC), the System submitted a Strategic Business Case to NHSE in April 2022 for £24m funding to develop CDCs within the County. Two locations were confirmed. £3m has been allocated towards Sir Robert Peel Community Hospital in Tamworth, leaving £21 to be allocated to Stoke-on-Trent. In addition to this, £4.7m to increase endoscopy capacity has been made available, which would be incorporated within the CDC function. The Phase 1 and Phase 2 Business Cases were presented to FPC. The Committee noted: the expected positive impact on health inequalities; the capital requirements of £39.8m (against an original allocation of £25.7m); and an on-going revenue deficit of £3.8m. Conversations are taking place with NHSE to try and resolve these gaps and an update will be provided to the June FPC.	The Committee supported the CDC business cases for consideration by NHSE (recognising that the business cases are currently going through UHNM's internal governance) and supported UHNM in seeking to find a resolution with NHSE for the capital and revenue funding gap.
System Transformation and Service Change Update	The Committee noted the following key points: • The UEC Technical Event held in March with follow up event scheduled for May. • Maternity teams from UHNM and UHDB update on their strategic intent for the free standing midwifery birth unit (FMBU) at Stafford and Lichfield and communication with NHSE. • Update on the consultation for Inpatient Mental Health Services previously provided at George Bryan Centre.	
Staffordshire and Stoke-on-Trent ICS	The Committee was presented with the Green Delivery Plan and noted	Board to note that a new SRO for the Greener Programme is

Green Delivery Plan 2023-2025	the recent progress made to deliver against the ICS Green Strategy and further work required in relation to governance, capacity, skills and knowledge to deliver on the SSoT ambition for sustainability.	required. ICS Executive lead is identified; NED champion to be identified. The Plan highlights that there is no specific sustainability post for the ICB or wider ICS which may slow delivery of our Green ambitions.
ICB Approach to Oversight and Assurance	The System is currently in NHS Oversight Framework Segment 3, with areas of heightened concern regarding the financial position, elective care (long waits and cancer backlog) and UEC. The paper detailed the ICB's approach to oversight and assurance and the work taking place on the exit criteria needed for all organisations in Segment 3.	
What Good Looks Like Digital Maturity Assessment	The Digital Maturity Assessment (DMA) is an annual assessment coordinated by NHSE which allows organisations to measure their progress towards the core capabilities set out in 'What Good Looks Like' and identify the areas they need to prioritise to deliver the digital transformation vision.	Board to note the system is rated as low (2/5) on the DMA. Improvements particularly required in Empowering Citizens and Population Health Analytics and Intelligence.
PART B		
Risk Register	The ICB Risk Register was presented for assurance and approval of the proposed closing of 1 risk, 2 new risks and changes to risk scores.	
ICB Finance Report (Month 12)	The report set out the CCG/ICB March 2023 year end financial performance for scrutiny, assurance and approval.	The Committee approved the ICB's year-end position of a £0.5m surplus and noted the challenge the ICB faces in 2023/24 to continue to achieve a balanced position.
Financial Stretch	The paper set out the actions being implemented to deliver the ICB's 2023/24 financial plan. The paper provided an update on the commencement of the line by line expenditure review, the plans for a System Management Cost Reduction Programme and a recommendation that the PIPs should be part of a wider report looking at the delivery of the stretch target in totality.	
Procurement Update	The paper reported the key activities co-ordinated by the Procurement Operations Group and the NHSE requirement for a Provider Accreditation Process covering Providers within the scope of patient choice.	
Individual Funding	The Committee received the reports	

Request Annual Report	and overview of the activity for 01.04.21-30.06.22 and 01.07.22-31.03.23	
Medicines Optimisation Service Level Agreement Report	The paper reported the achievements of the Medicines Optimisation Service Level Agreement with General Practice (MO SLA) during 2022/23. Prescribing cost savings of: • £2,921,256 during 2022/23 • £1,645,383 to be realised in 2023/24. A significant number of Practices participated in successful antibiotics prescribing and medicines safety audits. FPC approved the 2023/24 MO SLA.	Board to note the significant achievements of the 2022/23 MO SLA, and FPC approval of the 2023/24 two year plan to deliver ££6,386,625 with an investment of £1,709,958. FPC approved the Business Case for the 2023/24 MO SLA.

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal, Non Executive Director
Executive Lead:	Alex Brett, Chief People Officer
Date:	Wednesday 10th May 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	A story based on the People Hub was presented. Committee members heard from Whitley Senior, Whitley is a Mental Health Practitioner in CAMHS and a Dramatherapist by background. She explained how the People Hub had introduced her to her role within the NHS and supported her in that journey. Committee members welcomed her story and the success of introducing someone to an NHS career who had previously not felt it was an option for them.	
Strategic People, Culture and Inclusion Update	MI updated members on key strategic updates since the previous meeting. The Operating Plan was submitted on Thursday 4th May, this was the third and last submission. The plan encompasses the Mental Health plan and the wider System plan. A key change in the last submission was around the number of WTEs this number has reduced as the baseline number had increased since the previous submission. Committee members noted there remains financial challenge and were assured that the People Programme is working closely with finance colleagues. Committee members noted that the Joint Forward Plan will be shared at a future meeting once finalised. Committee members noted the ongoing strike actions and were assured that organisations across the system were working and supporting each other closely.	
HEE Update	Committee members received an update in relation to Health Education England who have gone through some major change recently and since 1st April 2023, they now form part of the Workforce and Training Directorate for NHS England.	

People, Culture and Inclusion Metrics and Programme Assurance	Committee members noted key highlights from the programme around the annual report, workforce summit, wellbeing hub and the virtual work experience which has been shortlisted for two HSJ Digital Awards. Committee members were assured by the high quality of information provided for the meeting and the wealth of data that is shared. Assured on delivery of PCI programmes.	
People Culture and Inclusion Operating Model & Governance Structure	As the ICS strengthens its approach to transformation and delivery of services for our local population within the 7 portfolios, the ICS People Function is aligning its operating model to support. Committee members were presented with a diagram detailing the governance structure, the programme workstreams and the task and finish delivery groups. Committee members discussed the alignment of portfolios alongside the above detail.	
People Culture and Inclusion Annual Report	Committee members received the Annual Report in full and noted the key achievements contained within the report. Members also received highlights from the following programmes - Health and Wellbeing; Race, Inclusion and Differently Abled; High Potential Scheme; SSOT People Hub Collaboration; Seldom Heard Community Outreach; and the ICS Apprenticeship Scheme. Committee members noted that the Annual Report will be discussed at the June meeting of the ICB Board and would welcome the opportunity for the People Programme to be the subject of one of the newly introduced 'deep dives' that the Board has introduced.	Annual Report on the agenda for the June ICB Board.
Portfolio/ Profession/ Provider Spotlight – Integrated Care Partnerships	Lynn Millar attended the People, Culture and Inclusion Committee to present the Integrated Care Partnership Strategy. Committee members received information on the approach to the development of the strategy, the drivers for change, the importance of the prevention agenda and the need for cultural change. Committee members welcomed the presentation and discussed how the People, Culture and Inclusion Committee can support this important strategy and what their focus should be.	
Workforce Transformation and Future Supply	The Committee had a detailed discussion around Workforce Transformation and Future Supply, noting both the local and national drivers. The discussion focused on what do we deliver and how and how do we prioritise the importance of our collective actions.	

Risk Review and Assurance Summary

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Sally Young/Paul Brown
Date:	9th May 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Management	The Committee reviewed both the BAF and the latest Corporate Risk Register. This was in the context of the Committee's role to provide assurance around the risk management process and the opportunity to have an overview of risk levels following consideration by individual committees. Further progress is being made in refining these documents with the corporate risk register re-designed to reflect Treasury guidance. Both reports demonstrated review of risks by Finance and Performance and Quality and Safety Committees. Proposed changes to risk levels set out in the reports were discussed and agreed.	Work ongoing to further develop the 2023/24 strategic priorities and BAF Risks and the committee expressed some concern about the pace of completion which requires the full commitment and support of risk owners. There are discussions ongoing around the frequency of both Quality and Safety and the Audit Committee and risk monitoring and reporting will need to be a consideration in these discussions.
Financial -22/23 Draft Annual Accounts - Scheme of Financial Delegations - Prime financial policies -Review of losses, special payments and single contract tenders	Draft 2022/23 Annual Accounts were submitted in accordance with the required deadlines. There were no material changes to forecast position highlighted and key metric requirements have been achieved. Revised financial delegations and prime financial policies were considered in the light of the delegated authority relating to Pharmacy, Optometry and Dentistry. There were no recorded losses and compensations and single action tenders were reviewed and challenged and received assurance that these had been appropriately scrutinised internally.	The Committee would like to commend the hard work of the Finance Team in the production of the draft 22/23 Accounts in meeting submission deadlines and the achievement of key metrics. It is anticipated that final submission date of 30th June will be achieved. The Committee approved the proposed changes to the scheme of delegation and prime financial policies
Internal Audit -Internal Audit Reports	The Progress report from RSM was discussed and particularly to understand the tracking of recommendations Three reports were	**2022/23 Draft Head of Internal Audit Opinion-**The Committee were pleased to receive the draft opinion demonstrating adequate and

- 2022/23 Draft Internal Audit Opinion	received. These were: **Board Assurance Framework -** Reasonable Assurance. This Audit supported many of the comments that have been made internally around the development of risk management arrangements and all recommendations have been accepted and being actioned or completed. **ICB Governance arrangements-** Reasonable Assurance. Again, the recommendations received reflect the work that is ongoing to understand and improve governance arrangements particularly below the level of Board and its' sub-committees. The recommendations were accepted and are being implemented. **Primary Care Commissioning-Additional Reimbursement scheme-** Partial assurance. The findings from this audit were not unexpected and welcomed to provide a focus on the improvements required to improve the robustness of systems and processes.	effective frameworks of Internal Control, Risk Management and Governance arrangements within the ICB.
External Audit	The Committee received a report setting out the planned scope and timing of the 2022/23 statutory audit. The report outlined the risks which require special audit and proposed levels of materiality. Value for money work will now also commence.	Both External Audit and internal Teams are working closely together within tight timescales to ensure that submission dates are achieved.
Counter Fraud	RSM presented their 2022/23 annual report which included a summary of work completed to deliver each element of their plan including a detailed update on active cases.	The annual report included the draft Counter Fraud Functional Return to be submitted to the NHS Counter Fraud Authority. Although this shows that each requirement is being fulfilled, work and attention will continue to ensure further improvements.
Governance -Annual Report -Freedom of Information -Information Governance	The Committee received an update on the comments received on the draft Annual Report. These were broadly very positive with some further refinement required and now in hand.	The Committee received confirmation that trend information will be included in future FOI Reports.
Emergency Preparedness Resilience and Response (EPRR)	The Committee received the annual EPRR report and fully discussed the areas of non -compliance in the documentation required to demonstrate compliance with the EPRR Core Standards Framework. Significant work has been undertaken and ongoing to implement the action plan supporting improvements.	The Board will receive a full update report at it's June meeting showing progress in delivering the Action Plan to demonstrate compliance for the 22/23 assessment.

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