

# STW ICS Board v.3

MEETING  
**29 June 2022 14:00**

PUBLISHED  
**29 June 2022**

# AGENDA

<b>Meeting Title</b>	STW ICS Board	<b>Date</b>	Wednesday 29 June 2022
<b>Chair</b>	Sir Neil McKay	<b>Time</b>	2:00pm
<b>Minute Taker</b>	Jayne Knott	<b>Venue/ Location</b>	Via Microsoft Teams

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Reference	Agenda Item	Presenter	Purpose	Paper	Time
29-06.001	Introduction and Apologies	Neil McKay	I	Verbal	2.00
29-06.002	Declarations of Interest	Neil McKay	I	Paper	
29-06.003	ICS Chairs report	Neil McKay	I	Verbal	
29-06.004	Minutes from the previous meeting held on 25 May 2022	Neil McKay	I	Paper	
29-06.005	Matters arising and action list from previous meeting	Neil McKay	I	Paper	
29-06.006	Questions from Members of the Public Guidelines on submitting questions can be found at: <a href="https://stwics.org.uk/get-involved/board-meetings">https://stwics.org.uk/get-involved/board-meetings</a>  <ul style="list-style-type: none"> <li>Responses to questions from members of the public for the shadow ICB 25<sup>th</sup> May 2022 meeting – for noting</li> <li>Responses to questions from members of the public for STW CCG 8<sup>th</sup> June 2022 meeting – for noting</li> </ul>	Neil McKay	I	Paper  Paper	
29-06.007	Residents Story – Access and referrals for children into learning disability and autism services	Rachel Robinson	I	Verbal	2.15
	<b>Strategic System Oversight</b>				
29-06.008	Interim ICB CEO Designate update <ul style="list-style-type: none"> <li>ICS Update</li> <li>ICP</li> </ul>	Simon Whitehouse	I	Paper	2.35
29-06.009	Final Ockenden Report Update – <ul style="list-style-type: none"> <li>SaTH assurance on action plan</li> <li>CCG Governing Body Paper</li> </ul>	Louise Barnett Mark Brandreth	D, A	Paper Paper	2.55
29-06.010	Pledge 3 Population Health Management and Outcome Framework	Rachel Robinson	D, I	Paper	3.30
29-06.011	Place Based Governance arrangements	Gareth Robinson Andy Begley David Sidaway	D, A	Paper	3.45
	<b>System Governance and Performance</b>				
29-06.012	ICS Performance Update inc. People and Finance <ul style="list-style-type: none"> <li>Ambulance handover performance</li> <li>104 week waits</li> </ul>	Julie Garside	A	Paper	4.20

29-06.013	22/23 NHS Operational Plan	Claire Skidmore Gareth Robinson	R	Verbal	4.30
29-06.014	<b>Committee Reports</b> <ul style="list-style-type: none"> <li>Sustainability Chair's report for meeting held on 25<sup>th</sup> May</li> <li>Sustainability Chair's report for meeting held on 21<sup>st</sup> June</li> <li>Quality &amp; Performance Committee Chair's report for meeting held on 25<sup>th</sup> May</li> </ul>	Gareth Robinson  Meredith Vivian	S  S	Paper  Verbal  Verbal	4.45
	<b>For Information</b>				
	Any other business (notified in advance to the Chair)	Neil McKay		Verbal	4.55
	Date and time of next meeting: 1 July 2022 at 4pm via Microsoft Teams				
<b>RESOLVE:</b> To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)					

ADD SIGNATURE



Sir Neil McKay  
Chair Designate of STW ICB

ADD SIGNATURE



Mr Simon Whitehouse  
Interim Chief Executive Designate of STW ICB

**Members of Shropshire, Telford and Wrekin Integrated Care System (STW ICS) Board**

**Register of Interests - 22 June 2022**

Surname	Forename	Position/Job Title	Type of Interest				Nature of Interest	Date of Interest		Date Declaration Reviewed	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To		
Barnett	Louise	Member, ICS Board	X			Direct	Chief Executive, Shrewsbury & Telford NHS Trust	Feb-20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
		Chief Executive, Shrewsbury & Telford Hospital NHS Trust	X			Indirect	Husband is Chair of QEH Kings Lynn NHS Trust	Feb-20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Indirect	Husband is Chair and Client Partner of SSG Health Ltd	Feb-20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					X	Indirect	Husband is visiting Chair of Cranfield University	Feb-20	ongoing	17.2.22	Level 1 - Note on Register
Begley	Andrew	Member, ICS Board	X			Direct	Chief Executive, Shropshire Council	1.9.20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
		Chief Executive, Shropshire Council									

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Brandreth	Mark	Member, ICS Board  Interim Accountable Officer - Shropshire, Telford and Wrekin CCG	X		X	Direct	Interim Accountable Officer - Shropshire, Telford and Wrekin CCG	1.8.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					X	Indirect	Close friends with Director of Innermost Consulting	2013	ongoing	17.2.22	Level 1 - Note on Register
					X	Indirect	Close friends with Corporate Team at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2012	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					X	Indirect	Partner is an employee of RJAHS and also works with Shropshire Community Health NHS Trust (SCHT)	2022	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Burford	Andy	Member, ICS Board  Cabinet Member for Adult Social Care and Health Integration, Telford & Wrekin Council	X			Direct	Cabinet Member for Adult Social Care and Health Integration, Telford & Wrekin Council	May-19	ongoing	18.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Bussey	Alison	Member, ICS Board  Chief Nursing Officer					None declared	Not applicable	Not applicable	14.6.22	

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			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To		
Carr	Neil	Member, ICS Board  Chief Executive, Midlands Partnership NHS Foundation Trust	X		X	Direct	Chief Executive, Midlands Partnership NHS Foundation Trust	2005	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
						Direct	Doctor – Staffordshire University	2007	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
						Direct	Programme Director – Staffordshire STP	2018	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
						Direct	Visiting Professor – Wagner College New York	2007	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Chan	Ian	Member, ICS Board	X	X		Direct	GP Partner, Teldoc	5.4.17	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
						Direct	Telford & Wrekin Locality Chair	1.7.20	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions

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			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To			2.
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				X		Direct	Place based care clinical lead	1.8.20	ongoing	22.2.22	Level 1 - Note on Register	7.
			X			Direct	Teldoc PCN Clinical director	1.7.19	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	8.
			X			Direct	Acupuncturist	10.9.19	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	9.
			X			Direct	In receipt of Keele University fees for Medical Student	1.7.19	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	10.
												11.
Davies	Patricia	Member, ICS Board	X			Direct	Chief Executive, Shropshire Community Health NHS Trust	1.4.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	12.
		Chief Executive, Shropshire Community Health NHS Trust										13.
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			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To		
Dunshea	Roger	Member, ICS Board  Non-Executive Director	X			Direct	Royal Wolverhampton NHS Trust - Non-Executive Director	01.04.22	ongoing	25.4.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Black Country Healthcare NHS FT - Non-Executive Director	01.04.22	ongoing	25.4.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Dymond	Nicola	Member, ICS Board  Director of Strategy and Integration					To be confirmed				
Jones	Simon	Member, ICS Board  Shropshire Council Councillor & Cabinet Member with portfolio for Adult Social Care and Public Health	X			Direct	Shropshire Council Councillor & Cabinet Member with portfolio for Adult Social Care and Public Health	24.9.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Keegan	Stacey	Member, ICS Board  Chief Executive, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	X			Direct	Chief Executive, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Aug-21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions



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Mckay	Neil	Independent Chair, ICS Board	X			Direct	Independent Chair, ICS Board	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	7.
			X			Direct	Director of Neil McKay Associates Ltd	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	8.
			X			Indirect	Wife Director of Neil McKay Associates	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	9.
			X			Direct	Associate with GE Healthcare	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	10.
			X			Direct	Associate with PA Consulting	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	11.
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			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To		
			X			Direct	Senior Adviser to ZPB Associates	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Strategic Adviser and Health Strategy Board Chair , Browne Jacobson LLP	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Adviser to Harvey Nash, Executive Search	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
McMahon	Catriona	Member, ICS Board	X			Direct	Chair, Shrewsbury & Telford Hospital NHS Trust	2020	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
		Chair, Shrewsbury & Telford Hospital NHS Trust	X			Direct	Shareholdings and other ownership interests: Holder of small number of shares in AstraZeneca	2000	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions

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			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From	To		
			X			Direct	Shareholdings and other ownership interests: Owner, CMMK Ltd, a pharmaceutical medical consultancy working with ABPI and NHS Scotland (Co. number 9150498)	2014	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Shareholdings and other ownership interests: Owner TAC Ltd, an executive coaching business, proving services to wide range of organisations, including healthcare (Co. number 11437635)	2017	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Non-Executive Director, University Hospitals Birmingham NHS Foundation Trust	2014	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
McMillan	Trevor	Member, ICS Board	X			Direct	Vice-Chancellor Keele University	1.8.15	ongoing	12.5.22	Level 1 - Note on Register
		Non-Executive Director		X		Direct	Chair of Midlands Innovation Partnership	12.5.22	ongoing	12.5.22	Level 1 - Note on Register

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				X		Direct	Chair of Newcastle-under-Lyme Town Deal Board	12.5.22	ongoing	12.5.22	Level 1 - Note on Register
				X		Direct	Universities UK Member	12.5.22	ongoing	12.5.22	Level 1 - Note on Register
				X		Direct	Member of Staffordshire and Stoke-on-Trent Local Enterprise Partnership Board	12.5.22	ongoing	12.5.22	Level 1 - Note on Register
Nurse	Megan	Member, ICS Board  Vice Chair, Midlands Partnership NHS Foundation Trust	X			Direct	Vice Chair, Midlands Partnership NHS Foundation Trust	14.06.16	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
O'Kane	Nuala	Member, ICS Board	X			Direct	Chair, Shropshire Community Health NHS Trust	Feb-19	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Indirect	Husband is Chief Executive of Small Woods Association (Provider of mental health and well being support, and may benefit from Social Prescribing)	Jan-16	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions

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Pall	Niti	Member, ICS Board  Non-Executive Director					To be confirmed				
Robinson	Gareth	Member, ICS Board  Director of Delivery & Transformation					None declared	Not applicable	Not applicable	10.05.22	
Sidaway	David	Member, ICS Board  Chief Executive, Telford and Wrekin Council	X			Direct	Chief Executive, Telford and Wrekin Council	01.04.22	ongoing	01.04.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Skidmore	Claire	Member, ICS Board  Chief Finance Officer		X		Direct	ICS Chief Finance Officer Designate	01.07.22	ongoing	22.6.22	Level 1 - Note on Register
Turner	Harry	Member, ICS Board  Chair, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	X			Direct	Chair, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1.2.22	ongoing	8.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					X	Direct	Chair, Hospice Charity Partnership	Oct-16	ongoing	8.2.22	Level 1 - Note on Register

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					X	Direct	Chair, Dudley Integrated Care NHS Trust	Jul-19	ongoing	8.2.22	Level 1 - Note on Register	7.
					X	Direct	Presiding Justice, West Mercia Judiciary	Oct-06	ongoing	8.2.22	Level 1 - Note on Register	8.
												9.
Vivian	Meredith	Member, ICS Board			X	Direct	Trustee of the Strettons Mayfair Trust, a community organisation providing health and care activities, facilities and services to the residents of the Strettons, Shropshire	01.06.19	ongoing	22.6.22	Level 1 - Note on Register	10.
		Independent Non-Executive Director										11.
White	Nicholas	Member, ICS Board		X		Direct	Employed part-time by University Hospitals Birmingham NHS FT as a Consultant Plastic Surgeon	01.05.22	ongoing	03.05.22	Level 1 - Note on Register	12.
		Chief Medical Officer										13.
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Whitehouse	Simon	Member, ICS Board  Interim CEO Designate for the ICB	X			Direct	Interim CEO Designate for the ICB	01.01.22	ongoing	01.01.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					X	Direct	Trustee for the Port Vale Football Club Foundation Trust	01.01.22	ongoing	01.01.22	Level 1 - Note on Register
					X	Indirect	Spouse is a senior staff nurse at University Hospital of North Midlands	01.01.22	ongoing	01.01.22	Level 2 - Restrict involvement in any relevant commissioning decisions

# Attendees of Shropshire, Telford and Wrekin Integrated Care System (STW ICS) Board

## Register of Interests - 22 June 2022

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Cawley	Lynn	Attendee, ICS Board Chief Officer, Healthwatch Shropshire					None declared			06.07.21	
Garside	Julie	Attendee, ICS Board Director of Performance NHS Shropshire, Telford and Wrekin CCG	X			Direct	Director of Performance NHS Shropshire, Telford and Wrekin CCG	1.4.21	ongoing	23.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
O'Connor	Nicky	Attendee, ICS Board ICS Programme Director					None declared			Jul-21	
Parnaby	Barry	Attendee, ICS Board Chair, Healthwatch Telford and Wrekin	X			Direct	Chair, Healthwatch Telford and Wrekin	23.2.22	ongoing	23.2.22	Level 1 - Note on Register
			X			Direct	Councillor, Great Dawley Town Council	23.2.22	ongoing	23.2.22	Level 1 - Note on Register



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												4.
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Pepper	John	Member, ICS Board	X			Direct	Chair, NHS Shropshire, Telford and Wrekin CCG	1.4.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	7.
		Chair, NHS Shropshire, Telford and Wrekin CCG	X			Direct	Salaried General Practitioner at Belvidere Medical Practice (part of Darwin Group)	19.1.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	8.
			X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	19.1.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	9.
			X			Direct	NHS England GP Appraiser	19.1.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions	10.
			X			Direct	Associate Non-Executive Director, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	01.07.22	ongoing	01.07.22	Level 2 - Restrict involvement in any relevant commissioning decisions	11.
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					X	Indirect	Family member provided evidence to Ockenden Review	1.4.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions or discussions on historical issues raised within the scope of the Ockenden Review. This does not exclude from commissioning decisions or discussions on current maternity and neonatal services or any service provided by SaTH more generally.
Povey	Jane	Attendee, ICS Board  Clinical Lead		X		Direct	Member of University Centre Shrewsbury (University of Chester) Consultative Board	2017	ongoing		Level 1 - Note on Register
Redfern	Steven	Attendee, ICS Board  Assistant Director of Strategic Transformation with NHS England and NHS Improvement (Midlands Region)		X		Direct	Assistant Director of Strategic Transformation with NHS England and NHS Improvement (Midlands Region)	23.2.22	ongoing	23.2.22	Level 1 - Note on Register

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Riley	Catherine	Attendee, ICS Board	X			Direct	Managing Director, Midlands Partnership NHS Foundation Trust	Jun-18	ongoing	18.2.22	Level 1 - Note on Register
		SRO for Mental Health, Learning Difficulties & Autism			X	Indirect	Wife of CCG Officer in Medicines Management team	1.3.21	ongoing	18.2.22	Level 1 - Note on Register
Steel	Fran	Attendee, ICS Board		X		Direct	Director of Strategic Transformation for North Midlands, NHS England & Improvement	23.2.22	ongoing	23.2.22	Level 1 - Note on Register
		Director of Strategic Transformation for North Midlands, NHS England & Improvement									



**STW ICS BOARD**  
**25 MAY 2022 - 3PM**  
**MINUTES OF MEETING**

**Present:**

Sir Neil McKay	Chair STW ICS Board
Simon Whitehouse	Interim ICB CEO Designate STW ICS
Trevor McMillan	Non-Executive Director, STW ICS
Niti Pall	Non-Executive Director, STW ICS
Roger Dunshea	Non-Executive Director, STW ICS
Nicholas White	Chief Medical Officer STW ICS
Gareth Robinson	ICB Director of Delivery and Transformation STW ICS
Meredith Vivian	Deputy Chair/Lay Member, Patient and Public Involvement STW CCG
Claire Skidmore	Executive Director of Finance STW CCG
Alison Bussey	Chief Nurse Midlands Partnership Foundation NHS Trust
Neil Carr	Chief Executive, Midlands Partnership Foundation NHS Trust.
Patricia Davies	Chief Executive Shropshire Community Health NHS Trust.
Andy Begley	Chief Executive, Shropshire Council
David Sidaway	Chief Executive, Telford and Wrekin Council.
Dr Ian Chan	Primary Care Network Clinical Director.

**In Attendance**

Dr John Pepper	Chair NHS Shropshire, Telford and Wrekin CCG (STW CCG)
Mark Brandreth	Interim AO of STW CCG
Lynn Cawley	Chief Officer Healthwatch Shropshire
Barry Parnaby	Chair Healthwatch Telford and Wrekin
Terry Gee	Chief Officer STAY Telford
Cllr Simon Jones	Portfolio Holder for Adult Social Care and Public Health Shropshire Council
Cllr. Andy Burford	Cabinet Member for Health and Social Care, Telford and Wrekin Council
Nuala O'Kane	Chair Shropshire Community Health NHS Trust
Harry Turner	Chair Robert Jones and Agnes Hunt Foundation Trust
Dr Catriona McMahon	Vice Chair STW ICS and Chair Shrewsbury and Telford Hospital NHS Trust
Nicky OConnor	ICS Programme Director, STW ICS
Edna Boampong	Director of Communications and Engagement STW ICS
Craig Macbeth	Chief Finance and Planning Officer. RJAH
Alison Smith	Director of Governance STW CCG
Vanessa Whatley	Deputy Director of Nursing and Quality STW CCG
Nigel Lee	Interim Director of Strategy and Partnerships SaTH
Will Nabih	Associate Director, Estates and Hospital Site Transformation SaTH
Frank Collins	Chair ICS Sustainability Committee STW ICS
Adrian Cooper	Climate Change Task Force Leader, Shropshire Council
Melissa Asbury	Business Manager, STW ICS
Georgina Groom	Senior Digital Communications Officer STW ICS
Jayne Knott	ICS Programme Support

## Apologies:

Louise Barnett	Chief Executive Shrewsbury and Telford Hospital NHS Trust
Cathy Riley	Managing Director Midlands Partnership Foundation NHS Trust
Megan Nurse	Vice Chair, Midlands Partnership Foundation NHS Trust
Stacey Lea-Keegan	Interim Chief Executive Robert Jones and Agnes Hunt Hospital NHS Foundation Trust
Zena Young	Executive Director of Nursing and Quality STW CCG
Sam Tilley	Director of Planning STW CCG
Heather Osborne	Chief Officer AGE UK
Fran Steele	Director Strategic Transformation NHSE/I
Dr Ian Rummens	Shropshire Local Medical Committee

Minute No	Title
25/05/1.0	<p><b>Introduction and Apologies</b></p> <p>Apologies were noted as outlined above.</p> <p>The Chair welcomed everyone and reminded Board members that this was a meeting held in public and welcomed the members of the public to this Board meeting. He went onto explain that the papers had been standardised and shortened with the additional detail contained in a separate pack with appendices included:</p> <ul style="list-style-type: none"> <li>• Readiness to Operate Assessment update</li> <li>• ICB Constitution</li> <li>• STW ICS Green Plan</li> <li>• STW People and Communities involvement strategy</li> </ul> <p>The Chair welcomed the newly appointed Chief Medical Officer Mr Nick White who joined today's meeting for the first time.</p> <p>The Chair also announced the appointment of our fourth independent Non-Executive Director- Mr Meredith Vivian. Meredith also chairs the Quality and Performance Committee for the CCG and has been involved as a Lay Member of the CCG Governing Body for some time.</p>
25/05/2.0	<p><b>ICS Chairs report</b></p> <p>The Chair highlighted the following:</p> <ul style="list-style-type: none"> <li>• He acknowledged that we are a system still operating under pressure as we manage various service issues on several fronts.</li> <li>• Urgent and emergency care is still facing significant challenges. We have seen some improvements in urgent and emergency care flow and discharges out of hospital have improved significantly. The Chair paid tribute to Shropshire Community Health Trust/social care/local authorities for the work that they have done to help to alleviate the situation and managing the difficulties they have to sustain the support provided.</li> <li>• Covid related activity has levelled off and reduced.</li> <li>• We have issues that we need to focus upon and resolve in terms of ambulance handover performance. There have been discussions with our MPs since the last Board meeting and it has been agreed that there will be a two-part summit arranged in the very near future with the MPs and with WMAS. The CEO of WMAS Anthony Marsh, and our Chair will chair the summit.</li> <li>• There are service issues with 104-week waiters but there is recognition that it is very difficult with some of these specialist cases, to be able to fulfill the</li> </ul>

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	<p>guarantee of them being treated by the end of June. But people are working incredibly hard to try to deliver that for as many people as is possible.</p> <ul style="list-style-type: none"> <li>• A lot of time has been spent agreeing our operational plan for the new financial year.</li> <li>• A large amount of activity is taking place preparing for the ICS statutory status on the 1 July, and we are making good progress which has been recognised by the Regional Office.</li> <li>• The Chair also paid tribute to our staff across the system, many of whom have been, and continue to be, concerned about job security given the transition the system is going through. Despite this the CCG and staff within the ICS core team have been working tirelessly and highly professionally to support the efforts of this Board and even more importantly, support the efforts of improving and managing services for patients and for clients.</li> <li>• Board development sessions are to be set up for our new Board members to come together and have space to think about some of the strategic issues we need to focus upon and think about how as a Board, we want to operate.</li> <li>• Recruitment continues for Board members. We are now advertising and seeking applicants from GPs for the two Primary Care Partner members for our Board.</li> <li>• Agreement has been reached with WMAS that although they will not be a full member of the ICB, they will be invited to attend the Board as a participant and contribute to future meetings.</li> <li>• An Ockenden update is to be discussed at June Board, with a further discussion at our Board in July, when the boards for the CCG and SaTH have had the opportunity to think about their responses, and then we will be able to draw that together for an integrated discussion, across the whole of our system.</li> </ul> <p>Dr Catriona McMahon commented that the first of the Ockenden review assurance committee meetings in relation to the second report, is due to be publicly streamed on the 21 June. There will be an update with regards to the number of actions, plans, timelines and the future work that would be required.</p> <p>Niti Pall mentioned that she is also a non-executive for Birmingham Women and Children's Hospital and offered Dr McMahon feedback from their Quality committee where Ockenden has been discussed extensively.</p>
25/05/3.0	<p><b>Minutes and Actions from Previous Meeting – 27/04/2022</b></p> <p>Minutes of the last meeting were approved as a true and accurate record with the following amendments agreed:</p> <p>Attendance list should be amended as Mr Trevor McMillan did attend the last Board in April.</p> <p>The Action log was noted with the following observations:</p> <ul style="list-style-type: none"> <li>• Action log needs revising and updating.</li> <li>• Place based dashboard needs to go through SHIPP and TWIPP to be signed off then brought back to this board in June.</li> </ul> <p>Mr Simon Whitehouse commented that the format of Board papers has been changed so that we are working on a much tighter cover page to provide the summary report on a couple of pages that then gives the detail with the supporting documentation in a second separate pack. He asked for papers to be clear on what was being asked from this Board.</p> <p>Mr Whitehouse said he welcomed any feedback around the paper format.</p>

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25/05/4.0	<b>Matters arising and action list from previous meetings</b>  Outstanding actions will be discussed later on today's agenda.
25/05/5.0	<b>Questions from Members of the Public</b>  The Chair thanked Gill George for her questions saying that this was the first month we had received questions from the public. The questions included: <ul style="list-style-type: none"> <li>• Inequalities and access to primary care.</li> <li>• Ambulance response times and related questions about rural areas and Community Hospital beds.</li> <li>• Treatment facilities for neurodiverse children.</li> </ul> The Chair went on to outline the process that would take place. <ul style="list-style-type: none"> <li>• We will prepare a detailed response to the questions when we receive them each month.</li> <li>• We will respond within three weeks of receipt</li> <li>• Following the Board meeting, we will publish a note of the questions and the response for information.</li> </ul> Mr Meredith Vivian asked the Chair if Board members would have sight of the answers to the questions before they were signed off?  The Chair responded by confirming that this would be part of the process.
25/05/6.0	<b>Resident's story/experience- Dougs story.</b>  Dr John Pepper introduced the video and asked the Board to reflect upon what we might be able to do as a system to provide a dedicated and sustainable service and asked the board to consider the extreme inequalities and disparities that the homeless experience.  Doug describes some of his experiences, the services he has struggled to access and other services that have been able to help him.  Dr Pepper highlighted the following: <ul style="list-style-type: none"> <li>• There are some wonderful examples across Shropshire, Telford and Wrekin of incredible work being done, often by small groups of volunteers to care for the homeless.</li> <li>• The homeless experience health issues which can include drug and alcohol problems, mental health difficulties, often including traumatic life experiences, PTSD, and respiratory illnesses and they often suffer from wound infections, which can lead to sepsis.</li> <li>• The homeless do not have the same structures that others have in their lives to attend appointments in a system that has evolved with others in mind. So, their personal changes and circumstances change frequently.</li> <li>• Having access to a place where they trust, feel safe, valued, and respected, can have a real positive impact for their own health and reduce the reliance on A&amp;E and other emergency services.</li> <li>• The ARK in Shrewsbury is run by a charity and hosts a hepatitis outreach service, counselling, funded by the charity.</li> <li>• There are great examples of work being done by individuals in SaTH</li> <li>• The ARK in Shrewsbury and Manning Place in Telford provides daycare facilities, a safe place to go with an opportunity for a hot meal, washing facilities, warmth, a place to charge a phone, and companionship.</li> </ul>

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	Dr Pepper asked how can we better support and make sustainable the services to this marginalised group of society across our system? Funding for this work is frequently uncertain, and it is frequently short-term making planning difficult. Can we provide greater certainty and a clear strategy by working closer together across our various organisations?	1.
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	We need to have a clear strategy around how we are tackling homelessness, but also looking at the cost-of-living crisis and how that is having an impact in some of our most disconnected areas and what we can do to try and stabilise that.	3.
	Mrs Patricia Davies commented that this problem is likely to increase with the economic situation that we are in.	4.
	Mr Terry Gee commented that the rough sleeper task force in Telford has met every morning since March 2020. Over 450 rough sleepers that have come through hotels have been supported. Telford and Wrekin are looking at a homelessness and rough sleeper strategy this summer.	5.
	Mr Andy Begley commented that homelessness was a small part of a very big problem, but there was a lot of incredible work done around trying to support our rough sleepers. He went onto highlight that services can use data to pinpoint much more accurately when people are going to face and come near to the point of becoming homeless. Undertaking intervention work before someone becomes homeless is far more cost effective, improves quality and outcomes of life for individuals and reduces costs. It is a prime example of using this to pivot our system and concentrate on what we need to.	6.
	Mr David Sidaway commented that in this system we have two local authorities that work hard on doing the right thing and working really hard with housing providers. But we need to do much better in this because the inequalities are unacceptable.	7.
	The Chair asked Mr Simon Whitehouse whether this discussion should form part of a CEO meeting to help decide on the actions and timelines, then for CEO group to update this Board to describe what the plan is and by when.	8.
	Mr Whitehouse responded by saying he thought this item should be taken through the place boards for discussions but need to get the data right and CEOs could have oversight of that.	9.
	The local authority intelligence, the population health data that is available and the health need and the JSNA information that we already have identified can be brought together. We need to understand where that need is and then plan our services on that basis. There is a data and intelligence piece that the CEOs can have oversight of.	10.
	The Board at a system level, needs to have that oversight to seek assurance from the place boards and from the CEOs and from the data intelligence work that works progressing at pace, and we are targeting that investment in the right area.	11.
	The Chair commented that it would be useful if we could use this theme in SHIPP and TWIPP as a big priority 'A big ticket item' and show what integration really looks like?	12.
	Dr John Pepper responded by saying that SHIPP and TWIPP are at a very early stage and he would not like this to be lost in the ether of the development of the system.	13.
	The Chair asked members of the Board that had further comments to email him due to the time constraints.	14.
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	<b>The Board noted the presentation.</b>
25/05/7.0	<p><b>Interim ICB CEO Designate update</b></p> <p>Mr Simon Whitehouse presented the item and highlighted the following:</p> <p><b>ICS Update</b></p> <p>The Health and Care Bill has now received Royal Assent, and this confirms that ICBs will be legally established on the 1 July 2022. He recognised that there is some frustration around the time being taken to develop the governance for the ICS as we put one statutory organisation in place and close another organisation down. However, we need to make sure we look after our people and ensure that their transfer to the ICB is done in a robust way.</p> <p><b>ROS update/sign off</b></p> <p>All evidence to support our Readiness to Operate statement has now been submitted to NHSE/I and there have been no significant changes since the last submission in March. Risk areas are outlined in the report and remain the same as the previous report in May. The feedback session with the Regional team took place on Friday 27 June to discuss outcomes and next steps. Following this there will be regional sign off on 15<sup>th</sup> June and on the 16th June a letter of sign off by Simon Whitehouse and Dale Bywater that will outline any further areas of development that we might need to undertake.</p> <p><b>ICP update</b></p> <p>The paper outlines where we are up to with the Integrated Care Partnership (ICP). Active on-going discussions are happening in the system about how that partnership becomes a meaningful arrangement within our overall governance and how it is going to contribute significantly to the strategy for the system. There are draft terms of reference which are being discussed within both local authorities.</p> <p>As the ICP is a joint committee of this Board and the two local authorities the governance handbook will include the terms of reference which will come to this Board for final agreement. Elected members of both local authorities are content with the process and timeline so far but this needs to develop over time. The next steps include finalising the draft terms of reference and it is planned that the first meeting will be in September 2022 and the chair of the ICP will rotate between the two local authority leaders.</p> <p><b>ICB Constitution</b></p> <p>The constitution has gone through several iterations. This will be the document that once the establishment order is received, will legally constitute the organisation. The constitution will be signed off and approved for final submission by the end of this week.</p> <p><u><b>ACTION:</b></u> The Chair asked for a more detailed report about what is being planned around timelines for place committees to go on agenda for June Board.</p> <p><b>The Board-</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the detail provided in part one of the report</b></li> <li>• <b>Acknowledged the risk detailed in relation to the ICB People Function</b></li> <li>• <b>Confirmed its support for the submissions detailed in relation to the ICB establishment</b></li> </ul>

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	<ul style="list-style-type: none"> <li><b>Noted and commented on the progress made towards the establishment of the ICP.</b></li> </ul>
25/05/8.0	<p><b>STW ICS Green Plan</b></p> <p>Mr Andy Begley, Mr Adrian Roberts and Mr Will Nabih presented the paper and highlighted the following:</p> <ul style="list-style-type: none"> <li>NHSE/I have required that all systems approve system ICS Green Plans by April 2022. The Board approved the plan at the April meeting but agreed to bring it back to allow broader discussion on its content. The governance of this key area centres on the ICS Climate Change Group, with subgroups for waste, carbon, energy and procurement, travel planning and biodiversity.</li> <li>The ICS Green Plan has been co-ordinated with all system partners via the ICS Climate Change Group which has good attendance with representation from all system partners.</li> <li>Health and social care services across Shropshire and Telford will need to respond to the challenge of climate change. Climate and carbon issues will need to be embedded into everything we do now and in the future.</li> <li>The next three years will be fundamental in building collaboration across the system and establishing early investment to maximise benefits later.</li> <li>During 2022 the ICS will identify a Sustainability Lead - a person accountable to the board lead and responsible for providing support to the respective organisations within the ICS, holding those organisations to account and ensuring that their respective action plans are being addressed in the agreed timeframes.</li> </ul> <p>Mr Macmillan asked for confirmation on how quickly the coordination role could be filled. My Nabih confirmed that this role was dependent on a self funding business case being developed so this may take some time but this will not prevent us delivering against the agenda.</p> <p>Mr Dunshea asked if the data being captured for carbon footprint calculations was accurate? Mr Coper replied that it is for local authorities who have had to collect this type of data for a longer period of time and this will be a key focus of action for the health sector going forward.</p> <p><b>The Board:</b></p> <ul style="list-style-type: none"> <li><b>noted the report and ratified its decision at the April meeting to adopt the STW ICS Green Plan.</b></li> <li><b>Noted the next steps will be to develop a 'plan on a page' summary for implementation. In addition, a costed action plan will be produced setting out how existing commitments made by each organisation would be implemented.</b></li> </ul>
25/05/9.0	<p><b>STW People and Communities involvement strategy (pledge 8)</b></p> <p>Mrs Edna Boampong presented the paper and highlighted the following:</p> <p>The strategy explains how the newly formed NHS Shropshire, Telford, and Wrekin (NHS STW) intends to involve people and communities.</p>

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	<p>To be a strong and effective organisation, we need a deep awareness of all our communities and the people living within them.</p> <p>Understanding their diverse hopes, needs and experiences will be essential in enabling us to tackle health inequalities and the other challenges all health and care systems face.</p> <p>The strategy will help us to make sure we establish a shared approach to hearing the needs, experiences and wishes of local people, learning from them, and ensuring they inform our priorities and key decisions about health and care services.</p> <p>The document describes our approach and our methods to ensure we are putting the people of Shropshire, Telford, and Wrekin at the heart of everything we do</p> <p>Next steps are to hold a workshop to talk about how this is implemented and how do we embed it, and has it worked, what has been successful?</p> <p>Mr Vivian welcomed the document and thanked Mrs Boampong and her team for their efforts in overseeing its development. He highlighted to the Board the importance of having a strategy that enabled the ICS as a system to listen to its patients and citizens to design services that were needed and accessible and that additional effort was undertaken to hear the vies of the “often ignored” groups in our communities.</p> <p>Cllr Burford welcomed the strategy’s aims to help join up people’s experience of the services that are delivered across the system as well as helping to target services for disadvantaged communities.</p> <p>Mrs Boampong clarified that although the strategy seeks to utilise digital technology where that is appropriate, there are parts of our community for different reasons who do not have access to a smart phone so the way the ICS will need to involve and engage needs to use multiple mechanisms for communication to prevent it excluding groups in our communities.</p> <p>Ms Cawley supported the strategy in seeking to provide many different mechanisms for people to be involved and engaged.</p> <p>The Chair concluded the discussion and asked Mrs Boampong to consider adding output measures to help the Board evaluate the effectiveness of the strategy at future meetings. Mrs Boampong confirmed that a workshop to develop measures has already been arranged.</p> <p><b>The Board reviewed and approved both the full strategy document and summary version, and the associated toolkit.</b></p>
25/05/010	<p><b>ICS Performance Update inc. People and Finance</b></p> <p>Mrs Julie Garside presented the paper and highlighted the following issues:</p> <ul style="list-style-type: none"> <li>• The parts of the report for finance and people are missing as this is reporting on the beginning of the financial year where this information is not available, but it will be brought back to next month’s Board.</li> <li>• The vaccination weekly meetings have been stepped down for the summer, future updates will be determined by the reporting schedule.</li> <li>• Still significant challenges with urgent and emergency care performance.</li> </ul>

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	<ul style="list-style-type: none"> <li>Improvement plan is being refreshed which will go through UEC Board in June with the key highlights of that and progress against that will continue be reported to this Board in the future.</li> <li>Major focus on ambulance handovers, but we are seeing improvement. Still some anxiety that it is not sustainable which continues to be a priority.</li> <li>Elective care, the reports note that the plan in 22/23 is slightly short of our national ambition of 104%. Re-submission is 20 June.</li> <li>There is a significant dependency in quarter four for the delivery of the elective Hub at Princess Royal, with some delays in the approval process.</li> <li>Concerns around eating disorders discussed at the quality and performance committee today and it was agreed that a specific paper would be presented to the committee in June. Mrs Garside will bring that report back to this Board in the future.</li> </ul> <p>Mr Craig Macbeth commented that RJA H 104-week breaches sit within one specialty, this being spinal surgery as it is specialist surgery which means it is limited in terms of the options, as they rely on only that cohort of surgeons that have the required specialism. Discussions continue daily and they are also relooking at the way they are allocating internal capacity as well with the view to trying to investigate the clearance.</p> <p>It was noted that RJA H are looking at internal realignment of resources and trying to get mutual aid from other hospitals to enable prioritisation if the 104-week patients.</p> <p>Dr McMahon commented that RJA H are supporting SATH with more complex orthopaedic work that does not fall into their spinal category. SaTH are also looking at external resource as well as internal resource as the Covid numbers come down</p> <p>Mr Roger Dunshea asked if there could be more information around the actions within the summary pages i.e. what the action is and when the action will take place.</p> <p>Mr Simon Whitehouse agreed that the report should include more detailed information as suggested by Mr Dunshea and also commented that we are still at present forecasting to be the only system in the country that is still proposing to have 104 week waits at the end of the financial year March 2023.</p> <p>The Chair said that this is untenable, and an unacceptable position and we have to do whatever we need to do to make sure that it is improved. Mr Harry Turner, Chair of RJA H, assured the Chair that he will not accept a position that has 104 week waits at the end of the current time scales. There is a revised trajectory which can deliver this, and he gave his commitment to that.</p> <p><b>The Board noted the current integrated performance of the system in this summary, and the on-going challenges with our systems operational performance and associated risks with our financial performance and workforce.</b></p>
25/05/011	<p><b>Update 22/23 NHS Operational Plan</b></p> <p>Mr Gareth Robinson and Mrs Claire Skidmore presented the paper and highlighted key issues:</p>

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	<ul style="list-style-type: none"> <li>• The shortfall against the 104% of activity number, this is being resubmitted middle of June. Revised plan and trajectory will be brought back to this Board</li> <li>• The issue of the 104 week wait, which was discussed earlier on this agenda.</li> </ul> <p>The finance plan was submitted with a £38m deficit. There is likely to be further work required on this and at the time of writing this report we are awaiting guidance from NHSEI. In the meantime, several next steps have been agreed across the system which include:</p> <ul style="list-style-type: none"> <li>• Working through 4 areas of review (action plan held by System CFO) <ul style="list-style-type: none"> <li>○ Plan build (i.e. testing the run rate, understanding the cost and income base)</li> <li>○ Assumptions (i.e. testing assumptions for income, Elective Recovery Fund (ERF) earnings/claw back, impact of IPC guidance etc.)</li> <li>○ Investments (i.e. clarity about what level of cost pressure/investment we accept in our plan up front)</li> <li>○ Efficiency and Productivity (i.e. have we maximised our opportunities here and are we confident in delivery plans?)</li> </ul> </li> <li>• Establishment of in-year monitoring to closely track performance against plan and allow early identification of any deviation. Areas of focus to include (but not limited to): <ul style="list-style-type: none"> <li>○ Covid costs</li> <li>○ ERF/UEC impact on system</li> <li>○ Efficiency and</li> <li>○ Transformation programme delivery</li> <li>○ Rapid identification of SROs and programmes of work to concentrate on the £7.9m unallocated savings target.</li> </ul> </li> </ul> <p>Dr McMahon raised her concerns about references to capital restraint from NHSE/I as the system is reliant on capital to just keep it delivering at the current level, nevermind improving this position. Dr McMahon added that the Chairs of the provider trusts are working together, and the risk mitigation narrative helps the Chairs to articulate how the risks are being managed to the rest of their Board members.</p> <p>Mr Collins confirmed that the Sustainability Committee had discussed many of these issues which is contained in the Chairs report in the following item. He added that the system needed to be honest about its level of productivity and how it can produce better output for the same budgets by challenging ourselves as individual members of respective Boards.</p> <p>Mrs O’Kane endorsed the comments made by Dr McMahon and added that the balance that was needed between the legal responsibility for individual organisations versus being good system partners is challenging, but there is not a lack of will.</p> <p>Mr Simon Whitehouse commented that we are not going to deliver the financial performance and workforce challenge by driving efficiency programs and hoping that that gets us to the right endpoint. It must be about commitment to a model of care that delivers a sustainable footing, both financially performance and workforce with the right level of productivity, this will involve that left shift. This is within the gift of our providers with the facilitation of the ICB to work through how that resource moves around the system.</p> <p><b>ACTION:</b> Mrs Skidmore and Mr Robinson to present a further draft of the Operational Plan at the June meeting.</p>
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	<b>The ICS Board:</b> <ul style="list-style-type: none"> <li>• noted the contents of this report,</li> <li>• commented on the actions described within it and the associated risks</li> <li>• note and be aware that the system is not currently planning to meet the 104% activity target or the 104 week wait target</li> <li>• noted that the current financial plan contains significant risk and that there will be a need for organisation's to revisit their own financial plans as a result of these risks.</li> </ul>
25/05/012	<b>Committee Reports were noted as read</b>
	<p>The Chair thanked members of the Board for their contributions and notified them that the next meeting would take place on 29 June at 3:00pm. He notified new Board members that we are required by statute to have an initial meeting on the 1 July, this is where we sign off appointments, governance arrangements, various policies and procedures. Members will be notified of the timings etc. in due course.</p> <p>The Chair also mentioned that he will be meeting with the new Non-Executive Directors as we are now in a position to start to finalise the committee structure and chairing arrangements.</p> <p><b>The meeting closed at 17:35hrs.</b></p>

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## Action Log – Open

30/03/2022					
30/03/22.011	Mrs Garside to present a summary dashboard for the system containing 19 key metrics and CQC compliancy reports for each local authority is being finalised and it is expected that these will be reported to the ICS Board from April.	JG	27/07/22	Summary dashboards have not yet been signed off by both place partnerships in June. Will be presented to 27 <sup>th</sup> July Board meeting.	
25/05/2022					
25/05/7.0	ICB Constitution - The Chair asked for a more detailed report about what is being planned around the development of place and any agreed timelines. Place update to go on agenda for June Board.	SW AS	29/06/22	Place item is on the 29 <sup>th</sup> June agenda.	Recommend that this action is closed. 29 <sup>th</sup> June 2022
25/05/011	Mrs Skidmore and Mr Gareth Robinson to present refreshed Operational Plan to the Board in June	CS GR	29/06/22	Operational Plan is on 29 <sup>th</sup> June agenda.	Recommend that this action is closed. 29 <sup>th</sup> June 2022



Name, Date and Time	Submitted questions	Summary Response
<b>23/5/2022 – 10:53hr</b> <b>Gill George</b>	<b>GP access in Shrewsbury</b> Bus services in Shropshire face significant cuts, with reduced frequency of many routes and the complete loss of others. How will the ICS ensure access to centralised GP services based in Meole Brace? Is there not a predictable detrimental impact on older people in particular, and also on young people, people with disabilities (including learning disabilities), people with long-term conditions, and of course, people who face socioeconomic disadvantage (e.g. poverty or social isolation)? Are the plans consistent with NHSE guidance on reducing inequalities in access to general practice services ('Improving access for all')? What are the modelled cost savings associated with the proposal?	<p>Transport to and from the proposed Shrewsbury Health and Wellbeing Hub is a key consideration for the Programme Team. They will ensure that a travel and access analysis is part of an integrated impact assessment which we will undertake as soon as we confirm the location for the hub.</p> <p>An integrated impact assessment will look at the impact that the change or relocation of service could have on patients at the practices involved, and with the help and input from patients will seek to identify ways to minimise any negative impacts as much as possible. We cannot undertake a full integrated impact assessment until we have agreed and secured a site for the hub.</p> <p>The programme is working with the Council to ensure that there is a specific bus route that stops next to the new Hub. There are also Section 106 monies from the wider SUE South development to support a new bus route.</p> <p>The modelled cost savings will be developed as part of the business case.</p> <p><u>Response provided by:</u>            Claire Parker, Director of Partnerships            Gareth Robinson, ICB Director of Delivery &amp; Transformation</p>
<b>23/5/2022 – 10:53hr</b> <b>Gill George</b>	<b>Ambulance Response Times</b> A recent FOI request by the Liberal Democrats showed that WMAS is a complete outlier in its closure of community ambulance stations, and that other ambulance trusts have maintained their commitment to local ambulance stations to serve local areas. Is the ICS confident that the closure of seven community ambulance stations and two 'standby points' in rural Shropshire has been in the interests of our rural communities? What is your evidence for this?	<p>STW CCG has reviewed the decision of WMAS to close some of its ambulance stations to gain assurance that the decision making has been evidence based and robust            To build on the detailed responses to the public questions asked in relation to a range of ambulance matters in March 2022 we would advise that WMAS have provided the following comment:            "There is a common misconception that where an ambulance starts or finishes a shift will have a substantial impact on the area that it is based in. However, as soon as an ambulance is available it will be sent to the nearest case so that we can minimise the time a patient waits to be seen."            In tracking ambulance performance, the CCG has yet to find any evidence that the closure of the ambulance stations has had a negative impact upon response times.</p>



	<p>Shropshire CCG took the view in 2014 that it would not expect national response time targets to apply in rural Shropshire. Is this the current position of the ICB? What steps is the ICB taking to resolve critical issues around handover time, including bed capacity and availability of social care? Does the ICB still intend the closure of community hospital beds? How will the ICB ensure equitable ambulance provision for Shropshire's rural communities on a long-term basis?</p>	<p>Seasonal demand pressures increase response times as activity increases combined with pressures at the receiving hospitals. The ambulances across Shropshire Telford and Wrekin are fully utilised, therefore only return to base locations at the start and finish of their shifts.</p> <p>For further details regarding the decision-making process in relation to the closure of ambulance stations, we suggest your question is directed to WMAS - <a href="https://www.wmas.nhs.uk">Contact us – West Midlands Ambulance Service University NHS Foundation Trust (wmas.nhs.uk)</a></p> <p>The current regional commissioning arrangements for ambulance provision will continue under the ICB as they have done for the CCG.</p> <p>Whilst it remains the case that if you live in a rural area you will not get the same level of provision as if you live in an urban area, the ICB would add that smaller areas such as Shropshire, Telford and Wrekin benefit from a collective approach to commissioning services such as these which would otherwise be unaffordable if commissioned in isolation. It would remain the case that whatever the level of ambulance resource rurality and accessibility will impact on response times</p> <p>However, the ICB will work closely with the regional commissioners and WMAS to improve response times wherever possible within this context. Ambulance handover times are part of a cycle of activity which relies on good flow within the hospital and the ability to discharge patients' home and into community settings. If any parts of the cycle are under pressure it has a knock-on effect on other parts.</p> <p>The ICB will continue to support the implementation of a range of measures to mitigate these issues including funding additional capacity in primary care, purchasing additional Domiciliary Care packages and community beds, securing additional staff and focusing the staff we have on areas of highest pressure, enhancing our 2 hour community response service and increasing direct access to specialties in the Acute Trust therefore avoiding A&amp;E. We have initiated a Single Point of Access for clinical referrers which provides alternatives to conveyances to A&amp;E and has enabled ambulances to be released back into the community to respond to calls more quickly. This list is not exhaustive but gives a snapshot of the steps the CCG has been taking. We are beginning to see some performance improvements as a result of this work and will continue to utilise our system focused collaborative approach to addressing issues along the Urgent</p>
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		<p>and Emergency Care pathway that impact on ambulance handover times. There are no current plans to close community hospital beds</p> <p><u>Response provided by:</u> Sam Tilley, Director of Urgent Care &amp; Planning Gareth Robinson, ICB Director of Delivery &amp; Transformation</p>
<b>23/5/2022 – 10:53hr</b> <b>Gill George</b>	<b>Needs of Young People (Questions passed to me by a local parent)</b> Why there is no treatment after diagnosis for neurodiverse children? There is a specialist team in Staffordshire, nothing here. Why there are no mental health inpatient beds for young people, 16-18, in Shropshire (despite NICE guidance)?	<p>Neurodiversity commonly refers to conditions such as Autism, ADHD &amp; Learning Difficulties, it is important to differentiate between neurodiversity and mental health as they are separate challenges for children; although not the same it is the case that the prevalence of mental health issues amongst those with neurodiversity issues is higher than the population in general.</p> <p>In Shropshire, investment by the NHS in neurodiversity services can be summarised as follows:</p> <ul style="list-style-type: none"> <li>• ADHD – assessment and treatment available</li> <li>• Autism – assessment service</li> <li>• Learning Difficulties – assessment, therapeutic interventions and group sessions for children and parents.</li> <li>• Healios is an NHS funded on-line service offering advice and psychological therapies, in particular for Autism and ADHD.</li> <li>• There is also a growing programme of Mental Health Support Teams in Schools,</li> </ul> <p>In addition, in charities sector, groups such as Autism West Midlands, National Autistic Society &amp; the Curly Hair Project offer advice and support to children with autism. Support is also available through the Autism Hub in Telford and through the Parent Support Groups in Shropshire (PACCs) and Telford (PODS).</p> <p>The local authority is also involved, as many children with neurodiversity will hold Education, Health &amp; Care Plans and so will be getting additional support in the classroom.</p>

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ICS board – Questions received from members of the public

		<p>We are currently looking at the best way to provide services but recognise that without additional investment there remains a significant gap.</p> <p><u>Response provided by:</u>          Claire Parker, Director of Partnerships          Gareth Robinson, ICB Director of Delivery &amp; Transformation</p>
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**Submitted Questions by Members of the Public  
for the Governing Body meeting on: 08.06.22**

Name, Date and time	Submitted questions
<b>Gill George</b> <b>6 June 2022</b> <b>at 11:23</b>	<p>1. The minutes of the 9<sup>th</sup> March meeting record (page 18 of integrated Board papers): 'it is more difficult to achieve those targets in the more rural areas because of the distances needing to be covered from an operational point of view. That is why it [the ambulance service] is commissioned on a regional basis (rural and urban) as opposed to locally.'</p> <p>Could the CCG please provide an explanation of commissioning arrangements for the ambulance service, including clarification of which decisions are made locally and which at regional level? How is it decided what level of provision should be available to rural areas of STW and urban areas of STW? Has the CCG had the same expectation of response time targets for rural and urban areas within STW? On what basis is WMAS paid for the ambulance service, and has there been a recent change to this? How is WMAS compensated for ambulances being unavailable for calls due to handover delays?</p>
<b>CCG Summary Response</b>	<p>Ambulance provision is commissioned on a regional footprint, within a national framework. For STW the regional commissioner is Black Country and West Birmingham CCG on behalf of the region. STW CCG (and subsequently the ICB) is part of the regional commissioning group and attends regular contract meetings. This gives us the ability to input into the commissioning and contracting process, to feedback on issues for our area and influence contract discussions. However, ultimately decision making rests with the regional commissioner. The regional position sits within a national approach to the provision of ambulance services overseen by NHS England. For further information regarding how National and Regional expectations are set, information on payments to the ambulance service providers and any compensation arrangements your queries should be directed to the regional commissioner and NHSE.</p> <p>Response provided by Sam Tilley, Director of Urgent Care and Planning</p>

<b>Gill George</b> 6 June 2022 at 11:23	2. Will the CCG ensure that outstanding FOI requests are concluded before it ceases to exist?
<b>CCG Summary Response</b>	On 30 June 2022, NHS Shropshire, Telford and Wrekin CCG will be dissolved, all Freedom of Information (FOI) requests that have not been concluded by this date, will automatically transfer over to a new organisation that comes into being on 1 July 2022, NHS Shropshire, Telford and Wrekin. Requesters whose request will not be completed by 30 <sup>th</sup> June will be notified of the change in organisation prior to the 30 June and advised that they do not need to do anything. A response to their FOI request will be provided within the 20 working days statutory timeframe, from the date of receipt, as outlined in the Freedom of Information Act 2000.  Response provided by Alison Smith, Director of Corporate Affairs
<b>Gill George</b> 6 June 2022 at 11:23	3. Will the business papers of the CCG be transferred to the ICS (and if not, what will happen to them)? Will the outgoing CCG Board make arrangements to ensure that business papers will be held safely and will remain accessible for future FOI requests? Will information currently on the CCG website remain accessible to the public in archive form?
<b>CCG Summary Response</b>	The business papers of the CCG, both hard and electronic copy will be transferred to the ICB which is the statutory body that will inherit the CCG's functions. The CCG has undertaken a due diligence exercise to identify the information it holds to ensure that this is transferred in a safe and secure way to the ICB. Information currently on the CCG's website will still be accessible to the public via the ICS website.  Response provided by Alison Smith, Director of Corporate Affairs and Edna Boampong, Director of Communications & Engagement

<b>Gill George</b> <b>6 June 2022</b> <b>at 11:23</b>	<p>4. The 'Seven Principles of Public Life' (the Nolan Principles) feel even more relevant in 2022 than they did when written in 1995. These include <i>'Openness: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.'</i></p> <p>Health bodies in Shropshire, Telford and Wrekin have perhaps drifted into a default position of 'Don't tell the public' rather than 'Of course we will make this information available as a matter of course'.</p> <p>Will the Board members moving on to leadership positions in the ICS or elsewhere please re-read the Nolan Principles and consider how those can be made real in STW?</p>
<b>CCG Summary Response</b>	<p>The Nolan Principles are a key cornerstone of the governance of the new ICB. The ICB Constitution outlines in section 3.1.1 (b) that each member of the ICB must be willing to uphold the seven principles of public life (known as the Nolan Principles).</p> <p>Response provided by Alison Smith, Director of Corporate Affairs</p>
<b>Gill George</b> <b>6 June 2022</b> <b>at 11:23</b>	<p>5. Have any local CCG staff been downgraded or been made redundant as a result of the transition to the ICS/ICB? If so, how many?</p>
<b>CCG Summary Response</b>	<p>No CCG staff have been downgraded or been made redundant as a result of the transition to the ICB.</p> <p>Response provided by Alison Smith, Director of Corporate Affairs</p>

## STW ICS Board

<b>Author:</b>	<b>Nicky O'Connor</b> ICS Programme Director <b>Alison Smith</b> Director of Corporate Affairs <b>Sarah Walker</b> Principle Improvement Consultant for MLCSU <b>Tracy Hill</b> Interim Chief People Officer <b>Claire Parker</b> Director of Partnerships	<b>Paper date:</b>	23 <sup>rd</sup> June 2022
<b>ICS Board Member Sponsor:</b>	<b>Simon Whitehouse</b> Interim ICB CEO Designate	<b>Paper Category:</b>	Information
<b>Paper Reviewed by:</b>		<b>Paper FOIA Status:</b>	Releasable
<b>Action Required (please select):</b>			
A=Approval	<input type="checkbox"/>	R=Ratification	<input checked="" type="checkbox"/>
S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input checked="" type="checkbox"/>
I=Information	<input type="checkbox"/>		

### 1. Purpose of Paper

The purpose of this paper is to share with Board members an update across several business areas that are not reported elsewhere in the agenda.

The first part of the paper provides a generic update on activities at both a national and local level – CEO Business Update

The second part then provides a detailed progress report on the safe and effective establishment of the ICB. This second section is broken down into three parts:

- A. Readiness to Operate statement update and Clinical Care and Multi Professional Leadership (CCMPL) Framework
- B. ICP update
- C. ICB appointments, committee structure and transition update

### 2. Executive Summary

#### 2.1. Context

The CEO business update is set out in full in the main body of the report.

The second section of the paper focusses on the activities required to support the safe establishment of the ICB on the 1<sup>st</sup> July 2022. It is set out in 3 main sub sections as detailed below-

- A. **ICS Transition – Readiness to Operate Statement (ROS) Update and Clinical Care and Multi Professional Leadership (CCMPL) Framework**

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This section provides an update following the final ROS submission, including assurance from NHS England that STW ICB will be ready to fulfil its statutory functions from 1<sup>st</sup> July 2022, preparations for the inaugural meeting of the ICB on 1<sup>st</sup> July and the formation and development of the CCMPL framework.

## **B. ICS Transition – ICP Update**

This section provides an update as to the progress of the Integrated Care Partnership work including working arrangements, terms of reference and the details of the inaugural meeting.

## **C. ICS Transition - ICB appointments, committee structure and CCG Transition due diligence process**

This section provides a progress report to the Partner Members of the ICB, committee leadership structure and the work undertaken by the CCG

### **2.2 Link to Pledges**

All parts of this document have been linked to the system pledges.

### **2.3 Summary**

**Section A** of this paper provides an update of the final ROS submission and CCMPL framework

**Section B** of this paper provides an update on ICP arrangements within STW

**Section C** of this paper provides an update on the transition from CCG to ICB regarding board appointments, committees, and governance arrangements

### **2.4 Conclusion**

The Board is asked

- **Note the detail provided in part one of this report**
- **Note that following the final submission of the ROS, NHS England are satisfied that adequate preparations are in place for the 1<sup>st</sup> July and that STW ICB will be ready to fulfil its statutory functions from that point**
- **Agree that the NHS Shropshire, Telford and Wrekin response to the Fuller Review come back to the September Board**
- **Note that ICP terms of reference will be brought to the ICB at the end of July and that the first meeting of the ICP will be held in September**
- **Ratify the emergency decision made by the Chair and Chief Executive to approve submission of the ICS Operational Plan to NHSE/I in order to meet the deadline set.**

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## ICB CHIEF EXECUTIVE OFFICER UPDATE REPORT

### 1. INTRODUCTION

The purpose of this paper is to share with Board members an update across several business areas that are not reported elsewhere in the agenda. The paper is supported with appendices that are contained in the supporting pack of Board papers.

The first part of the paper provides a generic update on activities at both a national and local level – CEO Business Update.

The second part then provides a detailed progress report on the safe and effective establishment of the ICB. This second section is broken down into three parts:

- A. Readiness to Operate statement update and Clinical Care and Multi Professional Leadership (CCMPL) Framework
- B. ICP update
- C. ICB appointments, committee structure and CCG Transition due diligence process

### 2. CEO BUSINESS UPDATE

2.1 On the 22<sup>nd</sup> May 2022, system colleagues and I took part in the Quarterly System Review Meeting (QSRM) with colleagues at NHSE/I. This was a constructive session with recognition of partners across STW working well together, and an acknowledgement of the challenging circumstances under which we are currently operating. The full feedback letter is provided as **Appendix A** to this paper. The regional team gave positive feedback on several areas including –

- Strong appointments to the ICB leadership team
- Progress with the strategic outline case of the HTP
- Continued access to support for families impacted by Ockenden
- System working to deliver the Covid vaccination programme
- Clear examples of system working in times of operational pressures including close working with Local Authority partners

There remain challenges, well known in the system, which are identified in the response regarding finances, urgent care and ambulance handover delays, elective care (particularly around 104 week waits) and workforce, but as I detail further in my report there are mitigating actions being taken to support these. There are ongoing actions for the system, which are being undertaken at pace and the next QSRM is 9<sup>th</sup> September 2022.

2.2 I was delighted to attend the first face to face gathering of CCG staff since the pandemic for the CCG Away Day on 8<sup>th</sup> June. This was a transition event for staff, which was well attended, and provided the teams with the opportunity to celebrate the work that the CCG has undertaken, and how we look to future plans and develop

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visions for working as an ICB. I was delighted that so many members of staff were so engaged and face to face sessions will now commence in a regular schedule.

- 2.3 There have been a number of visits and wider system conversations that have taken place since the last Board meeting-
- An afternoon was spent at the Redwoods facility speaking to staff re the current mental health service provision. There was a significant amount of discussion (and enthusiasm) about the mental health transformation agenda, balanced with realism re the amount to be done and the associated financial challenges. Thank you to Neil Carr, Cathy Riley, Sam Kearnes and the wider team for their hospitality and time.
  - On the 22<sup>nd</sup> June I spent an afternoon on a planned trip to SaTH, specifically Princess Royal Hospital ED team. There was an opportunity for me to hear from ED clinicians, acute medicine clinicians, senior nursing staff and senior ops staff. Despite the pressure there was a very clear view on the areas to drive improvement and I heard a genuine focus on the patient being at the centre of the care. It was reinforced that the Hospital Transformation Programme is necessary to enable the next steps of consolidation to take place and to support the staffing challenges across all areas.
  - I attended a meeting with the principle of Telford College where we discussed the link between the 3 FE colleges and the future health and care workforce. We have committed to further work in this area and to build on the success of the HCSW academy that Telford and Wrekin Council were instrumental in establishing.
  - The NHS Confederation asked me to chair a recent meeting of ICB CEO's and the Minister of State for Health (Edward Agar MP). This was a useful first conversation in regard to expectations of the refreshed Long Term Plan and any immediate challenges in relation to the recent legislation on the establishment of ICS's.

The NHS Confederation also invited me to make my 'podcast debut' in conversation with Matthew Taylor. For those interested then the podcast can be found here <https://www.nhsconfed.org/publications/health-line>

It is absolutely appropriate that we also take this opportunity to congratulate two members of our system for the recognition of their hard work and commitment to both the NHS and Education. Trevor McMillan and Frank Collins have both been awarded an OBE, for services to Higher Education and services to the NHS respectively.

Finally, this Board meeting is taking place at the very end of June and just a few days before the close down of the CCG. I would like to thank both Dr John Pepper and Mark Brandreth for their support in making this transition as smooth as possible. John of course is staying in the system and will also be taking up a role as an Associate Non Executive Director with RJA. Mark is leaving the system but has spent many years here, both as CEO of RJA and more recently as the CCG AO and

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System Lead. I am sure that you would all wish to join me in thanks Mark for his work on behalf of local people and the NHS, and in wishing Mark well in his future endeavours.

- 2.4 I am pleased to update the Board that an interim appointment has been made to Chief People Officer (CPO) and to offer a further update for the ICS People Team. Feedback from Regional colleagues in relation to the leadership of the People Function of the ICB confirmed that whilst they are supportive of a consolidated approach to our System People function, it was recognised action was necessary to mitigate risks in the short term. As a result, Tracy Hill has been appointed into the interim CPO role in the short term. As well as fulfilling the interim CPO role, Tracy will manage the ICS People Team and continue to lead the Workforce BTI Programme.

The ICS People Team is responsible for the development and delivery of the ICS People Plan, facilitating collaborative working across all ICS partners on the people priorities. Furthermore, the team currently lead the programmes of work associated with the Sustainable Workforce Big Ticket. Since its creation this team has historically been funded from Health Education England Workforce Development monies. Once again, this year, the allocation has afforded temporary extensions until October 2022 to the employment contracts for four part-time Workforce Transformation Managers, with some administrative support running until December 2022. Whilst the intention is to develop and implement an integrated People function and service across the System, this currently is in the pre-planning phase, and it has been widely recognised the significant risk to the successful delivery of the workforce objectives contained within both the Big Ticket and People Plan we are facing into with employment contracts being terminated in October 2022.

To mitigate this risk, commitment has been given to extend employment contracts until 31<sup>st</sup> March 2023 with opportunities being explored to attract further funding and support from Health Education England and NHSE/I. Meetings are being arranged with the Interim CPO, HEE Midlands Regional Director and the Director of Workforce and OD for NHS England and NHS Improvement.

- 2.5 On the 8<sup>th</sup> June 2022 the Messenger report was published. This review examined the state of leadership and management in the health and social care sector and found that the development of quality leadership and management is not adequately embedded or institutionalised in our health and care communities. The report demonstrates the important role leaders play in delivery of high-quality care and setting the tone for cultural change across the NHS.

It also recognises the change of environment that the NHS is now operating in, as more integrated care and ways of working are delivered. This calls for increased levels of collaboration, trust and relational leadership and means that leaders can no longer work autonomously in their own organisations. New skills and changes to mindset are required to support this way of working.

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It focused its findings on areas which *improve awareness of the impact that good leadership can have*, and which instil it as an instinctive characteristic in everyone, not just those with the word in their job title. The report has many observations including, the pressures working in health and care inevitably has on behaviours in the workplace, with many incidences of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. The report concludes with seven recommendations:

1. **Targeted interventions on collaborative leadership and organisational values**
2. **Positive equality, diversity, and inclusion (EDI) action**
3. **Consistent management standards delivered through accredited training**
4. **A simplified, standard appraisal system for the NHS**
5. **A new career and talent management function for managers**
6. **More effective recruitment and development of Non-Executive directors**
7. **Encouraging top talent into challenged parts of the system**

Within STW several actions to support Leadership Development are in place and will meet the recommendations made by the Messenger review.

1. **The High Potential Scheme**, delivered in partnership with SSOT ICS and the National Leadership Academy is a 2 year development programme and a building block of development for Director, Executive, Senior Manager, and Chair and Board roles. The programme is designed to increase the diversity of senior leaders and retain leaders with high potential to accelerate their careers into Executive Director roles.
2. **Development of STW Leadership and Management competencies** is underway. Co-created by representatives from People teams across the system and lead by the ICS People Team, these frameworks identify foundation competencies to achieve such as H&S and Information Governance, and Civility and Respect competency through to Leading Change, Talent management and Systems working.
3. Behavioural competence is also featured with Human Factors, Compassionate Leadership and Appreciate Enquiry competency identified. A learning needs analysis is underway which will identify areas of good practice and gaps in development opportunity.
4. **Collaboration to Improve Care in the Community (CIIC)** a place-based leadership development programme that addresses grounded, real-time challenges is launching September.
5. **Leading for Systems Change programme** launching within Place Based Care transformation in August 2022 has been developed with the Regional Talent Management team and Regional Leadership Academy to support learning and bring best practice to STW.
6. **PCN Development**, a programme developed in partnership with the Kings Fund to identify themes and priorities for development is underway and will support the development of PCN relationships as well as inform delivery of Leadership Development in STW.

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- 2.6 Primary Care medical services delegation will transfer to the ICB on 1<sup>st</sup> July 2022. A new delegation agreement based on the current delegated powers for CCG's will be signed on behalf of the ICB by the Chief Executive at that point.

In April 2023 the delegation of further primary care services: pharmacy, optometry and dental will also transfer to the ICB but with regional governance arrangements that will link into each system. STW system has signed up to these principles with further work ongoing to October 2022 on the financial risks and the detailed governance.

Finally, the Fuller Report was published on 26<sup>th</sup> May 2022 - all 42 ICB CEO have signed up to the 15 recommendations. The report highlights transforming primary care led by integrated neighbourhood teams whilst recognising the need to address current pressures in primary care such as workforce, primary care estates, digital infrastructure, primary care access. Following the publishing of the Fuller Review, we are delighted to have Claire to speak to our GP primary care and community colleagues on Thursday 30<sup>th</sup> June to hear first-hand about the integration of community and primary care from her recommendations. The Fuller review paper following this presentation will come to the ICB in September for a more detailed discussion and set out our response to the recommendations.

### 3. ICS ESTABLISHMENT UPDATE

The Health and Care Bill has now received Royal Assent, and this confirms that ICBs will be legally established on the 1<sup>st</sup> July 2022.

#### 3.1 SECTION A – READINESS TO OPERATE STATEMENT UPDATE AND CLINICAL CARE AND MULTI PROFESSIONAL LEADERSHIP (CCMPL) FRAMEWORK

##### Final ROS submission

In accordance with the NHSEI establishment timeline, systems had been asked to share final evidence of readiness for transition on 10 June 2022. In addition to the ROS checklist and supporting evidence a signed Readiness to Operate Statement was required. In the statement the Chief Executive of the ICS and the NHS England and NHS Improvement Regional Director confirm that

- they are satisfied that adequate preparations have been made for the legal establishment of the Shropshire, Telford and Wrekin Integrated Care Board with effect from 1 July 2022
- the Shropshire, Telford and Wrekin Integrated Care Board will be ready to fulfil its statutory functions from that point.
- that the Shropshire, Telford and Wrekin Integrated Care Board will develop as a new statutory organisation with ongoing support from NHS England.

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Following the submission on 10 June a joint position between systems and NHSEI has been agreed. Overall, the submitted ratings were approved apart from changes in the following four areas:

2.5 'Designate appointments made and postholders ready to take up post' rating changed from Blue 'Complete' to Amber 'Delivery is at risk but mitigation plan in place for delivery by 1 July' based on national steer that all systems with an outstanding pay case for an executive role should be rated as amber.

7.1 'Clinical Professional leadership model developed' - following the submission of a revised Clinical Collaboration Multi Professional Leadership Framework the rating was upgraded from Amber to Green 'On target for delivery by 1 July'

9.1 'Arrangements for NHS oversight and the MOU' - changed from Blue to Green, based on confirmation of the national position that all systems should be green for oversight MoU to reflect the pending publication of national guidance and ongoing conversations

10.1 'Planning for 2022/23 has been carried out' re-rated from Blue to Amber. The rating reflects the challenging financial position for the system and not achieving a break-even position alongside the need to re-submit the 22/23 plan. The rating will result in further assurance measures from NHSE and mirrors the level of risk that the system is carrying.

A full statement showing progress and RAG ratings is included as **Appendix B**.

### **Inaugural ICB Board meeting**

Preparations for the remaining actions listed in version 0.9 of the Establishment timeline, (published on 9 June 2022) have been made in readiness for the transition date of 1 July 2022.

The inaugural meeting of the ICB board has been arranged for 1 July.

Expected outcomes of the inaugural meeting as set out in the ICS Establishment timeline are:

NHSE will have brought the ICS constitution into effect with standing orders through the Establishment Order.

The following business will need to be transacted:

- agree standing financial instructions
- agree SoRD (and functions and decisions map)
- establish committees, appoint the chairs of committees and agree the terms of reference. Appoint the memberships of ICB committees (as a minimum this must include the remuneration committee)
- adopt suite of policies, including at least all those mentioned in the constitution and any that statutory bodies are required to have in place

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- appoint to special/lead roles on the board (eg conflicts of interest guardian)
- appoint the ICB founder member of the ICP
- whilst not a legal requirement, the constitution, appointments and delegation arrangements are also likely to be noted.

#### Next steps

Preparations for a managed project closure of the ICS transition programme have commenced. Activities will include archiving and record management of key documents and evidence, legacy handover and capturing lessons identified throughout the programme to facilitate continuous improvement. Recommendations will also be made for on-going ICS development based on the outcomes of the ROS.

#### Clinical Care and Multi Professional Leadership (CCMPL) Framework

Following discussions with the Midlands region a revised CCMPL was submitted. The final framework shows

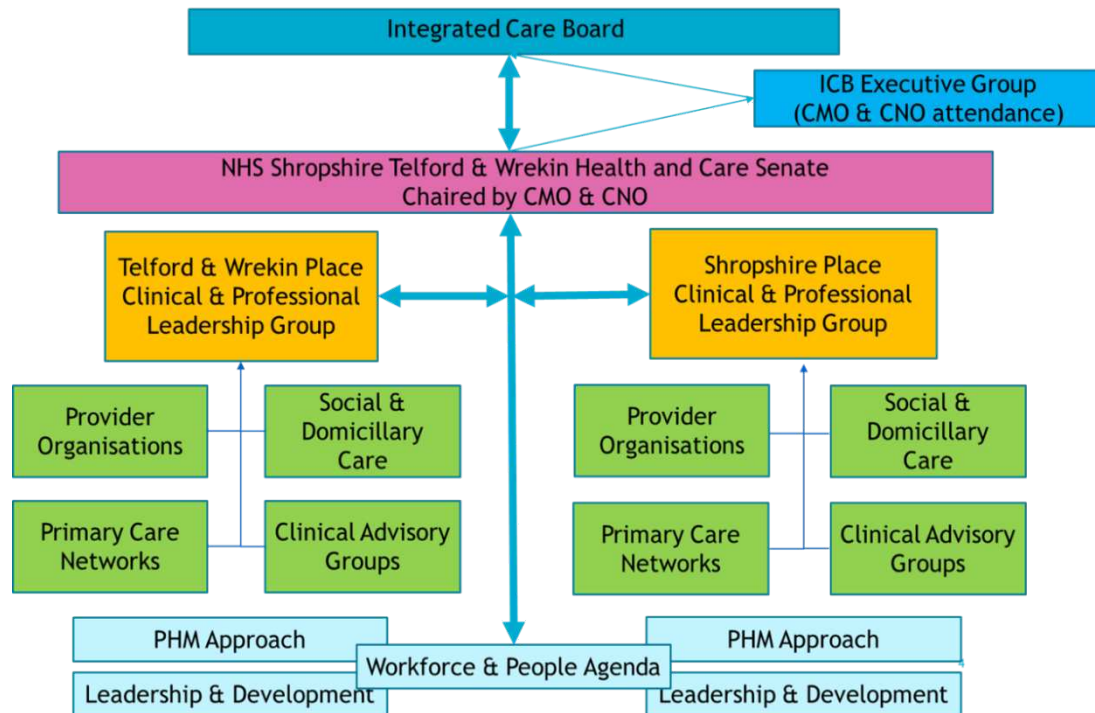
- How the system has involved leaders from all clinical and care professions in this work to date
- Confirmed arrangements to be in place for day 1 of the ICS and how this explicitly aligns to the 5 principles set out in national guidance
- A plan for how to take CCMPL forward (including a clear route map for further development and implementation of the framework beyond day 1 arrangements)
- a high level plan for how the model will be socialised with system stakeholders
- how/where the ICS will focus efforts of these arrangements to tackle and support system challenges

Engagement with system stakeholders over recent weeks has included conversations with the Directors of Nursing and leaders of the Allied Health Professional network and initial contacts between the Medical Directors. Weekly meetings between clinical leads have been set up; MSK clinical advisory group and Cardiology clinical advisory group are being established. The first meeting of the NHS Shropshire, Telford and Wrekin Health and Care Senate has been scheduled for the end of June and will build further momentum for the CCMPL.

The revised CCMPL framework was accepted by the Region and consequently the ROS rating was upgraded from Amber to Green.

CCMPL structure:

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### 3.2 SECTION B – INTEGRATED CARE PARTNERSHIP (ICP) UPDATE

Improving outcomes and experience through the integration of services can be done where the NHS, local authorities, social care providers, voluntary and community organisations, social enterprises, and wider partners come together to deliver in the best interests of residents in their area

ICPs are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. The ICP provides a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.

Discussions are continuing to progress this locally particularly the terms of reference and working arrangements for the first Integrated Care Partnership meetings for STW. The principles of working are agreed and in line with the legislative requirements. The ICP will be chaired by both local authorities – the chair arrangements rotating between the two.

Having considered the requirements of the Health and Care Act, the needs of the residents of Shropshire Telford and Wrekin, the current challenges in the system and the fact that this part of the system will be new, it has been agreed to start the ICP as a relatively small meeting initially, with statutory partners, Healthwatch and the VCSE sector as members. It has also however been agreed that the operation of the

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ICP will be reviewed after 6 months, to evolve and learn from the initial meetings and consider any amendments at that time.

Key issues to resolve in the next couple of weeks centre around the resources required to both service the ICP and produce the Integrated Care Strategy for the system, finalising the voting and quoracy arrangements and arrangements for public participation.

It is intended that this work will be finalised in early July with a view to bringing the final terms of reference to the ICB at the end of July and the first meeting of the ICP being in September.

### 3.3 SECTION C – ICB APPOINTMENTS, COMMITTEE STRUCTURE AND CCG TRANSITION DUE DILIGENCE PROCESS

#### Appointment confirmations:

Following a process of nomination and selection, the ICB Chair has approved the appointment of the Trust/Foundation Trust, Primary Care and Local authority Member Partners on the ICB:

Partner Member	Organisation
Louise Barnett	CEO Shrewsbury and Telford Hospital NHS Trust
Neil Carr	CEO Midlands Partnership Foundation Trust
Patricia Davies	CEO Shropshire Community Health NHS Trust
Stacey Keegan	Interim CEO Robert Jones and Agnes Hunt Orthopaedic Teaching Foundation Trust
Andy Begley	CEO Shropshire Council
David Sidaway	CEO Telford and Wrekin Council
Dr Ian Chan *	Telford and Wrekin
Dr Julian Povey *	Shropshire

\* these are designate appointments and subject to final checks and references

The arrangements for chairing the ICB committees have now been confirmed:

Committee	Chair	Vice Chair
Finance Committee	Trevor McMillan	Claire Skidmore
Quality and Performance Committee	Meredith Vivian	Alison Bussey/Nicholas White
Audit Committee	Roger Dunshea	N/A
Remuneration Committee	Trevor MacMillan	N/A
Integrated Delivery Committee	Harry Turner	Gareth Robinson
Strategy Committee	Nuala O’Kane	Nicola Dymond
Primary Care Commissioning Committee	Dr Niti Pall	Nicholas White

System People Committee	Dr Catriona McMahon	(Interim) Tracy Hill
Shropshire Integrated Partnership Committee	Jointly chaired:  Tanya Miles Executive Director of People, Shropshire Council  Patricia Davies CEO, Shropshire Community NHS Trust	N/A
Telford and Wrekin Integrated Partnership Committee	Jonathan Rowe Executive Director Adult Social Care, Health Integration and Wellbeing	N/A
Shropshire, Telford and Wrekin Health and Care Senate	Alison Bussey/Nicholas White	N/A
Integrated Care Executive Committee	Simon Whitehouse	N/A

### Amended ICB meeting schedule

A proposed schedule of both formal meetings to be held in public and development sessions for the ICB as a new unitary board were presented in March 2022.

For the ICB to both transact business in public and to develop as a unitary Board it is proposed that from 1<sup>st</sup> July 222 formal meetings in public will take place generally bi-monthly throughout the year. However, the meeting sequence has been refined to consider the timings of the main business of the ICB across the whole financial year to ensure we have meetings in place to facilitate efficient decision making.

For those months where a formal meeting does not take place, an informal development session will be held. We are also proposing that meetings are not held in August and December, recognising these are popular times of the year for annual holidays. The proposed schedule of ICB formal meetings to be held in public and Board development sessions from 1<sup>st</sup> July is outlined below. These will take place on the last Wednesday of the month for 3 hours from 2pm – 5pm.

Month	Formal meeting held in public on last Wednesday of the month 2 – 5pm	Development session On last Wednesday of the month 2 – 5pm	No meeting to be held

July 2022	In addition: 1 <sup>st</sup> July (inaugural meeting to be held once only – time to be confirmed)	X	
August 2022			X
September 2022	X		
October 2022		X	
November 2022	X		
December 2022			X
January 2023	X		
February 2023		X	
March 2023	X		
April 2023	X		
May 2023		X	
June 2023	X		

### Emergency Decision: Submission of ICS Operational Plan

The system has been developing its Operational System Plan for some time. Due to last minute changes to the submission date of the plan to NHSE/I to 12 noon on 20<sup>th</sup> June and the inability to call a meeting of the shadow ICB in enough time to make this decision, myself and the ICB Chair made an emergency decision under the ICB Constitution – section 4.9.5 of Standing Orders on Friday 17<sup>th</sup> June to approve submission of the Operational Plan.

The Board is asked to ratify the emergency decision made by the Chair and Chief Executive to approve submission of the ICS Operational Plan to NHSE/I in order to meet the deadline set. Please note that the detailed submission has been fully shared with all partners and the summary positions is detailed later in this pack of papers.

## 4. CONCLUSION

The Board is asked to-

- Note the detail provided in part one of this report
- Note that following the final submission of the ROS, NHS England are satisfied that adequate preparations are in place for the 1<sup>st</sup> July and that STW ICB will be ready to fulfil its statutory functions from that point



- Agree that the NHS Shropshire, Telford and Wrekin response to the Fuller Review come back to the September Board
- Note that ICP terms of reference will be brought to the ICB at the end of July and that the first meeting of the ICP will be held in September
- Ratify the emergency decision made by the Chair and Chief Executive to approve submission of the ICS Operational Plan to NHSE/I to meet the deadline set.

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## 29-06.009 – Final Ockenden Report Update – SaTH assurance on action plan

<b>Author:</b>	<b>Hayley Favell</b> Director of Nursing for SaTH	<b>Paper date:</b>	24 June 2022
<b>ICS Board Member Sponsor:</b>	<b>Louise Barnett</b> CEO SaTH	<b>Paper Category:</b>	Information
<b>Paper Reviewed by:</b>		<b>Paper FOIA Status:</b>	Releasable
<b>Action Required (please select):</b>			
A=Approval	<input type="checkbox"/>	R=Ratification	<input type="checkbox"/>
S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input checked="" type="checkbox"/>
I=Information	<input type="checkbox"/>		

### 1. Purpose of Paper

The purpose of this paper is to share with Board members:

- A. An update on outstanding actions from the first Ockenden Report (2020)
- B. The current position in relation to the actions from the final Ockenden Report (2022), as at 10<sup>th</sup> May 2022
- C. Next steps being taken to progress this work

### 2. Executive Summary

#### 2.1. Context

Significant work has been undertaken already to undertake a preliminary review of all the actions from the final report. This work is complex but will continue at pace, and with the due diligence required to deliver them all fully and properly.

There is a great deal of work arising from these new actions, which include prioritising them and, also, undertaking assessments to determine the resource and time requirements to deliver them.

#### 2.2. Link to Pledges

All parts of this document have been linked to the system pledges.

#### 2.3 Summary

This paper summaries the current actions being undertaken by SaTH to provide assurance for the Ockenden Report action plan.

#### 2.4 Conclusion

The Board is asked to:



- A. Note the update on outstanding actions from the first Ockenden Report (2020)
- B. Acknowledge the current position in relation to the actions from the final Ockenden Report (2022), as at 10<sup>th</sup> May 2022
- C. Note the Next steps being taken to progress this work

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1.0 PURPOSE OF THIS REPORT

1.1 This report provides the following information:

- An update on outstanding actions from the first Ockenden Report (2020) • The current position in relation to the actions from the final Ockenden Report (2022), as at 10<sup>th</sup> May 2022.
- Next steps being taken to progress this work

2.0 THE OCKENDEN REPORTS (2020) AND (2022)

2.1 The First Ockenden Report 2020

2.2 The Board of Directors received the first Ockenden Report – “*Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: our first Report following 250 clinical reviews*”<sup>1</sup> at its meeting in public on 7<sup>th</sup> January 2021.

2.3 The Board of Directors received the final Ockenden Report – “*Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust – Our Final Report*”<sup>2</sup> at its meeting in public on 14<sup>th</sup> April 2022.

2.4 The numbers of actions for the Trust to implement from the two reports are, as follows:

Report	Local Actions for Learning (LAFL's) - SATH only	Immediate and Essential Actions (IEA's) - All providers of maternity care in England	Total no. of actions
First – Dec 2020	27	7 Themes – (25 sub actions)	52
Final – Mar 2022	66	15 Themes – (92 sub actions)	158
Totals	93	117	210

3.0 STATUS OF REQUIRED ACTIONS

3.1 On receipt of the final report, the Women and Children’s Division commenced work to review all the new actions to determine how best to address them fully. These actions are large in number, many have several ‘sub-component’ actions to deliver, and some are complex to address. As at 10<sup>th</sup> May 2022, the anticipated delivery and completion dates have been set for 101/158 actions, which leaves fifty-seven yet to be dated. These actions will require more detailed consideration, negotiation, and discussion with various stakeholders (e.g., Local Maternity and Neonatal System (LMNS), specialist networks, the Anaesthetics Division, etc.) before the delivery and completion dates can be determined for them. This work is being planned for.

3.2 Of the 101 that are dated, the current delivery profile is, as follows:

Financial year	Number of actions expected to be fully implemented during this period
2022-23	38
2023-24	63
Yet to be determined	57

3.3 With regards to the overall responsibility for leading on the delivery of the required actions, the breakdown is, as follows:

Lead agent	Number of Actions
Internal (Trust only)	132
External (combined Trust- external agencies)	26

3.4 Current position with all actions

3.5 All the actions from both reports are summarised in one single Action Plan at **Appendix One**. More detail in relation to any of the actions can provided on request or as required.

<sup>1</sup> www.gov.uk/official-documents. (2020) Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews.

<sup>2</sup> www.gov.uk/official-documents. (2022) Ockenden Report – Final. Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital HS Trust.

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3.6 At its meeting on 10<sup>th</sup> May 2022, the Board of Directors was given provisional ratings for actions that were yet to be approved and validated by the Maternity Transformation Assurance Committee (MTAC). This meeting took place on 10<sup>th</sup> May 2022, and (MTAC) confirmed the following changes to action ratings:

### 3.6.1 First Report (2020)

#### Approved to move to next level rating

Action Ref.	Theme	Previous Rating	MTAC Approved Rating 10/05/22
LAFL 4.85	Obstetric Anaesthesia	Delivered Not Yet Evidenced	Evidenced and Assured
LAFL 4.86	Obstetric Anaesthesia	Delivered Not Yet Evidenced	Evidenced and Assured
LAFL 4.90	Obstetric Anaesthesia	Delivered Not Yet Evidenced	Evidenced and Assured
LAFL 4.91	Obstetric Anaesthesia	Delivered Not Yet Evidenced	Evidenced and Assured
IEA 4.4	Maternal Mental Health Services	Delivered Not Yet Evidenced	Evidenced and Assured

#### Rejected

Action Ref.	Theme	Previous Rating	MTAC Approved Rating 10/05/22
IEA 1.4	Single LMNS	Not Yet Delivered	No Change Evidence Insufficient

#### Additional Approvals

- Exception reports for overdue delivery, with agreed revised delivery dates, were accepted for the following actions: LAFL's 4.87, 4.88, 4.99, 4.100 and IEA 1.1
- LAFL 4.99 was re-affirmed as having been 'Evidenced and Assured' following an earlier query.

### 3.6.2 Final Report (2022)

#### Approved to move to next level rating

Action Ref.	Theme	Default Starting Assumption	MTAC Approved Rating 10/05/22
LAFL 14.9	Patient Safety Incidents	Not Yet Delivered	Delivered Not Yet Evidenced
LAFL 14.18	Improving Audit Process	Not Yet Delivered	Delivered Not Yet Evidenced
LAFL 14.25	Leadership and Oversight	Not Yet Delivered	Delivered Not Yet Evidenced
LAFL 14.29	Fetal Growth Assessment and Management	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 3.3	Escalation and Accountability	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 3.4	Escalation and Accountability	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 4.1	Clinical Governance – Leadership	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 4.2	Clinical Governance – Leadership	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 4.4	Clinical Governance – Leadership	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 4.6	Clinical Governance - Leadership	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 4.7	Clinical Governance - Leadership	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 5.7	Clinical Governance – Incidents/Complaints	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 7.2	Multi-Disciplinary Training	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 7.5	Multi-Disciplinary Training	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 10.3	Labour and Birth	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 10.6	Labour and Birth	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 13.3	Bereavement Care	Not Yet Delivered	Delivered Not Yet Evidenced
IEA 13.4	Bereavement Care	Not Yet Delivered	Delivered Not Yet Evidenced



## Rejected

Action Ref.	Theme	Default Starting Assumption	MTAC Approved Rating 10/05/22
LAFL 14.24	Leadership and Oversight	Not Yet Delivered	No Change Evidence Insufficient

3.7 The Delivery and Progress Statuses of all the actions, as validated on 10<sup>th</sup> May 2022, are summarised in the following tables:

### Delivery Status

Report	Domain	Total Number of Actions	Not Yet Delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
First Report 2020	LAFL	27	1	4	22
First Report 2020	IEA	25	5	1	19
First Report Sub-Total	BOTH	52	6	5	41
Final Report 2022	LAFL	66	62	4	0
Final Report 2022	IEA	92	78	14	0
Final Report Sub-Total	BOTH	158	140	18	0
Total Both reports	ALL	210	146	23	41

### Progress Status

Report	Domain	Total Number of Actions	Not Started	Off-Track	At Risk	On Track	Completed
First Report (2020)	LAFL	27	0	0	0	5	22
First Report (2020)	IEA	25	0	1	0	5	19
First Report Sub-Total	BOTH	52	0	1	0	10	41
Final Report (2022)	LAFL	66	61	0	0	5	0
Final Report (2022)	IEA	92	78	0	0	14	0
Final Report Sub-Total	BOTH	158	139	0	0	19	0
Total Both reports	ALL	210	139	1	0	29	41

## 4.0 RISKS TO DELIVERY AND MITIGATING ACTIONS

- 4.1 Whilst it is important to maintain focus, momentum, and pace with the delivery of the required actions, it is essential that these are all addressed and considered fully, are not rushed, and that all the Trust's agreed assurance and validation processes are followed.
- 4.2 The Board of Directors is aware that the Trust uses a software system called 'Monday.com' to store the Maternity Transformation Programme, all maternity action plans, action movements and evidence. There is provision within this system to record any risks related to each action. Currently, this records the risks to delivering each action, as opposed the risks to women and families and the quality of service provision. Discussion has taken place with the Women and Children's Division, and they are going to review all actions as a multidisciplinary team, and at an away day, in relation to recording formally their overall risks to women and families and the quality of service provision.
- 4.3 At its first review of all actions, the division considered each, in turn, to ensure there are no immediate or actual risks to patient safety that would impact women and families. In doing so, the Division is confident of the ongoing commitment to improving care quality and clinical safety. This can be evidenced through the progress against Year 4 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme, The Saving Babies Lives Care bundle, and the overall Maternity Transformation programme.
- 4.4 A question at the last Board of Directors' meeting in public in May 2022 centred on the risk appetite for the Ockenden actions. Essentially, all the Ockenden actions are required to be delivered in full. However, it will not be possible to achieve all actions at once and/or necessarily within a relatively short time frame. The Women's and Children's Division is taking some time out

as a team to consider how best to prioritise the actions. When this has been completed, the Board of Directors will be apprised of this work and the assessments made which, in turn, will describe the risk appetite applied until all actions have been delivered.

**5.0 THE OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC)**

5.1 ORAC will reconvene monthly from Tuesday 21<sup>st</sup> June 2022 and will continue to be live streamed to the public. The June meeting will acknowledge receipt of the final Ockenden Report, and provide updated positions in relation to the delivery of actions from both reports. Discussions are underway to look at how to make future ORAC meetings more interactive and outcome/impact focused.

**6.0 NEXT STEPS**

- 6.1 As mentioned earlier, the next steps include the Women and Children’s Division taking some time as a multidisciplinary team to prioritise the 158 new actions, along with recording formally any risks to women and families and the quality of service delivery. This will include an assessment of whether any additional resources could help achieve the required actions any more quickly. Work will also commence with external partners in relation to the actions that they are required to lead on or that require their input.
- 6.2 Once this work has been undertaken, it is proposed that the executive directors undertake a confirm and challenge exercise with the Women and Children’s Division to review the action plan and proposed approach.
- 6.3 The Board of Directors will appreciate that there are many other maternity transformation projects that address a broader range of issues beyond the actions of the Two Ockenden Reports, such as CNST and Saving Babies Lives. LAFL 14.24 from the second report requires monthly reporting of the progress of the overall Maternity Transformation Plan to the Board monthly. The Division and Transformation Team will consider how best to achieve this.

**7.0 SUMMARY**

- 7.1 Significant work has been undertaken already to undertake a preliminary review of all the actions from the final report. This work is complex but will continue at pace, and with the due diligence required to deliver them all fully and properly.
- 7.2 There is a great deal of work arising from these new actions, which include prioritising them and, also, undertaking assessments to determine the resource and time requirements to deliver them.

**8.0 ACTION REQUIRED OF THE BOARD OF DIRECTORS**

- 8.1 The Board of Directors is requested to:
- Receive this report for information and assurance
  - Decide if any further information, action and/or assurance is required.

**Hayley Flavell Executive Director of Nursing 26<sup>th</sup> May 2022**

Appendix One: The Ockenden Report Action Plan at 10<sup>th</sup> May 2022 (confirmed)

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## 29-06.010 – Pledge 3 Population Health Management and Outcome Framework

<b>Author:</b>	Craig Kynaston/Rachel Robinson/Sam Tilley	<b>Paper date:</b>	29 <sup>th</sup> June 2022
<b>ICS Board Member Sponsor:</b>	Andy Begley	<b>Paper Category:</b>	Governance
<b>Paper Reviewed by:</b>	Rachel Robinson/Sam Tilley	<b>Paper FOIA Status:</b>	
<b>Action Required (please select):</b>			
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	
S=Assurance		D=Discussion	
I=Information			

### 1. Purpose of Paper

This paper is to update on the Population Health Management work programme. It describes the progress to date, the next key priorities and resourcing required to progress.

The programme is reported as part of the Population Health Board deliverables.

The paper sets out:

- A brief overview of Population Health Management
- Summary of the workplan to date
- Key priorities and to progress in line with local and national priorities
- Resource and investment to achieve phase 1 of the need
- A summary of the future need

The paper seeks support for the recommendations from ICS Chief Executives, before taking a final paper to the ICS Board in June.

### 2. Executive Summary

Taking an overarching Population Health approach to improve health and wellbeing is a priority for Shropshire, Telford and Wrekin with all partners making the commitment that improving population health requires collaboration across the system.

The aim of the Population Health Management (PHM) approach is to improve population health by data driven planning and delivery of proactive care to achieve maximum impact.

During 2021 a number of key activities have been delivered including delivery of a work programme on key deliverables, recruitment of an interim lead (until September 2022) recruitment of two joint analysts, reestablishment of analysts network, capacity review which showed significant gaps, initiation of outcome and key metrics development. However, despite progress even during a challenging background of COVID and NHS pressures, to develop key infrastructure projects including the “engine room” and to deliver a population health management approach across the

ICS, greater prioritisation of this programme and resources to support this is required to maintain momentum and deliver the ask.

### 3. Main Report

#### 3.1 Context

Taking an overarching Population Health approach to improve health and wellbeing is a priority for Shropshire, Telford and Wrekin with all partners making the commitment that improving population health requires collaboration across the system

Currently we know that:

- Life Expectancy has stopped increasing and has fallen in recent years in STW, there remains a gap in healthy life expectancy across STW
- Health inequalities are widening (linked more recently to the impacts of Covid19)
- Demand on NHS services has been increasing and waiting times will increase post Covid19
- Much of this extra demand is for treatment of conditions which are preventable.

At heart, the NHS remains a treatment service for people when they become ill. This needs to be reversed, we need to focus on early intervention and prevention and taking a population health approach

By understanding our population health and inequalities and tackling these collectively we will improve health and wellbeing outcomes for our residents and reduce health inequalities as well as investing up stream to save resources and reduce demand.

Our overarching approach to Population Health includes a number of work streams, of which Population Health Management is one:

- Population Health Management
- Prevention and Inequalities
- Economic Regeneration
- Climate Change

The Population Health programme is over seen via the Population Health Operational Board (SRO Andy Begley, Shropshire Council CEO) within the ICS Board governance structure.

A full review of the Boards deliverables was carried out in March 2022 (attached appendix 1). During this next quarter the Board is focusing on detailed deliverables, planning and requirements from each workstream to ensure the programmes deliver the requirements of the ICS moving beyond July 2022. This report provides an update on the **population health management** workstream.

The aim of the Population Health Management (PHM) approach is to improve population health by data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts – and, in turn, designing and targeting interventions

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to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

### 3.2 Progress to date

The PHM work stream, which underpins the Population Health approach, has two elements; Firstly infrastructure to deliver a Population Health Management approach including analytic capability and creating the “engine room” to provide a rich evidence base to support programmes of work and secondly providing the evidence to support the development of our priorities to ensure the maximum impact for our population and secondly a dedicated work programme to ensure that PHM underpins all STW priorities.

Work to ensure the enabling infrastructure is developing and linking in with existing Programmes, includes:

- Establishing a System wide Analysts Network, utilising our access to wider system resources via the West Midlands Strategy Unit/ West Midlands Decision Support Unit (CSU)
- IT Infrastructure capability development, led through the Digital Operational Group
- Developing our performance dashboard capability to support the PHM approach
- IG / Data Sharing / data safety compliance, led through the Digital Operational Group
- Professional Leadership assurance of data and evidence to support priorities, led through system professional Leadership Group
- Requirements gathering for data flows, their content and quality to support analysis for priority areas

### 3.3 Data requirements

Building on the outline above, the Data and Digital strategy is in development of which one of the top priorities is levelling up. Currently system partners are in different places with their data architecture, levelling up will allow us to achieve a common baseline. This will then allow us to;

- Define standards and interoperability of systems
- Understand and describe the needs from EPRs and Datawarehouse’s within system partners and build analytics and insight on these at a system, place and PCN level
- Understand and define technical architecture needed from PHM and wider intelligence/performance/constitutional asks
- Utilise the insight in national approaches around data architecture

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- Build/procure PHM solution(s)/tool(s) on data and visualise through a system platform
- Understand where data is to be processed and stored
- Agree a data warehouse vision for the future

Whilst the Digital and Data strategy and individual system partners strategies allow for organisations to develop, the ask from the system has not yet been defined and there is a gap. The ask is for the PHM group to own and co-ordinate the requirements at a system level and produce an options appraisal to define infrastructure investment. This will facilitate the ask not just for PHM, but wider BI and reporting needs at system level and accessible to all system partners.

Having all analysts access the data across the system will unlock extreme potential to further develop programmes of work. To compliment this, the PHM group will look to own and co-ordinate the development of the strategy for the visualisation platform. The potential to share insight to all system partners in a secure way again will allow for workstreams to progress at a faster pace.

The above will establish the “Engine Room”. This was agreed as a system to be a key fundamental priority and deliverable to develop as a system following the CSU report in May 2021.

Additionally, requirements in line with other national priorities, such as the One Health & Care programme for example, also have links to the future provision of data. Such programmes have specific focuses but could contribute to benefits for securing data to provide insight for PHM. The PHM group will define and contribute to the requirements of analytics and insight in other system priorities where data is provisioned. The benefit of this will be to avoid duplication and align strategies and priorities.

Whilst the Digital and Data Strategy will encompass the wider data asks, there needs to be a clear definition on where the data ask for PHM starts and ends. The PHM/BI ask is a subset of the overall data provision.

The ask is to agree that the PHM board will own the above and also secure the funding for additional resource (outlined below) to coordinate. In addition, reviewing current investments into data architecture and future requirements will allow the PHM group to utilise the best potential solution for the “Engine Room”.

### 3.4 Information Governance requirements

In the transition to the ICS and closedown of the CCG moving to ICB, a number of information governance related documents will need to be reviewed. However, moving forward to what we need the current provision for sharing data lawfully may not be fit for purpose. As we progress through the journey for PHM we are looking to update/amend create new documentation.

There are a number of resources available to support from national sources and other developing systems, we need to take these and make them into what we need to progress STW.

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Whilst again there is still national direction and legislation to be defined, we can progress in line with the initial phase of deliverables. One such example is to link adult social care and secondary care data at record level visible to analysts across health and social care to inform PHM and Health Inequalities. We can use existing methodologies to ensure that this is achieved safely, securely and complies to all governance processes. The PHM group can own this and progress.

Following this the PHM group can support in the creation and facilitation of enabling data sharing across the system, again unlocking the potential benefits for all system partners, for example, pathway analytics to understand the true demand of services across STW and the impact on the citizens.

The ask is to make this a core part of the PHM groups with dedicated support to progress.

### 3.5 Programme Management requirements

As Population Health Management links to several system priorities as an enabler, at present the visibility of impact is not clear whilst we recognise its importance. A number of programmes have “BI” resource built in but it is not clear how intelligence and insight can be defined and measured.

The ask is for all programmes to define the requirements and for these to be monitored and reported. The current work programme is attached (appendix A). Current resources are not enough to deliver the wider requirements.

### 3.6 Workforce requirements

Good insight and intelligence require a dedicated skilled workforce. Across STW there are analysts working at system partner level contributing to organisational priorities. Whilst resource is varied along with skillsets, the establishment of a system level analytics, intelligence and data group has started to develop this. The network has recognised the need to work together whilst balancing competing priorities and that it has been challenging to allocate the time to develop.

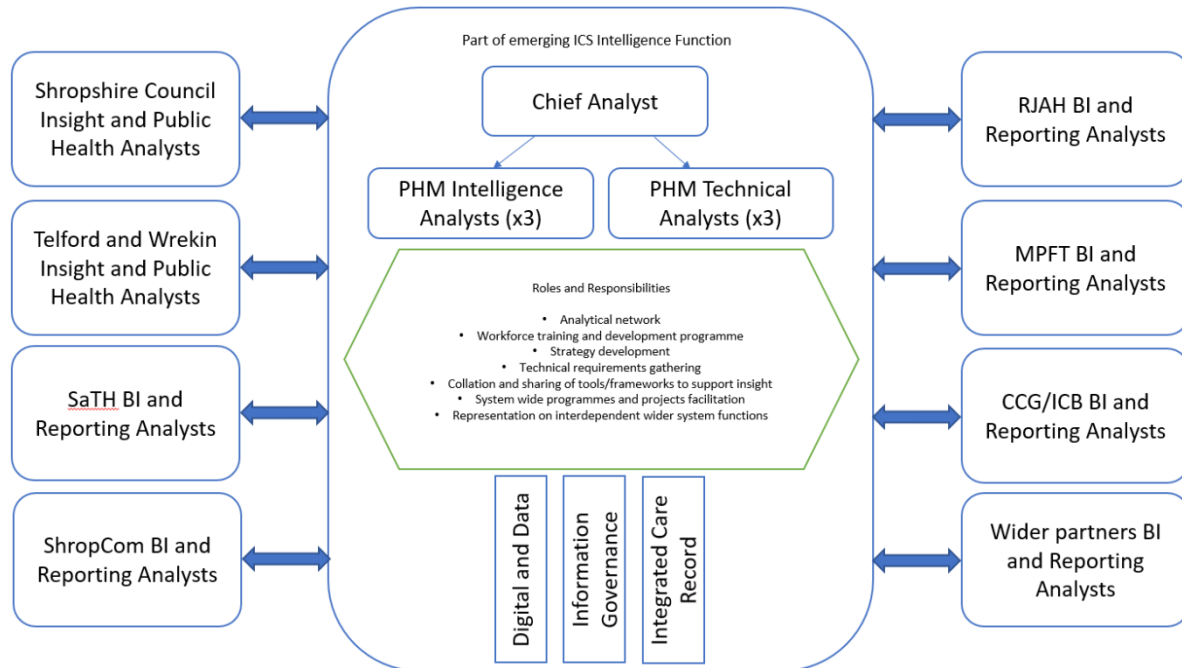
Following the recent skills audit we now have the opportunity to look at our analytical capabilities and develop using the upcoming national competency framework. We have begun this journey through realising our two dedicated PHM posts but this has only scratched the surface on what we need.

The Population Health Management workstream has delivered the skills mapping and system work programme asks. The Board has seen a number of successful funding bids brought into the system including Population Health Fellows, Additional Cost of Teaching (ACT) funding and Core20Plus5.

In addition, systems are recognising the need to appoint leadership in the form of a Chief Analyst at system level. There have been various models on how this works for each emerging ICS, however, not all these models work for STW. To achieve the elements outlined in the sections above, a proposed structure to deliver these elements along with the key deliverables is illustrated in the diagram below;

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### *Proposed phase 1 of the ICS Intelligence Function structure*



To support the roles and responsibilities, STW is also part of the Midlands Decision Support Network. An outline of the MDSN support is below;

- Expand the training & development programme in response to highly positive feedback and significant demand, with offerings aimed at analysts and decision-makers
- Deliver a regional analytical programme focused on member priorities, with an enhanced focus on supporting systems to move 'insight into action'
- Actively promote knowledge exchange and collaborative working between systems as a means of supporting continuous learning and improvement
- Add value through regional co-ordination – attracting investment, building partnerships and proactively supporting local DSU development

The training and delivery programme for 22/23 has been shared by the MDSN of which there are a number of training and development opportunities. Currently due to pressure and demands, the current analytical workforce across the system find it difficult to create the time to learn. Allowing the staff professional development time, in line with CPD of other professions, will allow STW to grow its own cutting edge resource utilising the current investment by linking with the MDSN and other CPD organisations such as ApHA (Association of Professional Healthcare Analysts).



The MDSN is also producing up to 3 analytical products per annum working with all systems. STW are limited in representation due to capacity issues, however creating the space to be part of these products will allow us to share wicked problems and address them with learning from across the region.

The ask is to secure the funding for the resource of a Chief Analyst and a small team of an additional 4 analysts. With the current financial challenges in STW it is recognised that to fund the ask will be challenging. There are a number of options as proposed below;

- The funding of the additional posts can be shared between system partners, thus sharing the costs and benefits
- The system could look to utilise additional revenue funding by bidding for national opportunities as they arise or by requesting support from NHSE/I
- The ICB could look to proceed “at risk” with an aim to reshaping the resource internally
- As the ask is similar across system, the ICB could look to source joint resource across multiple ICBs
- With the support from Information Governance professionals, deliver a longitudinal linked dataset by April 2023

The recurring resource cost is £330k. However, as mentioned the resource will contribute to wider Business Intelligence and Analytical needs for the system.

The benefits of the resource will be to deliver the above sections along with achieving our outlined key deliverables including;

- A data strategy for the system incorporating PHM and HI requirements
- A defined, scalable, affordable “engine room” design
- A defined platform for visualising analytics
- A full training and development programme to “grow our own” analytical resource
- Responding to national requirements to build an ICS Intelligence Function

The resource will coordinate/facilitate this delivery along with ensuring that progression is reported and assured.

## 4.0 Conclusion and Recommendations

During 2021 a number of key activities have been delivered including delivery of a work programme on key deliverables, recruitment of an interim lead (until September 2022) recruitment of two joint analysts, reestablishment of analysts network, capacity review which showed significant gaps, initiation of outcome and key metrics development. However, despite progress even during a challenging background of COVID and NHS pressures, to develop key infrastructure projects including the “engine room” and to deliver a population health management approach across the ICS, greater prioritisation of this programme and resources to support this is required to maintain momentum and deliver the ask.

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This report makes several recommendations to the Board to move this significant and important programme of work forward.

The Board are asked to

- Recognise and endorse the importance of PHM and a PHM approach to the system.
- Champion and support the PHM approach outlined in this paper to allow STW to move forward and achieve the priorities and requirements outlined in the paper.
- Fully commit to and support the cultural change needed across business intelligence and insight team functions within partner agencies in the system to develop a shared system resource.
- Ensure that all system programmes define their PHM requirements and for these to be monitored and reported via the work programme. The current work programme is attached (appendix A).
- Agree for the system Chief Executive leads to secure the resource requirements needed to deliver the programme; commencing with mapping current resource against the infrastructure requirements set out in the paper to quantify any residual gap to be addressed.

#### Appendix A – STW PHM Delivery Plan (March 2022)



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## 29-06.011 – Place Based Governance arrangements

Author:	Claire Parker Director of Partnerships	Paper date:	23 <sup>rd</sup> June 2022			
ICS Board Member Sponsor:	Gareth Robinson Exec Director of Delivery and Transformation	Paper Category:				
Paper Reviewed by:		Paper FOIA Status:	FOIA			
Action Required (please select):						
A=Approval	X	R=Ratification	S=Assurance	D=Discussion	I=Information	X

### 1. Purpose of Paper

To provide briefing information to Integrated Care Board members on the place-based partnership work and next steps for the integrated place partnerships, Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Integrated Place Partnership (SHIPP).

### 2. Executive Summary

#### 2.1. Context

This briefing paper has been developed in the context of the White Paper *Integration and Innovation: working together to improve health and social care for all*, and more recently (February 2022) the White Paper; *Health and social care integration: joining up care for people, places and populations*. The full document can be read here [Health and social care integration: joining up care for people, places and populations - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/108422/Health_and_social_care_integration_joining_up_care_for_people_places_and_populations.pdf)

#### 2.2. Link to Pledges

**Integrating services at place and neighbourhood level** - developing local health and care hubs to improve not just the physical but mental health of people, build on the principles of one public estate and the assets of individual communities, better manage the volume of hospital admissions and establish new models of care to best serve all our communities.

#### 2.3. Overview

The principles of place-based working are to work together to improve the health and care for the populations of STW by reducing health inequalities and improving outcomes, not just health outcomes, at a place and neighbourhood level. The integrated place partnerships will deliver the objectives and outcomes of the Integrated Care Board (ICB).

TWIPP and SHIPP arrangements operate within the wider system governance as committees of the ICB as well as within their own place-based governance arrangements, including the Health & Wellbeing Board and other democratic processes.

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The intention is for the ICB to eventually delegate decision-making powers to place-based partnerships. However, this will require further maturity and development of the place-based approach to cement it in ICB governance. This could then include delegated funding that may sit outside the Better Care Fund (BCF) mechanism.

Currently, the representatives on TWIPP and SHIPP are sufficiently senior to be able to make decisions on behalf of their own organisation within their schemes of delegation, this will strengthen and develop over the next 6-12 months.

Telford & Wrekin Integrated Place Partnership (TWIPP) brings together senior representatives from the local authority, local NHS trusts, Primary Care Networks (PCNs), Healthwatch and the voluntary sector.

The purpose of TWIPP is to drive the delivery of community centred health and care integration, with a key focus upon place-based proactive prevention, seamless services and all age support in Telford and Wrekin.

The TWIPP is a formal partnership that is accountable to the Telford & Wrekin Health and Wellbeing Board and the Shropshire and Telford & Wrekin Integrated Care Board.

In Shropshire, SHIPP, is a partnership of commissioners, providers of health and social care and involvement leads, to ensure that the system level outcomes and priorities agreed at ICB, and other programme committees are implemented at place and neighbourhood level across all ages including children and young people.

SHIPP takes into account the different communities across the Shropshire Council area, the individuals/ citizens (including carers) and the different delivery models that are needed, with a clear focus on reducing inequalities.

STW currently has 8 Primary Care Networks (PCNs), 4 in Telford and Wrekin, where the PCN clinical directors have a seat at the TWIPP partnership and 4 in Shropshire where the 4 PCN clinical directors have a seat at the SHIPP partnership as providers of primary care services.

Current and next steps:

- A detailed draft paper jointly developed by the CCG with senior officers in each of the Local Authorities was presented to a workshop of system chief executives for discussion and onward development. It is proposed after further refinement this paper will be presented to the ICB.
- An NHSE/I sponsored programme on development of place-based working is currently underway in Telford and Wrekin. The programme has several modules to develop thinking around leadership, governance, resources, delegation and engagement/co-production.
- A review of the function mapping work previously undertaken is to be considered in the wider context of delivering at place.
- An informal place oversight group, of senior decision makers, has been established for the next few weeks to develop the role of neighbourhoods at place and discuss the recommendations of the integration white paper.
- A nomination process and job description for a lead chief executive officer for each of the places is being developed.
- The development of the governance structure that sits beneath the integrated partnerships is to be discussed by each of the places.

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- Development of the comms and engagement work for coproduction and place narratives needs to be strengthened.
- The oversight group will ensure the Local Care programme and the place development work are closely aligned.
- A primary care development programme is underway through the PCN development group (transferring from the CCG to ICB) including leadership. Wider primary care needs to be considered that is out with the PCN's alone.

## 2.4. Recommendations

The Board are asked to-

1. Note the progress update provided on the Place development
2. Comment on this progress and explore the linkage with the PHM approach detailed elsewhere in this pack of papers
3. Agree to support the appointment process for the 2 place leaders.
4. Confirm that the ICB and the 2 LA's should work in partnership to agree the job description for the place leaders and set out the timeframe for these appointments to be made
5. Task the system CEO group and strategy leads to map out the various strategic plans and set out in one place. Form this collation of work to bring back an update to the Board that shows an alignment of the strategic plan for the system
6. Confirm support for the progression of the work to identify the strategic commissioning functions that will remain at system level and the tactical commission functions that will sit at the place level – building on the work that was previously completed with the support of Deloitte's
7. Sponsor the next steps of the governance work that will be required to enable a clear road map setting out how the two place partnerships can develop the governance arrangements to enable them to become formal joint committees of the ICB as per the agreed governance framework
8. Support the need for an OD and cultural change programme to underpin our shift to place based working.
9. Request a future update that will set out the financial flows at the place level and how that will be actioned through the joint committee arrangements
10. Note the importance of a safe transition and evolution to place based working arrangements

## 2.5. Conclusion

The Board is asked to note the briefing information and recommendation to receive the jointly written paper on place- based working at a future meeting.

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## System Level Integrated Performance Report

<b>Author:</b>	Julie Garside	<b>Paper date:</b>	23/6/22
<b>ICS Board Member Sponsor:</b>	Mark Brandreth /Gareth Robinson	<b>Paper Category:</b>	Performance
<b>Paper Reviewed by:</b>		<b>Paper FOIA Status:</b>	Full disclosure
<b>Action Required (please select):</b>			
A=Approval	R=Ratification	S=Assurance	x D=Discussion
			I=Information x

### 1. Purpose of Paper

This paper provides a summary of the current integrated system performance for Shropshire Telford & Wrekin, including the latest position regarding our:-

- Urgent & emergency care, elective and cancer and mental health operational performance
- People performance (Summary only)
- Financial summary (Summary only)
- By appendices SHIPP and TWIPP annual reports

### 2. Executive Summary

#### Operational Performance

##### Urgent & Emergency Care

Urgent and Emergency Care includes Four Hour A&E decision to admit, twelve hour trolley waits, ambulance handover times and time to Initial Assessment. Overall A&E performance has remained stable with a deteriorating position in decision to admit performance. Continued concern remains around the initial assessment of patient upon their arrival in the Emergency Department <15 minutes. Emergency Department total performance (Type 1 and Type 3) remains stable, with Minors Type 1 and all Type 3 activity achieving >95%.

##### Ambulance Handover

Ambulance handover time greater than 60 minutes (Number) continues to increase at both PRH and RSH. The >60mins performance is shown on slide 6 of the pack and lost resource hours in April increased and reported as ~2000, more than double the previously reported months. This continues to have an impact upon Category 1 and Category 2 response standards for STW. These handover delays result from a range of issues across the patient pathway. It is where the failure in flow processes across the patient pathway from pre-hospital to discharge back to the correct patient setting manifests as risk in the system. Within STW, the causes are multiple and spread across the entire pathway. There are a range of immediate actions that are being taken:

- The development of a new system wide approach to operational management which will increase grip within the system. Evidence from other systems is clear that full transparency on operational position, the plan for the next 24 hours, and the closing down of specific actions has a material impact on flow and reducing ambulance handovers
- Rota-ing of SaTH staff to ED cohort areas to release WMAS staff from the current cohorting arrangements which will reduce/ eradicate patients reported as being delayed, but actually being cared for within the ED environment
- Existing site safety arrangements remain in place to provide assurance that patients being cared for in cohort environments or on

More structurally, our most significant tool in improving ambulance performance, specifically ambulance handover delays, is our system Urgent and Emergency Care (UEC) Improvement Programme. This plan focuses on the set of key actions we believe will have the biggest impact across the UEC pathway and ultimately in improving ambulance performance

This programme has been developed based on known best practice. The overall programme aims and workstreams were presented to and ratified by the UEC Delivery Board in June. The specific request of the Delivery Board in June was for all projects to provide a clear scope, milestones, and benefits by the July Delivery Board which will allow a set of trajectories for a set of KPIs – specifically including ambulance handover performance – to be set out

In addition to this improvement work programme, an Ambulance Handover MP summit was recently held to focus on briefing MPs on background and specific actions that are being taken under the UEC Improvement Programme. This session was jointly chaired by Sir Neil McKay, ICB Chair and Anthony Marsh, WMAS CEO

The summit noted a number of areas where developments were already having a positive impact on performance including the Single Point of Access, developments in relation to primary care access, increased care home provision and the roll out of the Rapid Response service

The Summit agreed a number of actions which will be followed up with a further Summit in July

- The ICS through the UEC Improvement Programme to set out the top priorities, specific actions and anticipated benefits. To map these to a clear trajectory of ambulance handover improvement that we will monitor through the ICS and with summit attendees
- A clear action plan to be shared with summit attendees and form the basis of the second ambulance handover summit
- Continued support for Hospital Transformation Programme by all parties

It is proposed that a further detailed report is presented to the next ICB setting out the key improvement programmes sitting within the Improvement Plan, their associated metrics

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and improvement trajectories and progress to date as well as further detail on the outcome of the next Ambulance Handover Summit and the overall agreed route forwards

## Cancer

Cancer Waiting times (2 weeks) Suspected Cancer and Cancer Waiting times (2 weeks) for Breast Symptoms have consistently failed to achieve the target since September 2020. The SPC indicates that these are areas with deteriorating performance. The 31-day Standard monthly performance has shown a significant increase following the drop in last month's performance and will not consistently meet the target. The 62-day standard also remains consistently below the target and showing deteriorating performance, there is a real effort to increase the diagnostic capacity to both stabilise and then improve the recovery trajectory. Although our planned reduction in the STW 62day backlog is in line with regional /national expectations due to the current level of our backlog at >500 there has been a recommendation to place the system in Tier 1 for intensive support to aide recovery from the National/regional resource. The system is already meeting with NHSE region on a weekly basis to ensure any support is timely and effective.

## Elective Care

This includes 18 weeks RTT, RTT 52 week waits and Diagnostic Waiting times. The percentage of Incomplete pathways treated within 18 weeks remains consistently below the target of 92% with a deterioration coinciding with the onset of COVID. Consequently, the number of people on the incomplete pathways continues to rise and indicates a high pressure in the system. From the onset of COVID the number of people waiting 52 weeks has shown a steady increase until April 2021, with the numbers remaining significantly higher than the end of 2020. Patients waiting more than 6 weeks for a Diagnostic test has also failed to achieve the target and although this is showing a reduction from the peak in May 2020, it remains high. Workforce remains the key constraint to reducing this and delivering recovery. Several recruitment actions (including overseas) are underway in this area with signs of limited success.

### 104 week waiters

STW Patients waiting >104 weeks by the end of June is on track to be at the level forecast to NHSE of 102. This consistency of 81 complex spinal, 10 patient choice and 2 capacity related cases at RJA and a total of 9 at SaTH, 6 of which are due to capacity and 3 are patient choice. SaTH did restart their orthopaedics on 20<sup>th</sup> June as per the de-escalation plan. This has been maintained despite recent further emergency pressures.

The system at the end of July will have 64 >104wk waiters - consisting of 52 complex spinal and 9 patient choice at RJA and 3 patient choice at SaTH. SaTH will have zero >104wk waiters at the end of August. RJA are currently forecasting to be at zero by the end of February 22. The system continues to make use of mutual aid offered by both Royal Orthopaedic in Birmingham and the Cleveland Clinic in London to reduce our longest waiters more quickly where patients are willing to travel.

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## Mental Health

Mental Health includes Early Intervention in Psychosis (EIP) 2 week waits, Dementia Diagnosis Rates, CYP Eating Disorders and IAPT. The EIP waiting times have consistently achieved the target of 60% with deteriorating performance from November 2020, however, data is now showing a special cause improving variation. Dementia Diagnosis rates have a deteriorating performance and the SPC indicates that the rate will not achieve the target, however, work is underway to simplify pathways in line with the new Dementia Strategy. CYP Eating Disorders 4 week waits for routine is showing deteriorating performance and is expected to fail the target. CYP Eating Disorders 1 week wait for urgent cases, although not achieving the national target is showing no significant change. Due to the concerns raised by the Quality & Performance Committee a detailed report on both adult and CYP eating disorders is being taken back there in July. IAPT Recovery rate has consistently achieved the target with a slight drop in October 2021. However, there are no significant changes in trends for the Recovery rate.

Also included as Appendices 1 & 2 are the annual reports from SHIPP and TWIPP including the development of the place-based dashboards. They remain work in progress and the places are both working on high level quarterly updates which will come to the ICB board via this integrated performance report from September 22.

Finally, the following developments are underway on this report and will be available to the ICB from July onwards: -

- 1) Elective care - reporting on levels of >78ks and associated actions & trajectories to reduce
- 2) Community services performance - 2hr urgent response time
- 3) Maternity dashboard - the high-level performance metrics from the local dashboard will be included with comparators to the regional and national performance where possible.
- 4) Improvement trajectories that have been recently included in the planning resubmission will be included in this report key actions for the following month to deliver the required recovery

## People Performance

Agency WTE and staff group steadily increased to the end of the financial year, but is now in an improving position with a reduction to 30% for support to clinical, and an increase across GP, Medical and Dental to 18% and 45% for Nursing and Midwifery. Vacancies, SATH continues to have the highest vacancy rate of 7.9% with an overall increase in vacancies across the system, partly this is due to new budgets. The system turnover of staff has decreased from M1 to M2, with the highest turnover being Care Workers at 32%.

## Financial Position

A forecast position has not been provided due to the on-going discussions around the full year plan submission. As part of the plan resubmission in June an opportunity will be taken to correct any phasing issues. The current YTD position illustrates a £3.2m overall adverse variance to plan at Month 2.

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## Context

STW remains a challenged system but has seen some movement away from the bottom quartile for its urgent care performance. There remains a significant impact upon the ability to respond to 999 calls promptly due to unacceptable Ambulance waits which remains a major risk for the system.

Despite recent COVID and non-elective pressures, the system continues to plan improvement in its pace of elective and cancer recovery with diagnostic capacity and theatre staff its main constraints. There remains a relentless drive to reduce the 104week waiters and eliminate these for the system as soon as possible.

## Link to Pledges

This report currently links to pledges 1, 2, 3 and 4.

### 2.3. Conclusion

The board is asked to note the current integrated performance of the system in this summary, and the on-going challenges with our systems operational performance and associated risks with our financial performance and workforce.

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**Shropshire, Telford & Wrekin**  
Integrated Care System

# System Level Integrated Performance Report Shadow ICS Board M1

Julie Garside  
June 2022

Provider Level Metrics

Analytical Support from Midlands & Lancashire CSU

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# Regular Contents/Reports

- ◆ System Summary
- ◆ Urgent and Emergency Care
- ◆ Cancer Waiting Times
- ◆ Planned/Elective Care
- ◆ Mental Health (Monthly, Quarterly due June 2022, will report to board in July22)
- ◆ Neonatal and Maternity (Due June 2022, will report to board in July 22)
- ◆ Integrated Finance Report
- ◆ STW People Performance



# System Summary












Metrics Consistently Failing	Metrics Consistently Passing
A&E 4 Hour Performance consistently below the target of 95%.	Type 3 Minor A&E within 4 hours above the target of 95%
Type 1 Major within 4Hr %	Cancer Waiting Times 31 day standard
Cancer Waiting times 2ww Suspected cancer	Early Intervention in Psychosis
Cancer Waiting times 2ww Breast symptoms	IAPT Recovery
Cancer Waiting times 62-day standard	
18 weeks RTT	
RTT 52 week waits	
Diagnostics	
Dementia Diagnosis Rate	
CYP Eating Disorders	
Smoking at Time of Delivery	



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# Urgent & Emergency Care

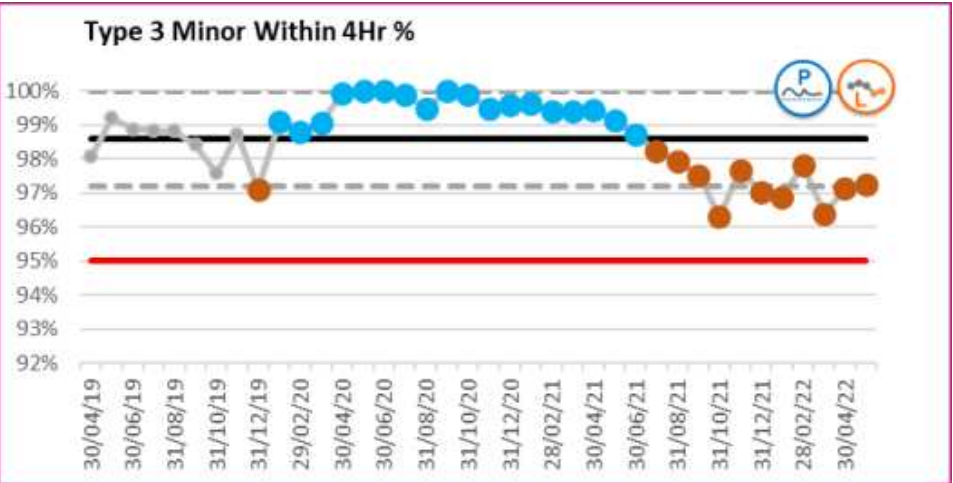
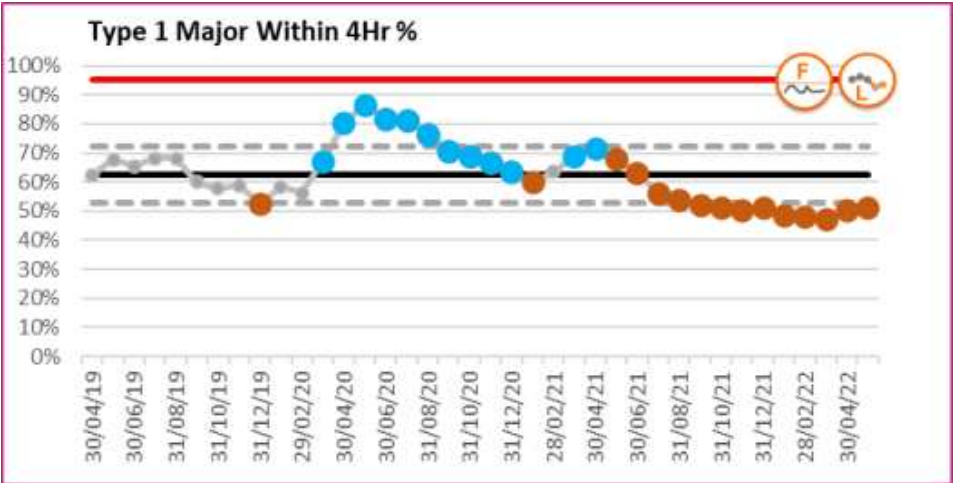
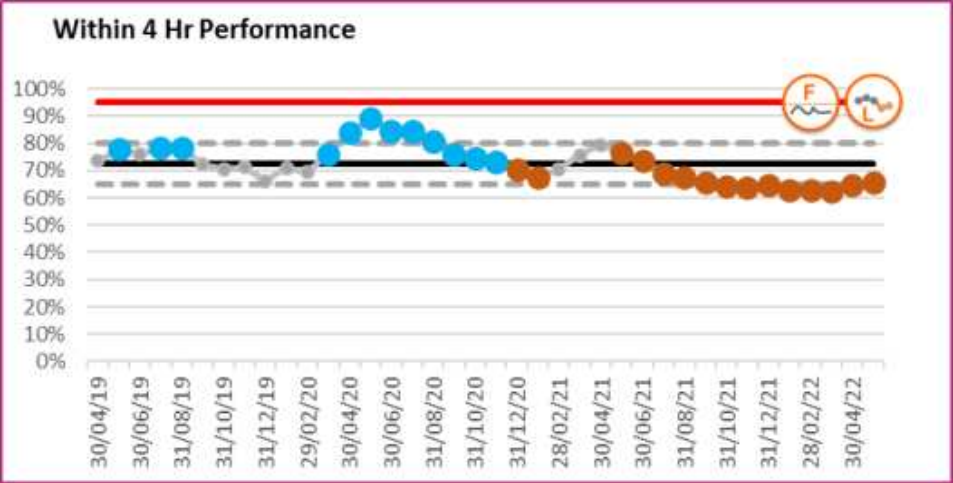
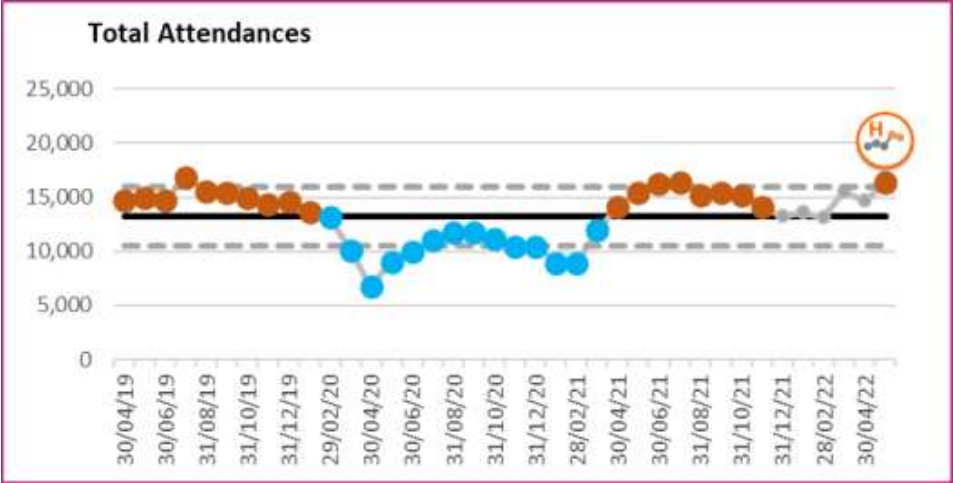
## Metric Summary

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Attendances	May 22	16388	0			13256	10539	15973
Within 4 Hr Performance	May 22	65.6%	95.0%			72.5%	65.0%	80.0%
Type 1 Major Within 4Hr %	May 22	51.4%	95.0%			62.5%	52.8%	72.2%
Type 3 Minor Within 4Hr %	May 22	97.3%	95.0%			98.6%	97.2%	100.0%
Trolley Breaches	May 22	176	0			119	0	295
Handover time Greater than 60mins	Apr 22	1063	0			407	111	703
Patient brought in by ambulance%	May 22	24.1%	0.0%			30.3%	26.3%	34.3%

- ◆ The total attendances is for Type 1 and Type 3 activity across the system has returned to pre-covid levels, with an increase in walk-in presentations and ambulance transportations consistently lower
- ◆ The four-hour decision to admit across the Majors pathway has been consistently failing the standard since April/May 2021, at the same time Ambulance conveyance reduced removing a cohort of low acuity patients. Potentially this has had an impact upon performance with a sub-department acuity shift.
- ◆ The total number of '12 hour Trolley Breaches' is now higher than before the pandemic. The SPC indicates that the system will fail to achieve the target without system change
- ◆ The number of ambulance handovers taking over an hour to complete is showing special cause of a concerning nature. With activity over the last 6 months remaining above the upper process limit.



# Urgent & Emergency Care Metric Performance

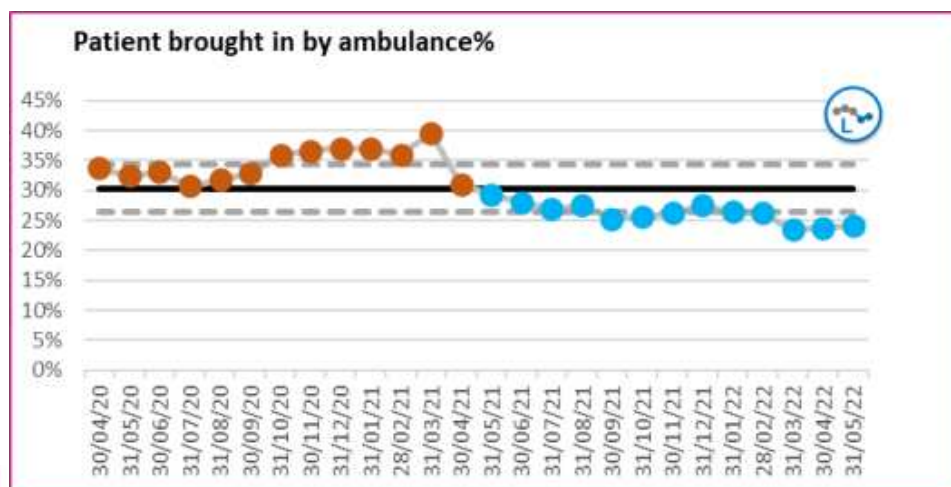
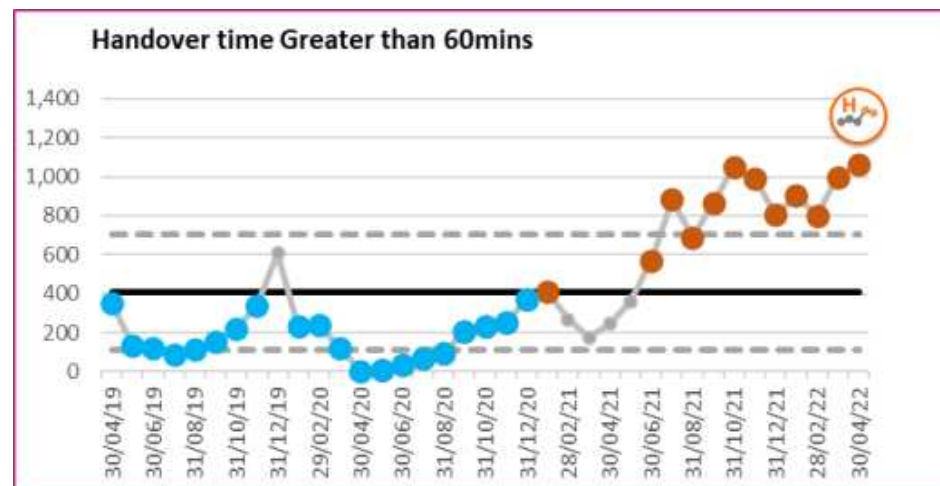
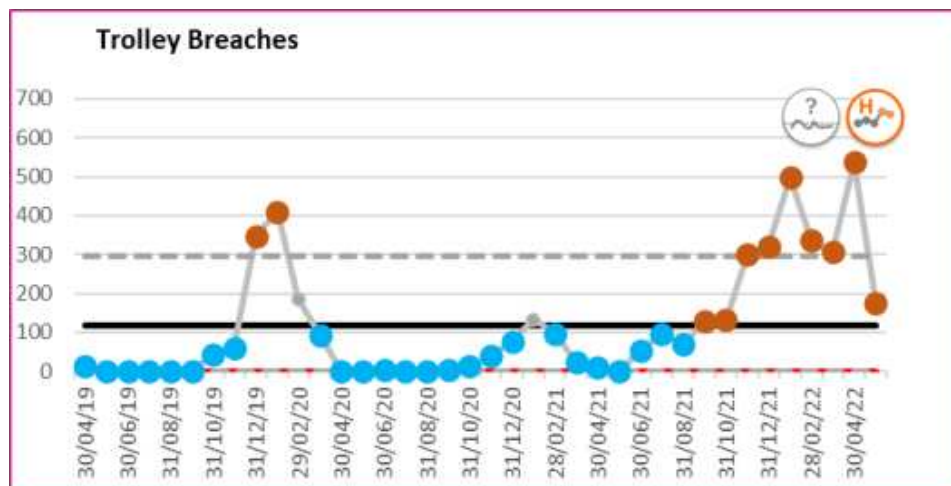


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# Urgent & Emergency Care

## Metric Performance



### ◆ Actions:

System level data interrogation to identify cohorts of patients that walk in with then specific comms / engagement planned to address the rise in activity

System demand and capacity group (bi-weekly meeting) to unblock constraints in capacity at system level with then a daily focus on discharge

System UEC Improvement plan signed off and detailed PIDs and trajectories for core standards and supporting metrics being finalised by mid July.

### ◆ Assurance:



UEC operations group, reporting to UEC Board. Progress on improvement trajectories for core standards will also be reported to the Quality & Performance Committee from July





# Urgent & Emergency Care – Time to Initial Assessment of 15 mins or less

## Metric Summary

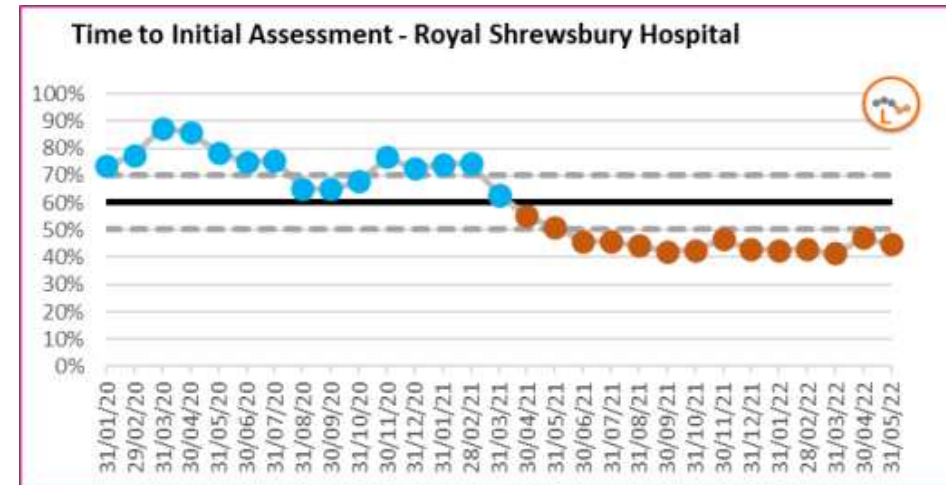
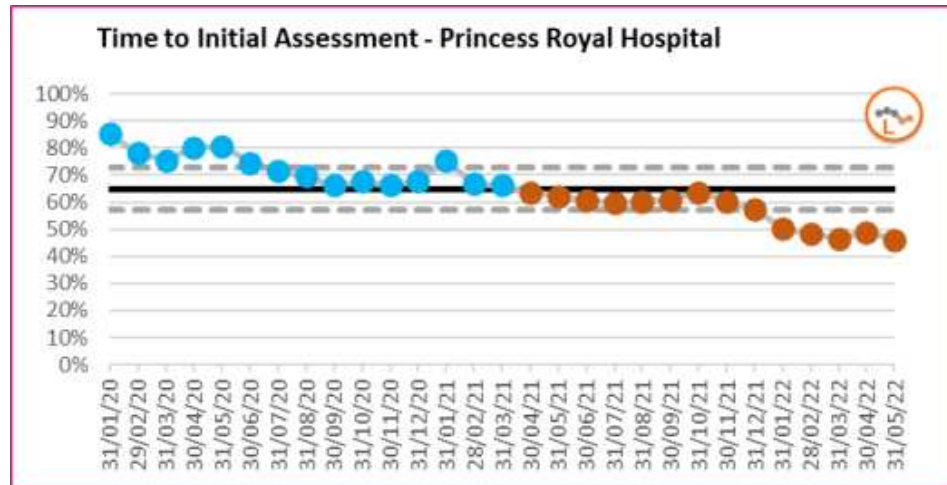
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Time to Initial Assessment - Princess Royal Hospital	May 22	46.1%				64.9%	57.0%	72.8%
Time to Initial Assessment - Royal Shrewsbury Hospital	May 22	44.8%				60.3%	50.3%	70.3%

- ◆ (SAFETY METRIC) The Percentage of patients assessed within 15 minutes for both sites is significantly low and remains below the lower process limit and is showing a deteriorating position



# Urgent & Emergency Care – Time to Initial Assessment of 15 mins or less

## Metric Performance



### ◆ Actions:

Direct access for ambulance crews to SDEC initiated for WMAS & WAS. Recruited 7wte band 6 paramedics cross site, launch of the EDP (Emergency Department Paramedic) into ED to support with initial assessment process.

Last phase of ED Refurb in progress from June, to include completion of new Fit to Sit model to work collaboratively with Initial Assessment.

RSH UTC Streaming trial completed – identified with an ACP streaming direct to UTC at booking in, 50% reduction in Initial Assessment for ED. Review of data to be formally presented to ED SMT and then UEC Ops group in July. To carry out trial at PRH ED also, expected in August 2022.

Project to expand acute floor and introduce direct admission areas in Oncology and Trauma and Orthopaedics – business case being submitted to system next week

### ◆ Assurance;

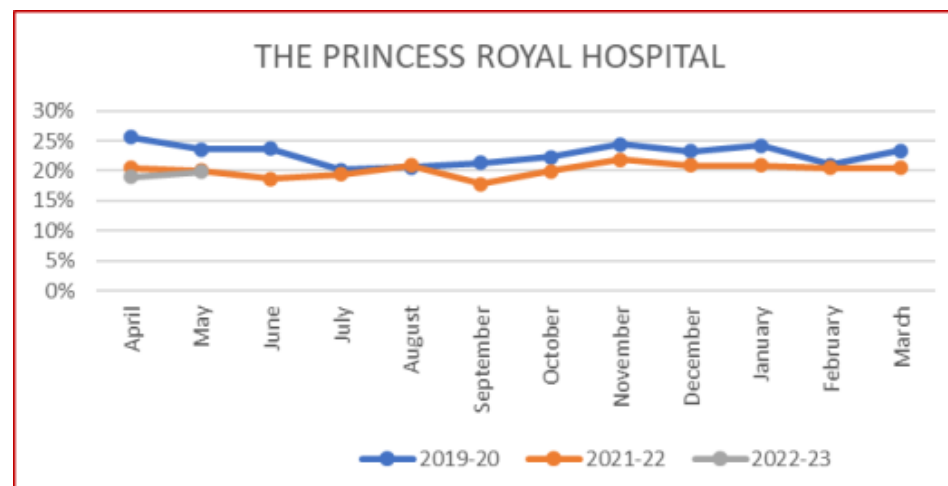
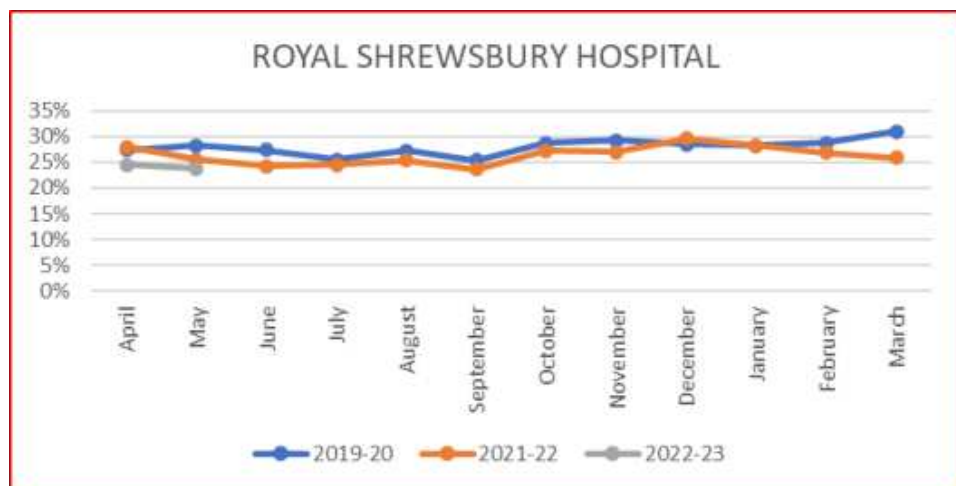
UEC operations group, reporting to UEC Board. Progress on improvement trajectories for core standards will also be reported to the Quality & Performance Committee from July



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# Urgent & Emergency Care Metric Performance

Percentage of total A&E attendances (including Minor Injury Units) admitted to the trust by site






- ◆ Comparison of the three years illustrates that both sites now have a lower percentage compared to the baseline of 2019/20, this demonstrates the benefits to the Urgent Community Response model.



# Medically Fit for Discharge

## Metric Summary

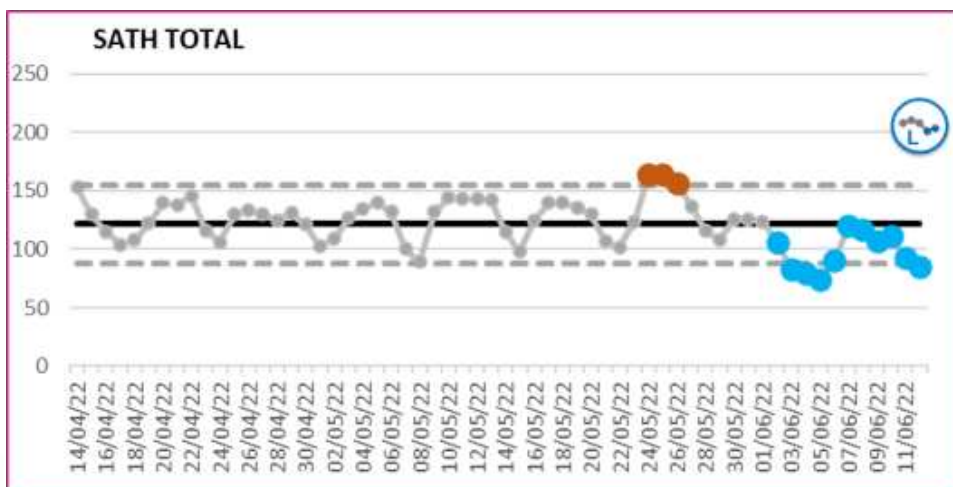
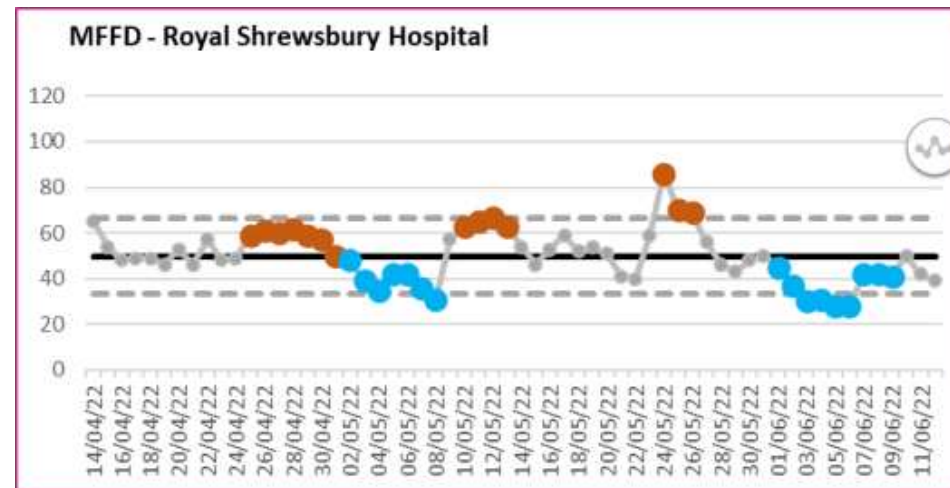
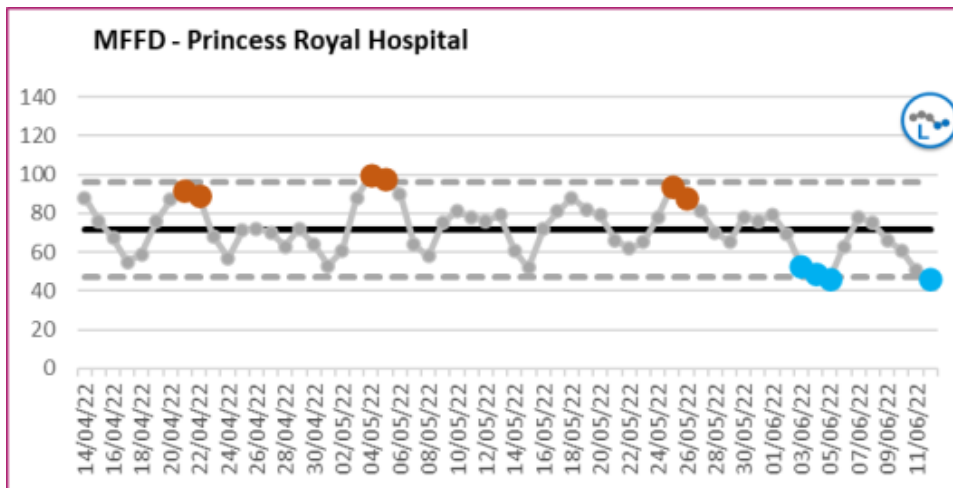
KPI	Latest date	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MFFD - Princess Royal Hospital	12/06/2022	46	0			72	47	96
MFFD - Royal Shrewsbury Hospital	12/06/2022	39	0			50	33	66
SATH TOTAL	12/06/2022	85	0			122	88	155

- ◆ The number of patients medically fit for discharge as at 12<sup>th</sup> June 2022 is Special cause Improving variation over the 60 day period for both sites
- ◆ This particular metric is now reported as 'No longer meeting the criteria to reside' and is currently measured across community and acute provider, this will be included from next month
- ◆ Patients that no longer meet the criteria to reside shows a shift in pattern (deteriorating position) weekly Friday to Monday



# Medically Fit for Discharge

## Metric Performance



### ◆ Actions:

New 3x day system catch up on discharge process being introduced replace system bronze & silver –will be reviewed in 8wks.

System review of current Integrated Discharge Team underway led by ShropComm, due to report end of June.

### ◆ Assurance:

UEC operations group, reporting to UEC Board



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# Cancer Waiting Times

## Metric Summary

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
% Patients seen within two weeks for an urgent GP referral for suspected cancer	Apr 22	71.3%	93.0%			85.3%	76.8%	93.9%
% of patients seen within 2 weeks for an urgent referral for breast symptoms	Apr 22	17.8%	93.0%			47.4%	11.9%	82.9%
% of patients receiving definitive treatment within 1 month of a cancer diagnosis	Apr 22	90.8%	96.0%			96.8%	91.9%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments)	Apr 22	80.8%	94.0%			95.7%	87.1%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Surgery)	Apr 22	88.6%	94.0%			90.7%	76.2%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments)	Apr 22	91.5%	98.0%			98.7%	95.0%	100.0%
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Apr 22	52.8%	85.0%			70.2%	54.1%	86.3%
% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service	Apr 22	59.6%	90.0%			73.9%	29.1%	100.0%
% of patients receiving treatment for cancer within 62 days upgrade their priority	Apr 22	78.2%	0.0%			83.9%	72.8%	95.0%

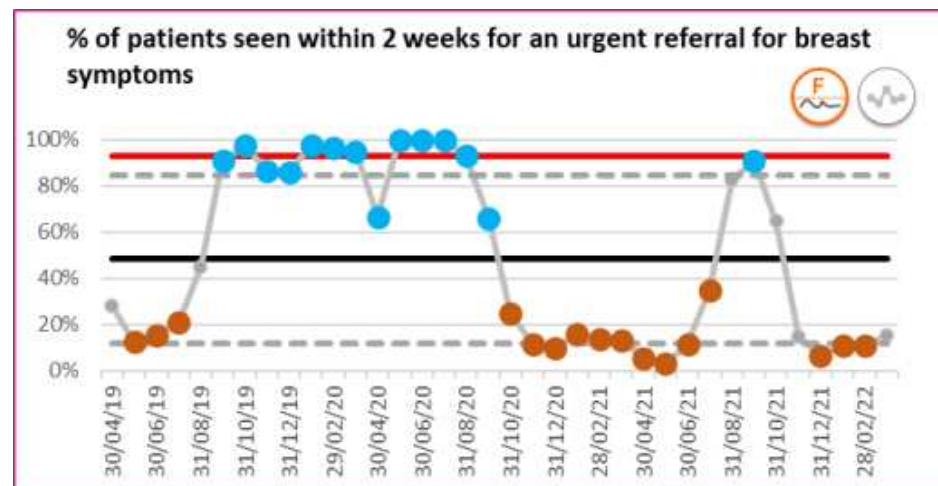
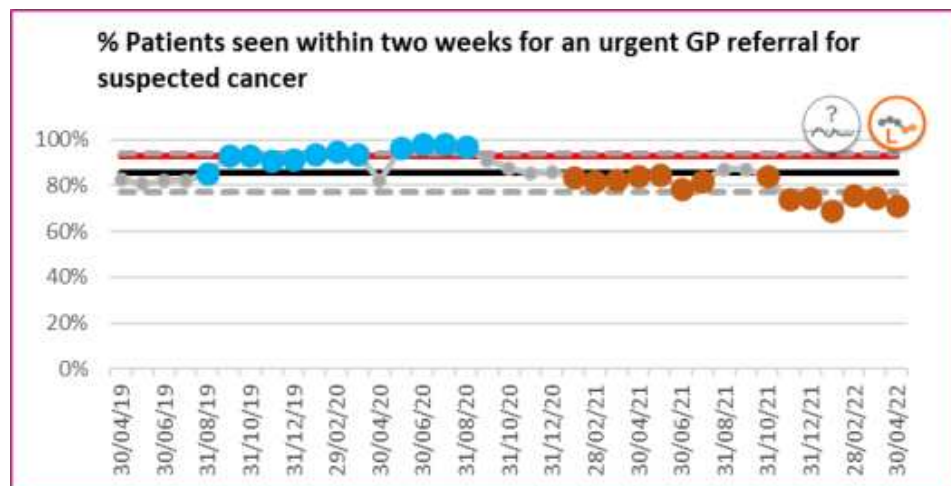
- ◆ Includes Shrewsbury and Telford Hospitals and Robert Jones and Agnes Hunt Trusts (whole provider data). Nuffield Trust data is not published at individual hospital level.
- ◆ The percentage of patients seen within two weeks for an urgent GP referral for suspected cancer is showing a downward trend and monthly performance is expected to remain below the target.
- ◆ The percentage of patients seen within two weeks for an urgent referral (breast symptoms) performance is still low compared to November 2021 and is not expected to achieve the target.
- ◆ The percentage of patients receiving definitive treatment within 1 month has deteriorated again, showing a downwards trend the last two months.
- ◆ The percentage of patients receiving definitive treatment within 2 months is showing deteriorating performance.





# Cancer Waiting Times

## Metric Performance



### ◆ Actions:

Weekly cancer performance meeting tracking delivery of improvement actions by tumour site. Recovery trajectories being reported in system performance report for Quality & Performance Committee from July.

Recruitment – seeking international workforce and out to advert to fill Cancer Nurse Specialist roles and diagnostic workforce key to capacity for one stop clinics.

### ◆ Assurance

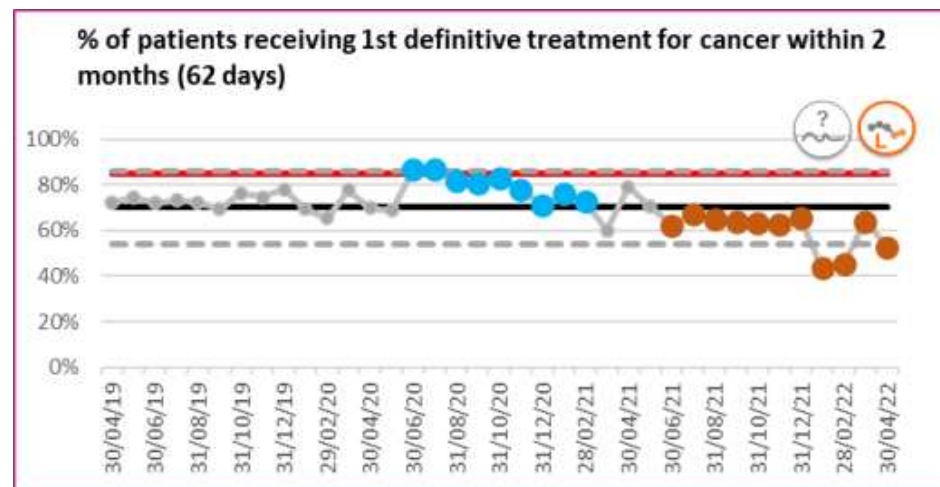
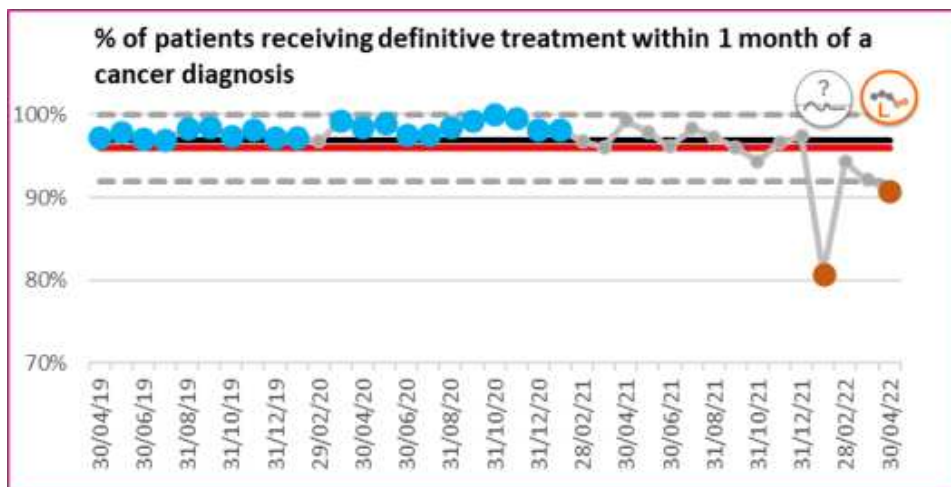
Delivery being overseen by monthly System Elective & Cancer Recovery Group reporting to System Planned Care Group and ultimately Integrated Delivery Committee. Assurance is via ICS Quality & Performance Committee for impact on standards' recovery trajectories



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# Cancer Waiting Times

## Metric Performance



### ◆ Actions continue from last month:

Increasing diagnostic capacity (Workforce) which will reduce the time to diagnosis for urgent suspected cancer patients

Each pathway team has produced an operational recovery plan to increase the current productivity across workforce and capacity, preventing if possible any further deterioration, working towards delivering the target

Regulation/oversight of actions weekly with the regional team from 1<sup>st</sup> July.

### ◆ Assurance:

31 day waits remain in standard and stable

Delivery being overseen by monthly System Elective & Cancer Recovery Group reporting to System Planned Care Group and ultimately Integrated Delivery Committee. Assurance is via ICS Quality & Performance Committee for impact on standards' recovery trajectories

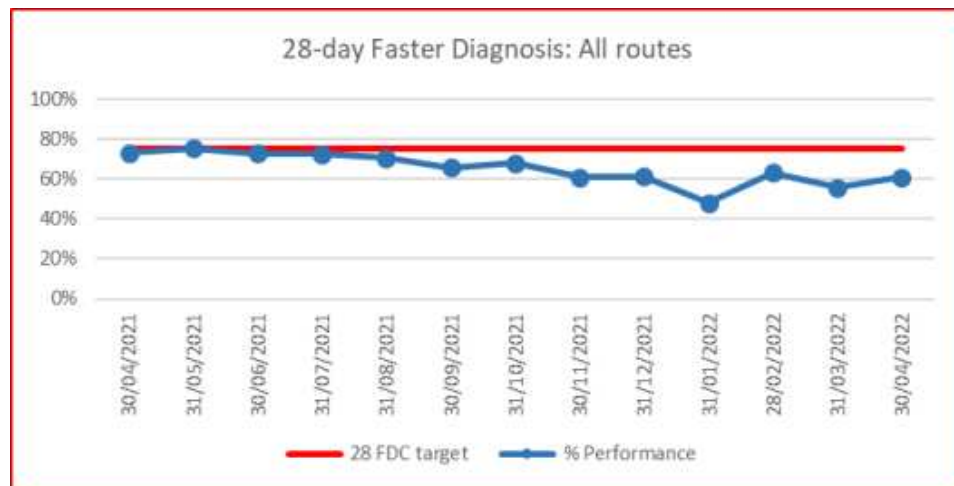


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# Cancer Waiting Times

## Metric Performance



### The 28-Day Faster Diagnosis Standard

Systems will be expected to meet the new Faster Diagnosis Standard of 75% (for all routes urgent suspected cancer, urgent breast symptomatic, and urgent screening referrals in aggregate) from Q4 2022/23

#### ◆ Actions:

Following publication of the elective guidance the 75% target now has to be delivered by March 2024.

This is part of the system cancer transformation programme of work. The STW Cancer Strategy has a focus on a number of themes including: Healthy Lifestyles; Awareness; Screening; Early Presentation; Diagnosis; Treatment; Living with and Beyond Cancer.

STW trajectory for 2022/23 is to achieve 57% by March 23, all plans are currently under review to push for further improvement limitation is diagnostic capacity.

#### ◆ Assurance:








Delivery being overseen by monthly System Elective & Cancer Recovery Group reporting to System Planned Care Group and ultimately Integrated Delivery Committee. Assurance is via ICS Quality & Performance Committee for impact on standards' recovery trajectories



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# Elective Care

## Metric Summary

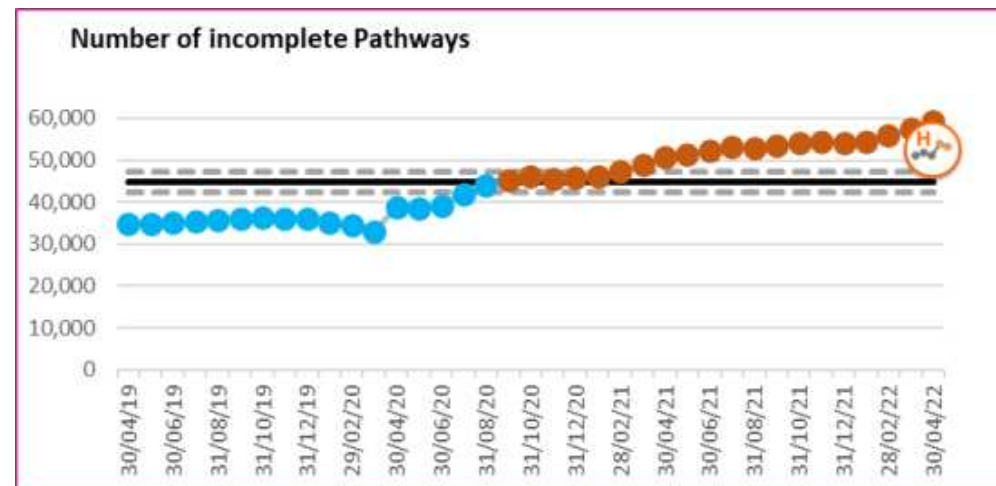
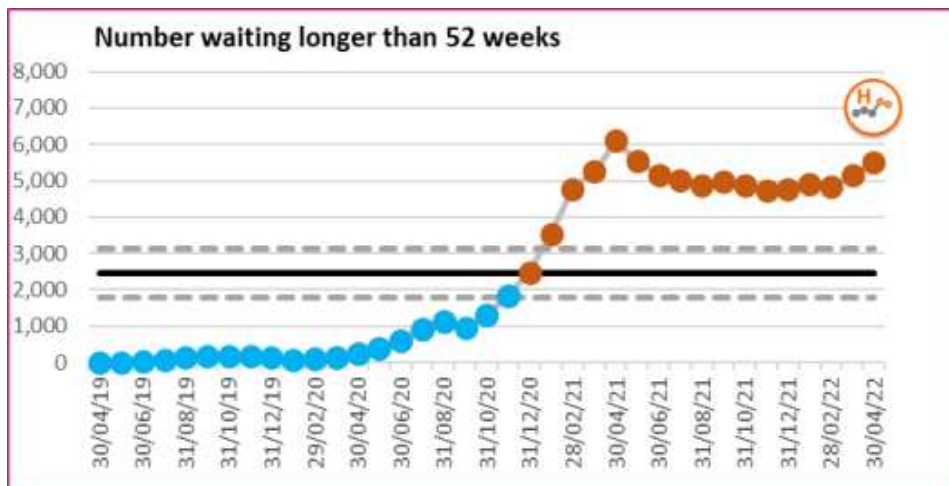
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
% RTT Incomplete Pathways < 18 weeks	Apr 22	56.8%	92.0%			66.3%	61.1%	71.4%
Number of incomplete Pathways	Apr 22	59478				44743	42269	47217
Number waiting longer than 52 weeks	Apr 22	5498	0			2465	1789	3141
% Diagnostics > 6 weeks	Apr 22	40.7%	1.0%			29.5%	17.0%	42.0%
Average Diagnostics Activity	Apr 22	696				604	474	734

- ◆ RTT Data is for Shrewsbury and Telford Hospitals, Robert Jones and Agnes Hunt Hospital, Shropshire Community and Nuffield Health Shrewsbury Trust.
- ◆ Diagnostics activity has been standardised by calculating average activity per number of days in the month.
- ◆ The SPC for <18 week RTT target is indicating special cause of a concerning nature where the performance is significantly low and monthly performance is expected to remain below the target.
- ◆ The SPC for percentage of Diagnostic waits > 6 weeks is indicating special cause concerning variation and monthly performance is not expected to achieve the 1% target.



# Elective Care

## Metric Performance



### ◆ Actions:

- Clinically prioritising patients, utilising the Vanguard and booking longest waits as a priority
- Developing internal recovery plans (planning) with weekly oversight from region
- Ward returned from SATH (Ward 36) to Elective care to restart T&O
- Theatre planning lists, maximising productivity with staffing and availability with slow commencement of P3 & P4 lists
- Mutual Aid sourced Cleveland, ROH and South Warwickshire to help with the recovery against the 104 week target
- Maximising use of IS both locally and further out of area where patients are willing to travel.
- Regional weekly oversight/scrutiny that plans/planning will meet expectation of 104wks

### ◆ Assurance:

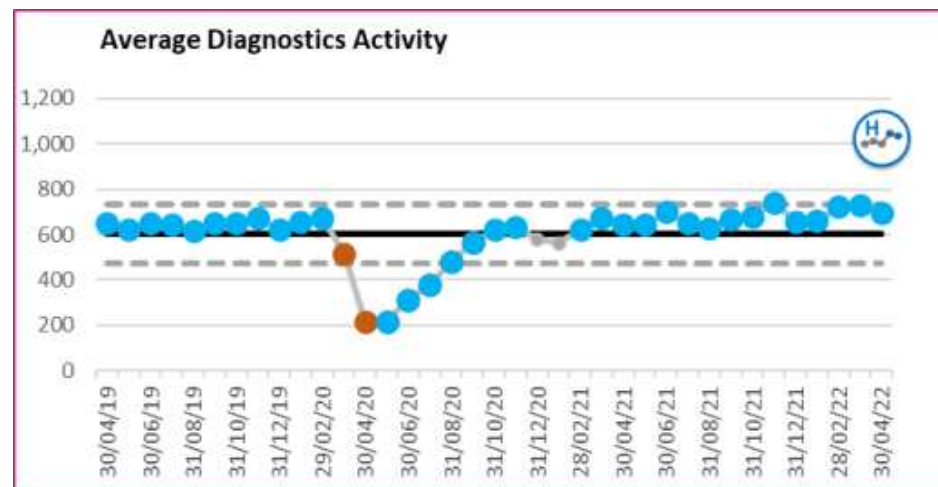
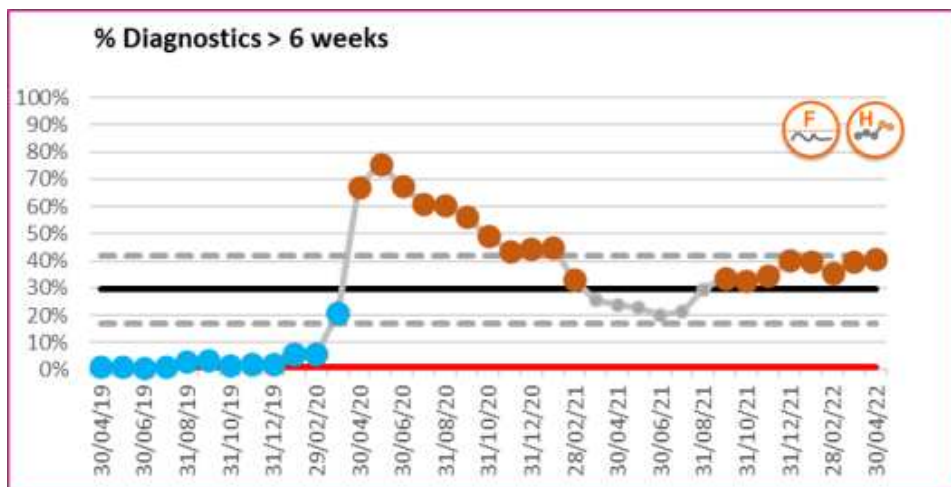
System Elective & Cancer Recovery Group overseeing delivery of all elective recovery including 104wks, >78wks , reporting to system planned care operational group and ultimately Integrated delivery Committee.



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# Elective Care

## Metric Performance



### ◆ Actions:

Radiographer shortages continue to be a risk to the ICS recovery, escalated Regionally/Nationally

The modular CT/MRI unit to increase capacity & reduce the current backlog and aide overall rate of elective recovery is now in operation but limited days per wk due to staffing

Recruitment across the diagnostic pathway continues to include exploring overseas options







### ◆ Assurance:

System Elective & Cancer Recovery Group overseeing delivery of all elective recovery including 104wks, >78wks , reporting to system planned care operational group and ultimately Integrated delivery Committee.

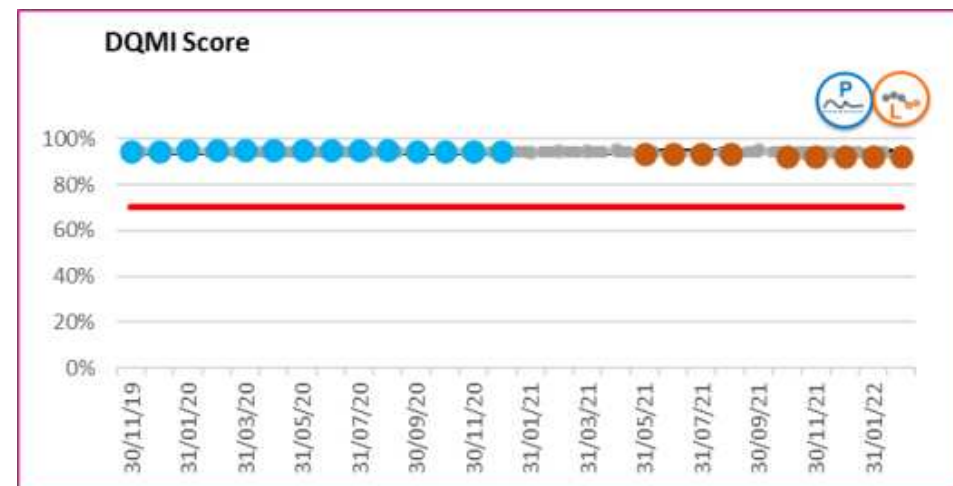


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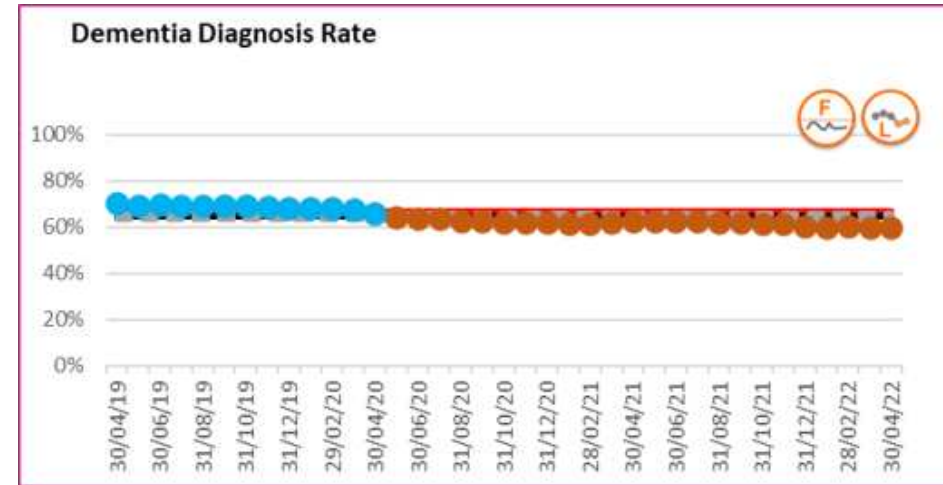
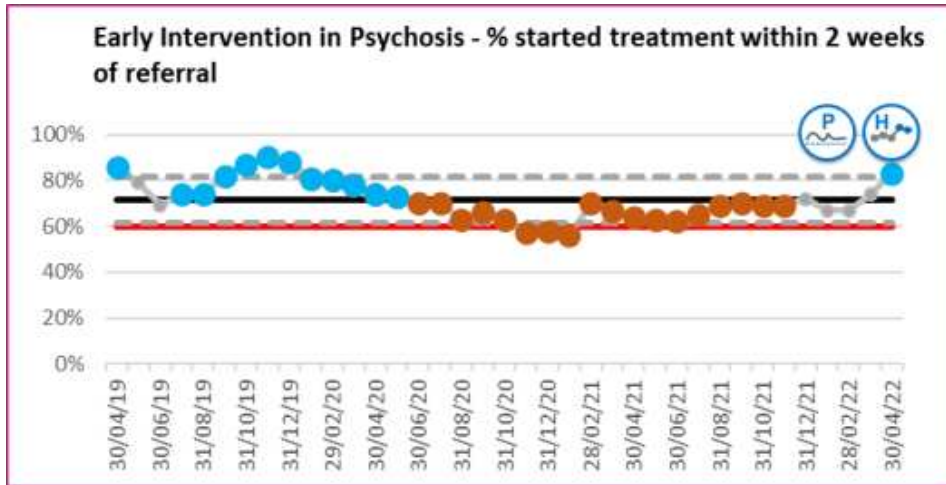
# Mental Health - Monthly Metric Summary

	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Early Intervention in Psychosis - % started treatment within 2 weeks of referral	Apr 22	83.0%	60.0%			71.6%	61.6%	81.6%
Dementia Diagnosis Rate	Apr 22	60.0%	66.7%			64.4%	63.3%	65.4%
Inappropriate OAPs started in period	Mar 22	10	0			5	0	13

- ◆ The Data Quality Maturity Index (DQMI) for the Mental Health Data Set (MHSDS) for Midlands Partnership NHS Foundation Trust is consistently achieving the target (see chart on the right).
- ◆ Published data for the Total number of Inappropriate Out of Area Placements (OAP) days and Inappropriate OAPs started in the reporting period is rounded to the nearest 5 to prevent patient identification. The numbers are too low to apply SPC.
- ◆ Dementia Diagnosis Rate – NHS Digital has advised that the outbreak of Coronavirus (COVID-19) has led to unprecedented changes in the work and behaviour of General Practices and subsequently the data in the national publication will be impacted.



# Mental Health - Monthly Metric Performance



## ◆ Actions:

Dementia Diagnosis although dropped is tracking in line with the National position. A new National Dementia Strategy has been developed to improve access for diagnosis and address capacity issues in the memory service to improve response times and an improvement plan is development with trajectory to be reported from August.

## ◆ Assurance:


System Q&P committee & MH & LD partnership board





# Improving Access to Psychological Therapies (IAPT)

## Metric Summary

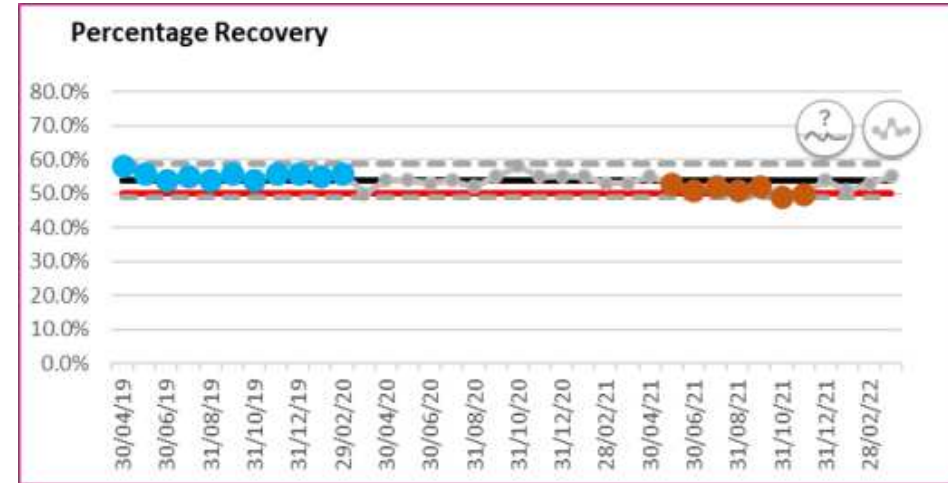
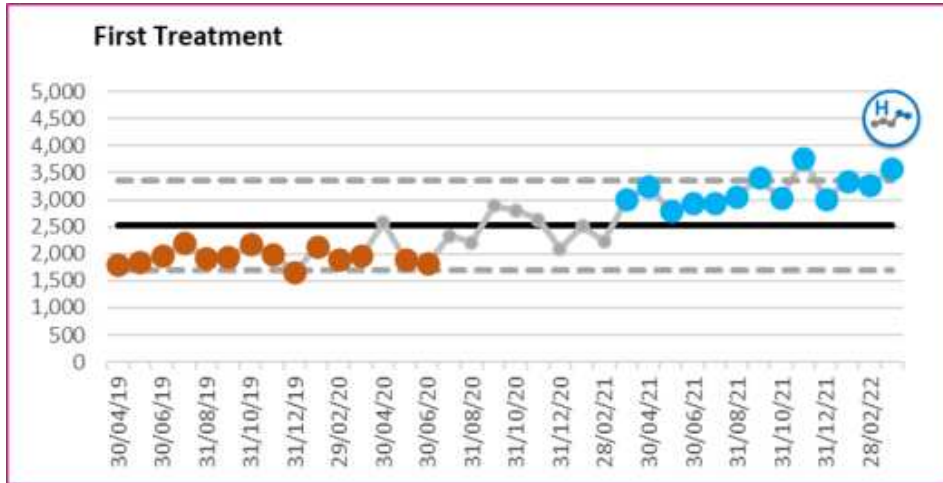
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
First Treatment	Mar 22	3580				2528	1689	3367
Percentage Recovery	Mar 22	55.0%	50.0%			53.8%	49.0%	58.6%
Percentage First Treatment 6 Weeks Finished Course Treatment	Mar 22	92.0%				92.2%	88.9%	95.4%
Percentage First Treatment 18 Weeks Finished Course Treatment	Mar 22	98.0%				98.4%	96.5%	100.0%

- ◆ Includes all activity at Midlands Partnership NHS Foundation Trust.
- ◆ Patients receiving their first IAPT treatment are on a steady increase with numbers significantly higher than the beginning of report time period.
- ◆ IAPT recovery is showing no significant change and will not consistently meet the target. Percentage recovery is on target for March.
- ◆ Percentage First Treatment within 6 weeks is showing no significant change.
- ◆ Percentage First Treatment within 18 weeks is showing no significant change.



# IAPT

## Metric Performance



### ◆ Actions:

IAPT One actions;

Clinical oversight/Audit of current internal waits & a system review to understand the drop in the number of patients accessing the service c.25% below expected levels

### ◆ Assurance:

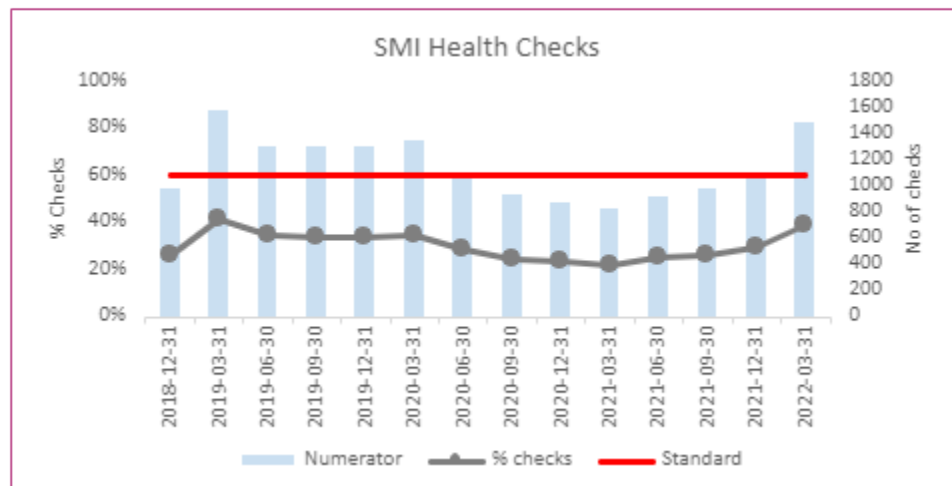
System Q&P committee & MH & LD partnership board





# Health Checks

## Metric Performance



- ◆ Percentage of people on the GP mental health register at the end of the quarter to have received health checks in the preceding 12 months
- ◆ Please note that there are not enough points of data to populate an SPC chart for this metric
- ◆ Data Quality completeness for the Health Checks is 88.3% for Quarter 4 2021-22. This is calculated by NHSE for 2020/21 and 2021/22, where the expected denominator is estimated from QoF and ONS population projections.

### ◆ Actions:

IT interoperability solution to support data flow from secondary care system (RIO) to Primary care (EMIS) approved and being tested to roll out July/August across all practices. Once in place this will enable greater visibility of where checks are taking place, and importantly to identify areas across PCNs where there is inequality of access & opportunities for improvement.

Additional devices have also been secured across general practices to assist with near-patient testing which gives much quicker test results and reduces the reliance on pathology tests via SaTH/other.

### Assurance:

System Q&P committee & MH & LD partnership board





# Shropshire, Telford & Wrekin

## Integrated Care System

### 2022/23 Month 2 - Integrated Finance Report

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# Month 2 System Overall Financial Summary

This report provides an overall summary of the key financial information for Month 2 for the Integrated Care System against the financial plan submitted in April.

A forecast position has not been provided due to the ongoing discussions around the full year plan submission. As part of the plan resubmission in June an opportunity will be taken to correct any phasing issues.

The current YTD position illustrates a £3.2m overall adverse variance to plan at Month 2.

FINANCIAL POSITION	YTD		
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000
Organisation			
<b>Commissioners</b>			
Shropshire, Telford and Wrekin CCG (STWCCG)	(3,064)	(2,621)	443
System Efficiency stretch target	1,667	0	(1,667)
<b>Total Commissioners</b>	<b>(1,397)</b>	<b>(2,621)</b>	<b>(1,224)</b>
<b>Providers</b>			
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(3,656)	(5,453)	(1,797)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(1,641)	(1,797)	(156)
Shropshire Community Healthcare NHS Trust (SCHT)	292	277	(15)
<b>Total Providers</b>	<b>(5,005)</b>	<b>(6,973)</b>	<b>(1,968)</b>
<b>TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)</b>	<b>(6,402)</b>	<b>(9,594)</b>	<b>(3,192)</b>



# Month 2- Financial Position by Organisation

## NHS Shropshire, Telford and Wrekin CCG

At Month 2 the CCG has a favourable position against plan of £0.4m YTD. However, the main reason for the favourable variance is due to prior year benefits released in Month 2 now that M12 21/22 data is available. These benefits are non recurrent and are offsetting significant overspends relating to acute independent sector activity (particularly ophthalmology) and Individual Commissioning. There remains significant risk for plan delivery in year.

## Shrewsbury and Telford Hospitals NHS Trust

At Month 2 SATH has an adverse position against plan of £1.8m YTD. This variance is mainly due to escalation areas remaining open due to COVID and staffing cost increases due to higher tier agency staff. Significant risk remains with regards to bringing the COVID overspend back in line with plan.

## Robert Jones and Agnes Hunt

At Month 2 RJAH has an adverse position against plan of £156k YTD. This variance is mainly driven by private patient income shortfalls (activity driven) and mental health agency support on the spinal injuries ward which is unfunded.

## Shropshire Community Health Trust

At Month 2 SCHAT has an adverse position against plan of £15k YTD. A small pay overspend is offset with an underspend in non pay.

## System stretch target

The system currently has a £2.9m unidentified BTI target and a further £5m stretch target to achieve to meet the plan submitted in April. The £5m was phased into the first 6 months of the year and therefore in M2 there is a target of £1.7m. This has not been achieved and is therefore contributing to the overall Month 2 adverse position. The phasing of the stretch target is being revisited as part of the June plan resubmission and we are currently forecasting that this will be delivered by year end through the development of system transformation programmes.



# Efficiencies

IDENTIFIED EFFICIENCIES		YTD	
Organisation	Plan £000	Actual £000	Variance to Plan £000
Shropshire, Telford and Wrekin CCG (STWCCG)	671	701	30
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	712	379	(333)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAHS)	274	277	3
Shropshire Community Healthcare NHS Trust (SCHT)	80	20	(60)
System BTI Efficiency offset with growth	634	634	0
<b>TOTAL SYSTEM</b>	<b>2,371</b>	<b>2,011</b>	<b>(360)</b>

At Month 2 the system overall is falling short of the M2 identified efficiency target by £0.4m.



# COVID-19 Expenditure

COVID EXPENDITURE	YTD		
Organisation	Plan £000	Actual £000	Variance to Plan £000
Shropshire, Telford and Wrekin CCG (STWCCG)	200	393	(193)
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	642	2,227	(1,585)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	177	199	(22)
Shropshire Community Healthcare NHS Trust (SCHT)	248	268	(20)
<b>TOTAL SYSTEM</b>	<b>1,267</b>	<b>3,087</b>	<b>(1,820)</b>

At Month 2 system COVID expenditure exceeds the plan by £1.8m.



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# Capital

CAPITAL PROGRAMME		YTD	
Organisation	Plan £000	Actual £000	Variance to Plan £000
Shropshire, Telford and Wrekin CCG (STWCCG)	0	0	0
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	1,876	315	1,561
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	1,461	738	723
Shropshire Community Healthcare NHS Trust (SCHT)	337	256	81
<b>TOTAL SYSTEM</b>	<b>3,674</b>	<b>1,309</b>	<b>2,365</b>

The System capital programme is currently £2.4m under plan, but this is expected to be recovered and plans are forecast to be fully spent in the year.





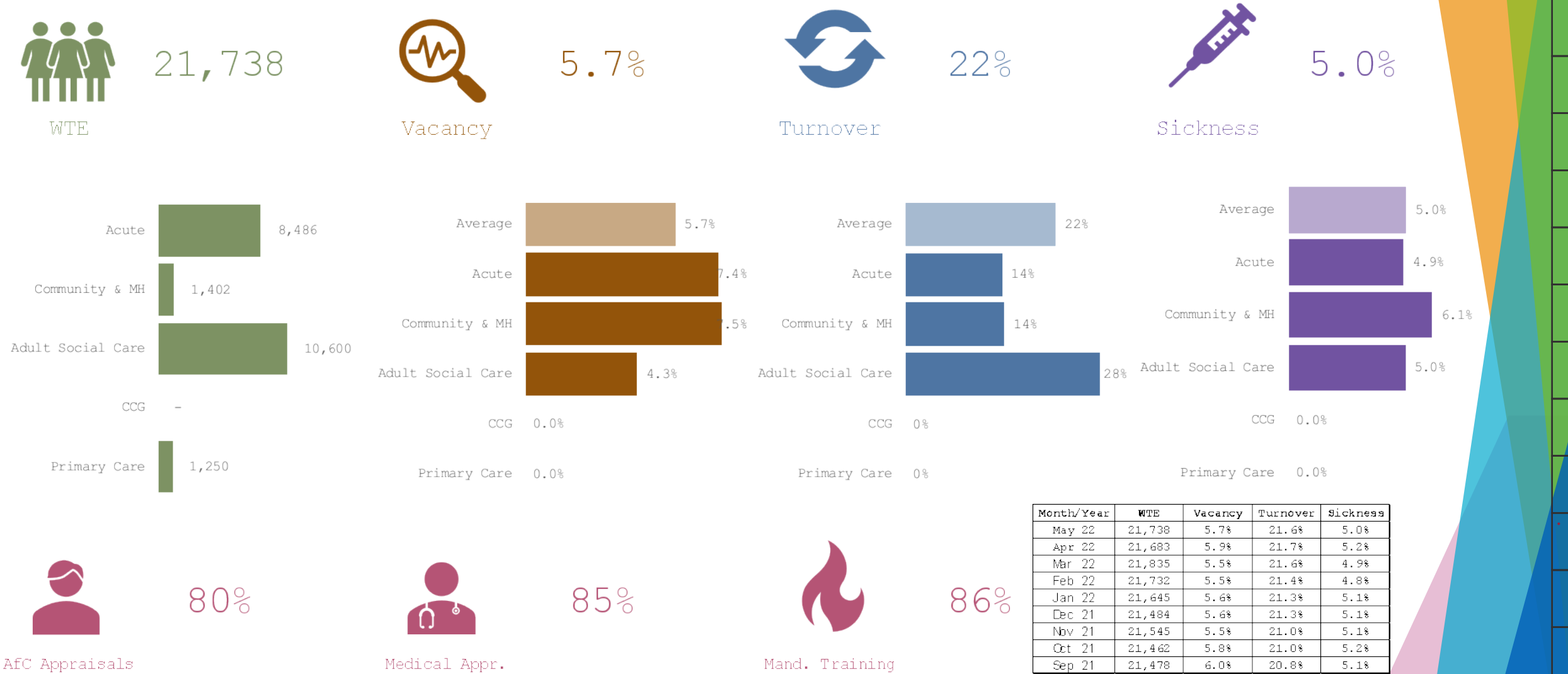
**Shropshire, Telford & Wrekin**  
Integrated Care System

## STW People Performance Report

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# ICS Workforce Dashboard – M02 May 2022





AfC Appraisals

80%



Medical Appr.

85%



Mand. Training

86%

Pillar	Theme	Outcome Measure	Indicator	Data Source	Data Period	System		SaTH		RJAH		SCHT	
Looking After Our People	Health & Wellbeing	Sickness Absence	Monthly Sickness Absence Rate	PWR	May 22	5.1%		4.9%		4.9%		6.1%	
Growing for the future	Workforce Capacity	Staff in Post (WTE)	Total	PWR	May 22	8,874		6,158		1,417		1,298	
			Registered Nursing & Midwifery	PWR	May 22	2,563		1,815		285		464	
			HCSW	PWR	May 22	1,157		843		170		143	
			GPs in Primary Care	NHS Digital	Apr 22	309							
		Vacancies (WTE)	Total	PWR	May 22	708		530		73		105	
			Registered Nursing & Midwifery	PWR	May 22	224		163		27		35	
			HCSW	PWR	May 22	91		76		12		3	
		Vacancy Rate %	Total	PWR	May 22	7.4%		7.9%		4.9%		7.5%	
			Registered Nursing & Midwifery	PWR	May 22	8.0%		8.2%		8.6%		7.0%	
			HCSW	PWR	May 22	7.3%		8.2%		6.7%		2.0%	
		Temporary Staffing	Bank WTE	PWR	May 22	615		487		56		72	
			Agency WTE	PWR	May 22	400		349		19		32	
			HCSW Bank WTE	PWR	May 22	207		169		22		17	
			HCSW Agency WTE	PWR	May 22	121		105		9		7	
	Retention	Turnover	In-month leavers rate	PWR	May 22	14.0%		14.9%		9.9%		14.3%	
			Leavers - All	PWR	May 22	1,241		916		140		186	

# ICS Workforce Dashboard – M02 May 2022

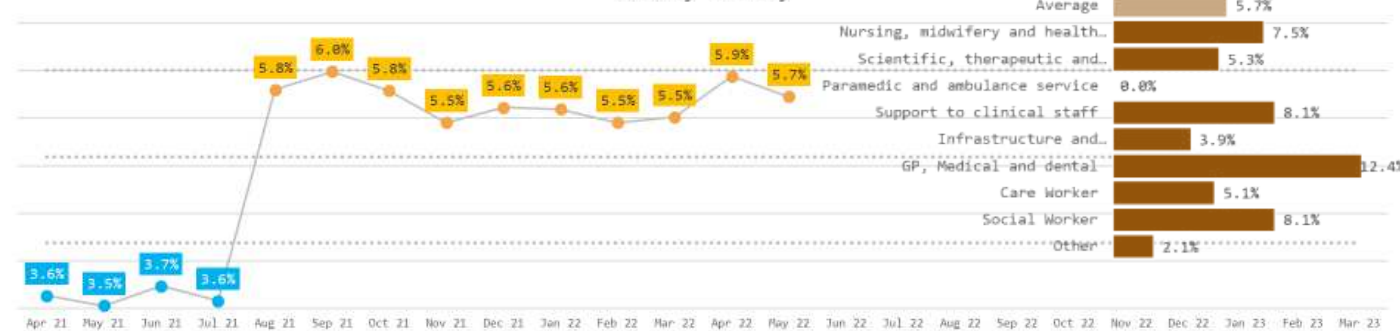
WTE History - Agency



## Agency WTE and Staff Group

- Steadily increased to end of FY but is falling this FY
- 45% of agency is for nursing & midwifery (increased)
- 30% of agency is for support to clinical (decreased)
- 18% of agency is for GP, medical & dental (increased)

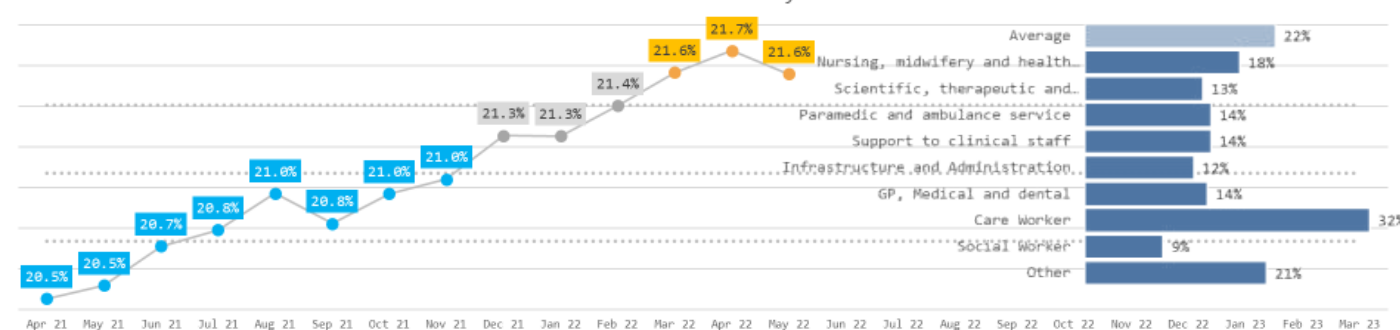
Vacancy History



## Vacancies

- SaTH continues to have the highest vacancy rate of 7.9%
- Vacancy rates have risen slightly this FY which will be partly due to new budgets
- Medical & dental 12.4% (increasing)
- Support to clinical staff 8.1% (slowly increasing)
- Nursing & midwifery 7.5% (decreasing)

Turnover History



## Turnover

- Turnover has slightly decreased from M1 to M2
- Highest turnover is care workers at 32%
- Nursing turnover is at 18% (steady increase from 15% in Apr 21)
- Remaining staff groups are at 12-14%

## 29-06.0013 – 22/23 NHS Operational Plan

Author:	Sam Tilley, Director of Planning and Urgent Care	Paper date:	22 June 2022						
ICS Board Member Sponsor:	Gareth Robinson ICB Director of Delivery & Transformation	Paper Category:	Strategy						
Paper Reviewed by:	N/A	Paper FOIA Status:	Full						
Action Required (please select):									
A=Approval	X	R=Ratification	X	S=Assurance		D=Discussion	X	I=Information	

### 1. Purpose of Paper

The purpose of the report is to update the Board on the re-submission of the Operational Plan and the emergency decision making process utilised to approve the submission due to the timescales the system was required to meet

The paper sets out the key elements of the plan that have been updated following NHS England (NHSE) feedback.

### 2. Executive Summary

#### 2.1. Context

As part of the NHSE national planning process a system operational plan was submitted on 28 April 2022. Feedback was received from NHSE and a decision was made nationally for a resubmission of all operational plans, to be completed 20 June 2022. This resubmission is the focus of this report.

As a result of the timing of the submission not coinciding with the sitting of the ICS Board the emergency decision making process under the ICB constitution was utilised to ensure approval of the plan before submission

The emergency decision was made on 17 June 2022. The following ICB members were present:

Sir Neil McKay	Chair
Simon Whitehouse	Interim ICB CEO Designate
Gareth Robinson	Executive ICB Director of Transformation and Delivery
Claire Skidmore	Chief Finance Officer

In attendance at the meeting were:

John Pepper	CCG Chair
Mark Brandreth	Interim CCG Accountable Officer
Geoff Braden	Lay Member for Governance
Sam Tilley	Director of Planning & Urgent Care
Julie Garside	Director of Performance

The information presented set out the key areas of the resubmission considered for approval, noting changes from April submission in the areas of:

- Activity and Performance;
- Workforce numbers;
- Finance

### 2.1.1 Activity

Feedback was provided by NHSEI relating to elective, cancer and diagnostic plans. The table below summarises the changes made into the 20<sup>th</sup> June submission

Planning assumption	Target	Submission		Comment
		28.4.22	20.6.22	
<b>Elective activity</b>	104% of 19/20 activity levels	102.3%	104%	See section 2.1.1a at base of table
<b>78 week waits</b>	0 by March 2023	508	458	Submission remains non-compliant. Delay to PRH elective hub contributes to this non-compliance
<b>62 day cancer</b>	Feb 2022 levels (173)	76	169	Position has deteriorated but remains compliant with planning assumption
<b>Faster diagnostic standard</b>	75% by March 2024	RJAH 77.8% SaTH 52.2%	RJAH 77.8% SaTH 57.0%	Key constraint: MRI capacity at SaTH
<b>Diagnostics</b>	120% of 19/20 levels	RJAH 104% SaTH 98.77%	No change	The delivery of diagnostics will not meet the target due to workforce shortfalls.

#### 2.1.1a. Elective activity target

The system has a clear plan to achieve 102.8%. The system has increased this position further to achieve the required 104% by committing to pursue a plan to enhance activity through use of the Independent Sector. This will require the commissioning of 100 day cases and 529 inpatient spells from the Independent Sector.

This effectively replaces the capacity lost as a result of the delay to the implementation of the PRH Elective Hub which had been a major component of the initial system plan for 22/23.

This final independent sector component of the plan is assessed as *having significant risk and is predicated on:*

- The availability of sufficient Independent Sector capacity. The system will work with all local providers across Wales, STW and the broader West Midlands to maximise this capacity
- The availability of sufficient numbers of patients willing to be transferred to this provider along with the availability of system resource to manage a resource-heavy process
- Additional financial resource being made available to support this course of action linked to the impact of the delay in the elective hub capacity that was out of the systems control

### 2.1.2 Workforce

Amendments have been made following the April 2022 submission to reflect a more accurate position. The amendments address:

- Negative pay growth
- Double counting - A number of areas had been included in both the 21/22 out-turn position and the 22/23 workforce plan
- Additional CIP measures relating to bank and agency, international recruitment and rota improvement

The numerical impact of these changes are:

- Nurse staffing levels at SaTH will increase from 2,086 wte in March 2022 to 2,132 wte by the end of 2022/23. The 2,132 wte was incorporated in the April submission as 2,172 wte
- Use of bank and agency at SaTH reduces by 70 wte
- Overall staff levels at SaTH reduce by 221 wte (7,454 to 7,233) which reduces growth from 6.5% to 3.4%

### 2.1.3 Finance

The previous system plan submission on 28<sup>th</sup> April delivered an in-year system plan carrying a £38.1m deficit (with a £69.3m underlying deficit).

The 20<sup>th</sup> June plan submission shows an overall in year system deficit plan of £19.0m (with a £61.0m underlying deficit).

There are a number of key movements to highlight:

#### Additional Allocation

- Additional recurring funding had been made available to systems to support increased costs due to pressures outside of System control of £9.1m with in additional costs of £1.6m resulting in an improvement to the overall position of £7.5m.



- Additional non-recurring regional allocation of £2.8m.

#### Change in Expenditure Assumptions

- Review of current expenditure at Month 2, review of SDF and the delay in the Elective Hub project has resulted in an improvement to the position of £1.5m.
- Review of the CHC uplift requirements has improved the position by £1.2m (although has added a corresponding value within the system's identified risks).
- The inclusion of an additional efficiency stretch of £6m, above the original stretch of £7.9m, (with a corresponding 75% of the value added to the system's identified risks

The total of the above changes results in a £19m improvement in the position within the 20<sup>th</sup> June submission compared to the submission on 28<sup>th</sup> April.

This position carries significant risk and the Board need to be aware of the challenges associated with the delivery of this position.

The system key planning assumptions included:

- No contingency
- No C19 costs June 22 onwards
- ERF income not clawed back,
- No further price inflation,
- Deliverability of workforce changes to (i) contribute to changing models of care and (ii) reduce premium cost of bank and agency,
- Significant step up in efficiency programme whilst handling operational pressures

Our plan assumes a post covid position (as directed by the national planning assumptions) when we continue to be challenged across our area. Urgent and emergency care pressures prevail, for which we have noted a particular risk around support to discharge post cessation of Hospital Discharge Funding (a national decision was taken to cease the provision of any additional national funding to support this).

The system has been frugal in inflation funding assumptions in the plan and therefore if costs do exceed the allocation (i.e. pay awards) then the system would be reliant on support to avoid deteriorating our position.

There is recognition that to reach our planned position some difficult decisions about investments that we deem to be of strategic importance have already been made. These include investments in our hospitals, community and mental health services (circa £23m). Whilst these do not pose an immediate financial risk as we are not currently investing, we do risk significant care and quality implications if these remain unaddressed longer term.

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## 2.2. Link to Pledges

The plan contributes to delivering the following pledges:

- Improving safety and quality
- Integrating services at place and neighbourhood level
- Tackling problems of ill health, health inequalities and access to health care
- Delivering improvements in mental health and learning disability/autism provision
- Leadership and governance
- Creating system sustainability
- Workforce

## 2.3. Conclusion and Recommendations

The outcome of the emergency decision making process on the 17 June 2022 was to approve the plan for submission to NHSE, noting the further work needed to implement the plan and to continue the focus on performance improvement

The Board is asked to ratify the submission, noting:

- The areas of non-compliance against the national planning guidance
- The specific risk attached to the delivery of activity levels at 104% of 19/20 levels and reliance on independent sector activity / additional funding
- The revised financial position and the associated assumptions to reach this point

The Board is further asked to:

- Comment on the system partner requirements to achieve the planning and financial submission as detailed and as shared with providers this week
- Ask each NHS Board to play a role in the monitoring and delivery of the stretch targets and move beyond the tracking the current individual provider plans
- Develop (over the next 2 weeks) a list of the areas where further difficult decisions (not a wish list) could be made to address the unmitigated risks contained in the plan
- Consider, at Board level, what else can be done to support the system improving its compliance with the planning guidance expectations – noting that, in the main, the targets are set in a way to support local people being able to access timely and high-quality healthcare in their local system
- Reinforce the need for a twin track approach that creates the capacity to focus on the delivery of some of the medium and longer term solutions –
  - Sustainable and high-quality GP services – tackling workforce, workload, estate and access issues
  - Delivery of the local care programme with resilient community-based teams wrapped around local communities and aligned with PCN footprints
  - Delivery of the Hospital Transformation Programme
  - Fundamentally different partnerships between health and local authorities to drive the prevention agenda and to start to work upstream



## Chair's Assurance Report Sustainability Committee – 23 May 2022

### 0. Reference Information

Author:	Gayle Murphy, Executive EA at RJA	Paper date:	29 June 2022
Executive Sponsor:	Frank Collins, Chair of the Sustainability Committee	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	Paper
Forum submitted to:	STW ICS Board	Paper FOIA Status:	Full

### 1. Purpose of Paper

#### 1.1. Why is this paper going to the Board and what input is required?

This paper presents an overview of the Sustainability Committee Meeting held on 23<sup>rd</sup> May 2022 and is provided for assurance purposes.

### 2. Executive Summary

#### 2.1 Summary

- The meeting was well attended
- The agenda items included:
  - 22/23 Budget and Next Steps
  - BTI Summary Update from May IDB
  - STW SOF4 Exit Criteria
  - Funding Request Submitted to NSHEI
  - Deep Dive – MSK
  - Deep Dive - Outpatients

#### 2.2. Conclusion

The Board is asked to *note* the meeting that took place and the assurances obtained.

## Chair's Assurance Report Sustainability Committee – 23 May 2022

### 3. Main Report

#### 3.1 Introduction

This report has been prepared to provide assurance to the Board from the Sustainability Committee which met on 23 May 2022. The meeting was quorate with 1 Non-Executive Director and 4 Chief Finance Officers present. A full list of the attendance is outlined below:

Chair/ Attendance:	
Frank Collins	Chair, External Advisor
Clive Deadman	Non-Executive Director, SaTH
Claire Skidmore	Chief Finance Officer, STW CCG
Clair Young	Deputy Director of Finance, SaTH
Sarah Lloyd	Director of Finance, SHT
Chris Sands	Director of Finance, MPFT
Gareth Robinson	Director of Transformation, STW CCG
Julie Garside	Director of Performance, STW CCG
Cllr Andy Burford	Telford Council Cabinet Member for Adult Social Care
Mark Brandreth	STW CCG Interim Accountable Officer
Simon Whitehouse	Interim ICB CEO Designate
Cherry West	Executive Chief Transformation Officer, UHB
Caroline Kurzeja	Improvement Director, NHSE/I
Jan Heath	Programme Manager, Midlands and Lancashire CSU
Tracy Hill	Workforce SRO, STW ICS
Nigel Lee (part)	Interim Director of Strategy and Partnerships/MSK Lead, SaTH
Apologies:	
Rachel Hardy, Peter Featherstone, Oliver Newbould, Claire Spencer, Geoff Braden, Steve Grange, Sam Tilley, Jonathan Rowe, Craig Macbeth, Nicky O'Connor, Martin Newsholme, Harmesh Darbhanga, Helen Troalen, Claudette Elliott, Kerry Robinson, Stacey Keegan and Debbie Nixon.	

#### 3.2 Actions from the Previous Meeting

Except for an amendment for accuracy within section 3.3, as requested by Clive Deadman, it was agreed that the minutes from the previous meeting were an accurate reflection of the meeting

It was noted that action 33 is ongoing with an extended due date of the end of July 2022 and action 37 has been superseded so therefore has been closed.

#### 3.3 Key Agenda

The Committee received the following items with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
3.0 System Sustainability		
3.1 22/23 Budget and Next Steps	Y	
A summary of key points were provided for the Committee and a slide showing the summary position of the planning		

## Chair's Assurance Report

### Sustainability Committee – 23 May 2022

<p>submission.</p> <p>The Chair asked what the next steps are for the new submission. CSK noted there are several actions in the period until 20th June; she added that she will look to a finalization of the position in early June and gain sign off before submitting.</p> <p>It was highlighted that a Committee member felt anxious as the risks have increased since the first plan. He felt conflicted between delivering the needs of regional/national requests and the reality on the ground.</p> <p>The Chair responded that such emotions are felt by many others across the System. However, as System leaders we have a duty to do all we can to deliver care within the financial allocation available. Unless or until the System can genuinely claim that it has reviewed every piece of expenditure and is confident that all activities are delivered as efficiently and effectively as possible, it is not credible to claim that we have done all we can. That said, he acknowledged the progress made in the last year and the remaining challenges.</p> <p>The Committee <i>noted</i> the report.</p>		
<b>4.0 BTI Updates and Deep dives</b>		
<p><b>4.1 BTI Summary Update from May IDB</b></p> <p>The report was presented to the Committee to provide assurance on the progress made on the Sustainability Transformation Programmes ('big-ticket items') and provide an overview of the Integrated Delivery Board which met in May.</p> <p>GR added the BTI oversight responsibility moves to him as of 1st June. He noted the huge amount of progress that has been made so far; he is coming into this post covid and post planning so the focus will be on the execution of programmes and making sure each organisation is signed up to the benefits that potentially are delivered, even if this is through other organisations. He added it is all about getting the figures sorted, signed off and moving forward with the delivery and expanding the figures.</p> <p>A Committee member asked for the inclusion of information against each BTI to show the benefits for the patient/user of the service. GR agreed and will include this going forwards.</p> <p>The Committee <i>noted</i> the report.</p>	Y	
<p><b>4.2 STW SOF4 Exit Criteria</b></p> <p>An update was provided for the Committee on the progress towards the SOF4 exit criteria. The Chair thanked CW for the insight into the process.</p> <p>The Committee <i>noted</i> the report.</p>	Y	

## Chair's Assurance Report

### Sustainability Committee – 23 May 2022

<b>4.3 Funding Request Submitted To NHSE/I</b>  A verbal update was given on the support funding request submitted to NHSE/I. It was noted that £540k of investment for this financial year has been awarded. A further 3 posts (total £280k) are pending approval by NHSEI once additional information has been received.  The Committee <i>noted</i> the report.	Y	
<b>4.4 Deep Dive – MSK</b>  A verbal update was provided for the Committee. The supporting slide deck is available for Committee members if required.  The Chair thanked NL for the succinct overview and commented he was particularly assured to see the governance structure in place and the obligation placed on the stakeholders to have their own internal systems that link in to the MSK programme board.  The Committee <i>noted</i> the report.	Y	
<b>4.5 Deep Dive – Outpatients</b>  A very comprehensive verbal update was provided for the Committee. The supporting slide deck is available for Committee members if required.  The Chair thanked JG for the focused overview and her candor around the risks of the programme.  The Committee <i>noted</i> the update.	Y	
<b>5.0 Any Other Business</b>		
The Committee members were asked to recognize the date of 1st July, when the ICB is established and the sub-committee structure changes. SW requested and it was agreed that the Chairs of the Strategy Committee and Delivery Committee should be invited to the June Sustainability meeting for continuity. He also proposed that there should be a discussion at the next Sustainability Committee meeting on the new Committee structure, post 1st July.  A discussion took place regarding the BTI discussions and the threads emerging - cash benefits, cash growth and productivity. It was noted by the Chair that productivity had been discussed during the meeting. He agreed that having some additional focus on the initiatives the System is looking at to enhance productivity would be a good idea, particularly to make this work more visible and transparent to System colleagues. An action was taken to initiate a productivity focus/strategy group.  Lastly, the Chair added the reconciliation of the numbers	Y	

## Chair's Assurance Report Sustainability Committee – 23 May 2022

was a challenge but it was important to CSK to provide a consistency in messaging and understanding.		
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### 3.4 Approvals

Approval Sought	Outcome
N/A	

### 3.5 Risks to be escalated

In the course of its business the Committee did not identify any risks to be escalated to the ICS Board.

### 3.6 Conclusion

The Board is asked to [note](#) the meeting that took place and the assurances obtained.