

# STW ICS Board v.1

MEETING  
27 April 2022 15:00

PUBLISHED  
22 April 2022

## AGENDA

<b>Meeting Title</b>	Shadow Integrated Care Board	<b>Date</b>	Wednesday 27 April 2022
<b>Chair</b>	Sir Neil McKay	<b>Time</b>	3:00pm
<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
27-04.001	Introduction and Apologies	Neil McKay	I	Verbal	3.00
27-04.002	ICS Chairs report	Neil McKay	I	Verbal	
27-04.003	Declarations of Interest	Neil McKay	S	Paper	
27-04.004	Minutes from the previous meeting held on 30th March 2022	Neil McKay	I	Paper	
27-04.005	Matters arising and action list from previous meetings	Neil McKay	I	Paper	
27-04.006	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>	Neil McKay	I	Verbal	3.20
27-04.007	Residents Story	Neil Carr	I	Verbal	3.25
27-04.008	Interim ICB CEO Designate update	Simon Whitehouse	I	Paper	3.35
27-04.009	Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust	Louise Barnett	I & D	Paper	3.45
27-04.010	System Planning and Finance Submission	Claire Skidmore Sam Tilley Julie Garside	S & D	Paper	4.00
27-04.011	<b>Pledge 6</b> Climate Change <ul style="list-style-type: none"> <li>ICS NHS Green Plan</li> </ul>	Andy Begley	A	Paper	4.15
27-04.012	<b>For Information Only (Issues or key points to be raised by exception with the Chairs of the Committees or report authors outside of the Shadow ICB meeting)</b>				
27-04.013	ICS Performance Update including vaccination progress and finance update	Julie Garside	S & I	Paper	
27-04.014	<b>Committee Reports</b> <ul style="list-style-type: none"> <li>Sustainability Committee Chairs Report for meeting held on 28 March 2022</li> </ul>	Frank Collins	S & I	Paper	
27-04.015	ICS Development Report (incorporated in the CEO report)	Nicky O'Connor	S & I	Paper	
27-04.016	Any other business	Neil McKay		Verbal	4.25
	Date and time of next meeting: <b>Wednesday 25<sup>th</sup> May – 3:00pm</b>				

**RESOLVE:** *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*

# Agenda

<i>Location</i>	<i>Date</i>	<i>Owner</i>	<i>Time</i>
Via Microsoft Teams	27/04/22		15:00
1. Welcome and Apologies		Neil McKay	15:00
2. ICS Chairs report		Neil McKay	
3. Declarations of Interest		Neil McKay	
4. Minutes from the previous meeting held on 30th March 2022		Nel McKay	
5. Matters arising and action list from previous meetings		Neil McKay	
6. Questions from Members of the Public		Neil McKay	15:20
7. Residents Story		Neil Carr	15:25
8. Interim ICB CEO Designate update		Simon Whitehouse	15:35
9. Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust		Louise Barnett	15:45
10. System Planning and Finance Submission		Claire Skidmore/Sam Tilley/Julie Garside	16:00
11. Pledge 6 Climate Change		Adrian Cooper/Will Nabih	
11.1. ICS NHS Green Plan			16:15

# Agenda

<i>Location</i>	<i>Date</i>	<i>Owner</i>	<i>Time</i>
Via Microsoft Teams	27/04/22		15:00

## 12. For Information Only

12.1. ICS Performance Update including vaccination progress and finance update

Julie Garside

### 12.2. Committee Reports

12.2.1. Sustainability Committee Chairs Report for meeting held on 28 March 2022

## 13. ICS Development Report (incorporated in the CEO report)

Nicky 'Connor

## 14. Any Other Business

Neil McKay

16:25

## 15. Date and time of next meeting; Wednesday 25th May - 3.00pm

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Contents

	<i>Page</i>
1. Welcome and Apologies	
2. ICS Chairs report	
3. Declarations of Interest	8
4. Minutes from the previous meeting held on 30th March 2022	10
5. Matters arising and action list from previous meetings	
6. Questions from Members of the Public	
7. Residents Story	
8. Interim ICB CEO Designate update	25
9. Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust	42
10. System Planning and Finance Submission	55
11. Pledge 6 Climate Change	79
11.1. ICS NHS Green Plan	79
12. For Information Only	126
12.1. ICS Performance Update including vaccination progress and finance update	126
12.2. Committee Reports	163
12.2.1. Sustainability Committee Chairs Report for meeting held on 28 March 2022	163
13. ICS Development Report (incorporated in the CEO report)	
14. Any Other Business	

# Contents

*Page*

15. Date and time of next meeting; Wednesday 25th May - 3.00pm

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

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

**Register of Interests - 10 March 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 Chief Executive, Shrewsbury & Telford Hospital NHS Trust	X			Direct	Chief Executive, Shrewsbury & Telford NHS Trust	Feb-20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			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 Chief Executive, Shropshire Council	X			Direct	Chief Executive, Shropshire Council	1.9.20	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Brandreth	Mark	Member, ICS Board Interim Accountable Officer - Shropshire, Telford and Wrekin CCG	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 RJAH 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
Carr	Neil	Member, ICS Board Chief Executive, Midlands Partnership NHS Foundation Trust	X			Direct	Chief Executive, Midlands Partnership NHS Foundation Trust	22.2.22	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
Chan	Ian	Member, ICS Board	X			Direct	GP Partner, Teldoc	5.4.17	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
				X		Direct	Telford & Wrekin Locality Chair	1.7.20	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
				X		Direct	Place based care clinical lead	1.8.20	ongoing	22.2.22	Level 1 - Note on Register
			X			Direct	Teldoc PCN Clinical director	1.7.19	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Acupuncturist	10.9.19	ongoing	22.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			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
Davies	Patricia	Member, ICS Board Chief Executive, Shropshire Community Health NHS Trust	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
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
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
			X			Direct	Director of Neil McKay Associates Ltd	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Indirect	Wife Director of Neil McKay Associates	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Associate with GE Healthcare	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			X			Direct	Associate with PA Consulting	17.2.22	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			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 Chair, Shrewsbury & Telford Hospital NHS Trust	X			Direct	Chair, Shrewsbury & Telford Hospital NHS Trust	2020	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
			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
			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, providing 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
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
Pepper	John	Member, ICS Board Chair, NHS Shropshire, Telford and Wrekin CCG	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
			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
			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
			X			Direct	NHS England GP Appraiser	19.1.21	ongoing	17.2.22	Level 2 - Restrict involvement in any relevant commissioning decisions
					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.
Sidaway	David	Member, ICS Board Chief Executive, Telford and Wrekin Council	X			Direct	Chief Executive, Telford and Wrekin Council	To be advised	ongoing	To be advised	Level 2 - Restrict involvement in any relevant commissioning decisions
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
					X	Direct	Chair, Dudley Integrated Care NHS Trust	Jul-19	ongoing	8.2.22	Level 1 - Note on Register
					X	Direct	Presiding Justice, West Mercia Judiciary	Oct-06	ongoing	8.2.22	Level 1 - Note on Register
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 - 10 March 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		
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	Bary	Attendee, ICS Board					Chair, Healthwatch Telford and Wrekin	23.2.22	ongoing	23.2.22	Level 1 - Note on Register
		Chair, Healthwatch Telford and Wrekin					Councillor, Great Dawley Town Council	23.2.22	ongoing	23.2.22	Level 1 - Note on Register
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		23.2.22	ongoing	23.2.22	Level 1 - Note on Register
Riley	Catherine	Attendee, ICS Board  SRO for Mental Health, Learning Difficulties & Autism	X			Direct	Managing Director, Midlands Partnership NHS Foundation Trust	Jun-18	ongoing	18.2.22	Level 1 - Note on Register

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
9

**STW ICS BOARD**  
**30 MARCH 2022 - 3PM**  
**MINUTES OF MEETING**

**Present:**

Sir Neil McKay	Chair STW ICS Board
Simon Whitehouse	Interim ICB CEO Designate STW ICS
Dr John Pepper	Chair NHS Shropshire, Telford and Wrekin CCG (STW CCG)
Mark Brandreth	Interim AO of STW CCG
Nuala O'Kane	Chair Shropshire Community Health NHS Trust
Patricia Davies	Chief Executive Shropshire Community Health NHS Trust.
Harry Turner	Chair Robert Jones and Agnes Hunt Foundation Trust
Stacey Lea-Keegan	Interim Chief Executive Robert Jones and Agnes Hunt Hospital NHS Foundation Trust
Andy Begley	Chief Executive, Shropshire Council
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
Dr Ian Chan	Primary Care Network Clinical Director

**In Attendance**

Nicky OConnor	ICS Programme Director- STW ICS
Cathy Riley	Managing Director, Midlands Partnership NHS Foundation Trust
Cherry West	Executive Lead for the UHB-SaTH-NHSEI Improvement Alliance and Improvement Director SaTH
Frank Collins	Chair ICS Sustainability Committee STW ICS
Claire Skidmore	Executive Director of Finance STW CCG
Meredith Vivian	Deputy Chair/Lay Member, Patient and Public Involvement STW CCG
Julie Garside	Director of Performance STW CCG
Sam Tilley	Director of Planning STW CGG
Zena Young	Executive Director of Nursing and Quality STW CCG
Terry Gee	Chief Officer STAY Telford
Heather Osborne	Chief Officer AGE UK
Lynn Cawley	Chief Officer Healthwatch Shropshire
Barry Parnaby	Chair Healthwatch Telford and Wrekin
Jonathan Rowe	Director of Adult Social Care, Telford and Wrekin Council
Fran Steele	Director Strategic Transformation NHSE/I
Georgina Groom	Senior Digital Communications Officer STW ICS
Jayne Knott	ICS Programme Support

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## Apologies:

Edna Boampong	Director of Communications and Engagement STW ICS
Dr Ian Rummens	Shropshire Local Medical Committee
Dr Catriona McMahon	Vice Chair STW ICS and Chair Shrewsbury and Telford Hospital NHS Trust
Louise Barnett	Chief Executive Shrewsbury and Telford Hospital NHS Trust
Alison Smith	Director of Corporate Affairs STW CCG

Minute No	Title
30/03/1.0	<p><b>Introduction and Apologies</b> Apologies were noted as outlined above.</p> <p>The Chair welcomed everyone and commented that this Board was the final meeting as the originally constituted ICS Partnership Board. From 1<sup>st</sup> April, the new Integrated Care Board will commence in shadow form.</p> <p>He reminded Board members that this was a meeting held in public.</p>
30/03/2.0	<p><b>ICS Chairs report</b></p> <ul style="list-style-type: none"> <li><i>To note the publication of the 2nd Ockenden report with full discussion scheduled for April ICB.</i></li> </ul> <p>The Chair commented that today was a sombre day for those involved in the work of the Shropshire and Telford and Wrekin Integrated Care System as today saw the publication of the second and final report by Donna Ockenden about Maternity services in Shrewsbury and Telford Hospital. In the report she talks about findings, conclusions, and essential actions for the trust, the system and national bodies</p> <p>Arrangements for discussing the detail will be set out in the very near future. The Boards of SaTH and the CCG, will be focusing on the content of the report and carefully considering its implications.</p> <p>The Integrated Care Board will become a legal entity from the 1July and will have responsibilities as the successor to the CCG but also as a system oversight Board to make sure that all that needs to be done to respond to Donna Ockenden's concerns are dealt with as expeditiously as possible.</p> <p>Detailed discussions will take place at the ICS Board in April.</p> <p>The Chair stated he had the utmost admiration for the courage and the determination shown by the families of people who have experienced poor care from our maternity services. Their courage in bringing forward their concerns and speaking so openly about the issues they have had to address is to be commended</p> <p>As an NHS leader, he regreted and apologised for the harm that people have suffered.</p> <p>The Chair wanted to make it publicly known his determination to lead with colleagues in SaTH and the CCG and others in the system, the necessary response to create the safest possible services for maternity care that we possibly can. He was pleased that there are signs of improvement, which are reflected in the Donna Ockenden report. The CQC acknowledged and recognised improvements when they visited at the end of last year.</p>

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

	<p>Mrs Lynn Cawley wanted to encourage the ICS to explain to the public how the movement from CCG to ICS will work as one of the key points in the report is around organisational and system memory. We need to be able to demonstrate that people have been on this journey and that those same people are going to take it through to when we start seeing the response to this current report.</p> <p>Mr Harry Turner commented that Robert Jones and Agnes Hunt FT were ready to support SaTH on their improvement journey.</p> <p>The Chair agreed that the system should give the trust as much support as possible to manage the changes that are necessary.</p> <p>The Chair then turned to other pressures in the system and noted that Covid continues to create huge operational pressures across the whole of the system.</p> <p>Ambulance handover issues continue to be a concern both locally and these nationally as a key part of the urgent care pathway is at risk.</p> <p>The Chair then referenced the Hospital Transformation Program. The SaTH team supported by people within the CCG, the ICS and others are working to draw together the strategic outline case for the capital investment needed to implement the conclusions of the Future Fit consultation</p> <p>There was an exchange of correspondence between the Secretary of State and Mr Mark Brandreth setting out Mr Brandreth's response supported by SaTH setting up the way services can be distributed, but making it clear there is still a lot of detail to be provided.</p> <p>The Board will be briefed in April about the Strategic Outline Case which will need approval through the Boards of SaTH and the CCG before it is submitted at the end of April.</p> <p>Negotiations will then take place with national bodies about the capital needed to enable us to proceed.</p>
30/03/3.0	<p><b>Declarations of Interest</b></p> <p>Ms Fran Steele to send her Declaration of Interest form in for noting. She stated that there was nothing to declare.</p>
30/03/4.0	<p><b>Minutes and Actions from Previous Meeting – 26/01/2022</b></p> <p>Minutes of the last meeting were approved as a true and accurate record.</p>
30/03/5.0	<p><b>Matters arising and action list from previous meetings</b></p> <p>Outstanding actions will be discussed later today's agenda.</p>
30/03/6.0	<p><b>Questions from Members of the Public</b></p> <p>No questions submitted this month.</p>
30/03/7.0	<p><b>Resident's story/experience</b></p> <p>Mr Simon Whitehouse introduced the video:</p> <p>This month's story is Clive's story who describes his experiences with local services. Clive, who is a veteran, describes his diagnosis and support with his</p>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

	<p>early onset of dementia, he covers the memory service, GP annual review and diminished self-help groups.</p> <p>Mr Simon Whitehouse commented that his view was the Board should not just be getting the good news stories when everything has gone well, we should hear about the times where the services are not connected and are not as joined up.</p> <p>It is our responsibility to be thinking about how we make sure that we plan and develop services around the residents that we serve at rather than services that meet the needs of our staff or our organisations and our financial plans. There is a challenge about that connected nature of service provision which is stated clearly from a local resident.</p> <p>Mrs Heather Osborne asked if there were any plans for Shropshire to have Admiral nurses as this service would help join up and support people through their journey.</p> <p>Mrs Lynn Cawley commented that it felt like the system is waiting for there to be a crisis. There needs to be more investment in support for people and their families around dementia.</p> <p>Mrs Cathy Riley mentioned that there is a Transformation program about to start in June, and involvement and engagement will be key to that, linking in the different parts of provision that happen at the moment the Admiral nurses, the memory clinic, the GPs, voluntary sector and Alzheimer's Society.</p> <p>Dr John Pepper commented that wherever our public are seen within our system, that those people have to be seen as individuals, listened to as individuals and respected in that way and that their care is tailored to what that individual's needs are, as these vary from person to person. We need to focus on restoring services that are no longer visible due to Covid.</p> <p>Dr Ian Chan said that there are many dots to join up for this piece of work, and many other aspects of local health that are similar to this needs to join up. We need to make sure that what we do together is seamless, effective and avoiding duplication.</p> <p>Mrs Lynn Cawley responding by saying that our system is not set up to work with people who do not want to acknowledge that they have got dementia. How do you support families and carers when the person with dementia is refusing care, but is needed by the wider families?</p> <p>The Chair asked where in our arrangements for programme management dementia sits, and who is leading that work for improving dementia care?</p> <p>Mr Simon Whitehouse responded with Midlands Partnership NHS Foundation Trust is leading but involves all partners and sits within the wider mental health transformation work across Shropshire, Telford, and Wrekin.</p> <p><b>The Board noted the presentation.</b></p>
--	---

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

30/03/8.0

## **Interim ICB CEO Designate update**

Mr Simon Whitehouse highlighted the following

Shropshire County Council have received the Ofsted good rating for children services.

The Quarterly System Review meeting was held on 24 February that recognised the pressures on the urgent emergency care system, and some of the progress being made in a number of areas. Feedback letter received and will be circulated to this Board.

[Mrs Jayne Knott to circulate QSRM feedback letter with the minutes of today's Board meeting.](#)

He recognised the work and effort that has been done for the NHS planning and finance submissions that are due this week, and include both Local Authorities, Healthwatch and the Voluntary sector.,

Mr Whitehouse wanted to thank colleagues who were involved with the recruitment process for the Non-Executives and for the Executive Directors:

### **Executive Directors**

- Chief Finance Officer - Mrs Claire Skidmore
- Chief Medical Officer – Mr Nick White
- Director of Delivery Transformation – Mr Gareth Robinson
- Director of Strategy and Integration - Ms Nicola Dymond.

### **Non-Executive Directors:**

- Chair of Digital Committee - Dr Niti Pall
- Chair of Audit Committee – Mr Roger Dunshea
- Chair of Remuneration Committee – Professor Trevor McMillan

Mr. Whitehouse noted that the system has been successful in accessing some of the national funding to support the elective hub.

He also commented on positive feedback from Professor Tim Briggs after the national visit from the Getting it Right First Time (GIRFT) team, this is the national program designed to look at variation in clinical pathways and does in depth reviews of the benchmarking and a data driven evidence approach.

Dr John Pepper asked if there were any areas of weakness in the feedback from GIRFT.

Mrs Julie Garside responded by saying that the two specialties acknowledged as areas for improvement are Gynecology and Urology.

Urology - we are aware of the local and national workforce challenges.

There are some surgical practices where we can do better, the regional team have offered to support our local system and our local clinical leads

Mr Nigel Lee highlighted that our joint orthopaedic teams presented a very integrated and joined up picture about what has happened over the last 18 months during the pandemic and what the plans are going forward.

[Mrs Garside to share feedback letter from Professor Tim Briggs once received.](#)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

Mr Whitehouse commented that Mr Frank Collins as Chair of the Sustainability Committee and members have asked for more detail on the national benchmarking.

Mr Whitehouse with GP colleagues and other partner colleagues launched the Men's Health forum on 17 March.

Ms Nicky OConnor presented the following:

- **System Development Plan**

The System Development plan will be circulated once finalised.

To be submitted to regional colleagues by close of play 31 March

Progress in areas includes our population health position, reference to the 22/23 operational plan, governance and leadership structures, and outline draft plans around data and digital.

[Ms OConnor will update at next Board any feedback received.](#)

- **Readiness to Operate update**

This is a gateway assessment on our progress around becoming a statutory Integrated Care System. The ROS will be submitted to the regional team on 31 March, with a final submission on 20 May.

Some areas of our governance are being worked on further to progress for the May submission including Committee terms of reference, standing financial instructions and scheme of delegation which, we are waiting for further legislation to come through. But good progress being made.

Ms Fran Steele commented that there were no issues to raise at this point and the work between the regional team and Ms OConnor and her team has been a very positive relationship in terms of developing this plan.

- **Governance report**

Mr Whitehouse highlighted the following:

At the last Development session some time was spent looking at priorities and discussing what the governance structure would look like for the Integrated Care Board and what the sub-committee structure would start to look like and how to populate it.

We are going through the process of finalising the Constitution for the Integrated Care Board that will enable us to receive the establishment order once the legislation passed. This will mean we become a statutory organization on 1 July.

In the Constitution we must set out the membership of the Integrated Care Board and set out our governance structure and how we will make decisions.

The paper clarifies from the 1 July the voting members and other members of the board e.g., attendees and puts them into the groups that the national legislation articulates.

The paper sets out the proposed meeting schedule, recognising that there will be a first meeting that must be held on 1 July to deliver the establishment of the statutory organisation and sets out a proposed program of formal and development sessions. It also suggests that no meetings will be held in August and December, due to main holiday periods and pressures in the system.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

	<p>Strategy, Delivery and Assurance are the three strands of governance that we will form our governance in future and build our subcommittee structure around.</p> <p>Mr Harry Turner asked when the structure would be finalised so any changes can be considered.</p> <p>Mr Whitehouse's responded that the intention will be the next three months, but they cannot take formal responsibility because the CCG will continue with statutory responsibility until 30<sup>th</sup> June.</p> <p>Mr Turner raised a concern that there was no mention of workforce in the assurance part of the paper.</p> <p>Mr Whitehouse replied that the system People Committee sits on the strategy side of governance and currently the Quality and Performance committee assure a number of the workforce and people plan measures through into their work plan. We want to work with the chairs of the two committees to connect those across from the strategy side to the assurance side to make sure that we have got A grip on workforce, as workforce is one of our biggest challenges.</p> <p>Ms OConnor explained to the Chair that there was a small steering group to oversee the setup of the Integrated Care Partnership (ICP) with the second meeting of this group scheduled for 31 March, so an update on the ICP will prepared for the next Board in April. We continue to develop our place-based arrangements and proposals to extend this work will be brought to this Board in April/May.</p> <p><a href="#">Ms OConnor to update on the Integrated Care Partnership at April's Board</a></p> <p>The Board is asked to agree to the membership constitution aspects of the plans.</p> <p>To agree the committee structures which are included in this paper.</p> <p>To comment, agree or disagree with the suggestions about the frequency of meetings and way the meetings are managed going forward from the start of the ICB.</p> <p><b>The Board agreed and noted the papers.</b></p>
30/03/9.0	<p><b>Pledge 9: Creating System Sustainability and System Finance Plan 2022/23</b></p> <p>Mrs Claire Skidmore presented the System Finance Plan 22/23 and highlighted the following:</p> <ul style="list-style-type: none"> <li>• We have drafted a financial position for the system and a draft finance plan for the year.</li> <li>• The numbers are in draft and not in the public domain yet.</li> <li>• It is important that these numbers are considered, improved upon and refined before we get to our point of final submission.</li> <li>• We have posted an initial draft that delivers a deficit position for the system, which is out of line with the national requirement to break even.</li> <li>• We recognise as a system that this position is not acceptable.</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- We have made commitments to our financial recovery program and to regain our financial balance for the system.
- Meetings and discussions have been held with further meetings to be scheduled to test the assumptions and propositions that have been put into the modelling so far and to be clear about what they deliver for our population.
- Things to highlight for the Boards attention are some of the forums and the conversations that we have pulled together, which are a testament to the work happening collectively as a system that is standing us in good stead for these difficult conversations.
- In depth discussions have taken place at the Sustainability Committee, that involves several of our non-executives from across the system.
- A finance summit was held earlier this week which Sir Neil McKay chaired including most of the system Chief Executives and Directors of Finance to set the scene for the work that we need to do and the difficult decisions we need to make over the next few weeks.
- A series of system to organisation challenge meetings to take place over the next week to start to refine the presentation of the numbers that we have.
- Good input from both local authorities and MPFT.

Mr Frank Collins commented that

- We had made significant progress working collectively in the past 12 months and have been able to demonstrate that we have a stabilised financial position.
- He felt there was organisational fatigue around the challenges of continuing to work on a sustainable financial model.
- There is a collective desire in all of the agencies, both health and local authority, and across the trust and the CCG to deliver on the expectations and the requirements for the next 12 months and beyond.
- The challenge is significant, and there is still a big gap.

Mrs Skidmore commented that the deadline for the final submission to NHSEI of the plan numbers, including the activity plan, the workforce plan and the narrative was 28 April. A series of checkpoints are scheduled in for April that will take scrutiny of all those elements through various parts of our governance both in individually as organisations, and through the system.

[Review will be done through Chief Executives meeting and Sustainability committee and Mrs Skidmore will update this Board in April.](#)

Mr Harry Turner asked:

- As we discuss the difficult decisions, have we got an aligned risk appetite across the system, is the provider risk appetite the same as the system risk appetite? If not, this will cause a challenge.

*Mrs Skidmore responded with - We are continuing to pursue this.*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

	<ul style="list-style-type: none"> <li>• Will there be a robust QA process as we go through the decision making? <i>We have individual organisation agreement for a business case system agreement, through recommendation by the Investment panel and NHS England support</i></li> <li>• As decisions emerge will we hold a risk register on those emerging decisions so we can be clear of the impact on the system and individual providers and code dependencies between providers? <i>Mrs Skidmore to discuss with Ms Nuala O’Kane to see how to link what is happening around some of the investment and sustainability work with what is happening around some of the assurance processes we have got in our Audit Committee for the system.</i></li> </ul> <p>Mr Roger Dunshea is one of our new Non-Executive Directors and will be chairing Audit Committee and has great expertise in previous NHS bodies in this area.</p> <p>Dr Ian Chan and Dr John Pepper both commented that the focus should be on our transformative work, rather than cutting, adequately resource and staff the transforming work recognising the impact of workforce in delivering that through the recent Covid crisis.</p> <p>Mr Meredith Vivian commented that we need to build in meaningful engagement with our population including our patients and service users in a comprehensive, systematic way.</p> <p>Mr Andy Begley mentioned that the financial pressures that local authorities are under are significant and increasing year on year. We need to continually talk about a system, where do we need to invest in a system so that we can stop people becoming patients? There are a lot of opportunities so that we can start to avoid unnecessary demand and make some of those stop decisions.</p> <p><i>Mrs Skidmore to bring a briefing to the next Board on: How we include the risk arrangements, the quality, and other impact assessment approaches. The timeliness of decisions and making sure that we have got the right people involved in the right place to encourage those things to emerge.</i></p>	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.
30/03/010	<p><b>Pledge 1. Improving Safety and Quality – revision of Pledge 1</b></p> <p>Mrs Zena Young presented the item and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The last update of the Quality paper was at this Board in October 2021.</li> <li>• It was identified at October’s Board that pledge 1 needed a refresh which has now been completed following engagement with quality and performance committee for the system.</li> <li>• Section one: describes the changes that helps us to focus more specifically on what we are trying to achieve with pledge one and updates it in terms of the terminology we use.</li> <li>• Section two: provides some updates in terms of our progress with quality governance.</li> <li>• Appendix one: details a road map which identifies a significant amount of work some of which has already been undertaken.</li> <li>• Pledge one includes a reference to elective procedures.</li> </ul>	11. 12. 13. 14. 15.

	<ul style="list-style-type: none"> <li>• Reference to the improvements at Shrewsbury and Telford Hospital because of the CQC inspection.</li> <li>• Significantly reduced number of regulatory notices at SaTH, Mrs Young paid tribute to all those involved.</li> <li>• Good progress continues to be made in delivering the recommendations arising from the first Ockenden report; as of March 2022, over 80% of actions are completed, a small number are off track or not started due to interdependencies at regional and/or national level.</li> <li>• Work is being undertaken to instigate a peer review process. Regional team are leading the visit with the LMS and ICS supporting with the providers and Maternity voices partnership team.</li> </ul> <p>It was noted that the Ockenden recommendations for everything that is directly attributable to SaTH has been implemented. Other recommendations are being worked on with colleagues outside of the system.</p> <p>Mrs Young commented that part of the Peer review was get to the bottom of assurance rather than reassurance.</p> <p>The Chair raised concerns around the timing of changing the wording of Pledge one:</p> <ul style="list-style-type: none"> <li>• There is no mechanism for refreshing all the pledges yet</li> <li>• We need to think about the implications of the other pledges when rewording pledge one.</li> <li>• Do we think there is a different framing of the pledge that we want to introduce the discussion around Ockenden?</li> </ul> <p>The Board agreed to defer the rewording of the pledge until a more appropriate time.</p> <p><b>The Board noted the paper</b></p>
30-03.011	<p><b>ICS Performance Update including vaccination progress and finance update</b></p> <p>Mrs Julie Garside presented the paper and highlighted the following:</p> <ul style="list-style-type: none"> <li>• STW remains a challenged system and is the bottom quartile of the region for its urgent care performance, this in turn is impacting upon the ability to respond to 999 calls promptly due to Ambulance waits.</li> <li>• With continued pressure resulting from managing the pandemic and winter pressures, cancer performance has started to see a decline.</li> <li>• Elective care is facing similar challenges, the system is working hard to maximise its delivery in H2 and with the use of additional independent sector capacity and third-party insourcing to improve its elective rate of recovery.</li> <li>• Despite this, STW is one of the few systems regionally to be forecasting its number of long waiters &gt;104wks at the end of March to be below that originally planned in October. This is a great achievement and for our providers who have worked incredibly hard, in very challenging circumstances, to get our patients treated.</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- Further progress has been made with placed based metrics; TWIPP and SHIPP now have internal operating dashboards that reflect both local and national targets, with system level key metrics and reporting in final stages of development.

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.

The Chair asked for a separate meeting to be arranged to discuss numbers, to include Mrs Garside and others.

Mr Frank Colins highlighted the following:

- Two recommendations coming through to the Sustainability Committee from the Chief Executive Group and NHSEI colleagues have been approved: -
  - Two financial commitments for FY24, around the vaccination programme and the pillar one testing programmes. The Chief Executives support the resource consequences should we not get the funding.
  - Sustainability Committee was asked in the absence of the investment board to act as the approving forum for that and the recommendations of the CEO Forum and the Directors of Finance Forum were accepted.
- The Terms of reference of committees need to be updated to reflect the expectations being placed upon those committees.

**Mrs Sam Tilley presented slides on Ambulance Handovers and highlighted the following:**

- STW System continues to see long ambulance handover delays at both acute hospital sites.
- Significant backdrop of Covid within the county. High prevalence rates within the Community and unprecedented staff sickness levels.
- Significant numbers of care homes that are also tackling Covid outbreaks and are
- therefore, closed to admissions, creating a challenging situation on the impact on flow.
- This issue is across all our system, all our providers, which are all struggling with staffing issues.
- Activity in A&E is still rising, which is impacting on the ambulance position.
- System Silver and Gold arrangements are still in place and managing this in incident mode with full oversight from the system.

A vast range of work ongoing to try and tackle this situation.

- Implementation of a single point of access, involving ShropDoc colleagues as the point where clinical referrers can seek advice of alternatives to A&E, due to the success of this it has been extended for a further 12 months.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

	<ul style="list-style-type: none"> <li>• Over 90% of referrals that come through that route are being diverted away from A&amp;E.</li> <li>• The system is working together around staffing mutual aid.</li> <li>• Looking at IPC issues daily as a system, drawing in partners from the local authority, the CCG and other organisations to apply their IPC expertise.</li> <li>• Regular communications being sent out to residents to keep them informed of the situation and to advise them about where they can seek treatment from alternatives to A&amp;E.</li> <li>• Continuing to roll out the two-hour Community response this helps to divert activity before it gets too A&amp;E.</li> <li>• Developing Direct Access pathways.</li> <li>• Looking how to develop the cohorting spaces within SaTH.</li> <li>• Local authorities have been supportive, with purchasing additional bed capacity in the community and enhancing domiciliary care.</li> <li>• There is regular performance monitoring through the UEC group and board, CCG Committees and other providers through their governance routes and the ICS Board.</li> <li>• Agreed a set of improvement trajectories go through the urgent care improvement plan, this is in the process of being refreshed, followed by a refreshed set of improvement trajectories for the coming year.</li> </ul> <p><b>The Board noted the presentation</b></p>
30-03.012	<p><b>Committee Reports</b></p> <p>The Board noted that the Quality and Performance committee is going to run together as a joint committee with the CCG Quality Performance Committee over the next two or three months.</p> <p><b>The committee reports were noted by the Board</b></p>
	<p>The Chair thanked everyone for their on-going contributions and suggested that a message of gratitude was sent out to all our staff who are doing a magnificent job under very difficult circumstances.</p> <p>He went on to say that the next meeting would be moved into a slightly different mode of operation with a shadow board, which would be similar to the board subject to legislation and will be running from the 1 July, with the membership being slightly different.</p> <p><b>The Meeting closed at 17:15hrs</b></p> <p><b>The next meeting is scheduled for 27 April 2022 at 3pm</b></p>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## Action Log – Open

Date & Ref No	Action	Owner	Date Due	Update	Completed date
<b>26/01/2022</b>					
26/01/22.0.7	Mr Whitehouse to discuss with Mrs Tilley and colleagues about the processes to go through and contributions from this Board towards the development of our plans and build into the timeline	SW ST	23/2/22		
26/01/22.0.8	Mr Whitehouse and Mrs Barnett to meet and discuss HTP and bring update back next month.	SW LB	23/2/22		
<b>30/03/2022</b>					
30/03/22.0.8	<ul style="list-style-type: none"> <li>Mrs Jayne Knott to circulate QSRM feedback letter with the minutes of today's Board meeting.</li> <li>GIRFT visit - Mrs Julie Garside to share feedback letter from Professor Tim Briggs once received.</li> <li>System Development plan - Ms Nicky OConnor will update at next Board any feedback received.</li> <li>Ms OConnor to update on the Integrated Care Partnership at April's Board.</li> </ul>	JK  JG  NOc	27/04/22		
30/03/22.009	<p>System Finance Plan 2022/23 - Review will be done through Chief Executives meeting and Sustainability committee and Mrs Claire Skidmore will update this Board in April.</p> <p>Mrs Skidmore to bring a briefing to the next Board on:</p> <ul style="list-style-type: none"> <li>How we include the risk arrangements, the quality, and other impact assessment approaches.</li> <li>The timeliness of decisions and making sure that we have got the right people involved in the right place to encourage those things to emerge.</li> </ul>	CS	27/04/22		
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			

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

	The Chair asked for a meeting to be arranged to discuss numbers, to include Mrs Garside and others.	JK			Complete 5/4/22
--	---	----	--	--	--------------------

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

**Decision Log**

Ref	Discussion	Decision
30/03/2022		

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

STW ICS Board
 

---

<b>Author:</b>	<b>Nicky O'Connor</b> ICS Programme Director <b>Alison Smith</b> Director of Corporate Affairs <b>Edna Boampong</b> Director of Communications and Engagement <b>Claire Parker</b> ICB CFO Designate <b>Roz Lindridge</b> Regional Director of Commissioning <b>Tracy Hill</b> – HR Director	<b>Paper date:</b>	22 April 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 checked="" 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

---

1.1 This report provides a progress report on ICS transition in nine parts:

- A. Update – ICS Partner Staff Survey Results Summary
- B. Update – System Oversight Framework – level 4 (SOF4) Stocktake Meeting
- C. Update - Urgent Care
- D. ICS transition - update to the Readiness to Operate Statement (ROS)
- E. ICS transition – Finance overview
- F. ICS transition – Communications and engagement update
- G. ICS transition – Update on Primary Care and Place Development
- H. ICS Transition – update on ICB Committees and development of the ICB Constitution
- I. ICS Transition - Integrated Commissioning

## 2. Executive Summary

---

### 2.1. Context

#### A. The ICS Partner Staff Survey Results Summary

The Staff Opinion Survey results 2021 for Shropshire, Telford and Wrekin ICS were published on 30th March 2022. A short summary from each NHS Provider is attached as [Appendix B](#).

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

**B. Update – System Oversight Framework – level 4 (SOF4) Stocktake Meeting**

System CEOs and other senior team members were invited to a meeting with NHSEI colleagues from the Midlands Region and National Intensive Support team on 5th April and a summary of this discussion is presented in this paper.

**C. Update on Urgent Care**

This section provides an update on Urgent Care pressures within STW ICS.

**D. ICS transition - update to the Readiness to Operate Statement (ROS)**

In accordance with the NHSEI establishment timeline, systems had been asked to share evidence of progress against the ROS checklist at Q4 2021/22. STW ICS submitted the required evidence and following discussion with the region the ratings, set out in Appendix A of this paper were agreed.

**E. Finance Overview**

An update on the reviews of the finance plan and financial position of the ICS are provided in this paper.

**F. Communications and engagement update**

As part of the ICB constitution the principles and arrangements for how it will work with people and communities have to be set out. This paper provides an update on these activities as well as details of the appointment to the Chief Nursing officer.

**G. ICS transition – Update on Primary Care and Place Development**

Information on the development of place based partnerships arrangements and ongoing work within Primary care is provided in this section of the paper.

**H. Update on ICB Committees and development of the ICB Constitution**

This section provides information on the recruitment of a possible recruitment of an additional Non-Executive Director as well as a progress report on the development of the ICB Constitution.

**I. ICS Transition - Integrated Commissioning**

An update on the national policy position on the delegation of NHSEI directly commissioned services and the and critical dates for implementation is provided with Appendix B.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## 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 on the latest staff survey results of the ICS.

**Section B** of this paper provides an update on the possible need to reframe the system oversight framework – level 4 (SOF4) exit criteria.

**Section C** of this paper provides an update on Urgent Care pressures within STW ICS

**Sections D to I** are providing updates on key stages of the ICS transition process.

## 2.4 Conclusion

The Board is asked **to note** sections A to I as well as Appendix A and B of this paper.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## ICB CHIEF EXECUTIVE UPDATE REPORT

### 1. INTRODUCTION

The purpose of this paper is to provide a progress report in nine parts:

- A. Update – ICS Partner Staff Survey Results Summary
- B. Update – System Oversight Framework – level 4 (SOF4) Stocktake Meeting
- C. Update - Urgent Care
- D. ICS transition - update to the Readiness to Operate Statement (ROS) and appointment of Chief Nursing Officer
- E. ICS transition – Finance overview
- F. ICS transition – communications and engagement update
- G. ICS transition – Update on Primary Care and Place Development
- H. ICS Transition – update on ICB Committees and development of the ICB Constitution
- I. ICS Transition - Integrated Commissioning

### SECTION A - ICS PARTNER STAFF SURVEY RESULTS SUMMARY

The Staff Opinion Survey results 2021 for Shropshire, Telford and Wrekin ICS were published on 30<sup>th</sup> March 2022. A short summary from each NHS Provider is attached as [Appendix B](#).

### SECTION B – SYSTEM OVERSIGHT FRAMEWORK – level 4 (SOF4) Stocktake Meeting

System Chief executives and other senior team members were invited to a meeting with NHSEI colleagues from the Midlands Region and National Intensive Support team on 5th April. This meeting was to discuss the progress of the system against the agreed exit criteria – outlined below, and the support needs for the system

It was recognised in the 5th April meeting that some of the exit criteria may need to be reframed, recognising the difference between transactional and transformational criteria, and suggesting the need for some weighting criteria to be applied. The need to strengthen clinical leadership was recognised, as was the requirement for an overarching clinical strategy bringing together the twin aims of the Hospital Transformation Programme and the Local Care Programme.

All parties accepted the need to bring expertise into the system to support the delivery of the exit criteria, alongside the need to create internal capacity and expertise. The completion of the recruitment to the ICB executive team was acknowledged as a significant step forward alongside other positive external reviews such as the recent GIRFT review (Getting it Right First Time). However, the very significant challenges for the system including financial, quality and service delivery were also accepted.

A business case for additional external support is being developed, including financial expertise, workforce and programme management support.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



## System Oversight Framework

There are six key areas set out with the exit criteria:

SOF4 EXIT CRITERIA	METRICS
1. Development of an agreed 5 Year STW Integrated System Improvement Plan.	The plan is agreed and owned by all system stakeholders and signed off by NHSEI The plan contains clear milestones for delivery with process and outcome metrics, and savings delivery targets.
2. Effective System Working - demonstrate robust system governance structure, processes and mechanisms established and fully functional, including financial governance	Joint ICS governance structures in place with agreed terms of reference. Evidence of effective joint decision making, including risk management.
3. Leadership and governance competency	Evidence of whole system ownership of quality and financial challenges, with clear partnership working to address organisational and/or system challenges.
4. Focus on delivery - evidence of meaningful mobilisation and delivery of year 1 of the Integrated System Improvement Plan, and significant progress against year 2 milestones.	Effective PIMO in place and operating. Demonstrate clinical engagement in design and delivery of ICS plan. Evidence of patient and public engagement. Delivery of financial plan exit run-rate for 2021/22. Significant demonstrable progress against year 2 milestones, including delivery of planned savings. Hospital Transformation Programme Business case agreed. Significant and demonstrably sustainable improvement in UEC performance metrics.
5. Evidence of whole system ownership of quality - system to demonstrate effective partnership working and delivery of the undertakings agreed by SaTH that require a system response.	Clear partnership working to address organisational and/or system challenges. This will include mutual holding to account for all organisations to deliver individual and collective actions.
6. Financial exit criteria	Evidence of sustained improvement and delivery of all financial targets and forecasts including improvement to the underlying position and governance culture.

- ▶ Our ICS was formally placed in the new national Recovery Support Programme (RSP) on 13 July 2021.
- ▶ This was as a result of being assessed at segment 4 of the NHS System Oversight Framework (SOF4) due to serious, complex and critical quality and/or finance concerns within our system that require intensive support.
- ▶ A Memorandum of Understanding was agreed between NHSEI and Shropshire, Telford & Wrekin ICS, which clearly sets out the exit criteria our system must meet in order to exit SOF4 and the RSP.

### SECTION C – UPDATE ON URGENT CARE

The system has continued to see high numbers of Covid19 positive patients in the acute trust c.100+, but there has been an overall downward trend. Fluctuating levels of staff sickness absence of which Covid19 absence is a factor, are still being seen but there are signs that this is improving. Overall sickness is at approximately 6% with Covid isolation at approximately 2%.

There is an overall improvement in the number of care homes in Shropshire closing due to Covid outbreaks and staffing issues, with a static number of care homes having closed in Telford and Wrekin.

The Ambulance handover position remains challenging with increasing discharges needed daily to maintain flow through the trust.

Staffing mutual aid from the system into Shrewsbury and Telford Trust has continued and is helping to ease pressures in key areas which will continue until 30th April. Several GP practices initiated business continuity arrangements due to Covid outbreaks but this is improving. Primary care are extremely busy but additional appointments are being added for the Bank Holiday weekends.

The system critical incident was stood down on 19th April 2022, but the trust has continued internal critical incident with twice daily reviews.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## SECTION D – UPDATE ON THE READINESS TO OPERATE STATEMENT (ROS) AND APPOINTMENT TO THE CHIEF NURSING OFFICE POST ON THE ICB

### Chief Nursing Officer Announcement

I am pleased to announce that Alison Bussey has been appointed as the Chief Nursing Officer for the Shropshire, Telford and Wrekin Integrated Care Board (ICB).

Alison has extensive experience working at board level in both operational and nursing roles for provider trusts. For the past 10 years Alison has held both Chief Nurse and Chief Operating Officer roles at the Midlands Partnership NHS Foundation Trust (MPFT).

### Readiness to Operate Assessment (ROS)

In accordance with the NHSEI establishment timeline, systems had been asked to share evidence of progress against the ROS checklist at Q4 2021/22. The purpose was to provide confidence that all is on track for system and regional director sign off in June.

Following the submission on 31 March 2022 a joint position between systems and NHSEI has been agreed (see Appendix A) for details.

Good progress was noted by the regional team and overall, the submitted ratings were approved.

Following discussions, the changes listed below were agreed

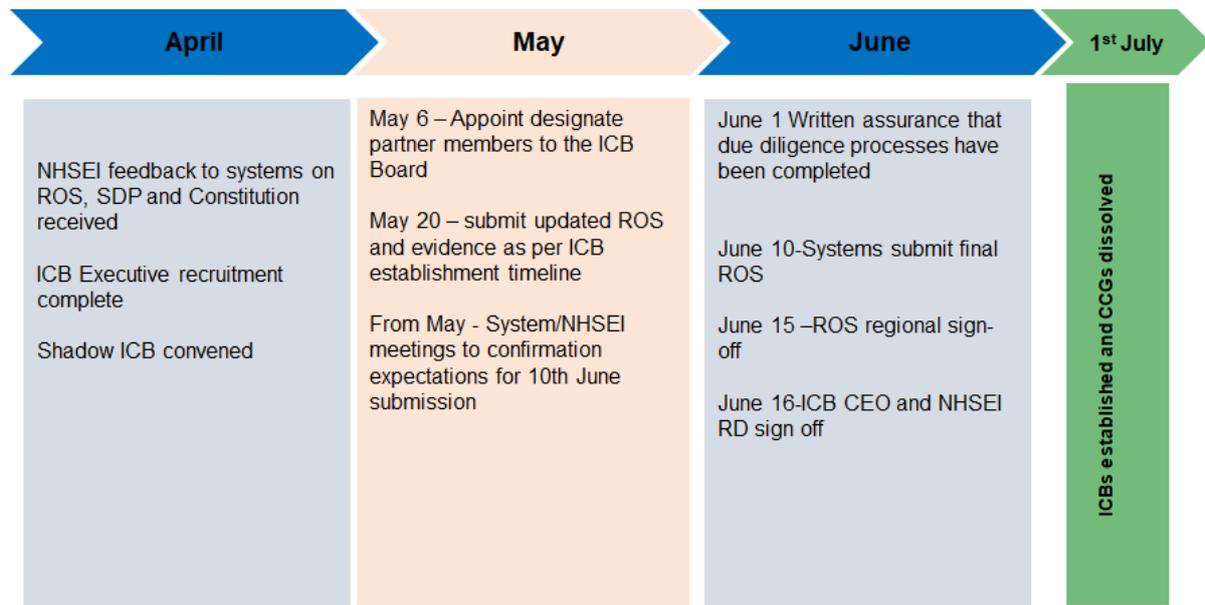
- **Designate Chief Executive appointed** and ready to take up post on 1 April' – marked 'Complete' rather than minor concerns – as in line with other systems
- **Joint commissioning arrangements** for 2022/23 documented, ready to take effect on 1 July 2022' and associated requirements of the ROS – agreed as Green ('On target, no concerns) in line with other ICSs in the Midlands region.
- **EPRR responsibilities** clear and systems and function ready to operate from 1 July 2022' - downgraded to Amber ('Progress made, minor concerns') in line with all systems
- **Clinical and care professional leadership:** Model arrangements prepared' - downgraded to Red ('Not on target, significant concerns') – this is awaiting input from the future Medical Director of the ICS.
- **Finance** – downgraded to Red due to the financial position of the ICS and in line with other systems in the Midlands region

The timeline and key activities for the next ROS submission due on 20 May 2022 have been

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



laid out below:



A full statement showing progress and RAG ratings is included as [Appendix A](#).

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

**SECTION E – FINANCE and PLANNING OVERVIEW**

Considerable amounts of work have been dedicated by the finance team to reviewing and refining the finance plan since the draft submission to NHSEI in mid-March.

Productive meetings with provider partners have taken place to better understand the drivers of the planning position and the risks associated with the choices the system is making about what can and cannot be delivered in the current financial year.

There has been significant movement in the finance position and firming up of activity and workforce plans over the last few weeks however further work is required and progress will be reported through future board reports.

**SECTION F – COMMUNICATIONS AND ENGAGEMENT UPDATE**

**Development of the ICB - Involving People and Communities Strategy**

As part of the ICB constitution we must set out the principles and arrangements for how we will work with people and communities.

Our involving people and communities’ strategy will enable us to establish a system-wide approach to hearing and learning the needs, experiences and wishes of local people and ensure they inform our priorities and key decisions. It will also set out our ambition and commitment for embedding a culture of involvement within our ICS.

Last month, to inform our strategy, we held a workshop which brought together people representing organisations and communities across Shropshire, Telford and Wrekin to discuss our principles and approach to involvement. The workshop built on learning from previous engagement activity about embedding involvement in our system and strengthening our relationship with the VCSE. We have also directly sought and incorporated the views of members of the public to ensure we capture the voices and views of our diverse population.

We aim to bring a final draft of the strategy to the shadow ICB meeting next month, ahead of submission to the NHS E/I regional team in early June.

**SECTION G - UPDATE ON PRIMARY CARE AND PLACE DEVELOPMENT**

A series of meeting with partners in Shropshire and TW to develop the Place Based Partnerships have commenced. The groups are developing the delivery model at Place and exploring how to use mechanisms such as the better care fund in the delivery of services. Place assurance methods, via quality and performance committees up to the ICB and linking the place base work to the operational delivery boards for Children’s and Young People, Mental Health & Learning Disabilities and Autism, and Planned/urgent care is also being determined.

The role of the Primary Care at Place is supporting the development of the delivery conversation. This helps integrate the work of the Local Care Programme and Care homes work. There are opportunities being discussed about how the partnership boards get

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

assurance and evaluation of services and the terms of reference for both Place partnerships are being reviewed considering the above work.

Work is ongoing with Primary Care about the changes from a CCG membership organisation to the ICB to ensure their continued engagement and influence. There are some options developed by primary care and the CCG and the practices can influence the design of the new structure. A single proposal will need to link to the wider system work on clinical leadership and engagement.

## **SECTION H - UPDATE ON ICB COMMITTEES AND DEVELOPMENT OF THE ICB CONSTITUTION**

### **ICB Committees**

Further to the update provided on development of the committee structure presented at the last meeting, it has become clear that the capacity of the newly appointed Non-Executive Directors is insufficient to support the proposed structure. Further discussions have taken place with NHSEI with a view to appointing a fourth Non-Executive Director to the ICB which has been agreed in principle. As a result, further work is continuing the chairing arrangements for board sub committees and a proposal will be brought to the next shadow ICB meeting in May.

### **Development of the ICB Constitution**

The Constitution has undergone several changes following amendments to the Bill in the House of Lords. A draft is required to be submitted by 22<sup>nd</sup> April at which point NHSEI will consider specifically the section on nomination and appointment of partner members to the ICB with an expectation of allowing ICBs to follow the drafted text in their respective constitutions to begin the nomination and appointment process for partner members of the ICB. It should be noted that the Constitution will not have been formally approved by NHSEI at this point as this will require passing of the legislation, it will however allow ICBs to form their full boards in the run up to the 1<sup>st</sup> July 2022. A draft of the Constitution will be presented at the next ICB meeting in May.

## **SECTION I - UPDATE ON INTEGRATED COMMISSIONING**

NHSE commissions a range of services at national and regional level for the population of the Midlands these include: circa 150 Specialised Acute and Specialised Pharmacy Services; Primary Care Dental, Optometry, Pharmacy Services; Specialised Mental Health Learning Disability and Autism; Screening and Immunisation; and, Health and Justice Services. These services are due to be delegated to ICBs over the coming months.

In summary the National Policy position is:

- **In July 2022** – The **Delegation of Primary Medical Services** (GP services) will transfer (legal term ‘confer’) from CCGs to ICSs
- **In April 2023** – ICS will take on the **delegated responsibility for Primary Care Dental, Optometry, Pharmacy Services.**

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- **In April 2023** – ICS will take on the **delegated responsibility for some (circa 65) Specialised Acute and Specialised Pharmacy Services**
- **In April 2023** – ICSs and NHSEI will work together to commission non-delegated Specialised Acute and Pharmacy services, Specialised Mental Health Learning Disability and Autism, Screening and Immunisation and Health and Justice services
- NHSEI will retain accountability for all delegated services

In order to ensure that any transition is safe, effective and benefits are maximised, NHSEI and ICS designate chief executives have agreed a phased transition to our future state through 2022 to 2024.

The 11 Chief executives have reviewed the NHSEI Commissioning portfolio over the past 12 months, and agreed that the Primary Care decision making is best undertaken at an ICS level, with Specialised Service decision making due to the complexity and risks associated with these services are best undertaken at a Multi-ICS level.

A full briefing will be distributed to ICB members.

## 2. CONCLUSION

The Board is asked **to note** the report.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

### Introduction to the Readiness to Operate Statement (ROS) Checklist V4

**IMPORTANT - THIS CHECKLIST SHOULD ONLY BE USED ONCE YOU HAVE READ THE ICS ESTABLISHMENT GUIDANCE ENTITLED: 'ICB READINESS TO OPERATE STATEMENT (ROS) AND CHECKLIST' AND THE CONTENT OF THIS TAB.**

The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8 and again on 2 March 2022 to reflect the change in the target date for ICB establishment.

The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICs where appropriate to take account of local circumstances.

The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.

In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that:

- all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; and
- arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies.

Once completed in June 2022, the checklist should be appended to the signed ROS.

The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment.

There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April.

There will be a final assessment and each ICB's ROS will need to be signed off in June 2022.

Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.

Tab 2 includes the full checklist and the key points to note are as follows:

- column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements
- the date of completion should be included at line 6 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission)
- column F seeks a current RAG rating based on the descriptions on the drop down list
- column G seeks a projected RAG rating based on the description on the drop down list
- column H provides a commentary column

Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform: <https://future.nhs.uk/ICSGuidance/grouphome> on the FutureNHS Collaboration Platform

#### Version Control

The final draft of the ROS Checklist is contained in the guidance document and this working version is accessible via the Hub. Changes are not anticipated but if deemed necessary, strict version control will be applied. The version number and date of issue will be included below and any changes clearly identified

**Current version number**

V4

**Date of current version**

3/2/2022

#### Comments Regarding Versions Released

V1 was released on 18.08.21

V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V4 was released on 02.03.22 - most changes relate to the change in date for ICB establishment and a change in the narrative re prompt 9.1 - see changes in the version control log

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

**SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT**  
**Readiness to Operate Statement (ROS) Checklist - to prepare for legal establishment on 1 July 2022 V4**

Please refer to the ROS Guidance before using this checklist  
 Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform:

<b>Name of ICB:</b>	Shropshire, Telford and Wrekin ICS
<b>Date:</b>	31-Mar-22
<b>Completed by:</b>	Nicky O'Connor
<b>Contact details:</b>	

Hierarchy	Ref	Description
High Level Summary	<b>1</b>	<b>Integrated care partnership (ICP): Initial ICP arrangements and principles agreed</b>
Supporting elements	1.1	Initial Integrated Care Partnership (ICP) arrangements agreed, including principles for operation from 1 July 2022, in line with relevant guidance
High Level Summary	<b>2</b>	<b>Integrated care board (ICB): Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance</b>
Supporting elements	2.1	Designate Chair appointed and ready to take up post on 1 April 2022
Supporting elements	2.2	Designate Chief Executive appointed and ready to take up post on 1 April 2022
Supporting elements	2.3	Designate Non-Executive Directors (minimum of two) appointed and ready to take up post on 1 April 2022
Supporting elements	2.4	Designate Partner members appointed and ready to take up post (timing dependent on the Partner Member Regulations)
Supporting elements	2.5	Other designate appointments made and postholders ready to take up post on 1 April 2022 (minimum additional Executive roles: finance; medical; nursing) to ensure quorum of the ICB Board, according to its Constitution
High Level Summary	<b>3</b>	<b>System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place</b>
Supporting elements	3.1	System development plan (SDP) in place indicating how the ICB will work with its partners in the ICP from April 2022 to meet the needs of the population, with a focus on reducing health inequalities
Supporting elements	3.2	ICB Constitution, including the Standing Orders and agreed ICB name, approved by NHS England before 1 July 2022, ready to be adopted on 1 July 2022 - in line with relevant guidance
Supporting elements	3.3	ICB Scheme of Reservation and Delegation (SoRD) prepared and ready to be adopted on 1 July 2022
Supporting elements	3.4	ICB Standing Financial Instructions (SFIs) prepared and ready to be adopted on 1 July 2022
Supporting elements	3.5	ICB Governance Handbook (setting out the governance arrangements) prepared and ready to be adopted on 1 July 2022
Supporting elements	3.6	ICB functions and decision map prepared and ready to be adopted on 1 July 2022 - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements
Supporting elements	3.7	Any joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs and NHS England and NHS Improvement) documented, ready to take effect on 1 July 2022
Supporting elements	3.8	Schedules of delegation to be in place for 1 July 2023 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]
Supporting elements	3.9	Standards of business conduct policy prepared and ready to be adopted on 1 July 2022
Supporting elements	3.10	Conflicts of interest policy prepared and ready to be adopted on 1 July 2022
Supporting elements	3.11	Essential policies identified through risk assessment (eg commissioning [eg IVF commissioning], safeguarding, HR) and prepared
High Level Summary	<b>4</b>	<b>Provider partnerships: Provider partnership arrangements agreed</b>
Supporting elements	4.1	Provider partnership arrangements which will apply from 1 July 2022 agreed in line with relevant guidance. These include provider collaboratives, primary care networks and other collaborative arrangements
High Level Summary	<b>5</b>	<b>People and culture: People function ready for operation</b>
Supporting elements	5.1	Governance and delivery arrangements for people function agreed and ready for operation as set out in line with relevant guidance, and workforce and organisational development priorities identified in the system development plan
High Level Summary	<b>6</b>	<b>Quality, safety and EPRR: Quality, safety and EPRR systems and functions ready for operation</b>
Supporting elements	6.1	Quality and safety systems and function ready to take effect from 1 July 2022, including implementation of System Quality Groups in line with the National Quality Board's guidance
Supporting elements	6.2	EPRR responsibilities clear and systems and function ready to operate from 1 July 2022 in line with relevant guidance
High Level Summary	<b>7</b>	<b>Clinical and care professional leadership: Model / arrangements prepared</b>
Supporting elements	7.1	ICB leadership model / arrangements prepared in line with relevant guidance
High Level Summary	<b>8</b>	<b>Working with people and communities: Public involvement and engagement strategy / policy</b>
Supporting elements	8.1	ICB public involvement and engagement strategy / policy prepared in line with relevant guidance
High Level Summary	<b>9</b>	<b>NHS oversight and ways of working: NHS oversight and ways of working between NHS England and NHS Improvement regional team and ICB</b>
Supporting elements	9.1	Arrangements for NHS oversight and the MOU to describe the agreed ways of working between the NHS England and NHS Improvement regional team and the ICB prepared, ready to take effect from 1 July 2022
High Level Summary	<b>10</b>	<b>Finance and planning: Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation</b>
Supporting elements	10.1	Planning for 2022/23 has been carried out in line with relevant guidance
Supporting elements	10.2	Activities as outlined in the NHS SBS finance / ledger reconfiguration programme plan as due by 1 July 2022 have been delivered e.g. new bank account in place for the ICB, ICB able to make payments for goods and services, finance function ready to operate, etc.
Supporting elements	10.3	Plan for ESR changes in place (if using IBM for a technical merge of ESR systems, technical slot booked)
High Level Summary	<b>11</b>	<b>Data, digital and information governance: Systems ready to operate and information governance activities on target</b>
Supporting elements	11.1	Activities outlined in the Organisation Data Service (ODS) reconfiguration toolkit as due by 1 July 2022 have been delivered
Supporting elements	11.2	Activities outlined in the information governance / data security and protection toolkit (DPST) (e.g. Caldicott Guardian, Information Asset Owner, Senior Information Risk Owner, records retention, etc.) as due by 1 July 2022 have been delivered
High Level Summary	<b>12</b>	<b>Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSOP guidance, staffing and property lists prepared and first day arrangements confirmed</b>
Supporting elements	12.1	Equalities duties
Supporting elements	12.1.1	Evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process
Supporting elements	12.2	People transfer
Supporting elements	12.2.1	Consultation completed in line with TUPE requirements / COSOP guidance and staff list shared by sending CCG(s) to receiving ICB(s) (designate Chief Executive) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])
Supporting elements	12.2.2	CCG(s) staff due diligence completed and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])
Supporting elements	12.3	Property transfer
Supporting elements	12.3.1	CCG(s) due diligence completed on all property (assets and liabilities, including contracts e.g. with CSUs) in line with guidance; and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD). List of property and liabilities from sending CCG(s) to receiving ICB(s) produced - in line with relevant guidance (Due Diligence Guidance)
Supporting elements	12.4	First day arrangements
Supporting elements	12.4.1	Appropriate arrangements made in relation to NHS Resolution Scheme (Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and the Property Expenses Scheme) to provide indemnity in line with NHS Resolution guidance (when available)
Supporting elements	12.4.2	First ICB Board meeting to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)
Supporting elements	12.4.3	First day communications plan in place
Supporting elements	12.4.4	ICB website in place

RAG Rating October 2021	RAG Rating December 2021	Current RAG Rating	Projected RAG Rating at June 2022	Comments
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	The first shadow board meeting has been booked for 31 March 2022 <b>SDP: Chapter 4.1 Governance</b>
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Governance handbook and ICP TORs are being drafted and will be submitted in line with revised ICB establishment timelines
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.1 Governance and 4.3 People and Culture</b>
Completed	Completed	Completed	Completed	
Not on target, significant concerns	Progress made, minor concerns	Completed	Completed	Interim Chief Executive has commenced in post; intentions for the designate Chief Executive post will have been firmed up over the coming weeks
Changed to green	On target, no concerns	Completed	Completed	All three NED posts have been appointed with NHSEI approval <b>Evidence: announcement, see line 2.3 in the evidence log</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	The National model stipulates that the nomination processes must fulfil the requirements of being "jointly nominated"; details of this process are being set out in the Draft Constitution
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Chief Financial and Chief Medical Officer have been appointed; Chief Nursing officer post is due for appointment in early April: all posts will start in line with revised ICB establishment timelines
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	<b>SDP is this document - Chapters 4.1 Governance , 4.6 Place Development and 4.8 Commissioning</b>
On target, no concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	A refreshed SDP is attached to this ROS submission; further updates are being prepared for final submission on 10 June 2022
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Draft constitution has been submitted and feedback has been received from NHSEI; a further iteration will be submitted in line with revised ICB establishment timelines on 22 April 2022
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	ICB Scheme of Reservation and Delegation (SoRD) is being prepared in line with the ICB draft constitution and will be submitted in line with revised ICB establishment timelines on 20 May 2022
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	ICB Standing Financial Instructions (SFIs) are being prepared and will be submitted in line with revised ICB establishment timeline on 20 May 2022 <b>Evidence: see draft SFIs in line 3.4 of the evidence log</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	The ICB governance handbook is in development and will be completed alongside the ICB constitution;
Changed to amber	On target, no concerns	On target, no concerns	On target for delivery by June 2022	STW ICS operating model is in development and will be submitted in line with revised ICB establishment timeline on 20 May 2022
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2023	Conversations with neighbouring ICSs have commenced to discuss and reflect on the advantages and potential barriers associated with collaborative commissioning for a range of functions; key aim for this area is that any future collaborative commissioning arrangements would ensure delivery of efficiency of scale. A further update on these conversations will be provided for the next ROS submission on 20 May 2022.
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2024	The ICS will be working with an NHSEI Link Person to liaise with regarding the level of NHSEI input and where this is most valuable. Work with partners will continue to progress our plans for July 2023 delegated function readiness.
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Policies are in development, building on policies in place in CCGs; updated drafts will be submitted in line with revised ICB establishment timeline on 20 May 2022
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Policies are in development, building on policies in place in CCGs; updated drafts will be submitted in line with revised ICB establishment timeline on 20 May 2023
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	A programme of work is ongoing within the current CCG to refresh the policies that are currently in place. This has been risk assessed and prioritised. The programme will extend beyond 1st April 2022. Critical policies will be in place and work will be undertaken to ensure naming and other information is changed to reflect the move from CCG to ICS.
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery by June 2022 is at risk but mitigation plan in place	<b>SDP: Chapter 4.7 Provider Collaboratives</b>
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery by June 2022 is at risk but mitigation plan in place	Principles of provider collaboration have been agreed; provider collaboration within the system reflects the small number of providers and therefore most provider collaborative discussions will occur at place; supra ICS collaborations already in existence
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.3 People and Culture</b>
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by June 2022	OD plan has been agreed by ICS People Board; TORs of reference for the people committee have been agreed;
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.2 Quality</b>
Changed to red	Progress made, minor concerns	Progress made, minor concerns	On target for delivery by June 2022	Meetings of the Quality & Performance Committee (QPC) are taking place monthly; operational assurance processes are arranged to allow the QPC to focus on strategic oversight of quality and safety across the system.  The revised System Quality/ Quality Surveillance model will include strengthened arrangements with other learning partners. In addition, a System Patient Safety Group has been implemented with agreement on system priorities and the implementation of the NHS Patient Safety Strategy.  The QPC feeds into the Integrated Care Board with subgroups and sub committees reporting into QPC.  Local quality governance, implementing a structure and function have been set up in accordance with National Quality Board (NQB) and NHSEI published guidance as well as the needs of the system. Further NQB publication which will confirm the operating framework for System Quality Groups is expected.  The system continues to work closely with NHSEI who co-chairs SOAG as part of the quality governance, particularly focussing on quality and safety of clinical services at SaTH.
Progress made, minor concerns	On target, no concerns	Progress made, minor concerns	On target for delivery by June 2022	The requested ICB assurance template will be completed for submission by 6 April 2022
Progress made, minor concerns	Progress made, minor concerns	Not on target, significant concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.11 Clinical, Care and Professional Leadership</b>
Changed to red	Progress made, minor concerns	Not on target, significant concerns	On target for delivery by June 2022	A Clinical & Care Professional Leadership and Engagement Strategy is currently being developed and will be progressed under the guidance of the newly appointed Chief Medical officer of STW ICS; updated drafts will be submitted in line with revised ICB establishment timeline on 20 May 2023
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.4 Working with People and Communities</b>
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	Draft communication and engagement plan is in development with the intention of being taken to the ICS board in April 2022 and completion by 20 May 2022
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.10 Accountability and Oversight</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Arrangements for system oversight have been outlined in SDP and the system MOU;
Progress made, minor concerns	On target, no concerns	Not on target, significant concerns	On target for delivery by June 2022	<b>SDP: Chapter 4.9 Financial Allocations and Funding Flows</b>
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Preparation work in line with planning guidance will be completed by 28 April 2022 <b>Evidence: see financial evidence in line 10.1, 10.2 and 10.3 of the evidence log</b>
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Full due diligence plan has been developed and reviewed by the Due Diligence panel; Monthly project boards with SBS have been established. No significant risks currently identified
Progress made, minor concerns	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Plan for ESR changes covered in detailed due diligence plan. Minimal action required as STW ICS does not require a technical merge <b>Evidence: see line 10.3 in the evidence log</b>
Progress made, minor concerns	Progress made, minor concerns	Progress made, minor concerns	Delivery by June 2022 is at risk but mitigation plan in place	<b>SDP: Chapter 4.5 Data and Digital Standards and Requirements</b>
Progress made, minor concerns	Progress made, minor concerns	Completed	Completed	Confirmed by region for October ROS submission and due diligence checkpoint in November that this action is not required for STW ICS
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	DSPT actions are underway and will be complete by 31/3/22. Confirmation received that Shropshire, Telford and Wrekin has successfully submitted their 21/22 DSP Toolkit with a 'Standards Met' status on Friday 25th March 2022. <b>Evidence - Confirmation email of DPST submission and full DPST tool kit in line 11.2 of the evidence log</b>
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	<b>SDP: Chapter 5.1 Transitioning as an ICS</b>
Progress made, minor concerns	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	Equality Impact Assessment (EQA) has been undertaken and is attached as <b>evidence in line 12.1.1 of the evidence log</b> Actions set out in the DD checklist. HR tab 2.1 action 2.1.3.4 are being progressed and monitored
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Equality Impact Assessment (EQA) has been undertaken and is attached as <b>evidence in line 12.1.1 of the evidence log</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	As set out in DD checklist tab 2.2 Relevant data is due to be produced in April 2022 followed by a checking and reconciliation exercise; data will be made available to the ICB on 1 June. The prescribed template is currently being tested on ESR with sample data. People Impact Assessment (PIA) Action 2.1.1.1 has been completed and updated on a regular basis and EQIA Initial work completed (see above)
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. <b>The most recent checklist has been included in the evidence pack for this submission.</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. <b>The most recent checklist has been included in the evidence pack for this submission.</b>
Changed to green	On target, no concerns	On target, no concerns	On target for delivery by June 2022	As set out in DD checklist Actions 1.7.4-7
Changed to green	On target, no concerns	On target, no concerns	On target, no concerns	A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. <b>The most recent checklist has been included in the evidence pack for this submission.</b>
No possible to start	Progress made, minor concerns	On target, no concerns	On target for delivery by June 2022	Confirmation on the continuation of the CCG's membership has been confirmed by NHS Resolution on 4 March 2022 <b>Evidence: confirmation letter from NHS Resolutions in line 12.4.1 of the evidence log</b>
No possible to start	On target, no concerns	On target, no concerns	On target for delivery by June 2022	The first ICB board meeting has been confirmed for 1 July 2022, further meeting arrangements were proposed in the ICB board meeting of 30 March 2022 and will be firmed up over the coming weeks
No possible to start	On target, no concerns	On target, no concerns	On target for delivery by June 2022	Draft communication and engagement plan is in development with the intention of being taken to the ICS board in April 2022 and completion by 20 May 2022
No possible to start	On target, no concerns	On target, no concerns	On target for delivery by June 2022	ICS Website is under development; a link to the site will be included in the final ROS submission

## RAG Rating Guidance

### RAG RATING FOR ALL LINES EXCLUDING 3.8

**Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022)**

<b>R</b>	Not on target, significant concerns
<b>A</b>	Progress made, minor concerns
<b>G</b>	On target, no concerns
<b>C</b>	Completed

V2 V3 To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.

**Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22)**

<b>R</b>	Delivery by June 2022 is not achievable
<b>A</b>	Delivery by June 2022 is at risk but mitigation plan in place
<b>G</b>	On target for delivery by June 2022
<b>C</b>	Completed

### RAG RATING FOR LINE 3.8 ONLY

**Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022)**

<b>R</b>	Not on target, significant concerns
<b>A</b>	Progress made, minor concerns
<b>G</b>	On target, no concerns
<b>NA</b>	Not applicable - applies to 3.8 only
<b>C</b>	Completed

V2 V3 To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.

**Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22)**

<b>R</b>	Delivery by March 2022 is not achievable
<b>A</b>	Delivery by March 2022 is at risk but mitigation plan in place
<b>G</b>	On target for delivery by March 2022
<b>NA</b>	Not applicable - applies to 3.8 only
<b>C</b>	Completed

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

VERSION CONTROL - LOG OF CHANGES

Date of Change	Version Change	Tab	Ref	Original Drafting	Revised Drafting	Comment Regarding Change
<b>Version 1 released 18 August 2021</b>						
<b>Version 2 released 14 October 2021 - Changes shown below</b>						
10/14/2021	V2	Introduction	Line 19	N/a	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Added to provide confirmation of all versions released
10/14/2021	V2	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not in place, not started or position unknown A - Progress made G - Completed and in place	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options
10/14/2021	V2	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 C - Completed	Change to RAG rating options
<b>Version 3 released 3 December 2021 - Changes shown below</b>						
12/3/2021	V3	Introduction	Line 19	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Updated to reflect version control
12/3/2021	V3	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NA - Not applicable - applies to 3.8 only C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options. Not possible start has now been removed as work will now have started for all areas of the ROS. N/A option introduced for prompt 3.8 only.
12/3/2021	V3	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 NA - Not applicable - applies to 3.8 only C - Completed	Change to RAG rating options. N/A option introduced for prompt 3.8 only.
<b>Version 4 was prepared on 16 February 2022 (approved by the C&amp;TSG) but not released and updated again on 2 March 2022 - Changes shown below</b>						
2/16/2022	V4 16.02.22	Introduction	Line 7	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICs) and other stakeholders.	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8 and again on 16 February 2022 to reflect the change in the target date for ICB establishment.  The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICs where appropriate to take account of local circumstances.  The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.	Extended description
2/16/2022	V4 16.02.22	Introduction	Line 8	In March 2022 (exact date TBC) each ICB chief executive designate and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: • all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 April 2022; and • arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in March 2022, the checklist should be appended to the signed ROS.	In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: • all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; and • arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in June 2022, the checklist should be appended to the signed ROS.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 9	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint review of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team at the end of Q2 and Q3 2021/22. ICs will be asked to share their checklist with the regional team at these points, alongside their updated system development plans. There will be a final progress review in mid-February 2022 and each ICB's ROS will need to be signed off in March 2022 (deadline date to be confirmed).	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April. There will be a final assessment and each ICB's ROS will need to be signed off in June 2022. Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 10	Tab 2 includes the full checklist and the key points to note are as follows: • column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements • the date of completion should be included at line 8 and as outlined above, it is expected that an assessment will be completed at Q2, Q3 2021/22, mid-February 2022, with a final submission in March (noting that no projected position will be required for the final submission) • column F seeks a current RAG rating based on the descriptions on the drop down list. • column G seeks a projected RAG rating based on the description on the drop down list. • column H provides a commentary column.	Tab 2 includes the full checklist and the key points to note are as follows: • column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements • the date of completion should be included at line 8 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission) • column F seeks a current RAG rating based on the descriptions on the drop down list • column G seeks a projected RAG rating based on the description on the drop down list • column H provides a commentary column	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	Cell G10	Projected RAG Rating at March 2022	Projected RAG Rating at June 2022	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	1.1, 3.2-3.10 incl, 4.1, 6.1, 6.2, 10.2, 11.1, 11.2	Date previously referred to 1 April 2022	Date now refers to 1 July 2022	Changed date to respond to the new target date of 1 July 2022 - for all prompts shown [note line 24 below which later included prompt 9.1]
2/16/2022	V4 16.02.22	ROS checklist	3.8	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]	Clarified that this prompt relates to POD services only

## ICB Report – April 2022

### Staff opinion survey 2021

The Staff Opinion Survey results 2021 were published on 30<sup>th</sup> March 2022. A short summary from each NHS Provider is presented below.

Whilst each Trust has prepared an individual response to their results, areas of common ground across the System will be identified and a collaborative approach to improvement supported through delivery of the STW People Plan.

#### **Midlands Partnership NHS Foundation Trust (MPFT)**

Despite increasing demands and pressures and fatigue from working through the pandemic, MPFT received its highest ever number of responses to the survey with 5161 staff taking the time to complete the survey. This equals the response rate of 59% which was achieved in 2020 and remains significantly above the national average for Trusts of its type. The national median response rate for the 51 comparator Trusts was 52%, which is a 3% increase since 2020.

Overall, MPFT results show they scored above average on the 2 measures (staff engagement and morale) and above average on 6 out of 7 people Promise elements. They scored average on 1 People Promise element. MPFT scored above the national score average on many questions and in those directly comparable questions, areas of improvement are noted.

#### **Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust**

The results of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust are benchmarked against Acute Specialist Trusts.

The Trust is proud they remain best in their benchmark group when responding to the question, if a friend or relative needed treatment staff would be happy with the standard of care provided by the organisation.

The results demonstrate a further improvement in the percentage of staff agreeing that they feel secure raising concerns about unsafe clinical practice. An improvement has been seen in this score for the last four years. The percentage of staff agreeing they were confident that the organisation would address concerns about unsafe clinical practice also improved.

The results further demonstrated the Trust was average in the following People Promise Themes:

- \* We are compassionate and inclusive. There was improvement in the percentage of respondents who said the organisation acts fairly about career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability, or age.
- \* We are safe and healthy. Scores showed a reduction in the percentage of staff saying they had experienced at least one incident of bullying or abuse from managers compared to last year.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

\* Morale. The Trust scored the best within the benchmark group, with the lowest percentages of staff agreeing that they would probably look for a job at a new organisation in the next 12 months or staff agreeing that as soon as they can find another job, they would leave this organisation. These were however a deterioration in comparison to the views of staff last year.

### **Shrewsbury and Telford Hospital NHS Trust (SaTH)**

A total of 3,011 staff members responded to the 2021 Staff Survey a response rate of 45%, the highest response rate since 2013. SaTH scored below average for the sector (Acute and Acute & Community Trusts) in questions aligned to the NHS People Promise and in the themes of Staff Engagement and Morale. The Staff Engagement score has declined over the last 5 years and this year was the lowest in the sector. The Trust has embraced the feedback and is committed to tackling these challenges to ensure that SaTH is the supportive, positive, and caring place to work that all staff deserve. These results inform the Trust's cultural dashboard, with 6 main themes, namely compassion, teamwork, health and wellbeing, vision and values, goals and performance and learning and motivation. The cultural dashboard will inform focussed interventions to improve future results. Plans have already begun to review Divisional and Corporate People Plans to ensure action is taken to make improvements for the benefit of patients, colleagues and communities.

The Trust has commissioned an independent external organisation to support their "speak up safely" arrangements to ensure staff who may feel vulnerable or concerned over challenging or exposing poor practice, can do so independently from the Trust. The aim is to develop and promote a completely open and transparent culture within the Trust where colleagues can ask any questions or highlight worries, and know they will be listened to, and meaningful action will be taken.

### **Shropshire Community Health NHS Trust**

Pleasingly, 61% of staff completed the survey in 2021 which is a record high for Shropcom. The Trust convey there is much to be recognised within the survey results that is positive – but there are also some areas where added focus is required. The Trust acknowledge they are not unusual in this regard, and that across the NHS, Trusts are seeing survey results that are less favourable this year than they were 12 months ago. The Trust recognises the ongoing pandemic as a contributory factor; but equally do not wish to use this as an excuse. They express their intention to offer all their people a positive experience at work and will take it seriously when staff highlight problems.

Positives worthy of note include significant improvements around the reporting of bullying, harassment and abuse; and in being able to show initiative at work. Shropcom have also retained very good staff satisfaction around experience of low levels of bullying, harassment, and abuse; violence and discrimination; feeling trusted; making a difference to patients; enjoying working with colleagues; and good relationships with immediate managers. Good scores were also recorded from new questions in the survey around support and relationships within teams and from colleagues.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

Highlighted areas for improvement, where things could have been grouped into four themes: Recognition and Reward, Learning and Development, Flexible Working and Staff Morale.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## 0. Reference Information

Author:	Zena Young STW CCG Executive Director of Nursing & Quality	Paper date:	27/04/22
ICS Board Member Sponsor:		Paper Category:	I, D
Paper Reviewed by:		Paper FOIA Status:	Disclosable

## 1. Purpose of Paper

### Ockenden 2 report – Independent Review of Maternity Services at SaTH

The purpose of this paper is to inform the ICB of the publication on 30 March 2022 of the second and final report of the *Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust (SaTH)* – known as the Ockenden Review.

Along with the Secretary of State and with professional bodies, the ICB accepts in full the findings and recommendations contained within the report and this paper provides a summary overview and details next steps for ICS assurance.

The ICB are invited to note and discuss:

- That further assurances are required relating to continued concerns regarding safety and staff culture within maternity services at SaTH and a report responding in detail will be presented at a future ICB meeting.
- The governance oversight processes in place within our system.
- Progress against completion of the 27 local and 25 national recommendations arising from the first review report.
- The scale of further improvements required - the 66 Local actions for learning and 15 Immediate and Essential Actions for maternity services in the NHS as identified in the second review report.

## 2. Executive Summary

The second report sets out the findings of the review into care provided to 1,486 families, (involving 1,592 clinical incidents), primarily between 2000 and 2019, and sets out a blueprint for safe maternity care in the NHS.

This paper provides a brief summary of the main findings and recommendations – the essential and local actions for learning arising from this second report; an update on progress against the completion of recommendations arising from the first report published in December 2020 (which considered the care of 250 cases only); and details of next steps for ICS assurance.

Key findings from the independent review are:

- failure in governance and leadership
- failure to identify and investigate incidents

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- failure to learn lessons and prevent avoidable harms; patterns of repeated poor care
- insufficient workforce numbers, skills and supervision to ensure safe services
- continued concerns described by maternity services staff regarding fear to speak up about concerns

The second report identifies recommendations:

- 66 Local Actions for Learning (LAFL's)
- 15 Immediate and Essential Actions for Learning (IEA's)

Following publication of the first report, the CCG and Trust moved quickly to implement a revised perinatal quality surveillance approach as mandated by NHSEI which reports through to ICB. This includes a robust assurance process for reviewing progress with completing all of the 52 local and national actions identified in the first report – a process which will now be expanded to include the additional recommendations arising from the second report.

The Local Maternity and Neonatal System Programme Board (LMNS – which is the NHSEI mandated local arrangement), on behalf of the ICB, is the key assurance forum for validating any reporting to NHSEI on achievement of progress with all recommendations as well as other transformation schemes and all perinatal quality and safety matters. This is in addition to SaTH's statutory responsibilities to report to their Trust Board on assuring safe services.

The CCG and LMNS are working with SaTH to identify priorities within the numerous recommendations and agree what will be delivered by when.

SaTH will be receiving a detailed action plan to their Trust Board meeting in public in May and this will also be subsequently presented to the SaTH Safety Assurance Oversight Group (SOAG) for scrutiny and debate. The ICB will receive a further detailed report following those meetings.

A slide set is appended for information and the full second report can be found at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf)

## 2.1. Context

Maternity services at Shrewsbury and Telford Hospitals NHS Trust (SaTH) have been under scrutiny since the publication of the 2018 CQC inspection report which showed deteriorated ratings, particularly in the 'safe' domain:

At the same time, and over an extended period, the trust was subject to a number of long-standing complaints regarding maternity services and their responsiveness to these concerns – notably their approaches to safety and care & compassion. As a result of these cases and the findings from other more recent maternity governance reports commissioned by regulators, in 2017 the then Secretary of State (SoS) for Health commissioned an independent review of maternity cases spanning the time period 2000 to 2019.

The first Ockenden report on 250 cases was published in December 2020 and highlighted emerging themes and findings; the SoS accepted all findings and recommendations.

This second publication is the much anticipated final review report into maternity care failings and published on 30 March 2022. The final report sets out the findings of the review into care provided to 1,486 families, (involving 1,592 clinical incidents), primarily between 2000 and 2019, and sets out a blueprint for safe maternity care in the NHS.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## 2.2. Link to Pledges

This paper links to Pledge 1 - Improving safety and quality.

## 2.3. Summary

The review, which rightly put families' voices centrally also listened to staff experiences. It reinforces the importance of establishing and improving critical oversight of patient safety in maternity units and identifies 15 Immediate and Essential Actions (IEAs) to be implemented across maternity services in England to bring about timely positive and essential change, along with 66 Local Actions for Learning (LAFs) which are specific to SaTH.

The patterns of poor clinical care identified in the final report mirror issues identified by previous national reports into maternity care; the report highlights significant failings in governance procedures and leadership which resulted in repeated missed opportunities and failures to learn.

The review acknowledges the huge pressure maternity services and their staff continue to face, which have been compounded by the pressures arising from Covid-19.

Funding issues and significant workforce challenges were recognised, particularly in the recruitment and retention of midwives and obstetricians. However, the indication within the report that there remain ongoing barriers to staff raising concerns and the implication that this continues to prevent learning following serious maternity incidents is highly concerning.

The SoS has responded by accepting the report findings and recommendations in full and an additional funding of £127 million has been announced to support services across England to implement changes. Additional allocations will be overseen by the LMNS.

Similarly a joint statement from representative bodies including the RCM, Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists and others was issued, committing to working collaboratively to implement the required changes.

### Summary of the Immediate and Essential Actions

The final report sets out 66 Local Actions for Learning (LAFs) specific to SaTH. However, many of the issues identified by the Ockenden review team are not isolated to SaTH and all maternity services in England now need to build on the work they started following the first Ockenden report.

With this in mind, the final report sets out 15 Immediate and Essential Actions (IEAs) which are intended to make a significant contribution to the delivery of safe maternity care, and which complement and expand on the IEAs issued in the first report. These actions must be implemented across all maternity services. It is recognised that change will not be achieved overnight but clear that action is required now at all levels, from ward to Board, in order to improve care and safety in maternity services.

The report summarises the actions into the following areas:

#### Operationally and at ward level

- **Workforce planning and sustainability**, including the need for nationally agreed minimum staffing levels, or where there is no national agreement, staffing levels agreed locally with the Local Maternity and Neonatal System (LMNS).
- **Training** for midwifery staff needs to be formalised, to include a robust preceptorship programme for newly qualified midwives (NQMs), which supports supernumerary

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

status during their orientation period and protected learning time for professional development, as per the RCM position statement for this. A proportion of maternity budgets must be ring fenced for the provision of appropriate training.

- **Safe staffing** - including the need to maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals. Trusts must also review and suspend if necessary the existing provision and further roll-out of midwifery continuity of carer model unless they can demonstrate staffing meets safe minimum requirements on all shifts.
- **Escalation and accountability** - staff must be able to escalate concerns with clear guidelines for when a consultant obstetrician should attend.
- **Multidisciplinary training** – a reinforcement of the need for staff who work together to also train together, to include training on local handover tools and mandatory training on human factors. All staff must be trained and up to date in CTG and emergency skills.
- **Complex antenatal care** - local maternity systems, maternal medicine networks and Trusts must work together to ensure that women have access to pre-conception care in line with relevant national guidance.
- **Labour and birth** – the report sets out various requirements to improve care, including the need for women who choose birth outside a hospital setting to be provided with accurate advice with regards to transfer times to an obstetric unit should this be necessary. In addition, all women must undergo a full clinical assessment when presenting in early or established labour to include a review of any risk factors and consideration of whether any complicating factors have arisen that might change recommendations about place of birth. These must be shared with women to enable an informed decision regarding place of birth to be made. Centralised CTG-monitoring systems should also be mandatory in obstetric units.
- **Pre-term births** - The LMNS, commissioners and Trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version Two (2019), also Safety Action 6 of NHS Resolution’s Maternity Incentive Scheme.
- **Obstetric anaesthesia** - In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every Trust to address incidences of physical and psychological harm.
- **Post-natal care** - Women readmitted to a postnatal ward and all unwell postnatal women must have timely consultant review.
- **Bereavement care** - Women who have suffered pregnancy loss must have appropriate bereavement care services.
- **Neonatal care** - There must be clear pathways of care for provision of neonatal care and the recommendations from the Neonatal Critical Care Transformation Review (December 2019) must now progress at pace.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- **Supporting families** - Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. The report sets out a number of strategies to achieve this including the need for robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.

### **Clinical governance and Organisational Learning**

- **Incident investigation and complaints** - this includes the need for incident investigations to be meaningful for families and staff and for lessons to be learned and implemented in practice within 6 months of the incident. Maternity governance teams must ensure the language used in investigation reports is easy to understand for families. The report supports the move towards a more proactive approach to safety and learning investigations under the Patient Safety Incident Response Framework (PSIRF) which is due to be gradually implemented across NHS Trusts from July 2022, replacing the Serious Incident Framework (2015). Under PSIRF, there will be a standardised investigation template and providers are encouraged to bring patient safety and complaints teams together to encourage a collaborative and coordinated process. The importance of monitoring complaints themes and trends is also highlighted.
- **Learning from maternal deaths** - nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies. In the case of a maternal death, a joint review panel or investigation of all services involved in the care must include representation from all applicable hospitals or clinical settings. Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel and shared across the Local Maternity System (LMS).

### **Leadership including the Board**

- **Clinical governance leadership** – the report builds on the first report to reinforce the need for leadership and critical oversight of the quality and performance of their maternity services. This includes the requirement for the director of midwifery and clinical director for obstetrics to be jointly operationally responsible and accountable for the maternity governance systems and the appointment of a Patient Safety Specialist dedicated to maternity services. Trust boards must also work together with maternity departments to develop regular progress and exception reports and assurance reviews, and regularly review the progress of any maternity improvement and transformation plans.

## 2.4. Conclusion

The ICB are invited to note and discuss:

- That further assurances are required relating to continued concerns regarding safety and staff culture within maternity services at SaTH and a report responding in detail will be presented at a future ICB meeting.
- The governance oversight processes in place within our system.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

- Progress against completion of the 27 local and 25 national recommendations arising from the first review report.
- The scale of further improvements required - the 66 Local actions for learning and 15 Immediate and Essential Actions for maternity services in the NHS as identified in the second review report.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



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

# Ockenden 2 report: Independent Review of Maternity Services at SaTH

Zena Young – Executive Director of Nursing &  
Quality STW CCG

27 April 2022

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# The 2<sup>nd</sup> and final independent report published 30 March 2022 sets out the findings of the review into care provided to:

1,486 families, (involving 1,592 clinical incidents) primarily between 2000 and 2019 and sets out a blueprint for safe maternity care in the NHS.

- ◆ 27.9% of all incidents reviewed graded as poor care
- ◆ 25% stillbirths graded as poor care
- ◆ 65.9% of Hypoxic-Ischemic Encephalopathy (HIE – brain damage due to oxygen shortage) cases graded as poor care
- ◆ 12 maternal deaths, 9 graded as poor care



# Themes included in 2<sup>nd</sup> report:

The 2<sup>nd</sup> Ockenden report identifies:

- ◆ **66 Local Actions for Learning (LAFL's)**
- ◆ **15 Immediate and Essential Actions for Learning (IEA's)**

**Themes identified:**

- ◆ Failures in governance and leadership;
- ◆ Failure to identify and investigate incidents robustly;
- ◆ Failure to learn lessons and prevent avoidable harms; with patterns of repeated poor care
- ◆ Insufficient workforce numbers, skills and supervision to ensure safe services
- ◆ Continued concerns described by maternity services staff regarding fear to speak up about their concerns



# Immediate and Essential Actions for all providers



## Immediate and Essential Actions from the Ockenden Report

### Workforce planning and sustainability

Minimum staffing levels should be those agreed nationally or locally with the LMNS.  
A proportion of maternity budgets must be ring-fenced for training in every maternity unit.



### Safe staffing

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals



### Escalation and accountability

Staff must be able to escalate concerns if necessary



### Clinical governance – leadership

Trust boards must have oversight of the quality and performance of their maternity services



### Clinical governance – incident investigation and complaints

Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner



### Learning from maternal deaths

Nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies



### Multidisciplinary training

Staff who work together must train together



### Complex antenatal care

Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care

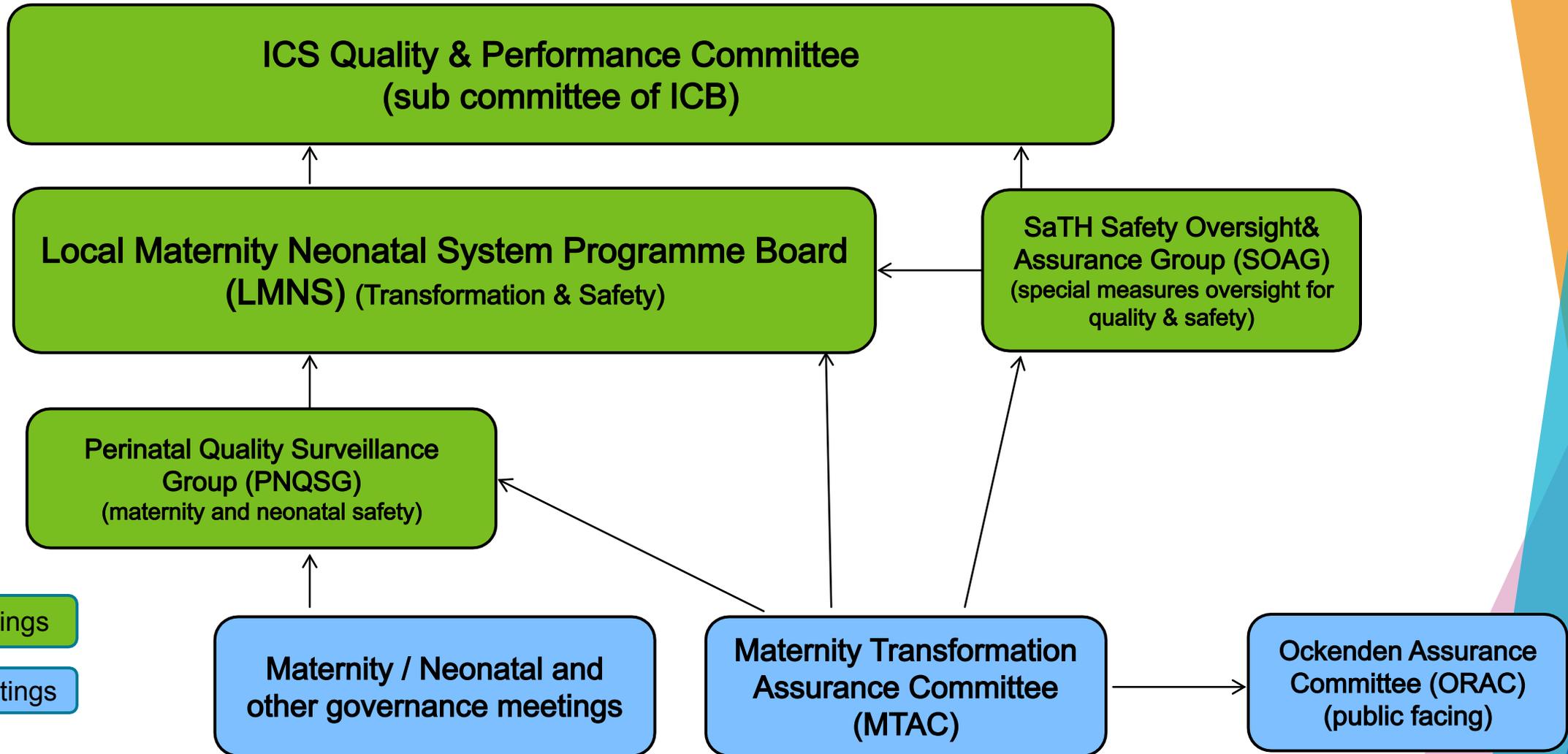


### Preterm birth

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth



# Maternity & Neonatal Governance within the ICS



Key

ICS Meetings

Trust Meetings



# Ockenden 1 – progress in relation to IEA’s and LAFL’s as presented to ORAC 15/03/22



LAFL 4.54	LAFL 4.55	LAFL 4.56	LAFL 4.57	LAFL 4.58	LAFL 4.59	LAFL 4.60	LAFL 4.61	LAFL 4.62	LAFL 4.63	LAFL 4.64	LAFL 4.65	LAFL 4.66
LAFL 4.72	LAFL 4.73	LAFL 4.74	LAFL 4.85	LAFL 4.86	LAFL 4.87	LAFL 4.88	LAFL 4.89	LAFL 4.90	LAFL 4.91	LAFL 4.97	LAFL 4.98	LAFL 4.99
LAFL 4.100	IEA 1.1	IEA 1.2	IEA 1.3	IEA 1.4	IEA 1.5	IEA 1.6	IEA 2.1	IEA 2.2	IEA 2.3	IEA 2.4	IEA 3.1	IEA 3.2
IEA 3.3	IEA 4.1	IEA 4.2	IEA 4.3	IEA 4.4	IEA 5.1	IEA 5.2	IEA 6.1	IEA 6.2	IEA 6.3	IEA 7.1	IEA 7.2	IEA 7.3

- Evidenced & Assured
- Delivered, Not Yet Evidenced
- Not Yet Delivered



45 Actions Implemented (86% overall), comprising:

- 35 (67%) Evidenced & Assured
- 10 (19%) Delivered, Not Yet Evidenced

7 (14%) Actions 'not yet delivered'



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# ICB are invited to note and discuss:

- That further assurances are required relating to continued concerns regarding safety and staff culture within maternity services at SaTH and a report responding in detail will be presented at a future ICB meeting.
- The governance oversight processes in place within our system.
- Progress against completion of the 27 local and 25 national recommendations arising from the first review report.
- The scale of further improvements required - the 66 Local actions for learning and 15 Immediate and Essential Actions for maternity services in the NHS as identified in the second review report.



## 0. Reference Information

<b>Author:</b>	<b>Angela Parkes Deputy Director of Planning</b>	<b>Paper date:</b>	21 April 2022
<b>ICS Board Member Sponsor:</b>		<b>Paper Category:</b>	Strategy
<b>Paper Reviewed by:</b>		<b>Paper FOIA Status:</b>	Full
<b>Action Required (please select):</b>			
A=Approval	<input checked="" type="checkbox"/>	R=Ratification	<input type="checkbox"/>
S=Assurance	<input type="checkbox"/>	D=Discussion	<input type="checkbox"/>
I=Information	<input type="checkbox"/>		

## 1. Purpose of Paper

- 1.1. The purpose of the report is to present the final system operational plan headlines for approval prior to the submission deadline of 28 April 2022.

## 2. Executive Summary

### 2.1. Context

As part of the national process a draft system operational plan was submitted on 17 March 2022. Following this feedback was received from NHSEI and a final submission will be made on 28 April 2022. This final submission is the focus of this report.

The following returns are due for submission on 28 April 2022: Narrative Operational Plan; Activity and Performance; Workforce numbers and Finance which is subject to a separate approval process.

### 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. Summary

The narrative submissions contains information around the assumptions that have been used when completing the returns, the actions to be taken during 22/23 and the risks and mitigating actions that may affect delivery. Section 3.3. summarises the actions identified for each of the following areas:

- Health inequalities
- Workforce
- Covid-19 response
- Elective recovery
- Cancer

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

- Diagnostics
- Maternity
- Urgent and emergency care
- Community services capacity
- Primary care access
- Mental health
- Learning disability and autism
- Population health management
- Digital technologies
- Use of resources
- Financial framework
- ICB and system working

The activity return contains submissions for the commissioner, the ICS, the Acute Providers within the system and the Mental Health Provider. There are challenges with meeting some of the national targets set for elective recovery due to a number of constraints including availability of funding, diagnostics capacity, workforce, Covid IPC constraints affecting delivery and theatre capacity. Discussions are still being undertaken across the system to determine what should be included within the activity return. Further work is required within the system to finalise the return before the submission date.

The workforce return outlines the annual plan and shows increases in total workforce and substantive staffing. The return also shows a decrease in bank and agency staff. Narrative for actions relating to workforce can be found in Section A of the narrative return.

## 2.4. Conclusion

The ICS Board is asked to:

- Note the contents of the report
- Approve the submission of the returns to NHSEI

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

## 3. Main Report

### 3.1. Introduction

As part of the national process a draft system operational plan was submitted on 17 March 2022. Following this feedback was received from NHSEI and a final submission will be made on 28 April 2022. This final submission is the purpose of this report.

The following returns due for submission on 28 April 2022:

- Narrative Operational Plan return
- Activity and Performance return
- Finance return
- Workforce numbers return

### 3.2. Operational Plan Approval

Planning and Operational leads across the system has been working together to complete all of the submissions to ensure they have all of the relevant information and present a system view of our plans and priorities. In addition, the system leads have been working closely with PwC who, as part of the elective recovery work, have reviewed all the elements of the plan to be submitted to NHSEI

The plans have been reviewed by the Sustainability Committee with a request to approve a recommendation to the ICS Board for submission of the returns on 28 April 2022. At the time of writing this paper, the committee had not met therefore any specific feedback from that meeting will be given verbally.

### 3.3. System Narrative

The original operational planning guidance had a series of narrative sections and following further guidance from NHSEI it was identified only some sections were required for national submission. The system agreed that it was important to still cover all of the sections identified so a decision was made to create a local template for completion that covered these sections. Each section contains information around the assumptions that have been used when completing the returns, the actions to be taken during 22/23 and the risks and mitigating actions that may affect delivery. The national and local narratives have been joined together to create a single narrative for the system.

#### Health inequalities

This section outlines the system approach to maintaining focus on preventing ill health and tackling health inequalities. It focuses on the actions being taken to deliver the five priority areas and Core20plus5 approach.

#### *Priority 1: Restore NHS services inclusively*

This area of work will focus on:

- Undertaking further data analysis to understand the statistical significance of variances
- Establishing partnership working with the population health programme for PCN level analysis
- Progression of Community Diagnostic Hubs
- Clinical review of referral to reduce first come first served inequalities

#### *Priority 2: Mitigate against digital exclusion*

- Understand baseline of digital access offer and segmentation of uptake by Core20+ grouping
- Develop the role of Digital Advisory Group to mitigate against digital exclusion
- Ensure robust systems in place to safeguard individuals for whom non face-to-face communication places them at increased risk
- Ensure sufficient information available to enable patients to access digital methods

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

*Priority 3: Ensure datasets are complete and timely*

This area of work will focus on monitoring datasets through performance reporting, cross mapping of records of ethnicity and supporting workforce through training.

*Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes*

- Apply learning from vaccination approach to implement targeted programme to focus on inequalities
- Acute Trust to implement Alcohol Care Team
- Continued rollout of tobacco prevention programme
- Participate in National Obesity Audit
- Targeted programme of work to increase referrals from Core20+ communities to weight management services
- Develop a physical health pathway for mental health programmes and ensure annual health checks for those with serious mental illness
- Provide continuity of care for 75% of women from BAME communities and most deprived groups
- Focus on COPD and increased uptake of Covid, flu and pneumonia vaccination
- Focus on early cancer diagnosis
- Focus on hypertensive case finding

*Priority 5: Strengthen leadership and accountability*

- Complete system wide care assessment to include the use of HEAT as a shared health inequalities impact tool
- Inclusion of health inequalities as a factor in sustainable investment board decisions
- Adopt a system wide QI approach
- Support leaders at all levels through training programmes including Inclusive Leadership Programme, Race Equality Change Agents and the High Potential Scheme which will be delivered in partnership with SSOT ICS and the National Leadership Academy

**Section A: Invest in our workforce (national submission)**

This section outlines the workforce plan actions that will be undertaken in 22/23 and these are summarised in the table below.

Area	Actions
Retention	<ul style="list-style-type: none"> <li>• Career next steps interviews/focus groups complete with age 55+ nursing workforce</li> <li>• Enhanced exit interview process</li> <li>• Research barriers to flexible working for nursing groups</li> <li>• System wide preceptorship scheme and enhanced preceptorship support for student nurses</li> <li>• Golden ticket scheme to offer substantive employment to current student nurses</li> <li>• Enhance flexible working practices</li> <li>• Participation in Midlands Reservist pilot</li> <li>• Pilot taking learning from Rural Racism research for International Nurses Retention</li> <li>• Introduction of career clinics for nurses to explore development opportunities</li> <li>• Rotation programme for newly qualified nurses to gain experience</li> </ul>
Health and wellbeing	<ul style="list-style-type: none"> <li>• Trauma and Resilience Management Pathway</li> <li>• Staff Psychological Wellbeing Hub</li> <li>• Menopause wellbeing offer</li> <li>• Health and wellbeing conversations supported by toolkits and training sessions</li> <li>• Collaborative procurement of Occupational Health Services</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>• Support to avoid or recover from burnout and stress</li> <li>• Peer support network for mens health</li> <li>• Sleep school at work programme</li> <li>• Lifestyle medicine sessions, clinics and coaching</li> <li>• Additional support to carers and families</li> <li>• Root cause on non-Covid related sickness absence and supporting return to work</li> <li>• Support for long Covid in the workplace</li> </ul>
Equality, diversity and inclusion	<ul style="list-style-type: none"> <li>• Support Inclusive Leadership Development Programme</li> <li>• Enable Race Equality Change Agents programme to support transformation</li> <li>• Use ICS EDI group to build partnership approach</li> <li>• Explore how recruitment and retention reaches into communities and acts on feedback</li> <li>• Deliver High Potential Talent Management Scheme</li> <li>• Support staff to speak up where there are challenges</li> <li>• Implementation of reverse mentoring schemes</li> <li>• Senior management and board members to have performance objectives on workforce race equality built into appraisals</li> <li>• Act on outcomes of Rural Racism research report</li> <li>• Recognise and celebrate diverse workforce</li> </ul>
New ways of working	<ul style="list-style-type: none"> <li>• Collaborative working</li> <li>• Temporary staffing management</li> <li>• NHS Reservist Scheme</li> <li>• eRostering</li> <li>• Agency Reduction</li> <li>• International Recruitment including supernumerary support, a supportive buddy programme, an onboarding team offering additional support to find suitable long-term accommodations.</li> <li>• Apprenticeships including nursing</li> <li>• System model for education, learning and development</li> </ul>
Primary Care	<ul style="list-style-type: none"> <li>• Ongoing work with PCNs to refine recruitment plans</li> <li>• Training Hub delivering upskilling opportunities for key practice staff groups including Mental Health training and ICS Personalised Care Programme</li> <li>• PCN led workforce health and wellbeing initiatives</li> <li>• Working with MPFT on deployment of MHPs in PCNs</li> <li>• Continued recruitment and deployment of ARRS funded Personalised Care Roles</li> <li>• Increase the take-up of the Lantum digital staff platform and utilise its full functionality</li> </ul>

**Section B: Respond to Covid-19 more effectively (local submission)**

The Community Trust is the lead partner within the system for three Covid specific response developments; Vaccination Programme, Long Covid Service and Community Delivery Unit for nMAB treatments while SaTH deliver nMAB treatment for hospitalised patients.

The key focus of the vaccination programme will be embedding a dedicated and focussed vaccination service including clinical posts, operational management and senior leadership into business as usual. The staffing has been based on 2 vaccination centres, 2 hospital hubs, 2 or 3 roving buses and popup teams, in school programme, primary care network and community pharmacy delivery. The focus will be on inequalities and hyper-local work in low uptake areas of high ethnic minority and/or deprived areas.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

The Long Covid services will focus on a multi-agency approach led by the Community Trust delivering assessment and onward referral. It will utilise technology available specifically 'Your Covid recovery' to support patients. A communication plan will be developed to ensure local people suffering from Long Covid are aware of the service offer.

The system will be developing and embedding a sustainable delivery model for community based patients for nMAB treatments. The Community Trust is leading Pillar 1 testing with the Acute Trust providing laboratory processing capacity for results. The plan includes the requirement to develop a long-term programme to meet the ongoing need for testing.

### Section C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services (national submission)

This section outlines the actions that are planned for 22/23 to achieve delivery of the plan for 100% of pre-pandemic levels with a view that the additional interventions may enable the system to achieve the target of 104%.

Area	Actions
Elective Recovery	<ul style="list-style-type: none"> <li>• Mutual aid agreement of one combined shared orthopaedic waiting list</li> <li>• Maximise the use of available independent sector capacity and scope insourcing options</li> <li>• Clinical prioritisation of long waiting patients</li> <li>• Progress the capital plans for successful orthopaedic hub schemes</li> <li>• Explore out of county and third sector provider options for increasing diagnostic capacity</li> <li>• Increase use of patient-initiated follow-up for patients to release capacity</li> <li>• Improve theatre utilisation across the system including a process to backfill short notice cancellations</li> <li>• Review operating procedures at Community Trust and implement improvements</li> <li>• Develop a system view of Covid prevalence and factors including IPC, isolation and patient choice</li> </ul>
Long waiters	<p>In addition to the actions above:</p> <ul style="list-style-type: none"> <li>• Mutual aid for Acute Trust from Specialist Orthopaedic Trust for elective orthopaedics and imaging</li> <li>• Twice weekly booking and scheduling meetings to ensure P2 and longest waiting orthopaedic patients are booked into available clinical capacity</li> <li>• Vanguard unit ring fenced</li> <li>• Support request with Regional Spinal Network</li> <li>• Mutual aid discussions for spinal (UHNM, RNOH and Independent Sector)</li> <li>• Ensuring full utilisation of clinical sessions</li> <li>• Maximise availability of additional sessions</li> <li>• Community Trust exploring options for patients requiring injections under radiology who are at risk of long waits</li> <li>• Community Trust and Specialist Orthopaedic Trust working together to manage rheumatology patients at risk of breaching</li> <li>• Proactive discussions with patients to establish current status, encourage to undertake treatment and discuss transfer to alternative consultant where appropriate</li> <li>• Continued rollout of PIFU across all appropriate specialties</li> <li>• Continue to support stratified follow up</li> <li>• Review existing models and operating procedures to maximise capacity</li> <li>• Validation exercise for waiting lists</li> </ul>
Transformation	<ul style="list-style-type: none"> <li>• Standardisation of pathways including diagnostics</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>Transformation programmes including Eye Care transformation Programme, MSK Transformation Programme, Outpatient Transformation Programme</li> <li>Reconfigure Cardiology services at Acute Trust to create more outpatient capacity</li> <li>Develop Directory of Services to ensure clear and concise communication to referrers</li> <li>Personalised care focus including stratified follow-up on cancer pathways, continued rollout and increased use of patient initiated follow-ups</li> <li>Implementation of Telemedicine and Tele-dermatology</li> <li>Digital transformation including continued rollout of virtual appointments, implementation of My Planned Care app, working with NHSEI Midlands on the implementation of Electronic Eye Care Referrals, launch and use of a 'My Recovery App' at the Specialist Orthopaedic Hospital</li> <li>Increased offer of advice and guidance by telephone or email including streamlining process, exploring potential for use of Consultant Connect, integration into triage process where possible and increased monitoring of advice and guidance</li> </ul>

### Section C2: Complete recovery and improve performance against cancer waiting times and standards

The system is in the process of finalising an Integrated Cancer Strategy 2022/27 and the plans within this draft strategy for 22/23 have been included in the operational plan.

Area	Actions
Cancer waiting times	<ul style="list-style-type: none"> <li>All division to develop improvement plans to bring down backlogs</li> <li>Training opportunities for LAMP prostate biopsies, radiology for FNA, Tomosynthesis for 3D mammography reading and Mammographer courses</li> <li>Specialist Orthopaedic Trust Sarcoma Services operating at 19/20 levels</li> <li>Specialist Orthopaedic Trust workshops for tumour and diagnostic teams focusing on improving cancer standards</li> <li>Continued use of virtual appointments where clinically appropriate</li> <li>Weekly PTL meetings so actions and escalations are timely and clinical prioritisation of surgical lists</li> <li>Breast Service pain only clinics in primary care</li> <li>Tele-dermatology implementation</li> <li>FIT testing for all 2ww referrals</li> <li>Colorectal Team working on straight to test rectal bleed pathways</li> <li>Development of a Trans-nasal endoscopy service</li> <li>Implementation of prostate led CNS 2ww clinics</li> <li>Improved FNA capacity due to upskilling sonographers</li> <li>Exploring Independent Sector capacity</li> <li>Community Diagnostic Centre will benefit waiting times on some pathways</li> <li>Business case being prepared for purchase of a robot for surgery</li> </ul>
Non-specific pathways	<ul style="list-style-type: none"> <li>Will be delivered as part of the Integrated Cancer Strategy 2022/27.</li> <li>Expressions of interest have gone out to GPs, Acute Trust clinicians and Specialist Orthopaedic Trust clinicians</li> <li>Service will be supported by CNS, administrators and a Cancer Care Navigator</li> </ul>

### Section C3: Diagnostics

Access to diagnostic capacity is key to the system delivery of elective recovery but remains challenged. Key actions identified for 22/23 include:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

- Pro-active recruitment and retention campaigns including international recruitment for radiographers
- Development of additional non-professional roles of APs and radiographer apprentices
- Develop a system wide tool for demand and capacity for each imaging modality
- Delivery of Community Diagnostic Hubs (Phase 1 Telford) in Q3
- Development of business case for Community Diagnostic Hub phase 2 including mobile MRI
- Development of breast screening action plan for recovery
- Joint digital project as part of the network partnership; implementation of the replacement LIMSs and implementation of digital pathology

#### Section C4: Deliver improvements in maternity care

This section briefly outlines the LMNS Priorities and Deliverables as per National Planning Guidance 22/23 while supporting the Quality Surveillance requirements. Key actions include:

- Finalise outstanding Ockenden criterion
- Communicate and provide assurance to staff, women, families and the community while enabling a culture of supporting staff and community
- Key staff to attend LMNS Governance meetings to provide oversight and assurance that Perinatal Quality criteria is fully met
- Embed a buddying partnership arrangement which formalises the sharing of knowledge, joint approached external / internal clinical assessments through Serious Incidents. While working with Regional teams supporting further Peer Support models
- Engage and support the Equality and Equity Strategy and further embed within the system
- Address service gaps via the Triage unit and through Birthing Centre across the system
- Review staffing models to ensure fully optimised
- Address infrastructure limitations within maternity service
- Develop Estates Maternity Plan for the next 5 years
- Creation of a new and revised continuity of care plan in line with latest guidance including Ockenden requirements
- Ensure accurate and consistent data quality
- Work with Acute Trust ensuring all quality and safety areas are supported through appropriate resources. Assurance of incidence management, trending and learning is paramount while delivery of a safe environment and safe systems remain as a priority.
- Ensure dashboards support Maternity and Neonatal are fully enabled
- MVP pivotal in the co-production of all system and services both from a developing roadmap of initiatives through to day-to-day communications and feedback with all women and their families. This approach is key to getting personalised services while meeting the needs of the community.

#### Section D1: Urgent and emergency care

A 2022/23 System UEC Improvement Plan and this has been used as the basis for the operational plan.

Area	Actions
12 hour breaches	<ul style="list-style-type: none"> <li>• Develop enhanced Acute Medicine footprint at RSH and PRH</li> <li>• Additional capacity in ED at RSH will enhance facilities for mental health patients, children and young people, improve 'Fit to sit' facilities and provide a bespoke Clinical Decisions Unit</li> <li>• Alternative spaces to ED including Trauma Assessment Unit to pull patients from ED; oncology assessment area at RSH, frailty assessment area at RSH,</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<p>vulnerabilities suite at RSH for learning disability patients and Short Stay Discharge Hub at RSH</p> <ul style="list-style-type: none"> <li>• Additional spaces in hospitals including development of Short Stay Ward at PRH, additional 32 bedded ward on RSH from June 2022</li> <li>• Access to UEC portals including review ED streaming model to increase footfall to UTCs, community and primary care; implementation of ED redirection tool; explore the potential to implement electronic referrals to SDEC; expand remit of referrals through Single Point of Access</li> <li>• 111 – review demand and capacity for 111 directly bookable appointments in UTCs, consolidation of deliver and monitoring of recently implemented workforce models, review Directory of Services,</li> <li>• Develop virtual ward rollout for Covid, respiratory, frailty and other specialities</li> <li>• Review pre-hospital urgent care services</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Develop future model of provision in community to mitigate care sector pressures</li> <li>• Implementation of specific winter schemes</li> <li>• Increase primary care access</li> </ul>
Mental health	<ul style="list-style-type: none"> <li>• Specialist perinatal teams providing an MDT approach to specialist care</li> <li>• Development of enhance IAPT service</li> <li>• Increased access to a range of therapies and diagnostic support from MPFT</li> <li>• Development of expansion to CYP Eating Disorders Service</li> <li>• Develop a business case for Enhanced Support for CYP with Neuro-Development issues</li> <li>• Lack of Tier 4 bed availability resulted in need for a bespoke offer for CYP in crisis – business case in development</li> <li>• Enhanced support for admission avoidance and timely discharge back into the community</li> <li>• Development of Learning Disability Community based Forensic Team</li> <li>• Development of a multi-disciplinary BeeU Intensive Support Team, a Positive Behaviour Support informed service working with those young people most at risk of hospital admission or family breakdown identified through the Dynamic Support Register process</li> </ul>
Minimise handover delays	<p>The actions relating to increasing capacity identified within the 12 hour breach section will also contribute to minimising handover delays.</p> <ul style="list-style-type: none"> <li>• Improved GP streaming model to increase UTC, primary care usage</li> <li>• Continue to work with NHS111 to improve access to appropriate appointments</li> <li>• Direct access to SDEC Medical and Surgical for paramedics</li> <li>• Increase number of referrals into SPA</li> <li>• Explore the potential for virtual UTC</li> <li>• Regular review of NHS111 DOS to maximise use of alternative pathways</li> <li>• Continue to work to mitigate high walk-in activity</li> </ul>
Ambulance response	<p>The system understands that the Ambulances service has a finite amount of resources at their disposal to respond to 999 calls and that failure to respond to 999 calls in a timely manner presents a significant risk to our patients. A widely acknowledge contributing factor associated with resources not being available is delays at hospital and availability of locally accessible urgent and pre-hospital pathways. The lead commissioner will continue to work with the regional commissioners and providers on the development and refinement of measures to improve local performance against the national ambulance response standards:</p> <ul style="list-style-type: none"> <li>• Reduction in Emergency Department Ambulance Handover Delays.</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>• Maintain within the Emergency Operations Centre (EOC) significant levels of 999 Category 3 &amp; Category 4 clinical validations.</li> <li>• Continually monitor Directory of Service profiles of all services to maximise the usage of emergency department alternatives and hospital avoidance pathways.</li> <li>• Adherence across local emergency care pathway of regional policy for Professional Standards of Care for Patients Waiting in Ambulances (2021) and managing ambulance conveyances to hospital (2020).</li> </ul> <p>The system will continue to work with WMAS to improve standards and in addition to actions highlighted above, will focus specifically on:</p> <ul style="list-style-type: none"> <li>- Further development of our Single Point of Access</li> <li>- Enhancements to 111 bookable appointments</li> <li>- Improving direct access to SDEC and specialties within SaTH</li> </ul>

**Section D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge**

Area	Actions
Virtual ward	<ul style="list-style-type: none"> <li>• Develop rollout plan for Covid, End of life care, complex medical care (including acute respiratory care) and EMI/dementia care</li> <li>• Ensure robust shared clinical governance arrangement in place</li> <li>• Agree clear operational pathways with referral, transfer, discharge and escalation pathways</li> <li>• Establish opportunities for cross organisational education, learning and review of case studies</li> <li>• Design future workforce</li> <li>• Develop system wide implementation of remote monitoring technology and virtual ward tracking software</li> </ul>
2-hour emergency response	<ul style="list-style-type: none"> <li>• Continued rollout across the county</li> <li>• Accessed by 111, 999 and emergency department via single point of access</li> <li>• Undertake review of Children and Young People Admission Avoidance pilot implemented as part of the 21/22 winter plans to determine if should be embedded as business as usual</li> </ul>
Community service waiting lists	<ul style="list-style-type: none"> <li>• Waiting list to be prioritised based on clinical need</li> <li>• Review operating procedure to implement improvements including the use of technology and PIFU</li> <li>• Review will be undertaken for CYP services to quantify demand and develop robust capacity plans</li> <li>• Explore Independent Sector diagnostic opportunities</li> <li>• Waiting list to be reviewed weekly</li> <li>• Review pathways for challenged services and those that contribute to avoiding admissions</li> </ul>
Hospital discharge	<ul style="list-style-type: none"> <li>• Clarification of the D2A process throughout the pathway</li> <li>• Rehabilitation leaflets.</li> <li>• Education for completion of Fact-Finding Assessment including process for escalating missing essential items for discharge.</li> <li>• Ensuring professional roles and responsibilities are clear with an assigned lead.</li> <li>• Social workers providing face to face support on wards.</li> <li>• Discharge delay escalation process.</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>• Improve the timely information and reporting for inclusion in the Senior review process.</li> <li>• Strengthening links with Mental Health.</li> <li>• Reablement goal setting to be shared across the health and social care system.</li> <li>• Improve the ward processes across acute wards to improve pre 12pm discharges including ward huddles, transport booking and links to the system IDT as well as eliminating variation between wards.</li> <li>• Expand the discharge lounge on the PRH site.</li> <li>• Demand and capacity model for complex discharges to be reviewed and agreed to deliver the improvement trajectory required.</li> </ul>

### Section E: Improve timely access to primary care

Area	Actions
PCNs and workforce	<ul style="list-style-type: none"> <li>• Refine recruitment plans including utilising third party arrangements with partner organisations</li> <li>• Minimise movement of key ARRS staff groups from Trusts to PCNs</li> <li>• Develop training/development packages for ARRS staff</li> <li>• Increase support to GPs including growing GP/GPM Fellowship schemes, increase levels of GP mentoring, increase support to Tier 2 GP trainees and newly qualified locums following recruitment of champions, measure impact of local GP Retention Funding</li> <li>• Increase number of placements in practices including pre-reg nurses and other clinical role students</li> <li>• Training Hub to offer upskilling opportunities for key practice staff</li> <li>• Increase use of Lantum staff bank</li> <li>• PCN led workforce health and wellbeing initiatives to be rolled out</li> </ul>
Estates	<ul style="list-style-type: none"> <li>• Develop PCN Estates and Workforce plans ensuring future estate will be aligned to improving patient access, providing adequate staff accommodation, facilitating GP retention and training requirements</li> <li>• Use of SHAPE to inform decisions around new premises build and overall estate requirements</li> <li>• Estates plan to be aligned with local PC Digital Roadmap</li> <li>• Use of PCN estates and workforce toolkit to inform planning when available</li> <li>• Capital spending – next round of Facet surveys due in late 2022</li> </ul>
Access	<ul style="list-style-type: none"> <li>• Continue to increase GP capacity through the provision of extended access</li> <li>• Continue to use triage services as well as online consultation and face-to-face appointments</li> <li>• Review of 111 and A&amp;E data to identify PCN and practice level issues with access in hours</li> <li>• Explore new ideas to address overflow</li> <li>• Grow use of new roles including First Contact Practitioner, Community Pharmacy Consultation Service, social prescribers, community care co-ordinators</li> <li>• An ‘enhanced telephony support’ offered to all practices to enable them to increase efficiency of telephone systems and enable easier access for patients</li> <li>• Monitor practice websites and telephone messages to ensure consistency</li> <li>• Complete system Phlebotomy Redesign project to improve service offer</li> <li>• Complete review of Locally Commissioned Services to ensure high quality, equitable and appropriate care for all patients.</li> </ul>
PCN Delivery of services	<ul style="list-style-type: none"> <li>• Deliver DES requirements</li> <li>• Implement strategies to address inequalities in care utilising ARRS staff</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>Expand MDT model of working to deliver anticipatory and personalised care for frail and vulnerable patients</li> <li>Use of ARRS roles to expand work such as structured medication reviews and inequalities plans</li> </ul>
Digital	<ul style="list-style-type: none"> <li>Implementation of notes digitisation programme with the greatest need to realise space within premises for service delivery</li> <li>Rapid rollout of Remote Patient Monitoring starting with care homes</li> <li>Maintain role in system virtual ward work</li> <li></li> </ul>
Dental care	<ul style="list-style-type: none"> <li>Ensure availability of GDS service for new patient NHS care specially for children</li> <li>Oral Health Improvement Programmes to support a preventative approach to oral health and reduce health inequalities</li> <li>Ensuring availability of well signposted urgent dental care services to meet urgent care demand and reduce dental related hospital admissions. Dental advice line will be operational from Q1</li> <li>Shared care approach to paediatric dental provision where appropriate</li> </ul>

### Section F1: Expand and improve mental health services

Area	Actions
Crisis care	<ul style="list-style-type: none"> <li>Continue to expand and improve provision for all ages (24/7 crisis lines, CRHT, MH Liaison in acute hospitals)</li> <li>All age 24/7 MH helpline crisis service expanded to include professionals supporting CYP within the Access Team</li> <li>Working with third sector to develop non-clinical alternatives to broaden Crisis Intervention Support</li> <li>Engaging ambulance service to consider street triage models for patients with MH needs</li> </ul>
Children and Young People	<ul style="list-style-type: none"> <li>24/7 BeeU Crisis Service</li> <li>Place of safety for children to bridge gap due to lack of Tier 4 beds</li> <li>Increase support through specialist perinatal teams</li> <li>Developed a dedicated specialist psychological service to support the Ockenden Review</li> <li>Lighthouse service – Maternal Mental Health Service</li> <li>Service to support women maybe in danger of having their unborn child taken into care</li> <li>Increasing access to therapies and diagnostic support as part of early intervention in schools</li> <li>Use evidence based alternative ways of assessing for ASD to help improve the process of assessment and diagnosis</li> <li>Develop CYP Eating Disorder service to meet growth in demand.</li> <li>Develop a specific pathway to meet the needs of Avoidance Restrictive Food Intake Disorder (ARFID) or suspected ARFID</li> <li>Business case for enhanced support for children and young people with neuro-development issues being developed</li> </ul>
Dementia	<ul style="list-style-type: none"> <li>Dementia Transformation Programme will commence in June</li> <li>Development of Dementia Crisis Service to extend current admission avoidance offer</li> <li>Develop a dementia strategy</li> <li>Improve assessment and diagnosis process</li> <li>Exploring how to develop a more personalised and integrated pathway from diagnosis to end of life.</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
	<ul style="list-style-type: none"> <li>Linking with expert in the voluntary sector to improve signposting and access to community services</li> </ul>
Mental Health Transformation Programme	<ul style="list-style-type: none"> <li>Develop service model in partnership with local authorities and CCG</li> <li>Embed Mental Health Practitioners in PCNs</li> <li>Integrated physical health care pathway</li> <li>Further development of virtual MDTs and embed in PCNs</li> <li>Move towards integrated care plan over the three year programme</li> <li>Use population health data packs to understand communities</li> <li>Build relationships with VCSE – a lead VCSE provider model has been agreed</li> <li>Support patient groups at PCN level</li> <li>Programme for elimination of inappropriate OOA placements</li> <li>Embed trauma informed approaches</li> <li>Suicide prevention through effective referral pathways, monitoring, risk assessments and effective training</li> <li>Working with primary care to develop Shared Care</li> <li>Wellbeing Wheels initiative outreach to those who are physically, socially or geographically isolated</li> </ul>
Other pathway	<ul style="list-style-type: none"> <li>Implement single service for IAPT across county</li> <li>Virtual Single Front Door for Mental Health development</li> <li>Establish local rehabilitation pathway to support return of people to the area</li> <li>Continue to deliver Rough Sleeper Initiative and replicate across the county</li> </ul>
Inequalities	<ul style="list-style-type: none"> <li>Use champions and lived experience workers to support tackling inequalities by supporting transformation work</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>System to develop a mental health workforce plan</li> <li>PCNs and MH Trust to embed mental health practitioner ARRS roles to improve care and treatment</li> <li>Utilise Peer Support Workers within specialist areas</li> </ul>

### Section F2: Meeting the needs of people with a learning disability and autistic people

The system has developed a strategy for people with Learning Disabilities and Autism with the development of LD&A roadmap and the implementation of a three year plan. This has been used to develop the submission for the operational plan.

Area	Actions
Health checks	<ul style="list-style-type: none"> <li>Working with primary care networks and CCGs to increase the uptake and quality of Annual Health Checks</li> <li>Ensure every health check is accompanied by a health action plan</li> <li>Reduce the use of psychotropic medication for people with learning disabilities</li> <li>Intensive Health Outreach Team supporting best practice in relation to Annual Health Checks</li> </ul>
Reducing inpatient care	<ul style="list-style-type: none"> <li>Implement community service model to reduce reliance on inpatient care</li> <li>Expand Intensive Support Team</li> <li>Development of Learning Disabilities Community Based Forensic team</li> <li>Explore options for dementia assessment and post-diagnostic for people with learning disabilities</li> </ul>
Children and Young People	<ul style="list-style-type: none"> <li>Multi-disciplinary BeeU Intensive Support Team - Positive Behaviour Support informed service</li> <li>Addition of Speech and Language Therapy and Occupational Support in the BeeU Team</li> <li>Autism in schools pilot to create more autism-friendly environments</li> </ul>

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

Area	Actions
Adult Autism	<ul style="list-style-type: none"> <li>Exploring expanding the Adult Autism Service - Diagnostic, Forensic and Mental Health</li> </ul>

### **Section G: Continue to develop approach to population health management, prevent ill health and address health inequalities**

This section should be read in conjunction with the Health Inequalities section at the start of the plan. A refresh of our Population Health Strategy (of which Population Health Management (PHM) sits as a key enabling work stream) is being refreshed during Q1 2022. As part of this work, a refresh of the Population Health Management work programme is being undertaken to ensure it can adequately meet the needs of the Population Health strategy and to identify where there are gaps that need to be addressed.

This refresh will address key actions:

- Develop governance arrangements to ensure that current groups linked to the Population Health Management (PHM) agenda are working in unison and decision making and processes are aligned
- Further develop our Decision Support Unit local arrangements and offer
- Ensure robust links to the local digital agenda to maximise on digital developments and create the right infrastructure for our PHM approach to thrive
- Ensure appropriate links with Information Governance to ensure we are compliant in taking forward our PHM approach and its associated work streams
- We have developed a system wide analytical network and completed the first step in a skills mapping exercise. This will inform how we develop our future system capacity and capability to support the PHM approach

During 22/23 the system will continue to progress the PHM approach to support a number of specific priority areas.

### **Section H: Exploit the potential of digital technologies to transform the delivery of care and patient outcomes**

The primary digital focus will be the development of a 12-month costed digital plan by the end of March 22 and a 3 year costed plan by the end of June 22. The ICS Digital Strategy will continue to be developed and will be an iterative process to ensure this aligns to the strategic priorities of the system. Actions include:

- Establish a core team to support the ongoing development of the digital strategy and delivery of the digital project across the system
- Continue to secure external funding when available
- Develop business cases to support the progression of the system digital and digitally enabled priorities and use these to support external funding bids
- Continue to develop shared care record
- SaTH to implement a new EPR which will include replacement PAS, Theatres and ED systems
- RJAH to progress procurement of a new EPR
- ICB digital plan to focus on delivering the digital strategy and roadmap for both primary care and corporate services.
- Work with regional and national colleagues to review opportunities for EPR convergence and continue the journey to progress interoperability between the digital solutions.
- Progress the monitoring and management of cyber security at organisational and system level
- Progress digitally enabled technology through remote monitoring, digital consent and system level reporting

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

## Section I1: Use of resources

The 22/23 financial plan for STW is set within the national context of:

- A resource allocation based on current costs (21/22) and including a ‘convergence’ improvement back to fair share allocations over time
- A requirement to break even and hold no underlying deficit
- An expectation to fully restore core services and make significant inroads into the elective backlog and NHS Long Term Plan commitments
- An expectation of delivery of significant additional efficiencies in order to address the excess costs of the pandemic and move back to and beyond previous levels of productivity

For STW ICS

- Significant work as a system has been developed over recent years to produce a 5 year finance plan that was reviewed at system committees in September 2021, 21/22 has been our year of cost stabilisation
- 22/23 is the first year of our recovery trajectory towards underlying recurrent balance and requires focused effort on driving costs out

In order to work within the financial envelope and achieve a year of financial recovery, the system has needed to make some difficult decisions about what can and cannot be delivered affordably in-year

- This plan indicates the system will be around £53.2m away from delivering the required break-even position in 22/23 and £69.7m away from a break-even underlying position (correct as at 21/04/22).
- *This is after assuming we deliver:*
  - a. 1.6% CIP in each organisation
  - b. £3m of cost out from workforce
  - c. £11m of productivity savings – i.e. flattening the demand curve
- Significant work is underway to reduce this deficit before the April plan submission. This includes internal system challenge meetings and prioritisation of cost pressures/investments that are currently included. The impact of the ERF is also to be worked through in detail.

Expenditure plans have been refreshed to reflect system priorities and the ‘ask’ of the NHS Long Term Plan. In order to do that we have been through a system process of :

- a. Confirmation of system priorities and recovery trajectories (linked to NHS Long Term Plan and supported by NHSEI)
- b. Recognition of workforce as a material constraint.
- c. Action to hold to account for programmes already in place i.e. 1.6% CIP; Transformation Programmes etc.

## Section I2: Financial framework

In January 2021 the system was placed into the National Recovery Support Programme with a specific requirement to develop an approach to recovering a deteriorating financial position. This is also in the context of the quality and safety challenges that the system faces. A system financial

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

framework was therefore developed and agreed by all organisations and all system partners have worked closely together to develop a roadmap for financial recovery.

All organisations agreed to:

- approve the approach of one model, one consistent set of assumptions and recognise that the position of each organisation will transparently evolve and change.
- mobilise and deliver the plan to enable the development and delivery of the financial strategy and Financial Improvement Framework as part of an Integrated System Strategy.
- an approach that ensures the transparent and agile approach to financial planning and management continues across the system.
- recognise the financial control totals in the financial Improvement Framework with a commitment to agree organisational control totals once operational planning has commenced.
- work together to use our resources flexibly and effectively to deliver the system vision.

In order to ensure that all decisions made are open and changes are understood and approved by all, the system has been operating under the triple lock process and the ‘moving parts’ principles. This means that decisions are made at local, ICS and Region level (triple lock) and that new expenditure can only be committed if it is backed by new income or efficiency (the moving parts). The principles are designed to ensure decisions are owned at each of organisation and system level, overseen by NHSEI as required whilst the system remains in the Recovery Support Programme.

In 22/23 the core structures for making decisions across the system will remain as the Sustainability Committee in conjunction with the CEO Forum. This will link both with organisational boards and with the ICS Board to ensure all organisations are part of the discussion and all changes and approaches are openly discussed and agreed by all. Board Workshops will continue to develop thinking and understanding. The Investment Panel was formed to manage the decision-making process required on any new expenditure. It is proposed that it will evolve to proactively review and prioritise resource across the system and actively incorporate consideration of quality, safety, operational and finance demands. This will be a continual feature of system working across all disciplines for the foreseeable future.

*Intelligent Fixed Payment Approach:*

In order to promote collaboration not competition, all partners have agreed that the national NHS payment arrangements will be set aside in 2022/23. Instead the system will concentrate on the cost of providing healthcare within the system, and in bringing the whole health system back to clinical, operational and financial balance. In line with the national 2021/22 Operating Framework, the intention of the IFP model is to encourage a movement towards a “system by default” model while recognising the statutory roles and responsibility of individual organisations. The system deficit will therefore be shared between all partners.

*LA and MPFT:*

Although the Local Authorities and MPFT are not included in this system financial plan submission, all three organisations are involved in system decision making and prioritisation with representation on the Sustainability Committee, CEO forum and system finance group.

Local Government faces considerable uncertainty over its future financial outlook. The Comprehensive Spending Review (CSR) made no announcements about the long awaited major potential reforms of the local government finance system which include reform of the assessment of Review of Relative Needs and Resources and the new homes bonus system. Despite 3 year CSR, in

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

December 2021 when the Local Government Funding settlement was announced it was a **one-year funding settlement** only which provides no certainty on funding levels beyond the end of the next financial year.

## Section J: Establish ICBs and collaborative system working

1. Continue preparations for closure of CCGs and establishment of ICBs working toward the new target date.

- Handover between CCG and ICS is being managed in accordance with ICS implementation guidance: Due diligence, transfer of people and property from CCGs to ICBs and CCG close down
- A baselined Due Diligence checklist was submitted in January 2022, further checkpoints and scrutiny by the CCG Audit Committee, ICS Audit & Risk Committee and the Transition Steering Group/CEO Group (ICS) are planned out until final written assurance from CCG AOs to ICB designate CEs on 1 June 2022 that due diligence processes have been completed.

2. National programme team will work closely with systems and in regional teams to identify what support is needed to manage the new timetable

- Progress on ICS transition is reported through Quarterly Service review meetings with the region;
- Regional representative is linked in to bi-weekly transition meetings
- Funds made available by the region have allowed us to secure PMO support for Clinical Leadership Programme and continued PMO support for the transition team

3. Systems to have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders

- The Comms and Engagement strategy of the ICS will place a system-wide focus on encouraging a creative, positive, and welcoming environment within which people can contribute in a meaningful way.
  - o As part of this strategy partners across the ICS will be involved in order to develop arrangements for:
    - ensuring the ICP and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
    - gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.
- It is planned to seek approval for the Comms and Engagement strategy in April for roll out in May 2022
- A comms plan and messages to provide assurance to staff within the ICS are being phased during the transition period

4. Progress recruitment to designate leadership teams

- Chair and interim Chief Executive have been appointed; appointments for NED roles have been confirmed; recruitment for mandatory roles and other executive roles within the senior leadership team has been completed.

5. Formal transition to future leadership arrangements should now be planned for 1 July 2022

- It is intended that the ICB commence in shadow form from 1st April, enabling the new board to have a 3-month period to test new working arrangements; workshops have been held in recent weeks to formalise the shadow board structure

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

1. Regional teams will work with CCG leaders to ensure:
  - CCGs remain legally constituted and able to operate effectively
  - Individual roles and circumstances are clear during the extended preparatory phase
  - Arrangements have been agreed in the January Board meeting to ensure CCGs remain legally constituted and are able to operate effectively for the additional transition period; Arrangements have also been made to ensure the quoracy of the CCG Governing body and sub committees; Nonessential meetings have been minimised and CCG decisions are also fed through to the ICS board meetings and the subsequent ICB.
  
2. Employment commitment arrangements for other affected staff and the talent based approach to people transition previously set out will be extended to reflect the new date
  - All staff transition plans and arrangements have been adapted in order to reflect the new implementation date
  
3. The requirements for ICB Readiness to Operate and System Development Plan submission has been revised to reflect the extended period
  - SDP and transition plan work has commenced and was presented at the ICS board meeting on 30 March.
  - A completed ROS with supporting evidence has been prepared and submitted to region on 31 March; further steps for the remaining transition period until 1 July 2022 have been factored into the planning
  
4. Designate ICB leaders, CCG accountable officers and NHSE/I regional teams agreed ways of working for 22/23 at the end of March 2022. This included agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICS and the oversight of quality governance arrangements in the system
  - A draft Concordant to describe the agreed ways of working for 2022/23 between regions and ICBs is being developed as part of the Governance and Constitution deliverables for the 31 March checkpoint. A version reviewed and tested by systems will be ready to be introduced from 1 July 2022.

Planning during 2022/23:

- The ICS is aware of the requirements for a five year forward plan and prep work has started; further details will be incorporated into plans in line with timelines and guidance if and when available;
- Partnership arrangements have been drafted and will be further progressed over the coming months;
- Once the ICS and local authority partners have agreed a strategy, detailed plans to support the implementation, including the development of place based integration, will be drawn up
- The ICS is already undertaking work to ensure their five year system plan is delivering the specific objectives set out in the planning guidance. These objectives are reflected in the aim, vision and principles of the ICS and have been incorporated into the System Development plan.

The ICS is preparing to take on further commissioned services in the future such as wider primary care (community pharmacy, ophthalmology and dental) and some specialised services.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

### 3.4. System Activity Submission

The activity return contains submission for the commissioner, the ICS, the Acute Providers within the system and the Mental Health Provider. This section outlines some of the key activity submissions particularly those relating to delivery of elective recovery.

There are some key targets in relation to elective recovery over the next twelve months. One target is that the system should deliver in excess of 104% of pre-pandemic value weighted elective activity. Due to constraints in the system including diagnostic capacity, workforce, Covid IPC restrictions affecting delivery and theatre capacity the system may find it difficult to deliver the 104% target. In addition, delivery of this target is dependent on ERF funding delivering the modelled impact. Further work is required within the system to determine if this national target can be met.

To begin to combat long waiting patients there are national target in relation to 104 week waits and 78 week waits. The target for 104 weeks is that they should be eliminated by the end of June. For the Acute Trust there are 99 patients in the cohort at risk of being over 104+ ww at the end of June 22. There are currently plans in place for c.80 out of the 99 patients however challenges remain with the following:

- 5 Paediatric Ophthalmology – Current consultant resigned, potential locum booked for 2wks in May to clear but not yet confirmed. NHSE Elective lead aware.
- 10-14 Post Op intervention Orthopaedics – need to book by mid-May – risk is current escalation and lack of green Orthopaedic capacity co located with ITU, other Trusts nearby have the same pressures. NHSE Elective lead aware- Regional Mutual aid sought.

For the Orthopaedic Trust there are 231 patients in the cohort at risk of being over 104+ ww at the end of June 22. Of these the main concern is spinal disorder patients (c.184). We believe that with appropriate staffing and IS provision (Spinal Disorders) we will be able to clear the 215 patients with the remaining patients as P6 which is patient choice to wait. This leaves a total system risk of approximately 35 patients.

The national target for patients waiting over 78 weeks is that by April 2023 these should be eliminated. The system is not currently predicting any issues with delivering this target.

There are national targets to return the number of people waiting 62 days for cancer treatment to the level in February 2020 and to deliver the Faster Diagnosis Standard. The Specialist Orthopaedic Trusts is seeing significant increases in the level of referrals and the Acute Trust has identified that delays within the pathways have increased. The system is planning to significantly reduce the number of people waiting 62 days by the deadline and to enable this each division within the Acute Trust have developed improvement plans to address the waiting times. These plans rely on increasing staffing levels, improving diagnostic waiting times, purchasing additional diagnostic equipment, additional training and staff development, pathway improvements and expected referral levels to stabilise. The system is expecting to deliver the Faster Diagnosis Standard in only some specialties as the availability of diagnostic capacity will affect the ability to deliver this standard.

There is a national target to deliver diagnostic activity to a level of 120% of pre-pandemic levels. This is challenging for the system. The plans for the system indicate delivery of increased levels of diagnostic activity in some areas but it is unlikely that the 120% target will be achieved. Delivery of improvements is dependent upon the ability to secure the relevant workforce and the Community Diagnostic Hub opening to schedule.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

### 3.5. System Workforce Submission

The system workforce submission outlines the annual plan split by type of staff member and levels of substantive, bank and agency staff. The table below shows the total planned workforce against the baseline.

System Input Summary Shropshire And Telford And Wrekin STP	2021/2022	Staff in post outurn	As at the end
	Year End (31- Mar-22)	Year End (31- Mar-22)	of Mar-23
Workforce (WTE)	Total WTE	Total WTE	Total WTE
<b>Total Workforce (WTE)</b>	9463.79	9782.158	10278.86
Registered nursing, midwifery and health visiting staff (substantive total)	2778.21	2883.134	2989.44
Registered scientific, therapeutic and technical staff	1132.984	1137.339	1183.309
Registered ambulance service staff	0	2	2
Support to clinical staff	2650.473	2818.722	2960.416
Total NHS infrastructure support	1916.093	1944.236	2053.468
Medical and dental	972.03	982.727	1016.017
Any other staff	14	14	74.21

It can be seen in the figure above that the system is planning for an increased workforce across all areas with particular increases in registered nursing, scientific, therapeutic and technical staff.

System Input Summary Shropshire And Telford And Wrekin STP	Establishment	Baseline	Plan
	2021/2022	Staff in post outurn	As at the end
Workforce (WTE)	Year End (31- Mar-22)	Year End (31- Mar-22)	of Mar-23
Workforce (WTE)	Total WTE	Total WTE	Total WTE
<b>Substantive WTE</b>	9463.79	8861.828	9483.496
Registered nursing, midwifery and health visiting staff (substantive total)	2778.21	2560.01	2779.006
Registered scientific, therapeutic and technical staff (substantive total)	1132.984	1085.055	1125.665
Registered ambulance service staff (substantive total)	0	2	2
Support to clinical staff (substantive total)	2650.473	2492.497	2657.507
Total NHS infrastructure support (substantive total)	1916.093	1855.389	1963.231
Medical and dental (substantive total)	972.03	852.8772	881.8772
Any other staff (substantive total)	14	14	74.21
<b>Bank</b>		551.0894	474.8835
Registered nursing, midwifery and health visiting staff (Bank Total)		152.5941	85.5641
Registered scientific, therapeutic and technical staff (Bank Total)		25.8737	28.3737
Registered ambulance service staff (Bank Total)		0	0
Support to clinical staff (Bank Total)		217.6146	202.0987
Total NHS infrastructure support (Bank Total)		84.9472	86.3372
Medical and dental (Bank Total)		70.0598	72.5098
Any other staff (Bank Total)		0	0
<b>Agency</b>		369.24	320.48
Registered nursing, midwifery and health visiting staff (Agency Total)		170.53	124.87
Registered scientific, therapeutic and technical staff (Agency Total)		26.41	29.27
Registered ambulance service staff (Agency Total)		0	0
Support to clinical staff (Agency Total)		108.61	100.81
Total NHS infrastructure support (Agency Total)		3.9	3.9
Medical and dental (Agency Total)		59.79	61.63
Any other staff (Agency Total)		0	0

The table above shows that the system is planning to increase substantive staff and decrease the use of bank and agency staff.

 1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

### 3.6. 22/23 System Finance Plan

The national context around financial planning for 22/23 includes the following key principles:

- Statutory requirement to break even and hold no underlying deficit
- Expected to fully restore core services and make significant inroads into the elective backlog and NHS Long Term Plan commitments
- Significant additional efficiencies are expected to be delivered in order to address the excess costs of the pandemic and move back to and beyond previous levels of productivity
- Resource allocation based on current costs (21/22) and requires a ‘convergence’ improvement back to fair share allocations over time

The system recognises the need to deliver a financially balanced plan but at this point is unable to submit one. For the draft system plan submission on 17<sup>th</sup> March, an in-year system plan carrying a £73m deficit was submitted (with a £77.8m underlying deficit). The system did not see this as an acceptable position, noting this as a ‘worst case’ position and committing to work together to reduce the deficit for the final plan submission on 28<sup>th</sup> April 2022.

Since the draft plan submission in March a number of key actions have taken place, these include:

- Neil McKay (ICS chair) chaired a finance summit with chief executives and directors of finance invited from all system partners. Its aim was to ensure collective understanding of the financial pressures and challenges in the system and to prepare for further work to refine the plan
- System to organisation confirm and challenge meetings were held to review and challenge each organisations element of the financial plan
- Directors of Finance continued to meet regularly to review the technical assumptions and estimates within the plan
- A second system wide finance touch point meeting was held with chief executives and directors of finance to confirm progress to date and ensure continued focus on drafting a realistic but challenging plan
- A number of cost pressures/investments have been taken outside of the plan to be held on a ‘to be prioritised’ list. The system investment panel will meet to assist with prioritisation decisions required so that when funding becomes available the system is ready to mobilise quickly. The panel will also ensure that the impact and consequences of not funding these pressures is captured and visible across the system.

As a result of the above actions, the 28<sup>th</sup> April plan submission will show an overall in year system deficit plan of £53.2m (with a £69.7m underlying deficit). This is an improved position since the draft plan on the 17<sup>th</sup> March but still remains a significant distance from break even. Work therefore continues to review and refine plans and we expect discussions to continue with both the regional and national NHSEI team.

#### Headlines from the Plan

The financial plan is part of a suite of documents alongside the operating plan (incl activity and workforce plans) and must be read in conjunction with them.

##### *1. Allocations/Income*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

The 22/23 **recurrent** system allocation is £917.8m and the table below shows growth since the allocations in 21/22. As previously discussed at Sustainability Committee, the system intends to move to the 'Intelligent Fixed Payment' (IFP) arrangements in 2022/23 so that contracts within the system are no longer based on a traditional payment by results basis (PbR). Activity information will continue to be captured and is important to outline what our funding is buying. The distribution of funding allocated to system providers will be based on sharing the overall core system allocation split on an underlying cost basis. This means that the system deficit is shared across all system partners. The principles of IFP have been applied in the April plan submission to allocate an overall position to each organisation. The first IFP management group will meet to sign off the key documentation and opening baselines on 29th April.

<b>Recurrent Allocations</b>	<b>22/23</b>	<b>21/22</b>	<b>Change</b>
	<b>£m</b>	<b>£m</b>	<b>%</b>
Programme	825.6	791.71	4.3%
Primary Care Delegated	82.95	76.52	8.4%
Running Costs	9.25	9.18	0.8%
<b>TOTAL</b>	<b>917.8</b>	<b>877.41</b>	<b>4.6%</b>

Providers also receive income from outside of the system, this is included in the plan at a value of £228.7m in year, taking the total system funding envelope to £1,146.5m.

There are also a number of non recurrent income streams for COVID, ERF (Elective Recovery Fund) and SDF (Service Development Funding).

## **2. Expenditure**

Total **in year** expenditure (including non recurrent) in the 22/23 plan equates to £1,261.8m which is 0.5% higher than the total expenditure for 21/22. Recurrent expenditure has increased between the years by 5.9%.

<b>Expenditure</b>	<b>22/23</b>	<b>21/22</b>	<b>Change</b>
	<b>£m</b>	<b>£m</b>	<b>%</b>
Recurrent	1216.3	1148.5	5.9%
Non Recurrent	45.5	106.5	-57.3%
<b>TOTAL</b>	<b>1261.8</b>	<b>1255.0</b>	<b>0.5%</b>

## **3. Deficit**

The overall **in year** deficit for 22/23 currently stands at £53.2m. Approximately £23.6m of this deficit is deemed 'unavoidable' due to:

- £13m 'loss' on allocation conversion
- £11m excess inflation costs (energy, care market etc)

Work continues to test the modelled position with focus on both income assumed and across the entirety of the cost base.

## **4. Efficiency**

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

In order to deliver the position, 3.3% of overall efficiency/savings have been assumed being 1.6% cost improvement in individual organisations (c£18m) and an additional £14m of transformation/growth avoidance savings. The Integrated Delivery Board is in place to oversee delivery of the efficiency/transformation programmes across the system.

### **5. Risk**

The financial plan assumes April has occurred as we have experienced it with a significant impact of high levels of covid in our population (including in hospital) and staff sickness across all health and care partners impacting on service delivery. For May onwards however it assumes a return to pre covid levels. There is a material risk that this may not happen immediately and therefore delivery against the future months plan will be impacted.

£18.6m of identified expenditure sits outside of the plan and is held in a 'to be prioritised' list. These are important areas of investment across the system that cannot proceed until we can unlock sufficient funds to pay for them. They include:

- waiting list recovery in both community and mental health,
- investment above Mental Health Investment Standard given that whilst we achieve the minimum investment, we need to exceed that to improve services
- additional capacity to support long covid
- a number of key investments in the acute setting

The system investment panel will consider each of the items on the list to ensure that the impact and consequences of not funding them are widely known and that an order of priority is recommended so that mobilisation can be enacted at pace once funds become available.

Approximately £24m of other financial risk has been identified which includes risks in relation to:

- Elective recovery – failure to meet activity trajectory would mean clawback of non recurrent funds (up to 75% of the £16m that is available)
- Urgent and Emergency Care pressures prevailing – impacting from the front door of the hospital through to discharge. We have included in the plan a reasonable level of funding for all parts of the pathway (for example including West Midlands Ambulance Service and a small amount of community discharge support) but there is a risk that these costs could be far exceeded if system pressures do not fall in line with the planned activity assumptions
- Risk remains around delivery of some of the efficiency and transformation programmes due to delays in implementation due to operational pressures
- Individual commissioning volume and pricing

### **Next Steps**

Whilst the system plan submission is made at a fixed point, our work continues to review and refine the position that we have modelled. There is still work to be done to test our assumptions and make sure that we have produced a deliverable but challenging plan.

Areas of focus for the coming weeks are as follows:

- Further triangulation of activity, workforce and finance plans alongside testing 'run rate' to make sure that finances align to planned workforce and activity changes

1.
2.
3.
4.
5.
6.
7.
8.
9.
10
11.
12.
13.
14.
15.

- Agreement of the elective recovery plan to optimise the recovery to be delivered and allocation/income that can we earned to support this. This will also include consideration of the impact of the newly released IPC guidance.
- Final review of income and expenditure assumptions to ensure consistency of treatment (where possible) and identify potential areas for further work to secure efficiency or productivity improvement
- Strengthening of efficiency and transformation plans to mitigate risk of slippage against plan and seeking additional options for increased savings. (This includes allocation of 'growth avoidance' BTIs not yet mapped to a 'host' organisation and identification and sign off of plans to address the balance of savings to be found (£2.9m)

### 3.7. Risks to Delivery

While the plan addresses most of the key lines of enquiry across the areas raised by NHSE/I there are significant risks associated with delivery including:

- Availability of funds to deliver the actions
- Availability of workforce across the system
- Skill mix of workforce across the system
- Diagnostic capacity across the system
- IT infrastructure to deliver the transformational change required
- Any remaining impact relating to Covid

### 3.8. Conclusion

The ICS Board is asked to:

- Note the contents of the report
- Approve the submission of the returns to NHSEI

1.
2.
3.
4.
5.
6.
7.
8.
9.
<b>10</b>
11.
12.
13.
14.
15.

## 0. ICS Green Plan

<b>Author:</b>	<b>Will Nabih ICS Climate Change Shadow Board Chair</b>	<b>Paper date:</b>	12/04/2022
<b>ICS Board Member Sponsor:</b>	<b>Andrew Begley</b>	<b>Paper Category:</b>	
<b>Paper Reviewed by:</b>		<b>Paper FOIA Status:</b>	
<b>Action Required (please select):</b>			
<b>A=Approval</b>	<b>R=Ratification</b>	<b>S=Assurance</b>	<b>D=Discussion</b> <b>I=Information</b>

### 1. Purpose of Paper

The purpose of this paper is to present to the ICS CEO group the draft ICS Green Plan for approval in April 2022 as required by NHSE/I. Green plan is appended to this cover paper.

### 2. Executive Summary

#### 2.1. Context

NHS E/I have required that all systems approve system ICS Green Plans by April 2022. Towards this end the ICS Climate Change Shadow Board has developed a draft Green Plan with system partners who are all represented at the group.

The ICS Green Plan has been co-ordinated with all system partners via the ICS Climate Change Shadow Board. The board has good attendance with representation from all system partners.

The Green Plan and associated action plan reflect the standards adopted by each organisation in addressing climate change. The plan pledges only what has already been commonly agreed by all organisations and identified within their own individual green plans. In addition, it sets aspirational standards identified by each organisation and those identified by NHSE/I guidance 'Delivering Net Zero NHS 2020'.

Sub-groups to the Climate Change Shadow Board have been set up to co-ordinate joint reporting of actions delivered across the ICS in areas such as waste, energy, procurement, travel and energy and therefore provide assurance on delivery of the action plans.

#### 2.2. Link to Pledges

This paper and accompanying draft ICS Green Plan is linked to the system Climate Change Pledge and Tackling Problems of Ill Health.

#### 2.3. Summary

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.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

Failing to reduce carbon emissions and implement climate change adaptation measures represents a significant financial threat to the revenue costs of health and social care services. The recent increases in the cost of fossil fuels, means that the viability and long-term financial merits of decarbonisation are becoming even more compelling. A review of energy and carbon performance can often help to identify wider efficiency savings. In addition waste and bio-diversity will need to be developed system wide.

Pledge 7 of the ICS plan commits system partners to developing a multi-agency strategy setting out our joint response to the threat of climate change. The ICS has established a 'Climate Change Working Group', chaired by Will Nabih (SaTH), which reports to the Population Health Board. The Working Group has drafted a 'Joint Green Plan' to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working on this agenda.

The draft joint 'Green Plan' outlines the progress made so far, key targets, time frames and collaboration opportunities between system partners for a range of topics. The draft plan outlines collective goals not only at system level.

Individual ICS System partners will need to progressively engage with their staff and service users to explore the need for, and implications of, service changes which may result from the adoption of carbon reduction and other measures and will need to adopt an agile approach keep abreast of national good practice in order to maximise opportunities for equality and social inclusion within the overall policy context of addressing the climate emergency.

The next three years will be fundamental in building collaboration across the system and establishing early investment to maximise benefits later. 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.

Establishing an accurate baseline is also a priority. To do this, the aim is to determine the carbon footprint for the overall ICS system, focussing initially on direct emissions (by April 1<sup>st</sup>, 2023), followed by indirect emissions later in 2023. To address goods and services which are commissioned from external organisations and ICS system partners are working closely together and with their procurement teams to identify the carbon impact of specific contracts and will then use this information to discuss these further with the relevant suppliers as part of the procurement process.

Adopting a collaborative approach at both organisational and system levels will ensure that the system can maximise benefits and realise any financial savings. It will also provide consistency in reporting and some resilience in terms of team member movement.

## 2.4. Conclusion

It is recommended that the ICS Green Plan is approved and adopted. Following on, next steps will be to develop a 'plan on a page' summary for implementation. In

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

addition, a costed action plan will be produced setting out how existing commitments made by each organisation would be implemented.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
<b>11.</b>
12.
13.
14.
15.

# Shropshire Telford & Wrekin Integrated Care System

## Green Plan

2022-2025



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Contents



Welcome	3
Introduction	5
Integrated Care System Vision	7
Key Milestones — Our Progress So Far	8
The Next Three Years and Beyond	9
Leadership & Workforce	11
Sustainable Models of Care	13
Digital Transformation	15
Journeys, Transport and Active Travel	17
Estates (Hard Facilities Management)	20
Facilities (Soft Facilities Management)	23
Medicines	25
Supply Chain & Procurement	28
Food & Nutrition	31
Biodiversity	33
Adaptation	34
Action Plan	36
References	42
Acronyms	43

# Welcome

## Our activities as a species on Earth are having a profound impact on the environment with **irrevocable consequences** -

biodiversity loss and mass extinction, plastics in our food chain, acidification of our seas and climate change that will bring about frequent and often disastrous weather events. We must therefore maintain momentum in minimising our contribution to carbon in the atmosphere, products that persist in nature, and the destruction of other species due to loss of natural habitats. Extreme weather events and infectious diseases are now a very real and tangible part of our lives. Human activities have already set in motion these occurrences and therefore, we must adapt.

The UK typically experiences 10 severe storms per annum, and some of the most severe heatwaves experienced over the last 60 years have been in the last ten years or so (Kendon, et. al, 2021). These incidents will clearly have an impact on our communities' health and wellbeing - be it through heatwaves, flooding, or storms. Moreover, the buildings and infrastructure we use to provide care must do so throughout these events, enabling the business that our clinical and support services colleagues deliver to continue uninterrupted — particularly because of the impact that major incidents have on our service delivery.

We must, then, adapt our services to ensure that we mitigate for emerging risks brought about by climate change and loss in biodiversity.

The Shropshire, Telford and Wrekin Integrated Care System (STW ICS) has thus far reached significant milestones in its journey to realising Net Zero. We must ensure that we speed up our efforts now, in a joined-up approach, to meet targets set out by NHSEI in the document Delivering a Net Zero NHS (2020). We are fortunate enough to be situated in one of the most beautiful areas of the UK, and because of this are reminded daily how precious our world is, and that we must take responsibility for caring for the environment we live and work in.

This document is a representation of our system's organisations, the STW ICS, three-year plans to do just that.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



**It is not the strongest,  
nor the most intelligent  
of species that survives,  
but the one that is most  
adaptable to change.**

Charles Darwin (1808–1882)

*naturalist, biologist and geologist, born in Shrewsbury*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Introduction

## Shropshire, Telford and Wrekin Sustainable Transformation Partnership (STP) became an **Integrated Care System (ICS)** from 1st April 2021.

In an integrated care system, NHS organisations, in partnership with local authorities and other partners, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

Our ICS footprint covers 1,347sq miles, but is one of the smallest in terms of population, covering around 500,000 people. We have one Clinical Commissioning Group covering the area of Shropshire, Telford & Wrekin. The CCG is responsible for buying NHS services for local people. We have two acute hospitals, sited less than 20 miles apart, with services delivered by one acute trust, Shrewsbury and Telford NHS Trust (SaTH). There is also a specialist orthopaedic hospital, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), which provides elective orthopaedic surgery, sited in the northwest of the county. Additional providers include a community trust (SCHT), a mental health trust (MPFT) which covers Shropshire and Staffordshire, and the region is served by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS). In summary, our ICS System partnership consists of;

- NHS Shropshire, Telford and Wrekin Clinical Commissioning Group,
- The Shrewsbury and Telford Hospital NHS Trust -SaTH
- The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust -RJAH
- Midlands Partnership NHS Foundation Trust -MPFT
- Shropshire Community Health NHS Trust -SCHT
- Shropshire Council- SC
- Telford and Wrekin Council - TW

- The Primary Care Network including GPs
- West Midlands Ambulance Service - WMAS
- The voluntary sector and other core partners involved in transforming the provision of health and care services across Shropshire, Telford and Wrekin for those we serve.

The ICS has two unitary authorities: Shropshire Council and Telford & Wrekin Council. The area covered by Shropshire Council is 3,197 square kilometres, or 1,234 square miles. This is 91.7% of the ceremonial county of Shropshire, with the remainder being covered by Telford & Wrekin Council. The footprint has a number of towns, but no major cities. Shropshire has an estimated population of around 310,000 and Telford & Wrekin has an estimated population (for the borough) of around 170,000. Of these, around 150,000 live in Telford itself, making it the largest town within the ICS and it is one of the fastest-growing towns in the United Kingdom. In the Shropshire Council area, Shrewsbury is the largest town with a population of 70,600 with the second largest being Oswestry with a population of just 16,600.

Our ICS area is one of a handful that borders Wales and provides some hospital services for people from the Welsh health system who are external to the ICS footprint. Some residents of mid-Wales therefore rely on the services at SaTH and RJAH.

Each organisation within the ICS currently has their own Green Plan, with their own specific Action Plan. This document outlines the achievements already made, our ambition as a system, and how we aim to achieve these ambitions. We see our journey to net zero as a collaboration of the organisations in our system to approach with a broader view of delivering care to our communities.

In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become Net zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. The document is a milestone for NHS Organisations in that they now have key targets to achieve by the 2030s and 2040s.

Both Telford and Wrekin, and Shropshire Councils have a target to be 100% net zero carbon by 2030

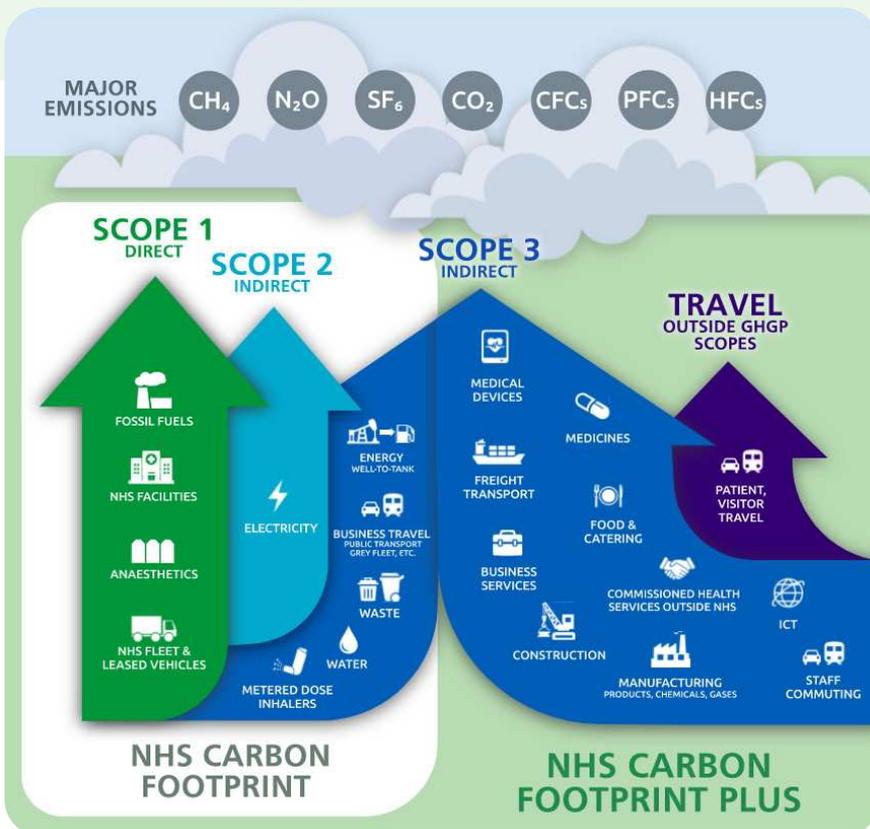
The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 has brought, protecting patients, our staff, and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

Clearly, there will be financial investment required across the system. We aim to return on these investments over the lifetime of the output projects, or where this is not possible, for them to be cost-neutral. This may not always be possible so we must be careful in how we initiate projects and consider the benefits they provide in a holistic approach.

**The two key net zero targets for the NHS set in the 'Net Zero' (NHSEI, 2020) paper:**

**1** 100% by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032

**2** 100% by 2045 for the NHS Carbon Footprint Plus (see below), with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

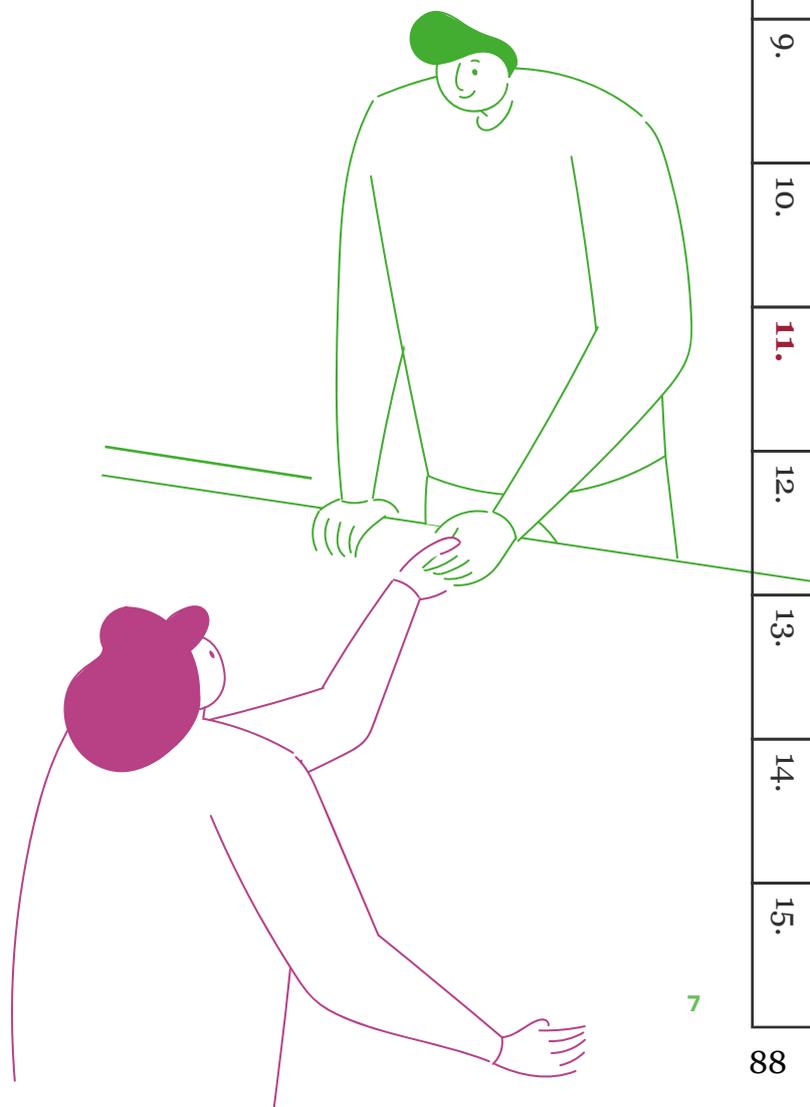
# Integrated Care System Vision

We will **work together** with the people of Shropshire, Telford & Wrekin to develop innovative, safe and high-quality services, attracting and retaining the best staff to deliver world class care that meets our current, and future, rural and urban needs.

We will support people — in their own communities — to live healthy and independent lives, helping them to stay well for as long as possible. Creating partnerships to find solutions that work better for the people we serve and those who provide care.

As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources. We want this journey to net zero carbon to provide population health benefits to our communities and staff throughout the process and capitalise on financial benefits where possible.

Our journey is towards local sustainability while being sensitive to global sustainability and delivering on net zero. Our approach will be one of collaboration between our member organisations to ensure we achieve our targets comprehensively and systematically together in good time, realising all of the benefits that come with it environmentally and in terms of health and service provision.



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Key Milestones — Our progress so far

Our journey to **net zero** has already started at our organisational levels. Our key milestones are:

An overall system reduction in reliance on fossil fuels of circa **1,066,000 kWh** for PV arrays

**Achieved by the installation of renewable on site energy**

Diverting around 440 tonnes of waste from landfill each year

Achieved by RJAH in the period April 2020 — March 2021, 100% of RJAH waste was diverted from landfill = saving of 440 tonnes waste, breakdown below:

Area	Weight (tonnes)
Incineration (Clinical) Waste Volume	102.49
Alternative Treatment (Clinical) Waste Volume	76.05
Offensive Waste Volume	119.87
Recycling Waste Volume	53.07
Domestic Waste Volume	78.20
Food Waste Volume	14.39

#### Achieved by

- segregation of waste
- collaborating with waste partners to adopt practices that make energy from waste

Around  
**£2.98<sub>m</sub>**  
saved from reduction  
in journeys

#### Achieved and quantified by MPFT:

- moving outpatients clinics to telephone/video calls, delivering over **80,000** virtual consultations
- adapting agile (hybrid) working for our colleagues
- planning our services better

Adapted our sites to accommodate local wildlife

#### Achieved by

- Installing swift and bat boxes
- Sited beehives on some of our hospital sites
- Encouraged a diverse range of plants and fauna in our green spaces.

Completely eliminated Desflurane from our clinical practices

Achieved by adopting alternative methods such as less environmentally harmful anaesthetic gases and **Total Intravenous Anaesthetics (TIVA)**

Each metric outlined in the document covers more of the achievements we have made in further detail.

# The Next Three Years and Beyond

The next three years will be fundamental in **building collaboration** and establishing early investment to maximise benefits later.

There are many early interventions we must address, but establishing our benchmarks is a priority. To do this, we aim to determine the overall system carbon footprint from scopes 1 & 2 emissions by April 1st, 2023, with scope 3 emissions later in 2023. We will also review waste metrics, travel and medicines. This will give us a point of reference in which to measure our progress. Some organisations within the system have already completed a carbon foot-printing assessment, so we intend to complete a joint exercise for those who have not, to capitalise on economies of scale.

Adopting a collaborative approach to both the actions at organisational and system levels will ensure we maximise benefits and realise any financial saving opportunities. It will also provide consistency in reporting and some resilience in terms of team member movement.

Therefore, our key actions are to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working.

#### To do this, we will:

1. Establish our system baseline positions
2. Ensure that we have the right people delivering our net zero agenda
3. Consider how we can deliver care in a sustainable, balanced way

4. Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services
5. Encourage our communities to avoid contributing to our carbon output
6. Focus on our supply chain's commitments to achieving net zero
7. Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count
8. Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
9. Adapting our services to meet the challenges of climate change and extreme weather events
10. Encourage biodiversity at our properties



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Our Green Plan structure follows the NHS England Guidance:



LEADERSHIP AND WORKFORCE



SUSTAINABLE MODELS OF CARE



DIGITAL TRANSFORMATION



TRAVEL AND TRANSPORT



ESTATES (Hard Services)



FACILITIES (Soft Services including Waste)



MEDICINES



FOOD & NUTRITION



SUPPLY CHAIN & PROCUREMENT



ADAPTATION

This structure will form the basis of our strategy. Each subheading discusses the progress made so far (and our baselines, where applicable), our key targets, timeframe and how we intend to achieve this. We also feel that it is important to include Biodiversity under its own subheading because a broad and diverse environment locally, nationally and internationally is central to tackling the key issues addressed in this document.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Leadership & Workforce

Our people are central to delivering our care services **sustainably**.

Currently, many of the organisations in our system manage sustainability through various roles such as sustainability managers, energy managers or waste managers (or a combination of these). Whilst we already have excellent examples of collaboration and governance through the ICS Climate Change Working Group, there are opportunities to focus the co-ordination of collaborative working to drive efficiencies between the organisations - both environmentally and financially.

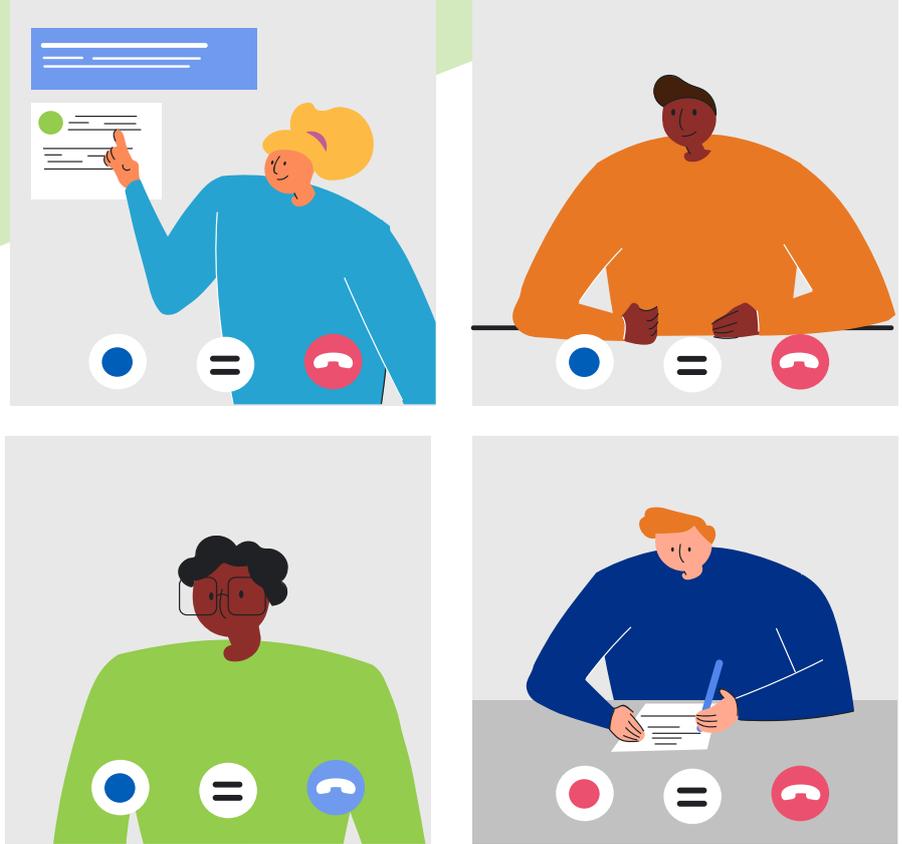
**All our staff have a responsibility for contributing to achieving net zero, and can help by:**

- Where practical, and meeting the service needs, work from home wherever possible
- Use greener methods of transportation such as 'active travel', and where this is not possible, use public transportation and carpools
- Minimise waste, reuse if safe to do so and use recycling facilities provided
- Holding local sustainability working groups
- Challenge colleagues where socially and sustainably responsible behaviours need improvement

- Increase awareness by discussing with colleagues and teams
- Sensible use of technology to enable remote working and drive efficiencies — for example, embracing the use of electronic devices for delivering services in the community or holding a MS Teams meeting rather than traveling to meet face-to-face.
- Raising sustainability awareness to our colleagues, service users and communities by participating in campaigns, Sustainability Days, Sustainability Competitions, and so on.
- Collaboration with schools and nurseries to promote sustainability as part of their curriculums; providing advice and help with planning activities to teachers, administrators, business managers.

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

## Sensible use of technology to enable remote working and drive efficiencies.



As job descriptions throughout the whole workforce are reviewed and refreshed on a routine basis, we must ensure that sustainability & waste management are highlighted as an essential requirement to the day-to-day responsibilities of each colleague, expecting sustainability as ‘business as usual’ facet of our work practices.

Our ICS board lead for sustainability is Shropshire Council’s Chief Executive.

In 2022 we will look to identify a Sustainability Lead for the ICS — 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.

Some of the organisations in our system already have colleagues in senior leadership positions who have completed carbon literacy training. This training is a formally recognised certificate which we intend to roll out for senior leaders in the whole system using a train-the-trainer model, capitalising on collaboration, to improve our understanding of how we can tackle our emissions by changing behaviours and embedding carbon performance in our service delivery. A by-product of this training would encourage and identify climate and carbon champions in all service areas.

### Collaborative Opportunities

1. Individual and System Baseline Carbon Footprinting (we have a stronger position for negotiation through economies of scale)
2. Introduce a network of Net Zero Carbon Champions (staff, service users and members of the public)
3. Improvement in comms by sharing regular cross-system sustainability-related information, such as benchmarks and how colleagues can change behaviours to have a collective impact on our carbon footprint
4. Share training to provide consistent approaches, and capitalise on economies of scale

We will recognise the fantastic work and milestones achieved by our colleagues throughout the system through nominations at national level sustainability awards and at local levels through internal nominations for individual recognition.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Sustainable Models of Care

Delivering the best care is our business — it's what we do. As a system we have huge opportunity to organise our services in such a way that patient care improves whilst we **make carbon efficiencies.**

We must consider the location of our services to suit — utilising existing buildings, collaborating on projects that improve care across our membership and ensuring we have the right services in the right places.

We are harnessing technologies to reduce the need to invite patients to sites, often through 'virtual' consultations. For example, MPFT has completed over 80,000 of these appointments since March 2020 — demonstrating an estimated £3m saved in travel. There is therefore much opportunity for the system, where it is clinically safe to do so, to adopt this approach.

In 2015, NICE published guidelines on medicines optimisation, advising that the environmental impact of each bed day is 63.7kg of CO<sub>2</sub>e, 0.6m<sup>3</sup> of direct fresh water used (98.6 m<sup>3</sup> of indirect freshwater use) and 8.15kg of waste produced. From 1,271 (700 SaTH, 174 RJAH, 24 Ludlow, 25 Bridgnorth, 348 MPFT) bed spaces in the system, this translates to a total of 81tCO<sub>2</sub>e, 762.6m<sup>3</sup> direct fresh water, 125,321m<sup>3</sup> indirect fresh water and 10,359kg of waste (per day).

We must encourage our patients to live balanced, healthy lifestyles, and geographically we must provide this care that is accessible for all engaging in active travel. The **#TogetherWeMove** movement is a charity-led initiative encouraging active travel, exercise and the benefits that come with this.

There are also opportunities to signpost patients, staff and service users to energy efficiency advice outlets, such as Beat the Cold and Keep Shropshire Warm.

## Collaborative Opportunities

Align individual digital technology to offer Care Closer to Home to reduce bed days

Partner to develop and deliver the Shropshire Joint Health and Wellbeing Strategy, specifically: -

- reducing stigma of mental illness
- reduce inequalities that are the cause of ill health
- influence planning decisions regarding fast food takeaways and green spaces
- support people as they are discharged from hospital
- promote the health, wellbeing and social change needed to improve health in Shropshire

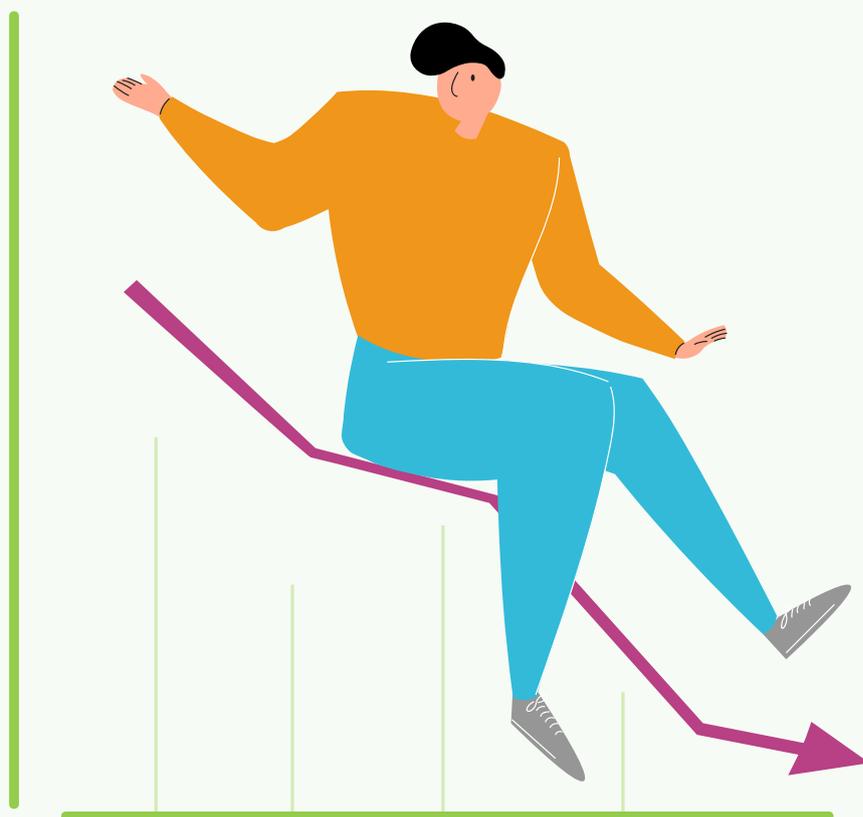
Signposting to energy efficiency advice to patients, staff, public, financial help with energy bills, improve their health and wellbeing, etc. directly or via charities (e.g. Beat the Cold, Keep Shropshire Warm **#WeMoveTogether**).

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant

All Shropshire Council commissioned activity will seek to identify opportunities to reduce carbon admissions; including locality-based models of care, reducing the need for paper and moving to digital solutions, incentivise sustainable transport solutions. The same is true for Telford and Wrekin Council; increasing its environmental evaluation criteria weightings to encourage suppliers to use sustainable practices and to reduce carbon emissions in the supply chain. This is an opportunity for the NHS organisations in the system to both support and adopt best practices.

The development of a new Wellbeing Centre in Shrewsbury will provide opportunities to introduce innovative ways of working and delivering health care, including related green initiatives. There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant — the commissioned services are primarily from ShropCom— Drugs and Alcohol (DAT), School Nursing, Health Visiting, health checks commissioned from primary care, and some weight management programmes commissioned from SaTH. Building this integration into our zero-carbon journey will enable us to adapt as we need to and expedite the carbon reductions.



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Digital Transformation

With the advent of SARs-CoV-2 and the subsequent COVID-19 pandemic, our **organisations had to adapt** to continue to provide services whilst protecting patients and staff.

To do so, our IT teams worked around the clock to enable more colleagues to work from home or working remotely to provide services where this did not impact business needs - as discussed in the Sustainable Models of Care chapter, for example, assisting with moving to online consultations.

This inadvertently reduced our carbon footprint significantly, within the space of just a few weeks. There is now real opportunity to further drive down our key carbon emissions through harnessing digital infrastructure, particularly in delivering patient care but also as colleagues return to site.

We are building resilience in the event of major incidents, outbreaks, and enabling colleagues to perform flexibly and efficiently by improving communications — for example, pivoting to VOIP telephones and integrating telephone services with Microsoft Teams. Digital exclusion, the term used for inequalities in access to digital technology, is a barrier to providing care in our communities; particularly with respect to our ambition to provide 25% of outpatient activity and we will aim to review progress with this in mind and exploring options to support our communities to overcome this.

## Collaborative Opportunities

Enable ability for staff to work from other stakeholders locations if closer to home or patients

Encouraging staff across the system to use Ecosia to contribute to biodiversity around the world.

Joint booking systems for clinical and non-clinical spaces



1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.  
96

Collaboration between council and NHS organisations may also benefit our services; particularly where we share building spaces, whereby staff can work from nearest office space throughout the entire system. A joint space booking system is currently being investigated to cover the entire system both for non-clinical and clinical space. Councils also have a role to play in working with NHS partners in the system to develop and enhance digital solutions to support people to live safe and well at home, to ensure the right care, at the right time in the right place in needed and care is not being overprescribed.

### Electronic Patient Records (EPR)

The recent NHS Long Term Plan has an expectation that all services should have met 'a level of core digitalisation by 2024'. The move to EHRs supports this as well as helping with compliance with the General Data Protection Regulation (GDPR) as well as the visibility of patients notes improves care. WMAS and SCHAT are already using an electronic system, RJAH are implementing for go live in 12 months, SATH in 18 months.



**There is an opportunity for all organisations to adopt Ecosia**

### Ecosia

The free-to-use search engine that donates approximately 80% of its profits to fund tree planting projects around the world.

University College London Hospital (UCLH) have recently rolled this out and provided a case study. In the first full month (February 2022) of Ecosia being used trust wide UCLH has funded the planting of 2,238 trees. UCLH employs 11,000 staff, which is a tree planting rate of:  $2238/11000 = 0.203$  trees funded per staff per week. Although the exact rate of tree planting will vary between organisations, this gives an approximation for potential tree planting impact. If the system adopts this approach, the number of trees planted could reach close to 84,000 per year ( $34,345 \text{ staff} \times 0.203 \times 12 = 83,664$ )

### Work From Home and Agile (Hybrid) Working

The Covid-19 crisis has kickstarted a movement to agile (hybrid) working, and where service delivery is not impacted there are clear benefits to continuing this model:

- Improved wellbeing for staff due to reduced commuting, better work-life balance, local emissions reductions and so on.
- Reduction in carbon from commuting, less local pollution, improved access to parking for site visitors,
- Reduction in utilities usage, such as water, electricity and gas on site

### Improving building services monitoring and control

Adopting the latest technologies in Building Management Systems (BMS) will provide significant and often direct carbon emissions at local level. Although frameworks exist for service providers in this industry, there is real opportunity to collaborate on maintenance contracts where similar systems are being employed across multiple sites, and to support transition to improved equipment. Organisations can link and pool expertise through peer meetings to ensure that benefits of BMS systems are being maximised.

Work underway, by Shropshire Council, to help staff with insulations and loan scheme for solar and battery installation in their homes.

It is important to note that Ecosia does allow for 'carbon offsetting', so the carbon sequestered from tree's planted cannot be used in any official carbon accounting. Nor does NHSEI encourage tree planting as a route to net zero, rather, this method will be a tool for us to contribute to biodiversity in some of the most environmentally important areas across the globe — South America, Africa, Europe and East Asia.

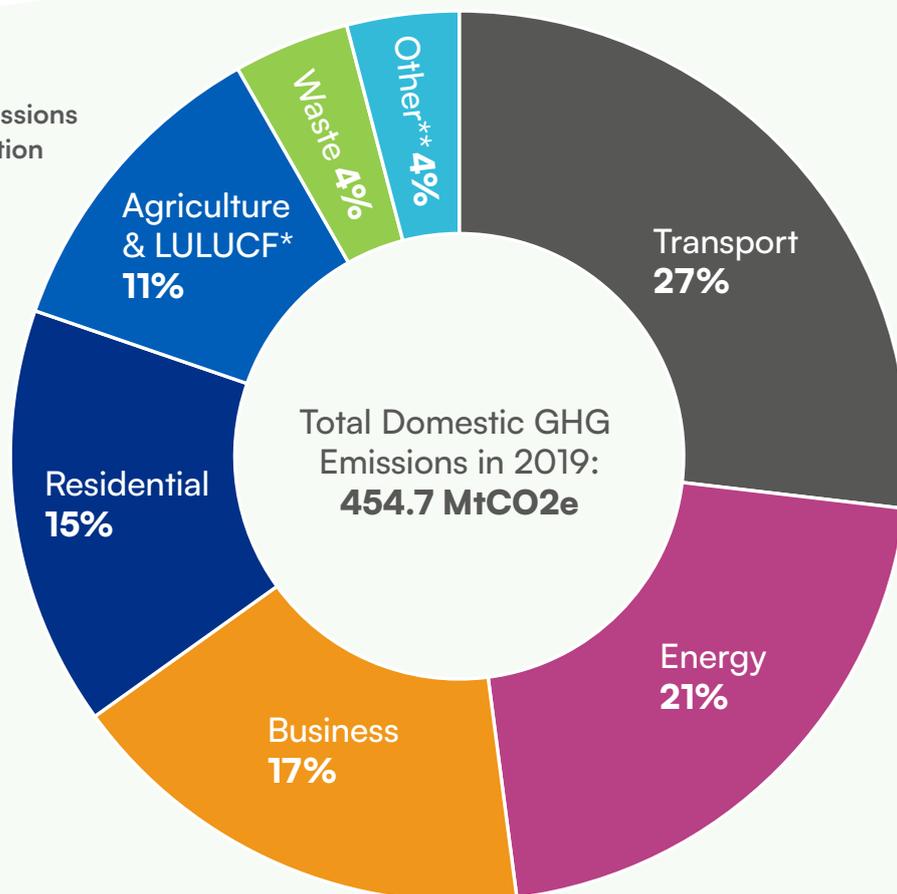
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Journeys, Transport and Active Travel

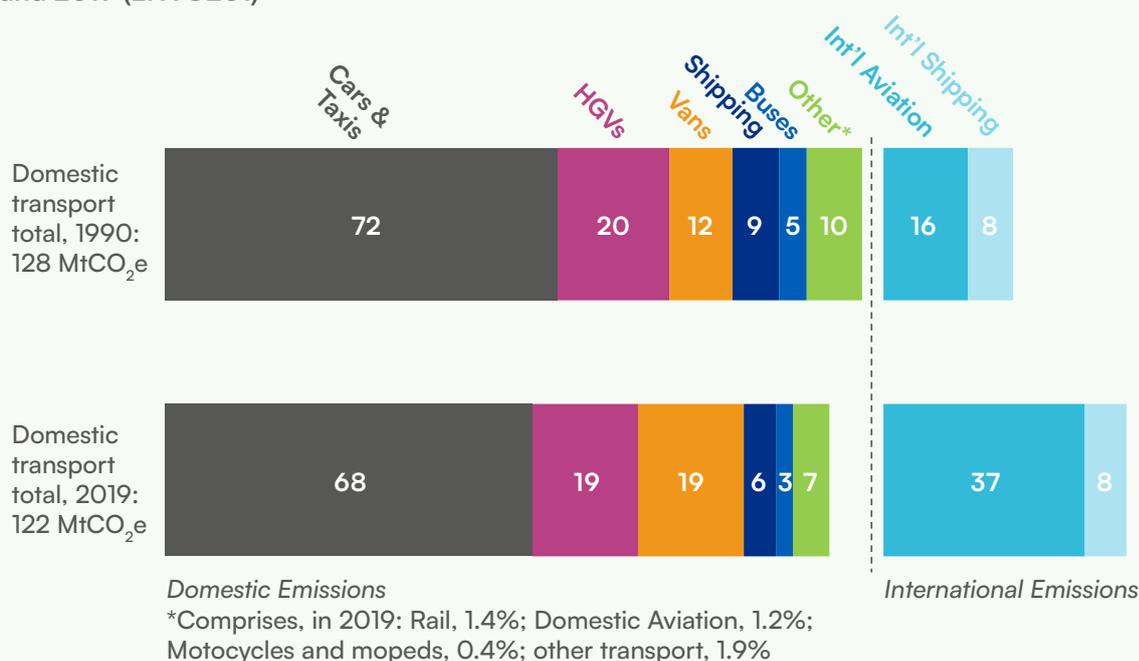
Business Travel and Staff Commuting are one of the major contributors to Trust Scope 3 emissions. Trusts are tasked with **outlining plans to reduce the carbon emissions** arising from Travel and Transport.

Fig 3: Greenhouse gas emissions by sector, 2019, by proportion (BEIS, 2020)



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

**Fig 4: Greenhouse gas emissions by transport mode, 1990 and 2019 (ENVO201)**



Source: [www.gov.uk/government/statistics/transport-and-environment-statistics-autumn-2021/transport-and-environment-statistics-autumn-2021](https://www.gov.uk/government/statistics/transport-and-environment-statistics-autumn-2021/transport-and-environment-statistics-autumn-2021)

The NHSi Greener NHS Fleet Data Collection tool can be completed by all non-ambulance NHS provider Trusts and was created to enable reporting on fleet carbon emissions and to understand the vehicle landscape to support planning for the necessary transition to zero emissions vehicles.

This uses vehicle registration numbers (VRNs) to look up emissions data. Understand operated vehicles and how these may be replaced.

Organisations will need to identify a named individual who will complete and submit the return on their behalf. Multiple people can respond for each organisation.

**After identifying the responsible individual, they should:**

1. Register for OKTA:  
<https://apps.model.nhs.uk/register>
2. Register for the data collection:  
<https://forms.office.com/r/PUq5Bre4rz>
3. Start collating the data required
4. Access and submit to the DCF portal:  
<https://dcfdatacollections.improvement.nhs.uk>

Data collection portal opens: Friday 1st April 2022  
 Data collection portal closes: Tuesday 24th May 2021

Investing in low emission fleet and reviewing the organisations transport of goods, patient transport, work patterns and location of services are also beneficial. For example, Telford & Wrekin Council are looking to implement an optimum flexible working pattern to reduce the carbon impact of staff travel and enable reduction in required office space as well as developing a Corporate Travel Plan to minimise car travel between offices.

The current process of renewing the Local Transport Plan (LTP4) for Shropshire will provide opportunities to generate co-benefits for both health and carbon performance.

Shropshire Council health and transport colleagues are working together to improve the health impact of the new Shropshire LTP, along with the LCWIP — Local Walking and Cycling Infrastructure Plan and the Bus Strategy. The actions will increase access to public and active travel and help to mitigate any negative health impacts.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

**Additional effort and investment is required to:**

- Reducing barriers to using active travel
- Reduce Business Milage
- Develop and appraise Travel Plans to assess progress and quantify emissions saved
- Replace fleet with low emission (LEV/ULEV/ZLEV) alternatives

Travel plans can make a real contribution towards encouraging and promoting alternatives to the car.

Organisation can utilize the Clean Air Hospital Framework — a free resource available to help clean up their air.

This is a self-assessment tool designed to benchmark and shows areas to improve air quality across sites and in the local community.

**The framework is focused on seven key areas:**

1. Travel
2. Procurement and supply chain
3. Construction
4. Energy
5. Local air quality
6. Communication and training
7. Hospital outreach and leadership

Increasing ‘Active Travel’ and use of public transport are some of the interventions which some of the organisations in the ICS have already underway. For example, improvements to availability of shower facilities and increased cycle storage, as well as improving footpaths and lighting and introducing salary sacrifice schemes for cycle purchase or season tickets. Not only improving staff fitness but improving site emissions. SATH have, to date, 38 electronic vehicles on lease (another 19 on order) and 60 bicycle purchases via salary sacrifice.

Car sharing just once a week will help to reduce the amount of traffic on our roads, improve the local environment and our health. Similarly, walking once a week has obvious health benefits and helps to reduce the amount of traffic on our roads.

There are currently two Air Quality Management Areas (AQMAs) in the Shropshire Council area, in Shrewsbury and Bridgnorth, where action is required to address poor air quality. Traffic management measures and new infrastructure, together with support for a move to ULEV transport options are likely to result in a reduction of particles and other more harmful emissions

Telford & Wrekin Council are implementing discounts available from Arriva and West Midlands Trains to staff. Arriva also offers discount on monthly season tickets to NHS Staff

Staff commuting contributes to Trust Scope 3 emissions, therefore, any action taken now will begin to reduce our contributions.

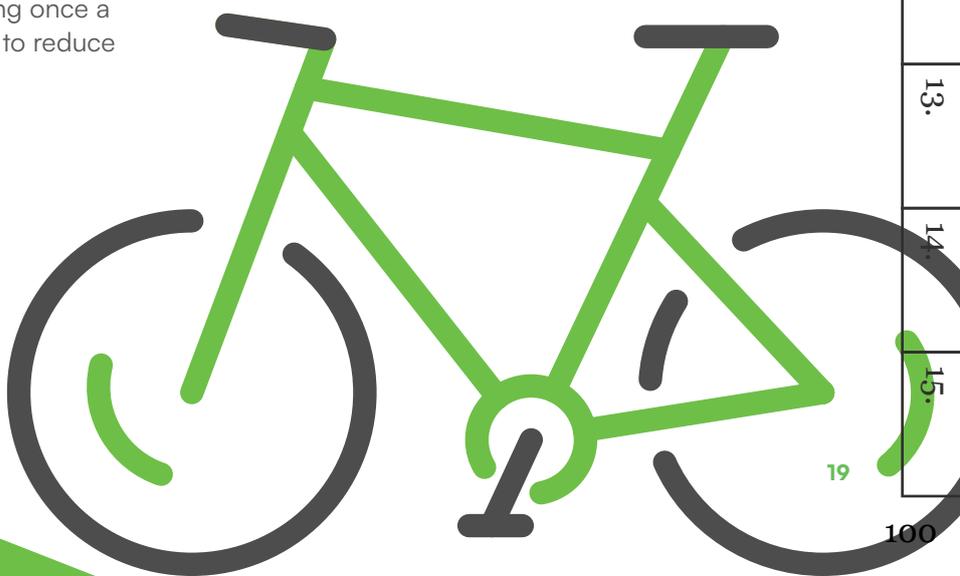
Currently SaTH have 60 bikes purchased under salary sacrifice, a bicycle user group and cycle champion promoting the service and benefits amongst staff.

**Collaborative Opportunities**

Develop a system-wide Green Travel Plan which will in turn influence organisations’ Green Travel Plan — focusing active travel, business travel and grey fleet

Manage the combined Non-patient transport service contract (due to start Mar22)

Set up regular meeting between key staff from each stakeholder to share ideas, developments and successes.





# Estates (Hard Facilities Management)

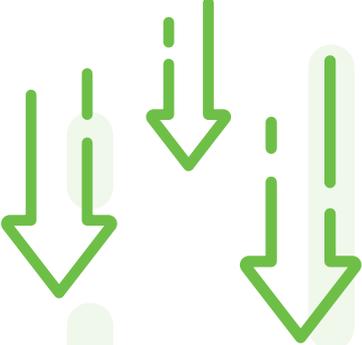
NHS England's guidance, **Estates 'Net Zero' Carbon Delivery Plan**, advises a four-step approach to decarbonising estates.

Taking this holistic approach will enable organisations in our system to make easier, quicker wins in the short term, gradually building to net zero. Our Estate has a significant role in reducing our Scope 1 emissions and organisations within our system have made huge progress with reducing our direct emissions burden by installing photovoltaic (PV) solar panels, replacing lighting for LEDs, replacing boilers and associated equipment with ultra-efficient alternatives, improving installation to buildings and pipework, and for indirect (scope 2) emissions, switched to REGO energy from the national grid (electricity supplied to the grid from renewable energy sources). We have achieved electrical savings of at least 1,066,000 kWh/annum through the installation of PV solar panels, protecting future finances from expected grid cost inflation and price rises from the supply crisis.

#### Some examples of the efforts so far include:

- The installation of photovoltaic (PV) solar panels to many buildings,
- Replacing boilers with ultra-efficient equipment; for example, RJAH have been able to reduce their gas consumption by up to 1.8mWh per year,
- Installing LED lights across multiple sites,
- Improving the insulation, or U-Value, of our buildings so that it takes less energy to reach required temperatures,
- All our organisations will purchase only renewable (REGO) electricity from the national grid by April 2022,
- Replacing antiquated Building Management Systems (BMS) with smarter controls

We're taking responsible measures to not only reduce our carbon emissions, but to realise financial benefits using the philosophy that less kWh used means less money spent - making every kilowatt count. We're also pro-actively accessing public grants and funding available such as the Public Sector Decarbonisation Scheme (PSDS); for example, Shropshire Council are implementing low carbon heating and lighting through this funding on one site to reduce energy use by over 65% and carbon emissions by 15 tonnes per year. Similarly, Telford and Wrekin Council are initiating an air source heat pump and thermal upgrade, saving 115 tonnes CO<sub>2</sub>e.



**Our Estate has a significant role in reducing Scope 1 emissions**

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## The four-step approach to decarbonise the NHS estate by 2040

(Source: Estates 'Net Zero' Carbon Delivery Plan, NHSEI)



Includes indicative numbers to illustrate the scale of the challenge to decarbonise the NHS estate by 2040. These are not actuals.

The above infographic, published in the NHSE 'Estates 'Net Zero' Carbon Delivery Plan, estimates that every £1 million invested across the NHS in the actions listed will deliver a 1.33ktCO<sub>2e</sub> saving per year. The cumulative capital costs of these investments would be offset by equal revenue savings over only 3.8 years. By generating a proportion of the energy we consume at our sites, we are protecting our finances against inflationary and market price rises of importable utilities. There is opportunity to collaborate on large scale projects between our organisations and a key action is to explore the development of a PV farm on Shropshire Council land near to RJAH.

There are other exciting and potentially ground-breaking opportunities for the system to adopt emerging technologies that could see a reduction of direct and indirect carbon emissions in the near-to-medium-term. We will explore these opportunities and some member organisations may lead case studies with a view to adapting infrastructure at other sites.

# The NHS organisations in our system collectively consumed over

# 116,000,000 kWh

We intend to collaborate between our organisations at a local level; sharing building space, day services are being reviewed with view to offer building-based services to a wider group across all ages. This space utilisation will in some cases reduce the burden on capital budgets and have an impact on carbon output, as well as reducing our consumption of building products which further contribute to climate change.

The NHS organisations in our system collectively consumed over 116,000,000 kWh (NHSEI, 2021) in natural gas in the year 2020-21. These scope 1 emissions are a key challenge that we will aim to reduce over the next three years.

However, we are already mitigating and reducing our reliance on grid energy by utilising Combined Heating and Power (CHP) technology to use fossil fuels in the most ethical way:

- Approximately 13,800,000 kWh electrical generation from CHP across all NHS sites in the system
- Approximately 13,900,000 kWh thermal energy generation from CHP across all NHS sites in the system.
- Approximately 18,600,000 kWh grid energy consumed across all NHS sites in the system in 2020-21, but our organisations are transitioning to on-site generation. Some examples of this are:
  - RJAH generate around 440,000 kWh pa
  - Telford & Wrekin Council produce a combined 498,000 kWh from PV solar arrays across multiple sites
  - MPFT generate around 128,000 kWh pa

Source: NHSE ERIC Data Collection, 2021

Collaborative Opportunities	
5.	Share benefits of installation of EV charging points through joint tender exercises
6.	Give early warning to peers on grants, loans and other schemes that may benefit our reduction of scope 1 emissions
7.	Share benefits of adopting emerging technologies and offer unique access to case studies.
8.	Explore feasibility of shared power generation and consumption from PV farms, district heat networks and other renewable technologies.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Facilities (Soft Facilities Management)

In our current economy, we take materials from the Earth, make products from them, and eventually throw them away as waste — the process is linear. In a circular economy, by contrast, **we stop waste being produced in the first place.** The world's economy is only 9% circular. We must be bolder about saving resources.

## LINEAR ECONOMY



ENERGY FROM FINITE SOURCES

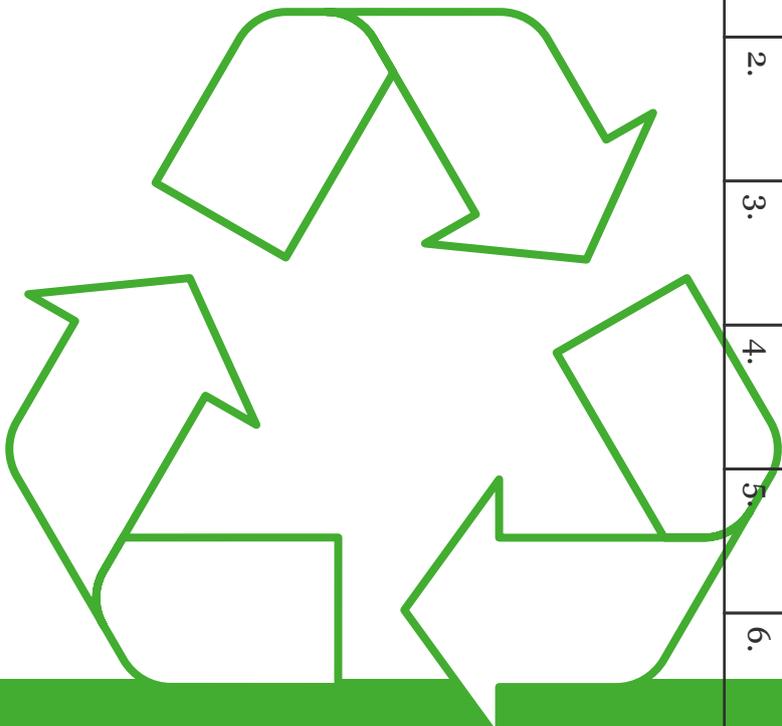
## CIRCULAR ECONOMY



ENERGY FROM RENEWABLE SOURCES

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



As the area the sites depend on to maintain a pleasant, healthy and safe working environment are instrumental in the day-to-day operations it is a key priority that we work to reduce waste as well as air & water pollution to improve local environments.

WMAS have already made some major benefits from changing their cleaning to a single multi use, low packaging product as well as successfully piloting & beginning to roll out Domestic Waste recycling in its office locations. RJAH regularly divert 100% of domestic & clinical waste from landfill.

## Waste

The management of healthcare waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection and are securely managed. UK-wide guidance provides a framework for best practice waste management.

### The management of waste in the NHS falls into 3 main categories:

- Domestic** — generated as a result of the ordinary day-to-day activities
- Clinical (including sharps)** — waste produced from healthcare that may pose a risk of infection, e.g. swabs, bandages, dressings; or may prove hazardous, for example medicines.
- Offensive** — non-infectious but may be unpleasant to anyone who encounters it e.g. nappies, feminine hygiene products, used but uncontaminated PPE.

WMAS has undertaken a survey for the implementation of recycling processes for the control and segregation of domestic waste. Following which they plan to introduce recycling at all sites across the Trust to fall in line with the successful introduction of Mixed Recycling at the Erdington Hub.

The initial trial of introducing Mixed Recycling at one of our major Hubs has resulted in the sites waste production being at 50% recycling, which is a 6,000kg saving in CO<sub>2</sub>e,

MPFT no longer purchase single use plastic stirrers and straws and are looking into alternatives to single use plastics in catering & reduce use of cups, cutlery, gloves & aprons in other areas.

## Collaborative Opportunities

Set up quarterly meeting between facilities managers from each stakeholder to share ideas, developments & successes.

Share ways to improve waste management practices & improve specifications for tendering

Develop or update organisations Food & Drink Strategy - starting with aims to improve staff & patient nutrition & hydration as well as ways to reduce carbon

Combined procurement for provision of food & drink & use of local supply chains

Combined procurement of environmentally friendly catering items (e.g. takeaway containers, cups & cutlery)

Upon renewal of MPFT waste contracts requirements will be reviewed to ensure more efficient recycling of waste & are investigating using re-usable sharps and pharmaceutical boxes/bins. As well as displaying “bring your own bottle” notices and the introduction of bespoke MPFT water bottles and reusable bamboo cups.

SATH, RJAH & SCHAT utilize the same contracts meaning 98% of domestic waste is incinerated & converted into electricity for homes near the plant in Shrewsbury. Clinical & offensive waste is either safely processed & sent to energy recovery (by a third party) or burnt. SATH also use reusable sharps containers.



# Medicines

Medicine optimisation as well as safe & effective use in health & social care can contribute to **Scope 3 emission reductions.**

## Progress so far against key national targets:

### Anaesthetic Gases

Measures already taken by all the ICS members have successfully eliminated the use of Desflurane.

### Inhalers

Carbon emissions from inhalers have been assessed as responsible for approximately 3% of all NHS carbon emissions. The majority of emissions come from the propellant contained in pressurised metered dose inhalers (pMDIs). pMDIs contain propellants known as hydrofluorocarbons (HFCs), powerful greenhouse gases, which are used to deliver the medicine rather than the medicine itself.

Source: NHS England and NHS Improvement. *Delivering a 'Net Zero' National Health Service. Published October 2020.* & NICE. *Inhalers for asthma (patient decision aid). Published 23 May 2019. Last updated 01 Sept 2020.*

pMDIs account for 71.6% of all inhaler device types prescribed in England, 68.8% in Wales and 66.6% in Scotland Source - NHSBSA Apr-Jun 21.

The NHS England Long Term Plan published in January 2019, outlined the national targets of reducing the carbon footprint of health and social care in line with the Climate Change Act targets of 51% by 2025.

Many people will be able to achieve the same benefit from DPIs. DPIs have lower average estimated carbon footprints of 20 g CO<sub>2</sub>e per dose (two puffs) compared O<sub>2</sub> to pMDIs which are estimated at 500 g CO<sub>2</sub>e per dose (two puffs).

The Shropshire, Telford and Wrekin Health Economy Formulary review is) already well underway updating the respiratory section to produce a green inhaler formulary to provide guidance to all prescribers and to support PCNs to deliver the IIF targets in a cost-effective manner. The draft formulary is currently with specialist consultation to ensure there are no clinical gaps before approval and launch.

## There are key national targets which the ICS is working towards:

1. The IIF ES-01 has a target for pMDI prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October 2021 (range: 35% to 44%). This aims to reward increased prescribing of DPIs and SMI where clinically appropriate with a target of 25% of non-salbutamol inhalers prescribed will be pMDIs by 2023/24.
2. The IIF ES-02 indicators has a target for the mean carbon emissions per salbutamol inhaler prescribed on or after 1 October 2021. This aims to reduce the mean propellant carbon intensity of salbutamol inhalers prescribed in England to 11.1 kg per salbutamol inhaler prescribed by 2023/24

## Shropshire, Telford and Wrekin Current Performance

Commissioner Benchmarking	Total Items	Carbon footprint per inhaler kgCO <sub>2</sub> e	Total carbon footprint gCO <sub>2</sub> e (K = thousands)	Carbon footprint per 1,000 patients gCO <sub>2</sub> e (K = thousands)
NHS Shropshire, Telford and Wrekin CCG	46,645	25.1	1,651,348K	3,177K

Currently STW CCG prescribes 55.66% on non-salbutamol inhalers as pMDI, ranking 57<sup>th</sup>/133 CCGs or health boards in England and Wales. Target is 25%

	pMDI (excluding salbutamol)		DPI & SM I (excluding salbutamol)		Grand Total
Commissioner Benchmarking	Total Items	% of Total Items	Total Items	% of total Items	Total Items
NHS Shropshire, Telford and Wrekin CCG	36,619	55.66%	29,177	44.34%	65,796

Source: Medicines Management, Shropshire, Telford and Wrekin CCG

Local Authority transport measures can influence air quality & Shropshire Council are acting to improve air quality through the air quality strategy and through reduction of emissions in the Local Transport Plan 4 (<https://shropshire.gov.uk/roads-and-highways/local-transport-plan-ltp4/>). This can lead to reduction in the numbers of asthma cases diagnosed and to reduction in the number of asthma attacks.

### Other actions in our progress include:

- Monitoring how local prescribing data on the inhaler carbon footprint compares to the national data using the PrescQIPP inhaler carbon footprint data tool and visual data pack to and identify where local improvements can be made to ensure timely progress is being made.
- Optimising prescribing to improve both patient outcomes and reduce carbon impact of inhaler choices by;
  - Reviewing patients regularly; demonstrating, checking and improving inhaler technique.
  - Discussing lower carbon footprint inhalers during reviews or when a change in treatment is clinically necessary.
  - Ensuring newly initiated treatments have a low carbon impact and switching existing therapies to lower carbon impact options where clinically appropriate
  - Reducing SABA overuse and increasing the percentage of patients on the Quality and Outcomes Framework (QOF) Asthma Register who were regularly prescribed an inhaled corticosteroid over the previous 12 months (target for IIF RESP-01 indicator in PCN DES is range 71% to 90%)
- Increase use of leukotriene receptor antagonists where clinically appropriate
- Wherever possible use combination inhalers for patients on dual or triple inhaled therapy.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

Support prescribers through education in lowering inhaler carbon footprint, sharing data, reviewing respiratory prescribing guidelines to include lower carbon footprint inhalers, and how to optimise prescribing ensuring lower carbon footprint inhaler options are included in medicines formularies and ensure stock availability with suppliers.

Reduce waste through encouraging patients to; return their used or unwanted inhalers to a pharmacy (for either recycling where available, or environmentally safe disposal); to look after their inhalers and not over-order & increasing the use of re-usable inhalers.

Other opportunities for medicine optimisation include reductions in Polypharmacy (most defined as the use of five or more medications daily by an individual) could decrease the risk of avoidable hospital admissions.

Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year (*Source: Environmental impact report: Medicines optimisation Implementing the NICE guideline on medicines optimisation (NG5)*)

We also need to begin to discuss with suppliers to assess and reduce blister pack carbon footprint and recycling opportunities. For example, the Association of the British Pharmaceutical Industry tool can be used to provide a quick approximation of the carbon impacts

[www.abpi.org.uk/r-d-manufacturing/abpi-blister-pack-carbon-footprint-tool](http://www.abpi.org.uk/r-d-manufacturing/abpi-blister-pack-carbon-footprint-tool)

**Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year**



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Supply Chain & Procurement

Over 60% of the total NHS Carbon Footprint sits within the supply chain, therefore, **suppliers and procurement will play a pivotal role in reducing our emissions.**

To ensure a better quality of life now and for future generations, we need to look seriously at the way we use the earth's resources, operate our businesses and live our lives. A sustainable approach recognises the broader impacts of our actions and aims to minimise any adverse effects.

Sustainable procurement requires taking environmental and social factors into account in purchasing decisions. For example, looking at what products are made of, where they come from, and who has made them and, therefore, minimising the environmental and social impacts of the purchases we make.

MPFT are looking to increase sustainable procurement principles within their procurement, collaborating with other NHS Trusts and other organisations to improve knowledge and understanding of sustainable procurement and to seek shared opportunities and benefits, consolidate orders to reduce deliveries, improve stock rotation to avoid product expiry.

## Collaborative Opportunities

Set up quarterly meeting between procurement team members from each stakeholder to share ideas, developments and successes

Develop ICS Procurement Workplan for projects which would benefit from joint working

Engage and work with local suppliers, where possible within current rules, to reduce delivery miles

**In January 2020, a Greener NHS which sets out a path to a 'net zero' NHS and as a result the below targets have been set:**

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



**We must demonstrate leadership in sustainable procurement and will work with our supply chains to achieve this by addressing specific aspects of sustainable procurement such as:**

- Reducing fossil fuel usage to minimise climate change
- Reducing usage of hazardous materials
- Reducing waste
- Ensuring fair pay and working conditions through the supply chain
- Reducing use of transport
- Reducing the use of Single Use Plastics
- Move to working with suppliers to minimise packaging, use reusable containers for deliveries and manufacture using renewable energy

**A more sustainable product can be described as:**

- Fit for purpose and providing value for money
- Energy and resource efficient
- Reusable and recyclable or durable, easily repairable or upgraded
- Ethically sourced (i.e. Wasn't made in a socially irresponsible way)
- Doesn't deplete natural, non-renewable resources
- The production, distribution, and/or consumption uses as little energy as possible and minimizes/responsibly disposes of waste.

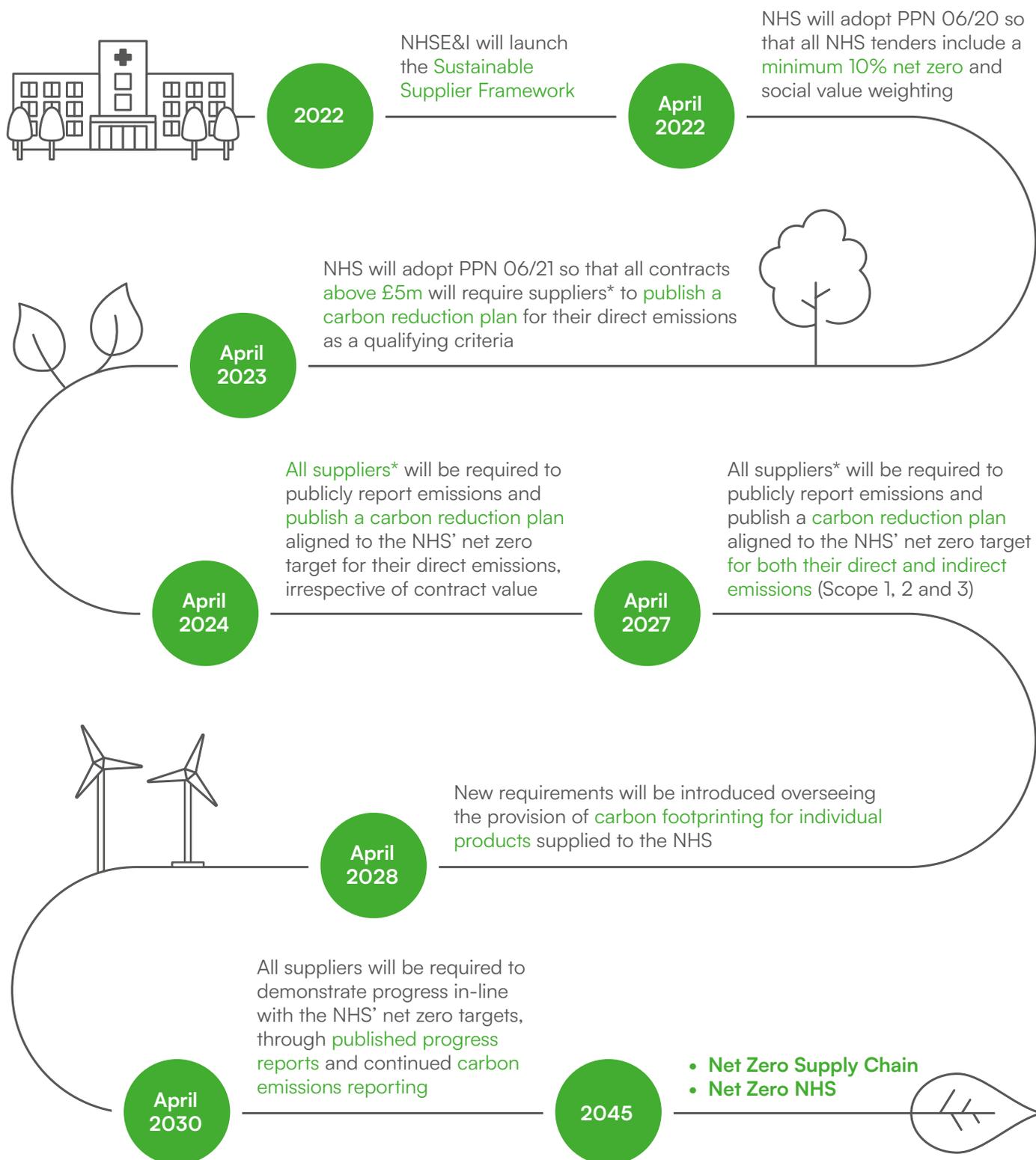
## The benefits of moving to an ICS model

The shift to the ICS way of working will provide the foundation for scale procurement across the NHS with significant monetary and non-monetary benefits, achieved through unlocking efficiencies and improving operational performance across the system.

<b>Improved resilience</b>	C-19 taught us that working together is essential to mitigate risk. Working together across the ICS and at greater scale (where appropriate) provides greater protection from supply failures, price increases and quality defects
<b>Reduced total cost</b>	The ICS represents a publicised and policy driven way of driving 'at scale' procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and reduced repetition
<b>Greater value</b>	The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients
<b>Better supplier management</b>	Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories
<b>Optimised workforce</b>	The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access more diverse roles across the system
<b>Improved capability</b>	Working together frees up capacity to give us time to develop and leverage specific skills and expertise
<b>Great careers</b>	ICS provides a great platform for career growth with a more diverse set of challenges and opportunities across the commercial life cycle.
<b>Empowered culture</b>	The ICS provides an opportunity to fundamentally change and shape the way we work across the system and into the future

Source: NHSEI Commercial Directorate procurement Target Operating Model "ICS Based Procurement Guidance" January 2021 <https://future.nhs.uk/PTOMHub/view?objectId=122643621>

# Building Net Zero into NHS procurement



\*To account for the specific barriers that Small & Medium Enterprises and Voluntary, Community & Social Enterprises encounter, a two-year grace period on the requirements leading up to the 2030 deadline, by which point we expect all suppliers to have matched or exceeded our ambition for net zero.

Source: www.england.nhs.uk/wp-content/uploads/2021/09/item4-delivering-net-zero-nhs-updated.pdf page 7

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Food & Nutrition

“It is estimated that food and catering services in the NHS accounts for approximately **6% the NHS’ Carbon Footprint Plus**” — *Source NHS England Greener NHS website*

Members need to consider ways to reduce the carbon emissions from the food made, processed and served within our organisations. Members currently have various solutions, but it is essential work on reducing overall food waste and ensuring provision of healthier and seasonal menus. Making menus seasonal and adaptable can save money as buying items in season is more cost effective.

Challenging the amount of food waste and reducing the carbon emissions of the food consumed as well as changing to healthier items can have a large impact.

## Collaborative Opportunities

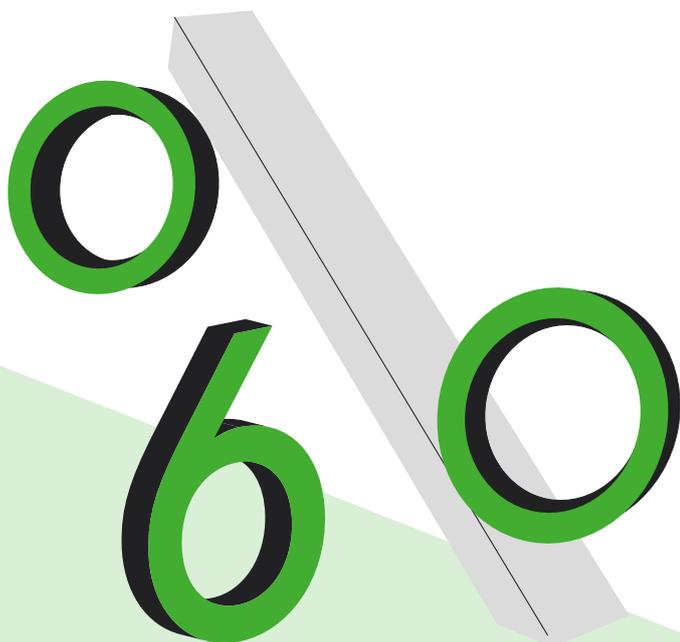
Set up quarterly meeting between catering staff and dieticians from each stakeholder to share ideas, developments and successes

Look to award joint contracts to enable utilisation of fresh food sourced locally, where applicable

Share strategies to minimise food waste

ICS members to join the Shropshire Good Food Partnership and Marches good food group

MPFT have a 4 year plan to provide healthier eating for whole hospital community, achieve Soil Association Food for Life Catering MARC - bronze standard, introduce on the day ordering to reduce waste. Food provided in in-patient wards will be purchased and produced in sustainable way. As well as looking to re- instating greenhouse and plots to grow in hospital gardens/health centres, community outside space etc.



1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

Shropshire Good Food Partnership are working across Shropshire taking a food systems approach to improve sustainability, amongst other objectives, in the local food system. Engagement by ICS partners with the local food system is an opportunity to reduce food miles and to engage with producers who are using sustainable forms of food production.

Food production is responsible for one-quarter of the world's greenhouse gas emissions.

UK Agriculture contributed 10 per cent to total greenhouse gas emissions in 2018, including 70% of nitrous oxide emissions, (generated by synthetic fertilizer use), and nearly half of total methane emissions.

### Greenhouse gas emissions across the food supply chain:



#### Land Use Change

Aboveground changes in biomass from deforestation, and belowground changes in soil carbon



#### Farm

Methane emissions from cows, methane from rice, emissions from fertilisers, manure, and farm machinery



#### Animal Feed

On-farm emissions from crop production and its processing into feed for livestock



#### Processing

Emissions from energy use in the process of converting raw agricultural products into final food items.



#### Transport

Emissions from energy use in the transport of food items in-country and internationally



#### Retail

Emissions from energy use in refrigeration and other retail processes



#### Packaging

Emissions from the production of packaging materials, material transport and end-of-life disposal

Source: <https://ourworldindata.org/food-choice-vs-eating-local>

It is also important to utilize each patient contact to promote healthy and sustainable lives, inc. diet and exercise options.



# Biodiversity

Biological diversity, or biodiversity can be described as **“the variety of life on Earth,** it includes all organisms, species, and populations; the genetic variation among these; and their complex assemblages of communities and ecosystems.” (Benn, 2010)

Biodiversity is incredibly important for sustaining life on the planet; the interdependency we have with the species of flora, fauna, animals, birds, insects and micro-organisms is vital in sustaining our existence through absorbing carbon and regulating environmental change such as climate and disease, providing renewable sustenance at all levels of the food chain, and balancing species population.

It is important, then, that the activities we carry out in providing the services we are commissioned to deliver do not negatively impact our local, national and worldwide ecosystems.

## What are we doing to sustain biodiversity?

There are great examples of encouraging biodiversity in our Integrated Care System. SaTH are collaborating with local beekeepers to provide hives at the Shrewsbury site, as well as bat boxes and Swift boxes to divert such creatures away from buildings whilst providing space for them to live, in addition to planted trees and improved gardens and courtyards with native plants to attract pollinators. RJAH are planting 100 trees across the site around the Captain Sir Tom Moore Path of Positivity, an area for patients (including those bed-bound) and staff to enjoy the local wildlife.

In 2021, TWC gave away 14,525 free trees to residents and organisations in Telford and Wrekin as part of our Trees4TW project.

## Collaborative Opportunities

Share funding models / share information on available grants for investment in surveys introduction of habitats

Work together develop or update organisations ICS Green Space Strategy

## What will we do now?

Look to ensure any impact of development is replaced e.g. trees, wild areas or hedges removed are replaced nearby.

As discussed in Digital Transformation, by adopting Ecosia as our default search engine, we are indirectly contributing the planting of trees and in turn promoting biodiverse habitats in areas outside of Shropshire, Telford and Wrekin.

We will ensure that the local habitats of our native species are considered during capital works to ensure that any works we complete have a positive impact on local wildlife.

We will adopt methods already employed by some organisations in the system to provide beehives, bat and swift boxes where appropriate and plant trees and plant species in our green spaces.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

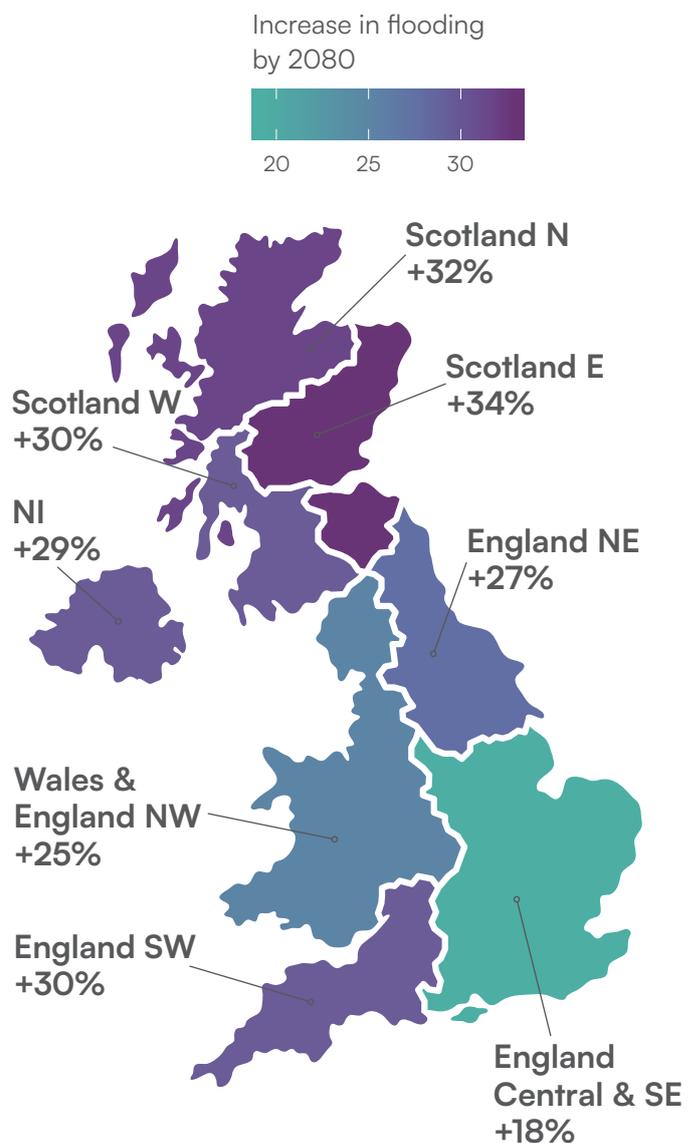


# Adaptation

The care we provide must be **consistent throughout major incidents** such as wildfires, floods, heatwaves, droughts and infectious diseases.

**Sustained extremes in weather and climate are likely to become the status quo in the UK, and varied sources and data indicate that:**

- Wildfires are likely to increase 14% by 2030, 30% by the end of 2050 and 50% by the end of the century (UNEP, 20)
- Flooding will increase by 15-35% by 2080, with Shropshire, Telford and Wrekin likely to experience an increase of around 25% (figure, left) (Visser-Quinn, 2021)
- Heatwave frequency, length and average temperatures are significantly increasing -their average length more than doubling — increasing from 5.3 days in 1961-90 to over 13 days in the decade 2008-2017 (Met Office, 2018)
- Sustained droughts are more common. From September 2010 to March 2012 many parts of England experienced the driest 18 months for over 100 years (Environment Agency, 2017)
- The emergence of SARS-CoV-2 and subsequent Covid-19 crisis in 2020 set a precedent for future outbreaks and how the country will address subsequent variants and other pandemics.



Source: Heriot-Watt University



Although it is unrealistic to expect a service to continue in the event of localised flooding or incidents that incapacitate certain service delivery for some organisations, there may be opportunity to provide contingency, support or mutual aid from the wider system. Preparedness for infectious disease outbreaks is not covered in detail this document, although it is recommended that there be a systematic approach to building resilience to future pandemics and infectious disease outbreaks - for example, the mutual aid between NHS organisations in the system during the Covid-19 pandemic.

How we adapt now to the climate crisis will have significant influence on the investments required later, so it would be prudent to intervene at an early stage. The Department of Health publication for resilience in estate planning (HBN 00-07) offers guidance and all our NHS organisations should adopt this approach when producing Estates Plans. Some of the guidance is transferrable for council estates planning, and other documents such as the CIBSE guidance suite is relevant and applicable.

### Collaborative Opportunities

Shared working spaces and agile (hybrid) working to generate carbon and climate resilience benefits

Mutual aid

A co-ordinated Clinical Strategy

A co-ordinated Estates Strategy

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Action Plan

The action plan developed below outlines **collective goals** not only at system level, but at organisation level with the support from the ICS.

The target dates and completion of the actions will be monitored by the ICS Climate Change Working Group and assurances/escalations will be provided to ICS Board. Executive leads are to be agreed for each area over the next 12 months.

Leadership & Workforce			
Action	What resource is needed?	How will we measure our progress?	Target date
Explore options for a Sustainability Lead for the ICS	1 WTE to be banded	Once postholder is in role	April 2022
Establish a baseline carbon footprint	Funds for external consultancy to deliver	System-wide carbon footprint figure	March 2023
Make carbon literacy training available for senior leaders, expecting at least one from each organisation to have completed by April 2023	Funds for training provider to deliver training	Once one senior leader from each organisation has completed the training	April 2023
Green Plan to be reviewed and actions measured within 12 months, with a view to amend accordingly	Central co-ordination/Climate Change Working Group to review	Updated version of Green Plan to be published April 2023	April 2023
Develop benchmarks on system performance to demonstrate assurance and/or areas for further development	Central co-ordination/Climate Change Working Group to review	Quarterly benchmark reporting to Climate Change Working Group	October 2022
Ensure that sustainability behaviours are considered when reviewing job descriptions	Communications and engagement with human resources/people services	Job descriptions updated to include sustainability behaviours	April 2023

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

## Sustainable Models of Care

Action	What resource is needed?	How will we measure our progress?	Target Date
Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely	ICT equipment and training, engagement with clinical teams	All outpatients services delivering ≥25% of activity	April 2023

## Digital Transformation

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations encouraged to adopt Ecosia as their default internet search engine	Engagement with IT departments to add Ecosia as an extension to MS Edge	IT departments to provide collective data (against UCLH data benchmark)	October 2022
Promote the option of agile (hybrid) working where there is no negative impact on service delivery	Engagement with IT departments, it is anticipated that no significant extra equipment be required as those that could work from home did so during the covid-19 crisis and were provided with equipment then	IT departments to provide collective data (against benchmarks during covid-19 crisis)	April 2023

## Travel & Transport

Action	What resource is needed?	How will we measure our progress?	Lead
Organisations will need to identify a named individual who will complete and submit the return NHSEI Greener Fleet Data Collection tool	Time and named individual	Successful and routine return of data to NHSEI	April 2022
ICS to develop a system Green Travel Plan, ensuring a hierarchy of travel starting with active travel	Central co-ordination, climate change working group for peer support	Document to be published April 2023	April 2023
Ensure that, for new (fleet) purchases and (fleet) lease arrangements, the system (and organisations) solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs)	It is anticipated that this transition will occur when existing contracts are renewed, so those organisations still in contract by April 2023 will aim to move to ULEVs/ZEVs once those contracts end. Electric Vehicle (EV) charging infrastructure will be required at base sites	All contracts transitioned at their end	April 2023

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

## Estates

Action	What resource is needed?	How will we measure our progress?	Lead
NHS Organisations to ensure they procure only REGO energy from grid as soon as their existing contracts allow	Small cost pressures to utilities (typically less than £2/mWh additional)	All organisations to confirm at Climate Change Working Group	April 2022
Organisations to commit to invest in on-site renewable energy, insulation, and energy efficient technologies (such as LED lights) as part of their Estates Strategies	Capital commitment during schemes, although there would be an expectation of ROI	Sustainable technologies specified in all organisations' Estates Strategies	April 2025
Where possible, invest in emerging renewable technologies	Capital investment where there is attractive ROI	Successful completion of projects	April 2025
As a minimum, adopt BREEAM as a benchmark for constructing sustainable buildings, with a shared design benchmark to follow on from the work from Shropshire Council	Could be absorbed in capital projects	Successful BREEAM validation on capital projects	April 2023
Develop a heat decarbonisation plan for the system	External consultancy and central co-ordination, climate change working group for peer support	Document to be published October 2023	October 2023
Replace any habitat removed during developments	Could be absorbed in capital projects	External verification	April 2023

## Facilities

Action	What resource is needed?	How will we measure our progress?	Target Date
Explore options to appoint a system waste manager	1 WTE to be banded	Once postholder is in role	October 2022
Organisations to assess waste management practices against better-performing peers and adopt where reasonably practicable (i.e. segregation)	System Waste Manager to co-ordinate	Quarterly benchmarking to climate change working group	April 2023
Organisations to aim to divert 100% household waste from landfill	Review contracts and amend when renewing, where applicable	Quarterly benchmarking to climate change working group	April 2023
Organisations to sign up to the single use plastic pledge (catering)	Cost pressure to some catering budgets — opportunities to collaborate on procurement	All organisations to confirm through the climate change working group	April 2023

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

## Facilities (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Reduce food waste through smarter working (i.e. patient ordering strategies, management of stock, etc)	Could be pursued through existing catering structures	Quarterly benchmarking to climate change working group	April 2024
Adopt, where clinically safe to do so, environmentally friendly domestic cleaning chemicals	Could be pursued through existing procurement structures	Organisations to report through climate change working group	April 2023

## Medicines

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to encourage use of low-carbon alternatives to inhalers and similar environmentally harmful medicines (where it is clinically safe to do so)	Continue specialist consultation before launch of green inhaler formulary	All organisations to confirm via the climate change working group	April 2023
Organisations to consult with their clinicians to agree alternatives to environmentally harmful anaesthetic gases such as Sevoflurane, Isoflurane and Nitrous Oxide	Engagement clinicians and Medicines Managements teams	All organisations to confirm via the climate change working group	April 2024

## Supply Chain & Procurement

Action	What resource is needed?	How will we measure our progress?	Target Date
Adopt PPN 06/20 so that all NHS tenders include a minimum 10% net zero and social value weighting on contracts >£5m per annum	Add to pre market engagement process	An NHS wide TOMs (Themes, Outcomes and Measures) reporting portal is being developed	April 2022
Procurement staff to complete training on Social Value in tenders	Staff time, although free training available via: <a href="http://www.govcommercialcollege.co.uk">www.govcommercialcollege.co.uk</a>	Staff appraisals	December 2022
Ensure process/contract for reuse of Walking Aids is in place	Introduction of process and minimal ongoing staff resource to prepare for reissue	Reduction in expenditure	March 2023
Ensure reusable surgical instruments have been investigated and implemented as appropriate	Validating and introducing process by clinicians / H&S	Reduction on expenditure	March 2023
Review procurement procedures to embed awareness of sustainable in procurement processes	Amend with regular reviews	Processes embedded	December 2023

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  
11.  
12.  
13.  
14.  
15.

## Supply Chain & Procurement (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure the whole life cycle impacts of the procurement	Include in pricing exercise and evaluation	Expenditure better managed	December 2023
Begin to communicate NHS Net Zero targets for Scope 3	Carry out via contract management	Awareness improved	March 2024
Promote the value of human rights and equality within our supply chain	Carry out via contract management	Awareness improved	March 2024
All suppliers will be required to publicly report emissions and publish a Carbon Reduction Plan for their direct emissions and social value included in the evaluation and award, irrespective of contract value. *SME and Voluntary Sector have a 2-year grace period to adhere to this	National requirements	Awareness improved	April 2024

## Food & Nutrition

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to expand plant-based menu options, reduce meat-based menu options and hold 'meat-free' days regularly	Amend menus, there may be a need for new suppliers/ contracts	Use of meat-based items	April 2023
Organisations to employ seasonal menus to enable provision of fresh food sourced locally	Amend menus, may be a need for new suppliers/contracts	Use of more fresh produce	April 2023
Organisations to attain sustainable catering accreditation (i.e. Soil Association Food for Life Catering MARC)	Tie commitment and small cost pressure for validations, in house awareness and inspection	MARC Accreditation	April 2025
Organisations to develop a strategy to minimise food waste	Co-ordination and peer review via climate change working group	Quarterly benchmarking to climate change working group	April 2024

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## Biodiversity

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to consider the impact of capital estates projects on local wildlife and ensure neutral or positive impact by developing green spaces in proximity to the works	Could be absorbed in capital projects	External verification	April 2023
Organisations to 'rewild' green spaces by planting diverse range of trees and plant species	External funding, for example the Queen's Green Canopy	Organisations to report via climate change working group	April 2025
Develop an ICS Green Space Strategy	Central co-ordination/ Climate Change Working Group to review	Document to be published September 2023	September 2023

## Adaptation

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure our NHS organisations consider HBN 00-07 when developing Estates' Strategies	Engagement with Estates teams	HBN 00-07 to be specified in Estates strategies	April 2023
Organisations to ensure contingency plans are in place in the event of adverse weather and major incidents to provide business continuity, staff and patient safety and care provision	Engagement with whole organisations to ensure comprehensive and joined-up approach	Organisations to escalate concerns via climate change working group	April 2022

# References

Benn, J (2010), 'United Nations Environment Programme: What is Biodiversity?'. Available at [https://www.unesco.pl/fileadmin/user\\_upload/pdf/BIODIVERSITY\\_FACTSHEET.pdf](https://www.unesco.pl/fileadmin/user_upload/pdf/BIODIVERSITY_FACTSHEET.pdf)

Environment Agency (2017), 'Drought Response: our Framework for England'. Available at [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/625006/LIT\\_10104.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625006/LIT_10104.pdf)

Kendon, M., Jevrejeva, S., Matthews, A., Sparks, T. & Garforth, J. (2021), 'State of the UK Climate 2020'. *International Journal of Climatology*. Volume 41, Issue S2. Available at <https://doi.org/10.1002/joc.7285>

Met Office (2018), 'State of the UK Climate 2017: Supplementary report on Climate Extremes'. Available at [https://www.metoffice.gov.uk/binaries/content/assets/metofficegovuk/pdf/weather/learn-about/uk-past-events/state-of-uk-climate/soc\\_supplement-002.pdf](https://www.metoffice.gov.uk/binaries/content/assets/metofficegovuk/pdf/weather/learn-about/uk-past-events/state-of-uk-climate/soc_supplement-002.pdf)

NHSEI (2020), *Delivering a Net Zero NHS*. Available at <https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf>

NHSEI (2021), *Estates Return Information Collection 2020-2021 Data*. Available at <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection>

Visser-Quinn, A. (2021), 'UK's flooding to get 15-35 percent more intense by 2080'. Available at <https://www.hw.ac.uk/news/articles/2021/uk-s-flooding-to-get-15-35-percent-more.htm> (Heriot Watt University)

NICE (2015), *Medicines Optimisation: The Safe and Effective use of Medicines to Enable the Best Possible Outcomes*. Available at: <https://www.nice.org.uk/guidance/NG5>

# Acronyms

Acronym	Definition
CO2e	CO2e accounts for carbon dioxide and other gases such as methane and nitrous oxide
DPI	Dry Powder Inhaler
EPR	Electronic Patient Records
GHG	Greenhouse Gases
ICB	Integrated Care Board
ICS	Integrated Care System
MPFT	Midlands Partnership NHS Foundation Trust
MS	Microsoft
NICE	National Institute for Clinical Excellence
pMDIs	Pressurised Metered Dose Inhalers
PV	PhotoVoltaic (Solar panels that convert the Sun's energy into useful electrical power)
QIPP	Quality, Innovation, Productivity and Prevention
REGO	Renewable Energy Guarantees of Origin
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ROI	Return on Investment
SATH	The Shrewsbury & Telford Hospital
SC	Shropshire Council
SCHT	Shropshire Community Health NHS Trust
SM	Salmeterol
STW CCG	Shropshire, Telford & Wrekin Clinical Commissioning Group
TW	Telford & Wrekin Council
WMS	West Midlands Ambulance Service

# Further Information

If you have a general enquiry about Shropshire, Telford & Wrekin Integrated Care System(ICS), please email [stw.stp@nhs.net](mailto:stw.stp@nhs.net)

Visit us online [www.stwics.org.uk](http://www.stwics.org.uk)

Our partnership is made up of the following organisations:



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

## System Level Integrated Performance Report

<b>Author:</b>	Julie Davies & Dave Ashford	<b>Paper date:</b>	27/04/22
<b>ICS Board Member Sponsor:</b>	Mark Brandreth	<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	<input type="checkbox"/>	R=Ratification	<input type="checkbox"/>
S=Assurance	<input checked="" type="checkbox"/>	D=Discussion	<input type="checkbox"/>
I=Information	<input checked="" type="checkbox"/>		

### 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
- Financial summary

### 2. Executive Summary

#### Operational Performance

Urgent and Emergency Care includes Four Hour A&E waits, Trolley Waits, Handover times and Time to Initial Assessment. Overall A&E performance has remained consistently below the 95% four hour wait target with deteriorating performance. Monthly performance is not expected to achieve the target. Type 1 Major A&E Departments which have the largest proportion of the total A&E activity also remain below the target. With the inclusion of Shropshire Community Trust, Type 3 Minor Units remain above the target but show a deteriorating performance.

Trolley breaches peaked at the end of 2019 and beginning of 2020 and have remained consistently low from April 2020 onwards with a rise between November 2020 and January 2021. This measure is now showing a significant increase in numbers.

Ambulance Handover time greater than 60 minutes is increasing and is significantly higher than the beginning of 2021.

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.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.

Elective Care includes 18 weeks RTT, RTT 52 week waits and Diagnostics 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.

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. Dementia Diagnosis rates also have a deteriorating performance and the SPC indicates that the rate will not achieve the target. 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. 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.

Maternity metrics included in this report include Smoking at Time of Delivery (SATOD), Neonatal Mortality & Stillbirths, Low birth Weight, Smoking status at booking, Gestational age of 0 to 70 days at booking, Continuity of Carer pathway and Delivery Method.

Smoking at time of delivery remains above the national ambition of 6% at 11.4% and is showing an improving performance. Continuity of carer pathways remains below the England rate at a consistent level for the most recent 5 months.

COVID It does appear that this Covid event is following a similar pattern to the Delta (sharp up, sharp down). If this similarity continues, we would expect a slowing of the decline in case numbers, but continuing a skewed decline for the next couple of months. Albeit that is without any other 'new' factors like a new variant or a significant change in population behaviour. There have been some early signs that operational pressures are easing and the mitigating actions to reduce wider system risks are having the desired outcomes. The vaccination programme has been recognised regionally and nationally as one of the best performing with over 1.1million vaccine doses administered to date.

### **People Performance**

Agency WTE and Staff Group the has been a steady increase since lowest point in April 2020, the new peak usage of 412wte exceeding previous peak of 363wte in Jul21 & Oct21, current usage is at 412wte, 91% of agency is acute NHS. Bank usage also increased to 641wte from low of 506wte in Dec21 and high of 799wte Feb21.

SaTH continues to have the highest vacancy rate which has increased 0.7% to 8.3% (note budget was updated Aug21), vacancy rates have slowly decreased for the last 20 months.

Current NHS system absence and Isolation; Covid absence peaked at 5% at the end of March but has decreased during April to around 2% SCHAT has highest total absence of 7.3% (Covid 2.0%) NHS paramedic sickness is the highest 5.9% NHS Nursing & Midwifery sickness 4.8% up from 5.6%, RJAHS N&M sickness is high at 7.1% Care worker sickness absence is 5.8%

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.

## Financial Position

### Revenue Position

The 21/22 planned deficit for the year was a £6.4m deficit. The actual deficit for the system is a £6.3m deficit, a £0.1m favourable variance to plan.

The actual revenue outturn position has remained in line with previous reported forecast outturn revenue position

### Capital Position

The 21/22 full year capital expenditure is £55.2m, which is in line with our previously reported forecast outturn and reported figures to NHSEI

## Context

STW remains a challenged system and is the bottom quartile of the region for its urgent care performance, this in turn is impacting upon the ability to respond to 999 calls promptly due to Ambulance waits which remains a significant risk for the system.

With continued pressure resulting from managing COVID and winter pressures, the cancer performance has started to see a decline. Elective care is facing similar challenges, the system is working hard to maximise its delivery in H2 and with the use of additional independent sector capacity and third party insourcing to improve its elective rate of recovery. Despite this, STW is one of the few systems regionally to be forecasting its number of long waiters >104wks at the end of March to be below that originally planned in October. This is a great achievement and our providers who have worked incredibly hard, in very challenging circumstances, to get our patients treated.

Further progress has been made with placed based metrics; TWIPP and SHIPP now have internal operating dashboards that reflect both local and national targets, with system level key metrics and reporting in final stages of development. 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 May.

### 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.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.



# Shropshire, Telford & Wrekin

Integrated Care System

## System Level Integrated Performance Report Shadow ICS Board

Julie Davies  
27 April 2022

Provider Level Metrics

Analytical Support from Midlands & Lancashire CSU

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Regular Contents/Reports

- ◆ System Overview (metrics summary)
- ◆ Urgent and Emergency Care
- ◆ Cancer Waiting Times
- ◆ Planned/Elective Care
- ◆ SATH and RJAH Elective Activity Recovery (ERF)
- ◆ Mental Health
- ◆ Neonatal and Maternity (Due May 2022)
- ◆ Covid-19 update (Vaccination data due May 2022)
- ◆ Integrated Finance Report
- ◆ STW People Performance



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Overview

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	



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Urgent & Emergency Care

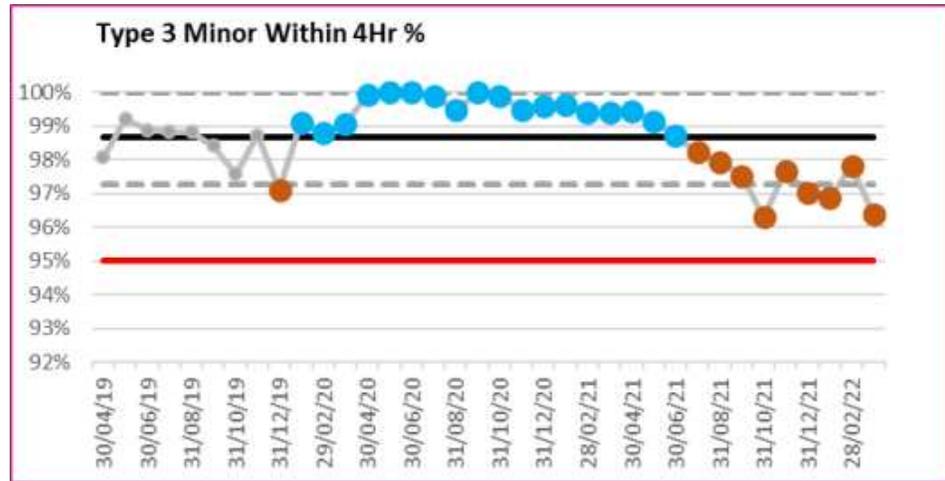
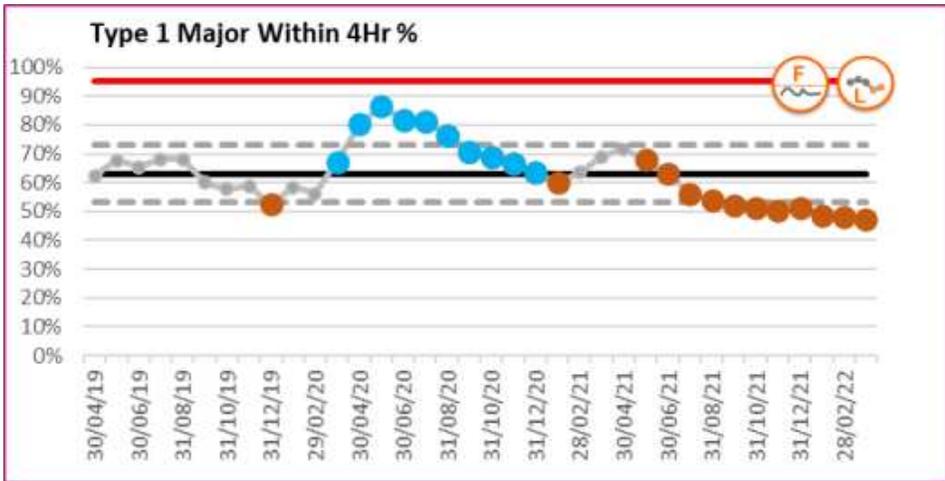
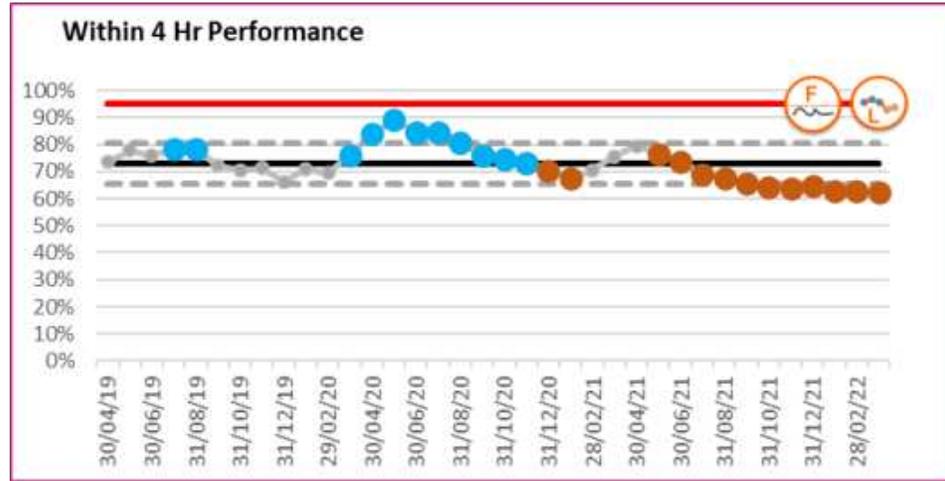
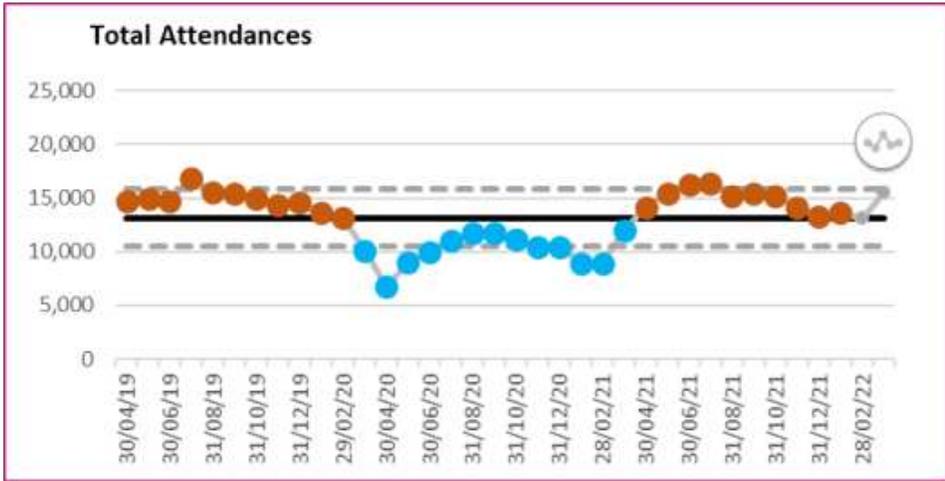
## Metric Summary

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Attendances	Mar 22	15482	0			13130	10452	15809
Within 4 Hr Performance	Mar 22	62.1%	95.0%			72.9%	65.3%	80.5%
Type 1 Major Within 4Hr %	Mar 22	47.3%	95.0%			63.2%	53.2%	73.1%
Type 3 Minor Within 4Hr %	Mar 22	96.4%	95.0%			98.7%	97.3%	100.0%
Trolley Breaches	Mar 22	307	0			106	0	247
Handover time Greater than 60mins	Mar 22	998	0			389	89	688
Patient brought in by ambulance%	Mar 22	23.5%	0.0%			30.9%	26.6%	35.1%

- ◆ Data available for Shrewsbury & Telford Hospitals Trust and Shropshire Community Health NHS Trust
- ◆ Total attendances at A&E attendances are now returning to pre COVID levels and remain above the mean since April 2021.
- ◆ The four-hour waiting time target has been consistently failing and the monthly performance is not expected to achieve the target, however many Trusts in England were failing this target prior to 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.

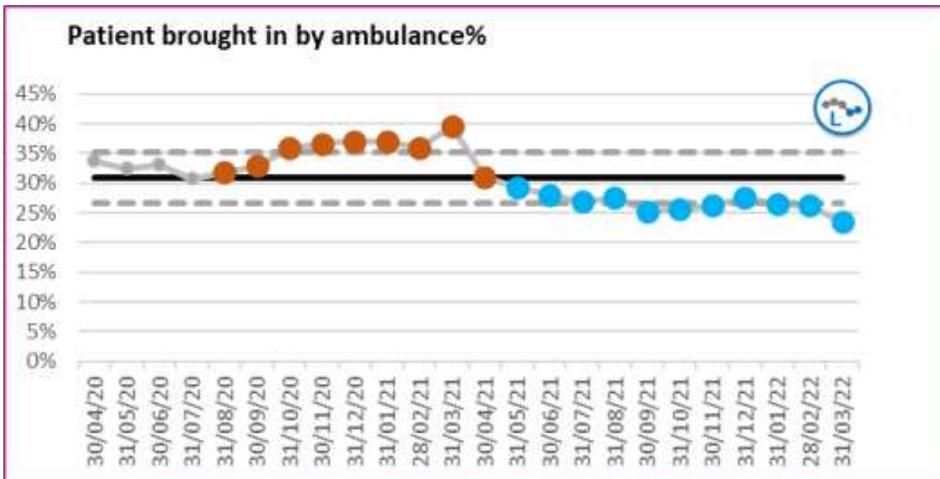
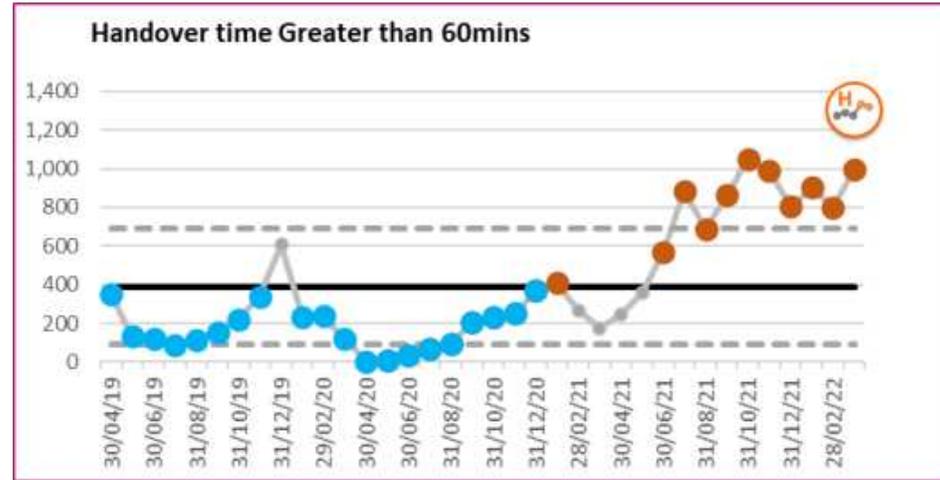
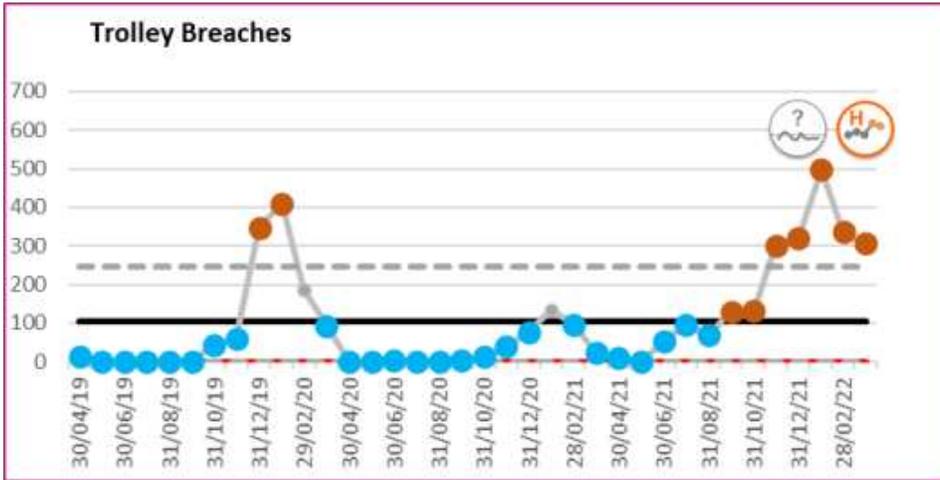


# Urgent & Emergency Care Metric Performance



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Urgent & Emergency Care Metric Performance



◆ **Actions:**

The trend/pattern continues with the uplift in COVID numbers, constraints around workforce and bed closures across the system.

SATH and the wider system have scheduled a number of Multi Agency Discharge Events to encourage flow and make best use of available bed stock.

SATH have introduced additional cohorting areas to ease front door pressures and improve 999 Category 2 responses

◆ **Assurance:**

UEC operations group, reporting to UEC Board on delivery of improvement plan and trajectories (to be added to the next report)



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

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

## Metric Summary

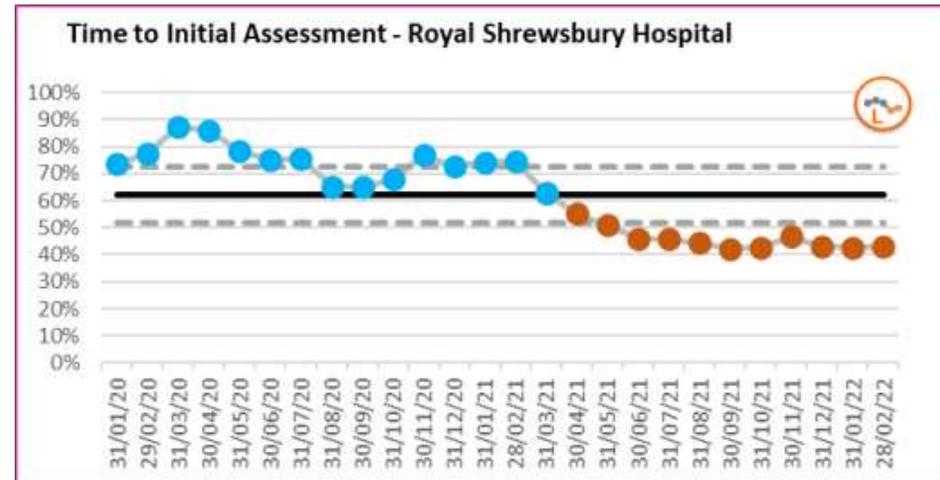
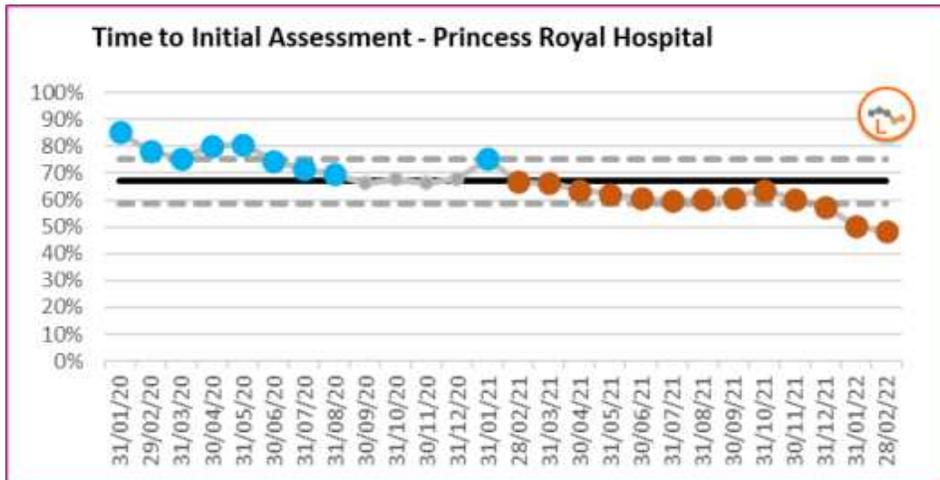
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Time to Initial Assessment - Princess Royal Hospital	Feb 22	48.3%				66.9%	58.8%	75.0%
Time to Initial Assessment - Royal Shrewsbury Hospital	Feb 22	43.1%				62.1%	51.9%	72.3%

- ◆ The Time to Initial Assessment is extracted locally from the Emergency Care Data Set (ECDS) tables which is a relatively new data set. The published Time to Initial Assessment as part of the ECDS quality indicators commenced in January 2020.
- ◆ The Percentage assessed within 15 minutes for both sites is significantly lower and remain below the lower process limit.



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

## Metric Performance



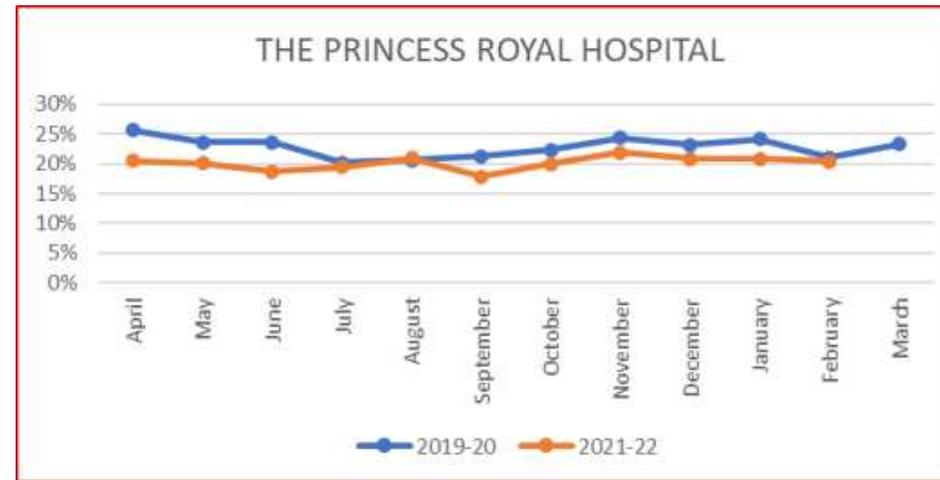
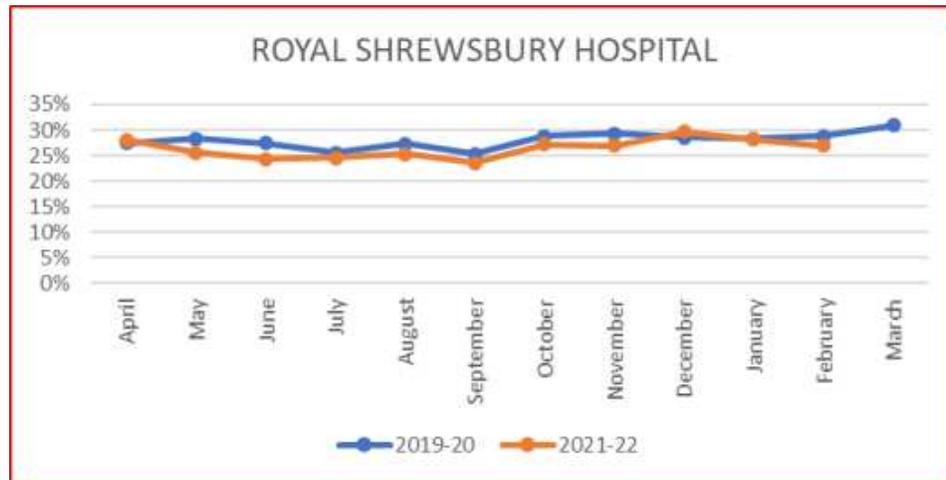
- ◆ Action:
  - Data consistency and compliancy remains a challenge, the national position is trending around the same, the regional position is c.30% above where SATH is, the new operating system will help resolve the IT issues
  - A recent trial of ECP at RSH for re-direction did give the opportunity to lean up processes, learning from this to be reported to UEC group.
  - NB Constraints do exist with this metric related to Amber/Green ED pathways and early identification of COVID+ patients
- ◆ Assurance;
  - UEC operations group, reporting to UEC Board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Urgent & Emergency Care Metric Performance

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



- ◆ Data extracted locally from the Emergency Care Data Set (ECDS) tables which is a relatively new data set.
- ◆ The above charts provide a year on year comparison between 2019/20 and 2021/22 by site as a percentage of the total A&E attendances admitted into the trust.
- ◆ Comparison of the two years illustrates that both sites now have a lower percentage compared to the baseline of 2019/20. Royal Shrewsbury Hospital is now in line with 2019/20 admission percentage.



# Medically Fit for Discharge

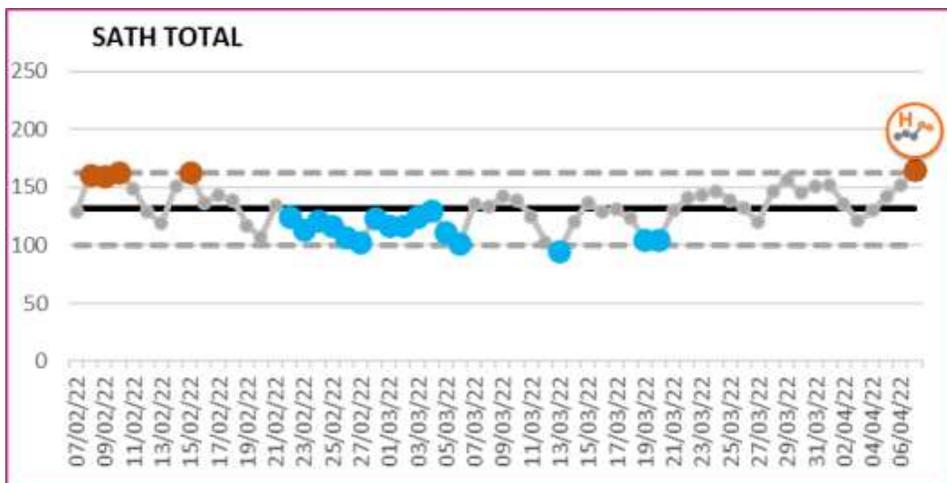
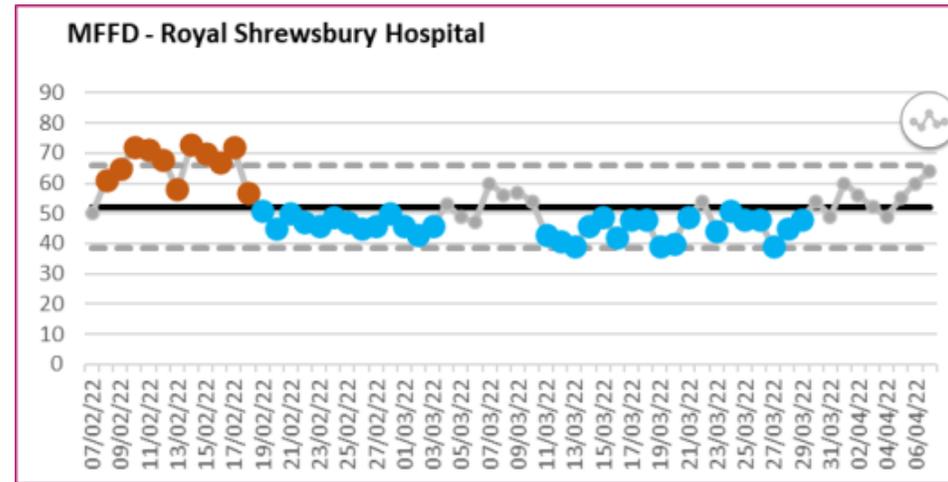
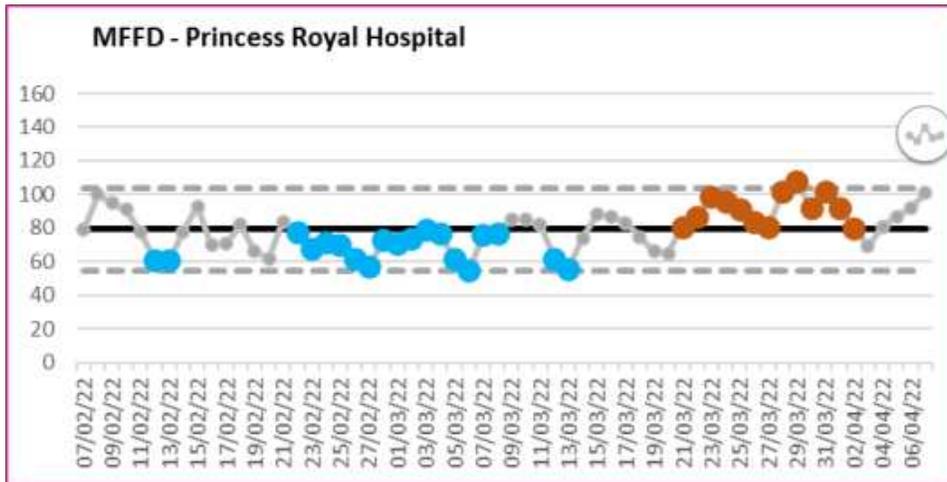
## Metric Summary

KPI	Latest date	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MFFD - Princess Royal Hospital	07/04/2022	101	0			79	55	104
MFFD - Royal Shrewsbury Hospital	07/04/2022	64	0			52	39	66
SATH TOTAL	07/04/2022	165	0			131	100	163

- ◆ The data flows directly from SaTH for patients who have been identified as Medically Fit for Discharge.
- ◆ The data shown is for the latest 60 days.
- ◆ The number of patients medically fit for discharge as at 7<sup>th</sup> April 2022 is Special cause concerning variation over the 60 day period for both sites.



# Medically Fit for Discharge Metric Performance



## ◆ Actions:

There is a daily focus (Silver level) on numbers of MFFD and reasons for delay

The demand and capacity group modelling has been the main driver for the reduction in numbers, identifying/predicting bed/resource models across the discharge pathway

Local Authorities have been using the Demand and Capacity modelling to manage the market with some success

## ◆ Assurance:

UEC operations group, reporting to UEC Board



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Cancer Waiting Times

## Metric Summary

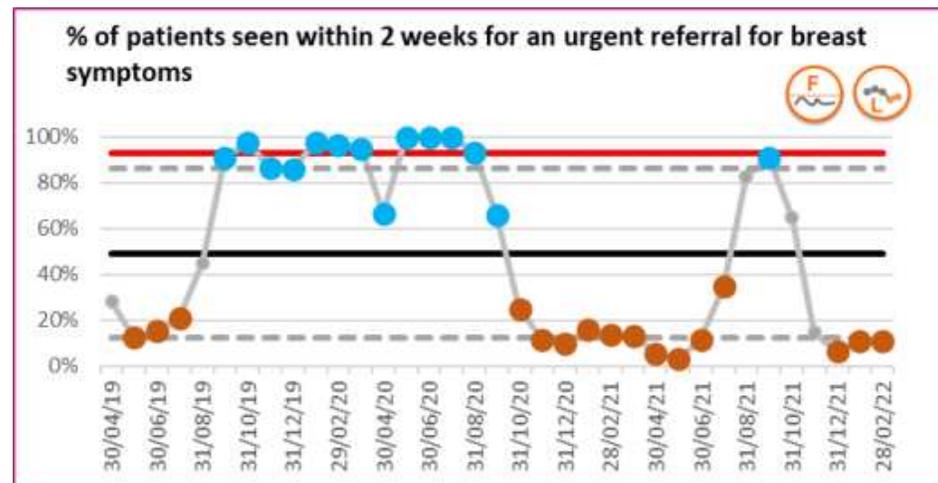
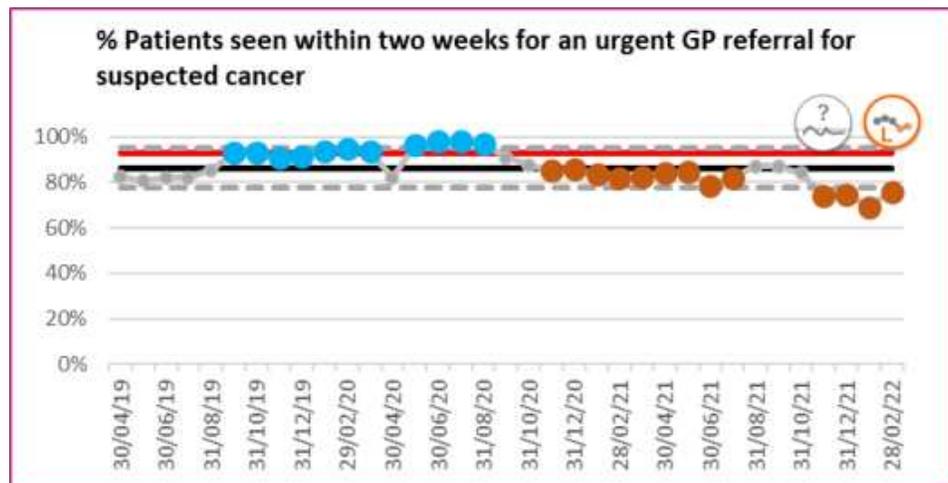
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
% Patients seen within two weeks for an urgent GP referral for suspected cancer	Feb 22	75.8%	93.0%			86.1%	77.4%	94.7%
% of patients seen within 2 weeks for an urgent referral for breast symptoms	Feb 22	10.9%	93.0%			49.2%	12.1%	86.2%
% of patients receiving definitive treatment within 1 month of a cancer diagnosis	Feb 22	94.3%	96.0%			97.1%	92.2%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments)	Feb 22	77.8%	94.0%			96.9%	89.6%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Surgery)	Feb 22	93.5%	94.0%			91.1%	77.4%	100.0%
% of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments)	Feb 22	94.5%	98.0%			99.1%	95.7%	100.0%
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Feb 22	45.5%	85.0%			70.9%	56.1%	85.6%
% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service	Feb 22	35.1%	90.0%			74.5%	30.2%	100.0%
% of patients receiving treatment for cancer within 62 days upgrade their priority	Feb 22	75.2%	0.0%			84.3%	73.0%	95.7%

- ◆ 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 improved significantly, returning to levels seen prior to January.
- ◆ The percentage of patients receiving definitive treatment within 2 months is showing deteriorating performance.



# Cancer Waiting Times

## Metric Performance



### ◆ Actions:

Community breast clinics that started in November are now seeing 100+ cases per month, however the number of breast referrals increased for November and December and now remain higher c.10% above pre covid levels so the true benefits aren't yet being realised.

### Assurance:

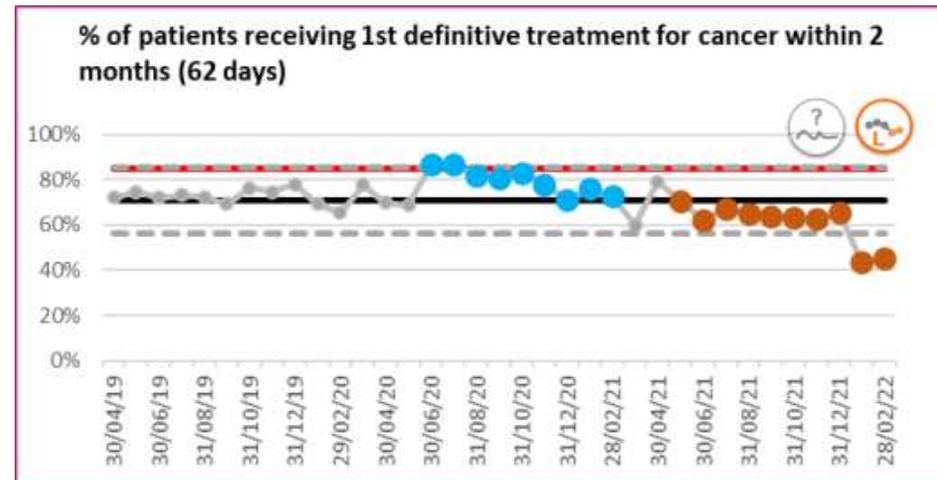
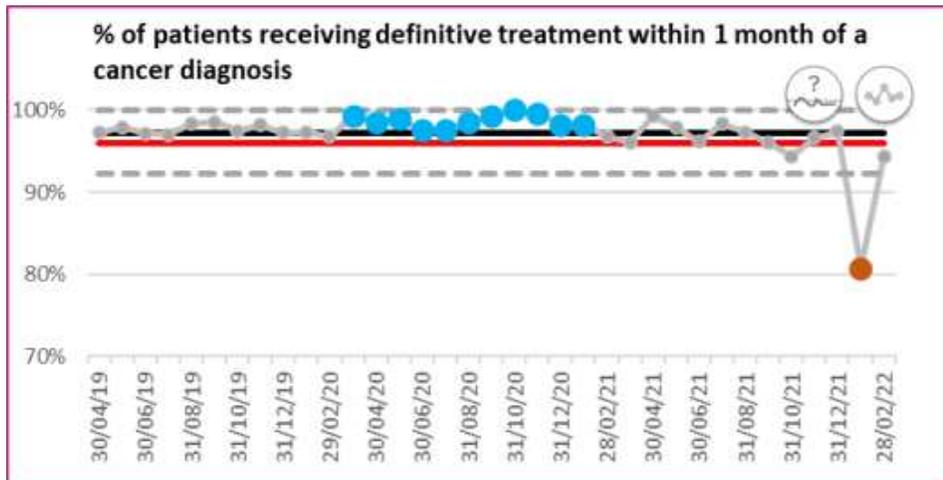
- ◆ System Elective & Cancer Recovery Group now overseeing delivery of improvement and reporting to System Planned Care Board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# 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 team is developing improvement plans to improve pathways and increase productivity with staffing, there is an interdependency relating to diagnostic workforce which SATH are actively recruiting to including overseas with some success

◆ **Assurance:**

31 day waits remain in standard and stable

System Elective & Cancer Recovery Group now overseeing delivery of improvement and reporting to System Planned Care Board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Elective Care

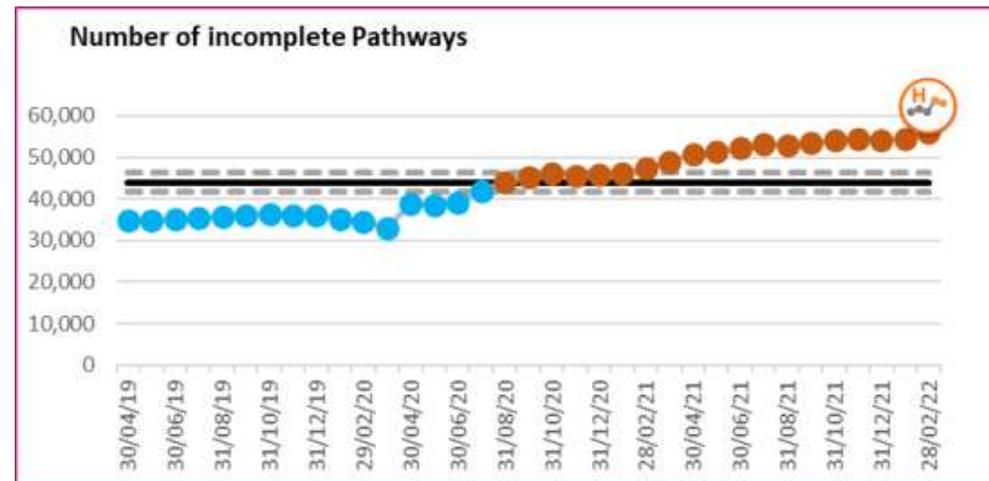
## Metric Summary

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
% RTT Incomplete Pathways < 18 weeks	Feb 22	57.6%	92.0%			66.8%	61.4%	72.2%
Number of incomplete Pathways	Feb 22	55944				43958	41615	46301
Number waiting longer than 52 weeks	Feb 22	4837	0			2302	1638	2966
% Diagnostics > 6 weeks	Feb 22	35.5%	1.0%			28.9%	16.1%	41.7%
Average Diagnostics Activity	Feb 22	724				597	463	732

- ◆ 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 common cause variation with no significant change and monthly performance is not expected to achieve the 1% target.



# Elective Care Metric Performance



◆ **Actions:**

System Demand and Capacity group for Elective/planned has been care re-formed

Waiting list movement and available capacity is being monitored at system and Trust level

Independent sector provision including ophthalmology, orthopaedics, urology, general surgery, vascular, pain management and gynaecology has been sourced. Most recently RJAH has secured some spinal independent sector capacity

Continued use of virtual clinics and expanded advice and guidance helping to manage outpatient demand

Continued roll out of patient initiated follow up is helping manage the volume of patient reviews

Investment in CT capacity and opening of MRI/CT POD to improve time to diagnosis and shorten the RTT pathway

◆ **Assurance:**

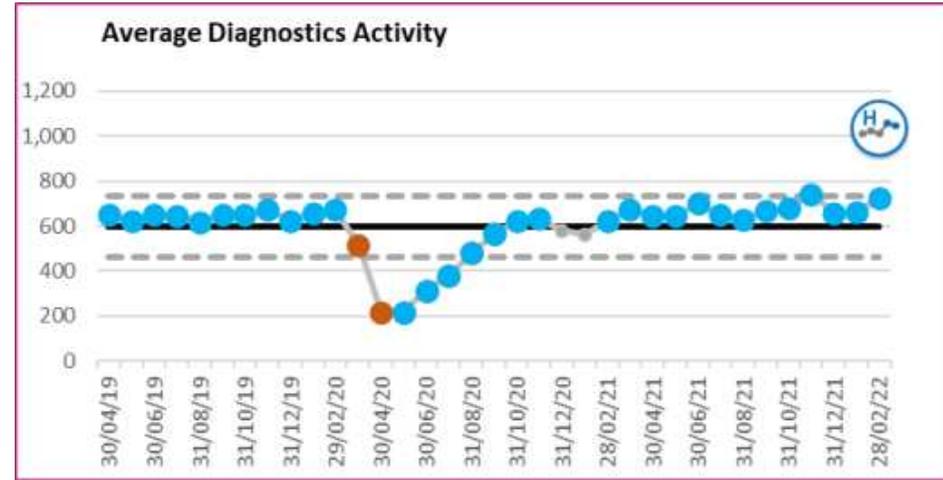
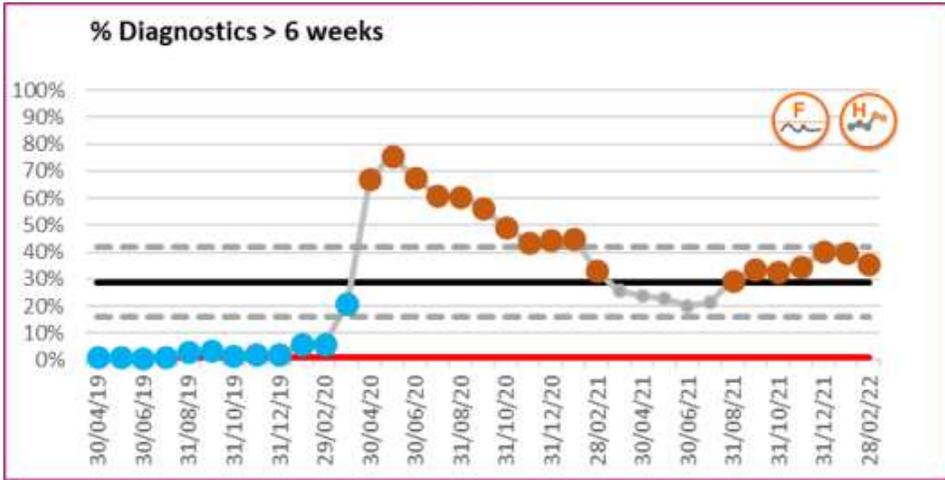
**104 weeks original system plan/tragjectory was to have 241 patients waiting by the end of March, this currently stands at 144 STW is one of the only systems in the region under plan**

System Elective & Cancer Recovery Group overseeing delivery of H1 plan now reporting to system planned care board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Elective Care Metric Performance



◆ **Actions:**

Radiology/diagnostics continue to perform well overall, despite an uplift in demand

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

The modular CT unit to increase capacity & reduce the current backlog and aid overall rate of elective recovery is now in operation

Recruitment across the diagnostic pathway continues

◆ **Assurance:**

System Elective & Cancer Recovery Group overseeing delivery of plan now reporting to system planned care board



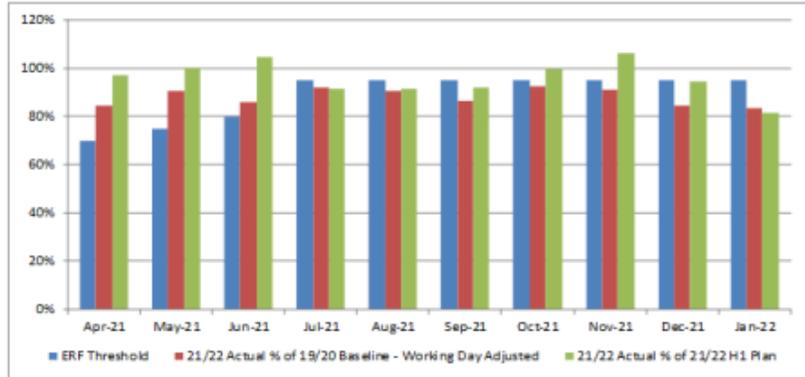
- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# SATH and RJAH Elective Activity Recovery against H1/H2 Plan and 19/20 Working Day Adjusted Baseline

Actual figures supplied by SATH and RJAH. January is un-validated data and may be subject to change.

## Daycases

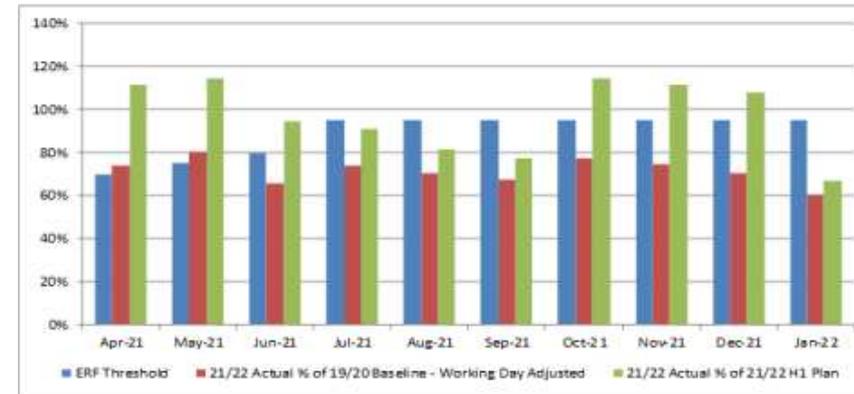
Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	5911	5138	4991	70%	84%	97%
May-21	5807	5251	5247	75%	90%	100%
Jun-21	6456	5307	5546	80%	86%	105%
Jul-21	6065	6100	5587	95%	92%	92%
Aug-21	5861	5783	5310	95%	91%	92%
Sep-21	6202	5829	5378	95%	87%	92%
Oct-21	5844	5428	5407	95%	93%	100%
Nov-21	6367	5459	5802	95%	91%	106%
Dec-21	5937	5307	5021	95%	85%	95%
Jan-22	5861	5981	4882	95%	83%	82%



From October 21 SATH and RJAH Daycases are very close to H2 plan and just below 95% of 19/20 Baseline. There was a noticeable increase seen in November 21 but performance has deteriorated in the Dec 21 and Jan 22

## Elective

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	868	576	642	70%	74%	111%
May-21	906	636	730	75%	81%	115%
Jun-21	1115	775	734	80%	66%	95%
Jul-21	1028	831	758	95%	74%	91%
Aug-21	973	842	685	95%	70%	81%
Sep-21	1089	949	733	95%	67%	77%
Oct-21	1037	700	801	95%	77%	114%
Nov-21	1096	735	818	95%	75%	111%
Dec-21	963	630	680	95%	71%	108%
Jan-22	816	734	492	95%	60%	67%



From October 21 SATH and RJAH Elective are well achieving the H2 plan but are still considerably lower (@-25%) than the 19/20 baseline. There was a noticeable drop in Jan 22

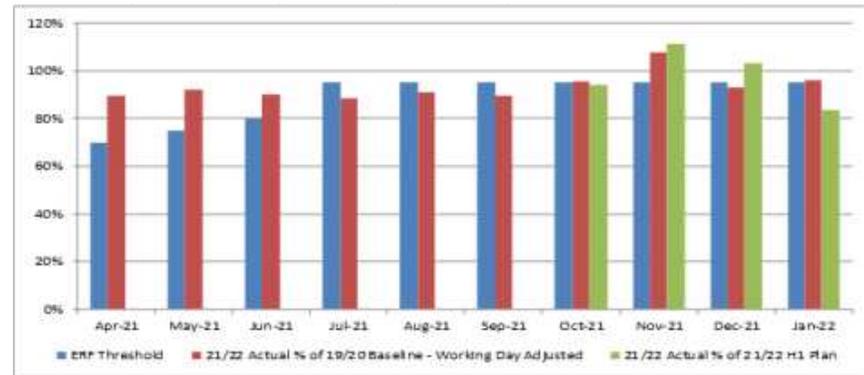


# SATH and RJAH Elective Activity Recovery against H1/H2 Plan and 19/20 Working Day Adjusted Baseline

Actual figures supplied by SATH and RJAH. January is un-validated data and may be subject to change.

## 1<sup>st</sup> Outpatients

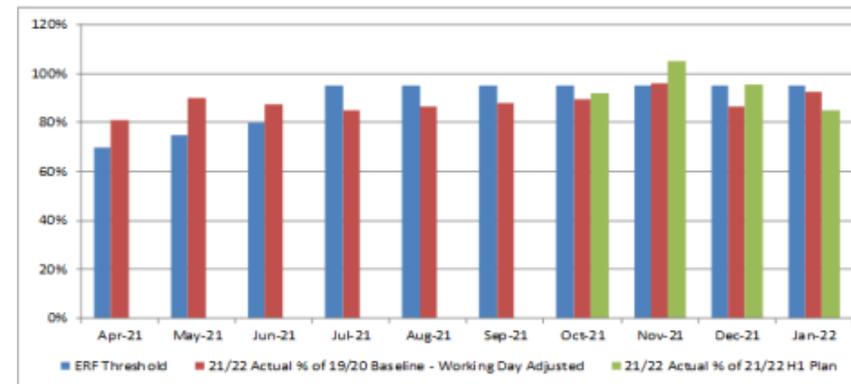
Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	20173	0	18047	70%	89%	0%
May-21	19644	0	18126	75%	92%	0%
Jun-21	22477	0	20251	80%	90%	0%
Jul-21	22160	0	19587	95%	88%	0%
Aug-21	20205	0	18390	95%	91%	0%
Sep-21	22244	0	19943	95%	90%	0%
Oct-21	21087	21376	20143	95%	96%	94%
Nov-21	20920	22029	22506	95%	108%	111%
Dec-21	19454	17584	18117	95%	93%	103%
Jan-22	19502	22448	18761	95%	96%	84%



From October 21 SATH and RJAH 1<sup>st</sup> Outpatients are close to the H2 plan and with the exception of December achieving the 95% of the 19/20 baseline. November 21 shows a marked increase in monthly actuals. A change in criteria in H2 to not include unbundled radiology means H1 plans and H2 plans are not comparable

## FU Outpatients

Month	19/20 Baseline - Working Day Adjusted	21/22 H1 Plan	21/22 Actual	ERF Threshold	21/22 Actual % of 19/20 Baseline - Working Day Adjusted	21/22 Actual % of 21/22 H1 Plan
Apr-21	42478	0	34484	70%	81%	0%
May-21	39304	0	35429	75%	90%	0%
Jun-21	44133	0	38605	80%	87%	0%
Jul-21	43345	0	36887	95%	85%	0%
Aug-21	38703	0	33560	95%	87%	0%
Sep-21	41772	0	36735	95%	88%	0%
Oct-21	40496	39302	36258	95%	90%	92%
Nov-21	42950	39170	41308	95%	96%	105%
Dec-21	37820	34237	32793	95%	87%	96%
Jan-22	37820	41233	34991	95%	93%	85%



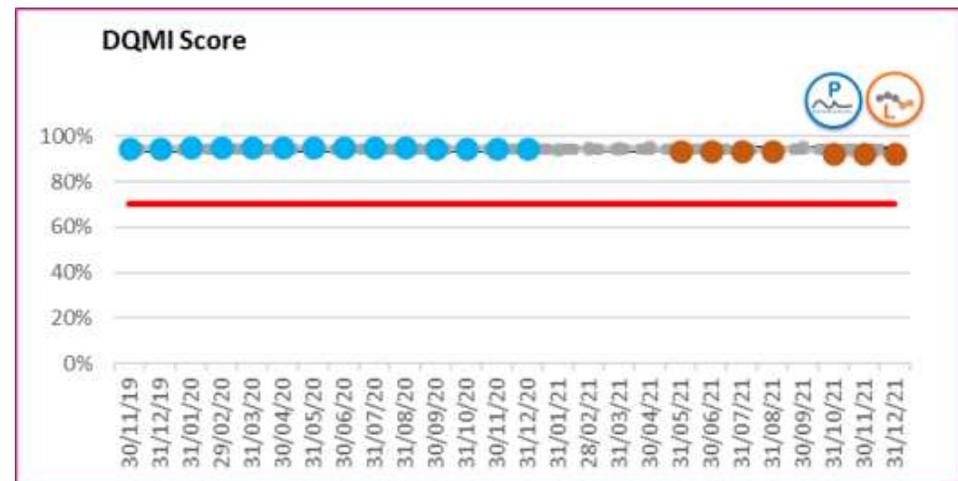
From October 21 SATH and RJAH FU Outpatients are close to the H2 plan and on average 6% below 95% of the 19/20 baseline. A change in criteria in H2 to not include unbundled radiology means H1 plans and H2 plans are not comparable



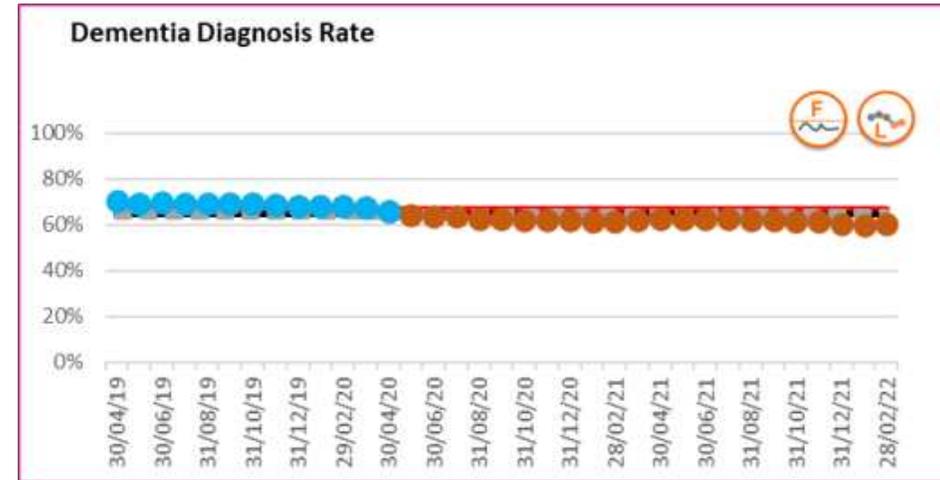
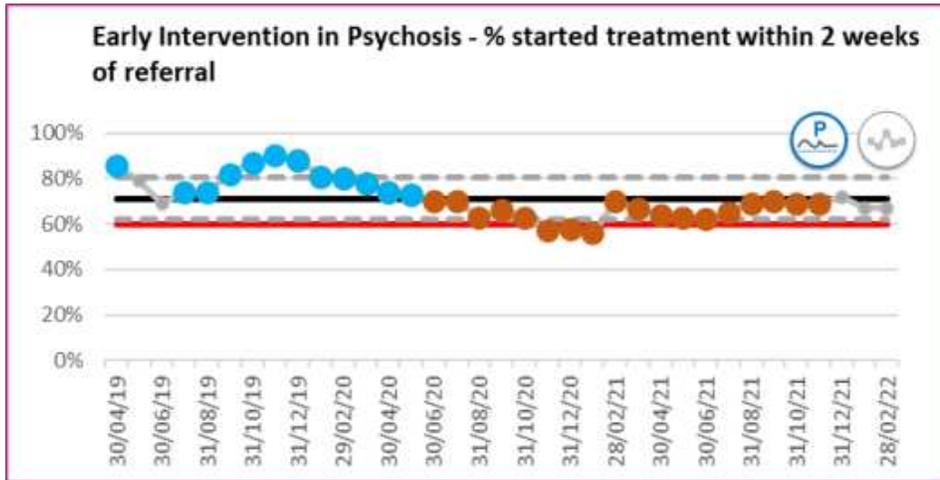
# Mental Health - Monthly Metric Summary

KPI	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	Feb 22	67.0%	60.0%			71.2%	61.9%	80.5%
Dementia Diagnosis Rate	Feb 22	60.4%	66.7%			64.6%	63.5%	65.7%

- ◆ 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:**

Plans are well underway to bring together Shropshire and Telford & Wrekin services into IAPT One – demand v capacity is being explored to understand any opportunities and how risks can be mitigated

Dementia diagnosis rates, number of referrals have increased into the service with performance remaining stable, additional ‘Admiral’ nurses are being recruited to drive improvement
- ◆ **Assurance:**

Q&P committee & MH & LD partnership board



1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

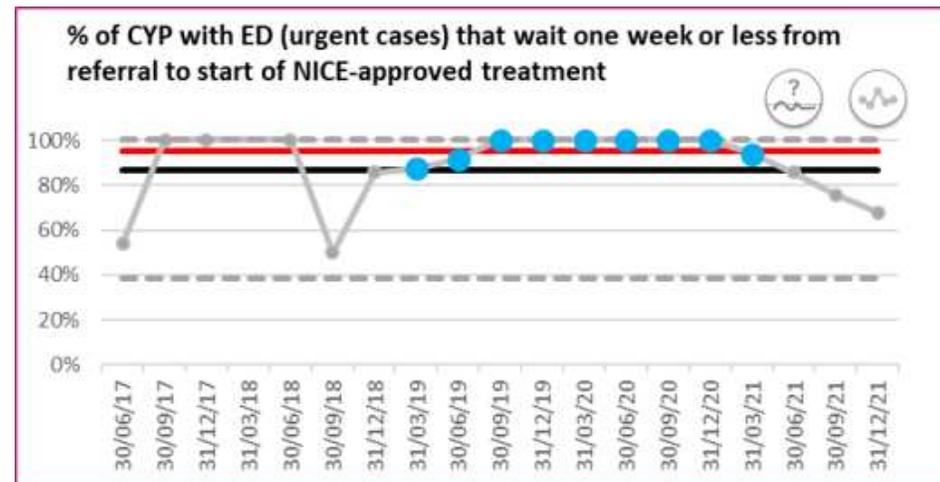
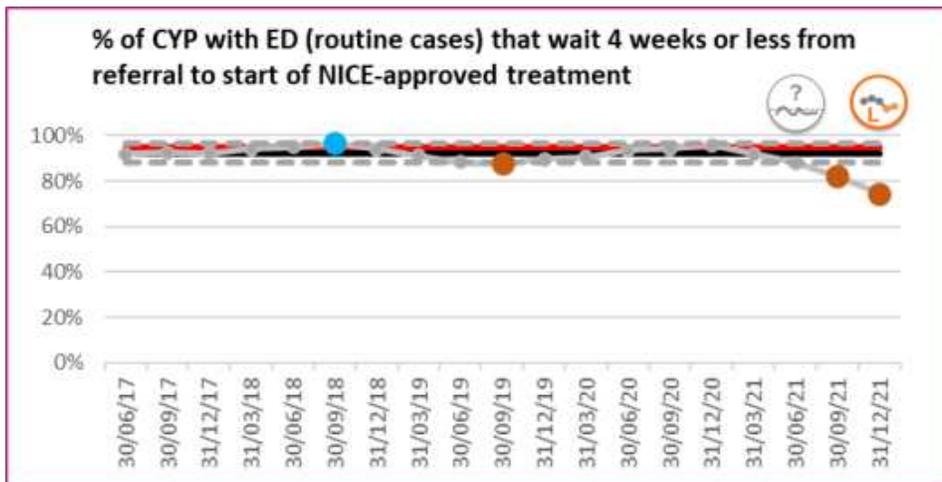
# Mental Health – Quarterly Metric Summary

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
% of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment	Dec 21	74.5%	95.0%			92.1%	87.8%	96.4%
% of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment	Dec 21	67.9%	95.0%			86.9%	38.3%	100.0%

- ◆ Both metrics above have been hit and miss with achieving the national target since reporting began in 2016.
- ◆ The percentage of urgent cases of Children & Young People (CYP) with Eating Disorders (ED) that wait one week or less from referral to start of NICE-approved treatment remained above the target between September 2019 until December 2020. The SPC indicates that there is no significant change and that the metric will not consistently meet the monthly target.
- ◆ For percentage of routine cases that wait 4 weeks, the SPC indicates a Special Cause of a concerning nature with performance showing a downward trend and the system will not consistently meet the monthly target.



# Mental Health - Quarterly Metric Performance



- ◆ **Actions:**
  - Constraints around workforce have also impacted upon service delivery for MPFT
  - MPFT are recruiting staff to address the decline in waiting time performance
  - Working with Avoidant/Restrictive Food Intake Disorder (ARFID UK) to understand and benchmark for opportunities or developments
  
- ◆ **Assurance:**
  - Q&P committee & MH & LD partnership board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# Improving Access to Psychological Therapies (IAPT)

## Metric Summary

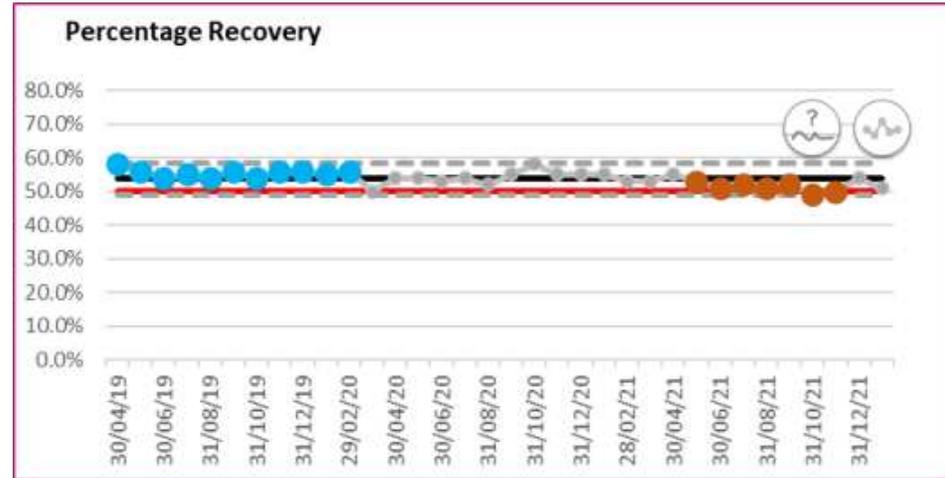
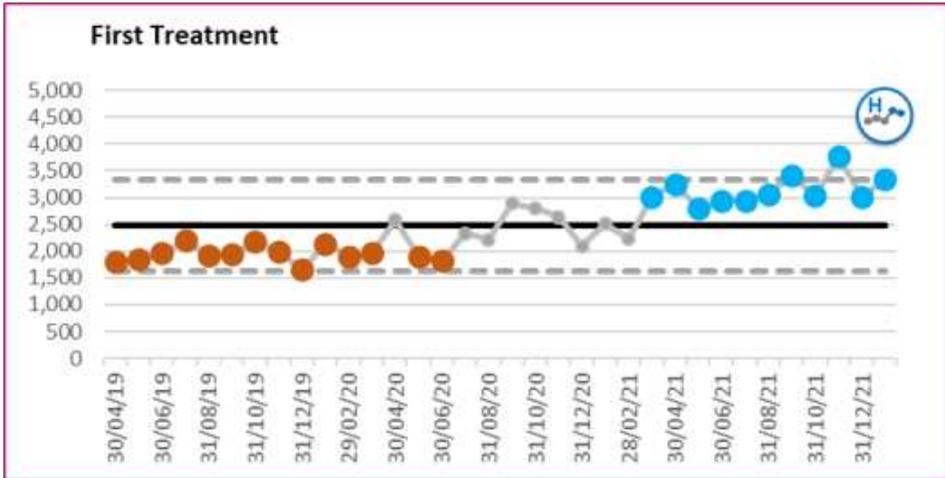
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
First Treatment	Jan 22	3335				2475	1615	3335
Percentage Recovery	Jan 22	51.0%	50.0%			53.8%	49.0%	58.5%
Percentage First Treatment 6 Weeks Finished Course Treatment	Jan 22	91.0%				92.2%	88.8%	95.6%
Percentage First Treatment 18 Weeks Finished Course Treatment	Jan 22	98.0%				98.4%	96.6%	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 December.
- ◆ 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:

Referrals continued to increase throughout Q3 and into Q4

Work is underway in the merging of services across Shrewsbury and Telford

The % recovery is expected to reach locally commissioned targets by year end.

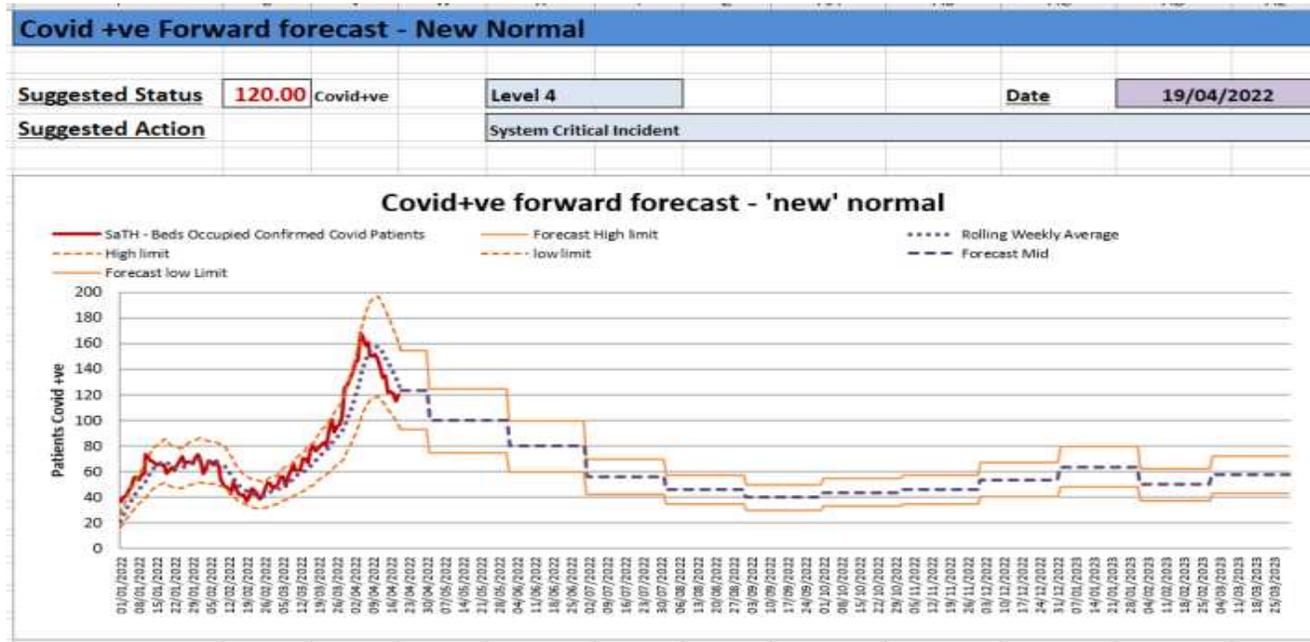
### ◆ Assurance:

Q&P committee & MH & LD partnership board



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

# STW COVID position



- ◆ The system adapted a new methodology of predicting COVID in-patient numbers at system level from January 2022
- ◆ This Covid event is following a similar pattern to the Delta (sharp up, sharp down). If this similarity continues, we would expect a slowing of the decline in case numbers, but continuing a skewed decline for the next couple of months. Albeit that is without any other 'new' factors like a new variant or a significant change in population behaviour
- ◆ Vaccination Data is currently unavailable





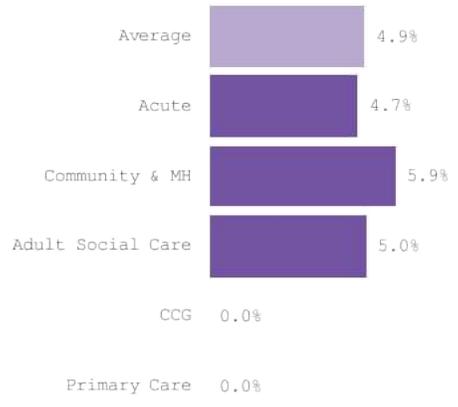
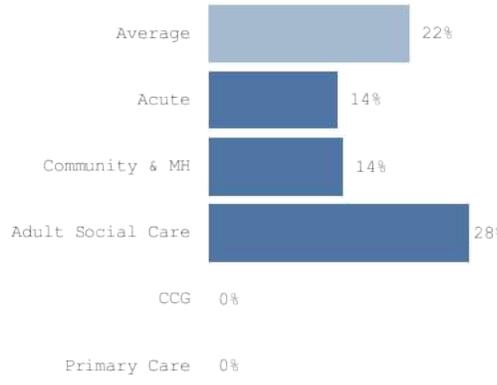
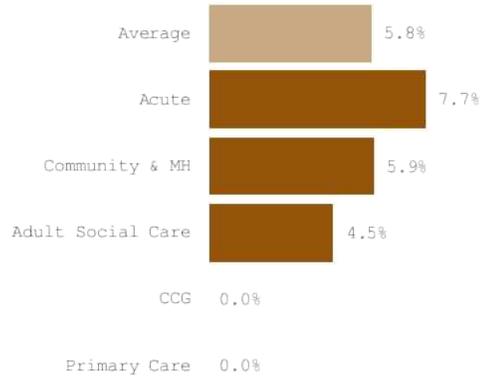
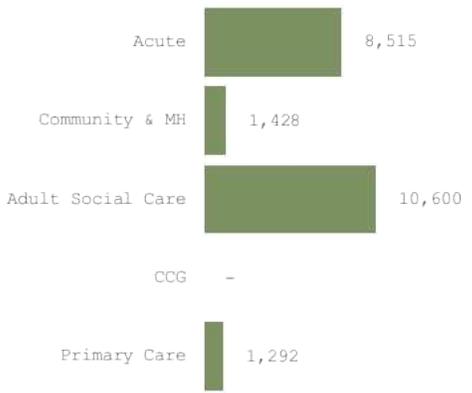
# Shropshire, Telford & Wrekin

## Integrated Care System

# STW People Performance Report

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# ICS Workforce Dashboard – M12 March 2022



Month/Year	WTE	Vacancy	Turnover	Sickness
Mar 22	21,835	5.8%	21.6%	4.9%
Feb 22	21,732	5.8%	21.4%	4.8%
Jan 22	21,645	5.9%	21.3%	5.1%
Dec 21	21,484	5.9%	21.3%	5.1%
Nov 21	21,545	5.8%	21.0%	5.1%
Oct 21	21,462	6.1%	21.0%	5.2%
Sep 21	21,478	6.4%	20.8%	5.1%

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	Mar 22	4.9%		4.1%		7.1%		5.9%	
Growing for the future	Workforce Capacity	Staff in Post (WTE)	Total	PWR	Mar 22	8,896		6,137		1,442		1,317	
			Registered Nursing & Midwifery	PWR	Mar 22	2,552		1,793		291		467	
			HCSW	PWR	Mar 22	1,295		971		173		152	
			GPs in Primary Care	NHS Digital	Jan 22	317							
		Vacancies (WTE)	Total	PWR	Mar 22	663		508		78		78	
			Registered Nursing & Midwifery	PWR	Mar 22	224		162		25		37	
			HCSW	PWR	Mar 22	109		89		20		0	
		Vacancy Rate %	Total	PWR	Mar 22	7.4%		8.3%		5.4%		5.9%	
			Registered Nursing & Midwifery	PWR	Mar 22	8.8%		9.0%		8.7%		7.8%	
			HCSW	PWR	Mar 22	8.4%		9.1%		11.7%		0.3%	
		Temporary Staffing	Bank WTE	PWR	Mar 22	635		513		48		74	
			Agency WTE	PWR	Mar 22	412		347		29		37	
			HCSW Bank WTE	PWR	Mar 22	225		187		19		19	
			HCSW Agency WTE	PWR	Mar 22	129		106		14		9	
		Retention	Turnover	In-month leavers rate	PWR	Mar 22	14.0%		15.2%		8.6%		14.5%
Leavers - All	PWR			Mar 22	1,248		933		124		191		

# ICS Workforce Dashboard – M12 March 2022

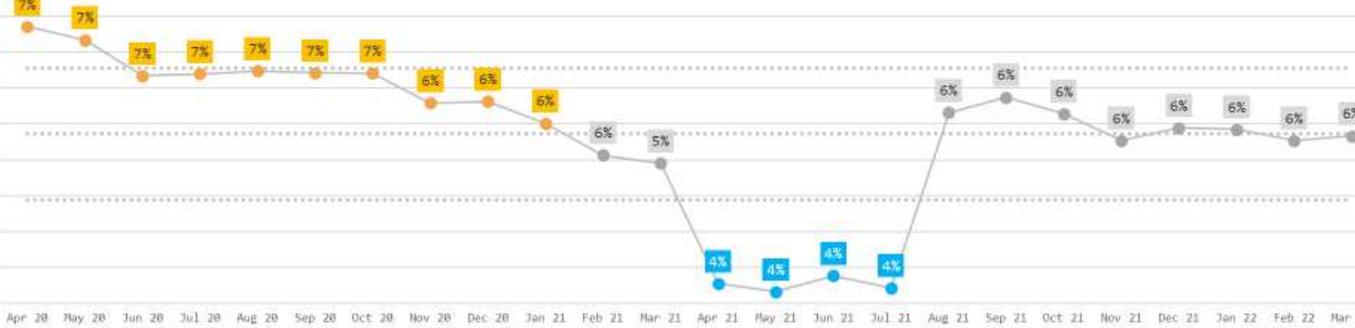
WTE History - Agency



## Agency WTE and Staff Group

- Steadily increased since lowest at April 2020
- New peak usage of 412wte exceeding previous peak of 363wte in Jul21 & Oct21
- Currently at 412wte, 91% of agency is acute NHS
- Bank usage also increased to 641wte from low of 506wte in Dec21 and high of 799wte Feb21
- 44% of agency is for nursing & midwifery (decreased)
- 31% of agency is for support to clinical (increased)
- 17% of agency is for GP, medical & dental (increased)

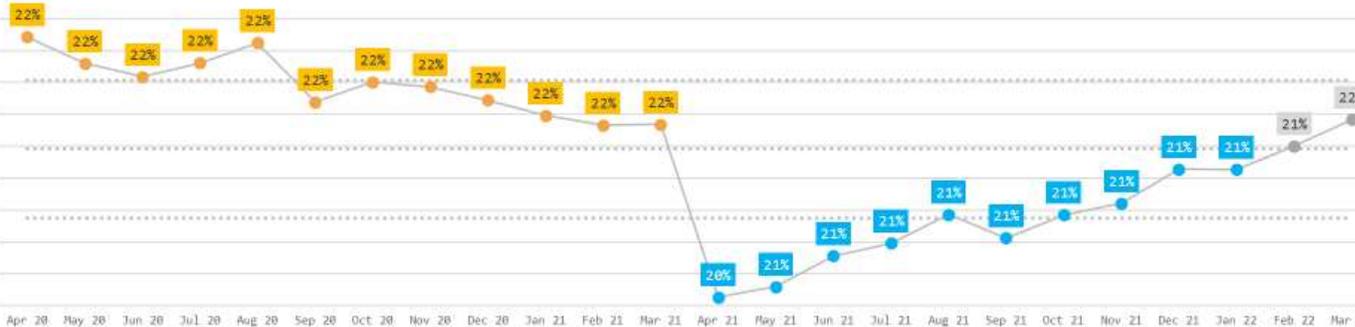
Vacancy History



## Vacancies

- SaTH continues to have the highest vacancy rate which has increased 0.7% to 8.3% (note budget was updated Aug21)
- Vacancy rates have slowly decreased for the last 20 months
- Medical & dental 9.5% (slowly decreasing)
- Support to clinical staff 7.9% (slowly increasing)
- Nursing & midwifery 8.2% (decreasing from Aug21 11.4%)
- Social workers 8.8% (stable)

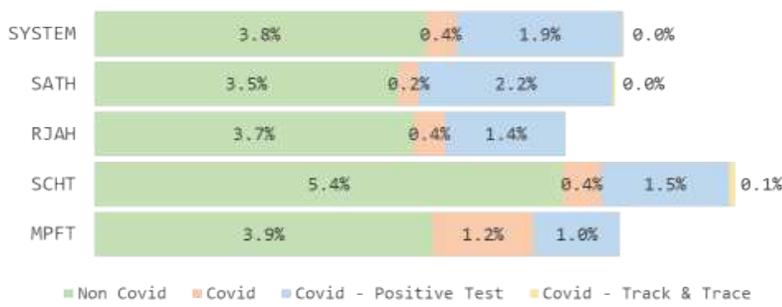
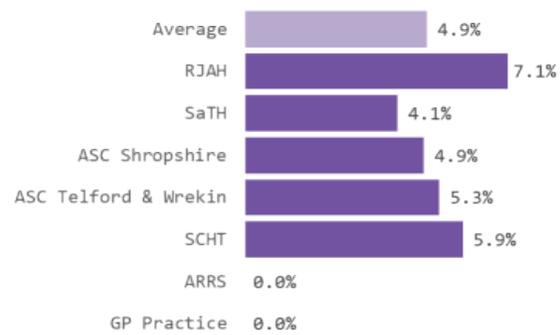
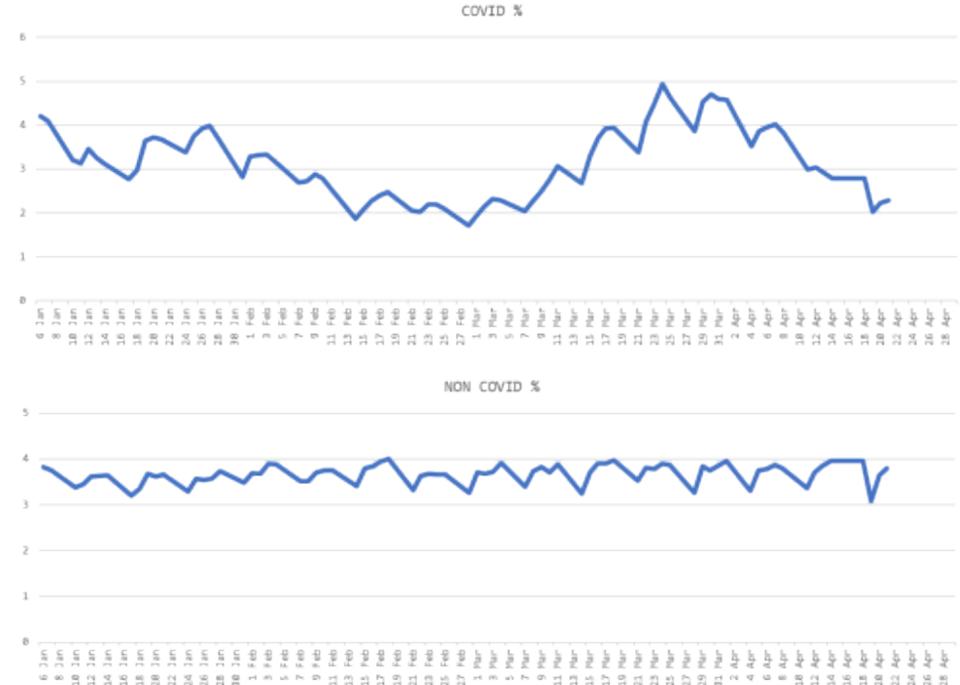
Turnover History



## Turnover

- Turnover has slowly increased from 20.0% in Apr21 to 21.6%
- Highest turnover is care workers at 32%
- Other staff group is at 21% (stable)
- Nursing turnover is at 18% (steady increase from 15% in Apr21)
- Remaining staff groups are at 12-14%
- Adult Social Care Telford has the highest turnover at 32% and Adult Social Care Shropshire is at 26%

# ICS Workforce Dashboard – M12 March 2022



## Sickness Absence and Isolation

- Covid absence peaked at 5% at the end of March but has decreased during April to around 2%
- SCHT has highest total absence of 7.3% (Covid 2.0%)
- NHS paramedic sickness is the highest 5.9%
- NHS Nursing & Midwifery sickness is high at 7.1%
- Care worker sickness absence is 5.8%



# Shropshire, Telford & Wrekin

## Integrated Care System

### Month 12

# Integrated Finance Report

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

# Key Headlines – Overall System I&E Position

Organisation	H1 Plan & Actual (6 months)			YTD H2 Plan and Actual (6 months)			21/22 Outturn			Previous Month Forecast Outturn Actuals £000
	YTD In Year Plan Surplus/(Deficit) £000	YTD In Year Actual Surplus/(Deficit) £000	YTD In Year Surplus/(Deficit) Variance to Plan £000	YTD In Year Plan Surplus/(Deficit) £000	YTD In Year Actual Surplus/(Deficit) £000	YTD In Year Surplus/(Deficit) Variance to Plan £000	YTD In Year Plan Surplus/(Deficit) £000	YTD In Year Actual Surplus/(Deficit) £000	YTD In Year Surplus/(Deficit) Variance to Plan £000	
<b>Commissioners</b>										
Shropshire, Telford and Wrekin CCG (STWCCG)	(4,754)	(4,569)	185	(5,230)	496	5,726	(9,984)	(4,073)	5,911	(4,257)
System Affordability Gap	6,005	0	(6,005)			0	6,005	0	(6,005)	0
<b>Total Commissioners</b>	<b>1,251</b>	<b>(4,569)</b>	<b>(5,820)</b>	<b>(5,230)</b>	<b>496</b>	<b>5,726</b>	<b>(3,979)</b>	<b>(4,073)</b>	<b>(94)</b>	<b>(4,257)</b>
<b>Providers</b>										
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(3,219)	(5,766)	(2,547)	(3,824)	(5,124)	(1,300)	(7,043)	(10,890)	(3,847)	(10,898)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	1,810	3,550	1,740	1,419	2,347	928	3,229	5,897	2,668	5,865
Shropshire Community Healthcare NHS Trust (SCHAT)	158	244	86	1,193	2,517	1,324	1,351	2,761	1,410	2,910
<b>Total Providers</b>	<b>(1,251)</b>	<b>(1,972)</b>	<b>(721)</b>	<b>(1,212)</b>	<b>(260)</b>	<b>952</b>	<b>(2,463)</b>	<b>(2,232)</b>	<b>231</b>	<b>(2,123)</b>
<b>TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)</b>	<b>0</b>	<b>(6,541)</b>	<b>(6,541)</b>	<b>(6,442)</b>	<b>236</b>	<b>6,678</b>	<b>(6,442)</b>	<b>(6,305)</b>	<b>137</b>	<b>(6,380)</b>

## Key Messages

The figures illustrated within this report relate to the draft submission and before an external audit review

### Revenue Position

The 21/22 planned deficit for the year was a £6.4m deficit. The actual deficit for the system is a £6.3m deficit, a £0.1m favourable variance to plan.

The actual revenue outturn position has remained in line with previous reported forecast outturn revenue position

### Capital Position

The 21/22 full year capital expenditure is £55.2m, which is in line with our previously reported forecast outturn and reported figures to NHSEI



# System Capital Programme

Organisation	Total Capital Programme		
	21/22 Outturn		
	Plan	Actual	Variance
	£'000	£'000	£'000
Shropshire Community Health NHS Trust	4,717	4,337	380
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	10,700	8,125	2,575
The Shrewsbury And Telford Hospital NHS Trust (net of disposal)	32,311	42,760	-10,449
<b>SHROPSHIRE AND TELFORD AND WREKIN STP Total</b>	<b>47,728</b>	<b>55,222</b>	<b>-7,494</b>

Forecast Outturn @Month 11		
Plan	Actual	Variance
£'000	£'000	£'000
4,717	4,559	158
10,700	7,983	2,717
32,311	42,856	-10,545
<b>47,728</b>	<b>55,398</b>	<b>-7,670</b>

Scheme	Total Capital Programme		
	21/22 Outturn		
	Plan	Actual	Variance
	£'000	£'000	£'000
Business as Usual (ICS Allocation)	32,591	28,704	3,887
Other Central Programmes	9,363	13,149	-3,786
Targeted Investment Fund (TIF)	0	9,290	-9,290
Donated	5,774	4,079	1,695
<b>SHROPSHIRE AND TELFORD AND WREKIN STP Total</b>	<b>47,728</b>	<b>55,222</b>	<b>-7,494</b>

Forecast Outturn @Month 11		
Plan	Actual	Variance
£'000	£'000	£'000
32,591	28,759	3,832
9,363	13,099	-3,736
0	9,290	-9,290
5,774	4,250	1,524
<b>47,728</b>	<b>55,398</b>	<b>-7,670</b>



## Chair's Assurance Report Sustainability Committee – 28 March 2022

### 0. Reference Information

Author:	Gayle Murphy, Executive EA at RJAH	Paper date:	27 April 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 28<sup>th</sup> March 2022 and is provided for assurance purposes.

### 2. Executive Summary

#### 2.1 Summary

- The meeting was well attended
- The agenda items included:
  - Month 11 financial update
  - Financial Plan 2022/23
  - SOF4 Update
  - BTI Summary Update from March IDB
  - Deep Dive - Local Care Transformation Programme
  - Update following the February Shadow Board Seminar on Priority Setting
  - Vaccination Service
  - Pillar 1 Testing
  - COVID Medicines Delivery Unit

#### 2.2. Conclusion

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

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.

## Chair's Assurance Report Sustainability Committee – 28 March 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 28 March 2022. The meeting was quorate with 4 Non-Executive Directors and 3 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
Debbie Nixon	Non-Executive Director, MPFT
Peter Featherstone	Non-Executive Director, SCHAT
Harry Turner	Chair, RJA
Harmesh Darbhanga	Non-Executive Director, SCHAT
Claire Skidmore	Chief Finance Officer, STW CCG
Helen Trolaen	Director of Finance, SaTH
Sarah Lloyd	Director of Finance, SCHAT
Cllr Andy Burford	Telford Council Cabinet Member for Adult Social Care
Jonathan Rowe	Telford Council Director Adults Social Care, Health, Integration & Wellbeing
Mark Brandreth	STW CCG Interim Accountable Officer
Simon Whitehouse	Interim ICB CEO Designate
Stacey-Lea Keegan	Interim Chief Executive, RJA
Cherry West	Executive Chief Transformation Officer, UHB
Caroline Kurzeja	Improvement Director, NHSE/I
Jan Heath	Programme Manager, Midlands and Lancashire CSU
Simon Elliott	Deputy Improvement Director, NHSE/I
Angie Wallace	COO, Shrop.Comm. SRO for Vaccination Programme
Julie Garside	Director of Performance, STW CCG
Claudette Elliott	Programme Director – Local Care Programme, SCHAT
Steve Ellis	Assoc. Director Primary Care and Service Director, STW CCG
Cephas Nhari	Finance Advisor, SaTH
Apologies:	
Nicky O'Connor, Tracy Hill, Kerry Robinson, Craig Macbeth, Rachel Hardy, Claire Spencer, Chris Sands, Sam Tilley, Sarah Theaker, Geoff Braden, Adrian Roberts, Steve Grange, Victoria Rankin.	

#### 3.2 Actions from the Previous Meeting

Except for an amendment for accuracy within section 3.1, as requested by Clive Deadman, it was agreed that the minutes from the previous meeting were an accurate reflection of the meeting.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.

## Chair's Assurance Report Sustainability Committee – 28 March 2022

### 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
<b>3.0 2021/22 plan</b>		
<p><b>3.1 Month 11 Financial update</b></p> <p>The report was presented to the Committee which included a summary of the key points.</p> <p>Referring to the chart on page 16 of meeting pack, the Committee questioned if the figures were closer for Capital Expenditure (System envelope). It was confirmed there was significant spend in March to minimise difference and figures are as projected.</p> <p>The Committee noted the report.</p>	Y	
<p><b>3.2 Financial Plan 2022/23</b></p> <p>The plan was presented to the Committee, it was confirmed the ICS Sustainability Committee would remain for at least Q1 for continuity and FC has agreed to continue in the role of chair for Q1.</p> <p>The highlights of a call with CSK and Julian Kelly, FD NHSE/I with others was provided, it was reported the key message taken was - there will be no funding to the NHS for the Hospital Discharge Programme at a local System level presenting a financial plan where continuation of the programme translates into further deficit for a system in deficit. This would have challenges, but the System had Q1 to review and work through. A further call with Julian Kelly was scheduled for the coming days and local stakeholders should attend a financial summit scheduled on 29/3.</p> <p>A presentation was given to the Committee on the Financial Plan. A number of points and concerns were raised by the Committee particularly around current decision-making methodology, benchmarking and review and decisions being finance led. Members raised workforce issues as a major factor. SW summarised the need for a 4-pillar approach across the System's NHS bodies and need to have linkage between Activity, Workforce and Finance.</p> <p>The Committee <i>noted</i> the report.</p>	Y	
<p><b>3.3 SOF4 Update</b></p> <p>The Committee were guided through the SOF4 'Recovery Support Programme' paper. In conclusion, the Committee were advised that there are green shoots of change but it is still clear that SaTH would need ICB support and the System will need a robust governance structure.</p> <p>The Committee raised some concerns about the wording and lack of clarity on trigger points to move to SOF3/SOF2.</p>	Y	

## Chair's Assurance Report Sustainability Committee – 28 March 2022

The Committee <i>noted</i> the report.		
<b>4.0 BTI Updates and Deep dive</b>		
<p><b>4.1 BTI Summary Update from March 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 March.</p> <p>The Committee <i>noted</i> the report.</p>	Y	
<p><b>4.2 Deep Dive - Local Care Transformation Programme</b></p> <p>An overview of the paper was provided for the Committee, the Chair thanked CE for the presentation and for the insight into the activities and initiatives.</p> <p>CE concluded by suggesting that rather than year on year view, this needed a long-term view with some bold decisions. Transformational change and reconfiguration of services will require longer term planning.</p> <p>The Committee <i>noted</i> the update.</p>	Y	
<p><b>4.3 Update following the February Shadow Board Seminar on Priority Setting</b></p> <p>A verbal update was provided, following the seminar.</p> <p>The Committee <i>noted</i> the update.</p>	Y	
<b>5.0 Vaccination Service</b>		
<p>The paper was presented to the Committee. The Chair made the point that requests for policy or funding approval by the Sustainability Committee fall outside of the Committee's formal ToR, he asked SW to ensure that all ICB Committee ToRs are reviewed as part of the establishment of the ICB to ensure they reflect current System expectations.</p> <p>The Committee were assured that they were not being asked to formally approve investment prioritization's and that such decisions were going through other Committees for approval and prioritization. The Committee was being asked for collective oversight acceptance of the policy on the basis that the more granular scrutiny had occurred elsewhere and recognizing that the Investment Panel was currently not meeting. The Chair asked for wording in any Committee papers to be more reflective of the expectation which CS will take forward.</p> <p>In summary, the Committee is being asked to lend approval to the acceptance of a financial risk for FY24 (commencing</p>	Y	

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.

## Chair's Assurance Report Sustainability Committee – 28 March 2022

<p>April 23) the extent of risk contained within the policy included in meeting pack and policy has received approval from Shropcom, Chief Executive Forum and Regional Office so can the Committee take assurance it has been through the appropriate levels of scrutiny.</p> <p>The Committee <b>confirmed</b> their support and were assured by the process.</p>		
<b>6.0 Pillar 1 Testing</b>		
<p>The Committee were informed that from the 31<sup>st</sup> March STW will have no Pillar 1 or Pillar 2 testing advising this will impact elective recovery surgery as PCR's go through Pillar 1 testing.</p> <p>Raising concerns about the impact this will have, the Committee questioned if there was any leeway to put this through or does it need to go back through the process. It was advised that there have been conversations with Shrop Comm and confirmed that funding had been factored into their plans and the financial risk to the System is if the service needs extending into 2024 and no dedicated funding source is identified.</p> <p>The Committee <b>confirmed</b> their support.</p>	Y	
<b>7.0 Covid Medicines Delivery Unit</b>		
<p>It was confirmed the paper has been reviewed through several Committees and brought to this Committee to ensure it is known and supported by the Committee members.</p> <p>The Committee <b>noted</b> the paper</p>	Y	
<b>7.0 Any Other Business</b>		
None raised	n/a	

### 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.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12
13.
14.
15.