Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board

MEETING

29 November 2023 14:00 GMT

PUBLISHED
24 November 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

AGENDA (PART 1)

Meeting Title	Integrated Care Board	**Date**	Wednesday 29 November 2023
Chair	Sir Neil McKay	**Time**	2.00pm
Minute Taker	Board Secretary	**Venue/ Location**	The Reynolds Suite Holiday Inn Telford International Centre Telford St Quentin Gate Telford TF3 4EH

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

Reference	Agenda Item	Presenter	Purpose	Paper	Time
OPENING MATTERS (approximately 30 minutes: 2.00pm – 2.30pm)					
ICB 29-11-118	Apologies and Introductory comments by the Chair	Sir Neil McKay	I	Verbal	2.00
ICB 29-11-119	Declarations of Interest: To declare any new interests or existing interests that conflict with an agenda item Register of Board member's interests can be found at: Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)	Sir Neil McKay	S	Verbal	
ICB 29-11-120	Minutes from the previous meeting held on Wednesday 27 September 2023	Sir Neil McKay	A	Enc	
ICB 29-11-121	Matters arising and action list from previous meetings	Sir Neil McKay	A	Enc	
ICB 29-11-122	Questions from Members of the Public: Guidelines on submitting questions can be found at: https://stwics.org.uk/get-involved/board-meetings	Sir Neil McKay	I	Enc	
ICB 29-11-123	Patient's Story: Armed Forces Covenant	Gareth Robinson	S	Verbal	2.10

STRATEGIC SYSTEM OVERSIGHT (approximately 1 hour 35 minutes - 2.30pm – 4.05pm)					
ICB 29-11-124	ICB Chief Executive (CEO) Report: • Industrial Action • Shaping the STW ICB Programme • Armed Forces Covenant • National Allied Health Professional Day • Black History Month • Provider Selection Regime (PSR) • Awards and Recognition for our Staff • Good Governance Institute Making Meetings Matter review of ICB/ICS meetings	Simon Whitehouse	S	Enc	2.30
ICB 29-11-125	Hospital Transformation Programme (HTP): Update on Full Outline Business Case *(Presentation by Matthew Neal)*	Louise Barnett	S	Verbal	2.50
ICB 29-11-126	Winter Planning	Gareth Robinson	S	Enc	3.10
ICB 29-11-127	Local Care Programme and next steps in Place Development	Patricia Davies	S	Enc	3.30
10 MINUTE BREAK AT 3.45PM					
SYSTEM GOVERNANCE AND PERFORMANCE (approximately 45 minutes – 3.55pm– 4.40pm)					
ICB 29-11-128	System Board Assurance Framework	Alison Smith	S	Enc	3.55
ICB 29-11-129	Integrated Care System Performance Report: • Finance • Performance • Quality • People	Claire Skidmore	S	Enc	4.05
ICB 29-11-130	Amendments to Governance Handbook • Updated Terms of Reference for the Audit Committee • Updated Terms of Reference for the System People Committee	Simon Whitehouse	S	Enc	4.15
ICB 29-11-131	System Level Primary Care Access Improvement Plan	Gareth Robinson	S	Enc	4.25
BOARD COMMITTEE REPORTS (approximately 15 minutes - 4.40pm-4.55pm)					
ICB 29-11-132	**Assurance**				4.40
ICB 29-11-132.1	Quality and Performance Committee Chair's Report for meetings held on 27 July and 28 September 2023	Meredith Vivian	S	Enc	
ICB 29-11-132.2	Audit & Risk Committee Chair's Report – no report	Roger Dunshea	S	Verbal	
ICB 29-11-132.3	Finance Committee Chair's Reports for meetings held on 11 August and 3 October 2023	Professor Trevor McMillan	S	Enc	
ICB 29-11-132.4	Remuneration Committee Chair's Report – no report	Professor Trevor McMillan	S	Verbal	

	Strategy				
ICB 29-11-132.5	Strategy Committee Chair's Report for meeting held on 11 October 2023	Cathy Purt	S	Enc	
ICB 29-11-132.6	System People Committee Chair's Report – no report	Dr Catriona McMahon	S	Verbal	
ICB 29-11-132.7	Primary Care Commissioning Committee Chair's Report for meeting held on – 4 August	Dr Niti Pall	S	Enc	
	Delivery				
ICB 29-11-132.8	Integrated Delivery Committee Chair's Report for meetings held on 9 October 2023	Harry Turner	S	Enc	
ANY OTHER BUSINESS (approximately 5 minutes - 4.55pm-5.00pm)					
ICB 29-11-133	Any Other Business: *(To be notified to the Chair in advance)*	Sir Neil McKay	D	Verbal	4.55
	Date and time of next meeting: • Wednesday 31 January 2024 - Shrewsbury				

Sir Neil McKay
Chair
NHS Shropshire, Telford and Wrekin

Mr Simon Whitehouse
Chief Executive
NHS Shropshire, Telford and Wrekin

NHS Shropshire Telford and Wrekin Integrated Care Board

Minutes of Meeting held in public on
Wednesday 27 September 2023 at 2.00pm
The Reynolds Suite, Holiday Inn Telford International Centre,
St. Quentin Gate, Telford, TF3 4EH

Present:

Sir Neil McKay	Chair, NHS STW
Professor Trevor McMillan	Deputy Chair and Non-Executive Director, NHS STW
Meredith Vivian	Non-Executive Director, NHS STW
Niti Pall	Non-Executive Director, NHS STW
Simon Whitehouse	Chief Executive, NHS STW
Claire Skidmore	Chief Finance Officer, NHS STW
Nicholas White	Chief Medical Officer, NHS STW
Gareth Robinson	Executive Director of Delivery and Transformation, NHS STW
Stacey Keegan	Foundation Trust Partner Member and Chief Executive Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Patricia Davies	Trust Partner Member and Chief Executive Shropshire Community Health NHS Trust
Andy Begley	Local Authority Partner Member and Chief Executive, Shropshire County Council
Dr Ian Chan	Primary Care Partner Member for Telford and Wrekin
Cllr. Paul Watling	Cabinet Member for Adult Social Care and Health Systems Telford and Wrekin Council (representing Shaun Davies)

In Attendance:

Dave Bennett	Associate Non-Executive Director, NHS STW
Dr John Jones	Medical Director, Shrewsbury and Telford Hospital NHS Trust
Dr Catriona McMahon	Chair, Shrewsbury and Telford Hospital NHS Trust
Harry Turner	Chair Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Tina Long	Interim Chair, Shropshire Community Health NHS Trust
Edna Boampong	Director of Communications and Engagement NHS STW
Cathy Purt	Non-Executive Director, Shropshire Community Health NHS Trust
Cllr Lezley Picton	Leader of Shropshire Council
Lynn Cawley	Chief Officer, Healthwatch Shropshire
Jackie Jeffrey	Vice Chair Shropshire, VCSA
Simon Fogell	Chief Executive, Healthwatch Telford & Wrekin
Richard Nuttall	Joint Chair, Telford & Wrekin Chief Officers Group (COG)
Vanessa Whatley	Director of Quality and Safety/Deputy Chief Nurse, NHS STW

Masood Ahmed	Chief Digital Information Officer/Deputy Chief Medical Officer, NHS STW
Jonathan Rowe	Executive Director Adult Social Care, Telford & Wrekin Council
Jan Suckling	Lead Officer, Healthwatch Telford & Wrekin
Tracy Eggby-Jones	Corporate Affairs Manager, NHS STW

Minute No. ICB 27-09-102 Introduction and Apologies

102.1 The Chair opened the meeting of the STW Integrated Care Board (ICB) and welcomed everyone. The Chair specifically welcomed and introduced Dave Bennett as a new Non-Executive Director who officially joined the ICB on the 2 October 2023. It was noted that Mr Bennett was currently a Non-Executive Director at the Southampton University Hospitals Foundation Trust.

102.2 Apologies were noted as follows:

Roger Dunshea	Non-Executive Director, NHS STW
Alison Bussey	Chief Nursing Officer, NHS STW
Alison Smith	Director of Corporate Affairs, NHS STW
Neil Carr	Foundation Trust Partner Member and Chief Executive, Midlands Partnership University NHS Foundation Trust
David Sidaway	Local Authority Partner Member and Chief Executive, Telford and Wrekin Council.
Dr Julian Povey	Primary Care Partner Member for Shropshire
Louise Barnett	Trust Partner Member and Chief Executive, Shrewsbury and Telford Hospital NHS Trust
Cllr Cecilia Motley	Portfolio Holder for Adult Social Care, Public Health and Communities, Shropshire Council
Pauline Gibson	Non-Executive Director, Midlands Partnership University NHS Foundation Trust
Julie Garside	Director of Performance & Planning, NHS STW
Alex Brett	Chief People Officer, NHS STW
Sara Hayes	Deputy Chief People Officer, NHS STW
Nigel Lee	Interim Director of Strategy & Partnerships, NHS STW
Cllr Shaun Davies	Leader of Telford and Wrekin Council

102.3 The Chair apologised to Board members for the lateness of the papers for the meeting. Papers were circulated as normal on the Friday before this meeting, however one of the papers there were late changes that needed to be made and this had resulted in a delay in the pack being circulated. The Chair went on to say that it was not the ICB's normal practice to have delays with the publication of papers. There had been a query from a member of the public about this and the Chair wanted to reassure everybody that this was an extraordinary circumstance and should not happen again. The Chair advised that he would comment on this further under agenda item number ICB 27-09-114.

102.4 The Chair also commented on the doctors' industrial action which would be discussed during the CEO report.

102.5 The Chair mentioned the impact following the verdict in the Letby case, he noted that would also be discussed later in the meeting. It was noted that there was now an enhanced fit and proper person test which the ICB would need to apply and further details were contained within the CEO report.

102.6 The Chair reported that the local system continued to face challenges on both the financial agenda and in the urgent and emergency care arena. This would be discussed as part of the Finance and Integrated Performance report later on the agenda.

102.7 It was noted that there had been a Shropshire Community Health NHS Trust in public, with a single agenda item focussed on the future of the inpatient service provided from Bishops Castle hospital. The Chair acknowledged the leadership provided by Mrs Patricia Davies and Mrs Tina Long. There was a plan of action for moving forward with this issue which had support from the public.

Minute No. ICB 27-09-103 Declarations of Interest

103.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and was available to view on the website at:

Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Minute No. ICB 27-09-104 Minutes from the previous meeting held on Wednesday 28 June 2023

104.1 The minutes were approved as an accurate record.

Minute No. ICB 27-09-105 Matters arising and action list from previous meetings.

105.1 Action: Minute No. ICB 28-06-095 - Operational Plan 2023/24 update:
Mrs Claire Skidmore commented that conversations had not yet taken place with program leads but activities since the last Board meeting have superseded that. There has been focus on all of the areas which Mr Harry Turner has presided over as Chair of the Integrated Delivery Committee. There had also been confirm and challenge opportunities. Agreement had been reached at the CEO meeting earlier in the day around a way forward in terms of some actions. **Action recorded as complete.**

105.2 Action: Minute No. ICB 28-06-097 - Integrated Care System Performance Report:
Mrs Claire Skidmore to check with her team for clarification. **Action on-going**.

105.3 Action: Minute No. ICB 26-04-078 - Introduction and Apologies – Hewitt review:
Agreed to close action as currently written, further actions will come out of the ICB reshaping agenda item.

105.4 Action: Minute No. ICB 29-03-069 – Follow up to Patient's Story: MSK Integration across Shropshire Telford and Wrekin.
Discussions have taken place between Mr Simon Whitehouse and Miss Stacey Keegan on the progress being made. It felt appropriate to include this in the Development session in October as there is a wider conversation to had, and it was felt there was not sufficient time

in a public Board meeting to do this item justice. After the development session the learning from this and the work that will have been progressed from that would be presented to a future Board meeting held in public. **Action on-going.**

Minute No. ICB 27-09-106 Questions from Members of the Public:

106.1 The Chair acknowledged receipt of questions from members of the public and said that replies would be sent out to individual questioners and attached as an appendix to the minutes of the meeting.

106.2 The Chair mentioned a question received about the delay in the issuing of Board agenda papers and advised that full response would be given to the person who had raised the question.

106.3 Another question was around whether the Board would be congratulating Robert Jones and Agnes Hunt on their results in the CQC patient survey, whereby they had emerged as the best Specialist Trust Hospital in the country. The Chair commented that this was a fantastic achievement and asked Mr Harry Turner to pass on the ICB's congratulations to their Board and Staff.

Minute No. ICB 27-09-107 Patient's Story: Learning Disabilities and Autism Services: Luke's Story

107.1 Mrs Vanessa Whatley introduced the item and introduced Mrs Sarah Summers and Mr Alan Simmons. Mr Simmons was from the Intensive Support Team (IST) which was part of Midlands Partnership University NHS Foundation Trust. Mrs Summers is Lukes's mother and spoke about the experience of care for people with learning disability and in the services which are offered across the country.

107.2 Mrs Summers thanked the Board for inviting her to come and share her story.
Mrs Summers went on to say that Luke's story was a long and complex journey over many years. Mrs Summers reported that Luke was now 34 and that she wanted to share the core experiences of care that Luke had endured over many years, but also to share the highly positive support given by the Intensive Support Team in September 2022, which she felt had saved Luke's life.

107.3 Mrs Summers asked the Board to consider what oversight there was to ensure that these experiences were not happening in the Shropshire, Telford and Wrekin area.

107.4 Mrs Summers went on to give a summary of Luke's medical history and placement history and the extremely poor experiences he had encountered.

107.5 Mrs Summers stated that IST have had a tremendous impact on Luke's life and was extremely thankful to them.

107.6 Mrs Summers thanked Board members for listening to Luke's story.

107.7 The Chair commented that Luke's story had been very moving and powerful. He thanked Mrs Summers for her bravery in coming to present the story to the Board and for describing her experiences.

107.8 The Chair asked members of the Board for comments/observations.

107.9 Mrs Tina Long asked how the Board could be assured that people that the ICB had responsibility for were not enduring similar experiences.

107.10 Dr Niti Pall commented that community services were often neglected, and that we were now seeing many years of disinvestment in some of these services.

107.11 The Chair responded by saying that we listen to many patient stories in different Board settings, but he had never felt so moved as he had been by Luke's story. He went on to thank Mrs Summers again and Mr Simmons from the IST for sharing Luke's experiences.

107.12 The Chair commented that Mrs Tina Long had made an important point about how the Board got assurance on the patients within the ICB's responsibility. He suggested returning to this subject at a future Board and asked Members to think carefully about the issues raised during Luke's story and learn from this to improve care for individuals and their families.

107.13 Mr Simon Whitehouse also agreed that Luke's story was very powerful and moving. He went on to say that as a system it would be appropriate for the Board to ask for a review of the residents that it had in placements.

Action: Gareth Robinson and Vanessa Whatley to lead on review and ensure this goes through correct Governance route then bring back to future Board. Look at numbers and identification before agreeing whether this will come back to a public or private Board.

107.14 Mr Simmons from the IST commented that there was a need to listen to the person and understand their behaviour as a function and what that function was.

107.15 The Chair suggested planning the ICB response outside of the Board meeting.

Minute No. ICB 27-09-108 ICB CEO Report

108.1 Mr Simon Whitehouse introduced his report and acknowledged the lateness of the papers this month. The following key points were noted.

108.2 **Emergency Preparedness, Resilience and Response (EPRR)**
The ICB was now a Category 1 responder and going through a process of what that meant and how it would work through on-call etc.

108.3 **GP Practice Recovery Plans NHSE STW Annual Assessment Letter 2022/23**
As part of the annual assessment process the ICB had received a letter from NHSE (attached in appendices) which set out their review of the ICB for 2022/23. Mr Whitehouse stated that it was worth taking the time to read the letter as it sets out several areas which were included in the ICB's workplan.

108.4 **GP Patient Satisfaction Survey Results 2023**
It was noted that the results had now been published and Mr Whitehouse commented that he did not want to understate the work that was happening behind the scenes working on this. He went on to say that the variation was not where it should be, Shropshire Primary Care Networks (PCNs) scored significantly higher than the national average for most of the questions. Telford and Wrekin PCNs scored lower than the national average for most questions. There continued to be significant pressure on General Practice services and there was a clear need to continue to drive the support and improvement work that was in place.

108.5 **Winter Planning**
All system partners across health and social care and the voluntary sector had come together to attend Winter Planning workshops to identify the key area of focus for the STW ICS Winter Plan. The data had been reviewed and lessons learned from previous years.

A review of the bids proposed took place on 29th August and the final plan presented to UEC Board in September 2023. The system has liaised with NHSE regionally and nationally to ensure that the winter response was fully aligned to the Operational Plan and UEC Recovery Plan.

Mr Whitehouse proposed that a more detailed conversation should take place at the development session in October.

108.6 **Update on QRSM Output**
The latest quarter one system review meeting took place on the 14 July. The headlines from the meeting were noted in the paper.

108.7 **ICB response to the letter from NHS England to the NHS following the verdict in the trial of Lucy Letby**
Mr Whitehouse commented that it was important that we recognise and acknowledge the impact on families and colleagues following the trial of Lucy Letby. In response he noted that it was key that the ICB focus on patient safety and freedom to speak up. Mr Whitehouse invited Mr Vivian to comment given the work and development that was being done in this area.

108.8 Mr Vivian stated that the ICB had over the past year had a provisional arrangement in place for a Freedom to Speak Up Guardian for the ICB, with all system providers having their own Freedom to Speak Up arrangements in place.

108.9 Mr Vivian noted that the Letby case has highlighted the need to put extra measures in place to ensure patient safety. He reported that the ICB was going to be establishing a new

substantive Freedom to Speak Up Guardian role with the possibility of it being shared with other ICBs.

108.10 Mr Vivian commented that the system Freedom to Speak Guardians would come together on a regular basis (i.e. once a quarter) to discuss learning, commonalities of problems, and to ensure there were no gaps in the system.

108.11 Mr Vivian went on to say that it was important that people know about Freedom to Speak Up and feel safe and able to do so, with assurance that any concerns raised would be followed up.

108.12 Mr Whitehouse stated that the ICB's Freedom to Speak Up Guardian had dual responsibility, not only for ICB staff but system responsibility too.

108.13 It was noted that the ICB had two Freedom to Speak Up Guardians in place in General Practice, one in Shropshire and one in Telford and Wrekin.

108.14 Mr Vivian commented that the ICB was looking at arrangements for Pharmacy, Optometry and Dentistry.

108.15 **Fit and Proper Person Test**

Mr Whitehouse updated the Board on the Fit and Proper Person Test, including an update from NHSE. The paper sets out how the ICB would be putting processes in place to ensure that roles that are responsible and accountable in terms of The Fit and Proper Person Test would now go through relevant full checks.

108.16 Mr Whitehouse also highlighted that the tests are extensive and take a significant amount of time, which will be built into the recruitment process.

108.17 Mrs Lynn Cawley commented that Healthwatch had been around for 10 years and over that time people working across this system have contacted them because they felt confident of their independence and felt able to share their experiences safely. Mrs Cawley reported that a page had been added to the Healthwatch Shropshire website for staff where information about relevant information on freedom to speak up channels could be found.

108.18 Mrs Cawley said she would welcome a conversation with the People Team to check that the information was correct.

108.19 Mrs Cawley also commented that she felt that there needed to be some support for people particularly working for domiciliary care agencies, and people working in care homes who she thought didn't have access to Freedom to Speak Up.

108.20 Mr Whitehouse said that the information needed to be checked for accuracy and make sure that the governance arrangements were correct. He went on to say that the approach to care homes needed to carefully managed to ensure it adds value and that it adhered to statutory guidance.

108.21 Councillor Paul Watling commented about the GP survey which had been highlighted as a concern and which he felt needed to be looked at to understand what was going to be done in partnership with primary care. This was especially the case given the survey results for the Telford and Wrekin area

108.22 Councillor Watling also referred to the recovery plans and asked how we can work together and be sighted on delivery.

108.23 Councillor Watling also asked about the letter from NHSE and noted that reference was made to the HTP and the Outline Business Case, which was scheduled to be reviewed in quarter two. Councillor Watling was unsure about what this meant.

108.24 Dr Ian Chan responded to Councillor Watlings question about General Practice by stating that there was a clear discrepancy between the outcomes between the two places, Shropshire and Telford and Wrekin, particularly central Shrewsbury. Analysis had been done by the health foundation, which was published last year, which had two key observations which were pertinent to the system.

1. In the survey of 2021, it demonstrated that more deprived areas were more likely to report a poor overall experience and less likely to report that their needs had been met.

2. Between 2015 and 2021practices serving the most deprived areas received the lowest overall patient satisfaction score while practises in most affluent areas received the highest satisfaction.

108.25 Dr Chan also stated that this paper is specifically focused on the inverse care law which has been recognised since 1971. Dr Chan thought that the difference between the two places was partly reflective of these observations which coincides with the outcomes of our Joint Strategic Needs Assessment where Telford had a significant higher inequality gap and poor health outcomes compared to Shropshire. This needed to be recognised by this Board, the system and our public health colleagues.

108.26 Dr Niti Pall commented that this was about place-based care and what networks should be doing and where investments should go in for the future. Co-creation of a plan with the councils was essential, especially in relation to recovery plans, where partnership working with councils was going to be paramount.

108.27 Mr Simon Fogell commented that Telford and Wrekin Healthwatch were concerned with what had come out in the GP annual assessment and the difference between Telford and Wrekin and Shropshire and asked why the PCNs were so varied in their scoring. Mr Fogell requested that both Healthwatches be party to the work that was going on in the background to look at primary care and the recovery plan.

108.27 Mr Fogell also mentioned that Healthwatch were currently running a survey in response and asking people about their access to GP care. Over 1000 responses had been received so far. He raised some concerns in relation to the narrative around Telford and Wrekin residents in deprived areas judging the services they received more harshly and said that the Board needed to be mindful how this was framed.

108.28 The Chair responded saying that Mr Fogell made a very good point, and that Dr Chan was referencing that there were particular challenges with the population that needed to be responded to as part of the recovery plan.

Action: Recovery plans need to be socialised locally before next Board in November. Mr Gareth Robinson, Dr Ian Chan and Mr Nick White to work with both Councils and partners on the development of the plan and what can be done to improve Primary Care access.

108.29 Mr Richard Nuttall also commented that it would be useful if the voluntary sector were also party to the work going on in the background around primary care access.

108.30 The Chair stated that he and the Board would want to see evidence of engagement in response to the survey.

108.31 Mrs Patricia Davies thought it would be useful to schedule in an ICB development session round Primary Care/GP access. The Chair agreed.

108.32 Mr Simon Whitehouse added that every Board Member had a responsibility to make sure that scrutiny, challenge and insight in the terms of the work, as well as an understanding of the data.

108.33 It was agreed that a briefing note on HTP update would be circulated at a later date.

Action: Dr Catriona McMahon and Mr Matthew Neal to draft updated briefing note and circulate to Board members.

The Board is asked to NOTE the:

- **Emergency Preparedness, Resilience and Response (EPRR)**
- **GP Practice Recovery Plans NHSE STW Annual Assessment Letter 2022/23**
- **GP Patient Satisfaction Survey Results 2023**
- **Winter Planning**
- **Update on QRSM output**
- **ICB response to the letter from NHS England to the NHS following the verdict in the trial of Lucy Letby**
- **Oversight of patient safety data**
- **Fit and Proper Person Test Framework**
- **Freedom to Speak Up**

<u>Minute No. ICB 27-09-109 ICS Digital Strategy 2023-26</u>

109.1 The Chair introduced Dr Masood Ahmed, Chief Information Officer and Deputy Medical Director, who had been overseeing the development of the digital strategy. Dr Masood presented the paper and highlighted the following.

109.2 A new Digital Strategy had been developed to provide a framework for adopting digital tools across the Integrated Care System (ICS). The strategy sets the approaches for implementing technologies such as electronic health records, virtual care platforms, remote monitoring devices and data analytics.

109.3 Digital initiatives would be logged on a tracking register and reviewed regularly by the Digital Delivery Group. Ownership would be assigned for delivery and adoption of digital tools.

109.4 The strategy establishes guidance for prioritising investments in digital to ensure they align with strategic goals around quality, accessibility, and sustainability. Training and change management strategies were incorporated to support adoption by staff and service users.

109.5 The strategy aims to promote inclusion, empower patients and providers through digital channels and make data-driven improvements to population health management. Implementation would be supported through stakeholder engagement.

109.6 Mr Nick White stated that this was an important piece of work and that STW ICS was behind other ICSs in the country but it gave the ICS an opportunity to think about where it wanted to be in five years' time.

109.7 Dr Niti Pall stated that until the ICS had a defined ambition around digital then it would be business as usual.

109.8 Ms Lynn Cawley mentioned that not all residents have digital access and commented that as a system we need to find other ways of communicating with people and how information was given that was not digitally exclusive.

109.9 Mr Dave Bennett commented that to sign this off as a strategy it would need to be reviewed and asked if it was implementable. He didn't feel this could be signed off by the Board at present as the strategy stated that in three years' time the work would be completed but he was unsure that this would be the case, given the many other competing demands that were of equal importance.

109.10 Mrs Claire Skidmore mentioned that digital was an area where there was some capital available, the constraint would be in relation to any revenue consequence of the capital, and that ICS would not be able to afford to maintain any on-going costs.

109.11 Mrs Skidmore also mentioned that the ICS needed to be able to scope as an estimate what the revenue impact was of the things that we want to do. She stated that digital needed to be in the prioritisation process along with other service changes.

109.12 Professor Trevor McMillan asked the Local Authorities if there was a political will in Shropshire, Telford and Wrekin to have a digital presence and an overall strategy that linked all communities. Professor McMillan also asked if this was one area where more collaboration was required and asked how it could be taken forward.

109.13 Councillor Paul Watling commented that it was a necessity and that there was a willingness to do it. It was important to move towards implementation.

109.14 Mr Andy Begley acknowledged the potential for digital exclusion and that the ICS needed to be forward thinking and seek out opportunities.

109.15 Dr Catriona McMahon wanted to seek clarification in the approving the document that the Board will also be approving the Chief Digital Information Officers function as there could be a significant financial requirement.

109.16 Professor McMillan noted that the ICS was operating within a financially constrained world and it could not afford to waste any money or duplicate resources, and asked how the system could work better to ensure we were not replicating things.

The Integrated Care Board is asked to:

- **Note the contents of the report.**
- **Support the adoption of the STW ICS Digital Strategy**
- **Approve the implementation of the Digital Strategy across the Integrated Care System**

109.17 The Chair suggested having further discussions and get further engagement from people across the Board and think about a system wide approach to develop an integrated digital transformation strategy.

Action: Dr Masood Ahmed and Mr Nick White to produce the next piece of work to show next steps and actions that we should take to develop further thinking.

Minute No. ICB 27-09-110 NHSE Delegation of Specialised Commissioning – Pre-Delegation Assessment Framework

110.1 The paper was taken as read. Mr Nick White highlighted the following.

110.2 Mr White reported that as part of the reorganisation of ICBs, the way in which services are commissioned had changed.

110.3 The first step in the delegation process was the development of a Pre-Delegation Assessment Framework (PDAF). This had been developed to support ICBs prepare for delegation arrangements and underpins the assessment of system readiness.

110.4 Mr White noted that it was aligned to the framework developed for the delegation of Primary Care, Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services commissioning functions, but had been tailored specifically for specialised services commissioning.

110.5 Mr Dave Bennett asked if the ICB was potentially going to be operating in a multi ICB framework and, if so, what were the risks in terms of repatriation and redirection of specialised services.

110.6 Mr Nick Wite responded by saying that it was not about redirection but about ensuring STW patients had access to the best possible services available across the West Midlands footprint.

110.7 Mrs Claire Skidmore commented that the ICB needed to be clear on the risks and plan, prepare and mitigate them appropriately. There also needed to be clear ways of working in order to get the best from this arrangement. Mrs Skidmore also noted that there were potential financial and resource implications.

110.8 Mr Meredith Vivian asked if all implications had been taken into consideration.

110.9 Mr Nick White explained the hub hosting arrangements being put in place to facilitate the delegation and noted that a number of existing staff would be moving to the hub. This would retain the expertise and knowledge.

110.10 Mr Simon Whitehouse highlighted that if the Board were to sign off the Pre-Delegation Assessment Framework it would not commit the ICB to final position, as it was a pre-delegation. Mr Whitehouse reported that a supporting letter would also included which would set out the nature of the Board's conversation so there would also an audit trail.

110.11 Mr Whitehouse proposed that the Board signs the PDAF and that Mr Nick White draft a supporting letter on behalf of the Board that outlines the challenges and concerns. It was agreed that a copy of the letter would be shared with Members once sent.

110.12 The Chair agreed that this was the right thing to do and felt that delegation gave the ICB more influence over the services that are provided for its population. Although he noted that it e to be needed to be properly constructed and be clear on the risks and how they were managed. The Chair asked that the letter states that the ICB agrees in principle with the direction of travel but there are some caveats as noted above by Members.

Action: Risks to be mapped carefully and make sure they have been considered along with any other risks.

Action: Mr Nick White to draft supporting letter on behalf of the Board

The integrated Board is asked to:

- **Review the papers and approve the PDAF for formal sign off and submission.**

<u>Minute No. ICB 27-09-111 STW ICS People Collaborative</u>

111.1 Miss Stacey Keegan introduced the paper and highlighted the following key points.

CEO and HR Director (HRD) conversation on our STW People approach had progressed positively over recent months. Discussions explored the following areas:

- reframing the current People Strategy,

- agreeing the Senior Responsible Officers for each Programme portfolio, and work had been done around realigning the people resource and how it we have aligned the capacity we have across the system to their workstreams, which enables us to identify where the gaps are.
- agreeing a meetings governance structure so that we can work successfully and collaboratively together, looked at how we drive delivery through governance, revised governance in appendices.
- the role of the ICS Chief People Officer and People Programme team,
- the statutory role the ICB has for workforce matters on behalf of the ICS.

111.2 It was noted that the paper had been presented at the People Committee last week.

111.3 Miss Keegan also added that there was a piece of work underway associated with identifying risks in relation to capacity and finance that HRDs were leading on which would be presented to CEOs in a few weeks' time.

111.4 Mrs Patricia Davies commented that there needed to be clarity around the key areas of focus jointly as providers, especially in relation to workforce and HR, and stated that she would support this approach.

111.5 Dr Ian Chan commented that there was no mention of General Practice in the paper and noted that in 2.2 of the paper it stated that the strategy was created in collaboration with senior decision makers with all Trusts and other providers.

111.6 Miss Keegan assured Dr Chan that General Practice representatives where in the meeting when it was discussed.

111.7 Mr Whitehouse commented that the training hub and the funding needed to come together in one place.

111.8 Dr Catriona McMahon added that people need to have a strong voice in the ICB in terms of what overarching workforce requirements were important.

111.9 Mrs Lynn Cawley asked what consideration has been given to people who would be prepared to change career to work and support this system.

111.10 Miss Keegan responded saying that there was a lot of focus on younger people and apprenticeships.

111.11 Dr McMahon mentioned that at the last People Committee there was an action to look at how people towards the end of their careers were supported when deciding to take a lateral move into a different career.

111.12 Dr McMahon added how important the People Strategy was in terms of the economic elements of the ICB's responsibilities, and by ensuring that its own residents were accessing jobs across the organisations within ICS would also enhance the economic strength of local communities.

111.13 Miss Keegan stated that.

- Conversations were scheduled with CEOs to unpack the risk elements.
- Work had started with the SROs leading.
- Governance structure and committees and groups were now in diaries.

111.14 Dr McMahon stated that the deliverable and KPIs are structured against the old strategy structure. Work was underway to realign the strategy structure and looking at the intermediate KPIs

The ICS Board is asked to:

- **Recognise the progress made by system senior leaders to develop & agree the approach to system people, culture & inclusion.**
- **Support the approach to system people, culture & inclusion set out in this paper.**
- **Note the gaps and risks to delivery, bearing in mind capacity within provider organisations from a People perspective and the significant transformation required to address the workforce challenges we face.**

The Board accepted the recommendations.

Minute No. ICB 27-09-112 Integrated Care System Performance Report:

112.1 Mrs Claire Skidmore introduced the paper and noted the key points.

112.2 It was noted that it was a continually evolving report, covering all four domains - quality, finance, workforce and operational delivery.

The Board is asked to.

- note the Month 5 headlines for the system financial position (£59.2m YTD deficit, £23.1m adverse to YTD plan) and that the system is reporting forecast delivery of the plan but with significant unmitigated risk of £81.8m. All organisations are working hard to develop phased mitigation plans to mitigate as much of the current risk as possible and agree a forecast position with NHSE.

- note the improvements in Cancer diagnosis and waiting times and the elimination of 104 and 78 weeks waits for Elective treatment resulting in the move from Tier 1 to Tier 2 for SaTH for Elective.

- note that performance across headline UEC metrics of Ambulance handovers and A&E 4-hour waits have reduced in July and August and the actions that are being taken as a system and with NHSE and production of a revised UEC

recovery trajectory for performance improvement. It was noted that Louise Barnett now chairs the UEC Board.

- note the long waits in Adult and CYP Mental Health Services and in particular Adult assessment for ADHD, recognising that this is a national issue but noting the local actions that are being undertaken to address the longest waiters and more complex patients.

- note the high numbers of mixed sex accommodation breaches in SaTH and the system risk around *Clostridioides difficile* (*C diff*) for which an action plan is in place.

- note that Month 5 shows a combined positive variance of substantive staff in post against plan by 202 WTE but the Pharmacy workforce has fallen across all providers and is an area of concern.

- note that the IPR report includes performance data against all four domains of Quality, Operational delivery, Finance and Workforce and that further work will be undertaken to improve the report taking advice and guidance from NHSE colleagues and considering exemplar reports.

112.3 Mr Dave Bennett asked why the ICB was not performing well on elective recovery.

112.4 Mr Gareth Robinson responded by saying that the data demonstrated performance on the elective side and 78 weeks, 104 weeks and 65 was quite positive. The ICB was ahead of plan and there had been a significant turnaround from last year. It was noted that the ICB continued to struggle with the cancer performance, but on faster diagnosis and the 62-day standard were ahead of plan. The recovery plan was on track.

112.5 Mrs Skidmore commented that work was being done on ERF and that it was calculated on value weighted activity.

112.6 Mr Dave Bennett said it would be useful to know the 'no criteria to reside' position.

112.7 Dr McMahon stated that 'no criteria to reside' fluctuates between 18 – 27 % of bed capacity.

Action: Dr McMahon invited Mr Dave Bennett to visit SaTH to talk to Dr John Jones and colleagues about his experiences and what help can be given.

112.8 The Chair asked Mrs Skidmore what happens next as the current position was unsustainable and unacceptable, with some aspects of the overspend difficult to manage.

112.9 Mrs Skidmore responded by saying that:

- A set of actions had been agreed at the CEO meeting earlier in the day, predominantly the areas that the system collectively could influence together.

- Some activity assumptions had been made
- Escalation and how to try and de-escalate and reduce associated cost.
- Commitment given from all to go back and make sure that we can confidently describe mitigations within our positions.
- Rob Cooper who has been providing some interim financial recovery support and Lorna Gibson will speak to people next week in terms of action owners and organisations to chase progress.
- At the next CEO meeting in two weeks' time, attendance to be widened for Directors of Finance and Chief Operating Officers to ensure actions are followed up.
- Paper going to Finance Committee in the next week which will look at some early scenario modelling around the medium-term financial plan, which will then underpin conversations about next year.
- There will be guidance around how ERF may be changed due to industrial action.
- We are expecting updated National protocol around how we secure agreement for any changes to forecast outturns.
- Part of the protocol will be to describe the recovery plan between now and the end of year.

112.10 Mr Simon Whitehouse commented that as part of the agenda there would be an opportunity at the October development session to better understand the financial aspects linked to escalation and the ongoing capacity challenges.

Minute No. ICB 27-09-113 System Mortality Metrics

113.1 The Chair firstly wanted to comment about the reason for the Board papers being late. He explained that the System Mortality Metrics report required a more detailed explanation and a stronger narrative to ensure that the detail was better understood and to ensure that the paper was set in the context of the overall approach that the ICB wanted to take for service improvement, safety and surveillance to enable it to track improvements, trends and concerns that needed to be acted upon.

113.2 The Chair apologised for the ways in which some areas were described in the paper and for any concern or upset that it had caused to families. He stated that any child death was a tragedy and that any written papers or Board conversations around this topic should be cognisant of the need to be sensitive and that all colleagues should be aware of the impact on parents and families impacted on by these tragic events. The Chair advised that focus needed to be given to the issues that the paper draws to the Board's attention. He stated that this needed to be part of the business rhythm of the ICS and ICB and that this was the first opportunity to start thinking about some of the metrics that are available to us. He reiterated the importance of being sensitive to the impact of Board papers, but that the Board did need to be discussing and monitoring some of these metrics.

113.3 Mr Nick White introduced the presentation and highlighted the following.

113.4 Mortality surveillance in its broadest sense is a core part of how the system can assess the safety of services and identify those areas where improvements can be made.

113.5 At a system level there is a need to look at an entire patient journey which can be effective for the entire population. Targeted surveillance data and reporting has been undertaken and shared with Trusts for many years and is known as the Standard Hospital Mortality Indicator (SHMI)

113.6 SHMI is a measure of death in a hospital or 30 days after discharge.

113.7 STW ICS has a higher mortality rate than the national average which varies from year to year, with higher mortality rates in children.

113.8 System mortality was higher than the national average within areas of deprivation.

113.9 Shropshire had significantly lower rates of leading cause mortality than the national average. Despite this the rates of stroke mortality in females was an outlier. Telford and Wrekin was an outlier for all leading cause mortality. This was because of higher mortality rates for females, driven by mortality rates for respiratory conditions.

113.10 Premature mortality metrics show that Shropshire was on or better than the national average on all measures except Under 75 mortality for people with a severe mental illness. Telford and Wrekin were also an outlier for Under 75 mortality for people with a severe mental illness but also show higher levels of mortality for CVD, Heart Disease and respiratory conditions.

113.11 For preventable mortality Shropshire, Telford and Wrekin performed well and were not mortality outliers. The key opportunities for improvement for the system were around CVD and respiratory which were within tolerance levels currently.

113.12 Tobacco usage was a key driver of premature mortality due to respiratory and CVD in the STW system. The most recent tobacco control metrics show that Telford and Wrekin had a good number of quitters, whereas Shropshire had a significantly lower rate of quitters across all measures.

113.13 A key component of the Clinical Strategy was improving the cardiac pathways for the entire patient journey.

113.14 There had been vast effort over the past 2 years within the Pharmacy Team to ensure patients were on the correct medication when it came to stroke and cardia, to ensure control of hypertension, anticoagulation and arterial fibrillation.

113.15 MPUFT were doing a considerable amount of work around serious mental illness. Good screening now in place and the next step was to ensure that physical health issues were identified and addressed.

113.16 Mr White reported that it was the first time that the mortality metrics had been presented to the Board and that having an open and transparent discussion around performance was important and meant that efforts could be focussed going forward.

113.17 The Chair added that report would become part of the ICB's routine reporting and its intention was to highlight areas that required more detailed investigation. He asked Board members for comments.

113.18 Mr Dave Bennett commented that the ICB should not lose sight of differing outcomes between Shropshire and Telford & Wrekin and ensure that efforts were focussed on addressing the issues raised. This needed to be a core part of the systems health inequalities work.

113.19 Dr Niti Pall referred to the stroke outliers and the cardiac pathway and noted that these would form part of the next steps, but Dr Pall also wanted to highlight the hypertension pathway. She felt that this was an area where targeted intervention could have a big impact and something that could be actioned quickly.

113.20 Mrs Cathy Purt asked how the ICB would engage with the wider health population to help in coming up with solutions within the communities. Mrs Purt reported that there were Health & Social Care Forums in Whitchurch and Oswestry, and may be something similar in other parts of the country, which could be used as the platform for engagement.

113.21 Mrs Patricia Davies stated that mortality and morbidity was driven by a number of other key factors and formed part of bigger picture across the system. Mrs Davies felt that a much broader piece of work was required to understand the context, particularly in relation to prevention and learning to reduce mortality and morbidity. This would help to drive an approach based around better understanding the what the problems were and subsequently seek to resolve them in a systematic and appropriate way.

113.22 Dr Ian Chan commented that the risks to these cohorts of patients were multi-factorial, which required both a clinical and non-clinical approach. He reported that the combined deprivation index in Telford & Wrekin had declined over recent years which was resulting in poorer health outcomes. The Clinical Strategy and Joint Forward Plan, along with place based partnership working would be fundamental to driving improved health outcomes.

113.23 Mr Meredith Vivian commented that one of our key drivers was the assurance system and reported that the Quality & Performance Committee (QPC) comprised of executives from across the local system, along with non-executives and representatives from public health, who were responsible for this. He advised that the agenda was driven by risk, with the risk register being the main focus. This provided the ability to challenge and provide assurance. Mr Vivian felt that more could be done with further intelligence to build up the assurance process.

113.24 Mr Vivian also felt that the data should be received by the Board as part of the regular reporting and assurance, as well as be presented to the QPC.

113.24 The Chair stated that the responsibilities of Boards should not be diminished and that organisations should also ensure they had their own surveillance arrangements in place.

113.25 Dr John Jones firstly commented about child mortality, stating that all child deaths were tragedies and there should be an expectation that no child should die, and the impact of any child dying was profound for the families involved from which they never recover. Dr Jones added that there needed to be complete understanding why a child had died.

113.26 Dr Jones reported on neo-natal mortality (where a baby dies in the first 28 days after delivery) across the West Midlands which he noted was higher compared to the rest of the country and was also high locally. He advised that every neo-natal death had a full investigation into the cause of death, with external expertise supporting the investigation.

113.27 In relation to paediatric mortality, Dr Jones stated that the National Childhood Mortality database produced a report in 2021 that showed that 30% of deaths in childhood had potential modifiable things related to deprivation that could have prevented a child's death (ie Vitamin D deficiency, overcrowding). This needed to be picked up locally through the health inequalities work and the work of the Childrens Board.

113.28 Dr Jones reported that the approach the Trust (SATH) took in relation to neo mortality and paediatric mortality came from the learning from the maternity review. This included setting up a Transformation Programme, which pulled together all data and intelligence surrounding paediatric mortality for review, assurance and any learning or changes that were required as a consequence. Dr Jones noted that ensuring the voice of the families involved was paramount and the Trust was working with Maternity Voices to see how engagement could be made.

113.29 Dr Jones reported on the next steps and proposed the following:

- Neo-natal mortality - strengthen links with the West Midlands Neo-Natal Network.
- Paediatric mortality – look at the various contributing factors of deprivation to see what influences could be made.
- Broader mortality – receive and review as much data as possible from the 'Learning from the Deaths Programme' and medical examiners' reports, which would identify areas for increased focus. A similar approach could be used across the system.
- Deaths in hospital – continue to use the toolkit for reviewing deaths in hospital.

113.30 Mr Bennett felt there was a need to speed up recognition of trends/patterns of death and take appropriate action. Dr Jones noted caution, as he felt that given the small numbers it could take a long time for a trend or pattern of death to emerge and encouraged the use of the new Patient Safety Incident Response Framework (PSIRF).

113.31 Dr Pall referred to the patient story presented earlier in the meeting and felt that triangulating patient experience, patient safety and clinical effectiveness data would be the best approach.

113.32 The Chair welcomed the comments made and hoped that the Board took assurance by the breadth of work being undertaken and the depth of enquiry that takes place to help understand deaths across the system. The Chair noted that mortality was not just about hospitals but several facets, including deprivation. He thanks Dr Jones for his comprehensive contribution and for setting out the main considerations in a structured manner.

113.33 Mr Whitehouse noted that the Board needed to have confidence in the assurance that each statutory organisation within the ICS had appropriate governance mechanisms in place to review and triangulate data, including serious incidents.

113.34 From a system point of view, Mr Whitehouse stated that the QPC would have oversight from a quality and risk perspective and give assurance to the ICB Board, including escalating any trends/patterns. This would be responsibility of Mr Vivian as Committee Chair and Mrs Bussey as Chief Nursing Officer.

113.35 In terms of the deprivation aspect, Mr Whitehouse advised that the Joint Strategic Needs Assessment (JSNA) would be the key driving factor, along with population health, place based work, reducing health inequalities and prevention.

113.36 Mr Whitehouse commented that the mobilisation approach would need to be done in a systematic way across the ICS using the evidence and data to target it in the right place.

113.37 Mr Whitehouse summarised the number of strands that were key factor of the next steps and stated that the triangulation of data was fundamental and reliance on statistics should not be the sole driver.

- Board responsibility and governance for specific detail
- Quality oversight at a system level
- Population health
- Health inequalities
- Prevention agenda

113.38 Mr White echoed the comments made and stated that partnership working across the ICS was vitally important to take forward the next steps. Mr White referred to the Long Term Conditions Strategy which he noted should also be the focus of attention.

113.39 The Chair felt that the ICB owed it to the population to provide assurance that actions were being taken forward and felt that the next steps outlined by Dr Jones's addressed this.

113.40 Dr Catriona McMahon felt that the ICB's QPC had the real opportunity to identify what the providers might be missing and triangulating data would be key to this.

The Board is asked to review the report and note the key outlier.

Minute No. ICB 27-09-114 Shaping the Shropshire Telford & Wrekin (STW) Integrated Care Board (ICB)

114.1 The Board noted the paper as read.

Minute No. ICB 27-09-115 GMC Responsible Organisation

115.1 All ICB's had been asked to become Responsible Organisation's by the General Medical Council with regard to the appraisal and revalidation of doctors they employ. By becoming a Designated Body the ICB becomes accountable for the doctors who have a prescribed connection to it.

115.2 It was noted that the ICB did not deliver patient facing medical services directly but commissions them from other provider organisations. The medical staff it employed were employed in non-clinical leadership roles.

115.3 The report was noted for information.

Minute No. ICB 27-09-116.1 Quality and Performance Committee Chair's Report for meetings held on 25 May and 29 June 2023

116.1 The Board noted the papers as read.

Minute No. ICB 27-09-116.2 Audit & Risk Committee Chair's Report for meeting held on 21 June 2023

116.2 The Board noted the paper as read.

Minute No. ICB 27-09-116.3 Finance Committee Chair's Reports for meetings held on 30 May and 26 June and 27 June 2023

116.3 The Board noted the papers as read.

Minute No. ICB 27-09-116.4 Remuneration Committee Chair's Report – 16 August 2023

116.4 The Board noted the paper as read.

Minute No. ICB 27-09-116.5 Strategy Committee Chair's Report for meetings held on 15 June, 9 August 2023

116.5 The Board noted the papers as read.

Minute No. ICB 27-09-116.6 System People Committee Chair's Report

116.6 No report to note.

Minute No. ICB 27-09-116.7 Primary Care Commissioning Committee Chair's Report

116.7 No report to note.

Minute No. ICB 27-09-116.8 Integrated Delivery Committee Chair's Report for meetings held on 10 July, 14 August and 11 September 2023

116.8 The Board noted the papers as read.

Minute No. ICB 27-09-117 Any Other Business:

117.1 No further matters to report

The Chair closed the meeting at 17:25

NHS Shropshire Telford and Wrekin
Integrated Care Board
Actions Arising from the Board Meetings

Agenda Item	Action Required	Owner	By When	Update/Date Complete
Minute No. ICB 27-09-107 Patient's Story: Learning Disabilities and Autism Services: Luke's Story	Gareth Robinson and Vanessa Whatley to lead on review and ensure this goes through correct Governance route then bring back to future Board. Look at numbers and identification before agreeing whether this will come back to a public or private Board	Gareth Robinson Vanessa Whately	January 2024	
Minute No. ICB 27-09-108 ICB CEO Report Minute No. 108.34	Recovery plans need to be socialised locally before next Board in November. Mr Gareth Robinson, Dr Ian Chan and Mr Nick White to work with both Councils and partners on the development of the plan and what we can do to improve Primary Care access. It was agreed that a briefing note on HTP update would be circulated at a later date. • Dr Catriona McMahon and Mr Matthew Neal to draft updated briefing note and circulate to Board members.	Gareth Robinson Dr Ian Chan Mr Nick White Dr Catriona McMahon Matthew Neal	29 November 2023	
Minute No. ICB 28-06-097 - Integrated Care System Performance Report	Mr Harry Turner commented around the data of the number of GPs increased, but over the same period the number of appointments seem to have gone down, which the figures didn't tally. • Mrs Skidmore to ask the team to provide a statement specifically to map what has driven the changes and why they don't correlate. • Mr Whitehouse to have discussions with Chief Executives around escalation capacity and then update Board.	Claire Skidmore Simon Whitehouse	27 September	Mrs Claire Skidmore to check with her team for clarification. Action – On-going

Minute No. ICB 29-03-069 – Follow up to Patient's Story: MSK Integration across Shropshire, Telford and Wrekin	Mr Mike Carr to present objectives and clinical outcomes of the MSK Transformation Programme to ICB once agreed by the MSK Transformation Board.	Mike Carr	When available	On-going

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-124
Meeting date:	29 November 2023
Paper title	Chief Executive Officer Report
Paper presented by:	Simon Whitehouse, Chief Executive Officer
Paper approved by:	Simon Whitehouse, Chief Executive Officer
Paper prepared by:	Tracy Eggby-Jones, Corporate Affairs Manager
Signature:	
Committee/Advisory Group paper previously presented:	Not applicable

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	x	D=Discussion		I=Information	

Previous considerations:	

1. Executive summary and points for discussion

1.1. The purpose of this paper is to share with Board members an update across several business areas that are not reported elsewhere on the agenda. The paper provides a generic update on activities at both a national and local level.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	x
Integrating services at place and neighbourhood level	x
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	x
Economic regeneration	
Climate change	
Leadership and Governance	x
Enhanced engagement and accountability	x
Creating system sustainability	x
Workforce	x

3. Recommendation(s)

3.1. NHS Shropshire, Telford and Wrekin Integrated Care Board is asked to note the contents of the report for **ASSURANCE** and ask any questions of the Chief Executive Officer.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

4.1. None

5. Appendices

5.1. None

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	The report demonstrated a continued organisational focus to improve outcomes in population health and healthcare.
Quality and Safety	The report demonstrated a continued organisational focus to improve outcomes in population health and healthcare.
Equality, Diversity, and Inclusion	The report demonstrates a continued organisational focus to tackle inequalities in outcomes, experience and access.
Finances and Use of Resources	The report demonstrates a continued organisational focus to enhance productivity and value for money.
Regulation and Legal Requirements	The report outlines the organisations response to the updated Procurement Legislation.
Conflicts of Interest	No conflicts of interest have been identified within this report.
Data Protection	N/A
Transformation and Innovation	The report provides an update on the major organisational change programme within the organisation.
Environmental and Climate Change	The report provides an update on the major organisational change programme within the organisation.

Future Decisions and Policy Making	The report outlines the organisations response to the updated Procurement Legislation.

Action Request of Paper:	NHS Shropshire, Telford and Wrekin Integrated Care Board is asked to note the contents of the report for **ASSURANCE** and ask any questions of the Chief Executive Officer.		
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	ICB BOARD MEETING
Meeting date:	29 November 2023
Agenda item no.	ICB 29-11-124
Paper title	ICB CEO Update Report

1. Introduction

1.1. The purpose of this paper is to share with Board members an update across several business areas that are not reported elsewhere on the agenda. The paper provides a generic update on activities at both a national and local level.

2. Industrial Action

2.1. The current pause in the industrial action is welcomed. This has enabled the focus to be on elective recovery and on the ongoing pressures across the UEC system.

3. Shaping the STW ICB Programme

3.1. As shared at the September 2023 Board Meeting we are conducting major organisational change of the Integrated Care Board (ICB) to ensure that the organisations is fit for purpose and that it complies with the nationally mandated running cost reductions. On 3 March 2023 NHS England wrote to ICBs informing that running cost allowances for all ICBs would be subject to a 30% real terms reduction by 2025/26, with at least 20% being delivered in 2024/25. For NHS Shropshire, Telford & Wrekin (STW) the real terms cumulative reduction by 2025/26 is 26%. Although the 2023/24 running cost allocation from NHS England is £9,485,000, NHS STW have a recurrent running cost spend of £10,515,000. To support narrowing the allocation gap, NHS STW have agreed a running cost efficiency target of £1,575,000 to be delivered in 2023/24. This is on track to be delivered as part of the delivery of the 23/24 operational and finance plan. To achieve the required savings for 2024/25, we are undertaking an organisation wide single process of restructuring the ICB. Our ambition is to have an agreed final plan by March 2024 to achieve the whole of the 26% reduction.

3.2. To support delivery of the reorganisation project the ICB have commissioned Clarity Consulting Associates Ltd for a period of 6 months. As part of this project, it is proposed that our new mission and values document will be presented to the January 2024 Board, followed by the operating model for presentation to the March 2024 Board. We recognise these are very challenging times for our staff who are continuing to do the day job and deliver on key pieces of work, whilst we review and revise our operating model.

3.3. As part of the relocation project, we have successfully completed a consultation exercise with our staff, and we can now confirm that the ICB offices will be relocated to Wellington. Our staff will move out of Ptarmigan House, Shrewsbury and Halesfield, Telford during early 2024. As part of the move, we will also be updating our Agile Working Policy to support new ways of working and maximising utilisation of our office space.

3.4. We are currently in the annual NHS Staff Survey period and earlier this year we ran one of the quarterly NHS Pulse Surveys. The results of the NHS Pulse Survey have shown that staff satisfaction and morale are lower than we would want and that this is linked to the uncertainty and the ongoing changes. To address this and encourage organisational development as part of the programme, we have begun working with our Senior

Leadership Team to look at how we can improve the experiences of our staff. As Chief Executive of the organisation I am committed to listening to our staff and making sure the ICB is a great place to work for everyone.

4. Armed Forces Covenant

4.1. As an organisation deeply committed to inclusivity and support, we are proud to reaffirm our dedication to the Armed Forces Covenant. Our pledge stands as a testament to the unwavering support and recognition we extend to serving personnel, reservists, veterans, and military families. Through this commitment, we aim to champion the principles of the Covenant by empowering our provider organisations, enabling our GP Practices to achieve Veteran Friendly Accreditation, and actively promoting an Armed Forces-friendly culture within our organisation and beyond.

4.2. Central to our renewed commitment is the reinforcement of support systems for our armed forces community. We are dedicated to empowering our provider organisations within the Shropshire, Telford, and Wrekin Integrated Care System to fulfil their respective Armed Forces Covenants. Additionally, our concerted effort involves aiding our 51 GP member Practices in attaining Veteran Friendly status, ensuring equitable access to dedicated support for all veterans within Primary Care.

4.3. Furthermore, we are committed to fostering an environment that recognises and values the unique contributions of veterans, reservists, and military families. We actively advocate for their employment, provide support and flexibility, encourage Reservist participation, and promote involvement in military cadet organisations. This renewed commitment underscores our unwavering gratitude and support for those who have served and continue to serve our nation.

4.4. In summary, our dedication to upholding the principles of the Armed Forces Covenant extends beyond mere words, it is ingrained within our actions, policies, and culture. By strengthening our support networks, fostering inclusivity, and promoting an Armed Forces-friendly environment, we stand united in honouring the service and sacrifices of our armed forces community.

5. National Allied Health Professional (AHP) Day

5.1. National Allied Health Professional (AHP) Day is celebrated annually on 14th October, this year falling on a Saturday. Suzanne Rastrick (Chief Allied Health Professions Officer) delivered her address on Friday 13th October, attended by AHPs across Shropshire, Telford & Wrekin (STW).

5.2. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) showcased their AHPs through a series of videos, shared across social media (AHPs_STW).

5.3. Shropshire Community Health NHS Trust (SCHT) marked the day with a virtual Chief AHP conversation, celebrating successes and looking to the future.

5.4. Shrewsbury & Telford NHS Trust (SaTH) thanked their AHP workforce with the support of their Communications team, highlighting the important roles AHPs provide for the local population.

5.5. STW AHPs celebrated the AHP Community, with a system wide conference ‘STW AHPs Deliver’ in June, themed around the new national AHP strategy. There were over 100

attendees across the county, with national, regional speakers, and our local talent showcasing the developments and transformation led by our AHPs.

6. Black History Month

6.1. Within Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS), Black History Month is always an opportunity for us to recognise, reflect on and celebrate the invaluable contributions that black people make to the NHS and British society every day and inspire and empower future generations. The theme for Black History Month 2023 was "Saluting our sisters", an extra special opportunity to celebrate and emphasise black women's vital role in shaping history, inspiring change, and building communities. Our system partners celebrated and recognised Black history by hosting activities, events, collaborative newsletters, and communicating recognition of their talented colleagues.

6.2. Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) recognised various inspirational black women from nursing and medicine. They highlighted the achievements of a young black woman with multiple disabilities through different communication channels each week of Black History Month. In addition, colleagues were invited along with their friends and family to share their creative skills and showcase any art, writing or photography that celebrates the inspirational black women in our lives.

6.3. At Shrewsbury and Telford Hospital NHS Trust (SaTH), their Equality, Diversity and Inclusion (EDI) team hosted inclusion events at both hospital sites with food, music, stalls with games and competitions. They also cascaded articles about the experiences of people from Black African and Caribbean backgrounds, focussing on Black History Month and World Mental Health Day. In keeping with this year's theme of "Saluting our sisters", the trust held a poetry competition. Staff were asked to submit a poem about a pioneering black woman who has impacted their chosen field, explaining why she is an inspiration.

6.4. Shropshire Community Health NHS Trust (SCHT) invited all staff to participate in their "proud to be" campaign, allowing people to share individual stories and celebrate the rich diversity of their workforce. This was an opportunity for all staff, particularly those from ethnic minority backgrounds, to celebrate their achievements, contributions, values, and experiences of working within the NHS. SCHT wanted to inspire and share people's pride in their heritage and culture – in their own way, in their own words.

6.5. Our Local Authorities' focus for the month was Show Racism the Red Card Day on 20th October. They featured the strapline for this on payslips that month and updated their computer lock screens to show respect for the day; photos of staff wearing red or with red in the background were added as a collage, together with photos of Executive Team and Cabinet.

7. Provider Selection Regime (PSR)

7.1. Subject to parliamentary scrutiny and agreement, the Department of Health and Social Care intends for the Provider Selection Regime (PSR) to come into force on 1 January 2024.

7.2. The PSR will be a set of new rules for procuring health care services in England by organisations termed relevant authorities. Relevant authorities include NHS England, Integrated Care Boards, NHS Trusts and Foundation Trusts and Local Authorities.

7.3. The PSR will **not** apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by relevant authorities.

7.4. The PSR will be introduced by regulations made under the Health and Care Act 2022. In keeping with the intent of the Act, the PSR has been designed to:

- introduce a flexible and proportionate process for deciding who should provide health care services.
- provide a framework that allows collaboration to flourish across systems.
- ensure that all decisions are made in the best interest of patients and service users.

7.5. There are broadly 3 circumstances that may occur when deciding how to arrange services and the circumstance will drive the approach taken, while consistently demonstrating transparency and that the decision-making bodies are acting in the best interest of patients, taxpayers, and the population. The options available are the continuation of existing arrangements, identifying the most suitable provider, or undertaking a competitive procurement. Competitive procurement is still an option allowed in every circumstance.

7.6. The new legislation will require amendments to the Integrated Care Board (ICB) procurement policy, standing operating procedures, Standing Financial Instructions (SFIs) and governance arrangements.

7.7. A PSR working group has been set up to rapidly work through the requirements following several sessions held with NHS England. The new legislation will require amendments to the ICB procurement policy, standing operating procedures, SFIs and governance arrangements.

8. Awards and Recognition for our Staff

8.1. The communications and engagement team has been recognised at the national Public Relations and Communications Association (PRCA) UK awards. The team won the Public Sector Value for Money Award for the Shropshire, Telford & Wrekin (STW) winter campaign 'Think Which Service' and were highly commended for the In-House Public Sector Team of the Year award.

8.2. The PRCA is the world's largest professional Public Relations (PR) and communications body. As the most prestigious PR and communications awards in the United Kingdom, the team has gained national recognition for their outstanding work, which included extensive research, creativity and a targeted communications approach.

9. Good Governance Institute Making Meetings Matter Review

9.1. Board members will be aware that the Integrated Care Board (ICB) have commissioned the Good Governance Institute (GGI) to undertake a review called 'Making Meetings Matter' to review the ICB and Integrated Care System (ICS) governance meeting structure one year on from the formal creation of the ICB and ICS as suggested by good practice and to also address one of the system National Oversight Framework 4 (NOF4) exit criteria.

9.2. The scope of the work so far has included analysis of current structure and the development of a proposal for a revised and leaner governance structure. This seeks to provide the ability for the system and ICB to transition in the future to a more mature operating model, that includes Place based and provider collaborative governance structures. The GGI have produced their initial draft report with a proposed structure which is being disseminated to Board members and key stakeholders for their information with a view that the proposal is translated into changes that will be required to the ICB's Governance Handbook that will be presented at the next Board meeting in January for approval.

9.3. The second phase of the GGI scope of work is to provide focused support to the ICS and ICB to implement the agreed new structure and preparatory discussions are currently taking place between the ICB and GGI to agree the detail.

10. Recommendation

10.1. NHS Shropshire, Telford and Wrekin Integrated Care Board is asked to note the contents of the report for **ASSURANCE** and ask any questions of the Chief Executive Officer.

Simon Whitehouse
Chief Executive Officer
NHS Shropshire, Telford and Wrekin
November 2023

ICB Public Board – 29 November 2023

Agenda item no.	**ICB 29-11-126**
Meeting date:	**29 November 2023**
Paper title	**NHS STW System Winter Plan**
Paper presented by:	**Gareth Robinson, Dir of Delivery & Transformation**
Paper approved by:	**Gareth Robinson, Dir of Delivery & Transformation**
Paper prepared by:	**Betty Lodge, Dir of Urgent & Emergency Care and EPRR** **Sharon Clennell, Head of Urgent & Emergency Care** **Clay Flattley, Programme Lead UEC**
Signature:	
Committee/Advisory Group paper previously presented:	**UEC Operational Delivery Group** **Presented to UEC Delivery Board on 31st October. To be re-submitted on 30th November**
Action Required (please select):	
A=Approval ☐ R=Ratification ☐ S=Assurance ☐ D=Discussion ☐ I=Information ☐	
Previous considerations:	

1. Executive summary and points for discussion

This paper outlines the NHS STW system winter plan for 2023/23. It is comprised of the following core elements:

- **The key measures that will be monitored during implementation**. These are standard national measures supplemented by system measures that will be overseen by the UEC Delivery Board on behalf of the ICB Board
- **The impact of a revised bed model.** The initial 2023/24 system operating plan demonstrated a surplus bed position from December. Due to an increase in demand, a reduction in the impact of the virtual ward beds, a reduction and delay in the sub-acute beds, and a deterioration in the No Criteria to Reside position, a re-modelled bed position has identified a potential bed deficit of 91 beds in November, reducing to a deficit of 30 by March
- **The detailed set of interventions from all system partners.** These are described in significant detail within the Winter Plan and represent a material investment from all system partners in preparing for Winter

The paper sets out the significant preparation that has been made for winter. The joint working and collaborative approach is noteworthy. Two key issues are required to be specifically brought to the attention of the Board as NHS STW prepares for Winter:

1a. Bed model

Section 4 of the Winter Plan sets out the impact on the bed model of operational changes that have taken place within 2023/24 which moves the system from an anticipated bed surplus (as set out in the System Operating Plan) to a bed deficit (as set out in the updated bed model).

These changes were outlined at the October NHS STW Board Development Session and are summarised as:

- An increase in admission activity during 2023/24 above anticipated levels, driving a requirement for an additional 19 beds
- The loss of anticipated acute bedded capacity being delivered as a result of the lower than planned impact of virtual ward – the equivalent of 38 lost beds
- A reduction in and delay to the implementation of sub acute wards, resulting in a loss of 64 beds from the model in December reducing to a loss of 18 beds from January
- A deterioration in the No Criteria to Reside and Ready to Go position placing an increased demand of the equivalent of 51 beds on SaTH

The actions required to mitigate this are:

Area	Intervention	Lead partner	Required output	Bed impact
Integrated Discharge Team/ Complex Discharges	Maximise the operational grip on reducing delays to discharge and utilising all available capacity within social care. Reduce the post-NCTR LOS through deployment of Discharge Management Tool into complex discharge pathway management.	SCHT/ NHS STW T&W/ SC SaTH	Deliver R2G[1] list of no more than 61 Gap between R2G and NCTR patients of no more than 21[2]	Improvement of 40 beds Improvement of 30 beds
Virtual Ward	Significant challenges remain with fully deploying the virtual ward service. During November, there has been a step forward in the number of step-down patients accessing the service from SaTH and this will be the continuous focus of the team	SCHT/ SaTH	Move from most likely scenario of approx. 22 beds to delivering 50% of initial plan (31 beds)	Improvement of 9 beds
Criteria to admit/ demand management	There is considerable evidence of patients that attend and are subsequently admitted that do not require acute care.	NHS STW/ SaTH	Reduce inc demand to 2023/24 planned levels	Improvement of 19 beds
Total				**98 beds**

[1] R2G: "Ready to Go" patients. These patients have No Criteria to Reside and have been prepared for discharge. Where the NCTR list is higher than the R2G list, this is where the patient is medically fit for discharge but has not completed all of the non-clinical supporting processes to allow discharge from the acute setting

[2] The combination of a maximum of 62 R2G patients and patients with No Criteria to Reside (NCTR) but not R2G of 21, creates a total list of 82 NCTR patients which is in line with the initial operating plan assumption

System partners are driving the improvement activity in these areas. Given the timelines required to be met, there is risk to the implementation of these schemes delivering the improvement to the required level. In the event that these do not deliver (or are only partially successful) the Board should be aware that patients will be cared for in unconventional care areas.

These areas should not be considered as bed capacity and are not included within the bed model as they will have a negative impact in either the ability to maintain flow (e.g., the use of major's cubicles for delayed DTAs) or quality of care and patient safety.

In certain unconventional care areas (e.g., fit to sit or waiting rooms), the evidence is clear that clinical risk increases with the length of time patients remain in these settings. By accepting the use of this space, NHS STW is required to accept that risk. It should be noted that these areas are currently used as part of the escalation responses to Urgent & Emergency Care pressures within the system.

Area	PRH	RSH	Total
Respiratory Investigation Unit	3 trolleys, 3 chairs	4 trolleys, 4 chairs	14 spaces
Use of Majors Cubicles	12 plus 1 side room	14 plus 1 triage room and 2 F2S spaces	30 spaces
Triage	2 adults	2 adults	4 spaces
GP Minors	4 rooms plus eye cubicle	4 trollies, 2 treatment rooms plus eye cubicle	7 spaces
Fit to Sit	8	12	20 spaces
AMA Waiting Room	12	9	21 spaces
TOTAL			**96 spaces**

In summary

- The most likely scenario for the revised bed model is a deficit in November of 91 reducing to a deficit of 30 by March
- There are opportunities to reduce this deficit by up to 98 beds with interventions set out in the Winter Plan, but these carry risk in terms of implementation
- Where these opportunities do not deliver, there is capacity for unconventional care locations to provide for 96 spaces

1b. Elective Orthopaedic Activity

System partners continue to develop an operating model which will secure elective orthopaedic activity through the provision of capacity at RJAH. This work is still to be finalised.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	X
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	

3. Recommendation(s)

The Board is asked to **approve** the 2023/24 Winter Plan including:

- **Noting** the extensive set of interventions from all system partners in preparing for Winter
- **Requesting** Shropcomm, T&W Council, Shropshire Council, Powys Council and NHS STW to deploy the operational requirements to deliver a Ready to Go position of fewer than 61 patients
- **Requesting** Shrewsbury & Telford Hospitals to implement the required capacity and processes to reduce those patients on the No Criteria to Reside list that are not yet ready to be discharged to below 21
- **Requesting** Shropcomm and SaTH to continue the improving work on Virtual Ward in relation to the pathway expansion and clinical engagement across the service
- **Requesting** NHS STW and SaTH to deliver the improvement work identified from the criteria to admit review
- **Noting** the impact on patient care (should these actions not be delivered) through the use of unconventional care areas
- **Requesting** RJAH and SaTH finalise the plan for securing elective orthopaedic activity
- **Requesting** UEC Delivery Board receive detailed updates from each system partner against these actions through winter

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

NA

5. Appendices

NA

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Improved access to Urgent & Emergency Care Services through the winter period
Quality and Safety	N/A
Equality, Diversity, and Inclusion	N/A
Finances and Use of Resources	N/A
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Moving towards a modern general practice access model
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	N/A

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Shropshire, Telford and Wrekin Winter Plan 2023/24

Version History

Authors:	Clay Flattley Programme Lead UEC Sharon Clennell Head of UEC, Transformation and Commissiong/SCC Commander Gareth Robinson Director of Delivery & Transformation
Date:	22nd November 2023
Version:	25

Table of Contents

01 Executive Summary

The purpose of this Winter Plan is to highlight the capacity and demand assumptions for winter, set out the NHS STW planned response and communicate the system approach for winter. Recognising significant aspects of the winter plan were built into the overall 2023/24 System Operating Plan at the start of the year, it also incorporates the additional extra initiatives, capacity and information to manage the urgent care and patient flow pressures that the system will inevitably experience.

The Shropshire, Telford & Wrekin Integrated Care System (ICS) Winter Plan has been developed collaboratively and influenced by national best practice, guidance issued by NHS England and learning from previous winters within our system and be done using five key steps for sourcing information and developing appropriate plans detailed below:

- Utilising existing system groups to maximise interaction of all system partners and relevant programmes of work. This has culminated in a final review by the System Planning Group to ensure that the Winter Plan is incorporated within all partner planning processes.
- Targeted work within the System Demand and Capacity Group to develop the detailed bed modelling. This has been particularly important given the potential bed deficit that remains and fluctuations in planning assumptions during the latter parts of the planning phase.
- Individual discussions with key stakeholders across the system to get specific information for the plan.
- Utilising existing business cases and documents for information on interventions
- Incorporation of the plans and proposed impact of the NHS STW Urgent & Emergency Care Improvement Program 2023/24

The health and social care system in Shropshire has experienced significant levels of pressure over the summer period with the continued impact of a range of industrial action and patient demand manifesting in a significant change to demand for all services. This has presented in particular in the demand for escalation beds within SaTH and this document sets out a revised bed model and mitigation plan. **Section 4** sets out the impact of the revised modelling, what this means for our patients, and the required actions of all partners in mitigating the risk that this model suggests will be present in the system

Sections 5 – 18 set out the relevant interventions at a system or individual provider level that will help deliver the required performance within the system. These interventions will be overseen by the Urgent & Emergency Care Delivery Board, either as part of standard reporting (where the interventions are part of business as usual) or as specific implementation plans (where the interventions are specific to winter)

02 Approach

The STW ICS system approach to developing the winter plan is driven by two key influences:

2.1 National requirements:

This year a guidance letter from NHSE 'PRN00645 Delivering operational resilience across the NHS this winter' was issued on 27 July 2023 with a number of key requirements and expectations:

- To conduct a demand and capacity analysis, as the basis for the Winter Plan,
- underpinned by robust planning assumptions.
- To clarify and agree within the system the key roles and responsibilities for
- managing the winter effort.
- Implementation of a System Co-ordination Centre (SCC); and
- To adopt the revised Operational Pressures Escalation (OPEL) Framework

In addition to the NHSE's guidance, a number of specific requirements have been issued for all trusts and provider organisations relating to:

- Improving and protecting the wellbeing of the workforce.
- Protecting the public and healthcare workforce from flu and other infectious
- diseases; and
- Ensuring there is an established pathway for identifying patients at risk of Covid and
- flu in those that are immunosuppressed.

To provide assurance over delivery of the national requirements and expectations, the system was required to complete a narrative and numerical return which was submitted in September 2023. While there will be some degree of overlap with the content of the NHSE return, this does not negate the need for a system plan which articulates the specific areas of focus in STW ICS and how partners will work together to deliver it.

2.2 Shropshire, Telford & Wrekin requirements:

In addition to the national requirements, the Shropshire, Telford & Wrekin system considers what specific priorities or areas of focus are required to best meet the needs of the local population. (based on locally observed demand and capacity) and the governance arrangements required to ensure all parts of the system work together to best mitigate the risks for the entire population. This requires bringing together actions and intelligence at provider, place and system level, prioritising the areas of focus and ensuring response and delivery mechanisms are in place that reduce duplication and maximise impact without adding unnecessary burden on operational and clinical teams.

The plan incorporates the requirements set out within the NHSE guidance letter and describes the focus on three key priority workstreams:

- Demand management:
- Admissions avoidance: and
- Hospital Flow

The plan includes summaries of enabling work across the system including:

- Winter surge plans across all aspects of the health and social care system
- The in-year development of the bed capacity and demand model initially set out in the 23/24 system operating plan.
- Critical care capacity
- Vaccination plans
- Comms and engagement

The NHS core objectives and actions have been introduced to begin to address these issues. These are summarised in the table below with links showing to the appropriate section of the plan:

Core objective/action	Section of plan
Increase capacity outside of acute trusts, including the scaling up of additional roles in community care, primary care and releasing funding to support mental health through the winter	**06**: Interventions Primary care **07**: Interventions Community **08**: Mental Health
Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999	
Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged providers	**05:** Interventions Acute **07**: Interventions Community
Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.	**05:** Interventions Acute **07**: Interventions Community **10**: Social Care **11**: System Wide Resources
Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical sub-acute beds, virtual wards, and improvements elsewhere in the pathway.	**05:** Interventions Acute **07:** Interventions Community **10:** Social care
Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.	**05**: Interventions Acute **07:** Interventions Community **08**: Mental Health **10**: Social Care **11**: System Wide Resources
Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.	**07**: Interventions Community **10**: Social Care **11**: System Wide Resources
Prepare for variants of Covid-19 and respiratory challenges including an integrated Covid and flu vaccination programme.	**12**: Vaccination/ immunisation

Table 1 NHSE Core Object/Action to Winter Plan Sections

03 Key measures

The 2023/24 System Operating Plan sets out a range of key performance indicators that UEC performance are measured against (see Appendix 4 Operational Performance Report Mth6) These are monitored at a system level through the following mechanisms:

- Weekly performance review of operational KPIs
- Monthly performance review of operational KPIs, improvement programme milestones and winter plan delivery through the Operational Delivery Group
- Monthly oversight and scrutiny on behalf of the NHS STW Board by the Urgent & Emergency Care Delivery Board
- Monthly performance review through on behalf of the NHS STW Board by the Quality and Performance Committee

NHS England (Midlands) have signalled a focus on three specific measures that will drive the operational performance review from their perspective through the winter months. These are:

NHSE Midlands Key Performance Indicator
Category 2 ambulance response times for West Midlands Ambulance Service (target to be below 30 mins average)
Twelve Hour Breaches within the Emergency Department (target to be below 2%)
Compliance with 4-hour performance target (target to be above 76%)

Table 2: NHSE Midlands primary measures

From a system perspective, we have also identified 3 key performance indicators that drive the specific challenges facing NHS STW. These will be combined with the three measures in table 2 above:

NHSE STW Key Performance Indicator
Hours lost to handover delays over 15 mins (target to be 0)
The number of simple and timely discharges (no target, system works to achieving higher than six week rolling average)
Total number of NCTR patients (target to be below 82 by March 2024)

Table 3: NHSE Key Performance Indicators

04 Bed Modelling

4.1 System Operational Plan 2023/24

The approved NHS STW operational plan developed for 2023/24 included a range of schemes (described in Section 5 below) intended to reduce the reliance on escalation beds within this system. This range of schemes was also designed to bring significant additional G&A bed capacity on stream in advance of the winter pressure periods.

Figure 1 shows the initial 2023/24 bed model incorporating the following planning assumptions (figures use December 2023 as a proxy month):

- The gap between demand and available bed capacity created an unmitigated bed deficit of -164 beds.
- The impact of a range of interventions deployed as part of the system UEC improvement plan reduces this deficit to -118
- Three primary schemes were then planned to provide significant additional bed capacity in time for the winter months:
    1. The expansion of the Integrated Discharge Team (with an investment of £1.2m) was intended to reduce the NCTR backlog by 26 as a result of improved pathway management for complex discharges and the expansion of therapist resource to increase capacity in assessments and accelerate discharge.
    2. The further roll out of the Virtual Ward service, reducing the Length of Stay for step down patients and delivering the equivalent of 50 acute beds in extra capacity (provided for by 250 virtual ward beds) into the system.
    3. The opening of an additional 64 sub-acute beds as a result of the construction of two modular wards at RSH from December 2023
- The combined impact of these schemes resulted in a small bed surplus from December 2023 through the remainder of the year:

	30/04/2023	31/05/2023	30/06/2023	31/07/2023	31/08/2023	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024	29/02/2024	31/03/2024
NEL core available - 92% occupancy	**590**	**590**	**590**	**590**	**590**	**590**	**590**	**590**	**590**	**590**	**590**	**590**
NEL demand	719	692	710	681	681	678	694	725	710	734	739	706
Unmet demand	9	0	6	13	12	15	27	34	43	36	42	40
Bed Position	**-138**	**-102**	**-127**	**-104**	**-103**	**-103**	**-131**	**-169**	**-164**	**-180**	**-191**	**-156**
21+ day excluding NCTR	1	1	2	3	3	4	5	5	6	6	8	8
14+ day excluding NCTR	0	1	1	1	1	1	2	2	2	2	3	3
Ward processes (medicine)	16	17	15	17	18	20	21	21	19	18	19	18
Ward processes (surgery)	0	0	0	2	3	5	6	7	7	9	9	9
Criteria led discharge (medicine)	0	0	2	3	5	6	7	7	7	7	7	7
SDEC	0	0	0	4	4	4	4	4	4	4	4	4
Revised Bed Position	**-121**	**-83**	**-107**	**-73**	**-68**	**-63**	**-86**	**-122**	**-118**	**-134**	**-140**	**-107**
IDT	10	9	16	15	21	21	26	27	26	26	28	26
Virtual Ward - agreed trajectory	13	13	13	25	25	32	47	48	50	66	71	66
Revised Bed Position	**-98**	**-61**	**-78**	**-33**	**-22**	**-10**	**-14**	**-47**	**-42**	**-41**	**-41**	**-15**
Escalation beds	44	44	44	41	41	41	41	41	0	0	0	0
Impact of modular wards									64	64	64	64
Revised Bed Position	**-54**	**-17**	**-34**	**8**	**19**	**31**	**27**	**-6**	**22**	**23**	**23**	**49**

Figure 1: Bed modelling for initial position for most likely and original case scenario

4.2 Factors affecting 2023/24 System Operating Plan assumptions

A review of the modelling assumptions in October has shown a deterioration in the capacity available within the bed model with four key factors creating a significant bed deficit instead of the bed surplus:

Factor	Impact on bed position
The actual demand profile has shown an increase in attendances and admissions into SaTH with a 7.8% increase in activity resulting in an increase of 2.5% in bed day demand	Increased requirement of 19 beds
A review of the virtual ward service has shown that the anticipated impact on acute beds is significantly lower than planned. For November 2023, the anticipated impact had been the equivalent of 48 extra beds. Due to a combination of a lower utilisation of available capacity and a reduction in the assumed LoS saving within SaTH, this is now likely to deliver 10 beds	A loss of 38 beds capacity
A reduction and delay to the implementation of the sub-acute wards. At the time of the system operational plan, 64 beds were scheduled to come online from December 2023. 46 beds will now be brought on stream from January 2024	A loss of 64 beds in December reducing to a loss of 18 beds for Jan, Feb and Mar
A deterioration in the NCTR position. From April to August, the NCTR position showed sustained improvement, tracking slightly behind trajectory. In September and October, this position has deteriorated, significantly impacting on bed availability	A loss of up to 51 beds

Table 4: Factors driving variation from the 2023/23 System Operating Plan

The impact of these factors has resulted in a most likely scenario for the bed deficit as set out in figure 2 below[1]. The section highlighted in the red box sets out the overall bed deficit position on a monthly basis through the winter period.

[1] Please note this model also includes a small increase in capacity delivered through the additional of the OPAT service and frailty model.

	30/11/2023	31/12/2023	31/01/2024	29/02/2024	31/03/2024
NEL core available - 92% occupancy	**591**	**591**	**591**	**591**	**591**
NEL demand	725	710	734	739	706
Unmet demand	34	43	36	42	40
Increased in year demand	19	19	19	20	19
Additional NCTR patients	47	54	57	64	51
LA discharge capacity impact - no additional impact	0	0	0	0	0
Bed Position	**-233**	**-236**	**-256**	**-273**	**-225**
Internal LOS interventions - best case, 0.5 day LOS reduction	**47**	**47**	**48**	**53**	**51**
21+ day excluding NCTR - best case	*5*	*6*	*6*	*8*	*8*
14+ day excluding NCTR - best case	*2*	*2*	*2*	*3*	*3*
Ward processes (medicine) - pre 5pm discharges - best case	*21*	*19*	*18*	*19*	*18*
Ward processes (surgery) - best case	*7*	*7*	*9*	*9*	*9*
Criteria led discharge (medicine) - weekend discharges - best case	*7*	*7*	*7*	*7*	*7*
SDEC - best case	*4*	*6*	*6*	*6*	*6*
ED audit	0	0	0	0	0
OPAT service	1	1	2	2	3
Frailty model	1	1	2	2	3
Revised Bed Position	**-185**	**-187**	**-203**	**-216**	**-169**
IDT - Shropcomm	27	26	26	28	26
Virtual ward - revised forecast 2 day LOS	10	10	14	14	14
Revised Bed Position	**-148**	**-150**	**-163**	**-175**	**-129**
Escalation beds	42	42	30	38	38
ED escalation spaces	15	15	15	15	15
Modular ward - 46 from Jan			46	46	46
Revised Bed Position	-91	-93	-72	-76	-30
Hospital Full Policy Enacted - In extremis only	49	49	49	49	30
Revised Bed Position	**-42**	**-44**	**-23**	**-27**	**0**

Figure 2: Bed modelling for most likely final bed position

4.3 Further mitigating plans

The following actions are required in order to expand the available bed capacity within the system with all system partners focussing on the delivery of their aspect:

Area	Intervention	Lead partner	Required output	Bed impact
Integrated Discharge Team/ Complex Discharges	Maximise the operational grip on reducing delays to discharge and utilising all available capacity within social care. Reduce the post-NCTR LOS through deployment of Discharge Management Tool into complex discharge pathway management.	SCHT/ NHS STW T&W/ SC SaTH	Deliver R2G[2] list of no more than 61 Gap between R2G and NCTR patients of no more than 21[3]	Improvement of 40 beds Improvement of 30 beds
Virtual Ward	Significant challenges remain with fully deploying the virtual ward service. During November, there has been a	SCHT/ SaTH	Move from most likely scenario of 10 beds to delivering 50%	Improvement of 21 beds

[2] R2G: "Ready to Go" patients. These patients have No Criteria to Reside and have been prepared for discharge. Where the NCTR list is higher than the R2G list, this is where the patient is medically fit for discharge but has not completed all of the non-clinical supporting processes to allow discharge from the acute setting

[3] The combination of a maximum of 62 R2G patients and patients with No Criteria to Reside (NCTR) but not R2G of 21, creates a total list of 82 NCTR patients which is in line with the initial operating plan assumption

	step forward in the number of step-down patients accessing the service from SaTH and this will be the continuous focus of the team		of initial plan (31 beds)	
Criteria to admit/ demand management	There is considerable evidence of patients that attend and are subsequently admitted that do not require acute care.	NHS STW/ SaTH	Reduce increased demand to 2023/24 planned levels	Improvement of 19 beds
Total				**110 beds**

Table 5: Factors driving variation from the 2023/23 System Operating Plan

It is worth noting that the impact of the £1m investment in additional winter schemes (outlined in section 5) has not been included in the potential mitigation. The impact of the winter schemes in 2022/23 will be accounted for in the demand profile as this is based on the actual 2022/23 activity. If the schemes are then included as a potential mitigation, their benefit will be counted twice. Nevertheless, the schemes which are focussing on admissions avoidance will have an impact on 12 hour waits in ED and 4 hour performance and they have been built into the revised trajectory for these measures.

4.4 Securing patient safety

The revised bed model now demonstrates a material bed deficit that represents a significant risk to patient safety. Further work from all system partners demonstrates the opportunity to deliver significant improvements in both expanding capacity and reducing demand (see table 2).

In the event that these are only partially successful, there are two further options that can be deployed to maintain patient safety in the context of a bed deficit:

Use of unconventional care areas

There are a number of areas not included within the bed model that can provide additional capacity for caring for patients. These should not be considered as bed capacity and are not included within the bed model as they will have a negative impact in either the ability to maintain flow (e.g., the use of major's cubicles for delayed DTAs) or quality of care and patient safety.

In certain unconventional care areas (e.g., fit to sit or waiting rooms), the evidence is clear that clinical risk increases with the length of time patients remain in these settings. By accepting the use of this space (as is currently the case), the system is required to accept that risk.

Area	PRH	RSH	Total
Respiratory Investigation Unit	3 trolleys, 3 chairs	4 trolleys, 4 chairs	14 spaces
Use of Majors Cubicles	12 plus 1 side room	14 plus 1 triage room and 2 F2S spaces	30 spaces
Triage	2 adults	2 adults	4 spaces
GP Minors	4 rooms plus eye cubicle	4 trollies, 2 treatment rooms plus eye cubicle	7 spaces
Fit to Sit	8	12	20 spaces
SAU Waiting Room		12	12 spaces
AMA Waiting Room	12	9	21 spaces
TOTAL			**108 spaces**

Table 6: Use of unconventional care areas in SaTH Hospitals

Deployment of Hospital Full Protocol

SaTH have updated the Hospital Full Protocol. The deployment of this protocol can release up to 49 additional beds but would require the cessation of all elective activity including cancer services. The escalation triggers for the deployment of this are included within the protocol

4.5 The role of the UEC Escalation Summit

In October 2023, a UEC Escalation Summit was held to bring together clinical and operational leaders from across all partners within the system. Recognising the bed deficit and the fact that this placed an unbalanced level of risk for patients within SaTH, the purpose of this event was to establish a range of interventions that could more effectively balance the risk across the system. In simple terms, the aim was to reduce the number of patients delayed waiting for ambulance response, delayed waiting outside an Emergency Department, or experiencing significant waits to be transferred from an ED to their next care setting. The summit identified the following potential interventions:

UEC Escalation Summit Interventions
Increasing thresholds for admission and decreasing discharge
Shared workforce across the system (therapies/ pharmacy etc.)
Establish clear triggers for the use of escalation beds (Whitchurch and RJAH)
Establish clear triggers for all actions at each escalation level without requiring exec sign off to maximise time in action
Identify any services that could be temporarily paused to release staff to help secure patient safety and address delays in opening capacity
Review of domiciliary care visits to increase Pathway 1 discharges
Creation of a dashboard for pathway beds split by demand/ capacity to identify what should be commissioned by Local Aurthorities
Movement of elective activity from SATH to RJAH – review process and levels of activity
Consideration of +1 within the Community Hospitals to provide an additional capacity
Formalisation of the transfer to Community Hospital at start of day against known discharges
Determine what activity can be moved from unscheduled care to scheduled care (e.g., use of hot clinics/ redirection tools)
Further maximisation of SDEC for agreed pathways

UEC Escalation Summit Interventions
Further senior review at front door of services e.g., GP / Consultant in ED or SPA
Link MPFT plans and triggers to SaTH's escalation triggers/ actions
Review and change clinical prioritisation to patients waiting for MH beds in ED (versus community)
Strengthen hospital avoidance for dementia
Mental Health Crisis team to avoid escalation to ED (where possible)

Table 7: UEC Escalation Summit Interventions

Further work is required by the leadership of partner organisations to increase the appetite to adopt these interventions. This is being progressed by the NHS Chief Medical Officer and Chief Nursing Officer through the Chairs and CEOs of each organisation. This will not be complete in time for the submission of the Winter Plan through the formal system governance processes.

Successful deployment of a number of these interventions will help reduce the residual bed deficit and will be monitored through the operational leadership team,

05 2023/24 Winter Plan Schemes: Acute

A range of schemes have been developed to expand capacity across social care, primary care, mental health, community services and acute services within NHS STW

5.1 Virtual Ward

The System Operating Plan includes a £4.4m investment in the development of 251 virtual ward beds by the end of 23/24. This was expected to create the equivalent of 66 acute beds[4] within the system bed model through the development of a model of care that provided for:

- **Step Up Care**: To provide access to services in the community that would prevent attendance at a hospital setting, or where a patient attends ED, the patient can be discharged home with the confidence of virtual ward cover, thereby avoiding a hospital admission.
- **Step Down Care**: To provide access to services in the community that allow earlier discharge from the acute setting.

The 2023/24 System Operating Plan sets out the full details of this service.

Significant progress has been made in developing the virtual ward service, but challenges have been experienced in maximising step-down patients into the service which has resulted in a revised capacity assumption as set out in Section 4

5.2 Sub-Acute Ward

Two modular ward facilities have been procured with substantial investment in both revenue and capital to expand the physical bed capacity within the system. The new facilities will be constructed at RSH, but with estate changes related to the Community Diagnostic Centre and Elective Hub, SaTH are able to realise this capacity with additional beds at both PRH and RSH.

The primary need for capacity within the system has been identified as sub-acute care. On this basis, the beds will be run by Shropshire Community Trust to run as sub-acute wards with the intention to deliver 52 additional beds. Due to implementation challenges, this is now likely to be 46 beds delivered from 2nd January 2024 with the final beds to be determined.

5.3 Integrated Discharge Team

A £1.3m investment has been made in the Integrated Discharge Team to expand the capacity for complex discharge pathway management and an increase in therapy capacity in order to ensure timely and appropriate assessments (to improve the process of discharge) and therapy (to reduce the length of stay of patients as a result of improved reablement. This will deliver improvement in capacity of up to 26 beds through a reduction in the number of NCTR patients remaining within SaTH, predominantly through the reduction of post-NCTR length of stay from 5 days to 3.8 days.

[4] Experience of virtual wards in other systems shows that virtual ward capacity does not replace acute demand on a like for like basis. Detailed modelling was based on proposed a likely conversion of 251 virtual ward beds releasing 66 acute beds due to the patient cohort and anticipated Length of Stay savings.

5.4 In-hospital improvement programme

A range of improvements have been progressed through the course of 2023/24 within the in-hospital component of the Urgent & Emergency Care Improvement Programme. The impact of these are set out in the table below (refer to the 2023/24 System Operating Plan for further detail):

Intervention	Expected Impact
14+ Days - Reduce length of stay from current average of 16 day to 13 days to prevent stranded status	Release of the equivalent of 3 beds by the end of 2023/4 through improved use of the weekly stranded patient reviews
21+ Days – Reduce length of stay from current average of 31 Days by 10 days to prevent super stranded status	Release of the equivalent of 3 beds by the end of 2023/4 through improved use of the weekly stranded patient reviews
Ward Processes Medicine & Surgery	Release the equivalent of 27 beds through improved simple and timely discharge processes that reduce LoS and increase timely discharge
Criteria Led Discharge	Release the equivalent of 7 beds through the deployment of criteria led discharge in pilot specialties
Same Day Emergency Care	Prevent inappropriate admissions to ED – through the maximising of activity through SDEC for agreed pathways – release of 6 bed equivalent capacity by March 2023/24
Use of Escalation Beds	A range of escalation areas have been identified within both the initial and revised model that identifies up to 53 additional spaces to contribute to the bed model.

Table 8: Identified interventions and the expected impact by area

06 2023/24 Winter Plan Schemes: Primary Care

General Practice

Demand in General Practice continues at levels significantly above pre-Covid levels. Primary Care in NHS STW has been successful in expanding overall capacity with more appointments being provided than ever before. The Additional Roles Reimbursement scheme and PCN-led services have been crucial to expanding this capacity. A range of services have been developed within primary care to help address the increased pressure that will be experienced in primary care practices.

Pressure point for General Practice	How General Practice will address
Increased winter demand whilst managing the impact of the backlog in elective care	• Practices will provide additional appointments through locum, agency and extension of existing staff hours, 111 directly bookable appointments. • PCNs and Practices will implement their Capacity and Access Improvement Plans.
Business continuity – the relatively small nature of practices means that anything that adversely impacts on staff numbers whether illnesses or	• Access to work from home for most staff. • Clinical remote appointments are now normal practice.

recruitment and retention can severely impact their ability to deliver core services	• Growing number of Additional Roles Reimbursement Scheme (ARRS) Reimbursing PCNs for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners roles and strengthening of clinical team. • Growing number of locums and other clinical staff on the Lantum online booking platform
Rurality; patients being able to access services	• Remote triage and appointments via phone and video. • Use of remote monitoring digital solutions such as Docabo in Care Homes • LA support with cost-of-living grants
Delivery of Flu and Covid vaccinations	• Early planning and ordering for staff and public alongside Flu campaign.

Table 9: GP Pressure Points and Actions to address Pressure Points

NHSE published the GP Access Recovery Plan in May 2023. This puts GP Access recovery on the same national priority status as elective and urgent and emergency care recovery. The aim of the recovery plan is to improve ease of access and patient experience of General Practice. It aims to tackle the 8am rush and to stop patients being told to call back another day. Primary Care Networks have worked with their member practices to establish a baseline on access across a range of national metrics and develop an improvement plan which will be implemented to deliver improved access throughout the winter up to 31st March 2024.

The focus of the recovery work includes recruiting more professionals to practices widening the clinical breadth of the team; expanding the use of alternative digital routes of access, such the NHS App for ordering prescriptions, booking appointments, and accessing information; making more use of digital solutions for consultations and expanding the community pharmacy offer to see more patients for common conditions.

Dentistry

Practices are responsible for their own normal contracted hours other than Mon 25th Dec, Tues 26 Dec and Mon 1st January.

On those days, ICB based services will cover on an Out of Hours basis. STW has the following OOH Dental provision which is given when patient rings the on-call dentist. The hours by area are below:

- Shrewsbury – 0900 – 1200 and 1900 – 2100 Saturday and Sunday
- Telford – 0900 – 1200 Saturday and Sunday.

All Dental Practices have been required to meet minimum standards through the Christmas period where they are planning to open for less than contracted opening hours. Where practices may wish to close early or indeed shut during this period. As a minimum:

- Buddying arrangements must be with an NHS Contracted dental surgery who will provide emergency appointments on your behalf. The practice providing emergency cover should, where possible, be located in close proximity to the contracted practice to ensure that

patients are not inconvenienced by having to travel excessive distances to access alternative dental services.

- A dedicated emergency mobile phone number may be used for patients to access emergency care and/or advice during normal in hours.
- Answer phones must be updated to reflect the arrangements and notification of changes should be clearly displayed on the door of the practice at least 4 weeks prior to Christmas so people with active courses of treatment are forewarned. Practice websites must also be updated.
- A practice must not state that it will be closed with no alternative arrangement in place. It must not redirect patients to the Out of Hours service during contracted hours, nor refer patients to NHS 111. To do so would be considered a breach of its contract
- A practice should ensure that arrangements for cover do not disadvantage patients that are undergoing an open course of treatment (i.e., through patient charges).

In order that we are prepared for any patients contacting 111, established Dental Advice Lines or the NHS England Customer Call Centre, we require practices to complete a Microsoft Form to advise us of the practice in hours provision and opening hours during the Christmas and New Year period by Mid-November 2023.

Community Pharmacy

Every year the Community Pharmacy Commissioning Team reviews the feedback from the bank holiday arrangements in the previous year to identify any required changes and then agrees a Bank Holiday rota to ensure that there is appropriate access to pharmacies over the festive period across both counties. The team works closely with LOCs on the rota, which applies to the Bank Holidays only, and all other days are normal working days.

Any requests to close early on Christmas Eve/New Years eve are dealt with as per the Regulations and depends on whether they are applying to amend their Core Hours or giving notification of a change to their Supplementary Hours.

Once the rota has been finalised, it will be shared in advance of to the start of the festive period with the ICB Communications Teams and all other stakeholders. This includes NHS England and the ICB for publication on their websites. Out of Hours providers, NHS111 and the Directory of Services, and LPCs. Plans will be to complete this by the end of November 2023

07 2023/24 Winter Plan Approach: Community Services

Minor Injury Units

As part of the systems review of capacity for the Minor Injuries Units (MIU), SCHT will make available further 111 directly bookable appointment slots to enable the 111 providers to directly book patients into the MIU increasing patients diverted away from the Emergency Departments. The STW communications strategy for 2023/24 further emphasis and signposting information will be readily available to support members of the public to access MIU's in preference to our Emergency Departments.

The community team will continue to ensure full operational and geographical coverage with a minimum of 7 days a week and 08.00-20.00 operating times, working with the ambulance service and Shrop Doc's single point of access to communicate and pro-actively divert patients to

alternative community pathways targeting particularly category 3 /4 calls and primary care referrals to safely be redirected to UCR community pathways.

Rapid Response

The Rapid Response Service is a multi-disciplinary team that responds within 2 hours to support people with an urgent need to remain well and recover in their usual place of residence. The model promotes a Home First approach and focuses on early intervention and timely discharge. Integration with Virtual wards to safely continue to monitor patients beyond their 72 hours initial intervention will be vital this winter to prevent readmission and support patients to remain safe and well at home.

Additional care home support

Through our Virtual ward workforce, two nurses will be aligned as additional immediate admission avoidance capacity to the care home MDT team. Integration between the virtual ward team and care home team provides opportunity for local care homes to access to advanced clinical decision-making to support (where appropriate) alternative options to an admission to hospitals.

Provide a falls response service

Additional equipment was provided last year and will continue to be utilised by Rapid Response teams to build a responsive community-based falls service working closely with our ambulance partners to support people who have fallen at home including care homes but do not require conversion to a hospital setting. By aligning this pathway with Rapid response, we have built a 72-hour support system around these patients post a fall and if required can provide further follow up on the virtual ward pathway. The service has been enhanced this year with the support of the Winter Falls scheme (appendix two section 4.13.16).

08 2023/24 Winter Plan Approach: Mental Health Services

There are a range of schemes that will be delivered across the Shropshire Telford and Wrekin ICB over the winter period, all of which will contribute to the overall resilience of the system. For children and adults experiencing mental ill health:

- 24/7, all-age mental health telephone helpline. Delivered by Midlands Partnership Foundation Trust (MPFT). MPFT coms will ensure that the profile of this service is further raised in time for and during the winter season.
- NHS 111 'select MH option'. MPFT will be working with system partners to ensure that the soft launch of a new mental health crisis option for NHS 111 callers is in place over the winter period, commencing 1st December 2023
- Hospital Avoidance Team for older adults with co-morbid frailty and dementia. MPFT deliver this service 7 days per week, focussing on supporting Care Homes to manage the mental health of their residents to avoid transfer and admission to our local acute and mental health hospital. This service will see a further temporary uplift in capacity between December and April to manage winter demand.

- Rough sleeper team. MPFT will again be working with system partners to proactively deliver health and social care interventions to the homeless/rough-sleeping community to reduce demand on the urgent/emergency care system.
- Housing and debt advice services. People with Severe Mental Illness (SMI), both in community settings and in mental health hospital, can take advantage of schemes to access advice via MPFT through subcontracted provision from Landau and Stafford and Cannock League of Hospital Friends respectively.
- BEAM drop in. The extended hours drop in provision provided by The Children's Society for children and young people with emotional and mental health conditions will continue to operate again this winter.

For people delivering mental health services:

- Seasonal vaccination programme. MPFT will continue to deliver its ambitious flu and covid vaccination programme to ensure that fewer of its staff become ill over the winter period, thereby maintaining the level of mental health support and intervention available.
- Health and Wellbeing Hub and resources. MPFT have a range of health and wellbeing resources available to its staff throughout the year which support the maintenance of good mental and physical health. Again, this helps ensure fewer absences and maintains the level of mental health support and intervention available.
- Since last winter MPFT has appointed Mental Health Practitioners within the Primary Care Networks. These roles are integral to the multi-disciplinary team who will support people presenting with mental health problems to achieve overall wellbeing.

09 The Roberts Jones and Agnes Hunt Orthopaedic Hospital (RJAH)

There is agreement to support the transfer of elective activity from SATH to RJAH which will ensure continuity of elective orthopaedics over the winter period. Detailed plans are being developed to support this.

10 2023/24 Winter Plan Approach: Social Care

he system needs to have the right level of preventative support within local communities in order to meet needs without the need for acute hospital interventions, resources to plan and support complex discharges and work in partnership to ensure continued system flow out of the acute and community hospitals. Both councils have a centralised Brokerage team who understand the market capacity, source domiciliary care and care home placements. This enables social workers to carry out more assessments, MDT and reviews that support discharge planning. The Brokerage teams also source care home placements and domiciliary care provision for identified CHC, Fast Track and NHS funded care. This also helps clinical staff to complete more assessments. Social workers are on site at the hospitals supporting the integrated discharge process to enable swifter discharge.

There is on-going work to support the care market to ensure continued capacity, sustainability and high-quality provision. There will be specific work with ICS colleagues and specified care homes to manage safe discharges and support them to manage IPC outbreaks, reducing the risk for hospital admissions and to address any workforce issues across the system and targeting areas of high risk such as the domiciliary care and care home sector.

Telford & Wrekin Council

Prevention

Enabling people to stay well and independent at home for longer has increased importance through the winter period. There are increased risk due to covid19, influenza, cold and bad weather. Preventative services target reducing inequalities, promoting healthier lifestyles; self - directed and early help.

These include:

- Healthy Lifestyles Hubs
- Social Prescribers offering range of support for long term conditions by linking into local communities.
- Care and Community Navigators to support and signpost to support groups within local communities.
- Voluntary Community Sector offering range of community support in local communities' access directly or through voluntary organisations or statutory services including support for those in food poverty and welfare benefits advice.
- Housing related support for vulnerable groups including homeless and tenancy support.
- Housing related support and older people within tenancies including Trusted Assessors for equipment and minor adaptations.
- Digital Hub for virtual calls for assessment or support
- OT assessments for equipment and adaptions at home, Carer Moving and Handling assessments.

Information and Advice

Telford and Wrekin Council offers a range of options for self-help and information and advice from community services:

- Accessible information and Advice through Live Well Telford for self -directed support.
- Accessible Information Advice and Advocacy from the Well-Being Independence partnership first point of contact for information and early help including Trusted Assessors for equipment.
- Direct access the Independent Living Centre - a town centre location - that offers to Access to information and advice, Assistive Technologies including community alarms, predictive technologies; Early Help and OT assessments for aids and adaptations

Technology

A sensory based falls technology pilot will continue to be implemented to reduce calls and reduce the level of 1: 1 care that is provided to maintain safety. A Telford care home will have the technology for 12 months. The systems will profile behaviours and habits and will therefore be a preventative measure as well as detection as they will be able to see when people's habits change which may indicate a deterioration in health leading to hospital admission or medical intervention.

The implementation of Digital Social care records within the care provider market to support care delivery and data management. The data can be used to profile behaviours, habits and used as a preventative measure to highlight changes in health, especially deterioration resulting in A&E visit and subsequent hospital admission.

Market sustainability

The Council is utilising The Market Sustainability and Improvement Fund (MSIF) Workforce Fund to meet the increasing fee requests from providers which are above the Councils set budget in order to maintain stability of the care market. Commissioning of such services will support safe and timely discharge thus freeing up hospital beds.

Integrated with system planning

Telford and Wrekin Council will continue to support key Urgent Care programmes across the winter identified by DHSC visits and updated urgent care priorities related to discharge:

- Falls prevention, funded through Winter monies.
- Social Workers within the integrated Rapid Response Team Further development of the Integrated Discharge Team approach to reduce length of stay and promoting Home First
- Supporting hospital flow programmes including attending ward and board rounds,
- Support utilisation of Admission Avoidance and Virtual ward to maximise interventions to reduce need for care in hospital (step up or step down), continuing to support with assessment and facilitate alternatives to admission.
- Review of utilisation of Intermediate Care beds and care at home hours against predictions during winter surges in order to maintain timely discharges.

Shropshire Council

Reablement - START

Shropshire councils in-house reablement provision START has been successful in recruitment and retention. The START team now have a bank of staff they can utilise to support surge demand and or high periods of sickness to improve resilience throughout the year and in particular the winter period. The team are working as part of a wider reablement review which has resulted in actions to streamline processes cross teams to enable swifter action and response; these actions will support the upcoming winter pressures.

ICS

ICS is part of the integrated discharge system for hospitals. ICS have increased MDT working within the IDT and are engaged with SaTH and Shrop Comm to improve practices which will result in decreased LOS and improved discharge numbers. There are clear trajectories showing measurable performance improvements. ICS will continue to develop with all partners to improve this position as the winter progresses.

Prevention

Cost of living: Across Shropshire a Task Force will continue to support people on the rising cost of living and its social impact locally. The forum provides an opportunity to bring a range of stakeholders together to share their knowledge of the impact and support available for our population and communities. The Task Force continues to meet monthly to look at gaps and further actions stakeholders can take jointly within Shropshire to support our residents struggling with the cost-of-living increases, with a focus on ensuring that the most vulnerable in our community are supported.

Information and Advice

Shropshire Choices Support Finder | Care Choices is promoted across all staff to ensure they are aware of how they can sign post people to services within their own communities.

Technology

Shropshire council is investing in additional technology solutions to support people to live independently; this includes a newly launched Virtual Care Delivery (VCD) to reduce the need for physical visits ensuring resources can be targeted where they are needed the most. This will not only reduce the need for workforce and to travel but it will also support people to maintain and improve their independence.

Assistive Technology is being continuing to be explored for all discharges, with recent project piloted in START for the use of Genie, this is a robot that can be configured to suit individuals needs including live monitoring and dashboard reporting, with many capabilities such as; prompting & scheduling.

Staff briefings have taken place providing Officers with the opportunity to look at alternative and or complimentary equipment available to support people wellbeing and independence as well as an understanding of the available community assets.

Carers

Carers are essential individuals across our communities, whilst they support others; they too also need to be supported to stay well. The work of the Carer Support team is integral to this and assists with admission avoidance and discharge from hospital by:

- Identifying and providing relevant information and support to reduce carer breakdown, which may lead to avoidable hospital admission.
- Regular contact with carers to check on their wellbeing - helping to prevent crisis developing and ensure carers needs are met.
- Raising awareness of carers throughout the sector so that no 'wrong front door' exists and carers get the support needed when they need it.

The Hospital Carer Support practitioner (HCSP), within the team, facilitates discharges – ensuring carers are aware of what to expect on discharge and where to contact if any concerns arise once home, so preventing escalation and readmittance to hospital.

The carers support team raises awareness of carers with teams within secondary care and provides information and support to the carers of their patients to help prevent the admission to hospital through carer breakdown.

11 2023/24 Winter Plan Approach: System Wide Resources

11.1 System Control Centre

The purpose of the Shropshire Telford & Wrekin System Control Centre (SCC) is to ensure the safest and highest quality of care possible for the population, balancing the clinical risk within and across the ICS system - acute, community, mental health, primary care, and social care services. Led by senior operational and clinical leaders harnessing the power of our Integrated Care System (ICS), SCC will ensure a consistent and collective approach to managing system demand and capacity as well as the mitigation of risks. The Strategic Control Centre (SCC) will maintain oversight of the systems flow of activity into and out of the Acute. SCC will provide insight and intelligence to system partners and NHSE colleagues and support the system with unfolding operational challenges and risk mitigation.

As part of their role, SCC's will be responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the SCC at each stage.

The SCC Operates from 8:00am to 20:00pm Monday – Friday and will be extend to 7 days a week from 1st November 2023 8:00am to 20:00pm Monday to Sunday.
During the designated hours of 08:00am to 20:00pm, SCC is responsible for ensuring that the potential and actual operational pressures across the system are identified early and to ensure that partners can proactively prevent the escalation of those pressures through effective collaboration.

Utilising as near to real time data in keys areas of our collective operation the SCC provides a pivotal role in horizon scanning, identifying trends and the ability to see where capacity exists or is challenged across the system. The ability to influence and connect the partner providers to understand and alleviate those pressures is fundamental to their role.

It is recognised and accepted that our provider partners are in themselves independent organisations with their own structures, governance, and operating models in place. The SCC should not be interpreted as having the authority to, nor should there be expectation placed upon them to make decisions on behalf of our providers. The role is clearly defined as bringing partners together, informing using the real time data and advising on the potential mitigations for agreement and enactment.

Horizontal and vertical communication with system partners and NHS England is a mainstay of the role and it should be seen as the conduit between all parties helping to manage patient flow, the management and sharing of risk, coordinating actions, and ensuring timely and appropriate reporting and escalations are made where required.

Upon declaration of a system wide critical or major incident the SCC will undertake the role of Tactical Commander for STW ICB and will be empowered to make decisions on behalf of STW ICB internally at such level. Where required or advisable to do so, the SCC should be supported by the on call ICB Tactical or Strategic Commander to resolve or deescalate incidents declared quickly.

11.2 Single Point of Access/Care Coordination Centre
£0.4m of additional funding has been provided by NHS STW to continue the winter provision of the Care Co-ordination Centre and Single Point of Access (CCC/SPA) provided by Shropdoc. The service is the Point of Access to help and support all healthcare professionals to arrange urgent/same day/next day referrals reducing the reliance on Emergency Departments. Using a Trusted Assessor Model, the service will ensure that our patients receive the right care, in the right place, at the right time, effectively managing patients in a community setting 7 days a week, 365 days a year, preventing avoidable hospital admissions/attendances. The service consistently achieves a non-ED conveyance rate of 93% and above using alternative pathways.

As one of the key workstreams outlined in the UEC Improvement Plan 2023/24, partners are working collaboratively to expand the current 40 alternative pathways in use to ensure patients are seen and treated in the right healthcare setting first time, other than our emergency departments.

CCC/SPA will continue to work with West Midlands Ambulance to review the ambulance stack of calls twice a day with the Urgent community Response Team to identify further cases that are deemed clinically appropriate for an alternative pathway other than ED.

CCC/SPA are looking to implement the "Call Before You Covey" principle with West Midlands Ambulance. The focus will be on the age 75 and over cohort. The work is being led by NHSE colleagues in the region with an implementation start date predicted to be in late November 23.

11.3 Winter Schemes 2023/24

The ICB has successfully awarded winter monies to a number of schemes to support the system through the winter period. The schemes were prioritised based on those able to make the biggest impact in supporting our patients and the system this year until the end of March 2024.

- Additional Discharge Vehicles (NEPTS)
- Mental Health: targeted rapid intervention to patients over 65 (MPFT)
- Communications
- British Red Cross: 72 hour and 6-week home support programme including a focus link with aging well.
- Voluntary Sector; staying well this winter, supporting social prescribing.
- Falls (hospital avoidance): combined SCHT Social Care and Fire Service.
- SPA and Clinical Co-ordination

For Detail of the Winter Schemes, please see Appendix Two.

12 Vaccination / Immunisations

COVID-19 Vaccination Programme Introduction

Delivering a sustainable COVID-19 vaccination programme, is an essential mainstay of health prevention. We will make vaccination services accessible to all eligible groups, including those affected by health inequalities by:

- Ensuring we have a skilled and competent workforce to deliver the programmes safely
- Develop a vaccination offer that provides convenience and ease of access across the system. This will include outreach sessions and focused work that addresses inequalities and harder to reach communities.
- Develop contingency plans for periods of surged activity (for example new COVID-19 variant response)
- Develop a coordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and that Makes Every Contact Count (MECC) by incorporating appropriate health advice/screening in line with the NHS Core20PLUS5 approach.

Covid-19 Vaccination Programme Planning

The following groups of people will be eligible for an Autumn Booster according to the current JCVI Guidance (as of September 2023):

- Residents in a care home for older adults
- All adults aged 65 years and over.
- Persons aged 6 months to 64 years in a clinical risk group, as laid out in the Immunisation Green Book, COVID-19 Chapter (Green Book)
- Frontline health and social care workers
- Persons aged 12 to 64 years who are household contacts (as defined in the Green Book) of people with immunosuppression.
- Persons aged 16 to 64 years who are carers (as defined in the Green Book) and staff working in care homes for older adults.

The JCVI also advises primary course vaccination for individuals in the above cohorts who have not had any previous doses should be offered. They should receive a single dose of COVID-19 vaccine during the campaign period.

Following the JCVI guidance, STW have identified 239,905 individuals who would be eligible for a booster vaccination within our system.

On 30 August 2023 NHS England informed systems that a decision had been made to accelerate the campaign timings due to risk from a new COVID-19 variant, with a new start date of 11 September 2023 through to 15 December 2023. Systems are required to prioritise care home residents, housebound and the immunosuppressed patients. Activities to address vaccine health inequalities will continue, until 31 January 2024.

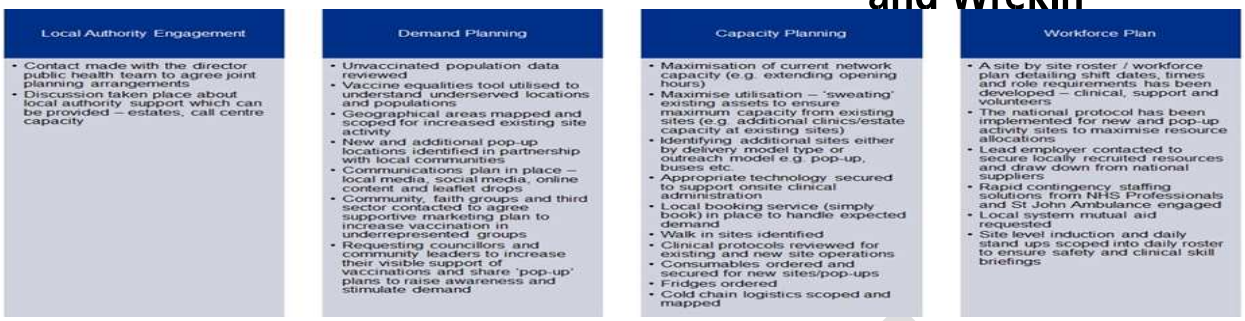
STW will use a blend of providers; PCNs, Community Pharmacies, and Shropshire Community Health NHS Trust (SCHT) located across the county. Pop-up clinics and roving teams will also be utilised by the programme to ensure we maximise potential to reach our eligible cohorts. Our COVID-19 Vaccination sites will offer both booked and walk-in appointments. We will have a total of 39 static sites delivering COVID-19 Vaccinations to all eligible groups.

The programme is forecasting to deliver 142,844 booster vaccinations to the eligible cohort. This assumes an overall programme uptake performance of 60%. The total planned capacity across the system to deliver vaccinations and achieve our uptake target is 186,900.

COVID-19 Vaccination Surge Planning

The COVID-19 Vaccination programme has developed a surge plan to be implemented in the event of a National Directive (figure 4).

The COVID-19 Vaccination Programme team will work closely with system partners to ensure that during periods of surge the system is supported both in the response to COVID-19 Infection and increasing demand for COVID-19 Vaccinations. As a system our aim is to manage our response appropriately while minimising impact on our elective care activity.



Monitoring and Modelling Infection

Rates of infection are actively tracked utilising national and local intelligence to pre plan and if needed pro-actively implement cohorting plans in our hospitals to keep our staff and patients safe. Extra vigilance in this area will continue throughout this winter so that if needed we can be responsive to any emergence of new variants in relation to Covid. Modelling is therefore an essential activity at both a national, regional, and local level that enables decisions to be made about service capacity and the best use of our skilled staff. SCHT do attend a system weekly demand and capacity modelling group to support with seasonal planning in both the elective and non-elective arena's, there is regular senior representation from The Trust to feedback into operational planning and preparing for potential predictable patterns in system surge.

Seasonal Influenza

Alongside the COVID-19 vaccination programme our healthcare teams are delivering the seasonal influenza (flu) vaccination programme as a preventive measure for at risk groups (e.g. people with clinical conditions) and for our health and social care workforce. Our Childrens Immunisation team are also delivering a robust plan working with parents, children and young people to maximise uptake of childhood and flu vaccinations as part of winter preparedness. Measles is a highly contagious, serious airborne disease caused by a virus that can lead to severe complications. After a period of very low rates, measles is rising again in the UK. The most effective action is preventing measles through vaccination, which is highly effective through the MMR vaccination. Therefore, in line with national guidance, public health teams in Shropshire Telford and Wrekin are looking to see how they support communities with increasing childhood vaccination rates. Occupational Health Teams in NHS Trusts are ensuring that clinically facing healthcare staff are offered the vaccination as part of their ongoing health assessment, and work has commenced on ensuring there is a pathway for any suspected cases to identify contacts and offer treatment to those who are especially vulnerable to prevent severe disease.

13 Emergency Planning

Flooding

Winter flooding preparedness and resilience we are working closely with colleagues across the council and the Environment Agency to ensure that our action plans for times of flooding are joined up with, and part of the wider response. Shropshire has experienced significant flooding for the past 2 years and we now have a well-developed approach to mapping the locations of potentially vulnerable people using forecasting data and contacting them to check their own preparation plans and any support needs they have.

14 Workforce Wellbeing

Supporting the well-being of the workforce health and social care staff; they are being encouraged to have a Covid and flu vaccination and ASC staff have been issued with flu vouchers to facilitate this. There continues to be a range of wellbeing services on offer to council staff to support their health and wellbeing. Resilience and wellbeing of the workforce continues to be a priority in preparing for winter pressures. A Health and Wellbeing Hub and resources. MPFT have a range of health and wellbeing resources available to its staff throughout the year which support the maintenance of good mental and physical health. Again, this helps ensure fewer absences and maintains the level of mental health support and intervention available, which will run until March 2024.

15 Infection Prevention and Control

- E-education rolled out across all care homes including care home managers outbreak training.
- Arrangement with primary care out-of-hours provider to prescribe flu prophylaxis to those meeting the clinical requirements.
- Care home IPC support including local outbreak management provided by the health protection hubs, support and a prompt re-opening review process supported by a system supported SOP.
- ICS wide IPC group to share best practice, standardise approaches to guidance implementation, learn from outbreaks and monitor infection rates.
- Assurance given from all NHS providers on ventilation policies.
- Care home bulletins sent fortnightly include reminders on outbreak messages, identification and control.
- The Virtual Ward working with the Care Home Team supports admission avoidance of those with infectious conditions to prevent further spread in the hospital environment where possible.
- ICB engagement in outbreak meetings across the system.
- Provider local policies and processes are in place to maintain safe respiratory pathways and prevent the spread of infection and winter 24/25
- IPC advice provided through central email address 8-6 pm and out of hours via UKHSA.

16 Workforce

ICS Workforce Strategy is a year around approach to developing and enhancing our workforce. This will be supplemented by targeted staffing enhancement across our providers and partners in line with the detailed plans set out within this winter plan document.

17 Elective Care

Elective Recovery

The impact of Covid 19 on access to health and social care services is well documented. Although there has been very concerning impact on access to urgent care and cancer services, it also had a significant impact on the delivery of elective care services and, as a result, on the lives of many patients who are being referred for or already waiting for treatment, with deterioration of many patients on those waiting lists becoming more urgent in nature.

To help enable speedy recovery of full services, reduce waiting lists and waiting times, and improve timely access to services and treatment for patients, the combined health system agreed a 3-year plan in alignment with the NHS England Long Term Plan.

There is also a risk to elective care over the winter in that urgent care pressure takes priority which results in elective activity getting suspended and clinical and operational colleagues being diverted to support with dealing with these pressures. This usually then compromises progress of some of the elective care transformation work that has to be paused to release staff to focus on service delivery.

Throughout this 2023/24 Winter period our three main hospitals within the system, two acute sites and the specialist orthopaedic hospital, will aim to continue to provide elective surgery and appointments where possible to minimise any potential impact on waiting lists.
The system will continue to make use where possible and appropriate of the independent sector capacity both in and out of area (due to the limited capacity within the local system) as well as mutual aid provision through agreement with other NHS providers.

All three main providers will also continue to focus on Outpatient transformation with ongoing increased focus on optimising the use of virtual appointments, advice & guidance, patient initiated follow ups, one stop clinics, remote reviews, and validation of waiting lists to maintain activity levels when capacity is constrained.

There will be an increased promotion of self-care and pharmacy support for certain conditions and symptoms, as well as the “My planned care” app to ensure patients are kept informed of the status of their pathway.

There is a broad elective recovery programme which can be reviewed within the system operating plan. This approach built around significant operational oversight and scrutiny will be maintained.

Protecting Elective Activity

RJAH

Theatre capacity will be provided where possible to Shrewsbury and Telford Hospitals (SATH) by Robert Jones and Agnes Hunt (RJAH). This will be facilitated by identifying theatre capacity through the 6-4-2 theatre scheduling process within RJAH and identifying workforce requirements to deliver elective orthopaedic surgery at RJAH depending on workforce gaps in each provider. Where there is workforce gaps each provider will consider utilising the system workforce sharing agreement already in place in order to share (provider to provider) the workforce to deliver elective inpatient orthopaedics.

A manual process is in place to ensure that those patients waiting the longest or have a high priority rating will be scheduled equitably across the system. The focus for listing patients will be within those patients requiring arthroplasty surgery (Hips and Knees) and excludes day surgery procedures in advance of the planned single PTL. Any inpatient activity delivered at RJAH will be counted as activity at RJAH.

Mutual aid winter elective capacity process

Elective Hub

A £24 million capital investment was secured in November 2022 to create an Elective Surgical Hub (EH) on the Princess Royal site. The unit is expected to be completed and open to patients in early January 2024 and will provide a total of 20 additional trolleys and 4 new state-of the-art theatres. Two of these are additional and the other two will replace theatres in the current Day Surgery Unit. The Elective Hub will provide ringfenced capacity for elective surgery and will be protected from urgent care pressures all through the year during frequent periods of high escalation and particularly through the winter period. The investment includes patient recovery spaces and associated administrative accommodation which is expected to open in November 2023. The unit will enable us to carry out an additional 1800 elective cases in 2023/24

STW Community Diagnostic Centre (CDC)

A £10.15 million capital investment secured in November 2022 to create a STW Community Diagnostic Centre at Hollinswood House, which is located in Telford. SaTH has been commissioned by STW to deliver the CDC and the unit will be delivered in 3 phases. Phase 1 will open to patients on 2nd October 2023 and will provide additional diagnostic capacity for STW patients in phlebotomy, plain x-ray, non-obstetric ultrasound, and CT. Phase 2 will provide MRI and phase 3 will provide cardio-respiratory testing and tele-dermatology.

The opening of the CDC means that many patients will no longer need to attend the acute hospital sites for their diagnostic appointments, releasing capacity for developing one-stop services and opening opportunities to implement 'straight to test' as part of agreed clinical pathways.

18 Communications and Engagement

Through UEC Team Winter Funding there is a specific communication for the Winter period which will be around **Think Which Service (STW ICB)**

The 'Think Which Service' campaign, will drill down into four pillars.

The aim of the STW winter comms campaign will be:

- To empower the citizens of Shropshire, Telford and Wrekin to keep well this winter.
- Ensure our health and social care system runs as smoothly as possible.
- Reducing ambulance handover delays

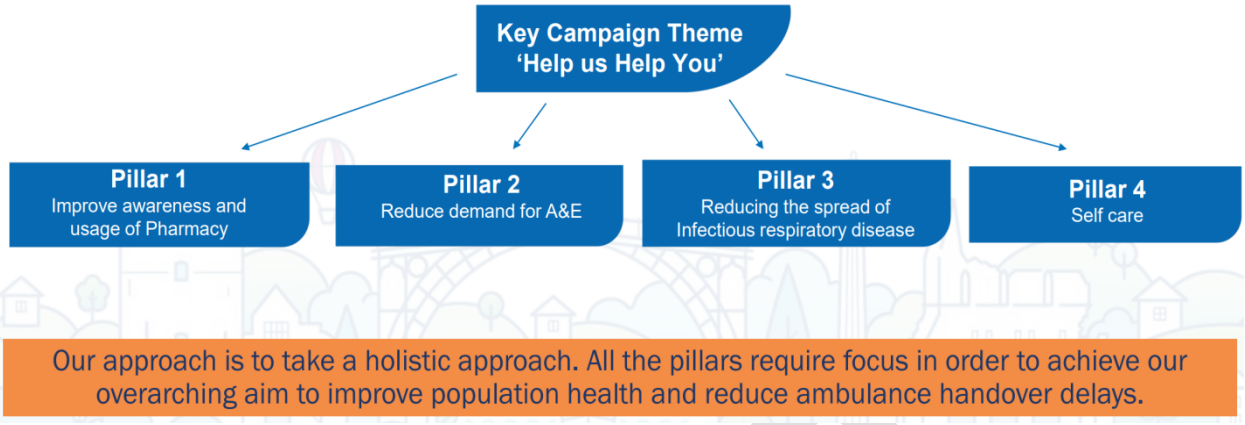


Figure 3: Overarching winter comms campaign and pillars

For the detailed plan, please see Appendix Three.

19 Risk Analysis

The system has identified a number of risks to the delivery of the winter plan, and these are outlined in table three.

Table 10: Risk summary

Risk Description	**Mitigating actions**
The winter schemes implemented could address unmet need which would mean that the expected impact was not achieved	Work with project leads to identify key measures and milestones for monitoring. Closely monitor winter schemes to identify if they are addressing the expected cohorts.
The system may not be able to change the established behaviours of its workforce	Use the clinical leadership within the system to drive change. Comms and engagement with key stakeholders to ensure workforce is informed and involved. Clinically led Risk Summitt.
The system may not be able to change the established behaviours of patients and the general population	Comms and engagement with our population. For further details please refer to section 9.
The system may not be able to recruit to the required posts which could affect the ability to deliver the expected changes	Implement workforce plan in relation to recruitment. For further details please refer to section 7. Senior oversight of the utilisation of bank and agency staff.
The system may have to rely on agency staffing which will be more costly than planned	Implement workforce plan. Ongoing monitoring of use of agency staffing. For further details please refer to section 7.
The system may destabilise another area with its recruitment to additional posts by creating an internal market	Implement workforce plan in relation to recruitment. For further details please refer to section 7.
The system may not be able to manage competing priorities e.g., additional Covid-19 waves, industrial action	Regular monitoring of demand and review of plans
The inconsistency in relation to 7 days working across the system may affect the ability to manage out of hours discharge	Regular monitoring of impact at weekends. Planning discharges early to mitigate impact of weekend discharges. 7-day SCC oversight from Nov 1st
There may be an expected bed gap may not be able to be bridged	Interventions detailed throughout the operational and winter plan. For further details please refer to section 4.

Risk Description	**Mitigating actions**
The system may not be able to effectively manage walk in demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of walk-in demand for urgent and emergency care. For further details please refer to section 4.
The system may not be able to effectively manage admitted demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of ambulance and prebooked demand. For further details please refer to section 4.
The impact of infections, e.g. Covid-19 or influenza, may be underestimated which could destabilise the system	Modelling of impact and projections to be monitored for early warning.
The impact of unexpected severe seasonal weather on the system ability to deliver services	Business continuity plans
The system may not be able to effectively deal with the conflict between dealing with system recovery and the winter demand	Ongoing monitoring of elective recovery and winter demand. For further details of interventions relating to elective recovery please refer to section 8. Review of risk to elective position through clinical risk summit
The system may not be able to identify the capacity for EMI to meet the demand	Quantified as part of demand and capacity modelling. Winter scheme to support elderly patients within the community via a rapid response model.
The system may not be able to manage the specific workforce constraints within theatres and radiology	Plans in place to manage specific workforce constraints within theatres and radiology
The impact of the market issues relating to domiciliary care may restrict flow out of hospital or reduce the number of patients able to be discharged home	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
The impact of market issues relating to community bed based care may restrict flow out of hospital	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
Capacity in people team to develop plans	Work with System Planning and Performance Group to identify resource requirements in relation to planning
Independent sector capacity is not at sufficient scale to mitigate gap in NHS capacity	Ongoing monitoring of independent sector capacity. Maximise use of available independent sector capacity. Explore mutual aid arrangements.

A full risk register with mitigating actions will be developed to coincide with the move into the implementation stage which will be owned by the System Planning and Performance Group.

Appendix One: Engagement activities

Engagement	Impact
Winter planning workshop held in July with representation from health and social care	Launched process for winter proposals. Identified areas of focus for winter planning Information from breakout sessions fed into demand and capacity work and winter plan.
Non-elective demand and capacity group with representation from health and social care	Demand and capacity information used to frame winter plan. Identification of assumptions and known interventions
Head of Planning and System Operations - Vaccination Services Directorate	Covid vaccination information for winter plan
Director of Communications and Engagement (ICB)	Communications winter planning summary for the winter plan
Head of Elective Care and Transformation (ICB)	Elective care section of the winter plan
Associate Director of Primary Care (ICB)	Primary care section of the winter plan
Deputy Chief Operating Officer (SCHT)	Local Care Programme impact for winter plan
Assistant Director of Joint Commissioning (Shropshire Council) and Service Delivery Manager: Hospital and Discharge and Better Care Fund (Telford and Wrekin Council)	Social care section for winter plan
Interim Deputy Chief Operating Officer (SaTH)	Discharge Alliance Plan for inclusion in the acute interventions section of the winter plan
Centre Manager, Patient Access, Theatres, Anaesthetics and Critical Care (SaTH)	Critical care section of the winter plan
Head of Operations (MPFT)	Mental health section of the winter plan
Head of Specialist Unit with Operational Responsibility for MCSI, peri-operative service and Care of the Elderly)	Surge plan section of the winter plan
Interim Deputy Chief Operating Officer (SaTH)	Finalising acute bed modelling used to frame winter plan
Deputy Director of Nursing and Quality	Infection, Prevention and Control
Deputy Director – Mental Health, Learning Disabilities and Autism, Children and Young People	CHC Winter Plans
Urgent and Emergency Care Team	Winter Schemes 23/24 shared at the UEC Operational Group October 23
Urgent and Emergency Care Team	Shared Draft Winter Narrative Plan with planning leads

Appendix Two: Winter Schemes

2.1 EMED – Third Party Non-Emergency patient transport discharge 2 crews.

EMED to provide 2 additional Third-Party ambulance crews for patient transport, the crews are for discharges only.

1 crew started from the 3rd of October 2023 to the11th of October and then increasing to 2 crews from the 12th of October to 31st of March 2024.

The crews are a Monday to Friday service.

1 of the 2 crews will be Bariatric enabled and both crews will carry scoop stretchers.

Reporting will be on a Monday of each week and a subsequent collation of the weekly reports provided on a 4 weekly basis.

2.2 Hospital Avoidance Team (MPFT)

The scheme funding is to provide 2 additional staff to support the current Hospital avoidance service. There would be 2 staff (Band 6) and they would provide 08.00-20.00 assessment and treatment to older people with mental health problems following referrals from ED/SPA/ GP /WMAS /and SaTH. Interventions are focused on maintaining people in their own home/care environments and on facilitating early discharge from hospital.

The scheme is starting the 1st of November 2023 to the 31st March 2024 (5 months). 1 Band 6 in place from the 1st of November and current staff doing over time. 2 weekly monitoring to be provided by MPFT.

2.3 Hospital Discharge Assistance (British Red Cross)

The scheme is for Royal Shrewsbury Hospital, Princess Royal Hospital and Virtual Ward and will incorporate transport for mobile able patients.

Service	Service description	Indicative monthly target	Operational hours
Assisted Discharge (ADS)	Support with discharge from hospital and VW(including transport or transport support) safe and well check and support, signposting and supported referrals, including home risk assessment 72 hours of support maximum	50	Operating eight-hour shifts five days per week (assumes Monday-Friday), can be flexible to follow discharge pattern

The service will support elderly and vulnerable patients and will provide initial support for up to 72 hours, to help people settle back in at home and ensure their safety. Opportunity for 6 weeks program of support as required. This is for Pathway 0 and Pathway 1 Patients and can support RSH, PRH and Virtual Ward Patients. This will also incorporate patient transport.

There will be 2 Support Workers and 1 Co-Ordinator on each site.

Commencing 13th November 2023 to 31st March 2024.

2.4 Communication – Think Which Service (STW ICB)

The 'Think Which Service' campaign, will drill down into four pillars:

1. Reduce demand for A&E (promote MIUs and NHS 111 online)

2. Improve awareness and usage of pharmacy

3. Reduce the spread of infectious respiratory disease (e.g. encourage people to take the Covid & Flu vaccination)

4. Promote self-care.

The integrated PR and marketing campaign will target key audiences, using channels most appropriate for the audience.

Channels include PR, targeted social media adverts, videos featuring health professionals, posters, OOH adverts, targeted leaflet drop, ad vans, podcasts, and radio adverts. For more information see appendix 3.

2.5 Voluntary Services - Support for residents, supporting good health and wellbeing.

Linked to falls response and night-time response with signposting and referral offer. The VCS partners outlined above (WIPS / BRC / Shropshire MH Support) along with our Customer Service Centre colleagues and RJAH will work in partnership to identify, deliver and/or source support for residents which promotes good health and wellbeing. By doing so this scheme will both prevent hospital admissions and ensure supported hospital discharges.

This activity will include:

- Transport returning home from hospital.
- Settling people in at home following discharge from hospital
- Sourcing of low-level assistive technology
- Collecting and delivering medications
- Shopping and delivery
- Wellbeing home visits
- Companionship for isolated or lonely people
- Connectivity into the wider offer of support from across the VCS and public sector (e.g. Carers Support, Welfare and Benefits, Warmer Homes initiatives and Social Prescribing)

Shropshire residents will be referred into the service via a single referral point by employees working across the health and social care workforce. The support provided through this service will be free of cost for residents referred.

Service starting the 13th November 2023

2.6 Falls Response Service with additional follow on 'night sit'

The Falls Response Service with additional follow on 'night sit' aims to provide a dedicated service to respond to:

- People who report a fall with minimal injury to provide timely response to assist them back to a safe place, refer on to other services and prevent long periods in the fallen position which lead to other health concerns (e.g. chest infection).
- People who require a response to falls alarm where it cannot be identified the reason for the alarm to ensure they are safe and well, if fallen respond as above or liaise with emergency services, therefore reducing
- Falls response to make community referral/ signposting into Falls prevention services and other community services such as Social Prescribing
- Will respond to support individuals who need support at home in the night to enable:
- Falls response and ambulance crews to move on to other calls in circumstances where they would otherwise be unable to leave due to non-clinical support needs.
- Will be able to provide night sit to a 'looked after' person to care for them when a carer is taken into hospital to prevent the person needing to be also transported into hospital.
- Will be able to further support individuals who have fallen, (on referral from the falls response or as an extension to the falls response); those who are not at immediate clinical risk whilst other services are delayed, or needs are social.

The service would be 24/7 focus on vulnerable and frail and cover the whole geography of STW working in partnership with ambulance and raid response. The service would attend people's homes, care homes and support carers. The service would link directly into the Rapid Response Nursing Team at SCHT for going health and care assessments.

The impact of the scheme Reduction in those attending ED following due to frailty, carer breakdown, or a fall, reducing the demand on WMAS so they can prioritise other categories of call outs.

This scheme is starting the 13th of November 2023.

2.7 SPA and Clinical Co-ordination

The service will simplify the access routes to alternative pathways for health care professionals by bringing a number of 'single points of access (SPA) across the Shropshire. Telford and Wrekin footprint into one single point of access.

The service will provide a single point of referral/access for primary and emergency care workers when seeking pathways for patients other than the Emergency Department (ED). The service aim is to increase the number of referrals from unplanned care back to a managed process, reducing the footfall on the ED, potentially reducing the number of admissions, improving quality of care and patient experience.

The SPA will facilitate patients being seen in the community or via direct access pathways in the acute setting, where clinically appropriate.

The Single Point of Access (SPA) will deliver a model of unplanned referral management that streamlines and improves patient care and optimises the use of available local resources across acute and community ensuring that the patient is seen by the right service, in the right place at the right time to meet their needs. Provision of a single point of access via a dedicated team and trusted Clinical Assessors with quality outcomes contributing to improved A&E performance.

The Care Co-Ordination Centre will operate between the hours of 8.30am – 8.30pm Monday to Friday. In addition to the core hours as set out in CCC, the service will run extended hours between 20:30 – 22:30 Monday to Friday and 08:30 – 22:30 Saturdays, Sundays, and Bank Holidays

Appendix Three: STW Winter Communications Campaign

Pillar 1: Improve awareness and usage of Pharmacists.

The system conducted interviews with residents, pharmacists, and GPs with the STW system to gain insight on the role and barriers to using pharmacy. The key finding of this were:

- A significant proportion were not aware that the pharmacy offered advice and treatment of minor ailments.
- The highest rated benefit of a pharmacist was the fact that no appointment was needed followed by receiving faster answers.
- The lowest satisfaction was the ability to talk in private.

Drive awareness of the wide range of advice and treatment offered by Pharmacists, whist, highlighting the speed in which you can be seen.

Pillar 2: Reduce demand for A&E

The attendances at A&E between April and June were analysed to gain insight into behaviours. The key findings were:

- Over half of attendees fell into categories indicating minimal or no investigation or treatment was necessary, with 75-80% of these relating to soft tissue injuries.
- These attendances are most likely to happen in the evenings.
- These attendances are slightly more prevalent amongst our younger and less affluent populations.

Drive awareness of when to use A&E, alternatives to A&E (NHS 111 & MIU) and highlight everyone's part in making our system run well this winter

Pillar 3: Reducing the spread of infectious respiratory disease.

As we move into colder months viruses such as flu and Covid are more likely to spread quickly when people are crowded together. Cold weather can also make some health problems worse and even lead to serious complications, especially for those aged 65 and over. This can put additional pressure on our hospitals. We can reduce the spread of respiratory disease by:

- Keeping vaccinations and boosters up to date (Flu and Covid)
- Hygiene: Hand washing
- Staying home when ill
- Masks (in some settings)

Drive awareness and need of minimising the spread of respiratory disease this winter and actions they can take to minimise the risk

Pillar 4: Self-care and maximising your wellbeing

We can raise awareness of important self-care techniques that will help people and their families to stay well and help each pressure on local health services:

- Simple steps include eating well, taking daily vitamins and staying active.
- Wrapping up warm whilst you're out and about this winter.
- Stocking up on self-care essentials (OTC medicines, at pharmacies and supermarkets, help relieve many common symptoms of illness)
- Look after yourself, your loved ones, and your neighbours, and get the right care in the right place.

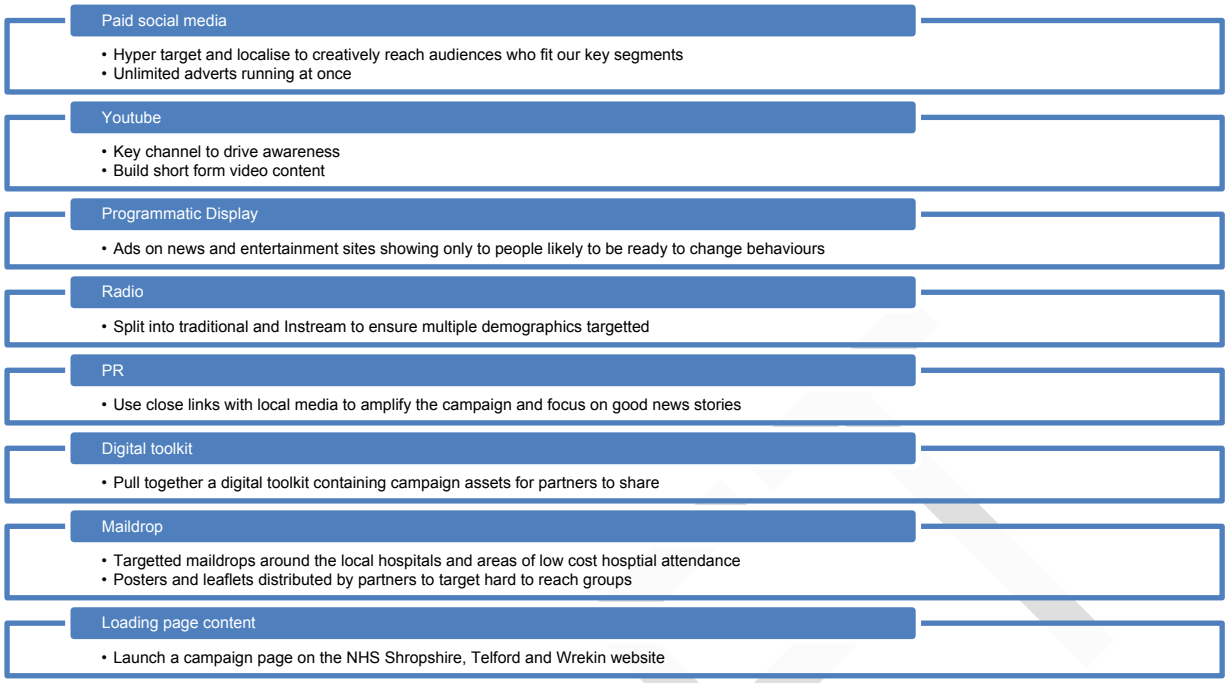
Drive awareness of how to keep yourself, your family, and neighbours healthy this winter by doing all you can to stay healthier

Schedule of communications:

Overarching message	Launch day	Self-care	111.nhs.uk	Pharmacist	GP	Minor Injury Unit	A&E / 999	Winter campaign messages
Day	Wed, 18 Oct	Thu, 19 Oct	Fri, 20 Oct	Sat, 21 Oct	Sun, 22 Oct	Mon, 23 Oct	Wed, 25 Oct	Thu, 26 Oct
*Time – tbd	9am to 12noon	6am to 9am	4pm to 7pm	10am to 1pm	6pm to 9pm	1pm to 4pm	12noon to 3pm	7am to 10am
Post 1: message	Chief Nurse Campaign launch message	Video – GP: talking staying active and eating well.	Video -GP: when to use NHS 111	Video- Pharmacy: What can you use a local pharmacist for	Video – GP: advice on how to stay well this winter	Video – MIU Nurse: when to use a MIU	Video – A&E consultant: when to use A&E	How to look after your Mental Health this winter
Post 2: message	Motion video: Scarf	Motion Video: Medicine cabinet	Resident case study graphic: benefit of NHS 111	Resident case study graphic: benefit of pharmacy	GP graphic Importance of self-care: eat well, stay active and stay warm – Linked to cost of living support	Resident case study graphic: benefit of MIUs	Health Professional Graphic: When to use A&E	Falls prevention - Advice on how to avoid falls and local services
Post 3: message	Graphic: Scarf with the health professionals	Resident case study graphic: Importance of Covid & flu vaccination	Residents case study graphic: benefit of NHS 111	Video Pharmacy: benefit of pharmacy	Video -GP: video importance of flu and covid vaccination	Health professional case study graphic: benefit of MIUs	Video – A&E consultant: when to use A&E	Importance of self-care – MSK message

Highlighted = We don't currently have the content Partners to support with content

Communications Strategy:



Appendix Four: Month 6 Operational Plan

REPORT TO:

NHS STW Integrated Delivery Committee

held on 12th November, 2023

Agenda item	
Enclosure No	
Date:	

Title of report:	Urgent & Emergency Care Delivery Board					
Responsible Director:	Louise Barnett, CEO, SaTH and NHS STW Lead CEO for Urgent & Emergency Care					
Author of report:	Gareth Robinson, Director of Delivery & Transformation, NHS STW					
Presenter:	Gareth Robinson, Director of Delivery & Transformation, NHS STW					
Programme Delivery:	N/A					
Task & Finish Group	N/A					
Regular Report	Yes					
Please Tick:	Noting/Verbal	X	Recommendation		Action	

Purpose of the report:

To provide an update to the Integrated Delivery Committee from the Urgent & Emergency Care Delivery Board

Key issues or points to note:

1. UEC PERFORMANCE

1.1 Areas of performance Delivery

- NHSE has signalled three primary KPIs that will be monitored in order to focus on maximising the flow across the system and providing the best care for our patients. These are summarised below along with the September performance position

WMAS Cat 2 Performance	Target: 30 mins average wait. YTD Perf: 38 min. Sep Perf: 49 mins
4 hour Performance	National Target and system plan (76%): Sep Perf: 50.8%
% of patients 12hr+ in ED	National Target 6%. System Plan 12.1%. Sep Perf: 18.2%

- Two other key metrics that UEC Delivery Board focuses on are:

NCTR position	Target: 82; Plan: 92, Actual: 131
Virtual Ward	Target and system plan utilisation: 76%. Sep Actual: 45%

1.2 Escalations

UEC Operational Group provides a detailed performance review of all areas of UEC to the Delivery Board and outlined all areas of performance. The Delivery Board is escalating the following areas for the IDC's information:

1.2.a. 4 hour performance

4 hour performance is significantly below plan. In August, UEC DB reported a SaTH recovery plan in relation to the minors performance with the first draft being reviewed at the August UEC DB with a full implementation plan for approval expected at September UEC DB. This plan has not been developed with the action being carried forward. At this point the IDC should be clear that the risk is identified and mitigating plans are still to be developed

The impact of specific winter plans will have an impact on the 4 hour performance, with winter funds investment in the following areas being deployed:

- Two additional NEPTS discharge vehicles
- Target rapid intervention for MH patients over 65 (aimed at admissions avoidance)
- Additional communications campaign to direct patients to the most appropriate service
- British Red Cross home support programme
- Voluntary sector stay well at home this winter
- Falls hospital avoidance service

A revised trajectory for 4 hour performance is being developed by SaTH for the next UEC Delivery Board

1.2.b. Virtual Ward performance

Virtual Ward performance in September stabilised a previously deteriorating position but remains at 45% utilisation. A review of the impact of virtual ward has significantly reduced its anticipated impact on escalation beds which will increase the risk of a bed deficit during the winter period (see below)

1.2.c. No criteria to reside (NCTR)

Following five months of consistent improvement, the NCTR position has deteriorated in August (133) and September (133). Further work is being developed in terms of the IDT improvement programme and the interaction of the Discharge Management Tool, but at this point UEC DB is unable to provide assurance to the IDC of a recovery plan for NCTR

Additionally, the previously described issues around Hospital Discharge Funding remain an outstanding issue to resolve. All discharge services continue to operate, but the financial implications (a possible system risk of approx. £7m) are yet to be resolved.

1.2.d UEC Improvement Plan Sub Groups
No detailed reports were provided to the UEC DB. As such, limited assurance was gained on progress. The new UEC DB Chair (SaTH CEO) has requested detailed briefing for each programme of work ahead of the next UEC DB, to gain assurance on the detail of plans and risks attached to the current programme of work

2. 2023/24 SYSTEM OPERATIONAL PLAN/ WINTER PLAN

2.1. Sub acute wards The implementation plan for sub acute wards has changed from the initial operational plan assumptions. The initial plan was for 64 beds to come on-stream from Dec 2023. Due to delays in the planning process, there is no clear delivery date for the modular ward facilities

SaTH has developed an intermediate plan which delivers 20 beds from 2nd Jan 2024 and a further 26 beds available from 1st Feb 2024. Shropcomm (lead recruiter) confirmed confidence in the recruitment plan in order to deliver a mixed blend of permanent and temporary staffing to ensure these beds were available to these timelines. Risk remains (and is being mitigated) around the physical establishment of the beds

This has had a material impact on the bed deficit for the winter months (see below).

2.2 Virtual wards modelling

Although there is some potential improvement identified within the Virtual Ward processes, remodelling of the impact on SaTH has shown a significantly reduced number of acute beds released as a result of the VW capacity. This has materially impacted on the bed deficit for the winter months

2.3 Winter Plan

UEC DB reviewed the winter plan and was unable to approve it based on the outstanding work. Further work is required on establishing the anticipated bed gap (a verbal update on progress will be provided at the UDC) along with the mitigating actions

UEC DB requested that these actions are completed and submitted to an extraordinary UEC DB in parallel with the November Board submission that is required

IDC should note the significant current level of risk identified in that draft modelling suggests a c. 90 bed deficit in November and December. At this point, the mitigations for this have not been identified

3. SUMMARY

IDC is required to:

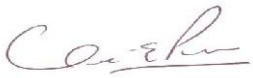
- **Note** the non-delivery of core performance targets and mitigating plans for addressing 4 hour performance and NCTR
- **Note** the delayed and reduced impact of the sub-acute ward
- **Note** the limited assurance on the delivery of the UEC Improvement Plan and the mitigating actions requested by the UEC DB Chair
- **Note** the delayed submission of the winter plan and recommended approach of the parallel approval through an extraordinary UEC Delivery Board and ICB Board

Enc 3b M6 Operational Plan Sum

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

INTEGRATED CARE BOARD

Agenda item no.	ICB 29-11-127
Meeting date:	29th November 2023
Paper title	Local Care Programme – next steps and link with Place Based Development
Paper presented by:	Patricia Davies, SRO for Local Care and CEO SCHT Claire Parker, Director of Partnerships and Place
Paper approved by:	Simon Whitehouse, Chief Executive Officer NHS STW Patricia Davies Chief Executive Officer Shropshire Community Trust
Paper prepared by:	Claire Parker, Director of Partnerships and Place Lisa Keslake, System Programme Director Local Care Transformation Programme (LCTP) Additional content from Tracey Jones - Director
Signature:	
Committee/Advisory Group paper previously presented:	N/A

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance		D=Discussion		I=Information	

Previous considerations:	

1. Executive summary and points for discussion

1.1. As the Integrated Care Board (ICB) and the system moves into the next phase of commissioning and delivery, this paper discusses the role of the Local Care Programme and the role of place as a more prominent feature within the system governance architecture, and the interrelationship with 'local care', at both a system and place level.

1.2. Place based partnerships, Shropshire Integrated Place Partnership (ShIPP) and Telford & Wrekin Integrated Place Partnership (TWIPP), have delivered some innovative and exciting work within the current capacity and resource. However, there is an appetite for the 'places' to do much more and continue to deliver on their individual place strategies, as set out in the Joint Forward Plan (JFP). Ensuring person centred care and local care are at the heart of the outcomes the places can deliver to improve quality and care provided for local people.

1.3. Recent conversations and discussions across the system increasingly align around the need for the governance between ICB and its two place partnerships to be moved to a more formal footing. It should be noted that the original ICS and ICB governance diagram did show the two place partnerships reporting directly into the Board. The consensus view is that it increasingly makes sense to formalise this arrangement and to further develop the role of place in relation to the delivery of the Local Care Programme. If this change is supported, a review of the role, remit, constitution, and terms of reference of place committees would be required including looking at the role of place in delivering the Local Care Programme. This would also require a focus on the chair of the place based partnerships to ensure that they were aligned to the system Board governance.

1.4. Finally, the importance of the local care transformation programme and its relationship with place and system, as commissioning, assurance, and delivery mechanisms, are also included within the body of this report to ensure that the system is further developing the operating model to deliver its actions and ambitions as set out in the JFP. It is essential that this is clear, understood and effective given the importance of the successful delivery of the local care programme as one of the main transformation programmes for the system.

2. Report align with?

Improving safety and quality	X
Integrating services at place and neighbourhood level	X
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	X
Enhanced engagement and accountability	X
Creating system sustainability	X
Workforce	

3. Recommendation(s)

3.1. The NHS Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) is asked to note and approve the following recommendations:

3.1.1. **Recommendation 1**: Place base partnerships to review current and future governance arrangements to strengthen the role of the places in the system, moving the governance relationship between place and system/ICB to a more formal footing.

3.1.2. **Recommendation 2**: Expand the Local Care Transformation Programme (LCTP) to include a broader set of interrelated programmes under the umbrella term of 'Local Care' to include expansion of community-based services, primary care development, health and care integration and prevention and health in equalities - in line with the Joint Forward Plan (JFP).

3.1.3. **Recommendation 3**: Define which Local Care programmes/projects would be predominantly designed and delivered at Place and which at System/ICB. (Noting there would need to be collaboration and co-production between the two levels to ensure the interdependencies are addressed).

3.1.4. **Recommendation 4**: Engage with staff and stakeholders to work through the detailed roles and responsibilities for each individual programme including the Project Management requirements, aligning with the ICB operating model.

3.1.5. **Recommendation 5**: Continue at pace with the following work programmes: modular wards and community beds, integrated neighbourhood teams and Multidisciplinary Teams (MDT's) for proactive care.

3.1.6. **Recommendation 6**: Develop detailed plans for the governance of the 'Local Care' programmes to ensure delivery against population health outcomes, performance, quality, and finance.

3.2. Should these recommendations be supported, it is proposed that the detailed design work is formally commenced at the next Local Care Transformation Board on 18th December with a series of workshops/design events to take place in Quarter 4, the process of which the Local Care Transformation Board would steer and oversee. This would result in the production of a detailed delivery and governance framework for Local Care by the end of Quarter 4. Alongside this design work, progress on existing Local Care programmes will continue within the existing governance arrangements.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

4.1. None.

5. Appendices

5.1. Appendix 1 (Potential projects at place or system level)

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Improving integration and local services, responding to the Big Health and Wellbeing Conversation
Quality and Safety	Improve quality and outcomes for health and care services delivered at place
Equality, Diversity, and Inclusion	Improving access and addressing
Finances and Use of Resources	Delivering person-centred care and prevention, keeping people well at home for longer and reducing pressure on the urgent care system and general practice.

Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Place based delivery and local care will deliver further integration of social care, Voluntary, Community and Social Enterprise (VCSE), community and primary care services to manage urgent care demand.
Environmental and Climate Change	Potential options for greener digital and carbon neutral services.
Future Decisions and Policy Making	Integrated Strategy and Joint Forward Plan

Action Request of Paper:	To note and approve the recommendations on Place development and Local Care as a wider remit of programmes that are clearly defined as the remit of ‘place’ or ‘system’.		
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	Integrated Care Board
Meeting date:	29th November 2023
Agenda item no.	
Paper title	Place Based Development and Local Care next steps

1. Introduction

1.1. As the Integrated Care Board (ICB) and the system move into the next phase of strategic commissioning, integrated delivery and provider collaboration, there is a need to build on the recent Board development session around the role of place. There is a need for the two place based partnerships to become a more prominent feature within the system governance architecture, and the interrelationship with local care, at both a system and place level.

1.2. Place based partnerships, Shropshire Integrated Place Partnership (ShIPP) and Telford & Wrekin Integrated Place Partnership (TWIPP), have delivered some innovative and exciting work within the current capacity and resource. However, there is an appetite for the 'places' to do much more and continue to deliver on their individual place strategies, as set out in the Joint Forward Plan (JFP). Ensuring person centred care and local care are at the heart of the outcomes the places can deliver to improve quality and care.

1.3. Recent conversations and discussions across the system increasingly align around the need for the governance between ICB and its two place partnerships to be moved to a more formal footing. It should be noted that the original ICS and ICB governance diagram did show the two place partnerships reporting directly into the Board. The consensus view is that it increasingly makes sense to formalise this arrangement and to further develop the role of place in relation to the delivery of the Local Care Programme. If this change is supported, a review of the role, remit, constitution, and terms of reference of place committees would be required including looking at the role of place in delivering the Local Care Programme.

1.4. Finally, the importance of the Local Care Transformation Programme (LCTP) and its relationship with place and system, as commissioning, assurance and delivery mechanisms, are also included within the body of this report to ensure that the system is further developing the operating model to deliver its actions and ambitions as set out in the JFP.

2. Background

2.1. Shropshire, Telford and Wrekin (STW) produced an integrated care strategy to set the strategic direction for health and care services across the whole geographic area of the Integrated Care System (ICS), including how commissioners in the NHS and local authorities can deliver more joined-up preventative and person-centred care for their local population. This was followed by the publication of the five-year joint forward plan and the operational plan for 2023/24.

2.2. The ICB is now further developing its operating model to support delivery of its statutory responsibilities to support both strategic commissioning and to support commissioning expertise at place and in provider collaboratives.

2.3. In July 2023, a development session on place-based partnerships with the Board was led by representatives from both ShIPP and TWIPP. This session demonstrated the significant work that our places are delivering within existing resources and capacity. It also set out the ambition and the local commitment to go further and to really start to drive this agenda. It was recognised that there is a need to ensure that any desire to 'formalise the governance' is done sensitively and to ensure that it is done in a way that does not impact on the goodwill and the enthusiasm that currently exists. There is also a need to work through this with both HWBBs to ensure that there is clarity on responsibility, accountability and that we avoid duplication and confusion.

2.4. ShIPP and TWIPP's focus are on improving outcomes for residents and communities in each place by enabling the following to happen:

2.4.1. Ensuring that the proper constitutional, governance, and development arrangements are in place to enable the functioning of ShIPP/TWIPP. This includes developing cross organisational principles that facilitate priority-setting, strategic alignment, and decision-making between organisations across multiple sectors.

2.4.2. The prominence of a person-centred focus, a culture of continuous improvement and meaningful engagement and codesign with all stakeholders as the default way in which system partners in health and social care develop and deliver integrated care.

2.4.3. Foster positive working relationships with and between senior statutory and non-statutory officers in NHS Trusts, Adults and Children's Social Care and Public Health to support the full range of contributions to integrated care and population health.

2.4.4. Progression of the integration of health, social and domiciliary care services, and Voluntary Sector to deliver sustainable high-quality care for residents in STW. This includes developing integrated provision where this is beneficial to population outcomes.

2.4.5. In delivering the above ensure that partners work together to deliver on required outcomes and agreed ambitions, with a particular transformation focus upon prevention-based approaches across place.

2.4.6. Ensure an integrated approach to reducing identified place-based health inequalities across all partners reflecting both the wider determinants of health in addition to NHS identified priorities.

2.5. ShIPP and TWIPP continue to evolve and mature, and it has become clear, over time, that direct reporting to the ICB from the place-based partnerships on assurance, delivery, quality and finance would raise the profile of place and the importance of place-based delivery across the system, including delivery of integrated neighbourhood teams and 'local care'.

3. Place Based Partnerships Review

3.1. This report recommends that place base partnerships review, with partners, the current and future governance arrangements. The Board is asked to support that this review is undertaken and that as part of the review the following points are considered:

3.1.1. The role of the Chair of the Place Based Partnership / Board – both in terms of function and who that should be. This needs to consider how the chair will link through to the system Board. On this basis it makes sense for this to be a current Board member, but this will require agreement and discussion.

3.1.2. Engagement, input and attendance at the STW Integrated Care Partnership (ICP).

3.1.3. The relationship with and the alignment of priorities with the Health and Wellbeing Boards (HWBB) in recognition of the connections between the HWBB, ICB and the ICP.

3.1.4. Consideration of the future role place will take in the system and therefore how quality, performance and finance will be monitored and reported should we agree to move through a delegated functions route.

3.2. A review of the arrangements will ensure that the voice of 'place' informs and influences decision making. This is not being proposed as being 'done to' but rather done with and the importance of building on the current 'bottom-up' evolution and enthusiasm is paramount in all of this work.

4. Wider Considerations

4.1. The ICB is currently reviewing and refining its operating model to deliver:

4.1.1. An efficient streamlined system strategic commissioner with the ability to discharge its core statutory functions.

4.1.2. Devolution (once set out and agreed) of certain functions and resources to Place, with work to identify the detail of which functions at place, and which at system.

4.1.3. 'Place' role and profile within the ICB will have more prominence.

4.1.4. Place role with Providers (including GP and PCN) to have more prominence and support.

4.1.5. Place role with LA's will have greater prominence and the ability to bring areas of focus to this work around housing, education and the other wider determinants of health and well-being.

4.2. With these points in mind, the recommendation to further develop the maturity of the partnerships will need to also consider accountability, and how it will interact with the Chief Finance Officer of the ICB and other provider Directors of Finance, including the two local authorities to ensure services commissioned are good value for money and contributes to a stable and sustainable health and care economy.

4.3. However, it is important that in the evolution of any commissioning and financial delegation fulfils the key objective of fundamentally changing the way we develop and deliver integrated care together as a system.

4.4. To maximise the opportunities delegation to place presents for integrated care, the place partnerships will need to consider if the membership is suitable to engage wider stakeholders and partners, with thought given to primary care, general practice, the PCN's and Voluntary, Community and Social Enterprise (VCSE) Sector.

5. Local Care Programme

5.1. There are currently some challenges with continuing to run the LCTP in the way it was originally constituted in 2021/22, given the clearer development of the system architecture since then and the changes to the wider environment. Now is therefore the right time to review our framework for delivery of Local Care alongside the development of the system architecture, the future ICB operating model, and place development.

5.2. The challenges with continuing to run Local Care as originally constituted are:

5.2.1. There are multiple programmes of significant strategic and operational importance sitting 'outside' of the LCTP which would have a major bearing on cohort 2 programmes (such as the development of sub-acute and rehabilitative care in modular beds).

5.2.2. There are aligned programmes with major interdependencies which also sit 'outside' of LCTP (such as primary care development).

5.2.3. Greater levels of resource are consumed in time and effort because of gaps and lack of connectivity; exposure to risk is increased.

5.2.4. Challenges for effective governance with the remit of the revised Local Care Transformation Board being limited to in-scope programmes.

5.2.5. "System scope" of cohort 2 is narrower than "place scope" with places opting to incorporate the dependent and interrelated areas of prevention and health inequalities. Therefore, the connection between the LCTP Board and the place partnership boards is not explicit or fully coherent at present.

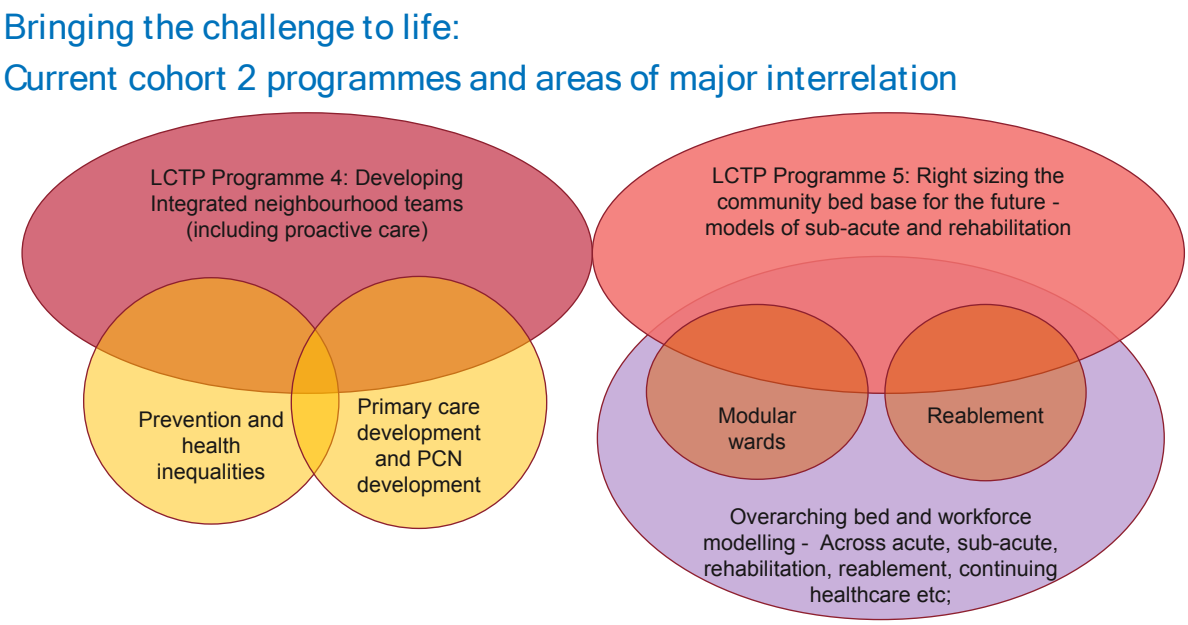
5.2.6. Clarity on system v's place responsibilities is needed, in relation to local care areas that are for commissioning at system level and those at place level.

5.2.7. Resources required to run a central programme akin to the Hospital Transformation Programme (HTP) cannot be met either from within the system or from Recovery Support Programme (RSP) funding.

5.2.8. RSP funding is unlikely to be available to support Local Care from April '24 - therefore the transition to management of Local Care through the system architecture needs to be accelerated (original assumption was that RSP funding would likely continue into 24/25).

5.3. Figure 1 demonstrates these challenges visually within the Venn diagram.

5.3.1. Figure 1: Brining the Challenge to Life



6. Conclusion

6.1. The recommendations which follow support the strengthening of place within the system architecture and would help to create a local and sustainable delivery framework for the delivery of local care programmes, with clarity over the appropriate responsibilities and accountabilities that sit with 'place' or system. There will need to be consideration within the operating model of the need for 'Project Management Office (PMO)' activity to support delivery at both levels of the system architecture. This PMO activity will need to be targeted, selective and value adding, complementing commissioning and contracting arrangements.

7. Recommendations

7.1. The NHS Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) is asked to note and approve the following recommendations:

7.1.1. **Recommendation 1**: Place base partnerships to review current and future governance arrangements to strengthen the role of the places in the system, moving the governance relationship between place and system/ICB to a more formal footing.

7.1.2. **Recommendation 2**: Expand the Local Care Transformation Programme (LCTP) to include a broader set of interrelated programmes under the umbrella term of 'Local Care' to include expansion of community-based services, primary care development, health and care integration and prevention and health in equalities - in line with the Joint Forward Plan (JFP).

7.1.3. **Recommendation 3**: Define which Local Care programmes/projects would be predominantly designed and delivered at Place and which at System/ICB. (Noting there would need to be collaboration and co-production between the two levels to ensure the interdependencies are addressed).

7.1.4. **Recommendation 4**: Engage with staff and stakeholders to work through the detailed roles and responsibilities for each individual programme including the Project Management requirements, aligning with the ICB operating model.

7.1.5. **Recommendation 5**: Continue at pace with the following work programmes: modular wards and community beds, integrated neighbourhood teams and Multidisciplinary Teams (MDT's) for proactive care.

7.1.6. **Recommendation 6**: Develop detailed plans for the governance of the 'Local Care' programmes to ensure delivery against population health outcomes, performance, quality, and finance.

7.2. Should these recommendations be supported, it is proposed that the detailed design work is formally commenced at the next Local Care Transformation Board on 18th December with a series of workshops/design events to take place in Quarter 4, the process of which the Local Care Transformation Board would steer and oversee. This would result in the production of a detailed delivery and governance framework for Local Care by the end of Quarter 4. Alongside this design work, progress on existing Local Care programmes will continue within the existing governance arrangements.

Appendix 1 - **DRAFT Potential projects at place or system level**

Place led (for example)

Place to lead on detailed design and delivery: ICB to set outcomes, conduct a convener role of driving system wide ambition, create the right conditions and levers for change)

- Prevention and health inequalities – e.g., including KLOEs, LTP priorities, Core20plus priorities, local place priorities.
- Primary care development including improved access to services.
- Integrated neighbourhood teams to support people (all ages) with complex needs and to focus on tackling health inequalities with an initial focus on:
    - Proactive care – MDTs to proactively support people with frailty, LTCs and unplanned admissions with a care model comprising care co-ordination, social prescribing, and a single point of access.

      NB: this is not to suggest that other INTs should not be established (e.g., INTs supporting children with or at risk of mental health challenges) but asks that as a minimum all PCNs establish MDTs for people meeting the NHSE proactive care criteria.
- Community navigation (*no wrong door* to access health, care, community or voluntary sector assistance – effective signposting and referral mechanisms)
- Community hubs – co-location of health and social care staff (which can assist with INTs including the MDTs for people with frailty/LTCs/unplanned admissions)

System led (for example)

System to lead on outcome setting, high level design and conduct detailed design in collaboration with providers; commissioning may include options for lead provider options)

- Sub-acute care and rehabilitation models of care
- Intermediate care review including step down, sub-acute, reablement and rehabilitation/right sizing the community bed base.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-128
Meeting date:	29th November 2023
Paper title	System Board Assurance Framework
Paper presented by:	Alison Smith, Director of Corporate Affairs
Paper approved by:	Simon Whitehouse, Chief Executive Officer
Paper prepared by:	Alison Smith, Director of Corporate Affairs
Signature:	
Committee/Advisory Group paper previously presented:	Audit Committee – 9th October 2023

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

Previous considerations:	None identified.

1. Executive summary and points for discussion

1.1. The Board of an NHS organisation is responsible for ensuring there is an effective system of internal control which comprises the systems and processes that an organisation has in place to give the Board and other stakeholders reasonable assurance that the functions of the organisation are operating as they should do, and the organisation is achieving its objectives and meeting its legal and other obligations.

1.2. In practice this means that at the core of an effective internal control system there needs to be a structured approach to identifying objectives, risks and problem areas. In the NHS this structure is provided by an "assurance framework", also referred to as a Board Assurance Framework (BAF) underpinned by a risk management framework.

1.3. A proactive and robust approach to risk management can:

1.3.1. Reduce risk exposure through the more effective targeting of resources to address key risk areas.

1.3.2. Create improvements in economy, efficiency and effectiveness resulting from a reduction in the frequency and/or severity of incidents, complaints, claims, staff absences and other losses.

1.3.3. Support informed decision-making to allow for innovation and opportunity.

1.3.4. Enhance compliance with applicable laws, regulations, and national guidance.

1.3.5. Increase stakeholder confidence in corporate governance and ability to deliver.

1.3.6. Development of a 'lessons learnt' environment.

1.4. The risk management approach outlined in the Integrated Care Board (ICB's) Risk Management Policy adopted by the Audit Committee in April 2023 outlines two mechanisms for capturing risk at a system level and a strategic operational level for system and ICB:

1.4.1. the first is the System Board Assurance Framework (SBAF) which outlines the principal risks to the system of not meeting its three objectives set out in the Joint Forward Plan.

1.4.2. the second is the Strategic Operational Risk Register (SORR) which outlines the strategic but more operational risks below those on the SBAF which also may have an impact on the delivery of both the strategic objectives of the Integrated Care System (ICS) and ICB as a corporate body.

1.5. The SBAF together with supporting SORR, seek to provide the ICB and system with a simple but comprehensive method for the effective and focused management of the principal risks that may impede or assist the ICS and/or the ICB in meeting strategic objectives and statutory obligations.

1.6. In March 2023 the Board was presented with a draft System Risk Appetite and SBAF for approval. However, with the development of the Joint Forward Plan in June 2023 and adoption of three new objectives, work has been undertaken to review the BAF risks that were presented in March and realign these and any new emerging risks with these three new objectives:

1.6.1. Reducing Health Inequalities:

1.6.1.1. Wider determinants

1.6.1.2. Tackling health inequalities

1.6.2. Improving population health

1.6.2.1. Best start in life

1.6.2.2. Healthy weight

1.6.2.3. Alcohol drugs domestic abuse

1.6.2.4. Mental health and wellbeing

1.6.3. Improving Health and Care

1.6.3.1. Strengthen prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers, and musculoskeletal disease.

1.6.3.2. Urgent and Emergency Care

1.6.3.3. Integrated person-centred care within communities – strong focus on primary and secondary care.

1.7. Attached is an appendix which sets out the updated SBAF for assurance. The SBAF will now be regularly presented to ICB committees together with the SORR for detailed scrutiny.

1.8. The Board is asked to consider the following:

1.8.1. Are the risks identified correct and in line with the Board's strategic knowledge of the system?

1.8.2. Are there any other risks that should be included?

1.8.3. Are there adequate controls and assurances identified or are there gaps that should be cited?

1.8.4. Are appropriate actions identified to address known gaps in controls and assurances?

1.9. The Board is asked, having given due to consideration to the above outlined questions, to approve the SBAF.

2. Which of the ICS Pledges does this report align with?

Improving safety and quality	X
Integrating services at place and neighbourhood level	X
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	X
Economic regeneration	X
Climate change	X
Leadership and Governance	X
Enhanced engagement and accountability	X
Creating system sustainability	X
Workforce	X

3. Recommendation(s)

3.1. The Board is recommended to:

3.1.1. **REVIEW** the current System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR) for system and ICB and consider if, for those risks falling within its remit:

3.1.1.1. any additional assurances are necessary that the risks to the strategic objectives, are being properly managed.

3.1.1.2. any additional risks or amendment to risks are required following discussions in the Committee meeting.

3.1.2. **APPROVE** the System Board Assurance Framework (SBAF).

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

4.1. The report provides assurance that Shropshire, Telford and Wrekin Integrated Care System (ICS) has a risk management framework in place to ensure that strategic risk is being identified and managed appropriately.

5. Appendices

5.1. Appendix A – System Board Assurance Framework (SBAF)

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	There are no direct implications on these areas from this report. However, the SBAF may include risks related to these areas.
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

Request of Paper:	**The Board is recommended to:** **REVIEW** the current System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR) for system and ICB and consider if, for those risks falling within its remit: • any additional assurances are necessary that the risks to the strategic objectives, are being properly managed. • any additional risks or amendment to risks are required following discussions in the Committee meeting. **APPROVE** the System Board Assurance Framework (SBAF).		
Action approved at Board:		**If unable to approve, action required:**	
Signature:		**Date:**	

ICB Board meeting

Agenda item no.	**ICB 29-11-129**
Meeting date:	
Paper title	**Integrated Performance Report – November 2023**
Paper presented by:	**Claire Skidmore**
Paper approved by:	
Paper prepared by:	**Sam Cook, Deputy Director of Performance** **Julie Garside, Director of Performance and Planning**
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	x	D=Discussion		I=Information	x		

Previous considerations:	**Not applicable**

1. Executive summary and points for discussion

On 8th November the ICB and all providers received a letter from NHSE addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take. As a result of these pressures the agreed priorities for the remainder of the financial year are confirmed as:

- Achieve financial balance
- Protect patient safety
- Prioritise emergency performance and capacity
- Protect cancer care and high priority electives

Any revisions to forecasts, because of this process will be reflected in the Integrated Performance Report (IPR) when agreed and signed off by all system partners.

The System continues to have two significant performance pressures, Urgent and Emergency Care (UEC) and Finance.

<u>Operational Performance</u>

- Whilst Category 2 Ambulance response times remain close to national target, ambulance handover performance continues to decline with compliance

significantly below both regional performance and localised targets. A&E 4-hour waits is consistently short of national and local targets. Recovery against the 4-hour target remains extremely challenged and work to agree a revised recovery trajectory is near complete.

- Following feedback from recent review visits from NHSE and DHSC, delivery priorities have been aligned to programmes that will have the most impact on Category 2 Ambulance performance (by reducing handover delays), A&E 4-hour waiting targets and reduction in No Criteria to Reside (NCTR) patients. In addition, 7 Winter schemes have been approved and mobilising.
- Following improved end of Quarter 1 delivery of Referral to Treatment (RTT) waits, SaTH moved to Tier 2 for Elective long waits, SaTH have no patients waiting over 104 or 78 weeks. RJAH have zero 104 week waits but have 11 patients waiting over 78 weeks with plans to treat by January. Patients wating over 65 weeks remain challenging with all Trusts forecasting breaches by the end of March if no additional support is made available.
- Whilst Cancer services continue to be challenged, significant improvement has been seen in the Faster Diagnosis Standard (FDS) with early indications that October is close to the end of year target of 75%. The number of patients waiting over 62 days continues to be better than trajectory and targeted funding from the WM Cancer Alliance will assist with the most challenged specialties.
- Diagnostic tests within the 6-week standard is showing sustained improving performance overall but endoscopy capacity is still constrained. WM Cancer Alliance have provided non recurrent funding to provide additional capacity from mid-October whilst a sustainable solution is worked through. Further capacity will be provided through the CDC which went live in early October and initial patient and public feedback is positive.
- In both Adult and CYP Mental Health services there has been sustained and steady improvement towards targets, over several metrics:
    - Dementia Diagnosis Rates
    - CYP access 1+ contact
    - Access to community MH
    - SMI Health Checks
- The Talking Therapies service whilst undertaking service transformation has identified necessary changes to activity reporting that have had a detrimental effect on performance against the access target. Work is in process with MPFT to develop and improvement plan and revised trajectory.

<u>Finance</u>

- At Month 7 the system has a deficit of £89m, which is £44.5m adverse to plan, a variation from in-month plan of £10.5m. The system is forecasting a break even position against the financial plan submitted but cannot currently provide assurance that this will be achieved. The total unmitigated risk reported at M7 is £91.7m .

- A number of actions are being pursued to narrow the forecast range so that a position can be agreed with NHSE. All partners are pursuing additional mitigations to reduce the forecast to the lowest possible variance to plan.

Quality

- Infection Prevention and Control Metrics are showing that the system will exceed its yearly national target of 76 cases, with 70 cases to the end of September 2023. Quality assurance is provided by peer review visits but capacity issues at SaTH are preventing deep cleans. This risk continues to be monitored through the Quality and Performance Committee.
- A system workshop is planned into child mortality to develop an action plan for improvement as the number of neonatal deaths remain above the national average.

Workforce

- Workforce metrics show an improvement in the number of substantive staff in post against plan. At the end of September the plan has been exceeded by 311 WTE staff when considering the 3 Trusts combined, however, the positive variance to plan in month at SaTH is compensating for small under performance in RJAH and SCHT.
- Tracking the data at staff group level shows that the Pharmacy workforce continues to be an area of concern though SaTH is starting to see an increase in this staff group.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	x
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	x
Economic regeneration	
Climate change	
Leadership and Governance	X
Enhanced engagement and accountability	
Creating system sustainability	x
Workforce	x

3. Recommendation(s)

- To note the Month 7 system financial position deficit of £89m deficit and total unmitigated risk of £91.7m and the ongoing work to identify mitigations to reduce the forecast to the lowest variance to plan.
- To note the significant improvements in cancer Faster Diagnosis Standard and the continued improvement in reducing long waits for diagnostic and elective activity.
- To note that the concerning performance in UEC across several metrics and the action taken to reprioritise action plans that will have the most impact on ambulance handover delays and A&E 4-hour waits.
- To note significant improvements in several Mental Health metrics and the ongoing work to recover performance against access to Talking Therapies.
- To note that IPC metrics are likely to exceed the national target and the quality assurance actions to manage the risk.
- To note that Month 7 shows a combined positive variance of substantive staff in post against plan by 311 WTE but the Pharmacy workforce remains an area of concern.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

The IPR provides assurance on all aspects of performance, Quality, Finance, Operational and Workforce.

5. Appendices

Please see the attached IPR report.

6. What are the implications for:

** For each section the ask will be to either refer to a section of the paper, identify that there are no implications or to submit a separate comment **

Shropshire, Telford and Wrekin's Residents and Communities	No
Quality and Safety	See Quality Section
Equality, Diversity, and Inclusion	No
Finances and Use of Resources	See Finance Section
Regulation and Legal Requirements	No
Conflicts of Interest	No
Data Protection	No
Transformation and Innovation	No
Environmental and Climate Change	No

Future Decisions and Policy Making	No
Citizen and Stakeholder Engagement	No

Request of Paper:	To note the contents of the report.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Performance Report

November 2023

Operational Performance

The validated activity data month for the purposes of this report is September/October 2023, however, where possible more current unvalidated data from providers has been included.

This month, charts show performance against national targets using the Making Data Count (MDC) methodology: this uses Statistical Process Control (SPC) to better illustrate variation in performance over time and enable the identification of Special Cause Variation in performance data. SPC is far more useful at identifying significant changes than, for example, comparing year-on-year or month-on-month performance. Charts produced in this manner feature the following key:

Variation				Assurance		
						
The default grey line is for common cause variation, with no significant change.	Variation points highlighted in orange: special cause of concerning nature or higher pressure due to values being H – higher or L – lower.	Variation points highlighted in blue: special cause of improving nature or lower pressure due to values being H - higher or L – lower.	Purple arrows represent special cause variation; neither a concern nor an improvement	A question mark indicates inconsistent performance, with indicator passing and failing target.	Charts with a blue P are those in which metrics consistently achieve target. Such charts will not normally feature in this report unless a significant risk is foreseen.	Where indicated with an orange F the target is consistently missed, and no assurance can be given based on past performance.

The charts feature a black line to represent the mean, and a red line to indicate relevant targets.

Performance against the operational metrics using the MDC principles is summarised below in a matrix of assurance against current performance:

Variation	Assurance: Consistently Failing the Target	Assurance: Inconsistently Achieving the Target/No Target	Assurance: Consistently Achieving the Target
Concerning Variation	• Talking Therapies Access	• Primary Care Appointments Same/Next Day • Primary Care Appointments < 2 weeks	• Urgent Community Response < 2 hours
Normal Variation	• A&E Percentage of patients managed <4 hours • Cancer Referral to Treatment <62 days	• Category 2 Ambulance Response times • Inpatients with No Criteria to Reside • Virtual Ward Utilisation rate • Elective Recovery Fund (VWA) • Primary Care No of Appointments • No of GPs in Post	
Improving Variation	• Faster Diagnosis Standard < 28 days • Cancer 62-day Backlog • Elective: Referral to Treatment >65 weeks • Diagnostics: Patients seen <6 weeks • CYP access for MH Services 1+ contact • Dementia Diagnosis Rate • Access to Community MH Teams • SMI Health Checks	• ARRS roles recruited – FTE • Bed Occupancy (General & Acute) • No of Inappropriate OoA Beddays	

1. Primary Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Primary Care Appointments	Sep 23	257662				239727	182390	297065
Appointment Same Day/Next Day %	Sep 23	48%	54%			53%	48%	58%
Appointment within 2 weeks %	Sep 23	79%	88%			85%	81%	89%
Gps in post (FTE)	Sep 23	296				302	295	310
ARRS roles - (FTE)	Oct 23	267	260			198	124	272

1.1 General Practice continues to provide more appointments now than before the pandemic, with 72% of these appointments being face-to-face and showing normal variation. Despite the increasing demand, the percentage of GP appointments seen within 2 weeks is 78.6% and the percentage seen the same day or next day is 47.6% and replicates a similar dip in performance at the same time last year. Whilst not achieving national targets STW continues to perform better than national performance.

1.2 In support of access to Primary Care, the WTE number of GP and ARRS roles in post are monitored and are within normal variation. Further development in monitoring will expand the number of metrics captured to measure performance including Pharmacy and Dental activity.

1.3 The GP Access Recovery plan is included as a separate paper to the November Board and includes the metrics that will be used to monitor performance. This will be included in the IPR from January.

2. Urgent Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Category 2 Ambulance Response times	Oct 23	62	30			55	-6	116
A&E - Percentage of patients managed < 4 hours (Type 1-3)	Oct 23	61%	76%			62%	56%	67%
Bed Occupancy (General & Acute) %	Oct 23	93.9%	92.0%			90.9%	88.5%	93.3%
Inpatients with No Criteria to Reside - not discharged	Oct 23	143	110			136	103	169
Virtual Ward Utilisation Rate	Oct 23	48.1%	76.4%			58.2%	30.2%	86.3%
Urgent Community Response < 2 hours	Sep 23	93.7%	70.0%			96.4%	92.6%	100.2%

2.1 Category 2 Ambulance response times are on target against trajectory and to achieve the national target of an average 30-minute response time across the year, however handover delays for both <60 minutes and <15 minutes have not met planned trajectory over the last 3 months and for October are 63.1% and 12% respectively. Compliance remains significantly below both regional performance and localised targets.

2.2 A&E 4-hour performance has reduced since quarter 1 with 61% of patients in October being admitted, transferred, or discharged within 4 hours. This does not appear to be due to increased demand as number of attendances to A&E show no significant variation. All Trusts are expected to achieve at least 76% by March 2024. Recovery against the 4-hour performance target remains extremely challenged and work to agree a revised recovery trajectory is near complete.

2.3 Bed occupancy remains high within the system, compounded by both front door demand (admissions) and back door discharge processes. Escalation capacity remains at levels experienced for most of 23/24 and is predicted to remain at these levels for the remainder of the year. To bridge the gap for winter, additional beds will be introduced through the sub-acute wards on both sites at SaTH.

2.4 The number of patients with no criteria to reside (NCTR) and not discharged from hospital beds has continued to decrease from the high in December, reporting a low of 114 in July. Since August the number of patients began to rise which is impacting on hospital flow. October saw an average of 143 patients against a trajectory of 109. Work continues to focus on reducing length of stay of these patients which has reduced from 5 days at the start of the year to 4 days in October, aiming for a year-end target of 3.8 days. The discharge alliance is taking forward at pace several key workstreams to improve NCTR.

2.5 Capacity targets for Virtual Wards (VW) were based on total population however a recent service review has reduced the number of beds from 250 to 167 by March 2024 to exclude children from the calculation. Applying November's reduced capacity would see October utilisation rates increase to 84.5%. A total of 251 patients were cared for under the VW in October which allowed patients to be treated for higher acuity needs whilst being able to stay in their own home. Focus will be on developing additional clinical pathways for frailty and respiratory conditions as winter approaches.

2.6 The Urgent Care Response (UCR) team continue to support patients to remain out of an acute setting by providing a 2-hour response. Performance is significantly above the 70% national standard and continues to remain above 90%.

2.7 The 3 UEC Improvement programmes, Appropriate Access to Care, Early Flow and Discharge have all been reviewed following feedback from recent review visits from NHSE and DHSC. The delivery priorities have been aligned to programmes that will have the most impact on Category 2 Ambulance performance, A&E 4-hour waiting targets and reduction in NCTR patients. Delivery of all these programmes will be overseen by the UEC Board.

2.8 The ICB have approved 7 winter schemes for 2023/24. The schemes are in mobilisation phase with reporting and monitoring key performance indicators being developed with the leads of the schemes. The SCC has now been operational 7 days a week from 1st of November '23

3. Planned Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer: Faster Diagnosis Standard <28 days	Sep 23	72.7%	75.0%	H	F	62.3%	54.6%	70.0%
Cancer: Referral to Treatment <62 day	Sep 23	46.4%	85.0%		F	46.0%	32.2%	59.9%
Cancer: 62 day Backlog	Oct 23	368	202	L	F	496	367	625
Elective: Referral to Treatment Patients waiting > 65 weeks	Sep 23	587		L		1534	1156	1913
Elective Recovery Fund (VWA)	Oct 23	96%	103%		?	101%	93%	108%
Diagnostics: Patients seen < 6 weeks from referral	Sep 23	71.18%		H		63.60%	57.68%	69.53%

3.1 Following improved end of Quarter 1 delivery of Referral to Treatment waits (RTT) SaTH has moved to Tier 2 for Elective long waits but remain in Tier 1 for Cancer. Monitoring moves to fortnightly instead of weekly, however, cancer performance papers are still prepared on a weekly basis.

3.2 The latest data shows that the Faster Diagnosis Standard (FDS) has continued to improve to 72.7% in September against the target of 75% by the end of March 2024. The unvalidated October performance is 74.1% and ahead of trajectory. As performance of FDS improves, more patients will be seen within the referral to treatment (RTT) cancer waiting targets.

3.3 Cancer services continue to be very challenged. The backlog of patients at SaTH waiting over 62 days for treatment or diagnosis in October was 368 and better than trajectory at 379. The unvalidated position for the 2nd of November is 359.

Detailed action plans are in place for the most challenged cancer pathways, urology, colorectal and gynaecology, supported by £600k of funding from the WM Cancer Alliance to reduce reporting delays in Radiology.

3.4 The percentage of patients seen within 62-days of referral continues to show concerning variation at 46.4% in September against a target of 85%. As performance improves in cancer metrics, focus is moving to improving the RTT standard supported with additional resource from NHSE.

3.5 Recruitment has commenced to establish a dedicated cancer transformation team. The team will develop a whole system approach to delivering improved health outcomes and reducing inequalities of care, utilising non recurrent funding from the WM Cancer Alliance.

3.6 As of the 9th November, SaTH had zero patients waiting over 104 and 78 weeks. RJAH had zero 104-week waits and 11 waiting 78 weeks. Patient plans are in place to reduce to 1 patient by December. This patient will be treated in January when specialist kit becomes available.

3.7 The 2023-24 Operational Plan sets a target of zero 65-week waits by the end of the year. To achieve this all patients in this cohort would need to have had a first appointment by the 31st of October. Latest modelling shows that without further funding or additional support SaTH expect to have 848 breaches of the 65-week cohort and RJAH 457 breaches at the end of March. SCHT are also forecasting 130 breaches.

3.8 Providers have shared the latest iteration of their forecast outturn positions and the Elective Recovery Fund (ERF) rules have been applied to obtain both a system and provider forecast year-end ERF position. Recent national guidance requested that forecasts be recalculated to factor in assumptions of the impact of further industrial action; to which the system looks to achieve a year end position of 104.5% against the revised target of 100%. Because of the effect on productivity due to Industrial action and planned theatre works, RJAH continue to remain lower than target.

3.9 The ICS is in recovery against the overall 6 weeks standard for diagnostics but is showing sustained improving performance with the latest validated position for September of 71.2% against plan of 76% The operational plan sets an ambition of 95% of diagnostic referrals to be seen within 6 weeks, by the end of March 2025. Although diagnostics is above plan overall, there is a shortfall in Endoscopy capacity.

3.10 Plans based on additional non-recurring funding of £1m from the West Midlands Cancer Alliance, commenced mid-October and will deliver 16.5 weeks of endoscopy activity, to treat circa 1730 patients. A sustainable endoscopy business case was supported in principle by SaTH's Board in early November and is waiting on formal feedback to progress.

4.0 Mental Health, Learning Disabilities and Autism

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
CYP access for MH Services 1+ contact (rolling 12months)	Sep 23	5590	8341			5159	5025	5294
Talking Therapies Access @ MPFT	Sep 23	297	1222			586	317	856
Access to Community MHT - Transformed Model	Aug 23	3925				3550	3268	3832
Dementia Diagnosis Rate	Oct 23	60.6%	66.7%			58.7%	57.7%	59.7%
No. of Inappropriate OoA Beddays	Aug 23	410	600			517	333	702
SMI Patients with Health Checks	Sep 23	1852				1697	1565	1830

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers accessing specialist perinatal MH services monthly	Sep 23	70	92			66	5	128
LD patients aged 14+ having Annual Health Checks - monthly	Oct 23	221				140	-10	291
Adults with LDA in Inpatient Unit per million	Oct 23	45.8	30.0			50.2	42.2	58.3
Children with LDA in Inpatient Unit per million	Oct 23	30.1	15.0			20.0	11.1	28.9

4.1 NHS Talking Therapies access numbers show concerning variation and have stabilised around 300 patients per month in September, equating to 24% of plan in month and 37% year-to-date. This is due to the correction of errors in counting and coding which were identified whilst bringing the two local services together. There is now a risk that the service may not achieve the year-end target. MPFT will provide an improvement plan and revised trajectory by the 24th November which will identify when the service will be able to meet the target.

4.2 Dementia diagnosis rates are showing significant and sustained improvement at 60.6% for October with current projections of 62-64% by March 2024 against a target of 67%. A recovery plan has been in place since August to increase the pace and rate of diagnosis. The number of patients wating for assessment has reduced from 683 in July to 519 at the end of September and the average waiting time has reduced to 6 weeks from the date of referral.

4.3 A core long term plan is for children under 18 to receive at least 1 contact against a target of 8,341 by March 2024. Performance is showing significant improvement but remains behind plan at 80% in September. Capacity and some data recording issues have led to the underperformance and an improvement plan is in place but will take time to show in the metric due be being calculated on a rolling 12-month basis.

4.4 Psychiatric Intensive Care Unit (PICU) and Acute Out of Area placements demand is volatile but occupied bed days for inappropriate placements continue to be within the operational plan target and showing sustained improving variation. At the end of September there was 1 inappropriate acute placement, and 5 inappropriate PICU placements The high demand is a national issue and is continually under review. A bed base review across STW and Staffordshire Systems led by MPFT and supported by NHSE will commence in December.

4.5 Women accessing Perinatal Mental Health services continues to exceed target by circa 18%. Waiting times from referral have seen an increase due to capacity issues combined with increasing demand for this service but have started to show some improvement since August. A demand and capacity review is underway and the completed report is due in December.

4.6 The number of physical health checks for serious mental illness (SMI) remains below target with the rolling 12-month performance in September of 1,852 against a target of 2,879 by March 2024. Data flow issues between secondary and primary care have been identified and there is a backlog of activity circa 450 health checks that have been completed but are not yet captured in primary care systems. A task and finish group has been established to correct the data flow issues and improve data recording and combined with increased activity in Quarter 4 will improve performance against the target.

4.7 Adult access to community Mental Health teams is showing sustained improvement though is currently below the target at 80% at the end of August but activity is expected to increase from Quarter 4 as additional MH teams e.g. Eating Disorders, become operational. Transformation programmes are on track to deliver improved access, address inequalities and embed new operational processes.

4.8 Annual Health Checks (AHC) for patients with LD is 710 year-to-date against a plan of 716 and on trajectory to meet the target by March 2024. A working group is focused on improving AHCs across primary and secondary care using quality audits and sharing of learning.

4.9 Inpatient stays for adults with a Learning Disability (LD) are 18 inpatients (45.8 per million population) in October against a plan for Quarter 3 of 16 due to 2 admissions in month. A root cause analysis is completed for all new admissions to determine how the admission could have been avoided. The ICB are working with regional colleagues via supportive performance reviews to ensure that the end of year target is met.

4.10 There are 3 children (30 per million population) with LD in inpatient beds against a target of 1 child at the end of Quarter 3. Changes in an inpatient's condition can result in planned discharge being put on hold but the situation is closely monitored.

4. Quality

A summary of quality indicators is provided at Appendix B.

5.1 Infection Prevention and Control Metrics are showing that the system will exceed the national objective set of 76 cases. It is currently reporting 70 cases against a trajectory for 2023/24 year-to-date of 36 (to end September 2023) and this is being quality assured with peer review visits, however, capacity issues at SaTH are preventing deep clean from progressing. A risk is now on the System risk register and continues to be monitored through the Quality and Performance Committee

5.2 The maternity dashboard continues to be monitored locally providing increased assurance of improvement, however, neonatal deaths remain above the national average with a rate of 3.2 against national rate of 2.8 deaths per 1,000 total live births. This is included in a planned system workshop into child mortality which is intended to develop a system action plan.

5.3 There have been no never events reported in the period.

5.4 Mixed sex accommodation breaches at SaTH have reduced to 72 in September from 102 in June 23. Numbers are associated with UEC pressures and high bed demand. An internal action continues.

6. Finance

Month 7 Financial Position

Revenue:

6.1 At Month 7 has a deficit of £89m, which is £44.5m adverse to plan, a variation from in-month plan of £10.5m in Month 7.

6.2 The main area of overspend continues to be in SaTH and relates to the key drivers around escalation costs, elective activity costs and staffing issues. The ICB also continues to see a year-to-date variance to plan attributable to expenditure in Prescribing and Individual Commissioning, particularly driven by price increases outstripping planned inflation.

6.3 The system is forecasting a break even position against the financial plan submitted but cannot currently provide assurance that this will be achieved. The total unmitigated risk reported at M7 is £91.7m . The main areas of concern are escalation capacity (and cost) not reducing in line with plan; potential for unavoidable discharge costs to avoid SaTH becoming overwhelmed; under delivery of efficiency plans; significant pricing increases in prescribing and individual commissioning (CHC).

6.4 System Chief Executives are overseeing work to describe the likely forecast position with delivery of actions being overseen with support from the system financial improvement director. A number of actions are being pursued to narrow the forecast range so that a position can be agreed with NHSE. All partners are pursuing additional mitigations to reduce the forecast to the lowest variance to plan possible.

6.5 A recent letter from NHSE asking all systems to review FOT positions for a national submission on 22nd November is currently being worked through at system level.

Capital:

6.6 At Month 7 the overall system capital position is £7.8m under planned expenditure (before any impact of IFRS16 treatment of leases).. All organisations are reporting slippage in phasing of internal programmes. There is also now a £1m underspend forecast against the full year plan.

6.7 IFRS16 impacts are currently excluded when reviewing total charges against the current capital allocation as they have been treated separately at a national level. However, our understanding is that this may change from Month 8 so that an allocation to include IFRS 16 impact will be distributed to all systems to manage within. The risk is that the allocation will not be enough to cover current forecast IFRS16 impacts in 23/24. We await further information from NHSE.

7. Workforce

7.1 The ICS workforce dashboard monitors the trajectory of actual substantive staff in post against plan. At the end of Month 5, when considering the 3 Trusts combined, the plan has been exceeded by 202 WTE staff (See Appendix D). Drilling down by organisation demonstrates that:

- RJAH is -53 WTE behind plan
- SaTH is +405 WTE ahead of plan
- SCHT is -41 WTE behind plan

7.2 Tracking the WTE of staff groups used in the operational plan, data shows that the Pharmacy workforce has been and continues to fall across the system, which is an area of concern. SaTH is starting to see an increase in Pharmacy workforce, now within tolerance at 87 WTE.

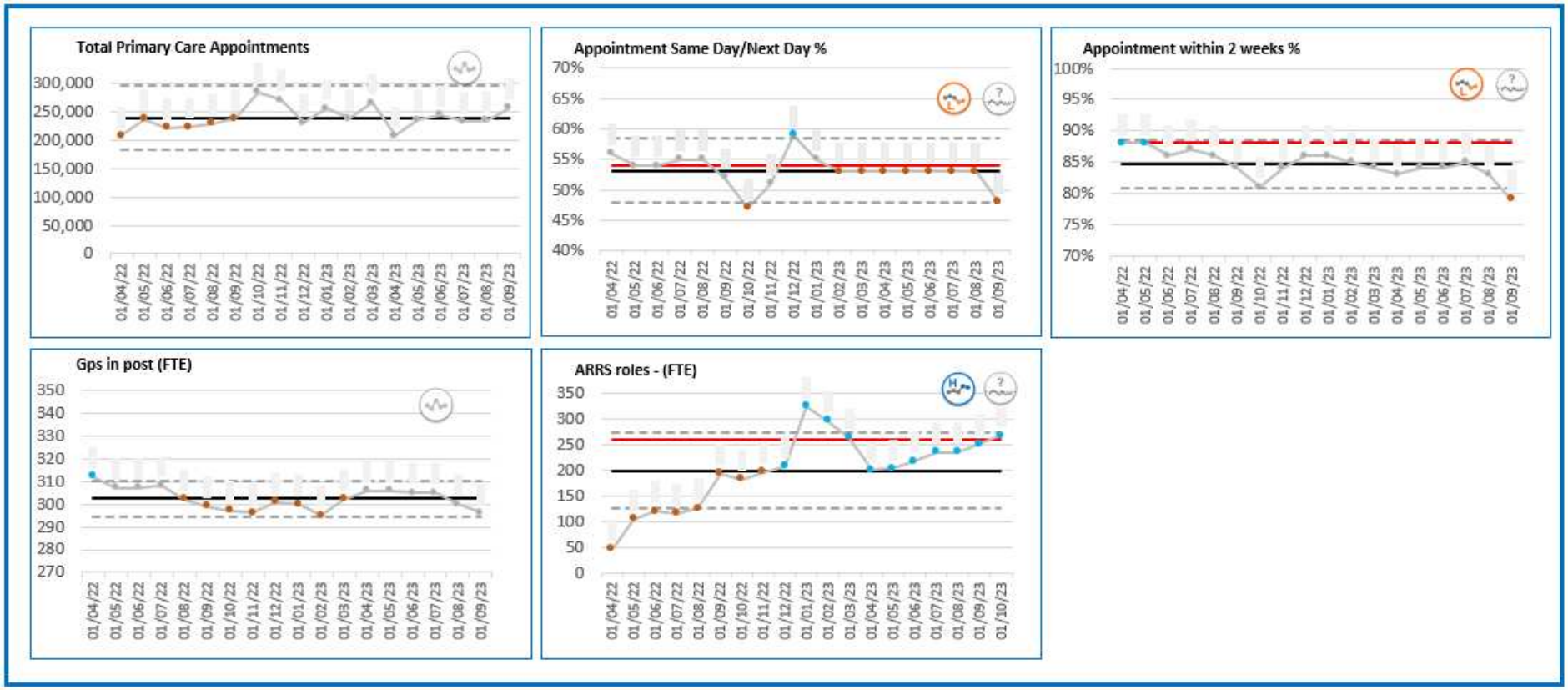
7.3 Tracking vacancies by employer, our data shows us that vacancies continue to fall overall (a reduction of 163 WTE on Month 5). Vacancies are still falling in RJAH & SaTH. There has been a slight decrease in vacancies at system level, 234 WTE are within the Nursing and Midwifery (N&M) staff group. In month 5, we noted vacancies within Allied Health Professionals (AHP) were rising, however, Month 6 has seen a small recovery (reduction of 26 WTE).

7.4 From the perspective of our temporary, flexible workforce, bank WTE there is an increasing trend for the system overall, however, Month 6 has seen a small reduction from 784 WTE to 753 WTE.

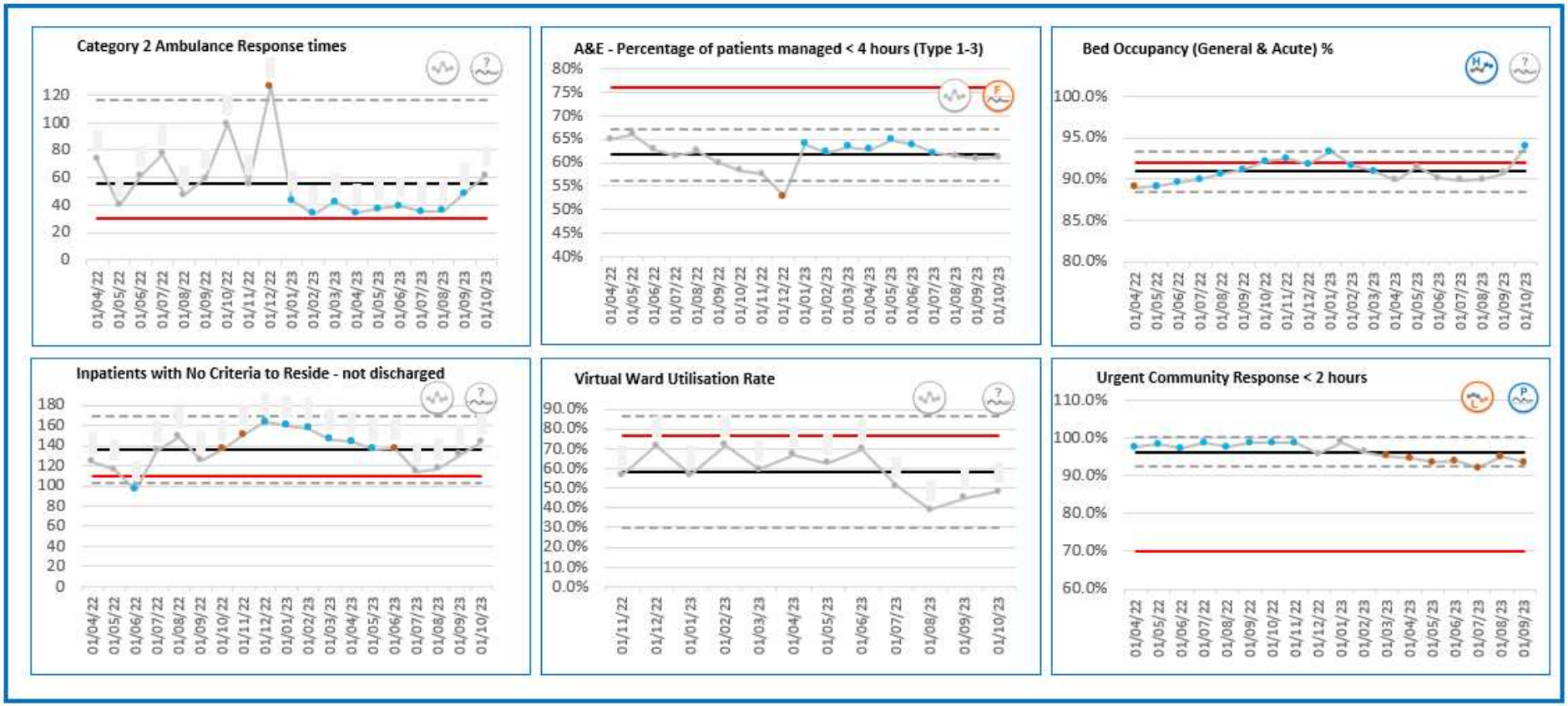
7.5 Considering sickness and turnover (in-month, not 12-month average), all employers are performing well. Each employer set targets in their operational plan and the average of these is our system target. For sickness absence, our system average target is 5.3% and for turnover is 11.9%. Trajectories for all three employers are heading in the right direction and RJAH is meeting its organisational targets.

Appendix A – Operational Metrics

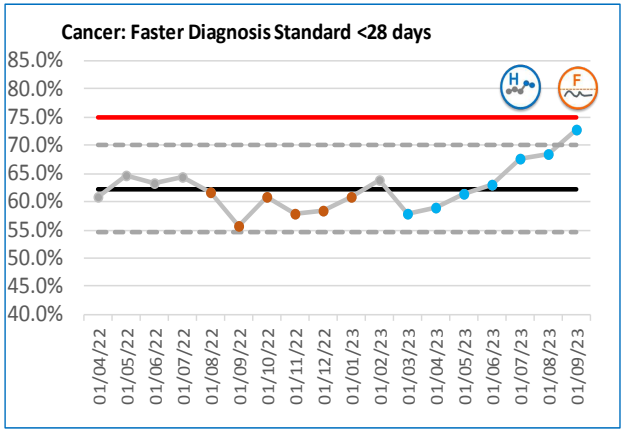
Primary Care SPC Charts

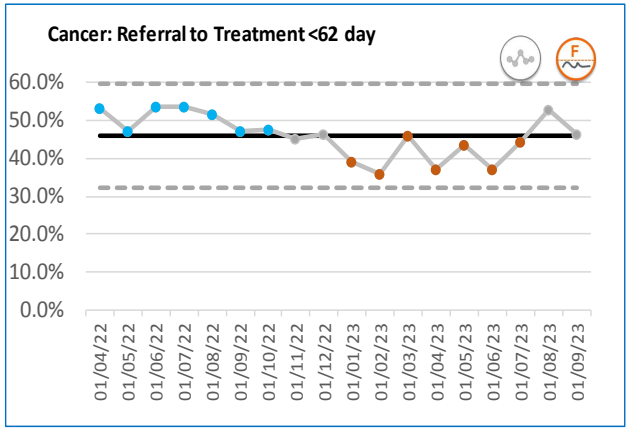


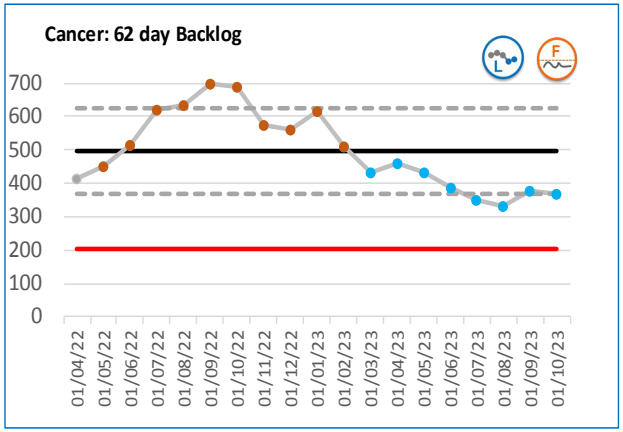
Urgent & Emergency Care SPC Charts

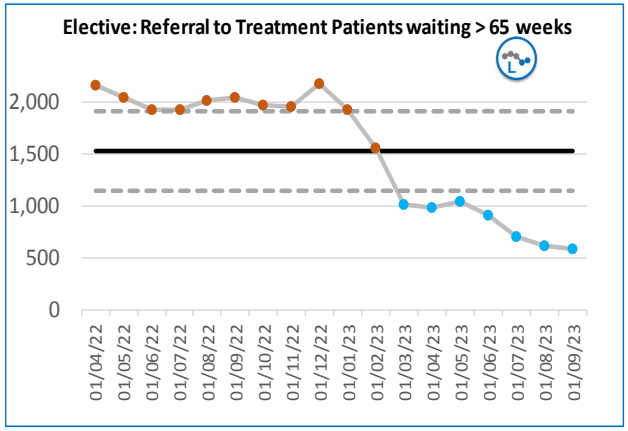


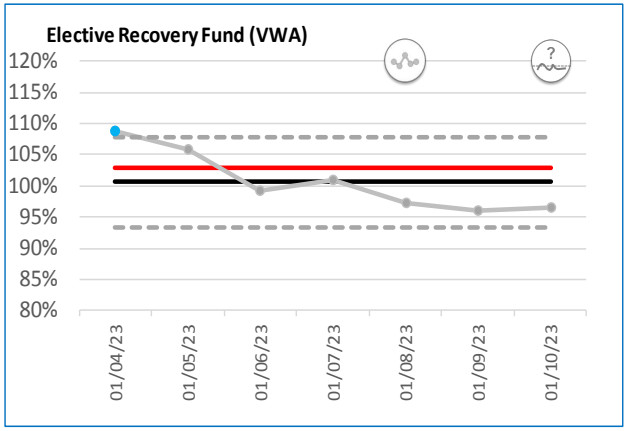
Planned Care - Elective

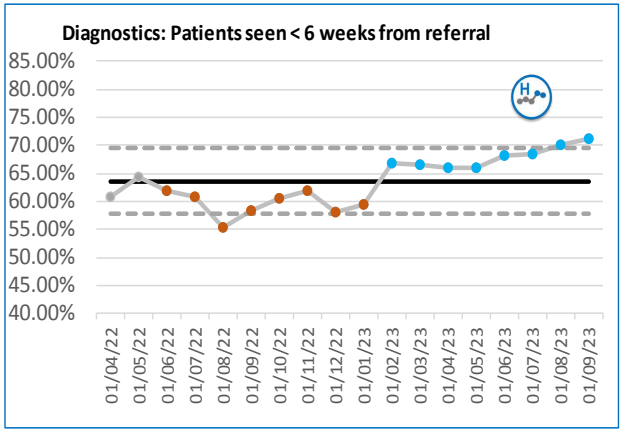




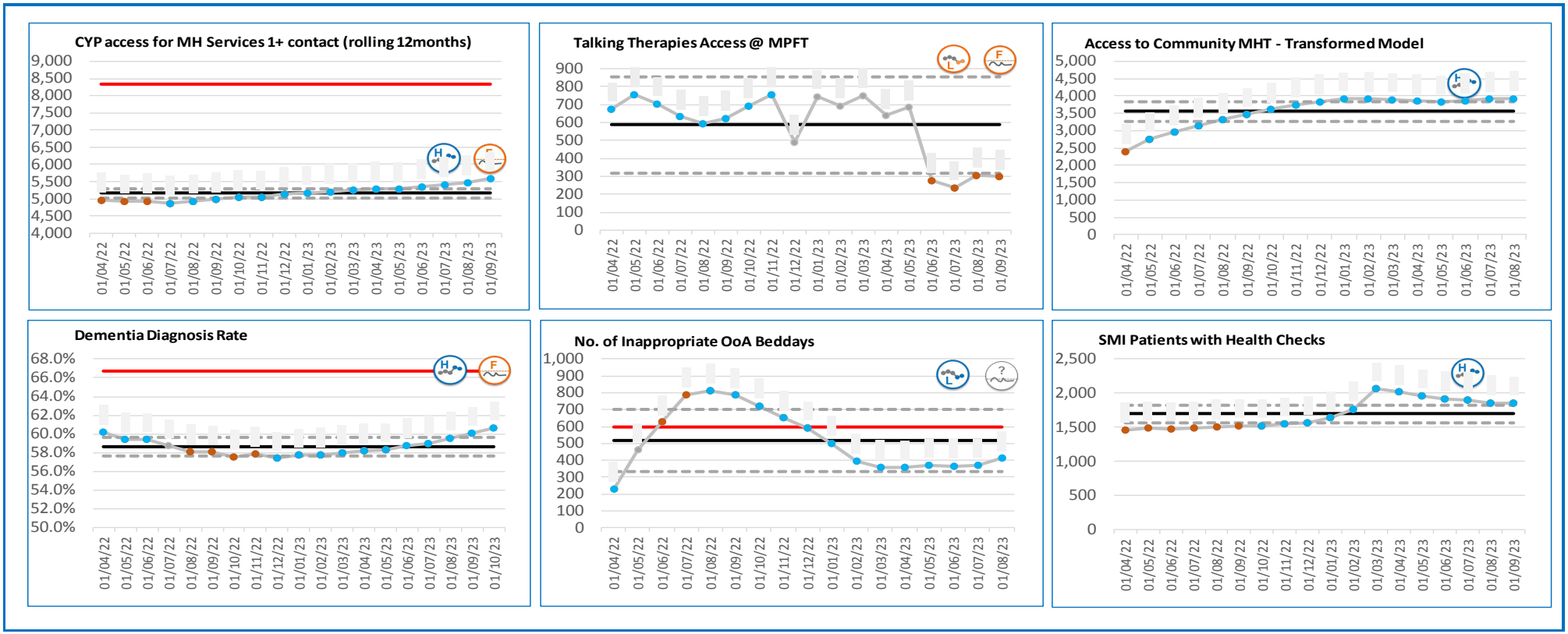


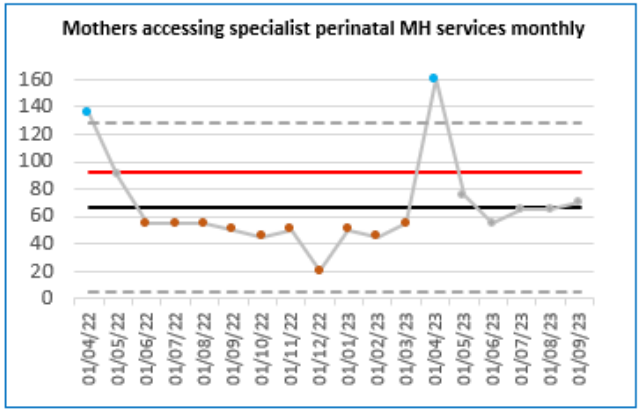


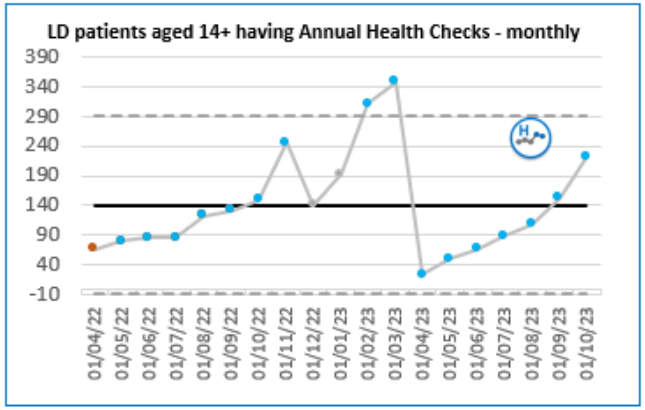


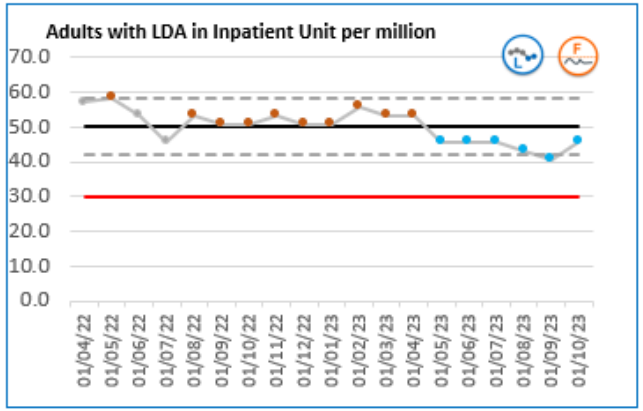


Mental Health, Learning Disabilities & Autism SPC Charts




Mothers accessing specialist perinatal MH services monthly
160
140
120
100
80
60
40
20
0
01/04/22
01/05/22
01/06/22
01/07/22
01/08/22
01/09/22
01/10/22
01/11/22
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23

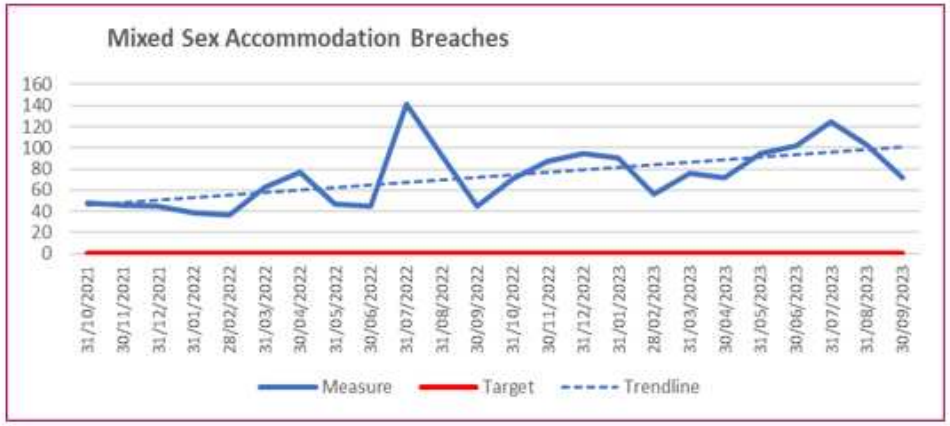

LD patients aged 14+ having Annual Health Checks - monthly
390
340
290
240
190
140
90
40
-10
H
01/04/22
01/05/22
01/06/22
01/07/22
01/08/22
01/09/22
01/10/22
01/11/22
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23


Adults with LDA in Inpatient Unit per million
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
L
F
01/04/22
01/05/22
01/06/22
01/07/22
01/08/22
01/09/22
01/10/22
01/11/22
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23

Appendix B – Quality Metrics

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
CHC	% Referrals completed within 28 days			47.0%	2023/24 Qtr 2	England = 75.8%												
	Incomplete Referrals delayed >12 weeks			77	2023/24 Qtr 2													
	% of IRPs taking place in 6 months or less from IRP request date																	
Incidents	Number of Never Events				Cumulative Apr 23 - Sep-23	0	1			1								
	Number/Trend Serious Incidents				Monthly Apr 23 - Jun-23		1452			133			1557			45		
Friends & Family Test	Friends & Family Test - Inpatient				Sep-23 Public	Not applicable Higher is better	98.8%	1526		98.0%	247							
	Friends & Family Test - Community				Sep-23 Public	Not applicable Higher is better										96.4%	251	
	Friends & Family Test - A&E				Sep-23 Public	Not applicable Higher is better	38.1%	21										
	Friends & Family Test - Mental Health				Sep-23 Public	Not applicable Higher is better							90.00%	320				
MSA	Mixed Sex Accommodation Breaches				Sep-23	Zero Lower is better	72											
IPC	C.difficile		36	70	Cumulative Apr 23 - Sep-23	SATH Objective = 16 RJAH Objective = 1	42			4								
	E.coli Bacteraemia		156	222	Cumulative Apr 23 - Sep-23	SATH Objective = 45 RJAH Objective = 1	59			3								
	Pseudonmonas aeruginosa Bacteraemia		16	20	Cumulative Apr 23 - Sep-23	SATH Objective = 9 RJAH Objective = 0	12			0								
	Klebsiella spp Bacteraemia		36	50	Cumulative Apr 23 - Sep-23	SATH Objective = 11 RJAH Objective = 0	14			0								
	MRSA Bacteraemia		0	3	Cumulative Apr 23 - Sep-23	SATH Objective = 0 RJAH Objective = 0	1			0								
	MSSA Bacteraemia		0	70	Cumulative Apr 23 - Sep-23	No trajectory set	30			1								
Maternity	Stillbirths per 1,000 total births	3.3			2018 - 20	England = 3.9												
	Neonatal deaths per 1,000 total live births	3.2			2018 - 20	England = 2.8												

Primary Care Recovery plans will be presented to ICB Board in November and will be incorporated into future reports.



The Mixed sex accommodation breaches at SaTH have reduced to 72 in September from 103 in August. These remain high and the trust is staking action to reduce these further as part of an ongoing action. Incidents of *Clostridioides difficile* (C diff) infection remain above the monthly trajectory for the system and all partner NHS organisations have breached their annual trajectories. A system action plan is in place and is reviewed monthly at the System IPC and Antimicrobial Resistance Group. There are no new never events to report in this period.

Due to national changes information on Serious Incidents numbers is currently paused while NHSE considers future publications in line with the introduction of the Learning from Patient Safety Events Platform. The System is implementing the Patient Safety Incident Response Framework (PSIRF) and NHS partners are committed to implementing this by January 2023.

Appendix C – Finance M7

Organisation	MONTH Plan Surplus/ (Deficit) £000	MONTH Actual Surplus/ (Deficit) £000	MONTH Variance to Plan £000	YTD Plan Surplus/ (Deficit) £000	YTD Actual Surplus/ (Deficit) £000	YTD Variance to Plan £000	FULL YEAR Plan Surplus/ (Deficit) £000	FULL YEAR Forecast Surplus/ (Deficit) £000	FULL YEAR Variance to Plan £000	PRIOR YEAR Actual £000	Prior Month FOT Actual £000	Movement £000
Commissioners												
NHS Shropshire, Telford and Wrekin	(639)	(2,628)	(1,989)	(7,961)	(16,415)	(8,454)	(11,828)	(11,827)	1	(21,516)	(11,828)	1
Total Commissioners	**(639)**	**(2,628)**	**(1,989)**	**(7,961)**	**(16,415)**	**(8,454)**	**(11,828)**	**(11,827)**	**1**	**(21,516)**	**(11,828)**	**1**
Providers												
The Shrewsbury and Telford Hospital NHS Trust	(3,881)	(11,212)	(7,332)	(35,902)	(68,661)	(32,759)	(45,462)	(45,462)	0	(47,206)	(45,462)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	475	(761)	(1,236)	(1,007)	(4,354)	(3,347)	191	192	1	2,454	191	1
Shropshire Community Healthcare NHS Trust	(6)	6	12	296	355	59	0	0	0	1,092	0	0
Total Providers	**(3,412)**	**(11,967)**	**(8,555)**	**(36,613)**	**(72,660)**	**(36,047)**	**(45,271)**	**(45,270)**	**1**	**(43,660)**	**(45,271)**	**1**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(4,051)**	**(14,595)**	**(10,544)**	**(44,574)**	**(89,075)**	**(44,501)**	**(57,099)**	**(57,097)**	**2**	**(65,176)**	**(57,099)**	**2**

Key Data

- £89.0m YTD System deficit
- £10.5m in month adverse variance to plan
- £44.5m adverse to plan YTD at M7.
- Forecasting delivery of the plan but with significant risk (unmitigated £91.7m). If the full unmitigated risk was added to the planned deficit this would result in a £148.8m in year system deficit. All organisations are working through updating risk values and developing phased mitigation plans for the year in preparation for confirming a realistic forecast position with NHSE through the FOT change protocol. The recent letter from NHSE asking all systems to review FOT positions for a national submission on 22nd November is currently being worked through at a system level and will impact on the forecast outturn and risk position at month 8.
- £17.7m above agency expenditure plan at M7 and £26.9m above the agency cap (£15.8m cap ytd) for the system. Excluding the insourcing costs core agency spend is £7.4m above plan. £10.3m of the ytd spend relates to insourcing staff costs at SaTH and RJAH which are now required to be accounted for as agency costs.
- SATH run rate overspend continues and in M7 there is a further deterioration in the ICB position due to overspend in CHC and in the RJAH position due to ongoing industrial action and staff cost impacts.

What have we done and next steps

- All organisations are working through phased mitigation plans for the year.
- Medium to Long Term Financial Plan Development underway in line with system demand and capacity modelling.
- Operational leads working collectively on system bed model, discharge schemes and reducing escalation costs.
- Strengthening system-wide financial governance, particularly around pay controls. Fortnightly agency reduction meeting chaired by ICB Chief Nursing Officer.
- Efficiency and transformation plan development led through the Financial Improvement Programme Group.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Finance - M7 position by organisation

SATH

YTD deficit of £68.7m, an adverse position to plan of £32.8m YTD. This variance is split between elements deemed to be within SaTHs control (£11.7m) and outside of SaTHs direct control (£21.1m).

- Within SaTHs control, the key drivers are in year CIP slippage of £3.0m, £2.5m junior doctor staffing above funded levels, £2.4m ongoing nurse staffing above funded levels, £2.2m nursing unavailability, £1.4m enhanced bank rates, £1.4m historic workforce BTI efficiency slippage These pressures are partially offset by substantive vacancies not covered through temporary staffing.

- Outside SaTHs control, the key drivers are £7.2m escalation cost above funded levels, £6.2m of increased elective activity costs (insourcing and internal costs), £2.2m industrial action cover, £1.6m Enhanced Care Support linked to high levels of NCTR patients, £1.3m pay award cost pressure, £2.5m excluded drugs costs.

SATH flagging £61.9m of unmitigated risk to delivering the financial plan for 23/24.

RJAH

YTD deficit of £4.4m, an adverse position to plan of £3.3m YTD. This variance is driven by

External drivers £2.6m :
- £1.7m industrial action impact on income unmitigated
- £0.6m technical income shortfalls (Road traffic accident and Low Value Agreement block overperformance)
- £0.3m excess inflation impact

Internal drivers £0.7m :
£1.0m capacity (workforce driven)
£2.6m cost pressures
Partially offset by £2.9m mitigations (vacancy, private patient income, balance sheet, interest receivable)

RJAH flagging £4.8m of unmitigated risk to delivering the financial plan for 23.24.

SCHT

YTD surplus of £0.4m, £59k favourable YTD position to plan.

- Overall pay position is a small favourable variance but agency spend continues to exceed plan. There has been a continued downward trend in the monthly-rate of agency spend compared to Q1 reduced in month and weekly agency scrutiny group now in place
- CIP performance adverse by £62k YTD but operational areas working at pace to increase recurrent CIP delivery and identification of additional schemes to address forecast shortfalls.

SCHT flagging £1m unmitigated risk to delivering the financial plan for 23/24.

STW ICB

YTD deficit of £16.4m , an adverse position to plan of £8.5m YTD. This variance is driven by:

- £1.1m overspend on acute due to prior year and independent sector activity overperformance and a reduced assumption in anticipated additional ERF income.
- £6.3m overspend on individual commissioning budgets which appears to be predominantly due to price increases above the levels funded.
- £1.4m overspend on primary care predominantly due to the overspend YTD on in year prescribing offset with a prior year benefit Prescribing has seen monthly increases compared to previous year ranging from 7-18% in the first few months of the year. NCSO and Cat M pricing issues continue to hit as well as volume increases.
- £1.6m overspend on other due to Welsh ERF income not materialising in line with planning assumptions
- £1.2m YTD hit to the position due to unidentified efficiency
- These variances are offset with £3.0m of underspends across community, running costs and POD (Pharmacy, Optometry, Dental)

ICB flagging £24m of unmitigated risk to delivering the financial plan for 23/24

NHS

2

Financial Risk

System Risk	23/24 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk £'000	Prior Month Un-Mitigated Risk £'000	Movement from Prior Month £'000	Un-Mitigated 23/24 Plan Risk £'000	Movement from Plan £'000
NHS Shropshire, Telford & Wrekin ICB	41,522	(17,531)	23,991	27,141	3,150	17,661	(6,330)
Robert Jones & Agnes Hunt Hospital	9,244	(4,443)	4,801	4,701	(100)	7,066	2,265
Shrewsbury & Telford Hospitals	94,649	(32,738)	61,911	66,461	4,550	63,678	1,767
Shropshire Community Hospital Trust	2,925	(1,923)	1,002	3,459	2,457	4,876	3,874
Grand Total	148,340	(56,635)	91,705	101,762	10,057	93,281	1,576

A number of areas remain a high financial risk for the ICS. The current net risk for each organisation is presented above including the movement from prior month and since the plan submission.

The un-mitigated risk total has improved by £10.1m overall since M6. This is largely driven by increased mitigations for ERF, inflationary factors, dental underspend and staff cost impacts.

The total SaTH risk position is in relation to staffing pressures (sickness, maternity, industrial action), and activity/escalation growth. Additional risk is identified within RJAH arising from lost activity due to industrial action (Welsh commissioner income (differential in funding rules)).

The key themes of risk are:

- Efficiency delivery
- Elective recovery delivery and receipt of associated income
- Escalation costs
- Staffing and related cost pressures
- Discharge monitoring
- Prescribing and CHC

Efficiency

£000's	Month 7 YTD			Full Year Plan and Forecast								
Organisation	YTD Plan	Actual	Variance	Plan Value £000's	Low Risk	Medium Risk	High Risk	Unidentified Core Target	Unidentified Stretch	Total Forecast £000's	Variance from Plan	% of Recurrent Savings forecast compared to Plan
SaTH	12660	5533	-7127	35,452	18,296	3,139	9,364	0	4653	35,452	0	100%
RJAH	2331	2309	-22	4,563	3,875	403	155	0	0	4,433	130	102%
SCHT	1973	1911	-62	4,108	2998	663	223	0	224	4,108	0	100%
ICB	13578	13043	-535	25,947	14,492	6,796	2,517	0	2,142	25,947	0	109%
Total	**30,542**	**22,796**	**-7,746**	**70,070**	**39,661**	**11,001**	**12,259**	**0**	**7,019**	**69,940**	**130**	

	M7 YTD			Full Year		
Recurrent	Plan	Actual	Variance	Plan	Forecast	Variance
SaTH	6612	2409	-4203	17,079	17079	0
RJAH	2016	2099	83	3,933	4,013	80
SCHT	1118	837	-281	2386	2386	0
ICB	10192	10415	223	18731	20325	1,594
Total	19938	15760	-4178	42,129	43,803	1,674

	M7 YTD			Full Year		
Non Recurrent	Plan	Actual	Variance	Plan	Forecast	Variance
SaTH	6048	3124	-2924	18373	18373	0
RJAH	315	210	-105	630	420	-210
SCHT	855	1074	219	1722	1722	0
ICB	3386	2627	-759	7216	5622	-1594
Total	10604	7035	-3569	27941	26137	-1804

- At M7 YTD the system efficiency programme is £7.7m adverse to plan. £7.1m is within SATH with the majority relating to ongoing escalation costs. Mitigations are in place to address this which are being overseen by the UEC delivery group.
- 90% of the total plan has now been identified however, there is high risk associated with the delivery of non-recurrent plans and there remains £7m of unidentified system stretch target.
- System wide opportunities to address the remaining stretch target are tracked though the financial improvement programme group. Further non recurring opportunities remain within the ICB and organisations are looking to stetch forecasts of local plans where possible. Opportunities will focus on recurrent delivery where possible.

Although the system is currently forecasting full delivery of the efficiency plan, there is overall risk associated with delivery which is flagged within the financial risk slide.
A review of forecast is currently being undertaken which is to be agreed with NHSE.

NHS

4

CAPITAL PROGRAMME	MONTH			YTD			FULL YEAR			PRIOR YEAR	Prior Month FOT	Movement
Organisation	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Forecast £000	Variance to Plan £000	Actual £000	Actual £000	Actual £000
Total Charge against Capital Allocation (before impact of IFRS16)												
NHS Shropshire, Telford and Wrekin	(134)	0	134	(161)	0	161	(883)	(883)	0	(1,243)	(883)	0
The Shrewsbury and Telford Hospital NHS Trust	(1,480)	(721)	759	(7,433)	(3,087)	4,346	(19,391)	(18,450)	941	(19,798)	(19,391)	941
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(913)	(491)	422	(4,439)	(1,267)	3,172	(7,360)	(7,344)	16	(10,137)	(7,344)	0
Shropshire Community Healthcare NHS Trust	(210)	(89)	121	(1,044)	(949)	95	(2,500)	(2,500)	0	(2,497)	(2,500)	0
TOTAL SYSTEM	**(2,737)**	**(1,301)**	**1,436**	**(13,077)**	**(5,303)**	**7,774**	**(30,134)**	**(29,177)**	**957**	**(33,675)**	**(30,118)**	**941**
Total CDEL												
NHS Shropshire, Telford and Wrekin	(134)	0	134	(318)	0	318	(1,150)	(1,996)	(846)	(1,243)	(883)	(1,113)
The Shrewsbury and Telford Hospital NHS Trust	(27,434)	(20,420)	7,014	(27,434)	(20,420)	7,014	(69,226)	(85,507)	(16,281)	(19,798)	(19,391)	(66,116)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(1,101)	(597)	504	(6,729)	(1,831)	4,898	(12,080)	(12,064)	16	(10,137)	(7,344)	(4,720)
Shropshire Community Healthcare NHS Trust	(1,621)	(167)	1,454	(2,927)	(1,132)	1,795	(4,546)	(6,168)	(1,622)	(2,497)	(2,500)	(3,668)
TOTAL SYSTEM	**(30,290)**	**(21,184)**	**9,106**	**(37,408)**	**(23,383)**	**14,025**	**(87,002)**	**(105,735)**	**(18,733)**	**(33,675)**	**(30,118)**	**(75,617)**

Summary

- IFRS16 impacts are currently excluded when reviewing total charges against the current capital allocation as they have been treated separately at a national level. However, our understanding is that this may change from Month 8 so that an allocation to include IFRS16 impact will be distributed to all systems to manage within. The risk is that the allocation will not be enough to cover current forecast IFRS16 impacts in 23/24.
- The SaTH capital programme is behind the YTD plan due to the phasing of the internal programme. The full year forecast is slightly under plan and is expected to deliver. Cash support to enable the delivery of the BAU programme has been approved in month. The total CDEL forecast is £16.3m greater than plan due to £13m for HTP enabling costs plus £6m HTP professional fees, offset by £3m reduction against modular wards (£21m against plan of £24m).
- RJAH YTD slippage relates to the theatre project which will be delivered in year.
- SCHT YTD slippage is due to asset disposal and delays in new projects. The total CDEL forecast exceeds plan due to the impact of incorporating IFRS16 leases.
- STWICB YTD slippage is expected to be fully spent in year. The total CDEL forecast is above plan due to the net impact of new and terminating IFRS16 leases arising from corporate office relocation. Papers have been submitted seeking approval of national CDEL funding to support this.

What have we done and next steps

- There are a number of approved schemes that are due to be delivered in 2023/24 including the Elective Hub at PRH, the Community Diagnostic Centre in Telford, the modular wards to support sub-acute care and the continuation of national digital funding.
- The OBC for HTP was presented to the national Joint Investment Committee (JIC) in early August.
- The system capital prioritisation and oversight group is closely monitoring the delivery of the 2023/24 capital plan including the management of the 105% planning assumption.
- A Capital Approval Summary has been submitted to the Regional & National teams for the new ICB IFRS16 – this is expected to be approved in Dec.

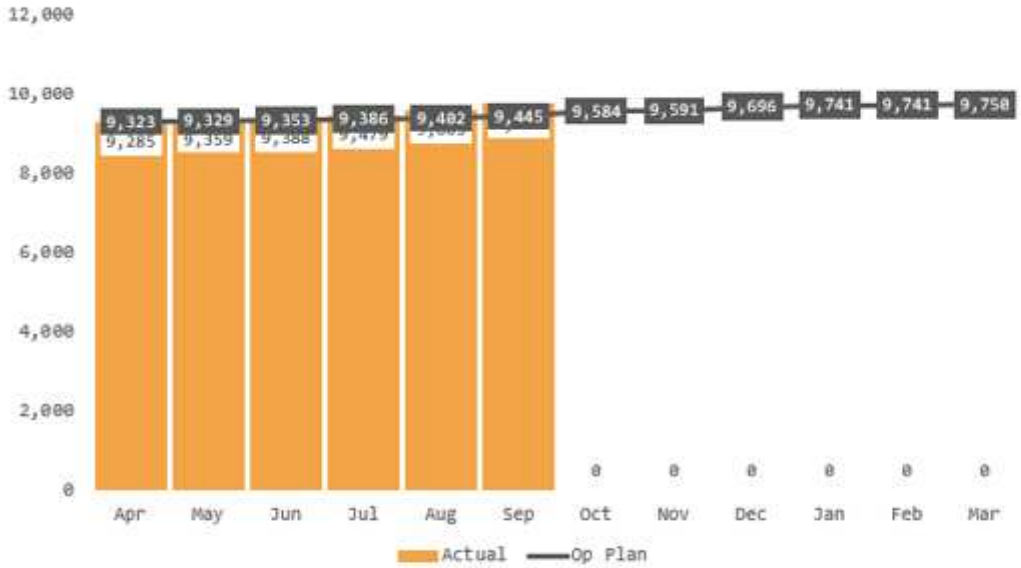
Integrated Care System
Shropshire, Telford and Wrekin

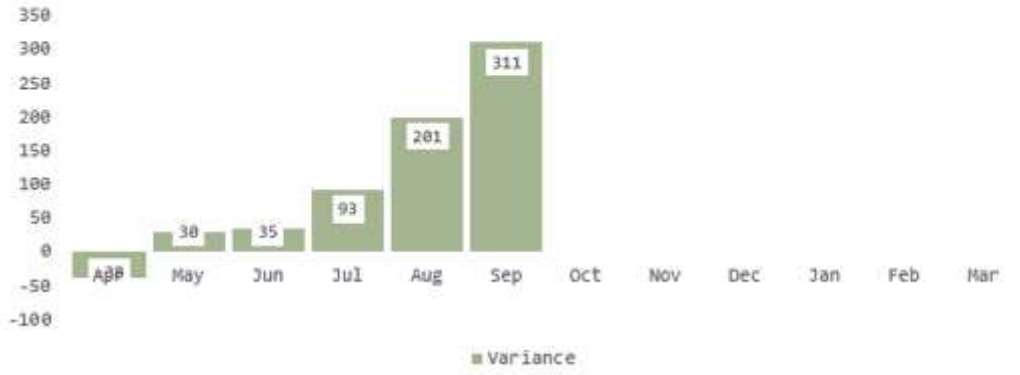
NHS
Shropshire, Telford and Wrekin

Appendix D - Workforce

Staff in Post: Plan vs Actual

WTE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Op Plan	9,323	9,329	9,353	9,386	9,402	9,445	9,584	9,591	9,696	9,741	9,741	9,750
Actual	9,285	9,359	9,388	9,479	9,603	9,756	0	0	0	0	0	0
Variance	-38	30	35	93	201	311						





NB. National Occupation Code changes are responsible for the large movement between Other STT and Infrastructure in all workforce metrics.

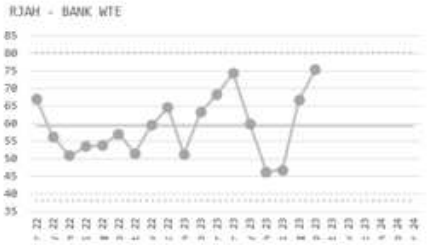
Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Substantive (WTE)	Total	PWR	Sep 23	9,756	6,892	1,483	1,381
	Registered Nursing & Midwifery	PWR	Sep 23	2,637	1,872	284	481
	HCSW	PWR	Sep 23	1,313	997	181	136
	Infrastructure	PWR	Sep 23	2,680	1,724	562	393
	Allied Health Professionals	PWR	Sep 23	720	397	162	160
	Pharmacy	PWR	Sep 23	122	87	15	20
	Other STT	PWR	Sep 23	295	239	25	31
	GP, Medical and Dental	PWR	Sep 23	988	810	153	24

NB. For this purpose, vacancies are defined as the difference between budgeted establishment an actual staff in post. They are not intended to match actual vacancies authorised for advert by any employer

Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Vacancies (WTE)	Total	PWR	Sep 23	476	192	85	199
	Registered Nursing & Midwifery	PWR	Sep 23	234	125	33	76
	HCSW	PWR	Sep 23	119	72	24	23
	Infrastructure	PWR	Sep 23	83	24	9	51
	Allied Health Professionals	PWR	Sep 23	107	57	16	34
	GP, Medical and Dental	PWR	Sep 23	40	24	10	6
Vacancy Rate %	Total	PWR	Sep 23	4.7%	2.7%	5.4%	12.6%
	Registered Nursing & Midwifery	PWR	Sep 23	8.1%	6.3%	10.4%	13.6%
	HCSW	PWR	Sep 23	8.3%	6.7%	11.8%	14.7%
	Infrastructure	PWR	Sep 23	3.0%	1.4%	1.5%	11.4%
	Allied Health Professionals	PWR	Sep 23	13.0%	12.6%	9.0%	17.5%
	GP, Medical and Dental	PWR	Sep 23	3.9%	2.9%	5.9%	20.9%


SYSTEM - BANK WTE

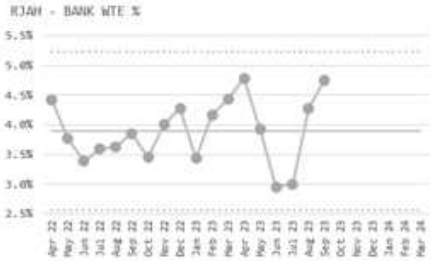

SATH - BANK WTE

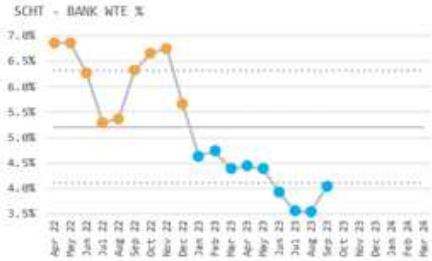

RJAH - BANK WTE


SCHT - BANK WTE

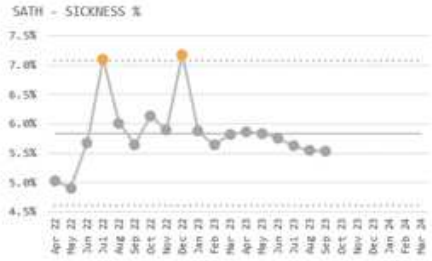

SYSTEM - BANK WTE %

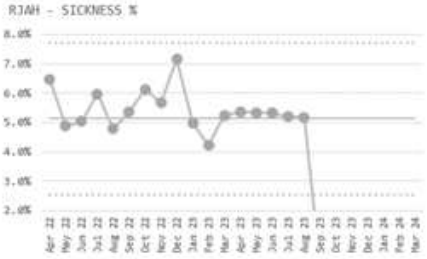

SATH - BANK WTE %


RJAH - BANK WTE %


SCHT - BANK WTE %

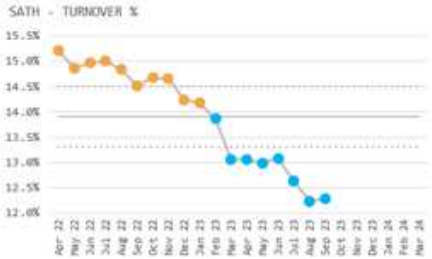

SYSTEM - SICKNESS %


SATH - SICKNESS %


RJAH - SICKNESS %


SCHT - SICKNESS %


SYSTEM - TURNOVER %


SATH - TURNOVER %


RJAH - TURNOVER %


SCHT - TURNOVER %

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-130
Meeting date:	29 November 2023
Paper title	Amendments to the Governance Handbook
Paper presented by:	Alison Smith, Director of Corporate Affairs
Paper approved by:	Alison Smith, Director of Corporate Affairs
Paper prepared by:	Tracy Eggby-Jones, Corporate Affairs Manager Sara Hayes, Deputy People Officer
Signature:	Alison Smith
Committee/Advisory Group paper previously presented:	N/A

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance	X	D=Discussion		I=Information	

Previous considerations:	Not Applicable

1. Executive summary and points for discussion

1.1. The purpose of this report is to seek approval from the Board on a number of proposed amendments to the Audit Committee and Integrated Care System (ICS) People Culture and Inclusion Committee Terms of Reference (TOR) and related changes to the Scheme of Reservation and Delegation (SoRD), which have been highlighted from internal audit reports and a review of the System People Committee operating model.

1.2. The paper also sets out a proposal to create a new sub-committee of the System People, Culture and Inclusion Committee to oversee the Integrated care Board (ICB) employer's responsibilities and have specific delegated decision making on behalf of the Board.

1.3. The report below outlines in detail what changes are being proposed and the rationale for these. The attached appendices propose changes in red text.

1.4. The Board is asked to consider and approve the suggested amendments and additions to facilitate efficient operational processes of the system, and the ICB.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	X
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	

3. Recommendation(s)

3.1 NHS Shropshire, Telford and Wrekin Board is asked to.

3.1.1. **APPROVE** the proposed amendments to the Terms of Reference for the Audit Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

3.1.2. **APPROVE** the proposed amendments to the Terms of Reference of the **ICS** People, Culture and Inclusion Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

3.1.3. **APPROVE** the proposed new Terms of Reference of the **ICB** People, Culture and Inclusion Sub-Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

4.1 N/A

5. Appendices

5.1. Appendix 1 - Updated Terms of Reference for the Audit Committee with changes highlighted in red text.

5.2. Appendix 2 – Updated Terms of Reference for the System People, Culture and Inclusion Committee with changes highlighted in red text.

5.3. Appendix 3 – Newly created Terms of Reference for the ICB People Culture and Inclusion Sub-Committee.

5.4. Appendix 4 - Updated Scheme of Reservation and Delegation with changes highlighted in red text.

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	No impact identified
Quality and Safety	No impact identified
Equality, Diversity, and Inclusion	No impact identified
Finances and Use of Resources	No impact identified
Regulation and Legal Requirements	No impact identified
Conflicts of Interest	No impact identified
Data Protection	No impact identified
Transformation and Innovation	No impact identified
Environmental and Climate Change	No impact identified
Future Decisions and Policy Making	Inability to demonstrate effective oversight of policy management.

Action Request of Paper:	**NHS Shropshire, Telford and Wrekin Board is asked to.** • **APPROVE** the proposed amendments to the Terms of Reference for the Audit Committee and the related addition to the ICB's Scheme of Reservation and Delegation. • **APPROVE** the proposed amendments to the Terms of Reference of the ICS People, Culture and Inclusion Committee and the related addition to the ICB's Scheme of Reservation and Delegation. • **APPROVE** the proposed new Terms of Reference of the ICB People, Culture and Inclusion Sub-Committee and the related addition to the ICB's Scheme of Reservation and Delegation.		
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Agenda Item	ICB 29-11-130
Meeting Date	29th November 2023
Report Title	Amendments to the Governance Handbook:

	• Updated Terms of Reference for the Audit Committee • Updated Terms of Reference for the **System** People Committee • Proposed Terms of Reference for the **ICB** People, Culture and Inclusion Sub-Committee

1. Introduction

1.1. The purpose of this report is to seek Board approval on the proposed amendments to the Audit Committee terms of reference (TOR) and System People, Culture and Inclusion Committee TOR.

1.2. The report also proposes the creation of a new Sub Committee; Integrated care Board (ICB) People Culture and Inclusion, to specifically oversee the discharge of the Board's statutory duties as an employer.

1.3. Finally, the report sets out in appendix 4 the related amendments needed to the Scheme of Reservation and Delegation (SoRD), to support the proposed changes.

2. Audit Committee Amendments

2.1. As part of the Internal Audit review in respect of policy management, the ICB's Policy on the Management of Policies was reviewed. One of the findings noted that the policy states the Audit Committee was the sponsoring committee for policy management oversight within the ICB, however, this was not reflected in the Audit Committee's TOR.

2.2. The proposed amendments to the Audit Committee TOR to align the TOR with the policy are outlined below:

2.2.1. New section

6.10 - Policy Management

6.10.1 The Committee shall satisfy itself that NHS STW's policy, systems and processes for the management of polices are effective including receiving reports relating to non-compliance with NHS STW policy on the management of polices.

***2.2.2.* New bullet point**

6.13 Decision Making

- *Approve NHS STW's policy management arrangements and oversight, including the policy on the management of policies, supporting plans, policies and procedures.*

2.3. The changes are highlighted in the TOR attached at appendix 1 for information.

3. Scheme of Reservation and Delegation (SoRD)

3.1. The ICB's SoRD (page 10 of the Governance Handbook) and attached as appendix 4 to this report has also been updated to include a new line under Section 2 – Constitution & Governance, giving delegated authority to the Audit Committee to:

3.1.1. Approve the arrangements, including supporting plans, policies and procedures for policy management.

3.2. The Internal Audit review also identified several areas of good practice for potential inclusion to the ICB's Policy on the Management of Policies. The policy is currently being reviewed to consider and incorporate these suggestions and the comments received from the ICB's Commissioning Working Group. Once the Board has given approval for the Audit Committee to approve this policy then the Audit Committee can receive the additional amendments highlighted by the internal audit report at its meeting in January for consideration.

4. System People Committee Amendments

4.1. The Chief People Officer and Deputy Chief People Officer have undertaken a review of the system People agenda and the governance infrastructure needed to support this significant area of work for Shropshire, Telford & Wrekin (STW).

4.2. As a result, the TOR for the System People Committee, now the Integrated Crae System (ICS) People, Culture and Inclusion Committee, have been reviewed and revised as shown in appendix 2 attached.

4.3. In addition, it is also proposed that a new Sub Committee called the ICB People, Culture and Inclusion Sub-Committee is created as a sub committee of the ICS People, Culture and Inclusion Committee. It is proposed that this sub-committee has delegated decision making on behalf of the Board in relation to presentation of workforce dashboards, approving related policies, procedures and plans in relation to Human Resources (HR) and Health and Safety and other areas related specifically to ICB staff.

4.4. Attached as appendix 3 are draft TOR for this new sub-committee and the specific approval delegation is outlined in the SoRD attached as appendix 4.

5. Recommendation

5.1. NHS Shropshire, Telford and Wrekin Board is asked to.

5.1.1. **APPROVE** the proposed amendments to the Terms of Reference for the Audit Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

5.1.2. **APPROVE** the proposed amendments to the Terms of Reference of the ICS People, Culture and Inclusion Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

5.1.3. **APPROVE** the proposed new Terms of Reference of the ICB People, Culture and Inclusion Sub-Committee and the related addition to the ICB's Scheme of Reservation and Delegation.

Appendix 1

NHS Shropshire, Telford and Wrekin

Audit Committee

Terms of Reference

1. Constitution

1.1 The Audit Committee (the Committee) is established by the Board of NHS Shropshire, Telford and Wrekin (the Board or NHS STW) as a Committee of the Board in accordance with its Constitution.

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

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The Audit Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS STW's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

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

3. Purpose

3.1 To contribute to the overall delivery of NHS STW objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS STW.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.3 The Audit Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these terms of reference.

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.1.2 The Board will appoint no fewer than four members of the Committee including four who are Independent Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

4.1.3 Neither the Chair of the Board, nor employees of NHS STW will be members of the Committee.

4.1.4 Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to NHS STW's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.1.5 The membership of the Committee will be as follows:

- Non Executive Director – Audit Committee (Chair)
- Non Executive Director – Remuneration Committee
- Non Executive Director – Digital
- Non Executive Director - Inequalities

4.2 Chair and vice chair

4.2.1 In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of

their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 The Committee will be chaired by the Non Executive Director – Audit Committee.

4.2.3 The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

4.2.4 Committee members may appoint a Vice Chair who may or may not be a Non Executive of NHS STW.

4.2.5 In the absence of the Chair, or nominated Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

4.2.6 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

a) Chief Finance Officer or their nominated deputy;
b) Representatives of both internal and external audit;
c) Individuals who lead on risk management and counter fraud matters;

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

4.3.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

4.3.4 The Chief Executive should be invited to attend the meeting at least annually.

4.3.5 The Chair of NHS STW may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

4.4 Attendance

4.4.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

4.5 Access

4.5.1 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.

5. Meetings Quoracy and Decisions

5.1 The Audit Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

5.4 Quorum

5.4.1 For a meeting to be quorate a minimum of 50% members is required, with at least two ICB Non Executives in attendance.

5.4.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.4.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.5 Decision making and voting

5.5.1 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.5.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.5.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.5.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows.

6.1. Integrated governance, risk management and internal control

6.1.1 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of NHS STW's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

6.1.2 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

6.1.3 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS STW's objectives, the effectiveness of the management of principal risks.

6.1.4 To have oversight of system risks where they relate to the achievement of NHS STW's objectives.

6.1.5 To ensure consistency that NHS STW acts consistently with the principles and guidance established in HMT's Managing Public Money.

6.1.6 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.1.7 To identify opportunities to improve governance, risk management and internal control processes across NHS STW.

6.2 Internal audit

6.2.1 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 External audit

6.3.1 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

6.4 Other assurance functions

6.4.1 To review the findings of assurance functions in NHS STW, and to consider the implications for the governance of NHS STW.

6.4.2 To review the work of other committees in NHS STW, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

6.4.3 To review the assurance processes in place in relation to financial performance across NHS STW including the completeness and accuracy of information provided.

6.4.4 To review the findings of external bodies and consider the implications for governance of NHS STW. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

6.5 Counter fraud

6.5.1 To assure itself that NHS STW has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet the requirements of the Government Functional Standard 013: Counter Fraud and which will assist the NHS Counter Fraud Authority (NHSCFA) nationally in providing assurance to Cabinet Office of how the ICB is identifying and mitigating the risk of fraud, bribery and corruption.

6.5.2 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports should the ICB be chosen for a quality inspection by the NHSCFA during the year.

6.5.3 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

6.5.4 To be responsible for ensuring that the counter fraud service prepares an Annual Counter Fraud Report, which will incorporate a self-assessment against the Government Functional Standard 013: Counter Fraud (this self-assessment will be known as the Counter Fraud Functional Standard Return (CFFSR)). The report will outline key work undertaken during each financial year to meet the Government Functional Standard 013: Counter Fraud and will be approved by the Audit Committee Chair and Executive Chief Finance Officer in advance of submission by a deadline specified by NHSCFA.

6.5.5 To report concerns of suspected fraud, bribery and corruption to the NHSCFA using the national NHS counter fraud management system (known as CLUE).

6.6 Freedom to Speak Up

6.6.1 To review the adequacy and security of NHS STW's arrangements for its employees, contractors to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

6.7 Information Governance (IG)

6.7.1 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

6.7.2 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

6.7.3 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

6.7.4 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

6.8 Financial reporting

6.8.1 To monitor the integrity of the financial statements of NHS STW and any formal announcements relating to its financial performance.

6.8.2 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

6.8.3 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

6.9 Conflicts of Interest

6.9.1 The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

6.9.2 The Committee shall satisfy itself that NHS STW's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with NHS STW policy and procedures relating to conflicts of interest.

6.10 Policy Management

6.10.1 The Committee shall satisfy itself that NHS STW's policy, systems and processes for the management of polices are effective including receiving reports relating to non-compliance with NHS STW policy on the management of polices.

6.11 Management

6.11.1 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

6.11.2 The Committee may also request specific reports from individual functions within NHS STW as they may be appropriate to the overall arrangements.

6.11.3 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of NHS STW's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

6.12 Communication

6.12.1 To oversee communications on governance, risk management and internal control with stakeholders internally and externally.

6.12.2 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

6.13 Decision Making

The Committee has the authority to make the following decisions on behalf of NHS STW as set out in the Scheme of Reservation and Delegation:

- To approve policies and procedures specific to the Committee's remit which include, but are not limited to:
  - Approve NHS STW's counter fraud and security management arrangements including supporting plans, policies and procedures
  - Approve NHS STW's risk management policies and procedures
  - Approve the arrangements, including supporting policies and procedures for ensuring appropriate security, storage, management and transfer of information and data.
  - Approve NHS STW's Freedom to Speak Up processes including supporting plans, policies and procedures.
  - Approve NHS STW's conflicts of interest policy and procedures
  - Approve NHS STW's arrangements including supporting plans, policies and procedures for EPRR and business continuity.
  - Approve arrangements including supporting policies and procedures for handling freedom of information requests.
  - Approve NHS STW's policy management arrangements and oversight, including the policy on the management of policies, supporting plans, policies and procedures.

6.14 Auditor Panel

6.14.1 To meet Regulations under the Local Audit an Accountability Act 2014 the Chair and members of the Audit Committee will also constitute the Chair and membership of the Auditor Panel, which will meet separately to the Audit Committee as required and that these are recorded in formal minutes to be submitted to NHS STW and will:

- Advise NHS STW on the maintenance of an independent relationship with external auditors;
- Advise NHS STW on the selection and appointment of external auditors
- If asked, advise NHS STW on any proposal to enter into a limited liability agreement.

7. Behaviours and conduct

7.1 ICB values

7.1.1 Members will be expected to conduct business in line with NHS STW values and objectives.

7.1.2 Members of, and those attending, the Committee shall behave in accordance with NHS STW's Constitution, Standing Orders, Conflicts of Interest Policy and Standards of Business Conduct Policy.

7.2 Conflicts of interest

7.2.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed.

7.2.2 Members should have regard to both NHS STW's policies and national guidance on managing conflicts of interest.

7.2.3 All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and diversity

7.3.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The minutes of the meetings shall be formally recorded by the secretary.

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

8.4 The Audit Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements.

9. Secretariat and Administration

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

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

10. Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 29th November 2023

Date of review: 29th November 2024

Appendix 2

NHS Shropshire, Telford and Wrekin Integrated Care Board
System People, Culture & Inclusion Committee

Terms of Reference

1. Constitution

1.1 The System People, Culture & Inclusion Committee (the Committee) is established by the Board of NHS Shropshire, Telford and Wrekin (the Board of NHS STW) as a Committee of the Board in accordance with its Constitution.

1.2 These terms of reference, which must be published on NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The System People, Culture & Inclusion Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice.
- Create sub-Committees and task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS STW's constitution, standing orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, in the event of any conflict, NHS STW Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Purpose

3.1 The Committee's main purpose is to contribute to the overall delivery of ICB objectives by providing oversight and assurance to the Board in the development and delivery of the STW ICS People Plan and its People agenda.

3.2 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with NHS STW Constitution.

4.1.2 The Board will appoint no fewer than four members of the Committee including one independent non-Executive member of the Board. Other members of the Committee need not be members of the Board, but they may be.

4.1.3 Members will possess between them knowledge, skills and experience in:

- Human Resource Management
- Succession Planning and Talent Management
- Organisational Development
- Equality, Diversity & Inclusion
- Education and training
- Strategic Workforce Planning
- Risk management
- And technical and specialist issues pertinent to NHS STW's business

4.1.4 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.1.5 Members are expected to attend 75% of meetings held each calendar year. Where this is not possible a nominated deputy of sufficient seniority (as named above) may attend with delegated authority to make decisions on behalf of their organisation or role on the Committee.

4.1.6 The core membership of the People Committee will be:

- Chair of an NHS Trust Partner ICB Member (Chair)
- Non-Executive Director of NHS STW
- 4 Non-Executive Directors, one from each partner provider
- ICS Chief Executive SRO for People
- ICS Chief People Officer
- System People Collaborative SRO for the People Strategy portfolios:

- Train
- Retain
- Reform
- Transform (Leadership, Culture & EDI)

4.2 Chair and Vice Chair

4.2.1 The Committee will be chaired by the Chair of a Partner Provider NHS Trust of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 In the event of the Chair being unable to attend, the System Chief People Officer or the ICS Chief Executive SRO for People (who are joint Vice Chairs) will chair the meeting.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Directors of Nursing from each provider organisation
- A representative from Shropshire Council
- A representative from Telford and Wrekin Council
- Director of Strategy & Delivery NHS STW
- Associate Director of Primary Care NHS STW, representing PCNs
- Chair of ICS AHP Council
- Representatives from local further education institutions
- Representatives from local higher education institutions
- Representative from Shropshire Partners in Care (SPiC)
- Representative from Shropdoc
- Representative from the Voluntary Community and Social Enterprise (VCSE)
- Representative from NHS England Workforce, Training and Education Directorate
- At least one representative from any working groups created by or reporting to the Committee.

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

5. Meetings Quoracy and Decisions

5.1 Meetings

5.1.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

5.2.1 The Board, Chair or Chief Executive(s) may ask the People Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required including the Chair or Vice Chair (or their deputy), and one NED (NHS STW or provider).

5.2.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision Making and Voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.3.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Reporting Procedures

6.1 The Chair of the People, Culture and Inclusion Committee attends the ICB Board, and is the conduit for reporting to and receiving updates and requests from this Board.

6.2 The Chair's report of the People, Culture and Inclusion Committee may be shared with ICB Board to provide updates on activity and risks.

6.3 Provider representatives are responsible for ensuring their Boards and Committees are sighted on the programmes of work and strategic plans from the ICB People,

Culture and Inclusion Committee. Representatives will be required to provide assurance that this has taken place.

7. Responsibilities of the Committee

7.1 The Committee's duties can be categorised as:

7.1.1 The aims of the People Committee are to:

- Provide assurance to the ICB on all aspects of workforce, education and OD supporting the provision of safe, high quality, patient-centred care across Shropshire, Telford and Wrekin.
- Ensure strategic priorities and System ambitions, in relation to workforce and OD, are delivered in an affordable manner and that corporate risks are identified and managed.

7.1.2 The objectives of the People Committee are to:

- Align partners across the ICS, to co-create and support a shared approach to the people agenda.
- Develop strategic relationships with key stakeholders at a system, regional and national level.
- Oversee achievement of the ICS People Plan and any underpinning delivery plans.
- Provide assurance to the ICB Board on the delivery of the People, Culture and Inclusion strategic objectives.
- Provide senior leadership, strategic advice and guidance back to the system and to the leadership board on people, culture and inclusion issues.
- Promote creativity in the design, delivery and evaluation of workforce solutions across all partners in the ICS.
- Set the strategic direction for delivery groups ensuring that clear outcomes for each group are agreed, monitored and delivered, including impact on outcomes, performance, activity, quality and finance.
- Oversee achievement of the ICS Workforce Plan and the NHS Long Term Workforce Plan, to ensure alignment to ICS strategies and provide assurance that the System has adequate staff with the necessary skills and competencies to meet the future health and care needs of patients and service users.
- Oversee the development and delivery of workforce, OD and cultural change strategies that support the ICB's strategic priorities, in the context of System and national picture (including the National People Plan).
- Oversee the development and delivery of education, training and learning strategies to upskill and reskill the workforce of the future.
- Actively seek to reduce inequalities in the staff experience and to promote equality, diversity and inclusion in a systematic and effective way.

- Receive reports from People Collaborative Programme SROs in relation to their Portfolio.
- Develop and deliver a coherent approach to measuring people, culture and inclusion outcomes and strategic objectives to support delivery of ICS ambitions & deliverables.
- Provide oversight and insight to the use of Workforce Development Funding entering the system, ensuring appropriate governance.
- Provide a platform for Organisations and ICS workstreams to escalate strategic people, culture and inclusion risks, debate control and mitigation and provide assurance to the Board that such risks are being effectively controlled and managed.
- Oversee the work of identified sub-committees and groups.
- Receive reports on workforce specific FTSU Issues.
- Review and provide assurance on those elements of the Board Assurance Framework delegated to the People Committee, seeking where necessary further action/ assurance.

8. Conflicts of Interest

8.1 The Committee will maintain a standing register, as per any other corporate decision-making body. In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

8.2 At the beginning of each meeting of the Committee, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they continue to comply with relevant organisational policies / guidance.

8.3 The Chair of the People, Culture and Inclusion Committee will determine how declared interests should be managed, which is likely to involve one the following actions:

a) Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee decision-making arrangements.

b) Allowing the individual to participate in the discussion, but not the decision-making process.

c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee decision-making arrangements.

9. Secretariat

9.1 The Committee will be serviced by the secretary to the Chair and will operate using the following principles:

- Agenda items will be sought from the members of the Committee 14 days prior to the meeting.
- The Chair will agree the final agenda.
- Papers will be circulated 5 working days before each meeting.
- Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.
- The minutes of each meeting will be circulated within 10 working days of the meeting being held and will be ratified at the following meeting.

9.2 Ratified minutes of the meeting will be circulated to sub-groups for dissemination to their members as required.

Date of approval: 29th November 2023

Date of review: 29th November 2024

NHS Shropshire, Telford and Wrekin

ICB People, Culture and Inclusion Sub-Committee

Terms of Reference

1. Constitution

1.1 The ICB People, Culture and Inclusion Sub-Committee (the Sub-Committee) is created specifically to oversee the discharge of the ICB's people and workforce responsibilities as an employer.

1.2 The Sub-Committee is a sub-committee of the System People, Culture & Inclusion Committee in accordance with the Constitution of NHS Shropshire, Telford & Wrekin.

1.3 These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Sub-Committee and may only be changed with the approval of the ICB Board.

1.4 Members of the ICB People, Culture and Inclusion Sub-Committee are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The ICB People, Culture & Inclusion Sub-Committee is authorised by the ICB Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the sub-committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Sub-Committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice;
- Create task and finish groups or working groups as required.
- To approve the policies and procedures to support the arrangement for discharging the statutory duties on NHS STW as an employer.

2.2 For the avoidance of doubt, in the event of any conflict, NHS STW Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Purpose

3.1 The Sub-Committee is established to reflect the ICB's commitment to partnership with its staff in developing, monitoring, improving employment practice, enhancing the working environment, health and wellbeing, and improving outcomes and provide solutions. The Sub-Committee will support the delivery of the ICB's Vision, Values and People Plan, and alignment to national people strategy documents and approaches.

3.2 The Sub-Committee will ensure that the ICB discharges its statutory responsibilities and duties as an employer, which includes but is not limited to; approval of People policies and procedures, Health and Safety policies and procedures and presentation of workforce dashboards to identify trends and common themes.

3.3 The Sub-Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these terms of reference.

4. Membership and attendance

4.1Membership

4.1.1 The Sub-Committee members shall be appointed by the ICB Board in accordance with NHS STW Constitution.

4.1.2 The Board will appoint no fewer than four members of the Sub-Committee including two independent Non-Executive/Associate Non Executive members of the Board. Other members may be part of the ICB Executive Leadership Team or their representatives and specific staff representatives.

4.1.3 Members will possess between them the knowledge, skills and experience to champion better work and working lives, and technical and specialist issues pertinent to NHS STW's business.

4.1.4 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.1.5 Members are expected to attend 75% of meetings held each calendar year. Where this is not possible a nominated deputy of sufficient seniority may attend with delegated authority to make decisions on behalf of the person they are representing and taking into account the role on the Sub-Committee.

4.1.6 The core membership of the Sub-Committee will be:

- ICB Non-Executive/Associate Non Executive Director (Chair)
- ICB Non-Executive/Associate Non Executive Director (Vice Chair)
- ICS Chief People Officer

- ICS Deputy Chief People Officer or their representative
- 2 ICB Executive Directors or their representatives

4.2 Chair and Vice Chair

4.2.1 The Sub-Committee will be chaired by an ICB Non-Executive Director/Associate Non Executive Director appointed by the Chair of the ICB, on account of their specific knowledge skills and experience making them suitable to chair the Sub-Committee.

4.2.2 In the event of the Chair being unable to attend, the other Non-Executive Director/Associate Non Executive Director will chair the meeting.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee.

4.3.2 Meetings of the Sub-Committee may also be attended by the following individuals who are not members of the Sub-Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

Attendees

- CSU Senior HR Business Partner or their representative
- Director of Corporate Affairs or their representative
- Communications and Engagement representatives
- Chair of Staff Health & Wellbeing Group
- Chair of other Staff Engagement Groups
- Representatives from any working groups created by or reporting to the Sub-Committee.

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

5. Meetings Quoracy and Decisions

5.1 Meetings

5.1.1 The Sub-Committee will meet on a bi-monthly basis and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

5.2.1 The Board, Chair or Chief Executive may ask the People, Culture and Inclusion Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice.

5.3.1 In accordance with the Standing Orders, the Sub-Committee may meet virtually or face to face.

5.2 Quorum

5.2.1 For a meeting to be quorate their must be 50% of members present and of those one must be a NED or Associate NED and one must be an Executive Director.

5.2.2 If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting either may be postponed until the meeting can be quorate or the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members. Where this happens the decision made in this way must be reported to the next meeting to ensure it is captured in the minutes.

5.3 Decision Making and Voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of the Sub-Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.3.3 Where there is a split vote, with no clear majority, the Chair of the Sub-Committee will hold the casting vote.

6. Reporting Procedures

6.1 The Chair of the Sub-Committee attends the Board and is the conduit for reporting to and receiving updates and requests from the Board.

6.2 The Chair's report of the Sub-Committee will be shared with the ICB Senior Leadership Team and may be shared with Board to provide updates on activity and risks.

7. Responsibilities of the Sub-Committee

7.1 The Sub-Committee's duties can be categorised as:

7.1.1 The aims of the Sub-Committee are to:

- To behave in a principles-led, evidence-based and outcomes-driven way.

- Provide assurance to the Board on all aspects of employment and employment experience, including (but not limited to) terms and conditions, policy development, recruitment, health and wellbeing, statutory and mandatory training, education and learning, Apprenticeships, career development, talent management, equality diversity and inclusion, organisational development, people management, employee benefits and reward, work-life balance, workforce planning, workforce information and employee voice.
- Provide assurance that legal and regulatory requirements i.e. Health and Safety, relating to the ICB's workforce are met, and that the ICB policies and procedures address its statutory responsibilities and duties as an employer.

7.1.2 The role of the Sub-Committee are to:

- To approve on behalf of the Board policies and procedures in relation to people, workforce matters and Health and Safety.
- Provide senior leadership, strategic advice and guidance to ICB Leaders and Board on people, culture and inclusion issues;
- Set the direction of People, Culture and Inclusion strategic objectives for the ICB as an employer;
- Provide assurance to the Board on the delivery of the People, Culture and Inclusion strategic objectives for the ICB as an employer ensuring that clear outcomes are agreed, monitored and delivered, including equality, performance, activity, quality and finance impacts;
- Provide assurance to the Board on adherence to statutory legislation and good practice in relation to Health and Safety duties as an employer.
- Develop strategic relationships with key stakeholders at a system, regional and national level;
- To work in partnership with the MLCSU People Services Team to support the effective delivery of the HR service for the ICB workforce.
- Oversee achievement of the ICS People Plan and any underpinning delivery plans;
- Promote creativity in the design, delivery and evaluation of workforce solutions across all partners in the ICS;
- Actively seek to reduce inequalities in the staff experience and to promote equality, diversity and inclusion in a systematic and effective way;
- Provide a platform for ICB employees and Leaders to escalate strategic people, culture and inclusion risks, debate control and mitigation and provide assurance to the Board that such risks are being effectively controlled and managed;
- Receive reports on workforce specific Freedom To Speak Up Issues;
- Review the workforce performance indicators to support the implementation and monitoring of strategies and plans to address any themes or trends as necessary.
- Review and provide assurance on those elements of the Board Assurance Framework delegated to the ICB, seeking where necessary further action/ assurance.

8. Conflicts of Interest

8.1 The Sub-Committee will maintain a standing register, as per any other corporate decision-making body. In advance of any meeting of the Sub-Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

8.2 At the beginning of each meeting of the Sub-Committee, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they continue to comply with relevant organisational policies / guidance.

8.3 The Chair of the Sub-Committee will determine how declared interests should be managed, which is likely to involve one the following actions:

a) Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Sub-Committee decision-making arrangements.

b) Allowing the individual to participate in the discussion, but not the decision-making process.

c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Sub-Committee decision-making arrangements.

9. Secretariat

9.1 The Sub-Committee will be serviced by the administrator to the Chief People Officer and Deputy Chief People Officer and will operate using the following principles:

- Agenda items will be sought from the members of the Sub-Committee 14 days prior to the meeting.
- The Chair will agree the final agenda.
- Papers will be circulated 5 working days before each meeting.
- Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.
- The minutes of each meeting will be circulated within 10 working days of the meeting being held and will be ratified at the following meeting.

9.2 A Chair's report will be created from the minutes.

Date of approval: 29th November 2023

Date of review: 29th November 2024

2. Scheme of Reservation and Delegation (SoRD)

Key:

CEO – Chief Executive
CFO – Chief Finance Officer
CMO – Chief Medical Officer
CNO – Chief Nurse Officer
EDD&T – Executive Director of Delivery & Transformation
DS&I – Director of Strategy & Integration

NHS Shropshire, Telford and Wrekin - Scheme of Reservation and Delegation								
Decision / Function	Delegation							
	Reserved by the Board	Committee	Chair	CEO	Director	Joint Committees	Other Statutory Committees	PLACE based / Provider Collaborative committees
1. STRATEGY AND PLANNING								
Agree the vision and values of the ICS	✓							

Approve the overall strategic direction of the ICS	✓							
Develop an integrated care strategy to inform the strategic direction of the ICS.						ICP		
Recommend the overall strategic direction of the ICS to the Board		Strategy Committee						
Approval of the consultation arrangements for the commissioning plan.		Strategy Committee						
Approve the commissioning plan.	✓							
Recommend the commissioning plan to the board		Strategy Committee						
Approve any revisions to Commissioning plans		Strategy Committee						
Approval of the ICS operating structure.	✓							
Approval of key strategies	✓							
Agree a plan to meet the health and healthcare needs of the population, having regard to the Partnership integrated care strategy and place health and wellbeing strategies.	✓							
Agree a plan to meet the health and healthcare needs of the population within each place, having regard to the Partnership integrated care strategy and place health and wellbeing strategies		Integrated Delivery Committee						

Recommend allocation of strategic resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)		Finance Committee						
Allocate resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)	✓							
Allocate resources to deliver the plan in each place, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)		Integrated Delivery Committee						
Arrange for the provision of health services in line with the allocated resources across the ICS	✓							
2. CONSTITUTION AND GOVERNANCE								
Establish and approve terms of reference and membership for ICB Committees	✓							
Approve NHS STW scheme of reservation and delegation (SoRD) which sets out those decisions reserved to the Board, committees and sub-committees, individuals or specified persons	✓							

Approve NHS STW financial scheme of delegation, which sets out those key operational decisions delegated to individuals or specified persons	✓							
Agree any functions delegated to other statutory bodies	✓							
Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.	✓							
Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	✓							
Exercise or delegate those functions of NHS STW which have not been retained as reserved by NHS STW Board or delegated to its Committees and sub-committees or delegated to named other individuals as set out in this document				✓				
Approve the arrangements for discharging NHS STW's functions to have regard to and act in a way that promotes the NHS Constitution				✓				
Approve the arrangements for discharging NHS STW's functions to exercise its functions effectively, efficiently and economically				✓				
Approve the arrangements for discharging NHS STW's functions in relation to children including safeguarding and promoting welfare					CNO			
Approve the arrangements for discharging NHS STW's functions in relation to Equality, including the public-sector equality duty					D S&I			

Approve the arrangements for discharging NHS STW's functions in relation to Information law					D S&I			
Approve the arrangements for discharging NHS STW's functions under the Civil Contingencies Act 2004				✓				
Approve the arrangements for discharging NHS STW's functions to secure improvement in quality of services					CNO			
Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes					CMO			
Approve the arrangements for discharging NHS STW's functions to reduce inequalities					ED D&T			
Approve the arrangements for discharging NHS STW's functions to obtain appropriate advice from Directors of Public Health					D S&I			
Approve the arrangements for discharging NHS STW's functions to regard to effect of decisions	✓							
Approve the arrangements for discharging NHS STW's functions relating to Public involvement and consultation					D S&I			
Approve the arrangements for discharging NHS STW's functions to have regard to assessments and strategies					ED D&T			
Approve arrangements for complying with the NHS Provider Selection Regime	✓							
Agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime.		Integrated Delivery Committee						
Approval of the annual report and annual accounts.	✓							

Recommend the annual report and accounts for approval to the Board		Audit Committee						
Approve the arrangements for discharging the statutory financial duties					CFO			
Approve the arrangements for discharging the statutory health and safety duties as an employer.					System People Lead			
Preparation of proposed amendments to the constitution and standing orders				✓				
Approval to submit proposed amendments to the constitution and standing orders to NHS England for final approval	✓							
Preparation of proposed amendments to the Governance Handbook					D S&I			
Approval of proposed amendments to the Governance Handbook	✓							
Approval of the arrangements, policies and procedures, for the management of conflicts of interest (contained in the Governance Handbook)	✓							
Propose changes to terms of reference for the committees		All Committees as required				All, as required		

Propose changes to terms of reference for the sub-committees		All Sub committees as required				All, as required		
Approve the appointment of the Deputy Chair of NHS STW from amongst the Non Executive Directors except for the Audit Committee Chair.	✓							
Approve changes to terms of reference for committees	✓							
Approve changes to terms of reference for sub committees		Parent Committee						
Approve membership of committees			✓					
Approve membership of sub committees			✓					
Approve arrangements and appointments of Board membership			✓					
Prepare the scheme of reservation and delegation contained in the Governance Handbook					D S&I			
Discharge an urgent decision where a meeting of NHS STW cannot be convened consulting with as many members as possible given the circumstances			✓	✓				
Approve (including any changes) the scheme of reservation and delegation contained in the Governance Handbook	✓							
Execute a document by signature/use of seal			✓	✓	CFO			

Approval of changes to the provision or delivery of audit assurance services to the Board	✓							
Propose changes to the provision or delivery of audit assurance services to the Board		Auditor Panel						
Approve proposals for action on litigation against or on behalf of the Board				✓	CFO, CNO, CMO, ED D&T , D S&I			
Responsibility for overseeing discharge of statutory responsibilities in relation to safeguarding		Quality and Performance Committee						
Receive and approve annual internal and external audit plans		Audit Committee						
Receive and approve internal and external audit reports and recommendations		Audit Committee						
Approve NHS STW's policy management arrangements and oversight, including the policy on the management of policies, supporting plans, policies and procedures.		Audit Committee						

3. FINANCE. CONTRACTING AND PROCUREMENT								
Preparation of Finance policies and Procedures					CFO			
Approval of Finance Policies and Procedures		Finance Committee						
Development of Standing financial instructions					CFO			
Approval of Standing Financial Instructions as part of the Governance Handbook	✓							
Determine the strategic financial framework of NHS STW and monitor performance against		Finance Committee						
Develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy		Finance Committee						
Approve an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy	✓							
Develop a medium- and long-term financial plan for recommendation to the Board which demonstrates ongoing value and recovery		Finance Committee						
Approve a medium- and long-term financial plan	✓							

Oversee the management of the system financial target and NHS STW 's own financial targets against the Finance Plan		Finance Committee						
Develop a system finance staff development strategy					CFO			
Approve a system finance staff development strategy		Finance Committee						
Monitor arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).		Finance Committee						
Approve arrangements for managing exceptional funding requests.		Integrated Delivery Committee						
Approve exceptional individual funding requests		Individual Funding Request Panel						
Determine whether proper process has been followed by the Individual Funding Panel when considering an individual funding request.		Individual Funding Request Appeal Panel						
Approval of the banking arrangements					CFO			
Approve the counter fraud and security management arrangements, including supporting plans, policies and procedures		Audit Committee						

Approval of contracts/contract variations for any healthcare services within approved budgets *With the exception of GMS, PMS and APMS – see separate delegation*		Integrated Delivery Committee						
Approval of non-healthcare contracts outside approved budgets.				✓	Or CFO			
Approval of non-healthcare contracts within approved budgets.		As per budget holder delegation outlined in the Standing Financial Instructions						
Recommend approval of healthcare contracts outside approved budgets.		Finance Committee						
Approval of healthcare contracts outside approved budgets.	✓							
To approve, that NHS STW proceeds to procurement for healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.		Integrated Delivery Committee						
To approve the award of healthcare services procurement.		Integrated Delivery Committee						
To approve the extension of a non-healthcare contract, where provision for an extension has been made within the contract terms.				✓	or one of: CFO, CMO, CNO,			

					ED D&T, D S&I			
To approve the extension of a healthcare contract, where provision for an extension has been made within the contract terms.		Integrated Delivery Committee						
To approve procurement for non-healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.				✓	Or one of: CFO, CMO, CNO, ED D&T, D S&I			
To approve the award of non-healthcare services procurement within approved budgets.				✓	Or one of: CFO, CMO, CNO, ED D&T, DS&I			
Approval of tenders and contracts	In line with financial limits set within Standing Financial Instructions							
4. COMMISSIONING								
Approve the policies and procedures to support the arrangements for discharging the statutory duties associated with its clinical and non-clinical commissioning functions.		Integrated Delivery Committee						

Developing a plan to meet the health and healthcare needs of the population (all ages) within NHS STW area having regard to the partnerships strategy		Strategy Committee						
Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.		ShIP and TWIP, Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by putting contracts and agreements in place to secure delivery of its plan by providers		Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes		ShIP and TWIP, Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by supporting the development of primary care networks (PCNs) as the foundations of out of hospital care and building blocks of place based partnerships including through investment in PCN management support, data and digital capabilities, workforce development and estates		Primary Care Commissioning Committee						

Arranging for the provision of health services in line with allocated resources across the ICS by working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care and agreeing personal health budgets and direct payments for care.		ShIP and TWIP, Integrated Delivery Committee						
Leading system wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care		Strategy Committee						
Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes		Strategy Committee						
Through joint working between health, social care and other partners including police, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability	✓							
Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.		Strategy Committee						

Planning for, responding to and leading recovery from incidents (EPRR) to ensure the NHS and partner organisations are joined up at times of greatest need, including taking on incident co-ordination responsibilities as delegated by NHS England and NHS Improvement				✓				
Approval of delegated responsibilities by NHS England in relation to specialised commissioning						Joint West Midlands NHS Delegated Commissioning Committee		
Preparing a performance assurance framework (PAF)		Quality and Performance Committee						
Approving a performance assurance framework (PAF)	✓							

5. PEOPLE							
Develop ICS System People Plan		ICS People, Culture and Inclusion Committee					
Approval of ICS System People Plan	✓						
Leading system implementation of people priorities including delivery of people plan and People Promise by aligning partners across the ICS to develop and support "one workforce" including through closer collaboration across the health and care sector with local government the voluntary and community sector and volunteers.		ICS People, Culture and Inclusion Committee					
Preparation of HR systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer.				System People Lead			
Preparation of Health and Safety systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer.				CEO			
Approve the policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer to include but not limited to; HR and Health and Safety.		ICB People, Culture and Inclusion Sub Committee					
Recommend the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change.			✓	System People Lead			

Approve the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change.		Remuneration Committee						
Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change.			✓	✓	System People Lead			
Approve pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change.		Remuneration Committee						
Recommend the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees			✓	✓	System People Lead			
Approve the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees		Remuneration Committee						
Recommend the business cases for staff who wish to retire and then return to employment that have been considered and recommended by the Executive team.				✓	System People Lead			
Approve business cases for staff who wish to retire and return to employment		Remuneration Committee						

Recommend disciplinary arrangements for employees, including the Executive Officers and for other persons working on behalf of NHS STW				✓	System People Lead			
6. QUALITY AND SAFETY								
Approve arrangements, including supporting strategies and plans, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Quality and Performance Committee						
Approve arrangements for supporting NHS England/Improvement in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.		Primary Care Commissioning Committee						
Preparation the Quality Strategy		Quality and Performance Committee						
Approve the policies and procedures to support the arrangements for discharging the statutory duties associated with and including, but not limited to; quality, safety, safeguarding and IPC		Quality and Performance Committee						
Approval of the Quality Strategy	✓							
Oversee the implementation of the Quality Strategy		Quality and Performance Committee						

Oversee the effective reporting and learning from safety incidents		Quality and Performance Committee						
Monitor feedback from compliments and complaints and provide assurance to the Board regarding their timely management		Quality and Performance Committee						
7. RISK MANAGEMENT								
Prepare the arrangements, policies and procedures in relation to risk management					D S&I			
Approve the arrangements, policies and procedures in relation to risk management		Audit Committee						
Approval of the risk appetite of the ICS/ICB	✓							
Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).	✓							
Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the ICS		Audit Committee						
Approve the arrangements, including supporting plans, policies and procedures for business continuity and EPRR.		Audit Committee						
Approve the use of resources out of hours for exceptional circumstances and limited to situations of necessity					Director on Call			

8. INFORMATION GOVERNANCE								
Develop arrangements, including supporting policies and procedures, for handling Freedom of Information requests.					D S&I			
Approve arrangements, including supporting policies and procedures, for handling Freedom of Information requests.		Audit Committee						
Recommend arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.					D S&I			
Approval of arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.		Audit Committee						
Oversee the management of IG breaches and the reporting of IG Breaches, where appropriate, to the ICO					CFO (as SIRO)			
9. PARTNERSHIP WORKING								

To the extent permitted by law, authority to enter into arrangements with one or more relevant Local Authority in respect of: • delegating specified commissioning functions to the Local Authority; • exercising specified commissioning functions jointly with the Local Authority; • exercising any specified health-related functions on behalf of the Local Authority.	✓							
Agree formal and legal arrangements to make payments to, or receive payments from, a Local Authority or pool funds for the purpose of joint commissioning.	✓							
For the purposes of collaborative commissioning arrangements with a Local Authority, make the services of its employees or any other resources available to the Local Authority; and receive the services of the employees or the resources from the Local Authority.	✓							

For the purposes of joint commissioning arrangements with other ICSs, to • delegate any of the ICSs commissioning functions to another ICS • exercise any of the Commissioning Functions of another ICS; or • exercise jointly the Commissioning Functions of the ICS and another ICS; and for the purposes of the above; to: • make payments to, or receive payments from, another ICS; or • make the services of its employees or any other resources available to another ICS; or • receive the services of the employees or the resources available to another ICS.	✓							
For the purposes of joint commissioning arrangements with other ICSs, to establish and maintain a pooled fund made up of contributions by all of the ICSs working together jointly.	✓							
Approve decisions that individual members or employees participating in joint arrangements can take. Such delegated decisions must be disclosed in this scheme of reservation and delegation.	✓							
Authority to enter into strategic or other transformation discussions with its partner organisations	✓							
10. DELEGATED FUNCTIONS RELATED TO THE COMMISSIONING OF PRIMARY MEDICAL SERVICES UNDER SECTION 83 OF THE NHS ACT								
Discharge of the delegated commissioning by								

NHS England of primary care commissioning in accordance with section 65Z5 of the NHS Act and as outlined in the NHSE delegation agreement dated March 2023.								
Decisions in relation to the commissioning and management of Primary Medical Services;		Primary Care Commissioning Committee						
Planning Primary Medical Care Services in the Area, including carrying out needs assessments;		Primary Care Commissioning Committee						
Undertaking reviews of Primary Medical Care Services in respect of the Area;		Primary Care Commissioning Committee						
Management of the Delegated Funds in the Area;		Primary Care Commissioning Committee						
Co-ordinating a common approach to the commissioning and delivery of Primary Medical Care Services with other health and social care bodies in respect of the Area where appropriate; and		Primary Care Commissioning Committee						
Such other ancillary activities that are necessary in order to exercise the Delegated Functions.		Primary Care Commissioning Committee						
11. DELEGATED FUNCTIONS TO THE WEST MIDLANDS ICBs JOINT COMMITTEE								
The ICB's Chief Executive Officer or their designated representative where they are unable to attend, has full authority to act on behalf of the ICB within the delegation		The West Midlands ICBs Joint Committee		✓				

outlined in this section below at the West Midlands ICBs Joint Committee.								
Discharge of the delegated commissioning by NHS England of primary care commissioning in accordance with section 65Z5 of the NHS Act and as outlined in the NHSE delegation agreement dated March 2023, schedule 4 and in the Schedule of Services in the Agreement in relation to the establishment and operation of the joint working arrangements - Tier One Joint Committee West Midlands: Decisions in relation to the commissioning and management of: a) Primary Prescribed Community Dental Services b) Primary Prescribed Community Pharmaceutical Services; and c) Primary Ophthalmic Services.		The West Midlands ICBs Joint Committee						
Primary Prescribed Community Dental Services: • Decisions in relation to the commissioning and management of Primary Prescribed Community Dental Services; • Planning Primary Prescribed Community Dental Care Services in the Area, including carrying out needs assessments;		The West Midlands ICBs Joint Committee						

• Undertaking reviews of Primary Prescribed Community Dental Care Services in respect of the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Prescribed Community Dental Care Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions.								
Primary Prescribed Community Pharmaceutical Services: • Decisions in relation to the commissioning and management of Primary Prescribed Community Pharmaceutical Services; • Planning Primary Prescribed Community Pharmaceutical Services in the Area, including carrying out needs assessments; • Undertaking reviews of Primary Prescribed Community Pharmaceutical Services in respect of the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Prescribed Community Pharmaceutical Services with other		The West Midlands ICBs Joint Committee						

health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions.								
Primary Ophthalmic Services • Decisions in relation to the commissioning and management of Primary Ophthalmic Services; • Planning Primary Ophthalmic Services in the Area, including carrying out needs assessments; • Undertaking reviews of Primary Ophthalmic Services in respect of the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Ophthalmic Care Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions.		The West Midlands ICBs Joint Committee						
Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.		The West Midlands ICBs Joint Committee						

Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs.		The West Midlands ICBs Joint Committee						
Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs.		The West Midlands ICBs Joint Committee						

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-131
Meeting date:	29 November 2023
Paper title	System-level Primary Care Access Improvement Plan
Paper presented by:	Gareth Robinson, Executive Director of Delivery and Transformation
Paper approved by:	Gareth Robinson, Executive Director of Delivery and Transformation
Paper prepared by:	Emma Pyrah, Associate Director of Primary Care Janet Gittins, Partnership Manager Alec Gandy, Partnership Manager
Signature:	
Committee/Advisory Group paper previously presented:	The Integrated Delivery Committee reviewed and approved the Primary Care Access Improvement Plan in October 2023.

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	
Previous considerations:											

1. Executive summary and points for discussion

1.1. Following the publication of the Delivery plan for recovering access to primary care in May 2023, Integrated Care Boards (ICBs) are required to develop system-level access improvement plans. This aligns with their leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

1.2. The Primary Care Access Recovery Plan aims to improve patient ease and experience of accessing their General Practice. Its focus is on streamlining access to care and advice with two central ambitions:

1.2.1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment.

1.2.2. For patients to know on the day they contact their practice how their request will be managed.

1.2.2.1. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

1.2.2.2. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.

1.2.2.3. Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

1.3. National guidance was published at the end of July 2023 detailing the required contents of the system level plan. ICBs are required to develop their Access Improvement Plan to go for approval to Public Board by the end of November together with progress on implementation.

1.4. The Shropshire, Telford & Wrekin (STW) system level access plan sets out the national expectation and requirements to improve access and clarifies our local position in terms of the Primary Care Network (PCN) plans in place and alignment to other system plans and pieces of work. However, there remains challenges to progressing this work which include tackling the shortfall of overall workforce capacity in the system.

1.5. NHS STW has reviewed the governance structure to ensure it reflects the priority status of GP access recovery and there is a direct line of sight to Board. A new Primary Care Improvement and Transformation Board has been set up that is chaired by the Chief Medical Officer. The Board reports into the system Integrated Delivery Committee (IDC) in line with the established reporting arrangements for Elective and Urgent and Emergency Care (UEC) Recovery Boards. The IDC reports into Board. This is a transitional arrangement as the revised governance structure is developed and implemented. At present the Primary Care Commissioning Committee would not routinely review the recovery aspect of GP services.

1.6. Progress will be monitored via both nationally set metrics and additional local ones. These will be presented in a new Primary Care Access Recovery Programme performance pack produced by the new resource within the ICB Business Intelligence Team.

1.7. The STW draft local plan has been shared with key stakeholder groups to both socialise the contents and provide opportunity to gain feedback.

1.8. Table 1: Timeline for socialisation and finalising the STW plan.

System operational Leads	11/10/2023
GP Board	11/10/2023
SHIPP	19/10/2023
TWIPP	26/10/2023
ICB Senior leadership Team	07/11/2023

Integrated Delivery Committee	14/11/2023
ICB Public Board	29/11/2023

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	

3. Recommendation(s)

3.1. The NHS Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB) is asked to:

3.1.1. **Review** and consider the NHS Shropshire, Telford & Wrekin (STW) system-level Primary Care Access Improvement Plan.

3.1.2. **Approve** the plan in the context of the need for the Programme to develop clear benefit outcomes.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

4.1. None

5. Appendices

5.1. ICB 29/11/131 – Appendix 1 – STW System Level Primary Care Access Improvement Plan

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Improving access for patients to GP services.
Quality and Safety	N/A
Equality, Diversity, and Inclusion	N/A
Finances and Use of Resources	N/A
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A

Transformation and Innovation	Moving towards a modern general practice access model
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	N/A

Request of Paper:	3.1. The NHS Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB) is asked to: 3.1.1. Review and consider the NHS Shropshire, Telford & Wrekin (STW) system-level Primary Care Access Improvement Plan. 3.1.2. Approve the plan in the context of the need for the Programme to develop clear benefit outcomes.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-131.1
Meeting date:	29th November 2023
Paper title	Quality and Performance Committee Chair's Report
Paper presented by:	Meredith Vivian, Non-Executive Director NHS STW
Paper approved by:	Meredith Vivian, Non-Executive Director NHS STW
Paper prepared by:	Vanessa Whatley, Director of Quality and Safety/Deputy Chief Nurse

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	

1. Executive Summary and Points for Discussion

1.1 The purpose of the paper is to provide a summary of NHS STW Quality and Performance Committee meeting held on Thursday 27th July 2023.

1.2 The minutes of the meeting are attached for information.

1.3 The meeting was quorate and no conflicts of interest were declared.

1.4 A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration.

2. Alerts

2.1 Despite some promising signs of improvement in the underlying UEC performance measures -reduction in the number of patients with No Criteria to Reside (NCTR), and LoS for NCTR and reductions in the number of patients with >14 and >21day LoS, progress remains fragile and the 4hr wait in ED performance remains significantly off the planned recovery trajectory.

2.2 Talking therapies was discussed as recovery rates are variable and have struggled to meet the 50% target due to the number of complex patients who had previously been waiting for Talking Therapies being discharged from the service due to not meeting the service criteria for low mental health. Previously waits were accumulating for the most complex cases, a company called SILA has been commissioned for Shropshire which has brought down waiting times by around 50%. Improvement continues to be monitored.

2.3 Challenges remain for the achievement of the Faster Diagnosis Standards, this was reported as behind trajectory, SaTH remain confident the target of 75% by the end of the March 24 will be met. The ambition for FIT testing was 80% of the referrals from primary care would be accompanied with a FIT result by July, the actual current position will be just over 70%. The shortfall is a small number (<10) and STW is now one of the best in the region for this measure. Primary care colleagues do seem to be utilising the FIT test, however the corresponding reduction in request for colonoscopies has not been seen, which adds pressure into the diagnostic service. Work continues with primary care colleagues to understand this situation.

2.4 Nicotine Replacement Therapy (NRT) is no longer funded at SaTH, the service contuse under cost-pressures and the LMNS is supporting with identifying the future of this service. The deadline for CNST year 5 submission is the end of November. SaTH are at significant risk without the NRT, £750,000 was not received for year 3 of CNST.

3. Assurance

3.1 SaTH have established a Paediatric Transformation Programme, the first meeting of the committee (PTAC) that gains assurance that actions are being addressed and assured met in June. A small number of actions has been seen by the group so far and there are plans to review the actions associated with paediatrics from the Thematic Review, CQC recommendations and Joint Regional Paediatrics Network visit. Actions from the quality visits and immediate actions from visits are either duplicated in other reports or have been previously addressed. This will inform the risk associated with the paediatric acute pathways.

3.2 Rising numbers of Clostridioides difficile (C diff) infection and gram negative blood stream infections were identified as an emerging risk and a risk for C diff was under development for the system as all NHS partners are seeing numbers above trajectory.

3.3 Progress had been made with long waits, however one additional patient, affected by industrial action in July, will be added to the over 78-week wait for RJAH, making a total of 3.

3.4 SaTH are continuing to reduce their >62 day cancer backlog in line with their agreed recovery trajectory.

3.5 The foetal medicine service at SaTH has ceased due to staffing challenges, However a referral process has been agreed and is now in place for patients wishing to access the foetal medicine service.

3.6 The ICB had received no complaints in relation to maternity care in Quarter 1. At SaTH the Ockenden Assurance Committee monitors complaints and feedback from the service in public.

4. Advise

SaTH and RJAH report choice is being offered to patients who have been waiting long periods under the national guidance.

5. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to consider the following recommendations arising from the meeting which require a decision:

5.1 Accept the report.
5.2 Consider the alerts for further action.

6. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

The report provides assurance that the QPC is seeking assurance on the elective care and diagnostics and discussing challenges.

7. Appendices

Appendix 1 – Quality and Performance Committee minutes from the meeting held on Thursday 27th July 2023

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Enclosure 1 QPC Minutes 25th January

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-132.1
Meeting date:	29th November 2023
Paper title	Quality and Performance Committee Chair's Report
Paper presented by:	Meredith Vivian, Non-Executive Director NHS STW
Paper approved by:	Meredith Vivian, Non-Executive Director NHS STW
Paper prepared by:	Vanessa Whatley, Director of Quality and Safety/Deputy Chief Nurse

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	

1. Executive Summary and Points for Discussion

1.1. The purpose of the paper is to provide a summary of NHS STW Quality and Performance Committee meeting held on Thursday 28th September 2023.
1.2. The minutes of the meeting are attached for information.
1.3. The meeting was quorate, and no conflicts of interest were declared.
1.4. A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration.

2. Alerts

2.1. A new Risk was escalated to the QPC Risk Register on increases in Clostridioides difficile infection in NHS partners.
2.2. The Child Death Review process has been reviewed externally. A number of recommendations have been made to improve processes across the pathway involving strengthening the team, governance and education around child death processes. System Quality Group are monitoring. Elevated neonate and stillbirth rates were acknowledged, and it was confirmed that maternity and neonatal services look at deaths in detail and learning is acted on. HSIB reviews are also undertaken which are supportive. Public Health and the ICB are co-ordinating a workshop to bring all information together to direct future action.
2.3. Fast-track discharge information was a new addition to the performance report which details the longest days between outcome and the package approval was 16 days. Action to address this is through a risk on the ICB risk register but is impacted by access to services in rural areas of the county. Further information is being gathered to inform improvement.
2.4. Issues around discharge, access and waiting times for services and medication issues remain the top issues of feedback from the public to the ICB. Suboptimal care, the diabetic foot pathway and discharge had been raised through professional concerns concerns. These are all feedback to the source of the issue and the themes are monitored for quality improvement actions.

2.5. There was concern that the diabetes programme of work was not progressing as planned. This was escalated in the ICB for further action, a business case is being developed to resource this programme and additional clinical engagement.
2.6. There was deterioration in all the UEC performance metrics in August and this was believed to be due to annual leave and a cumulative effect of industrial action. There have been a number of external visits and peer reviews to help understand the underlying issues and the outcomes/ recommendations of these visits will be pulled together into a refreshed UEC improvement plan in the coming weeks.

3. Assurance

3.1. Perinatal mental health appointments within 6 weeks were reported as improving with 53% in July which increased to 64% in August.
3.2. The CQC re-inspection report relating to Working Age Adult and PICU in patient services had been received and the previously issued section 29A had been met. The service remains inadequate due to the re-inspection not being there to rate the service and the Trust remains Good overall. The ICB continues to work with the Trust to monitor actions and outcomes for staff and patients and had undertaken a positive quality visit.
3.3. The system continues to make good progress in its reduction of long elective waits and SaTH is expected to come out of Tier 1 as a result of the improvement. For 78 weeks, the system has been congratulated by NHSE on being the best performing in the region.
3.4. The system continues to make steady progress in its cancer performance although SaTH is to remain in Tier 1. The 62-day backlog reduction was impacted by annual leave in August but is expected to be back on planned trajectory by the end of September.

4. Advise

4.1. MPFT have 5 workstreams on reducing the deaths from people with mental health needs. Progress is being brought back to the committee in 6 months.
4.2. The ICB Patient Group Directive Policy was approved by the QPC on behalf of the Board.
4.3. The Safeguarding Adults Policy was approved by the QPC on behalf of the Board.
4.4. The Court of Protection Policy was approved by the QPC on behalf of the Board.
4.5. A discussion was held the outcome of the Lucy Letby trial in relation to speaking up and what QPC could monitor to oversee this safety aspect. National guidance is being updated and members are considering how oversight could be developed.
4.6. Both Shropshire and Telford and Wrekin Healthwatch continue to undertake 'Enter and View' visits. There were no themed reports for noting at this meeting.

5 Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to consider the following recommendations arising from the meeting which require a decision:

5.1 Accept the report.
5.2 Consider the alerts for further action.

6 Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

The report provides assurance that the QPC is seeking assurance on performance and quality in the system.

7 Appendices

Appendix 1 – Quality and Performance Committee minutes from the meeting held on Thursday 28th September 2023.

Request of Paper:	To provide assurance on performance and quality in the system.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-132.3
Meeting date:	29th November 2023
Paper title	Finance Committee Chair's Report – 8th August Meeting
Paper presented by:	Trevor McMillan; Non Executive Director
Paper approved by:	Trevor McMillan; Non Executive Director
Paper prepared by:	Claire Skidmore; Chief Finance Officer

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

1. Executive Summary and Points for Discussion

1.1 The purpose of the paper is to provide a summary of NHS STW Finance Committee meetings held on 8th August for noting.

1.2 The minutes of the meetings are attached for information.

1.3 Both sections of the meeting were quorate and no conflicts of interest were declared.

1.4 A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration.

ALERT: Matters of concerns, gaps in assurance or key risks to escalate to the Board	**Section 1 (ICB)** The Committee noted that the ICB was delivering close to plan at month 3 and forecasting breakeven against the submitted 23/24 plan however there remains significant financial risk (£15.8m) reported at month 3. **Section 2 (System)** A £7.6m year to date adverse variance to plan was discussed, with the main drivers of that variance being within SATH. Three key areas of overspend and risk to delivery of the plan were noted as: • Delivery of efficiency plans, particularly identifying plans to deliver the system stretch target submitted in the financial plan. • Delivery of the elective recovery plan and achieving associated income built into the financial plan for both English and Welsh income.

	• Risk of increasing system costs without a clear system operational and expenditure plan associated with hospital discharge. The Committee considered progress with the overall efficiency programme and noted that there was still a way to go to close the £10m gap on unidentified schemes.
ADVISE: Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	**Section 1 (ICB)** The Committee noted the ongoing work to reduce the level of unidentified efficiency savings and will continue to closely scrutinise progress with the work programme. **Section 2 (System)** Claire Skidmore shared with the Committee a recently notified requirement to set out to the Regional NHSE team our governance for financial recovery and a granular assessment of controls in place in individual organisations. She confirmed that related work was already underway in the system and that a copy of the response would be shared with the committee once submitted. The Committee were briefed on work to produce a System wide demand, capacity and finance model and preparation for work to develop a medium term plan to deliver financial recovery.
ASSURE: Positive Assurances and highlights of note for the Board	**Section 1 (ICB)** Laura Clare highlighted that in month 3 we started to see the benefit of the implementation of an ICB allocation policy. The committee welcomed new guidance from NHSE that offered financial support to systems to allow for the impact of April's Industrial Action though noted that further guidance was outstanding for support for the impact of subsequent action. **Section 2 (System)** The Committee spent time considering the draft Board Assurance Framework and entries in the associated operational finance risk register.
Changes to the BAF risk(s) and Directorate risk register risk(s) agreed	Financial risk is already reflected in the BAF. The topics discussed at the meeting and resulting conclusions did not materially change the existing assessment of risk.
ACTIONS: Significant follow up actions commissioned (including discussions with other Board Committees, changes to work plan)	**Section 1 (ICB)** N/A **Section 2 (System)** It was agreed that regular updates would be provided to the Committee on progress with the medium term financial plan and associated modelling
ACTIVITY SUMMARY:	**Section 1 (ICB)** • M3 finance position overview (revenue and capital) • Efficiency Plan Update

Presentations/reports/items of note received including those approved	**Section 2 (System)** - M3 finance position overview (revenue and capital) - Efficiency plan update - ICS financial risk update - ICS medium term financial plan update
Matters presented for information or noting	N/A

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to note the areas highlighted in the report.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

The Finance Committee is established to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

The significant underlying financial deficit of the system features in the Board Assurance Framework and therefore this report describes the work of the committee in overseeing financial recovery and presents any conclusions that it may draw about risks to the delivery of the financial plan.

4. Appendices

Appendix 1 - Finance Committee minutes from the section 1 and section 2 meetings held on 8th August 2023

Request of Paper:	NHS Shropshire, Telford and Wrekin Board is asked to note the areas highlighted in the report	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	29th November 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-132.3
Meeting date:	29th November 2023
Paper title	Finance Committee Chair's Report – 3rd October Meeting
Paper presented by:	Trevor McMillan; Non Executive Director
Paper approved by:	Trevor McMillan; Non Executive Director
Paper prepared by:	Claire Skidmore; Chief Finance Officer

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

1. Executive Summary and Points for Discussion

1.1 The purpose of the paper is to provide a summary of NHS STW Finance Committee meetings held on 3rd October for noting.

1.2 The minutes of the meetings are attached for information.

1.3 Both sections of the meeting were quorate and no conflicts of interest were declared.

1.4 A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration.

ALERT: Matters of concerns, gaps in assurance or key risks to escalate to the Board	**Section 1 (ICB)** The Committee noted that the ICB had recorded a £10.5m deficit at month 5, being £3.8m adverse to plan. Whilst the reported outturn remains at achieving plan (£11.8m deficit) there is a significant risk that this would not be achieved. The Committee considered deterioration between month 4 and 5 numbers driven predominantly in the areas of prescribing and CHC where is it becoming apparent that price increases are exceeding planned uplifts. It also noted that delivery of unidentified efficiency was phased into the plan from month 5 which puts additional pressure on the position if schemes cannot be found. The committee acknowledged actions taken by Simon Whitehouse to increase scrutiny of the emerging position with the senior leadership team. **Section 2 (System)** A year to date system deficit of £59.2m compared to a £36.1m plan was discussed. Pressures in SATH prevail as discussed at previous committees with the addition of the

	emerging ICB pressure. The Committee heard that whilst the reported FOT was the planned £57.1m deficit, there was £81.8m risk to that position.
ADVISE: Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	**Section 1 (ICB)** The Committee noted the ongoing work to reduce the level of unidentified efficiency savings and will continue to closely scrutinise progress with the work programme. **Section 2 (System)** A paper was brought to the Committee to remind members of the Forecast Outturn Protocol issued by NHSE. Whilst last year's document is yet to be updated, it is thought that the protocol for 23/24 will be similar. This was in preparation for opening discussions with NHSE about the potential FOT for the system.
ASSURE: Positive Assurances and highlights of note for the Board	**Section 1 (ICB)** The Committee were briefed on progress to develop the medium term financial model and work with support from the Recovery Support Programme (RSP) team on the development of a refreshed financial strategy document. These are both key to satisfying NOF 4 exit criteria. **Section 2 (System)** The Committee heard that CEOs, CFOs and COOs are meeting regularly to review the forecast with support from a Financial Turnaround Director supplied through the RSP.
Changes to the BAF risk(s) and Directorate risk register risk(s) agreed	Financial risk is already reflected in the BAF. The topics discussed at the meeting and resulting conclusions did not materially change the existing assessment of risk.
ACTIONS: Significant follow up actions commissioned (including discussions with other Board Committees, changes to work plan)	**Section 1 (ICB)** The Committee approved a new provider for the Corporate Credit Card and associated refreshed policy for its use. **Section 2 (System)** It was agreed that regular updates on progress with the medium term financial plan and associated modelling should continue.
ACTIVITY SUMMARY: Presentations/reports/items of note received including those approved	**Section 1 (ICB)** • M5 finance position overview (revenue and capital) • Efficiency Update • Corporate Credit Card and Policy Approval • ICB Medium Term Financial Plan **Section 2 (System)** - M5 finance position overview (revenue and capital) - Efficiency update - ICS FOT Change Protocol - ICS medium term planning update
Matters presented for information or noting	N/A

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to note the areas highlighted in the report.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

The Finance Committee is established to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

The significant underlying financial deficit of the system features in the Board Assurance Framework and therefore this report describes the work of the committee in overseeing financial recovery and presents any conclusions that it may draw about risks to the delivery of the financial plan.

4. Appendices

Appendix 1 - Finance Committee minutes from the section 1 and section 2 meetings held on 3rd October 2023.

Request of Paper:	NHS Shropshire, Telford and Wrekin Board is asked to note the areas highlighted in the report	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	29th November 2023

Integrated Care Board

Agenda item no.	ICB 29-11-132.5
Meeting date:	Wednesday 11th October 2023
Paper title	Strategy Committee Chair's Report
Paper presented by:	Mrs Cathy Purt, Chair ICB Strategy Committee
Paper approved by:	Mrs Cathy Purt, Chair ICB Strategy Committee
Paper prepared by:	Gemma Smith, ICB Director of Strategic Commissioning

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	

1. Executive Summary and Points for Discussion

1.1 The purpose of the paper is to provide a summary of NHS STW Extraordinary Strategy Committee meeting held on 11th October for noting.

1.2 The minutes of the meeting were ratified on the 8th November and are attached part of the Chair's report..

1.3 The meeting was quorate and no conflicts of interest were declared that conflicted with an item on the agenda.

1.4 A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration:

Digital Strategy

The Committee received the ICS Digital Strategy for discussion and the following points were highlighted:

- It was explained to the Committee that this is a public facing document which would provide an overview to our population regarding what our intentions are and that underpinning the Digital Strategy is a significant amount of work, that will create the Road map.

- It was noted by the Committee that the other key discussion at the ICB Board Meeting was about developing an operating model where we have a strategic and supportive group of digital capabilities at an ICB level and that a Chief Digital Information Officer would represent Digital at a Board level. This also included a Programme Director role, to pull together all the various work streams and make sense of those and the interdependencies along with strengthened clinical leadership.

- The Committee noted that the Digital Strategy was to be bought back to the next Board meeting alongside a briefing paper.

- The Committee queried if the Delivery Group is made up of Digital Leads from the all organisations and it was confirmed that all providers are represented, including the Local Authorities.

- The Committee also asked for assurance that we are learning from others and it was confirmed that this was the case.

- It was requested from the Chair of the Committee the Road Map could be bought to the Committee to illustrate how that aligns to the Strategy, and how it draws and aligns to the Clinical Strategy and works to support the objectives of the Joint Forward Plan which was agreed.

Histopathology Transformation

The Histopathy Transformation programme was presented to the Strategy Committee and the following points were highlighted:

- It was explained that the presentation had been produced using a document which had set out a National Strategy to address performance issues in histopathology, or cellular pathology as it is locally referred too including a request to ICBs to have carried out optimization exercises in histopathology.

- The Committee noted that at SaTH, the pathology service is currently one of the best Nationally and certainly in the region with the urgent turn-around time for SaTH work has been consistently either the best or one of the best labs in the region.

- It was explained to the Committee that the RJAH cell pathology had deliberately not been included, as this was a specialist niche orthopaedic pathology service.

- The Committee were informed that SATH had been successful in getting national and regional funding to support significant investment in digital reporting.

- The presenter was asked in relation to the transformation, what is the impact you are going to have on the other services across STW and how will that impact on the clinical strategies and it was explained there is a direct link to cancer and further developments for patients with chronic lifelong diseases, and that there would be the aim in place build that capacity in parallel.

- The Committee also queried if by doing the transformation, were there any further resources that could then be used by the hospital transformation programme in other ways. The presenter responded that they thought that the strategy that could work well is using what we have here and to recruit and develop a reporting service that could support other areas in the region and bring in resource in terms of being a net exporter of cellular, pathology, brain power and perhaps an importer of income that helps our financial position rather than releasing resource.

.

- The Committee noted that the system is a really strong pathology partner, and that our network with Stoke and the two Cheshire hospitals who have a set up called North Midlands and Cheshire Pathology Service are bringing a strong set of abilities to that network partnership.

- The Committee asked for assurance as to how are we taking our Primary Care colleagues on the journey for histopathology transformation and it was explained that pathology has got a very small primary care input but that the ICE Project is the best way into that to get engagement with primary care, to unlock the benefits of electronic requesting and reporting.

- The Committee noted the good work underway and asked for this to be bought to a future meeting to look at progress and the dovetailing with the Clinical Strategy.

Any Other Business

- It was asked if the Committee felt that the meetings were too frequent, or if this was going to be part of the Good Governance Review and it was agreed the meeting in November should remain in place whilst it was worked through what they wanted the Strategy Committee to be in the future alongside future agenda items to be set and confirmed.

- The Committee also agreed that PA consulting work around capacity and demand, should be presented at the Strategy Committee in November.

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to consider the following recommendations arising from the meeting which require a decision:

2.1 To note the Strategy Committee Chair's report for the October 2023 meeting.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

None identified.

4. Appendices

Minutes of the meeting on the 11th October

Request of Paper:	To note the Strategy Committee Chair's report.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 29-11-132.7
Meeting date:	29 November 2023
Paper title	Primary Care Commissioning Committee Chair's Report
Paper presented by:	Niti Pall, Non-executive Director (Chair)
Paper approved by:	Nick White, Chief Medical Officer (Deputy Chair)
Paper prepared by:	Nick White, Chief Medical Officer (Deputy Chair)

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	

1. Executive Summary and Points for Discussion

1.1 The purpose of the paper is to provide a summary of NHS STW Primary Care Commissioning Committee meeting held on 4 August 2023 for noting.

1.2 The minutes of the meeting are attached for information.

1.3 No conflicts of interest were declared.

1.4 A summary of the discussion, assurance received and areas for escalation are outlined below for the Board's consideration:

- **Lantum Contract (Flexible Pools) Renewal: -** The Committee agreed that the contract does not represent value for money. A decision must be made as to how it is decommissioned subject to obtaining NHSE support for the ICB not having a digital platform.

- **GP Access Performance Report: -** NHS STW is in line with the UK average. 83.83% of patients are seen within 2 weeks and 52.65% are seen within 2 days or by the next day.

- **Primary Care Commissioning Governance:** Proposed changes to Primary Care Commissioning governance were discussed by the Committee at their October meeting for comment only. The GGI work is taking place in parallel with this rather than this being contained within it. However, care will be taken that Mr White aligns with the GGI to ensure that none of the decisions made by PCCC conflict with any recommendations they may make.

- **GP Occupational Health Service:** Discussions are ongoing regarding provision of an ICB-wide GP Occupational Health Service.

- **ICS Estates Strategy:** Development of the ICS Estates Strategy is commencing and must be completed by March 2024.

- **GP Access:** Appointments and pharmacy service referrals are increasing. One key area outstanding that requires more work are the trajectories on improvement and how that will be measured. That information is still outstanding from the PCNs and Practices.

- **Risk Register:** A new risk was added to the Register that General Practice will not receive any winter monies for additional same day appointments this year.

- **Asylum Seeker Update: -** One of the key areas is around screening for Tuberculosis. Due to changes in the way in which funding for health checks is allocated by NHSE, a cost pressure will result. However, that will not be known until details of our allocation are received.

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to consider the following recommendations arising from the meeting which require a decision:

2.1 Note this report.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

Not applicable

4. Appendices

Appendix 1 – Primary Care Commissioning Committee minutes from the meeting held on 4 August 2023.

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

INTEGRATED CARE BOARD

Agenda item no.	ICB 29-11-132.8
Meeting date:	Wednesday 29th November 2023
Paper title	Integrated Delivery Committee (IDC) Chair's Report
Paper presented by:	Gareth Robinson, Executive Director Delivery and Transformation (IDC Vice Chair)
Paper approved by:	Harry Turner, Non-Executive Director (IDC Chair)
Paper prepared by:	Jan Heath, Programme Manager
Signature:	
Committee/Advisory Group paper previously presented:	None

Action Required (please select):											
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X		

Previous considerations:	

1. Executive summary and points for discussion#

1.1. The purpose of the paper is to provide a summary of the NHS Shropshire, Telford & Wrekin (STW) Integrated Delivery Committee (IDC) meeting Part One – Open, held on Monday 9th October 2023.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	X
Integrating services at place and neighbourhood level	X
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	X
Economic regeneration	X
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	X
Workforce	X

3. Recommendation(s)

3.1. NHS Shropshire, Telford & Wrekin Integrated Care Board are asked to:

3.1.1. **Note** System performance reported within the System Operational Plan Dashboard including both the impact of industrial action and the positive news that Shrewsbury and Telford Hospital NHS Trust (SaTH) have been taken out of Tier 1 for elective care.

3.1.2. **Note** the good performance on 104 and 78 week waits within the Planned Care Delivery Board, the work underway on the cancer strategy and the introduction of Patient Initiated Requests to Move Provider (PIDMAS) to Shropshire, Telford & Wrekin (STW).

3.1.3. **Note** the work underway within the Urgent and Emergency Care (UEC) Board to mitigate the non-delivery of Virtual Ward and the delay to mobilisation of sub-acute beds that presents a significant risk to the escalation plan.

3.1.4. **Note** that the Financial Improvement Programme (FIP) is on track to achieve the NHS England target to identify plans for 90% of the overall efficiency plan by Month 6, but that there remains significant risk to the overall programme.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail.

4.1. None

5. Appendices

5.1. None

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	The committee terms of reference detail implications.
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	

Action Request of Paper:	3.1. NHS Shropshire, Telford & Wrekin Integrated Care Board are asked to: 3.1.1. Note System performance reported within the System Operational Plan Dashboard including both the impact of industrial action and the positive news that Shrewsbury and Telford Hospital NHS Trust (SaTH) have been taken out of Tier 1 for elective care. 3.1.2. Note the good performance on 104 and 78 week waits within the Planned Care Delivery Board, the work underway on the cancer strategy and the introduction of Patient Initiated Requests to Move Provider (PIDMAS) to Shropshire, Telford & Wrekin (STW). 3.1.3. Note the work underway within the Urgent and Emergency Care (UEC) Board to mitigate the non-delivery of Virtual Ward and the delay to mobilisation of sub-acute beds that presents a significant risk to the escalation plan. 3.1.4. Note that the Financial Improvement Programme (FIP) is on track to achieve the NHS England target to identify plans for 90% of the overall efficiency plan by Month 6, but that there remains significant risk to the overall programme.		
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	Integrated Care Board
Meeting date:	29th November 2023
Agenda item no.	ICB 29-11-132.8
Paper title	Integrated Delivery Committee (IDC) Chair's Report

1. **Introduction**

1.1. The purpose of the paper is to provide a summary of the NHS Shropshire, Telford & Wrekin (STW) Integrated Delivery Committee (IDC) meeting Part One – Open, held on Monday 9th October 2023.

1.2. The meeting was quorate, and no conflicts of interest were declared.

1.3. The minutes of the meeting held on Monday 11th September 2023 were approved.

1.4. The IDC Chair's Report for September 2023 was approved.

1.5. A summary of the discussions held, assurance received and areas for escalation are outlined below for the Board's consideration.

2. **System Operational Plan Dashboard**

2.1. The Director of Planning & Performance presented key points of note from the Operational Plan dashboard for Month 5 including:

2.1.1. Annual leave and industrial action have contributed to a deterioration in performance in relation to Urgent and Emergency Care (UEC), particularly in relation to ambulance handovers and 4 hours.

2.1.2. No Criteria to Reside (NCTR) Length of Stay (LoS) remains at average 4 days and is being closely monitored.

2.1.3. Positive news that Shrewsbury and Telford Hospital NHS Trust (SaTH) have been taken out of Tier 1 for elective care.

2.1.4. Industrial action has had a significant impact on value weighted activity, particularly at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), mitigations are being worked up at Planned Care Board.

2.1.5. Diagnostics is ahead of plan apart from endoscopy. A business case has been submitted to address capacity and demand in relation to endoscopy.

2.1.6. Patient Initiated Follow-up (PIFU) performance has improved and is now at 3.7%.

2.1.7. There has been gradual but sustained improvement around dementia diagnosis and Children and Young People.

2.1.8. Concern raised around Talking Therapies but currently working through trajectories and can update at the next meeting.

2.2. The committee noted the performance highlights, and areas for further discussion to be addressed in more detail elsewhere on the agenda.

3. **Planned Care Board Update**

3.1. The Director for Elective Recovery presented key highlights from the Planned Care update including:

3.1.1. All but one of the 104-week waits has been cleared and all providers are in a good position.

3.1.2. 78 week waits significantly reduced with 10 waiting but being managed and all providers are in a good position.

3.1.3. 65 weeks on track but there are some pressures due to industrial action and support still being received from NHS England.

3.1.4. Improvement trajectories for Outpatients transformation are still being refined but all organisations are expected to meet national standards by March 2024 and progress towards this is good so far.

3.1.5. Implementation of changes to patient choice that requires an offer of 5 different providers.

3.1.6. There is significant work underway regarding cancer prevention, diagnosis and patient pathways and on the cancer strategy.

3.1.7. Faster Diagnosis Standard (FDS) trajectory there were no issues to escalate, and SaTH are close to FDS target.

3.1.8. Faecal Immunochemical Test (FIT) testing has improved and is now around the 80% target.

3.1.9. Value-weighted activity is off-track by £2.2m collectively but may be partly due to counting and coding issues which are being addressed.

3.1.10. The number of breaches due to industrial action presents a key risk to delivery of our elective care standards.

3.1.11. Cancer remains at Tier 1 and weekly calls continue.

3.1.12. Patient Initiated Requests to Move Provider (PIDMAS) has now commenced in STW.

3.2. The committee noted the risks escalated in terms of the impact of industrial action and the work underway to mitigate.

4. **Urgent and Emergency Care (UEC) Board Update**

4.1. The committee received a verbal update as the UEC Board had been stood down due to critical incident.

4.1.1. A significant concern is the delay to the mobilisation of sub-acute wards caused by the delay to planning permission and recruitment issues.

4.1.2. The current projection (worst case scenario) is that 20 beds of the overall 52 beds come on stream at Princess Royal Hospital (PRH) in January 2024 as planned, with 32 Royal Shrewsbury Hospital (RSH) beds coming on stream over March/April.

4.1.3. The delay will have a considerable impact on escalation beds over the winter period.

4.1.4. Work is underway to explore all options to bring forward opening of additional beds and a report will be taken to the upcoming Oversight Group.

4.2. The committee requested that assurance be provided to the next meeting that actions previously agreed relating to the milestone plan and risk management had been completed.

4.3. In terms of UEC performance and the key metrics overseen by NHS England, there was a deterioration in 12-hour breaches and Category 2 performance during July and August due to industrial action.

4.4. Key areas of focus for all operational teams are Virtual Ward, core internal SaTH processes and the Winter Plan: areas of concern relate to SaTH processes in social care capacity and Virtual Ward unused capacity which is not having the expected impact on escalation spaces.

4.4.1. Work is underway to understand the underlying causes and drivers behind non-delivery but it is unclear whether the position is recoverable.

4.5. The committee noted the issues regarding Virtual Ward and the delay to the sub-acute wards that presented a key risk to the escalation plan.

5. **Financial Improvement Programme**

5.1. The Head of Programme Management Office (PMO) provided an update on the Financial Improvement Programme (FIP) position at Month 5 and the mitigations in place to address the adverse variance of £4m Year to Date (YTD), primarily due to escalation costs within SaTH.

5.2. However, progress has been made in identifying plans to meet all of the core target and the unidentified stretch has reduced from £15 million at the beginning of the year to £8.1 million largely due to progress made by the Medicines Value Group.

5.3. Identified plans now represent 89% of the overall savings target, and we are on track to achieve the NHS England 90% target by end of Month 6.

5.4. However, there is still significant risk to the overall £70 million programme due to the level of efficiencies that are loaded to the final quarter of the year and challenges faced by SaTH in meeting the core internal efficiency programme.

5.5. The Chair emphasised that delivery of the financial efficiency target was a key priority across the system and would require focused attention for the second half of the year.

6. **Hospital Transformation Programme Update**

6.1. The Director of the Hospital Transformation Programme (HTP) presented an overview of the HTP and progress to date including:

6.1.1. Design of the new hospital buildings and rationale including Net Zero target

6.1.2. Pathway redesign

6.1.3. Patient, community, and staff engagement

6.1.4. Travel and transport

6.1.5. Approval process for the Outline Business Case

6.1.6. Timelines and trajectory

6.2. The presentation was very well received, and the Chair requested that it was also taken to the RJAH Board for information.

7. Other Agenda Items

7.1. Other Standing Agenda items were provided for information and taken as read including:

7.1.1. Shropshire Integrated Place Partnership (ShIPP) Chair's Report

7.1.2. Mental Health (MH) and Learning Disability and Autism (LDA) Chair's Report

7.1.3. COVID-19 Vaccination Programme Report.

8. Recommendations

8.1. The NHS Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB) is asked to:

8.1.1. **Note** System performance reported within the System Operational Plan Dashboard including both the impact of industrial action and the positive news that Shrewsbury and Telford Hospital NHS Trust (SaTH) have been taken out of Tier 1 for elective care.

8.1.2. **Note** the good performance on 104 and 78 week waits within the Planned Care Delivery Board, the work underway on the cancer strategy and the introduction of Patient Initiated Requests to Move Provider (PIDMAS) to Shropshire, Telford & Wrekin (STW).

8.1.3. **Note** the work underway within the Urgent and Emergency Care (UEC) Board to mitigate the non-delivery of Virtual Ward and the delay to mobilisation of sub-acute beds that presents a significant risk to the escalation plan.

8.1.4. **Note** that the Financial Improvement Programme (FIP) is on track to achieve the NHS England target to identify plans for 90% of the overall efficiency plan by Month 6, but that there remains significant risk to the overall programme.