Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board

MEETING
27 September 2023 14:00

PUBLISHED
25 September 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

AGENDA (PART 1)

Meeting Title	Integrated Care Board	**Date**	Wednesday 27 September 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 27-09-102	Apologies and Introductory comments by the Chair	Sir Neil McKay	I	Verbal	2.00
ICB 27-09-103	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 27-09-104	Minutes from the previous meeting held on Wednesday 28 June 2023	Sir Neil McKay	A	Enc	
ICB 27-09-105	Matters arising and action list from previous meetings	Sir Neil McKay	A	Enc	
ICB 27-09-106	Questions from Members of the Public: *(There were no questions submitted in May)* Guidelines on submitting questions can be found at: https://stwics.org.uk/get-involved/board-meetings	Sir Neil McKay	I	-	
ICB 27-09-107	Patient's Story: Learning Disabilities and Autism Services: Luke's Story	Gareth Robinson	S	Enc	2.10

STRATEGIC SYSTEM OVERSIGHT (approximately 1 hour 20 minutes - 2.30pm – 3.50pm)					
ICB 27-09-108	ICB Chief Executive (CEO) Report: • 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 verdict in the trial of Lucy Letby	Simon Whitehouse	S	Enc	2.30
ICB 27-09-109	ICS Digital Strategy 2023-26 *(Dr Masood Ahmed to attend)*	Nick White	A/S	Enc	2:50
ICB 27-09-110	NHSE Delegation of Specialised Commissioning – Pre Delegation Assessment Framework	Nick White	A	Enc	3.10
ICB 27-09-111	STW ICS People Collaborative	Stacey Keegan / Rhia Boyode	S	Enc	3.20
10 MINUTE BREAK					
SYSTEM GOVERNANCE AND PERFORMANCE (approximately 35 minutes - 4.00pm– 4.35pm)					
ICB 27-09-112	Integrated Care System Performance Report: • Finance • Performance • Quality • People	Claire Skidmore	S	Enc	4.00
ICB 27-09-113	System Mortality Metrics	Nick White	S	Enc	4.15
ICB 27-09-114	Shaping the Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB)	Simon Whitehouse	S	Enc	4.25
FOR INFORMATION ONLY (acknowledge information item - 4.35pm)					
ICB 27-09-115	GMC Responsible Organisation	Nick White	A	Enc	4.35
BOARD COMMITTEE REPORTS (approximately 20 minutes - 4.35pm-4.55pm)					
ICB 27-09-116	**Assurance**				4.35
ICB 27-09-116.1	Quality and Performance Committee Chair's Report for meetings held on 25 May and 29 June 2023	Meredith Vivian	S	Enc	
ICB 27-09-116.2	Audit & Risk Committee Chair's Report for meeting held on 21 June 2023	Roger Dunshea	S	Enc	

ICB 27-09-116.3	Finance Committee Chair's Reports for meetings held on 30 May and 26 June and 27 June 2023	Professor Trevor McMillan	S	Enc	
ICB 27-09-116.4	Remuneration Committee Chair's Report – 16 August 2023	Professor Trevor McMillan	S	Enc	
	Strategy				
ICB 27-09-116.5	Strategy Committee Chair's Report for meetings held on 15 June, 9 August 2023	Cathy Purt	S	Enc	
ICB 27-09-116.6	System People Committee Chair's Report – no report	Dr Catriona McMahon	S	Verbal	
ICB 27-09-116.7	Primary Care Commissioning Committee Chair's Report for meeting held on – no report	Dr Niti Pall	S	Verbal	
	Delivery				
ICB 27-09-116.8	Integrated Delivery Committee Chair's Report for meetings held on 10 July, 14 August and 11 September 2023	Harry Turner	S	Enc	
ANY OTHER BUSINESS (approximately 5 minutes - 4.55pm-5.00pm)					
ICB 27-09-117	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 29 November 2023 - Telford				

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 28 June 2023 at 2pm
The Sovereign Suite, Shrewsbury Town Football Ground,
Montgomery Waters Meadow, Oteley Road, Shrewsbury, SY2 6ST

Present:

Sir Neil McKay	Chair, NHS STW
Professor Trevor McMillan	Deputy Chair and Non-Executive Director, NHS STW
Roger Dunshea	Non-Executive Director, NHS STW
Meredith Vivian	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
Alison Bussey	Chief Nursing Officer, NHS STW
Stacey Keegan	Foundation Trust Partner Member and Chief Executive Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Neil Carr	Foundation Trust Partner Member and Chief Executive, Midlands Partnership 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
David Sidaway	Local Authority Partner Member and Chief Executive, Telford and Wrekin Council.
Dr Ian Chan	Primary Care Partner Member for Telford and Wrekin
Dr Julian Povey	Primary Care Partner Member for Shropshire
Cllr. Paul Watling	Cabinet Member for Adult Social Care and Health Systems Telford and Wrekin Council (representing Shaun Davies)

In Attendance:

Mrs Inese Robotham	Deputy Chief Executive, 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
Alison Smith	Director of Corporate Affairs, NHS STW
Claire Parker	Director of Partnerships & Place, NHS STW
Cllr Cecilia Motley	Portfolio Holder for Adult Social Care, Public Health and Communities, Shropshire Council (representing Lezley Picton)

Pauline Gibson	Non-Executive Director, Midlands Partnership NHS Foundation Trust
Edna Boampong	Director of Communications and Engagement NHS STW
Cathy Purt	Non-Executive Director, Shropshire Community Health NHS Trust
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)
Melanie France	C&YP Integration Lead - Public Health, Shropshire Council
Vanessa Whatley	Director of Quality and Safety/Deputy Chief Nurse NHS STW
Harriet Hopkins	Communications and Engagement Lead NHS STW
Jayne Knott	Corporate PA (minute taker) NHS STW

Minute No. ICB 28-06-087 Introduction and Apologies

87.1 The Chair opened the meeting of the STW Integrated Care Board (ICB) and welcomed everyone. The Chair apologised for the lengthy papers this month, this was due to the annual reports and accounts for both the old CCG and the ICB.

The Chair also welcomed and introduced Councillor Paul Watling who has been recently appointed as Cabinet Member for Adult Social Care and Health Systems for Telford and Wrekin and has taken over from Cllr. Andy Burford and is representing Cllr. Shaun Davies at today's meeting. The chair asked that Cllr Burford be thanked for his work in this area whilst he was the portfolio holder.

87.2 Apologies were noted as follows:

Louise Barnett	Trust Partner Member and Chief Executive, Shrewsbury and Telford Hospital NHS Trust
Julie Garside	Director of Performance & Planning, NHS STW
Tracy Eggby-Jones	Corporate Affairs Manager NHS STW
Alex Brett	Chief People Officer, NHS STW
Cllr Lezley Picton	Leader of Shropshire Council
Cllr Shaun Davies	Leader of Telford and Wrekin Council
Jan Suckling	Lead Officer, Healthwatch Telford & Wrekin

87.3 The Chair highlighted the planned five-day industrial action by Junior Doctors followed by two days of action by consultant medical staff, which is having an impact in terms of the stress on Organisations trying to manage the consequences of that eventuality whilst dealing with busy agendas.

87.4 The Chair also referenced that we were waiting for the NHS Long Term Workforce/People plan, which is understood to have been available for publication for a while and has been the subject of intense funding negotiations between NHS England, the Department of Health and Social Care and the Treasury. The Chair said that it would be useful to have the plan as soon as possible so that we can start thinking about how we can deploy our workforce and employ them in a more effective way and recruit better than we have in the past.

Minute No. ICB 28-06-088 Declarations of Interest:

88.1 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)

88.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items.

88.3 It was noted that expressions of interest had not been captured for Mrs Pauline Gibson, this will be dealt with off-line and will be included in the register.

Minute No. ICB 28-06-089- Minutes from meeting held on 26 April 2023

The minutes were approved as an accurate record.

Minute No. ICB 28-06-090 - Action List from previous meetings

90.1 Action 1- Minute No. ICB 26-04-078 – Hewitt Review, The Government published its response on the 14 June 2023. The Chair requested that we build this into a future agenda for discussion.

90.2 Minute No. ICB 29-03-069 – Follow up to Patient's Story: MSK Integration across STW – To be added to the agenda for Septembers Board.

The Chair referred to the Action List and confirmed that all actions were either completed or in progress.

90.3 The action list was then approved.

Minute No. ICB 28-06-091- Questions from Members of the Public

91.1 No questions were submitted from members of the public.

Minute No. ICB 28-06-092 - Patient's Story: Falls Prevention

92.1 Mrs Alison Bussey, Mrs Vanessa Whatley and Mrs Mel France introduced the item and highlighted the importance of preventing falls in our system. The service is called Energize.

92.2 The prevention of falls, which accounts for around 30 ED attendances per day from our population of over 65-year-olds and over, is an important area in the prevention of ill health and keeping our older people well. It is part of the approach that we need to develop around improving care for frailty across our geography. It was important to note that this is not just about the NHS services, but about how integrated care can work to improve outcomes and to prevent falls in the first instance.

92.3 Mr Harry Turner asked how this was integrated into local care particularly around Primary care.

92.3 Mrs Vanessa Whatley responded by saying this service is part of the normal commissioning and contracting route for the ICB, but recognised that there is a greater need for integration across this agenda and the reduction of 'stand alone' services that worked in an isolated or fragmented manner. Money was received from NHSE to support the service development around fall prevention. Some of this money was used to look at these services with leads to see what could be done better one of these was to develop an approach that would increase the number of primary care referrals.

92.4 Mrs Mel France commented that there had been a significant growth in referrals from partners at 23%. In the 6-month period since launch, the service has had a remarkable 823 referrals, helping to prevent falls and reduce ambulance call out costs. The programme has now ended, as funding has ended.

92.5 Mrs Whatley commented that there is more that could be done to make use of these services and to look at a more integrated model of care.

92.6 Mrs Pauline Gibson asked how the success of the programme was being measured.

92.7 Mrs Whatley stated that the number of hospital admissions (ED attendances) were being monitored by both SaTH and from GP practice patients. A business case is now being put together to secure long-term funding to continue this programme of work.

92.8 Dr Julian Povey asked if the funding had run out for the carers in the car with the fall's services. He went onto query if the system should be prioritising carers in the car and are there any plans to reinvest in that service.

92.9 Mrs Patricia Davies commented that this was an impressive piece of work, and it warrants the further development of an integrated approach. This would require commissioners and providers (including the voluntary sector) to think about how we can commission and deliver these services in a more coordinated and effective manner. This would drive an approach to help demonstrate the need to invest in the service (aligned to demonstrating added value) and to make the connections across other falls services that currently exist.

92.10 Mrs Davies went onto say that the system needs to make sure that we are picking people up' and that they are then receiving the appropriate clinical assessment to ensure there are no on-going concerns, and to ensure clinically it is being managed and treated, as well as receiving the confidence building and exercise.

92.11 Mrs Lynn Cawley commented that Healthwatch Shropshire would support further work around falls as it would benefit the whole system.

92.12 Mrs Whatley commented that the project group was unique, it was a lot of practitioners and people that had never met, although they were all part of the fall's agenda, i.e. Ambulance service, community practitioners, rapid response team, partners from a Community Trust and the Fire service were also engaged. Time has been secured by the ICB to review in detail the falls pathway over the next nine months in the hope that next year there will be a new falls pathway.

92.13 Mrs Whately also mentioned that she would liaise with Mr Gareth Robinson to address the response service as part of our response to the winter and see how this can be worked up and make this affordable and practical.

92.14 Councillor Paul Watling asked if any cost benefit analysis had been undertaken of how much it costs for the service and the benefits it provides. He also asked if any work had been done with Communities/local community trusts and the third sector.

92.15 Mrs Whatley responded by saying that there was not enough time for community engagement to have taken place because the money received had to be spent within a few weeks due to it being a winter response. Getting a business case together and cost analysis will need to be done.

92.16 Mrs Alison Bussey commented that over the next few months we need someone to unravel what we have and build in the costs and benefit analysis and putting forward a comprehensive account. It is important that there is engagement with communities as well as they have a role to play in this.

92.17 The Chair commented that this was interesting and extremely beneficial. He suggested that we have some idea/proposals in an appropriate way of what this might look like if it is industrialised, what kind of investment it might need to put on a sustainable footing and tell us about the benefits.

The Chair thanked those who presented the item and those who featured in the video.

Minute No. ICB 28-06-093 - ICB Chief Executive (CEO) Report

93.1 Mr Simon Whitehouse, CEO, presented his ICB CEO update report highlighting the following:

93.2 **Pharmacy, Optometry and Dentistry (POD) Hosting Agreement – emergency decision**
An emergency decision has been taken with regard to the Pharmacy, Optometry and dentistry (POD) hosting agreements, due to the timing of that as part of the NHSE transition and delegation.

93.3 Mr Meredith Vivian asked how we were communicating information around changes with patients.

93.4 Miss Alison Smith agreed to send out a briefing note to all Board members and attendees to let them know what is happening around the POD delegation by NHSE, and specifically how we are dealing with communications directly with patients about how complaints around these services will be managed and by whom.

Action: Miss Alison Smith to send out briefing note to board members and attendees this week.

93.5 **Latest Position regarding Access Recovery Plan**

93.6 In response to the GP Access National Recovery Plan, GP practices, PCNs are submitting their recovery plans to the ICB.
This needs to link to and underpin the connection with other providers in the system and how do we get into the development plan for general practice and PCNs to support general practice engagement and inputs into the system work.

93.7 **Visit to SaTH by Nina Morgan**

93.8 Visit to Paediatric Services at SaTH on 31 May 2023 by NHSE - Nina Morgan, Chief Nursing Officer for the Midlands Regional Team of NHSE, and Julie McCabe, Deputy Director for Nursing & Quality had led the visit.

93.9 **Update on Industrial Action**

93.10 RCN did not reach the 50% thresholds for industrial action so no further industrial action will be taken by the Royal College of Nursing but continue with Junior Doctors and Consultants mandate.

93.11 **Feedback from the Office of the West Midlands**

93.12 Feedback from the Office of the West Midlands
Mr Whitehouse updated the Board following the West Midlands ICB CEOs monthly meeting held on 9 June 2023:

93.13 **Integrated System Improvement Plan (ISIP)**

93.14 As a system we are in the national oversight framework four, which is for the most challenged systems. As part of this we need to have a clear plan that is focussed on developing a sustainable and improved position across a number of areas that will enable us to be considered for movement out of this level. A fundamental aspect of this is the exit criteria and we need to develop an integrated system improvement plan against those exit criteria. This plan will get submitted to NHSE and, as part of the recovery and support programme and intervention we have, will get signed off with the Region and with the National team. This will then be monitored as part of our delivery of the exit criteria to move from NOF 4 to NOF 3.

93.15 **ICS Digital Strategy 2023-2026**

93.16 The public-facing draft digital strategy has been shared with the board, and it provides a high-level overview of our strategic direction. We have also shared this draft with various provider stakeholders, including primary care and local authorities, and we are actively incorporating their feedback.

The key elements of the strategy include:

- A focus on patient-centred care: The strategy will ensure that digital technology is used to improve the patient experience of care.
- A focus on efficiency: The strategy will use digital technology to improve the efficiency of care delivery. This will include the use of electronic health records, clinical decision support tools, and other tools to reduce administrative costs and improve the quality of care.
- A focus on equity: The strategy will ensure that digital technology is used to reduce health inequalities. This will include the use of digital tools to reach underserved populations and recognises the challenges around digital literacy.
- The final strategy will be brought back to the next full Board meeting.

93.17 Professor Trevor McMillan commented that the digital strategy has to be a critical component of the way forward for the ICS/ICB that will transcend NHS into local authority, help us deliver things differently in order to address many of the challenges

that we have. Professor McMillan asked how we embed this into every conversation that we have in board and beyond in the committee structures.

93.18 Mr Nick White responded that it was essential and being digitally mature is a vital part of the digital strategy.

93.19 Professor McMillan suggested having a Chief Information Officer to sit at the board table to take part in conversations around digital having a role.

93.20 Mr Nick White stated that Dr Masood Ahmed deputy Chief Medical Officer is the interim Chief Digital Information Officer. Many neighbouring ICBs have an Executive level Chief Information Officer.

93.21 The Chair asked Professor McMillan, Mr Nick White and Board members to give some thought to whether having a CIO on the Board would be beneficial.

93.22 **Premature Mortality in adults living with severe mental illness (SMI**)

93.23 A recent briefing shared by the regional health inequalities team has shown that the rates of excess mortality for residents with an SMI are worse in some areas than the national average.

It was agreed that the link between premature mortality and SMI (severe mental illness) and deprivation was a particular concern for our system and a fuller discussion/review was required and should be brought back to the Board at a later date.

93.24 Subsequent conversations took place around Primary Care and GP Access Plan

93.25 The Chair asked Dr Julian Povey and Dr Ian Chan to what degree did they feel that general practice has been engaged in discussions about the development of the GP Access recovery plan.

93.26 Dr Povey respond by saying yes there had been beginnings of engagement, but he thought that the plan needs more socialisation and engagement with practices and PCNs about why as a system we are depending on some actions, not just for improving patient care and access to primary care but ticking some of the boxes to improve the system.

93.27 The Chair commented that there was a sense that as a Board we do not spend enough time talking about primary care, general practice access and related issues. The Chair went on to say that he would welcome at a future Board meeting a discussion/advice about how we are going to make sure that issues relating to primary care adding dentistry, optometry and pharmacy and finding a way to bring these together in a concerted way around this Board table.

93.28 Mr Nick White commented that the Primary Care Commissioning Committee is a formal sub-committee of the Board. However, the place to have discussions is at the Strategy Committee because this would be the better forum to do this, and as well as regular reporting from the strategy committee there could be individual standing items when something comes through which is important to come to this Board.

93.29 Mrs Cathy Purt Chair of the Strategy Committee agreed that this would be the correct place to start conversations and give a broad view on primary care and associated clinicians that are aligned to primary care. The Chair suggested that the membership of the strategy committee may need to be revised to include Pharmacist, Optometrists, Dentists and GP's.

93.30 Mr Roger Dunshea commented that discussions around this had taken place and thought this needed a separate piece of work to bottom it out.

93.31 The Chair noted that the Good Governance Institute are doing a review of some of our governance arrangements including the functions of the different committees.

93.32 Mr David Sidaway asked if the GP access recovery plan could be shared before submission as this has significant implications for place.

93.33 Dr Ian Chan said there had been an influx of new housing developments in the Telford and Wrekin area, with no additional estate investment that would cater for primary care and the community. The view from General Practice is that this is a major risk over the next five to ten years unless we do something about it. If there is money there, we need to maximise the use of that. Mr Robinson commented that he was exploring the situation in relation to applying for Section 106 monies that are made available when any new development is agreed.

93.34 **The Board NOTED the:**

- **detail provided in part one of this report, including RATIFYING the emergency decision on the POD Hosting Agreement**
- **latest position regarding GP Access Recovery Plan**
- **visit to Paediatric Services at SaTH on 31 May 2023 by NHSE - Nina Morgan, Chief Nursing Officer, and Julie McCabe, Deputy Director for Nursing & Quality**
- **update on Industrial Action**
- **feedback from the Office of the West Midlands**
- **update on the Integrated System Improvement Plan (ISIP) and APPROVE it for final sign off by NHSE at the Improvement Review Meeting on the 7th July.**
- **update on the draft ICS Digital Strategy 2023-2026**
- **update on the work to improve the premature mortality rates in adults living with severe mental illness (SMI)**

Minute No. ICB 28-06-094 - Joint Forward Plan

94.1 Ms Claire Parker presented the plan and highlighted the following:

- This is a plan for the integrated strategy that was built off the back of the Health and Wellbeing strategy, and all of those plans align well.
- A number of actions and ambitions have been built into the plan.
- Workforce/national people plan will feed into the JFP and improve it.
- Feedback from GP Board, voluntary and community sector, children and young people, mental health/LDA has been captured. Engagement work is still being done and will carry on feeding into the document.
- Publication of the documents is by 30 June.

94.2 The Chair asked the Board what were the things that we were passionate about and we need to focus on and where everything fits, and to raise points of clarity and give some thought on priorities.

94.3 The Chair asked Mrs Cathy Purt as chair of the Strategy Committee if she had any additional points.

94.4 Mrs Purt responded saying the Committee had been through various iterations of the JFP, and it felt like it was coming together. The Committee has attempted to do the links between HTP, and the Local Care Program and a further meeting has been set up with Mr Nick White to put the Clinical strategy overarching piece across it. Include the enabler of workforce. Mrs Purt thought the three main priorities are:

- HTP (Hospital Transformation Program)
- LCP (Local Care Program)
- Overarching Clinical Strategy

94.5 Mrs Patricia Davies said as the Chief Executive with responsibility (SRO) for the Local Care program she agreed with the priorities stated, however it was important to note that we are with the wider integrated care system looking at the local care transformation program, what its key priorities are going to be over the next few years.

94.6 Mr Neil Carr asked that as a Board are we clear within the contents of the document what our priorities are, we need to be able to demonstrate how we are moving forward on the key clinical priorities. He thought we should engage more with primary care.

94.7 Professor McMillan thought the Research and Innovation needs a bigger impact if we are going to change things over the next five years.

94.8 Dr Chan said we were a challenged system; elective backlog has a lot of impact to general practice.

94.9 Mrs Tina Long commented that our priorities should be collective ones, and we would benefit from having two or three key enablers i.e. place and neighbourhoods.

94.10 Mr Meredith Vivian congratulated Ms Parker and everyone involved in the plan, saying it was a very good piece of work also with the outreach into communities has been good. We need to maximise the benefits of us being an integrated care system, the biggest part are the residents that live here, so the focus should be around people's health and prevention. He also mentioned about how we were going to arrange our finances to support it.

94.11 The Chair asked Mrs Claire Skidmore how we organise our finances to support it and what kind of mechanisms did she want to see deployed in the short term to think about how we distribute our resources differently to help deliver the priorities.

94.12 Mrs Skidmore responded by saying that the plan starts to build the framework from which she can add some numbers on from a financial perspective. The team have produced a model that sits around money, and we need it to be grounded in activity, workforce information and highlight the ambitions that we have got over five-ten

years. Work is being developed over the summer around and integrated demand capacity and finance model which will be available to support all the work. Mrs Skidmore said that this work was reliant on system partner organisations to help feed into it.

94.13 Dr Povey asked the Chair how we were going to report the numerous plans back to the Board and is there any read across or a simple document that shows us how the Integrated System Improvement plan aligns with the JFP as this may drive some of the targets in the JFP. Dr Povey also asked if we were going to engage with the public and ask them what they think we should prioritise which will tie into the financial plan. How do we establish a process?

94.14 Mr Andy Begley commented that there was one major workstream within the Shropshire plan called breaking generational cycles – opportunity to reduce demand on our services, but also improving outcomes for our residents.

94.15 Mr Simon Whitehouse commented that the JFP is the equivalent of the Long-Term Plan that was there previously. We have a twelve-month operational delivery plan for this year that we need to focus on, the priorities are clearly set out in there and we need to ensure that we deliver against that. The key is how do we evolve and make sure we get into the medium-term financial planning.
Our challenge as we get into planning for 24/25, how do we make sure we reference back to the Joint Forward Plan and the Integrated System Improvement plan, and we align the Joint Forward plan with the Health and Wellbeing strategies.

94.16 **The Chair suggested with agreement from the Board:**

- **Ms Claire Parker supports the Strategy Committee and to give some thought about how everything fits together and try and explain them to us as a Board.**
- **Give some thoughts about priorities and remind us about the discussions that have taken place before and tell us whether they are still relevant and help us with a synthesis of that.**
- **Help us understand the enablers and their priorities.**
- **We need a broader discussion about how we organise as a Board to oversee the implementation of our plans and our priorities.**
- **Consideration of whether our governance arrangements and committee structures are adequate for that purpose.**

94.17 The Chair congratulated Ms Parker and contributors stating that the JFP was an impressive piece of work, and reads well, however, there is still more to be done in terms of its implementation**.**

94.18 Mr Whitehouse stated that our priority should be driven by the data that is the joint strategic needs assessment that tells us what the population needs are.

94.19 Ms Parker reassured the Board that work had been done to make sure the JFP aligns with the System Improvement plan, the Operational Plan and financial plans and that all the strategies align. We have worked with SaTH to make sure all the local care plans and HTP align into this plan, also the Health and Wellbeing strategies.

Minute No. ICB 28-06-095 - Operational Plan 2023/24 update

95.1 Mrs Claire Skidmore presented the plan and highlighted the following:

95.2 This report provides an update on key elements of the 2023/24 operational plan and describes how the operational plan now transitions to delivery. It also responds to the request made at the previous board meeting to outline the benefits the plan will deliver to patients.

95.3 The final national operational plan for NHS STW was submitted on 4 May to NHS England. Following this the Planning Team has been focussed on developing a more detailed local operational plan which clearly describes the actions and commitments identified within the narrative and the related KPIs and associated trajectories whilst aligning them to the existing programme board structure beneath the Integrated Delivery Committee (IDC) to ensure clear ownership of delivery.

95.4 Each of the Programme Boards has a CEO lead:-

- Urgent & Emergency Care – Louise Barnett
- Planned Care (Elective, Cancer & Diagnostics) – Stacey Keegan
- MH & LD – Cathy Riley for Neil Carr
- CYP – Proposed David Sidaway/Andy Begley
- Financial Improvement – Simon Whitehouse
- Workforce (agency specific)– Patricia Davies

Oversight of the delivery of our financial forecast will be via the System Finance Committee. The detailed arrangements of the oversight of our workforce plan are being finalised.

95.5 Next steps for delivery of the operational plan:

- Relevant sections of the detailed local plan are being distributed to the respective programme boards so that they are aware of expectations in relation to the delivery of the operational plan and can track progress.
- The ICB planning and communications teams will develop a patient/public summary of the plan to be available during July.
- A lessons learned exercise is planned to identify improvements for future years plan development. This will be considered by the System Planning Group at the end of July.
- The process and timetable for producing the 2024/25 Operational Plan is to be developed, incorporating the feedback from above.
- It was noted that all partners would need to contribute to the support required to drive these programmes.
- The Board holds an extraordinary part 2 Board meeting within an extended attendance list to review the position vs the plan to date (month 2) and test the delivery mechanisms to ensure the system has a recovery position for the year end, which would be co-chaired by the Chairs of the Finance and Integrated Delivery Committees.

95.6 Benefits to patients include:

- Patients receiving the right care first time.
- Improvements in waiting times.
- Increased support for our most vulnerable patients
- Increased options for support outside of hospital
- Increased partnership working to streamline patient pathways.
- Increased awareness in communities of the needs of individuals.

95.7 **The Board is asked to:**

- **Note the overview and next steps outlined in the report.**
- **Take assurance that the Integrated Delivery Committee will oversee delivery of the plan through the work of the Programme Boards and using data dashboards to evidence progress.**
- **Note the impact of the plan for patients.**

95.8 The Chair suggested having conversations with program board leads about the progress and the risks associated with the work and how collectively how we might be able to assist with unblocking them.

Action: Mrs Claire Skidmore to arrange meeting with programme leads.

Minute No. ICB 28-06-096 - Learning Disabilities Mortality Review (LeDeR) Annual Report

96.1 Mrs Alison Bussey introduced the report with the following key points.
LeDeR is an NHS service improvement programme 'Learning from lives and deaths for people with a learning disability and autistic people.

96.2 The key principles of the programme are to:

- Improve care for people with a learning disability and autistic people.
- Reduce health inequalities for people with a learning disability and autistic people.
- Prevent people with a learning disability and autistic people from early deaths.

96.3 ICBs have a statutory responsibility to produce an annual report on LeDeR process and learning and submit this to NHSE at the end of Quarter 1.
The annual report contains a wide range of information and learning gathered during 2022-2023 and influences the quality improvement in this area of health inequalities in the coming year.

96.4 The LeDeR Programme is overseen by a Governing Panel which has representation across NHS providers in STW, as well as those people and their families with lived experience and Healthwatch.

96.5 The report demonstrates a range of progress to improve the lives and deaths for people with LD & A and their families. It also highlights areas where more progress is needed including:

- Strengthen links with, and reduce inequalities for, people from minority ethnic communities.
- Continue to strive for better performance of Learning Disability Annual Health Checks (LDAHC).

- Increase the training around reasonable adjustments and healthy living across the STW system partners that incorporates Healthwatch/Treat me well.
- LeDeR is an NHS programme 'Learning from lives and deaths a service of people with a learning disability and autistic people'.
- Improved use of the Mental Capacity Act.

96.6 The LeDeR Annual Report 2022-2023 outlines the learning and challenges identified from the reviews in the lives and deaths of those who have died with LD & A in Shropshire Telford and Wrekin. It sets our direction and opportunities for quality improvement in 2023-24 and beyond and requires approval at a public meeting of the Integrated Care Board.

96.7 Mr Neil Carr commented that we should be embracing the needs of people with LD into every policy or every service that we are operating, there was a request that organisations should be thinking about people with LD to try and embrace them into their generic services.

96.8 The Oliver McGowan training was mentioned, and Mrs Bussey commented that there was a pilot for tier two training starting. Resourcing and funding will be an issue, but work is being done jointly with local authorities.

The Board approved the LeDeR Annual Report 2022-2023

Minute No. ICB 28-06-097 - Integrated Care System Performance Report

97.1 The Chair started by acknowledging that the Integrated Care System Performance Report was very well organised and congratulated the authors and presenters.

97.2 Mrs Claire Skidmore presented the report and highlighted the key headlines:

- This is the first redesigned report that also captures quality information as well as the other strands.
- Still reflections within the team on what could be done differently and how it could be improved.
- The System continues to have two significant performance pressures, Urgent and Emergency Care (UEC) and Finance.
- Whilst there have been improvements in some aspects of UEC performance with Ambulance handovers and Category 2 response rates, A&E performance remains a challenge, particularly around the 4-hour target which is failing to meet the improvement trajectory. Improvements have been seen in triage within 15 minutes and numbers of patients spending more than 12 hours in the department.
- At Month 2 the STW system is reporting a £4m adverse variance to the plan (£22.9m deficit against and £18.9m deficit plan. The main area of overspend is in SaTH and relates to continued areas of open escalation space and the associated agency expenditure as well as the impact of strike action.
- Due to changes in national reporting from April 2023 the number of workforce performance metrics has been reduced and will no longer be available for sickness, turnover and training. A process to receive this data direct from providers will need to put in place for future reporting but was not available for this report.

97.3 Mrs Patricia Davies commented that we recognise the huge pressures on the urgent care agenda. It was noted that the schemes were the right schemes and are delivering, whilst we are behind plan, we have seen progress around the virtual ward which is a joint piece of work between Shropshire Community Health NHS Trust, SaTH and the wider system around the step-down patients into the community. We are currently on the agreed trajectory that is in the operational plan and confident that we will deliver the 249 beds by December. We have received some national media and other interests which is positive, which is helping with recruitment. Mrs Davies thought the narrative should be changed slightly in terms of we are delivering.

97.4 Mr Harry Turner commented around the data appeared to indicate that the number of GPs had increased, but over the same period the number of appointments seem to have gone down. He asked for clarification on the data and what it was showing.

Action: Mrs Skidmore to ask the team to provide a statement specifically to map what has driven the changes and why they don't correlate.

97.5 Mr Roger Dunshea thought it would be useful to have some narrative around each of the graphs to explain why the trend is adverse and a section saying what the mitigations would be to reverse the trend.

97.6 The Chair requested that the Board spend a few minutes looking at page 20 the month two finance position where we are showing about £4m variance but showing that we are on track to deliver our plan at the year end.

97.7 Professor McMillan wanted to note a couple of items that were discussed at his Finance Board yesterday.

- Things will get harder because of the way we have profiled the efficiency savings.
- He also mentioned agency being a 'large chunk' of the £4m deficit.
- Could there be a cross system debate to see if there is anything more strategic that can be done around the whole issue of agencies and their use and how they are paid?

97.8 Dr Catriona McMahon stated that there is a piece of work being done across the system. The majority of agency volume sits within SaTH, who are very involved in looking at that. A lot of work has been done in terms of rationalising the level of off framework of agency usage. This is initially within the Paediatric division but is now moving on to the next stage of development which is about the E-rostering. Dr McMahon also thought it was important that we map out the potential trajectory of the risk particularly around the potential gap between the assumptions that we have around agency use of escalation.

97.9 Mrs Skidmore responded saying that work is done each month when we produce the position to look at what the financial risk is. The unmitigated risk is running at just over £90m.

97.10 Mr Whitehouse commented that we urgently need to unlock and reduce the escalation capacity as that was driving sme of the agency staffing costs.

Action: Mr Whitehouse to have discussions with Chief Executives and then update Board.

97.11 The Board noted and accepted the report.

Minute No. ICB 28-06-098 – CCG (months 1–3) and ICB (months 4 –12) Annual Reports and Accounts 2022/23 – for approval

98.1 Mrs Claire Skidmore introduced the agenda item and highlighted the following:

- Two sets of annual accounts have been produced this year.
- Paperwork will be submitted tomorrow 29.6.23 subject to the Board being content with papers presented today.
- The CCG annual reports and accounts are for noting and information only.
- The ICB annual reports and accounts are for this board to sign off.
- Included in the documents are letters of representation that need to be sent off alongside those that Mr Simon Whitehouse will sign on behalf of the board, and the audit findings report.
- Both sets of accounts have been approved as unqualified (a positive outcome) and with very minor adjustments.

98.2 Mrs Skidmore asked the Board to support these documents and delegate responsibility to herself and Mr Whitehouse to sign off any last amendments.

98.3 Mr Roger Dunshea commented that from internal audit a slight caveat around the risk management processes and board assurance framework that needs to be up and running as soon as possible. Hopefully by September onwards we have an effective board assurance framework operating across the committees.

98.4 **The Board is asked to:**

- **support the recommendations,**
- **approve the final versions.**
- **delegate authority to Claire Skidmore and Simon Whitehouse to do last minute adjustments.**

Minute No. ICB 28-06-099 - Finance Committee – amendment to Terms of Reference

99.1 Mr Harry Turner commented that the paper read that the requirements for the finance committee is to only meet four times a year, he thought symbolically that they should be meeting more.

99.2 Mrs Skidmore stated that they meet ten times a year as August and December are excluded.

99.3 **The Board is asked to accept the amendments to the terms of reference.**

Minute No. ICB 28-06-100 – Committee Reports

Minute No. ICB 28-06-100.1- Quality and Performance Committee Chair's Report for meetings held on 22 March, 27 April and 25 May 2023

The Board noted the paper as read.

Minute No. ICB 28-06-100.2 -Audit & Risk Committee Chair's Report for meeting held on 19 April 2023

The Board noted the paper as read.
The Board will be updated on the Board Assurance framework in September.

Minute No. ICB 28-06-100.3 - Finance Committee Chair's Reports for meetings held on 8 March 28/30 March and 3 May 2023

The Board noted the paper as read.

Minute No. ICB 28-06-100.4 -Remuneration Committee Chair's Report for meeting held on 20 June 2023

The Board noted the paper as read.

Minute No. ICB 28-06-100.5 - Strategy Committee Chair's Report for meetings held on 18 May 2023

The Board noted the paper as read.
Extraordinary Strategy Committee is scheduled for 9 August, Mr Nick White to attend and present the Clinical Strategy.

Minute No. ICB 28-06-100.6 -System People Committee Chair's Report - no meetings held since last report.
The people committee has not met recently.
Conversations are being planned with Mr Simon Whitehouse to look at the purpose of the People Committee.

Minute No. ICB 28-06-100.7 - Primary Care Commissioning Committee Chair's Report for meeting held on 2 June 2023

The Board noted the paper as read.

Minute No. ICB 28-06-100.8 - Integrated Delivery Committee Chair's Report for meetings held on 10 May and 12 June 2023

108.8.1 Mr Harry Turner presented the paper and highlighted the following key points from meeting on 12 June 2023.

- 12 recommendations
- 4 recommendations regarding virtual ward and raising issues, but a solution there around the expansion forum that has been created to solve issues.
- Endoscopy and faster diagnosis standard which was behind trajectory but did have a trajectory to achieve by end of year.

108.8.2 The Chair wanted to remind everyone that the Good Governance Institute are doing a review of the committee structures, and they are looking at functions, considering overlaps and how things may be simplified.

108.8.3 The Chair asked Miss Alison Smith to remind Board members of the engagement process and timelines.

108.8.4 Miss Smith mentioned that she was in the process of emailing Board members, Chairs of committees and to those who attend our committees whether they are members or attendees with some information, so there is an awareness of what the

terms of reference are and also a request that a survey is completed and also some conversations will be set up directly with the Good Governance Institute Consultants that are leading the piece of work.

108.8.5 Timelines – originally the terms of reference stated that the first phase - mapping exercise would be finished in June. Clearly this has taken longer for some of the paperwork and collation of information and are now looking at July. The second phase of work will go into the autumn and winter, will be about embedding what processes we want to put in place, embedding the structures that we want to move to if there are any changes around committees, getting some of the culture and behaviours in place that we all need to attend to. Making sure that committees are running in the right way, and the right level of support.
More detail will be in the email.

Minute No. ICB 28-06-101 - Any Other Business (To be notified to the Chair in advance)

No further matters to report

Date & time of Next Meeting

Date and time of next meeting: Wednesday 27th September 2023.
The Chair closed the meeting at 4.37pm.

NHS Shropshire Telford and Wrekin
Integrated Care Board

Actions List from ICB Meeting Agenda Item	Action Required	By Whom	By When	Date Completed/Comments
Minute No. ICB 28-06-093 - ICB Chief Executive (CEO) Report	Miss Alison Smith agreed to send out a briefing note to all Board members and attendees to let them know what is happening around the POD delegation by NHSE,	AS	27 September	Complete
Minute No. ICB 28-06-095 - Operational Plan 2023/24 update	The Chair suggested having conversations with program board leads about the progress and the risks associated with the work and how collectively how we might be able to assist with unblocking them. • Claire Skidmore to arrange a meeting with program leads	CS	27 September	
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.	CS / SW	27 September	

Agenda Item	Action Required	By Whom	By When	Date Completed/Comments
Minute No. ICB 26-04-078 - Introduction and Apologies	ICB to have dedicated session to discuss outcome of the Hewitt Review, to be arranged once the government had responded to the recommendations in the review.	SW / AS	When appropriate – following government's response	28.6.23 - The Chair requested that we build this into a future agenda for discussion.
Agenda Item	**Action Required**	**By Whom**	**By When**	**Date Completed/Comments**
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	To be added to agenda in September
Minute No. ICB 29-03-072 – People Programme Annual Report 2022/23 & ICS People Strategy 2023-2027	Chief People Officer to present updated People Strategy 2023 – 2027 to ICB Board in June 2023.	Alex Brett	28 June Board meeting	Deferred to September Board meeting as Strategy and key priorities are currently under review.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 27-09-108
Meeting date:	27 September 2023
Paper title	ICB CEO Update Report
Paper presented by:	Simon Whitehouse, ICB Chief Executive
Paper approved by:	Simon Whitehouse, ICB Chief Executive
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	x		

Previous considerations:	West Midlands Office of the ICBs presented in September 2022

1. Executive summary and points for discussion

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

The paper provides a generic update on activities at both a national and local level (CEO Business Update), which is set out in full in the main body of the report.

A. Emergency Preparedness, Resilience and Response (EPRR)
B. GP Practice Recovery Plans NHSE STW Annual Assessment Letter 2022/23
C. GP Patient Satisfaction Survey Results 2023
D. Winter Planning
E. Update on QRSM output
F. 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**

A. Emergency Preparedness, Resilience and Response (EPRR)

This section provides an update on the ICB's submission of the annual assessment against the NHSE Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

B. NHSE STW Annual Assessment Letter 2022/23

To note the annual assessment of Shropshire, Telford and Wrekin Integrated Care Board's performance in 2022-23.

C. GP Patient Satisfaction Survey Results 2023

This section provides the latest GP Patient Satisfaction Survey results published in July 2023.

D. Winter Planning

This section provides an update on the key areas of focus of the ICB's winter plan.

E. Update on QRSM output

This section provides an update on the QSRM held on 14 July 2023.

F. ICB response to the letter from NHS England to the NHS following the verdict in the trial of Lucy Letby

This section provides an update on the actions the ICB is taking in relation the letter from NHS England following the verdict in the trial of Lucy Letby.

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

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Integrated Care Board is asked to NOTE the:

A. Emergency Preparedness, Resilience and Response (EPRR)
B. NHSE STW Annual Assessment Letter 2022/23
C. GP Patient Satisfaction Survey Results 2023
D. Winter Planning
E. Update on QRSM output

F. 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**

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

4. Appendices

Appendix 1 - GP Practice Recovery Plans NHSE STW Annual Assessment Letter 2022/23
Appendix 2 - Letter re Verdict in the trial of Lucy Letby
Appendix 3 - Fit and Proper Person Test Framework

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Please see Section 3
Quality and Safety	Please see Section 3
Equality, Diversity, and Inclusion	Please see Section 3
Finances and Use of Resources	Please see Section 3
Regulation and Legal Requirements	Please see Section 3
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	Please see Section 3

Action Request of Paper:	**To NOTE the:**
	• **Emergency Preparedness, Resilience and Response (EPRR)**
	• **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**

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

Meeting:	ICB BOARD MEETING
Meeting date:	27 September 2023
Agenda item no.	ICB 27-09-108
Paper title	ICB CEO Update Report

A. Emergency Preparedness, Resilience and Response (EPRR)

1.1 In line with NHS England (NHSE) requirements the ICB has submitted its annual assessment against the NHSE Core Standards for EPRR which assesses the ICB's compliance against the statutory duties set out in the Civil Contingencies Act 2004 for Category 1 responders and their preparedness to respond to incidents. The outcome of this assessment is expected towards the end of December. The ICB will also assist NHSE with assessing the compliance of other health organisations in the Shropshire, Telford and Wrekin (STW) system.

1.2 As part of the preparation for this assessment the following EPRR polices have been refreshed to ensure they reflect updates in national policies, procedures and guidance. Whilst the ICB has no specific incidents to report as an organisation, it has been involved in supporting the system in several incidents and the learning from these has also been reflected in policy updates.:

- EPRR Policy
- Incident Response Plan
- Business Continuity Plan
- On Call Policy
- EPRR Communications Plan
- Risk Management Policy

1.3 The ICB has refreshed its EPRR training for all relevant staff and can report compliance with the National Occupational Standards for Civil Contingencies for all eligible staff. The ICB has also led and participated in a number of EPRR exercises to test plans and their activation, the learning from which has been incorporated into policy updates and the annual work plan.

1.4 The ICB has in place a detailed work plan to set out the areas of focus in its EPRR continuous development cycle for the 2023/24 period. This along with the refreshed EPRR risk register will be overseen by the multi-agency STW Local Health Resilience Partnership (LHRP) and reported to the Audit Committee

1.5 The ICB continues to look at the most efficient ways of working and developing partnership approaches to build resilience. On this basis STW ICB has agreed to merge its LHRP Forum with that of Hereford and Worcestershire ICB with whom we share a Local Resilience Forum footprint. This arrangement, which will allow us to share administrative and chairing responsibilities, will also enable us to share common areas of work as well as expertise. This arrangement will be implemented during the Autumn of 2023

1.6 A further update will be provided in the spring of 2024

B. NHSE NHS STW Annual Assessment Letter 2022/23

2.1 To note the annual assessment of Shropshire, Telford and Wrekin Integrated Care Board's performance in 2022-23. This is set out in the attached letter.

C. GP Patient Satisfaction Survey Results 2023

3.1 Every year the NHS undertakes a national GP Patient Satisfaction Survey. The latest results were published in July 2023 and are based on field work undertaken between January and April 2023. The results are made available publicly.

3.2 The results of this survey are one of many valuable feedback sources on patient experience, accessing local practices, and the service quality offered, however, it is important to recognise that these survey results only measure data about appointments and is not a measure or indication of practice quality or patient care. Practice performance needs to be assessed and measured through a range of other methods viewed collectively.

3.3 A comparison summary of the survey results between this year and last is provided below. Key points to note:

1. Compared to the NHS STW performance in 2022 – there is a mixed picture of small movements in deterioration and improvement.

2. There can be wide variation in scoring at Primary Care Network/practice level however.

3. Compared to the 2023 national average – NHS STW is generally performing better than the national average.

4. As with the previous year's performance, both locally and nationally, scores related to access and appointments score much lower than those related to the quality of care received.

5. Shropshire Primary Care Networks (PCNs) scored significantly higher than the national average for most of the questions. Telford and Wrekin PCNs scored significantly lower than the national average for most questions. This variation can be seen in the table below.

Survey questions	2023 national average	STW 2023	STW 2022	2023 Score range
Access Questions				
Overall how would you describe your experience of your GP practice? % Good	71	73	73	52-84
Generally, how easy is it to get through to someone at your GP practice on the phone? % Easy	50	48	52	18-82
How helpful do you find the receptionists at your GP practice? % Helpful	82	82	84	62-92
How easy is it to use your GP practice's website to look for information or access services? % Easy	65	64	68	38-81
On this occasion (when you last tried to make a general practice appointment), were you offered a range of choices of appointment? % Yes	59	58	60	43-75
Were you satisfied with the appointment (or appointments) you were offered? % Yes	72	73	74	55-83
Overall, how would you describe your experience of making an appointment? % Good	54	55	57	32-73
Were you given a time for the appointment? % Yes	91	93	92	88-97
How satisfied are you with the general practice appointment times that are available to you? % Satisfied	53	52	55	32-68
Quality of Care Questions				
Last time you had a general practice appointment, how good was the healthcare professional at giving you enough time? % Good	84	85	85	71-90
Last time you had a general practice appointment, how good was the healthcare professional at listening to you? % Good	85	86	86	72-90
Last time you had a general practice appointment, how good was the healthcare professional at treating you with care and concern? % Good	84	85	85	72-91
During your last general practice appointment, did you feel that the healthcare professional recognised and/or understood any mental health needs that you might have had? % Yes	81	82	81	60-88
During your last general practice appointment, were you involved as much as you wanted to be in decisions about your care and treatment? % Yes	90	91	91	80-95
During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to? % yes	93	93	95	80-96
Thinking about the reason for your last general practice appointment, were your needs met? % Yes	91	92	92	83-96
In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)? % Yes	65	63	67	47-77

3.4 Our GP teams across Shropshire, Telford and Wrekin continue to work hard to meet exceptional demand, delivering more appointments than ever before. We appreciate that some of our patients continue to find access to their GP practice challenging, but we continue to work hard to provide additional support where necessary and strive towards access improvement across the county.

3.5 GP access recovery is a national and local priority. We are now focused on delivering the requirements of the national GP Access Recovery Plan, published in May 2023, which has been designed to make it easier for patients to get through to their practice and receive the care they need when they need it, based on clinical need.

3.6 The PCNs have reviewed their baseline access performance against a set of national access metrics and developed a Capacity and Access Improvement Plan. These plans were signed off by the ICB Executive Team at the end of July and are being collated to form a wider System Improvement Plan which will be presented to the ICB Board in November, together with details of the progress being made against the plan.

D. Winter Planning

4.1 All system partners across health & social care and the voluntary sector have come together via winter workshops to identify the key area of focus for the NHS STW ICS Winter Plan. We have reviewed the data and lessons learned from previous years.

4.2 A panel review of the bids proposed will take place on August 29th and the final plan will be presented to UEC Board in September 2023. We have coordinated with NHSE regionally and nationally to ensure that our winter response is fully aligned to our Operational Plan and UEC Recovery.

4.3 The intention then is to use some time at the October Board development session to work through the proposed winter plan and the clinical escalations that have been agreed.

E. Update on QRSM Output

5.1 This section provides an update on the QSRM held on 14 July 2023

- Latest Quarterly System Review Meeting took place on 14th July.
- Number of key positive achievements were acknowledged:
  1. SaTH Maternity continues to make good progress
  2. All providers have made significant progress in reducing long waiting elective patients – and have more recently been highlighted as the best performing system in the region for 78 and 65 week waits. Reflecting this, both SaTH and NHS STW have been taken off Tier 1 monitoring for Elective Performance
  3. Telford & Wrekin Local Area SEND Inspection achieved an Outcome 1 (highest performance rating)
  4. Primary Care recovery continues with the highest rate in the region for in the day appointments and GP face to face appointments

- Key challenges identified:
  1. Delivery of system operational plan. Month 2's position was reported to QSRM in July. More recent performance is included within the Q&P report for September Board
  2. UEC trajectories are not being met and escalation beds remain open resulting in further agency spend and high financial impact. Significant performance concerns exist around recent spikes in ambulance waits and ED overcrowding at SaTH
  3. Outcome of the CQC inspection at MPUFT
- A range of actions relating to the UEC and financial performance challenges were agreed and taken forward by NHS STW in conjunction with system partners

F. ICB response to the letter from NHS England to the NHS following the verdict in the trial of Lucy Letby

7.1 Colleagues across health and care and the nation have been shocked and saddened by the appalling crimes that have been reported through the trial of Lucy Letby and our thoughts are with all the families and colleagues affected by these events.

7.2 It is, therefore, incumbent on us, to commit to do everything we can to prevent these circumstances reoccurring. A letter received from NHS England on 18th August 2023 **(Appendix 2)** asked NHS Leaders to undertake a number of urgent actions and this report seeks to provide assurance to the Board of this commitment and actions for noting:

<u>Oversight of patient safety data</u>

7.3 In relation to the ICB and ICS maintaining oversight of patient safety data the content of the item on the September 2023 agenda entitled 'Mortality Figures' presented by the ICB Chief Medical Officer provides detail on how this is being undertaken.

<u>Freedom to Speak Up</u>

7.4 In light of the NHS England letter, the ICB has reviewed the actions it is already taking in response to the revised guidance on Freedom to Speak Up which includes:

- Currently formalising an updated Freedom to Speak Up Policy in line with this guidance which will be presented to the Audit Committee at its meeting in early October for approval.
- Reviewed its Freedom to Speak Up Guardian arrangements and in the process of amending these to meet the guidance.

- Has undertaken a self assessment of current arrangements to identify where improvements can be made to develop an action plan for future improvement.
- Has recognised that the culture and environment of the organisation is a key driver that impacts on how well freedom to speak up arrangements operate. The Shaping the STW ICB programme aims to deliver organisational change and produce a new operating model for the ICB. Through this programme, one of the key objectives to is to demonstrate a culture of “do with” rather than “do to”. To support development of our new organisation the ICB are procuring a strategic partner with experience in organisational redesign. One of the specific requirements we have asked our partner is to explore culture within the organisation and shape our new culture, to make STW ICB a great place to work for our people and help us achieve our inclusion, diversity and wellbeing ambitions. Through the delivery of the organisational change programme, we will build a working environment where speaking up is not only welcomed, but valued as an opportunity to learn and improve.
- The role of the ICB in addition to its own responsibilities to the staff it employs, is to ensure that there are appropriate arrangements in place within partner ICS NHS organisations. The existing ICB Freedom to Speak Up Guardian is convening a regular meeting of Freedom to Speak Up Guardians across Shropshire Telford and Wrekin to provide a forum for assurance that each organisation has appropriate arrangements in place and to share best practice and themes and issues where appropriate.

Fit and Proper Person Test

7.5 The letter from NHS England also makes reference to the recently revised and published Fit and Proper Person Framework:

NHS England » NHS England Fit and Proper Person Test Framework for board members

- The framework is a response to the recommendations made by Tom Kark KC in his 2019 review of the Fit and Proper Person Test (the Kark Review) and also takes account of the requirements of the CQC in relation to directors being fit and proper for their roles.
- The revised framework strengthens and reinforces individual accountability and transparency for board members but particularly for the Chair of the Board in relation to the enacting of the framework.
- It sets out the additional background checks, including a board member reference template, which will also apply to board members taking on a non-board role.
- There is a requirement for an annual refresh and for the first time for this to be recorded on Electronic Staff Records so that it is transferable to other NHS Organisation as per of their recruitment processes.
- The full assessment focuses on three core elements when considering whether board members are a fit and proper person to perform a role on the Board. These are:
  - Good character
  - Possessing the qualifications, competence, skills and experience required
  - Financial Soundness.
- The framework is effective from the 30 September 2023 all boards are required to implement it.

- Board members within scope of the Fit and Proper Person test have received a letter outlining the requirements and a briefing note is appended **(Appendix 3**) for further information.
- Assurance can be given that ICB Company Secretary is supporting the ICB Chair to implement required processes outlined in the framework to ensure that the ICB complies with implementing the full FPPT framework for new and existing Board roles from 30 September 2023.

7.6 The Board is asked to note the actions being taken on these specific areas of work.

CONCLUSION

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**

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

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board

Agenda item no.	ICB 27-09-109
Meeting date:	27 September 2023
Paper title	STW ICS Digital Strategy
Paper presented by:	Dr Masood Ahmed
Paper approved by:	
Paper prepared by:	Dr Masood Ahmed
Signature:	M Ahmed
Committee/Advisory Group paper previously presented:	

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

Previous considerations:	

1. Executive summary and points for discussion

This report provides an overview of the proposed Digital Strategy for the Shropshire, Telford & Wrekin Integrated Care System. The strategy outlines approaches for adopting digital technologies and tools to enhance health and care.

The strategy aligns with the Improving Safety and Quality pledge.

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	✓
Enhanced engagement and accountability	✓
Creating system sustainability	
Workforce	✓

2. Recommendation(s)

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

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

Yes, this report relates to risks around inefficient use of resources and outdated technologies outlined in the Board Assurance Framework. The proposed Digital Strategy aims to provide a framework for adopting digital tools to drive efficiencies.

4. Appendices

Appendix 1 – STW ICS Digital Strategy

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	The Digital Strategy will support improved access to health services and information for residents through online platforms and tools.
Quality and Safety	Use of digital tools and data analytics will enhance clinical decision-making, quality of care and patient safety.
Equality, Diversity, and Inclusion	The strategy aims to improve accessibility and inclusion through digital channels. Digital 'first' but not digital 'only'
Finances and Use of Resources	The strategy will enable more efficient use of resources through optimised digital systems.
Regulation and Legal Requirements	The strategy will ensure compliance with digital standards and data protection regulations.
Conflicts of Interest	No known conflicts of interest.

Data Protection	The strategy highlights the importance of robust data security and governance.
Transformation and Innovation	The strategy will drive innovation through use of emerging digital technologies such as AI.
Environmental and Climate Change	Increased use of digital tools is expected to reduce paper waste and transportation needs.
Future Decisions and Policy Making	No related decisions or policies were identified at this stage.

Action Request of Paper:	The Integrated Care Board is asked to: of Paper: - Note the contents of the report - Support the adoption of the Digital Strategy - Approve the implementation of the Digital Strategy across the Integrated Care System		
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	Integrated Care Board Meeting
Meeting date:	27th September 2023
Agenda item no.	ICB 27-09-109
Paper title	STW ICS Digital Strategy

1. **Background**
   Adoption of digital technologies is a key priority for the Integrated Care Board to drive improvements in quality, efficiency and accessibility of health and care services. A robust digital strategy is essential for leveraging technologies to transform service delivery.

2. **Report**

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

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

   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 are incorporated to support adoption by staff and service users.

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

3. **Conclusions**

   The proposed Digital Strategy provides a robust framework for adopting technologies, platforms and tools to realise the benefits of digital transformation across the health and care system.

4. **Recommendations**

   The Integrated Care Board is asked to:

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

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 27-09-110
Meeting date:	27 September 2023
Paper title	Delegation of Specified Specialised Acute Service Lines
Paper presented by:	Mr Nick White, Chief Medical Officer
Paper approved by:	
Paper prepared by:	Mr Nick White, Chief Medical Officer
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):											
A=Approval	X	R=Ratification		S=Assurance		D=Discussion		I=Information	
Previous considerations:	**Not applicable**										

1. Background and Context

Background
There are currently 178 Prescribed Specialised Services that are commissioned by NHS England at a Regional and National level. Until the recent change to legislation NHS England could not delegate the commissioning of these services. The changes to legislation in 2022 mean that NHS England can now delegate the commissioning of Specialised Services to reduce pathway fragmentation at a system level and to improve outcomes for patients. These new commission arrangements are also expected to reduce health inequalities and enhance the quality of health and care for patients, by ensuring that ICBs can strategically plan and commission services for their whole population. Delegation of Specialised Services commissioning will begin with the delegation of 59 Acute Specialised Commissioning Service lines to ICBs in April 2024.

The first step in this delegation process will the development of a pre-delegation assessment framework (PDAF). This been developed to support Integrated Care Boards (ICBs) prepare for delegation arrangements; and underpins the assessment of system readiness. It is 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 has been tailored specifically for specialised services commissioning.

This paper request the Board approve this document for formal sign off by the ICB for national submission. In addition to the PDAF a briefing paper and a summary of STW expenditure and headline activity is also included.

Context
Specialised Commissioning Expenditure of the population Shropshire, Telford and Wrekin ICB in 2022/23 was £148m. This represents 3.7% of the total expenditure on specialised services in the Midlands of £4bn.

Providers within STW ICB delivered £64m of activity (STW £54m and RJAH £10m) to the population of STW. Out of system providers delivered the other £84m with the main outflows going to BSOL ICB (£38m) and SSOT ICB (£27m).

SATH and RJAH currently provide £90m of specialised services to patients across the country. The breakdown by provider is as follows:

- SATH – Expenditure (£66m) – Activity Units all types (149k) – Main service lines Cancer and Renal
- RJAH - Expenditure (£24m) – Activity Units all types (23k) – Main service lines Specialist Orthopaedics, Cancer and Complex Spinal

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

Improving safety and quality	
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)

The Board is asked to review the papers and approve the PDAF for formal sign off and submission.

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

No but there will be a full risk assessment as part of the Pre-Delegation assessment process that will be completed over the next few months.

5. Appendices

- Appendix 1 - Briefing Paper - Delegation of Specified Specialised Acute Service Lines
- Appendix 2 - Summary of STW Specialised Commissioning Activity and Expenditure
- Appendix 3 - Pre-Delegation Assessment Framework proforma for 2024/25: Specialised Services

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	Detailed analysis of flows was undertaken as part of preparations for 2023/24 joint working using 2022/23 data, and more recently using 2023/24 population-based budgets. This informs the action required to manage patient flows between different geographies.
Quality and Safety	ICB will continue to access the clinical, pharmaceutical, and quality governance functions provided by the NHS England regional multi-disciplinary team responsible for commissioning specialised services. These functions will continue to support delegated commissioning on a regional footprint post April 2024.
Equality, Diversity, and Inclusion	NHS England – Midlands and ICB colleagues have jointly worked on a health inequalities strategy for specialised acute and pharmacy services in the Midlands. The approach is based on the National Healthcare Inequalities Improvement Programme, and, like the ICB strategies, our strategy shares the overarching vision and 5 principles for delivery, under which actions are set out for delivery at service level.
Finances and Use of Resources	Finances and liability follow the function that is delegated, contracts will transfer and ICBs have decision making authority, details of which will be laid out in the terms of the delegation agreement.
Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	The 2022/23 planning cycle reflected improvements in process by systematically worked across all sectors and engaging with all 11 ICB in the co production of the 1-year strategic business plan. Going forward delegated commissioners need to develop key priorities smartly to enable us to monitor the performance matrix
Environmental and Climate Change	None
Future Decisions and Policy Making	ICB will continue to be partners in the West Midlands Joint Committee, where each ICB has equal authority and standing. A Multi-ICB

	Agreement (MIA) will set out the terms under which the Joint Committee will operate.
Citizen and Stakeholder Engagement	Public participation for services commissioned by NHS England and delivered by providers has often been undertaken by statutory providers, who have used their local contacts through PALs, local patient groups and local authorities to engage directly with patients and carers while NHS England has offered stakeholder support through HOSCs and with national and regional charities and patient groups. This has helped support ongoing feedback for existing services as well as decisions on new services and changes.

Request of Paper:	To approve the PDAF for national submission	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

ICB Board meeting

Agenda item no.	**ICB 27-09-111**
Meeting date:	**September 2023**
Paper title	**STW ICS People Collaborative**
Paper presented by:	**Stacey Keegan, CEO RJAH and System SRO for People Rhia Boyode, Director of People and OD SaTH**
Paper approved by:	
Paper prepared by:	**Sara Hayes, Deputy Chief People Officer, Alex Brett Chief People Officer on behalf of Chief People Officers and Director Leads**
Signature:	
Committee/Advisory Group paper previously presented:	**ICS CEO Meeting**

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

1. Background and context

CEO and HRD conversation on our STW People approach has progressed positively over recent months. Discussions have explored the following areas-

- reframing the current People Strategy,
- agreeing the Senior Responsible Officers for each Programme portfolio,
- agreeing a meetings governance structure so that we can work successfully and collaboratively together,
- 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.

This paper provides a summary of progress to date.

1. 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	X
Climate change	
Leadership and Governance	X
Enhanced engagement and accountability	X

Creating system sustainability	X
Workforce	X

2. Recommendation(s)

The ICS Board is asked to:

i. Recognise the progress made by system senior leaders to develop & agree the approach to system people, culture & inclusion.
ii. Support the approach to system people, culture & inclusion set out in this paper.
iii. 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.

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

.

Yes. The paper sets out evidence that could mitigate the following BAF risk:

Risk ID	Strategic Pledge	Opened / Added by	**Risk and description**
8	10	T Hill, A Brett	**ICS Workforce** There is a risk that the ICS will be unable to provide the workforce to deliver clinical and non-clinical services due to inability to recruit, retain, keep well, develop our inclusive culture and effectively deploy a workforce with the necessary skills & expertise that meet service requirements - resulting in a failure to deliver services.

4. Appendices

Appendix 1: PowerPoint ICS People Culture & Inclusion Collaborative

5. 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	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will directly impact on the people who work in health & care in our system and indirectly impact on the provision of health & care for all the residents of STW.
Quality and Safety	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will indirectly impact on the quality & safety of the services our people provide for our residents.

Equality, Diversity, and Inclusion	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will increase inclusion, equality & diversity for our workforce and help us to address EDI matters for the people who receive health &care services.
Finances and Use of Resources	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will impact on the best use of resources, will contribute to the delivery of the system's workforce supply plan and Agency reduction programme and help to support the system to meet the NHSE Agency cap.
Regulation and Legal Requirements	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities enables the ICB to meet the statutory responsibilities laid out in the document 'Building Strong Integrated Care Systems Everywhere: Guidance on the ICS People Function' (ICS People Function (england.nhs.uk), August 2021).
Conflicts of Interest	Individual organisations acting in their own interest rather than using the principle of subsidiarity.
Data Protection	None identified.
Transformation and Innovation	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will enable delivery of our ICS Big Ticket Patient Care Transformation Programmes.
Environmental and Climate Change	None identified.
Future Decisions and Policy Making	A successful, collaborative and sustainable approach to our collective workforce and people responsibilities will impact positively on many areas of care and service delivery for our patients and workforce.
Citizen and Stakeholder Engagement	None identified.

Request of Paper:	The ICS Board is asked to: i. Recognise the progress made by system senior leaders to develop & agree the approach to system people, culture & inclusion. ii. Support the approach to system people, culture & inclusion set out in this paper. iii. 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.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Meeting:	**ICS Board**
Meeting date:	**September 2023**
Agenda item no.	**ICB 27-09-111**
Paper title	**STW ICS People Collaborative**

2. Background and context

2.1 We know that as leaders and organisations we are expected to work together to deliver 10 outcome-based people functions from April 2022 – including agreeing what activities can best be delivered at what scale, and how to use the resources in our system most effectively to deliver these 10 functions and to achieve the NHS Long Term Workforce Plan.

2.2 Our System People Strategy was created in collaboration with senior decision makers from SaTH, SCHT, RJAH, MPFT, Local Authority, Further Education, Higher Education, Voluntary Sector, and the Care Sector to envision a new future for our people - a positive step towards working together with a shared strategic direction.

2.3 The plan aimed to set out our shared ambition for the next 5 years for the workforce of our collective ICS and was structured around the four core pillars of the NHS People Plan, underpinned by the NHS People Promise and the ambitions set out in the 2021 report, "The Future of NHS Human Resources & Organisational Development". These strategic ambitions were envisaged to drive and enable increased workforce availability to deliver patient care.

2.4 Alongside this, our NHS E Operational Workforce Plan for 2023 - 2027 sets out our ambitions to maximise staff in post, triangulated with our system needs to deliver agreed patient activity and within our financial envelope.

2.5 Within our long-term People Strategy our stakeholders identified an ambitious programme of workforce transformation that will enable improved system-wide workforce availability in the short- and long- term.

2.6 This programme includes aspirations to bring together NHS people services at system-level, as part of the wider national programme of delivering people services at scale, and the local programme of scaling all corporate services.

2.7 We know our system also has aspirations for other long-term workforce programmes – e.g., the creation of a system-wide Bank, a system-wide digital rostering platform, system-wide pay equity to support recruitment and retention, a system wide approach to apprenticeships, talent management and career development.

3. People, Culture & Inclusion Collaborative Operating Model

Our system CEOs and NHS Chief People Officers have agreed to work to create a System People Collaborative to drive this agenda across STW, and an operating model that is broader than HR and enables a collective approach to the discharge of our People & Workforce obligations and ambitions.

3.2 The operating model will be led by the ICS Chief People Officer and the organisational Chief People Officers collectively, working together to take responsibility for particular portfolios.

3.3 We will refresh our meetings governance and reset our current System People Committee into an ICS People, Culture & Inclusion Committee, and our People Delivery Committee into an ICS People Collaborative. These can be seen on **slide 2** of the accompanying PowerPoint presentation.

4. Strategic Priorities for People

4.1 Working together our system CEOs and NHS Chief People Officers have agreed a realignment of our People Strategy ambitions into the themes of the NHS Long Term Workforce Plan:

- Train
- Retain
- Reform
- Transform (Leadership, Culture and EDI)

4.2 These domains will bring together partners in a collaborative space to achieve system wide programmes of work at scale under the ethos of “one workforce”.

4.3 Our strategic priorities for 2023- 2027 have also been refocussed and reprioritised and these can be seen on **slide 3** of the accompanying PowerPoint presentation under the domains of Train, Retain, Reform and Transform.

The current system People programmes have been remapped to the new portfolios, and these can be seen on **slide 4** of the accompanying PowerPoint presentation.

Our August Programme Updates are also remapped to the new portfolios, and shared on **slides 6 - 11** of the accompanying PowerPoint presentation.

5. Resourcing our collective ambition

5.1 Our current system People Team was created to facilitate delivery of the People Plan (national and local) for the workforce of this system, and was originally born out of non-recurrent HEE programme funds which may not have been focussed where we, as a system, would have prioritised them.

5.2 There remains a clear need for a system people transformation team to facilitate, support and enable this change. This team is not intended to replace organisational people functions, but to facilitate collaborative working, improvement and transformation – at role, process, profession and/or function level. It is also there to coordinate activity to NHSE and the System statutory functions.

5.3 In the initial creation of the ICS, there was no Chief People Officer, and no resourced people transformation team. This meant no clear focus and responsibility for system-wide workforce programmes. Funding was identified from Health Education England (HEE) on a short-term, programme-specific basis. Through HEE funding the system was able to create the beginnings of a transformative function - but focussed on delivering programmes that HEE was prioritising for funding. These were not necessarily fully aligned to the priorities of the system.

5.4 Following our work with system CEOs and NHS Chief People Officers we have refreshed our legacy system People structure to ensure there are resources to successfully support and enable SROs to deliver our strategic priorities.

5.5 This refreshed structure clarifies the roles and responsibilities of the ICS Chief People Officer and the statutory responsibilities of the ICB, and will provide a level of consistency and resourcing in the system People Team to facilitate and enable delivery of many of the People Programmes.

5.6 Where Programmes are not yet scoped – for example a single system bank, new digital people innovations, scaling people services – there may be a need for business case development to enable adequate resources for programme delivery at an appropriate time.

6. Gaps and risks

6.1 System CEOs and NHS Chief People Officers acknowledged that whilst we have some People resource in some providers, others do not have the capacity to fulfil both and organisational and system asks. At present it was felt that there were undeniable risks of non-delivery across all elements of the People Strategy and that not having a central function was not an option. In time, bringing functions together at scale will release capacity and resource, but that will take time and significant transformation across the system to achieve this.

6.2 In addition, there was agreement that the system required an experienced CPO to lead and coordinate this agenda within the ICS, with an appropriately resourced team to help achieve this.

6.3 The reprioritising of current and new People Strategy programmes 2023-2027 on behalf of the system has identified a number of Programme gaps and risks, specifically:

- Workforce Planning
- Workforce Information
- Health and Wellbeing
- EDI
- OD and Leadership

6.4 In addition to these Programme gaps and risks, we also know that although the ICB as an employer purchase the services of MLCSU for HR and Recruitment services, many areas of people leadership, people services and governance are not provided for as part of this contract.

6.5 Previously untapped demand for these is through the Deputy Chief People Officer role, where the postholder is currently enabling provision of people services to the ICB as an employer as well as leading the delivery of the ICS People Strategy, operationally managing the ICS People Transformation Team, facilitating the People governance meetings for the ICS, and acting as the lead workforce planning expert across the ICS.

6.6 The post holder is also trying to cover for gaps in capacity, resource and capability more broadly across the function as responsibilities, expectations and the work has changed since the ICS/ICB came in to being formally on 1st July 22 and the devolvement of delegated People responsibilities to systems by NHSE.

7. Conclusion and Recommendations

The ICS Board is asked to:

i. Recognise the progress made by system senior leaders to develop & agree the approach to system people, culture & inclusion.
ii. Support the approach to system people, culture & inclusion set out in this paper.
iii. 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.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

ICB Board meeting

Agenda item no.	**ICB 27-09-112**
Meeting date:	**27 September 2023**
Paper title	**Integrated Performance Report**
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

The System continues to have two significant performance pressures, Urgent and Emergency Care (UEC) and Finance. The impact of Industrial Action (IA) continues into September and impacts on Planned Care activity and is putting increasing pressure on system plans to achieve its planned level of Value Weighted Activity (VWA). A snapshot of IA (19th and 20th of September) shows that over 500 outpatient appointments were cancelled and circa 80 procedures. Of those patients cancelled there were 3 patients who had been waiting over 78-weeks and 2 waiting over 104 weeks. Cancer patients are prioritised for treatment and no cancer patients were cancelled in that period of IA.

The financial impact of IA has been quantified by providers and equates to £1.7m as of July 2023, representing reduced income and the cost of re-providing activity by insourcing and additional waiting list initiatives.

Ambulance handover performance has seen a decline in July and August 2023 for the first time in 2023/24 and STW is no longer aligned with normal trends or regional performance. This is believed to be due to a combination of IA and annual leave/sickness and has also impacted on all other key UEC metrics. A&E 4-hour waits is consistently short of national and local targets whilst attendances and admissions from A&E show no significant variation. An Improvement Recovery Trajectory has been requested which will be presented to UEC Board in October and be monitored weekly through a KPI system meeting.

The ICB and system partners recently hosted 3 visits from NHSE focusing on patient pathways, discharge and winter readiness. Other improvement initiatives are focusing on

admitted and non-admitted time in the ED plus frailty and criteria to admit in preparation for winter. The outputs will be consolidated into a revised UEC improvement plan with a revised recovery trajectory.

Due to the improved end of Quarter 1 delivery of Referral to Treatment (RTT) waits it is anticipated that SaTH will move to Tier 2 but remain in Tier1 for Cancer. For the longest waiting patients, at mid-September, SaTH had no patients waiting over 104-weeks and 1 patient over 78 weeks. RJAH had 1 patient over 104-weeks and 5 patients over 78-weeks. This reflects a huge effort to reduce the long waits which were standing at several hundred a few months ago. NHSE have stated that STW are currently the best performing system for 78-weeks in the Region.

Whilst Cancer services continue to be challenged, progress is now being made with the Faster Diagnosis Standard (FDS)at 66.5% in July, an improvement of 3.5% on the previous month. Progress continues in reducing the number of patients waiting over 62 days which is better than the trajectory of 424 patients. From the 1st of October 2023, cancer standards will be simplified into 3 metrics:

- The 28-day Faster Diagnosis (75% target)
- One headline 31-day from decision to treat to treatment (96% target)
- One headline 62-day from referral to treatment (85%)

Adult and CYP Mental Health services continue to see increased demand following COVID-19 resulting in long waiting times for patients and access below the long-term plan target but unlike acute care, there is no additional recovery funding to meet the increased demand. The number of adults waiting for ADHD assessment continues to rise with 70% waiting over 18 weeks and the longest wait at 88 weeks. National discussions about ADHD are taking place and will be discussed at the Regional Mental Health Oversight Group in September. Locally, waiting list initiatives are in place to address the longest waiters and plans are being worked up to address those patients with more complex needs.

In Quality data there continues to be high numbers of mix sex accommodation breaches in SaTH associated with difficulties in timely transfer of patients out of ICU due to high bed occupancy. *Clostridioides difficile* (*C diff*) numbers are off trajectory, and a system risk and associated action plan is in place to support bring cases back to monthly expectation.

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.

Workforce metrics show an improvement in the number of substantive staff in post against plan at the end of July of 202 WTE staff against plan 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 has been and continues to fall across all three providers and is an area of concern.

The Integrated Performance Reports continues to evolve, and this month covers performance data across all four domains of Quality, Operational delivery, Finance and Workforce. Recognising that ICBs and ICSs are still relatively new, and requirements are evolving, work is underway with NHSE colleagues and the Making Data Count team to consider alternative

ways of presenting data (exemplar reports) that will improve assurance to the Board. These changes will start to be incorporated into the next IPR report in November.

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 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.

To 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.

To 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.

To 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.

To 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.

To 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.

To 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.

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:**	

STW Integrated Care Board

Agenda item no.	ICB 27-09-113
Meeting date:	27 September 2023
Paper title	System Mortality Metrics
Paper presented by:	Mr Nick White, Chief Medical Officer
Paper approved by:	
Paper prepared by:	Mr Nick White, Chief Medical Officer
Signature:	
Committee/Advisory Group paper previously presented:	

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

Previous considerations:	**Not applicable**

1. Background and Context

Background

This paper has been written to provide the Board with an overview of Mortality rates for the population of Shropshire, Telford and Wrekin ICB. The report provides metrics for four key measures of mortality:

1. **Standardised Hospital Mortality Index (SHMI)** – this is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
2. **Premature mortality** - mortality rates for deaths under age 75 for all causes combined and leading causes of death.
3. **Leading causes of death - all ages** - mortality rates for deaths in all ages for all causes combined and leading causes of death.
4. **Preventable mortality** – mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense.

Data Sources

- SHMI - Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital
- Premature, Leading Cause and Preventable - Mortality Profile - OHID (phe.org.uk)
- Child Mortality - NCMD | The National Child Mortality Database

Context
SHMI data places STW in the “As Expected” banding with observed deaths of 2340 being slightly below the expected deaths of 2385.

Premature mortality metrics show that Shropshire is on or better than the national average on all measures except Under 75 mortality for people with a severe mental illness. Telford and Wrekin are 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.

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

For preventable mortality there are no mortality outliers for Shropshire or Telford and Wrekin. The key opportunities for improvement for the system are around CVD and respiratory but these are within tolerance levels currently.

For a 4 year period between 2019-2023 Neonates (28 days), Infants (28 days – 1year) showed an above national average mortality whereas for children (1 years -17 years) there was a below average mortality. STW ICS are showing higher mortality rates than the national average. However, it should be noted that for 2022-2023 childhood mortality was above the national average. To clarify and ensure that this is properly understood, this translates to the variation between years being equivalent to 7 additional deaths. The statistical approach means that a small number can move the range and the local position considerably. It is also important to note that there is a significant variation in all the mortality categories relating to deprivation. For the lowest two quintiles (most deprived families) the mortality rate is high and above the national average. For the three highest quintiles (least deprived families), the mortality rate is the same or above the national average.

It is recommended that this is a focus for health inequalities work and is a priority area for all partners to work on as this is much wider than just the NHS response.

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	X
Creating system sustainability	X
Workforce	

3. Recommendation(s)

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

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 report does not highlight any significant risks, but the Board should note the leading cause mortality in Telford and Wrekin and the premature mortality for people with a severe mental illness

5. Appendices

- Appendix 1 - STW Mortality Data Pack

6. What are the implications for:

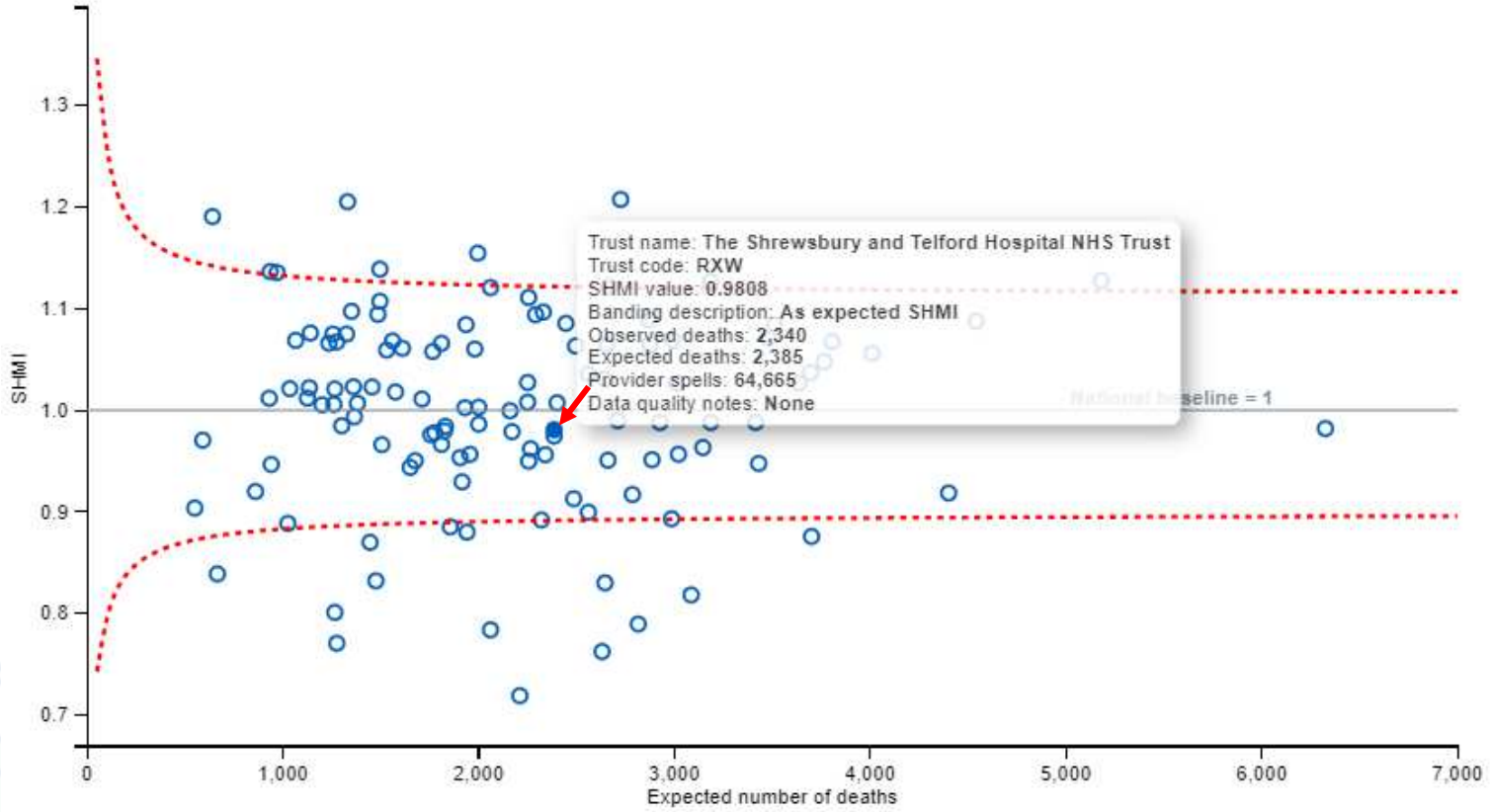
** For each section the ask will be to either refer to a section of the paper, identify that there are no implications or to submit a separate comment **

Shropshire, Telford and Wrekin's Residents and Communities	None
Quality and Safety	None
Equality, Diversity, and Inclusion	Mortality outliers for female residents
Finances and Use of Resources	None
Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	None
Environmental and Climate Change	None
Future Decisions and Policy Making	Identification of priorities to improve mortality. SMH, CVD and Respiratory
Citizen and Stakeholder Engagement	Assurance of hospital mortality rates

Request of Paper:	Inform and provide assurance to Board of Mortality rates across STW.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Standardised Hospital Mortality Indicator

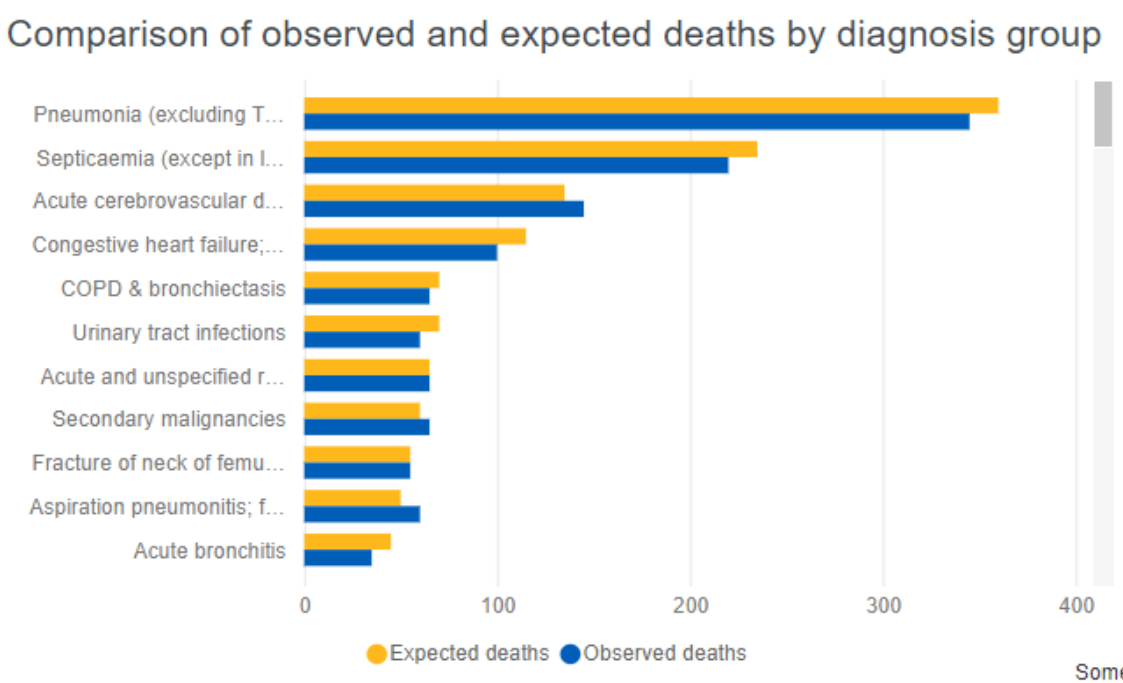
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.



SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	1.7	1.9
Percentage of provider spells with palliative care coding	1.7	1.9
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	32.0	40.0
Percentage of deaths with palliative care coding	32.0	40.0
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	3.8	3.5
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	61.0	70.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	39.0	30.0
Deprivation		
Percentage of provider spells in deprivation quintile 1 (most deprived)	13.8	23.3
Percentage of provider spells in deprivation quintile 2	21.1	20.4
Percentage of provider spells in deprivation quintile 3	24.1	18.9
Percentage of provider spells in deprivation quintile 4	21.2	17.8
Percentage of provider spells in deprivation quintile 5 (least deprived)	11.1	16.0
Percentage of provider spells where the deprivation quintile cannot be determined	8.7	3.5
Percentage of deaths in deprivation quintile 1 (most deprived)	11.0	21.0
Percentage of deaths in deprivation quintile 2	21.0	20.0
Percentage of deaths in deprivation quintile 3	26.0	20.0
Percentage of deaths in deprivation quintile 4	23.0	20.0
Percentage of deaths in deprivation quintile 5 (least deprived)	10.0	18.0
Percentage of deaths where the deprivation quintile cannot be determined	9.0	1.0
Primary diagnosis coding		
Percentage of provider spells with an invalid primary diagnosis		1.0
Percentage of provider spells with a primary diagnosis which is a symptom or sign	13.5	13.2
Depth of coding		
Mean depth of coding for elective admissions	5.3	5.7
Mean depth of coding for non-elective admissions	5.3	5.6
Percentage of provider spells with site of treatment change		
Percentage of provider spells with site of treatment change	1.0	0.9
Impact of COVID-19		
Percentage of provider spells with COVID-19 coding	5.1	4.3
Spells as a percentage of pre-pandemic activity (Jan19 - Dec19)	86.0	87.0
Elective spells as a percentage of pre-pandemic activity (Jan19 - Dec19)	68.0	80.0
Non-elective spells as a percentage of pre-pandemic activity (Jan19 - Dec19)	87.0	88.0

Standardised Hospital Mortality Indicator – Comparison of observed and expected for top diagnosis groups



Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Pneumonia (excluding TB/STD)	73	2,215	345	360	0.9612	As expected
Septicaemia (except in labour), Shock	2	1,035	220	235	0.9513	As expected
Acute cerebrovascular disease	66	890	145	135		
Congestive heart failure; nonhypertensive	65	880	100	115		
COPD & bronchiectasis	75	1,115	65	70		
Urinary tract infections	101	1,520	60	70	0.9005	As expected
Acute and unspecified renal failure	99	475	65	65		
Secondary malignancies	30	280	65	60	1.0964	As expected
Fracture of neck of femur (hip)	120	680	55	55	1.0496	As expected
Aspiration pneumonitis; food/vomitus	77	150	60	50		
Acute bronchitis	74	1,950	35	45	0.8263	As expected
Acute myocardial infarction	57	535	35	40	0.9704	As expected
Cancer of bronchus; lung	15	100	40	40	1.0818	As expected
Fluid and electrolyte disorders	37	615	35	40	0.9351	As expected
Gastrointestinal hemorrhage	96	455	20	30	0.7051	As expected

Some values are not shown because they have been suppressed for the purposes of disclosure control. All other counts are rounded to the nearest with SHMI values calculated from the unrounded values. SHMI values and bandings are only calculated for 10 of the SHMI diagnosis groups.

Deaths by diagnosis group were generally below the expected number of deaths. The key exceptions to this were acute Cerebrovascular disease (Stroke), Secondary malignancies (new cancer resulting from chemo or radio therapy) and aspiration pneumonitis (type of pneumonia).

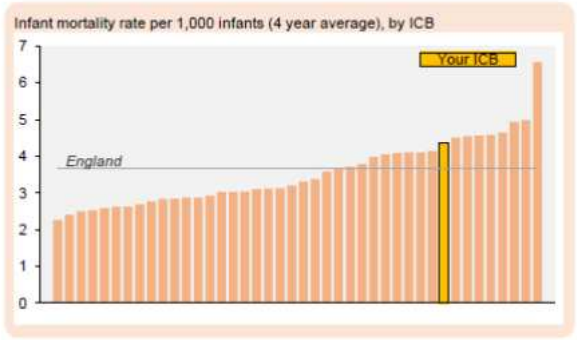
Mortality in Children – Neonatal, Infant and Childhood mortality

Neonatal Mortality

Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Neonatal deaths	Rate per 1,000 infants	Rate per 1,000 infants
2019-20	15	3.2 ●	2.5
2020-21	10	2.1 ●	2.4
2021-22	19	4.1 ●	2.5
2022-23	17	3.7 ●	2.7
Total	**61**	**3.3** ●	**2.5**

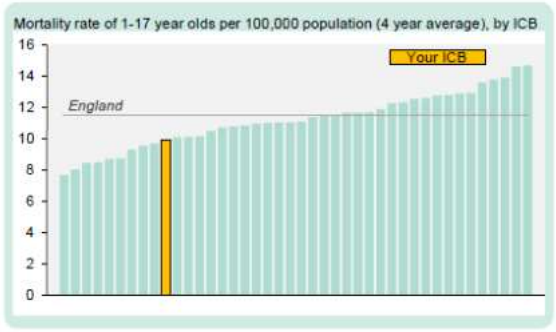
Infant Mortality



Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Infant deaths	Rate per 1,000 infants	Rate per 1,000 infants
2019-20	22	4.7 ●	3.7
2020-21	13	2.8 ●	3.4
2021-22	24	5.2 ●	3.7
2022-23	22	4.7 ●	3.8
Total	**81**	**4.4** ●	**3.7**

Childhood (Age 1-17) Mortality



Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
2019-20	5	5.2 ●	11.3
2020-21	4	4.2 ●	9.6
2021-22	11	11.5 ●	11.7
2022-23	18	18.9 ●	13.6
Total	**38**	**10.0** ●	**11.5**

For Neonates, Infants and Children STW ICB are showing higher mortality rates than the national average. The graphs show 4 years of data between April 2019 to March 2023.

Childhood mortality for the last financial year was significantly worse than the national average and as a standalone year was the highest mortality rate in the Country. The overall 4-year period childhood mortality was below national average with small numerical variations between individual years.

There is a range of additional data available around the demographic factors relating to mortality. This data can be made available on request but in summary:

- The is a significant variation in all the mortality categories relating to deprivation. For the lowest (worse off families) two quintiles the mortality rate is high and above the national average. For the three better off quintiles the mortality rate is on or above the national average. It is recommended that this is a focus for health inequalities work. Similarly, males have a significantly higher mortality rate than females in all categories

- There is variation in the ethnicity groupings but given the low denominator it would be difficult to assess variation and draw conclusions from this data as a small number of deaths would give a big swing in mortality. However, it is recommended that this is factored into any health inequalities programmes

Overall STW ICB has significantly higher levels of mortality in all three child groupings (Neonates, Infants and Children).

Public Health England Mortality Profile - Shropshire

Shropshire Leading Cause mortality

Leading causes of death - all ages - mortality rates for deaths in all ages for all causes combined and leading causes of death.

Female stroke mortality is an outlier in Shropshire

Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Mortality rate from all causes, all ages (Persons)	2021	–	3,801	900	1,054	1,008	1,382		760
Mortality rate from all causes, all ages (Male)	2021	–	1,932	1,058	1,248	1,190	1,677		910
Mortality rate from all causes, all ages (Female)	2021	–	1,869	761	895	860	1,233		652
Mortality rate for deaths due to COVID-19, all ages (Persons)	2021	–	297	69.2	126.9	116.7	295.8		45.1
Mortality rate for deaths due to COVID-19, all ages (Male)	2021	–	167	90.7	160.9	148.7	376.9		58.4
Mortality rate for deaths due to COVID-19, all ages (Female)	2021	–	130	50.5	100.0	91.8	229.5		33.1
Mortality rate for deaths involving COVID-19, all ages (Persons)	2021	–	369	86.1	147.5	134.5	313.6		54.0
Mortality rate for deaths involving COVID-19, all ages (Male)	2021	–	210	113.6	187.1	170.8	405.5		69.9
Mortality rate for deaths involving COVID-19, all ages (Female)	2021	–	159	63.1	116.5	106.4	251.9		40.6
Mortality rate from cancer, all ages (Persons)	2021	–	938	221.8	250.3	248.3	336.6		184.7
Mortality rate from cancer, all ages (Male)	2021	–	530	276.1	299.9	298.3	412.2		222.3
Mortality rate from cancer, all ages (Female)	2021	–	408	177.0	213.5	211.5	290.1		159.6
Mortality rate from lung cancer, all ages (Persons)	2021	–	152	35.7	48.6	48.5	94.7		27.0
Mortality rate from lung cancer, all ages (Male)	2021	–	87	43.9	56.1	56.2	112.0		28.5
Mortality rate from lung cancer, all ages (Female)	2021	–	65	28.5	42.6	42.4	89.4		19.4
Mortality rate from breast cancer, all ages (Female)	2021	–	53	22.4	31.6	30.3	42.2		
Mortality rate from colorectal cancer, all ages (Persons)	2021	–	91	21.3	24.8	25.4	38.2		.3
Mortality rate from colorectal cancer, all ages (Male)	2021	–	47	25.4	31.1	31.3	53.8		13.5
Mortality rate from colorectal cancer, all ages (Female)	2021	–	44	18.4	19.9	20.8	38.9		12.4
Mortality rate from all cardiovascular diseases, all ages (Persons)	2021	–	895	211.2	241.4	230.4	339.4		168.9
Mortality rate from all cardiovascular diseases, all ages (Male)	2021	–	487	265.1	305.2	289.5	431.2		217.7
Mortality rate from all cardiovascular diseases, all ages (Female)	2021	–	408	164.5	187.8	181.1	277.5		124.4
Mortality rate from heart disease, all ages (Persons)	2021	–	325	77.5	106.1	97.0	169.6		62.8
Mortality rate from heart disease, all ages (Male)	2021	–	214	115.6	159.2	144.1	246.6		90.8
Mortality rate from heart disease, all ages (Female)	2021	–	111	45.9	62.5	58.8	115.2		35.2
Mortality rate from stroke, all ages (Persons)	2021	–	243	56.6	50.3	49.8	70.7		3
Mortality rate from stroke, all ages (Male)	2021	–	96	51.3	50.7	52.4	80.1		33.7
Mortality rate from stroke, all ages (Female)	2021	–	147	58.1	49.0	47.2	68.3		
Mortality rate from dementia and Alzheimer's disease, all ages (Persons)	2021	–	495	113.8	107.7	106.3	166.9		58.1
Mortality rate from dementia and Alzheimer's disease, all ages (Male)	2021	–	175	101.8	93.3	92.8	152.5		53.5
Mortality rate from dementia and Alzheimer's disease, all ages (Female)	2021	–	320	120.3	115.7	113.8	173.6		2
Mortality rate from liver disease, all ages (Persons)	2021	–	91	23.0	29.4	27.1	57.4		15.7
Mortality rate from liver disease, all ages (Male)	2021	–	55	29.3	37.5	34.8	75.3		15.8
Mortality rate from liver disease, all ages (Female)	2021	–	36	18.0	22.2	20.2	43.1		9.5
Mortality rate from respiratory disease, all ages (Persons)	2021	–	354	82.0	101.9	93.8	178.5		57.2
Mortality rate from respiratory disease, all ages (Male)	2021	–	171	94.4	124.5	115.4	206.9		47.0
Mortality rate from respiratory disease, all ages (Female)	2021	–	183	72.1	85.8	78.7	174.4		43.0
Mortality rate from chronic obstructive pulmonary disease, all ages (Persons)	2021	–	124	28.5	42.8	39.8	92.9		17.7
Mortality rate from chronic obstructive pulmonary disease, all ages (Male)	2021	–	68	35.3	50.7	47.3	98.8		23.4
Mortality rate from chronic obstructive pulmonary disease, all ages (Female)	2021	–	56	22.4	37.0	34.5	100.1		13.0
Mortality rate from a range of specified communicable diseases, including influenza (Persons)	2021	–	-	7.2	10.3	9.4	21.6		5.4
Mortality rate from a range of specified communicable diseases, including influenza (Male)	2021	–	-	5.5	10.7	9.9	-	*Insufficient number of values for a spine chart*	
Mortality rate from a range of specified communicable diseases, including influenza (Female)	2021	–	-	8.7	9.9	8.9	-	*Insufficient number of values for a spine chart*	

Public Health England Mortality Profile - Shropshire

Shropshire Premature mortality

Premature mortality - mortality rates for deaths under age 75 for all causes combined and leading causes of death.

The leading risk factors for premature mortality are diet, high blood pressure, obesity and smoking

Shropshire is an outlier for Under 75 mortality for people with a severe mental illness

Indicator	Period	Shropshire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 75 mortality rate from all causes (Persons)	2021	–	1,024	294.5	394.4	363.4	625.1		205.7
Under 75 mortality rate from all causes (Male)	2021	–	642	379.8	487.8	448.0	819.5		250.4
Under 75 mortality rate from all causes (Female)	2021	–	382	212.6	304.6	283.4	474.2		165.6
Under 75 mortality rate for deaths due to COVID-19 (Persons)	2021	–	61	17.0	49.0	42.2	142.3		13.3
Under 75 mortality rate for deaths due to COVID-19 (Male)	2021	–	48	27.7	63.4	54.1	193.5		16.8
Under 75 mortality rate for deaths due to COVID-19 (Female)	2021	–	13	6.8	35.3	30.9	97.7		6.3
Under 75 mortality rate for deaths involving COVID-19 (Persons)	2021	–	85	23.8	56.0	48.0	151.1		16.0
Under 75 mortality rate for deaths involving COVID-19 (Male)	2021	–	61	35.0	72.2	61.5	200.5		22.9
Under 75 mortality rate for deaths involving COVID-19 (Female)	2021	–	24	13.0	40.5	35.3	104.7		8.6
Under 75 mortality rate from cancer (Persons)	2021	–	364	102.1	124.7	121.5	189.8		75.8
Under 75 mortality rate from cancer (Male)	2021	–	213	122.0	136.4	133.8	207.4		80.6
Under 75 mortality rate from cancer (Female)	2021	–	151	83.2	113.7	110.1	172.6		71.6
Under 75 mortality rate from lung cancer (Persons)	2021	–	68	18.6	27.3	26.0	55.8		10.4
Under 75 mortality rate from lung cancer (Male)	2021	–	42	23.4	30.2	28.7	58.3		11.8
Under 75 mortality rate from lung cancer (Female)	2021	–	26	14.0	24.7	23.5	55.1		10.3
Under 75 mortality rate from breast cancer (Female)	2021	–	19	10.1	18.6	18.1	28.8		.6
Under 75 mortality rate from colorectal cancer (Persons)	2021	–	31	8.6	12.0	11.7	19.6		5.2
Under 75 mortality rate from colorectal cancer (Male)	2021	–	19	10.8	14.4	14.2	29.9		6.4
Under 75 mortality rate from colorectal cancer (Female)	2021	–	12	6.4	9.8	9.4	-	Insufficient number of values for a spine chart	
Under 75 mortality rate from all cardiovascular diseases (Persons)	2021	–	-	66.2	83.5	76.0	133.9		9.6
Under 75 mortality rate from all cardiovascular diseases (Male)	2021	–	-	94.9	118.5	107.7	204.2		55.7
Under 75 mortality rate from all cardiovascular diseases (Female)	2021	–	-	38.9	50.0	46.1	86.0		25.7
Under 75 mortality rate from heart disease (Persons)	2021	–	117	33.3	47.3	40.7	80.1		19.5
Under 75 mortality rate from heart disease (Male)	2021	–	88	51.6	73.7	63.8	134.6		27.5
Under 75 mortality rate from heart disease (Female)	2021	–	29	15.9	21.9	19.0	52.7		8.1
Under 75 mortality rate from stroke (Persons)	2021	–	44	12.2	13.3	12.7	22.6		6.2
Under 75 mortality rate from stroke (Male)	2021	–	25	14.5	15.6	15.0	29.3		8.8
Under 75 mortality rate from stroke (Female)	2021	–	19	10.0	11.1	10.5	-	Insufficient number of values for a spine chart	
Under 75 mortality rate from liver disease (Persons)	2021	–	-	17.4	23.4	21.2	52.4		8.4
Under 75 mortality rate from liver disease (Male)	2021	–	-	20.1	29.8	27.2	70.7		13.2
Under 75 mortality rate from liver disease (Female)	2021	–	-	14.8	17.2	15.5	34.2		7.1
Under 75 mortality rate from respiratory disease (Persons)	2021	–	68	18.2	30.4	26.5	63.1		9.8
Under 75 mortality rate from respiratory disease (Male)	2021	–	41	22.9	35.9	30.8	84.3		12.2
Under 75 mortality rate from respiratory disease (Female)	2021	–	27	13.7	25.1	22.5	61.1		11.6
Under 75 mortality rate from injuries (Persons)	2018 - 20	–	144	16.6	15.2	14.4	43.1		5.2
Under 75 mortality rate from injuries (Male)	2018 - 20	–	96	22.3	21.9	20.3	55.6		7.8
Under 75 mortality rate from injuries (Female)	2018 - 20	–	48	10.6	8.6	8.6	30.6		3.7
Premature mortality in adults with severe mental illness (SMI)	2018 - 20	–	-	89.0	110.7	103.6	212.4		52.2
Excess under 75 mortality rate in adults with severe mental illness (SMI)	2018 - 20	–	-	477.6%	365.9%	389.9%	615.1%		

Public Health England Mortality Profile – Telford and Wrekin

Telford and Wrekin Leading Cause mortality

Leading causes of death - all ages - mortality rates for deaths in all ages for all causes combined and leading causes of death.

Leading cause mortality is an outlier in Telford and Wrekin. This is driven by a higher mortality rates for females which is driven by mortality rates for respiratory conditions.

Indicator	Period	Tel & Wrek			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Mortality rate from all causes, all ages (Persons)	2021	–	1,736	1,077	1,054	1,008	1,382		718
Mortality rate from all causes, all ages (Male)	2021	–	897	1,257	1,248	1,190	1,677		791
Mortality rate from all causes, all ages (Female)	2021	–	839	928	895	860	1,233		619
Mortality rate for deaths due to COVID-19, all ages (Persons)	2021	–	153	93.5	126.9	116.7	295.8		25.1
Mortality rate for deaths due to COVID-19, all ages (Male)	2021	–	76	101.0	160.9	148.7	376.9		43.0
Mortality rate for deaths due to COVID-19, all ages (Female)	2021	–	77	84.8	100.0	91.8	229.5		18.7
Mortality rate for deaths involving COVID-19, all ages (Persons)	2021	–	175	107.4	147.5	134.5	313.6		29.7
Mortality rate for deaths involving COVID-19, all ages (Male)	2021	–	90	121.7	187.1	170.8	405.5		47.8
Mortality rate for deaths involving COVID-19, all ages (Female)	2021	–	85	93.6	116.5	106.4	251.9		22.2
Mortality rate from cancer, all ages (Persons)	2021	–	451	269.5	250.3	248.3	336.6		178.2
Mortality rate from cancer, all ages (Male)	2021	–	245	328.1	299.9	298.3	412.2		206.3
Mortality rate from cancer, all ages (Female)	2021	–	206	224.7	213.5	211.5	290.1		147.2
Mortality rate from lung cancer, all ages (Persons)	2021	–	79	46.4	48.6	48.5	94.7		21.5
Mortality rate from lung cancer, all ages (Male)	2021	–	38	48.0	56.1	56.2	112.0		20.3
Mortality rate from lung cancer, all ages (Female)	2021	–	41	44.6	42.6	42.4	89.4		14.3
Mortality rate from breast cancer, all ages (Female)	2021	–	31	34.3	31.6	30.3	47.2		17.0
Mortality rate from colorectal cancer, all ages (Persons)	2021	–	46	26.9	24.8	25.4	46.1		13.4
Mortality rate from colorectal cancer, all ages (Male)	2021	–	24	29.8	31.1	31.3	65.1		13.5
Mortality rate from colorectal cancer, all ages (Female)	2021	–	22	24.0	19.9	20.8	38.9		12.0
Mortality rate from all cardiovascular diseases, all ages (Persons)	2021	–	385	239.1	241.4	230.4	347.8		148.7
Mortality rate from all cardiovascular diseases, all ages (Male)	2021	–	211	290.6	305.2	289.5	431.2		187.8
Mortality rate from all cardiovascular diseases, all ages (Female)	2021	–	174	193.1	187.8	181.1	302.4		118.1
Mortality rate from heart disease, all ages (Persons)	2021	–	178	108.2	106.1	97.0	169.6		45.5
Mortality rate from heart disease, all ages (Male)	2021	–	122	164.1	159.2	144.1	246.6		74.1
Mortality rate from heart disease, all ages (Female)	2021	–	56	61.6	62.5	58.8	121.0		20.3
Mortality rate from stroke, all ages (Persons)	2021	–	66	42.0	50.3	49.8	74.3		27.6
Mortality rate from stroke, all ages (Male)	2021	–	26	37.7	50.7	52.4	89.6		23.7
Mortality rate from stroke, all ages (Female)	2021	–	40	44.5	49.0	47.2	80.4		22.8
Mortality rate from dementia and Alzheimer's disease, all ages (Persons)	2021	–	162	109.7	107.7	106.3	166.9		58.1
Mortality rate from dementia and Alzheimer's disease, all ages (Male)	2021	–	64	108.9	93.3	92.8	152.5		52.8
Mortality rate from dementia and Alzheimer's disease, all ages (Female)	2021	–	98	110.4	115.7	113.8	174.9		57.2
Mortality rate from liver disease, all ages (Persons)	2021	–	61	34.9	29.4	27.1	57.4		6.9
Mortality rate from liver disease, all ages (Male)	2021	–	34	42.4	37.5	34.8	75.3		13.8
Mortality rate from liver disease, all ages (Female)	2021	–	27	29.1	22.2	20.2	43.1		9.5
Mortality rate from respiratory disease, all ages (Persons)	2021	–	188	117.2	101.9	93.8	178.5		53.3
Mortality rate from respiratory disease, all ages (Male)	2021	–	98	143.1	124.5	115.4	207.5		47.0
Mortality rate from respiratory disease, all ages (Female)	2021	–	90	100.0	85.8	78.7	174.4		41.1
Mortality rate from chronic obstructive pulmonary disease, all ages (Persons)	2021	–	92	56.0	42.8	39.8	92.9		16.4
Mortality rate from chronic obstructive pulmonary disease, all ages (Male)	2021	–	42	58.8	50.7	47.3	98.8		15.8
Mortality rate from chronic obstructive pulmonary disease, all ages (Female)	2021	–	50	55.1	37.0	34.5	100.1		12.7
Mortality rate from a range of specified communicable diseases, including influenza (Persons)	2021	–	11	6.9	10.3	9.4	-	Insufficient number of values for a spine chart	-
Mortality rate from a range of specified communicable diseases, including influenza (Male)	2021	–	3	*	10.7	9.9	-	Insufficient number of values for a spine chart	-
Mortality rate from a range of specified communicable diseases, including influenza (Female)	2021	–	8	*	9.9	8.9	-	Insufficient number of values for a spine chart	-

Public Health England Mortality Profile – Telford and Wrekin

Telford and Wrekin Premature mortality

Premature mortality - mortality rates for deaths under age 75 for all causes combined and leading causes of death.

The leading risk factors for premature mortality are diet, high blood pressure, obesity and smoking

CVD, Heart Disease and respiratory are mortally outlier across several measures

As in Shropshire, TW shows high mortality rates for people with a severe mental illness

Indicator	Period	Tel & Wrek			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 75 mortality rate from all causes (Persons)	2021	–	625	383.3	394.4	363.4	625.1		205.7
Under 75 mortality rate from all causes (Male)	2021	–	374	471.7	487.8	448.0	819.5		250.4
Under 75 mortality rate from all causes (Female)	2021	–	251	299.1	304.6	283.4	474.2		165.6
Under 75 mortality rate for deaths due to COVID-19 (Persons)	2021	–	64	39.3	49.0	42.2	142.3		13.3
Under 75 mortality rate for deaths due to COVID-19 (Male)	2021	–	36	45.9	63.4	54.1	193.5		16.8
Under 75 mortality rate for deaths due to COVID-19 (Female)	2021	–	28	33.0	35.3	30.9	97.7		6.3
Under 75 mortality rate for deaths involving COVID-19 (Persons)	2021	–	72	44.3	56.0	48.0	151.1		16.0
Under 75 mortality rate for deaths involving COVID-19 (Male)	2021	–	42	53.6	72.2	61.5	200.5		22.9
Under 75 mortality rate for deaths involving COVID-19 (Female)	2021	–	30	35.3	40.5	35.3	104.7		8.6
Under 75 mortality rate from cancer (Persons)	2021	–	196	120.8	124.7	121.5	189.8		75.8
Under 75 mortality rate from cancer (Male)	2021	–	112	142.3	136.4	133.8	207.4		80.6
Under 75 mortality rate from cancer (Female)	2021	–	84	100.1	113.7	110.1	172.6		71.6
Under 75 mortality rate from lung cancer (Persons)	2021	–	38	23.3	27.3	26.0	55.8		10.4
Under 75 mortality rate from lung cancer (Male)	2021	–	20	25.6	30.2	28.7	58.3		11.8
Under 75 mortality rate from lung cancer (Female)	2021	–	18	21.1	24.7	23.5	55.1		10.3
Under 75 mortality rate from breast cancer (Female)	2021	–	15	18.0	18.6	18.1	28.8		.6
Under 75 mortality rate from colorectal cancer (Persons)	2021	–	25	15.6	12.0	11.7	19.6		5.2
Under 75 mortality rate from colorectal cancer (Male)	2021	–	13	16.7	14.4	14.2	29.9		6.4
Under 75 mortality rate from colorectal cancer (Female)	2021	–	12	14.5	9.8	9.4	-	*Insufficient number of values for a spine chart*	
Under 75 mortality rate from all cardiovascular diseases (Persons)	2021	–	-	91.4	83.5	76.0	133.9		9.6
Under 75 mortality rate from all cardiovascular diseases (Male)	2021	–	-	126.7	118.5	107.7	204.2		55.7
Under 75 mortality rate from all cardiovascular diseases (Female)	2021	–	-	58.0	50.0	46.1	86.0		25.7
Under 75 mortality rate from heart disease (Persons)	2021	–	94	58.0	47.3	40.7	80.1		19.5
Under 75 mortality rate from heart disease (Male)	2021	–	75	95.1	73.7	63.8	134.6		27.5
Under 75 mortality rate from heart disease (Female)	2021	–	19	22.9	21.9	19.0	52.7		8.1
Under 75 mortality rate from stroke (Persons)	2021	–	15	9.5	13.3	12.7	22.6		6.2
Under 75 mortality rate from stroke (Male)	2021	–	7	*	15.6	15.0	29.3		8.8
Under 75 mortality rate from stroke (Female)	2021	–	8	*	11.1	10.5	-	*Insufficient number of values for a spine chart*	
Under 75 mortality rate from liver disease (Persons)	2021	–	-	21.1	23.4	21.2	52.4		8.4
Under 75 mortality rate from liver disease (Male)	2021	–	-	24.7	29.8	27.2	70.7		13.2
Under 75 mortality rate from liver disease (Female)	2021	–	-	17.7	17.2	15.5	34.2		7.1
Under 75 mortality rate from respiratory disease (Persons)	2021	–	54	33.5	30.4	26.5	63.1		9.8
Under 75 mortality rate from respiratory disease (Male)	2021	–	26	33.3	35.9	30.8	84.3		12.2
Under 75 mortality rate from respiratory disease (Female)	2021	–	28	34.0	25.1	22.5	61.1		11.6
Under 75 mortality rate from injuries (Persons)	2018 - 20	–	60	12.6	15.2	14.4	43.1		5.2
Under 75 mortality rate from injuries (Male)	2018 - 20	–	47	19.7	21.9	20.3	55.6		7.8
Under 75 mortality rate from injuries (Female)	2018 - 20	–	13	5.4	8.6	8.6	30.6		3.7
Premature mortality in adults with severe mental illness (SMI)	2018 - 20	–	-	134.4	110.7	103.6	212.4		52.2
Excess under 75 mortality rate in adults with severe mental illness (SMI)	2018 - 20	–	-	475.4%	365.9%	389.9%	615.1%		

Public Health England Mortality Profile – Shropshire, Telford and Wrekin

Shropshire Preventable mortality

Preventable mortality – mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by timely and effective healthcare interventions in the broadest sense.

Telford and Wrekin Preventable mortality

Although there are no clear outliers in the ICB Cardiac and Respiratory could be areas for improvement

Indicator	Period	Shropshire			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 75 mortality rate from causes considered preventable (Persons)	2021	–	-	132.4	202.4	183.2	334.2		95.8
Under 75 mortality rate from causes considered preventable (Male)	2021	–	-	187.1	267.7	241.8	445.0		126.1
Under 75 mortality rate from causes considered preventable (Female)	2021	–	-	79.9	139.7	127.6	254.5		60.2
Under 75 mortality rate from cancer considered preventable (Persons)	2021	–	133	37.3	53.0	50.1	100.7		24.5
Under 75 mortality rate from cancer considered preventable (Male)	2021	–	84	47.7	65.3	63.0	113.0		33.1
Under 75 mortality rate from cancer considered preventable (Female)	2021	–	49	27.5	41.3	38.1	88.6		14.1
Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2021	–	92	25.8	34.3	30.2	54.3		18.9
Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2021	–	66	38.1	50.2	44.1	80.7		25.3
Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2021	–	26	14.0	19.0	17.0	35.2		8.0
Under 75 mortality rate from liver disease considered preventable (Persons)	2021	–	-	16.6	21.1	18.9	47.7		7.9
Under 75 mortality rate from liver disease considered preventable (Male)	2021	–	-	19.0	27.5	24.8	64.9		11.7
Under 75 mortality rate from liver disease considered preventable (Female)	2021	–	-	14.3	15.0	13.3	31.6		6.7
Under 75 mortality rate from respiratory disease considered preventable (Persons)	2021	–	37	9.8	17.7	15.6	40.1		5.3
Under 75 mortality rate from respiratory disease considered preventable (Male)	2021	–	25	13.9	20.2	17.3	54.9		8.3
Under 75 mortality rate from respiratory disease considered preventable (Female)	2021	–	12	6.0	15.4	14.0	43.3		5.8

Indicator	Period	Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 75 mortality rate from causes considered preventable (Persons)	2021	–	-	190.7	202.4	183.2	334.2		95.8
Under 75 mortality rate from causes considered preventable (Male)	2021	–	-	238.8	267.7	241.8	445.0		126.1
Under 75 mortality rate from causes considered preventable (Female)	2021	–	-	144.8	139.7	127.6	254.5		60.2
Under 75 mortality rate from cancer considered preventable (Persons)	2021	–	75	46.0	53.0	50.1	100.7		24.5
Under 75 mortality rate from cancer considered preventable (Male)	2021	–	46	58.4	65.3	63.0	113.0		33.1
Under 75 mortality rate from cancer considered preventable (Female)	2021	–	29	34.1	41.3	38.1	88.6		14.1
Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2021	–	62	38.4	34.3	30.2	54.3		18.9
Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2021	–	45	57.2	50.2	44.1	80.7		25.3
Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2021	–	17	20.6	19.0	17.0	35.2		8.0
Under 75 mortality rate from liver disease considered preventable (Persons)	2021	–	-	18.7	21.1	18.9	47.7		7.9
Under 75 mortality rate from liver disease considered preventable (Male)	2021	–	-	23.4	27.5	24.8	64.9		11.7
Under 75 mortality rate from liver disease considered preventable (Female)	2021	–	-	14.2	15.0	13.3	31.6		6.7
Under 75 mortality rate from respiratory disease considered preventable (Persons)	2021	–	32	19.9	17.7	15.6	40.1		5.3
Under 75 mortality rate from respiratory disease considered preventable (Male)	2021	–	13	16.5	20.2	17.3	54.9		8.3
Under 75 mortality rate from respiratory disease considered preventable (Female)	2021	–	19	23.1	15.4	14.0	43.3		5.8

PHE - Tobacco Control Profile

Tobacco usage is a key driver of premature mortality in the STW system.

The most recent Tobacco control metrics show that Telford and Wrekin have a good number of quitters but the cost per quitter is £601 which is above the national average of 484

Shropshire has a significantly lower rate of quitters across all measures. The costs per quitter is lower than the national average at £431.

Telford and Wrekin

▶ Legend ▶ Benchmark ▶ More options

Geography version: Counties & UAs (2021/22-2022/23)

☐ CIPFA nearest neighbours to Telford and Wrekin

Indicator	Period	Tel & Wrek			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Smokers setting a quit date	2019/20	–	963	4,384	2,221*	3,512	48		12,040
Smokers that have successfully quit at 4 weeks	2019/20	–	416	1,894	1,154*	1,808	19		6,743
Smokers that have successfully quit at 4 weeks (CO validated)	2019/20	–	324	1,475	805*	1,113	11		4,645
Completeness of NS-SEC recording by Stop Smoking Services	2019/20	–	808	83.9%	89.9%	91.6%	0.0%		100%
Cost per quitter	2019/20	→	249,811	£601	£383*	£484*	-	*Insufficient number of values for a spine chart*	-
Rate of prescriptions for nicotine replacement products per 100,000 smokers	2018	→	1,610	7,252	8,625	11,781	690		59,493

Shropshire

▶ Legend ▶ Benchmark ▶ More options

Geography version: Counties & UAs (2021/22-2022/23)

☐ CIPFA nearest neighbours to Shropshire

Indicator	Period	Shropshire			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Smokers setting a quit date	2019/20	–	331	894	2,221*	3,512	48		12,040
Smokers that have successfully quit at 4 weeks	2019/20	–	137	370	1,154*	1,808	19		6,743
Smokers that have successfully quit at 4 weeks (CO validated)	2019/20	–	101	273	805*	1,113	11		4,645
Completeness of NS-SEC recording by Stop Smoking Services	2019/20	→	311	94.0%	89.9%	91.6%	0.0%		100%
Cost per quitter	2019/20	→	59,000	£431	£383*	£484*	-	*Insufficient number of values for a spine chart*	-
Rate of prescriptions for nicotine replacement products per 100,000 smokers	2018	↓	3,756	10,642	8,625	11,781	690		59,493

Clinical Strategy – Cardiac Pathway – Objectives

Treatment and Management on Discharge

Trust name	Hospital name	Heart failure admissions	ACEI on discharge (%)	ACEI/ARB on discharge (%)	Beta blocker on discharge (%)	MRA on discharge (%)	Received discharge planning (%)	Referral to HF nurse follow up (%)	Referral to HF nurse follow up (HFrEF only)(%)	Referral to cardiology follow-up (%)	Referral to cardiac rehabilitation (%)	ACEI/ARB, MRA and Beta Blocker on discharge (%)
England		61784	72	84	91	61	93	47	63	39	12	51
Shrewsbury and Telford Hospitals NHS Trust	Royal Shrewsbury Hospital	373	44.7	64.6	81.7	32.3	85.6	49.4	67.5	23.5	8.3	16.1
Shrewsbury and Telford Hospitals NHS Trust	Princess Royal Hospital (Telford)	357	36.9	58.3	77.4	26.2	93.4	58.3	74.3	33.7	1.6	17.2
Variation from national	Royal Shrewsbury Hospital	NA	-27.3	-19.4	-9.3	-28.7	-7.4	2.4	4.5	-15.5	-3.7	-34.9
	Princess Royal Hospital (Telford)	NA	-35.1	-25.7	-13.6	-34.8	0.4	11.3	11.3	-5.3	-10.4	-33.8

Increase the rates of early detection and treatment

This element of the programme will aim reduce the proportion of undiagnosed patients for three metrics: hypertension, Coronary Heart Disease and Heart Failure. Improvements in treatment metrics such as rates of NT-proBNP and Blood pressure monitoring as well are increase prescribing levels will also measured to show that newly identified patients are being treated and managed in primary care where appropriate

Restore inpatient and outpatient care through transformation

The overall aim of this work would to be to restore acute services to precovid levels and then increase treatment capacity to meet the elective target of 130% of precovid baseline by April 2025. Reducing the level of 52ww will be a core metric in demonstrating the progress in restoring services. The transformation element will be measured through metrics such as improved

Improve discharge and ongoing patient management and support

Improve the number and proportion in the number of patients accessing cardiac rehabilitation and being discharge on one of the 3 pharmacological pillars. Increased utilisation of virtual wards and nurse prescribing rates will also be used to demonstrate progress in this area. Readmissions will be monitored to ensure that the programme is not causing unexpected consequences. As the programme develops increases in the number of patients utilising telehealth and other modern technologies will demonstrate the continued improvements in cardiac care

Clinical Strategy – Cardiac Pathway – Objectives

Early Detection and Treatment

Development of collaborative commissioning arrangements between primary care, local authorities and public health to improve the early detection of patients. This programme will also plan and deliver a consistent model of modern cardiac care in primary care that fully utilised new technologies. This will include delivery of improvement in the measurement and screening or at risk patients as well as the development of consistent approaches to the treatment and management of patients in primary care.

Acute restoration and transformation

Acute providers and commissioners will undertake a capacity, demand and utilisation reviews to assess how services could be enhanced to better meet patient need and improve productivity. Best practice such as patient initiated follow-ups and virtual follow-up will be implemented to support outpatient restoration. Inpatient elective restoration will be linked to the delivery of the UEC delayed discharge programme but as this frees capacity a structured flow of patients into these beds will be needed to ensure that clinical priorities are treated and wating times are reduced. This workstream will also aim to improve the outcomes around ACS/NSTEMI patients receiving procedures in 3 days and access for non emergency consultant led treatment.

Enhancement of Discharge and ongoing management

Clinical from across primary, community and secondary care will develop a joint framework for the commissioning and provision of post discharge support and management. This will include the establishment or further development of services such as cardiac rehabilitation, Virtual wards, palliative care and personalised care to ensure that patients are being managed effectively in the right setting of care so that readmission or further escalation of their condition is prevented. The success of this programme will be measured initially through increased throughput in these services.

Improved Pharmacological Treatment and Management

This workstream links to all other cardiac initiatives and objectives but is a critical element of transformation in this area. A review of the utilisation of pharmacological interventions across all care setting will be undertaken to ensure effective, efficient consistent prescribing is taking place consistently across all providers. Increases in prescribing levels across the 14 categories of primary care and a greater level of discharges on one of the 3 pharmacological pillars will demonstrate the effectiveness of the programme

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 27-09-114
Meeting date:	27th September 2023
Paper title	Shaping the Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB)
Paper presented by:	Simon Whitehouse - Chief Executive Officer
Paper approved by:	Simon Whitehouse - Chief Executive Officer
Paper prepared by:	Bethan Emberton - Shaping the STW ICB Programme Manager
Signature:	
Committee/Advisory Group paper previously presented:	None
Action Required (please select):	

A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	
---	---	---	---	---	---	---	---	---	---
Previous considerations:	

Background and context

The introduction of statutory Integrated Care Systems (ICSs), and the transition from Clinical Commissioning Groups (CCGs) to the Integrated Care Board (ICB), is intended to be a fundamental shift in approach for the NHS. However, this transition can only be achieved if ICBs play a fundamentally different role to that historically played by CCGs and there is an associated provider reform agenda focussed on the delivery of integrated care. In addition, on 3 March 2023, NHS England wrote to ICBs informing that running cost allowances would be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% being delivered in 2024/25. For NHS STW the real terms cumulative reduction by 2025/26 is 26%.

The ICB Executive Team have allocated resource to lead a programme of organisational design, change and implementation of a new operating model, to reposition the organisation and its ways of working to create a fit for purpose ICB that can lead the delivery of the four key aims of ICSs. Changes in how the ICB operates will not be just about ICB staffing structures, but equally about opportunities for collaboration, integration, delegation, and distributed leadership across our ICS. The ICB changes are reliant upon a mature provider collaborative across the system and the maturity of placed based working and the 2 place Boards.

The ICB has developed an ambitious plan to deliver its new operating model from 1st April 2024. To support delivery of the programme within the ambitious timeframe, the ICB are procuring an organisational redesign strategic partner. The ICB are on track to award a contract to the successful bidder at the end of September with a contract start date of 1st October 2023.

The purpose of this paper is to update and provide assurance to the Board about the development in planning for organisational change and making the required reductions in running costs.

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	X
Leadership and Governance	X
Enhanced engagement and accountability	X
Creating system sustainability	X
Workforce	X

Recommendation(s)

The Board is asked to:

- consider the progress made and confirm support for the organisational change programme.
- support the development of an operating model for the system that looks to support decision making as close to the resident as possible.
- note the importance of the provider reform agenda and the development of a strong provider collaborative as a fundamental aspect of this change programme.
- note the importance of the development of the place-based working to enable delegation of agreed functions to the Place Boards

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

No.

Appendices

None.

What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	One of the programme objectives is to create a fit for purpose ICB that can deliver on the 4 key aims of the Integrated Care System (ICS).
Quality and Safety	None.
Equality, Diversity, and Inclusion	EDI assessments will be undertaken at various points during the programme.
Finances and Use of Resources	One of the programme objectives is to produce and implement a sustainable ICB Operating Model that is within the resource envelope.
Regulation and Legal Requirements	The scope of the programme is to deliver the NHS England mandate of reducing ICB running costs by 30% by 2025/26.
Conflicts of Interest	None.
Data Protection	The programme will ensure that any use or sharing of personal staff information is managed in line with GDPR. The HR Lead for the programme will advise as appropriate.
Transformation and Innovation	One of our programme assumptions is that in future the ICB will deliver some functions differently, for example through delegation, bringing inhouse, or collaborating with another ICB, or NHS Provider.
Environmental and Climate Change	None.
Future Decisions and Policy Making	One of the programme outputs will be a new ICB operating model.
Citizen and Stakeholder Engagement	One of the programme objectives is to produce and action a staff engagement plan that ensures staff are involved in the change programme. A stakeholder mapping exercise will also be undertaken as part of the programme.

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

Meeting:	Shropshire, Telford & Wrekin Integrated Care Board
Meeting date:	27th September 2023
Agenda item no.	ICB 27-09-114
Paper title	Shaping the Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB)

1. Introduction

1.1 The introduction of statutory Integrated Care Systems (ICSs), and the transition from CCGs to the Integrated Care Board (ICB), is intended to be a fundamental shift in approach for the NHS. However, this transition can only be achieved if ICBs play a fundamentally different role to that historically played by CCGs.

1.2 In addition, on 3 March 2023 NHS England wrote to ICBs informing that running cost allowances would be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% being delivered in 2024/25. For STW the real terms cumulative reduction by 2025/26 is 26%.

1.3 The purpose of this paper is to update and provide assurance to the Board about the development in planning for organisational change and making the required reductions in running costs.

2. Case for Change

2.1 Integrated Care Challenge and Context

2.1.1 Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. Integrated care enables health and care services to work together in a joined-up way that will improve the outcomes for individuals and the experience for service users and our workforce.

2.1.2 Integrated Care Systems (ICSs) are partnerships that bring together NHS organisations, Local Authorities and other partners (voluntary and community sector) to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.

2.1.3 Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities. Statutory ICSs comprise two key components:

- Integrated Care Boards (ICBs)
- Integrated Care Partnerships (ICPs)

2.1.4 The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by Clinical Commissioning Groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly accountable to NHS England for NHS spend and provider performance within the system. ICBs may choose to exercise their functions through delegating them to place-based committees or provider collaboratives, but the ICB remains formally accountable.

2.1.5 The ICP is a statutory joint committee of the ICB and Local Authorities in the area covered by the ICS. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the population. This strategy must build on local joint strategic needs assessments and health and wellbeing

strategies and must be developed with the involvement of local communities and Healthwatch.

2.1.6 A key feature of systems is that much of the activity to integrate care, improve population health and tackle inequalities will be driven by commissioners and providers collaborating over smaller geographies within ICSs ('places') and through teams delivering services working together on even smaller footprints ('neighbourhoods').

2.1.7 The 2022 Health and Care Act entailed significant structural change for NHS commissioning. CCGs were abolished, with their functions and staff transferred into ICBs. NHS England have also begun delegating some of their commissioning responsibilities to ICBs, giving local systems a greater say in how budgets for these services are spent in their area.

2.1.8 This is all part of a shift towards strategic commissioning and a more collaborative approach to planning and improving services. This means that, instead of focusing on procurement and contract management, the role of commissioners is to work closely with key partners across the system to understand population needs, determine key priorities and design, plan and resource services to meet those needs. Ultimately the focus is on improving outcomes for the population of Shropshire, Telford and Wrekin.

2.1.9 If the changes to the way an ICB operates happens in isolation though, there is significant risk that the opportunities it creates to deliver integrated care will not be realised or delivered in full. One of the main drivers of the national integration agenda was the need for provider reform that would sit alongside the commissioning reform. Changing one in the absence of the other risks missing this opportunity and failing to realise the true benefits of system working.

2.2 Running Cost Allowance Challenge

2.2.1 On 3 March 2023 NHS England wrote to ICBs informing that running cost allowances would be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% being delivered in 2024/25.

2.2.2 For NHS STW the real terms cumulative reduction by 2025/26 is 26%. NHS STW have a running cost allowance of £9,485,000 for 2023/24 financial year, by 2025/26 the running cost allowance for NHS STW will be £7,086,000.

2.2.3 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 of 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.

3. Organisational Change Programme

3.1 Programme Outline

3.1.1 To deliver integrated care effectively within Shropshire, Telford & Wrekin (STW) there is a need to ensure the ICB develops across several areas-

- It needs to develop new capabilities to support its new role,
- stop any duplicate activity that is no longer required in the new Integrated Care System,
- agree an approach to devolve activity to system partners that is better delivered closer to the resident,
- support and facilitate the development of a provider collaborative approach that can take on some of the functions that are currently undertaken by the ICB,
- support the development of a place-based approach that can take on increasing responsibility, and

Figure 2: Programme Case for Change

3.1.2 The aim of the programme is to deliver the organisational design, operating model, change and implementation process of Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB).

3.1.3 The objectives of the programme are:

- Create a fit for purpose ICB that can deliver on the 4 key aims of the Integrated Care System (ICS).
- Produce, and action, a staff engagement plan that ensures staff are involved in the change programme.
- Demonstrate a culture of “do with” rather than “do to”.
- Produce and implement a sustainable ICB Operating Model that is affordable within the resource envelope that is available.
- A relentless focus on-
  - What is the core business of the ICB and what does it need to do in order to discharge its statutory functions
  - Where can the ICB partner differently and support cost being taken out – this could be with LAs, with neighbouring ICBs and/or with providers

3.1.4 The scope of the programme is:

- Delivery of the organisational review, design and change programme to deliver the required reduction in running costs of at least 30%. This includes both pay and non-pay.
- The programme will include all staff and the board, to ensure we are able to deliver the programme aligned to our objectives and principles.
- As the approach is to undertake a review across all our functions, we will include in the scope the ICB Programme costs, to support us to start from first principles. It should be noted that this is not part of the NHS England requirement but will support us to create a model which meets our needs.
- Explore all opportunities for corporate function consolidation. Current benchmarking would indicate that the cost of some corporate services across the ICS are high and that there are opportunities to consolidate these in a number of areas in order to direct this resource into patient care.

3.1.5 The principles of the programme are:

- A focus on support for all our people will be key and the process will be designed and implemented with care and compassion in line with NHS values.
- The entire process will be carried out in partnership with our trade union colleagues.

- The approach to organisational design will be to set out our primary strategic aims, our statutory and mandated functions and work through the form needed to deliver these aims and functions within the new running cost allowance for the ICB.
- All levels of the organisation will be reviewed, including Board level (noting that we have already in 23/24 reduced the number of Directors and not replaced in a like for like basis).
- To ensure we maintain a level of flexibility in our approach, should the national requirements change.

3.1.6 It is important to understand that the ICB is given both a running cost allowance and programme budgets to support service delivery.

3.1.7 As this change programme develops then an approach will be adopted that considers both of these areas as previously stated. It is important to understand that services such as the Prescription Ordering Service and the Referral Service (RAS and TRAQ) are not funded through the RCA. This is important when reviewing staff numbers and considering the availability of resource to discharge the ICB statutory functions.

3.2 Programme Timeline

3.2.1 NHS STW have developed an ambitious and challenging timeline to support delivery of the programme:

- Baseline & Organisational Design: May – September 2023
- Organisational Change: October – December 2023
- Transition to new organisation: January – March 2024
- Delivery of new operating model: April – June 2024

3.3 Programme Resource

3.3.1 NHS STW have engaged a strategic partner that specialises in organisational development to support in the delivery of the programme within timeframes. This is currently subject to both strict procurement rules and requiring NHSE sign off. As a result, this cannot be discussed in detail.

3.3.2 In reviewing the internal capacity and the scale of the ask re the organisational change required, several factors were taken into account-

- The current operational and performance challenges
- The importance of navigating winter safely
- The scale of the financial improvement challenge
- The importance of commissioning to meet the needs of the population.
- The capacity required to focus on exiting NOF4

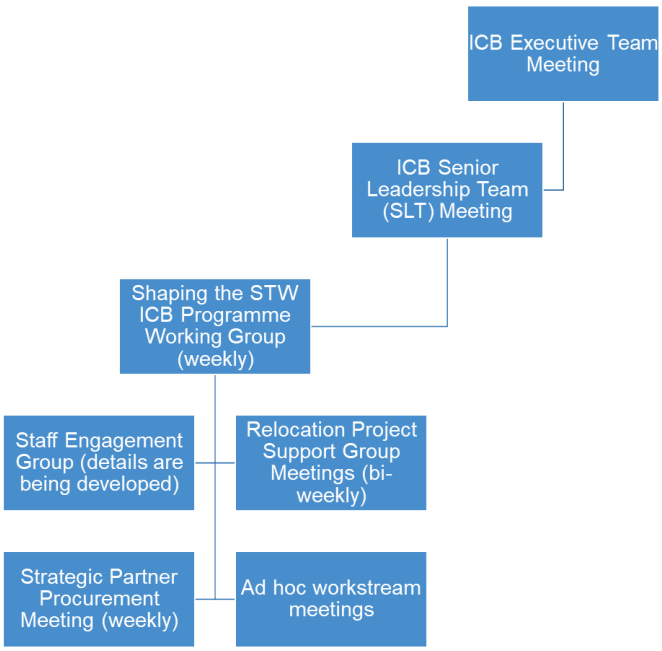
3.3.3 NHS STW are seeking a partner that can bring strong focus to values, behaviours and development of system leadership. They will need to engage with the system leadership team as well as the ICB Executive team and their teams.

3.3.4 The successful provider will have specific experience, skill and expertise around large scale organisational and system redesign, programme management at pace, driving cost efficiency, coupled with professional maturity to deliver on this challenge. They will support in a structured yet timely way through diagnostic, design and implementation phases to develop and implement this programme which will enhance maturity and employment experience for our workforce at all levels.

3.4 Programme Governance

3.4.1 NHS STW have identified a Senior Responsible Officer (SRO) and Programme Manager to develop and lead implementation of the plan. Several key workstream leads have also been identified across the ICB to support delivery of the plan e.g., finance, HR and communications. A weekly programme working group has been arranged which reports to the ICB Senior Leadership Team and ICB Executive Team (figure 3).

Figure 3: Programme Governance Structure



3.5 Programme Communications & Engagement

3.5.1 NHS STW have communicated the organisational change programme to ICB employed staff on Tuesday 22nd August 2023 via the bi-weekly virtual staff huddle forum. This was led by the CEO and will be followed up with further communications. Over 150 staff attended the team brief that was dedicated to this agenda item.

3.5.2 NHS STW Organisational Development Team have facilitated Executive Team and Senior Leadership Team development sessions to begin shaping the strategy and functions of the ICB.

3.6 Programme Risks

3.6.1 NHS STW have identified a number of risks that may impact the successful delivery of our programme:

- The level of maturity of our ICS to support delegation to Provider Collaboratives.
- The level of maturity of our ICS to support delegation to Place-based Partnerships.
- The level of engagement from other neighbouring ICBs to share functions and posts.
- The pace of change required to deliver the operating model and organisational design against a challenging operational plan and the focus required to navigate winter.

4. Board Assurance

4.1 NHS STW remains committed to delivering core functions and statutory duties during this period of change. The programme working group will maintain a risk and issues log which will be reported to ICB Senior Leadership and ICB Executive Team meetings. The Board will receive regular updates regarding the proposed changes and the associated impact.

4.2 In response to the running cost allowance challenge, NHS STW have raised concerns with NHS England that with funding allocated based on population size, we have a smaller resource from which to fund our team but have the same core statutory functions and duties as every other ICB. It was also noted that the scale of the system change required given the current position of our providers has further impact on the structure and working of NHS STW.

4.3 NHS STW have raised with NHS England colleagues that further support in the following areas would be appreciated:

- Discussion relating to the impact of NHS Oversight Framework (NOF) 4 in terms of the running cost allocation reduction ask.
- Detailed review of the Memorandum of Understanding (MoU) given the implications of work transference beyond the scope of the established statutory duties.
- NHS England support and approach to provider collaboration in the STW system.
- Examples from other smaller ICBs regarding structures and approaches.
- A more streamlined approach to in housing and contract change decisions with the Commissioning Support Unit (CSU) and a timeliness of any national decision making (if required).

4.4 To support Board assurance in delivering the running cost reduction, NHS STW key assumptions are that this will be met through a range of measures:

- Decommissioning two ICB offices and relocating staff to one new office location from 1st March 2023.
- Introduction of the Establishment Control Form (ECF) and Vacancy Review Panel Chaired by the ICB CEO to manage and scrutinise recruitment and vacancies. Each vacancy requires the support of both the CEO and the CFO unless it is a clinical vacancy, at which point the CMO and CNO are engaged.
- Delivering some of our functions differently, for example through delegation, bringing inhouse, or collaborating with another ICB, or NHS Provider.
- Decommissioning non-pay contracts where expenditure is not aligned to the delivery of ICB purpose or where value for money is not demonstrated.
- Development of a new staff structure that is fit for purpose and supports the delivery of the new operating model. This will be affordable and within the RCA resource envelope for 2025/26.
- Review of CSU contract to ensure it is driving best value for money by updating service specifications and contract management.
- Development of new processes and governance structures to reduce duplication and maximise efficiencies.

5. Conclusion

5.1 In conclusion, this organisational change programme is a complex and dynamic process that involves various factors and outcomes.

5.2 The change programme described will need engagement and support from all partners within our ICS. If we are to reposition the organisation and its ways of working to create

a fit for purpose ICB that can lead and support the delivery of the four key aims of ICSs, we need to manage an organisational change programme that supports delivery of the integrated care and running cost challenge.

5.3 The focus on our staff and a collective responsibility to treat colleagues fairly and with compassion is essential as this programme evolves.

6. Recommendations

6.1 The Board is asked to:

- consider the progress made and confirm support for the organisational change programme.
- support the development of an operating model for the system that looks to support decision making as close to the resident as possible.
- note the importance of the provider reform agenda and the development of a strong provider collaborative as a fundamental aspect of this change programme.
- note the importance of the development of the place-based working to enable delegation of agreed functions to the Place Boards

STW Integrated Care Board

Agenda item no.	ICB 27-09-115
Meeting date:	27 September 2023
Paper title	GMC Responsible Organisation
Paper presented by:	Nick White, Chief Medical Officer
Paper approved by:	Nick White, Chief Medical Officer
Paper prepared by:	Nick White, Chief Medical Officer Lisa Kelly, Senior HR Business Partner
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):											
A=Approval	X	R=Ratification		S=Assurance		D=Discussion		I=Information	
Previous considerations:	**Not applicable**										

1. Background and Context

All ICB's has 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.

The ICB does not deliver patient facing medical services directly but commissions them from other provider organisations. The medical staff it does employ are employed in non-clinical leadership roles. These staff work part time and have prescribed connections to other designated bodies where they work clinically. As such the ICB currently has no prescribed connections. This is required to be reported to the Board, even where there are no roles that fit under this remit.

Going forward as the ICB develops, it is plausible that some medical staff employed by the ICB will have no other prescribed connections and the ICB will be their designated body. In addition, roles and responsibilities currently held by the NHS Regional team may be delegated to the ICB which include Designated Body functions.

The work underlying this document, which is a statutory annual return, is in preparation and planning for future functions that the ICB may need to undertake.

The Responsible Officer for the Designated Body is the Chief Medical Officer.

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	X
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	X

3. Recommendation(s)

For Information Only

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

No

5. Appendices

Appendix 1 - A framework of quality assurance for responsible officers and revalidation

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	
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	No current implications
Regulation and Legal Requirements	No current implications
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

Request of Paper:	For information Only .	**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 27-09-116.1
Meeting date:	27th September 2023
Paper title	Quality & Performance Committee Chair's Report – 25 May 2023
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 25th May 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. Diabetes foot management actions were communicated in the risk but pace around this work was a concern for the committee.

2.2. Flow to help with the urgent care position was being taken forward as an urgent action with weekly meetings to progress.

2.3. The cancer standards including faster diagnosis standards and the 62-day were below expectation. Both have actions against them and will be updated in monthly performance reports to track progress, focus is around dermatology, diagnostics, endoscopy and FIT testing and colonoscopy.

2.4. Faster diagnosis standards were below expectation at 58% and further work was needed to understand the recovery trajectory. The Faster Diagnosis Standard is a standard that ensures patients will be diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer.

2.5. Urology is being supported by NHSE to help optimise pathways. This remains under careful monitoring to identify improvements.

2.6. Clostridioides difficile (C diff) infection has increased by 25% nationally. STW system numbers have doubled during April 2023. A risk will be developed at the ICS IPC groups and escalated as required. Over the last two to three years there has been a lot of and focus on the respiratory route infection rather than the enteric route for infection prevention and control.

2.7. An increase in torsion of testes cases at SaTH requiring orchidectomy have occurred. SaTH are reviewing the patient pathway-based on learning from root cause analysis.

3. Assurance

3.1. Six risks were on the risk register and discussed: Children and Young People's MH care, maternity care, UEC, Diabetes care, the acute paediatric pathway and Imaging and Imaging reporting delays. Three risks have been managed and de-escalated to relevant groups for ongoing monitoring: IPC at RJAH, Paediatric ophthalmology fragile service and PEoLC.

3.2. The quality metrics report was focused on the risks on the risk register, it was agreed that these would be monthly with quarterly additional metrics. Improving diabetes information was discussed.

3.3. The paediatric thematic review into paediatric serious incidents was reported as completed and a Paediatric Transformation Programme (PTP) overseen by a Paediatric Transformation Assurance Committee (PTAC) is planned at SaTH to commence in June 23. The thematic review identified 17 recommendations across three reviews. Leadership gaps were being addressed at SaTH (Clinical Director).

3.4. SaTH has introduced a new Paediatric tool for assessment of Sepsis developed by the Sepsis Trust.

3.5. In April 23 the time spent in ED reduced and there was an improvement in Category 2 response times. The target of at least 70% of urgent care responses being carried within 2 hours is consistently met, with achievement in the range 95-99%. This compares with a national figure of circa 83%.

3.6. Palliative and End of Life Care Steering Group has been successful in being accepted on to the Getting to Outstanding Programme which has been developed to provide 6 months of expert support for quality improvement projects.

3.7. A deep dive into Urgent and Emergency care was provided which highlighted the development of the UEC improvement plan following system workshops and partner engagement.

4. Advise

4.1. Both Healthwatch organisations are working with the system to prioritise their years activity in line with system priorities.

4.2.

5. 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 Accept the report.

2.2 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 25th May 2023

Request of Paper:	Accept the report. Consider the alerts for further action.	**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 27-09-116.1
Meeting date:	27th September 2023
Paper title	Quality & Performance Committee Chair's Report – 29 June 2023
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 29th June 2023 for noting.
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. Variation of numbers of virtual ward referrals were discussed. Though assurances were given clinical staff are fully aware of the criteria requirements to ensure these are met and providing staff with the confidence to use new services. Cultural change for staff groups across organisation boundaries is taking time to embed.

2.2. *Clostridioides difficile* (*C diff*) infection is increasing in numbers beyond monthly trajectory in SaTH and at System Level. The ICS IPC Group is overseeing organisations actions across the system and is building a risk for the risk register.

2.3. The Committee heard that an unannounced CQC inspection took place at MPFT in June 23. This was a follow up to the visit in Nov 22 in which a section 29A has resulted the report is awaited.

2.4. High dose opiates or high strength opiate prescribing is one of the three priorities identified in the Medicines Safety Programme; NHS STW is the highest in the country. An action plan is in progress.

2.5. It was reported that there had been an increase in the number of Serious incidents being reported from the Emergency Departments at SaTH. This was in line with increased activity and demands and SaTH Board are monitoring.

3. Assurance

3.1. Five risks were on the risk register and discussed: Children and Young People's MH care, maternity care, UEC, Diabetes care, the acute paediatric pathway and Imaging and Imaging reporting delays. It was agreed that imaging reporting and delays was now being managed well and delays were reducing, the Committee agreed that this would be de-escalated to the Planned Care Board for ongoing management.

3.2. There are now no nursing homes within the STW ICS rated as inadequate by CQC. Focus in on improving those rated as Requires Improvement.

3.3. An insight report highlighted no new issues but the ongoing requirement for action related to discharge, communication and medications. Quality Improvement projects are being developed to address some areas of concerns and the new Patient Safety Incident Response Framework (PSIRF) will also be used to respond to learning from themes.

3.4. STW is performing well in relation to its long waits >78wks and is now delivering ahead of the revised trajectory for 62day cancer performance,

3.5. STW continues to perform ahead of its local improvement trajectory for ambulance handover delays. This is leading to an improving Category 2 response time across the system and wider region.

3.6. There is a system response to the instruction of PSIRF coordinated through patient safety specialists.

3.7. A Deep Dive into children & young people's mental health including eating disorders was provided which highlighted that access to core mental health services is currently 50 weeks. However, a process to provide support to those waiting and prevent harm was in place. There is currently no reported waiting list for eating disorders and data validation is underway.

3.8. The Paediatric Ophthalmology work was provided as a positive case study of how to address challenges with a fragile service and provide a service with a collaborative approach between commissioning, contracting, acute and private partners.

4. Advise

4.1. CHC information is now included quarterly in the performance report.

4.2. Children and young people's quality metrics are now included in the quarterly Quality metrics report including some information on asthma admissions.

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 29th June 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 27-09-116.2
Meeting date:	27 September 2023
Paper title	Audit Committee Chair's Report – 21 June 2023
Paper presented by:	Roger Dunshea
Paper approved by:	Roger Dunshea
Paper prepared by:	Roger Dunshea

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 ICB Audit Committee meeting held on 21 June 2023 for noting.

1.2 The meeting was quorate and no conflicts of interest were declared.

1.3 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	**Annual Report and Accounts (ARA) 2022-23.** The STW CCG 3 months and STW ICB 9 months accounts and reports were reviewed. The external and audit opinions gave required assurances to the committee. The committee agreed to recommend approval of the accounts and reports to the next meeting of the ICB. The key concerns raised by the ARA and audits were: The annual report in future should be aligned to reporting on performance against the joint forward plan and operational plan of the ICB and ICS. The focus should be on accountability to our stakeholders and recognition of the contributions made by non NHS partners. The system's large financial overspend and sub optimal productivity remain a key concern. The risk management and board assurance framework needs to be implemented in full , as soon as possible.

ADVISE: Area's that continue to be reported on and/or where some assurance has been noted/further assurance sought.	**Internal audit plan 2023-24** is now underway: • Better Care Fund effectiveness and accountability • Triangulation of population and patient engagement, experience and outcomes. • Ophthalmology commissioning • Continuing Health Care (CHC) commissioning and contracting • Delegated direct commissioning P,O &D • Standard financial core systems audit.
ASSURE: Positive assurances and highlights of note for the Board	The counter fraud , internal audits and external audit were conducted for 2022-23 , to the required professional standards.
Changes to the BAF Risk(s) and Directorate Risk Register Risk(s) agreed	**The BAF and Strategic Risk Register:** Remain in development and should be based on the delivery of the ICB's operational plan and strategy goals.
ACTIONS: Significant follow up action commissioned (including discussions with other Board Committees, changes to Work Plan)	**Information policies and Information Governance .** The committee further requested a review by the executive of where these and related policies fit best within the Executive's and Board's subcommittee approval arrangements. It is hoped this will be covered by the GGI review.
ACTIVITY SUMMARY: Presentations/reports / items of note received including those approved.	The committee noted the : • IG DSPT progress report • IG bi monthly service report. The committee received updates on: • Counter fraud • Losses and waivers etc
Matters presented for information or noting	External and Internal audit professional briefings.
Committee self evaluation of effectiveness/ Terms of Reference Review/ Future Work Plan	Feedback was positive regarding engagement of all present. The volume of the pre reading is excessive (700 pages).

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to consider the following recommendations arising from the meeting which require a decision:

Approval of the annual report and accounts (3 and 9 months 2022-23).

None

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 yet applicable

Appendices: September 2022 audit committee minutes.

Request of Paper:	To note	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:	*RM Dunshea*	**Date:**	18.7.2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 27-09-116.3
Meeting date:	27th September 2023
Paper title	Finance Committee Chair's Report – 30th May 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 30th May 2023 for noting.

1.2 The minutes of the meetings are attached for information.

1.3 Section 1 of the meeting was quorate however Section 2 was not. Attendees agreed to continue. No conflicts of interest were declared at either meeting.

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)** Key areas of expenditure/income risk were noted as: - Individual commissioning - Prescribing - Running costs and programme pay - Discharge expenditure with the Local Authorities - Elective Recovery Funding (ERF) assumptions - Efficiency (incomplete programme and back ended profile) The ICB efficiency plan target was reported as £26m, being 5% of underlying non-system expenditure. Of this, £8m is unidentified at this point. **Section 2 (System)** It was noted that the system is already off track against plan. From the reports provided the following was highlighted: - SaTH month 1 position shows an adverse variance to plan of £1.4m. - RJAH month 1 position, there was a small adverse variance to plan of £0.2m.

	- SCHT month 1 position overall expenditure appears to be broadly in line with plan. - ICB month 1 position broadly in line with plan Significant work to secure plans to address the £15m efficiency gap (of £70m total plan) is needed. This will be overseen by the Financial Improvement Group. The committee were presented with an update on early work to refresh the long term financial model (LTFM). They reviewed a significant 'do nothing' deficit in the next 5 years which will need to be addressed through the financial recovery plan. Further updates will come to future meetings.
ADVISE: Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	**Section 1 (ICB)** Whilst 23/24 budgets had not yet been uploaded to the ledger, a high level review of risk areas had been undertaken to inform management discussion on key areas of risk and focus. 4th May final plan submission for the ICB was noted as £14.7m with an underlying deficit of around £27m. The plan is not without its risks (operational, financial, and quality) but the ICB is committed to delivery and managing risks in year. **Section 2 (System)** There were no material concerns related to capital expenditure at this early stage of the year. The final system finance plan was submitted on the 4th May 2023 with a planned £60m system deficit. Currently, the system is awaiting a formal letter from NHS England to recognise that plan.
ASSURE: Positive Assurances and highlights of note for the Board	**Section 1 (ICB)** The committee were briefed that budgets had been issued to budget holders for sign off by 19th May. Robust monitoring processes are in place to track progress of efficiency schemes. **Section 2 (System)** CS noted that immediate actions from all partners were necessary to seek to reduce or mitigate the risk to delivery of the annual plan. The Committee reviewed the scope of work for the Intelligent Fixed Payment sub group and agreed to recommended chances to the Terms of Reference and title of the group. This will help to ensure that the group remains current and continues to add value. No changes to ToR are required at this time for the Committee's other two sub groups (Capital Prioritisation Group and Finance Staff Training and Development Council).

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)** Additional information on efficiency requested for future meetings, focusing on identification of schemes to close the gap and confidence in delivery **Section 2 (System)** As the meeting was not quorate, it was agreed that the changes to the IFP Sub Group ToR and name would be confirmed via email. This was subsequently actioned and has since been ratified by the Board.
ACTIVITY SUMMARY: Presentations/reports/items of note received including those approved	**Section 1 (ICB)** • M1 finance position overview • Finance plan 23/24 update • Efficiency Plan Update **Section 2 (System)** - M1 finance position overview - Finance plan 23/24 update - ICS long term planning update - Efficiency plan update - Change to Intelligent Fixed Payment Management Group - Update from Capital Prioritisation and Oversight Group
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 30th May 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:**	27th September 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board

Agenda item no.	ICB 27-09-116.3
Meeting date:	27th September 2023
Paper title	Finance Committee Chair's Report – 26th & 27th June Meetings
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 26th June (Section 1 ICB) and 27th June (Section 2 System) 2023 for noting.

1.2 The minutes of the meetings are attached for information.

1.3 Section 1 of the meeting was quorate however Section 2 was not. Attendees agreed to continue. No conflicts of interest were declared at either meeting.

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 heard that since the final plan submission the ICB had received an additional non-recurrent allocation from NHSE as a contribution towards inflationary pressures. This totalled £2.9m and came with the directive that it should be incorporated against the final plan deficit. As a result, the ICB reported planned deficit for 2023/24 is now £11.8m in year (£26.9m underlying). The ICB is currently delivering close to plan at month 2 and forecasting breakeven against the submitted 23/24 plan but there remains significant financial risk in the following areas: - 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. - Operational risk and risk of increasing system costs Month 2 reports highlighted £16.4m unmitigated risk. **Section 2 (System)**

	The Committee noted the late receipt of a final allocation from NHSE and that this had amended the final deficit plan from £60m to £57.1m. A £4m year to date adverse variance to plan was discussed, with the main drivers of that variance being within SATH. Of note in the overall position and common to all providers was agency expenditure which exceeded plan by £2.5m at month 2 and also slow identification of programmes of work to bridge the gap in the efficiency numbers. The Committee were concerned at the scale of the variance to plan in only two months. The Committee undertook a 'deep dive' into discharge and escalation and, in particular, reviewed the activity and funding mechanisms with the Local Authorities and noted that all available recurrent funding has been deployed in the finance plan in support of the existing discharge services. The Committee discussed the fact that the current funding levels had been deemed insufficient for capacity required this year and that work was underway to scope that and also develop mitigations. Trevor McMillan expressed concern that if an agreeable solution is not found between NHS and Local Authority partners this would have a severe impact on the Trust's ability to discharge patients.
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 that the working assumption about recovery of ERF income relating to Welsh patients was recognised by the regional NHSE team and further conversations with the national team are expected. **Section 2 (System)** There remained no material concerns related to capital expenditure at this early stage of the year.
ASSURE: Positive Assurances and highlights of note for the Board	**Section 1 (ICB)** Gareth Robinson highlighted positive steps since the last meeting to reduce the unidentified efficiency figure in the ICB plan by £2.5m. Work continues on the remaining gap. **Section 2 (System)** Through the discussion about agency expenditure, the Committee were briefed on the newly formed System Agency Reduction Group, chaired by Alison Bussey, ICB Chief Nursing Officer. This will provide System oversight to agency reduction work and report to the Financial improvement Group.

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 for this financial year at least, there would be a stand alone item on each month's agenda to look at the financial impact of the efficiency delivery programme. Any subsequent assurances about delivery could then be sought from the Integrated Delivery Committee. After hearing an update on the work of the Finance Staff Training and Development Council, the Committee formally approved its Terms of Reference.
ACTIVITY SUMMARY: Presentations/reports/items of note received including those approved	**Section 1 (ICB)** • M2 finance position overview (revenue and capital) **Section 2 (System)** - M2 finance position overview (revenue and capital) - STW Training and Development Council Update - Deep Dive – discharge and escalation
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 26th and 27th June 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:**	27th September 2023

Integrated Care Board

Agenda item no.	ICB 27-09-116.4
Meeting date:	27 September 2023
Paper title	Remuneration Committee Chair's Report
Paper presented by:	Trevor McMillan, Non-Executive Director & Chair of Remuneration Committee
Paper approved by:	
Paper prepared by:	Lisa Kelly, Senior HR Business Partner (Client Delivery)

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 Remuneration Committee meeting held on 16 August 2023 for noting.

1.2 The meeting was quorate.

1.3 A summary of the report is outlined below for the Board's consideration:

1.3.1 There were two agenda items as outline below: -

- A report regarding the recruitment process for the post of Chief Executive Officer was presented for information and approval
- A report regarding the recruitment process for the post of Chief Nursing Officer was presented for information and approval

1.3.2 The papers presented were approved by the Remuneration Committee

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Board is asked to:

2.1 Note the business completed at the Remuneration Committee on 16 August 2023.

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

N/A

4. Appendices

None

Request of Paper:	To note.	**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 27-09-116.5
Meeting date:	Wednesday 27th September 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 9th August for noting.

1.2 The minutes of the meeting are to be ratified on the 20th September and are therefore not available to share as 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:

Clinical Strategy

The Committee received the ICS Clinical Strategy for discussion and the following points were highlighted:

- The Committee receive the information summarising the background of the Clinical strategy including that a Clinical professional leadership structure was set up May 2022 as a requirement of NHSE as part of our Readiness to Operate statement, we were RAG rated red and the only clinical leadership in the country to be RAG rated red and as a result a a three-tier structure has been developed.

- The Committee noted that the Clinical strategy has helped to focus on keys areas, where we want to prioritise and help improve our services and is not the Joint Forward Plan or a healthy needs assessment for the population. It is a discrete piece of work, which is principally clinical.

- The Committee heard that there had been six priorities identified delivered through Clinical Advisory Groups - Urgent and Emergency Care (UEC), Cancer, Cardiac Care, Diabetes, MSK and Mental Health and that in addition to these six priorities maternity and neonatal services were identified as a priority but there is already an established programme of work delivering improvement across this segment of care.

The Committee were invited to ask questions with as summarised below.

- How we are making sure that our GP colleagues are inputting, and their voices being heard, as it is critical that we get GPs to be part of the clinical strategy. It was confirmed that we have GP leadership and multiple levels in the system who are all fully involved.

- How do we align our strategies. It was agreed that there is still some work to be done to do the Integration Strategy, Joint Forward Plan, Clinical Strategy including how we get the clinical view that is supporting this coming up through Boards so that Board strategies align to a direction of travel on how we want to work. The Committee also heard that SaTH have developed a Clinical Services Strategy, which is aligned to the system Clinical Strategy, but have included HTP and SaTH's role in the wider system.

- The Committee received feedback that there needs to be a stronger prevention and health inequalities element into the clinical pathway and stronger interface.

- The Committee also received questions as to the purpose of the Clinical Strategy in the wider context of system ownership and individual organisational ownership with the feedback being given that it is a two -year strategy and the aim is to get conversations about commissioning intentions and how the landscape has changed going from a CCG to an ICB, and how we get things moving in the right direction.

- Further feedback was received by Committee clinical members that the clinical strategy acts as a catalyst for all the different plans in place to make sure that we focus on the right things and that it is about resource utilisation not competition.

- The use of Digital was also discussed by the Committee including how it will underpin the strategy and with Committee members referencing that they looked forward to seeing the digital strategy at a future committee meeting.

- The Committee raised questions around how do we ensure we have innovation going clinically and not just focussing on the six or seven priorities, how do we link the clinical strategy to place and neighbourhood and how are we going to measure the implementation. Concerns were raised regarding the difficulties in empowering frontline clinicians to make those changes and also difficulty in getting time for clinicians to be involved due to workloads recognising that there is a lot to do in the system and there needs to be an element of prioritisation.

- The Committee members proposed that the strategy is shared with place and health and wellbeing board and that there is an ask to get NEDs and clinical leads on boards is that what is the appetite of each of our providers to get into the right shared space around BI interpretation.

- It was agreed that it was important to have clinical and professional leadership in this committee to sit alongside the NED and Exec leadership including standing clinical professional membership and invite relevant members to discuss particular items on the agenda each month. Also, a GP representative, Primary Care representative and Nurse/Health visitor or Pharmacist should attend this Committee.

It was agreed that the Committee membership is reviewed, and the day of this meeting changed from a Thursday and for the Committee to receive diagrammatic representation of the clinical leadership structure.

Any Other Business

None

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 Extraordinary August 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 to be approved at the meeting on the 20th September so not yet available.

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 27-09-116.5
Meeting date:	Wednesday 27th September 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 Strategy Committee meeting held on 15th June for noting.

1.2 The minutes of the meeting are attached for information as appendix 1.

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:

Review Of TOR

The Committee reviewed the TOR for the Strategy Committee and the following points were highlighted:

- It was noted that the Clinical Strategy should be included in the Terms of Reference.
- It was noted that Population Health Board was being stepped down and Population Health Management would sit under the Strategy Committee.
- The Committee noted that the Procurement group no longer existed and need to make sure that each of the references to the other meetings are still relevant and reflects what we have got in the government structure.
- A small number of amendments were suggested and approved by the Committee.

The committee noted the recommendations and further actions with the amended TOR to be fully updated after the Good Governance Review outputs are known and TOR to be shared with Provider Boards for information.

NOF 4 exit criteria and Integrated System Improvement Plan

The Committee received a paper and presentation, and the following points were highlighted:

- There were no risks to highlight to the Committee, with delivery in May and the rest of June being very good.

- The Committee noted that the final version of the System Operating Plan had been delayed due to resubmission and was submitted in May for informal feedback with the system awaiting formal feedback from NHSE colleagues and undergoing lessons learnt exercise throughout June. This will report in July and be built into our planning for 24/25.

- The Committee noted that feedback from NHSE at the IRM meeting on 22 May was positive. They are pleased with progress being made and support our request for criteria five to be moved from red to amber. It was also noted that one of the elements of exit criteria five in in relation to SATH having a refresh CQC visit which is expected in quarter three.

- The Committee also received information that prior to Christmas twenty local authorities and twenty local authorities after Christmas are going to be inspected for adult social care. This is a new framework and there will be interrelationships so some early Intel might be useful.

- The Committee noted that NHSE wanted more detail on specific actions that we are taking to strengthen our clinical governance because of some of the issues around some paediatric deaths that we have had within the provider with an assurance committee set up which will involve multi agency with external views.

The Committee received and provided comments/ feedback on the final draft Integrated System Improvement Plan (ISIP) to support the system's exit from NOF 4.

Joint Forward Plan

The Committee received a presentation of the JFP and the following was highlighted:

- There was overarchingly positive feedback on the plan from NHSE with some recommendations.

- It was recognised by the Committee that the system were engaging with people in as many different ways as possible, ensuring that we can capture as many different groups as possible with public listening events having engaged around 300 people and that we will shape the things that we have heard through the big conversation, through the stakeholder engagement and some of the further work as a continuing process.

- The Committee raised a number of queries re next steps and process which were addressed and discussed including addressing any gaps.

- The Chair thanked all of the staff that had worked on the JFP and the hours they have put into pulling it together and getting it into a good shape.

The Committee agreed and noted the submission and sign off of the JFP.

Place and place development

The Committee received presentations on both SHiPP and TWiPP and the following areas was highlighted:

- The Committee requested information on how programmes would be prioritised and measured with the assurance being given that the metrics have been agreed through SHiPP and TWIPP local priorities set from the from the JSNA work. Further assurance was given to the Committee that we need to identify groups with the highest levels of needs that we need to address from preventative point of view and we need to make sure we are looking at those equity issues in terms of are we delivering the most for those that need it most.

- The Committee also noted that we are now starting to share some of the big items of work and understand the interrelationships between all of that.

- It was also noted that there is work being done on the Better Care Fund in terms of reframing over the next two years as well as to support some of the resource allocation. Look to align the place priorities with what was commissioned through the BCF and pull funds through that. Governance is being refreshed around the BCF to ensure all system partners are involved.

The Committee supported the aims and also recognised what more can be done to drive Place forwards.

Local Care Transformation Programme - feedback and proposed governance and reporting framework

The Committee received a verbal update on this item and highlighted the following:

- The Committee noted the action from previous meeting around feedback from Committee members about the Local Care Transformation Programme and the presentation given with a further request for feedback.

- It was noted that the first of the new Local Care Transformation Programme Boards was scheduled for the 17 July which would be be reflective of the new membership.

- The Chair commented that it is important to have good interlinkage with the place work and HTP which was supported by the Committee.

- He mentioned that it was important how we work together collectively with the Local Care Programme and what the Joint Forward Plan includes.

- The Committee also noted that a bid has gone into NHSE for some monies to help the system with the single demand and capacity model.

- The Chair commented that we look forward to the strategy being refreshed and returning to thus Committee.

Minute No. SC-15-06.055 Any Other Business

Schedule of Committee meetings

After a discussion it was agreed to keep this Committee meeting on a monthly schedule for the time being.

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 June 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

Appendix 1 - Strategy Committee minutes from the meeting held on 15th June 2023

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 (ICB)

Agenda item no.	ICB 27-09-116.8
Meeting date:	27 September 2023
Paper title	Integrated Delivery Committee (IDC): Chair's Report of meeting held on 10 July 2023
Paper presented by:	Gareth Robinson, IDC Vice Chair
Paper approved by:	Harry Turner, IDC Chair
Paper prepared by:	Jan Heath

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 Integrated Delivery Committee (IDC) meeting (Part One – Open) held on 10/07/23

1.2 The meeting was quorate and no conflicts of interest were declared.

1.3 The minutes of the meeting held on 12/06/23 were approved.

1.4 The IDC Chair's Report (June 23) was approved.

1.5 A summary of the discussions held, assurance received and areas for escalation are outlined below for the Board's consideration:

1.5.1 System Operational Plan Dashboard

The ICB Director of Planning & Performance presented the System Operational Dashboard that summarises Month 2 delivery against plan by key programme areas. The Dashboard highlights areas that are behind plan that may require targeted review to ensure that recovery plans and mitigations are in place. The Dashboard serves as a means of providing assurance to the ICB.

- **UEC & Community**

  Ambulance handovers continue to be on track against improvement trajectories.

  4 hr target performance is off track and was the focus of discussion at the June Quality & Performance (Q&P) Committee. A revised recovery trajectory is being agreed by the SaTH Chief Nursing Officer and the ICB UEC lead. This will go to the UEC Board in July for sign off before going back to Q&P at the end of the month.

  Non elective admissions showed a spike in Month 2 - this is being monitored by the Non Elective Demand & Capacity subgroup of the UEC Operational Delivery Group. If this trend

continues the group will look into underlying causes and report up to the UEC delivery group to inform any action required.

Progress against reducing the LoS on the No Criteria to Reside is slower than expected and is the area of greatest focus given the impact on escalation capacity at SaTH. NHSE is supporting the System to develop a response and implement a recovery plan.

Virtual Ward was still behind plan for Step Down Referrals in May but an action plan is in place and improvement is expected to be seen from June.

- **Planned Care, Diagnostics & Cancer**

The System is making good progress with regard to long waits and whilst it is off trajectory for >78wks at Month 2, it is expected to have only single figures still waiting at the end of July. NHSE is fully aware of the issues regarding these cases and that they are beyond the control of local providers. It must be noted that this good progress may be at risk due to the potential impact of the pending industrial action. This presents some concerns regarding the Value Weighted Activity plans that will be the focus of the next Planned Care Operational Delivery Board (PCODB) to ensure that the impact of industrial action is quickly understood and mitigations for recovery are put in place. The ongoing nature of the industrial action means this remains a risk to the system's ongoing delivery of activity to planned levels.

Since the last report, the Cancer position has been reforecast and is improving although still being closely monitored. Whilst the overall position for diagnostics is ahead of plan, this does mask a shortfall in Endoscopy capacity. The system does not have a plan to deliver the 85% within 6wks for this modality by the end of March 24. This key modality continues to be under scrutiny at the PCODB

A plan for the nationally mandated reduction in follow-up activity is still outstanding and this, directly linked to the work to reduce our past maximum wait follow up cohorts is being progressed via the PCODB.

- **Mental Health, Learning Difficulties & Autism**

CYP access is off track with 88% of target being delivered however this is based on provisional data only for Month 1. This is being overseen by the Contract Review Meeting between the ICB and MPUFT and will be closely monitored.

Talking Therapies (previously known as IAPT) is behind plan – recovery plans are in place to increase access. This needs to be kept under close scrutiny to ensure its effectiveness.
SMI measure appears to be off plan however historically activity is always lower in the first half of the year. The performance team are checking that the plan reflected this and seeking assurance via the MH &LD &A Board that the plan will be delivered.

NB It should be noted that Primary Care will start to be reported through the Dashboard from September as PCNS plans will be signed off by the end of July.

1.5.2 Virtual Ward Update

The Local Care Programme Director provided the latest update for the Virtual Ward project and performance against plan for June.

Following under-performance in Q1 due to under-performance of step-down referrals, there has now been some improvement and the June target has been exceeded – step down referrals at 87 against a target of 71 and step up referrals at 257 against a target of 200. The focus is currently on frailty and respiratory and about to go live with cardiology. Actions are in place to maintain the level of performance going forward and this will be monitored by the Virtual Ward Expansion Forum.

The Forum is currently considering a number of key areas of potential risk and opportunity such as implementation of the EPR system that will enable data sharing across Virtual Ward and Primary Care, implications for the end of the Falls pilot that supplied step up referrals, dedicated consultant support to finalise the cardiology pathway and options for a remote monitoring system. There were no issues for escalation to the IDC at the moment.

The IDC Deputy Chair provided some clarity regarding the costs of the Falls Pilot and current work to review alternative options based on value for money.

The IDC discussed the impact of step down referrals on escalation beds as so far, SaTH has not seen a reduction in bed spaces. Given that activity is now taking place at greater scale, there is an opportunity to revisit the original assumptions and modelling to reassess the impact on bed closures.

The IDC requested a specific action that

- The Local Care Programme Director reviews the operational assumptions within the system operating plan to understand if the step down referrals are converting to the anticipated reduction in bed levels. The review to be completed in conjunction with SaTH's Chief Operating Officer and the ICB Director of Planning & Performance.

The IDC also discussed the tracking of expenditure on workforce, technology and other project costs. The Programme Director confirmed that monitoring of the full suite of KPIs including financial metrics would sit with the VW Expansion Forum for escalation to the IDC as appropriate.

A further action was agreed regarding the delayed recruitment that

- The Local Care Programme Director would set out the variation to plan (both YTD and for the remainder of 23/24) in terms of workforce for both VW and IDT. Also, to set out the recruitment profile against plan and identify the potential non-recurrent benefit that has resulted from the delayed recruitment and propose recommendations for how this can be used to support implementation and/or what surplus is no longer needed.

Both actions to be completed and presented to the next IDC in August.

The Local Care Programme Director also highlighted some of the challenges in developing the Cohort 2 programmes of work including the Integrated Neighbourhood Teams and the

Community Beds Model. Both programmes have been subject to delays whilst resource has been focused on Cohort 1. A more detailed Local Care Highlight Report and Risk Register will be presented to the next IDC that will provide more visibility regarding the challenges and competing priorities across the overall programme so that the IDC is in a better position to make informed recommendations and decisions regarding redeployment of resources.

1.5.3 MH LDA Deep Dive

The IDC received a presentation from the MPUFT Chief Executive on the governance and priorities for the MH LDA programme in 23/24. The presentation set out the context of the MH LDA programme and consistent achievement of the Mental Health Investment Standard (MHIS) despite challenges regarding the level of investment - benchmarking indicates that investment is 28% below average whilst referrals are approx. 30% above. Services are experiencing not only increased demands but increased levels of complexity resulting in unmet needs.

- MH LDA Delivery Board has good attendance with representatives from local authorities and the voluntary community sector as well as ICB partners with six project steering groups reporting into it and most recently, a task and finish group to develop the mental health provider collaborative. The biggest programme is the Community Adult Mental Health Transformation Programme that involves development of integrated teams around the PCN and linking with voluntary sector social care and new primary care roles such as mental health practitioners and psychology and clinical associates. There were three priority areas for 2022/23 which were mental health rehabilitation, personality disorder and eating disorders. The Board is also focused on repatriating the large number of people who are out of area.

- The priorities for 23/24 are consolidation of new ways of working particularly around VCs E Grants and using population health needs analysis to identify gaps in service provision in each PCN area. One focus is transition between young people and adults and ensuring support for the 18 to 25 cohort within the community with a more personalised agenda. Another key priority is embedding the ‘no wrong door’ approach so that no-one is turned away regardless of the pathway and also tackling health inequalities for those with serious mental illness.

- Data is part of the community mental health priorities to ensure that it’s being collected irrespective of where people are receiving care. The Board is working towards cooperative care planning and the routine collection of patient-rated outcomes and ensuring that the new waiting time standards are being achieved.

- One area where performance is not as required is the SMI physical health pathway, Men with SMI die approx.24-25 years earlier than those without SMI and women approx. 20 years earlier. There are some data issues to be resolved to understand true performance levels and there is a remedial plan in place as part of the Community Mental Health Transformation Programme.

- As far as CYP mental health is concerned, access to services is under extreme pressure with significant waiting times of 50+ weeks including learning disability and neurodevelopmental pathways. Mental Health support teams in schools are being expanded and in accordance with the long term plan, considering more digital offers.

- There is a Suicide Prevention Strategy out for consultation that joins up both local authorities and there has been considerable work around real time surveillance systems and targeted intervention work. The sustainability of a suicide bereavement and postvention offer funded from Covid monies is currently under review.

- A business case has recently been submitted for a 24 hours crisis team at PRH and clinical nurse specialist posts are being developed for children and young people to change the liaison service to all-age.

- The 111 Option 2 for mental health is going fully live from April 2024 with a soft launch in October. The mental health ambulance or response vehicle in WMAS is also coming on stream to ensure appropriate transfers to emergency departments. The NHS talking therapies priorities for 2023/24 have initiated a massive service redesign – outcomes measures are being delivered consistently and currently on target to meet the access target from Quarter 4.

- The programme also includes Dementia Transformation that has resulted in the introduction of additional Admiral Nurses and ways to increase the number of Care Navigators. There is a strong focus on the dementia diagnosis rate and as demand continues to outstrip capacity, there is still a significant waiting list for provision of care.

- In line with the transforming care agenda, the programme aims to reduce reliance on inpatient care for people with learning disabilities and autism, seeking to reduce significant waiting lists for ASD diagnoses and tackle the huge health inequality that exists.

- In addition to the existing transformation programme, a task and finish group has recently been established to focus on the mandate from the ICB to design and develop a local provider collaborative for all-age mental health related services – the first stakeholder engagement in Telford has been scheduled to kick off the work.

The IDC discussed the scale of the programme and the finite financial envelope that necessitated some difficult decisions. The MPUFT CEO explained that a Finance & Planning Group met twice per month to review investment against priorities and any potential opportunities to leverage additional funding. However, given the financial challenges within the system, the level of risk in terms of quality and performance was a concern in some areas and required greater system-wide understanding.

It was noted that the challenge post-pandemic, particularly in relation to CYP mental health, was a regional and national issue and not exclusive to STW. However, unlike elective recovery funding for physical health, there was no national non-recurrent financial support for CYP mental health, despite a 300% increase in demand for services since the pandemic. There was a query raised regarding whether there was any regional or national work underway to understand the increase in demand and how long it was expected to last.

The MPUFT CEO confirmed that the increase in mental health practitioners, working across the community with the PCN, voluntary sector and the secondary mental health team was bringing some improvement, but still not providing sufficient capacity to meet demand.

The IDC Vice Chair highlighted the success of the Commissioning team in achieving investment through the triple lock process through development of a robust business case that demonstrated exceptional value for money and suggested that this route should also apply to mental health services.

The IDC thanked the MPUFT CEO for such a comprehensive and informative update and looked forward to updates on delivery.

1.5.4 Annual Procurement Plan

The System Head of Procurement shared progress on the Annual Procurement Plan and was able to provide assurance to the IDC that overall, despite underachieving on the SaTH target by £64k, it was on track to achieve planned efficiencies in 23/24 and currently was over-achieving the 3.5% target of £3.8m. This does not include support provided to the BTI procurement savings across Estates, Digital and Workforce to avoid double-counting.

It was also reported that, based on the national spend comparison tool for the top 500 items, the System is already purchasing at the lowest prices for the majority of goods so there is very limited opportunity to purchase the same things cheaper. Additional savings can only be realised by changing products or changing ways of working.

All spend is tracked by item by trust and by buyer on a month by month basis and compared with the target so all slippage is immediately identified and mitigations can be deployed.

The System Procurement team is also now initiating pilot schemes to expand purchasing opportunities across other system partners to standardise on products and maximise economies of scale. The long term objective is that the procurement service will become cost neutral. The team is also part of a number of national pilots such as working with the national supply chain on an inventory management system that may result in reduced stores requirement for providers.

The IDC noted the great work being delivered by the System Procurement Team and the positive reputation being established both regionally and nationally.

1.5.5 Financial Improvement Programme

The System PMO provided an update on the Month 2 position for the System Efficiency Plan and progress towards the 2023/24 System Efficiency Target at £70m, for which there are schemes in place amounting to just under £60m with a balance of £10.7m unidentified.

This demonstrates progress since last month with identification of a further £5m of schemes now in the plan, a significant proportion of which is attributed to the Individual Commissioning Team that has identified an additional £2m through reducing the cost of packages of care.

The position at Month 2 however shows that we are behind target by £800k and that directly relates to the cost of escalation beds. There is an improvement plan in place that is being monitored weekly through the UEC performance review group.

Work continues on developing the other two opportunities previously agreed within Medicines Management and Place Based Joint Commissioning alongside other pipeline opportunities being overseen by the FIP to bridge the unidentified gap.

So in summary, progress has been made to reduce the unidentified gap from £15m to £10.7m but the level of risk associated with some programmes already in delivery means that we cannot be complacent.

IDC discussed the actions required to reduce the risk around those programmes in delivery and how that movement from high to medium/low risk could be forecast and tracked. There were concerns raised around some of the system-wide programmes and the need to increase grip through weekly reviews at both organisation as well as system level.

The System CFO made the point that there is an element of the plan which is non-recurring and that would also require close monitoring as going forward, the drive needs to be towards more recurrent efficiencies.

In addition, plans now need to be developed for future years as the recovery trajectory is not over a one year period – the IDC therefore expects that Programme Leads will now be working on assumptions, modelling and the delivery plans for 24/25 and beyond in line with the MTFP.

1.5.6 Planned Care Update
The Programme Director provided a brief update and confirmed that the specific issues raised within the System Operational Dashboard would be discussed at the next Planned Care Delivery Board meeting including Outpatients, FDS for cancer and endoscopy diagnostics.

1.5.7 UEC Board Update
The Director of Delivery & Transformation presented a report from the UEC Board and confirmed that there were no items for escalation that required IDC action.

1.5.8 MSK Transformation ToR
The new ToR were presented to the IDC including new membership for the MSK Board with increased seniority that has resulted in improved attendance and a subcommittee structure that has been split across primary care and community therapy services. There is an issue around authority of the Board in relation to the provider collaborative conversation that needs further work.

The Programme Director also flagged that a number of different figures had been circulated in relation to the value of efficiency savings and this still needed to be finalised. The System CFO agreed and picked up an action to discuss offline.

1.5.9 Other Agenda Items
Standing agenda items were provided for information and taken as read including the TWIPP and ShIPP Chairs Reports, the Vaccination Programme Update and the MH LDA Chair's Report

2. Recommendations

The ICB is asked to:

- **Note** the performance update highlighted within the **System Operational Plan Dashboard** including:

  UEC
  - Ambulance handovers continue to be on track
  - 4 hour target performance is off track
  - NCTR performance is area of focus given impact on escalation beds

  Planned Care, Diagnostics & Cancer
  - Good progress made on long waits and expected to be into single figures by end July
  - Ongoing industrial action presents a risk to activity levels
  - Cancer position has been reforecast and is improving
  - Shortfall in endoscopy capacity remains an issue

  MH, LD&A
  - CYP access is off track
  - Talking Therapies (previously known as IAPT) is behind plan

- **Note** that the **Virtual Ward** June target for both step-up and step-down referrals has been exceeded

- **Note** the actions agreed for the **Virtual Ward** Programme Director:

  - Review the operational assumptions within the system operating plan to understand if the step down referrals are converting to the anticipated reduction in bed levels. The review to be completed in conjunction with SaTH's Chief Operating Officer and the ICB Director of Planning & Performance.

  - Set out the variation to plan (both YTD and for the remainder of 23/24) in terms of workforce for both VW and IDT.

  - Set out the recruitment profile against plan and identify the potential non-recurrent benefit that has resulted from the delayed recruitment and propose recommendations for how this can be used to support implementation and/or what surplus is no longer needed.

- **Note** the governance framework and priorities for the **MH LDA** programme set out in 1.5.3.

- **Note** the challenges to **mental health services** specifically CYP and the remedial actions being taken including the expansion of mental health support teams in schools and submission of a business case for a 24 hours crisis team at PRH with specialist posts for children and young people.

- **Note** the soft launch of 111 Option 2 for **mental health** in October with full go live from April 2024.

- **Note** the establishment of a Task and Finish Group for the establishment of a local provider collaborative for all-age **mental health** services

- **Note** the great work being delivered by the **System Procurement Team** and the positive reputation being established both regionally and nationally

- **Note** the risk associated with delivery of the **Financial Improvement Programme** and the requirement to identify plans for future years as well as further develop the 23/24 plans.

- **Note** changes to the **MSK Transformation** governance framework in light of the expanded programme scope.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Care Board (ICB)

Agenda item no.	ICB 27-09-116.8
Meeting date:	Wednesday 27th September 2023
Paper title	Integrated Delivery Committee (IDC): Chair's Report of meeting held on 14 August 2023
Paper presented by:	Gareth Robinson, IDC Vice Chair
Paper approved by:	Harry Turner, IDC Chair
Paper prepared by:	Jan Heath

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 Integrated Delivery Committee (IDC) meeting (Part One – Open) held on 14/08/23

1.2 The meeting was quorate and no conflicts of interest were declared.

1.3 The minutes of the meeting held on 10/07/23 were approved.

1.4 The IDC Chair's Report (July 23) was approved.

1.5 A summary of the discussions held, assurance received and areas for escalation are outlined below for the Board's consideration:

1.5.1 Local Care Transformation Programme (LCTP)

The LCTP Programme Director presented three papers relating to the LCTP:

- **LCTP Revised Governance Model**:
  An outline of recent changes to the governance model that includes refreshed membership to ensure sufficient clinical and executive level representation and revised ToR. The Virtual Ward and Rapid Response Expansion Group has also now been in operation for a few weeks and is working on solutions to tackle barriers to further expansion, the neighbourhood development working groups have been re-established now aligned to TWIPP and ShIPP and a steering group established to drive the Community Bed Based workstream.

  It has been agreed that the VW & RR Expansion Group will provide monthly updates to the UEC Operational Delivery Group to provide further visibility

and scrutiny of performance although the finer details are still to be clarified for example, inclusion of IDT performance within the LCP updates.

The IDC requested confirmation on a number of points before signing off the proposal:

- There needs to be a clear plan for IDT, VW and RR aligned to the UEC Operational Delivery Group

- Key risks related to leadership and resourcing are sufficiently articulated and mitigated

- LCTP Programme Director formalises the IDT reporting process into the UEC Operational Delivery Group with the Acting Director of UEC

- The UEC Operational Delivery Group confirms acceptance of the proposed changes including the reporting mechanism and the ToR

- **LCTP Highlight Report:**
  The Programme Director highlighted a number of key risks to programme delivery including:

    - High level of NCTR across the system
    - Limited availability of enabling resources such as digital initiatives and effective workforce planning
    - BI and analytics resource
    - Clinical championing

The IDC discussed the mitigations in place including reprioritisation of BI capacity and development of a network of clinical champions.

The IDC requested that the LCTP Programme Director review VW expenditure and report back to the committee on slippage that could potentially fund additional resource.

- **Virtual Ward Escalation Paper**:
  It was reported that whilst performance had been sustained over June and July with 78 and 79 step down referrals respectively, the target had doubled over that period to 141 in July and therefore was not achieved**.**

  The Programme Director also flagged an issue that had arisen following a data cleansing exercise that identified a high number of inappropriate referrals.

The IDC noted that the step down referrals are not converting into de-escalation of beds.

The LCTP Programme Director and the SaTH COO were asked to complete an urgent piece of work to consider how to improve referrals including:

- Discussion with clinical leads to understand the cause of inappropriate referrals

- Understand the scale of the opportunity by clinical pathway to determine where to target resource for maximum impact

- Determine the contribution to date of VW and IDT against the 151 beds

1.5.2 System Operational Plan Dashboard

The ICB Director of Planning & Performance presented the System Operational Dashboard that summarises Month 3 delivery against plan by key programme areas. The Dashboard highlights areas that are behind plan that may require targeted review to ensure that recovery plans and mitigations are in place. The Dashboard serves as a means of providing assurance to the ICB.

- There continue to be green shoots of progress in ambulance handovers but still work to do in 4 hour and 12 hour reporting. The dashboard highlights the number of patients still being cared for in corridors.

- Mental Health data is not fully available yet but there are signs of improvement in CYP IAPT and good progress in LD for moving both adults and children out of long-term care. However, concerns were raised regarding the 7 month waiting list for Core CAMHS and risk to children who have neurodiversity in particular in view of increasing suicide rates – a business case is currently being prepared to address resource issues in this area.

- The Director of Planning & Performance confirmed that Primary Care performance reporting would be included in the dashboard from September.

1.5.3 MSK Transformation

The IDC received a presentation on the MSK Strategy engagement day that was well-attended and produced some very positive outputs around key drivers for change (workforce, clinical pathways and provider collaboration) and the areas for focus and improvement.

An update on the overall programme highlighted that Phase 1 had successfully gone live the previous week including standardisation of processes and implementation of the workforce sharing agreement.

However, whilst the IDC recognised a key challenge for the team in gathering data to demonstrate benefits realisation, it expressed concern that there was no evidence of

benefits derived from the RSP investment so far and a lack of clarity on the value of benefits in 2024/25.

The IDC requested that the Programme Director work with the SRO and the Chair of the Planned Care Delivery Board (PCDB) to ensure that going forward, the PCDB was able to provide assurance to the IDC that the MSK Transformation programme was on track and on target to deliver the expected benefits.

The IDC requested that the Programme Director work with the CFO to articulate the financial value of benefits expected in 2024/25 and for the period of the MTFP.

1.5.4 Vaccination Programme Update

The SRO for the Vaccination Programme provided an update on the campaign that ran from Spring to end June 2023 targeting those over 75 years of age, the immunosuppressed and those in adult care homes. An uptake of 71% was achieved against a target of 61% which places STW above both the England and regional averages. However, there were differences in uptake across the ICS footprint that is now being used to form the basis of an equity audit.

The IDC requested that the outcome from this audit is reported back to a later meeting of the Committee.

Headlines of the proposed Autumn campaign were also presented including targeted cohorts, service fees, commencement dates for each cohort and the enhanced service for GPs.

The SRO proposed to return to IDC with a detailed report on delivery of the Autumn campaign in January 2024.

1.5.5 Financial Improvement Programme

The System PMO provided an update on the Month 3 position for the System Efficiency Plan and progress towards the 2023/24 System Efficiency Target at £70m, for which there are schemes in place amounting to just over £60m with a balance of £9.8m unidentified. This represents very limited progress since last month.

NHSE has specified that we must have 90% of our efficiency plan identified and in delivery by end September 2023 i.e. £63m.

Work continues on developing the pipeline plans as well as other opportunities previously agreed within Medicines Management and Place Based Joint Commissioning alongside to bridge the unidentified gap.

IDC discussed the actions required to reduce the risk around those programmes in delivery and how that movement from high to medium/low risk could be forecast and tracked. There were concerns raised around some of the system-wide programmes

and the need to increase grip through weekly reviews at both organisation as well as system level.

The System CFO made the point that there is an element of the plan which is non-recurring and that would also require close monitoring as going forward, the drive needs to be towards more recurrent efficiencies.

In addition, plans now need to be developed for future years as the recovery trajectory is not over a one year period – the IDC therefore expects that Programme Leads will now be working on assumptions, modelling and the delivery plans for 24/25 and beyond in line with the MTFP.

The IDC noted that a productivity meeting has been set up to review all areas of efficiency and productivity to be reported through the FIP.

1.5.6 Planned Care Update

The Chair of the Planned Care Delivery Board reported that all providers were on track for delivering both 78 and 104 week waits and that both SaTH and RJAH are ahead of trajectory for 64 weeks. NHSE are satisfied with improvement made and are stepping down from Tier One.

Cancer still presents a challenge and whilst better than trajectory overall, there is still much work to be done.

Outpatients is becoming an increasing focus for NHSE given the anticipated impact on waiting times. The transformation programme is now under review with a revised implementation plan and trajectories currently being developed. This will feed back directly into the Planned Care Delivery Board and assurance provided via that forum to the IDC.

The IDC requested that at the next IDC meeting, the SRO provide a gap analysis for 23/24 together with a remedial plan and headlines for the MTFP.

1.5.7 UEC Board Update

Areas for discussion and escalation already covered under other agenda items – no questions raised for the Chair.

1.5.9 Other Agenda Items

Standing agenda items were provided for information and taken as read including the TWIPP and ShIPP Chairs Reports and the MH LDA Chair's Report

2. Recommendations

The ICB is asked to:

Note the request from the IDC for confirmation on a number of points prior to approval of the revised **LCTP Governance Model:**

- There needs to be a clear plan for IDT, VW and RR aligned to the UEC Operational Delivery Group

- Key risks related to leadership and resourcing are sufficiently articulated and mitigated

- LCTP Programme Director formalises the IDT reporting process into the UEC Operational Delivery Group with the Acting Director of UEC
- The UEC Operational Delivery Group confirms acceptance of the proposed changes including the reporting mechanism and the ToR

Note the IDC request that the LCTP Programme Director reviews **VW expenditure** and report back to the Committee at the September meeting on slippage that could potentially fund additional resource

Note the requirement for the LCTP Programme Director and SaTH COO to complete an urgent piece of work in relation to the **VW Programme** to consider how to improve referrals, including:

- Discussion with clinical leads to understand the cause of inappropriate referrals

- Understand the scale of the opportunity by clinical pathway to determine where to target resource for maximum impact

- Determine the contribution to date of VW and IDT against the 151 beds

Note System performance reported within the **System Operational Plan Dashboard** and the inclusion of Primary Care performance from September.

Note the request by the IDC that the **MSK Transformation SRO** works with the System CFO to make rapid progress in developing a Benefits Realisation plan including the financial value of benefits in 2024/25 and for the period of the MTFP.

Note that the outcome of an equity audit related to the **Vaccination Programme** will be reported back to the IDC post-September.

Note the request for the **Outpatients Transformation Programme** SRO to provide a gap analysis and remedial plan for 2023/24

Integrated Care Board (ICB)

Agenda item no.	ICB 27-09-116.8
Meeting date:	27 September 2023
Paper title	Integrated Delivery Committee (IDC): Chair's Report of meeting held on 11 September 2023
Paper presented by:	Gareth Robinson, IDC Vice Chair
Paper approved by:	Harry Turner, IDC Chair
Paper prepared by:	Jan Heath

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 Integrated Delivery Committee (IDC) meeting (Part One – Open) held on 11/09/23.

1.2 The meeting was quorate, and no conflicts of interest were declared.

1.3 The minutes of the meeting held on 14/08/23 were approved.

1.4 The IDC Chair's Report (Aug 23) was approved.

1.5 A summary of the discussions held, assurance received and areas for escalation are outlined below for the Board's consideration:

1.5.1 System Operational Plan Dashboard

The Director of Delivery & Transformation presented key points of note from the Operational Plan dashboard for M4 including:

- Cat 2 ambulance performance remains ahead of the local improvement trajectory but worth bearing in mind that there has been a deterioration in performance during August.
- A&E attendances are slightly under plan, but admissions are slightly above plan at 7.8% cumulatively.
- VW occupancy levels, particularly for step-down patients, remain low and is part of an ongoing discussion.
- We are tracking behind plan on the value-weighted activity which presents a significant issue given the financial implications around ERF.

- We are now in a really strong position in terms of 104, 78 and 65 week waits with impressive performance improvement although a little concern beginning to surface regarding 65 week waits at RJAH.

- Cancer remains a significant challenge particularly with regard to the FDS position although strong performance on the backlog.

- There are particular risks related to endoscopy.

- Primary Care is ahead of plan for total appointments but slightly behind on recruitment of ARRS posts.

The Director of Delivery & Transformation reminded the IDC that the dashboard is intended to provide focus and areas for further discussion, some of which would be addressed in more detail elsewhere on the agenda.

1.5.2 LCTP - VW Escalations
The SRO for the VW programme presented an update on Virtual Ward and some of the issues currently being addressed:

- Whilst capacity has continued to increase in line with the trajectory, activity is not as expected so the % occupancy level is dropping.

- In August, step-down referrals were significantly below plan due to a number of factors including availability of the VW consultant and the time needed to bring about a change in clinical culture.

- A further issue has been not just in the level of demand but in the complexity of demand with higher than expected numbers of patients that require multiple calls per day

  A number of actions have been agreed to address this such as work of VW champions, targeting wards that are likely to deliver greatest impact, stronger clinical leadership and including VW as part of Junior Doctor induction.

The IDC posed a number of questions regarding the criteria for VW and whether there was a full understanding of that via the Single Point of Access.

The VW SRO agreed actions to undertake a rapid audit of the SPA directory to ensure accuracy and to follow up with more comprehensive reference material that will be regularly updated.

The IDC further requested a review of SPA activity that SaTH has agreed to undertake utilising improvement resource.

The Director of Delivery & Transformation expressed concern that given the current position and challenges, improvement was unlikely to bring the VW back to plan in 23/24. The SRO confirmed that whilst the focus now was to get back to the position expected for July, it was unlikely that the programme would deliver on plan in 23/24.

The NHSE Improvement Director offered some support in connecting with another trust that could share some learning and agreed to link in respective Medical Directors.

1.5.3 Planned Care Update
The Director for Elective Recovery presented key highlights from the Planned Care update including:

- All but one of the 104-week waits has been cleared.
- 78 week waits reduced considerably although not quite cleared to zero by end August although it is expected that by end September, all but one will be untreated.
- 65 weeks is then next significant target and is very close.
- A key focus of work for the PCDB has been in developing changes to the Outpatient Transformation programme to drive it forward at greater pace.
- Implementation of changes to patient choice that requires an offer of 5 different providers.
- FDS trajectory was presented to NHSE at end August that indicates it will be back on track by end March 2024.

Two key risks were flagged to the Committee in the value-weighted activity and the financial impact in respect of ERF and the ongoing industrial action.

The SaTH COO raised a significant risk around specific medical specialties in terms of achieving the 65-week target by end October, specifically cardiology which is a very fragile service. Discussions are underway to enter into a collaboration for cardiology services and alternative short and medium term measures are being considered.

The IDC noted the risks escalated in terms of the impact of value-weighted activity on ERF and the challenges within cardiology services and recognised the mitigations in place for monitoring.

1.5.4 UEC Board Update
The IDC received a verbal update on the UEC Board given very limited turnaround time for a formal paper**.**

Two areas were brought to the attention of the IDC specifically:

i) **Sub-Acute Ward** is due to come on stream on 1st January but there are a number of key risks to that including:

- Need for a more detailed mobilisation plan.
- Planning permission has not yet been received so capital changes are at risk.
- Recruitment has not yet started, there is no clear recruitment plan and marketing campaign.
- Impact of recruitment on volatility of services

So, there is significant work required in order to ensure achievement of the 1 January mobilisation date.

The IDC discussed resources available to complete the work and agreed a number of actions and timelines:

- Documentation relating to the **Sub Acute Ward** including Milestone Plan, Recruitment Strategy and Plan, Integrated Impact Assessment and fully detailed Business Case and Risk Register to be presented to the Operational Delivery Group on 20th Sept and subsequently UEC Delivery Board

ii) Cessation of **Hospital Discharge Funding** and the impact on discharges going forward – both T&W and Shropshire Council have clearly set out their position including cessation of services from as early as October that will require giving notice to providers as early as this week.

Discussions are taking place across all STW partners and other funding options being considered. However, the IDC was asked to note the very significant risk that may result in patients not being able to move through the pathway in numbers that may precipitate a critical or major incident.

1.5.5 Primary Care Improvement & Transformation

A paper was considered by the IDC to include an additional sub-group into the Committee at the same level of detail and contribution as the UEC DB and the Planned Care Board. This is in recognition of the national drive to elevate the primary care access and improvement to the same level of focus and UEC and elective recovery work.

The paper set out the proposed governance structure, the lead sub-group and 7 workstreams that will sit within the IDC infrastructure that will serve as the point of oversight and delivery assurance.

The IDC fully supported the proposal and agreed an action that the IDC ToR should be updated to reflect the incorporation of Primary Care Improvement & Transformation.

1.5.6 Financial Improvement Programme

The Head of PMO provided an update on the FIP position at M4 and the mitigations in place to address the adverse variance of £2m YTD, primarily due to escalation costs within SaTH.

However, progress has been made in identifying plans to meet all of the core target and the unidentified stretch has reduced to £8.7M.

Pipeline plans continue to be developed but the overall £70M programme continues to present significant risk due to the level of efficiencies that are loaded to the final quarter of the year.

In terms of the ICB efficiencies specifically, an additional programme of work has been initiated by the ICB CEO with a focus on medicines management, CHC and the Elective Recovery Fund.

The IDC also noted that following a recent change in governance arrangements for key programmes, the ICB CEO will Chair the FIP group from October onwards to accelerate progress.

2.0 Recommendations

The ICB is asked to:

Note System performance reported within the **System Operational Plan Dashboard** and the inclusion of Primary Care performance.

Note that the **Virtual Ward** SRO has agreed to undertake an audit of the SPA directory and a review of SPA activity.

Note the risks identified through the **Planned Care Delivery Board** namely**:**

- Financial impact of value-weighted activity in terms of ERF
- Fragility of Cardiology Services and potential impact on cancer performance

Note the requirement for documentation relating to the **Sub Acute Ward** including Milestone Plan, Recruitment Strategy and Plan, Integrated Impact Assessment and fully detailed Business Case and Risk Register to be presented to the Operational Delivery Group on 20th Sept and subsequently UEC Delivery Board

Note the significant risk presented by cessation of **Hospital Discharge Funding**: Both Local Authorities continue to highlight the risk to the provision of services as a result of the gap between available funding and demand. Joint work is underway to secure and draw down national funding to help bridge the gap between capacity and demand along with mitigating actions being put in place to reduce the demand.

Note the IDC approval to incorporate **Primary Care Improvement & Transformation** as a sub-group within the governance structure of the IDC and the requirement for the IDC ToR to be updated to reflect the change.

Note the changes in governance for key transformation programmes including the ICB CEO to Chair the **Financial Improvement Programme** from October.