Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board - Appendices

MEETING
27 September 2023 14:00

PUBLISHED
22 September 2023

Agenda

Location	*Date*	*Owner*	*Time*
The Reynolds Suite Holiday Inn Telford International Centre Telford St Quentin Gate Telford TF3 4EH	27/09/23		14:00

1. CEO Report

2. ICS Digital Strategy 2023-26

3. NHSE Delegation of Specialised Commissioning - Pre Delegation Assessment Framework

4. STW ICS People Collaborative

5. Integrated Care System Performance Report:

6. Quality and Performance Committee Chair's Report for meetings held on 25 May and 29 June 2023

7. Finance Committee Chair's Reports for meetings held on 30 May and 26 June and 27 June 2023

Contents

Classification: Official

From the office of Rebecca Farmer
Director of Strategic Transformation

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27 July 2023

By Email:

Neil McKay
Chair
Shropshire, Telford and Wrekin Integrated Care Board

Dear Neil,

Annual assessment of Shropshire, Telford and Wrekin Integrated Care Board's performance in 2022-23

As you are aware NHS England has a legal duty to undertake an annual assessment of Integrated Care Board (ICB) performance with respect to each financial year. This is in line with section 14Z59 of the NHS Act 2006 and as amended by the Health and Care Act 2022.

The annual assessment is focused on your organisation's performance against those specific objectives set by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and the wider role within your Integrated Care System (ICS) across the 2022/23 financial year. The evidence to support the assessment has considered your ICB's annual report and accounts; available data; feedback from stakeholders and the discussions that NHS England has had with the ICB and the wider system during the year.

The assessment has also considered your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS.

Annex A contains a detailed summary of the areas where the ICB is displaying good or outstanding practice and areas which further progress is required along with support or assistance being supplied by NHS England to facilitate improvement.

The assessment recognises the relative infancy of ICBs, having only been statutory bodies for nine months of the 2022/23 financial year, and the developing local strategic aims of ICS' set out in the Integrated Care Strategy for your system and articulated through your recently published Joint Forward Plan. 2022/23 has been a transitional year and you have had to balance the demands of establishing the new organisation with supporting service delivery.

Overall, you have made good progress over the last year and there are several areas of good practice. However, there are also areas of greater challenge and areas for the ICB to focus its improvement activity on in the coming year. In particular, there remain key challenges for the ICB to address before exit from the NHS England Recovery Support Programme can be supported.

Please could you share the assessment with your leadership team and consider publishing this alongside your annual report at your Annual General Meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments as part of its 2022/23 Annual Report and Accounts.

Thank you for all of your work during 2022/23 in what remain challenging times for the health and care sector.

Yours sincerely,

Rebecca Farmer
Director of Strategic Transformation, NHS England (Midlands)

cc. Simon Whitehouse, Chief Executive Officer, Shropshire, Telford and Wrekin Integrated Care Board
Dale Bywater, Regional Director, NHS England (Midlands)
Steven Redfern, Assistant Director of Strategic Transformation, NHS England (Midlands)

Annex A: detailed assessment

Section 1: System leadership

In its first year of operation post establishment, the ICB has developed its leadership approach with a particular focus on the development of Place-based Partnerships and Primary Care Networks (PCNs). Place-based partnerships are making good progress, examples of which include work on annual health checks for people with learning disabilities, physical care plans for children and young people, approaches to address drug and alcohol dependence, and the development of Social Prescribing, as well as integrating with Primary Care services.

The ICB has made good progress with developing its approach to governance and leadership and both the Joint Forward Plan (JFP) and the Integrated Care Partnership (ICP) Strategy make reference to governance improvements and potential gaps, for example, the JFP includes commentary on intention to "strengthen the consistency of governance arrangements for reporting Health Inequalities" and the annual plan states that the Health and Wellbeing Boards have been involved in a collaborative approach to the JFP development.

The ICB has worked well with system partners and recovery from the pandemic has been led well, with the ICB approach to the vaccination programme being particularly highlighted as best practice regionally. The ICB supported The Robert Jones and Agnes Hunt Orthopaedic Hospital FT in the removal of its NHS Undertakings related to inadequate infection prevention and control. During 2022/23 there was a Successful SEND review of Telford and Wrekin council resulting in level 1 for the joint OFSTED and CQC inspection and a significant improvement in the Shropshire equivalent inspection.

There are close links with the VCSE and Healthwatch. Both groups are actively involved in the work undertaken by the ICB and are an essential part of the design and development of the system.

The ICB has developed and published its clinical strategy, with involvement and agreement of partner medical directors. Terms of Reference, risk register and minutes of the Quality and Performance Committee indicate an emphasis on clinical safety and quality from the ICB nursing and medical leadership. There are also other examples in the annual report which evidence the ICB approach to clinical leadership of improvement programmes and a newly established Integrated Delivery Committee with Nursing representation specified although attendance has been variable.

The ICB has committed to collecting the views from a range of residents, including patients, the public, carers, and stakeholders from across the region. This includes listening to the views from protected characteristic groups. The ICB's engagement

strategy is recognised as being clearly laid out and accessible with a clear articulation of strategy and decision making, capacity building and reducing inequalities. Further development would be to make a clearer connection to the ICB's wider strategic priorities and challenges and how improved work with people and communities could help to address these.

The ICB and Shrewsbury and Telford Hospitals NHS Trust (SaTH) were placed in the Recovery Support Programme (RSP) in August 2021 and segment 4 of the NHS Oversight Framework (NOF). Whilst both provider and system have made progress towards delivery of the exit criteria in 2022/23, there is much work to be done in 2023/24 to meet RSP exit criteria. Several risks remain to RSP exit, including financial delivery and SaTH's CQC overall rating of 'Inadequate'. Formal governance arrangements for the RSP are in place between NHS England and the ICB for SaTH, via the Safety, Oversight and Assurance Group, and the ICB, via the Improvement Review Meetings.

Section 2: Improving population health and healthcare

The ICB has demonstrated its duty to improve the quality of services through a System Quality Group which is well-established and reports to the ICB Quality and Performance Committee. There is evidence that the System Quality Group is effective in managing safety concerns and ensuring actions take place. The ICB has embedded the NQB guidance on risk and escalation and there is evidence that this has been utilised to escalate issues within the System and to Regional Quality Group. However, there are limited examples given as to how the ICB has improved services and limited reference to ongoing work to strengthen quality improvement.

The ICB has made improvements in elective and cancer services and backlogs have continued to reduce. However, there is further work to do moving into 2023/24, particularly in relation to the eradication of the longest waiting patients for elective care and cancer. There are ongoing challenges into 2023/24 in performance and recovery within the core areas including cancer, diagnostics (especially endoscopy) and UEC flow. Effective and timely discharge remains a key concern for the system and its providers.

In July 2022 the Strategic Outline Case for the Hospital Transformation Programme (HTP), which focuses on acute service review and sustainability, was approved (with conditions). The HTP Outline Business Case is currently scheduled for review in Quarter 2 2023/24. The HTP remains a core strategic pillar for the ICB alongside the Local Care Transformation Programme (LCTP).

The ICB has delivered measurable improvements in timely access to Primary Care. GP appointments overall exceed the 2019 baseline and the ICB has made good progress on recovery of face-to-face appointments. The ICB has also shown

significant increase in referrals for GP to community pharmacist and met its ARRS target.

The ICB has participated in the national Place Development Programme which included a Population Health Management (PHM) development module. The system also has a digital PHM platform however further momentum is required regarding digital development to maximise identified opportunities. The ICB approach to PHM is still developing and joint PHM posts with each Local Authority are planned. There is a PHM SRO within the ICS structure but reporting lines and working group arrangements are in development.

Section 3: Tackling unequal outcomes, access and experience

The annual report outlines the need for revised governance across the ICB. The decision was made to not establish a Health Inequalities Board in March 2022 and instead take a dispersed approach to tackling Health Inequalities, which has not been effective. However, it is positive that the ICB has recognised this and taking action to review and strengthen governance arrangements in early 2023/24. Opportunities to strengthen performance reporting should also be reviewed to ensure that monitoring and actions to improve Health Inequalities are effective.

The two Local Authorities have mobilised digital projects dedicated to improving digital literacy within vulnerable groups through the recruitment of Digital Champions. At present digital inclusion data is being reported based on type of contact. Further work to mitigate digital exclusion is required and a plan to support the system approach should be developed.

The ICB has promoted preventative programmes aimed at those with greatest risk and the impact of this can be seen in several areas. Work has been undertaken across a wide range of areas, for example: Faster Cancer Diagnosis – Project B cancer champions; Annual Health Checks for Severe Mentally Ill patients and Hypertension case finding.

Section 4: Enhancing productivity and value for money

The ICB did not achieve financial balance in 2022/23 and faced challenges in delivering its efficiency plan. The financial plan for 2023/24 is an agreed deficit plan which is ambitious and has several associated risks to delivery. The agency threshold for the system was exceeded and there is work underway for 2023/24 to reduce agency spend, with ambitious targets for providers in place for this year. Further financial reporting and controls are required during 2023/24.

The ICB has evidenced strong delivery of its duty to promote and use research. The Chief Medical Officer is the Executive lead for research. An ICS Research and

Innovation Committee has been established, with an independent Chair, which includes all NHS partners, Local Authorities, National Institute for Health and Care Research Clinical Research Network West Midlands (NIHR CRN WM), West Midlands AHSN, two Universities (Keele and Staffordshire) and lead VSCA partners. There are formal links with Staffordshire and Stoke on Trent ICS for research and innovation via the Staffordshire and Shropshire Health Economy Research Partnership (SSHERPa), which is hosted by Midlands Partnership FT. The research strategy has been developed in draft form and will be approved in 2023/24. There is a formal ICS mechanism for monitoring research participation in place via NIHR CRN WM.

Section 5: Helping the NHS support broader social and economic development

The ICB, as an anchor institution, has contributed to the wider ICS anchor system which supports economic and social development, for example, the ICB is leading the ICS work with the Healthcare Support Worker Academy at Telford College to promote careers in health and care to local young people maybe without formal qualifications and/or from more deprived communities.

The VCSE sector brings considerable resource as well as influence and is a core part of service delivery in the ICS, with between 21% and 30% of the VCSE sector already providing health and wellbeing services. The ICB and VCSE sector have co-produced and signed an MOU with the next step to develop a VCSE Alliance to strengthen the partnership.

The ICB and its partners have an agreed Green Plan and have established governance for delivery of the plan. The ICB has a Green executive sponsor at ICB Board level and engaged Programme support. The annual report describes the ICB approach to reducing environmental and emissions targets and emissions reduction actions are also referenced throughout the document in supporting sections such as medicines.

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Appendix 3

NHS Shropshire, Telford and Wrekin ICB

Briefing Paper
September 2023

NHS England Fit and Proper Person Test Framework for Board Members

Introduction

1. The purpose of this paper is to provide the Integrated Care Board (ICB) with an overview of the Fit and Proper Person Test (FPPT) Framework, NHS England (NHSE) which has been developed in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review).

2. The purpose of the (FPPT) Framework is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

3. The Framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

4. As part of the Framework a standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks. A standard template for the board member reference is included in the attached guidance documents at Appendix 2.

5. The Framework is effective from 30 September 2023 and should be implemented by the ICB going forward from that date.

6. The ICB is not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

Applicability

7. The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

8. Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

9. The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

10. It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

11. Within this guidance, the term 'NHS organisations' refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- Integrated care boards (ICBs)
- the following arm's length bodies in the first instance:
  – Care Quality Commission (CQC)
  – NHS England.

12. ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members. Where partner members are not employed by the ICB, they can agree to seek assurance from employing organisations that the partner member has undergone a satisfactory FPPT or can choose to request that the partner member completes the assessment via the ICB.

13. A documented, full FPPT assessment by the employing ICB against the core elements *(good character, possessing the qualification, competence, skills required and experience, financial soundness)* will be needed in the following circumstances:

a) New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers: new appointments that have been promoted within an NHS organisation.

b) Temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis.

c) Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.

d) Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

e) When an individual board member changes their role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g., chief financial officer).

f) Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points a, b, c, and d above (new appointments) the full FPPT will also include a board member reference check.
For points e and f above, the board member reference check will not be needed.

Personal Data

14. Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual's own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

15. The launch of the framework will require the ICB to communicate with Board Members that their data will be held in ESR in advance of the new requirements going live from 30 September 2023. An Privacy Notice, based upon a template attached to the guidance documents at Appendix 6 has been developed for the ICB.

16. The information that will be held in ESR is described in the FPPT Checklist which is at Appendix 7 in the attached guidance documents.

Role of ICB Chair

17. The Chair is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of the ICB is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.
b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation. Template documents for the annual self-attestation by individual board members and the annual FPPT report submission are included in the attached guidance documents at Appendix 3 and Appendix 5 respectively.
c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.
d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.
e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.
f) On appointment of a new board member, consider the specific competence, skills, and knowledge of board members to carry out their activities, and how this fits with the overall board.
g) Conclude whether the board member is fit and proper.
h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5 of the attached guidance documents) to the relevant NHS England regional director.

18. It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

19. The Chair is also subject to the same FPPT requirements and confirming they have been subject to them.

Outcome of FPPT assessment

20. Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure. – Where this results in a board member being terminated from their appointed role, a BMR (board member reference)** must be completed and retained by the local organisation in accordance with the Framework.

- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first. – NHS organisations may wish to take their own legal advice or seek advice from NHS England.

21. At any point, employees have the right to take the matter to an ET*.

** Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.*

*** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.*

Quality assurance and governance

22. To ensure that the FPPT is being adequately embedded within the ICB there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

CQC quality assurance

23. The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations.

NHS England quality assurance

24. NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

Internal audit/external review

25. Every three years, the ICB should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

Governance

26. For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- Update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

1. CEO Report	2. ICS Digital	3. NHSE Delegation	4. STW ICS People	5. Integrated Care	6. Quality and	7. Finance

Integrated Care System

Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin

DIGITAL ICS STRATEGY 2023-26

FINAL Draft – for approval

Forward

Sir Neil McKay

Chair

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Developing digital capabilities that support people's health and wellbeing, and enabling the workforce to deliver best care underpins all elements of Shropshire, Telford and Wrekin Integrated Care System's Strategic Plan"

Simon Whitehouse

Chief Executive

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Digital transformation and the insight it unlocks can improve health and care outcomes. This strategy is a pledge by all ICS partners to embrace technology and use it to help people access the best health and care services for them, at the right time.

By ensuring that our partners have the right technology, system and skills in place we will be able to provide a better work environment where we can deliver safer care.

Using technology, will enhance our citizen's ability to participate in all elements of their care and data, giving better access to information and best practice advice and guidance. This will enable us to focus more on supporting people in their home when that is the more convenient and safer to do so."

Dr Nick White

Chief Medical Officer

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Clinical colleagues across the system face many challenges delivering care on a day-to-day basis – digital solutions described in this strategy will support improvements in care.

The potential for what we can achieve by having joined-up digital and technology programmes between healthcare and other public bodies is immense.

Better and faster sharing of information between citizens, patients and staff gives people a better experience and makes services more efficient. Digital tools that capture information or carry out analytical tasks will help increase safety and quality."

Digital transformation can realise our collective ICS ambition

Dr Masood Ahmed

Chief Digital Information Officer
NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"We will use digital to improve care for citizens, support our staff and enhance how we work together as an Integrated Care System delivering our collective ambitions."

At the heart of our digital journey in the Shropshire, Telford and Wrekin Integrated Care System (ICS), you'll find our most important driving force: you, our community members. Our mission is to weave technology into health and care in a way that enriches all our lives.

We are committed to a "digital-first, but not digital-only" philosophy, taking into account the genuine impacts on healthcare equity. Guided by national standards, we're committed to ensuring no-one is left behind as we navigate the digital tide.

We're aligning our digital initiatives with broader national objectives, striving to create a healthcare experience that meets your needs and expectations. Our diverse portfolio of programs tackles specific digital challenges, all anchored in our larger vision of enhanced community healthcare and reduced digital exclusion.

We're laying the groundwork for a more intelligent, seamlessly connected health and care system. We aim to deliver consistently excellent, easily accessible care transformed by digital innovation and inclusive by design.

My GP, mental health and community support workers are aware of my care needs as they receive high-quality information

I can book my appointments online and have secure video consultations with my GP and hospital

I can securely access my care record and get my test results digitally

I can access information I need from multiple devices, locations & organisations

I can receive care from the comfort of my home

I can access data enabling me to make better decisions about the care of my patients, including children and young people

Our ICS' challenges and ambitions give us focus for prioritisation in digital

An ambitious vision for person-centred, integrated care is central to our Integrated Care Strategy in Shropshire, Telford and Wrekin (STW). Our Joint Forward Plan lays out the practical steps to realise this vision, with our Digital Strategy serving as a critical enabler. Specifically, we aim to address health inequalities and counteract digital exclusion.

Our primary care providers have transitioned predominantly to electronic medical records, laying a solid foundation for digital maturity. As we move toward a system-wide transformation, we remain deeply committed to delivering an equitable and optimised health and care experience for our entire community.

Locally, our ICS faces significant challenges when compared to national averages:

- Currently STW is in segment 4 of the National Oversight Framework which means the ICS has very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support
- The system has a significant deficit that cannot be closed through traditional cost efficiencies
- We have a population and workforce that is ageing and living with more complex needs
- We have a workforce shortage due to unfilled vacancies, poor retention & high sickness rates
- Continuing quality concerns and inefficiencies at our acute trust

We are on a journey to increase our digital maturity

- SaTH's Digital Strategy makes a self-assessment of Level 1 on the HIMSS Electronic Medical Record Adoption Model (AMRAM)
- The system's digital exclusion level exceeds that of the national average
- We have an ageing estate across the system – community hospitals, primary care, Shrewsbury and Telford Hospital, Local Authorities
- We are silos based with digital services and digital management being delivered out of each organisation
- The geographical area of STW has seen digital challenges with rurality, an ageing population and high levels of deprivation

Our ICS

- *NHS Shropshire, Telford and Wrekin ICB*
- *51 General Practices formed into 8 Primary Care Networks*
- *Shropshire Council*
- *Telford & Wrekin Council*
- *The Shrewsbury and Telford Hospital NHS Trust*
- *The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust*
- *Shropshire Community Health NHS Trust*
- *Midlands Partnership University NHS Foundation Trust*
- *Care homes and hospices*
- *Community Pharmacies*
- *Optometry & Dental Practices*
- *The voluntary sector and other core partners, such as Imaging and Pathology Networks*

We want to design a health and care system that puts citizens and patients' needs first

Digital can enable the ICS to deliver effective and safe care for the citizens of Shropshire, Telford and Wrekin.

A two-way street of communication with you, our community members and patients is essential to our progress. We're all ears regarding understanding the issues that impact your lives and healthcare needs.

Using technology as a bridge, the partners across our region are uniting to realise your aspirations for a health and care system that meets and exceeds your expectations.

Importantly, as we chart our digital course, we're not going it alone. Both the voices* of our community and our dedicated staff serve as guiding lights, ensuring that our digital priorities are firmly rooted in the needs and insights of those we serve.

** These voices have been captured via numerous engagement routes with citizens, reflecting current feelings surrounding digital transformation within the ICS.*

"

My prescriptions are paper-free if I want them to be

All care providers have the most up to date information to provide consistent, reliable, high quality care

My digital experience is tailored to my needs & appropriate for my digital skills

I can contribute information to my healthcare record

I can easily access services that meet my needs via an online directory

My local hospital is modern

"

I can turn up for my blood test without a paper referral copy. The phlebotomist will know what tests I have been referred for and by whom

I know that my clinician has the most up to date information about my care & treatment plan

I am confident my care & personal information is safe & secure

I want my family and me to feel supported at the end of life

I can get access to my test results and status digitally

I can access Wi-Fi throughout the hospital

"

I only have to visit the hospital when I really need to

I have access to information about my care and treatment in a format that I understand

I can receive care from the comfort of my home

Clinicians and nurses can spend more time with me

I can book appointments online, when it suits me and without waiting a long time

I do not have to repeat myself

We will use digital to enable our workforce to deliver effective care

We will support all ICS partners to equip colleagues with the right tools and skills to allow them to focus on effective delivery of care to
our communities.

We're committed to rolling out digital services that empower our staff to deliver outstanding patient care and related services. Our eyes are always on the horizon, looking for innovative ways to enhance what we offer while ensuring our team is fully equipped to tap into the potential of these advancements.

Central to our strategy is the intelligent use of data. We'll leverage data-driven insights to fine-tune clinical quality, steer service planning, and manage organisational performance, all to elevate the care experience for you: our community.

"

Aspects of my work are automated, letting me focus on delivery

I can provide and receive effective handovers, supported by digital presentation of data

I can record and analyse information about patient outcomes and experience

I receive alerts or notifications that help me to safely & effectively care for our patients

I can access data that enables me to make better decisions about the care of my patients

We use digital insights to identify what we do well and what we can improve on

"

I only need to log on once to access the information I need

My work is automatically saved and readily accessible

I have the digital tools and skills to work effectively on site and remotely

I can view the results of tests for my patients even when they have been performed outside of this Trust

Patient records are 'digital-first' and I have minimised or eliminated the use of paper

I can access information I need from multiple devices & locations

IT support my needs and I feel involved in digital change

"

I am supported to use new digital solutions

I can view patient records in a way that is meaningful to me

I can access information I need from multiple devices, locations and organisations

I can capture information at the point of care

There is a single point of contact for any digital issues

I can easily request consultations & diagnostic tests digitally

I can share information easily with my colleagues

Our health and care organisations will benefit from taking a digital approach to delivering services

We will use technology that capitalises on effective data management and implementing innovation.

Digital tools will ensure we offer care that's not only safe and clinically sound but also creates a positive experience for you, our patients. These digital advancements will guide our ICS toward sustainability and cost-effectiveness, future-proofing our services for the foreseeable future and beyond.

Through careful data capture on our community, we'll enable more personalised support, thanks to our focus on population health management.

Our strategy is in perfect harmony with the ICS's ambitions. We're committed to delivering exceptional care to our communities, all backed by robust and seamlessly integrated technology.

"

We are striving to be a paper-lite ICS

Data returns are automated and submitted electronically

Our clinicians are involved in digital decision making and influential in shaping the future of digital

We work together to ensure our services are cost effective

"

Services are better connected, resulting in more efficient and effective data analysis

Our systems and services are modelled to meet future demand

We can manage, in real-time, our resources or assets across the ICS

Collaborating lessons learnt and resources in relation to key digital programmes

Medical Devices are secure and free of cyber threat

We co-ordinated an infrastructure collaboration group across the ICS

"

We have a single source of truth

Systems and hardware are safe from Cyber Security threats 24/7

We are able to share patient information between services safely and securely

Procurement and contract renewals are streamlined and converged where possible across the ICS

Test results can be captured electronically from anywhere within the ICS

Our decision making is data-led

Our prioritisation for investment is driven by national ambition

We will prioritise how and where we invest in digital across Shropshire, Telford and Wrekin Integrated Care System.

Nationally, the NHS is focused on meeting future challenges and investing £2 billion to support Digital Transformation. The Secretary of State for Health and Social Care set out in the *Plan for Digital Health and Social Care (June 2022)* the minimum digital foundations expected of all health and social care providers in England.

The national ask of us as an ICS is that we support our health and care organisations to work together to meet digital expectations, including:

- The core capabilities set out in The Frontline Digitisation Minimum Digital Foundations (MDF)
- Implementing standards defined in the *What Good Looks Like (WGLL)* framework for digital services
- Enabling providers to work towards *Level 5* on the *HIMSS EMRAM maturity model* to strengthen performance
- Develop a comprehensive digital strategy for the ICS, which includes a clear vision and objectives for the use and innovation of digital technology as per the *Hewitt Review*
- Establish a digital & data architecture for the ICS, whether this is locally or nationally, aligning to both the *Hewitt Review* and STW Population Health Management Strategy
- Invest in digital skills training to increase digital competencies across the workforce, improve the use of data and analytics that support clinical decision-making, and improve the patient experience as per the *Hewitt Review* and *Fuller Report*
- Deliver the operational planning guidance priority of mitigating digital exclusion
- Support alignment with the social prescribing information standard

As care providers, we are committed to delivering the NHS Long Term Plan, which emphasises transforming care through digital tools and data.

These national frameworks provide a structure for planning digital delivery and focused investment prioritisation.

We will work with NHS England to ensure that the STW ICS digital transformation programme meets the needs of national funding priorities and the e standards.

Our Digital Strategy will be considered against the 'What Good Looks Like' framework:

WELL-LED
A clear strategy for digital transformation & collaboration, with citizens & frontline perspectives at the centre.

SMART FOUNDATIONS
Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient.

SAFETY
Organisations maintain the standards for safe care set by the Digital Technology Assessment Criteria for health and social care.

QUALITY
Sharing information between organisations, technologies that support safer care, and developing analytical capabilities to support learning, knowledge generation, decision support and safer systems.

SUPPORT PEOPLE
We have a workforce that is digitally literate and able to work optimally with data and technology.

IMPROVE CARE
Citizens are at the centre of service design, with access to a standard set of digital services that suit all literacy and digital inclusion needs.

HEALTHY POPULATIONS
Embeds digital and data within our improvement capability to transform care pathways, reduce unwarranted variation and improve health & wellbeing.

EMPOWERING CITIZENS
We use data to design and deli improvements to population health and wellbeing, making t best use of collective resources. The insights we produce from d are used to improve outcomes a address health inequalities.

Our ICS' challenges and ambitions give us focus for prioritisation

To tackle these challenges, the ICS recognises a number of high level priorities that are reflected within the ICS Strategy and Joint Forward Plan. These include:

Transformational recovery of the six clinical priority pathways: Urgent and Emergency Care (UEC), Cancer, Cardiac, Diabetes, MSK and Mental Health (*STW Clinical Strategy, March 23*). The clinical strategy has been developed to set the clinical priorities and associated objectives to deliver a 2-year clinical service improvement programme. This is a crucial criterion for exiting segment 4 of the national oversight framework.

Complete alignment and delivery of the two large-scale transformation change programmes Hospital Transformation Programme, which includes the implementation of a new EPR system at SaTH and RJAH and the Local Care Transformation Programme, such as delivering Virtual Wards to deliver a sustainable health and care system for the residents of Shropshire, Telford and Wrekin, or deliver digital solutions for children and young people's mental health services, as well as adult mental health transformation.

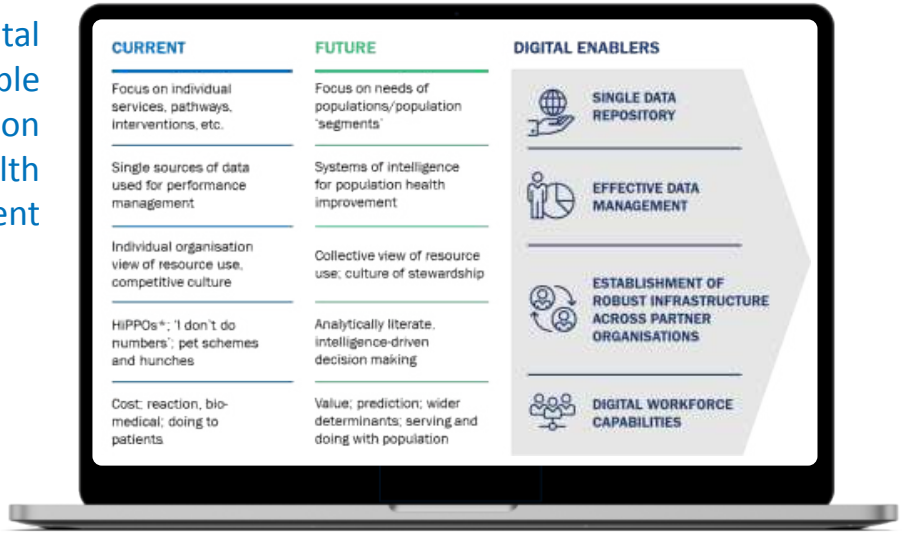
Service recovery including efficiency and productivity improvement.

Population Health Management (PHM) with digital and data at the heart of improving patient outcomes; this will support PHM by establishing a workforce analytics team to support the analytical requirements for PHM. Additionally, Identifying a solution for an 'Engine Room' for a single data repository across the ICS.

Delivery of ambitions in NHS Long Term Plan, including Prevention, Reduction of Health Inequalities, and Joined-up Coordinated Care.

How digital can enable the clinical strategy ambition

How digital can enable Population Health Management



Digital can act as an enabler to the ICS in meeting our key challenges and ambitions.

Our Digital Strategy makes the following pledges for the next three years:

1. Committed to reducing Digital exclusion and inclusive by design
2. Collaborative working across the ICS
3. Sharing resources & meeting workforce challenges together
4. Improved reporting capabilities & confidence in source of truth
5. Improved Cyber Security capabilities & infrastructure
6. Single technology where possible
7. Compliant with national standards and regulations
8. Agreed approach to procurement and contracting

We will be realistic in what we can achieve over the next three years

Our next three years will build upon our collaboration to date and focus on how we can support our organisations to meet national expectations and deliver against local priorities.

Not all of our current digital portfolio programmes are live, resourced or funded. We have no new budget for 2023/24, and we are operating in a financially constrained environment where Integrated Care Boards are having to assess and manage finances to continue to be sustainable. We have a pragmatic and realistic approach to bidding for additional NHSE funding.

As an ICS, we will structure and coordinate around the digital portfolio and make decisions together. In doing so, we can protect our staff's time by prioritising their workload and sharing our resources.

We, therefore, will be realistic in our ambition, deliver what we promise, and set the digital foundations that will enable future transformation and innovation.

Our Digital Strategy takes the needs of our citizens, workforce and organisations combined with the expectations of national bodies and regional partners to prioritise focus for investment and effort in digital over the next three years.

Despite our challenges we have proven that we can support each other to implement digital solutions:

RESILIENCE
Supporting staff to continue working during the COVID-19 pandemic through rapid deployment of home working solutions.

IMPROVED PATIENT EXPERIENCE
Introducing software to support online appointment booking & introducing virtual follow-up appointments for outpatients.

ENHANCING PERFORMANCE, SAFETY & SECURITY
Replacing ageing devices and infrastructure.

INCREASING COMMUNITY DIGITAL EXPOSURE
Allowing the digitally excluded citizens the opportunity to borrow an iPad to increase digital literacy.

IDENTIFYING DIGITAL LITERACY GAPS
Enabling the over 65's the opportunity to increase their digital literacy with citizens engagement events.

HOSPITAL OF THE FUTURE
Procurement of a network upgrade solution and commencement a two-year upgrade programme.

'AT A GLANCE' INFORMATION
Introducing digital tools to make it easier for clinical staff to see the information they need.

IMPROVING STAFF EXPERIENCE AND PRODUCTIVITY
Simplifying the sign on process for staff through single on software.

Our digital portfolio will enable us to put in place the core foundations to set us up for future transformation

The ICS will oversee the delivery of this digital portfolio for the next three years.

The digital pledges underpin the prioritised programmes, align to national frameworks and will enable the ICS to meet its local challenges and ambitions.

Most of these digital programmes will be managed and delivered by organisations and partnerships within the ICS.

DIGITISE
SAFE PRACTICE, SMART FOUNDATIONS, WELL LED

Electronic Patient Record
Level up access to electronic patient records & prescribing systems, allowing collaboration on implementation

Cyber Security
Ensuring that the ICS partners' cyber & support approach is robust & aligned

Infrastructure Optimisation & Alignment
Upgrade infrastructure across ICS and align technology, suppliers and processes to reduce variation

Digital Diagnostics
Providing joined up solutions to enable optimal diagnostic services at an Imaging and Pathology Network level

Outpatient Transformation
Supporting the digital delivery of outpatient care

Digitise Social Care
providers will adopt a Digitalisation of Social Care Records and care homes will install Sensory Based Fall equipment

CONNECT
EMPOWERING CITIZENS, SUPPORTING PEOPLE

Shared Care Records
Enabling clinicians and staff the ability to access patient records across multiple regions including Shropshire Telford and Wrekin, Staffordshire and the Black Country, and enhancing integration capabilities between primary, secondary and community care across the region

Workforce, Digital Inclusion and Leadership
Enable our workforce and community to thrive through a digital first approach to managing care and supporting transformational change: delivering on a strategy for the clinical & digital leadership, and managing a growing digital & clinical expert workforce

MSK Transformation
Enable a local integrated model using a digital system that standardises referrals, joins up records and creates a single point of access to the service

TRANSFORM
HEALTHY POPULATIONS, IMPROVING CARE

Local Care Transformation Programme
Expand technology such as Virtual Wards to support treatment and care at home and prevent health issues escalating in vulnerable or at-risk groups, and embed electronic prescribing across the system

Citizen Inclusion
Offering greater digital choice for how citizens can access & manage health and care services

Hospital Transformation Programme
Substantial investment into transformation hospitals digitally to deliver a sustainable health and care system for the residents of Shropshire, Telford and Wrekin

Population Health Management
Using digital and data to accurately predict and understand current health care needs and what the local population will require in the future

Collaborative ways of working and model for digital
Putting in place the right Operating Model, Standards and tools to foster collaboration

Data and Analytics
Enable effective data sharing, improve reporting capabilities and drive evidence-based decision making

Delivering this Strategy will allow us to work more collaboratively as an ICS

Most of our digital programmes will be managed and delivered by organisations and partnerships within the ICS.

Successfully implementing ICS digital change cannot be achieved by a single organisation. This requires all organisations as part of STW to unite as partners, challenge individual ways of working, and focus on finding solutions.

To aid this, we will embed sustainable ways of working to ensure we are all best set up to deliver the digital portfolio successfully. Our pledges align with our portfolio and will enable transformation to occur.

By adopting these ways of working, we are promoting continuity across the ICS and enabling all organisations and partnerships to streamline their approach to digital in the same manner. These ways of working encompass the key prioritised digital work programmes across the ICS and allow for a better and more sustainable future.

Ways of working to embed digital across the ICS

WORK FOR PATIENTS COLLECTIVELY FOCUSING ON CITIZEN INCLUSION IN ALL OUR DIGITAL DECISIONS

EMBRACE DIGITAL INTO OUR CULTURE

LEARN AND CONVERGE AS AN ICS

UPSKILLING WORKFORCE AND COMMUNITIES IN DATA LITERACY

GOVERN AND MANAGE OUR DIGITAL PORTFOLIO TOGETHER

COMMIT TO STREAMLINING PROCUREMENT ACROSS THE ICS

Embracing digital into the ICS Culture

As we forge our digital journey, significant transformations are on the horizon for our Integrated Care System. Over the next three years, we'll roll out large-scale digital initiatives, from new Electronic Patient Record (EPR) systems to infrastructure overhauls and enhanced cyber security measures. These changes will profoundly impact how we operate and communicate.

We must share lessons learned and actively reshape our organisational culture. We're challenging outdated modes of operation, aiming to become an ICS where digital tools aren't just facilitators of better care—they're catalysts that inspire our teams and organisations to communicate more effectively and deliver superior care across the entire system.

The culture principles our organisations and partnerships will adopt:

We support and empower our staff and citizens to understand the opportunities of digital ways of working

Staff and citizens are properly prepared for digital change

Digital Communications are honest, timely, relevant and engaging

Actions that our organisations and partnerships will embed to embrace culture:

- Organisations and partnership staff surveys to understand staff confidence and capabilities in digital.
- Digital change management programmes supporting the change in culture and help staff embrace and feel confident with new ways of working.
- Digital skills training to embed digital-first culture within the ICS.
- Super user programmes for ICS Wide digital programmes, which will enable staff to act as champions of new systems.
- Staff feedback sessions to input into digital expectations and current experiences.
- Hold regular digital meetings including a representative from all ICS organisations to raise issues, lessons learnt and direction.

Learn and converge as an ICS

To deliver digital initiatives across the ICS, transparent ways of working that empower collaboration and learnings from all organisations and partnerships across the ICS are required to embed a 'Joined Up' culture.

The momentum behind our Integrated Care System's Digital Transformation journey hinges on robust collaboration. By pooling resources, sharing hard-earned lessons, and aligning behaviours across organisations and partnerships, we're setting the stage for enhanced interoperability and higher-quality care and services throughout Shropshire, Telford, and Wrekin.

This collaborative ethos strengthens our ICS and fosters valuable partnerships with neighbouring ICS', ensuring patients experience a seamless and consistent continuum of care.

Actions that our organisations and partnerships will embed to embrace collaboration:

- EPR collaboration group to share lessons learnt, strategic direction and challenges.
- Infrastructure collaboration group to share lessons learnt, strategic direction and challenges.
- Post implementation teams to support the transition into business as usual and a managed service.
- Co-ordinate shared resources to make the best use of the capabilities and skillsets across the ICS.
- Converge Digital resources where possible to have one single point of contact.
- The ICS' Digital plans will support the overall ICS Strategy of being more joined up across organisations and partnerships.
- Collaborate across the ICS to learn and develop and seek opportunities for innovation.

Commit to streamlining procurement across the ICS

To ensure we provide all organisations with ‘value for money’, there is a collective ICS commitment to collaborate with current and future suppliers to procure hardware and software.

Our Integrated Care System is taking steps to future-proof our long-term supply chain strategy by reaching a consensus on a unified approach and shared goals. This will enable us to secure more enduring and sustainable contractual agreements across the ICS network.

We aim to amplify our purchasing power through a coordinated approach to market engagement and supplier selection, thereby forging more resilient and lasting partnerships that best serve our system's needs.

Actions that are required to embed a more streamlined supply chain:

- Coordinate a Contract renewal group that identifies opportunities for collaboration across the ICS.
- Streamline procurement and supplier service offerings across the ICS to achieve more significant economies of scale.
- Review contracts as a system to ensure the ICS is getting the best value for money and achieving purchasing power.
- Ensure decision-making is made at a system level and collaboration with procurement needs.
- Identifying each organisations current procurement & contract renewal to find opportunities for collaboration across the ICS.

Upskilling workforce and communities in data literacy

If, as an ICS, we want to embed a digital-first culture, we must ensure our workforce and community meets a minimum level of data, digital and cyber security literacy to enable this culture to exist within the ICS

As technology advances, it's crucial to equip our workforce across the ICS with the digital skills they need to excel. We're committed to upholding a baseline level of digital, data, and cyber literacy and will support staff in reaching this competency. Focusing on crucial strategies like 'Growing for the Future' and 'Looking after our People' will help cultivate an engaged, skilled workforce eager to develop alongside us, fostering a thriving work culture.

Simultaneously, we aim to empower our community to manage their healthcare digitally, streamlining our services. By encouraging community skill development and listening to citizen needs, we can custom-tailor digital engagement, making health and care more accessible and promoting a 'Digital First' culture.

Actions that are required to embed culture:

- Current capability analysis across ICS workforce and community digital, data and cyber security literacy via surveys.
- Support the workforce through training modules to increase data literacy.
- Utilising new and existing forums through all organisations and partnerships to work with the communities to increase digital health literacy.
- Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development.
- Provide a Digital resource with the mandate to support and improve staff digital literacy skills.
- Network of digital champions across the ICS to empower ‘Digital First’ mentality.

Work for patients collectively focusing on citizen inclusion in all our digital decisions

Creating an environment that encourages and empowers citizens' voices when making digital decisions will drive the innovation of the delivery of care. It will be a critical feature in the success of delivering digital transformation across Shropshire, Telford & Wrekin.

As our Integrated Care System matures digitally, it's vital to include citizens in shaping the future of digital healthcare, thereby helping us prioritise initiatives. Drawing on input from partners, clinicians, staff, and users allows us to pinpoint what's effective, what needs refinement, and what truly matters to our community in Shropshire, Telford & Wrekin.

Citizen engagement is a cornerstone of our ICS and aligns with the patient-centred ethos outlined in the recent Hewitt Review. Through interactive platforms like the 'Big Health and Wellbeing Conversation', we actively seek your feedback for service improvement. Council-led efforts further this aim; for instance, our local Councils are expanding community engagement with initiatives like the library tablet lending scheme and the 'Get Connect' Programme. These programs empower citizens, especially seniors, to navigate digital healthcare services comfortably.

Actions that are required to embed culture:

- Proactively seek community feedback on existing digital functionality for managing your own health, and input into digital developments.
- Develop an ICS Digital inclusion strategy adopting principles from the national strategy, where citizen engagement groups will be included.
- Identify the needs and preferences of the population across STW and use this insight to inform and develop digital strategies.

Embracing digital into the ICS Culture

We will adhere to the formal governance structures and ways of working of the Shropshire, Telford and Wrekin ICS and the Place Partnerships.

Our role is to assist our organisations in planning, executing, and refining digital services for our community. To do this, we'll offer unified strategic oversight across all digital transformation efforts detailed in this Strategy. This governance framework enables us to advocate for a system-wide approach to digital initiatives, ensuring they deliver value for money.

ICS organisations & partnerships

Digital programmes & digital enablement programmes

Digital decision making groups to bring programmes together

INTEGRATED CARE BOARD
Sets the strategy and determines budget. Provides overall decision making and alignment of strategies

ICS INTEGRATED DELIVERY COMMITTEE
Provide oversight and decision making in alignment with ICB strategic direction.

ICS DIGITAL DELIVERY GROUP
Recommendations and risk escalation up to IDC from the programmes. Decisions made and approved for Digital programmes to progress.

DIGITAL ENABLEMENT

MSK, LOCAL CARE

DIGITAL PORTFOLIO & PROGRAMMES

Electronic Patient Record, CYBER

PLACE PARTNERSHIPS

NHS PROVIDERS

PRIMARY CARE NETWORKS

LOCAL AUTHORITIES

The ICB will provide direction and programme management support across the digital portfolio

Chief Digital Information Officer function

- ICS Chief Digital Information Officer
- ICS Chief Clinical Information Officer
- ICS Chief Clinical Nursing Officer
- ICS Digital Programme Management Office

Aligning to What Good Looks Like guidelines we commit to investing in ICS-wide Chief Clinical Information Officer and Chief Nursing Information Officer functions. To deliver against this Strategy and to continue to improve our services through digital we need better digital cohesion, collaboration and coordination. We have identified vital interventions which are needed to take place in order to realise benefits:

- Increase ICB capacity to provide greater structure and oversight to enable effective decision-making aligned to the vision associated with national and local objectives. In enabling and prioritising a portfolio of work, there is an opportunity for financial efficiencies to be explored and realised.
- The ICS must define its digital vision and build capabilities to achieve short and long-term priorities. By creating a centralised workforce and enhancing current capabilities, the ICS can achieve the greatest value and build towards long-term strategic objectives with the future vision of a digital shared service.
- Establishing transparent governance within the ICS to ensure that the direction of travel is clear, staff are supported to deliver against priorities promptly, and there is appropriate accountability and decision-making.
- To achieve the desired digital transformation outcomes across the ICS, identifying opportunities for greater collaboration across all organisations will enable efficiencies across the ICS by sharing knowledge, processes and resources.
- STW ICS' approach to culture change must evolve to secure leadership, clinical and non-clinical buy-in, collaboration opportunities and citizen inclusion for the changes the Digital Strategy will deliver.

Contacts & Useful Links

For further information about the Shropshire, Telford & Wrekin (STW) ICS and our partner organisations across the health and social care systems, please see the links to the right to find out more about each organisation via their website. Additionally, you can find links to Organisations Digital Strategies.

The Shrewsbury and Telford Hospital Website

The Robert Jones and Agnus Hunt Orthopaedic Hospital Website

Shropshire Community Health NHS Trust Website

Midlands Partnership University NHS Foundation Trust Website

West Midlands Ambulance Service Foundation Trust Website

NHS Shropshire, Telford and Wrekin Website

Shropshire Council Website

Telford & Wrekin Council Website

Shropshire, Telford & Wrekin Primary Care Networks Website

The Shrewsbury and Telford Hospital Digital Strategy

Shropshire Council Digital Strategy

Telford & Wrekin Council Digital Strategy

Should you wish to contact STW ICS regarding this digital strategy or offer any feedback, please email: stw.generalenquiries@nhs.net

1. CEO Report	**2. ICS Digital**	3. NHSE Delegation	4. STW ICS People	5. Integrated Care	6. Quality and	7. Finance

Briefing Paper

Date: August 2023

Paper Title: Delegation of Specified Specialised Acute Service Lines

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Executive summary: This paper provides a summary of the process for the delegation of the 59 Acute Specialised Commissioning Service lines that are due for delegation to ICBs in April 2024

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1 Introduction and purpose of the paper

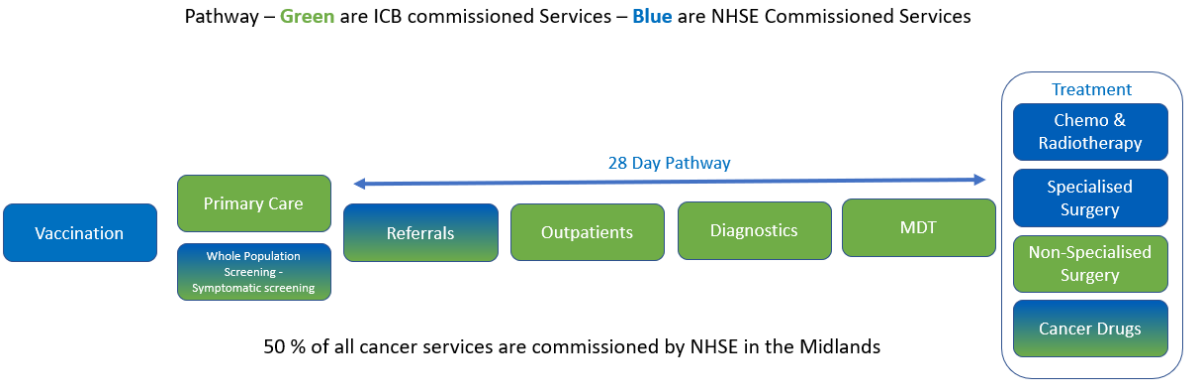
1.1 The commissioning of Specialised Services is a statutory function of NHS England and until the recent legislation NHSE could not delegate these functions to another organisation. However, the 2022 legislation enabled this.

1.2 Delegation means that NHS England will delegate its statutory functions to another organisation. 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.

2. What is delegation trying to achieve

2.1 The overarching aim is to bring the population resource closer to the populations served, breaking down organisational barriers across pathways of care. This is expected to reduce health inequalities, whilst improving the quality of health and care for patients, by ensuring that ICBs can strategically plan and commission services for their whole population.

2.2 The key objective of delegation is to join up fragmented pathways to improve outcomes for patients. The current cancer pathway illustrates fragmentation and opportunities for joint planning.



3. What services are being delegated from 2024?

3.1 There are 3 categories of specialised services illustrated below.

3.2 In April 2024 the 59 specialised Acute services in category 1 are being delegated to ICBs (see Annex 1). Specialised services include Acute and Mental Health, Learning Disability and Autism and specialised Pharmacy services.

3.3 There is currently no timeframe for the delegation of category 2 services. Mental Health Learning Disability and Autism and specialised Pharmacy services (as well as some additional Acute Services) are in category 2.

3.4 The delegation of specialised services will build upon experience and lessons learnt from the delegation of Pharmacy, Optometry and Dentistry. Each of the 11 ICB have senior representatives on current specialised commissioning groups and are active in the design and development of the approach to delegation.

3.5 Retention of the skills, knowledge and experience of existing teams and ensuring continuity of support and organisation memory of those operational teams remains a key priority.

3.6 Other services that NHS England commissions are:

- Screening services
- Vaccination services
- Health and Justice services

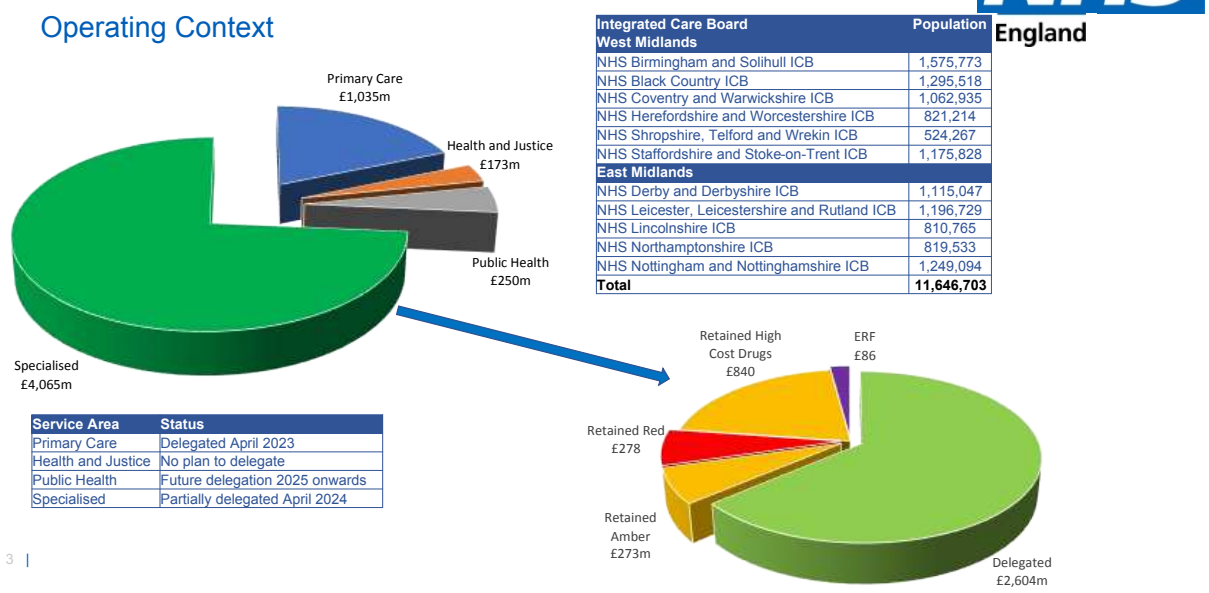
3.7 There is a national policy intention to work towards the delegation of Vaccination services in April 2025

3.8 Screening services may be considered for future delegation but there is not timeframe at present.

3.9 Health and Justice services will not be delegated.

4. Finance

4.1 The budget for these services will be transferred to ICBs upon delegation, ICB directors of finance and NHSE, through the finance working group are developing mechanisms for financial governance. The diagram below is an illustration of the financial operating context based on 23/24



4.2 Specialised Commissioned Services have the potential for significant variation in spend levels due to the high cost of procedures. These procedures could vary greater between areas. As with the delegation of Pharmacy, Optometry and Dental (POD) consideration is being given to establishing a financial risk framework (a set of rules and behaviours which govern the way we manage the risk that may arise within the specialised delegated budgets between delegated ICBs of the Midlands Region). The focus of the risk share being a pooling of resources enabling risks to be understood and managed.

5. The Delegation Process

5.1 Delegation agreements will be between individual ICBs and NHS England, who will be required (through clause 8 in the delegation agreement) to form joint working arrangement with other ICBs within a Multi-ICB footprint.

5.2 The Multi-ICB commissioning footprints for the Midlands are:

- East Midlands (Nots and Nottinghamshire ICB, Derby and Derbyshire ICB, Lincolnshire ICB, Leicester, Leicestershire and Rutland ICB, and Northamptonshire ICB)
- West Midlands (Birmingham & Solihull ICB, the Black Country ICB, Shropshire, Telford and Wrekin ICB, Staffordshire & Stoke-on-Trent ICB, Herefordshire & Worcestershire ICB, Coventry and Warwickshire ICB) footprint.

5.3 The draft delegation agreement has been published and is currently out with ICBs and regional colleagues for review and comment.

5.4 The delegation agreement will be supported by an ICB collaboration agreement which enables Multiple ICBs to formally come together. This will be tailored to local circumstances and mechanisms to enable collaborative working within existing legal frameworks.

5.5 The multiple ICB Joint commissioning will be operationally supported by Commissioning hubs (East and West). The teams within these hubs will undertake the commissioning functions for the delegated services for ICBs and for NHS England for its retained (category 2 and 3) services.

5.6 As a pre-cursor to delegation a Pre-Delegation Assessment is required. This is undertaken though the Pre-Delegation Assessment Framework (PDAF). This is for category A services only.

5.7 The PDAF assessment is required to be submitted on the 25th September 2023 for national review by a moderation panel, before being submitted and approved by the NHS England Board. This board approval is required for delegation to take place on the 1st April 2024

6. The PDAF

6.1 The Pre-delegation assessment is being co-produced by ICB and NHS teams for the East and West Midlands, though joint working groups and workshops led by the ICB Exec leads for specialised services. This collaboration ensures equitable assessment of the work all parties need to undertake in their readiness for the delegation of these services.

6.2 The Midlands model of Joint Commissioning, enables each partner to jointly exercise their statutory functions, making equitable decisions through Joint Committee arrangements. Joint Committees will need to update their terms of reference to reflect delegation.

End

Spec Comm overview STW ICB

Top 10 Provider based ICS/STP	
Shropshire and Telford and Wrekin	£63,876,966
Birmingham and Solihull	£38,112,981
Staffordshire and Stoke on Trent	£27,005,336
The Black Country and West Birmingham	£7,022,876
Cheshire and Merseyside	£2,702,882
Greater Manchester Health and Social Care Partne..	£2,218,399
North London Partners in Health and Care	£1,307,023
Herefordshire and Worcestershire	£1,014,583
Unknown	£989,706
West Yorkshire and Harrogate (Health and Care Pa..	£550,452

Top 10 Service Lines	
NCBPS01C : Chemotherapy Services	£23,389,036
NCBPS11B : Adult Specialist Renal Services	£13,490,854
NCBPS01Y : Specialist Cancer Services: Other Canc..	£13,006,064
NCBPS19T : Liver Transplantation Service	£8,668,021
NCBPS10Z : Cystic Fibrosis Services	£6,945,596
NCBPS08S : Adult Specialist Neurosciences Service..	£6,582,208
NCBPS13E : Adult Specialist Cardiac Services: Card..	£6,193,845
Unknown	£6,128,348
NCBPS01M : Specialist Cancer Services: Head And ..	£6,030,756
NCBPS08O : Adult Specialist Neurosciences Servic..	£5,985,849

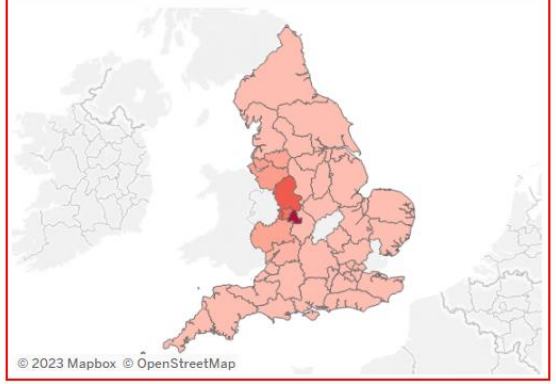
Top 10 Providers	
RXW : THE SHREWSBURY AND TELFORD HOSPITAL N..	£53,981,759
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS ..	£25,502,992
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FO..	£25,137,911
RL1 : THE ROBERT JONES AND AGNES HUNT ORTHOP..	£9,895,208
RQ3 : BIRMINGHAM WOMEN'S AND CHILDREN'S NHS..	£9,617,179
RL4 : THE ROYAL WOLVERHAMPTON NHS TRUST	£6,466,091
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	£3,017,260
RRE : MIDLANDS PARTNERSHIP NHS FOUNDATION T..	£1,502,345
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TR..	£1,014,583
RBS : ALDER HEY CHILDREN'S NHS FOUNDATION TRU..	£1,008,934

Activity undertaken for the NHS Shropshire, Telford & Wrekin ICB ICB, for patients treated in the ICB

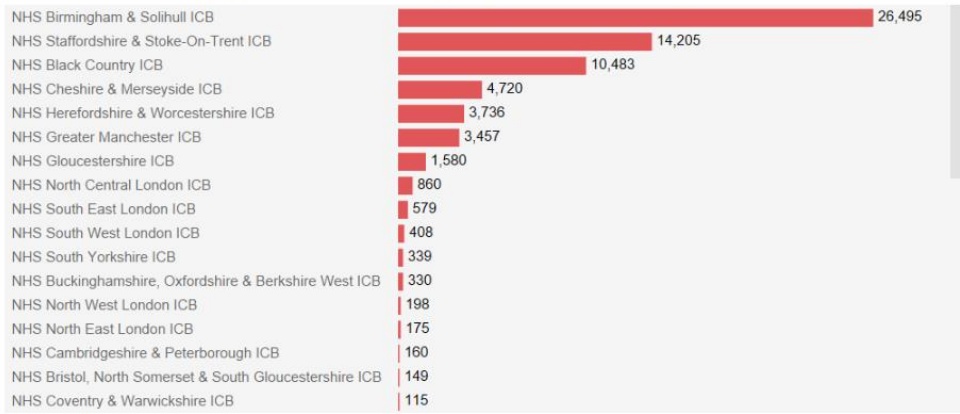
Total Number of Activity undertaken by NHS Shropshire, Telford & Wrekin ICB ICB	Total Activity within the NHS Shropshire, Telford & Wrekin ICB ICB	Total Activity for patients from the NHS Shropshire, Telford & Wrekin ICB ICB, treated in other ICB's
181,107	112,551	68,556

Percentage of activity within the NHS Shropshire, Telford & Wrekin ICB ICB

Breakdown of activity for the NHS Shropshire, Telford & Wrekin ICB ICB to show patient flow where activity is not undertaken within the ICB's geographical footprint



Breakdown of total activity for patients from the NHS Shropshire, Telford & Wrekin ICB ICB, treated in other ICB's



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).

Spec Comm Provider Detail

SATH – Spec comm expenditure

ICS	Expenditure 22/23
Shropshire and Telford and Wrekin	£53,981,759
Staffordshire and Stoke on Trent	£872,697
The Black Country and West Birmingham	£231,614
Herefordshire and Worcestershire	£146,931
Other	**£182,229**
Total	**£55,415,229**

Service Line	Expenditure 22/23
NCBPS01C : Chemotherapy Services	£16,628,787
NCBPS11B : Adult Specialist Renal Services	£13,471,167
NCBPS01Y : Specialist Cancer Services: Other Cancers	£11,454,394
NCBPS01M : Specialist Cancer Services: Head And Neck Cancer	£5,886,515
NCBPS23F : Specialist Gastroenterology, Hepatology And Nutritiona	£2,389,768
NCBPS30Z : Adult Specialist Vascular Services	£730,248
NCBPS11A : Atypical Haemolytic Uraemic Syndrome Services	£682,920
NCBPS13A : Adult Specialist Cardiac Services: Complex Device Th	£491,805
NCBPS23A : Specialist Cancer Services For Children And Young P	£410,536
NCBPS03Z : Specialist Services For Haemophilia And Other Relate	£375,972
NCBPSMOL : Molecular Diagnostics Service	£391,521
NCBPS29S : Adult Highly Specialist Respiratory Services: Severe A	£352,192
NCBPS01N : Specialist Cancer Services: Kidney, Bladder And Pros	£338,216
Other	£1,811,187
Total	**£55,415,229**

RJAH– Spec comm expenditure

ICS	Expenditure 22/23
Shropshire and Telford and Wrekin	£9,895,208
Herefordshire and Worcestershire	£4,445,285
Staffordshire and Stoke on Trent	£4,171,151
Cheshire and Merseyside	£2,937,257
The Black Country and West Birmingham	£1,126,406
Greater Manchester Health and Social Care Partnership	£407,443
Birmingham and Solihull	£250,520
Coventry and Warwickshire	£229,513
Other	£245,784
Total	**£23,708,567**

Service Line	Expenditure 22/23
NCBPS06A : Spinal Cord Injury Services	£7,390,114
NCBPS23Q : Specialist Orthopaedic Services For Children	£2,694,924
NCBPS06Z : Complex Spinal Surgery Services	£2,239,002
NCBPS23M : Specialist Neuroscience Services For Children	£1,393,445
NCBPS34A : Adult Specialist Orthopaedic Services: Specialist Orthopaedic Surgery	£9,180,739
NCBPS01Y : Specialist Cancer Services: Other Cancers	£417,451
NCBPS01O : Specialist Cancer Services: Bone Sarcoma	£192,823
NCBPS01L : Specialist Cancer Services: Soft Cell Cancer	£123,745
NCBPS31Z : Adult Highly Specialist Pain Management Services	£27,099
NCBPS23W : Specialist Rheumatology Services For Children	£24,709
NCBPSP23 : Stem Cell Transplantation Service For Juvenile Idiopathic Arthritis And Related Connective Tissue Disorders	£13,181
NCBPS02Z : Blood And Marrow Transplantation Services	£11,336
NCBPS23X : Specialist Paediatric Surgery Services	£0
Total	**£23,708,567**

STW Representation on Delegation Groups

	Midlands Acute Specialised Commissioning Group (MASCG)	Operating Model Group (OMG)	Finance and Contracting Advisory Group (FCAG)	Governance Working Group	BI/IT/IG	Workforce	Hosting	Planning	Contracting	Regional Quality Group	Clinical & Quality Workstream
Chair	**Matt Day**	**Karen Helliwell**	**Andrew Morton/Jon Cooke**	**Jo Melling/Paul Winter**	**Tiggy Foxon**		**Jo Melling**	**Jon Cooke**	**Nick Hey**		
STW Membership	**Nick White**	**Nick White**	**Claire Skidmore**	**Alison Smith**	**Craig Kynaston**	**Sara Hayes**	**Nick White**	**Julie Garside**	**Meryl Flaherty**	**Alison Bussey**	**Vanessa Whatley**
	Simon Collings	Simon Collings	Laura Clare		Simon Collings		Simon Collings	Simon Collings	Laura Clare	Nick White	
		Laura Clare							Simon Collings	Simon Collings	

NHS England

West Midlands multi-ICB

Pre-Delegation Assessment Framework proforma for 2024/25: Specialised Services

The pre-delegation assessment framework for specialised services has been developed to support ICBs prepare for delegation arrangements; and will underpin the assessment of system readiness.

Version 1.9, 5 June 2023

System readiness assessment for specialised commissioning

Purpose of the proforma

The pre-delegation assessment framework (PDAF) has 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. **Annex 1** sets out further information on the PDAF and wider process.

The questions set out in this proforma are aligned to the domains and criteria set out within the PDAF for specialised services (see **Annex 1**). In recognition of where ICBs are in their development journey, some questions look to examine strategic vision; whilst others are more focused on commissioning capacity and capability. The proforma should be completed and signed off by the ICB/s, and the relevant NHS England Regional Director of Commissioning. The responses should then be verified and signed-off by the relevant NHS England Regional Director, along with an overall assessment of whether the ICB/s is ready for delegation arrangements from April 24. The completed assessment proforma should then be sent to the national mailbox for the programme – fcmp.England@nhs.net – by **Monday 25 September 2023.**

Completing the assessment

- The proforma should be completed by the ICB/s forming the appropriate footprint to commission and plan the full set of in-scope services. We recommend that ICBs work together to draft a collective PDAF response where they are part of a wider multi-ICB footprint. Against each domain area, the response should (where relevant) consider both the overarching multi-ICB arrangement, and the individual ICBs forming that arrangement.

- If there are services that will be planned on a smaller geographical footprint (i.e. an individual ICB or a smaller group of ICBs within a wider multi-ICB footprint), this should be set out in domain 1, 'Health and Care Geography'.

- All questions are mandatory, and responses should build on the submissions made last year, reflecting on and noting where any key risks, issues or challenges that were previously highlighted have been addressed. Responses should also include reference to any new or emerging risks or issues that have been identified against each domain area and plans that are/will be in place to manage these. The responses should recognise where there are any developmental areas that will need to be addressed prior to delegation or – where applicable – when new arrangements go live.

- Regions should work with ICBs to provide support as they complete the proforma. As part of this assessment process, regional colleagues will be responsible for reviewing any evidence or further documentation supplied by ICBs, ahead of providing summarised responses below. **No additional attachments should be provided as part of the final submission to the national mailbox.**

- Examples of supporting evidence – which aim to support systems with their response in terms of what is considered 'essential' versus 'developmental' and will guide the regional assessment of system readiness – can be found in the response column in grey italics. If essential evidence is not provided, conditions should be considered to reflect this, and where this is significant, the (multi-)ICBs could be deemed as 'Category 3 (intensive support required)' against that domain. The text in italics should be deleted prior to submission.

- There is recognition that in some cases, the supporting evidence provided may include reference to policies or plans (e.g. in relation to patient and public involvement or digital inclusion) that have been developed with a broader scope than solely specialised services. Where this is the case, please confirm how these wider policies or plans will apply to specialised services.

- At the end of each domain, regions are asked to provide an assessment of the (multi-)ICB's readiness for delegation based on their responses and where applicable, note any conditions that maybe required.

- At the end of the proforma, the Regional Director will be asked to consider the responses across all the domain areas and determine where each ICB sits within the outcome categories below, as well as an overall assessment of the (multi-)ICB:

PDAF outcome categories	Description
Category 1 (delegation)	The (multi-)ICB is ready for full delegated commissioning responsibility from April 2024.
Category 2 (delegation with conditions)	The (multi-)ICB is ready for delegated commissioning responsibility from April 24 subject to developmental conditions being attached.
Category 3 (intensive support required)	Where the (multi-)ICB is not yet ready for full delegated commissioning responsibility from April 24 and needs an additional year of development and support through more intensive conditions being attached to the arrangement.

- Each ICB should be rated within each of these categories separately, and then an overall assessment of the multi-ICB footprint should be determined. Where there is variation of readiness across ICBs within a multi-ICB footprint, regions will need to take this into consideration when determining the most appropriate overall assessment of the multi-ICB footprint, and could follow a majority rule (i.e. if more than half of the ICBs are in the same category).

- This document should be signed by the ICB/s and the relevant NHS England Regional Director of Commissioning ahead of being verified and signed by the relevant NHS England Regional Director.

- Alongside this process, ICBs should also work through the Safe Delegation Checklist — which sets out the key actions to be completed to support a safe and smooth transition to new delivery arrangements — between now and March 24.

- A series of FAQs are available on NHS Futures to support this exercise, alongside further resources to support preparations for delegation. If you require any further support, please contact your Regional Director of Specialised Commissioning and

Health and Justice in the first instance. If any further clarification is required following this, please contact fcmp.England@nhs.net.

Name of ICB (if submission is on behalf of a multi-ICB footprint, please list each ICB that forms part of it)	West Midlands Multi-ICB consisting of • NHS Birmingham and Solihull ICB • NHS Black Country ICB • NHS Herefordshire& Worcestershire ICB • NHS Coventry & Warwickshire ICB • NHS Shropshire, Telford, and Wrekin ICB • NHS Staffordshire and Stoke-on-Trent ICB
For completion of the Safe Delegation Checklist, please confirm that: ➢ A senior responsible officer and workstream leads have been identified in each ICB ➢ A delivery plan, including key milestones has been agreed	Yes Yes

Domain 1: Health and Care Geography	
Question	**Response** - *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate*
1a. What is the geographical footprint(s) proposed and is it appropriate to manage the in-scope services (as per the Service Portfolio Analysis). ***(400 words max)***	From April 2024, both delegated and retained specialised services will be managed on a multi-ICB basis which matches the geographical footprint of the six ICBs in the West Midlands. The total population of the West Midlands is 6.0 million. The West Midlands multi-ICB footprint is consistent with the majority of patient flows agreed through the West Midlands Cancer Alliance, the West Midlands Operational Delivery Networks and the informal local provider collaboratives and other existing clinical arrangements. Where commissioning decisions are required to be informed by a larger footprint, for example neurosurgery and burns, these will be considered on a Midlands-wide footprint alongside the West Midlands multi-ICB. Some of the advantages of managing the in-scope services on a sub-regional footprint are: • Discussions are kept closer to the ICB, allowing for locally tailored solutions and manageable decision-making, to fit local populations and the patients being served; given the principle of ICBs taking responsibility for delegated specialised services. • Ability to utilise the local knowledge and understanding of the ICBs. • It provides the best balance of subsidiarity and scale. • It allows for joint working and sharing of innovations and approaches, particularly through Operational Delivery Networks (ODNs). • It links in well with other opportunities that the West Midlands Joint Committee is working on such as 111 and 999, and discussions around other areas of commissioning that would benefit from being looked at on a West Midlands footprint with the Office of the West Midlands and Midlands Commissioning Hub. • It develops broader competencies and builds expertise across systems allowing for greater efficiency.

1b. Are there plans in place to mitigate against any issues that arise because of significant patient flows in and out of the footprint(s) for the in-scope services - including working with neighbouring geographies to manage them? ***(400 words max)***

A detailed analysis of patient 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 has informed the actions required to manage patient flows between different geographies. The table below shows the percentage of specialised activity for East Midlands' patients across all Midlands providers and the percentage of patients treated outside of the Midlands.

			West Midlands - Provider ICB							East Midlands - Provider ICB						
	Specialised Activity		BSOL	BC	C&W	STW	SSOT	H&W	Total	LLR	N&N	Nhants	Lincs	Derbyshire	Total	Out of Region
		Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients	% of Total Patients
West Midlands - Patient ICB	BSOL	294,383	95.2	2.7	0.7	0.0	0.0	0.1	98.9	0.0	0.0	0.0	0.0	0.0	0.1	1.0
	BC	229,547	53.1	45.0	0.1	0.1	0.3	0.1	98.7	0.1	0.0	0.0	0.0	0.0	0.1	1.2
	C&W	116,478	22.0	0.5	67.9	0.0	0.1	1.1	91.6	1.3	0.1	0.2	0.0	0.2	1.8	6.6
	STW	79,219	14.6	5.6	0.0	62.4	7.8	2.0	92.6	0.1	0.0	0.0	0.0	0.0	0.1	7.3
	SSOT	294,265	13.6	10.7	0.1	0.2	63.7	0.0	88.4	0.4	0.6	0.0	0.0	7.6	8.6	2.9
	H&W	145,808	27.8	1.8	1.6	0.3	0.2	46.5	78.3	0.1	0.0	0.0	0.0	0.0	0.1	21.6

Source: NCDR ICB Patient Flow report

Cross-regional inflows:

There are significant patient flows from outside of the ICB coming into one of the West Midlands Multi-ICB's providers; this will result in funding from that patient's host ICB being paid to a provider in a West Midlands ICB.

Cross-regional outflows:

- There are significant patient flows from the within the West Midlands Multi-ICB to providers located within in another multi-ICB. This will result in funding from a West Midlands ICB being paid to the provider that treated the patient.

In region Cross-ICB flows:

- The majority of an ICB's population will attend a provider within their ICB, but a large proportion will also attend providers in other West Midlands ICBs. In these situations, all West Midlands funding will remain in the West Midlands multi-ICB, though there will be movement between individual ICBs. In region cross-ICB flows will be monitored via Operational Delivery Networks (ODNs) and the Midlands Acute Specialised Commissioning Group.

If there are changes to patient flows in the future, that impact significantly neighbouring multi-ICBs (i.e., the North-West, East of England, Yorkshire and Humber) it has been agreed that the relevant commissioning hub(s) will be engaged and consulted with, in line with legal duty, best practice and within the relevant commissioning or procurement processes. Using the specialised service data available, any proposed service changes that may impact on patient flows outside the geographical area will be identified by the Midlands Commissioning Hub. It will be the responsibility of the Midlands Acute Specialised Commissioning Group (MASCG) to ensure that any developments go through due process, including the development of business cases, and engagement with stakeholders is undertaken appropriately.

For completion by regional colleagues: With consideration of the responses above, please indicate the (multi-)ICB's readiness for delegation - including as part of any multi-ICB arrangements - against the 'Health and Care Geography' domain:

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Domain 2: Transformation	
Question	**Response -** *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate*
2a. Describe how you are going to plan for integrating delegated specialised services into wider pathways. This should include any plans to	There are two key pieces of work that will set out the plan for integrating delegated services: the health inequalities strategy and the specialised services clinical strategy. Firstly, the six West Midlands ICBs and NHS England colleagues have worked collaboratively on the development of a health inequalities strategy for specialised acute and pharmacy services in the West Midlands. The approach is based on the national Healthcare Inequalities Improvement Programme (HIIP) and is aligned with ICB strategies. The strategies share an overarching vision and five principles for delivery under which actions are set out for delivery at service level. Several frameworks will support delivery, including the Core20PLUS5 approach, use of the Health Equity Assessment Tool, and a bespoke health inequalities in specialised services framework. Cultural competency and community involvement is embedded into the strategy.

improve population health and reduce health inequalities. ***(400 words max)***	Addressing healthcare inequalities is a key factor in setting joint NHS England/ICB priorities. This was demonstrated in the selection of neonatal services (including perinatal and foetal medicine), adult critical care, and haemoglobinopathy as joint working priorities between the ICBs and NHS England in the West Midlands in 2023/24. The inequalities strategy has been informed by discussion with clinical colleagues, including pharmacists and medical directors from hospital trusts and ICBs. There will be joint responsibility at SRO level between NHS England and ICBs for the strategy. The document is expected to be fully signed off in September and influence the planning and delivery of services in 24/25. Secondly, the specialised services clinical strategy which will set out the joint priorities for both one, five and ten years. This will be clinically led, and the initial framework will be agreed in 2023/24 with the full strategy finalised in 2024/25. Within the Midlands, clinical engagement will be secured at multiple tiers. Closest to patients, commissioners will draw upon our clinical networks, both formally commissioned operational delivery networks (ODNs) and informal networks established over time. At director level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of acute provider and ICB CMOs, will continue to meet and provide clinical engagement and advice to the Midlands Commissioning Hub. The hub will continue to feed the CCEF's advice into the decision-making processes of the Midlands Acute Specialised Commissioning Group (MASCG) and the West Joint Committee.
2b. Describe how you intend to approach service transformation, service prioritisation and service sustainability	There were improvements to the process during the 2023/24 planning cycle, which resulted in joint working between all six ICBs and NHS England to co-produce the 1-year strategic business plan. Going forward the Midland Commissioning Hub will co-develop key commissioning priorities on behalf of the West multi-ICB, that can then be monitored through a performance matrix. The Business Intelligence (BI) function within the hub will systematically create a comprehensive pool of data across all services. The hub will work closely with ICB and NHS England colleagues to implement the health inequality strategy for specialised services. The data will be analysed to reveal any inequality in access or outcomes. These insights can then be used gain intelligence on what

across the in-scope services. This should include ensuring these align to national policy and service standards, as well as ensuring linkages with clinical networks. ***(400 words max)***	works, drive improvement, and plan interventions. In terms of specialised pharmacy, the safe, consistent use of medicines within delegated services will be via shared care arrangements across networks, which will support improved access to high-cost drugs. This year, one of the key aims is that plans for specialised services in 2024/25 are aligned with ICB plans, to integrate with wider pathways, improve population health and to clearly communicate this joined-up approach. The collective focus will then be the delivery of that plan. The planned outcome is that the population gets better value from healthcare delivery. The aim being to improve care at system level, reduce inequality, and improve outcomes by integrating systems and care to support people to live healthier lives. Service transformation will be clinically lead through the development of networks the engagement and involvement a of the networks and operational delivery networks (ODNs) that have already been established. ICB Chief Medical Officers (CMOs) and Programme of Care leads within the Midlands Commissioning Hub will work closely together with providers, networks and NHS England to identify service sustainability issues and ensure joint plans are in place to address them.
2c. How do you intend to involve people and communities (including those with lived experience) in the commissioning of the in-scope	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 Patient Advice and Liaison services (PALS), local patient groups and local authorities to engage directly with patients and carers. NHS England has offered stakeholder support through Health Overview and Scrutiny Committees (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. It is important that this combined approach continues so that the expertise in NHS England, ICBs and in providers is utilised to maximum benefit for patients. All the ICBs' people and communities' strategies make clear the importance and value of public involvement and detail several routes for keeping in touch with the public and seeking views on specific issues. These will be widened

specialised services from April 2024, including meeting legal duties around involvement? ***(400 words max)***	to include representation for specialised services. In particular, the strategies detail the levels of assurance in place to ensure that legal duties are being met. A system of communication will be established with the Midlands Commissioning Hub to ensure that no new services or service changes are introduced before full engagement/consultation with public and patients. This will be managed through the pre-existing Midlands ICBs Communications Directors Forum and will need to ensure that, the patient and community relationships are developed, utilised and nurtured. For example, the hub will work with the relevant ICBs in the region to ensure that they can deliver what's required. Collaboration between communications leads for the Midlands Commissioning Hub, ICBs and providers will also be developed, either by adding to existing system communications meetings or via the establishment of an online hub to allow sharing of information, updates, and participation in best practice identification. This would also allow for the cascading of national information and the sharing of national contacts and databases of stakeholders relevant to specialised services. Everyone involved in the commissioning of specialised services or in encouraging public participation related them will be offered training with the 10 steps to participation programme. This will ensure everyone involved is aware and supportive of the benefits of engaging with the public and patients. All ICBs have examples of working with their communities with summaries in their annual reports as evidence.
For completion by regional colleagues: With consideration of the responses above, please indicate the (multi-)ICB's readiness for delegation - including as part of any multi-ICB arrangements - against the 'Transformation' domain: ✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)	

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Domain 3: Governance and Leadership	
Question	**Response** *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate.*
3a. Describe the governance arrangements you will put in place for the oversight and management of in-scope specialised services. This should include the arrangements for specialised services with regard to Board and Committee	All delegated specialised services on a West Midlands' footprint will continue to be governed by the East Midlands Joint Committee and its sub-group, the Midlands Acute Specialised Commissioning Group (MASCG). NHS England regional teams will continue to work jointly with the Joint Committee on the commissioning of retained specialised services. An Executive Lead for Specialised Commissioning has been nominated to represent the West Midlands Joint Committee on the Midlands Specialised Executive Group. The group has an ongoing commitment towards engagement on the future governance arrangements across the Midlands region at executive level through Executive Time-Outs etc. Through these forums, the ICBs have agreed collectively with NHS England the following principles for the governance arrangements from 2024/25: • The six West ICBs will jointly share the responsibility for the commissioning of delegated services; no individual ICB has primacy over the others. Where services are commissioned over a Midlands footprint, they will also work with the five East Midlands ICBs. • The ICBs will continue to be partners in the West Midlands Joint Committee, where each ICB has equal authority and standing. • An ICB Collaboration Agreement (ICA) will set out the terms under which the Joint Committee will operate.

structures and Executive and senior management leadership. ***(400 words max)***	• Underpinning the Joint Committee there will continue to be joint sub-governance arrangements for finance, commissioning, and quality with ICB representation which will report into the Joint Committee. • These groups will have delegated authority from the Joint Committee laid out in schemes of reservation and delegation. • The operating models for these sub-groups will be revised to incorporate the delegation of commissioning responsibility for specialised services which are suitable and ready for delegation. • The operating models will also incorporate the continuation of joint working arrangements for specialised services which are suitable but not yet ready. • These arrangements would be in place solely for the oversight of multi-ICB collaboration, they stand apart from any other governance arrangements in the ICBs. • Other multi-disciplinary functional groups such as the Collaborative Commissioning Executive Forum (CCEF), West Midlands Acute Providers (WMAP) and West Midlands Cancer Alliances will act as advisory groups for the West Midlands Joint Committee and MASCG.
3b. Describe the governance arrangements you will put in place for the establishment and oversight of any multi-ICB commissioning arrangements and the powers and responsibilities delegated to	The West Midlands Joint Committee, established on 1st April 2023 and led by ICB Chief Executives, and NHS England Directors, will continue act as the forum where the six ICBs and NHS England work in partnership on: • Joint commissioning between the ICBs on delegated specialised services. • Joint working between NHS England and the ICBs on retained specialised services. • Joint commissioning between ICBs on POD services. • Joint working between ICBs on services they choose to work together on (999/111 services). • Joint working for ICBs on other areas of collaboration. As figure 1 overleaf shows, ICBs will delegate responsibility to the West Midlands Joint Committee. NHS England will also discharge its authority (through accountable directors) to the Joint Committee. The ICBs and NHS England will have an appropriate scheme of reservation and delegation in place to enable Joint Committee members to have the authority to make decisions without having to refer to their home organisations. The West Midlands Joint Committee will provide strategic decision-making, leadership, and oversight for the commissioning of specialised services in the West Midlands, and any associated activities. The aim of the Joint Committee will

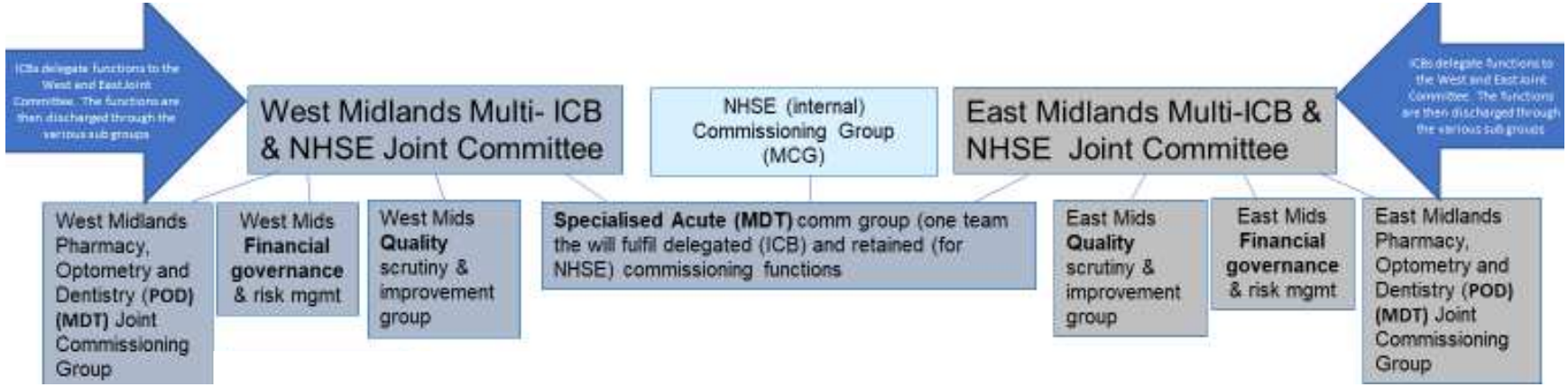
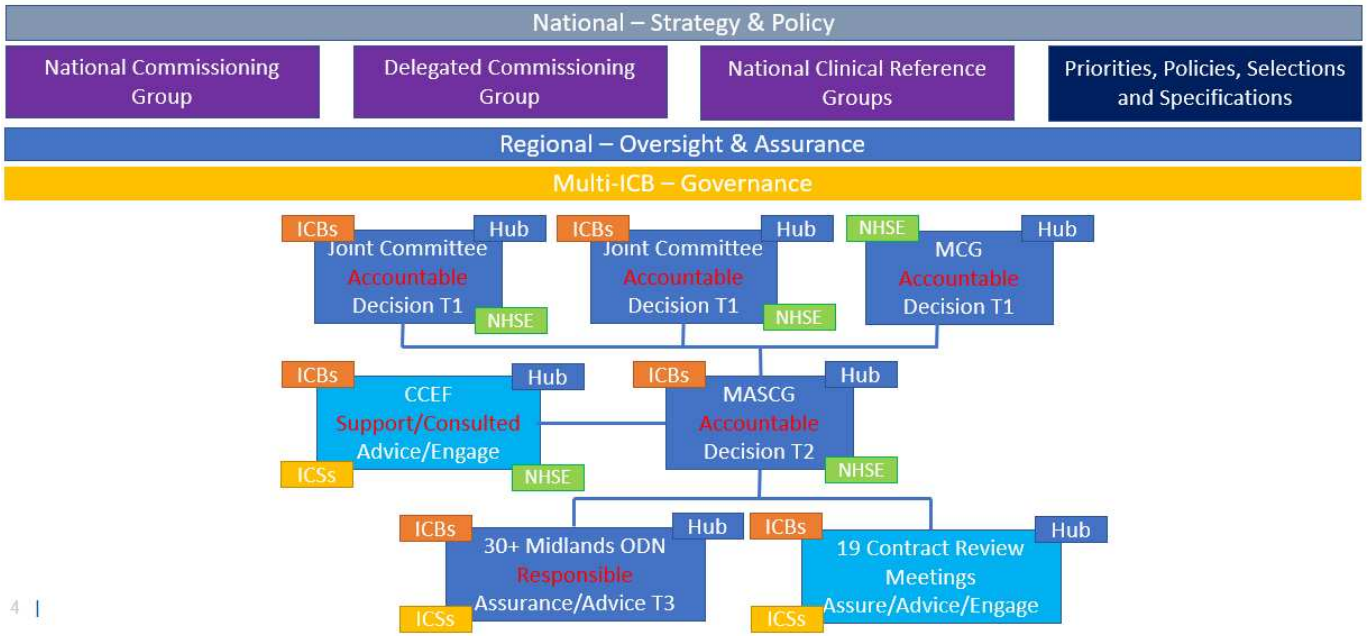
multi commissioning arrangements. ***(330/400 words max)***	be to achieve consensus decision-making wherever possible, and decisions made by the Committee will be consistent with the powers provided to it within the ICB Collaboration Agreement. Figure 1: Midlands Governance April 2024  The role of the Midlands Acute Specialised Commissioning Group (MASCG) is to support the Joint Committees and NHS England in discharging their duties with respect to delegated and retained prescribed acute specialised services safely, effectively, efficiently, and economically. Membership of MASCG includes a nominated representative from each ICB and is accountable for all Tier 2 decision-making in relation to the work of the Midlands Commissioning Hub. It engages and seeks clinical advice from the Collaborative Clinical Executive Forum (CCEF) and discharges it duties through the 30+ Operational Delivery Networks as shown in Figure 2. The hub will liaise directly with all National Groups on behalf of the Joint Committee and ICBs.

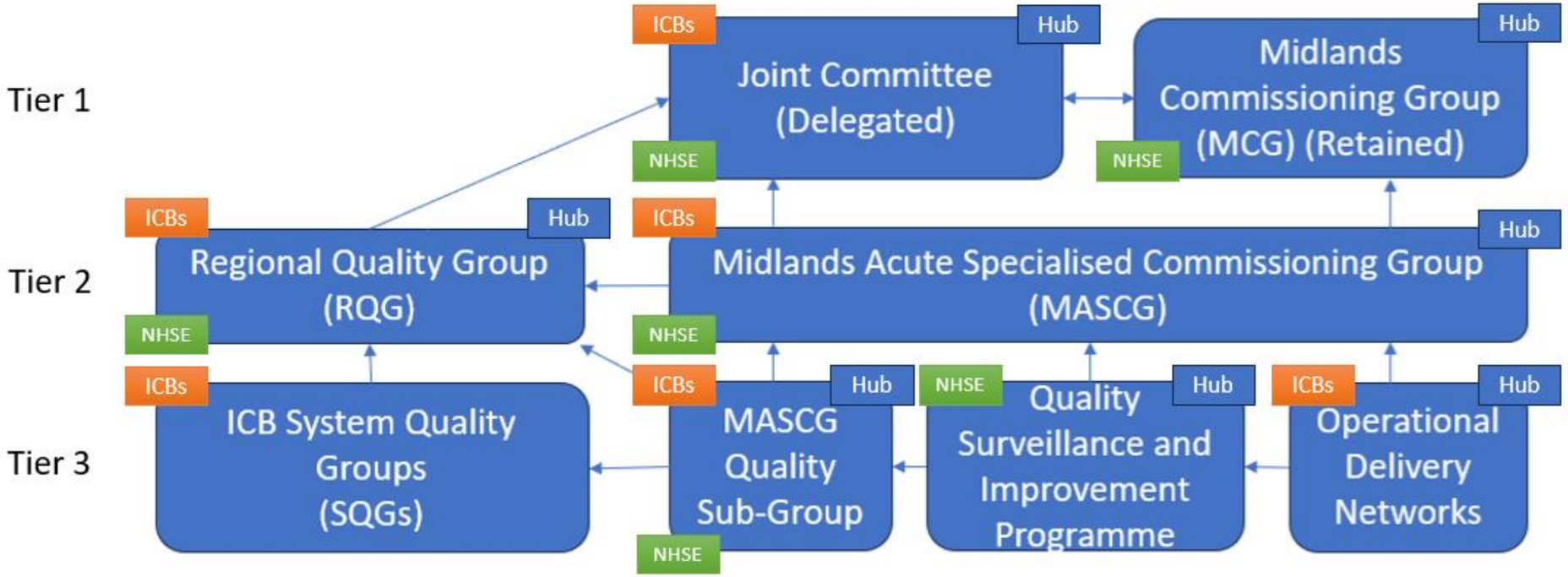
Figure 2: MASCG Regionals and National Context (Tiers, RASCI and Roles)



3c. Describe the clinical governance, accountability and leadership that will be in place to oversee in-scope	As per the existing joint working arrangements in 2023/24, the Midlands Region of NHSE and the West Midlands multi-ICB will continue to access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Hub responsible for commissioning specialised services. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Hub. The hub will continue to share the advice offered via that forum into the decision-making sub-group of the West Midlands Joint Committee, the Midlands Acute

specialised services. How will clinical leadership be developed and maintained? ***(400 words max)***	Specialised Commissioning Group (MASCG). The multi-disciplinary team within the hub will retain Medical Director, pharmacy, nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture. The NHS England formally commissioned networks will continue to play a key role supporting our understanding of clinical quality for the relevant services. The region has launched a pilot risk oversight and assurance framework for specialised networks. This framework gives clarity around network expectations around how to support mitigation of risks and how to report risks into statutory bodies. Progress has already been made in improving risk and issue log processes and transparency of reporting and this will remain a key challenge for the coming months. The oversight and triangulation of risks and issues identified by networks aligns to our wider processes within the Quality Surveillance and Improvement Programme (QSIP) which has been set up to monitor quality in specialised services. Further consideration of the interdependencies and ongoing work with the West Midlands Cancer Alliances will take place to inform new ways of working across the Midlands region. Governance and decision-making for high-cost drugs assurance will be via Joint Committees with links to the Regional Pharmacy Leadership Board. The work will continue to led and coordinated by the pharmacy team within the hub and informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists, with a view to review key clinical areas for future investment where appropriate.
3d. Describe the quality governance, accountability and leadership that will be in place to oversee in-scope specialised	Key quality concerns requiring escalation are currently reported monthly to the East Midlands Joint Committee and this will continue in 2024/25**.** Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level. The role of the Joint Committee is to provide strategic decision-making, leadership, and oversight for the services commissioned though the ICB collaboration agreement, and any associated activities. The Joint Committee have the following key responsibilities:

services. ***(400 words max)***	• Fulfilling the oversight, monitoring and management function for specialised services in relation to quality, operational and financial performance; including, co-ordinating risk and issue management and escalation, and developing the approach to intervention with providers where there are quality or contractual issues. • Identifying and setting strategic priorities and undertaking ongoing assessment and review of specialised services, including tackling inequity of outcomes and access. • Supporting partnership and enabling collaboration to integrate service pathways, improve population health and reduce health inequalities. This includes, establishing links and working effectively with provider collaboratives and cancer alliances, and working closely with other ICBs, Commissioning Hubs, Joint Committees and NHS England where there are significant cross-border patient flows. • Ensuring the Joint Committee has effective engagement with stakeholders, including patients and the public, and involving them in decision-making. • Ensuring the Joint Committee has appropriate clinical advice and leadership, including through clinical reference groups and local clinical networks. Key quality concerns involving specialised services will be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. A Tier 3 quality sub-group of MASCG has recently been established to devote more time to discussion and scrutiny of quality issues. This group meets monthly, is chaired by the Regional Medical Director for Commissioning (RMDC) and has ICB representation. The quality governance structure is described in the diagram overleaf.



To be proactive in the surveillance of quality concerns in specialised services, a Quality Surveillance and Improvement Programme (QSIP) has been set up to monitor quality. This involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.

3e. Describe the mechanisms you will put in	In 2024/25, the West Midlands Joint Committee will agree with all 11 Midlands ICBs and NHS England to share information and best practice, awork collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost. This will be discussed through the relevant sub-groups and then fed into the risk management approach at ICB level.

place to enable risks to be identified and monitored, including describing the potential impact on delegated specialised services. How will these mechanisms allow for the agreement and management of mitigating actions ***(400 words max)***	The role of the West Midlands Joint Committee is to provide strategic decision-making, leadership, and oversight for the specialised services, and any associated activities. The Joint Committee will safely, effectively, efficiently, and economically, discharge and deliver specialised services, and will fulfil the requirement to provide an oversight and assurance function, in relation to quality, operational and financial performance, through the Midlands Acute Specialised Commissioning Group and the Midlands Commissioning Hub. This will include the operation of a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. Further details of the process of how risk will be managed across the West Midlands multi-ICB footprint will be detailed in the joint working agreements and the terms of reference of the committees. A formal risk register will be maintained to ensure ICBs are aware of any risks they may impact their systems.

For completion by regional colleagues: With consideration of the responses above, please indicate the (multi-)ICB's readiness for delegation – including as part of any multi-ICB arrangements – against the 'Governance and Leadership' domain:

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Domain 4: Finance	
Question	**Response** *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate*
4a. How will specialised commissioning be embedded within the financial governance and accountability framework of the ICB, including multi-ICB working where applicable? e.g. Who will be accountable for the budget? What is the ICB arrangement for	The six West Midlands ICBs will develop the existing governance arrangements established for formal joint commissioning in 2023/24, so that the commissioning of all delegated specialised services on an West Midlands' footprint is governed by the Tier 1 West Midlands Joint Committee and the established governance structure. NHS England will continue to be part of the West Midlands Joint Committee with accountability for the commissioning of retained specialised services. The current Finance and Contracting Advisory Group (FCAG) that represents NHS England and ICBs will be developed into a formal finance sub-group of the Joint Committee providing financial leadership and advice to the established governance structure. Detailed financial processes and responsibilities will be set out in the financial governance and accountability framework being developed collaboratively with the national finance team. Financial services will be provided to the West Midlands ICBs by the Midlands Commissioning Hub, hosted by NHS England. The hub will provide knowledge and expertise to support ICBs to make commissioning decisions in accordance with allocations, national guidance, Standing Financial Instructions (SFIs), Schemes of Delegation and Standard Operating Processes. From 2024/25 the ICBs' financial allocation for delegated specialised services will be based on 2023/24 population-based allocations, updated in line with national guidance, to ensure contractual commitments can be met. From 2024/25, a needs-based target allocation will be applied to specialised commissioning delegated budgets. The regional commissioning finance team is linked into the national workstream developing needs-based allocations to fully understand and influence the impact of convergence towards these weighted allocation targets in coming years and consider it's implication on system wide financial sustainability.

governing financial risk and sharing these across multi-ICB footprints as appropriate? ***(400 words max)***	From 1st April 2024, ICBs will be responsible for commissioning delegated specialised services. NHS England will remain responsible for the commissioning of Highly Specialised Services (HSS) and other services deemed not ready for delegation. The Midlands Commissioning Hub will undertake commissioning, contracting and finance responsibilities on behalf of ICBs and NHS England in line with national planning guidance and remaining within the specialised commissioning delegated allocation. ICB SFIs will be amended to include commissioning of delegated specialised services where appropriate to do so. Commissioning allocations and expenditure of delegated specialised services will remain separately identifiable within ICB ledgers. A risk sharing arrangement between ICBs and NHS England will be approved prior to delegation to reduce in year financial risk from allocation movements and service volatility. ICBs are considering formal pooled budget arrangements to deliver this financial in year risk management.
4b. How will you manage the financial and contractual transactional elements of specialised commissioning? Please give consideration as to how this will relate to existing processes and agreements and the set-up	There is an established Finance and Contracting Advisory Group (FCAG) in the Midlands which will form the basis of a formal finance sub-group of the West Midlands Joint Committee. This sub-group will establish and manage the principles for managing the financial transactional elements of commissioning of delegated specialised services through formally approved terms of reference. The sub-group will advise ICB and NHS England Chief Finance Officers (CFOs) on all financial considerations in order to make recommendations into the Joint Committees and ICBs as appropriate through the approved governance structure. The roles and responsibilities of each ICB, NHS England, the Joint Committee and the Midlands Commissioning Hub will be clearly outlined in a documented financial governance and accountability framework ahead of 1st April 2024. ICBs have already approved a framework for delegated primary care services, and this will be the basis of the framework for specialised services. The hub will lead the annual financial planning round, ensuring full engagement and integration with individual ICBs. and system wide planning processes. The finance sub-group will oversee the process, reporting key information and agreeing how risks are managed at regular intervals. Financial plans will be agreed by ICB CFOs through the finance sub-group and will be approved before approval through the Joint Committee and individual ICB governance processes. For 2024/25 NHS England Midlands will lead the planning process but use the Finance and Contracting Advisory Group (FCAG) to ensure full engagement and integration with ICB planning.

of your local support Hub. ***(400 words max)***	Financial transactions will be maintained on individual ICB financial ledgers, with processing completed by the Midlands Commissioning Hub. Approval of expenditure will be set in line with delegation agreements and SFIs with escalation through to the relevant ICBs. The hub will provide reporting services to the commissioning function for delegated specialised services to each ICB individually, as well as the finance sub-group and Joint Committees, using a single agreed approach to maintain an efficient process. Specialised services will be contracted in line with the national contracting standard operating procedure using a lead and associate commissioner model. The hub will provide leadership to the contracting process, ensuring cohesion between commissioning and finance plans. The formal finance sub-group will provide oversight of the contract process on behalf of the Joint Committee.
4c. Has the finance function developed a model to support commissioning led changes to specialised service flows in the ICB or multi- ICB footprint, and the 3-5 transformation programmes identified through 23/24 Joint	An integrated planning process which includes joint identification of priority transformation programmes has been developed for 2024/25. This is a clinically led process, engaging the Chief Medical Officers and public health colleagues in the review of services and the prioritisation of investments. A tiered governance structure which provides leadership and oversight to the development and approval of transformational service change has been established. The group includes NHS England and ICB finance representation in its terms of reference. Additional finance support to these programmes is as follows: • Named individuals have been identified provide financial expertise and information. • Financial analysts are available to review data and understand financial flows, draw conclusions, and model the financial impact of proposed changes. • Models to support the financial evaluation of procurements have been developed. • The financial impact of pathway changes on providers and ICBs will be understood and the national SOPs will be adopted to manage the rate of change and avoid destabilising providers where activity may change substantially. Regional finance teams within NHS England are fully engaged in the development of the needs-based allocation formula for specialised services and are also establishing ICB representatives on the group on behalf of the region. Needs-based allocation formulas are to be implemented from 2024/25 with a convergence process to be applied to ICB allocation growth for specialised

Committee working? Are financial risks and opportunities, such as the impact of allocation convergence, clearly understood and is appropriate mitigation identified? Is this in line with the commissioning change management business rules? ***(400 words max)***	services, The hub will work with ICBs to fully understand the impact at an individual ICB level and build this into future financial planning processes. The Finance and Contracting Advisory Group have developed a comprehensive risk share framework for specialised services. This framework will be refreshed to take account of the formal governance structures for delegated specialised services and will be a key pillar of financial management across the Midlands. Whilst this framework is focused on the management of financial risk of service volatility, it also considers allocation movement risk associated with convergence adjustments. ICBs are working with NHS England to understand the interdependency of specialised services convergence with ICB allocation convergence adjustments, and this will be built into future the impact on system wide financial sustainability. Future financial planning will consider the application and management of the needs-based allocation formula within and across health systems. The ICBs and NHS England have established a joint working group to consider the safe delegation checklist for specialised services which will ensure that risks associated with the delegation process are identified and jointly addressed.
4d. Can the ICB or multi-ICB footprint demonstrate	Midlands ICBs face significant financial challenges, ending 2022/23 with a deficit of £185 million collectively. There is a combined plan deficit for 2023/24 of £173m. In accordance with the national expectation that all systems and regions will have checked and

ongoing financial sustainability and a plan for sound financial management and performance within current NHS finance and business rules? ***(400 words max)***	reviewed ongoing financial assumptions by September 2023/24, all Midlands ICBs have established Financial Recovery Plans will with the clear intention to be to address financial balance by 2024/25. Financial modelling will build on 2022/23 outturn bridging to 2023/24 exit underlying positions signed off by systems and regions. • Clear financial trajectories for financial sustainability by returning to underlying Long Term Plan and Financial Improvement Trajectories (FIT) within 3 years. • Efficiency and transformation timetables to effect medium-term programme delivery. • Effective governance to reinforce shared disciplines, ownership, and accountability for delivery – and for expenditure control over the system-led communities. • Engagement and ownership of system Chief Executives and Chief Finance Officers with oversight across partners. • Effective governance arrangements for the continued financial balance of specialised services – with appropriate governance across the 11 Midlands systems to maintain financial balance and explore efficiency delivery transformative opportunities. • Explore risk sharing approaches to maintain financial stability across systems. Specialised commissioning for the Midlands ended 2022/23 with a breakeven position and has submitted a balanced financial plan for 2023/24. Services maintain a recurrent underlying financial balance. The transfer of specialised services to ICBs will not deteriorate system financial performance. Delegated specialised commissioning allocation and expenditure will remain separately identifiable within ICB ledgers. The established financial risk management framework will mitigate ICB specific service volatility within a financial year. Achieving value for money on high-cost drugs spend will involve optimising and promoting use of national and regional procurement, homecare and commercial processes, prescribing analysis, better value medicines initiatives and horizon scanning according to national policy.
For completion by regional colleagues: With consideration of the responses above, please indicate the (multi-)ICB's readiness for delegation - including as part of any multi-ICB arrangements -against the 'Finance' domain:	

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Domain 5: Workforce Capacity and Capability	
Question	**Response** *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate*
5a. What is the staffing model you are proposing to support the delivery of functions delegated to ICBs? ***(400 words max)***	As part of the 'Creating the New NHS England' programme, the NHS England Midlands region has proposed that the existing Specialised Acute and Pharmacy team, along with its associated support functions are transferred across to a host ICB in 2025/26 as part of a 'Commissioning hub' model. The team will continue to be hosted by NHSE in 2024/25 but will operate as the Midlands Commissioning Hub on behalf of the East and West multi-ICBs and NHS England for the commissioning of delegated and retained specialised services. The regional design model also includes the transfer of the West Midlands Cancers Alliance to a host ICB which is yet to be determined. In April 2025, NHS England staff supporting the services that have been delegated to ICBs, whether in April 2024 or April 2025, will be transferred to a host ICB, in most cases joining the existing commissioning hubs for primary care services. For the West Midlands multi-ICB the commissioning hub will be hosted for 1sr April 2025 by NHS Birmingham and Solihull ICB for the specialised services workforce (including commissioning finance, and nursing and quality) and NHS Nottingham and Nottinghamshire for the commissioning support functions (Business Intelligence, Communications and Engagement, Planning and Commissioning Integration).

	A small number of staff will remain as NHS England employees to support those directly commissioned services that are retained by NHS England. Specialist members of the Healthcare Public Health team will remain as part of the NHS England regional team but will continue to be an integral component of commissioning and continue to work closely with the Midlands Commissioning Hub and ICBs. The hosts will provide corporate management and support for the workforce. Decision-making will be through the Joint Committee and ICBs are agreeing dispersed Chief Executive leadership for specific areas of joint working. Detailed conversations with future ICB hosts about working arrangements are underway and engagement sessions are planned as part of the TUPE consultation, with opportunities to meet with representatives of the host ICBs. The agreements will be subject to due diligence to ensure a safe transition, and the process for the proposed transfer of people will be in line with employment legislation and will comply with established NHS processes.
5b. Please set out any risks around the proposed staffing model, with regards to whether it will provide sufficient capacity, skills and knowledge to enable ICBs to carry out the delegated functions? ***(400 words max)***	The Commissioning Hub model described above has been designed for a number of purposes which include, • Retaining the knowledge, skills and experience of the existing team. • Aiding staff retention and talent management. • Building on existing relationships with ICBs and providers. • Providing clear points of contact for clinicians and networks. • Allowing commissioning decisions to made across patient pathways, geographical boundaries and in respect of both delegated and retained services. However there have been a number of risks identified with the future model, • Balancing the needs of two multi-ICBs and 11 ICBs. • Former NHS England staff will be split between two host ICBs in different multi-ICBs which may hamper close working relationships. • Having differing governance models dependent on whether a service is delegated or retained.

	• Increasing the number of stakeholders may increase the workload surrounding decision-making. • Holding vacancies within the team as a result of the recruitment freeze in the lead up the regional consultation on the Creating the New NHS England programme. • Staff wellbeing and retention being affected during the TUPE consultation required for transfer to host-ICBs. • Uncertainty around future infrastructure (IT/IG/Estates) leading to anxiety within the team. • Requirement for NHS England to retain oversight and assurance over delegated services, however the details of how this will operate are still being worked through.

For completion by regional colleagues: With consideration of the responses above, please indicate the (multi-)ICB's readiness for delegation - including as part of any multi-ICB arrangements against the 'Workforce Capacity and Capability' domain:

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Domain 6: Data, Reporting and Analytics Infrastructure	
Question	**Response** *Please ensure this reflects on both the individual ICB/s and multi-ICB arrangements as appropriate*
6a. Describe your approach to integrating	Business Intelligence is provided via a national service level agreement (SLA) held by the NHS England and supplied by Arden and GEM Commissioning Support Unit (CSU). The SLA is carried out through the provision of the data warehousing structure and the analytical resources which support the commissioning of NHS England services. For the commissioning of specialised services, this

specialised services into (existing) population health management analytics. This should provide assurances of the intended data and analytical framework, and CSU support that is required for the delegation of specialised services. ***(400 words max)***	is extended through the provision of SUS, ACM and PLCM data submissions by providers, as well as the provision of specific dashboards through the National Commissioning Date Repository (NCDR). Reporting is being made available to all ICB's via NCDR and this system is available to all those wishing to register. Information within NCDR will be reported and broken down by ICB to support joint working arrangements before delegation April 2024. There is ongoing work by NHS England to support ICBs, enable access to data services and data sets, and ensure that all relevant data sharing agreements, infrastructure, and reporting libraries are in place. ICB level analysis to support the provision and future planning of services at population level will be aligned through ongoing health inequalities work conducted by ICBs and the Public Health Team for NHS England in the Midlands region. Plans are being developed for ICBs to receive training on key resources that they will need to understand, and a forum for engagement with NHS England on the provision of new tools and analysis to support information and intelligence gathering is being established. Plans for the delivery of BI and the use of CSU support is being explored on both national and regional levels to ensure appropriate management of information services. The data and business intelligence workstream's aim is to understand the future operating model in order to transition to multi-ICB arrangements to support delivery of services. These discussions are continuing to develop and be fed into local plans following engagement on the outcome of national workstreams looking at the future capacity of the CSUs to support future commissioning arrangements with ICBs. A current SLA in place with AGEM CSU and the relevant divisions of the ICBs' Data Services for Commissioning Regional Office (DSCRO) services and NHS England is expected to continue through April 2024 to ensure coverage and access to service and analytical capacity to support transformation and contracting of services. Within the Midlands, this is expected to plan to join up specialist analytical capacity to support an MDT approach.
6b. How are the ICB/s planning	Data sharing agreements already exist which cover the sharing of Secondary Use Service (SUS) data through relevant DCROS to ICBs. Lessons learnt regarding the extraction and submission of Aggregated Contract Monitoring (ACM) and Patient Level Contract

to use data to support transformation and service redesign for delegated specialised services? ***(400 words max)***	Monitoring (PLCM) for specialised services is helping the CSU and NHS England to understand barriers which need to be overcome to improve sharing of information into ICBs. A workstream approach is being utilised to develop the BI support offer to ICBs to enable the data relating to the commissioning of specialised services which will be delegated to ICBs in the future. A nationally led commissioning BI group is in place, with leaders in attendance from across the regions and CSUs. This group will oversee the governance for national projects which cover Information Governance (IG) and the other compulsory duties related to the sharing and hosting information services for the purpose of transformation. Additional ICB governance to support and jointly own this process will be developed in line with other joint working agreements and existing proposed governance infrastructure. Midlands teams are supporting ongoing work with the CSU to share analysis of Programme of Care (POC) data via existing BI platforms such as NCDR and Power BI to support the understanding and future commissioning of services and to enable ICBs to be in possession of their data relating to their populations to inform decision-making. Work is continuing with POC leads and commissioning managers in the regional team to develop support, utilising nationally developed dashboards already in place as well as understanding whether there are further reports regionally which can be developed or amended to support local regional priorities.
6c. Describe your plan to ensure there will be appropriate access to data and reporting infrastructure across the system in	Lessons learned from the South London Project have now been disseminated to regional colleagues and these are being used to aid the development of processes and products which will be used by the Midlands Commissioning Hub following the delegation of specialised services to integrate systems, service delivery and transformation. Options relating to the processing of data through contracted DSCRO's, appropriate access to data, the reviewing of data sharing agreements and IG issues which need to be addressed are being considered. Data sources for high-cost drugs including, Blueteq, Model Health system, Define, Exend and MDSAS immunoglobulin database will be used by the pharmacy team within the hub to facilitate and promote the optimised use of high-cost drugs.

relation to the delegated services. This should include the requirements as set out in the NHS Standard Contract and Information Schedule. ***(400 words max)***	Work on the Data Protection impact Assessment (DPIA) is being managed nationally through single approach with regional support. DPIAs which are already in place for Pharmacy, Optometry and Dental (POD) services will be updated and altered for the inclusion of other services once operating and business model more fully understood. This is currently expected to be standardised approach as per POD delegation to ICBs.

For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements – against the 'Data, Reporting and Analytics Infrastructure' domain:

√ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Where conditions are required for this domain area, please set out what these are and include any actions, plans or support needed, along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Signatories

This document should be signed by the ICB(s) and the relevant NHS England Regional Director of Commissioning.

It should also be verified and signed by the relevant NHS England Regional Director.

For completion by the ICB Chief Executive(s) for the geographical footprint to manage the full set of in-scope services (and, where different, the duly authorised signatory of the delegation or as defined by the ICB Scheme of Reservation and Delegation):

I confirm that the information provided is accurate and complete. Where applicable, supporting evidence has been provided to the regional team. This submission indicates our willingness to proceed with delegation arrangements.

NHS Coventry & Warwickshire ICB

Philip Johns (Chief Exec)

Signature:

Date: 25.09.2022

NHS Herefordshire & Worcestershire ICB

Simon Trickett (Chief Exec)

Signature:

NHS Black Country ICB

Mark Axcell (Chief Exec)

Signature:

Date: 25.09.2022

NHS Birmingham & Solihull ICB

David Melbourne (Chief Exec)

Signature:

Date: 25.09.2022

NHS Staffordshire & Stoke-on-Trent ICB

Peter Axon (Chief Exec)

Signature:

Date: 25.09.2022

Date: 25.09.2022

NHS Shropshire, Telford & Wrekin ICB

Simon Whitehouse (Chief Exec)

Signature:

Date: 25.09.2022

For completion by the NHS England Regional Director of Commissioning:

I confirm that the information provided is accurate and complete. Where appropriate, supporting evidence has been provided by the ICB/s and reviewed by the regional team.

Roz Lindridge

Regional Director of Commissioning

Signature:

[insert scanned image of handwritten signature]

Print Name:

Date: 25.09.23

For completion by the relevant NHS England Regional Director:

Based on the information provided, I am satisfied with the following assessment of system readiness for the (multi-)ICB to take on delegated commissioning responsibility for the in-scope services, from April 2024.

Please check box as appropriate to provide an assessment of each ICB within the footprint:

NHS Birmingham and Solihull ICB
✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

NHS Black Country ICB
✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

NHS Herefordshire& Worcestershire ICB
✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

NHS Coventry & Warwickshire ICB
✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

NHS Shropshire, Telford, and Wrekin ICB
✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

NHS Staffordshire and Stoke-on-Trent ICB

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Please check box as appropriate to provide an overall assessment of the multi-ICB footprint:

✓ Category 1 (delegation) ☐ Category 2 (delegation with conditions) ☐ Category 3 (intensive support required)

Please provide any further comments below. If Category 2 (delegation with conditions) or Category 3 (intensive support required) has been selected as the overall assessment, please summarise the rationale behind this decision, set out what the conditions are, and include any actions, plans or support needed along with timescales. Where applicable, please detail where conditions will apply across the whole multi-ICB arrangement; and where they are specific to individual ICBs.

Dale Bywater

Regional Director

Signature:

[insert scanned image of handwritten signature]

Date: 25.09.23

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This publication can be made available in a number of alternative formats on request.

1. CEO Report	2. ICS Digital	**3. NHSE**	4. STW ICS People	5. Integrated Care	6. Quality and	7. Finance

1. CEO Report	2. ICS Digital	3. NHSE Delegation	**4. STW ICS**	5. Integrated Care	6. Quality and	7. Finance

Integrated Care System

Shropshire, Telford and Wrekin

Our ICS People Culture & Inclusion Governance & Operating Model

September 2023

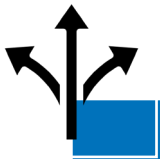
Mapping and Prioritising People Strategy to new Themes

SRO Clair Hobbs :Train

- Coordinate our approach to apprenticeship programmes
- Develop a 'one place, integrated approach to the development of our non-medical multi-professional health and social care clinical and non-clinical workforce.
- Work with HEI's to support reduction in pre –registration attrition for students on Shropshire clinical placement circuit
- Implement centralised CPD/ apprenticeship / development funds and their stewardship

SRO Denise Harnin: Retain

- Raise the profile of a consistent approach to flexible working
- Specifically support international recruits to enable improved retention
- Implement Legacy Mentors
- A single system approach/ offer to our people's wellbeing



SRO Rhia Boyode: Reform

- Scaling People Services corporate integration programmes (workforce information & ESR, Recruitment, HR, OD, Temporary Staffing/Bank, Rostering etc)
- Tracking, challenging & reporting on workforce availability/supply metrics
- Further develop the single workforce plan to articulate our future system workforce roles, numbers & skills
- Begin using a common & shared set of key workforce metrics for all system employers
- Embed the One Workforce principle (people first) in all our key work programmes
- Work together to develop recruitment marketing & branding for all STW health & care employers

SRO: Emma Wilkins: Transform

- Ensure our single approach to inclusion is for everyone, and focussed on key priorities (including inclusive leadership)
- Ensure there is visibility & reporting of system wide staff survey results
- ICB OD Development Programmes for Execs Board and staff
- ICB redesign
- System wide OD and coaching collaborative
- System Wide Talent management plan
- System Leadership Talent pool

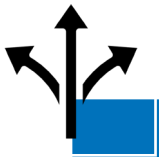
Mapping of Current People Programmes to new Themes

SRO Clair Hobbs: Train

- Increase our pre-registration student placements and develop a sense of belonging to STW from onset of placement
- Co-ordinated approach to attract, engage and grow a locally sustainable workforce talent pipeline: Step into Work / pre-employment progs, 11 -17 age group & 18 and over adults
- Work in partnership with local further education (FE) colleges to shape T-level and other foundation programmes to meet targeted workforce gaps (clinical /non-clinical)
- Work with FE's and Higher Educational (HI) institutions to develop robust workforce talent pipelines into local and further afield HEI's
- Continued roll-out of the Oliver McGowan Training
- 'One place'' co-ordinated approach to local delivery of clinical education and training
- Apprenticeships

SRO Denise Harnin: Retain

- System-wide Retention programme (5 HIAs)
- Annual H&WB programme
- Menopause: Business case for Staff group Consultation/STW model
- Menopause Education in line with Retention HIA's
- Menopause: STW Policy in line with Retention HIA's
- Psychological Wellbeing Hub – funding plan for 24/25
- Development of clear pathway for MH support and treatment in line with H&WB Framework and EDI HIA's
- Deliver Be Well West Midlands Programme
- Develop and improve engagement with the H&WB programme
- Development of STW rotation post including social and Primary care
- Develop retire and return opportunities



SRO Rhia Boyode: Reform

- Implementation of Workforce Transformation team (workforce planning, OD, workforce analytics and HR) approach to deliver strategic workforce planning & transformation for patient services
- Implementing Workforce Sharing (Passporting)

SRO Emma Wilkins: Transform

- Development of Staff Networks
- Deliver EDI improvement plan
- Respond to Rural Racism research findings
- Equality Reporting (WRES, WDES, Gender Pay & WREI
- Deliver Anti Racist Action Plan
- Implement SAND Covenant
- Freedom to Speak up 1° care
- Embed EDI in recruitment , onboarding & people management
- Leadership & management training for EDI related workforce issues
- System wide cultural ambassador development
- Aspirant ethnic minority N&M leader's programme
- Clinical leadership development
- ICB Executive Team Inclusive leadership Development
- High Potential Scheme

People, Culture & Inclusion: Proposed Governance Structure
(With current System Groups re-mapped under new portfolio headers)

New/refreshed

Train	Retain	Reform	Transform
Growing for the Future Group	Retention Steering group	Workforce Planning Group	OD & Leadership Steering Group
Education & Learning Group	H&WB Steering Group		EDI Steering Group
Widening Participation Group			High Potential Scheme

Integrated Care System

Shropshire, Telford and Wrekin

Detailed Update on Current ICS People Team Work Programmes

August 2023

Train Portfolio: Proposed SRO Clair Hobbs – (ShropCom)

Widening workforce participation

- **11-17 year olds = Next Gen**-co-ordinated engagement with schools/careers teachers /events to develop sustained future workforce talent pipeline
- **19+ year olds**
- virtual work experience
- step into work /pre-employment programmes to meet current nonclinical & HCSW domestic workforce talent pipeline
- Learning from success of HCSW strategy, further develop ICS website with active marketing to maximise system offer

Education & Learning

- One system approach to local delivery of education, training and skills development work toward single Learning management system
- work toward single Learning management system
- Work toward single Learning management system
- Maximise opportunities utilising simulated learning environments
- Development of educator development framework
- Roll out of Oliver McGowan statutory training

Growing for the Future

- Work with FE's to grow clinical /nonclinical T-level and foundation programmes in response to clinical/nonclinical workforce gaps
- Increase and vary pre-registration placements
- Work with HEE's to reduce pre -reg attrition and increase employability on registration
- Apprenticeships

Retain Portfolio : Proposed SRO Denise Harnin (RJAH)

Psychological wellbeing model

- Collaborative STW model
- Scoping pathway needs
- Comms across STW
- Mental health steering group

Menopause policy and staff group

- Menopause steering group
- Cultural change around menopause approach
- Staff group consultation model business case

Annual scheduled STW inclusive H&WB offer

- Scope STW H&WB offer across STW including financials
- Comms engagement inline with influential survey results
- H&WB dashboard

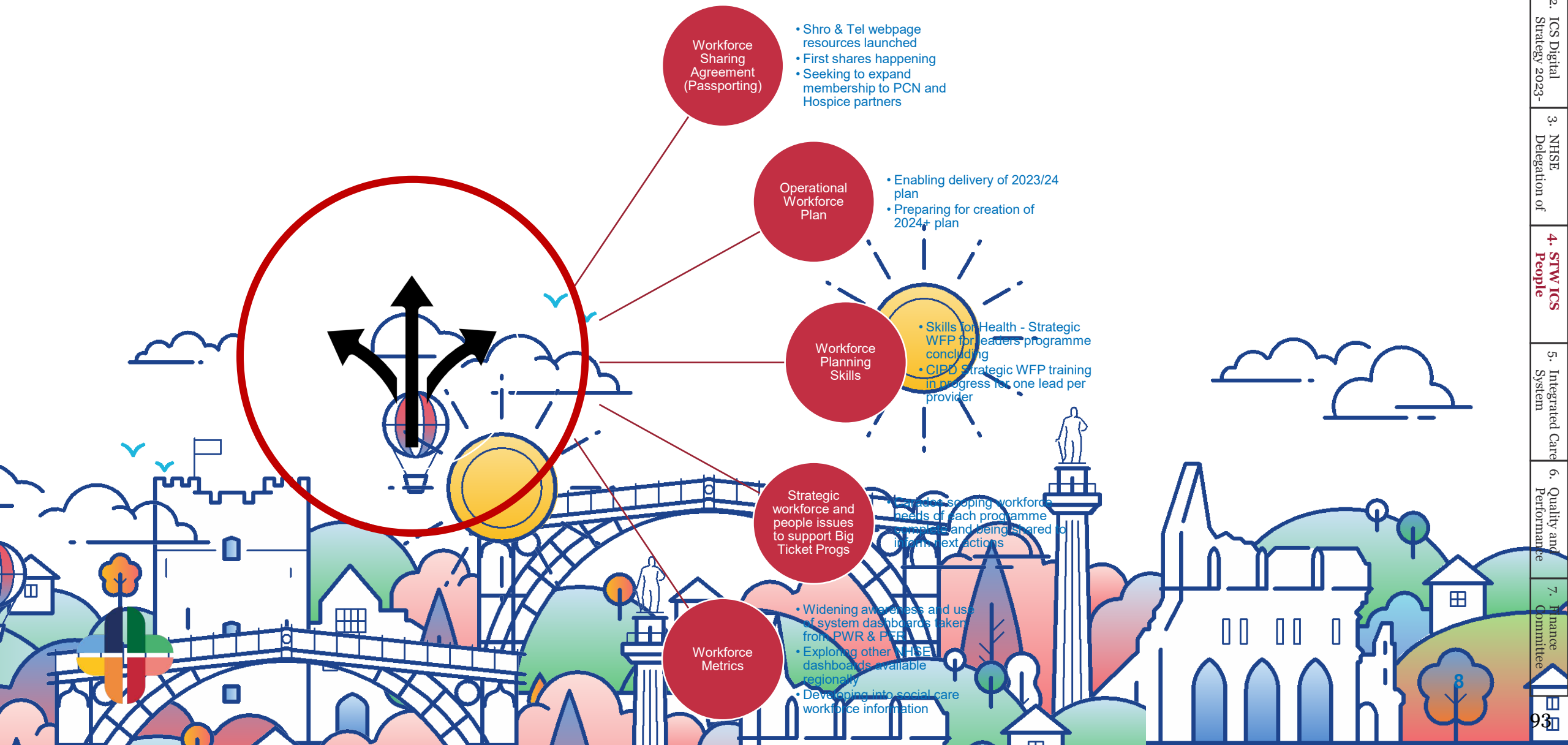
5 High Impact retention actions

- National preceptorship framework
- Legacy mentoring scheme
- Pension seminars (R&R)
- Retention self-assessment national tool – action plans
- Menopause policy

STW strategic retention objectives

- Measurable objectives
- Flexible working – embed through attract, retain and return models
- Career development
- Rotational post across STW
- Itch/ feet conversations
- Working towards standardising appraisal approach
- Workforce retention dashboard

Reform Portfolio: Proposed SRO Rhia Boyode (SaTH)



Transform- OD Portfolio: Proposed SRO Emma Wilkins (SaTH)

ICS OD & Leadership Skills

- Action learning set facilitator training
- Placement panels for stretch opportunities training
- Honest/Difficult Conversation training
- SDO Psychometric Diagnostic Facilitator training
- Career Coaching Workshops

Inclusive Talent Management: High Potential Scheme

- Informed by 6 EDI High Impact actions to have an inclusive talent pipeline for a stronger & more diverse cohort of aspirant leaders
- Cohort 2 (2023 – 2025)
- 29 participants
- Buddy model with SSOT

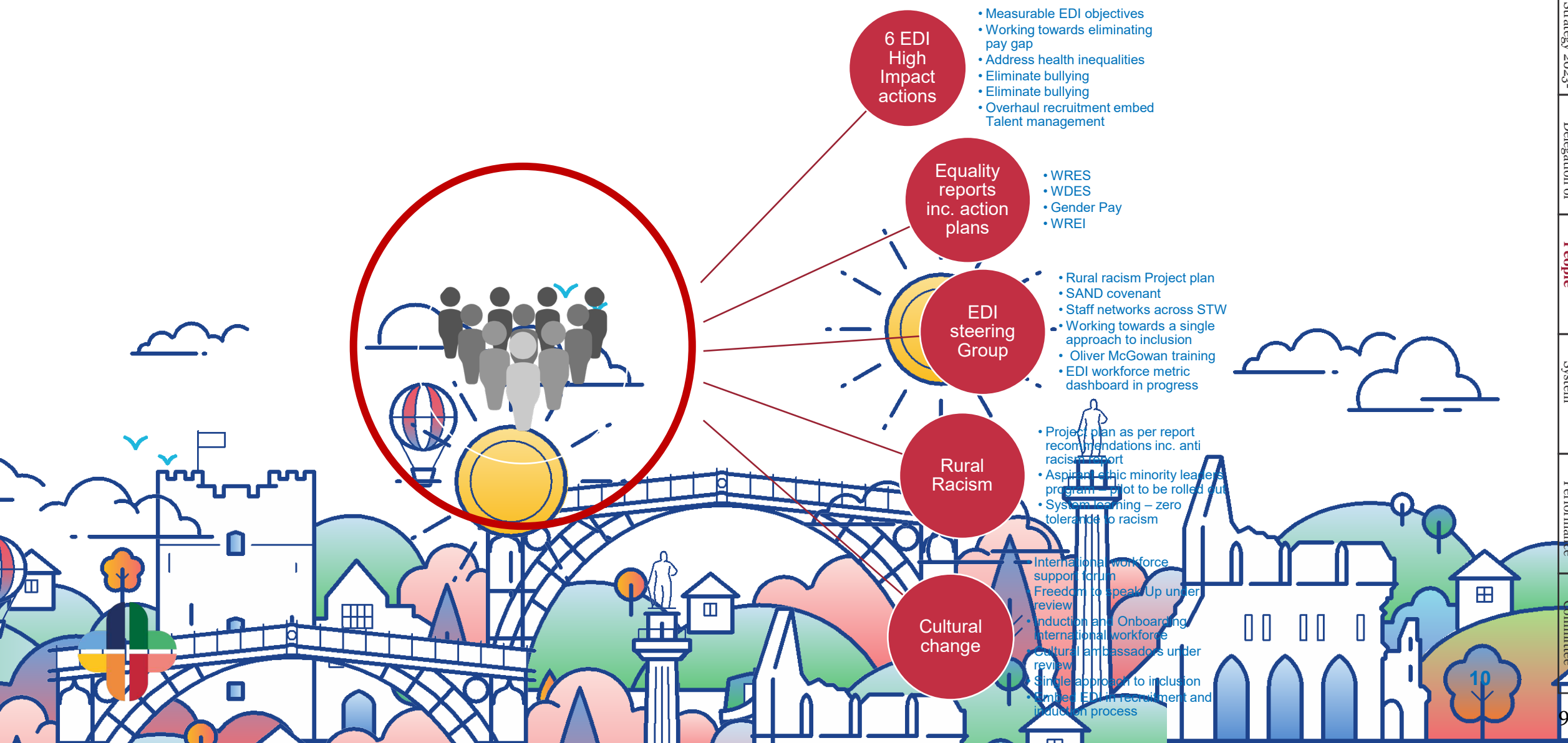
ICB Executive Team Development & ICB Inclusive Leadership Development

- Delivered ICB staff development day
- Board development day 5th September
- Programme to reshape ICB #3

People Team development

- Building coaching, improvement consultancy programme & project management skills to enable innovation & transformation in collaborative system workforce programmes

Transform- EDI Portfolio: Proposed SRO Emma Wilkins (SaTH)



Integrated Performance Report
September 2023

Summary

The September report includes performance reporting across the 4 domains of Operational delivery, Quality, Finance and Workforce to provide assurance to the system by representing individual functional risks and mitigations but also the wider strategic impact on performance for patients. An emerging risk to the system is the ongoing industrial action (IA) by staff. Whilst functional areas may reference IA specifically within the report, the Month 5 report is attempting to link these elements to highlight the impact at an overall system level.

Provider	M5 YTD Cost	Comments
RJAH	£0.3m	Decreases in clinical income due to reduced activity levels net of marginal costs, FOT Estimate £3.1m.
SaTH	£1.4m	Cost of re-providing activity through insourcing and additional waiting list initiative sessions.

	19th & 20th September Cancellations due to Industrial Action					
Provider	Outpatients	Elective Inpatient	Elective Daycase	78 weeks	104 weeks	Cancer patient
RJAH	349	19	25	2	1	0
SaTH	232	8	26	1	1	0

There may be an impact on staff well being as a result of IA, which is harder to identify and quantify. SaTH have noted that whilst their sickness rates reduced in August, 26% of their sickness absence is mental health related which remains a concern. Further investigation would be required to identify themes and additional support require

Operational Performance

The validated activity data month for the purposes of this report is July 2023, however, where possible unvalidated August data from providers has been included. Charts showing performance against national targets and improvement trajectories is included at Appendix A.

1. Primary Care

1.1 General Practice continues to provide more appointments now than before the pandemic, with 74% of these appointments being face-to-face, however, the rise in demand continues to outstrip this additional supply. Despite the increasing demand, the percentage of GP appointments seen within 2 weeks is 84.7% and the percentage seen the same day or next day is 52.9% with both standards performing better than national performance.

1.2 NHSE published the GP Access Recovery Plan on 9th May 2023 and puts GP Access recovery on the same national priority footing as elective and UEC recovery. In line with the guidance the System GP Access Improvement Plan is scheduled to come to Board in November 2023 and will include:

a) Empowering patients (NHS App, increasing self -directed care, expanding the community pharmacy offer)
b) Building capacity (additional roles, improving recruitment and retention, higher priority for General Practice in housing developer funding)
c) Implementing Modern General Practice (better digital telephony, similar on-line requests, faster navigation, assessment, and response)
d) Cutting bureaucracy (improving the interface between General Practice and Secondary Care).

1.3 Funding has been received to enable 17 practices to transition to digital telephony which will result in all 51 practices using digital telephony by March 2024 and significantly improve patient experience and satisfaction when contacting their practice.

2. Urgent Emergency Care

2.1 Whilst ambulance handover delays have declined in July and August for both <60 minutes and <15 minutes and for the first time in 23/24 is not meeting planned trajectory. Total ambulance hours lost increased to 2879. Regional performance has remained consistent, therefore STW are not aligning to the normal matched trend against the regional values. This is believed to be related to the combined impact of Industrial Action and annual leave/sickness which has also led to deterioration in all the key UEC metrics.

2.2 The ICB and wider system recently hosted 3 separate visits from NHSE focusing on patient pathways, discharge and winter readiness and feedback will be incorporated into recommendations for improvement. There are several existing improvement initiatives underway, that if successful would contribute to improving performance against both ambulance handover and A&E metrics including deep dives for admitted and non-admitted mean time in ED and a focus on frailty and criteria to admit in preparation for winter. This work will be consolidated into a revised UEC improvement plan, which may need to be re-prioritised to ensure delivery and used to set a revised recovery trajectory.

2.3 Mean ambulance response times for Category 1 remain significantly challenged but Category 2 response has shown improvement and at 35 minutes for August is ahead of planed improvement and close to the year-end national target of 30mins, and in line with regional performance.

2.4 A&E 4-hour waiting time performance has reduced since quarter 1 with 61.5% of patients in August being admitted, transferred, or discharged within 4 hours, whilst the number of attendances show no significant variation. A&E at SaTH is at 51.6% for August against an improvement trajectory of 71.5%. A revised improvement recovery trajectory will be developed as described above, monitored through weekly KPI system meetings, and presented to UEC Board in October. All trusts are expected to achieve at least 76% by March 2024.

2.5 The ability to triage patients within 15 minutes of arrival has been below trajectory since June with August performance being 32.1%% against trajectory of 40% and significantly below the regional average at 56.2%. Patients spending more than 12 hours in the department was reducing in line with trajectory but since the end of June has started to increase.

2.6 Several indicators assist with measuring the ability of an organisation to manage flow. Bed occupancy standards are set at a maximum of 92% and for the last 6 months SaTH has been below this level whilst also being lower than the regional and England rates, given the level of escalation capacity being used this reporting does not appear to be accurate and SaTH are investigating this.

2.7 A further factor is the number of patients with no criteria to reside (NCTR) in hospital beds. The number of NCTR patients has continued to decrease from the high in December with an average of 117 patients in August against a trajectory of 109. Work has been focused to reduce the length of stay of these patients which has reduced from 5 days at the start of the year to 4 days in July and August.

2.8 The virtual ward (VW) service continues to expand with capacity increasing to 148 virtual beds from the 1st August which has reduced the utilisation rate to 39%. September has seen utilisation rates begin to increase both in Step-up and Step-down patients. Referrals of 182 patients were received into the VW which allowed patients to stay at home while receiving treatment for higher acuity needs. Work is ongoing to develop clinical pathways and focus will be on targeting frailty and respiratory conditions as winter approaches.

2.9 The Urgent Care Response (UCR) team continue to support patients to remain out of an acute setting by providing a 2-hour response. In July there were 541 referrals to this service with response times consistently above 90%. This is significantly above the 70% standard and the national average.

2.10 Work is underway with NHSE to implement a 'Call Before You Convey' concept with WMAS and NHSE will be develop a memorandum of understanding which will outline the key principles and parameters. Focus will be on the patients over 75 with no 'red flags' and analysis will identify the top 5 missed opportunities i.e. cases that are bypassing the SPA and conveyed directly to ED. This concept is expected to be operational from mid-October.

2.11 ICBs are encouraged as part of the NHSE accelerator programme to have one single point of access for the system in line with national guidance currently under development which will simplify and provide ease of access for healthcare professionals. Further discussions will be necessary to establish if this is the route the system wishes to take.

3. Planned Care

3.1 At the end of January SaTH were moved into Tier 1 monitoring by NHSE due to the ongoing concerns with elective recovery concerning 62-day cancer progress and the elimination of 78-week Referral to Treatment (RTT) waits. Due to the improved end of quarter 1 delivery on Referral to Treatment waits (RTT) it is anticipated that SaTH will move to Tier 2 but remain in Tier 1 for Cancer.

3.2 Cancer services continue to be very challenged. The latest data shows that the Faster Diagnosis Standard (FDS) improved by 3.5% over the previous month to 66.5% in July, although it is still behind the trajectory of 67.3%. There were 386 patients waiting over 62 days which is better than the trajectory of 424 patients. An improvement trajectory to achieve compliance has been approved by NHS and is monitored at Tier 1 meetings.

3.3 From the 1st of October 2023 the current cancer standards will be simplified in to three standards:

- 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%)

3.4 The published position for July for long waits had 1 patient waiting over 104-weeks and 8 patients waiting more than 78-weeks. As at mid-September, SaTH had no patients waiting over 104-weeks and 1 patient over 78-weeks. RJAH had one ongoing over 104-week wait due to requiring complex kit and had forecast 5 over 78-week waits, although Industrial Action is expected to increase this to 9 patients. This reflects a huge effort to reduce the long waits which were standing at several hundred a few months back and has been mainly achieved using mutual aid arrangements with other providers and insourcing. It should be noted that NHSE have stated that STW were currently the best performing system for 78-week waits in the Region.

3.5 The 2023-24 Planning Guidance has a target of zero 65-week waits by the end of the year and to achieve this all patients in this cohort will need to have had a first appointment by the 31st of October. SaTH are comfortably ahead of trajectory and at the beginning of September has 360 patients against a trajectory of 438. RJAH have fallen behind trajectory by 103 patients, with Industrial Action a major concern to delivery but the Trust remain confident that all these patients will be dated before the October deadline.

3.6 Work is underway through the System Productivity oversight Group to forecast activity for the rest of the year to identify opportunities and to mitigate any risks to income in line with the new national ERF guidance. Provider forecasts were received mid-September and plans will be finalised by system leaders at the end of September. The ongoing industrial action is having an increasingly detrimental impact on the delivery of Value Weighted Activity, particularly at RJAH, which is impacting on the overall system position.

3.7 The ICS is in recovery against the overall 6 weeks standard for diagnostics, with the latest validated position of 68.4% being seen within 6 weeks versus the July plan of 68%. The operational plan shows delivery of 85% of diagnostics within 6 weeks by the end of March 24, overall and for all modalities except Endoscopy.

3.8 A deep dive report for diagnostics was presented to Planned Care Delivery Board in July to explain the current situation and quantify the gap in capacity for delivery. A non-recurring investment of £1m from the West Midlands Cancer Alliance was approved by SaTH Trust Board and will be operationalised shortly. The sustainable endoscopy business case is proceeding through internal governance processes and is at the final stage of approval by the Medical Director. Additional CT capacity will be provided through the CDC from October and MRI from the end of November.

4.0 Mental Health, Learning Disabilities and Autism

4.1 NHS Talking Therapies access numbers continue to fall with July being 22% of plan in month and 44% year-to-date. This is due to changes in counting and coding on implementing the new combined service. There is now a risk that the service may not achieve the year-end target. Assurance and a formal recovery plan has been requested from MPUFT and an update to Quality and Performance Committee will be provided through a deep dive paper in September.

4.2 Recovery rates are often below the 50% target due to incorrect referrals to the Talking Therapies service who are subsequently discharged without treatment. Those patients who did complete core treatment generally have a good recovery. A waiting list initiative is in place to address the more complex patients who are not suitable for the core service.

4.3 Dementia diagnosis rates to July 2023 are 59% and show a continuation of modest improvements in line with the trajectory but remain below the national target of 66.7% and the England average of 64%. A refreshed recovery plan has been developed to increase the pace and rate of diagnosis. Plans include, waiting list initiatives through August and September and work with GPs to identify areas for improvement. Focus on care homes and over-85s will identify people for earlier assessment. Waiting times from referral to starting assessment are now reducing which is a positive step.

4.4 Children's access to Mental Health Services is below the long-term plan target, with some data and recording issues identified. Further MH Support Teams (MHST) are being implemented to extend services to more schools and increase access. A deep dive paper was presented to the Committee in June detailing the current position and the risks of long waiting times. An update in respect of data quality improvements and refreshed access performance will be presented in September.

4.5 The number of children waiting more than 18 weeks at the end of August 2023 is 1010 equating to a 52% compliance rate against the 92% standard. The number of children waiting over 30 weeks has increased though the number waiting over 50 weeks have reduced due to prioritisation of the longest waits. Families waiting for ASD assessment have been given the option to remain on the waiting list or to have an online contact with an external provider. Of the 100 contacted, 50 have opted for the online contact. Demand continues to exceed current service capacity and short-term waiting list initiatives will focus on the longest waits.

4.6 CYP Eating Disorders quarterly published data is not yet available for 23/24. MPUFT data shows compliance for Urgent cases is 100% for July and 81% for routine referrals which represents improvement on previous months. This is due to increased capacity because of further investment.

4.7 Psychiatric Intensive Care Unit (PICU) and Acute Out of Area placements demand is volatile but occupied bed days for inappropriate placements continue to be within the operational plan target. At the end of July there was 1 inappropriate acute placement, and 3 inappropriate PICU placements The high demand is a national issue and is continually under review. Results of the bed base review for STW and neighbouring systems is awaited.

4.8 The number of adults waiting for an ADHD assessment continues to increase which exceeds current service capacity. Of the 2491 waiting at the end of July 1754 (70%) are waiting over 18 weeks with the maximum wait is 88 weeks. Waiting list programmes are in place to address the longest waiters. Some patients are exercising their right of choice of provider. National discussions about ADHD are taking place, including a quality audit completed. Progress will be discussed at the Regional Mental Health Oversight Group in September. Plans to procure a local assessment service are being worked through and a paper to discuss patients with complex mental health needs will be presented to Commissioning Working Group in September.

4.9 Inpatient stays for adults with a Learning Disability (LD) are 18 inpatients (45.8 per million population) in July against a plan for quarter 2 of 17. The ICB are refocusing in this area and working with regional colleagues via supportive performance reviews to ensure that the end of year target is met.

4.10 There are 3 children (30 per million population) with LD in inpatient beds against a target of 15 per million population plans are in place to discharge 2 children.

5. Quality

A summary of quality indicators is provided at Appendix B.

5.1 Infection Prevention and Control Metrics are showing that the system will exceed the national objective set of 76 cases. It is currently reporting 41 cases against a trajectory for 2023/24 year to date (end July 23). NHS providers have reviewed their action plans and a system plan will be in place from October 23. A risk is now on the System risk register and monitored through the Quality and Performance Committee

5.2 The maternity dashboard continues to be monitored locally providing increased assurance of improvement.

5.3 There has been 1 never event (SATH) which is currently under investigation reported to June 23. The ICB Quality Team is working with all health partners to understand ongoing assurances in relation to prevention of these incidents.

5.4 The Emergency Department friends, and family test has improved to 91.7%, however this is based on only 12 responses.

5.5 Mixed sex accommodation breaches at SaTH are increasing with 102 reported in June 23. Numbers are associated with UEC pressures and high bed demand. An internal action plan is in place but there is a lack of impact due to ongoing pressures. The NHS STW Quality Team continues to work with the Trust to review the action plan.

6. Finance

Month 5 Financial Position

Revenue:

6.1 At Month 5 the STW system is reporting a £23.1m adverse variance to the plan submitted (£59.2m deficit against an £36.1m deficit plan). The SaTH overspend continues in line with previous months in a number of areas and in Month 5 there is also a deterioration in the ICB position due to overspends in both prescribing and CHC. (See Appendix C for detail)

6.2 At Month 5 system agency expenditure is exceeding plan by £7.9m (£25.2m spend YTD versus £17.3m plan) and is exceeding the agency cap by £13.9m (cap is £11.3m YTD).

6.3 The system is reporting a forecast break-even position against the financial plan submitted (£57.1m deficit) but there remains significant high risk to delivery. Unmitigated risk reported at Month 5 totals £81.8m across the system. All organisations are working through updating risk values and developing phased mitigation plans for the year to discuss and agree a realistic forecast position with NHSE through the FOT change protocol. The main areas of risk are related to:

- Efficiency delivery- particularly delivery of the system stretch target
- Elective recovery delivery and receipt of associated income
- Escalation costs
- Staffing and related cost pressures
- Discharge expenditure with Local Authorities
- Prescribing and CHC-particularly around pricing increases seen regionally and nationally

Capital:

6.4 At Month 5 the overall system capital position is £3.7m under planned expenditure. All organisations are reporting slippage in phasing of internal programmes. All provider organisations are continuing to forecast break even against the capital plans by the end of the year.

7. Workforce

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

- RJAH is -60 WTE behind plan
- SaTH is +308 WTE ahead of plan
- SCHT is -47 WTE behind plan

7.2 Tracking the WTE of staff groups used in the operational plan, data shows that the Pharmacy workforce has been and continues to fall across all three providers, which is an area of concern.

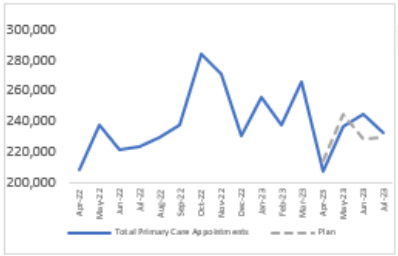
7.3 Tracking vacancies by employer, our data shows us that vacancies continue to fall overall, and also within RJAH & SaTH but are rising within SCHT. Considering vacancies by staff group, of the 639 WTE vacancies at system level, 263 WTE are within the Nursing and Midwifery (N&M) staff group. Vacancies within Allied Health Professionals (AHP)are also rising.

7.4 From the perspective of our temporary, flexible workforce, bank WTE is increasing overall and increasing within RJAH & SaTH but decreasing within SCHT.

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

Primary Care

Total Primary Care Appointments

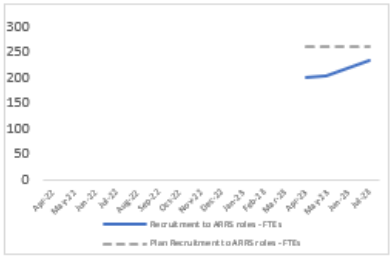


Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	236126	244819	232678

No of General Practice appointments within 2 weeks

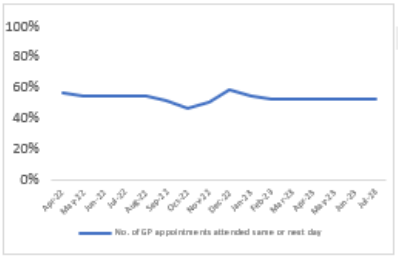
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	83.8%	84.4%	84.7%
National	82.5%	82.9%	83.5%

Recruitment to ARRS roles - FTEs



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	202	217	234

Number of General Practice appointments same or next day



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	52.7%	52.6%	52.9%
National	51.5%	51.2%	51.1%

Number of GPs in post (FTEs)

Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	306	305	305

No plan available

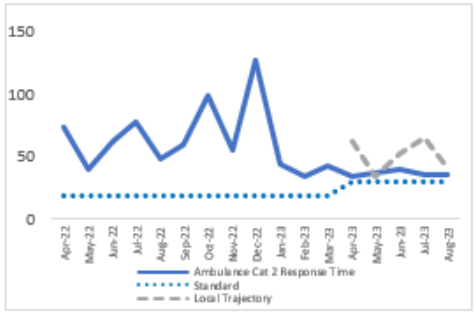
Primary Care Recovery plans will be presented to ICB Board in November and will be incorporated into future reports.

Integrated

Urgent & Emergency Care - Ambulance

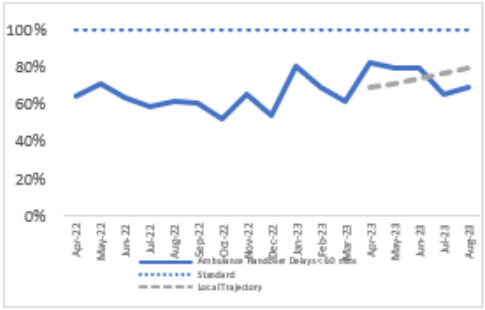
NHS
Shropshire, Telford and Wrekin

Ambulance Cat 2 Response Time



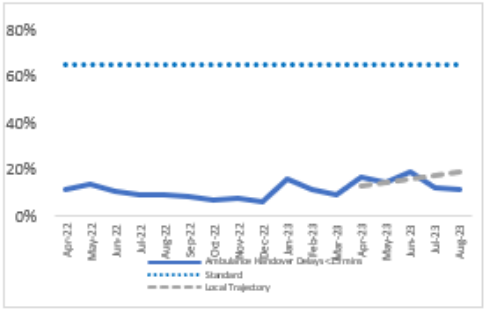
Organisation	Jun-23	Jul-23	Aug-23
Shropshire, Telford & Wrekin	39.3	35.0	35.6
Midlands	36.5	28.4	25.6

Ambulance Handover Delays < 60 mins



Organisation	Jun-23	Jul-23	Aug-23
Shropshire, Telford & Wrekin	79.2%	65.3%	68.8%
Midlands	91.4%	89.7%	89.5%

Ambulance Handover Delays <15 mins



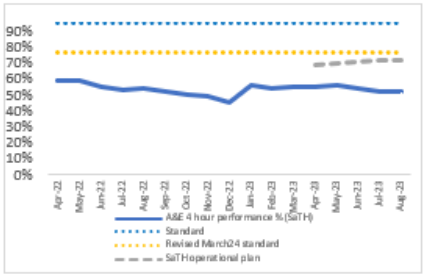
Organisation	Jun-23	Jul-23	Aug-23
Shropshire, Telford & Wrekin	19.3%	12.2%	11.7%
Midlands	33.3%	34.5%	31.3%

Integrated Care System

Urgent & Emergency Care –

NHS Shropshire, Telford and Wrekin

A&E 4 hour performance % (SaTH)

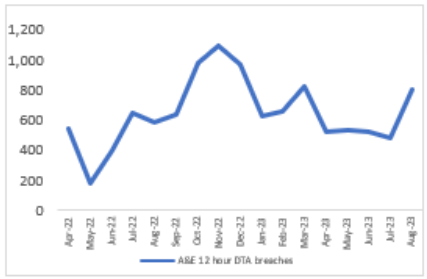


Organisation	Jun-23	Jul-23	Aug-23
Shropshire, Telford & Wrekin	63.8%	62.0%	61.5%
SaTH	53.8%	51.9%	51.6%
England	73.3%	74.0%	73.0%

% Patients who spend more than 12 Hours in ED

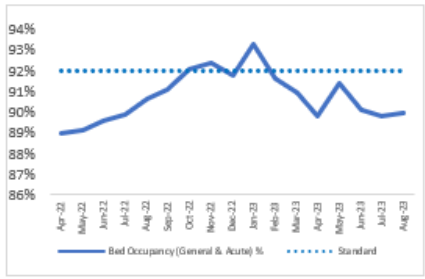
Organisation	Jun-23	Jul-23	Aug-23
SaTH	15.0%	17.4%	18.5%
Midlands	8.1%	8.4%	9.3%

A&E 12 hour DTA breaches



Organisation	Jun-23	Jul-23	Aug-23
Shropshire, Telford & Wrekin			
SaTH	525	479	803

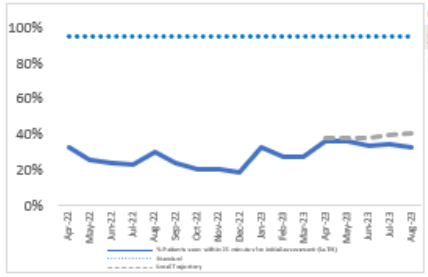
Bed Occupancy (General & Acute) %



Organisation	Jun-23	Jul-23	Aug-23
SaTH	90.1%	89.8%	89.9%
Midlands	93.7%	92.6%	92.3%
England	93.0%	91.8%	91.7%

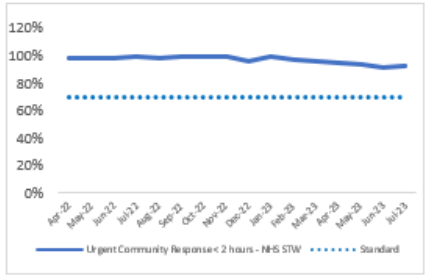
G&A occupancy rate - unadjusted

% Patients seen within 15 minutes for initial assessment (SaTH)



Organisation	Jun-23	Jul-23	Aug-23
SaTH	33.5%	33.9%	32.1%
Midlands	56.9%	56.4%	56.2%

Urgent Community Response < 2 hours - NHS STW



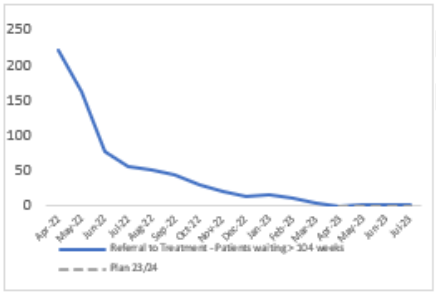
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	94%	91%	92%
Midlands	87%	89%	87%
England	84%	84%	84%

Integrated

Planned Care - Elective

NHS
Shropshire, Telford and Wrekin

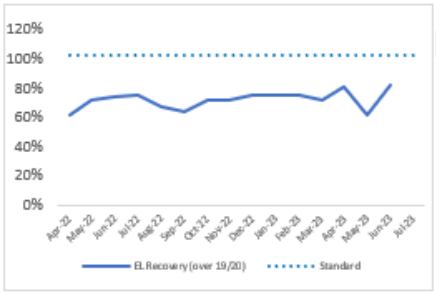
Referral to Treatment - Patients waiting > 104 weeks



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	2	1	2
SaTH	1	0	0
RJAH	2	1	1

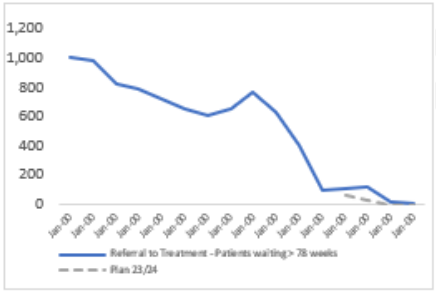
RJAH exc NONC patients

EL Recovery (over 19/20)



Organisation	Apr-23	May-23	Jun-23
Shropshire, Telford & Wrekin	80.8%	61.9%	82.0%
Midlands	82.2%	82.3%	81.8%

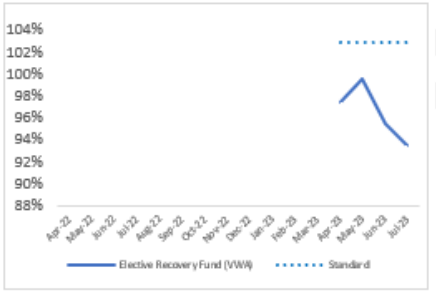
Referral to Treatment - Patients waiting > 78 weeks



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	121	13	11
SaTH	73	3	1
RJAH	46	6	4

RJAH exc NONC patients

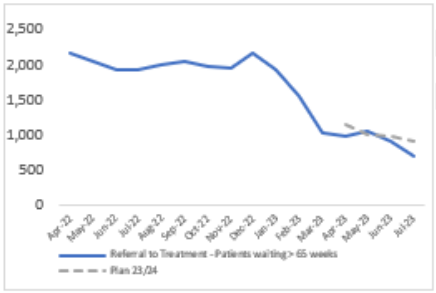
Elective Recovery Fund (VWA)



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	99.6%	95.5%	93.5%
Midlands	104.9%	102.3%	98.2%
England	104.4%	101.2%	98.2%

22-23 activity was monitored using a different criteria - so cannot compare year on year activity

Referral to Treatment - Patients waiting > 65 weeks



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	1047	921	709
SaTH	734	654	419
RJAH	363	353	330

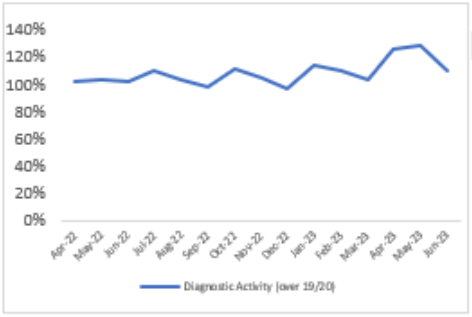
RJAH exc NONC patients

Integrated

Planned Care - Diagnostics

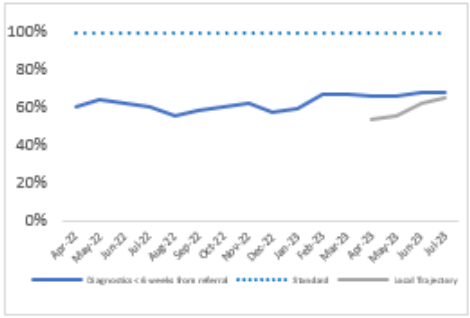
NHS
Shropshire, Telford and Wrekin

Diagnostic Activity (over 19/20)



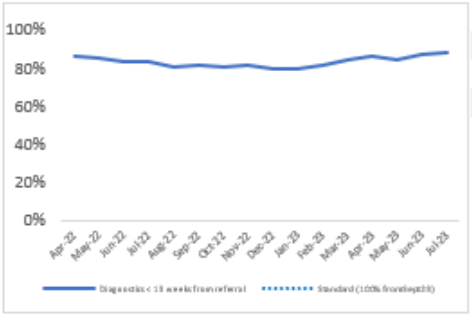
Organisation	Apr-23	May-23	Jun-23
Shropshire, Telford & Wrekin	126.9%	129.4%	110.3%
Midlands	136.9%	132.4%	120.7%

Diagnostics < 6 weeks from referral



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	66.0%	68.3%	68.4%
Midlands	66.4%	67.7%	68.4%
England	74.1%	74.8%	74.5%

Diagnostics < 13 weeks from referral

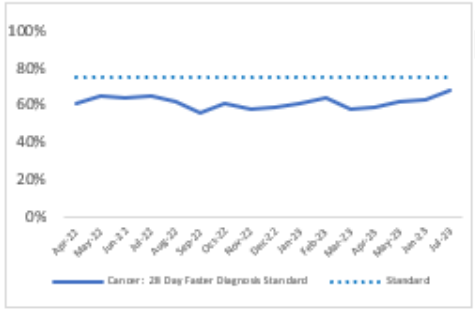


Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	85.1%	87.3%	88.2%
Midlands	84.8%	85.5%	86.9%
England	89.3%	89.5%	90.1%

Target is 100% from September

Planned Care - Cancer

Cancer: 28 Day Faster Diagnosis Standard



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	61.4%	62.9%	67.6%
National	71%	73%	74%

Cancer: No. of patients waiting 63 or more days after referral from cancer PTL

Organisation	Jun-23	Jul-23	Aug-23
SaTH	389	351	330

Snapshot - point in time data

Cancer: No. of patients waiting 104 or more days after referral from cancer PTL

Organisation	Jun-23	Jul-23	Aug-23
SaTH	108	99	96

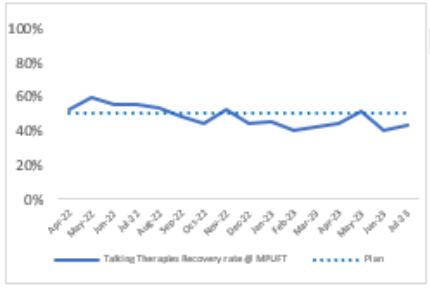
Snapshot - point in time data

Integrated

Mental Health, Learning Disabilities & Autism - Adults

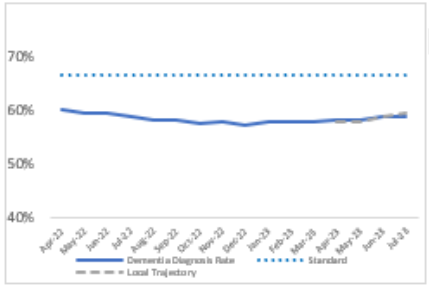
NHS Shropshire, Telford and Wrekin

Talking Therapies Recovery rate @ MPUFT



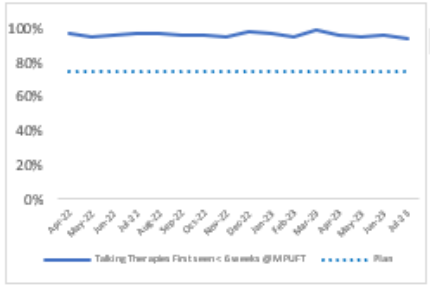
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	51.4%	40.1%	43.8%

Dementia Diagnosis Rate



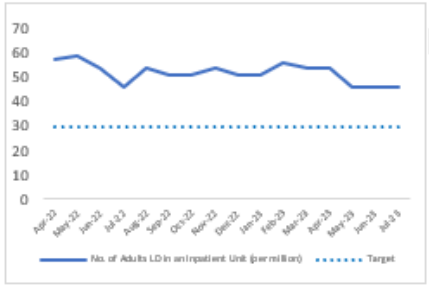
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	58.3%	58.8%	59.0%
England	63.1%	63.5%	63.8%

Talking Therapies First seen < 6 weeks @ MPUFT



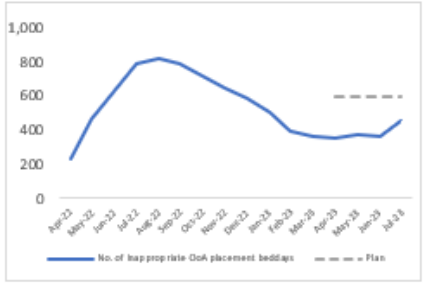
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	95.0%	95.7%	94.3%

No. of Adults LD in an Inpatient Unit (per million)



Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	45.8	45.8	45.8

No. of Inappropriate OoA placement beddays



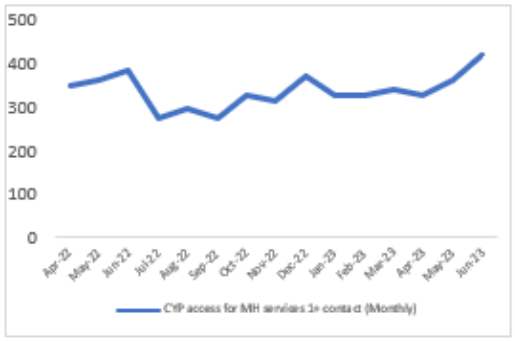
Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	370	365	450

Integrated

Mental Health, Learning Disabilities & Autism - CYP

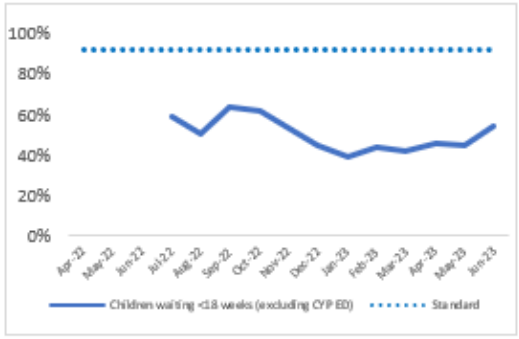
NHS
Shropshire, Telford and Wrekin

CYP access for MH services 1+ contact (Monthly)



Organisation	Apr-23	May-23	Jun-23
Shropshire, Telford & Wrekin	325	360	420

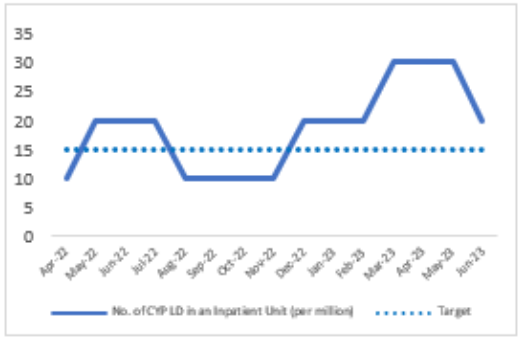
Children waiting <18 weeks (excluding CYP ED)



Organisation	Apr-23	May-23	Jun-23
Shropshire, Telford & Wrekin	45.9%	44.7%	53.9%

Snapshot - point in time data

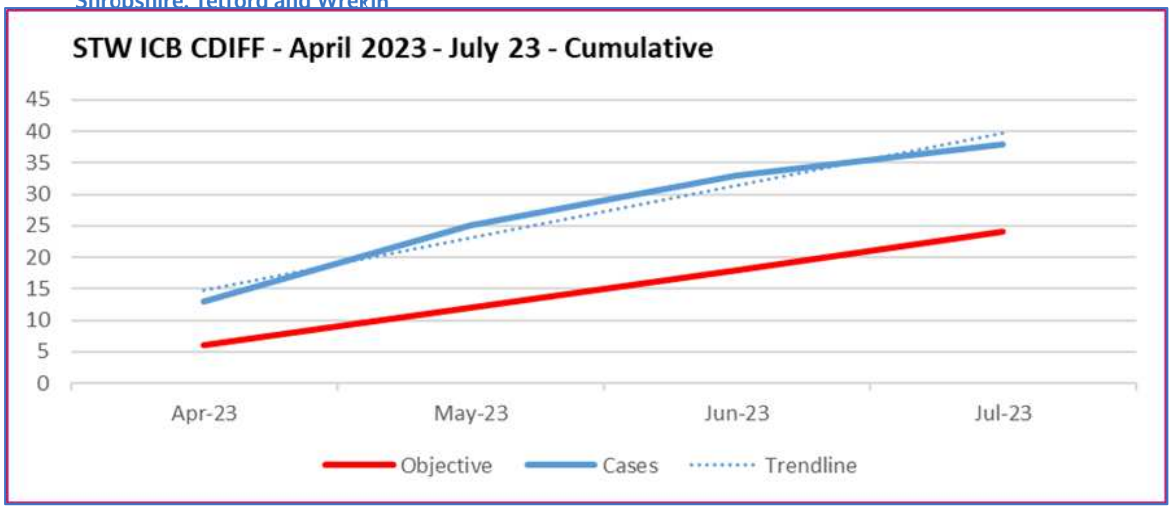
No. of CYP LD in an Inpatient Unit (per million)

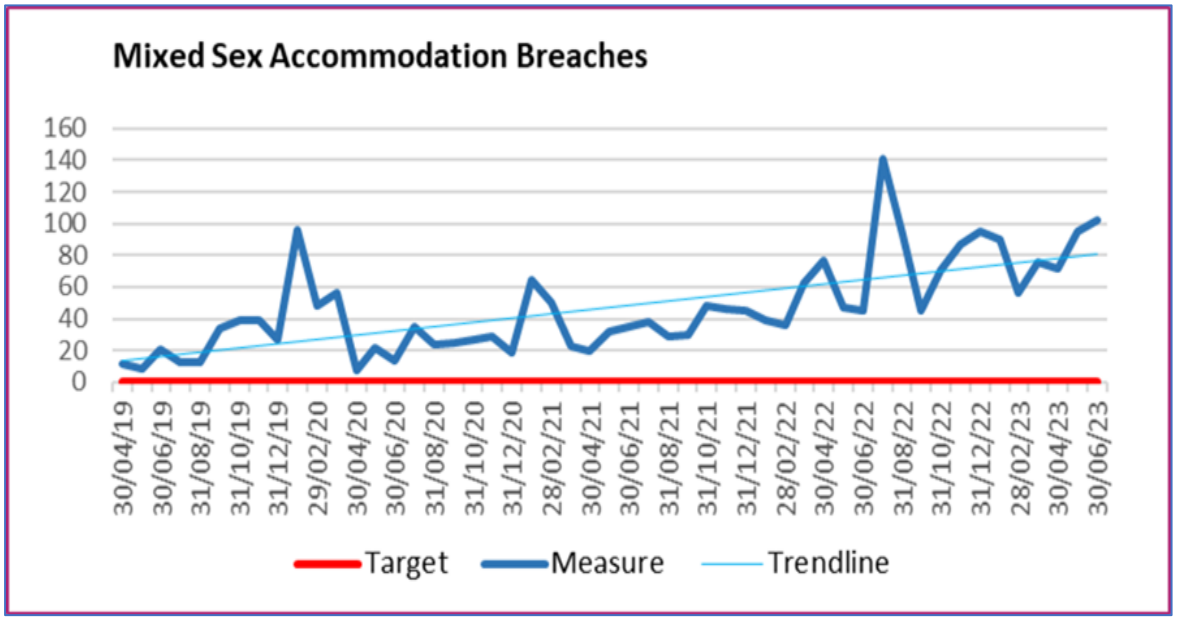


Organisation	May-23	Jun-23	Jul-23
Shropshire, Telford & Wrekin	30.1	20.0	20.0

Appendix B

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	Shropshire CCG - 05N	Telford & Wrekin CCG - 05X	SHROPSHIRE, TELFORD AND WREKIN (SUB ICB) - M2L0M				SaTH			RJAH			MPUFT			SCHT		
								Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
IPC	C.difficile			24	41	Cumulative Apr 23 - Jul-23	SATH Objective = 11 RJAH Objective = 1	25			1								
	E.coli Bacteraemia			104	136	Cumulative Apr 23 - Jul-23	SATH Objective = 30 RJAH Objective = 1	38			3								
	Pseudonmonas aeruginosa Bacteraemia			10	13	Cumulative Apr 23 - Jul-23	SATH Objective = 6 RJAH Objective = 0	8			0								
	Kiebsiella spp Bacteraemia			24	31	Cumulative Apr 23 - Jul-23	SATH Objective = 8 RJAH Objective = 1	7			0								
	MRSA Bacteraemia			0	1	Cumulative Apr 23 - Jul-23	SATH Objective = 0 RJAH Objective = 0	0			0								
	MSSA Bacteraemia			0	53	Cumulative Apr 23 - Jul-23	No trajectory set	23			1								
Maternity	Stillbirths per 1,000 total births	2.83	6.62			2017 - 19	England = 3.99												
	Neonatal deaths per 1,000 total live births	3.09	3.09			2017 - 19	England = 2.86												
CHC	% Referrals completed within 28 days				35.0%	2022/23 Q4 Data Collection	England = 75%												
	Incomplete Referrals delayed >12 weeks				124	2022/23 Q4 Data Collection													
	% of IRPs taking place in 6 months or less from IRP request date	Unable to source data for this metric																	
Incidents	Number of Never Events					Cumulative Position June 2023	0	1			0								
	Number/Trend Serious Incidents					Monthly Position April 2023	England Q4 22 = **569,261**	1452			133			1557			45		
Friends & Family Test	Friends & Family Test - Inpatient					Jun-23 Public	Not applicable Higher is better	98.7%	1154		99.2%	240							
	Friends & Family Test - Community					Jun-23 Public	Not applicable Higher is better										96.8%	310	
	Friends & Family Test - A&E					Jun-23 Public	Not applicable Higher is better	91.7%	12										
	Friends & Family Test - Mental Health					Jun-23 Public	Not applicable Higher is better							89.4%	226				
MSA	Mixed Sex Accomodation Breaches					Jun-23	Zero Lower is better	102											





The final number for the system for *Clostridioides difficile* (*C diff*) in 23/24 was 106 against and objective of 77. nationally there had been a 25% increase in reported cases. This potentially due to different practices in prescribing and infection prevention and control driven by the Covid19 pandemic. All partners in STW are reviewing current plans actions against national guidance and lessons learnt from local investigation to control *C diff* and a system action plan will be monitored through the system Infection Prevention and Control Group reporting to QPC from October. QPC has a risk rated Red currently. The aim is regain monthly trajectory.

Mixed sex accommodations breaches are a particular issue at SaTH as shown in the chart above but increasing breaches are driven by UEC pressures linked to bed pressures. SaTH have an action plan in place which is overseen at their quality committee. Key actions include to step down from the intensive care unit promptly. Providers of NHS-funded care are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected.

Finance- M5 position

Organisation	MONTH Plan Surplus/ (Deficit) £000	MONTH Actual Surplus/ (Deficit) £000	MONTH Variance to Plan £000	YTD Plan Surplus/ (Deficit) £000	YTD Actual Surplus/ (Deficit) £000	YTD Variance to Plan £000	FULL YEAR Plan Surplus/ (Deficit) £000	FULL YEAR Forecast Surplus/ (Deficit) £000	FULL YEAR Variance to Plan £000	PRIOR YEAR Actual £000	Month FOT Actual £000	Movement £000
Commissioners												
NHS Shropshire, Telford and Wrekin	(539)	(4,510)	(3,971)	(6,668)	(10,466)	(3,798)	(11,828)	(11,828)	0	(21,516)	(11,828)	0
Total Commissioners	**(539)**	**(4,510)**	**(3,971)**	**(6,668)**	**(10,466)**	**(3,798)**	**(11,828)**	**(11,828)**	**0**	**(21,516)**	**(11,828)**	**0**
Providers												
The Shrewsbury and Telford Hospital NHS Trust	(4,332)	(9,935)	(5,603)	(27,887)	(46,086)	(18,199)	(45,462)	(45,462)	0	(47,206)	(45,462)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	6	(621)	(627)	(1,801)	(2,935)	(1,134)	191	191	0	2,454	191	0
Shropshire Community Healthcare NHS Trust	37	149	112	284	290	6	(0)	0	0	1,092	0	0
Total Providers	**(4,289)**	**(10,407)**	**(6,118)**	**(29,404)**	**(48,731)**	**(19,327)**	**(45,271)**	**(45,271)**	**0**	**(43,660)**	**(45,271)**	**0**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(4,828)**	**(14,917)**	**(10,089)**	**(36,072)**	**(59,197)**	**(23,125)**	**(57,099)**	**(57,099)**	**0**	**(65,176)**	**(57,099)**	**0**

Key Data

- £59.2m YTD system deficit
- £10.1m in month adverse variance to plan
- £23.1m adverse to plan YTD at M5.
- Forecasting delivery of the plan but with significant risk (unmitigated £81.8m), if the full unmitigated risk was added to the planned deficit this would result in a £138.9m in year system deficit. All organisations are working through updating risk values and developing phased mitigation plans for the year to discuss and agree a realistic forecast position with NHSE through the FOT change protocol.
- £7.9m above agency expenditure plan (£25.2m ytd spend v's £17.3m plan) at M5 and £13.9m above the agency cap (£11.3m cap ytd) for the system
- SATH run rate overspend continues and in M5 there is a deterioration in the ICB position due to overspends in both prescribing and CHC

What have we done and next steps

All organisations are working through mitigation plans for the year to discuss and agree a realistic forecast position with NHSE through the FOT change protocol.

A system Chief Executive/Chief Operating Officer and Chief Finance Officer meeting is taking place on the 27th September to discuss the in year financial recovery plan and phasing of mitigations to year end.

Medium to long term financial plan development is underway -with a first cut submission planned by the end of September, which will include detailed mapping of the underlying position and a financial recovery trajectory

Updates to the 'triple lock' process underway to include scrutiny of substantial non recurrent investment.

Operational leads working collectively on system bed model, discharge schemes and reducing escalation costs

Efficiency and transformation plan development (see efficiency slide)

Strengthened system wide financial governance particularly around pay controls. Fortnightly agency reduction meeting chaired by ICB CNO.

Contract rebasing project to review current contractual arrangements and ensure all activity and costs are correctly captured

System wide productivity group set up to drive actions for improving productivity

Finance- M5 position by organisation

SATH

YTD deficit of £46.1m, an adverse position to plan of £18.2m YTD. This variance is split between elements deemed to be within SaTHs control (£7.9m) and outside of SaTHs direct control (£10.3m).

- Within SaTHs control, the key drivers are £1.8m junior doctor staffing, £1.7m ongoing nurse staffing above funded levels, £1.5m nursing unavailability, £1.0m enhanced bank rates, £1.0m historic workforce BTI efficiency slippage, £0.9m internal CIP plan slippage.
- Outside SaTHs control, the key drivers are £4.0m escalation cost above funded levels, £3.1m of increased elective activity costs (insourcing and internal costs), £1.4m industrial action cover, £1.2m Enhanced Care Support linked to high levels of NCTR patients, £0.6m pay award cost pressure.

SATH flagging £50.3m of unmitigated risk to delivering the financial plan for 23/24.

RJAH

YTD deficit of £2.9m, an adverse position to plan of £1.1m YTD. This variance is driven by

- Productivity loss (excluding Industrial Action) £1.4m
- Cost Pressures (Agency, Casemix) £0.6m
- Industrial Action (not mitigated by revised activity baselines) £0.3m
- Low Volume Activity funding shortfall £0.2m

Partially mitigated by:
-Additional income from private patients/interest £0.7m and Balance Sheet release £0.7m

RJAH flagging £4m of unmitigated risk to delivering the financial plan for 23.24.

SCHT

YTD surplus of £0.3m, break even position to plan.

- Agency spend reduced in month and weekly agency scrutiny group now in place.
- CIP performance adverse by £0.2m YTD but operational areas working at pace to increase recurrent CIP delivery and identification of additional schemes to address forecast shortfalls.

SCHT flagging £3.7m unmitigated risk to delivering the financial plan for 23/24.

STW ICB

YTD deficit of £10.5m , an adverse position to plan of £3.8m YTD. This variance is driven by:

- £1.1m overspend on acute due to prior year and Independent sector activity overperformance
- £1.8m overspend on individual commissioning budgets which appears to be predominantly due to price increases above the levels funded.
- £0.8m overspend on primary care predominantly due to the overspend YTD on in year prescribing offset with a prior year benefit. Overall an average of 15% increase has been seen in costs compared to 22/23 , this is also being seen in other ICBs in the region.
- £1.2m overspend on other due to Welsh ERF income not materialising in line with planning assumptions
- These variances are offset with some small non recurrent underspends (£1.1m in total) in community services due to slippage on expenditure and running costs due to vacancies.

NHS

2

M5 Financial Risk

System Risk	23/24 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk £'000	Prior Month Un-Mitigated Risk £'000	Movement from Prior Month £'000 Mitigated Risk £'000	Un-Mitigated 23/24 Plan Risk £'000	Movement from Plan £'000
NHS Shropshire, Telford & Wrekin ICB	36,226	(12,400)	23,826	15,539	(8,287)	17,661	(6,165)
Robert Jones & Agnes Hunt Hospital	11,808	(7,788)	4,020	2,805	(1,215)	7,066	3,046
Shrewsbury & Telford Hospitals	69,018	(18,700)	50,318	50,318	0	63,678	13,360
Shropshire Community Hospital Trust	4,690	(1,031)	3,659	3,579	(80)	4,876	1,217
Grand Total	121,742	(39,919)	81,823	72,241	(9,582)	93,281	11,458

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

The movement in the SATH risk position since plan submission is mainly due to the removal of a number of planned Service Developments which are not deemed to be a financial risk as expenditure has not been agreed or committed. These may still pose an operational/quality risk which will be captured separately. The increase in the ICB risk at M5 and since the plan is mainly due to increased risk in prescribing and CHC and materialising risk around potential increased discharge expenditure with Local Authorities.

The un-mitigated risk total has increased by £9.6m overall since M4. This is largely driven by additional un-mitigated risks being flagged within the ICB - additional gross risk of £14.7m (£8.3m after mitigation) has been identified in M5 for Prescribing, Individual Commissioning and Discharge Expenditure. This has been offset by fully mitigating the English ERF income due to an assessment of the risk based on the latest data available. The mitigation against unidentified efficiency has also reduced due to an increase in identification of efficiency plans and risk associated with the West Midlands Ambulance contract has now been removed now that contracts have been agreed. The SaTH risk position is in relation to staffing pressures (sickness, maternity, industrial action), and activity/escalation growth. Despite additional risk within RJAH arising from lost activity due to industrial action (Welsh commissioner income (differential in funding rules)) all other previously reported risks still stand. There is a small deterioration in the risk position reported by SCHT related to delivery of elective activity.

A system Chief Executive/Chief Operating Officer and Chief Finance Officer meeting is taking place on the 27th September to discuss the in year financial recovery plan and phasing of mitigations to year end.

The key themes of risk are:

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

M5 Efficiency

£000's	Month 5 YTD			Full Year Plan and Forecast								
Organisation	YTD Plan	Actual	Variance	Plan Value £000's	Low Risk	Medium Risk	High Risk	Unidentified Core Target	Unidentified Stretch	Total Forecast £000's	Variance from Plan	% of Recurrent Savings forecast compared to Plan
SaTH	7484	4102	-3382	35,452	17,798	3,636	10,469	0	3549	35,452	0	100%
RJAH	1488	1489	1	4,563	3,767	594	202	0	0	4,563	0	105%
SCHT	1197	996	-201	4,108	2513	898	252	0	445	4,108	0	100%
ICB	8,124	7,688	-436	25,947	5,860	6,624	9,330	0	4,133	25,947	0	100%
Total	**18,293**	**14,275**	**-4,018**	**70,070**	**29,938**	**11,752**	**20,253**	**0**	**8,127**	**70,070**	**0**	

	M5 YTD			Full Year		
Recurrent	Plan	Actual	Variance	Plan	Forecast	Variance
SaTH	3613	1335	-2278	17,079	17079	0
RJAH	1299	1363	64	3,933	4,143	210
SCHT	688	500	-188	2386	2386	0
ICB	6778	6645	-133	18731	18690	-41
Total	12378	9843	-2535	42,129	42,298	169

	M5 YTD			Full Year		
Non Recurrent	Plan	Actual	Variance	Plan	Forecast	Variance
SaTH	3871	2766	-1105	18373	18373	0
RJAH	189	126	-63	630	420	-210
SCHT	509	496	-13	1722	1722	0
ICB	1346	1043	-303	7216	7257	41
Total	5915	4431	-1484	27941	27772	-169

- At M5 the system efficiency programme is £4.0m off plan. £3.4m of this is within SATH – (£1.9m due to under delivery on the internal CIP programme and the balance due to escalation cost not reducing to required trajectory at SATH), the other £0.6m sits with under delivery in the ICB and SCHT due to not identifying schemes against the system stretch target.
- 89% of plans are in delivery at M5 (£62.5m), need a further £0.5m of savings to be identified and in delivery by end of Sept to be at 90%.
- Recurrent savings plans are set to deliver by year end. High risk associated with plans in place to deliver the non recurrent system stretch target.
- A financial improvement programme group has been established to track the development and progress of programmes and internal weekly meetings are being held within organisations. Opportunities will focus on recurrent delivery and multi-year programmes are being developed to inform the longer term financial recovery plan.

Integrated Care System
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Finance – Capital

CAPITAL PROGRAMME	MONTH			YTD			FULL YEAR			PRIOR YEAR	Prior Month FOT	Movement
Organisation	Plan £000	Actual £000	to Plan £000	Plan £000	Actual £000	to Plan £000	Plan £000	Forecast £000	to Plan £000	Actual £000	Actual £000	Actual £000
NHS Shropshire, Telford and Wrekin	(23)	0	23	(113)	0	113	(1,150)	(883)	267	(1,243)	(883)	0
The Shrewsbury and Telford Hospital NHS Trust	(1,550)	(580)	970	(3,128)	(1,564)	1,564	(19,391)	(19,391)	0	(19,798)	(19,391)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(1,119)	(105)	1,014	(2,340)	(545)	1,795	(7,360)	(7,344)	16	(10,137)	(7,344)	0
Shropshire Community Healthcare NHS Trust	(130)	(239)	(109)	(704)	(475)	229	(2,500)	(2,500)	0	(2,497)	(2,500)	0
TOTAL SYSTEM	**(2,822)**	**(924)**	**1,898**	**(6,285)**	**(2,584)**	**3,701**	**(30,401)**	**(30,118)**	**283**	**(33,675)**	**(30,118)**	**0**

Summary

- The SaTH capital programme is behind the YTD plan due to the phasing of the internal programme but is forecast to deliver in full by the end of the year.
- RJAH YTD slippage relates to the theatre project which will be delivered in year.
- SCHT YTD slippage is due to asset disposal and delays in new projects
- STWICB - the IFRS16 plan has been removed from the forecast as it was included in the capital plan in error as the cost associated relates to revenue

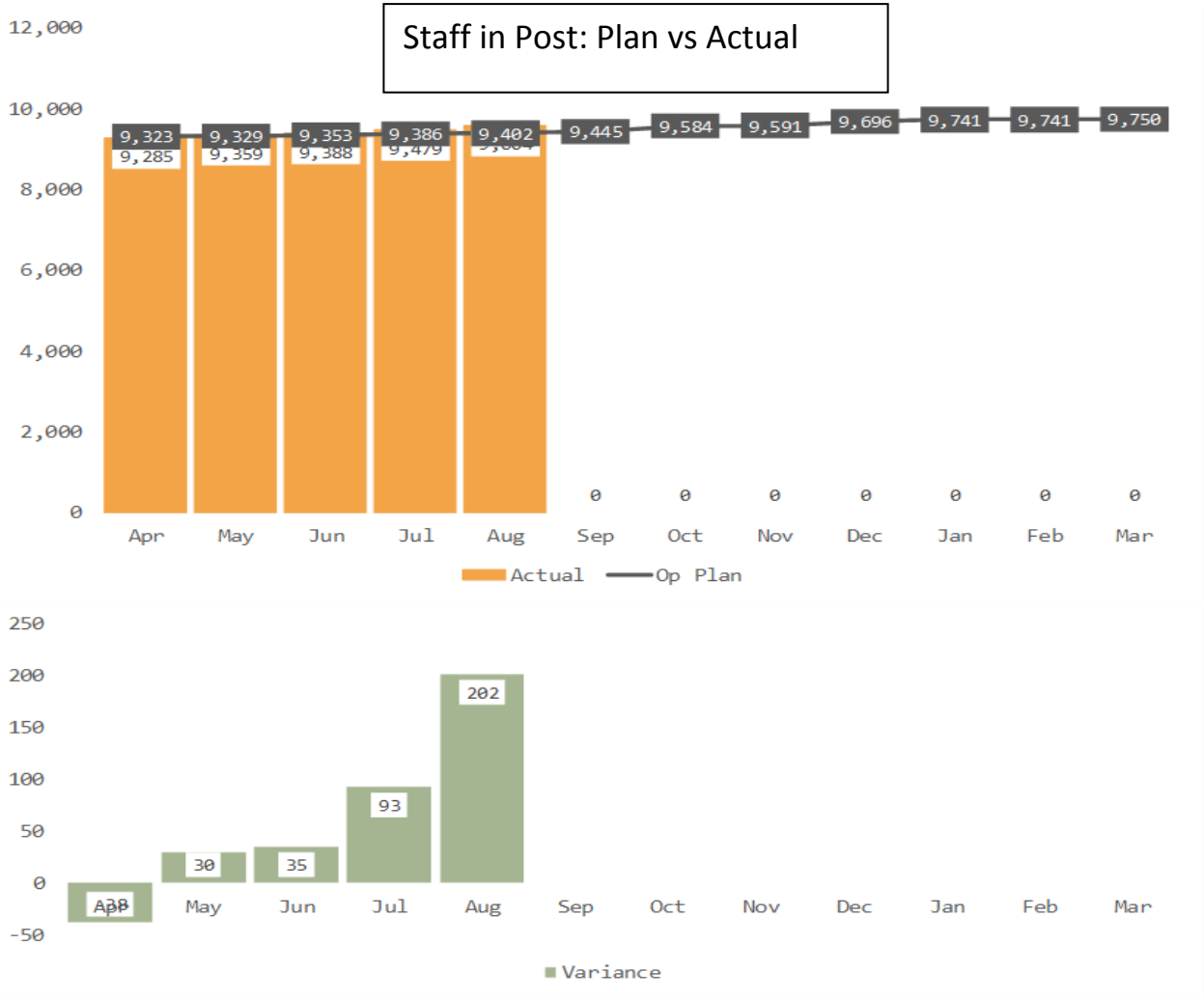
What have we done and next steps

- There are a number of approved schemes that are due to be delivered in 2023/24 including the Elective Hub at PRH, the Community Diagnostic Centre in Telford, the modular wards to support sub acute care and the continuation of national digital funding.
- The OBC for HTP was presented to the national Joint Investment Committee (JIC) in early August.
- The system capital prioritisation and oversight group is closely monitoring the delivery of the 2023/24 capital plan.

Appendix D

WTE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Op Plan	9,323	9,329	9,353	9,386	9,402	9,445	9,584	9,591	9,696	9,741	9,741	9,750
Actual	9,285	9,359	9,388	9,479	9,604	0	0	0	0	0	0	0
Variance	-38	30	35	93	202							

Staff in Post: Plan vs Actual

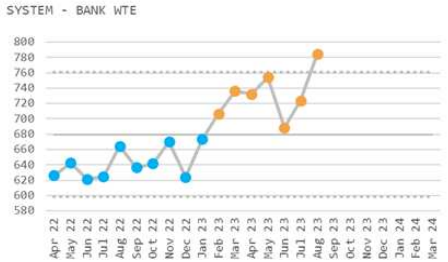


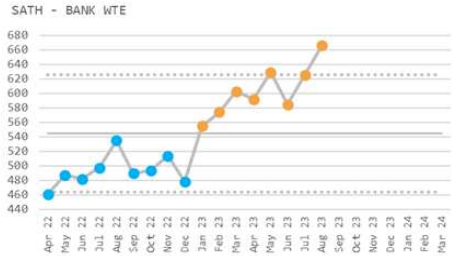
NB. National Occupation Code changes are responsible for the large movement between Other STT and Infrastructure in all workforce metrics.

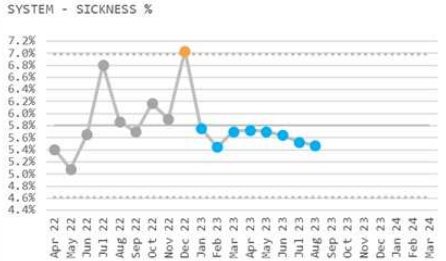
Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Substantive (WTE)	Total	PWR	Aug 23	9,604	6,776	1,464	1,363
	Registered Nursing & Midwifery	PWR	Aug 23	2,591	1,843	275	473
	HCSW	PWR	Aug 23	1,322	999	192	131
	Infrastructure	PWR	Aug 23	2,653	1,700	559	394
	Allied Health Professionals	PWR	Aug 23	698	382	160	156
	Pharmacy	PWR	Aug 23	123	86	16	21
	Other STT	PWR	Aug 23	297	238	27	32
	GP, Medical and Dental	PWR	Aug 23	950	790	137	23

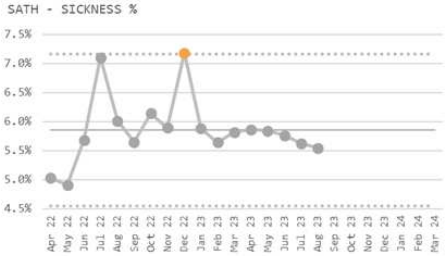
NB. For this purpose, vacancies are defined as the difference between budgeted establishment an actual staff in post. They do not are are not intended to match actual vacancies authorised for advert by any employer

Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Vacancies (WTE)	Total	PWR	Aug 23	639	335	97	207
	Registered Nursing & Midwifery	PWR	Aug 23	263	141	41	80
	HCSW	PWR	Aug 23	124	80	23	20
	Infrastructure	PWR	Aug 23	101	36	13	52
	Allied Health Professionals	PWR	Aug 23	133	77	18	38
	GP, Medical and Dental	PWR	Aug 23	81	64	10	7
Vacancy Rate %	Total	PWR	Aug 23	6.2%	4.7%	6.2%	13.2%
	Registered Nursing & Midwifery	PWR	Aug 23	9.2%	7.1%	13.1%	14.5%
	HCSW	PWR	Aug 23	8.6%	7.4%	10.9%	13.4%
	Infrastructure	PWR	Aug 23	3.7%	2.1%	2.3%	11.6%
	Allied Health Professionals	PWR	Aug 23	16.0%	16.7%	10.2%	19.6%
	GP, Medical and Dental	PWR	Aug 23	7.9%	7.5%	6.7%	23.0%


SYSTEM - BANK WTE


SATH - BANK WTE


SYSTEM - SICKNESS %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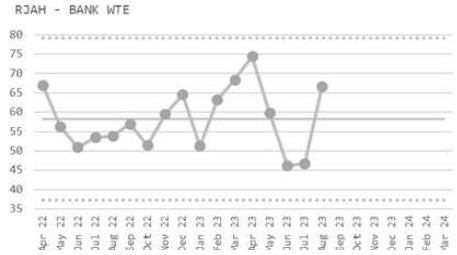
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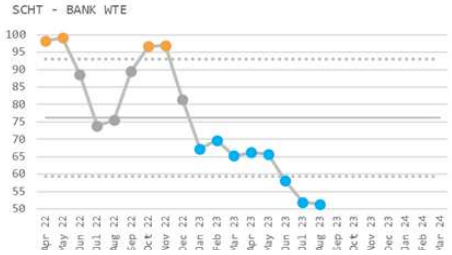
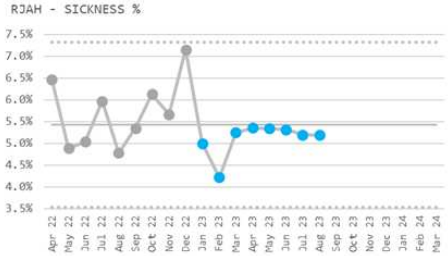
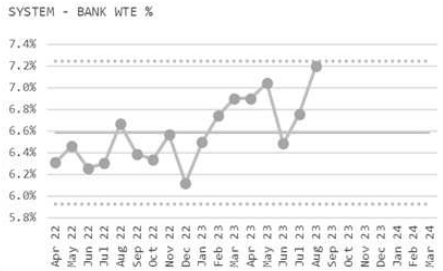

SCHT - BANK WTE


RJAH - SICKNESS %


SCHT - SICKNESS %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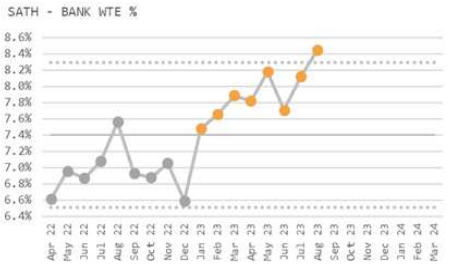
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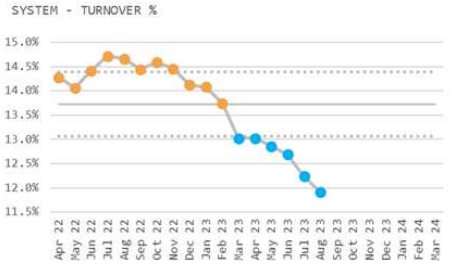
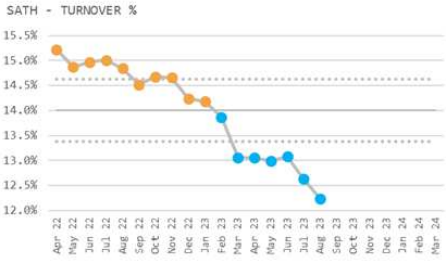
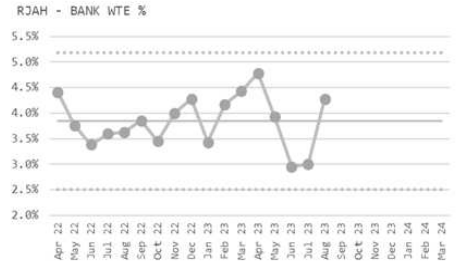

SYSTEM - TURNOVER %


SATH - TURNOVER %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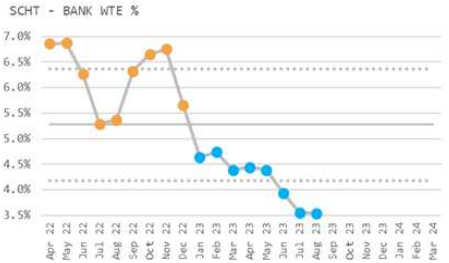
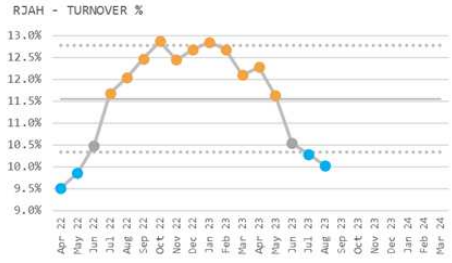
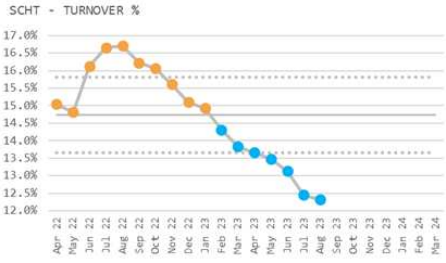

SCHT - BANK WTE %


RJAH - TURNOVER %


SCHT - TURNOVER %

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday 25th May 2023 at 2.00pm to 4.00 pm

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Alison Bussey	Chief Nursing Officer, NHS STW
Vanessa Whatley	Director of Quality & Safety, Deputy Chief Nursing Officer – NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Jill Barker	Associate Non-Executive Director, SCHT
Julie Garside	Director of Performance NHS STW
Liz Noakes	Director of Public Health, Telford LA
Mahadeva Ganesh	Medical Director SCHT
Claire Horsfield	Deputy Director of Nursing SCHT
Hayley Flavell	Director of Nursing, SaTH
Jan Suckling	Healthwatch Telford & Wrekin – Representing Simon Fogel

Attendees:

Alison Massey	Interim Transformation and System Commissioning Partner – Community, NHS STW
Betty Lodge	Acting Director UEC , NHS STW
Lisa Rowley	Corporate PA, Note Taker, NHS STW

1.0 Minute No. QPC-23-05.67 – Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and asked each member, when introducing themselves, to give a verbal synopsis of the roles they hold and what their thoughts were in relation to the importance of this meeting

1.14 Meredith Vivian added that a meeting is scheduled to discuss the role of the Quality & Performance Committee, it's functioning, purpose and how to make it deliver all areas identified in this discussion.

1.2.1 Apologies :

Apologies were received from

- Lynn Cawley, Healthwatch Shropshire
- Sarah Ellis- Anderson, RJAH.
- Simon Fogle - Telford and Wrekin – Jan Suckling representing.

- Tracey Slater – NHS STW
- Sonya Miller - Shropshire Council
- Liz Lockett, - MPFT
- Sharon Fletcher, NHS STW
- Clair Hobbs – SCHT – Claire Horsfield representing.

2.0 QPC-23-05.68 - Members' Declarations of Interests

2.1 There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-05.69 - Minutes of Meeting held on 27th April 2023

3.1 The minutes of the meeting held on 27th April 2023 were reviewed and accepted as an accurate record subject to the following:

3.2 Rosi Edwards referred to the attendance list and requested that the word Associate is removed from her title.

3.3 Rosie Edwards referred to Paragraph 5.13 (Page 3) of the minutes and asked that the following sentence is added at the end of this paragraph "***and a comprehensive action plan has been developed***".

4.0 QPC-23-05.70 Matters Arising and Action Log

4.1 Actions have been updated and are outlined on the action log.

5.0 Minute No. QPC-23-05.71 - System Quality Risk – Vanessa Whatley

The report was taken as read, a discussion ensued and the following key points were highlighted:

5.1 Children & Young People's Mental Health Services – The Group who were overseeing this risk have not been meeting consistently however, this oversight of childrens services is being reviewed to see how best to bring together several agendas. Tracey Jones who is now the Director lead for CYP is leading this.

5.2 Imaging and imaging reporting delays - there have been no updates received this month due to several pressures however, the risk owner has advised that she will be making a recommendation to de-escalate this risk to the Planned Care Board.

5.3 Diabetes – The continuous glucose monitoring has been rolled out although not yet complete. There are a number of actions detailed in the risk that have moved this risk forward.

5.4 Acute Paediatric Pathway – The thematic review has now been completed and presented at a number of forums by SaTH and actions are underway. A key step is the first meeting of the PTAC group on 21st June. In relation to the thematic review, Hayley Flavell explained that there have been four child deaths over the last 18 month at SaTH which were complex cases. Each of those individual cases were reviewed. There were three serious incidents and a divisional review. SaTH had a further death in March of this year which has gone through the SI process. The thematic review was then carried out by Lauren Morgan who is an expert in human factors together with clinical leads as lessons to be learnt were identified from the initial cases. Immediate actions were taken following each of the incidents. The thematic review presentation has been shared at the Quality & Safety Assurance Committee at SaTH; the ICB's Quality Surveillance Group; CQC and SaTH's Oversight Assurance Group. The thematic review identified 17 recommendations across all three reviews. These recommendations will form the platform for the Paediatric Transformation Programme (PTAC) to be developed.

5.8 Hayley Flavell highlighted that there are leadership gaps within Paediatrics in that the Trust do not have a Clinical Director for Paediatrics and have not done so since July 2022.

5.9 The Paediatric Transformation Assurance Committee will be led by John Jones, Medical Director and Kara Blackwell, Deputy Director of Nursing; the outcomes of these meetings will be fed directly into the Quality Safety Assurance Committee chaired by Rosie Edwards ensuring complete oversight of progress. A reverse Rag Rating methodology will be used. Themes identified from the review were regarding looked after children; deterioration; escalation equipment and these will be part of the discussions at the Transformation Programme meeting. Work streams in the Transformation Programme will include governance, leadership, workforce policies and education.

Action: Vanessa Whatley to raise governance issues at the PTAC meeting to see how it feeds into system working as well as SaTH governance framework..

5.10 Jill Barker referred to the diabetes foot pathway which is set to be put in place September of this year and questioned the ambition and pace around diabetes considering the issues around diabetes and said this needed to be progressed quicker.

Action: Vanessa Whatley to raise take Jill Barker's query regarding diabetes foot pathway at the Clinical Advisory Group,

The Committee:

- Discussed the risks for ongoing progress/action.

6.0 Minute No QPC-23-05.72 – Performance Exception Report

The report was taken as read, a discussion ensued and the following key points were highlighted:

6.1 Julie Garside highlighted to the Committee additional improvements to be made to the Performance Exception Report particularly around primary care data and said that the current snapshot around workforce did not give an indication of whether this was improving or not and did not provide the scale of the challenge therefore the report for June will include workforce trends.

6.2 Weekly meetings are taking place on improving flow to help with the urgent care position. Acknowledgement should be given on the albeit slow but steady improvements being seen particularly regarding ambulance handovers where local targets have been achieved for three out of four months.

6.3 There has been an improvement in category two response times across the region and patients being seen for triage within 15 minutes.

6.4 The admitted time in ED reduced during April 2023. There remain challenges around the non-admitted.

6.5 Julie Garside expressed concern regarding the deterioration in response for urgent eating disorders which appeared to be improving in quarter 3 however during quarter 4 , performance decreased from 80% to 33%. No information has been received from MPFT providing an explanation for this drop. It is anticipated that further details will be provided within the Deep Dive into Eating Disorder in June 2023.

Action: Julie Garside to liaise with colleagues at MPFT to understand the deterioration in response for urgent eating disorders.

6.6 Liz Noakes referred to the cancer waiting targets and commented that there appears to be very little improvement, and this is one area that should have focus on particularly the potential impact and outcomes for patients as the screening to treatment dropped down to 3% against a target of 90%.

6.7 Julie Garside responded that she has requested further information in relation to the drop in performance relating to screening to treatment and commented that in terms of cancer, both the faster diagnosis standards and the 62 day are not at the stage where they had planned to be. The two main areas being focussed on are the faster diagnosis standard where it is believed that improvements can be made particularly in the skin pathway and with tele dermatology; the second area which is linked to diagnostics and endoscopy improvement is around the use of the fit test and sending those results in with a referral which is doing well against plan as of last month. A balancing metric has been implemented to check, not only the referrals coming in with the results of a fit test, but also what that is doing to the request for the colonoscopies.

6.8 Urology remains a concern however NHSE are providing support in helping to optimise and deliver optimum pathways. There are some constraints around capacity, particularly clinical workforce and although the figures do not make good reading, the ICB are in the highest level of performance reporting to NHS England which will allow access to extra support.

6.9 Alison Bussey referred to the virtual ward trajectory and the impact on people and asked for further information to be provided regarding timelines.

6.10 Julie Garside responded that the impact is being monitored via the Urgent and Emergency Care Working Group and Board, it is also being tracked on a weekly basis. Referrals are not being received to deliver the level of step down regarding virtual wards. Reassurance has been given that clinical conversations are taking place but no timelines have been provided for when improvements will take place.

6.11 Dr Ganesh added that he had spoken with John Jones at SaTH where the clinical oversight regarding virtual wards was discussed and it was agreed that the step down was not consistent and has been episodic. SaTH have employed a Deputy Medical Director who has got a lot of experience from Dudley with virtual ward is going to drive this forward.

Action: Meredith Vivian asked that the cancer performance as well the position relating to Virtual Wards is highlighted in the Performance Exception report for June.

6.12 Julie Garside commented that in terms of the faster diagnosis standards, when targets, trajectories and the rate for improvement were being set for the Operational Plan 2023/24 significant challenge was put in place against the trajectory and assurance was given that the position expected for faster diagnosis standard would be 66% in March and would rise to 67.5% by the end of the quarter which was not unreasonable. However, actual performance in March was 58% which raised the question of how the projection could be so wrong. This causes a lack of confidence in the trajectories that have been put in the Operational Plan and the consequences of that with regulator colleagues. It also does not provide confidence and understanding of what is driving performance, what is going wrong and what needs to be done to improve this.

The Committee:

- Noted the content of the report and provided any feedback for incorporation into future reports.

- Noted the mitigations to address current risks/trends supporting the continual improvement journey across the ICS, noting that the report straddles two financial years due to data lags and that national targets may have changed.
- Noted there will be improvement in the detail of the recovery actions and associated timescales for recovery included in this report as performance recording is developed by the team.

7.0 Minute No. QPC-23-05.73 – System Quality Metrics – Vanessa Whatley

The report was taken as read, a discussion took place with the following key points highlighted:

7.1 The report presented was the shorter intermediate report which is risk focussed and the quarterly comprehensive quarter 4 report will be presented in June 2023.

7.2 Gradual improvement has been seen in relation to maternity which is continuous across the system particularly around the postpartum haemorrhage numbers. The number of women accessing specialist community perinatal mental health services as plateaued, 600 to 700 women are accessing the service every month.

7.3 Rosie Edwards commented that given that there may be funding for glucose monitoring, it would be helpful to see data in terms of outcomes, how it is being rolled out; how many people have been given a glucose monitor and whether GPs and their staff are going to be trained in providing people on how to use it.

7.4 Julie Garside commented that at a previous QPC meeting the diabetes strategy had been presented which included a dashboard with current performance and outcome related measures in terms of the various primary care, health checks, etc however, would be happy to submit a quarterly progress report on the roll out of the diabetes glucose monitoring.

7.5 Hayley Flavell commented that she would be happy to share SaTH's quality process outlining their best outcome priorities around diabetes and suggested metrics and by sharing this would demonstrate system working.

7.6 Alison Bussey referred to an earlier comment regarding perinatal mental health that has plateaued, and it had been reported by Jo Heaney from MPFT at a recent LMNS Board meeting that there has been sickness and vacancies however, plans are in place to rectify these issues. Further updates in these issues will be reported via the System Quality Group Meetings in due course.

7.7 There have been six paediatric deaths across the system and the metrics are being reviewed to see how they can support the themes. However, the sepsis tools have been updated this month in the paediatric department at the Trust with associated education and training taking place. Audit work is underway to see how this is being embedded.

The Committee:

- Considered the metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-05.74 - Exception Report - System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read, a discussion ensued and the following key points were

highlighted

8.1 Meredith Vivian referred to IPC and asked whether the figures around infection control were needed to be raised as a specific risk.

8.2 Vanessa Whatley responded that C diff is of concern and has increased by 25% across the country. From the system numbers and particularly from SaTH the number of C diff cases has doubled during April 2023. 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 which is a concern.

8.3 Hayley Flavell commented that in 2022 there were 60 cases of CDiff against a target of 33, this was both community on set and also hospital on set acquired. The Trust carried out a gap analysis in August 2022 against the most recent guidance which provided some in roads in terms of education regarding the use of gloves, gelling and washing. The micro and IPC team at the Trust have reviewed all of the 60 cases, the outcomes of the review have been shared with the Trust's Assurance Committee.

8.4 Hayley Flavell added that the target for 2023 is 32 and the Trust have already reached 10 cases so it is unlikely that this target will be met. The Trust have always reported hospital acquired C diff but have not reported for gram negative and bloodstream infections which had been put in the national contract for 2021/22 which the Trust had not picked up. The Trust has reviewed the contract and following discussions with their contracting team will highlight this at their Public Board Meeting advising of the output for 2022/23 which means the Trust will have also breached their E coli target.

8.5 Vanessa Whatley said that instead of escalating this risk, a further update should be provided in three months' time which will provide a clearer position for the first quarter of the year.

The Committee:

- Considered the alerts in this report and further assurance required.
- Accepted the report.

9.0 Minute No QPC-23-05.75 Palliative & End of Life Care Update- Alison Massey

The report was taken as read, a discussion ensued and the following key points were highlighted

9.1 The Palliative and End of Life Care (PEoLC) Steering Group have been successful in an expression of interest to be included in the NHSE Palliative and End of Life Care Getting to Outstanding Programme which has been developed to provide 6 months of expert support for quality improvement projects.

9.2 The PEoLC Clinical Development Group proposed a quality improvement project methodology for change to increase the number of adults in the last 12 months of life to be identified on GP practices' registers.

9.3 The Project Group will be meeting imminently to set trajectories for the next 6 months and a slightly different focus is needed to close the gap between the number of people on a Palliative Care Register and those that are offered an advanced care plan or a personalised care and support plan conversation.

9.4 The data collected during February and March 2023 shows that tells us that for the Hospice have sent out 314 letters to GP Practices and between the same time there has been 471 new people added to the practice registers.

9.5 Liz Noakes asked whether patients had died in their place of choice and were the family supported and asked what other measures are being used to make sure putting patients on the register enables all that family and person centred care to take place at that time.

9.6 Alison Massey responded that work is being carried out in parallel is a Palliative and End of Life Care Dashboard for the system. Shropshire Telford & Wrekin have a good record of people who die in their preferred place of care but do not have a good record of identifying those people earlier enough to make sure that they their care is better coordinated, reducing the incidence of an urgent admissions to hospital.

9.7 Vanessa Whatley commented that step one is to find a way through quality improvement of consistently getting people on the register. The methodology is being spread out to other groups where an agreed standard narrative is included in GP patient letters that indicate a person should be included on the practice palliative register. The second step is to improve the methodology and consistently code the patients correctly to avoid missing groups of patients.

9.8 Meredith Vivian asked about, firstly the health inequalities that may underpin some of these numbers, specifically some cohorts of the population who don not feature in the numbers and who might need more targeted action; and secondly, the qualitative asked, is it the experience of it all for people, not just the numbers, but the actual experience that people have had?

9.9 Alison Massey referred to the inequalities question raised by Meredith Vivian and responded a piece of work will be carried out this year with people within areas of deprivation on how they are accessing or whether they are accessing this service at the moment.

9.10 Alison Massey commented that for the qualitative experience, the Hospice was approached and were asked how patients felt about receiving letters advising they had been put on the PEoLC register and the feedback from the Hospice was that patients were grateful that this was said for them.

The Committee:

- Agreed a standard narrative to include in GP patient letters that indicate a person should be included on the practice palliative register
- Agreed the Snomed codes that would be included in this narrative and would support data collection

10.0 Minute No. QPC-23-05.76 – SOAG Exception Report: Vanessa Whatley

The report was taken as read, a discussion ensued and the following key points were highlighted:

10.1 Vanessa Whatley reported that the SaTH have completed a COVID19 and Root Cause analysis Report that has been done on their management of COVID19, also outbreaks and deaths The report has been accepted by the Commissioning Team at the ICB with some monitoring going forward as there are ongoing actions that the Trust is committed to.

10.2 Themes identified were not that different to other organizations. They were what would be expected around elements of patient care and the operational challenges.

10.3 Hayley Flavell commented that SaTH have had a number of testicular torsion cases which have been subject to SI review. Following the review, lessons have been learned across all three cases and there are key issues that is the torsion pathway which is being agreed and also the education that is in both Emergency Department with junior doctors and triage nurses.

10.4 Liz Noakes referred to the COVID-19 inquiry and the challenges and asked if challenges around design and building were being picked up.
10.5 Hayley Flavell responded and said yes design and buildings were being picked up.

The Committee:

- Noted the content of this report.
- Discussed the alerts.

11.0 Minute No. QPC-23-05.77 – Healthwatch Shropshire

There was no representation for Healthwatch Shropshire present at the meeting to provide a verbal update.

12.0 Minute No. QPC-23-05.78 – Healthwatch Telford & Wrekin – Jan Suckling

A verbal update was provided, and the following key points were highlighted:

12.1 Jan Suckling advised that Healthwatch Telford & Wrekin have now finalized their diabetic survey and this has been published on their website.
12.2 Meredith Vivian commented that due to diabetes being a recurring discussion, the extra dimension that Healthwatch could provide would be helpful.
12.3 Healthwatch Telford & Wrekin are carrying out work around barriers that certain groups can come across when they go into the GP, i.e., English not being their first language and disabilities. Meetings have taken place with various groups to get feedback and what they think should be looked at. This is going to be rolled out shortly.
12.4 Healthwatch Telford and Wrekin will be visiting PRH to look around their information accessibility I.e., if the information displayed up to date.
12.4 Hayley Flavell suggested that Jan Suckling links in with Ruth Smith at SaTH regarding accessibility.

Action: Jan Suckling to link in with Ruth Smith at SaTH regarding accessibility and to copy Hayley Flavell into any emails between them.

The Committee:

- Noted the comments made in the verbal update.

13.0 Minute No. QPC-23-05.79 - Deep Dive – Urgent & Emergency Care – Betty Lodge

The report was received as read, a discussion ensued, and the following key points were highlighted:

13.1 Betty Lodge opened the discussion by advising the information provided to QPC today is the 2023/24 Improvement Plan and that it felt very early in this process to do a deep dive and has suggested that a “true” deep dive into all areas of the Plan is presented to QPC in six months’ time when the newer programmes have been established.
13.2 The UEC Summits consisted of extremely good discussions drawing together what the priorities were for 2023/34 around urgent and emergency care. Attendees at the summit wanted to take an approach that created a sustained and standardised response to the challenges that are faced across urgent and emergency care and to also see some stabilisation against the metrics that had been included in last year's

plan and how those are taken from a stabilizing position into standardized business as usual.

13.3 The Plan has been written in line with the national UEC Recovery Plan and it has been interwoven from the Clinical Strategy.

13.4 There is still work to do about how the approach from urgent emergency care agenda is triangulated into the quality portfolio so that teams are not repeating work.

13.5 As part of the clinical summits, key points of focus were identified.

- the provision for intensive care service users,
- the redesign of the prehospital Integrated Urgent Care
- GP capacity and access/primary care access
- integrated discharge
- frailty escalation and system risk
- improving the discharge model

13.6 The above key points will be taken to the next UEC Board Meeting.

13.7 A clinical and operational lead has been identified for each project.

13.8 Each piece of work will have an EQIA completed.

13.9 UEC Metrics have been streamlined against each of the project plans and against the National UEC Recovery Plan and the operational delivery. Metrics are reported across the performance dashboard and those top metrics can be monitored weekly through the performance dashboard.

13.10 Jill Barker asked what assurance could be given that this plan is going to deliver what it needs to and what is different about this plan.

13.11 Betty Lodge responded that there is system and partner engagement across the board and the Plan was written as a system which was clinically led. Betty Lodge added that it has been recognised from a governance perspective that the monthly UEC group is the right forum, however, a more rigorous oversight of actions and milestones is required. The QI approach has been standardised across the system with representation from SaTH and partners so that the same improvement methodology is used.

13.12 Vanessa Whatley said that she was pleased to see quality included within the plan however, she did not see measures within the quality element such as patient experience, readmission and harm and said she would be happy to work with Betty Lodge from a quality lens.

13.13 Meredith Vivian asked if the role of the GP in the plan was sufficiently understood universally across practices.

13.14 Betty Lodge responded that the UEC CAG has good engagement from primary care and the meeting is predominantly primary care led, 19 GPs attended the last UEC CAG however, she has raised with Nicholas White, the Chief Medical Officer that speciality doctors, NED leads, acute medical leads and surgical leads are drawn into these meetings.

13.15 Betty Lodge added that Chris Picker, Associate Medical Director has been appointed whose focus will be predominantly around the 12 hours within the emergency department and how the UEC plan and the work that each project is progressing.

The Committee:

- Noted the contents of the Operation Plan.

14.0 Minute No. QPC-23-05.80 – Evaluation of Meeting

14.1 Meredith Vivian encouraged members to feedback comments and/or observations they may about the meeting or any improvements they wish to see. Please send comments to Lisa.rowley2@nhs.net

15.0 Minute No. QPC-23-05.81 – Items for Escalation/Referral to other Board Committees

15.1 There were no items for escalation.

16.0 Minute No. QPC-23-05.82 – Any Other Business

16.1 Alison Bussey highlighted to the Committee that the CQC carried out an inspection for acute and PQ services across MPFT in November 2022. The inspection report was published on Friday 19th May; the issue that led to this inspection was in relation to some fire safety issues that they had, a patient who had set fire on 4 occasions over quite a rapid period of time which resulted in the fire service attending and carrying out an inspection. They highlighted a number of areas that the Trust had not managed from a fire regulation perspective. A comprehensive plan is in place to address all of the issues that were raised and highlighted by CQC. The overall service line has now been rated inadequate, however, it has not impacted on the overall Trust's rating of good.

Date and Time of Next Meeting

Thursday 29th June 2023 @ 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …….. DATE ……

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday 29 June 2023 at 2.00pm to 4.00pm

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Alison Bussey	Chief Nursing Officer, NHS STW
Vanessa Whatley	Director of Quality & Safety, Deputy Chief Nursing Officer – NHS STW
Tracey Slater	Assistant Director of Quality, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Kirsty Foskett	Head of Clinical Governance and Quality, RJAH
Jill Barker	Associate Non-Executive Director, SCHT
Lynn Cawley	Healthwatch Shropshire
Claire Horsfield	Director of Operations and Chief AHP, SCHT
Hayley Flavell	Director of Nursing, SaTH
Angie Parkes	Deputy Director of Planning, NHS STW
Jane Williams	Performance & Assurance Manager NHS STW
Hassan Paraiso	Deputy Medical Director, SaTH
Simon Fogel	Chief Executive, Healthwatch Telford & Wrekin

Attendees:

Helen Rowney	Head of Transformation & Commissioning NHS STW
Brett Toro-Pearce	Associate Director Transformation and Commissioning, NHS STW
Sylvia Barnes	Quality Team Administrator, Note Taker, NHS STW

1.0 Minute No. QPC-23-06.84 – Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made.

1.2.1 Apologies:

Apologies were received from:

- Tracey Jones – NHS STW – Brett Toro-Pearce representing.
- Julie Garside – NHS STW – Angie Parkes/Jane Williams representing.
- Liz Noakes – Telford LA
- Paul Kavanagh-Fields – RJAH – Kirsty Foskett representing.
- Clair Hobbs – SCHT – Claire Horsfield representing.

2.0 QPC-23-06.85 - Members' Declarations of Interests

2.1 There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-06.86 - Minutes of Meeting held on 26th May 2023

3.1 The minutes of the meeting held on 26th May 2023 were reviewed and accepted as an accurate record subject to the following:
3.2 Item 9.3 Meredith Vivien asked advanced care plan is amended to advance care plan.
3.3 Meredith Vivien asked item 13.2 is amended to 2023/24.

4.0 QPC-23-06.87 Matters Arising and Action Log

4.1 Actions have been updated and are outlined on the action log.
4.2 It was noted that some completed actions had not been moved to the closed section.

Action: Vanessa Whatley and Sylvia Barnes to review and refine the Action Log. Concluded items to be shaded for ease of reference.

5.0 Minute No. QPC-23-06.88 - System Quality Risk – Vanessa Whatley

The report was taken as read, a discussion took place and the following key points were highlighted:

5.1 Children & Young People's (CYP) Mental Health Services – The ICB Lead is looking to develop oversight of the whole CYP agenda, physical and mental health. NHSE are supporting with how the process is governed as several groups have merged over time.
5.2 The report will be reworked and tabled at one of the CYP groups.
5.3 Lynn Cawley advised that previously, both Shropshire and Telford Healthwatch produced a piece of work regarding children's crisis and mental health services at Hayley Flavell's request, leading to a challenge event lead by both safeguarding Boards. Lynn Cawley asked for an update on how things are moving forward to provide assurance of improvement and understand the impact on families.
5.4 Hayley Flavell advised she was part of that work and agreed this conversation is very timely, a meeting is planned for September regarding Section 31. A lot of work has been undertaken both internally and across the system. The remaining section 31, SaTH being unable to admit anyone under 18 years with isolated mental health, is a system issue, Hayley Flavell is nervous that it is not removed without assurance that robust changes are in place.
5.5 The CYP place of safety at Redwoods has made a significant difference. Hayley Flavell advised Lynn Cawley that herself and SaTH colleagues would be pleased to be part of the group.
5.6 Alison Bussey advised CQC make the decision to remove the section 31. A risk summit is being put in place by Tracey Jones, ICB, and Ian Betts from the national team including local authorities, ICB, SaTH and MPFT colleagues to review work already undertaken and support SaTH to move forward out of NOF 4, this will take place in September. Lynn Cawley advised that Shropshire Healthwatch would like to be included in the risk summit as details are included in the Healthwatch work plan to ensure that patient voices are heard.

Action: Lynn Cawley to contact Tracey Jones and ask to be part of the risk summit for CYP.

5.7 Jane Williams advised that MPFT are working on an options appraisal for 24/7 children's crisis service which is currently going through governance and should be ready by the end of July for ICB input.

5.8 Vanessa Whatley thanked all for their comments and added that ultimately this is not about crisis management, but preventative measures and keeping CYP well and minimise crisis events.

5.9 Maternity services are showing constant progress and the risk register has been updated.

5.10 The urgent and emergency care risk is being reviewed by the UEC team and Vanessa Whatley is encouraging the Urgent Care Board to review the risk monthly.

5.11 Risk SQG3 The Ockenden action plan is not fully delivered (Nov 22) – Hayley Flavell asked this risk register item is updated with progress to date as SaTH are on track and ahead of schedule. Information is captured within Board meeting minutes.

Action: Vanessa Whatley to request the risk register is updated to reflect Hayley Flavell's comments.

5.12 Imaging and Imaging reporting delays – The leads are asking if this risk can be de-escalated back to the ICB Planned Care Board. The direction of travel is good and improvements have been made which has been acknowledged by the national team. Vanessa Whatley advised this item will continue to be reported here for oversight in the performance report. It was agreed that the risk should be de-escalated to the Planned Care Board given the evidence of progress.

5.13 Diabetes Management – The Diabetes Clinical Advisory Group has now met and 5 priorities have been agreed. Data is being reviewed to ascertain numbers of patients who are using blood glucose monitors, with input from the pharmacy team. The risk will not be downgraded until confirmation is received that changes have been made which directly impact on people with diabetes.

5.14 SaTH Paediatric Transformation Action Group (PTAC) has met, workshops, led by SaTH, are planned and work is taking place to identify measures required and how improvements are tracked. Vanessa Whatley added that the sepsis audit is now up to 59%, however more work is required, and assurance will be provided at PTAC as it develops.

5.15 Meredith Vivian asked if there were any comments on the risks and levels of assurance discussed, no comments were received.

5.16 Meredith Vivien noted that Fiona Smith was detailed as the risk owner for diabetes management and asked for assurance there is director oversight. Vanessa Whatley agreed to identify the director will provide an update at the July meeting.

Action: Vanessa Whatley to confirm who has director oversight of diabetes management.

The Committee:

- Discussed the risks for ongoing progress/action.

6.0 Minute No QPC-23-06.89 – Performance Exception Report

The report was taken as read, key points of discussion were:

6.1 Angie Parkes advised the 4-hour target is off track and an improvement is required.

6.2 Meredith Vivien asked members if they were unaware of any of the information contained in the report for their own organisation. No comments were provided.

6.3 Alison Bussey advised MPFT were unable to attend today's meeting due to a clash with their Board meeting, however representatives will be attending the July meeting.

6.4 Meredith Vivien advised the report details a GP recovery update will be provided in the September meeting.

6.5 Admission avoidance numbers are seeing an improvement.

6.6 Meredith Vivian questioned the progress with virtual wards and its profile. Hayley Flavell confirmed there is not a lack of knowledge regarding the virtual ward, work has been undertaken to ensure that clinical staff are fully aware of the criteria requirements to ensure these are met as well as the OPAT service and providing staff with the confidence to use new services. Claire Horsfield agreed and advised step-down numbers from acute services into the virtual ward have improved and achieved target for the first time this week.

6.7 Claire Horsfield added that this is a clinical cultural change for staff groups across organisation boundaries which takes time to embed, we should be more aware and programme this in when undertaking large scale changes in the future. The report was accurate when written, however a huge amount of work is being done across organisations including QR codes on wards for direct referral and MDT meeting attendance. Hassan Paraiso agreed, people are working hard in the background to ensure that awareness continues to be improved.

6.9 Lynn Cawley advised that Virtual Wards are part of Shropshire Healthwatch's work plan along with plavce-based work and is working will trusts to ensure that the public are aware of information and may find it less intimidating.

6.10 Meredith Vivien asked if there was an update on the procurement of dementia diagnosis service failing. Jane Williams advised that MPFT are leading on the procurement, other options are being reviewed including MPFT providing additional clinics. This is being discussed at the contract review meeting tomorrow.

Action: Jane Williams to provide an update on the procurement of dementia diagnosis services following the MFT CRM meeting.

6.11 Angie Parkes advised this is the first report containing CHC information and suggested that future CHC reports are tabled quarterly and asked members if future reports require any additional information. Vanessa Whatley advised CHC is a poor performer in comparison with regional colleagues, however mitigations are in place to ensure that quality is not affected. It was suggested that quarterly reports should be highlighted to ensure a full discussion can take place.

6.12 Vanessa Whatley asked if Fast Track referral data could also be included which details timescales of when referred into the service to when the person receives that care, whether that be at home with carers, into a care home or hospice. Improvements have been seen in the relationship between the hospice and CHC, bureaucratic barriers have been overcome. Vanessa Whatley added that assurance of timely home to die and care in the last few months of life are required.

6.13 Meredith Vivien asked that future reports also contain an executive summary of key points.

6.14 Lynn Cawley also raised concerns that CHC funding required further detail following public concerns over access to funding.

Actions: Angie Parkes to ascertain what information is available for Fast Track, how many cases are denied or appealing for CHC funding
Angie Parkes to ask that future reports include an executive summary.

6.15 Meredith Vivien asked if Betty Lodge was the correct person to provide an update on the 4-hour target slippage around the plan, Angie Parkes agreed.

6.16 Hayley Flavell added that the 4-hour target in isolation is not very informative, the deep dive needs to include other factors. SaTH have an Urgent Care Transformation

Programme which feeds into the system UEC but also looks at ED waiting times, 12-hour targets and medically fit for discharge. Hayley Flavell advised that a report could go to System Quality Group if required. Alison Bussey advised we should be moving towards joint reports, jointly presented where relevant and suggested Betty Lodge liaise with SaTH.

6.17 Meredith Vivien would like to understand why the plan is not working and asked Hayley Flavel and Betty Lodge to undertake an examination of what is happening and whether something specific needs to be adjusted to address issues prior to winter pressures commencing.

Action: Hayley Flavell and Betty Lodge to undertake an examination of what is happening within urgent care and whether something specific needs to be adjusted to address issues.

6.18 Meredith Vivien thanked Angie Parkes and her team for pulling the report together and understood it is an enormous amount of work.

The Committee:

- Noted the content of the report and provided any feedback for incorporation into future reports.

7.0 Minute No. QPC-23-06.90 – System Quality Metrics – Vanessa Whatley

The report was taken as read, a discussion took place with the following key points highlighted:

7.1 Vanessa Whatley advised this is the full report this month and some items have been covered thoroughly in the risk register discussion earlier.

7.2 Community falls response shows a steadying picture of how we prevent falls, improve postural stability in older people and who attends when the person falls.

7.3 Maternity metrics are included in the report.

7.4 CYP slides, page 11, are new into the report. Data is obtained from public health sources and are historic due to national reporting processes; some of the data reflects the first year of the pandemic. Previous reports show high numbers of admissions for children with asthma, these numbers reduced during the first year of the pandemic and came in in-line with the national average. Data for ED attendances in children with asthma and epilepsy is being sought for future reports to see if the ED attendance is in line with the national average. Rosi Edwards commented that the reduction in asthma admittance during 2020/21 is striking. The SQG Chairs report detailed that this drop in numbers requires further understanding.

7.5 Rosi Edwards advised the Health Protection Assurance Board Update report details that both local authorities reported good air quality, however Shropshire reported two AQMAs. Further research is needed to ascertain air quality figures for 2020/21 to achieve such a low level of admissions, which may reinforce the impact of air quality on admissions and provide more understanding. Vanessa Whatley added that public health colleagues have a lot of information on asthma and could be asked to provide further information to System Quality Group or this Committee if required in the future.

Action: Vanessa Whatley to discuss with public health colleagues how to gain a greater understanding of the link between air quality and asthma.

7.6 Hospital admissions caused by intentional or deliberate injuries to children continue to decrease and are now more in line with the national average.

7.7 SaTH SHMI remains below expected levels.

7.8 C.diff levels remain high across the system; discussions are taking place with partners to see what actions and system working can be taken to reduce cases. Hayley Flavell updated for 2022/23 SaTH reported 60 cases against a trajectory of 33. A deep dive has been undertaken on all cases; sampling and isolation issues have been noted, however nothing startling. Kirsty Morgan is working with SaTH IPC team and microbiologists, looking at other factors such as demographics, health inequalities, prescribing and infections. This will be discussed at SaTH's IPC Operational Group meeting. Challenges are noted with estates and isolation, however it is acknowledged that the Trust needs to understand they are acquiring increasing C.diff cases. Levels are close to pre pandemic rates, however nationally cases spiked in August 2022 and February 2023. For 2023/24, SaTH are currently reporting 20 cases against a trajectory of 32.

7.9 Meredith Vivien asked if SCHT are seeing a similar pattern; Claire Horsfield responded that she would not expect to see the same patterns due to the cohort of patients.

7.10 Vanessa Whatley advised good antimicrobial prescribing in the community and good follow-up procedures are also required; an Antimicrobial Stewardship Group are just about to launch a strategy which does include this.

7.11 Vanessa Whatley confirmed this is in discussion for the ICS IPC and AMR Group risk register at system level and suggested it needs to be on SaTH risk register. Hayley Flavell agreed.

Action: Hayley Flavell to add C.diff monitoring onto SaTH risk register.

7.12 Currently, there are no nursing homes within the system rated as inadequate by CQC which is positive.

7.13 An unannounced inspection took place at MPFT this week, following on from the section 29 issued at the previous inspection last year, the report is awaited.

7.14 The Diabetes dashboard is embedded within the report for information.

The Committee:

- Considered the quality metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-06.91 - Exception Report - System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read, a discussion ensued and the following key points were highlighted:

8.1 Vanessa Whatley drew attention to the alerts in the report and wished to advise that since this report was written, CQC have reinspected MPFT.

8.2 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.

8.3 Audit findings have resulted in actions around unmet training needs, time constraints, lack of patient engagement or commissioned services and limited understanding of where to signpost patients for pain management.

8.4 Following national alerts in the use of Valproate (to treat epilepsy) while pregnant which could result in harm to the new-born baby, an audit undertaken by the neurology service (RWT) has shown 32 STW women identified as being lost to follow-up who are of childbearing age. Action is underway with primary care colleagues to identify where

these patients are and to bring them back into specialist services to have an annual review to comply with national guidance.

8.5 Vanessa Whatley explained SaTH are reporting an increased number of serious incidents associated with deaths in the Emergency areas of the Trust which has been highlighted by SI reporting. An internal alert also identified through the learning from deaths processes. Hayley Flavell advised this has been discussed at Board and PSIRF, work is ongoing. For quarter 4 and going into quarter 1, the length of stay in ED has lengthened dramatically and work is being undertaken by the medical director and learning from deaths group to investigate if this has impacted figures. Meredith Vivien commented that this information was very helpful.

The Committee:

- Considered the alerts in this report and further assurance required.
- Accepted the report.

9.0 Minute No QPC-23-06.91 Insight Report – Quarter 4 – Tracey Slater

The report was taken as read, a discussion ensued and the following key points were highlighted:

9.1 Tracey Slater confirmed this report was for quarter 4 2022/23.

9.2 Meredith Vivien noted the same themes remain including, discharge, communication and medications. Tracey Slater advised enhanced work is in progress, SaTH are working with ICB Medicines Management Team and lines of communication have been opened up in real time. A reduction in N2Ns is being noted in quarter 1, SaTH Medicine Management Lead is setting up an improvement group to review medication themes and work directly with primary care pharmacists. An N2N patient group is being set up with SaTH and looking to broaden the membership, PSIRF principles after action reviews.

9.3 Hayley Flavell discussed the weekly Review and Learning from Incidents Group (RALIG) meeting, with representation from ICB colleagues. Complex cases which cross over system boundaries are being seen more frequently and a robust framework similar to the SI reporting framework is required. GP colleagues do not currently operate an SI framework and SI framework will be replaced by PSIRF. Proactive work is being undertaken; however, a robust system is in place for timely cross-system investigations is required.

9.4 Meredith Vivien advised that a detailed discussion will be held at the October meeting when the next Insight report will be tabled.

9.5 Lynn Cawley has discussed PSIRF with Sharon Fletcher and attended the SaTH workshop earlier this week. A system approach is required for PSIRF to ensure consistency across providers, one process, one set of documents that all providers use would simplify things for the public. The patient-facing document needs to be much shorter and both Healthwatch organisations can help to create this. Vanessa Whatley advised that the system patient safety specialists are all working together to keep it as consistent as possible, however there are different challenges, for example mental health have very different incidents to the acute, each trust will have their own plan. A joint workshop is planned for July and joint training being proposed. Hayley Flavell added that a huge amount of work is needed for training and cultural shift, and robust communications are needed for the patients and their families to make sure their expectations are managed.

9.6 Kirsty Foskett confirmed that system patient safety specialists are looking at standardised processes and documents, recognising that priorities for each provider may well be different. Processes for managing the deteriorating patient will be very different due to differing workforces and cohort of patients.

9.7 Meredith Vivien wished to note there is 100% acknowledgment of complaints, this is excellent, and asked that Doddington practice is removed as the practice closed 2 years ago.

9.8 Angie Parkes confirmed all feedback is provided to the primary care team quarterly.

The Committee:

- Noted the report content

10.0 Minute No. QPC-23-06.93 – SOAG Exception Report: Vanessa Whatley

The report was taken as read.

10.1 Alison Bussey confirmed that all issues discussed at SOAG are reported to the relevant committees for governance and assurance and was unsure of what value the report has for this meeting. Vanessa Whatley added the SOAG report is not in the QPC Terms of Reference, it was requested by the ICB Chief Executive as an add-on some months ago.

10.2 Meredith Vivien advised this report will no longer be required for future meetings on the understanding that everything covered is reported elsewhere.

The Committee:

- Agreed this report will no longer be required for future meetings.

11.0 Minute No. QPC-23-06-94 - Deep Dive – Children & Young Peoples Mental Health including Eating Disorders – Brett Toro-Pearce

The report was received as read, and the following key points were discussed:

11.1 Meredith Vivien thanked Brett Toro-Pearce for an informative, clear and precise report.

11.2 Lynn Cawley asked who has responsibility to advise adults on the ADHD waiting list of the choices available. Brett Toro-Pearce explained the choice of the 5 providers only came through in May and waiting lists are being worked through to notify patients of the choices available. National waits are being reviewed recognising that locally, 5 providers are not available to provide assessment. Nationally the waiting list is around 6 months and some providers have already closed their books until the end of 2024. Options are being reviewed to ascertain realistic local choices and this will be communicated to patients on the waiting list.

11.3 The ICB is responsible for financial obligations regarding private providers, a scoping exercise is being undertaken to put a realistic forecast in place.

11.4 Access to core mental health services is currently 50 weeks. Processes are in place ensuring people can 'wait well', so they are not reliant on a diagnosis and the wider access to general services and the clinical oversight and triage and crisis response is available. It is recognised that harm could occur, how to prevent the harm to future-proof services in how we commission services is being reviewed.

11.5 Brett Toro-Pearce did not have detailed information on the 21% of patients who waited longer than 4 hours for crisis and home treatment, however assured the group that he would be sighted on any cases waiting longer than 4-5 hours.

11.6 From June 2023, home treatment is available 24/7 and this is a regenerated service, availability has differed recently between day time only and 24/7. Changes to 111 are being looked at to ensure calls go to local providers for mental health response from the home treatment team and crisis team from April 2024 as part of the overall procurement for 111 services.

11.7 There are currently no waiting lists for eating disorders, however there are concerns regarding the data accuracy being reported for all services, relating to the recording of when contact is made with the patient.

11.8 Meredith Vivien asked that Miller Bownass is thanked for his hard work on this piece of work.

11.9 Vanessa Whatley has had discussions with Alder Hay Hospital CYP MH Team in Liverpool where 24/7 crisis care has been put in place; if a child presents at A&E during the evening, the hospital will hold the child until community care is in place to prevent an admission. Vanessa Whatley asked if prevention of ill mental health and the previously reported iThrive model was still the aim. Brett Toro-Pearce confirmed that iThrive is still being developed to provide wider support to prevent crisis or deterioration and is linked in with schools, the Wave 10 will go live in quarter 3 when work with be undertaken with system colleagues to look at how this model can be embraced as part re-invigoration of the transformation plan, recognising there is a huge demand for acute services and looking at how we can stem referrals and prevent deterioration.

11.10 Simon Fogell asked on average, how many people are accepted on to the 24/7 access helpline as the report states families are made aware on acceptance of referral. Brett Toro-Pearce confirmed this is the acceptance of the submitted referral which will have been triaged upon receipt.

11.11 Regarding crisis resolution home treatment service (available 08:00 to 22:00), Simon Fogell asked if details are available of how many times the service is contacted out of those hours. Brett Toro-Pearce advised that outside of these hours, support is available from the general 24/7 crisis team.

11.12 Is information available of how many of the young people waiting up to 50 weeks, suffer serious incidents or serious increases in their condition. Brett Toro-Pearce was not aware of anyone suffering serious harm, however will obtain details of anyone suffering lesser than serious harm and feedback to the Committee.

Action: Brett Toro-Pearce to ascertain how many young people suffer harm during the waiting period for treatment.

11.13 Alison Bussey advised we are financially challenged with workforce issues, how do we maximise the opportunities around specialist skills which may look towards all-age services. Brett Toro-Pearce agreed, he is passionate that all-age services are considered along with equal access to the services.

11.14 Meredith Vivien suggested it would be helpful for MPFT to present a report explaining their data collection to these services and the work being undertaken to ensure it is accurate so we are confident the data we have contains no gaps, is accurate and up to date. Jane Williams advised that data quality and consistency has been raised previously with the provider. A data quality improvement plan has been included in the contract with specified timelines for improvement; MPFT have employed specialist BI staff to assist with this.

Action: Brett Toro-Pearce to provide an update on MPFT data quality improvement plan at the September meeting.

The Committee:

- Noted the contents of the report.

12.0 Minute No. QPC-23-06-95 – Healthwatch Shropshire – Lynn Cawley

A verbal update was provided.

12.1 Lynn Cawley advised the Healthwatch Accessible Information Standard report was tabled at the Shropshire Health and Wellbeing Board and due to system pressures, provider responses were not sought at the time of publication. The Board has asked that all providers share with Healthwatch what they are doing to implement the standard.

12.2 Healthwatch are hoping to feed into the diabetes transformation to assist with quality and performance.

12.3 Meredith Vivien asked both Shropshire and Telford Healthwatch to provide Sylvia Barnes with a list of key items they wish to raise, one week prior to each QPC meeting so these can be included when the meeting papers are distributed.

Action: Lynn Cawley and Simon Fogell to provide Sylvia Barnes with a list of key items they wish to raise, one week prior to each meeting so these can be included when the meeting papers are distributed.

13.0 Minute No. QPC-23-06.96 – Healthwatch Telford & Wrekin – Simon Fogell

A verbal update was provided.

13.1 Simon Fogell advised he had no items to raise this month.

14.0 Minute No. QPC-23-06-97 - Health Protection Assurance Board Update – Liz Noakes

The report was received for information only.

14.1 Meredith Vivien commented that COVID-19 vaccination rates for over 75s are 63% which seems quite low. Vanessa Whatley advised this was discussed at the HP Assurance meeting and it was advised by Steve Ellis that work was is continuing to deliver vaccinations as this cohort of patients closes shortly and these are not final figures.

The Committee:

- Noted the contents of the report.

15.0 Minute No. QPC-23-06-26.98 - Paediatric Ophthalmology Service Summary – Helen Rowney

15.1 Helen Rowney explained that Vanessa Whatley has been actively involved in this task and the risk initially sat with this Committee. As the risk has been reduced it will be moved to the Planned Care and Delivery Group and through contract monitoring under fragile services, for continued monitoring.

15.2 Helen Rowney confirmed that Clare Roberts, ICB, is the clinical advisor.

15.3 Slide 8 'Monitor only those who really have a clinical need to make room for those who don't' – Meredith Vivien suggested this may need amending to: only monitor those who have an ongoing clinical need and not those who don't.

15.4 When asked about the expected timescale, Helen Rowney advised the initial contract is for 12 months, SaTH will need to undertake market testing however Clare Roberts is still actively involved and working with system colleagues with other transformation work.

15.5 Vanessa Whatley advised this was very satisfying work, starting with weekly meetings and small steps leading to the gradual incremental change. Waiting lists are small, SaTH are retraining AHP colleagues in advanced practice, taking some of the consultant workload for a more resilient service going forward.

The Committee:

- Noted the contents of the report.

16.0 Minute No. QPC-23-06-26 99 - LeDeR Annual Report – Jen Morris

16.1 Meredith Vivien confirmed the annual report was approved at Board yesterday.

16.2 Jen Morris advised that figures have improved since last year however, some significant gaps remain and further work will be carried out to address these as a system. Representation is required at all of the appropriate groups and necessary feedback will be given.

16.3 Tracey Slater advised that Jen Morris and Raphael Chichera have done an excellent job on this report in her absence. She wished to thank them for their hard work and also thank Meredith Vivien for allowing the paper to be distributed for comments in advance.

16.4 Challenges with engagement and commitment are being worked on as a system with the support of System Quality Group and other LD&A governance routes. In South, West and Central CSU, reviews are outsourced, it has taken 12 months to embed our quality assurance and reporting expectations; without excellent reviews we are not able to extract learning. We are in a much better position and are exploring how to develop enhanced sharing of the learning across the system. There is good representation on the governance panel from experts by experience and their families.

16.5 Lynn Cawley advised Healthwatch is mentioned in the report and questioned what contribution has been made. Jen Morris advised this was following a meeting with Julie Miller who shared a piece of work carried out jointly between Healthwatch and taking part, agreement was gained from Julie Miller to include this information in the report. Tracey Slater and Jen Morris agreed to have further discussions with Lynn Cawley outside of this meeting.

16.6 Meredith Vivien asked for an update in March or April 2024 to provide a preview of the next annual report.

Action: Tracey Slater and Jen Morris to provide a preview of the next annual report at the March or April 2024 meeting.

17.0 Minutes No. QPC-23-06.100 – Complaints and Compliments Policy – Angie Porter

17.1 Angie Porter explained that from 1 July 2023, the ICB is responsible for complaints relating to primary care services; pharmacies, optometrists and dentists, NHSE were

previously responsible for this. Patients can still choose to contact the provider directly or ICB.

17.2 If ICB are unable to resolve the enquiry outside of the complaint process, details are passed to Birmingham and Solihull who carry out the patient consent process, liaise with the service provider and format the response. The response is sent to ICB for CEO signoff and returned to allow Birmingham and Solihull to respond to the patient. Angie Porter confirmed patients will be advised of the process on ICB website along with Birmingham and Solihull's process and policy.

17.3 Lynn Cawley asked that any patient facing information be shared with Healthwatch. Angie Porter advised that information was sent to stakeholders, Healthwatch, GPs, pharmacists on 21 June 2023.

Action: Angie Porter to check that communications regarding the Complaints and Compliments Policy were sent 21 June 2023 and check for any gaps in the distribution.

17.4 Audit Committee asked that this policy is brought to QPC for approval as it sits in the Quality remit.

17.5 Simon Fogell asked if Healthwatch can receive an easy-read version to place on their website as the document is very long and members of the public may find this difficult to understand. Angie Porter confirmed this is the policy, and an easy read version of the process will be placed on ICB website for the public to access.

17.6 Hayley Flavell asked if documents are reviewed by a panel to obtain robust feedback from people who would use the leaflets. Angie Porter advised that previously the CCG had access to a patient group but was unaware of one in the ICB. Meredith Vivien suggested the Communications team may be able to assist as this must have been queried before.

Action: Angie Porter to explore how to ensure materials in relation to the complaints procedure are accessible, clear and open to all.

17.7 Lynn Cawley advised that Healthwatch Shropshire volunteers and Board were previously involved with reading documents for Shropshire CCG and would be happy to continue with this for ICB.

17.8 Jill Barker queried section 5.1 *A complaint may be raised under this policy by anyone who is receiving or has received services that are provided or commissioned by the NHS Shropshire, Telford and Wrekin, where they are registered with a GP in either the Shropshire or Telford & Wrekin area* and asked if this relates to primary care services or all services. Angie Porter confirmed the NHS Complaints Legislation states a patient can raise complaints with either the provider or commissioner; ICB already co-ordinates responses for SaTH, SCHT, MPFT and smaller providers.

18.0 Minute No. QPC-23-06.100 – Evaluation of Meeting

18.1 Meredith Vivian encouraged members to feedback comments and/or observations they may about the meeting or any improvements they wish to see. Please send comments to sylviabarnes@nhs.net

19.0 Minute No. QPC-23-06.101 – Items for Escalation/Referral to other Board Committees

19.1 There were no items for escalation.

20.0 Minute No. QPC-23-06-102 – Any Other Business

20.1 No additional items were raised.

Date and Time of Next Meeting

Thursday 27th July 2023 @ 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …….. DATE ……

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICB Finance Committee (Section 1) Meeting
Monday 26th June 2023 at 3.30pm
Via Microsoft Teams

Present:

Name	**Title**
Trevor J McMillan (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW

Attendees:

Gareth Robinson	Directory of Delivery and Transformation NHS STW
Laura Clare	Deputy Director of Finance NHS STW
Joanna Watson	Senior Consultant - Good Governance Institute (Observing)
Cynthia Fearon	Corporate PA NHS STW **(Note taker).**

Apologies:

None

Minute No. SFC-23-06.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **CF** confirmed that there were no apologies received.

Minute No. SFC-23-06.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-06.003 – Minutes from the Previous Meeting held on: 30th May 2023

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. SFC-23-06.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

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Minute No. SFC-23-06.005 - Monthly Update ICB on Financial Position Revenue and Capital Month 2

Report received as read.

6.1 **LC** highlighted that at Month 2 the ICB has a small favourable variance to plan of £0.2m. This is broadly due to £0.6m of non-recurrent benefit from prior year offset with £0.4m from the fact that there has been no Welsh elective recovery income received year to date.

The ICB is currently forecasting breakeven against the submitted 23/24 plan but there remains significant financial risk focussed around:

- 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 without a clear system operational and expenditure plan associated with hospital discharge.

LC stated that since the final plan submission - the ICB received an additional non-recurrent allocation from NHSE as a contribution towards inflationary pressures. This totaled £2.9m with the directive that it is to be incorporated against the final plan deficit. As a result, the ICB reported deficit for 2023/24 is now £11.8m in year (£26.9m underlying) with the overall system deficit plan moving from £60m to £57.1m in year (£83.1m underlying).

TMcM asked about actions to resolve the Welsh ERF query. **CS** stated that both Laura and herself are currently having weekly catch-up meetings with John Bailey from NHSE and this is discussed as part of those meetings. A further conversation with the national team is required.

TMcM made reference to the section of the report where it highlights that in 2022/23 there was a significant cost pressure around expenditure on faster discharge with local authorities and in 2023/24 the plan has been based on the fact that we will not fund any expenditure over and above the allocations that we are given. **GR** responded that, this is the line that we are holding. **GR** added that he will be presenting a report to outline the decision around that in the System Finance Committee – Section Two meeting, which is scheduled for tomorrow (Tuesday 27th June 2023).

TMcM asked for more information on the POD services, and the difference in reported positions outlined in the report. **LC** clarified that the year-to-date position reported by the NHSE POD Finance Team was a £34k adverse variance. **LC** added that in the ICB report, the variance is reported as £125k; the £91k difference being due to the rephasing of a reserves adjustment that had been enacted in NHSE reporting but had to be reversed in the ICB position due to the ICB not being able to deviate from planned phasing at Month 2. **LC** gave assurances that this is now being discussed with NHSE to resolve for future months (month 3 onwards) reporting.

GR stated that as previously reported, this is a very challenging efficiency plan to deliver within the ICB. He added that there has been progress within the Delivery and Transformation team in recent weeks to reduce the unidentified gap with £2.5m of additional savings plans being identified. Work continues across all areas of spend to identify further savings and new opportunities are emerging which are being tracked through a pipeline set of plans, which includes medicines management. **GR** added that there remains a £5.5m gap in the efficiency plan which equates to the ICB's share of the system stretch target.

Much more work needs to be done around the unidentified element of the efficiency plan. **GR** gave special recognition to Kate Owen PMO who is doing a sterling job overseeing this area of work.

CS stated, that NHSE are expecting that we have a view of the recurrent reach of the existing programme into next year. NHSE are asking that it will be in place by the end of Quarter one.

LC highlighted that there is £883k in the capital plan for the ICB which is related to Primary Care, Estates and IT. **LC** stated that it is very early in the year however she believes that we will spend all of the funds allocated.

LC flagged that there is currently £16.4m unmitigated risk to delivery of the ICB plan. The drivers of this being set out in the risk section of the report. **LC** added that it is important that we reduce or mitigate that risk and so we need to keep up pace of actions.

Regarding the run-rate - **LC** stated that M2 is the first month of reporting this for the ICB but in future months we will track month on month expenditure to note any reasons for any change in run rate. This will help to keep a close eye on whether spend is being controlled.

The System Finance Committee were asked to note the following:

- The M2 headlines for the ICB financial position (breakeven year to date but with high risk around FOT delivery).
- The key drivers of the risk presented and actions to reduce or mitigate those risks.
- The level of unmitigated financial risk currently reported alongside the forecast position (£16.4m).

Minute No. SFC-23-06.006 – Any Other Business

LC informed the committee that the team are engaging with a regional working group to look at the medium term finanical plan.

Action: LC to keep SFC briefed on outputs from this work.

There was no other business for discussion.

Meeting closed at 4.12pm.

Date And Time of Next Meeting

Friday 11th August 2023, 10.30am via Teams.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 27th June 2023 at 12.00 noon
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Anthony Simms (deputising for SL)	Deputy Director of Finance Shropshire Community Health NHS Trust
Mark Salisbury (deputising for CM)	Operational Director of Finance RJAH
Clair Young (deputising for HT)	Deputy Director of Finance – Strategy
Peter Featherstone	Non-Executive Shropshire Community Health NHS Trust

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS ST
Laura Clare	Deputy Director of Finance NHS STW
Joanna Watson	Senior Consultant - Good Governance Institute (Observing)
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Sarfraz Nawaz	Non-Executive - RJAH
Craig MacBeth	Chief Finance Officer RJAH
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust

[The meeting was not quorate, but attendees agreed to continue]

1.0 Minute No. SFC-23-06.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

2.0 Minute No. SFC-23-06.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

3.0 Minute No. SFC-23.06.003 Minutes of the Previous Meeting held on: 30th May 2023.

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-23.06.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

5.0 Minute No. SFC-23.06.005 Monthly Update ICS on Financial Position Revenue and Capital – month 2

5.1 **Report received as read.**

CS stated that the planned system financial position for 23/24 was a £60m deficit with an underlying/recurrent financial deficit of £83.1m. **CS** added that following submission, NHSE have issued an additional inflationary pressure allocation of £2.9m with a directive that this should be added to the plan position for the ICB and system. The system deficit plan position is therefore now a £57.1m deficit.

CS highlighted that at M2 the STW system is reporting a £4m adverse variance to plan. **CS** also highlighted that the main area of overspend is in SATH and relates to areas such as the impact of strike action, internal overspends and continued areas of open escalation space and associated agency expenditure. **CS** added that there are smaller overspends at both RJAH and SCHT. Also, a small favourable variance to plan at the ICB, mostly due to prior year benefits.

CS highlighted that at Month 2, system agency expenditure is exceeding plan by £2.5m (£10.4m spend year to date v's £7.9m plan) which is now exceeding the agency cap by £5.8m. The agency cap is £4.5m year to date.

CS stated that the system is reporting a forecast break-even position against the financial plan submitted but there remains significant high risk to delivery. The main areas of risk relate to:

- Delivery of efficiency plans - particularly identifying plans to deliver the system stretch target submitted in the financial plan.
- Lost opportunity for Welsh income – currently in discussion with the regional and national team to resolve that.
- Delivery of the elective recovery plan and achieving associated income built into the financial plan.
- Risk of increasing system costs without a clear system operational and expenditure plan associated with hospital escalation reduction (linked to discharge capacity).

CS emphasised that she is concerned that at month 2 we are already off track with the financial plan.

PF queried costs on agency spend at £4.5m and stated if we continue at that rate that will have a massive impact on the system over this financial year. **PF** added that he has been in discussions with **SL** on how they can get a grip on agency cost at SCHT. **CS** responded that all organisations have controls in place for sign off. **CS** added from a governance perspective, we are looking to have sight of that across the system. This will allow us to share notes and seek consistency across the delivery of the programmes of work.

CY mentioned that SATH are currently working through a significant agency reduction programme. Oversight is through SATHs' weekly Governance Board. **CY** also mentioned that they have a dashboard regarding agency reduction that is presented at SATH's weekly Executive Meetings for scrutiny.

MS stated that Robert Jones are £300K off their financial plan, year to date. Which is predominantly income driven, the biggest risk being the delivery of elective activity. **MS** added that Robert Jones took a big hit in month one, due to the industrial action that took place from the junior doctors. Robert Jones is now looking to recover that activity later in the year. A lot of work is currently going on internally and with the Planned Care Group.

MS stated year to date Robert Jones is down by £100k income, due to the Low Value Agreement (LVA). That is a block contract (per national rules) arrangement that Robert Jones

has which is calculated on historic information and doesn't take into account an increase in activity to help to reduce waiting lists.

Regarding reducing agency costs, **TMcM** asked whether the providers had explored use of different staff/skill mix in order to avoid using agency (eg using third year nursing students) **CS** replied that conversations to consider options to reduce agency costs are being had within the Workforce Group. The Integrated Delivery Committee also has oversight of progress against related savings plans.

CS stated that the first meeting of the System Agency Reduction Group is scheduled for Friday 7th July 2023. The meeting will be chaired by Alison Bussey – Chief Nursing Officer NHS STW. **CS** added that the Terms of Reference is to be finalised and signed off by that group.

PF also queried the efficiency plan and asked how we are collectively approaching that through our organisations, challenging our operational colleagues to deliver they plans through the PMO functions. **GR** replied that, currently the majority of the efficiency programmes (by value) are sat across the ICB and SATH. **GR** added that the intention is to leave the ICB and the providers to oversee their own cost improvement programmes. Then focus as a system on the £10 million cost improvement plan, which is currently unidentified and is flagged as a significant risk to the system.

GR stated that there are pipeline opportunities that are being developed into firm plans. However, they need provider and system support via their operational leads to commit to deliver in those areas of work. **GR** stated that what he is seeking from the System Finance Committee is for escalation through to the ICB Board and through provider organisations to ensure that the Executive Officers within the operational function have this as an equivalent priority.

CS suggested, for future System Finance Committee meetings (for this financial year at least) to have a separate agenda item on efficiency programmes on the agenda. If need be, further assurance on delivery or actions could then be sought from the IDC.

Action: It was agreed, for future System Finance Committee meetings (for this financial year at least) to have a separate agenda item on the efficiency programme on the agenda If need be, further assurance on delivery or actions could then be sought from the IDC.

System Finance Committee:

- Noted the M2 headlines for the system financial position and the level of financial risk in the forecast position.

6.0 Minute No. SFC-23-06.006 STW Finance Training and Development Council Update

Report received as read.

6.1 **CS** stated the STW Finance Training and Development Council (FT&D Council) has been established as a subgroup of the Finance Committee.

CS noted that the FT&D Council had met for the first time on 19th April 2023 and met again on 24th May. A work plan is in development and an away morning with all NHS finance teams is planned for the end of June.

All Directors of Finance across the system are committed to leading this agenda to support staff and the development of the system finance community.

CS asked that the Terms of Reference for the FT&D Council be approved.

The System Finance Committee:

- Approved the STW FT&D Council Terms of Reference noted the latest update from the STW FT&D Council.

7.0 Minute No. SFC-23.06.007 Deep Dive – discharge and escalation

Report received as read.

7.1 **GR** shared the background to discharge funding over the past few years and highlighted that post pandemic, additional non-recurring funding that had been in place had fallen away. Give the challenges in the STW system and in spite of a national ask to not fund beyond what was affordable in budgets, the ICB had incurred costs in 2022/23 over and above a non-recurrent allocation to support discharge in order to support flow through the hospitals.

GR stated that this funding was provided via the Adult Social Care Discharge Fund (totalling £7.8m through the Local Authorities and NSH STW) plus an unbudgeted investment of £10.6m from NHS STW. For 2023/24, some additional national funding through the Adult Social Care Discharge Fund has been received by both Local Authorities and NHS STW. however there remains a significant shortfall in funding if current expenditure continues all year.

GR noted that he has written to local authorities to make clear that the ICB cannot provide funding beyond what has been allocated and is working with both NHS and Local Authority colleagues to make sure that we avoid an overspend whilst also preventing the discharge position from worsening.

TMcM stated the system needs to work together to find an agreeable solution (for NHS and LA partners) as this will have a severe impact on the overall system discharge and escalation position if not resolved.

The System Finance Committee:

- noted that all available recurrent funding has been deployed in support of the existing discharge services. Local Authority plans for commissioning services will be made on the basis of the funding envelope as set out in the letter (circulated with this update) and that there will be no further additional funding provided by NHS STW in 2023/24
- noted the risk that this provides to existing services in that, without mitigating actions being put in place, services previously funded may need to cease.
- noted the impact that could have on hospital discharge rates and the impact that will have on no criteria to reside levels within SaTH and SCHT.

8.0 Minute No. SFC-23.06.008 Any Other Business

8.1 **CS** stated that they have a meeting with regional and national NHSE colleagues tomorrow. NHS England will be doing a stocktake on month 2, which they are currently doing with all ICBs.

Date and Time of Next Meeting

Friday 11th August 2023 at 11.45 via Teams.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 30th May 2023 at 2.00pm
Via Microsoft Teams

Present:

Name	**Title**
Trevor J McMillan (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW

Attendees:

Gareth Robinson	Directory of Delivery and Transformation NHS STW
Angus Hughes	Associate Director of Finance NHS STW
Jill Price	Financial Planning and Business Partner NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW **(Note taker).**

Apologies:	**None**
Laura Claire	Deputy Director of Finance NHS STW

Minute No. SFC-23-05.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **CF** confirmed that there were no apologies received.

Minute No. SFC-23-05.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-05.003 – Minutes from the Previous Meeting held on: 3rd May 2023

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. SFC-23-05.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

Minute No. SFC-23-05.005 – M1 ICB financial position overview

Report received as read.

5.1 **CS** highlighted that budgets have been issued to all budget holders on the basis of the 4th May financial plan submission, requiring sign off by the 19th May 2023. **CS** added that the budget upload guidance has now been received by NHSE with all budgets to

be uploaded to the system by the end of May in readiness for M2 reporting. Run rate reporting will be introduced in 23/24 to monitor monthly actuals against plan.

CS emphasised that as budgets are not yet uploaded to the ledger, the team could not produce a detailed M1 financial position. However, information has been compiled on key areas of expenditure risk within the current position, which include:

- Individual Commissioning (IC):
- Prescribing
- Running costs and Programme Pay
- Discharge expenditure with Local Authorities
- Elective Recovery Funding assumptions
- Efficiency Delivery

CS stated that the paper presented to this meeting gives an overview of each of the above areas. **CS** made particular reference to Efficiency Delivery and highlighted that there is a very challenging efficiency plan to deliver within the ICB. **CS** stated that there is a current £2.5m gap in the original efficiency plan that is yet to be identified and a £5.5m gap due to the share of the system stretch target. **CS** added that the data is not yet available for all identified efficiency plans but the majority appear to currently be on target at Month 1. Schemes need to be identified to meet the total gap, especially given that the scale of in-month efficiency target increases at month 3.

The System Finance Committee were asked to note the following:

The M1 headlines around the ICB financial position ahead of any formal 23/24 financial reporting.

Minute No. SFC-23-05.006 - Finance Plan 23/24 update

Report received as read.

6.1 **CS** highlighted that the final plan submission on the 4th May 2023, was at a position of a £60m system deficit. The ICB share of the planned system deficit submitted for 2023/24 is £14.7m, with an underlying plan deficit of nearly £27 million.

CS stated that the plan for 23/24 is not without risk (operational, quality, and financial) but the System is committed to its delivery and to managing risks in year. **CS** added that the ICB must manage its own risks but also has a signifcant role to play in managing the wider system financial risk. She anticipates further meetings with NHSE to discuss delivery against the plan submitted and also a meeting with the national team in September to review in year delivery as well as the longer-term financial recovery trajectory.

The System Finance Committee were asked to note the following:

The final 23/24 financial plan submission for the ICB and associated risks.

Minute No. SFC-23-05.007 – Efficiency Plan Update

Report received as read.

7.1 **KO** highlighted that the efficiency plan was submitted as part of the final financial plan on 4th May and has an overall target of £26m. The value represents the largest and most challenging efficiency target the ICB has faced and equates to 5% of the underly-Ing non system expenditure.

KO stated that there has been significant effort to date to identify schemes to meet the target and plans are in place to deliver savings of £18m (70% of plan). **KO** added that there are robust monitoring processes set up to track delivery which will be reported through to the monthly sustainability working group. **KO** emphasised that despite the work to date, there remains £8m of plans that are yet to be identified and this presents a high level of risk to the ICBs finance position.

KO highlighted that there are currently £8m of unidentified efficiency plans, of which £5.5m relate to the ICB's share of the system stretch target as agreed at CFO's in May and a further £2.5m of unidentified efficiencies from the original ICB plan. **KO** stated that there has been progress made in identifying plans to reduce the original gap over the past few weeks and this has continued to reduce since last month.

KO stated due to the urgency and risk, CEO's have agreed two focus areas to be explored to maximise potential savings, these are within Place Based Joint Commissioning and system wide Medicines Management. **KO** added that directors and senior leads are now looking to prioritise these areas of work which will help to provide maximum pace and focus. Weekly 1-1 meetings are being held with senior leads within the ICB's Delivery and Transformation team to review spend across each budget line to assess value for money and to identify potential opportunities, each department is looking to reduce their spend by 4.7% where possible.

CS requested for future reporting, if figures on recurring and non-recurring can be broken down more and presented clearly in the report.

CS stated although the report outlines the gaps and outlines the closing of the gaps. For future reporting the report needs to include more narrative around the confidence around the identified open and closed gaps, so it's clear what actions are being taken. **GR** stated that there are programmes of work currently being undertaken within primary care with meds management, which can be included in future reporting.

Action: KO to include more information on recurrent/non recurrent figures in future reports and also more narrative around the confidence around the identified open and closed gaps, so it's clear what actions is being taken for future reporting in the efficiency plan update.

The System Finance Committee were asked to note the following:

- The £26m value of the overall efficiency plan and the risk associated with the £8m unidentified gap.
- The actions that are in place to address the risk and the key areas identified by CEO's.

Minute No. SFC-23-05.008 – Any Other Business

There was no other business for discussion.

Meeting closed at

Date And Time of Next Meeting

Monday 26th June 2023 at 15.30 – 16.30 via Teams.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 30th May 2023 at 11.45am
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Anthony Simms (deputising for SL)	Deputy Director of Finance Shropshire Community Health NHS Trust
Mark Salisbury (deputising for CM)	Operational Director of Finance RJAH
Clair Young (deputising for HT)	Deputy Director of Finance - Strategy

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS ST
Kate Owen	Head of PMO NHS STW
Angus Hugues	Associate Director of Finance NHS STW
Jill Price	Financial Planning and Business Partner NHS STW
Meryl Flaherty	Head of Contracting
Cynthia Fearon	Corporate PA NHS STW **(Note Taker)**

Apologies:

Sarfraz Nawaz	Non-Executive - RJAH
Craig MacBeth	Chief Finance Officer RJAH
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust
Peter Featherstone	Non-Executive – Shropshire Community Health NHS Trust
Chris Sands	Chief Finance Officer – MPFT
Laura Clare	Deputy Director of Finance NHS STW

[The meeting was not quorate, but attendees agreed to continue]

1.0 Minute No. SFC-23-05.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

2.0 Minute No. SFC-23-05.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

3.0 Minute No. SFC-23.05.003 Minutes of the Previous Meeting held on: 3rd May 2023.

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-23.05.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

5.0 Minute No. SFC-23.05.005 M1 ICS Financial position overview

5.1 **Report received as read.**

CS highlighted that budgets across the system have now been set on the basis of the 4th May 2023 financial plan submission.

CS stated at Month 1 a formal report is not provided to NHSE however, SATH, RJAH and SCHT have produced internal reports that provide insight into their financial position for April 2023. The ICB is unable to upload budgets to its ledger until Month 2, so is unable to produce a full position report however has reviewed its high-risk areas of spend. From the reports provided the following financial risks were highlighted:

- SaTH month 1 position shows an adverse variance to plan £1.4m.
- RJAH month 1 position, there is a small adverse variance to plan £0.2m.
- SCHT month 1 position overall expenditure appears to be broadly in line with plan.
- ICB month 1 position headline information on key areas of ICB expenditure shows that both Individual commissioning and prescribing are in line with plan at month 1 and running costs are showing a small adverse variance as the known recurrent pressure is broadly offset with vacancies in month 1.

CS emphasised that the report indicates that at month 1, the system overall is already off track compared to its plan for revenue expenditure. That suggests that the significant financial risk in delivering the 23/24 financial plan that was noted during planning is starting to materialise, so urgent action is required to bring expenditure back in line with plan.

CY stated, most material risks to SATH's forecast remains the escalation costs. Which is really impacting greatly on SATH's position.

MS flagged the impact of industrial action in month 1 for RJAH - there is no industrial action in May 2023 for junior doctors. However, there is industrial action scheduled for June which will create further cost pressure. **MS** stated until that has been resolved, it is a significant risk for RJAH and that may lead to the cancellation of elective activity. **MS** added that RJAH are currently exploring ways of how they can mitigate the impact and recover some of the shortfalls later on in the year.

CS stated that there are no material concerns at month 1 regarding delivery of the capital plan. **CS** added that, the bid around modular ward capacity on the SATH site, has now been approved.

The System Finance Committee:

- Noted M1 headlines for the ICS financial position, in particular the fact that the system is already off track against its financial plan (revenue).

6.0 Minute No. SFC-23-05.006 Finance Plan 23/24 Update

Report received as read.

6.1 **CS** highlighted that the final 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. **CS** stated that she would share the letter with this committee once she has received it.

CS highlighted that no changes were made to the capital plan since the position presented at finance committee on 3rd May. The plan has also been published on the ICB website as per national guidance ('Lord Markham' letter).

CS emphasised that there is a significant risk to delivering the plan and organisations must hold a strong commitment to play their part. **CS** noted immediate action to define how to either reduce the risks we have or determine any mitigations available to us. **CS** added that further meetings with NHSE are anticipated to discuss delivery against the plan submitted and also a meeting with the national team in September to review in year delivery as well as look at the longer-term financial recovery trajectory.

The System Finance Committee:

- Noted the final 23/24 financial plan submission for the system and associated risks.

7.0 Minute No. SFC-23.05.007 ICS Long Term Planning Update

Report received as read.

7.1 **CS** highlighted that to reach full financial recovery for STW will be a multi-year programme to which focus urgently needs to be turned. **CS** stated that an updated financial 'do nothing' scenario has been constructed to begin to scope the scale of the 'ask' for future years and support conversations about strategic ambition and priorities. **CS** flagged that there is work to be done to test the assumptions used to construct the scenario but a first cut of the model indicated a 'do nothing' underlying recurrent position of a £267m deficit by year 5 (2028/29).

CS highlighted that the work on finance will be most robust when set alongside similar trajectories for activity and workforce. **CS** stated planning colleagues across the system are now focussing on the development of longer-term demand, capacity, and workforce models. **CS** added that this will also support and inform planned work to develop a focus on productivity and efficiency.

CS highlighted that a number of options are being explored in terms of the system support required to develop a robust demand and capacity model that links to workforce and finances and the Hospital Transformation Programme (HTP). **JP** added that the information used was the same as the assumption information sitting within HTP.

CS stated that the system has been asked to present a long-term plan and financial recovery trajectory to the national team by September 2023.

The System Finance Committee:

- Noted the initial 'do nothing' financial scenario constructed (£267m underlying deficit by 28/29), the assumptions used and resulting scale of the task to return to an underlying breakeven position.
- Noted the next steps to be taken to construct an overall financial recovery model and long-term planning model.

8.0 Minute No. SFC-23.05.008 Efficiency plan update

Report received as read.

8.1 **KO** highlighted that the efficiency plan was submitted as part of the final financial plan on 4th May and has an overall target of £70m.

KO stated that the value represents the largest and most challenging efficiency target the system has faced and equates to 6.7% of the underlying expenditure. **KO** added to date, that

there has been work undertaken across the system to identify schemes to meet the target and plans are in place to deliver savings of £55m (78% of plan). **KO** explained that the team now have robust monitoring processes set up to track delivery which will be reported through organisations own governance mechanisms and into system Financial Improvement Programme (FIP) Group. **KO** emphasised that despite the work undertaken to date, there remains £15m of plans that are yet to be identified and this presents a high level of risk to the systems finance position.

KO highlighted that of the £15m of unidentified efficiency plans, £12.5m relates to the systems stretch target as agreed via respective boards of provider organisations in April 2023. There is also a further £2.5m of unidentified efficiencies from the original ICB plan.

CS requested for future reports to outline the split of recurring and non-recurring savings.

Action: KO to include R/NR split in future reporting

AS stated, that 42% of SCHT target is non-recurrent. **AS** also stated, that there is zero noted in the report for high confidence for SCHT. **AS** added the SCHT now have some schemes which are rated as 'high confidence.' **KO** explained that she had already pull the report together for this meeting, when she had received **AS's** update. **KO** stated that the SCHT update will be included in the next reporting cycle for this meeting.

GR mentioned that there are a number of pipeline of opportunities coming up which will be reported on in future reporting cycles to this meeting.

The System Finance Committee:

- Noted the £70m value of the overall efficiency plan and the risk associated with the £15m unidentified gap and stretch target.
- Noted the actions that are in place to address the risk and the key areas identified by CEOs.

9.0 Minute No. SFC-23.05.009 Change to Intelligent Fixed Payment Management Group

Report received as read.

9.1 **CS** stated that the Intelligent Fixed Payment Management Group (IFPMG) has recommended that it amends its role to become the 'Strategic Finance, Productivity and Planning Group' (SFPPG), this is in order for its role to remain current and value adding.

CS requested that, as today's meeting was not quorate, CF circulate the ToR to the wider SFC membership for approval, via email. These can then be taken to the June IC Board for ratification.

Action: CF to circulate the SFPPG Terms of Reference to System Finance Committee for final comments and approval via email.

The System Finance Committee:

- Noted the work of the IFPMG to redefine its purpose and membership.
- Noted the revised Terms of Reference, including the expanded scope of the group, name, and membership.
- Agreed to receive regular updates on the work of this group at its meetings.

10.0 Minute No. SFC-23.05.010 Update from Capital Prioritisation and Oversight Group

Report received as read.

10.1 **CS** highlighted that the Capital Prioritisation and Oversight Group (CPOG) met on 15th May 2023. At the meeting, members agreed that there were no changes needed to the Terms of Reference and signed off the forward plan for the group for 2023/24.

CS stated that the commitment of CPOG remains from all Providers to not over deliver on the in-year programme and any material movements to the plan or delivery will be escalated to Finance Committee during the year.

The System Finance Committee:

- Noted that the Terms of Reference currently require no amendment
- Noted the work planned for the group for 2023/24
- Noted the further prioritisation work planned for future years of the capital plan.

11.0 Minute No. SFC-23.05.011 Any Other Business

11.1 There was nothing noted under this agenda item.

Date and Time of Next Meeting

Tuesday 27th June 2023 at 12 noon via Teams.