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Health and Care Overview and Scrutiny Committee

Monday 3 October 2022
10:00
Oak Room, County Buildings, Stafford

The meeting will be webcast live which can be viewed at any time here:
https://staffordshire.public-i.tv/core/portal/home

John Tradewell
Director of Corporate Services
23 September 2022

A G E N D A

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the last meeting held on 11 July and 1 August 2022** (Pages 1 - 20)

4. **System Pressures** (Pages 21 - 30)

   Report of the Integrated Care Board

5. **Integrated Care Board (ICB) Performance** (Pages 31 - 44)

   Report of the Integrated Care Board

6. **Social Care Performance Update** (Pages 45 - 56)

   Report of the Director for Health and Care

7. **The Future of Supported Living Services in Staffordshire** (Pages 57 - 80)

   Report of the Director for Health and Care

8. **Clinical Policy Alignment** (Pages 81 - 120)

   Report of the Integrated Care Board

9. **District and Borough Activity Update** (Pages 121 - 126)

Report of the District and Borough Representatives

10. **Work Programme 2022-23** (Pages 127 - 130)

Report of the Interim Scrutiny and Support Manager

11. **Exclusion of the Public**

The Chairman to move:-

That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs Part 1 of Schedule 12A Local Government Act 1972 (as amended) indicated below.

Membership

Jak Abrahams
Patricia Ackroyd
Charlotte Atkins
Philip Atkins, OBE
Rosemary Claymore
Richard Cox (Vice-Chair (Overview))
Ann Edgeller (Vice-Chair (Scrutiny))
Keith Flunder
Philippa Haden
Phil Hewitt
Lin Hingley
Jill Hood
Barbara Hughes
Thomas Jay
Jeremy Pert (Chair)
Bernard Peters
Janice Silvester-Hall
Mark Sutton
Mike Wilcox
Ian Wilkes

Notes for Members of the Press and Public

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Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 11 July 2022

Present: Jeremy Pert (Chairman)

Attendance

Charlotte Atkins	Lin Hingley
Philip Atkins, OBE	Jill Hood
Richard Cox (Vice-Chairman (Overview))	Barbara Hughes
Ann Edgeller (Vice-Chairman (Scrutiny))	Bernard Peters
Keith Flunder	Janice Silvester-Hall
Philippa Haden	Ian Wilkes

Also in attendance:

Tracey Shewan, Director of Communications and Corporate Services for the Integrated Care Board (ICB)
Lynn Millar, Director of Primary Care and Medicines Staffordshire and Stoke on Trent, ICB
Heather Johnson, Chief Nursing and Therapies Officer, Staffordshire and Stoke on Trent, ICB
Alison Budd, Lead Midwife, Maternity Transformation, Staffordshire and Stoke on Trent, ICB
Baz Taseem, Staffordshire Healthwatch Manager
Keith Luscombe, Strategic Policy and Partnerships Manager, Staffordshire County Council (SCC)
Councillor Mark Sutton, Cabinet Member for Children and Young People, SCC
Kate Loader, County Solicitor, SCC
Natasha Moody, Assistant Director for Children's Wellbeing & Partnerships
Karen Coker, Senior Partnership & Commissioning Manager, Children & Families, Health & Wellbeing, SCC

Apologies: Rosemary Claymore, Phil Hewitt, Thomas Jay and Mike Wilcox

Substitute: Councillor Steve Norman representing Tamworth Borough Council

PART ONE

1. Declarations of Interest

Councillor Ann Edgeller declared an interest as Staffordshire County Councils appointed Partner Governor at the Midlands Partnership Foundation Trust (MPFT).
Councillor Bernard Peters declared an interest as Staffordshire County Councils Local Authority appointed Governor at University Hospital Derby and Burton (UHDB).

2. Minutes of the last meeting held on 30 May 2022

Resolved that the minutes of the meeting held on 30 May 2022 be approved and signed as a correct record.

3. Integrated Care System (ICS) and Integrated Care Board (ICB) Update

The Director of Communications and Corporate Services ICB provided an update on the establishment of the ICS which included: ICB Board appointments, Integrated Care Partnership (ICP) strategy development, delivery portfolios, Place working, provider collaboratives, clinical professional leadership and 'Working with People and Communities Strategy'.

The following comments and responses to questions were noted:

- ICB was working with NHS England, who commission the dentistry service, to develop a programme of work to transfer the dentistry to the ICB by April 2023.
- The link to the 'Working with People and Communities Strategy' would be circulated to members, and ICB would present the strategy to a future meeting.
- Clarification was provided that the NHS Integrated Care Board (ICB) membership was set in statute and the Board focus was on the provision of health services. The Integrated Care Partnership (ICP) was the local partnership board between NHS and Local Authorities which would set the strategy for how the health and care for people in Staffordshire would be delivered.
- ICS funding - the impact of social care on health was recognised and more information about financial arrangements to help better integration, such as pooled budgets (e.g. Better Care Funding) would be circulated.
- Communication – A road show approach was used to inform the public about the Integrated Care Board (ICB). There were links to

information through the ICB webpage. Members were encouraged to share links in their District and Borough areas.

- In terms of addressing inequalities, ICB was reaching out to the public using lessons learned and mechanisms developed during the pandemic. The roadshows varied times to ensure they were accessible to all. ICB was working with voluntary organisations to focus on the right messages and Healthwatch was commissioned by the ICB to reach out to specific communities. It was highlighted that people would want to know how things will change for them, not just about the ICS structures. A suggestion was made about joint commissioning of Healthwatch when engaging public in campaigns.
- The ICB has taken on board all of the Staffordshire and Stoke on Trent Clinical Commissioning Groups (CCGs) transformation programme. The seven portfolios of work would be circulated.
- The need for the ICB to work closer with District and Boroughs was recognised. It was acknowledged that CCGs had previously asked people to come to them during consultations and ICB would reach the public using ways learned during the pandemic in future engagement.
- ICB appointments to portfolios had been made in accordance with NHS England recruitment process.
- ICB would continue to run the vaccination programme, although slowed down through the summer, there had been a number of popup vaccination walk-in sessions. It was confirmed there would be one at Leek hospital.
- ICB confirmed that mental health information would be made available in doctors' surgeries.
- ICB confirmed that the issue of flow of patients through hospitals was continually looked at and reviewed, a more detailed response about the targets across the system would be provided by the ICS Chief Delivery Officer.
- Future scrutiny would be of the whole integrated care system, monitoring the development of the ICP Strategy and a focus on the links between the Integrated Care Partnership (ICP) Strategy and the Health and Wellbeing Board Strategy which sets the overall ambition for health and care in Staffordshire.

The Chairman thanked the Director of Communications and Corporate Services for her contribution to the meeting. Committee focus was on the importance of communication, residents understand where the linkages are, also the need to focus on the outcomes for residents.

Resolved:

1. That the Health and Care Overview and Scrutiny Committee note the progress report.

2. That the following items be included on the Health and Care O&S Committee Work Programme:
    a. Dentistry service (March 2023)
    b. Presentation of the Working with People and Communities Strategy (To be confirmed).

3. That further information be circulated to members of the Health and Care Overview and Scrutiny Committee on the following matters:
    a. Link to the Working with People and Communities Strategy.
    b. Link to register to the ICS information roadshow.
    c. Targets across the system on patient flow through hospitals from the ICS Chief Delivery Officer.

4. Primary Care Access Update

The Director of Primary Care and Medicines Staffordshire and Stoke on Trent ICB provided a report and presentation which provided context and key drivers to the current situation regarding general practice access in Staffordshire and Stoke-on-Trent.

Committee noted a summary of completed actions and achievements relating to public communications, digital, and quality variance and resilience, training, and development work. The Director outlined the seven-point action plan for July 2022 to consider matters relating to communications, access improvement programme (Accelerator Programme); record keeping; digital solution; quality, variation, and resilience; training and development and workload initiatives.

Committee noted the following comments and responses to questions:

- Concerns were raised about communication to the public about transformation and process change coming out of the pandemic. Members were assured that work was ongoing to address concerns and get messages out to people about new roles and ways to access services.
- There continued to be increased demand for appointments, with 65% of appointments face to face. There was a significant amount of telephone appointments, however this did not create additional capacity, it was a more convenient way for some people to access the GP, but not a way of seeing more patients.
- Different ways of using telephony with a move to cloud-based telephone systems to book appointments was being rolled out over 12 months. The cloud-based telephony system tripped in when lines were busy, callers were able to leave their number and would be phoned back, without losing their place in the queue.

- Digital solutions, including blood pressure monitoring from home, had been introduced in practices. Online information and support, including 'Know your Gp Staffordshire' live website and an access support package was also available.
- For practices not performing well targeted support and training was available, including workload initiatives, directing people to the right service, working with the wider primary care and NHS England. There were twelve domains of work, each with a metric. The data being collated would inform the wider KPI dashboard being developed by the Health and Care Overview and Scrutiny Committee.
- Additional support for staff was available and advice for those who had concerns about financial wellbeing.
- Patient Participation Groups (PPGs) enable patient engagement with practice staff, the Primary Care Network (PCN) were strengthening PPGs and agreed to provide a list of PPG vacancies to the District and Borough Councillors to get involved. PPGs were not currently part of the Primary Care Access Plan but as a result of the discussion today would be considered for inclusion.
- Members highlighted that some people rarely contacted a GP surgery and would need to be informed about what was available in their community and of new ways to access alternative solutions. The ICS was looking at different mechanisms to inform and educate the public, looking at lessons learned during the roll out of vaccines in the pandemic, targeting different age groups in different ways.
- Members highlighted the move to preventative agenda and that there was a need to look at the pathways to early advice and support. Assurance was given that this would be part of the strategy going forward.
- In relation to making GP appointments on the APPS there was not currently a consistent approach across Staffordshire practices, but this was being worked on.
- 'Did Not Attend' (DNA) appointments was not a metric currently being used. Members felt that visibility of DNA appointments online should be considered in the range of metrics collated.
- GP Access had been a challenge before the pandemic but in terms of the backlog arising from the pandemic the largest group had a long-term condition. To accelerate the backlog before the winter period they were frontloading the Quality Assessment framework.
- 167 practices had reduced to 144 to optimise the footprint for resilience, practices were working together and had developed the universal offer - fifteen services commissioned across 100% of the practice population offering equal access to services. There was a need for the ICB to refresh the strategy, practices need to establish their own strategy and a primary care collaborative has been established consisting of senior leaders across the area to shape the strategy.

Within the strategy, workforce was an issue to address with a 7% reduction in GPs in the area, a workforce plan would be part of the strategy.

The Chairman thanked the Director for the presentation and for the work they were doing.

Resolved:

1) That Health and Care Overview and Scrutiny Committee note the progress report and include a further update in the Work Programme to review the Primary Care Access Plan in 3-4 months' time.

5. Maternity Services Update

The Chief Nursing and Therapies Officer and Lead Midwife for Maternity Transformation, at Staffordshire and Stoke on Trent, ICB provided an update on maternity services transformation, the temporary closure of free-standing midwife-led birthing services and an update on progress against recommendations of the Donna Ockenden report about failings at Shropshire and Telford Hospital.

Committee noted the following comments and responses to questions:

- The vision was to implement the Maternity Clinical Model agreed before the pandemic, the Continuity of Care Model would provide the framework to deliver the clinical model.
- The free-standing birth units for low-risk births at County and Samuel Johnson Hospitals were open for anti-natal and postnatal care however remained suspended for births. The Samuel Johnson Unit (FMBU) planned to re-open in December, but County hospital had workforce issues. Assurance was given that a strong communication plan was in place to re-iterate that the service was not closing, and any changes would be communicated to members.
- Both UHNM and UHDB Trusts had a shortage of midwives pre-pandemic, since the pandemic the Ockenden review had made reference to staffing issues in midwifery and made recommendations for higher numbers, which had in effect widened the gap.
- Ockenden recommendations:
    - The Maternity Board meet monthly, assurance was given that Ockenden was a priority and actions against the original seven recommendations from the Ockenden report were almost complete.
    - Members noted that a working group from the National Maternity Transformation Programme was working to benchmark against the additional fifteen recommendations from the Ockenden review and that a further report from East Kent would be published in September 2022.

- Members requested birth rate data and were advised that there had been 252 births last year at Samuel Johnson and 93 at County hospitals. There had not been an increase in births during the pandemic.
- Due to the shortage of midwives long working hours and additional shifts were adding to pressure on the remaining midwives and some were leaving the service. Recruitment and retention figures and comparison data would be calculated and circulated to members. The Chairman highlighted the need for joined up career development opportunities to help retain staff in maternity services. Members indicated the need to make midwifery an attractive option.
- The Chief Nursing Officer advised that an ICS Workforce Group was looking into workforce issues, employee numbers etc. and could report back to the Committee on workforce matters. The Chairman advised that there would be a system workforce discussion at the 17 October 2022 committee meeting.

The Chairman thanked the Partners for the presentation and their commitment to the services and re-opening of FMBUs. He welcomed the plans for communication, recruiting and retention of midwives.

Resolved:

1. That Health and Care Overview and Scrutiny Committee receive the update report and request that ICS midwife staffing data be circulated to Health and Care O&S Committee Members for information.

6. Staffordshire Healthwatch Update

The Chairman welcomed the Support Staffordshire to its new role from 1 April 2022, he advised that this committees' role was both to scrutinise the work of the Healthwatch contract and as a partner in terms of communication and collaboration.

The Healthwatch Manager provided a report and presentation on the structure and progress of the Staffordshire Healthwatch (SHW) service (under Support Staffordshire as the new provider). He also highlighted Healthwatch Staffordshire's 2022-23 outline focus and approach.

Committee noted the following comments and responses to questions:

- Women's services will be considered as part of the work priorities 2022-23 and mental health in maternity may be a focus coming from this work stream.
- Concern was raised that a member of the public had been unable to contact Healthwatch. Members were advised that there had been a short period during transition where systems were not operating. The

enquiry email form on the website along with telephone contact number and social media links, were now operational, but there had been some problems which were currently being tested. The Chairman suggested that a contact point be made for all councillors at County, District and Boroughs to contact Healthwatch so that the opportunity to hear residents' voices was not lost.

- Members were assured that lay members and volunteers would be offered training to on scrutiny, enter and view, and how to ask relevant questions.
- The Chairman indicated that Healthwatch had an open invite to attend this Committee as a non-voting member and encouraged the Manager to attend and bring the public voice to meetings as understanding developed through SHW work.
- A member indicated that the Stone area had lacked contact with SHW, the Manager SHW advised that HW reach was being extended across Staffordshire through work with voluntary organisations and local communities to engage wider to get feedback.
- SHW had two locality officers that extend reach across Staffordshire Moorlands and rural areas.
- The Commissioning Manager advised that the performance metrics were being finalised and data would be shared with Staffordshire County Council. The Chairman asked that the performance metrics and structure for performance management approach be circulated to members to enable the committee to monitor progress across key areas.

The Chairman welcomed the Healthwatch Manager and thanked him for the presentation and responses to questions.

Resolved:

1. That the Health and Care Overview and Scrutiny Committee note the update report.
2. That Staffordshire Healthwatch be requested to share the performance metrics and structure for performance management approach when finalised.

7. District and Borough Activity Update

The Chairman advised Members that the Joint Code of working between County and District Council Health Scrutiny Committees was currently being refreshed to better reflect the ways of working in Staffordshire health scrutiny. He emphasised the importance for members to be clear on roles of the County and Districts scrutiny committees to ensure that no matters were duplicated or omitted, and to seek advice from the Scrutiny and Support Officer if necessary.

District and Borough representatives presented update reports and highlighted the following matters being considered at District and Borough meetings.

- Cannock Chase DC Chairman Councillor Philippa Haden reported that at the first meeting of 2022-23:
  - An introduction was provided from Head of Service to explain the scrutiny role at the District Council.
  - Committee established a task and finish group which would focus on housing.
  - Committee would also carry out scrutiny of the 'Cannock Chase Can Project' which has a focus on obesity. Members will consider the success of the project and if people were using the APP.

- Lichfield DC: Substitute Councillor Steve Norman reported that:
  - Members had received a briefing paper on food safety which would be raised at the next committee.
  - Clarification was sought on two issues:
    a. The representative from the County on the District Committee; and
    b. Whether Burntwood Health Centre, would be a matter for County or District Scrutiny Committee.

The Chairman agreed to provide a response to Councillor Norman after the meeting.

Resolved:

1. That the District and Borough Updates be noted.

8. Work Programme 2022-23

Members considered the work programme and suggested the following additions:

- Add an item on dentistry to the March 2023 meeting
- Request a review of critical incident at UHMN (in terms of the lessons learnt) to 1 August meeting.
- Request an item relating to the Winter Flu Campaign to meeting on 1 August 2022

Councillor Janice Sylvester-Hall, Chairman of the Women's Health Working Group provided advised that the working group met on 13 June 2022 to consider a report from the Department for Health and Social Care (DHSC) call for evidence. The report informed the first-ever government-led Women's Health Strategy for England and focused on feedback from the survey component of the consultation. The Working Group had identified a list of topics that impact on women centric issues and

determined to meet again to consider the topics listed in more detail in relation to what happens across Staffordshire.
The group would then identify witnesses, prepare questions based on the information gathered and add an item to the work programme for committee to scrutinise Women's Health Matters.

The Vice-Chair Scrutiny Councillor Ann Edgeller provided an update on the Healthier Communities Workshop on 21 June 2022, the workshop focus was on the wider determinants of health. Members of the County, District and Borough Councils across Staffordshire, partners from NHS and Support Staffordshire, and officers from Public Health attended the workshop. The Vice-Chair advised the workshop had been very positive and a lot of information came from the discussion groups. A report capturing feedback, key messages and recommendations would be presented to committee in September 2022.

Resolved

1. That the work programme and work group updates be noted.

9. Exclusion of the Public

Resolved

1. That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs Part 1 of Schedule 12A Local Government Act 1972 (as amended).

10. The Families Health & Wellbeing (0-19) service (Pre-decision)

(Exemption Paragraph 3)

The Cabinet Member for Children and Young People provided a report and presentation relating to the Families' Health & Wellbeing (0-19) Service from 1st April 2024.

Chairman

Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 1 August 2022

Present: Jeremy Pert (Chairman)

Attendance	
Philip Atkins, OBE	Jill Hood
Richard Cox (Vice-Chairman (Overview))	Barbara Hughes
Keith Flunder	Janice Silvester-Hall
Philippa Haden	Mike Wilcox
Phil Hewitt	Ian Wilkes

Also in attendance:
Steve Grange, Deputy Chief Executive and Director of Strategy for Midlands Partnership Foundations Trust (MPFT)
Dr Abid Khan, Medical Director MPFT
Lisa Agell-Argiles Operational Director MPFT for Mental Health Services across the South and planned care across the County.
Dr Paul Edmondson-Jones, Chief Medical Director, Staffordshire and Stoke on Trent, Integrated Care Board (ICB)
Helen Slater, Head of Transformation Staffordshire and Stoke on Trent, ICB
Jenny Fullard, Communication and Engagement Service Partner ICB
Nicola Bromage, Head of Strategic Commissioning Staffordshire and Stoke on Trent, ICB

Apologies: Patricia Ackroyd, Charlotte Atkins, Rosemary Claymore, Ann Edgeller, Lin Hingley and Bernard Peters.

Substitute: Councillor Daniel Maycock substituted for Councillor Rosie Claymore.

PART ONE

11. Declarations of Interest

Councillor Daniel Maycock declared an interest in item 3 relating to the George Bryan Centre in Tamworth as a previous service user.

Councillor Richard Cox declared an interest in item 3 relating to the George Bryan Centre a family member was a previous service user.

12. Inpatient services for adults and older adults experiencing severe mental illness or dementia living in south east Staffordshire

The Deputy Chief Executive MPFT introduced the report and explained that the presentation would be led by the Integrated Care Board ICB as the commissioning body. The Chief Medical Director ICB confirmed that no decision had been made at this stage of the process and introduced the presentation.

The presentation – 'Finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre' provided background, context and highlighted matters in the business case and process to be followed for further discussion:

- Updated on the clinical case for change in mental health services
- Explained the recommendations from clinicians/staff for inpatient mental health services for people living in south east Staffordshire
- Shared the robust process followed
- Shared the next steps

The Chief Medical Director highlighted that proposals must be viable and invited members questions and points for clarification.

The Chairman thanked partners for the presentation. The slides and the link to the video would be circulated to members and uploaded to the webpage.

The following matters were discussed, comments and responses to questions during the debate were noted:

Role of Members: Members paid tribute to the dedication and hard work of staff and to the value of mental health services in Staffordshire. Members highlighted their role was to represent people in the community to ensure their voice was heard in developing mental health services in their communities.

Service User Satisfaction - A member questioned satisfaction ratings for inpatient services in 2021 and whether the business case proposal was moving away from what the people thought worked well. It was explained that population of the unit had reduced between 2019 -2021 and it was difficult to compare unit for unit. The 2022 figures were not available but would be provided.

Workforce safety on site – Members questioned if there had been an issue with the level of workforce at the George Bryan Centre (GBC) prior to the fire. Committee acknowledged that workforce in isolated buildings was difficult to manage and that there had been issues with the number

of staff to patient ratio. Recruitment and retention at the GBC had been a challenge, it was a small centre. As part of involvement process MPFT had talked to the staff that were previously employed at GBC – they ascertained that none of the staff who responded would want to move back, they had moved on to other roles and felt reassured in a hospital setting, which had more people on site. It was acknowledged that recruitment and retention was a big problem for the NHS in all settings.

Workforce safety in the community – Community Mental Health Services have larger teams; staff also work alongside police officers when required. Members were advised that staff safety in community services had not presented a risk. It was clarified that if someone was identified as a high risk to safety, they would be referred to an inpatient service. Members queried whether incidents where police were called to GBC were now happening in the community. It was explained that GBC was a small crisis unit with a small number of staff, safety was a concern, and prior to the fire GBC had become a pre-release setting where patients condition was stabilised before going on to community services. The inpatient crisis centre at St Georges worked better for crisis because there were more specialist staff and support services in one place.

Wider community safety – unintended consequences. It was explained that out of the people supported for their mental health issues in the community very few would need a hospital bed. From a community perspective there were wider integrated teams and specialist teams that provided support in the community and in their own home. There was a whole raft of provision in the community that manage the bulk of provision, starting with primary care, Improving Access to Psychological Services (IAPP) before moving into specialist services. The majority of people live at home and were supported by family and community services. The hospital was a small part of their lives. This model had been managed since the fire – unintended consequences had been part of the learning process and would continue to listen and learn from feedback.

Cancelled appointments – In response to a question about appointments being cancelled at short notice, it was explained that a person in crisis had to be the priority, the urgency of the call and safety of staff was paramount. It was clarified that on occasions community appointments had been cancelled - when a patient was in crisis more than one staff member may be called to attend – they had to prioritise and assess the risks.

Community Mental Health Services - Members questioned how the perception and understanding of community services would be improved. Members were advised that community mental health service was an evolving model in year two of the transformation. Work was ongoing to look at the entire model of mental health care, services were being built

into a cohesive community model - including embedding in community services and inpatient support in hospital 24/7. MPFT was evaluating and learning from the ongoing programme of work, looked at what meaningful care was and what was working best for residents.

Model based on a step care model, a staged approach to mental health service. The least intensive self care self help right through to the most intensive stage - inpatients. Community model focus was on more lower step care to prevent inpatient need.

Involvement – Members considered the reach of the involvement activity. It was clarified that provider engagement activities in October 2021 and March 2022 focused on services at GBC, it was acknowledged that there would be a need for wider involvement (and include patient satisfaction surveys) to get a broader perspective relating to St Georges.

It was clarified that there had been two key listening events:

- October 2021 online - a wider public listening event and survey- which informed the technical group. The event was online to ensure safety of participants during the pandemic, no in person events were held at this time. Support was provided for people to gain access online.
- March 2022 - This was a reference group not a wider public listening exercise, to consider the detail and receive clinical presentations, the group looked in detail at impact and any mitigations that needed to be taken into account.

The need for further involvement listening events was under consideration.

Transport / Accessibility to services. Committee raised concerns about transport for relatives to visit loved ones at St Georges. Anecdotal evidence was provided relating to a relative catching a bus from Tamworth to St Georges at 5.30 pm but being unable to secure public transport back. Data was requested to confirm that relatives had been receiving support with transport needs. It was confirmed this could be produced, however there may be difficultly evidencing the period over the pandemic.

It was confirmed that the business case included an offer to ensure people could access services through a variety of ways:

- Access via telephone and digital means.
- Transport (which may be re-imbursed).

The Chairman indicated that it would be impractical to handle travel claims on a case-by-case basis and indicated that there should be a transparent policy. MPFT confirmed that there would be a clear, user-friendly policy and there would be a more accessible transport guide for public on the website.

The Committee emphasised the need to look at how people travel to Stafford from all over Staffordshire and to consider the level of support required. The transport data in the business case was not very informative and the Chairman suggested that a map would be useful to look at the mode of transport and how people get to and from visits.

Volunteering – A member referred to the proposed reliance on community volunteer groups in the business case and indicated that the enthusiasm for community volunteering had reduced considerably post pandemic, it was questioned whether the number of volunteers leaving volunteering may be a risk in the business case. It was confirmed that when referring to voluntary community sector partners in the business case the commissioners were resourcing and commissioning voluntary sector groups. It was agreed that the shift in the pandemic has caused a shift in volunteering and there was a need to think about how to make mental health services an attractive place to be part of the workforce, both through formal qualified posts and through volunteering.

Centre of excellence at St Georges.
St Georges offered a range of services and delivered specialist mental health services – the hospital inpatient service was a small part of the mental health service; patients may only be in hospital for a short time and would continue their care in the community mental health services. Inpatient services required specialist skilled roles, the challenge was to train people in the community services, where the majority of mental health provision was. NHS England had released more training posts due to increase in mental health, most of the posts were based in the community, and trainee consultants were getting training in the local areas. Training roles included working with GPs, pharmacists and other health professionals to meet the need of the population.
Members welcomed that specialist providers would be on site at St Georges. There was a need to enter a collaborative level of commissioning understanding the value of commissioning in the community and do the specialist work in centres of excellence.

MPFT had developed services in Staffordshire and particularly in the South, a specialist team to support personality disorder, and particularly those with high risk behaviours. Built on evidence-based practice, based on structured clinical management process and this was part of key offer going forward.

Workforce / Staffing Members recognised that workforce was an issue and there was a need to recruit, there was no mention of vacancy numbers in the business case. It was clarified that workforce shortage was an issue Nationwide but that the posts referred to in the business case were recruited to when the decision was taken to close the George Bryant Centre temporarily. The biggest part of recruitment to posts in

MPFT moving forward was to recruit to the community model which had come from the NHS plan to support the development of the workforce. Although a challenge to recruit, MPFT was looking at development of a workforce strategy to develop staff from apprentice right the way through. Data would be provided re vacancies for the South Staffs mental health services.

Resource – Committee raised concern that there did not seem to be enough money allocated for the new community approach. It was explained that the community transformation work and mental health investment fund coming from Government would start to reinvest and bolster support in mental health services. There was a clear understanding that nobody should be disadvantaged across the County and that there would be a safe and good quality mental health offer.

MPFT welcomed any support to encourage the commissioners for increased funding. ICB advised that the £6.2 million across services in Staffordshire and Stoke on Trent by 2023-24 was specific to the community mental health transformation, it did cover the whole of the County but was only part of funding available (this was one programme amongst a number of programmes). The expectation was that the ICB increases investment year on year and would bring investment together across all areas to build resilience against poor mental health.

The ICB Mental Health Programme Board had a community mental health transformation steering group where partners and relevant bodies work at a whole ICB level.

Is the Mental Health Service in Crisis? – Members voiced concern that there was a big mental health service crisis and that it was how it felt and looked to the public. They sought assurance that monitoring, and outcomes were measured. Members were advised that during the pandemic mental health services were not stood down but were asked to deliver services differently. Service transformation was progressed quickly, and digital services were introduced at pace virtually.

This was the first-time there has been ringfenced funding for community mental health services, also there was the Mental Health Investment Funding. Assurance was given that even though mental health services were incredibly busy, there was dedicated investment to strengthen services and think about how to work differently. Partners re-assured and re-affirmed the assertion that the mental health service was not in crisis.

Contracts expire in 2023 – in the business case it was noted that many contract dates ended in 2023, the Chairman highlighted that in the move towards community services greater commitment in terms of timelines was needed so that when one service expired the next service was established. Members were advised that the contract date was not the

end of that commissioned service but an opportunity to look at how to transform the commissioning model into a collaborative style of commissioning services.

Relationship with Social Care –MPFT has had a partnership agreement with Staffordshire County Council (SCC) for 10 years covering the South Staffordshire area, predominately for social care around mental health services. When MPFT integrated with Staffordshire and Stoke on Trent Partnership Trust, MPFT took on a partnership arrangement with SCC for social care around older peoples and physical disabilities and provided integrated health and social care teams. The teams work together, deploy resource, share care loads, and case management, all work together well. It was noted that social care influence goes wider than the workforce and work together with Local Authority colleagues.

Statistics – There should be more performance statistics in the paper submitted to help evidence the business case.

Impact measurement – The Evaluation outcomes and performance quality group had been set up by ICB and regularly seeks service user/carer feedback. ICB was looking at how this model would improve access, improve outcomes, improve experience of service users and ensure that families were getting the support and care they need. Data would be used to build services as part of the programme.

The Chairman highlighted that the measures of success should capture a range of metrics broader than how patients feel, such as timelines for referral, when patient was seen etc and none of these were in the business case. The Chairman indicated that members should be able to see what was the commitment that ICB was proposing for our residents in relation to the specialist services. It was acknowledged that the measurements should see direct demonstrative benefits to patient care and capture tangible and non-tangible benefits which should strengthen the business case. These would be brought back to Committee to consider.

Use of the George Bryan Centre – The discussion focus was on the business case, clinical model associated with inpatient services not at this stage about the building use. However, the temporary community location for mental health services in Tamworth was at the sexual health clinic, the Trust had committed to review and strengthen the community service offer, the temporary location would be looked into. The Chairman accepted that provider did not include future use of the building in the business case, however indicated that the commissioner should be clear what future proposals were for the people of Tamworth and to see clear views as to what these building would be used for in the future.

Insurance money - Following the fire insurance money of £1 million revenue had been re-invested into the community service offer which was currently being reviewed. The Chairman was surprised that the rebuild costs were £8 million when insurance was only £1 million.

One viable option – closed East wing: the Chairman was disappointed that no modelling had been done to consider expanding services from the west wing. The transformation paper was silent on this. He understood that clinically there was only one viable option put forward, but the business case needed to demonstrate options had been considered.

Clinical quality and clinical safety – in-patients specialist workers – GBC does not have specialist services on site and would not have skills to support an acute in-patient ward.

Community Mental Health Strategy - There was a requirement on the ICB to develop a Community Mental Health Strategy over the next few months and the ICB would meet to start to see an overall strategic commissioning process across mental health which would span the life cycle. There would be a lot within the strategy that had a very specific focus, including developing community mental health options first and inpatient services as a last resort. There was more work needed to consider the strategic direction, how to provide in the community, what were the barriers to access, the need for in-patient beds and how to provide them in the safest way possible. This would be progressed by the Staffordshire Integrated Care Partnership ICP. Discussion would be joined up, a system wide conversation based on the needs of local residents.

Are resources sufficient and how do we measure that. This is the first-time investment in community mental health services, the money made available gives opportunity to invest in community mental health services and it will be important to work alongside our partners in local authority and in partnerships. We have to use public funding in the right way - Invest and re-engineer what we have got.

With regard to response time, the crisis resolution service was a good model of service delivery. They had really clear timelines about dealing with people within timelines especially with people in urgent need. They were in a good position with regards to finance and could provide data on this through key performance indicators. The services also work closely with the police, there was a whole range of services across the community that could respond when someone was in crisis.

ICB had a series of metrics that measure MPFT and other providers, building and refining metrics as part of the transformation programme. There was a whole dashboard that underpinned mental health services in terms of assurance that could be shared.

Clarity on Police involvement in the Community mental health services was considered and members asked to see some evidence on how this activity was being recorded. The data could be requested from the community triage team but also the PCC office could be asked, they collect data. It was agreed to ask through Police and Crime Panel next time they meet.

Mental Health Practitioners Committee asked how many mental health practitioners were imbedded in primary care networks in Staffordshire and if everyone had taken up the offer. This was a nationally mandated programme and an expanding programme, in year two. The figures were not available at the meeting, but committee were advised that Staffordshire had done well, with the exception of East Staffordshire, which had made the decision to delay to wait for the funding this year.

Needs analysis - Acute Admissions The Chairman referred to the business case - given that 36% of acute admissions were not known how did we know if we have built in the capacity required. MPFT advised that a Health Quality Assessment toolkit was used to assess needs analysis.

Mental Health Strategy partners were working with Staffordshire County Council on a draft Mental Health Strategy but it had been delayed. ICB advised that the strategic ambition in the NHS was outlined in the NHS long term plan, and the ICB was working towards the ambition in the plan. The Chairman stressed the need to align the strategies in the absence of the Staffordshire Mental Health Strategy. Assurance was given that all partners were working together across Staffordshire, it was noted there was also a Northern Staffordshire mental health provider that worked out of Harplands Hospital, North Staffordshire Combined Hospital Trust NSCHT.

Summing up

The Chairman thanked presenters for providing a detailed and useful presentation to better understand the professional advisors views and detailed analysis of the questions raised.

The Chairman established that Committee was broadly in support of the principle to move towards Community Services but stressed that further information and more clarity would be needed to strengthen and evidence the proposal. Committee was in support of the principle to move people with dementia into community services if it benefitted those individuals.

The Medical Director ICB welcomed the discussion and found the useful and interesting questions asked beneficial. He confirmed a composite response would be provided and indicated a desire to maintain scrutiny involvement to keep talking through the information to ensure we provide safe services for the people in Staffordshire.

Resolved:

1. That the Health and Care Overview and Scrutiny Committee note the report relating to Inpatient services in south east Staffordshire for adults and older adults experiencing severe mental illness or dementia.

2. That the comments and requests for further information of the Health and Care Overview and Scrutiny Committee be considered to strengthen and clarify matters in the business case for Inpatient services when next considered:

    a. The importance of communication and raising awareness of the community mental health offer, the patient pathway and the measures of success.
    b. Key performance indicators (KPIs) were lacking in the business case.
    c. Mental Health Inpatient Service user satisfaction rating data for 2022 requested.
    d. Evidence of transport and support provided for relatives visiting St Georges Data would be provided re vacancies for the South Staffs mental health services requested.
    e. The longer-term commitment in terms of the Community Mental Health Services.
    f. Clear transport policy was needed to look at impact on visitors due to a centralised site.
    g. Clarity whether the Community Services were ringfenced requested.
    h. Greater detail in terms of the transport mapping was needed.
    i. Technology complimenting human contact – more clarity on this needed.
    j. Safety aspects – there is a need to be satisfied.
    k. Discussion with wider partners about future commissioning at George Bryan Centre if it were not a mental health inpatient facility along with local need and timescales in ICP.
    l. Aligning proposals in line with the MH Strategy.

Chairman

Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee Monday 03 October 2022

System Pressures Update

Recommendation(s)

I recommend that:

The Committee to note the system pressures update for the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) population.

Report of Name Portfolio Holder/Director/Partner/Other

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

Note the system pressures update and delivery of actions for the Staffordshire and Stoke-on-Trent ICB population.

Staffordshire County Council

Report

1. Overview

1.1 Staffordshire and Stoke-on-Trent Integrated Care System (ICS) has continued to experience a number of system pressures during 2022/23 to date that have affected the Urgent and Emergency Care (UEC) pathway. The main challenges facing the ICS continue to be around workforce, demand, and acuity. The system is focused on ensuring disruptions to the Elective Care recovery plan are kept to a minimum as we work through the system pressures and actions within the UEC programme. Note, the pressure in UEC is both a local and national issue.

1.2 In December 2021, the NHS national incident level was once again raised to level 4, due to the increasing prevalence of the omicron COVID-19 variant. In addition, given the omicron pressures, public and emergency services in Staffordshire and Stoke-on-Trent declared a major incident due to the impact of coronavirus on the area in January 2022.

1.3 A further critical incident was declared at The University Hospitals of North Staffordshire NHS Trust (UHNM) prior to Easter due to workforce issues throughout Staffordshire and Stoke-on-Trent.

1.4 During the period of UEC pressures the system has sought to maintain and improve on its elective plan delivery, however, there have been unavoidable periods where elective work has had to be delayed due to staffing and capacity. Capacity in outpatient, diagnostic and theatre services have been impacted by the increase in COVID-19 cases and higher than normal staff absences along with an increase in demand from GP referrals, in particular clinically urgent referrals. Providers continue to prioritise according to clinical need while also bringing down very long waits.

1.5 Routine system oversight meetings involving system leaders are in place during weekdays and weekends to ensure the system is working collaboratively and supporting all partners.

1.6 Social Care remains consistently under pressure experiencing similar pressures to the NHS services around COVID-19 impact on care homes and severe workforce challenges which has reduced capacity in the market and across the county.

1.7 Workforce availability remains an area of challenge and risk. System-wide workforce planning continues in relation to delivery of the Winter Plan, operational plan workforce growth and agency reduction. It is acknowledged that the workforce numbers have not achieved planned growth, although recruitment activities have had successes there has been a significant number of people leaving the public sector nationally. In addition, a mandate has been issued on reducing agency spending: Staffordshire and Stoke-on-Trent target to reduce from £34m to £25m.

1.8 Workforce is a significant challenge to the UEC pathway however, the constraints are not restricted to the UEC portfolio, therefore the detail on the performance and mitigation are contained within the Performance paper.

1.9 Winter 2022/23 is predicted to be significantly challenging across the ICS, linked to the anticipated UEC/Covid/ Flu pressures underpinned by

workforce. A system approach to surge planning for winter is being developed which includes all partners in the UEC pathway. The approach is to develop a clear capacity plan and associated triggers. Given the elective care backlog it remains a system priority to maintain elective capacity over the winter period.

2. The system continues to work within the three following structures for UEC:

2.1 **Pre-Hospital**. This includes community-based care, primary care and ambulance service provision. The focus is to look after people in their own homes for as long as is clinically appropriate and look to provide alternative pathways that avoid hospital attendance.

2.2 **In Hospital**. This covers the work at the front door of the hospital through to the point of discharge. It is often referred to as 'managing the flow' through the hospital. It includes the management of the hospital site

2.3 **Discharge**. This workstream focusses on getting people to their usual place of residence as quickly as possible and supporting them to stay in their usual place of residence.

The UEC pressures and actions have been outlined below utilising this structure.

3. ICS Response to System Pressures

Urgent and Emergency Care

Pre-hospital

3.1 The ICS continues to maximise access to all non-Emergency Department (ED) pathways through a single access route which incorporates community pathways, including Urgent Community Response and Acute Respiratory illness, for all patients to support the reduction of ambulance handover delays.

3.2 Ambulance handover delays remain significantly high at acute sites. Royal Stoke University Hospital (RSUH) is one of 10 sites receiving support from the National NHS England (NHSE) team to reduce delays.

3.3 Ambulance handover delays are a symptom of the flow challenges throughout the health and care system, therefore a whole-system improvement response is required to address the issue.

i. Hours lost for Staffordshire and Stoke on Trent patients across all West Midlands Region hospitals (based on a 15 minute turnaround threshold) for April-June 2022 using West Midlands Ambulance Service (WMAS) data equated to 13,784. For UHNM specifically the total for the 3 months was 9,635.

ii. Ambulance conveyances to our acute sites remains below pre-pandemic level. Ambulance conveyances to UHNM and the University

Hospitals of Derby and Burton (UHDB) for the first three months of 2022/23 dropped to 18,453, a reduction of 5,539 on the 23,992 recorded for the April to June period in 2019/20, which equates to a 23.1% fall in ambulance conveyances. Overall, this equates to a drop of under 61 ambulances per day across the three sites.

3.4 Call volumes for NHS 111 continue to be above the pre-pandemic level; the national and local direction supports the population to call 111 as the first point of contact where patients have an urgent need. Given the sustained increase, there has been a pressure on call volumes particularly with call abandonment rate. This has seen significant improvement in-year.

4. Actions in Response to System Pressures

4.1 A series of additional and extraordinary actions have been developed and deployed. As a result, the level of 1 hour handover delays have seen a 35% reduction during August at RSUH and a 3% reduction at County Hospital. Whilst conveyances are reduced from pre-covid levels, there is a marked increase in the acuity of patients that are presenting to Emergency Departments.

i. A rapid improvement week took place in North Staffordshire prior to Easter. The Community Rapid Intervention Service (CRIS) team supported paramedics to navigate alternative community services, prior to patients presenting at ED. Social Care, North Staffordshire Combined Healthcare NHS Trust (NSCHT) and High Volume Users were also present throughout the week ensuring patients could be diverted from ED into an alternative community pathway and avoid admission.

ii. Further Rapid improvement weeks have taken place, identifying additional key improvement areas across the system which are carried forward and established as business as usual.

iii. Focus upon increasing the level of WMAS referrals directly to CRIS through enhanced collaborative Multi-Disciplinary Team (MDT) approach whereby collectively teams target those waiting an ambulance response.

iv. Cohorting capacity within the ED increased to support up to 6 patients at any one time.

v. Increased capacity for Virtual Wards, supported by £3.9m national funding. 130 Virtual Ward beds expected to be mobilised by December 2022.

vi. NHS 111 enhanced their clinical validation to reduce the number of ED and ambulance referrals, along with targeted work with care homes to direct these referrals to CRIS.

vii. NHS 111 call abandonment has seen significant improvement with an increased number of 111 call handlers. Staffordshire now has one of the lowest rates of call abandonment nationally in June 2022 with call handler volumes increasing.

5. In-hospital

5.1 Whilst ambulance handover delays are managed within the pre-hospital programme, the system recognises the interdependency with in-hospital. Ambulance handover delays impact the emergency department, particularly with cohorting.

i. A&E 4-hour target performance remains challenging for all acute providers locally and nationally.

ii. There have been a high number of 12-hour trolley breaches across the system post-winter.

iii. Bed occupancy has increased at all acute trusts across general and acute and Critical Care beds as the COVID-19 surge impacted on bed availability.

iv. Queen's Hospital in Burton continues to experience very high occupancy in their Emergency Department which has had an impact on both ambulance handover delays and performance. There is a trend of high walk-in attendances from the afternoon going into the evening.

v. UHNM ED has seen a level of reduction in Type 1 attendances since the end of June and whilst RSUH are within an acceptable range of the predicted volumes as supplied by the Regional Capacity Management Team they are still significantly below the numbers reported for 2019/20. County Hospital is tracking in-line both with predictions and with pre-COVID attendance levels.

6. Actions in Response to System Pressures

i. Integrated Front of House at RSUH utilising MDT approach across partners. The data indicates that the frailty cohort will be the biggest impact. The aim is to ensure patients are supported in their own home wherever possible and partners work collaboratively to achieve this as opposed to patients being admitted to the bed base.

ii. Cohorting capacity has been increased and assertive boarding carried out twice a day to support the decompression of ED; also initiated within community hospitals.

iii. Enhanced streaming options and capacity implemented to support direct transfer from ambulances to the Same Day Emergency Care (SDEC) unit.

iv. Relocation of portals within the RSUH ED, facilitated by two base ward moves and the maintaining of on-site modular capacity to create additional ambulance offload capacity and internal efficiencies

v. Targeted approach to support frequent attenders through community and mental health services.

vi. Additional workforce deployed by all partners to maintain flow.

vii. Additional interim bed capacity stood up within the community (26 beds) to support hospital flow.

viii. Additional ward capacity will be onboarding in a phased approach across October 22 to March 23 as part of the winter plan surge capacity.

Post Hospital

7.Discharges from Hospital and Social Care

7.1 High numbers of patients in hospital who are Medically Fit for Discharge (MFFD) are a result of increased complexity of patient need on discharge and increased fragility within the care home/domiciliary market.

7.2 Social care continues to see an increase in patients requiring long term care, limited Dementia Nursing capacity, increasing number of care packages and delays for patients awaiting discharge home with community support.

7.3 The average number of MFFD patients at our main acute provider remained between 100 and 120 throughout June with a gradual increase being seen each week up to 31st July to between 120 and 140.

7.4 Patients awaiting Home First have continued to rise throughout the year into the summer. In Staffordshire this number is now slowly reducing.

8.Response to System Pressures

8.1 Midlands Partnership NHS Foundation Trust (MPFT) has carried out an independent review supporting the system with improvements in discharge pathways. Following this a specification for a whole system review of discharge process and decision making is underway.

8.2 Staffordshire County Council have invested further in the domiciliary care market and are developing a new in-house Home Care service to take Provider of Last Resort (POLR) activity from Home First; this will enable Home First to increase to same day discharge timescales from hospital.

8.3 Within the Winter Plan, national funding received to support the increase of outsourcing to POLR.

8.4 The 100 Day Discharge Challenge has been completed against the 11 initiatives identified in the High Impact Change and submitted to NHS England. The establishment of flexible surge workforce capacity has been identified as an exemplary area.

8.5 Joint quality improvement work with UHNM is ongoing to streamline the discharge processes. Standardised work is being piloted across inpatient wards and Track and Triage.

8.6 Working with D2A care home providers to source additional D2A rehab capacity. 26 beds have been outsourced.

8.7 Increase sourcing spot-purchase care home beds over the winter period.

9. Learning from previous bank holidays, critical incidents and spikes

9.1 The ICS collates a resilience plan moving into bank holiday periods and partners work together to ensure clear and robust plans are in place to support the Urgent Care system. Learning identified from both the critical incident in April and bank holidays include:

i. Clear incident focus allowed all partners to manage immediate solutions and those that would aid recovery into the following weeks.

ii. Daily ICS calls (supported by NHSE) during the week prior to a bank holiday, reviewing current position and agreeing planning same day and into the next day.

iii. Senior leads had oversight of the position by hour, supported by the Single Health Resilience Early Warning Database (SHREWD).

iv. Coordination was key for operational teams with the ability to communicate the agreed actions to all partners.

v. Clear mitigations and routes of escalation are in place.

vi. Improved collaboration and partnership working was evident.

vii. The level of internal preparations and those of external partners supported increased flow and resulted in an improved ICS position.

10. Winter Planning

10.1 The ICB has commenced planning in advance of the winter period and is leading on a system approach to surge planning which encompasses all partners in the UEC pathway including a clear capacity plan and associated triggers. Workforce constraints remain the biggest risk to winter and the system workforce plan underpins the capacity plan.

10.2 Analysis has been undertaken to understand the potential demand over winter with the following assumptions being built into the capacity analysis:

i. Full elective programme continues as per 2022/23 plan submission;

ii. The bed gap assumes a worst-case scenario that non-elective demand, flu and COVID-19 all peak at the same time. Should we be in this position this will present complexities from a cohorting perspective;

iii. Assumed non-elective demand levels of 2019/20 and achieve 92% occupancy;

iv. Mitigating schemes have been converted to an equivalent bed number for the purposes of demonstrating mitigation against the bed deficit. Schemes have been broken down in to three sections of the UEC pathway: pre-hospital, in-hospital and post-hospital.

v. The residual gap is linked to the further work quantifying front of house gains, care home in-reach, and additional acute bed capacity, along with efficiency schemes.

10.4 The ICB has received £5.7m funding for capacity schemes. These focus on additional:

i. Ward based capacity within the hospital including integrated front of house offer
ii. D2A provision in the community
iii. Resource to outsource POLR.

10.5 The plan has been built utilising the principles of the ICB's culture commitment. All partners have worked together through a multi-disciplinary approach to build the plan and will continue to do as it is mobilised and continually monitored. Updates will be reported weekly with highlight reports going monthly to the UEC Board, System Finance and Performance Committee and System Quality and Safety Committee; the latter two are sub-committees of the ICB Board.

11. Link to Strategic Plan

N/A

12. Link to Other Overview and Scrutiny Activity

N/A

13. Community Impact

N/A

14. List of Background Documents/Appendices:

N/A

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Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee Monday 03 October 2022

ICB Performance Overview

Recommendation(s)

I recommend that:

a. The Committee to note the performance overview for the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) population.

Report of Name Portfolio Holder/Director/Partner/Other

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

1. Note the ongoing work across our portfolios that support addressing system pressures and delivery of actions for the Staffordshire and Stoke-on-Trent ICB population.

2. Note the attached dashboard which provides an overview of Integrated Care Board (ICB) performance against key standards and targets.

Staffordshire County Council

Report

1. Overview

1.1 The ICS has created a structure of eight priority areas underpinned by seven delivery portfolios. Performance of the seven portfolios is as below. This paper highlights the performance of each of the portfolios and the associated actions:

i. Population Health, Prevention & Health Inequalities
ii. Planned Care (inc. Elective, Cancer and Diagnostics)
iii. Children and Young People and Maternity
iv. Urgent and Emergency Care (*detail is provided in the UEC System Pressures paper)*
v. Frailty and Long-Term Conditions
vi. Primary Care
vii. Mental Health/ Learning Disability and Autism

1.2 A key enabler to the delivery of the portfolios is the People and Workforce programme. Detail of the workforce plan and the actions are provided within.

2. Population Health, Prevention & Health Inequalities

2.1 The Population Health, Prevention and Health Inequalities portfolio will enable, implement and embed a Population Health Management approach across the ICS, to understand current, and predict future health and care needs, so that together we can improve outcomes, reduce inequalities, improve use of resources and engage our community.

2.2 Whilst working as a portfolio in its own right, the Population Health, Prevention and Health Inequalities portfolio is also supporting and enabling all other portfolios and work on the Clinical and Professional Leadership Framework.

2.3 Portfolio Leadership resource has been identified as the ICB Chief Medical Officer and the supporting structures are being drafted, this includes the recruitment to a permanent Prevention Officer post that is underway.

3. Actions

3.1 Work with each tier of the system to link local data, build analytical skills to find 'rising risk' cohorts, design and deliver new models of care for impactable patients, risk stratify elective backlog and explore alternative models of care.

3.2 Support changes to integrated care delivery; through PCNs, community, acute and mental health providers and public health and social care teams to achieve demonstrably better outcomes and experience for selected population cohorts.

3.3 Advance the system's infrastructure to build sustainable capability across all tiers of the system which supports a focus on proactive population health management in tackling health inequalities.

3.4 Tobacco dependency steering group fully established and providers to mobilise the programme. Service launch expected for Burton (UHDB) on 5th September 2022.

3.5 The ICS Provider Collaborative endorsed an approach to develop a joint needs assessment for obesity with a view to transform services across tiers 3 and 4 initially.

3.6 Tuberculosis Partnership Group established for Staffordshire and Stoke-on-Trent.

Planned Care

4. Elective

4.1 During Quarter 1 of 2022/23 a further wave of COVID-19 resulted in acute providers needing to stand down some elective activities to ease pressure on bed capacity and workforce. This will continue to impact recovery in to Quarter 2.

4.2 All elective points of delivery (PODs) remain below 2019/20 activity levels. Year to date 86% of pre-pandemic elective activity has been delivered (ordinary spells and day cases).

4.3 Performance against national ambitions around elective recovery will continue and it is recognised that a significant amount of focused work needs to continue if the ICB are to deliver on elective recovery.

4.4 During the summer strong progress has been made in terms of addressing waiting time backlogs, and the focus is now on continuing this momentum and protecting elective activity during the winter months.

5. Performance

5.1 During the course of Quarter 1 the volume of patients on an incomplete RTT pathway has continued to grow, to 147,735 as at the end June 2022. The priority is to reduce the longest waiters.

i. **104 Week Waits:** Initial focus has been to eliminate patients waiting in excess of 104 weeks by end of July 2022. Staffordshire and Stoke-on-Trent ICB achieved this objective, with the remaining 63 >104 waiters in this category remaining on the waiting list due to complexity or patient choice. The aim is that the waiting list will be at zero by the end of September 2022.

ii. **78 Week Waits:** The number of >78 week waits is 1,480 as at the end of June 2022 and these have continued to reduce since April 2022. The target is to achieve zero by April 2023. This represents a significant challenge for our local acute trusts to achieve.

iii. **52 Week Waits:** The volume of patients who have waited more than 52 weeks for treatment is 8,498 as at June 2022 with numbers reducing across the ICB, but significantly higher than pre COVID-19 levels.

6. Actions

6.1 Working groups have been established across the system in demand management, productivity and efficiency and increasing and protecting capacity. The objective or the working groups is to accelerate elective recovery.

6.2 Demand Management; Patient initiated follow-up (PIFU) implementation to reduce outpatient first and follow up appointments, increasing Advice and Guidance to referrers and patients, targeted Referral Management and developing a sustainable model for virtual outpatient delivery.

6.3 Improving Productivity and Pathway Efficiency; validation of the waiting list and patient prioritisation, increasing Theatre utilisation and reducing DNA and cancellation rates, increasing bed capacity including reducing length of stay and ensure the system is operating to Getting It Right First Time (GIRFT) standards via speciality reviews.

6.4 Increasing and Protecting Elective Capacity; maximising value and opportunities in the Independent Sector, Increasing capacity in the number theatre sessions, creating a protecting diagnostics and elective capacity and sites, working with

neighbouring systems offering mutual aid and workforce planning and modelling to match demand with capacity.

Cancer

7. Performance

7.1 **62 day waits** have increased in recent months alongside an overall increase in suspected cancer urgent referrals. The majority of patients waiting more than 62 days is within the colorectal and skin pathways. The target for March 2023 is to reduce the number of people waiting over 62 days to the February 2020 level.

7.2 **31 days treatment** has met the 96% target during June but continued focus on the pathway is required to maintain performance.

7.3 **28 day waits** (faster diagnosis standard) is below the 75% standard again. As with the 62 day waits, the majority of patients breaching this target have been referred with colorectal or skin symptoms.

8. Actions

Plans are in place to increase capacity with key actions outlined below.

8.1 **Lower gastrointestinal (GI) (colorectal) actions**

i. Faecal Immunochemical Testing (FIT) before referral to be increased from about 40% to more than 90% from 12 September (UHNM and UHDB).
ii. Directory of service updated (information visible to GPs on the Referral Assessment Service (RAS).
iii. Text reminder service implemented for patients on pathway.
iv. Referral hub in primary care is being set up to manage mandatory clinical information before onward referral to secondary care. This will cover about 65% of referrals initially. After evaluation it may eb expanded to cover the whole ICB.

8.2 **Skin actions**

i. Outsourcing proposal for excision being worked up by directorate. To mirror Black Country Skin Analytics support and the Walsall successful Dermatology project. The West Midlands Cancer Alliance (WMCA) have agreed to support with investment.
ii. Working with theatre to staff to increase plastics access to Poswillo Dental Suite at UHNM
iii. Long-term plans to convert part of the estate of the skin unit to minor ops capacity have been approved at division. Expected go live in six months.
iv. Primary Care initiated teledermatology has been commissioned to be provided in the community. High quality photographs will be attached to referrals enabling swift virtual triage for most skin referrals within the hospital working to 1st October for implementation.

9. Diagnostics

Performance

9.1 Diagnostic Waiting Times remain challenging in Quarter 1, similarly to the RTT challenges, being impacted by COVID and workforce issues. Current levels of activity within all tests remain below pre-pandemic levels, with 67% of patients being seen within 6 weeks of referral versus the 95% target.

9.2 Year to date 79.2% of 2019/20 activity is being delivered, across all tests. Activity levels in computerised tomography (CT), Gastroscopy and Echocardiography are

above 85% of 2019/2020 levels, while Colonoscopies and Flexi Sigmoidoscopies are below 68% of 2019/2020 activity levels.

9.3 **Actions**

i. A working group incorporating all system stakeholders is being established to greater understand capacity and demand for future needs.

ii. Work ongoing to scope, agree governance and responsible provider to take the Community Diagnostic Centre business case forward, to increase and maximise capacity within the system.

10. Children and Young People (CYP)

10.1 The Children's Programme Board was established as a task and finish group over two years ago, however the outcomes for children are a priority for the ICS and this has been recognised with the CYP Programme Board being identified as an established group as part of the ICB Board structure. The group has already achieved significant progress in a short period of time with achievements and next steps outlined below:

10.2 **Actions**

i. A review of the status of the CYP board to ensure that all activity is being delivered collaboratively to improve outcomes for children across the system. This was recognised as a priority for the ICS in June 2022.

ii. Agreed priority areas identified with the partners to include mental health, infant mortality, long term conditions (asthma, epilepsy and diabetes) and healthy weight. Ongoing dialogue with health colleagues about the links with the Maternity Transformation Programme Board which have ensured a system wide approach is agreed. This will see an operational infant mortality steering group established to gain traction on this outcome area which has remained consistently poor.

iii. Interim clinical lead appointed to implement and drive our local ambitions within the National Asthma bundle. A key focus will be to complete a mapping workshop with colleagues across the ICS footprint to provide a clear focus on our strengths and areas of development to inform and shape future service provision.

11. Maternity

11.1 The NHS Operational Planning Guidance of 24th December sets out key priorities and deliverables for Local Maternity and Neonatal Systems (LMNSs) for 2022/23:

i. Safe staffing

ii. Midwifery Continuity of Carer

iii. Culture: LMNSs should ensure that all providers should work with Patient Safety Networks as part of the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) to undertake a repeat culture survey and debriefing process and use the insights to inform local quality improvement plans by March 2023.

iv. Equity and Equality

v. Develop, maintain or expand their Maternal Mental Health Services.

vi. Capacity and Capability framework self-assessment.

11.2 The LMNS have embedded the seven immediate and essential actions identified in the interim Ockenden report, alongside the learning shared in the second Ockenden report and East Kent review (when published) which are monitored via the LMNS. Safe staffing remains a significant risk for the LMNS alongside the ability to implement continuity of carer.

11.3 LMNSs have also been asked to support providers to prioritise reopening any services suspended due to the pandemic. The LMNS is also expected to write a local maternity equity and equality action plan in line with 'Equity and Equality: Guidance for local maternity systems.

11.4 **Actions**

i. Continue to work closely with UHNM, The University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and the ICS People Function around safe staffing. This involves developing a workforce plan in line with Nationally recognised Birth Rate Plus assessments, to enhance safety within local units.
ii. Continue to monitor Quality Impact Assessments (QIAs) for the suspended Freestanding Midwifery Birth Units (FMBUs).
iii. Safe midwifery staffing continues to be impacted by COVID-19 and so requires continuous review. This includes longer term proactive roster planning alongside constant responsive management of resource to ensure risks due to absence are balanced across the service.
iv. Continuity of carer provision reviewed by UHNM and reinstatement of continuity of carer teams and further roll out deferred, as per guidance.
v. LMNS monies allocated to fund a specific Ockenden midwifery lead.
vi. Allocated Programme Activity hours for an Obstetrician and Neonatologist to lead the peer review process in partnership with buddy LMNSs. This is supported through a revised Memorandum of Understanding with Derbyshire, Shropshire and Black Country LMNSs.
vii. UHNM have undertaken some direct listening events with staff via their 'Freedom to Speak Up Guardian'.
viii. Regional insight visits have taken place at UHNM and UHDB and attended by members of the LMNS team and ICB Chief Nursing and Therapies Officer.

11.5 Our local maternity system is working in partnership with women and their families to draw up and publish a 5 year Equity and Equality Action Plan.

12. Frailty and Long-Term Conditions

12.1 **Frailty**

12.2 Frailty and the care of older people remain a key challenge across the NHS especially with rapidly changing demographics and patterns of illness. It is recognised that the health and care system needs to do more to sufficiently improve the quality of life of older people. As an ICS there are opportunities to deliver care for older people in a collaborative, integrated and patient-centred way to the benefit of the population. It is hoped that new developments in treatments, service reconfigurations and technology will enable this strategic change and improve efficiencies and outcomes.

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service reconfigurations and technology will enable this strategic change and improve efficiencies and outcomes.

12.4 In 2020/21 the Healthier Ageing and Frailty Strategy was co-produced by all health and care system partners, with the joint aim of transforming frailty in 2022 to 2025.

12.5 **Actions**

i. Due to the scale and complexity of frailty, a Project Implementation Plan (PIP) will be created for each key theme.
ii. These plans will cover the aims, objectives and expected outcomes across prevention / healthy ageing, mild frailty, moderate frailty, severe frailty, falls (prevention) and the Community Rapid Intervention Service (CRIS).

13. Long Term Conditions (LTCs)

13.1 Anticipatory care of long term conditions is a priority in the Long Term Plan as the care of patients with long term conditions is one of the greatest challenges for our system. Metrics for the LTC programme are being developed however some are available for diabetes which demonstrate the work being undertaken.

13.2 **Performance**

i. There has been an increase in the percentage of people living with Type 1 and Type 2 diabetes who have received all eight care processes (2020-21 vs 2021/22) of 10.3% for Type 1 and 24.8% for Type 2.
ii. 100% of eligible pregnant women were offered and prescribed glucose monitoring in Quarter 1 of 2022/23.
iii. There has also been an increase in the number of referrals made to the Diabetes Prevention Programme each month for 2022/23, currently 87% of patients have been referred although the completion rate of the programme is 67%.

13.3 **Actions**

i. A Long Term Conditions Strategy will be developed to support the delivery of the Long Term Conditions programme focusing initially on respiratory, diabetes and cardiovascular disease.
ii. The Long Term Conditions Programme will be delivered under a system level framework, which will focus on system, place and pathway recommendations. Population Health Management will be at the heart of the model and the starting point for discussions.
iii. A key aim of the programme is the restoration and future improvement of performance for long term conditions and work has commenced with a focus on LTCs within the Primary Care Quality Improvement Framework alongside other work with provider organisations.

14. Primary Care

14.1 **Performance**

i. Appointments in General Practice are back at pre-pandemic levels with two thirds face-to-face. The majority of practices offer same day urgent appointments and extended access (08:00 – 20:00).

ii. 97% of Community Pharmacies are signed up to the Community Pharmacy Consultation Scheme to offer same-day pharmacist advice or treatment.
iii. Primary Care Team support in place for practices merging to ensure stability of general practice.
iv. Digital-first primary care (94% practices offering pulse oximetry and 96% practice offering blood pressure).

14.2 **Response to System Pressures**

i. There is a draft recruitment and retention plan for GPs in place looking at all stages of GP career. Practice Manager working group in place. Ongoing work regarding general practice nursing being led through the Staffordshire Training Hub.
ii. Additional Roles Reimbursement Scheme (ARRS) working group has been established. Partners engaged and Primary Care Network (PCN) representation secured.

14.3 **Fuller Review**

The 'Next steps for integrating primary care: Fuller Stocktake report' was published and outlines a new vision for integrating primary care. A local stocktake in response to the recommendations has taken place. The ICS is already progressing well against many of the recommendations, including:

i. Primary Care Collaborative comprising 25 PCNs established and meeting on monthly basis.
ii. Organisational development (OD) support and data sharing agreements are in place across the PCNs and work on the PCN Estates Plan has commenced.
iii. Taking the Fuller recommendations forward as shared actions across all partners, in the process of creating a development plan which will support the sustainability and evolution of primary care.

14.4 **Operational Delivery Ongoing Actions**

i. Practices will be supported to develop business continuity plans and encouraged to work within the PCN to build resilience as a group pf practices. Care Quality Commission (CQC) guidance produced to highlight key themes to support development in this area. Resilience funding will be offered to PCNs.
ii. Funding has been made available to GP practices to support patient access with ongoing engagement and monitoring of the support package taking place.
iii. General practice public communications campaign focusing on 5 key messages is being refined after listening to public feedback.
iv. A tactical cell is in place to coordinate a response to Ukrainian refugees and a GP registration process for Ukrainian refugees has been drafted.

14.5 **Primary Care Network (PCN) Development**

i. The PCN Clinical Director Collaboration meets monthly and is improving engagement with PCN Clinical Directors.
ii. PCN Development local offer is being rolled out with support from the primary care team and OD practitioners.
iii. Health Inequalities focus group established and first meeting took place in August.

iv. An assurance framework is being established to review delivery against each of the Direct Enhanced Service (DES) service specifications. A support package for PCNs is also in development.

14.6 Commissioning and Quality

i. Work is underway with PCNs to establish enhanced access to General Practice services through the network contract DES from 1st October 2022. Regular updates being provided to NHSE.
ii. The ICS local Quality Improvement Framework (QIF) scheme for 2022/23 has been finalised and shared with practices. Principles of focus on long term condition recovery and health inequalities.
iii. Offers of support and training by the community specialists have gone out to practices regarding improving uptake for annual health-checks for people with a learning disability and / or serious mental illness and dementia diagnosis. A small funding initiative has been offered to practices to focus on validation of their registers by end of Quarter 2.

15. Mental Health

The programme continues to receive extremely positive feedback both regionally and nationally for coordination and performance.

15.1 Performance

i. Access rates for Children and Young People continue to improve.
ii. The Improving Access to Psychological Therapies (IAPT) access rate is improving. The wellbeing IAPT bus is improving access for those in rural communities and has been well received by patients and GPs.
iii. The ICS is the 5th best in the Midlands region for Serious Mental Illness (SMI) COVID-19 vaccination.
iv. The ICB dementia diagnosis rate has been met for the first time in June 2022 (67.1%).
v. Perinatal Mental Health access rate has improved but the activity recovery plan remains in place.

15.2 Actions

i. The staff Mental Health Wellbeing Hub has received very positive feedback from the National Staff and Wellbeing Survey in June 2022. Due to demand on the Hub we are seeking to offer additional clinics. Wellbeing Ambassadors have been recruited and a 'Cost of living Toolkit' developed as there is a noticeable increase in uptake of bank shifts.
ii. Mental Health Practitioner roles continue to be expanded in primary care.
iii. Transformation of Community Mental Health services for adults with severe mental illness continues with the addition of Adult Eating Disorders pathway in 2022/23.
iv. All investments related to the Mental Health Investment Standard (MHIS) and NHS Long Term Plan ambitions for mental health continue to be implemented. However, a full financial rebasing exercise has been undertaken which will guide future investment for 2023/24.
v. Recruitment to established and new roles continue to prove problematic against the planned expansion of services. System workforce plan is in place.

vi. Mental health services have been planned in line with the MHIS and System Development Fund monies for 2022/23. Will incorporate Long Term Plan deliverables for 2022/23 plus a calculation of MHIS across the system.
vii. Mobilisation of significant expansion of Community Mental Health Transformation Programme in Year 2 with an additional £3.1m of investment to include Adult Eating Disorder Pathway.
viii. Expansion of Mental Health Support Teams in schools.
ix. Mental health UEC Capital bid submitted for two schemes.
x. To expand the Intensive Support (IOT and ISH) service.
xi. Stoke-on-Trent City Council is acting as lead partner, working with Staffordshire County Council and the ICB to apply for Individual Placement Support (support to gain and retain employment) in Primary Care for people with mental health needs.

16. Learning Disability and Autism

The ICS is embracing the concept of making Learning Disabilities and Autism (LDA) everyone's business to ensure reasonable adjustments are considered across all services. All system partners have signed up to a joint approach to Section 117 of the Mental Health Act, joint digital register and agreement to how Transforming Care Partnership (TCP) patients will be funded. This has resolved the financial issues that the system were struggling with for TCP individuals.

16.1 Performance

i. GP practices have increased the number of people on the Learning Disability register, compared to the same period last year. The register size increased during the 12 months to July 2022 from 5,652 to 5,953 (+5.3%).
ii. 1,100 Annual Health Checks (AHCs) have been completed year to date (July 2022) of people on the LD register aged 14+ eligible for review. The rate is 18.5%, up from 11.6% in July 2021. 63% of AHCs this year have been completed on a face to face basis and 16.8% by a home visit (provisional). Working towards the ambition for 75% of eligible patients to receive a health check in 2023/24.
iii. The ICS is on track to meet the adult trajectory, with two long stay patients discharged 36 and 22 years to bespoke community solutions.
iv. Increase in Children and Young People deteriorating in the community, leading to an increased number of CYP whose needs have escalated which could result in an admission to hospital.

16.2 Actions

i. The first in depth Joint Strategic Needs Assessment for LDA will be presented to the Health and Wellbeing Board in October.
ii. The Learning from Lives and Deaths (LeDeR) Governance Panel commenced in March 2022 and is well embedded. There is good representation from services including independent chairs and an expert by experience.
iii. LeDeR reports and updates are shared at key forums which include Quality meetings, the Learning Disability and Autism Programme (LDAP) Board and Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.
iv. Revised Digitised Dynamic Support register went live on 15th August.
v. A 'Health Passport' has been developed which has been circulated for implementation across the system.

vi. Alternatives to admission are being explored with social care. Options appraisal is due to be presented across the system in September.
vii. Targeted support by community teams with individuals and families is ongoing to facilitate and make recommendations on reasonable adjustments to enable access to AHCs and meet patients' needs.
viii. Community LD teams continue to support practices with in-house awareness training, validation of LD Registers, support sessions via Microsoft Teams and LD Champion Training.

17. Workforce

The ICS is working collaboratively to address workforce risks and shortages. This is enabled by a robust reporting and governance structure via the ICB Deployment and Resourcing Group, and we are taking forward solutions collectively to address workforce needs, challenges and gaps. The ICS, along with individual NHS providers and care organisations, continues to accelerate recruitment campaigns and deploy agency and bank workers where necessary.

17.1 Actions

i. The ICS is designing a process in partnership which is mutually beneficial to providers and supports the assurance process.
ii. Continuing to ensure delivery of planned changes to workforce, increases in substantive posts and where identified decreases in agency and bank staff.
iii. Encouraging more people into training and education and driving recruitment to ensure that our services are appropriately staffed.
iv. Working differently by embracing new ways of working in teams, across organisations and sectors, and supported by technology.
v. Focused retention activity at system and provider level; scoping and diagnostic work complete with specific actions being implemented.
vi. Winter planning is underway with leads to identify the additional workforce requirements of the priority winter schemes. Collaboration between NHS, local authority, primary care and voluntary sector partners on specific workforce actions including reserves, system-wide recruitment and agreeing incentives.

17.2 Next Steps

i. Engagement and collaboration with providers has commenced to address performance against plan / mitigations.
ii. Agree thresholds which would trigger deeper dive into reasons for variations in plan and mitigating actions.
iii. Agree touchpoints with providers to identify best practice, opportunities for system collaboration and understand provider mitigating actions.
iv. Scale and spread retention work with additional resource to support focussed work with providers and hotspot areas.

17.3 Agency

The system wide agency ceiling, confirmed July 2022, is at c£25m. This represents a 30% reduction from 2021/22 levels of expenditure.

17.4 Actions

Human Resources Directors and Directors of Nursing are leading the action plan:

i. Request made to the Regional and National NHSE teams to drill down data on agency spend by provider within the ICS.
ii. Working with providers to understand internal trust plans and actions that can be taken at system level e.g. Health Education England funded programme to support retention in targeted hot spot areas.
iii. All organisations signed up to Health Trust Europe (THE) framework which should deliver savings regarding medical and dental agency usage.
iv. Implementation of ICS Reserve proposal for winter 2022 which should reduce the reliance on agency for reactive shift cover and excess premium rates.
v. Progressing recruitment and retention to increase supply and deployment to fill gaps. International recruitment in train.
vi. Supporting workforce planning which will transform care with appropriate skill mix / recruitment schemes in place.

18. Link to Strategic Plan

N/A

19. Link to Other Overview and Scrutiny Activity

N/A

20. Community Impact

N/A

21. List of Background Documents/Appendices:

Attached Performance Overview, appendix 1.

Contact Details

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Performance Overview - Staffordshire & Stoke-on-Trent ICB

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Current Financial Year 2022-23

Report Month Jun-22

Notes on content: red and green shading is provided to illustrate achievement against target - red is below, green is above or equal to. Rolling trend charts detail a rolling 12 month period unless otherwise stated. Data collection paused for Mixed Sex Accommodation breaches, across the COVID-19 period.

Indicators	Target	Staffordshire & Stoke-on-Trent ICB 22/23 YTD	Apr-22	May-22	Jun-22	Rolling 12 Months Trend / Performance
Healthcare Acquired Infections						
MRSA	0	5	1	3	1	
C.difficile	28/20/37	91	28	28	35	
Referral to Treatment Times - % <18 weeks						
RTT Admitted	n/a	57.6%	57.9%	57.3%	57.6%	
RTT Non-Admitted	n/a	73.4%	75.6%	72.9%	71.9%	
RTT incompletes	92%	58.9%	57.7%	59.9%	59.0%	
RTT 52 week + waiters (Incompletes, all Providers)	0	8,498	8,415	8,550	8,498	
Diagnostic test waiting times						
Diagnostics 6 weeks +	95%	66.8%	65.7%	67.7%	67.1%	
Cancer waits						
Cancer 2 week wait	93%	58.21%	55.93%	59.53%	59.06%	
Cancer Breast Symptoms 2 week wait	93%	56.57%	29.63%	73.15%	80.18%	
Cancer 31 day first definitive treatment	96%	84.85%	89.25%	83.90%	81.89%	
Cancer 31 day subsequent treatment - surgery	94%	74.90%	78.75%	73.63%	72.37%	
Cancer 31 day subsequent treatment - drug	98%	87.27%	90.52%	85.27%	86.43%	
Cancer 31 day subsequent treatment - radiotherapy	94%	89.71%	91.91%	90.61%	86.55%	
Cancer 62 day standard	85%	45.64%	51.57%	40.99%	44.54%	
Cancer 62 day screening	90%	59.17%	63.41%	58.82%	55.56%	
Cancer 62 day upgrade	0%	72.40%	78.63%	71.22%	67.97%	
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation Breaches	0	13	2	5	6	

Note the following GP Appointment Data is publicly available and is 1 month behind the validated, published, performance data above.

Appointments in General Practice		Staffordshire & Stoke-on-Trent ICB 22/23 YTD	Apr-22	May-22	Jun-22	Rolling 12 Months Trend
GP Appointments by Type						
Face-to-Face		903,530	274,103	324,926	304,501	
Home Visit		14,004	4,182	5,254	4,568	
Telephone		431,482	142,681	151,784	137,017	
Unknown / Data Issue		2,380	787	883	710	
Video Conference/Online		4,550	1,541	1,547	1,462	
Total						
Time Between Book and Appointment						
Same Day		638,903	202,379	227,628	208,896	
1 Day		107,307	34,675	37,208	35,424	
2 to 7 Days		258,359	79,452	97,178	81,729	
8 to 14 Days		174,448	53,079	64,153	57,216	
15 to 21 Days		91,964	29,400	30,402	32,162	
22 to 28 Days		47,473	13,656	15,563	18,254	
More than 28 Days		36,620	10,381	11,943	14,296	
Unknown / Data Issue		872	272	319	281	

Note: The following CQC Rating Data is publicly available. The monthly counts are of inspection results for practices within each CCG as at the report run month.E.g. a practice inspection rating may have been allocated 12 months prior to the report run date, but the rating retained as no subsequent inspections have taken place.

In month snapshot of current CQC rating CQC Inspection Rating		Staffordshire & Stoke-on-Trent ICB Apr-22	May-22	Jun-22
CQC				
Outstanding		**8**	**8**	**8**
Good		**120**	**120**	**119**
Requires improvement		**5**	**5**	**5**
No published rating				
		12	**12**	**13**

Total inspection count in the financial year to date

Accident & Emergency - Provider	Target	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance
		UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST					THE ROYAL WOLVERHAMPTON NHS TRUST					THE DUDLEY GROUP NHS FOUNDATION TRUST				
A&E 4 Hour Target	95%	62.65%	62.91%	62.79%	62.27%		78.42%	76.77%	79.50%	78.91%		76.34%	80.34%	74.71%	74.03%	
12 hour trolley breaches	0	1,823	878	390	555		80	30	20	30		159	31	79	49	
		UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST					UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST					WALSALL HEALTHCARE NHS TRUST				
A&E 4 Hour Target	95%	62.63%	61.97%	64.18%	61.68%		54.18%	54.75%	54.63%	53.17%		72.87%	73.92%	72.30%	72.48%	
12 hour trolley breaches	0	1,076	432	388	256		1,034	271	211	552		17	6	10	1	

Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee - Monday 03 October 2022

Adult Social Care Performance

Recommendation

I recommend that the Committee:

a. Note the performance of Adult Social Care

Report of the Director for Health and Care

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

The Committee is asked to consider the current performance of Adult Social Care.

Report

Background

1. Cabinet has set four strategic objectives for Health and Care - This report will focus on performance against objectives (b) and (c):
   a. Promote good health and independence, and encourage and enable people to take personal responsibility for maintaining their well-being
   b. Ensure effective and efficient assessment of needs that offers fair access to services
   c. Maintain a market for care and support that offers services at an affordable price
   d. Ensure best use of resources, people, data, and technology

Care Act Assessments and reviews

2. People may request an assessment under the Care Act 2014. We complete a preliminary assessment initially to gauge likely eligibility, and for those unlikely to be eligible we offer information, advice, and guidance, along with referral to assets within their local community to help them remain independent.

3. For those with higher levels of need we complete a more detailed assessment to determine eligibility for Council funded care and support and develop a plan to meet their needs. We currently complete around 1350 Care Act assessments monthly, as shown in Table 1.

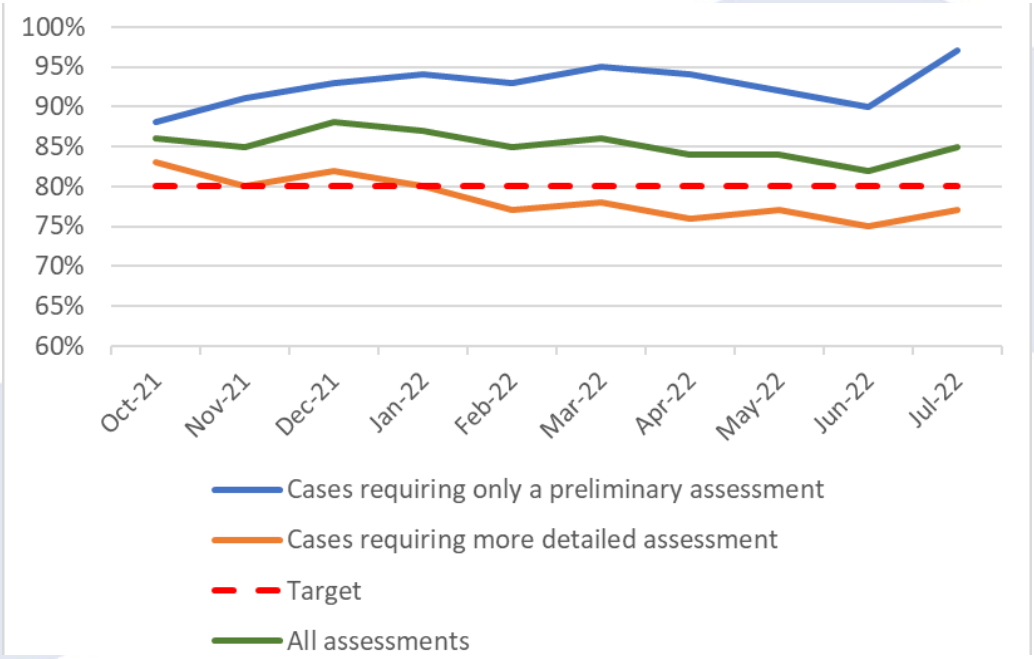
Table 1: Care Act assessment typical monthly volumes

	Preliminary assessment only	**Detailed assessment**	**Total**
New people living independently in the community or discharged from hospital	561	489	1050
People already receiving Council funded care and support whose situation has changed		316	316
Total	**561**	**805**	**1366**

4. We aim to complete 80% of all Care Act assessments within 28 days. Where assessments are not completed within 28 days this is often because cases are complex and require protracted discussions with individuals and their families to determine the most appropriate support.

5. In July 2022 we completed 85% of all assessments within 28 days, 97% of those requiring a preliminary assessment only, and 77% of those requiring a detailed assessment, as shown in Figure 1. Note that all assessments are managed so that urgent cases are dealt with quickly.

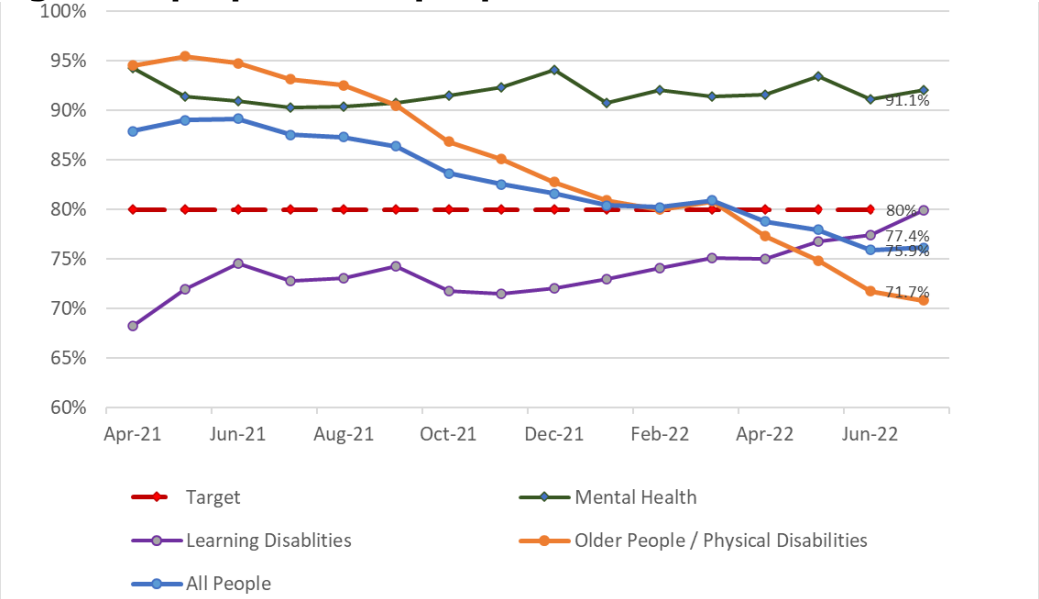
Figure 1: Care Act assessments completed within 28 days



6. For those people receiving Council funded care and support we aim to complete an annual review, to ensure that their needs are being met. Our target is that 80% of people have a review within 12 months.

7. Performance in July 2022 was below target at 76%, due to a reduction in the proportion of older people and people with physical disabilities who had a review within 12 months, as shown in Figure 2. 87% of people in receipt of Council funded care and support had a review within 15 months.

Figure 2: proportion of people with annual review within 12 months



8. This reduction in reviews performance is because the teams have had to prioritise a rising demand for new assessments as well as Safeguarding referrals. We are exploring options for additional capacity to allow performance to be recovered in the remainder of 2022/23.

Financial Assessments

9. We complete financial assessments to determine whether people are eligible for Council funded care and support and how much they are required to contribute to the costs. We receive around 500 referrals for financial assessments each month. We aim to complete financial assessments within 28 days.

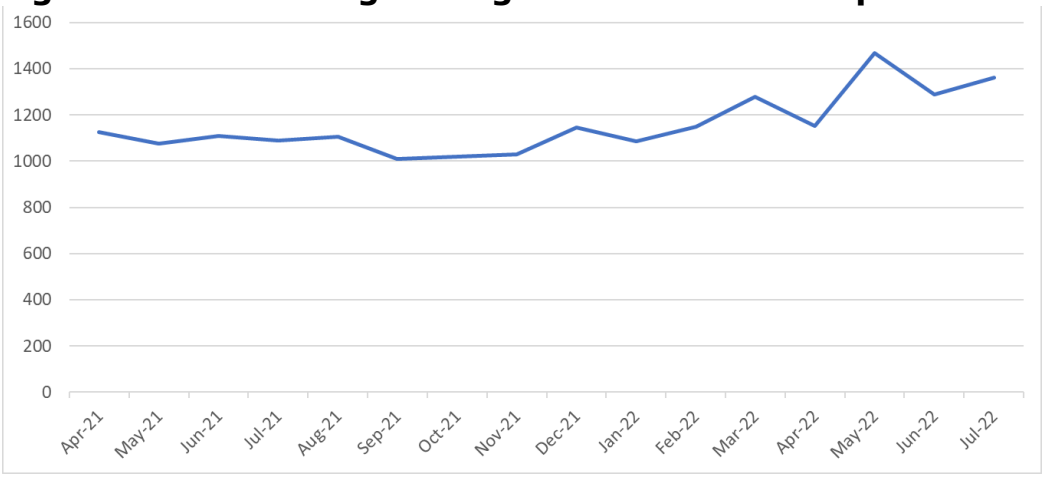
10. We currently have 916 people waiting longer than 28 days for their financial assessment to be completed: 446 are already in receipt of, or have received a care service at home, but are yet to be charged; 111 are being charged a provisional rate for a care home; and 359 are yet to receive a chargeable service and may not go on to receive Council funded care and support.

11. Delays in completing financial assessments generate complaints and increases the likelihood of people receiving a backdated invoice for their care and support costs, which may increase debt owed to the Council. In advance of Adult Social Care Reforms, we are reviewing and streamlining processes and recruiting additional capacity to enable financial assessments to be completed more quickly and eliminate the backlog.

Adult Safeguarding pathway

12. People and professionals may contact the Council with safeguarding concerns. We currently receive around 1200 contacts per month. However, over the past three months have seen a significant increase in contacts with 1,362 contacts received in July:

Figure 3: adult Safeguarding contacts received per month

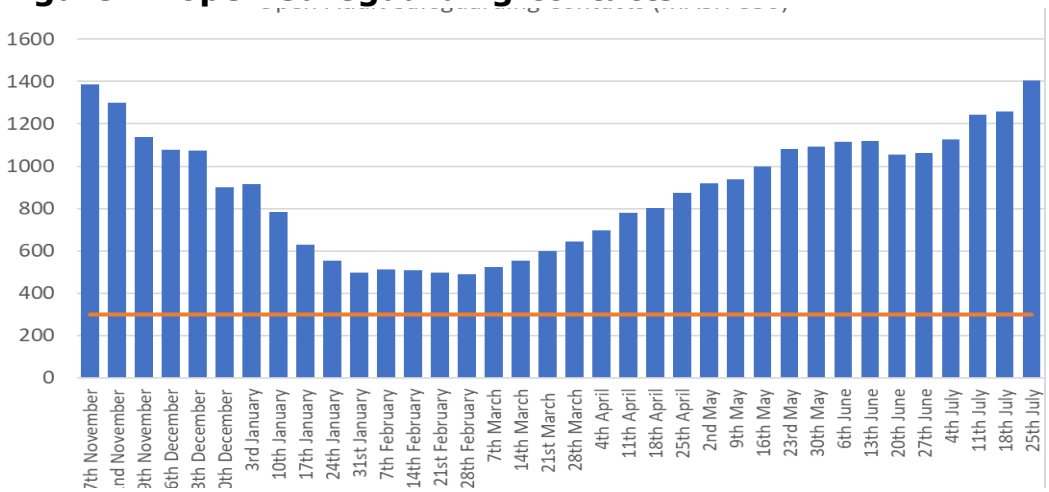


13. We have a target to review and close 30% of safeguarding contacts within 2 working days. Since April 2022 30% of contacts were closed within our 2-day target.

14. Our aim is to close the remaining 70% within 2 weeks, and to have no more than 300 safeguarding contacts open at any one time. The increased level of demand we have experienced means we are currently unable to achieve this aim - we currently have 1,404 safeguarding contacts open.

15. It is important to note that all contacts are assessed on receipt to ensure that the highest risk cases are prioritised immediately. The contacts that remain open are lower risk, where actions have already been taken to address immediate risks, or the contact is awaiting final closure.

Figure 4: open Safeguarding contacts



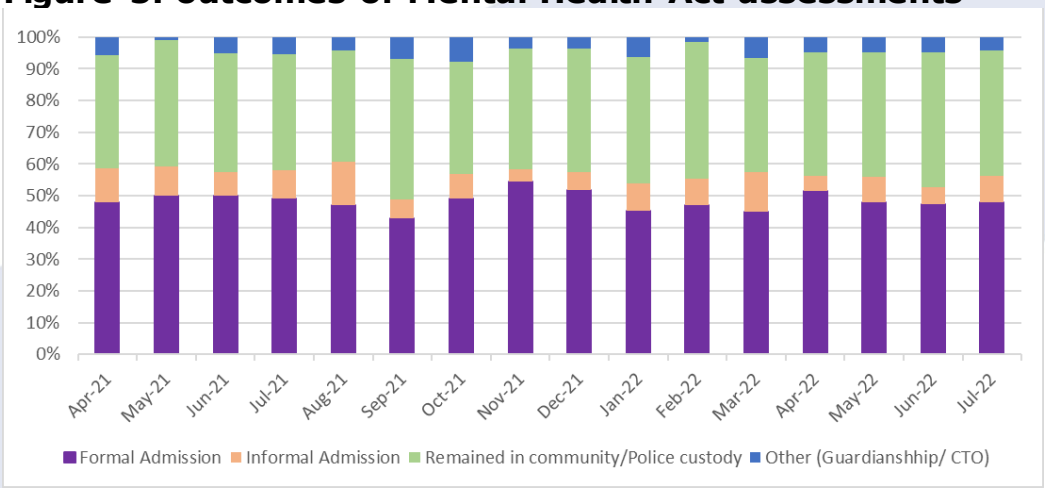
16. We have recently recruited additional permanent capacity, and additional temporary resource, to the safeguarding team to support with this work. Subject to contacts not increasing further, we therefore aim to reduce open contacts to 300 by February.

Mental Health Act and Deprivation of Liberty Safeguards

17. The Council complete Mental Health Act Assessments to decide whether a person should be detained in hospital under the Mental Health Act to make sure they can receive care and medical treatment for a mental disorder. We complete around 125 **Mental Health Act Assessments** each month. The number of assessments required can vary each day, and we have a rota in place to ensure that we are able to respond to requests 24 hours a day, 7 days a week.

18. Just under 50% of formal assessments result in an admission under the Mental Health Act, with this number consistent over the last 15 months as shown in Figure 5.

Figure 5: outcomes of Mental Health Act assessments

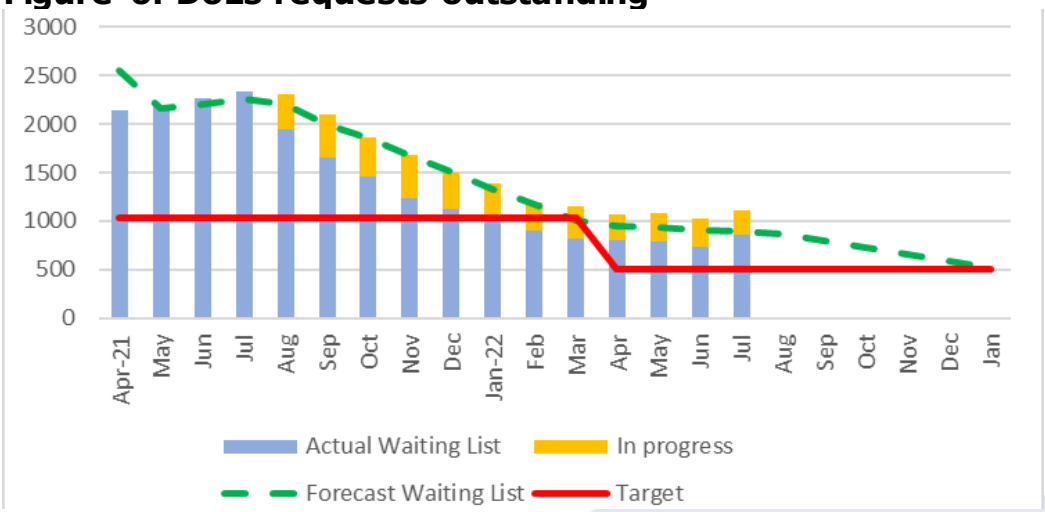


19. Some people living in care homes and hospitals lack the mental capacity to make key decisions about their care or treatment. For their safety, it may be necessary to restrict their liberty. **Deprivation of Liberty Safeguards (DoLS)** assessments ensure that any such arrangements are lawful and proportionate.

20. During 2021/22 we received an average of 447 referrals for DoLS. Between April and July 2022 this has increased to an average of 503 referrals per month. This increase is in part due to the work completed by the Council to reduce the waiting list position. Previously managing authorities did not request a further referral every 12 months as they were still waiting for the initial referral to be completed. Now that the Council has significantly reduced the waiting list more managing authorities are making a referral every 12 months.

21. There were 1114 DoLS referrals outstanding in July 2022, a substantial reduction on a year previously, as shown in Figure 6. We are continuing to use additional external capacity to reduce the waiting list.

Figure 6: DoLs requests outstanding



Appointeeship and deputyships

22. In circumstances where people are assessed as not having the mental capacity to manage their finances, we explore the option of enabling family members or carers to act as an appointee or deputy. Where there is no other person available to complete this role, the Council can offer an appointeeship and deputyship service.

23. We offer these services as a "provider of last resort" to ensure that people can pay their financial bills - including gas, electricity etc. In addition, the services ensure that invoices for care and support costs issued by the Council are paid to prevent people accumulating debt. For appointeeship we charge an administration fee where people are able to pay; for deputyship we charge the rates set nationally.

24. There is a requirement to increase awareness of Lasting Power of Attorney arrangements as an option to prevent the need for people to establish appointeeship and deputyship arrangements.

25. The appointeeship service administers people's benefits. We currently have **appointeeship** arrangements in place for 332 people. We monitor the balances of accounts monthly to ensure that funds are being spent and that balances are not accruing inappropriately.

26. Where people have financial assets or other types of income, the Council can apply to Court of Protection to act as deputy to manage the finances. We have these **Deputyship** arrangements in place for 458 people, and we are waiting for the Court of Protection to complete orders for a further 39 people.

27. We have a waiting list of 27 people who require deputyship arrangements. Similar to other local authorities the costs of operating deputyship arrangements have increased and now exceed the amount the Office of the Public Guardian allow the Council to charge people for this service.

28. The Council's audit team completes an annual review of the appointeeship and deputyship services to provide assurance that we have effective governance and management arrangements in place. The last audits completed for both services demonstrated that the services had adequate controls in place

Reablement services

29. The Council and the NHS offer reablement for people to help them regain their independence after episodes of ill health. The vast majority of reablement takes place as part of hospital discharge pathways.

30. We provide reablement services for around 580 people per month. Waiting times for reablement, from the time of referral to commencement of the service remain low, at just over a day. Outcomes are good, with around 70% of people having no ongoing need for social care at the end of episode, compared to our target of 66%

Quality of Care

31. For residential and nursing homes in Staffordshire the Care Quality Commission (CQC) rates 81% as 'good' or 'outstanding' or has not yet rated the care home. This is in comparison to 80% in the West Midlands and 82% in England, as shown in Table 2.

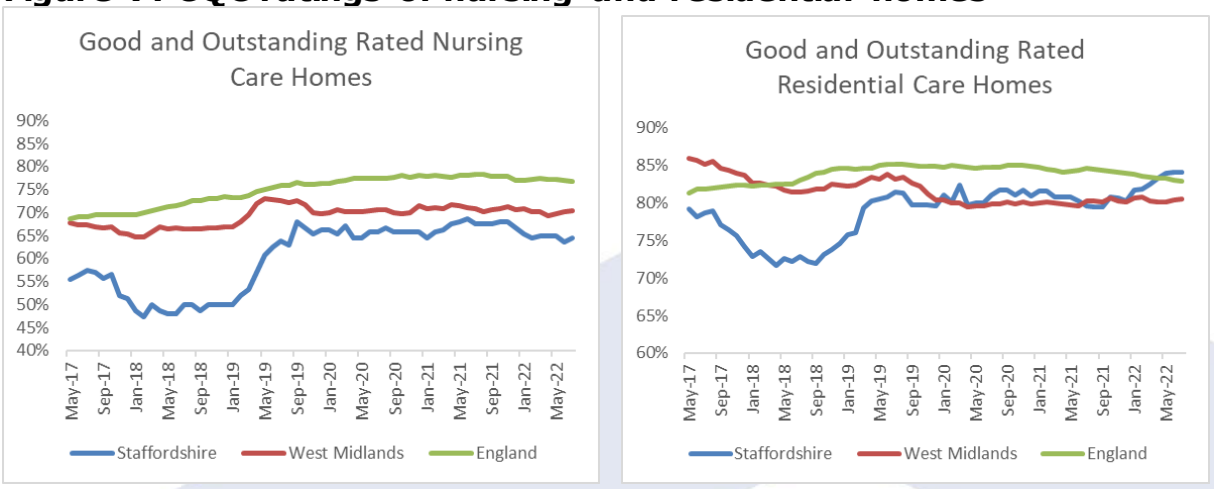
Table 2: CQC ratings of care homes

CQC Rating	Staffordshire	West Midlands	England
Outstanding	3% (8 homes)	2%	4%
Good	63% (162 homes)	69%	71%
Requires improvement	19% (48 homes)	19%	16%
Inadequate	1% (2 homes)	1%	1%
No Rating	15% (38 homes)	9%	7%

32. There has been an improvement in quality in residential care homes in Staffordshire over the last 12 months and the gap between the proportion rated 'good' or 'outstanding' has followed the improving trend within the West Midlands, while the National percentage has decreased.

33. The percentage of nursing care homes in Staffordshire rated 'good' or 'outstanding' is lower than for residential care homes without nursing, and correspondingly nursing care homes are a sector which is prioritised for the Council's quality improvement support, as shown in Figure 7.

Figure 7: CQC ratings of nursing and residential homes



34. The Provider Improvement and Response Team (PIRT) have undertaken 546 visits to care homes within the last 12 months, to provide assurance and improvement work. The impact and effectiveness of the team is evidenced through the completion of action plans, following advice and guidance delivered by the team. The majority of these care homes are awaiting reinspection from the CQC.

35. For community services in Staffordshire the CQC rates 89% as 'good' or 'outstanding' or has not yet rated the service. This is in comparison to 86% in the West Midlands and 90% in England, as shown in Table 3.

Table 3: CQC ratings of community services

CQC Rating	Staffordshire	West Midlands	England
Outstanding	1% (1 services)	2%	3%
Good	51% (79 services)	54%	59%
Requires improvement	10% (15 services)	13%	9%
Inadequate	1% (2 services)	1%	1%
No Rating	37% (58 services)	30%	28%

Access to Care

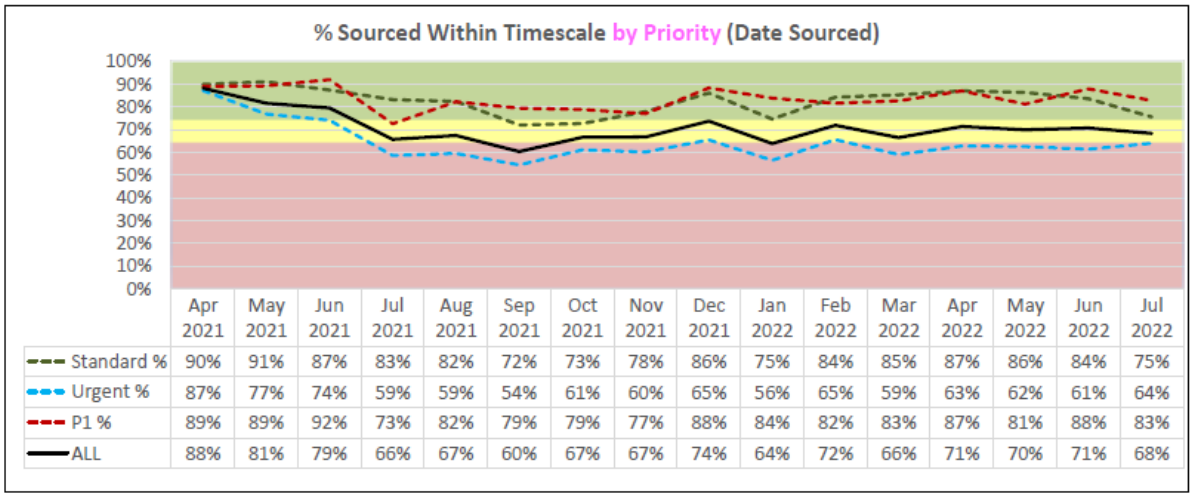
36. Our brokerage team arrange new care packages for people receiving support in their own homes as well as amendments to care packages if people's situation has changed. They also arrange placements for people requiring residential or nursing care.

37. Since April 2022 we have received an average of 908 referrals per month for new or amended care packages and placements, but this figure is growing (978 in July). This is a significant increase compared to the average of 838 per month we received during 2021/22 and 727 per month 'pre-Covid' in spring 2020.

38. We aim to arrange the highest priority (p1) care within 24 hours, urgent care within 7 days, and 'standard' care and support within 28 days. Currently 68% of our brokerage referrals are sourced within these timescales compared to a target of 75%, as shown in Figure 7.

39. The challenges are both the increasing volume of referrals as well as limited capacity in the home care and care homes markets due to the difficulties providers face recruiting and retaining staff. We are recruiting additional capacity to the brokerage team to help manage the volume, and we continue to support the market to maintain and develop the workforce.

Figure 7: care arranged within timescales



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022
Standard %	90%	91%	87%	83%	82%	72%	73%	78%	86%	75%	84%	85%	87%	86%	84%	75%
Urgent %	87%	77%	74%	59%	59%	54%	61%	60%	65%	56%	65%	59%	63%	62%	61%	64%
P1 %	89%	89%	92%	73%	82%	79%	79%	77%	88%	84%	82%	83%	87%	81%	88%	83%
ALL	88%	81%	79%	66%	67%	60%	67%	67%	74%	64%	72%	66%	71%	70%	71%	68%

Affordable and sustainable care

40. We are currently within budget for our spend on care.

41. 89% of our home care is procured with a contracted home care provider using our standard home care framework. The current standard rate is £20.00 per hour, this represents a total uplift of £2.14 per hour compared to the standard rate of £17.86 in 2021/22. The significant increase was possible in part due to additional Better Care Fund funding from the NHS.

42. Care home placements are procured through a Dynamic Purchasing System, with a number of block booked care home beds purchased and the number and location of blocked booked care home beds regularly reviewed, to achieve a balance between affordability and market sustainability.

43. The current average cost of new placements from April 22 for older person's residential care is £743 per week and for nursing home placements is £981 per week.

44. Older people's residential placement costs have increased by 8.4% over the previous two financial years. The percentage increase to date in this financial year is 5.5%, mainly due 6.24% fee uplift in 2022/23. Older people's nursing placement costs have increased by 8.5% over the previous two financial years. The percentage increase to date in this financial year is 5.4%, again mainly due to the 6.24% fee uplift in 2022/23.

45. In line with the national requirements to determine a 'fair' cost of care the Council is currently carrying out an analysis of costs of care for home care and for care homes for people aged 65 and over. Information from this and other analysis will inform our future intentions for ensuring affordability and sustainable care in both the short and longer term.

Link to Strategic Plan

This paper relates to the Outcome "Be healthier and Independent for longer"

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Staffordshire County Council

Health and Care Overview and Scrutiny Committee – Monday 03 October 2022

Outcome of stakeholder the engagement and recommended future commissioning arrangements for Supported Living Services in Staffordshire

Summary

The Overview and Scrutiny Committee is asked to:

a. Consider the feedback from stakeholders on the future commissioning arrangements for Supported Living Services in Staffordshire.

b. Consider the recommendations for Cabinet on the future commissioning arrangements for Supported Living services in Staffordshire.

Report

Background

1. On 19 January 2022 Cabinet:

   a. Endorsed the outcome of an options appraisal for future commissioning arrangements for Supported Living services in Staffordshire.

   b. Approved engagement with stakeholders to discuss the options and proposals.

   c. Requested that feedback from stakeholders be used to refine the options appraisal and develop recommendations for future commissioning, with these recommendations to be brought to a future Cabinet meeting for approval.

   d. Used the additional one-year contract extension available in the current Supported Living contracts to extend these contracts until 30th September 2023.

Recommended future commissioning arrangements for Supported Living Services in Staffordshire

2. Stakeholder engagement has now been completed and details of those involved and the feedback received is included at Appendix 1. Based on the original options appraisal and feedback from stakeholders the recommended future commissioning arrangements for Supported Living

Services are set out in paragraphs 4 to 9. The intention is to present these to Cabinet on 19th October 2022.

3. **Definition of Supported Living**. Supported Living should be defined as care and support provided for people with disabilities in a specialised housing scheme provided by registered housing providers. Where the care and support involve personal care and/or administration of medication, the care provider is required to be registered with the Care Quality Commission (CQC).

4. **Model of Supported Living**. Supported Living should have staff shared across a number of people in the scheme – typically four to six people - with additional 1:1 support provided for individuals, if necessary, based on their assessed eligible needs.

5. **Procurement and contracting arrangements.** Procurement of Supported Living should be with three tenders:

   a. All highly complex (around 60 people; 15% of all placements) would be procured by block contract from around 5 care providers with lots defined by geography. This would enable care providers to specialise and develop the necessary staff expertise and environmental adaptations to support these individuals. It would also allow individuals placed out of county to be repatriated to Staffordshire where their needs could be better met locally. Detailed discussions would be had with potential providers to ensure that demand is met and gaps in provision are filled.

   b. All complex individuals (around 300 people; 70% of all placements) would be procured by block contract from around 15 care providers with lots defined by geography. This would enable the Council to fill vacancies, benefit from economies of scale and establish a productive partnership with care providers and housing providers. It would also facilitate the development of a 'core and cluster' model using staff flexibly across more than one scheme. Detailed discussions would be had with potential providers to ensure demand is met and gaps in provision are filled. Systems would be put in place top manage capacity and fill vacancies.

   c. The block contracts above would be for a minimum of 5 years and a maximum of 10 years. This would give care providers a reasonable guarantee of long-term business and should enable investment in staff expertise and environmental adaptations.

   d. Remaining highly complex and complex individuals as well as less complex individuals (around 60 people; 15% of all placements) would

be procured by a flexible framework agreement from care providers appointed at the start of the contract. The framework would be periodically reopened to allow the Council to appoint additional care providers where there is unmet demand or gaps in service provision that cannot be filled by block contracting arrangements. Lots would be defined by complexity of need and geography. This would enable capacity to be flexed to meet demand and ensure that sufficient placements are available.

e. A small number of current placements are ad hoc arrangements provided by Personal Assistants or other community services rather than Supported Living by the new definition. Suitable alternative contractual arrangements would be established for these, using existing arrangements if possible or through approval of new arrangements if necessary. There are also a small number of individuals whose needs cannot be met by Supported Living longer term and who may need residential or nursing care.

6. **Pricing.** A series of weekly rates for Supported Living services should be set according to complexity of need, size of the scheme and number of placements commissioned. These would be determined by a cost of care exercise. Contracted placements would be paid on the basis of achieving outcomes for the individual, potentially using Individual Service Funds. This would allow care providers to flex the support they offer between individuals and across schemes without the need to continually request an assessment or review for minimal changes in needs. A change in payment from net to gross would be implemented in line with residential services, with the Council collecting people's own contribution to the cost of their care. People would still have the options of taking Direct Payments and using these to buy Supported Living, with existing Direct Payments reviewed to ensure that people were clear about their roles and responsibilities in managing their accounts.

7. **Quality assurance and care provider development.** Contracts would specify quality requirements including the care providers are compliant with CQC standards and providers adopt strengths-based approaches. The Council would work with care providers to develop their skills and facilities, especially in managing challenging behaviour, in order to minimise the use of 1:1 support. 1:1 is highly intrusive and should be avoided, if possible, although there would be some individuals who require this level of support in order to remain safe. Or less complex individuals, care and support would have a reablement focus to maximise people's independence.

8. The potential of Local Authority Trading Company (LATC) or in-house Supported Living is being explored to ensure that there are alternatives available in the event of an inadequate response from the local market.

Link to Strategic Plan

9. The recommended future commissioning arrangements for Supported Living Services would contribute to the following properties with the Strategic Plan:

   a. Support Staffordshire's economy to grow, generating more and better-paid jobs.

   b. Encourage good health and wellbeing, resilience, and independence.

   c. Offer every Staffordshire child and young person the best start in life, and the chance to achieve their potential.

List of Background Documents/Appendices:

Appendix 1 - Feedback from stakeholders on the future commissioning arrangements for Supported Living Services in Staffordshire

Appendix 2 – Community Impact Assessment for the future commissioning arrangements for Supported Living

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Appendix 1 - Feedback from stakeholders on the future commissioning arrangements for Supported Living Services in Staffordshire

1. This briefing is to provide an overview of all stakeholders the Council have engaged with as part of this process and a summary of the feedback.

Stakeholders engaged with to discuss Supported Living options and proposals

Service Users who reside in Supported Living Settings

2. Asist Advocacy Services supported the Council to engage with service users who reside in supported living settings. 39 providers were contacted to support with the request for feedback either via a questionnaire or an in person visit. 15 of these providers engaged in the process and a total of 34 individuals took the opportunity to share their views with the Council.

3. The 34 service users that took part represented a mix of learning disability, mental health and physical disability placements as well as a mix of models of support for example shared homes and flat schemes.

Families and Carers

4. The Council offered families and carers various options to engage which included an online questionnaire via MS Forms, a drop in event in each district of Staffordshire or to feedback by telephone call or email.

5. In total 36 families and carers engaged with the Council and they represented a mix of learning disability, mental health and physical disability placements as well as a mix of models of support for example shared homes and flat schemes.

Care and Support Providers

6. A briefing paper and questionnaire were distributed to all care and support providers where the Council currently have a placement with, and all providers signed up to the Supported Living DPS. This equates to over 200 providers. Providers were also invited to an engagement session to discuss the recommission via MS Teams.

7. At the point of writing this report, the Council have 424 placements with 65 providers. 18 (28%) of the 65 providers have placements outside the County of Staffordshire.

8. 20 providers completed the questionnaire, and an additional 6 providers attended the engagement events. Of the 26 (40%) care and support providers that engaged with us, they have a total of 186 (44%) the Council Supported Living placements.

9. The 186 placements also represented a mix of learning disability, mental health and physical disability placements as well as a mix of models of support for example shared homes and flat schemes.

Housing Providers

10. A total of 28 housing providers were approached to engage in this process. A total of 8 providers engaged via a MS Team event, email or phone call to gain their views on this process.

Local district and borough councils

11. All eight district and borough councils were invited to a MS teams meeting to discuss the recommissioning. Staff were invited from the Revenues and Benefits departments.

Internal Council Teams

12. As per the Cabinet Report presented in January 2022, SCS have engaged with the following internal teams

    a. Social Worker Teams which included children's, learning disability, mental health and physical disability teams
    b. Commercial which included procurement and contract management
    c. Brokerage
    d. Finance
    e. Legal which included contracted and adult social care legal teams
    f. ASC Pathway
    g. Information Governance

The Council also engaged with the following additional internal teams:

    h. Health (joint link with social care)
    i. Care Director
    j. Quality Assurance
    k. District Strategic Delivery Managers

l. Older People and Physical and Sensory Disability Commissioning Team

Summary of feedback received on the proposals

13. Stakeholders were supportive of the process the Council had followed in terms of the options appraisal and the results that it yielded.

14. Overall, the feedback received on the options and proposals were positive. Concerns were raised over the current Supported Living Dynamic Purchasing System (DPS) that is in place, that echoed the Council's own concerns that we have shared with stakeholders and that was documented in the initial cabinet report that was presented in January 2022.

15. Stakeholders recognised the need to change the way the Council currently works to support in resolving the current issues the Council and stakeholders are experiencing and to meet the key objectives for the future service.

16. Key feedback which has impacted on final proposals is as follows:

Key Feedback Item	Result of Feedback
a. Continued engagement with stakeholders as part of the recommissioning of supported living once final decision has been made by Cabinet. Stakeholders are keen to support the development of the proposed model and shape the service specification. Process will enhance communication and stakeholder partnership approach overall.	• For Service Users, Asist will support the Council to develop a subgroup to ensure full engagement of service users in the recommissioning process. • A subgroup will also be formed to allow families and carers to engage in the process. • A Supported Living Care and Support Provider Forum will be set up. • All 3 groups noted above will be established and first meetings to be held in October 2022. • An internal stakeholder bulletin will be developed to share with all internal SCC teams including all social work teams. • A Supported Living project group has been formed with

	key leads from internal SCC teams and social work teams to discuss current operational issues and the recommissioning. This group meets on a 6-weekly basis. • A dedicated supported living page on the SCC website will be set up to allow stakeholders to view progress on the project. To maximise the opportunity for co-design with the above groups different communication tools and methods for sharing information are being reviewed.
b. To be clear on the definition of supported living and what is included in this for example the model of care that the Council wish to be delivered and what is the Council's responsibility to pay for.	Summary definition included in Glossary. Please also refer to paragraph 6a of Scrutiny Report. This will form part of the Stakeholder engagement as stated in 16a above. SCC will engage with stakeholders over this and agree final definitions of cohorts of service users.
c. Concerns were raised over the numbers of providers suggested for all highly complex individuals and most complex and less complex individuals. It was agreed that the number of providers is too small, and consideration should be given to increase this figure. This is due to providers working in cycles and not all may have the ability to take on new placements immediately. Concerns were raised that if a smaller number of providers were block contracted that it would put pressure on the flexible framework providers	Please refer to paragraph 6a and 6b of Scrutiny Report. Numbers of providers have changed: • Previously 1-3 providers for complex individuals. This has now changed to 5. • Previously 8-12 providers for non-complex individuals. This has now changed to 15.

or there will be a need to commission a placement outside of the new arrangements. Smaller numbers of providers may lead to a lack of choice for the service user.	
d. Robust quality assessment does need to be completed up front to enable the Council to contract with providers who are skilled and experienced in working with all service users, whilst also not alienating new providers or Social Micro Enterprises (SMEs) from the market.	• Please refer to paragraph 8 of the Scrutiny report. A full robust quality assessment will be completed prior to appointment onto the new contracting arrangements, instead of at point of call off which is what currently happens now. • Pre-engagement work will be done with all providers to support them to be prepared for the release of the procurement tenders and reasonable adjustments will be made to ensure that SMEs are able to access and take part fully in the procurement exercise.
e. To be clear on cohorts of service users. To be clear on the definition of these to avoid confusion or debate.	Please refer to paragraph 6a and 6b of the Scrutiny Report.
f. Suggested that the use of Individual Service Funds is explored. This is a tri-party agreement between the service user, the Council and the care and support provider to offer flexible personalised support.	Please refer to paragraph 7 of the Scrutiny Report.
g. Contracts need to be as long as possible to allow providers the time to invest in Staffordshire. The specification will need to be	Please refer to paragraph 6c of the Scrutiny Report. SCC will ensure the final specification, once drafted and finalised will be future proofed and

future proofed and fit for purpose to last for the duration of the contract.	allowing for variations over the contract term to provide some flexibility for care providers to meet changing environments and needs as appropriate.
h. The rates proposed need to be financially viable and sustainable to allow for quality, investment and contract term length.	Please refer to paragraph 7 of the Scrutiny Report.
i. Future arrangements are to be fit for potential integration with health.	SCC will ensure that there is a clause in the final contract to allow for health partners to utilise either the block contracting arrangements and the flexible framework to secure care and support if required.
j. Will support with financial stability of care and support and housing providers to prioritise voids when contracted arrangements in place.	Please refer to paragraph 6a and 6b of the Scrutiny Report. As the proposal to is to move to block contracted arrangements, voids will be prioritised as part of this arrangement.
k. The block contracting arrangement will allow for tighter market control and to stop housing providers setting up new services without prior consent of the Council.	The new proposed arrangements will allow SCC to have more strategic conversations with housing and care and support providers around what provision is required. Better working relationships have been developed with district and borough councils as part of the engagement process and is ongoing in terms of communicating around new housing developments.
l. Need to ensure supported living housing qualifies as specialist support housing as is provided by registered providers to ensure service users can access the correct benefits and for the home to be affordable to live in.	This links into 16 k above. Several private and profit-making housing providers are setting up services which are expensive and not in line with specialist supported housing guidance. Expectations will be made clear in contracts in terms of housing providers so ensure our

	service users can access affordable accommodation which is fit for purpose and maintained to a high standard.
m. Concerns were raised around the suggestion of a Local Authority Trading Company (LATC) or inhouse model only to deliver care and support to the most complex individuals. It was felt that this could destabilise the existing market. The Council would be at high risk if for any reason the LATC / In house model happened to fail as no additional secure contracting method would be in place to support taking over care on that scale.	Please refer to paragraph 9 of the Scrutiny report.
n. In addition to the above feedback about the recommission, the Council have received invaluable feedback which will support development of details within the service specification for supported living.	All feedback will be reviewed and utilised to draft and finalise the specification and terms and conditions of the contract.
o. Constructive feedback has been received about the current Council teams and processes which will be shared accordingly with the teams involved.	Policies, processes, and guidelines will be streamlined and updated to reflect feedback received from stakeholders and shared as part of the Supported Living Project Group noted in section 16 a above.

Staffordshire County Council

Community Impact Assessment

Final Recommendations for the Future Commissioning Arrangements for Supported Living Services in Staffordshire

Sarah Taylor, Commissioning Manager

Date Friday, 23 September 2022

➢ Equality Assessment

The Public Sector Equality Duty is part of the Equality Act 2010 and this Duty requires us as a public body to have 'due regard' to eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act. It requires us to advance equality of opportunity and foster good relations between people who share a 'relevant protected characteristic' and people who don't.

Protected Characteristics	Benefits	Risks	Mitigations / Recommendations
Age - older and younger people	The new contracting arrangements will allow for all service users aged 16+ with assessed eligible needs to access care and support. This will allow sufficient time to plan for services for when a service user reaches their 18th birthday.		
Disability - people who are living with different conditions and disabilities, such as: mental illnesses, long term conditions, Autism and other neurodiverse conditions, learning disabilities, sensory impairment and physical disabilities.	The new contracting arrangements will ensure the Supported Living provider market delivers quality care, meets demand and delivers outcomes to prevent, reduce and delay needs and enable independence. SCC will develop a	Risk of complaint and challenge. Service Users who currently receive their support from a non-contracted Provider may be required to transition to a new Provider if:	Project currently in progress which is moving non contracted placements onto a contracted footing. This is anticipated to be completed by January 2023. All proposed ways of working will align with The Care Act (inclusive of Choice Policy) TUPE may be applicable in certain circumstances, thus providing the

Protected Characteristics	Benefits	Risks	Mitigations / Recommendations
	thriving care market which can prevent, reduce and delay needs, are asset focussed and promote independence. The process for making placements will be simplified and streamlined for all stakeholders involved. Service users will receive support to meet their assessed eligible care and support needs in a timely way. Service users will be able to express choice and control, as per the Care Act, when selecting their support, but not at any cost.	• Their current preferred provider wishes not to be a contracted provider. • Their current preferred Provider is not successful in joining the new arrangements and the Service User is not able to manage a Direct Payment to enable them to choose to remain with their current Provider. • They are not able to afford the required 'top up' – as per SCC Choice Policy, when exercising choice.	potential for continuity of staffing in particular circumstances. Completion of a Care Act compliant Asset Based Assessment and MCA (as appropriate) Project underway to look at the option to use Individual Service Funds (ISF) which is a tri-party agreement with the Service User, Care and Support provider, and the Local Authority. If successful, this will provide an alternative option to a contracted provider and for a Service User to take a Direct Payment. A final report for recommendation will be compiled.
Gender reassignment - those people in the process of transitioning from one sex to another	N/A	N/A	N/A
Marriage & Civil Partnership - people who are married or in a civil partnership should not be treated differently at work	N/A	N/A	N/A

Protected Characteristics	Benefits	Risks	Mitigations / Recommendations
Pregnancy & Maternity - women who are pregnant or who have recently had a baby, including breast feeding mothers	N/A	N/A	N/A
Race - people defined by their race, colour, and nationality (including citizenship) ethnic or national origins	N/A	N/A	N/A
Religion or Belief - people with any religious or philosophical belief, including a lack of belief. A belief should affect a person's life choices or the way they live for it to be considered	N/A	N/A	N/A
Sex - men or women	N/A	N/A	N/A
Sexual orientation - whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes	N/A	N/A	N/A

- **Workforce Assessment**

Who will be affected – consider the following protected characteristics: age, disability, gender reassignment, marriage & civil partnership, pregnancy & maternity, race, religion or belief, sex and sexual orientation	**Benefits**	**Risks**	**Mitigations / Recommendations**
SCC staff will only be affected if an agreement is reached to use a Local Authority Trading Company (LATC) or additional inhouse supported living services.	This will mean an increase in job opportunities.	If an LATC / additional inhouse supported living services are utilised there could be risk of complaint from providers around potential destabilisation of the market.	Project currently being undertaken to understand the benefits of an LATC or additional inhouse supported living services. Risks will be accounted for and a proposal for consideration will be drafted for final Cabinet decision.

- **Health and Care Assessment**

Key considerations	Benefits	Risks	Mitigations / Recommendations
A key priority within our Strategic Plan is to 'Encourage good health and well-being, resilience and independence'.	The new contracting arrangements will enable the Council to source care and support for our more complex clients with a range of needs in a simplified and consolidated commissioning approach to ensure the Council develops a thriving care market which can prevent, reduce and delay needs, are asset focussed and promote independence. Subject to assessed eligible needs and the personalised outcomes identified, the provision of effective Supported Living will support service users (where they are able) to meet the domains within the Care Act.	Evidence of positive outcomes achieved within existing Supported Living services shows that without the right support at the right time, an individual's overall health and wellbeing may deteriorate. Potential for market not to be able to deliver support for service users that have complex needs.	Continued engagement with key stakeholders to ensure that supported living provision meets an individual's assessed, eligible care and support needs - ensuring those needs and outcomes are identified at the point of assessment. This will be achieved through processes such as service user reviews and contract management meetings. Stimulation of the market to ensure we have providers in the County that can support service users with complex needs. As part of the new contracting arrangements, all providers will be required to demonstrate that they meet minimum quality standards prior to appointment, including Care Quality Commission registration where appropriate. Clear Quality Assurance process will be implemented as part of the new contracting arrangements to ensure that quality of care is maintained.

- **Communities Assessment**

Key consideration	Benefits	Risks	Mitigations / Recommendations
How will the proposal impact on Staffordshire's communities?	The new arrangements will provide an opportunity to encourage and work with providers in a strength based way to make more use of local community assets and services to increase independence such as through utilising community activities, volunteering opportunities which may result in reduced care support required.	Communities insufficiently resourced and/or equipped to meet any potential increase in need. Despite best efforts, via the new arrangements, to source local support opportunities, Providers may not wish to establish services in particular locations.	The recommission will work with the Public Health Supporting Communities Programme and People Helping People agenda to raise awareness and accessibility. Work with Provider marketplace and assessment and care management teams to identify and plug gaps in potential future services across Staffordshire.

- **Economic Assessment**

Key consideration	Benefits	Risks	Mitigations / Recommendations
A key priority within our Strategic Plan is to 'Support Staffordshire's economy to grow, generating more and better paid jobs'.	The new commissioning arrangements through block contracts with fewer providers will enable the Council to fill vacancies, benefit from economies of scale and establish a productive partnership with care and support providers and housing providers. It will facilitate the development of a 'core and cluster' model using staff flexibly across more than one scheme. The proposal for future pricing arrangements is for a range of weekly rates. This would allow providers to flex the care and support they offer between individuals and across schemes without the need to continually request an assessment or review This will provide the opportunity for existing	Risk of complaint and challenge from Providers (including increased risk of Provider failure) should SCC fail to set and implement sustainable rates.	Engagement will be undertaken with the marketplace with regards to a new contracting model, including the introduction of rates. Where appropriate, we will link providers to existing support schemes in terms of access to employment and support to retain employment.

Key consideration	Benefits	Risks	Mitigations / Recommendations
	Providers to potentially expand their existing provisions in Staffordshire as well as encourage new Providers to the region where applicable to do so. With fewer providers better relationships can be made and links made with supporting organisations to allow service users to become active members of society and, where appropriate, gain employment / volunteering experience in a step-down model of care.		

- **Climate Change Assessment**

Key considerations	Benefits	Risks	Mitigations / Recommendations
Our mission is to 'Make Staffordshire Sustainable', and we have made a commitment	The recommission provides an opportunity to work with care	Climate Change is not a primary responsibility	Progress and actions undertaken to reduce carbon footprints could be included in an annual report.

Key considerations	Benefits	Risks	Mitigations / Recommendations
to achieve net zero emissions by 2050 across every aspect of our service provision and estate.	providers to reduce their carbon footprint by adding a requirement in the service specification. Promote the use of public transport through support schemes such as 'travel buddies'	of the health and care directorate.	Information shared about ways to reduce carbon footprints and support schemes available.

Environment Assessment

Key considerations	Benefits	Risks	Mitigations / Recommendations
How does the proposal support the utilisation and maintenance of Staffordshire's built and natural environments, thereby improving health and wellbeing and strengthening community assets?	Under the recommission there is opportunity for providers to review how they are meeting the agreed care needs of individuals in their care in terms of access to the local community and transport options.	Providers not meeting care requirements in terms of access to the community due to transport issues.	Work with Provider marketplace and assessment and care management teams to try and identify potential future needs. Ensure providers are clear and in a position to deliver against care needs in terms of access to the community and transport.

Section 3: Submitting your CIA

Prior to submitting your Community Impact Assessment (CIA), please ensure that the below actions have been completed, to reassure yourself / SLT / Cabinet that the CIA process has been undertaken appropriately.

- The project supports the Council's Strategic Plan and Medium Term Financial Strategy
- The aims, objectives and outcomes of the project have been clearly identified and it is clear what the decision is or what decision is being requested
- For decisions going to Cabinet, the CIA findings are reflected in the Cabinet Report and potential impacts are clearly identified and mitigated for (where possible)
- The appropriate evidence has been used to inform the CIA and decision – engagement / consultation, data, research, local knowledge
- The appropriate people have been involved to provide knowledge and expertise to inform the CIA / decision
- The CIA evidences how the Council has considered its statutory duties under the Equality Act 2010 and how it has considered the impacts of any change on people with protected characteristics

Next Steps:

- When you are satisfied you have completed the above actions, the CIA needs to be approved as appropriate – depending on the size of your project, this could be your manager, project lead or SLT
- If your CIA is going to Cabinet, it should be submitted as part of the Cabinet papers
- You should also submit your CIA to amanda.dawson-blower@staffordshire.gov.uk

Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee Monday 03 October 2022

Clinical Policy Alignment (formerly Difficult Decisions)

Recommendation(s)

I recommend that:

a. The committee receives the Clinical Policy Alignment report relating to the involvement activities, options appraisal process and approved proposals from the Integrated Care Board.

b. The committee supports the implementation of the approved proposals from the Integrated Care Board and receives a report in 6 months that provides an update on the policy implementation and the development of an interim aligned assisted conception policy.

Report of Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

In January 2020, the former Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) launched the Clinical Policy Alignment (formerly known as Difficult Decisions) involvement process regarding five areas of care. These are:

i. Assisted Conception
ii. Hearing Loss in Adults
iii. Male and Female Sterilisation
iv. Breast Augmentation and Reconstruction
v. Removal of excess skin following significant weight loss

It was recognised public, patient, and stakeholder involvement was required to shape proposals that will inform the future commissioning policy therefore significant involvement has taken place when reviewing this intervention.

This has included public surveys and face to face events prior to the COVID-19 pandemic for interested parties to share their views.

During the options appraisal process the former CCGs held several technical events to develop and review the proposals and two virtual public events to review and score the proposals.

This report provides assurance on the process undertaken when developing the recommended proposals which has included both clinical and public facing involvement throughout the entire process.

The Overview and Scrutiny Committee is asked to receive the update regarding this area of work and support the implementation of the proposals approved by the ICB.

Report

1. Background

1.1. Introducing excluded or restricted criteria for any intervention are difficult decisions to make, which is why the Integrated Care Board (ICB) has a clinically led prioritisation process.

1.2. Inevitably, as some interventions/services score below the threshold for investment, difficult decisions have to be made; however, using a clinically led prioritisation process based on review of available scientific evidence of effectiveness ensures that where interventions are excluded from commissioning or where appropriate, restrictive criteria are used to ensure that these interventions are reserved for those most likely to benefit.

1.3. The ICB has a process for prioritising the use of the resources available to commission healthcare across Staffordshire and Stoke-on-Trent. This is set out in the Policy on the Prioritisation of Healthcare Resources[1].

1.4. The ICB has a group known as the Clinical Priorities Advisory Group (CPAG), which is a subcommittee of the Finance and Performance Committee. The membership consists of Clinicians, Medicines

[1] The Policy on the Prioritisation of Healthcare Resources can be found on the IBC webpage Contents (icb.nhs.uk)

Optimisations Representatives and Consultant(s) in Public Health (the full terms of reference can be found in the Policy on the Prioritisation of Healthcare Resources). The group considers interventions and services which are referred from the commissioning team. This may be because there is a recognised unmet need and the ICB wishes to identify the best interventions to invest in or, as is the reason in this case, because there is a view that services need to be reviewed.

1.5. CPAG undertakes the ranking of healthcare interventions using a scoring system of criteria based on the Portsmouth Scorecard. Interventions are scored by the group against eight criteria that include:

i. Strength and quality of evidence - how well does this treatment or service work?
ii. Magnitude of health improvement benefit for the patient group or population - to what extent does this intervention increase the health gain or life expectancy for the patients/population? Appraise outcome measures e.g. improvement in functionality or of clinical markers for the condition, Quality of Life (QoL), increase in health expectancy
iii. Does the intervention prevent a condition or detect a condition which is not yet known (i.e. screening)?
iv. Supporting people with existing conditions - Does this intervention prevent or reduce complications in people with ongoing conditions?
v. How cost effective is the intervention – how much health gain compared to the cost?
vi. Does it address health inequalities?
vii. Does it deliver national and/or local requirements/targets?

1.6. CPAG does not make decisions on whether a service should or should not be commissioned. The group makes recommendations which are reviewed by the commissioning teams and taken to the ICB Board meeting for discussion and approval.

1.7. As the policy explains there is a threshold score, and interventions scoring below the threshold will not be considered by the ICB for

new investment and where already commissioned, current eligibility criteria will be subject to review.

1.8. This is particularly important given the ICB's challenged financial position and the need to balance the services that are commissioned against their statutory responsibilities to ensure that they operate within their defined budgets and achieve financial balance.

1.9. In 2018, the former six Staffordshire and Stoke-on-Trent CCGs reviewed eligibility criteria for a range of interventions/procedures with the overarching aim of aligning criteria where there were differences across the CCGs and to review any outstanding recommendations from the CCGs' CPAG. A timeline of key dates is provided in Table 1 below.

1.9.1. Table 1: Timeline of key dates

Milestone	**Date**
Six separate CCGs came together under a single management structure. We began to review policies and procedures.	July 2018
Differences in policies for procedures discovered that meant patients received different levels of access depending on where they lived ('postcode lottery').	July - December 2018
Development of case for change – including possible solutions for making policies the same across Staffordshire and Stoke-on-Trent in five clinical areas.	March 2019
Paper presented to Health and Care Overview and Scrutiny Committee outlining the planned activities within this area of work.	March 2019
Patient and public involvement about views or experiences of the five procedures. This feedback was used when developing our proposals.	January - March 2020
Briefing shared with Leek Health Overview and Scrutiny Panel outlining the planned activities within this area of work.	February 2020
Programme paused due to COVID-19 pandemic.	March 2020

Paper presented to Health and Care Overview and Scrutiny Committee specific to North Staffordshire Hearing Aid policy.	September 2020
Involvement findings from start of 2020 published.	November 2020
Stakeholder briefing shared with Health and Care Overview and Scrutiny Committee regarding changes to the eligibility criteria for moderate hearing loss within the North Staffordshire Hearing Aid policy.	February 2021
Paper presented to Health and Care Overview and Scrutiny Committee to provide an update on the involvement process.	September 2021
Involvement conversation restarted – to sense check if anything had changed due to the impact of COVID-19. Patients, public and other stakeholders were surveyed.	September 2021
Two internal technical events with clinicians, which produced a revised number of proposals.	October - December 2021
Further involvement events to confirm the desirable criteria ('impact on overall health and wellbeing' and 'clinical benefit') and their weighting; and to score proposals against desirable criteria.	March 2022
Third technical event to review the outcomes of the involvement phase. This was used to move to a final set of proposals.	May 2022
Equality Impact Assessments (EIAs) and Quality Impact Assessments) QIAs finalised for each proposal to inform governance process.	May 2022 – July 2022
Present recommendations to Finance and Performance meeting (6 September).	September 2022
Present recommendations to Quality and Safety Committee (14 September).	September 2022
Present recommendations to ICB Board meeting (22 September).	September 2022
Present recommendations to Health and Overview and Scrutiny Committees (Staffordshire and Stoke-on-Trent).	October 2022

2. Summary of the process

2.1. The Commissioning teams have previously reviewed policies and procedures to identify differences in eligibility criteria and ensure any eligibility criteria is in line with recommendations from the former CCGs' Clinical Priorities Advisory Group).

2.2. The differences were collated and reviewed on a line by-line basis with clinical leads. A large proportion of amendments were not expected to have a material impact on patient access, referral processes or treatment pathways therefore these were approved in line with the former CCGs' governance process and implemented either within the Excluded and Restricted Procedures policy or within separate commissioning policies.

2.3. For the areas identified within this work programme, the former CCGs noted that further work was required to understand any potential impact on patients prior to aligning these policies and therefore it was agreed that public, patient, and stakeholder involvement would be undertaken to shape proposals that will inform the future commissioning policy in line with the Integrated Care Board's Duty to Involve[2].

[2] The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services and influence ICB decisions at the level of participation they choose.

The public sector Equality Duty (2011) means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It also requires that public bodies have due regard to the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between different people when carrying out their activities

2.4. In January 2020 the former Staffordshire and Stoke-on-Trent CCGs began the involvement and options appraisal process for this programme of work. An overview of the phases is detailed below:

2.4.1. *Phase 1* - Winter 2019/2020 Listening exercise

2.4.2. *Phase 2a* - Autumn 2021 Public involvement refresh/sense check

2.4.3. *Phase 2b* - Winter 2021 Development of proposals

2.4.4. *Phase 2c* - Winter 2021/Spring 2022 Options appraisal

2.4.5. *Phase 3* - Summer 2022 Governance process

2.5. Phase 1 - This took place between January and March 2020, the objective was to understand service users and patient views and experiences of the interventions under consideration.

2.5.1. The feedback came back via survey and at seven deliberative events that were held in the localities. These were structured as an interactive event - *'be a commissioner'* workshops. These allowed the former CCGs to understand how patients felt services should be prioritised.

2.5.2. Two additional events were held at the request of organisations representing people who were suffering from hearing loss. The feedback from these events was considered when developing the proposals.

2.5.3. The report of findings can be found here Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

2.5.4. Plans for further involvement were placed on hold when all local health services focused on managing the COVID-19 pandemic. Notification was sent to all stakeholders explaining the rationale for pausing the involvement.

2.6. Phase 2a - COVID-19 meant the NHS had to adapt and support new ways of working. Sense check involvement was undertaken with patients, stakeholders and the public in Autumn 2021 to understand any new experiences and considerations.

2.6.1. A survey was shared to understand if any new feedback needed to be considered since the pandemic. Feedback was gathered via online surveys; emails were sent to participants and community groups were contacted via social media and phone calls to encourage uptake. A phone number was provided

to enable people to respond to the survey if they did not have access to the internet.

2.6.2. The feedback was included with the feedback from the listening exercise to develop the proposals.

2.6.3. The report of findings can be found here Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

2.7. Phase 2b – Autumn 2021 to Winter 2022 – Involvement to develop potential solutions for each of the clinical areas. Clinicians, Quality Leads and Locality Leads were involved with developing and evaluating the potential solutions. This included reviewing the clinical evidence base, taking the involvement feedback into consideration and oversight of finance and activity/demand.

2.7.1. On 19 October 2021, the former CCGs convened a technical event, with clinicians, quality leads, project managers and the executive leads to develop and critique each of the proposals.

2.7.2. A second technical event was held on 14 December 2021 to confirm the proposals for each of the interventions.

2.8. Phase 2c - Spring 2022 – Involvement to evaluate the potential solutions for each of the clinical areas.

2.8.1. Interested stakeholders, patients and members of the public were invited to an interactive workshop to inform the desirable criteria and weighting that should be applied against each proposal.

2.8.2. During a second workshop the public, patients and wider stakeholders worked together to evaluate each of the proposals against the desirable criteria through a scoring process.

2.8.3. The report of findings can be found here Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

2.9. Phase 3 – Spring 2022 – Receive the report of findings from the workshops and determine any further involvement that is required.

2.9.1. A third technical event was held on 17 May 2022 to share the feedback from the workshops (phase 2c) and provide an update on any quality and equality impacts identified.

2.9.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

2.9.3. Following discussion at the technical group, a number of unviable proposals were removed from the shortlist which resulted in proposal per clinical area. These are summarised in section 3.

2.10. We have worked closely with the Consultation Institute, as experts in consultation and involvement activity, throughout this process to ensure a robust and transparent process.

2.11. Both quality and equality impact assessments have been completed for each of the proposals. These recognised the positive impact of aligning criteria across the country. Where any negative impact was noted, adequate mitigations were identified and all assessments were approved. Further detail on the individual impact assessments can be found in Appendices A-E.

2.12. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

3. Summary of approved proposals

3.1. The proposals for each of the interventions were refined through the technical events and options appraisal process. One proposal for each clinical intervention was presented the ICB Board meeting and approved.

3.2. Table 2 outlines the proposals and the impact on each of the geographical areas across Staffordshire and Stoke-on-Trent.

3.2.1. Table 2: Proposals for the interventions

Procedure / Proposal	Impact
Hearing loss in adults: *To commission hearing aids with no eligibility criteria.*	• Removal of current restrictions for mild hearing loss in North Staffordshire. • 343 (estimated) additional hearing aid fittings in North

	Staffordshire. No change in other areas.
Removal of excess skin following significant weight loss: *Abdominoplasty (tummy tucks)/ apronectomy (excess skin removal in lower abdomen) and body contouring (removing excess fat and skin) will not be commissioned.*	• A reduced offer for Stoke-on-Trent, South East Staffordshire and Seisdon Peninsular, Cannock Chase, Stafford and Surrounds, and East Staffordshire geographical areas where abdominoplasty/apronectomy is currently commissioned against criteria • A reduced offer within Stoke-on-Trent where body contouring is currently commissioned against criteria. Based on 2018/19 data the following numbers of patients could be impacted; -3 East Staffordshire, -2 South East Staffordshire and Seisdon Peninsular, -3 Stafford and Surrounds, -5 Stoke-on-Trent
Breast augmentation (enlargement) and reconstruction: *Will be routinely funded following mastectomies (breast removal) carried out due to suspected or proven cancer OR following double mastectomies for cancer prevention in high-risk cases.*	• An improvement on the policy within South East Staffordshire and Seisdon Peninsular, Cannock Chase, Stafford and Surrounds, and East Staffordshire where post-mastectomy reconstruction is only offered in the affected breast. • A reduced offer within North Staffordshire and Stoke-on-Trent where reconstruction due to burns is currently offered as well as for post-mastectomy. A reduced offer in Stoke-on-Trent where breast augmentation for

	developmental failure and significant asymmetry is currently commissioned against criteria. Reduction of approximately 14 non-cancer breast augmentations per annum in Stoke-on-Trent.
Male and female sterilisation: *Female sterilisation will be routinely funded for contraception when unable to tolerate other contraceptives OR absolute clinical contraindication (not suitable) to pregnancy.* *No amendment to male sterilisation is proposed.*	• Equal impact across Staffordshire and Stoke-on-Trent as currently no criteria in place. Potential reduction in activity. • **Note:** Vasectomies (male sterilisation) in an acute (hospital) setting will not be undertaken unless there is a clear clinical indication. Potential small decrease in surgical sterilisations (female) however this cannot be quantified based on available data
Assisted conception: *Develop an interim aligned policy*	• Following the publication of the national Women's Health Strategy on 20 July 2022, an aligned commissioning policy will be developed whilst the ICB awaits further guidance. Impact on activity unknown at this stage.

3.3. Further detail on each of the clinical areas is provided below in Appendices A-E.

4. Activity Implications

4.1. A review of previous activity was undertaken to understand the implications of the proposals.

4.2. Table 3 below provides an outline of the potential impact on activity within an acute (hospital) setting.

4.2.1.Table 3: Acute activity implications

	17/18 activity	18/19 activity	19/20 activity
Abdominoplasty	-8	-9	-13
Body Contouring	0	-4	0
Breast Augmentation and Reconstruction	-11	-11	-20

4.3. The above table outlines the reductions in activity within the ICB as a result of the approved proposals in these areas.

4.4. Table 4 below provides an outline of the impact on activity for the hearing loss in adults proposal.

4.4.1.Table 4: activity implications – hearing loss in adults

	Feb 2021 – Jan 2022 activity
Hearing Loss	343

4.5. The impact identified for hearing loss is based on the number of patients who did not qualify for hearing aids following assessment during the period February 2021 - January 2022 within North Staffordshire (data received through provider reports).

4.6. No impact is identified within Stoke-on-Trent, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds as these areas currently commission hearing aids in line with the approved proposal.

4.7. Table 5 below provides an outline of female sterilisations that are undertaken for contraceptive purposes.

4.7.1.Table 5: Female sterilisations activity

	17/18 Activity	18/19 Activity	19/20 Activity
Female Sterilisations: Acute	119	159	122

4.8. The introduction of eligibility criteria for female sterilisations may reduce activity however the level of reduction cannot be quantified from the data that is available.

4.9. Due to the publication of the Women's Health Strategy and the potential for further guidance on assisted conception services, an interim aligned commissioning policy within this area will be developed in this area. As a result, the activity implications are currently unknown within this area but will be taken through the ICBs governance process once the policy is developed.

5. Governance

5.1. An update on the work completed to date with the recommended proposals was presented to the ICB's Finance and Performance Committee on 6 September 2022. The committee was assured that a robust process had been followed through the work programme and approved the recommendations within the paper.

5.2. An update on the work completed to date with the recommended proposals presented to the ICB's System Quality and Safety Committee on 14 September 2022. The committee was assured that a robust process had been followed through the work programme and approved the recommendations within the paper.

5.3. An update on the work completed to date with the recommended proposals was presented to the Integrated Care Board Meeting in public on 22 September 2022. The Board was assured that a robust process had been followed through the work programme and approved the recommended proposals for implementation.

6. Implementation

6.1. There is some variation in the implementation of the proposals for each clinical area due to the differences in contractual arrangements. These are outlined in Table 6 below:

6.1.1. Table 6: Implementation by clinical area

Clinical Area	Implementation Plan
Assisted Conception	Develop an interim aligned commissioning policy. Timelines specific to this area is included in Appendix A, Table A3

Hearing Loss in Adults	Removal of North Staffordshire hearing aid policy. Implementation following one month notice to providers.
Male and Female sterilisation	Eligibility criteria to be included within the ICB Excluded and Restricted Procedures Policy. Implementation following one month notice to providers.
Breast augmentation and Reconstruction	Eligibility criteria to be included within the ICB Excluded and Restricted Procedures Policy. Implementation following one month notice to providers.
Removal of excess skin following significant weight loss	Eligibility criteria to be included within the ICB Excluded and Restricted Procedures Policy. Implementation following one month notice to providers.

6.2. The ICB recognises that there may be patients on a waiting list who meet the current eligibility criteria that is in place. The ICB will honour treatment for patients who have been added to a waiting list prior to the implementation of revised eligibility criteria.

6.3. Changes to policy will be clearly communicated to providers of services at all tiers of care (e.g. Primary, Community, Acute).

6.4. Updated policies will be uploaded to the ICB webpage, accessible to all, following implementation.

6.5. Patient advice on eligibility criteria can be accessed via the ICB's Patient Advice and Liaison Service.

Link to Strategic Plan

On 1 July 2022, Integrated Care Boards (ICBs) replaced clinical commissioning groups (CCGs), becoming the statutory organisations that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the Integrated Care System (ICS).

Working with partners in Staffordshire and Stoke-on-Trent, the ICS has agreed on an ambitious vision which is 'working with you to make Staffordshire and Stoke-on-Trent the healthiest place to live and work.' Their purpose is as follows:

• If you live in Staffordshire or Stoke-on-Trent, your children will have the best possible start in life and will start school ready to learn
• Through local services, we will help you to live independently and stay well for longer Page 12
• When you need help, you will receive joined-up, timely and accessible care, which will be the best that we can provide.

Link to Other Overview and Scrutiny Activity

Since 2018, the ICB has attended committee meetings to update on progress against the transformation programme. Today's meeting is a continuation of this ongoing conversation.

Previous updates were under the programme name of Difficult Decisions, however within the ICB this work is now known as Clinical Policy Alignment. A list of key dates when updates were shared with the committee is provided below:

Paper presented to Health and Care Overview and Scrutiny Committee - 19 March 2019.

Briefing shared with Leek Health Overview and Scrutiny Panel – February 2020.

Paper presented to Health and Care Overview and Scrutiny Committee 14 September 2020 (specific to North Staffordshire Hearing Aid policy)

Stakeholder briefing shared with Health and Care Overview and Scrutiny Committee – February 2021 (specific to North Staffordshire Hearing Aid policy)

Paper presented to Health and Care Overview and Scrutiny Committee 20 September 2021

Community Impact

A quality impact assessment (QIA) has been completed for each of the recommended and approved proposals. Overall, the panel recognised the positive impact of aligning criteria and eliminating variation across the

county. The panel noted the potential mental health impact on some patients if they are no longer able to access certain procedures. Risk scores were increased to to reflect the comments from the panel regarding the mental health impact, adequate mitigations were identified, and all assessments were approved by the QIA panel on 29 June 2022. Further detail on the individual impact assessments can be found in Appendices A-E.

An equality impact assessment (EIA) was completed for each of the recommended and approved proposals. The assessments recognised the positive impact of aligning criteria across the county. Where any negative impact was noted, adequate mitigations were identified and all assessments were approved. Further detail on the individual impact assessments can be found in Appendices A-E

No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments for the recommended and approved proposals.

List of Background Documents/Appendices:

Appendix A: Assisted Conception
Appendix B: Hearing Loss in Adults
Appendix C: Male and Female Sterilisation
Appendix D: Breast Augmentation and Reconstruction
Appendix E: Removal of excess skin following significant weight loss

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Appendix A: Assisted Conception

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to elective treatments/procedures depending on where they live. Table A1 below provides a high-level summary of the differences in policy.

1.1.1. Table A1: Differences in assisted conception services eligibility criteria

	North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Number of cycles	1 cycle consisting of 1 fresh embryo transfer only	1 Cycle and 1 fresh OR frozen embryo transfer	2 Cycles to include one fresh transfer and up to 3 frozen transfers per cycle
Age	Women aged 23-35 Male under 55	Women aged 23-39 No upper age limit for men	Women aged 23-39 No upper age limit for men
IUI	IUI Commissioned	IUI Not commissioned	IUI Not Commissioned
Investigations	Investigations not commissioned if patients do not meet eligibility criteria for IVF	No restrictions on investigations	No restrictions on investigations

Minimum ovarian reserve	No Criteria	It is proposed that a threshold of AMH >3 will be applied to all women 35 years or over for access to IVF treatment.	No Criteria
Donor Eggs	Not funded	Donor eggs commissioned if Premature ovarian failure, Gonadal dysgenesis including Turner syndrome, Bilateral oophorecto my, Ovarian failure following chemotherapy or radiotherapy	Not funded

1.2. Assisted conception was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

1.3. While the number of patients accessing assisted conception services is relatively low, we know that infertility is an area of considerable concern to the people affected. Table A2 below provides previous years activity.

1.3.1. Table A2: Assisted conception activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Activity (cycles)	216	169
Total cost	£875,952	£710,162

1.4. Assisted conception services are provided by specialist fertility providers with set fees per cycles which may include ovulation stimulation, egg retrieval, fertilisation and embryo transfer dependent on the individuals' clinical requirements.

1.5. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. Respondents raised concerns about the lack of access to treatment and the cost of self-funding.

2.2. The negative impact of infertility and unsuccessful treatment on patients' mental health, wellbeing and relationships were also highlighted.

2.3. Respondents tended to be in support of funding this service, but there were also suggestions to restrict the number of cycles (e.g. two or three) and who is eligible (e.g. prioritise those without children).

2.4. The Royal British Legion highlighted that Armed Forces couples' entitlement to three rounds of IVF should not be diminished.

3. Women's Health Strategy

3.1. Whilst developing the proposals for assisted conception services, the Women's Health Strategy was published which has indicated that a review of fertility provision across the UK will be undertaken

3.2. The strategy does not give an indication of whether ICBs will be expected to implement mandated access criteria however it is clear that the intention is to review geographic variation, address inequities of provision and remove any non-clinical criteria that is currently in place (for example, that people must not have children from previous relationships)

3.3. The strategy does not provide an estimated timeline for any policy mandates however a review of current NICE guidance has been initiated with expected publication in 2024.

3.4. In light of the publication of the strategy, a meeting was convened to consider the impact of this on the proposals for assisted

conception and whether this should be separated from the wider clinical policy alignment programme whilst awaiting further guidance.

3.5. The meeting was chaired by the Chief Medical Officer and included the following attendees:
3.5.1. ICB Clinical Lead Partnerships and Engagement
3.5.2. ICB Medical Director
3.5.3. Head of Transformation
3.5.4. Director of Communications and Corporate Services
3.5.5. Director of Corporate Governance
3.5.6. Senior IFR/Improvement Lead
3.5.7. IFR/Commissioning Support Manager

3.6. The meeting agreed that the ICB could not continue with proposals to reduce to zero cycles of IVF at this time and assisted conception should be separated from the wider clinical policy alignment programme.

3.7. The meeting highlighted that assisted conception policies are currently not aligned and this would need to be addressed to ensure there is a single policy across the ICB whilst waiting for further guidance.

3.8. The meeting recognised that, due to the differences in current policies, an aligned policy would inevitably result in levelling down in some areas of provision and a levelling up in other areas of provision.

4. Approved Proposal

4.1. Separate assisted conception from the wider clinical policy alignment programme and pause further work on proposals until further guidance is released.

4.2. Instruct the Chief Medical Officer to ensure that an interim aligned assisted conception policy is developed for implementation whilst the ICB awaits further directives following the national review of service provision.

4.3. Table A3 below outlines the process that will be undertaken to develop and interim aligned policy with indicative timescales.

4.3.1. Table A3: Assisted Conception policy alignment

Activity	Date
Clinical and technical working group(s) to review policy differences and recommend aligned criteria	September – October 2022
Draft aligned policy	October – November 2022
Complete quality and equality impact assessments	December 2022 – January 2023
Present aligned policy to F&P for approval	February 2023
Present aligned policy to ICB Board meeting for approval	February 2023
Present policy to Staffordshire and Stok-on-Trent HOSCs	March 2023
1 month notice of policy change to providers	April 2023
Policy implementation (if further public involvement is not required)	May 2023

4.4. To note, these are indicative timelines that may change if further public involvement is required.

Appendix B: Hearing Loss in Adults

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to this intervention depending on where they live. Table B1 below outlines the policy differences.

1.1.1. Table B1: Difference in hearing aid eligibility criteria.

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent
Not routinely funded for patients diagnosed with 'mild' hearing loss, unless the patient: • is aged under 18 or has had hearing loss since childhood • has a confirmed diagnosis of dementia, a learning disability, an auditory processing disorder or a severe multiple sensory disability • has tinnitus • has sudden onset hearing loss • has multiple severe physical disabilities.	Commissioned for all patients with a hearing loss greater than 25 decibels (diagnosed through an audiogram or by an audiologist).

1.2. Hearing aids for mild hearing loss was reviewed by the former CCGs CPAG. This did not score below the threshold but in line with current commissioning margins in the policy, the recommendation was to commission with criteria. This means that if the ICB did not

currently commission this, the implementation would include clinical eligibility criteria.

1.3. We know people have different communication needs and that their hearing loss may not affect them in the same way as it affects someone else

1.4. The NICE guidance is clear – communication difficulties should not be judged by measuring only hearing thresholds (such as an audiogram)

1.5. Around 1 in 6 adults in England have some form of hearing loss, and as the number of older people increases, demand for hearing aids is expected to rise. Table B2 below shows previous years activity.

1.5.1. Table B2: Hearing aid activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Activity (hearing aid fittings)	13,502	12,400
Total cost	£3,412,847	£3,621,722

1.6. Hearing aids services are provided by community and acute providers through any qualified provider contracts with set tariffs which may include initial assessment, fitting, six-week review, aftercare and annual review.

1.7. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. The key themes raised tended to be in support of funding hearing aids for all patients.

2.2. Respondents noted the importance of hearing aids in improving hearing, patients' social life, wellbeing and quality of life including

the potential of untreated hearing loss resulting in adverse patient outcomes.

2.3. The need to improve follow-up care, such as access to batteries and checking patients are using their aids, was also highlighted.

2.4. Respondents also raised concerns over the lack of access to hearing aids.

3. Recommendations from the technical group

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to commission this intervention with eligibility criteria.

3.4. The group stated that assessing the benefit of hearing aids in individuals is difficult to predict via a functional impact assessment in order to determine eligibility and the most effective way to assess benefit is once hearing aids are fitted and patients are supported to use them.

3.5. In addition, the group noted that the recommended functional impact assessment (HHIE-s) is a subjective tool that may be applied inconsistently and create inequalities amongst those who may benefit from hearing aids.

3.6. Whilst the group recognised the recommendation from CPAG to implement eligibility criteria, the consensus of the group was that the points noted above were sufficient to remove the proposal to commission in line with the CPAG recommendation and allow assessment of benefit to be undertaken during patients 6-week review following initial assessment and fitting of hearing aid(s)

3.7. The recommended proposal from the technical group was to commission hearing aids with no eligibility criteria and remove the current restrictions within North Staffordshire.

4. Impact assessments

4.1. A quality impact assessment (QIA) has been completed for the recommended and approved proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.

4.2. An Equality impact assessment has been completed for recommended and approved proposal which was approved on 20 July 2022.

4.3. Both assessments noted that the proposal improves access for patients with mild hearing loss within North Staffordshire. The proposal would also remove current inequities in access and improve patient experience.

4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix C: Male and Female Sterilisation

1. Rationale for review

1.1. There are no restrictions currently in place for these procedures other than the requirement to only undertake male sterilisations (vasectomies) within an acute setting if there is a clear clinical indication for doing so.

1.2. Male and Female sterilisation for contraceptive purposes was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

1.3. There are various forms of contraceptive available to patients, both surgical and non-surgical methods and it is estimated that in the UK 75% of women aged 16-49 use some form of contraceptive. Table C1 below provides previous years activity for sterilisation procedures.

1.3.1. Table C1: Male and Female sterilisation activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Female Sterilisation activity	370	354
Total Cost	£608,031	£693,433
Male sterilisation activity	1360	1309
Total cost	£294,976	£330,433

1.4. Female sterilisations are elective inpatient procedures undertaken by acute providers within block contracts. A small number of male sterilisations are undertaken in an acute setting but only where there is a clinical indication that means these cannot be undertaken within a community setting.

1.5. Male sterilisations are predominantly undertaken within a primary care or community setting with specialist clinicians through a service level agreement.

1.6. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. Respondents commented that these procedures should be available to anyone who wishes to be sterilised.

2.2. Respondents noted that not offering these procedures may have a financial impact on the NHS in the long-term e.g. maternity care and terminations.

2.3. Respondents also stated that there may be potential adverse impact of pregnancy on patients and this needs to be taken into consideration.

3. Recommendations from the technical group

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to not commission these procedures for contraceptive purposes. As previously noted, sterilisations undertaken for medical purposes such as ectopic pregnancy were not within scope of discussions as this was outside of the CPAG review.

3.4. Under this proposal, patients are likely to access long-acting reversible contraceptives as an alternative. This will convert one off procedures into a requirement for ongoing and long-term GP appointments. This equates to an additional 5,661 appointments within year one and as the case load grows there is a potential for up to 34,846 appointments by year 5 resulting in a significant impact on Primary Care workforce and capacity.

3.5. It was also noted that as this removes a significant proportion of community vasectomy activity, providers may not be able to maintain their competency standards and this could lead to the cessation of these services.

3.6. In addition to the workforce impact the group also noted this proposal may create an inequity of choice for males who do not have an alternative choice of long-term contraception.

3.7. The group also discussed the proposal to introduce eligibility criteria for male and female sterilisations where patients may access these interventions if the female has an absolute contraindication to pregnancy or cannot tolerate other forms of long-acting reversible contraception.

3.8. The group recognised that whilst this proposal reduced the workforce impact when compared to the previous proposal, there may still be a large cohort of patients transferring to long-acting reversible contraceptives that impacts primary care capacity and potentially destabilises community-based vasectomy services.

3.9. The group also stated that this does not address the inequity impact and may create further inequities due to the proposal requiring patients to be in a relationship in order to access this intervention (i.e. vasectomies would only be undertaken if the patient's partner cannot tolerate alternative long-acting reversible contraceptives or has an absolute contraindication to pregnancy.)

3.10. Whilst the group recognised the recommendation from CPAG to implement eligibility criteria, the consensus of the group was that the points noted above were sufficient to remove previous proposals from the shortlist and an alternative proposal was discussed.

3.11. The recommended proposal from the technical group was to apply eligibility criteria to female sterilisations only. This ensures females can access sterilisation where there is no viable alternative whilst ensuring patients are fully counselled on their alternatives prior to undergoing invasive surgery. This also minimises the workforce impact and ensures equity of choice for males.

4. Impact assessments

4.1. A quality impact assessment (QIA) has been completed for the recommended and approved proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.

4.2. An Equality impact assessment has been completed for the recommended and approved proposal which was approved on 20 July 2022.

4.3. Both assessments noted the significant reduction in workforce and equity impact within this proposal. It was recognised that this proposal ensures invasive female sterilisations are only undertaken following full exploration of alternative methods of contraception and consideration of the risks associated with invasive surgery.

4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix D: Breast augmentation and Reconstruction

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to this intervention depending on where they live. Table D1 below outlines the policy differences.

1.1.1. Table D1: Difference in eligibility criteria for breast augmentation and reconstruction.

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Commissioned following mastectomy, post burns or asymmetry following prophylactic bilateral mastectomy for cancer prevention in high-risk cases.	Not routinely commissioned for small breasts, congenital absence of breast or breast asymmetry. This procedure will ONLY be routinely commissioned in the following circumstances: - As reconstructive surgery following mastectomy for either suspected or proven malignancy *Treatment of the unaffected breast following cancer surgery shall not be routinely commissioned	Will be routinely funded under the following circumstances: - Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry (congenital amastia) OR - Significant degree of asymmetry of breast shape and/or volume at least a difference of 2 cup sizes as a result of: Previous mastectomy or excision breast

		surgery for cancer/lumpectomy or following prophylactic bilateral mastectomy for cancer prevention in high risk cases OR Trauma to the breast – post burns. Breast asymmetry, endocrine abnormalities, developmental asymmetry The following criteria must be met for surgery to be routinely funded: - Patient must have a BMI within the range of 18kg/m2 to 25kg/m2 AND - Minimum age for surgery is 18 of age and evidence that pubertal growth of breasts has ceased

1.2. Breast Reconstruction and Augmentation for cancer and non-cancer indications was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB

did not currently commission this, it would not be recommended for investment.

1.3. Although the number of people affected by a potential change in policy is relatively low, we know that this is an area of considerable concern to those people who are affected by it.

1.4. Breast cancer is diagnosed in approximately 55,000 patients in the UK every year. The incidence of breast cancer in western Europe is 89.7 per 100,000 women. Table D2 below provides previous years activity

1.4.1. Table D2: Breast reconstruction and augmentation activity across Staffordshire and Stoke-on-Trent

	2017/18	2018/19	2019/20
Activity	171	173	158
Total cost	£518,734	£540,674	£516,020

1.5. Within Stoke-on-Trent it is estimated that on average across the 3 years, 14 of the 30 procedures undertaken were for non- cancer indications.

1.6. Breast Augmentations and Reconstructions are elective inpatient procedures undertaken by acute providers within block contracts.

1.7. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. Service users highlighted the impact of the procedure on reducing discomfort and improving quality of life.

2.2. Key themes raised were that reconstructive surgery should be available for breast cancer or breast surgery patients. However, respondents were clear that the procedure should not be funded for cosmetic reasons.

2.3. The impact of this procedure on patient wellbeing, quality of life and relationships was also highlighted.

3. Recommendations from the technical group

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to not routinely commission this intervention for any indication.

3.4. The group stated that this would have a significant impact on cancer patients as this proposal removes access to all post mastectomy breast reconstructions and could be seen as a disruption to the cancer pathway.

3.5. The group also stated that removing post cancer breast reconstructions would create inequity as other post cancer prosthetics are commissioned e.g. testicular prosthesis.

3.6. Non cancer indications for breast augmentation such as congenital absence of breast and significant asymmetry was discussed as these procedures are currently offered within Stoke-on-Trent.

3.7. Whilst the group recognised the potential mental health impact for those affected if this access is removed, it was noted that Stoke-on-Trent is currently an outlier with this criterion and no adverse impacts have been noted within the other geographical areas who currently do not offer breast reconstruction and augmentation for non-cancer indications.

3.8. Within North Staffordshire and Stoke-on-Trent breast reconstruction is offered post burns but not for other types of trauma. The group agreed that it was inequitable to offer treatment for one type of trauma and not others but there was insufficient evidence to consider expanding the criteria to all types of traumas. The group

did however note that in the case of significant trauma, this would be addressed within an emergency setting immediately following the trauma. The group also noted that no adverse impacts have been identified within the south of the country where this procedure is not offered post-burns.

3.9. Whilst the group recognised the recommendation from CPAG to not commission the procedures for any indication the consensus of the group was that the points noted above were sufficient to commission the intervention for cancer related indications but remove proposals relating to non-cancer indications.

3.10. The recommended proposal from the technical group was to commission breast reconstruction/augmentation following mastectomy following mastectomies carried out due to suspected or proven cancer OR following double mastectomies for cancer prevention in high-risk cases

4. Impact assessments

4.1. A quality impact assessment (QIA) has been completed for the recommended and approved proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.

4.2. An Equality impact assessment has been completed for recommended and approved proposal which was approved on 20 July 2022.

4.3. Both assessments noted the potential mental health impact on patients who were not able to access this procedure however it was recognised that there are mental health services in place to support these patients. Emphasis was placed on the importance of good communication when amending policy to confirm what is commissioned and ensure patient expectations are not raised during their clinical pathway. It was also noted signposting to relevant support services is essential where adverse impacts on mental health are identified.

4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix E: Removal of excess skin following significant weight loss

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to these procedures depending on where they live. Tables E1 and E2 below outlines the policy differences.

1.1.1. Table E1: Difference in eligibility criteria for abdominoplasty/apronectomy procedures

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Not routinely commissioned	This procedure will ONLY be routinely commissioned in the following circumstances: - Weight loss of at least 10 points on BMI AND - An abdominoplasty /apronectomy has not already been performed AND - Presence of a large abdominal fold hanging below the level of the mons pubis AND - Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring	Will be considered providing that ALL of the following criteria are met: - Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment for a minimum period of one year or disability resulting in severe restrictions in activities of daily living AND - The patients BMI before weight loss must have been no

	repeated courses of treatment with anti-fungal and other topical skin products for a minimum period of one year or disability resulting in severe restrictions in activities of daily living AND - The patients current BMI must be between 18kg/m2 and 25kg/m2 AND - The patients weight must have been stable and within this range for a minimum of 1 year as measured and formally recorded by an NHS service OR - If this weight range is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and significant functional disturbance is also evident and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.	less than 40kg/m2 AND - The patients current BMI must be between 18kg/m2 and 25kg/m2 and has been within this range for a minimum of 1 year as measured and recorded by the NHS. If this is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin. AND - The patient's weight must have been stable and within this range for a minimum of 1 year as measured and recorded by the NHS AND - An abdominoplasty/ apronectomy has not already been performed

1.1.2. Table E2: Difference in eligibility criteria for body contouring procedures

North Staffordshire, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Not routine commissioned	Will be commissioned where the criteria for abdominoplasty/apronectomy is met

1.2. Procedures to remove excess skin was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

1.3. While the number of patients receiving these surgeries is relatively low, obesity rates are rising, so demand for treatments like these is expected to rise**.** Table E3 below provides previous years activity.

1.3.1. Table E3: Excess skin removal activity across Staffordshire and Stoke-on-Trent

	2017/18	2018/19	2019/20
Activity	8	13	13
Total cost	£16,478	£23,615	£28,494

1.4. Surgeries to remove excess skin are elective inpatient procedures undertaken by acute providers within block contracts.

1.5. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity

2. Themes from involvement activities

2.1. There were mixed views on whether the removal of excess skin should be funded. Respondents stated that the excess skin does impact on patients' health and wellbeing such as sores, itching and may impact on patients' mental health.

2.2. Respondents commented that removal of excess skin should be funded to support patients who have made significant lifestyle changes.

2.3. Respondents also stated that restricting access to this procedure may discourage patients from losing weight. This, along with adverse impact in patients from not funding the treatment, may cost the NHS in the long-term.

3. Recommendations from the technical group

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to not routinely commission these interventions.

3.4. Whilst the group recognised the potential mental health impact for those affected if this access is removed, patients would continue to access commissioned mental health services as required.

3.5. For some patients, there can be a functional impact of the excess skin, or example sores, rashes and potentially infections however the group noted conservative management would continue to be offered to support patients to manage their symptoms.

3.6. The group also noted that activity is minimal and no adverse impacts have been identified in areas where these procedures are not currently commissioned.

3.7. Following discussions the group agreed there was sufficient evidence to adopt the CPAG recommendation and remove proposals to commission these interventions.

3.8. The recommended proposal from the technical group was to not routinely commission abdominoplasty/apronectomy and body contouring procedures.

4. Impact assessments

4.1. A quality impact assessment (QIA) has been completed for the recommended and approved proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.

4.2. Equality impact assessments have been completed for the recommended and approved proposals for both abdominoplasty/apronectomy and body contouring procedures and these were approved on 01 August 2022.

4.3. Both assessments noted the potential mental health impact on patients who were not able to access this procedure however it was recognised that there are mental health services in place to support these patients. Emphasis was placed on the importance of good communication when amending policy to confirm what is commissioned and ensure patient expectations are not raised during their clinical pathway. It was also noted signposting to relevant support services is essential where adverse impacts on mental health are identified.

4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee – Monday 03 October 2022

District and Borough Health Scrutiny Activity

Recommendation

I recommend that:

a. The report be received, and consideration be given to any matters arising from the Health Scrutiny activity being undertaken by the Staffordshire District and Borough Councils, as necessary.

Summary

1. The Committee receives updates at each meeting to consider any matters arising from the Health Scrutiny activity being undertaken by the Staffordshire District and Borough Councils.

Background

2. The Health and Social Care Act 2001 confers on local authorities with social services functions powers to undertake scrutiny of health matters. The County Council currently have responsibility for social services functions but, to manage health scrutiny more effectively, they have agreed with the eight District/Borough Councils in the County to operate joint working arrangements.

3. Each District/Borough Council has a committee in which holds the remit for health and wellbeing scrutiny matters and matters that have a specifically local theme. The Health and Care Overview and Scrutiny Committee will continue to deal with matters that impact on the whole or large parts of the County and that require wider debate across Staffordshire.

4. District and Borough Councils each have a representative from the County Council Health and Care Overview and Scrutiny Committee as a member of the relevant committee with remit for health scrutiny matters. The County Councillors will update the District and Borough Councils on matters considered by the Health and Care Overview and Scrutiny Committee. A summary of matters considered by this committee is circulated to District and Borough Councils for information.

5. It is anticipated that the District and Borough Councillors who are members of this committee will present the update of matters considered at the District and Borough committees to the Health and Care Overview and Scrutiny Committee.

6. The following is a summary of the health scrutiny activity which has been undertaken at the District/Borough Council level since the last meeting of the Health and Care Overview and Scrutiny Committee on 11 July 2022.

7. **Cannock Chase District Council**

   Cannock Chase's Health and Wellbeing Scrutiny Committee last met on 29 June 2022.

   Date of next meeting: 26th September 2022.

8. **East Staffordshire Borough Council**

   East Staffordshire Borough Council's Scrutiny Community Regeneration, Environment and Health and Well Being Committee met on 23 June 2022.

   Date next meeting: 22 September 2022

9. **Lichfield District Council**

   Lichfield District Council's Overview and Scrutiny Committee will meet on 15 September 2022.

   Date of next meeting: 17 November 2022

10. **Newcastle-under-Lyme Borough Council**

    The Health, Wellbeing & Environment Scrutiny Committee met on 5 September 2022 and the following matters were considered:

    - Police Commander and DCI John Owen gave an update on the new policing model. The new model included 10 local policing teams with one for the borough of Newcastle under Lyme with dedicated officers.
    - The committee considered an update on the new recycling service following its introduction in 2020. The committee was advised that the new service had received positive feedback from residents; the streets looked tidier; tonnage volumes of recycling had increased and the overall volume of waste had decreased. The aims for the future were to increase separate food waste collections, enhance provision of services for residents living in flats and look at options for participation in recycling by commercial and business properties. The committee was

also informed of the longer term implications of the Environment Act 2021.

- The committee considered the latest report to Cabinet on odour issues at Walleys Quarry.
- The committee considered the regular reports from the County Health and Care Overview and Scrutiny Committee and the Police, Fire and Crime Panel and notes of a meeting with the Integrated Care Board.
- The Work Programme was discussed and Members proposed items for the next meeting on 28 November on the proposals by Tri-Services to set up a hub to support mental health, investment in the borough's tennis courts and the commemorations for the 850 anniversary of the borough. .

Date of next meeting: 28 November 2022.

11. **South Staffordshire District Council**

South Staffordshire Council's Wellbeing Select Committee will met on 13 September 2022.

Date of next meeting: 6 December 2022

12. **Stafford Borough Council**

Staffordshire Moorlands District Council's Health Overview and Scrutiny Panel met on 27 July 2022.

The Annual performance update for Royal Stoke Hospital was considered, along with a presentation on the temporary closure and re-opening of Leek Minor Injuries Unit.

Date of next meeting: 28 September 2022, at which a representative from the Frailty Falls Response Service will be in attendance following a request made by a member of the Panel.

13. **Staffordshire Moorlands District Council**

Staffordshire Moorlands District Council's Health Overview and Scrutiny Panel met on 27 July 2022.

The Annual performance update for Royal Stoke Hospital was considered, along with a presentation on the temporary closure and re-opening of Leek Minor Injuries Unit.

Date of next meeting: 28 September 2022, at which a representative from the Frailty Falls Response Service will be in attendance following a request made by a member of the Panel.

14. **Tamworth Borough Council**

The following is a summary of relevant business transacted at the meeting of Tamworth Borough Council's Health & Wellbeing Scrutiny Committee held on 12 July 2022 - link to Agenda and reports pack:

http://democracy.tamworth.gov.uk/ieListMeetings.aspx?CommitteeId=209

Minute No.	Title
5.	Update on Housing Strategy An overview of the 4 Priorities in the Housing Strategy was provided, with more detail on Priority 4 given its focus on wellbeing. Following the overview, the Committee agreed that it would be useful to receive regular performance reporting against the action plans set out in the Strategy and made a recommendation to Cabinet to that effect.

Date of next meeting: 22 September 2022.

Link to Strategic Plan

Scrutiny work programmes are aligned to the ambitions and delivery of the principles, priorities, and outcomes of the Staffordshire Corporate Plan.

Link to Other Overview and Scrutiny Activity

The update reports provide overview of scrutiny activity across Borough and Districts, shares good practice, and highlights emerging concerns which inform work programmes for Health and Care Overview and Scrutiny Committees across Staffordshire.

List of Background Documents/Appendices:

Council	District/ Borough Representative on CC	County Council Representative on DC/BC
Cannock Chase	Cllr Philippa Haden	Cllr Phil Hewitt
East Staffordshire	Cllr Mrs Patricia Ackroyd	Cllr Philip Atkins
Lichfield	Cllr Michael Wilcox	Cllr Janice Sylvester-Hall
Newcastle	Cllr Ian Wilkes	Cllr Ian Wilkes
South Staffordshire	Cllr Lin Hingley	Cllr Jak Abrahams
Stafford BC	Cllr Jill Hood	Cllr Anne Edgeller
Staffordshire Moorlands	Cllr Barbara Hughes	Cllr Keith Flunder
Tamworth	Cllr Rosey Claymore	Cllr Thomas Jay

Contact Details

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Health and Care Overview and Scrutiny Committee 3 October 2022
Work Programme 2022/23

This document sets out the work programme for the Health and Care Overview and Scrutiny Committee for 2022/23.

The Health and Care Overview and Scrutiny Committee is responsible for:

- Scrutiny of matters relating to the planning, provision and operation of health services in the Authority's area, including public health, in accordance with regulations made under the Health and Social Care Act 2001 and subsequent guidance.
- Scrutiny of the Council's work to achieve its priorities that Staffordshire is a place where people live longer, healthier and fulfilling lives and In Staffordshire's communities people are able to live independent and safe lives, supported where this is required (adults).

Link to Council's Strategic Plan Outcomes and Priorities

- Inspire healthy, independent living
- Support more families and children to look after themselves, stay safe and well

We review our work programme at every meeting. Our focus in scrutiny is on tangible outcomes for the residents of Staffordshire, to use the data provided and members experience to debate and question the evidence, to provide assurance in what is being done and reassurance that matters within the health and care system are moving in the right direction. Scrutiny of an issue may result in recommendations for NHS organisations in the county, the County Council and for other organisations.

Councillor Jeremy Pert
Chairman of the Health and Care Overview and Scrutiny Committee

Health and Care Overview and Scrutiny Committee Work Programme 2022-23

Date	Topic	Background/Outcomes

Committee Meetings, Reviews and Consultations

		Background	Basis	Outcomes from Meeting
Monday 30 May 2022 at 10.00 am Scheduled	• Elective Recovery • Changes to the Healthy Communitie Service from April 2023. • Work programme 2022-23		Risk & Performance Public Health Planning	Considered plans to address backlog & requested further information Noted the increased focus on priority services & outcomes, change to eligibility criteria, impact in communities and early prevention. Planning and prioritisation of work programme items
Tuesday 21 June 2pm	Healthier Communities day		Public Health	Workshop feedback and findings will form the evidence base for a report to committee.
Monday 11 July 2022 at 10.00 am Scheduled	• ICS and ICB Update • Primary Care Access update • Maternity Transformation • Health Watch Intro to HW year 1 priorities, focal investigations topics • The Families Health & Wellbeing (0-19) service. (Pre-decision)	ICS ICS ICS Healthwatch Pre-decision	Risk & Performance Risk & Public Concern Transformation Partnership Public Health	Peter Axon Lynn Millar Helen slater Bas Tazim SoS HealthWatch Karen Coker H&C
Monday 1 August 2022 at 10.00 am Scheduled	• ICS Transformation – George Bryan – Inpatient Mental Health Services	ICS	Transformation	Additional information was requested to strengthen the business case. Information arising from scrutiny and comments of the Committee informed discussion of Inpatient Mental Health Services at Integrated Care Board on 18 August 2022.
Monday 19 September 2022 at 10.00 am	Cancelled – Queens Funeral (B/H)			
Thursday 22 September 2022 at 1:30pm.	• RWT Acute Trust QA performance update	Joint with Wolverhampton Hybrid link available	Performance	HCOSC invited - joint scrutiny of RWT Quality Account

Monday 3 October 2022 at 10.00 am	• System Pressure update • ICB Performance • Social Care Performance • The future of Supported Living Services in Staffordshire • Clinical Policy Alignment	Social Care	• Risk and performance • Performance • Performance • Pre-decision • Transformation	• ICB • ICB • Dr Richard Harling • Sarah Taylor (Cabinet 19 October) • ICB

Monday 17 October 2022 at 10.00 am Scheduled	• Workforce Planning
	  ○ Health and Care
	  ○ Acute Trusts
	• Ockenden Report
	• Inpatient Mental Health Services
			Workforce
			
			Risk &performance Transformation
				H&C / ICS/ UHDB/UHNM/ NSCHT
				https://www.donnaockenden.com/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
				ICB

Monday 28 November 2022 at 10.00 am Scheduled	• Feedback from the Healthier Communities Workshop • Public Health Dashboard • Primary Care Access Plan Update		Wider determinants Performance Risk and public concern	Cllr Edgeller /Claire McIver Claire McIver Lynn Miller
Monday 30 January 2023 at 10.00 am Scheduled	• MPFT performance update • NSCHT performance update • UHDB Acute Trust QA performance update •		Performance	Ben Richards
Monday 20 March 2023 at 10.00 am Scheduled	• Dentistry		Risk and Performance	Children's Dentistry – Keep Stoke Smiling (inc. Staffs) Fluoridisation/ orthodontic access, 2023 transfer to ICS commissioning

Work programme for 2022-23 - items		Background	Basis	Target Scheduling Date
To Be Scheduled	• Impact of air pollution on health	Work planning	Risk	
	• Impact of Long COVID		Risk	
	• Obesity and Diabetes	29/11/21	Public Health	
	• Social prescribing	29/11/21	Public Health	
	• NHS estate – fit for twenty first century	13/12/21	Planning, Policy & Processes	
	• End of Life – compassionate communities		Patient journey	
	• Winter Flu • UHMN Critical incident lessons learnt			
	• Innovation / technology	30.05.2022		Staffordshire Universuty/ ICS – demonstration of technology
	• Health Visitor Service	30.05.2022		
	• NHS Visual Impairment Service	30.05.2022		
	• Draft Mental Health Strategy		Policy Public Health	Jan Cartman -Frost Strategy delayed

	• PH outcomes and services (Children's) • Mental Health Support in Schools		Partnership working	Natasha Moody / Karen Coker bring this at the same time as strategy and MHST Karen Coker/ MPFT/ NSCHT
	• Adult Social Care Reform			

Work Groups / Inquiries planned and ongoing – 1. Women's Health WG; 2. Mental Health session; 3. Innovation Day; 4. Developing Healthier Communities Workshop & report

Item	Focus	Suggested Items	
The Role of Community Hospitals within the Wider Health Economy (CCGs, MPFT, D&BUHFT)	Transformation		
Going Digital in Health	Transformation	Requested at meeting on 16 March 2021 Part of transformation programme	

Membership

Jeremy Pert Chairman)
Richard Cox (Vice-Chairman - Overview)
Ann Edgeller (Vice-Chairman – Scrutiny)

Jak Abrahams
Charlotte Atkins
Philip Atkins
Keith Flunder
Thomas Jay
Phil Hewitt
Jill Hood
Bernard Peters
Janice Silvester-Hall
Ian Wilkes

Borough/District Councillors

Jill Hood (Stafford)
Philippa Haden (Cannock Chase)
Patricia Ackroyd (East Staffordshire)
Michael Wilcox (Lichfield)
Ian Wilkes (Newcastle-under-Lyme)
Barbara Hughes (Staffordshire Moorlands)
Lin Hingley (South Staffordshire)
Rosemary Claymore (Tamworth)

Calendar of Committee Meetings

at County Buildings, Martin Street, Stafford. ST16 2LH
(at 10.00 am unless otherwise stated)

Monday 30 May 2022 at 10.00 am;
Tuesday 21 June 2022 at 14.00 am – Wider Determinants Workshop
Monday 11 July 2022 at 10.00 am;
Monday 1 August 2022 at 10.00 am;
Monday 19 September 2022 at 10.00 am;
Thursday 22 September 2022 at 3:30 Joint RWT with Wolverhampton Ccl
Monday 17 October 2022 at 10.00 am;
Monday 28 November 2022 at 10.00 am;
Monday 30 January 2023 at 10.00 am;
Tuesday 20 March 2023 at 10.00 am;

Work Group Meetings

Womens Health WG
Monday 13 June 2022 at 2.30pm

Innovations Day
TBA

Integrated Care Hubs
District meeting TBA