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.

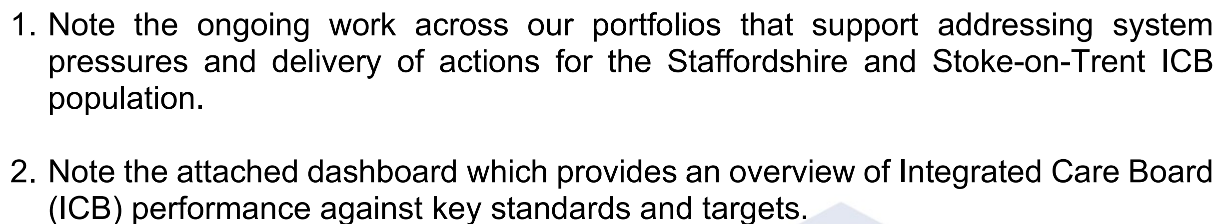
Report of Name Portfolio Holder/Director/Partner/Other

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.



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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.

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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.

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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:

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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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