STW Integrated Care Board - Appendices

MEETING

26 June 2024 14:00 BST

PUBLISHED

24 June 2024

Agenda

Location	Date	Time
Seminar Rooms 1&2, Shropshire Education & Conference Centre (SECC), Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ	26 Jun 2024	14:00 BST

	Item	Page
1	Perceptions and experience of racism in the workplace by health and social care staff & Staff Survey (ICB and System Partners)	3
2	Health and Healthcare Inequalities	59
3	Integrated Care System Performance Report:	109
4	ICB Annual Reports and Accounts 2023/24 – for approval	145
5	Review of Primary Care Access Recovery Plan (PCARP) 2023/24 and Planning for 2024/25	362
6	Learning Disability Mortality Review (LeDeR) Annual Report	388
7	Board Committee Minutes	438
7.1	Quality and Performance Committee Minutes	439
7.2	Audit & Risk Committee	461
7.3	Finance Committee Minutes	475
7.4	People Culture and Inclusion Committee	488

Perceptions and experience of racism in the workplace by health and social care staff in Shropshire, Wrekin and Telford

Lead author

Dr David J Matheson
(University of Wolverhampton)

Acknowledgements

I wish to express my thanks to all those who helped in their diverse ways to bring this project to fruition, most especially the members of the advisory group *(*Asha John, Bhawna Solanki, Prabjot Sahota and Dr Ranjit Khutan from the University of Wolverhampton) as well as those who helped in the design of the project and commented on the first and second interim report.

Dr Priya George	EDI lead, Shropshire, Telford & Wrekin Integrated Care System (from Nov 2022)
Laura Kavanagh	EDI lead, Shropshire, Telford & Wrekin Integrated Care System (until end Oct 22)
Heather Pitchford	Health Education England
Jo Bayliss	NHS Shropshire, Telford & Wrekin
Kal Parkash	EDI Lead, Shrewsbury and Telford Hospital NHS Trust
Lois Dale	Shropshire Council
Nina-Leigh Grix	Shropshire Partners in Care

I would also like to acknowledge Prabjot Sahota for providing an early outline draft for the literature review, I am indebted to Dr Catherine Matheson-Monnet (from the University of Wolverhampton) for her extensive help with the literature review, analysing and writing up the qualitative data of the survey and interviews, revising the final report and writing the two executive summaries, as well as preparing the PowerPoint presentation of our work.

Most importantly, I wish to acknowledge and express my gratitude to all those who took the time to share their perspective and experiences by completing the survey and/or volunteered to be interviewed.

TABLE OF CONTENTS

Executive Summary ***4***

Introduction 4
Key findings 4
Conclusion 6
Benefits of our study 6
Limitations of our study 6
Suggestions for improvements 7

Introduction ***8***

Racism in health, medical and social care in England ***8***

Rural racism in England ***8***

Methodology ***8***

Quantitative data analysis ***9***

Profile of respondents to the survey **9**

Racism in the workplace **10**

1 Racism from patients and their families, ... 10
2 Racism from colleagues 12
3 Racism directed at others in the workplace in the past year 13
4 Racism directed at self in the workplace in the previous year 15
5 Being falsely accused or criticised because of race 17
6 Assumptions about ability or behaviour based on racial stereotypes 18
7 Direct verbal racial abuse 20
8 Not always actively included in work activities by colleagues because of race/ethnicity 21
9 Intentional exclusion from work or social events because of race 23
10 Differential treatment due to race/ethnicity 24

Qualitative data analysis ***28***

Profile of free-text survey and interview samples **28**

Not experienced racism 29
Racism in the workplace 29
Racism from patients/family 29
Perspectives from EDI-related staff 30

Racism from colleagues **31**

1. Racism by members of staff towards patients/clients from ethnic minority groups 31
2. Racism by ethnic minority members of staff towards White British/White English members of staff 31
3. Racism by White English/British members of staff towards ethnic minority members of staff 31
3.1. Language and communication 31
Perspectives from EDI-related staff 32
3.2. Made to feel they do not belong and fit in 32
3.3. Contribution to the team and organisation less valued 33
Perspectives from EDI-related staff 34
3.4. Negative impact on career progression 34
3.5. Reluctance to report racism 35

Racism within the community (outside the workplace) **37**

Perspective of EDI related staff 37

Discussion ***38***

Acculturation of newly arrived international members of staff 38
Extent to which things have changed over the last 20 years 39

Conclusion *41*
Summary of key findings **41**
Racism in the workplace **41**
Racism in the community **41**
Benefits and limitations *42*
Suggestions for improvements *42*
References *44*
Appendix *46*
Table A: Demographic and work profile of the survey sample, free text comments sample and interview sample 46

EXECUTIVE SUMMARY

Introduction

Our co-created mixed method approach used an iterative process to gain a deeper understanding of the extent of and experiences of racism experienced by health, medical and social care staff of in NHS settings in the Shropshire, Telford and Wrekin area in the workplace and in the community.

Our three samples (survey n=177, free-text comments n=50 and interviews n=22) were wide-ranging and diverse and broadly mirrored the composition of the overall workforce.

- The proportion of non-White respondents in the survey was 56% vs 44% for Whites (out of n=156 who provided this information), 62% in the free-text comments compared to 38% for Whites and 95% in the interviews compared to 5% for White.
- The proportion of women was 57% in the survey, 70% in the free-text comments and 82% in the interviews.
- 58% of those who completed the survey were aged 18-45 but 78% of both those who made free-text comments and took part in interviews were aged 36-65.
- The proportion of nurses was 62% in the survey, 55% in the free text comments and 72% in the interviews.
- The proportion of social care practitioners was 25% in the survey, 14% in the free-text and 5% in the interviews.
- The percentage of hospital staff was 46% in the survey, 42% for the free text and 73% for the interviews. The percentage of non-hospital (social care, community, mental health and GP) was 54% in the survey, 58% for the free text and 27% for the interviews
- The proportion of medical practitioners was 10% in the survey, 22% in the free-text comments and 23% in the interviews.

The non-White and White survey samples broadly reflected the composition of the health, medical and social care workforce with twice as many South Asians as Black respondents in the non-White sample and more than twice as many White British/English as White Others in the White sample. The non-White interview sample also had twice as many South Asians as Blacks. The interview sample had only one White (British/English) participant.

Key findings

Racism in the workplace

Extent of problem

While 69.2% of White respondents compared with just over 77.2% of non-White respondents had observed racism directed at others in the previous year (on average 1-5 times), only 23.7% of White respondents compared to 75.9% of Non-White respondents had experienced racism directed at them in the previous year (on average 1-5 times). There was no difference between the South Asian and Black samples, but more than 4 times as many White Other as White British/English respondents had experienced racism directed at them in the previous year.

Only 49.2% of the White survey respondents compared to 84.8% of non-White survey respondents agreed that racism from patients and families was a problem in the workplace while 55.9% of the White respondents and 78.7% of those in the non-White category agreed that racism between colleagues was a problem in their workplace. For both questions there was no statistically significant

difference between South Asians and Black respondents, but White Other respondents were twice more likely than White British/English to agree with both questions.

Only two of the eight newly arrived international nurses who had been in England for two years or less (i.e. 10% of the overall interview sample) were working in highly proactive and supportive environments and had experienced no racism in their present job.

Main forms of racism

From patients and families

- 12.2% of White respondents compared to 45.9% of Non-White respondents agreed that they had been subjected to direct racially abusive language in the workplace, mostly from patients and families. There was no significant difference between South Asians and Blacks, but just under 3 times as many White Others (60%) than White British/English (24%) had experienced verbal abuse.
- 25% of those who provided free-text comments and 50% of the interviewees referred to experiencing or witnessing racism from patients or their families (comments about accent or way of speaking, racially abusive language, and requests by patients to be seen and cared for only by White/British/English practitioners).

From colleagues

- 40.5% of White survey respondents compared to 78.7% of Non-White survey respondents agreed that they had experienced racially based stereotyped assumptions and micro-aggressions about their ability and behaviour. There was no statistically significant difference between South Asian and Black respondents, but there was between White English (31%) White Other (75%) respondents.
- 44.1% of White but 66.7% of non-White respondents had not always felt included in work activities because of their race with more than twice as many South Asians (66.6%) than Blacks (27.8%) and more than 15 times as many White English/British (3.3%) than White Other respondents (46.9%).
- 12.2% of White compared to 45.9% of non-White survey respondents had felt intentionally excluded from work or social events because of their race with more than twice as many South Asians (57.6%) than Blacks (27.8%) and nearly six times as many White Others (42.9%) than White English/British (6.9%).
- 26% of those who provided free-text comments in the survey and 86% of interviewees underlined that their input to the team and organisation was less valued
- 10% of those who provided free-text comments in the survey (non-Whites) and 89% of the interviewees not brought up in the UK who did not have English as their first language, i.e. 77% of the interview sample, had experienced language and communication issues from colleagues
- 20% of those who provided free-text comments in the survey and just over 75% of interviewees (of whom 80% were not born, brought up, or initially trained in the UK) were made to feel that they did not belong or fit in
- 10% of those who provided free-text comments in the survey and 45% of the interviewees emphasised the negative impact of racism on their career progression

Reluctance to report racism

- 32% of those who had provided free-text comments in the survey and 73% of interviewees reported a reluctance and fear to discuss or report racism, whether experienced or observed, hence they never challenged it, spoke about it, reported it, or made a complaint about it. This

was because of a perception that complaints were not acted upon and/or a fear of retribution and even managers or supervisors advising not to report or challenge racism for the sake of career progression.

- 27% of the interviewees found that, as they became more senior and were subjected to less racism, they were more confident in challenging and reporting racism. This was largely because they knew that it would be taken into account and acted upon due to their greater seniority.

Acculturation of international staff

Even with acculturation sessions focussing on language and communication, individual acculturation takes a long time. It was reported that things were easier ten or more years ago when there was no input on acculturation because the fewer international nurses benefitted from more individual support. The increasing number of international nurses (now approximately 50% of the workforce), acculturation sessions and a more proactive approach to career progression appeared to have led to more international nurses successfully progressing in their career than in the past.

Racism in the community

40% of the overall sample had experienced racism in the community in the previous year: 63% of non-White survey respondents compared to 19% of White respondents. The former had also experienced racism more often.

Data from the survey, free text and interviews shows that racism in the community was mostly direct and explicit such as racially offensive derogatory comments and abusive language and occasionally differential treatment and micro-aggressions.

Conclusion

Racism in the workplace is less explicit and more indirect than that experienced in the community. Racism in the workplace has become more indirect and more subtle over time, but the impact is as damaging. However, members of staff largely still tend to do nothing about it, not even addressing issues directly with the person concerned. Our figures show that both non-White and White members of staff in the Shropshire, Wrekin and Telford experience more racism than either the national average or the average for the West Midlands.[1] [2]

Benefits of our study

Our study is the only study to have focussed on racism in health and social care in the NHS in the Shropshire, Telford and Wrekin. Our study is unique in having examined differences within the White British/English and White Other sub-groups and within the South Asian (Indian and Pakistani) Black (Black African and Black British) subgroups. In line with the Equality Act 2010, this is an acknowledgement that racism is more than just about colour, but also about actual or perceived nationality, culture and national origins.

Limitations of our study

The sample was cascaded, so it is unknown how many potential respondents were reached; therefore, the rate of response cannot be established. Rather than say they had not observed racism in the workplace in the past year, almost half the sample (48%) did not answer this question compared to 11%-15% non-response or non-disclosure of information for the demographic questions on gender, ethnicity and age.

Suggestions for improvements

Policies should be reviewed to avoid overlapping policies and initiatives and pathways.

Anti-racism training should be offered based on a concept of race consistent with the Equality Act 2020 (i.e. more than just colour)

'Nudge' posters should remind staff and patients of non-racist expected values and behaviours.

Acculturation sessions for international staff and especially nurses (now approximately 50% of the nursing workforce) should be reviewed to best meet their needs but continue to impart a more proactive approach to career progression.

Managers should be trained to proactively support international staff to successfully progress in their career.

All staff should be educated about how challenging it is for international staff not trained in the UK and with a different first language to overcome acculturation problems and that even with acculturation sessions focussing on language and communication, individual acculturation takes a long time and is a two-way process.

As international staff are clearly needed by the system, more effort should be made by all staff to ensure that they are proactively included in activities and made to feel they fit in

INTRODUCTION

The project, funded by Health Education England West Midlands, is a co-creation project between the University of Wolverhampton and diverse stakeholders (NHS Trusts; Shropshire, Wrekin and Telford [STW] Integrated Care Systems [ICS] and Health Education England. The fieldwork for this project (survey and interviews) started in October 2021 and ended in June 2022. Two interim reports (each oral and written) were made to stakeholders – 23 November 2021 and 17 March 2022 – to inform them of findings to date.

Racism in health, medical and social care in England

Racism within the NHS has been described as endemic [3-5] and racist behaviour has long been the experience of many healthcare workers, both indigenous and immigrant. [6-10] However, an issue common to studies and reports about racism is a lack of granularity about sub-categories within White and non-White groups; and yet, greater granularity can shed light on the complexity and multi-dimensionality of the racism experienced or observed within health and social care in Shropshire, Telford and Wrekin.

Rural racism in England

The Commission for Racial Equality (CRE) was set up by the Race Relations Act 1976 to work towards the elimination of unfair discrimination.[11] [12] In 1992, a ground-breaking report published by CRE [12] investigating the extent of racism in south-west England found a disturbing picture of racial prejudice and discrimination directed against ethnic minority residents which led to the setting up of the Rural Race Equality Project (RREP) in 1996.[13] [14] Soon after, the Equality Act (2010) replaced all previous equality legislation and the Equality and Human Rights Commission took over from CRE to work towards the elimination of unfair discrimination.

Although there have been claims that some progress had been made, there is agreement that progress has been slow and clearly insufficient and hate crimes with a racial element have sharply increased in rural areas including.[11] Calls have recently intensified for a renewed and urgent focus on rural racism [15]. Of the emerging but still limited body of research which over the past 30 years has begun to challenge 'problem-free' constructions of the countryside [16] [17] [18] [19] underlining the pervasiveness of racialised 'othering' in rural environments [20], the present study is the only to have focussed on health and social care in the NHS and on the Shropshire, Telford and Wrekin area.

METHODOLOGY

A co-creation process[21] [22] was undertaken with representatives of some of the relevant stakeholder organisations and advisory group to agree the aims and objectives and develop the scope, methodology and design of the study.

The primary aims were to gain a deeper understanding of the extent of racism and of experiences of racism experienced by health, medical and social care staff of perceived non-English heritage in NHS settings in the Shropshire, Telford and Wrekin area and suggest ways forward for the organisations concerned to promote culturally inclusive behaviours in staff, patients and/or visitors.

A mixed-methods approach[23] was selected to address the aims of the study using an iterative process to gain the deepest understanding of what has been going on. Quantitative data was collected from an electronic anonymous survey [n=177] to enable the identification of underlying patterns of similarities and differences. Qualitative data was collected from both the survey [n=50 participants made at least one free-text comment] and interviews [n=22] with healthcare, medical

and social care staff to provide insights into underlying complex social processes.[24] In addition, individual and collective background meetings were held with members of stakeholder groups [n=8], including trade unions representatives, human resources and EDI staff within organisations who provided background information and perspectives about racism.

The survey was cascaded to healthcare, medical and social care staff in the various stakeholder organisations between October 2021 to June 2022. Respondents had the opportunity to volunteer to be interviewed. The sampling strategy was to obtain as representative and balanced a sample as possible. Semi-structured interviews with 22 participants were held between November 2021 and June 2022. Meetings with EDI-related staff took place between March 2021 and March 2022. A comparative table of the profile of the samples is summarised in the Appendix (survey, free-text comments and interviews).

The proportion of non-White participants was 56% in the survey (with twice as many respondents identifying as South Asian compared to Black), 62% in the free-text comments (with a quarter as many South Asians as Blacks) and 95% in the interviews (with twice as many South Asian as Black). Women comprised 57% of survey respondents, 70% in the free-text comments in the survey, and 82% of the participants in the interviews. More than 50% of the those who completed the survey were aged 26-45 and 60% of both those who made free-text comments and those who took part in interviews were aged 36-55. See table 1.

Informed consent was received from all respondents and participants. Ethical approval for the study was granted on 30 April 2021 by the Health, Social Care and Social Work Ethics Sub-panel of the University of Wolverhampton.

Quantitative data from the survey was analysed using appropriate statistical means, while the qualitative data from the survey as well as the data from the interviews were analysed thematically and using the constant comparative method.[24 25]

QUANTITATIVE DATA ANALYSIS

Profile of respondents to the survey

The profile of the survey sample is summarised in table 1. Of note, n= 22 (12.3%) left the question on ethnicity blank, n=21 (11.9%) did not provide information on age and n=24 (13.4%) did not provide information on gender. While there was approximately the same number of White [n=48] and non-White females [n=53], the number of White males was approximately half [n=18] of that of non-White males [n=33]. The mean age of respondents identifying as White was in the 46-55 age group, while that of respondents identifying as Non-White was in the 36-45 age group.

Those who completed the survey were primarily non-White [56%], women [57%] and aged 18-45 [56%]. The majority were nurses [62%], 43% of whom worked in a hospital setting. Other respondents were social care practitioners [25%] and medical practitioners [13%] more than 66% of whom were GPs and 33% hospital based.

Table 1: Demographic and work profile of the survey sample, free-text comments sample and interview sample

Items	Survey sample n=177	Percentage
Gender	Female	57%
	Male	29%
	Non-binary	2.6%
Age	18-25	2%
	26-35	30%
	36-45	20%
	46-55	26%
	56-65	17%
Ethnicity	White	44% [n=68]
	White English/British	31%
	White Other	12%
	Non-White	56% [n=88]
	South Asian	34% [Indian 29%, British Indian 3%, Pakistani 1%]
	Black	15% [Black African 8%, Black British 5% Black Other 1%]
	Non-White Other (mixed)	8%
Place of work	Hospital setting	46% [75% of whom non-White]
	Social care	25% [25% non-White]
	Community care	9% [20% non-White]
	Mental health:	10% [20% non-White]
	General practice	10% [80% non-White]
Main type of role	Hospital nurses	43% [75% non-White]
	Social care practitioners	25% [25% non-White]
	Community care nurses	9% [25% non-White]
	Mental health nurses	10% [25% non-White]
	Hospital medical	3% [all non-White]
	GP practice medical	5% [80% non-White]
	Administrative roles	5% [75% White]

Racism in the workplace

The p-value is the probability of the results having occurred by chance in independent samples[26]. In the present work, p<.05 (i.e. there is less than 5% probability of the result being due to chance) is taken as the threshold for the result being statistically significant and p<.001 means a less than 0.1% probability a result being due to chance). As the data were not normally distributed, the Mann-Whitney U test was used.

1 Racism from patients and their families,

White vs non-White groups [statistically significant difference p<.001]

49.2% of White respondents and 84.8% of non-White respondents agreed that racism from patients and families and members of the public was a problem. Also, 35.5% of non-White respondents

compared to only 15.3% of White respondents agreed to *a great extent/a lot* that this was a problem.

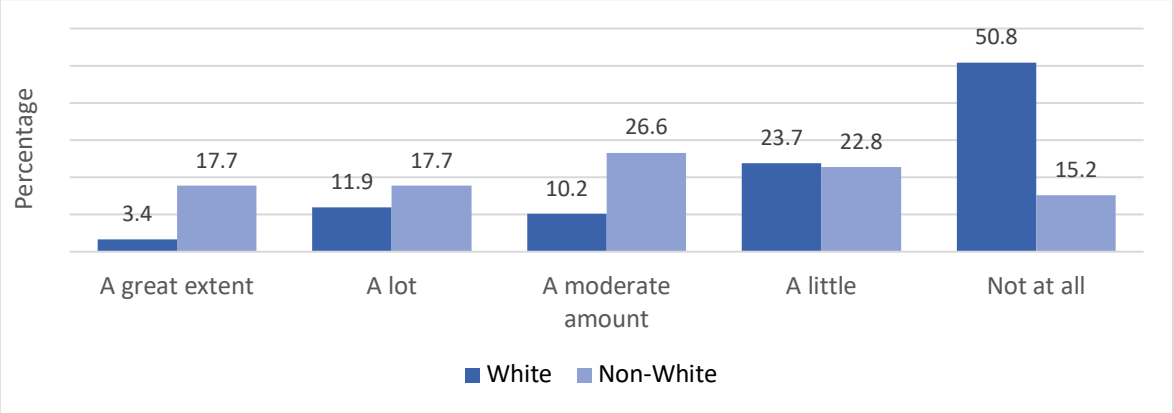


Figure 1 To what extent do you consider racism to be a problem in relation to interactions with patients, their families and the general public? Non-White cf. White

Black vs South Asian groups [no statistically significant difference]

87% of South Asian respondents and 81.8% of Black respondents agreed that racism from patients, families and the general public was a problem with 34.8% of South Asian respondents and 40.9% of Black respondents agreeing to *a great extent/a lot* and the rest agreeing *moderately/a little*.

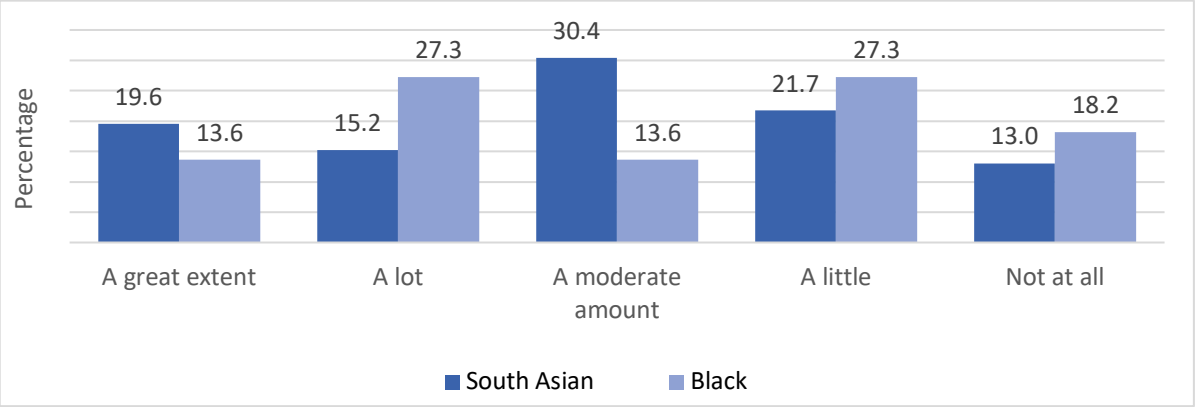


Figure 2 To what extent do you consider racism to be a problem in relation to interactions with patients, their families and the general public? Black cf. South Asian

White British/English vs White Other groups [statistically significant difference p<.001].

41.9% of White British/English respondents but 68.7% of White Other respondents agreed that racism from patients, families and the general public was a problem. 18.8% of White Other respondents but just 14% of White British/English respondents agreed to *a great extent/a lot* that this was a problem with the rest agreeing *moderately or a little*. This concurs with the notion that those close to the dominant group in society are those least likely to suffer detriment.

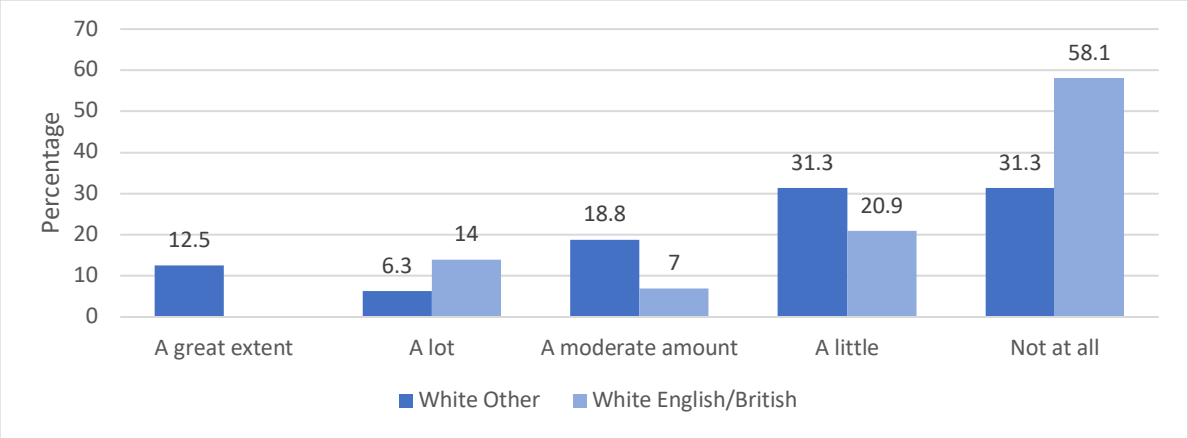


Figure 3 To what extent do you consider racism to be a problem in relation to interactions with patients, their families and the general public? White British/English cf. White Other

2 Racism from colleagues

White vs non-White groups [statistically significant difference p<.001].

55.9% of the respondents who had identified as White and 78.7% of those in the non-White category agreed that racism between colleagues was a problem in their workplace. Only 10.2% of White respondents but 37.6% of non-White respondents agreed to *a great extent/a lot* that this was a problem while 45.8% of White respondents and 41.3% of non-White respondents agreed *a moderate amount/a little*.

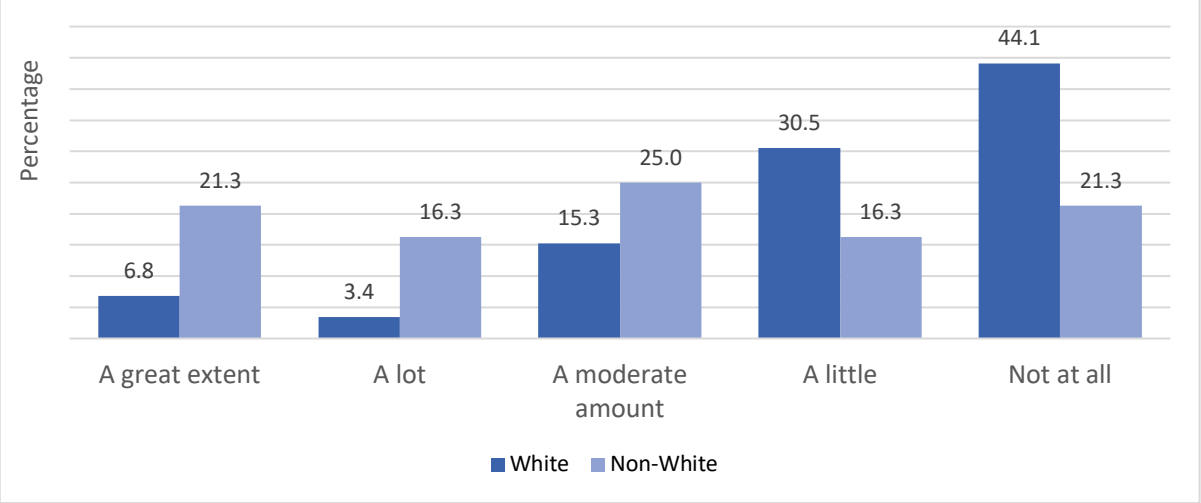


Figure 4 To what extent do you consider racism to be a problem in your workplace i.e. in relation to interactions between colleagues? Non-White cf. White

Black vs South Asian groups [no statistically significant difference]

82.9% of South Asian and 82.8% of Black respondents considered racism from colleagues or between colleagues to be a problem in the workplace. Respondents were equally divided as to the intensity of the problem with 36.2% of South Asian respondents and 40.9% of Black respondents agreeing to *a great extent/a lot* while 34.7% of South Asian respondents and 40.9% of Black respondents agreed *moderately/a little*.

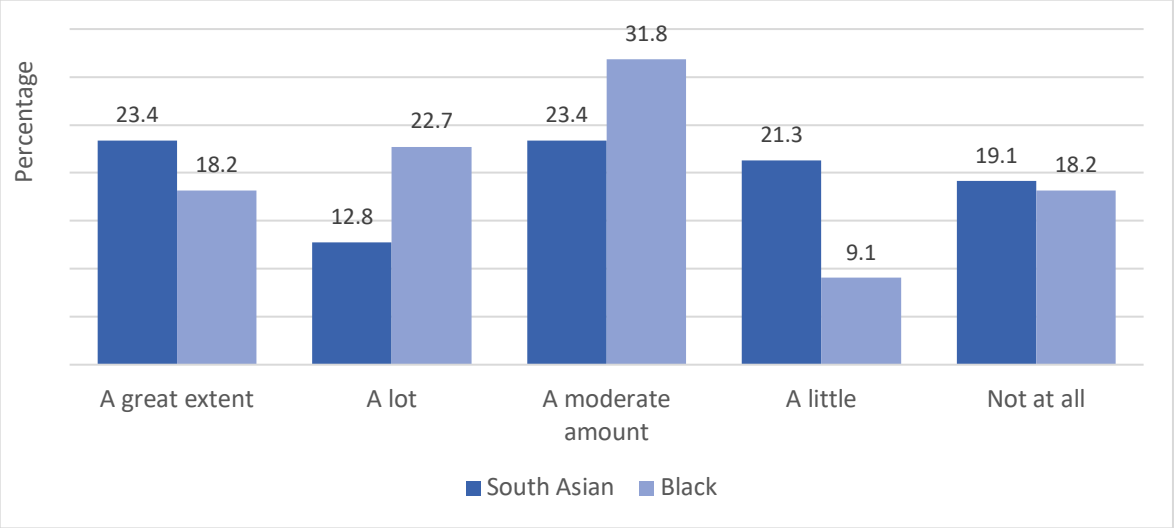


Figure 5 To what extent do you consider racism to be a problem in your workplace i.e. in relation to interactions between colleagues? Black cf. South Asian

White British/English vs White Other groups [statistically significant difference p<.001].

68.7% of White Other respondents and 51.2% of White British/English respondents considered racism from colleagues in the workplace to be a problem. 34.1% of White Other respondents agreed *to a great extent/a lot* that this was a problem compared to 7% of White British/English respondents. However, in relation to *moderately* and a *little*, both groups were in near complete agreement [44.7% of White Other and 44.2% of White British/English].

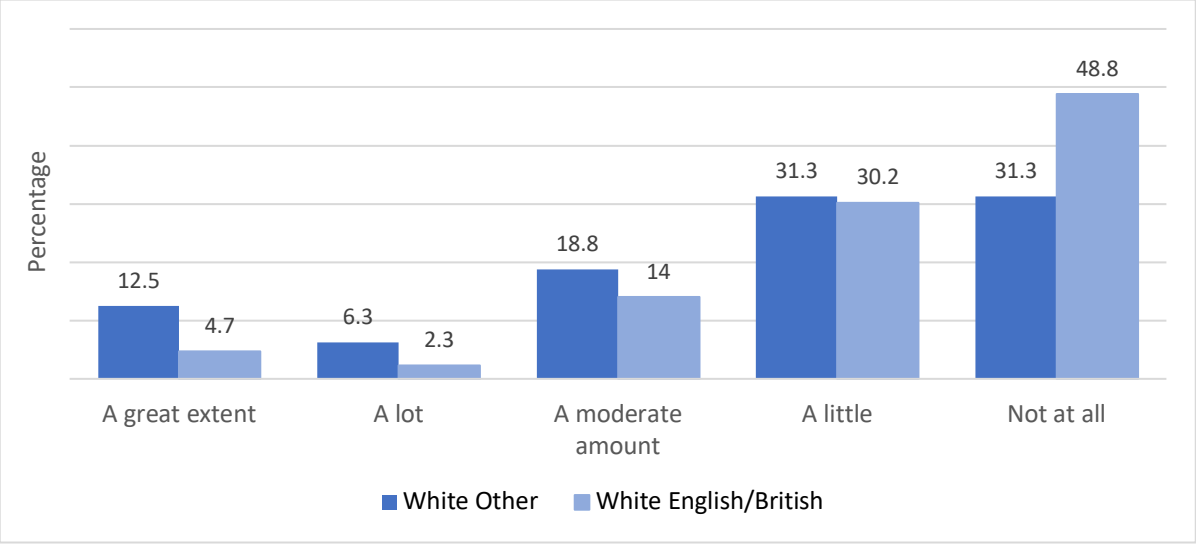


Figure 6 To what extent do you consider racism to be a problem in your workplace i.e. in relation to interactions between colleagues? White Other cf. White British/English

3 Racism directed at others in the workplace in the past year

The picture regarding racism directed at others in the workplace much less clearcut, there being no statistically significant difference between White and non-White respondents as well as a large proportion who did not give an answer to this question (55 White and 30 Non-White respondents).

White vs non-White groups [no statistically significant difference].
The majority [69.2% of White and 77.2% of non-White] who responded to this question had witnessed workplace racism directed at others in the last year. About the same percentage of White [46.2%] and non-White [45.6%] had witnessed racism 1-5 times. A lesser proportion of both White respondents [15.4%] and non-White respondents [14%] had observed racism more than 6 times in the last year.

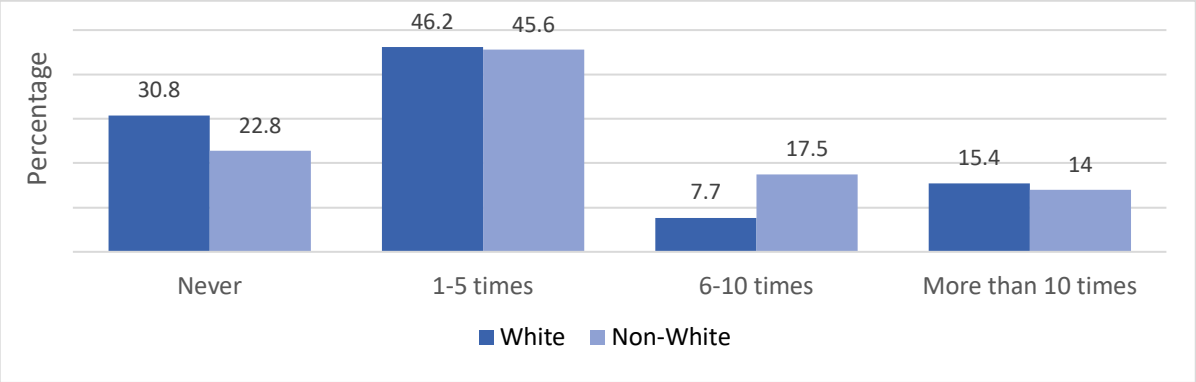


Figure 7 How often in the last year have you witnessed racism directed at others in your workplace? White cf. Non-White

A question hangs over the 85 participants who did not answer this item: it would be very positive if indeed there were no racist events to report. It may, however, be the case that there were no events that these participants remembered as having recognised as racist or they had limited opportunity to observe racism at play as much of the work in health and social care is done individually or in very small groups.

Black vs South Asian groups [no statistically significant difference]

73.5% of South Asian respondents and 80% of Black respondents had witnessed racism directed at others in the previous year with 58.9% of South Asian respondents and 73.4% of Black respondents having observed this 1-5 times.

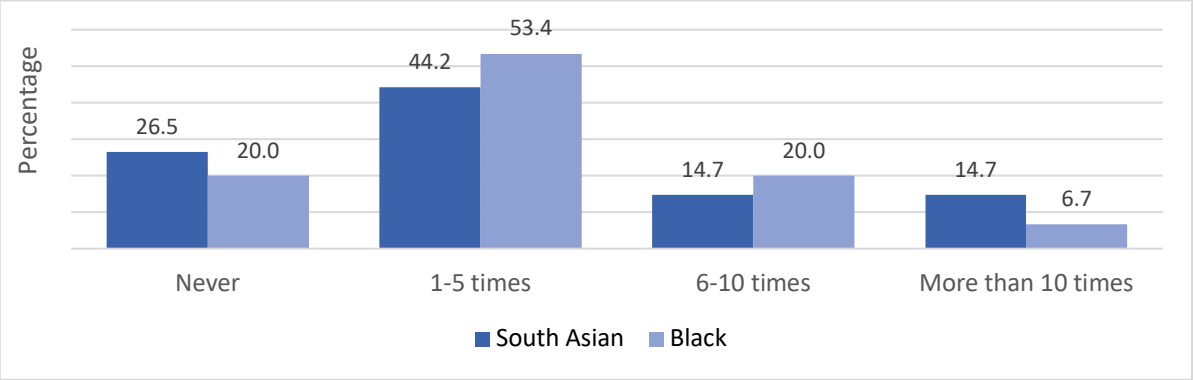


Figure 8 How often in the last year have you witnessed racism directed at others in your workplace? South Asian cf. Black cf. White

White British/English vs White Other groups [no statistically significant difference]

More White English/British respondents [80%] than White Other [74.7%] had observed racism directed at others in the previous year with 60% of White British and 45.6% of White Other having observed this happen between one and five times.

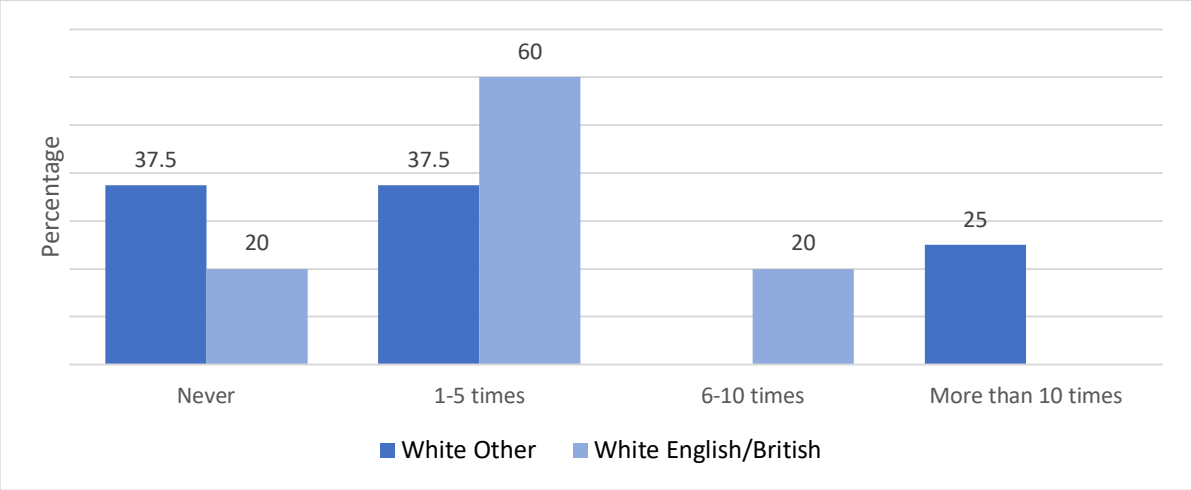


Figure 9 How often in the last year have you witnessed racism directed at others in your workplace? White Other cf. White English

4 Racism directed at self in the workplace in the previous year

White vs non-White groups [statistically significant p<.001].

75.9% of non-White respondents had experienced racism directed at them in the workplace in the past year compared to 23.7% of White respondents. 50.6% of the non-White sample had experienced this 1-5 times compared to 15.3% of the White sample. A minority of White [8.5%] and non-White respondents [25.3%] had experienced this 6 times or more.

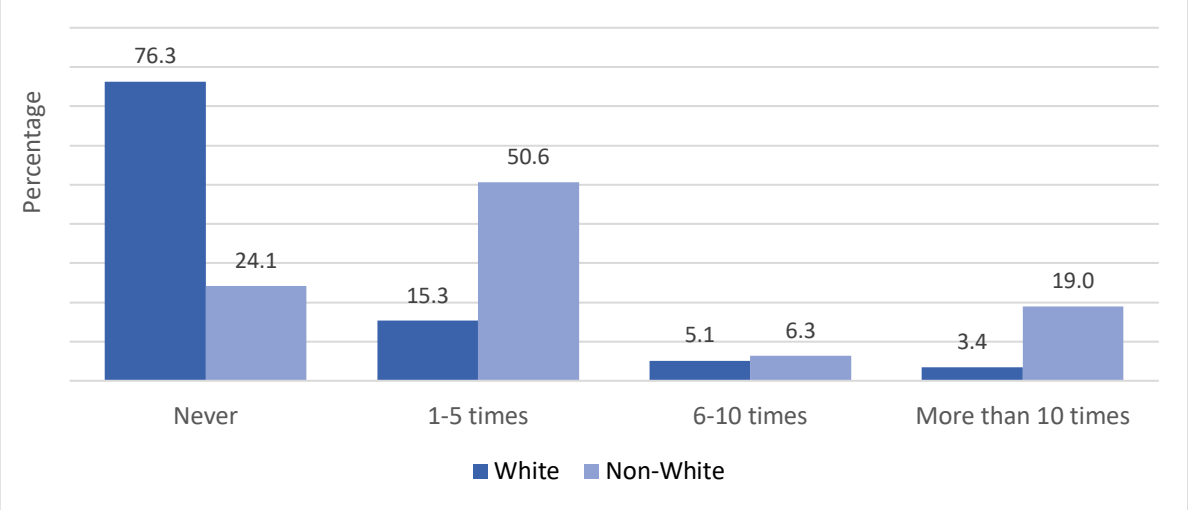


Figure 10 How often in the last year have you experienced racism directed at you in your workplace? White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

80.4% of South Asians and 71.8% of Black respondents had experienced racism directed at them in the past year. This happened between 1-5 times to 54.3% of South Asian respondents and to 50% of Black respondents and 6 times or more to 26.1% of South Asian respondents and to 18.2% of Black respondents.

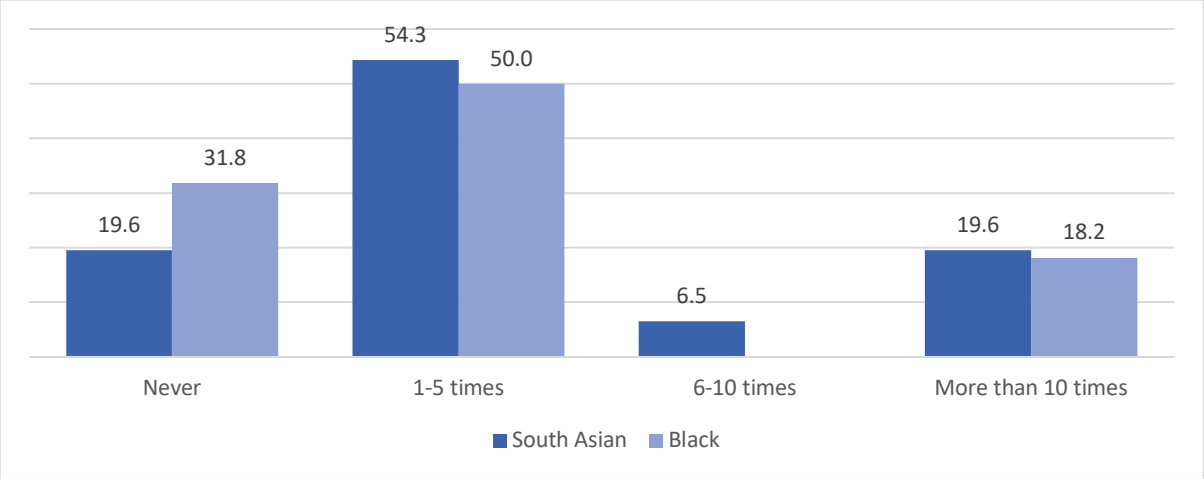


Figure 11 How often in the last year have you experienced racism directed at you in your workplace? South Asian cf. Black

White British/English vs White Other groups [statistically significant p<.001]

14% of those respondents identifying as White British/English had experienced racism directed at them in the previous year compared to 50% of those identifying themselves as White Other. This happened between 1-5 times to 25.1% to White Other respondents and 11.6% to White British/English respondents and more than 6 times to 25% of White Other respondents and to 2.3% of White English/British respondents. Those identifying themselves as the dominant group [White English/British] are by far least likely to experience racism and they experience racism far less often.

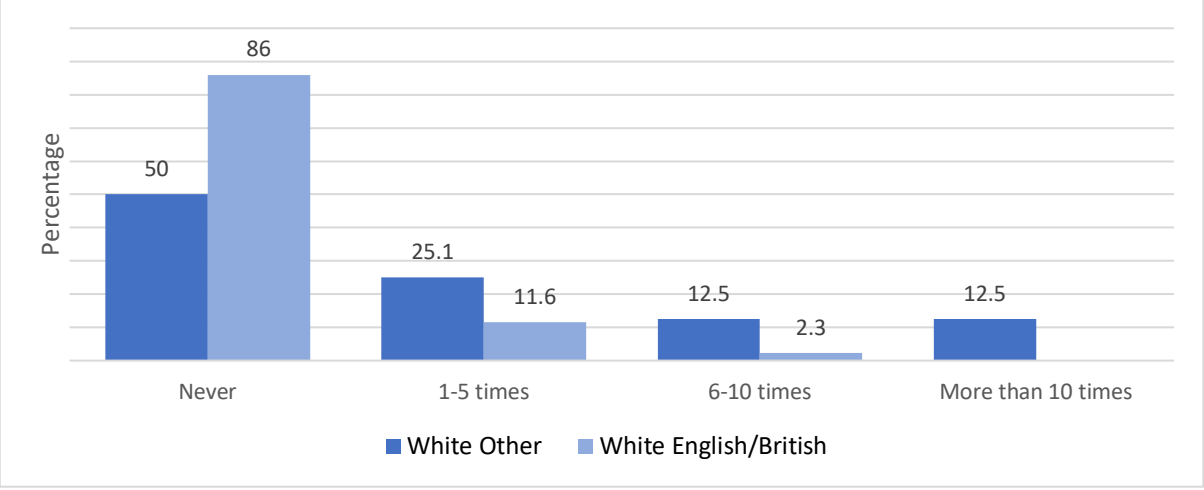


Figure 12 How often in the last year have you experienced racism directed at you in your workplace? White Other cf. White British/English

5 Being falsely accused or criticised because of race

White vs non-White groups [statistically significant difference p<.001].

26.2% of White respondents had been falsely accused or criticised because of their race compared to 57.4% of the non-White respondents. This happened *occasionally/sometimes* for 19% of White respondents and 43.3% of non-White respondents and *frequently/all the time* for 11.5 % of White respondents and 13.2% of non-White respondents.

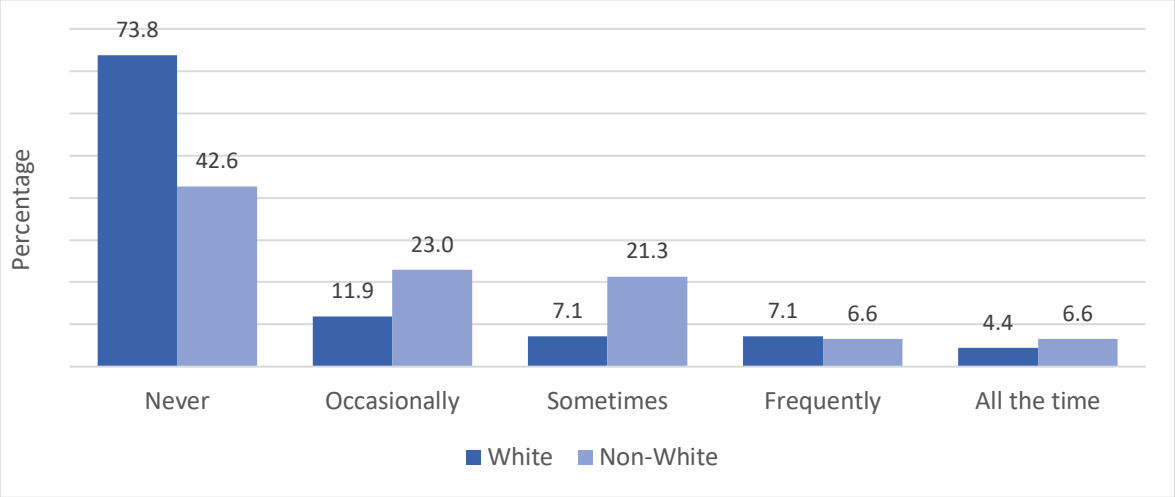


Figure 13 I have been falsely accused or criticized because of my race. White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

66.7% of South Asian respondents and 38.9% of Black respondents reported being falsely accused or criticised because of their race. This happened *occasionally/sometimes* for 54.6% of South Asian respondents and 22.3% of Black respondents and *frequently/all the time* for 12.2% of South Asian respondents and 16.7% of Black respondents.

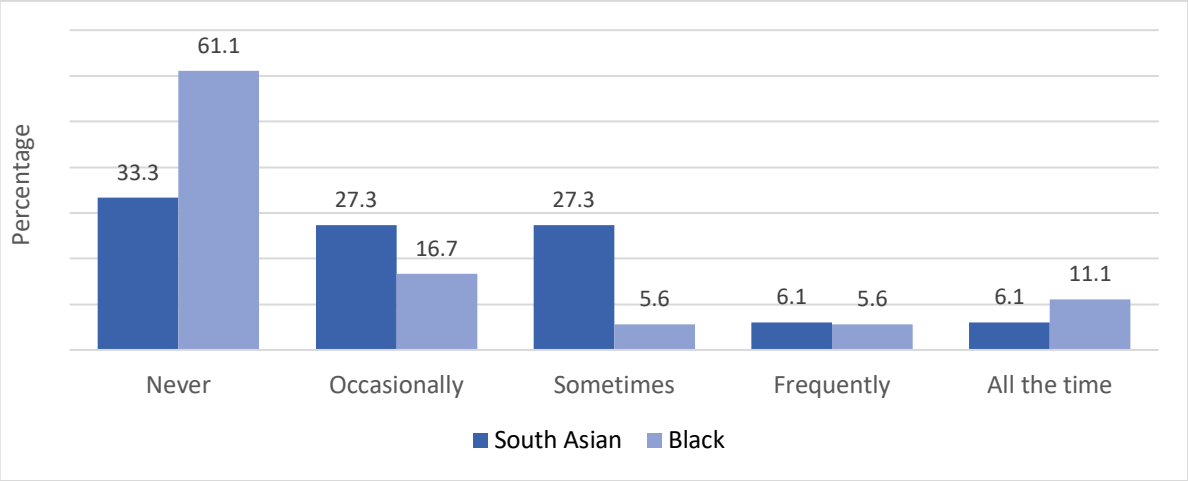


Figure 14 I have been falsely accused or criticized because of my race. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

17.2% of White English/British respondents said they had been falsely accused or criticised because of their race compared to 54.7% of the White Other respondents. This happened *occasionally/sometimes* for 17.2% of White British/English respondents and 39.1% of White Other respondents and *frequently/all the time* for 0% of White British/English respondents and 15.6% of White Other respondents.

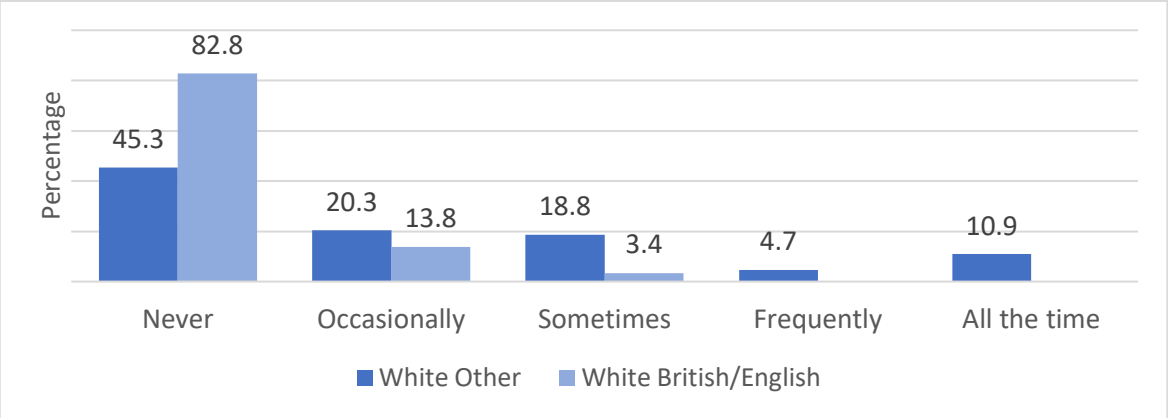


Figure 15 I have been falsely accused or criticized because of my race. White Other cf. White British/English

6 Assumptions about ability or behaviour based on racial stereotypes

White vs non-White groups [statistically significant difference p<.004].

78.7% of non-White respondents but only 40.5% of White respondents were subjected in the workplace to racially based stereotyped assumptions. This happened *occasionally/sometimes* for 21.4% of White respondents and 55.7% of non-White respondents and *frequently/all the time* for 19.1% of White respondents and 23% of non-White respondents.

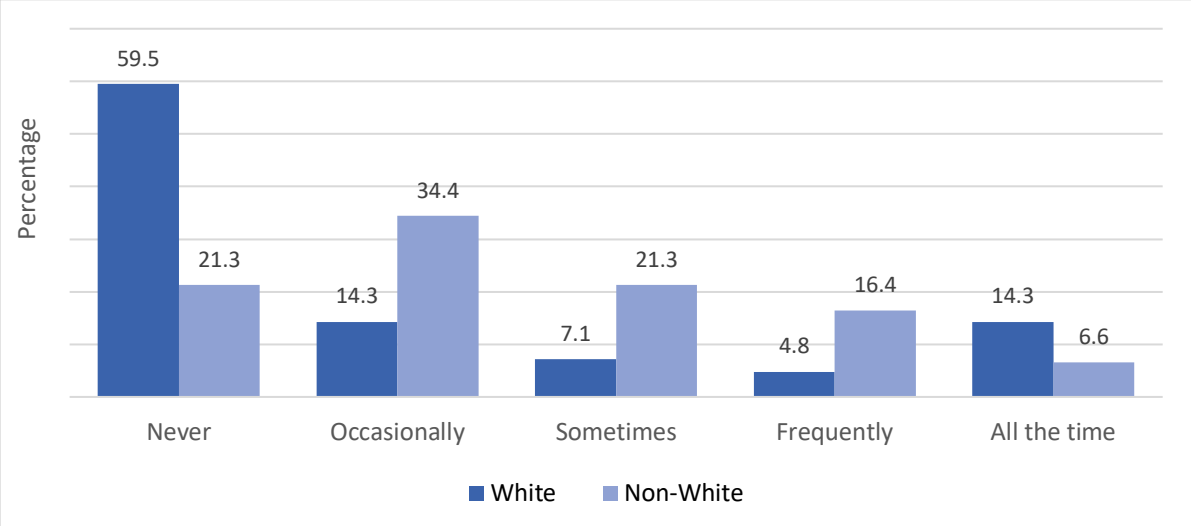


Figure 16 Assumptions about my ability or behaviour based on stereotypes of my race. White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

88.7% of South Asian respondents and 78.3% of Black respondents reported having been subjected to workplace racially based stereotyped assumptions. This happened *occasionally/sometimes* for 35.8% of South Asian respondents and 47.8% of Black respondents and *frequently/all the time* for 15.1% of South Asian respondents and 8.7% of Black respondents.

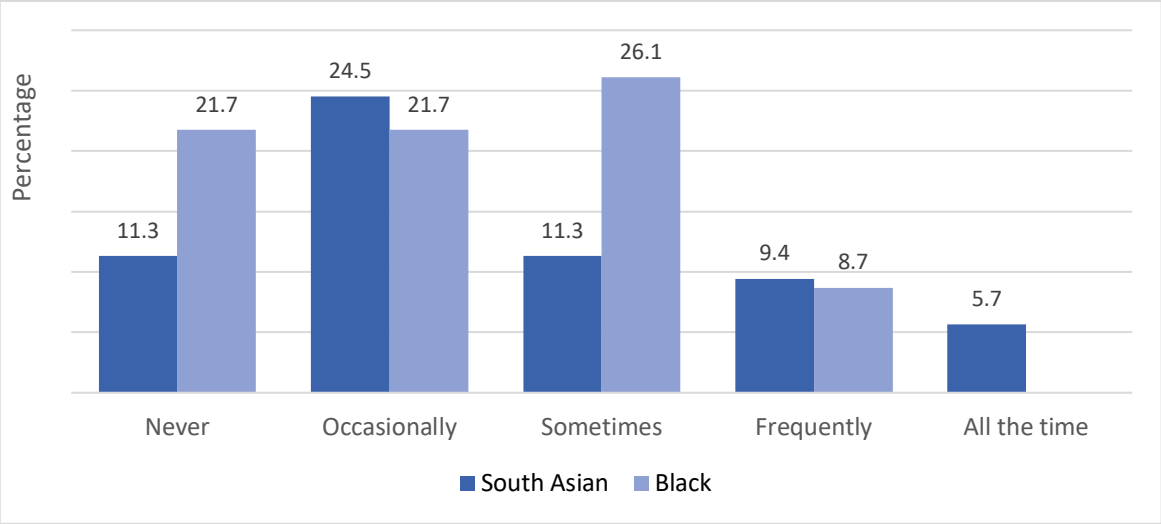


Figure 17 Assumptions have been made about my ability or behaviour based on stereotypes of my race. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

Only 31% of White English/British respondents but 75% of White Other said they had been subjected to racially based stereotyped assumptions about behaviour and ability. This happened *occasionally/sometimes* for 20.6% of White British/English respondents and 51.6% of White Other respondents and *frequently/all the time* for 10.3% of White British/English respondents and 23.4% of White Other respondents.

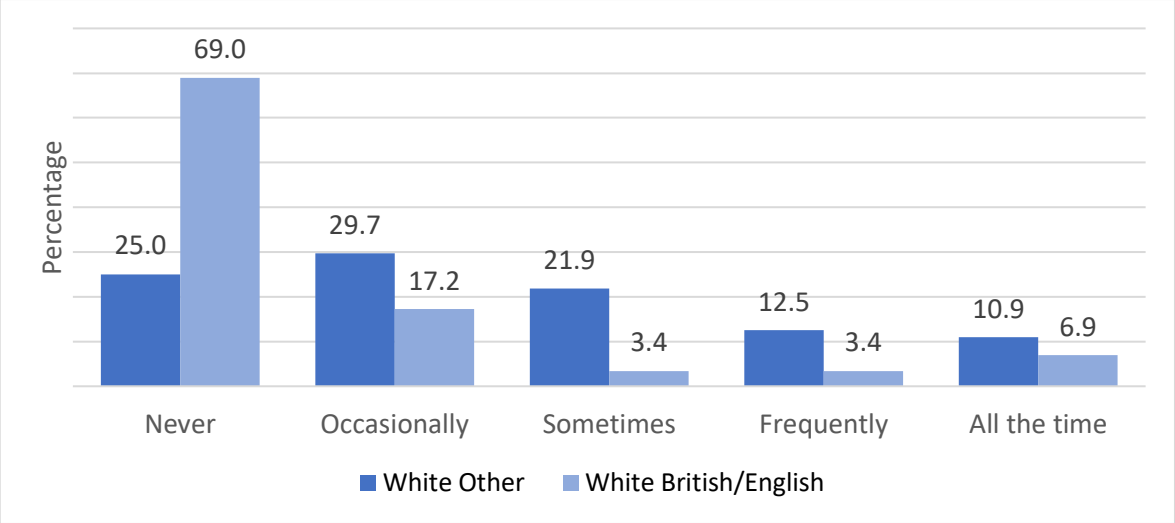


Figure 18 Assumptions made about my ability or behaviour based on stereotypes of my race. White Other cf. White British/English

7 Direct verbal racial abuse

White vs non-White groups [statistically significant difference p<.001].

Non-White respondents were nearly four times as likely [45.9%] as White respondents [12.2%] to say that they had been subjected to direct racial abuse in the workplace. Most of the non-White respondents said this happened *occasionally/sometimes* [39.4%] compared to most of the White respondents [7.3%]. 4.9% White respondents said this happened *frequently/all the time*, but 6.6% of non-White respondents indicated that it did.

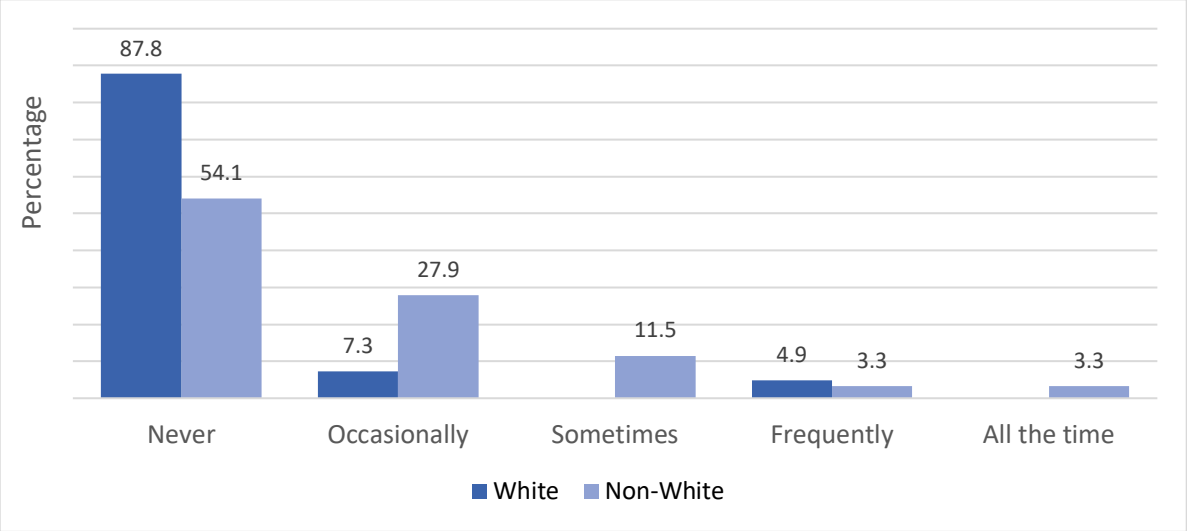


Figure 19 I have been verbally abused because of my race. White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

Nearly 63.6% of South Asian respondents and 61.1% of Black respondents reported having been verbally abused because of their race. This happened *occasionally/sometimes* for 57.6% of South Asian respondents and 44.5% of Black respondents and *frequently/all the time* for 6% of South Asian respondents and 16.7% of Black respondents.

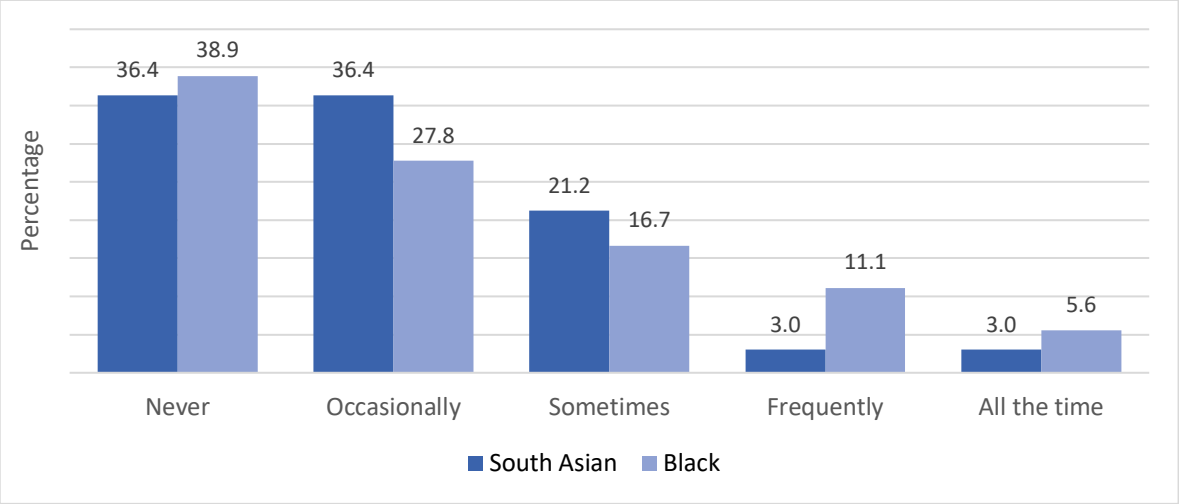


Figure 20 I have been verbally abused because of my race. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

24.1% of White British/English respondents said they had been verbally abused because of their race, compared to 60.3% of White Other respondents. The verbal racial abuse directed at White English/British respondents was only done *occasionally* [24.1%], but that directed at White Other respondents was done mostly *occasionally/sometimes* [52.3%] with 8% of White Other respondents experiencing this *frequently/all the time*.

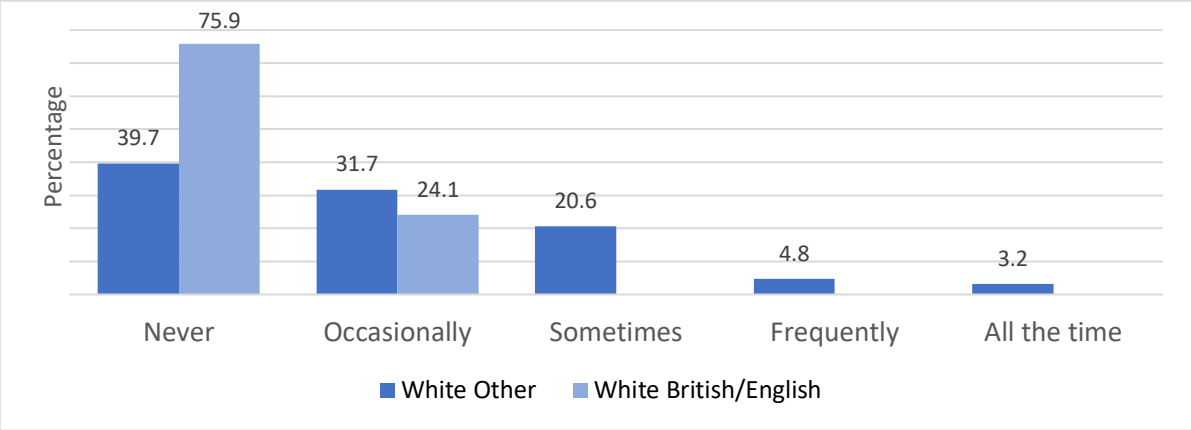


Figure 21 I have been verbally abused because of my race. White Other cf. White British/English

8 Not always actively included in work activities by colleagues because of race/ethnicity

White vs non-White groups [statistically significant p<.001].

66.7% of non-White respondents felt that they were not always included in activities because of their race compared to 44.1% of White respondents. This had happened *occasionally/sometimes* for 1.5% of White and 22.9% of non-White respondents and *frequently/all the time* for 4.4% of White and 13.8% of non-White respondents.

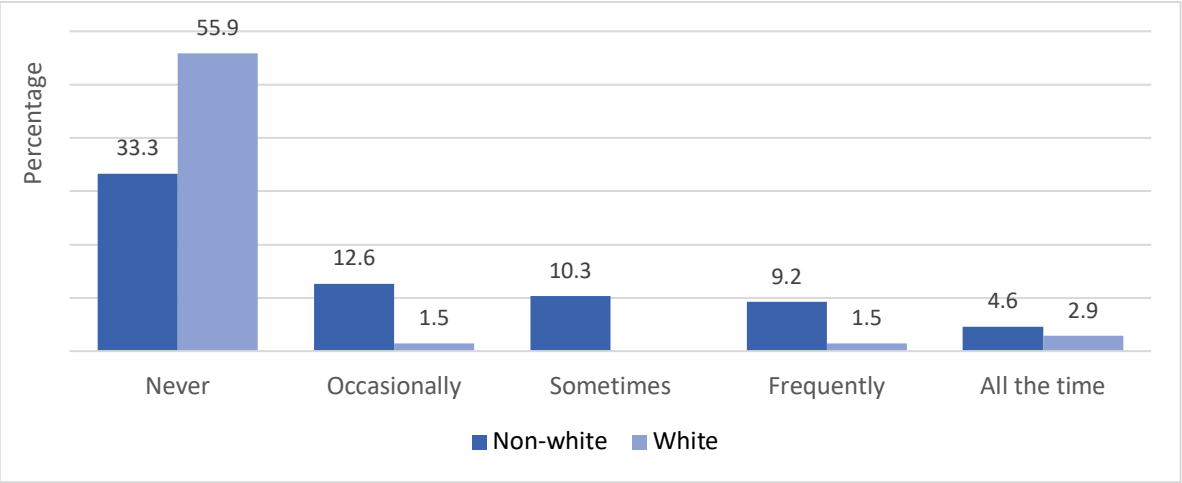


Figure 22 Because of my race/ethnicity, I am not always actively included in activities by my colleagues. Non-White cf. White

Black vs South Asian groups [statistically significant difference p=.028]

66.7% of South Asian respondents had felt not always included in activities because of their race compared to 27.8% of Black respondents. This happened *occasionally/sometimes* for 42.5% of South Asian and 16.7% of Black respondents and *frequently/all the time* for 24.3% of South Asian and 11.2% of Black respondents.

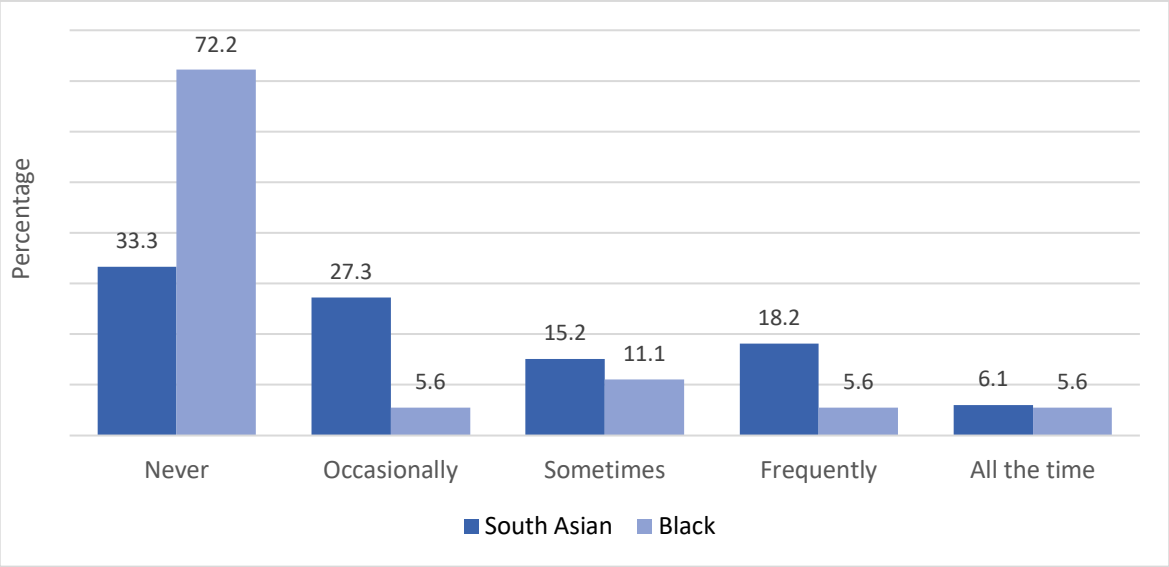


Figure 23 Because of my race/ethnicity, I am not always actively included in activities by my colleagues. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

Only 3.4% of White English/British but 46.9% of White Other respondents had felt they were not always included in activities by their colleagues because of their race. This happened *occasionally/sometimes* for 3.4% of White British/English respondents and 26.5% of White Other respondents and *frequently/all the time* for 0% of White British/English respondents and 20.3% of White Other respondents.

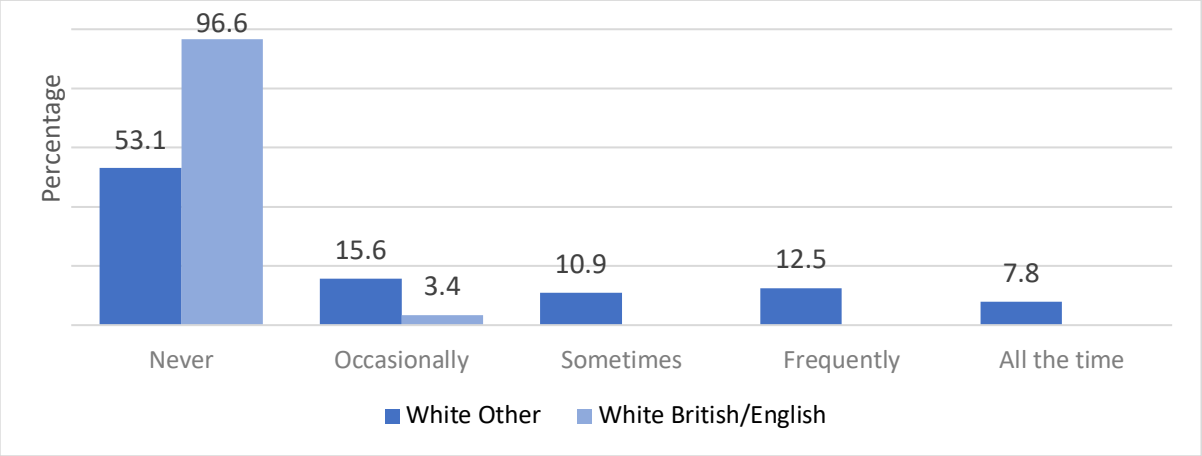


Figure 24 Because of my race/ethnicity, I am not always actively included in activities by my colleagues. White Other cf. White British/English

9 Intentional exclusion from work or social events because of race

White vs non-White groups [statistically significant difference p<.001].

Only 12.2% of White respondents but 45.9% of non-White respondents had felt intentionally excluded from work or social events because of their race. This happened *occasionally/sometimes* for 7.3% of White respondents and 39.4% of non-White respondents and *frequently/all the time* for 4.9% of White respondents and 6.6% of non-White respondents. The extent to which this reflects work or social events is not known.

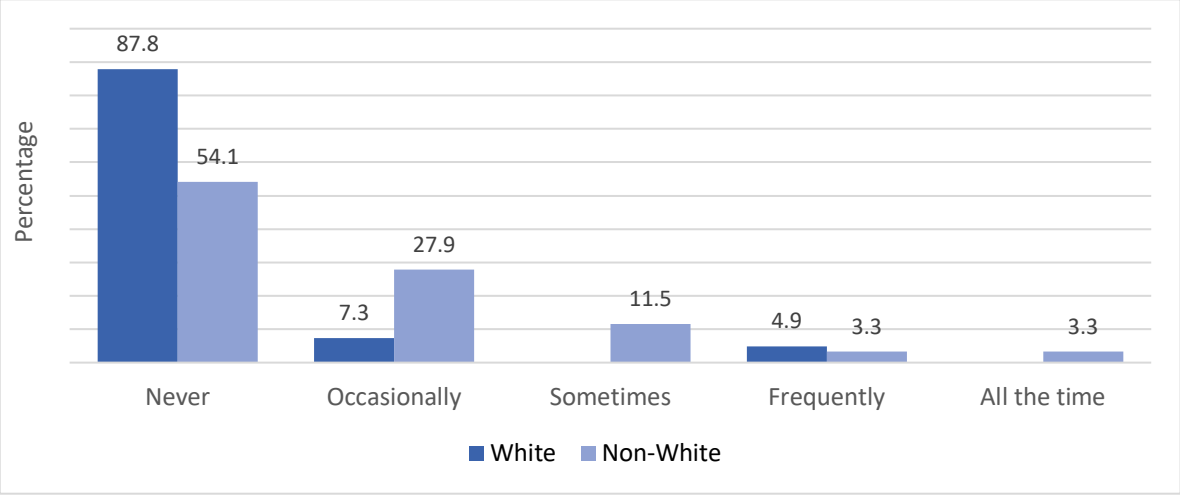


Figure 25 Intentionally excluded from work or social events because of my race. White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

Only 27.8 % of Black respondents but 57.6% of South Asian respondents had felt intentionally excluded from work or social events because of their race. This happened mostly *occasionally/sometimes* for 48.5 % of South Asian respondents and 22.3% of Black respondents and *frequently/all the time* for 9.1% of South Asian respondents and 5.6% of Black respondents.

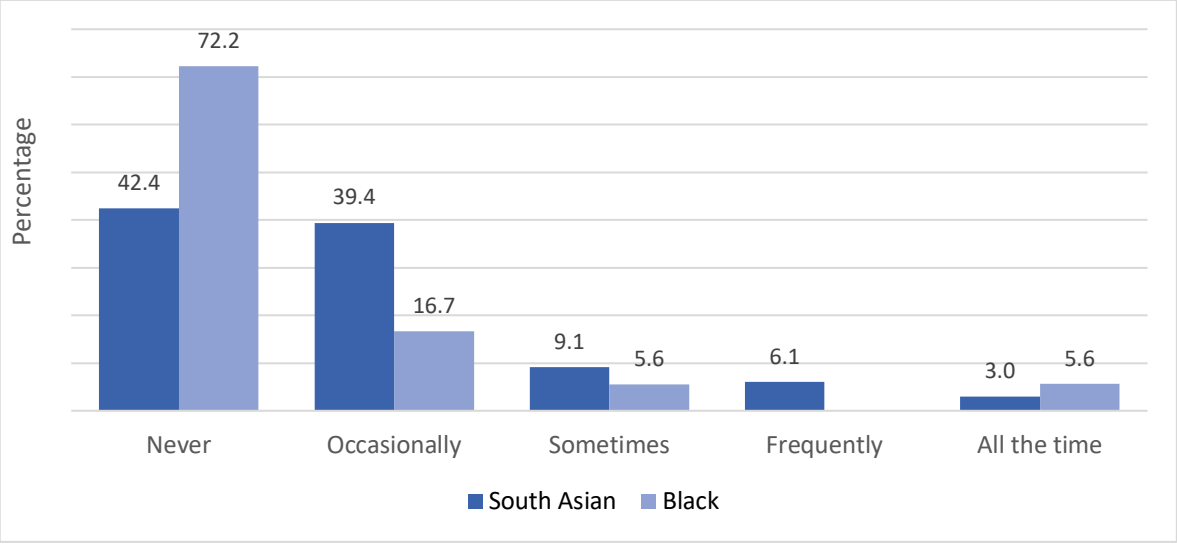


Figure 26 Intentionally excluded from work or social events because of my race. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

Only 6.9% of White English respondents compared to 42.9% of White Other respondents had felt intentionally excluded from work or social events because of their race. This happened *occasionally/sometimes* for 6.9% of White British/English respondents and 33.3% of White Other respondents and *frequently/all the time* for 0% of White British/English respondents and 9.5% of White Other respondents.

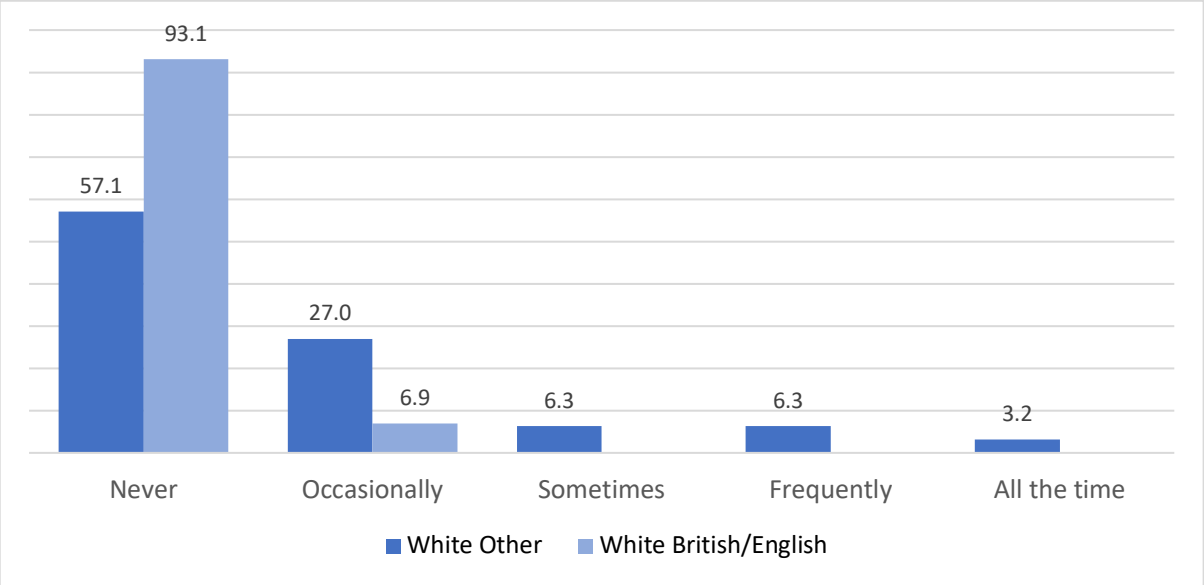


Figure 27 Intentionally excluded from work or social events because of my race. White Other cf. White British/English

10 Differential treatment due to race/ethnicity

White vs non-White groups [statistically significant difference p<.001].

52.9% the White respondents but 86.2% of the non-White respondents felt that they are treated differently (less well) because of their race. This happened *occasionally/sometimes* for 7.4% of White respondents and 35.6% of non-White respondents and *frequently/all the time* for 5.9% of White respondents and 19.5% of non-White respondents. This reflection of *Othering*, whereby the *Other* is seen as *not one of us* [27]. The extent to which this reflects work or social events is not known.

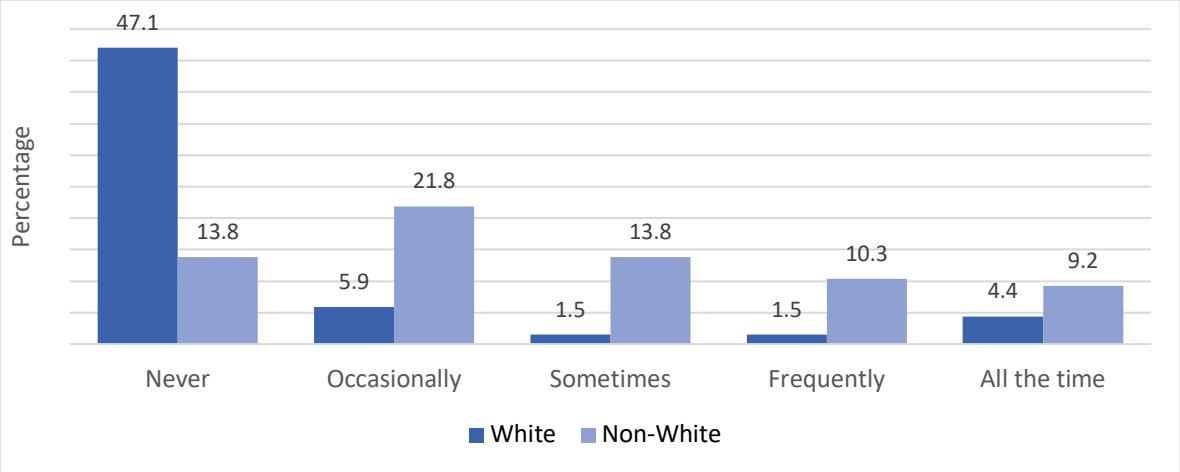


Figure 28 Because of my race, I am treated differently. Non-White cf. White

Black vs South Asian groups [no statistically significant difference]

87.5% of South Asian respondents but 72.2% of Black respondents felt that they had been treated differently because of their race. This happened *occasionally/sometimes* for 59.4% of South Asian respondents and 50% of Black respondents and *frequently/all the time* for 28.1% of South Asian respondents and 22.3% of Black respondents.

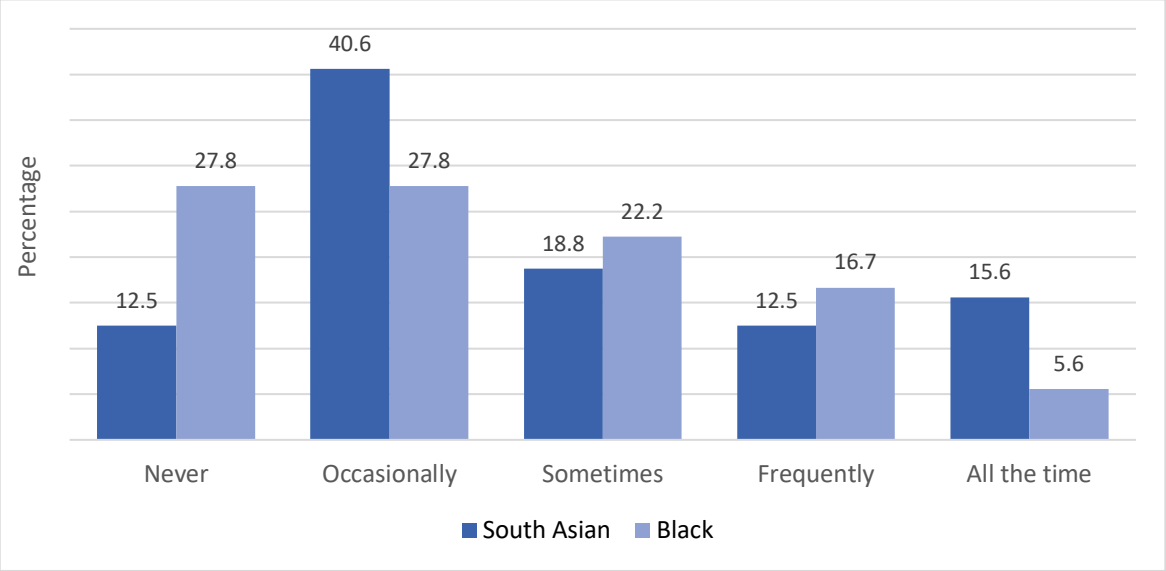


Figure 29 Because of my race, I am treated differently. South Asian cf. Black

White British/English vs White Other groups [statistically significant difference p<.001]

Only 17.9% of White English/British respondents compared to 71.4% of White Other respondents felt that they had been treated differently because of their race. This happened *occasionally/sometimes* for 14.3% of White British/English respondents and 46.1% of White Other respondents and *frequently/all the time* for 3.6% of White British/English respondents and 25.4% of White Other respondents. The highly statistically significant difference reflects the marked difference in experience between the White English/British and White Other groups.

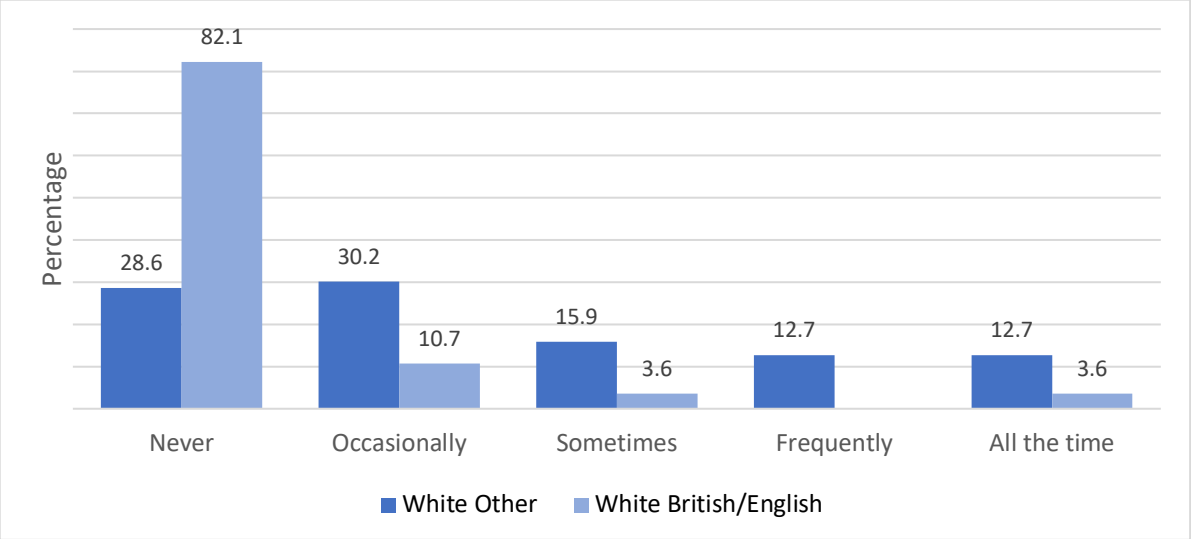


Figure 30 Because of my race, I am treated differently. White Other cf. White British/English

Racism in the community (outside the workplace)

White vs non-White groups [statistically significant difference p<.001].

Only 19.6% of White respondents compared to 62.5% of Non-White respondents were subjected to racism outside the workplace i.e. in the community during the previous year. This happened between 1-5 times for 19.6% of White respondents and for 45.9% of non-White respondents and 6 times or more for 0% of White respondents but 16.7% for non-White respondents. This reflection of *Othering*, whereby the *Other* is seen as *not one of us* [27]

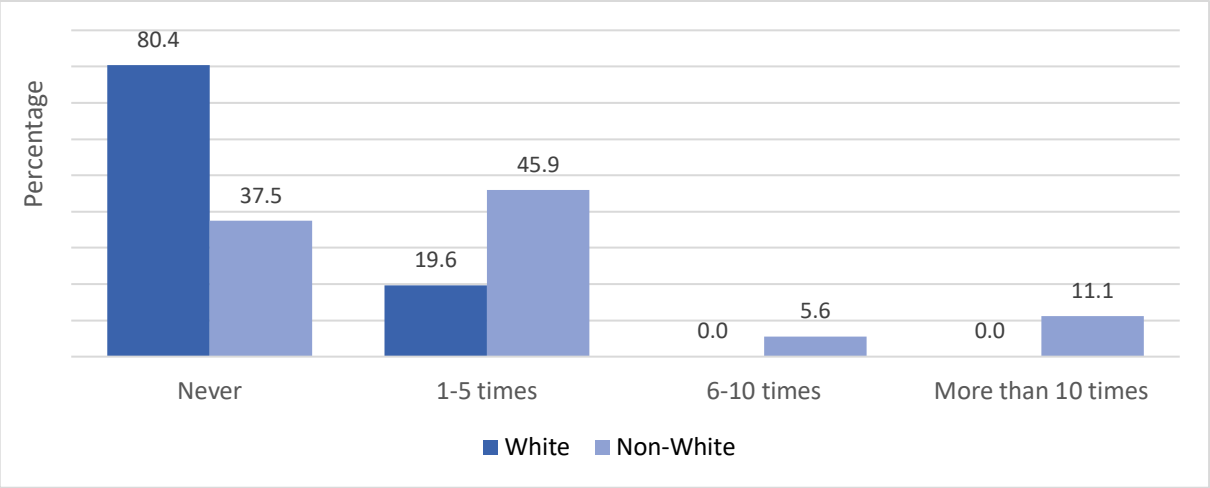


Figure 31 Frequency of racism directed at you in your local community? White cf. Non-White

Black vs South Asian groups [no statistically significant difference]

61% of South Asian respondents but 66.7% of Black respondents had experienced racism outside the workplace in the local community. This happened between 1-5 times for 43.9% of South Asian respondents and 42.9% of Black respondents and 6 times or more for 17.1% of South Asian respondents compared to 23.8% of Black respondents.

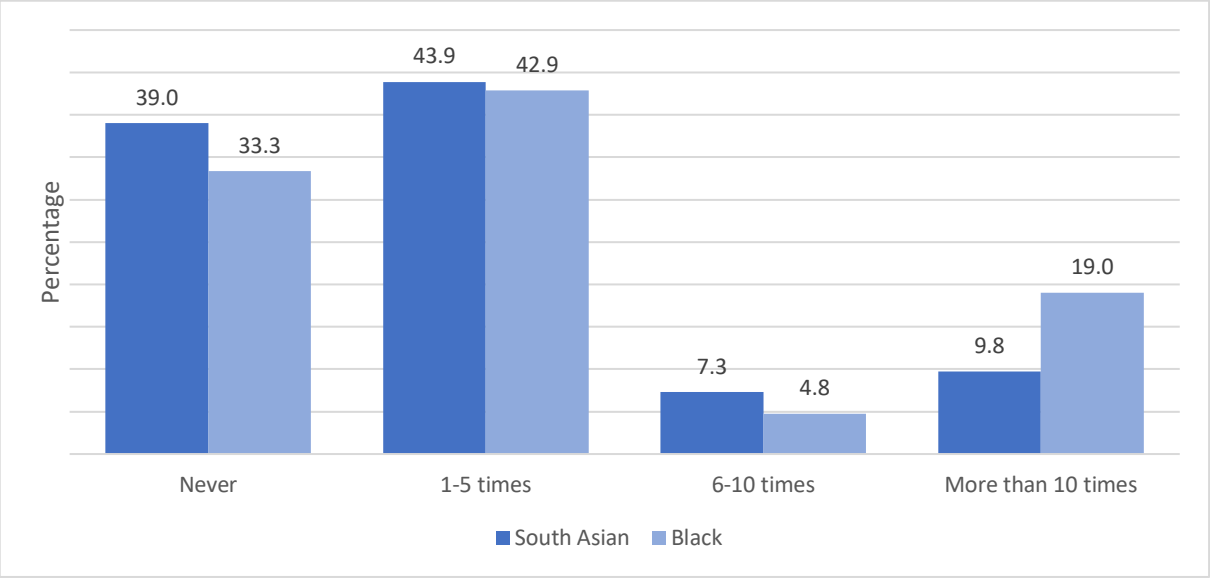


Figure 32 Frequency of racism directed at you in your local community? South Asian cf. Black

White British/English vs White Other groups [p<.001]

Only 19.4% of White English/British but 54.5% of White Other had experienced racism directed at them in the community. This happened between 1-5 times for 19.4% of White British/English respondents and 39% of White Other respondents and 6 times or more for 0% of White British/English respondents and 15.5% of White Other respondents.

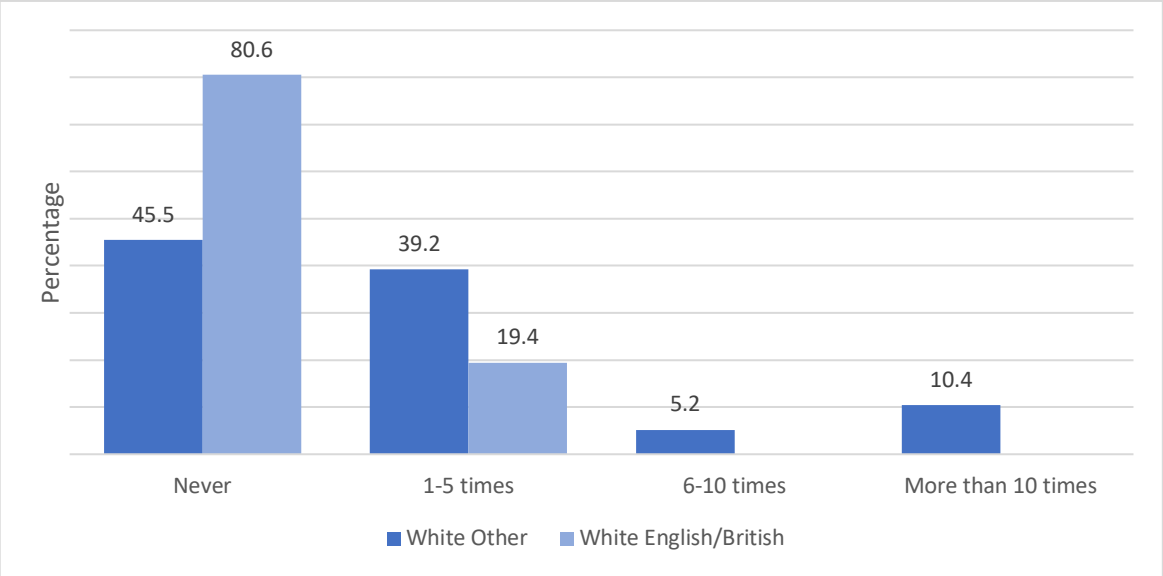


Figure 33 Frequency of racism directed at you in your local community? White Other cf. White British/English

QUALITATIVE DATA ANALYSIS

Profile of free-text survey and interview samples

The profile of the respondents to the survey who provided free text (qualitative data) and the profile of the those who took part in interviews is summarised in table 2.

Table 2: Profile of free-text survey respondents and interviewees

Items	Free text comments sample n=50	Interview sample n=22
Gender	Female: 70% Male: 28% Non-binary: 2%	Male 18% Female: 82% Non-binary: 0%
Age	18-25: 2% 26-35: 20% 36-45: 24% 46-55: 36% 56-65: 18%	18-25: 5% 26-35: 18% 36-45: 32% 46-55: 27% 56-65: 18%
Ethnicity	White: 38% White English/British: 24% White Other: 14% Non-White: 62% South Asian: 32% [Indian 28%, Pakistani 4%] Black: 24% [Black Africans 12%, Black British 12%] Non-White Other (mixed) 4%	White: 4% White English:4% White Other 0% Non-White: 95% South Asian: 59% [Indian 54%. Pakistani 5%] Black: 27% [Black African 27%] Non-White Other (mixed) 9%
Place of work	Hospital setting: 42% [4/5 non-White] Social care: 24% [3/4 non-White] Community care: 6% [1/3 non-White] Mental health: 20% [1/3 non-White] General practice: 8% [all non-White]	Hospital setting: 73% [97% non-White] Social care: 5% [all Mixed] Community care: 0% Mental health: 9% [1/2 non-White] General practice: 14% [all non-White]
Main type of role	Hospital nurses: 29% [4/5 non-White] Social care practitioners: 14% [3/4 non-White] Community care nurses: 6% [1/3 non-White] Mental health nurses: 20% [1/3 non-White] Hospital medical practitioners: 8% [all non-White] GPs: 8% [all non-White] Administrative roles: 14% [1/4 non-White]	Hospital nurses: 73% [97% non-White] Social care practitioners: 5% [100% Mixed] Community care: 0% Mental health: 9% [1/2 non-White] Hospital medical practitioners: 9% [all non-White] GPs: 14% [all non-White] Administrative role: 0%
Length of time in England	No information	n=5 UK <1 year [28%] n=3 for 2 years [14%] n=4 > 5 years [18%] n=10 >15 years [36%]

Those who made free-text comments were primarily non-White [62%] (South Asian = 32%; Black = 24%), women [70%] and aged 36-55 [60%]. Most of them were nurses [55%] split between hospital and community and mental health. Other participants were medical practitioners [22%] split between hospital and General Practice, and by social care practitioners [14%].

Those who took part in interviews were primarily non-White [95%] (South Asian = 59%; Black = 27%), women [82%] and aged 36-55 [59%]. 82% of them were nurses of whom 89% were working in a hospital setting. 5% were social care practitioners; medical practitioners made up 23% and, of these, 60% were GPs and 40% hospital based. See the Appendix for more details.

As part of their role, a total of 7 out of 22 clinical interviewees [32%] provided some form of support to international students or trainees (85% had been brought up and undertaken their initial professional training and education outside the UK, mostly in India, Nigeria, and Pakistan).

All those who provided background information [n=8] had a leading role in health and well-being or EDI within local NHS or Local Authority, and/or Royal College of Nursing. The demographic profile was 86% female [n=7] and 14% male [n=1] with 29% [n=2] from ethnic minorities and 71% White English/British [n=6], all of whom had been brought up, educated and trained in the UK.

Not experienced racism

Free text data from the survey

No comments were made about non-experience of racism.

Interviews only

Only 10% of interviewees had experienced no racism in their present jobs and were working in proactively highly supportive environments. They were given clear guidance as to what was required of them and were encouraged to speak up; what they suggested was taken into consideration; they were made to feel valued, had a supportive mentor, and worked as a team in which there was no degrading or disparaging of anybody. Interestingly, those few who experienced no racism were very newly arrived international nurses who had experienced racism while working in previous countries.

Racism in the workplace

Racism from patients/family

26% of those who provided qualitative comments in the survey and 50% of the interviewees referred to experiencing or witnessing racism from patients or their family as they carried out their professional duties (comments about accent or way of speaking, racial slurs, and requests by patients to be seen and cared for by White/British/English practitioners).

Free-text data from survey

- 25% of those who provided free-text comments described racism from parents and families. 54% of these respondents said it was because of their accent or way of speaking, which often was equated with lack of professionalism or cultural competence (in relation to British/English ways).
- 23% had experienced racial slurs, including one female White British.
- 14% had experienced [9%] or witnessed [5%] patients and families asking for White/Caucasian/English staff (*do not want to be seen by doctors who have hands that are not white)*

- 54% took no action, 20% had spoken to the perpetrator, 26% had either spoken to someone in charge of the unit [12%] or reported this to their manager [14%] with only 2% referred to EDI for support.

Interviews

Half the interviewees [n=11], three of whom had spent all or most of their lives in the UK, talked about racism from patients and/or their families which can be divided into four main types in descending order of frequency:

1 Racially abusive labelling comments directed at minority ethnic groups ("fucking nigger", "you look like a slave", "you're black like pooh", "you're too black to be a doctor")
2 Being told to go back to your country
3 Patients refusing to take their medication from ethnic minority members of staff, but not from White English members of staff
4 Demands to be seen by English/White/Caucasian staff (prompted by accents from minority ethnic groups perceived as foreign by patients/family)
5 Patients complaining about, and denigrating, the accent or manner of speaking of ethnic minority members of staff, including White Other
6 Minority ethnic groups directing racial abuse at White British member of staff ("White bitch")

Interviewees pointed out that things were made worse because the system is set up in such a way that unacceptable racist behaviours are not discouraged but are made more likely. 23% of interviewees reported that:

- Some patients ask for a White English doctor as soon as they hear a foreign accent instead of asking the clinician to speak a bit louder, clearer or slower
  - If patients are racially abusive to a minority ethnic doctor, they are seen by a White English doctor
  - English colleagues do not intervene to help them or provide support
  - Clinical staff are told they should understand the perspective of patients
- Raising concerns about racism from patients with senior staff is brushed off to the extent that it has become the norm, unless they try on purpose to get members of staff in some trouble
- Very few senior staff tell the patients that making racially abusive comments or asking for White, English, or Caucasian staff is unacceptable
- Refusal to write to the patient to make clear the inappropriateness and unacceptability of not wanting to be seen by someone from a minority ethnic group.
- Requests and suggestions to the senior leadership and decision-makers that letters to patients should indicate zero tolerance of racism have yet to be implemented.
- Typically, there are lots of equality & diversity and dignity at work policies, but these are ignored.

Perspectives from EDI-related staff

- EDI-related staff were aware that some of the ethnic minority workforce had been getting a lot of abuse from patient and their families.
- This tended to be managed by doing nothing if service users had to be looked after for a very short period, besides ensuring that service users not be cared for by staff from ethnic minorities if they have asked for non-ethnic minority staff or specifically White English staff.
- All too often staff from ethnic minorities 'just put up with it'. EDI-related staff were trying to help them to no longer put up with such unacceptable behaviour from patients.

Racism from colleagues

1. Racism by members of staff towards patients/clients from ethnic minority groups

Free-text data from survey only

- A total of n=2 [4%] of those who provided free-text comments referred to witnessing racism by White British/English members of staff towards patients/client from minority ethnic groups by ignoring or not speaking directly to the patient/client and blaming ethnic minorities patients for Covid-19.
- All those who witnessed this spoke to the perpetrators and supported communication client and service user. No interviewee referred to this topic.

2. Racism by ethnic minority members of staff towards White British/White English members of staff

Free-text data from the survey only

- A total of n=3 [6%] of those who provided free-text comments in the survey referred to experiencing [2%] or witnessing [4%] racism by male ethnic minority members of staff towards White British/White English female members of staff by direct bullying or making derogatory comments against about White females, including labelling them as promiscuous.
- None of them took any action as they were too shocked and afraid to be accused of racism

3. Racism by White English/British members of staff towards ethnic minority members of staff

3.1. Language and communication

Free-text data from the survey

A total of n=5 respondents (10%) of the free-text questions alluded to language and communication issues in relation to members of staff.

Interviews only

A total of n=17 of interviewees [77% of the interview sample and 89% of the international members of staff not brought up in the UK with English not as their first language] referred to language and communication issues between ethnic minority and non-ethnic minority colleagues (issues related to accent due to not having English as first language which equated to lesser competence, and which decreased as seniority increased and different culture and different working practices). Only n=3 interviewees out of n=17 [18%] raised detrimental issues related to accent with their line manager [12%] or the perpetrator [6%] with n=2 receiving no satisfactory action or response.
Two main language and communication themes and sub-themes emerged:

a) accent due to not having English as first language and
b) different culture and different working practices.

a) Accent and English not as first language
   - constant references to differences in accent and way of speaking at both individual and collective levels

- constant requests to repeat what was said
- disrespect, being ignored or isolated
- difficulties understanding native accents
- lesser career progression and job opportunities
- feeling left out, undervalued and isolated feeling left out, not able to make friends, undervalued and isolated
- frequency of comments slowed down with seniority
- more accepted when language improved but still not made to feel you fit in

b) Communications issues linked to different working practices
- way of speaking to and interacting with patients is very different in England
- some words are not used in everyday language 'back home in India' e.g. 'please' and 'thank you'
- speaking with international colleagues in their own language while on the ward led to patients making complaints
- international nurses get regular visits on the wards from a team of international nurses to check for problems, and, in particular, communication problems
- managing expectations is a two-way process

Perspectives from EDI-related staff

- The challenges faced by a nurse not trained in the UK and with a different first language of acculturating into the English context were strongly emphasised.
- Due to the negative impact of senior medical staff speaking disrespectfully to nurses on patient outcomes, EDI initiatives to improve civility and respect between NHS colleagues by using a nudge theory approach would soon be implemented.

3.2. Made to feel they do not belong and fit in

A total of n=10 [20%] of those who provided free-text comments in the survey and 17 interviewees [77%] (of whom 80% were 'international' i.e. not born, brought up, or initially trained in the UK) referred to experiencing racism based on micro-aggressions and unconscious bias which led them to being made to feel that they did not quite belong or fit in.

Free-text data from the survey

Micro-aggressions and covert/indirect /subtle/passive racism and feeling they do not quite fit in were divided into five categories outlined in descending order of importance:

- Negative assumptions based on race/ethnicity [40%]
- Subtle and micro-aggressions that may not be obvious to others [40%]
    - *The looks or the suspicions when they meet you and comments directed either at you or to other people about you behind your back*
    - A lot of unverbalised prejudice, but body language and actions often make the perpetuator's intentions obvious
- Using outmoded terminology [20%]

Interviews

- Of n=19 interviewees not brought up and initially trained in the UK, 75% were international nurses and 25% medical practitioners.
- Most of the international nurses [41% of the sample] emphasised how very welcome they were made to feel at the very beginning when they had just arrived.

- However, apart from two nurses (9% of the sample) who had been in the UK only for a few months, and who said they had experienced no racism in their current post and worked in a collegial and supportive environment, 'international' nurses and medical practitioners reported of being:
  - Viewed with suspicion when they first arrived in their unit/department
  - Made to feel they did not belong with a focus on differences
  - Subjected to negative untrue comments such as 'you have come in to take all our jobs'
  - Getting ignored by White/non-ethnic minority colleagues when making casual greetings in the corridor
  - Shunned by White colleagues who avoid interacting with them
    - Excluded from paired activities that required two members of staff (because they are not understood or assumed to not know what they are doing)
    - Excluded from some work-related social events
    - Non-minority ethnic/native team not talking to, thanking and/or saying goodbye them at the end of the shift during handover
  - Made to feel that they would fit in better in an urban rather than a rural area
  - Given mainly patients from visible ethnic minorities and non-English patients from the EU who don't speak English.

3.3. Contribution to the team and organisation less valued

A total of n=13 [26%] of those who provided qualitative comments in the survey and n=19 [86%] of interviewees referred to differential treatment with input to team and organisation less valued. This was done by way of micro-aggressions and unconscious bias.

Free-text data from the survey

Differential treatment with input to team and organisation less valued was described in the following way in order of importance:

- Constantly undermined and unsupported, put on the spot at meetings and made to feel stupid in front of others
- Not supported by senior staff
    - Always having to prove to senior and other colleagues that they can do the job
    - Made to feel that they do not know what they are doing and should not be there
    - Observing that junior members of staff who are from ethnic minorities had to be very careful about everything because of feeling scrutinised and unsupported by their managers
- Not supported by junior staff and having to do all the work themselves instead
- Given rotas in both secondary and primary care often set up in unfavourable ways without adequate senior support and not only providing fewer opportunities for career progression because they were Black or Brown medical trainees, but not ensuring patient safety while White colleagues were well-supported with many career development opportunities
- Treated as if they were at a lower grade than they actually were
- False allegations based on assumptions that people like them are not good at doing the job
- Derogatory hurtful comments made individually and collectively
- Their efforts were not recognised
- Their decisions and authority were questioned. The same decisions made by white clinicians were accepted.
- Mistakes by White staff went unnoticed whilst mistakes by those from ethnic minority groups were exaggerated
- Having to take the blame for things for which they were not responsible

- Institutional racism, very difficult to stop, starting at management level

Interviews

All but two of those interviewed were from visible ethnic minorities [95% of the sample] and had experienced various amounts of less favourable treatment and micro-aggressions from senior and other staff in relation to their input to the team and organisation with a lesser value attached to their contribution. Their experience was similar to those who had made free-text comments:

- Supervisors and managers underlining that the clinical knowledge of staff not brought up in the UK was somehow deficient
- Contribution not acknowledged when talking to managers or in staff meetings
- White colleagues praised for making a suggestion for improvement, which had been ignored when made by visible ethnic minority staff
- Mistakes by White staff went unnoticed, but theirs were exaggerated
- Getting blamed for mistakes and receiving no additional support whilst the same mistake made by a White/British colleague would be almost rewarded by reassurance and additional support/opportunities
- Not getting told what has been done wrong but instead being immediately reported to someone higher up
- Colleagues, particularly administrative staff, misusing multisource feedback mandatory assessments to target trainees from ethnic minorities by writing very bad and untrue feedback in their portfolio which becomes part of their record of work.

Interviewees underlined the disparity in treatment as shocking with those from ethnic minorities having to be very careful about everything because they feel so scrutinised for potential mistakes and so unsupported by their managers.

Very few interviewees had taken action about being treated less favourably because of their race**.**

- 77% had taken no action.
- Only two interviewees had reported less favourable treatment to their line manager [9%]
- Only one had filed a formal complaint to the employer [5%]

Perspectives from EDI-related staff

EDI staff emphasised an unfair pattern in relation to disciplinary procedures. Often White British or English nurses who have done ‘exactly the same thing’ as those from minority ethnic groups were not even subjected to a slap on the wrist while a nurse from a minority ethnic group was being put through a disciplinary process and potentially dismissed.

3.4. Negative impact on career progression

A total of n=5 [10%] of those who provided free-text comments in the survey and n=10 of interviewees [45%] referred to experiencing the negative impact of racism on career progressions.

Free-text data from the survey

The negative impact of racism on career progression was underlined by both those from ethnic minorities and by White English/British respondents as definitely playing a part in who is being chosen with unconscious bias preventing opportunity for career progression.

Those from minority ethnic groups also described that:

- Race had hindered promotions as others with less knowledge and experience have gone a lot further and the only reason that they could think of was race
- Not being given the same opportunity as others was due to an undertone of non-acceptance of non-white British professionals and subtle resistance towards giving them opportunities for development and career progression

Interviews

45% of those interviewed underlined differential treatment by way of lesser career opportunities linked to being from their belonging to an ethnic minority group.

- Had to do a lot of routine work that does not lead to career advancement
- Told several times not to apply for a job as they would not be interviewed
- When interviewed they were given spurious reasons for not being appointed
- Not made aware of schemes such as the Clinical Excellence Award until after completion of training

Some interviewees said that the notion of equality of opportunity was largely misunderstood by managers who did not grasp the concept of equity and the idea of mitigating or removing unnecessary barriers to equalise opportunities.

Perspectives from EDI-related staff

- The negative impact of racism on the career progression of ethnic minority staff has long been key concerns for healthcare and medical validating organisations.
- Members of staff from ethnic minority groups often do not feel that they can put themselves forward for promotion. If they do, they are typically told they did well and were 'almost' offered the job, but somebody else not from an ethnic minority group gave that little bit extra.
- Detailed feedback for development to enable knowing what to focus on next time is typically not given. Soon staff from minority ethnic groups no longer bother to apply for promotion as these always seemed to be lined up for someone who is not from a minority ethnic group.
- Cultural Ambassadors who have been trained to ask key questions to facilitate reflection in a structured way have started to be involved in recruitment processes and panels to gain a better understanding of how exactly [rationally and objectively] decisions are being made and where unconscious bias has overflown to inform appointment decisions. Trained Cultural Ambassadors educate other members of recruitment panels to recognise unconscious bias, so that they can make fairer decisions.

3.5. Reluctance to report racism

- 32% of those who had provided qualitative comments in the survey and 73% of interviewees referred to a reluctance to discuss or report racism (experienced or witnessed).
- In both the free-text survey sample and interview sample, the reluctance was due to the system made it difficult to do anything which led to the difficulty to a fear of blame or negative consequences when speaking up and speaking out about racism, no action taken by managers or Human Resources, and the difficulty to evidence racism.
- Interviewees furthermore explained the reluctance to report or discuss racism as the consequence of a no accountability position by management and the difficulty in evidencing racism (mostly micro-aggressions, which are easy to deny as well as a disagreement over what racism) and being advised to not report racism to safeguard career prospects. disagreement over what racism means.

- Reporting racism was associated with having achieved greater seniority and having more confidence in the likelihood that it would be acted upon.

Free-text data from the survey

Out of the reasons for the reluctance to report racism, the fear of blame and negative consequences was more important than managers taking no action or the difficulty to evidence and prove racism.

- Taking any action was described as 'a risky activity' because interviewees had 'lots of experience' that 'nothing can be done' and 'it cannot be proven' and that if they complained about racism, retribution would be exerted, and they would be 'targeted'.
- Some had experienced greater scrutiny and criticism of their work and had been made to shadow less experienced colleagues to learn 'ways of working'.
- Others had raised the issue with colleagues who disagreed it was racism, with the line manager asserting that that there was no racism, and nothing was done.

Interviews

- 73% of interviewees indicated that they had felt perturbed, upset, stressed, anxious or depressed because of racism by colleagues in the workplace.
- By comparison, only 50% of the interviewees had experienced racism from patients and/or their families.

Reasons for not speaking up or not reporting racism were:

- People feel it is too personal and get so upset and stressed that they are unable to do anything about it, so they step back mentally to be able to cope
  - Struggled to speak up and speak
  - Torn between fear of consequences and making excuses for mistreatment and unfair discrimination
  - Some let off steam by sharing their experiences in safe spaces with other colleagues from minority ethnic groups.
- Difficult to evidence [in the legal sense] as it is mostly indirect and micro-aggressions
- Easy for perpetrators to deny what happened and/or say that they had been misunderstood
  - Workplace racism is subtle with derogatory language used in such a way that perpetrators can get away with "I did not mean this way, I meant it that way"
  - There is a lot of gaslighting going on when we attempt to raise or discuss issues and our experience of racism.
  - Others disagree that a particular micro-aggression is evidence of racism
- Fear that retribution be exerted and that they will be 'targeted'
  - Fear of losing their job and be homeless and unable to provide for family, so not taking time off despite stress and distress
  - Fear that this will lead to even greater scrutiny, or even blame
  - Fear of unfair negative feedback in workplace-based assessment reports, especially multi-source feedback
- The system makes it difficult to do anything about racism
  - Advised by senior staff to 'keep your head down' and get on with it
  - Managers often prefer not to know what is going on
  - Complaints are usually ignored, and no action taken
  - Words and policies say that we have support and can make complaints, but the actions of people do not match this. The system is set up in such a way that it actively makes it difficult for us to do something about mistreatment

- There is a lot of 'pretend' listening, but nothing seems to be followed through with no consequences and no accountability for perpetrators and this hinders victims from reporting incidences of racism.

Six interviewees (27%) had eventually overcome their reluctance in speaking up, largely because they had become more senior, and their concerns were less likely to be ignored. Ironically, as they became more senior, they had experienced less racism.

Perspectives from EDI-related staff

Cultural Ambassadors who have been trained to ask key questions to facilitate reflection in a structured way have started to be involved in investigatory and disciplinary processes and panels to help these panels make rational and objective decisions minimising unconscious bias to inform decisions. Trained Cultural Ambassadors can facilitate investigatory and disciplinary processes directly or educate panels in recognising how unconscious bias can impact decisions, so that they can make fairer decisions.

Racism within the community (outside the workplace)

20% of the survey free-text sample and 23% of interviewees had experienced racism in the community. In the survey, one White British/English respondent had experienced racism and another two had witnessed racism against ethnic minority groups in the community.

Free-text data from the survey

- 20% of respondents had experienced racism in the community, ranging from racial profiling and harassment to offensive racial slurs/go back to your country, and micro-aggression (strange looks, refused entry, followed in the street).
- Two White English/British participants had also experienced racism directed at them, and one had witnessed racism directed at minority ethnic groups.
- 50% of the sample had taken no action, but three had challenged perpetrators, including a White British/English participant, and two had moved away from the area.

Interviews

- 22.5% of clinical staff interviewed had experienced racism within the community
- The issues highlighted were local landlords reluctant to rent accommodation to international nurses and one instance of racially abusive language.

Perspective of EDI related staff

- It was underlined that Brexit 'lifted the lid' and allowed people to say whatever they wanted to say and that incidents both in the community and at work 'skyrocketed'
- People from Black and Brown minority ethnic groups said that before Brexit they had felt it was safe to go running after work, whereas now they are likely to be suspected of being up to no good and subjected to harassment.

DISCUSSION

Acculturation of newly arrived international members of staff

The issue of 'acculturation' was not underlined in the free-text data from the survey but was strongly emphasised by 53% the interviewees who had arrived in England after completion of initial professional education and training and work experience in a different country, typically India or Nigeria [n=19 or 86% of the interview sample].

These health, social care and medical professionals had the additional challenge of acculturation to the way things are done in England. Key acculturation challenges identified by interviewees were:

- Different weather and food
- Difficult to live on your own when you have lived with extended family all your life
- Different professional practices and assumptions
  - Saying *please* and *thank you* which is not part of workplace language and culture in India
  - Writing detailed notes about tasks undertaken
  - The importance of going to drink tea with colleagues to discuss issues
  - Interaction with patients and tasks required when caring for patients are different in India and in England
- Communication and language barriers (accents and being shunned because others struggle to understand them and feeling isolated and lonely)
- International nurses find it insulting to be taught basic clinical things and to have to go through OSCEs for things that they already know how to do.
- Better acculturation to the English language and localised accents by listening to radio and watching television makes a positive difference, but does not ensure that you will fit in
- Even with additional support for language and communication as arranged for international members of staff, acculturation takes time

The length of time acculturation takes was underlined by half the interviewees as was the need for support, encouragement, and kindness to help international staff overcome the cultural challenges they face instead of being ignored or rejected by colleagues who should make proactive efforts to support them and to ensure that they are included and made to feel they belong as they are needed by the system.

Interviews revealed differential and contrasting perceptions of how different ethnic minority groups and sub-groups go through the process of acculturation and how they experience and react to racism. There was a perception that younger non-White doctors or nurses who are brought up in England are less likely to tolerate racist behaviour and more likely to make complaints. Another perception was that African women are more direct and proactive against racism than women from India or Pakistan, but less direct and proactive than African men. Those from India and Pakistan appear to be more afraid of potential negative consequences if they say something about racism. It was also pointed out that Black African staff are often the only Black members of staff in the unit/department whereas Indian nurses work alongside the many other Indian nurses to whom they can turn to for support and comradeship.

Extent to which things have changed over the last 20 years

Equality of opportunity has both improved and not improved

Interviewees described how things have both changed and improved and not changed and not improved over the last 20 years. Many pointed out that 30 or more years ago White men were at the top of the hierarchy with women and people from ethnic minorities at the bottom. Also, women and people from ethnic minorities were paid less well for doing the same job. Furthermore, patients and more especially clients in social care commonly refused to interact with Black members of staff.

Visible changes over the past 20 years are that there is much less gender inequality now. More women are at the top of the hierarchy and more minority ethnic groups not at the very bottom and being promoted to more senior positions. Racism has become more indirect and more subtle, and members of staff still largely tend to do nothing about it, not even addressing issues directly with the person concerned.

Refusal to interact with Black members of staff is no longer acceptable in social care where there has been a whole social change. Progress has been slower in healthcare. Refusal to interact with ethnic minorities was less evident in the past. Patients who want to see a clinician of the same ethnic group are not infrequently granted this request, especially in primary care. It therefore appears that things have changed for the better to a greater extent in social care than in healthcare.

Interviewees remarked that when people will start reacting to wrong things and speak up and speak out as the standard approach, the whole system will change. These views are echoed by representatives from the RCN. When the RCN undertook focus groups with nurses to find out about what they most needed in terms of support, they struggled against a culture of not wanting to speak up or speak out. Gaps in the support available to nurses were nonetheless identified with the aim to provide additional support and deliver training to empower international nurses.

Of note, two female and one non-binary respondents to the survey not from minority ethnic groups reflected that, if all the survey questions had been asked about gender, every question on unfair discrimination would have been answered 'all of the time'. One White English/British female referred to being bullied by a senior male from a minority ethnic group and two White English/British females referred to racist comments made by male colleagues from minority ethnic groups against White females, labelling all of them promiscuous, which is also evidence of sexism. All three were too shocked to do anything about it and feared being accused of racism if they reported the behaviour.

Support for international nurses

Contrasting perspectives emerged from the interviews. On the one hand, for the first batch of international nurses, there was no input on acculturation, so they struggled more. On the other hand, there were fewer international nurses a decade or more ago, so they had better individual support, and more recently arrived international nurses are therefore not getting the same level of support than in the past.

Interviewees and EDI staff explained that ten years ago there were very few international nurses, but they now make up about 50% of the workforce. They are regularly visited in the wards to see if they have any problems, especially communication problems and whether they need extra training. Specific acculturation sessions are now routinely provided focussing on language and communication to help acculturation because of the feedback received from the previous cohorts. Some of the new international nurses now ask proactively for opportunities and training and

escalate to their managers or Human Resources if they do not get the opportunities that have asked for. The increasing number of international nurses and a more proactive approach to career progression has led to more nurses successfully progressing in their career than in the past.

Comparison with other studies

At the heart of unfair discrimination often lies the notion of *Othering* [27] and this runs through the experiences presented to us in both the survey and the interviews, whether in terms of language employed, attitudes towards skill levels or simply preconceptions and stereotyping. Our results replicated findings by Edeh[28] and Woodhead et al.[10] with behaviours which are overt or subtle as in micro-aggressions[29 30]. As MacPherson[31] and others[10 29 30] have noted, racism in the insidious and subtle nature of micro-aggressions is as damaging as in its overt form, a point raised by several of our interviewees who felt undermined and demeaned but in subtle ways that the perpetrators could defend as "banter" or "misunderstanding."

In Derbyshire, 17% of BAME colleagues had experienced racism from a colleague in the previous 12 months and 30% reported racism from patients[32]. In our study, 78.7% non-White respondents agreed that racism between colleagues was a problem and 84.8% of non-White respondents agreed that racism from patients and families was a problem in the workplace.

Our figures contrast sharply with the 2021 WRES results where it is reported that 10.2% of BME staff and 4.4% White staff personally experienced discrimination from a manager or colleague[1]. Our figures show that 23.7% of White respondents compared to 75.9% of Non-White respondents experienced racism from colleagues directed at them, with no statistically significant difference between Black [80.4%] and South Asian [68.2%] respondents but a statistically significant difference between White English/British [14%] and White Other [50%] respondents.

The 2021 WRES report states that 30.3% of BME staff and 27.9% of White staff experienced abuse from patients, relatives or the public, although it is not clear whether this only concerns racist abuse or whether it concerns abuse in general[1]. By comparison, 84.8% of our non-White respondents and 49.2% of White respondents felt racism to be a problem encountered in the performance of their work in relation to interactions with patients and their families, with no statistically significant difference between Black respondents [81.8%] and South Asian [87%] but a statistically significant difference between of White English/British [41.9%] and White Other [68.7%].

Almost three times the proportion of White respondents had observed [69.2%] compared to experienced [23.7%] racism directed at them in the previous year. Almost the same proportion of non-White respondents had experienced [75.9%] racism directed at them in the previous year compared to observing [77.2%] racism directed at others. A staggering 48% of the sample did not respond to the question about observing racism from colleagues directed at others, yet the demographic questions on gender, ethnicity and age generated only 11-15% of non-responses. This shows that the very question of observing racism makes many people uncomfortable.

All too frequently, our participants reported having taken no action when they had had experienced or observed racism. There were also instances where they reported the racist behaviour and no action followed, or when retribution was exerted (including a White British respondent who had repeatedly escalated a complaint of racism directed at minority ethnic groups). Gaslighting, the denial of reality employed to undermine a person's confidence, was stated or implied in several interviews and free-text comments as being used as a means to silence reporting of racist behaviour. This is an example of *Othering*, where the victim is made to feel that they are not presenting reality as it really is but rather some fantasy or misinterpretation of events. All this builds to a reticence or fear at reporting racist behaviours.

CONCLUSION

Summary of key findings

Our co-created mixed-method[21 22 24] approach used an iterative process[23] to gain a deeper understanding of the extent of and experiences of racism experienced by health, medical and social care staff of in NHS settings in the Shropshire, Telford and Wrekin area in the workplace and in the community.

Our three samples (survey, free-text comments and interviews) were wide ranging and diverse, broadly reflecting the composition of the overall health, medical and social care staff. Of those who provided information about race/ethnicity in the survey (n=156 out of n=177), the proportion of non-White respondents was 56%. The proportion of non-Whites was 95% in the interviews (total n=22). The survey and interview samples had twice as many South Asians as Blacks. The White survey sample (44%) had twice as many White English/British as White Others. The interview sample had only one White British/English participant (5%).

Racism in the workplace

In the survey, 49.2% of the White respondents and 84.8% of non-White respondents agreed that racism from patients and families was a problem in the workplace while 55.9% of the White respondents and 78.7% of those in the non-White category agreed that racism between colleagues was a problem in their workplace. For both questions there was no statistically significant difference between South Asians and Black respondents, but White Other respondents were twice as likely than White British/English to agree with both questions.

While 69.2% of White respondents compared with just over 77.2% of non-White respondents had observed racism directed at others in the previous year (on average 1-5 times), only 23.7% of White respondents compared to 75.9% of non-White respondents had experienced racism directed at them in the previous year (on average 1-5 times). There was no difference between the South Asian and Black samples, but more than 4 times as many White Other as White British/English respondents had experienced racism directed at them in the previous year.

Racism took the form of stereotypical assumptions and micro-aggressions, non-inclusion in activities, language and communication issues with colleagues (especially if not brought up and initially trained in the UK), less value attributed to their input by both their team and their organisation, made to feel that they did not fit in, and negative impact on their career progression,

73% of interviewees reported a reluctance and a fear to discuss, challenge or report racism, whether experienced or observed (too upset, difficult to evidence, fear of retribution and the system making it difficult to do anything e.g. reporting not followed by action). Reporting racism was associated with having achieved greater seniority and having more confidence in the likelihood that it would be acted upon.

Racism in the community

40% of the overall sample had experienced racism in the community over the previous year: 63% of non-White survey respondents compared to 19% of White respondents. Non-White respondents also experienced racism more often. Data from the free text and interviews show that racism in the community was mostly direct and explicit such as racially offensive derogatory comments and abusive language with differential treatment and micro-aggressions less common.

Benefits and limitations

Main benefits of our study

It took place in a context of intensified calls for a renewed and urgent focus on rural racism [15]. Of the emerging but still limited body of research underlining the pervasiveness of racialised 'othering' in rural environments [20], the present study is the only to have focussed on health and social care in the NHS and on the Shropshire, Telford and Wrekin area. Our figures show that both non-White and White members of staff in the Shropshire, Wrekin and Telford experience more racism from both colleagues and patients and families than the national average and average for the West Midlands.[1 2]

It is a mixed-method iterative co-creation project between the University of Wolverhampton and multiple stakeholders, Health Education England West Midlands, NHS Trusts, and Shropshire, and Wrekin and Telford [STW} Integrated Care Systems [ICS]. This meant that the research design and survey were very closely linked to the needs and concerns of the stakeholder groups. They were also discussed with RCN representatives who also expressed their views and concerns on the problematic surrounding racism towards health and social care staff.

Our three samples (survey n=177, free text comments n=50 and interviews n=22) were wide-ranging and diverse including hospital and community and mental health nurses, social care practitioners and medical practitioners, both GPs and hospital based.

The study was comprehensive, and it is also unique in taking into account differences within the White (White English/British and White Other) and Non-White groups (mostly South Asian and Black). In line with the Equality Act 2010, our study is an acknowledgement that racism is more than just about colour, but also about nationality, culture and national origins, whether actual or perceived.

Main limitations of our study

The sample was cascaded, so it is unknown how many potential respondents were reached, and the rate of response cannot be established. There was a low response rate to some questions e.g. racism directed at others with n=85 who did not respond i.e. 48% compared to 10%-12% non-response or non-disclosure of information for the demographic questions on gender, ethnicity and age.

The size of the project is inevitably a limitation. Although aiming for a balanced sample, we cannot pretend that our sample of participants or our findings are representative, but they are indicative of the situation. Besides, as Weingardt (and various others) have said, "the world is run by those who show up"[33]. A total of n=177 staff members from health and social care across Shropshire, Wrekin and Telford "showed up" to do our survey, n=50 provided detailed free-text comments and n=22 of took part in a semi-structured interview. This report has aimed to give them voice.

SUGGESTIONS FOR IMPROVEMENTS

Respondents and interviewees suggested that there should be fewer policies and that the number of pathways to report racism (e.g. line manager, Human Resources, freedom to speak advisers) should be reduced. Also, overlapping initiatives should be avoided as they create confusion. It is best to address the root cause of racism rather than provide well-being tools and counselling.

Concise, emotionally impactful personalised race relations and anti-racism training should be designed and implemented and include the following elements:

- It should be based on stories rather than abstract concepts (as in the present online training)
- It should address real issues such as ethnicity being not only about colour, but also about actual or perceived nationality, national origins, and first language
- It should train members of staff to be more confident in challenging inappropriate behaviour.
- It should ensure that 'nudge' posters are displayed on walls showing a diversity of health medical and social care practitioners and reminding people of non-racist expected values and behaviours.
- Examples of what people say that is derogatory and racist should be provided, underlining that such behaviour is unacceptable.

It should be ensured that managers understand *equity* and the importance of unnecessary barriers being mitigated or removed for those from minority ethnic groups and that they follow policy and the recommended course of action when issues of racism are raised or reported. Research and education should be undertaken about how patients perceive members of staff from ethnic minority groups and why patients still make comments such as *You are too black to be a doctor*.

All staff, including managers, should be educated about how difficult it is for international staff not trained in the UK and with a different first language to overcome acculturation challenges. As international members of staff are clearly needed by the system, support, encouragement, and kindness are needed to help them overcome acculturation challenges for the benefit of patients.

Acculturation sessions for international staff and especially nurses (now approximately 50% of the workforce) should be reviewed regularly in order to best meet their needs.

Proactive efforts should be made to support international staff and ensure that they are included and made to feel they belong with a particular focus to paired activities.

> *For example, if colleagues did proactively pair up with international nurses instead of avoiding working closely with them, it would make it easier and quicker for international nurses to learn and adapt to the way things are done in England.*

Efforts should be made in language and communication such improve civility and respect between NHS colleagues and international staff and speaking more slowly and more clearly and enunciating better and likewise for international staff towards patients and colleagues.

Finally, it should be ensured that detailed feedback is provided for development or after an unsuccessful job interview to enable international members of staff to know what to focus on next to progress successfully in their career.

REFERENCES

1. WRES Implementation team. NHS Workforce Race Equality Standard (WRES). London: NHS WRES, 2021.
2. STW ICS WRES and WDES 2021 Outcomes Shropshire, Telford and Wrekin Sustainabilty and Transformation Partnership, 2022.
3. Carnall D. Circumventing racism in the NHS. *BMJ* 1997;314(7081):S2-7081.
4. Symon A. Institutional racism and discrimination: Are they endemic in the NHS? *British journal of midwifery* 2006;14(6):366-66.
5. Younis T. The muddle of institutional racism in mental health. *Sociology of Health & Illness* 2021;43(8):1831-39.
6. Alexis O, Vydelingum V. The lived experience of overseas black and minority ethnic nurses in the NHS in the south of England. *Diversity in Health & Social Care* 2004;1(1)
7. Allan HT, Larsen JA, Bryan K, et al. The social reproduction of institutional racism: internationally recruited nurses' experiences of the British health services. *Diversity and Equality in Health and Care* 2004;1(2)
8. Likupe G, Archibong U. Black African nurses' experiences of equality, racism, and discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture* 2013;3(S1):227-46.
9. Watson NA. ".. Here to stay… so….. deal with it": Experiences and Perceptions of Black British African Caribbean People about Nursing Careers. 2014
10. Woodhead C, Stoll N, Harwood H, et al. "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised inequalities among healthcare staff. *Sociology of Health & Illness* 2022;44(2):267-89.
11. Baker F. 'The English countryside was shaped by colonialism': Why rural Britain is unwelcoming for people of colour. *Metro* 2020.
12. Commission for Racial Equality. "Keep Them in Birmingham": Challenging Racism in South-west England: Commission for Racial Equality London 1992.
13. Henderson P. Isolation in the shires. *The Guardian* 1999 14 July.
14. Henderson P, Kaur R. Rural racism in the UK: examples of community-based responses: Community Development Foundation 1999.
15. Kay A. Rural racism 30 years on - what has changed since the first ever report? Somerset: GHR radio; 2021 [accessed 15/08/22.
16. Chakraborti N, Garland J. Rural racism. London: Willan 2004.
17. Agyeman J, Spooner R. Ethnicity and the Rural Environment. Contested countryside cultures. London: Routledge 1997:197-217.
18. Cloke P, Little J. Contested countryside cultures: Rurality and socio-cultural marginalisation. London: Routledge 1997.
19. Ray L, Reed K. Community, mobility and racism in a semi-rural area: Comparing minority experience in East Kent. *Ethnic and racial studies* 2005;28(2):212-34.
20. Chakraborti N. Beyond 'passive apartheid'? Developing policy and research agendas on rural racism in Britain. *Journal of Ethnic and Migration Studies* 2010;36(3):501-17.
21. Temple Clothier A, Matheson D. Using co-creation as a pedagogic method for the professional development of students undertaking a BA (Hons) in Education Studies. *Journal of Further and Higher Education* 2019;43(6):826-38. doi: 10.1080/0309877X.2017.1409344
22. Temple Clothier A, Matheson D. Twelve Tips for Using Co-creation for Value Creation and Professional Development. *MedEdPublish* 2020;9(194):194.
23. Plowright D. Using Mixed Methods. Frameworks for an Integrated Methodology. Thousand Oaks, CA: SAGE Publishing 2011.
24. Denzin N, Lincoln Y. The Discipline and Practice of Qualitative Research. In: N Denzin, Y Lincoln, eds. The Handbook of Qualitative Research 5th ed. Thousand Oaks, CA: Sage Publications 2018:1-26.
25. Braun V, Clarke V. .Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health* 2019;11(4):589-97. doi: 10.1080/2159676X.2019.1628806
26. Kirkwood B, Sterne J. Essential Medical Statistics. 2nd ed. Oxford: Blackwell 2009.
27. Groux D. Education and development: School and its role in lifelong learning. In: Papa R, ed. Handbook on Promoting Social Justice in Education. Chur CH: Springer 2020:247-65.
28. Edeh N. The Role of Professional Status in Mediating the Gendered and Racialised Experiences of Nigerian Women Working in the NHS: An Interdisciplinary Approach. Aberystwyth University, 2019.

29. Estacio EV, Saidy-Khan S. Experiences of racial microaggression among migrant nurses in the United Kingdom. *Global Qualitative Nursing Research* 2014;1:2333393614532618.
30. British Medical Association. Racism in Medicine. London: British Medical Association, 2022.
31. MacPherson W. The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William MacPherson of Cluny. Cm 4262-I London: The Stationery Office, 1999.
32. Imtiaz-Umer S. Derbyshire General Practice Discrimination – A report on racial, ethnic and religious discrimination experiences, 2021.
33. Weingardt RG. Leadership: the world is run by those who show up. *Journal of Management in Engineering* 1997;13(4):61-66.

APPENDIX

Table A: Demographic and work profile of the survey sample, free text comments sample and interview sample

	Survey sample n=177	**Free text comments sample n=50**	**Interview sample n=22**
Gender	Female: 57% Male: 29% Non-binary: 2.6%	Female: 70% Male: 28% Non-binary: 2%	Female: 82% Male 18% Non-binary: 0%
Age	18-25: 2% 26-35: 32% 36-45: 24% 46-55: 26% 56-65: 17%	18-25: 2% 26-35: 20% 36-45: 24% 46-55: 36% 56-65: 18%	18-25: 5% 26-35: 18% 36-45: 32% 46-55: 27% 56-65: 18%
Ethnicity	White: 44% [n=68] White English/British: 31% White Other: 12% Non-White: 56% [n=88] South Asian: 34% [Indian 29%, British Indian 3%, Pakistani 1%] Black: 15% [Black African 8%, Black British 5% Black Other: [1%] Non-White Other (mixed): 8%	White: 38% [n=19] White English/British: 24% White Other: 14% Non-White: 62% [n=31] South Asian: 32% [Indian 28%, Pakistani 4%] Black: 24% [Black Africans 12%, Black British 12%] Non-White Other (mixed) 4%	White: 5% [n=1] White English:5% White Other 0% Non-White: 95% [n=22] South Asian: 59% [Indian 54%. Pakistani 5%] Black: 27% [Black African 27%] Non-White Other (mixed) 9%
Place of work	Hospital setting: 46% [3/4 non-White] Social care: 25% [1/4 non-White] Community care: 9% [1/5 non-White] Mental health: 10% [1/5 non-White] General practice: 10% [4/5 non-White]	Hospital setting: 42% [4/5 non-White] Social care: 24% [3/4 non-White] Community care: 6% [1/3 non-White] Mental health: 20% [1/3 non-White] General practice: 8% [all non-White]	Hospital setting: 73% [97% non-White] Social care: 5% [all Mixed] Community care: 0% Mental health: 9% [1/2 non-White] General practice: 14% [all non-White]

	Survey sample **n=177**	**Free text comments sample** **n=50**	**Interview sample** **n=22**
Main type of role	Hospital nurses: 43% [3/4 non-White] Social care practitioners: 25% [1/4 non-White] Community care nurses: 9% [1/4 non-White] Mental health nurses: 10% [1/4 non-White] Hospital medical practitioners: 3% [all non-White] GP practice: 5% [4/5 non-White] Administrative roles: 5% [3/4 White]	Hospital nurses: 29% [4/5 non-White] Social care practitioners: 14% [3/4 non-White] Community care nurses: 6% [1/3 non-White] Mental health nurses: 20% [1/3 non-White] Hospital medical practitioners: 8% [all non-White] GPs: 8% [all non-White] Administrative roles: 14% [1/4 non-White]	Hospital nurses: 73% [97% non-White] Social care practitioners: 5% [100% Mixed] Community care: 0% Mental health: 9% [1/2 non-White] Hospital medical practitioners: 9% [all non-White] GPs: 14% [all non-White]
Length of time in the UK/England	No information	No information	n=5 UK <1 year [28%] n=3 for 2 years [14%] n=4 > 5 years [18%] n=10 >15 years [36%]

Integrated Care System
Shropshire, Telford and Wrekin

Action Plan

OBJECTIVE / ACTION	UPDATE/ HOW TO ADDRESS THIS	OUTCOME MEASURE	AIm and IMPACT Measure	RAG
Develop a Comms strategy for STW ICS	We are working with the ICB comms team who are helping to bring this together. Posters have been shared by SaTH so far. Template EDI strategy to be used systemwide. Comms team led by Jackie Robinson is helping with inputting all the documents in Shro and Tel for sharing with our wider staff - for e.g., events, good practice etc. Achieved Black history month and South Asian heritage month. Staff network support, ethnically diverse network Developing aspirant leaders programme Staff training – identify privilege and power. Race equality measures Cultural diversity celebration completed, Michelle Cox speaker	- An ICS standardised Comms Poster - ICS message from the Exec team (podcast/video) - EDI Strategy Subgroup to be created -Refreshed EDI page on the website -Additional EDI materials available on intranet	Raising cultural awareness	Green
ICB Board development Session	Senior leaders to arrange. Date confirmed for June 24. Session completed	Completion of the session	Raising the EDI profile among our leaders	Green
FTSUG forum for STW	Collaboration with the FTSUG across the STW ICS provider organisations. There has been increasing engagement with the FTSUG at the steering group and a session needs to be dedicated to this agenda. May 24	Setting up the FTSUG forum	Creating fairness and addressing concerns	Amber

Action Plan

OBJECTIVE / ACTION	UPDATE/ HOW TO ADDRESS THIS	OUTCOME MEASURE	AIm and IMPACT Measure	RAG
	Successful appointment of FTSUGs in the ICB. Progress effective communication method			
Cultural focus	Diversity calendar has been developed and events have been organised regularly in the last 2 years. Continuation of the diversity events with collaboration and widened participation across the ICS. Linking up with Telford and Wrekin Council	Celebrating cultural events with maximum participation from our ICS health and care workforce Diversity Calander refreshed annually every November	Celebrating diversity	Green
Bystander and Allyship training	ICS EDI steering Group has been involved with mapping out the training requirements for the EDI agenda. Shropshire and TWC leads to provide their resources on this. Explore Leicestershire model of active bystander training- JD to monitor progress. This requires completion in updated action plan. May 24 Completed, content on learning management platform and training ongoing  EDI content on the ICS LMS 24.07.23.do In spring 2022, a suite of training offers developed	Training Suite to include this.	Addressing poor behaviour	Green

Action Plan

OBJECTIVE / ACTION	UPDATE/ HOW TO ADDRESS THIS	OUTCOME MEASURE	AIm and IMPACT Measure	RAG
	These training offers were launched, circulated, and publicised across the ICS from September 2022. eLearning module titled "Identity, Privilege, and Power," which remains live on the LMS. Challenging Hate Incidents in the Workplace" with Northern Care Alliance (delivered in June 23).			
EDI training packages	People Team leading on this suite of training. Training Package put on system learning management system and available to all staff. Update May 24 Included across package of EDI training on the learning management system available to managers. Specific session under review.  EDI content on the ICS LMS 24.07.23.do	Ongoing training	Increasing skills sets helping with addressing concerns, and improve staff experience and reflecting on improved WRES data	Amber
FTSUG in primary care	Have identified 2 people for this and now we are formalising the governance structure for this. May 24 This was achieved but the personnel have changed, currently under review	Functional FTSUG system	Addressing poor behaviour	Amber

REFRESHING OF OBJECTIVES- April 23- Dec 23					
OBJECTIVE	**UPDATE/HOW TO ADDRESS THIS**	**OUTCOME MEASURE**	**AIm and IMPACT Measure**	**Named Leads**	**RAG**
System Anti-Racist strategy and mission statement	Collaborative project sponsored by the ICB Board Looking at current policy documents and Race equity action plans. Organisations to forward policy documents to the chair. Board development day addressed this and to be presented to Board in June 24	One single strategy development Single commitment statement to underpin the policy document for all providers in the system. Sharing good practice Improvement of WRES/Staff surveys	Better accountability and reducing poor behaviour Improving staff experience and better clarity to managers and leaders to tackle discriminatory behaviours		Amber
Standardised induction package-	Collaboration between the different providers would be useful to write this. Looking at current induction package across providers and consider revamping this with elements of cultural piece for everyone, including new staff and existing workplace. Completed. All trusts have refreshed induction packages, especially with the needs of international workforce included. Colleges also include in T level training.	One single document Creation of Subgroup to agree on the contents of this informative inclusive document.	Embracing diversity, sense of belongingness and inclusivity		Green
Cultural Ambassador Programme	Review the present arrangement in organisations, look at evidence. Also linking with TW council ambassador programme. Updated May 24 Progressing in primary care.	Creating a CA forum for the system	Improving minority staff experiences in disciplinaries and recruitment process		Amber
Staff Networks Refresh	Nurture and grow our staff networks- work with provider network leads. Focus on our 3 networks: BME, LGBT+ and Disability.	Regular engagement with exec sponsor for each network	Improved staff experiences and WRES and WREI		Green

REFRESHING OF OBJECTIVES- April 23- Dec 23					
OBJECTIVE	**UPDATE/HOW TO ADDRESS THIS**	**OUTCOME MEASURE**	**AIm and IMPACT Measure**	**Named Leads**	**RAG**
	Completed. TWC to explore options for nominations for LGBTQ+ network chair position.				
Focused Training for Managers	Ongoing work with our EDI training Lead Update May 24 "Challenging Hate Incidents in the Workplace" with Northern Care Alliance (delivered in June 23). LMS supported delivery (managing bookings etc)	More support to deal with concerns and create accountabilities	Increasing skill set for managers to deal with issues promptly		Green

LONG TERM OBJECTIVES- April 23- April 24					
OBJECTIVE	**UPDATE/HOW TO ADDRESS THIS**	**OUTCOME MEASURE**	**AIm and IMPACT Measure**	**Named Leads**	**RAG**
Inclusive Leadership and Development programmes	Making these programmes accessible to all minority groups Aspiring leaders programme developed. Regional programmes accessed. Continued drive needed to achieve this objective in a sustainable way. Update May 24 Ongoing work carry forward to next plan	Staff and colleagues reaching their full potential	Widening participation from minority groups in decision making improving staff retention, recruitment		Amber

LONG TERM OBJECTIVES- April 23- April 24					
OBJECTIVE	**UPDATE/HOW TO ADDRESS THIS**	**OUTCOME MEASURE**	**AIm and IMPACT Measure**	**Named Leads**	**RAG**
Role Modelling - Inclusive recruitment	Increasing diverse representation in senior roles by focused training upskilling and sponsorship programmes High Potential Scheme Exploring more wider options nationally aligning to NHS EDI High Impact actions Update May 24 Continued drive needed to achieve this objective in a sustainable way.	Diversity in the workforce at senior levels including executive board.	Staff retention, improved recruitment and improved WRES		Amber
EDI representation at recruitment panel	Having a system pool of EDI representatives preferably with protected characteristics for interview and selection panels Update May 24 To progressed with strategy following Board development day. Carry forward to next plan	More fair and inclusive recruitment process	Staff retention and improved WRES		Red
Inclusion of EDI objectives in all staff Appraisals	Appraisers need to have training on what constitutes an EDI objective This has been completed.	Prioritising EDI learning through clear objectives- This needs to incorporated into their appraisal templates.	Improved culture of organisations working more in collaboration		Green
Reverse Mentoring or reciprocal mentoring	Exploration of both the types of mentoring and analysing the effectiveness of these. Shropcom and MPFT to provide outcome measure for their programmes Update May 24 Continued drive needed to achieve this objective in a sustainable way.	Improvement of staff experiences reflecting on better WRES	More visible engagement and		Amber

LONG TERM OBJECTIVES- April 23- April 24					
OBJECTIVE	**UPDATE/HOW TO ADDRESS THIS**	**OUTCOME MEASURE**	**AIm and IMPACT Measure**	**Named Leads**	**RAG**
Staff Lived experiences	Developing staff voices through networks and forums with amplifications of these voices via leaders and representatives to the managers Linking to existing staff networks Update May 24 Ongoing requirement to continually drive this	More understanding of the concerns from these groups by the managers and senior leaders	Improved culture of organisations working more in collaboration		Amber
Inclusive Health and Wellbeing offers	Rebranding campaigns and High Impact action of the NHS EDI Improvement plan- regarding psychological support to colleagues who have experienced bulling and harassment. Dedicated area of system website developed with health and wellbeing opportunities. Requires ongoing support to maintain. Completed	Reduced staff absences and increased workforce retention	Improvement of WRES and Staff surveys		Green
Governance structure	Executive teams to draw out the governance framework for oversight of the EDI programme of work Linking with Population Health and inequalities board Update May 24 ICB Governance structure refreshed. Population health being overseen by Strategic commissioning committee Workforce now overseen by People, Inclusion and Culture Committee.	Improve accountability and scrutiny of the work	Staff retention and improved WRES		Amber

Objective	Work Programme / Project	Q2 RAG	Q4 RAG	All Actions complete?	Overall Progress?	System wide collaborative working	Enabling factors						
							Leadership, Ownership & planning	Training, education and shared learning	Strong C&E Approach	IT & Digital	Change in leadership	Additional capacity	HIQ Team involvement
LTP 2: Tobacco	Implementation of Tobacco Dependency Teams			Yes	Complete	Yes	Yes	Yes	Yes	Yes	x	Yes	Yes
KLOE 3: Datasets are Complete and Timely	Improved ethnicity recording			Yes	Complete	Yes	Yes	Yes	N/A	Yes	x	Yes	Yes - support/guidance
KLOE 5: Leadership and	Established senior roles across all organisations			Yes	Complete	Yes	Yes	Yes	x	Yes	x	Yes	Yes
Core20PLUS5 ADULT 5:	InHIP Hypertension Community Case-finding – Telford			Yes	Complete	Yes	Yes	Yes	Yes	x	x	Yes	Yes
Core20PLUS5 ADULT 5:	InHIP Hypertension Community Case-finding – Shropshire			Yes	Complete	Yes	Yes	Yes	Yes	x	x	Yes	Yes
Core20PLUS5 ADULT 4: Early Cancer Diagnosis	Core20PLUS Connectors (Cancer Champions)			Yes	Complete	Yes	Yes	Yes	Yes	N/A	x	x	Yes
Core20PLUS5CYP 4: Oral Health	Oral Health workforce training			Yes	Complete	Yes	Yes	Yes	Yes	N/A	x	x	x
Core20PLUS5CYP 4: Oral Health	Supervised toothbrushing for early years			Yes	Complete	Yes	Yes	Yes	Yes	N/A	x	x	x
Core20PLUS5 ADULT 5:	Targeted secondary prevention Lipid Management			Partially	Significant progress made	Yes	Yes	Yes	Yes	Yes	x	x	x
KLOE 3: Datasets are Complete and Timely	System-wide data-sharing			Partially	Significant progress made	Yes	Yes	N/A	N/A	Yes	x	Yes	x
Core20PLUS5 ADULT 5:	Hypertension Treatment to Target			Partially	Significant progress made	Yes	Yes	Yes	Yes	Yes	x	Yes	Yes

KLOE 3: Datasets are Complete and Timely	Provision of baseline data and intelligence to support objectives (using a PHM approach)			Partially	Significant progress made	Yes	Yes	Yes	N/A	Yes	x	Yes	Yes - support/guidance
KLOE 5: Leadership and	Improved governance (system-level and Provider)			Partially	Significant progress made	Yes	Yes	Yes	x	Yes	x	Yes	Yes
KLOE 5: Leadership and	Improved HI awareness and training			Partially	Significant progress made	Yes	Yes	Yes	x	Yes	x	Yes	Yes
LTP 3: Obesity/Weight Management	NHS Digital Weight Management Programme			Complete	Significant progress made	Yes	Yes	Yes	Yes	x	x	Yes	Yes
Core20PLUS5 ADULT 2: Severe Mental Illness	SMI Health Checks			Partially	Significant progress made	Yes	Yes	Yes	Yes	X	x	Yes	x
Core20PLUS5 ADULT 4: Early Cancer Diagnosis	PCN Cancer DES			Partially	Significant progress made	Yes	Yes	Yes	Yes	x	x	Yes	x
LTP 1: Alcohol Care Teams	Implementation of Alcohol Care Teams			Partially	Significant progress made	Yes	Yes	x	N/A	N/A		Yes	Yes
Core20PLUS Group 2: People Living in Rural Areas	Exploration of the impact of rurality			Complete	Significant progress made	Yes	Yes	Yes	Yes	N/A	x	x	x
Core20PLUS5 ADULT 1: Maternity	LMNS Equity and Equality Action Plan			Partially	Significant progress made	Yes	Yes	x	x	N/A	Yes	Yes	x
Core20PLUS5 ADULT 4: Early Cancer Diagnosis	STW Cancer Strategy Early Cancer Diagnosis Objectives			Partially	Significant progress made	Yes	Yes	x	Yes	N/A	x	Yes	x
Core20PLUS5 ADULT 3: COPD	Delivery of Flu and Covid-19 Vaccinations			Partially	Significant progress made	Yes	Yes	x	Yes	x	x	x	Yes - support/guidance

KLOE 5: Leadership and	Standardised approach to assessing impact			Partially	Some	Yes	Yes	Yes	x	Yes	x	Yes	Yes
Core20PLUS Group 1: Learning Disabilities	LeDeR Action Plan			Partially	Some	Yes	Yes	Yes	Yes	Yes	x	x	x
KLOE 5: Leadership and	Equality, Diversity and Inclusion (EDI)			Partially	Some	Yes	Yes	x	Yes	N/A	Yes	x	x
Core20PLUS Group 1: Learning Disabilities	LD Physical Health Checks			Partially	Some	Yes	Yes	Yes	Yes	x	x	x	x
Core20PLUS5CYP 4: Oral Health	Provision of toothbrushes and toothpaste			Complete	Some	Yes	Yes	x	Yes	N/A	x	x	x
KLOE 2: Mitigate Against Digital Exclusion	2023/24 Digital Strategy			Partially	Some	x	x	Yes	x	x	Yes	x	x
Core20PLUS5CYP 2: Diabetes	Diabetes Transformation for CYP			Partially	Some	x	Yes	x	x	x	x	x	x
KLOE1: Restore NHS Services Inclusively	Elective restoration programme			Partially	Limited Progress	Yes	Yes	Yes	Yes	Yes	Yes	x	x
Core20PLUS5 ADULT 4: Early Cancer Diagnosis	Early Cancer Diagnosis Improvement Plan			None	Limited Progress	Yes	x	Yes	x	Yes	Yes	Yes	x
Core20PLUS5CYP 3: Epilepsy	CYP Transformation for epilepsy			Partially	Limited Progress	Yes	x	x	x	x	Yes - At end	Yes	x
Core20PLUS5 ADULT 3: COPD	Spirometry Services			None	Limited Progress	x	x	x	x	x	x	x	x
Core20PLUS5CYP 4: Oral Health	Data analysis and audits of current waiting lists			None	Limited Progress	X	x	x	X	x	x	x	x

Core20PLUS5CYP 1: Asthma	CYP transformation for Asthma			NO RETURN - Post holder left, MOC	NO RETURN - Post holder left, MOC	Yes	Yes	Yes	Yes	Yes	Yes - At end	Yes	x
Core20PLUS5 CYP 5:	Data analysis and audits of CYP MH access			NO RETURN	NO RETURN	Yes	x	x	x	x	Yes	x	x
Core20PLUS5 CYP 5:	National Mental Health Support Teams in Schools			NO RETURN	NO RETURN	Yes	x	x	x	x	Yes	Yes	x
Core20PLUS5 CYP 5:	Education and awareness of childhood trauma			NO RETURN	NO RETURN	Yes	x	x	x	x	Yes	x	x

Appendix 2 – Key enabling factors and barriers to implementation

Key Theme	Context	Supporting Quotes
Enablers		
1. Working collaboratively	Project leads consistently reported collaborative working as a key contributor to project success for 2023/24, as it was in the previous year. The will of primary care, secondary care, voluntary sector, local authority and ICB to collaborate on inequalities-focused projects as equal partners demonstrates a system that is collectively committed to tackling health inequalities. In securing dedication from all system partners, projects benefit from the wealth of knowledge, skills, expertise and experience to optimally make a difference.	*"Having a strong partnership approach between ICB, Local Authorities and VCSE to capitalise on connections, contacts and relationships with Community Providers/ outreach teams enables us to better reach into our target communities as well as facilitate the conversations we needed to within health to share our community insights and influence local action".* *"Reporting into the ICS Asthma group has enabled the project to remain on track, and also enhanced system working between care services and the local authorities. System working has also led to the development of a new asthma policy for schools and initiation of training and support for early years education providers."* *"Continuing an outreach approach to offering community-based clinics following the success of the initial vaccination programme. Enabling factors are strong partnerships with VCSE to facilitate use of community-based spaces."*
2. Leadership, accountability and planning	Last year's evaluation tells us that delivery on health inequalities requires driven and focused leadership, direction and action planning within the ICB and partners. This message remains unchanged. What is very different to the previous year is the value the system holds for dedicated Health Inequalities leadership and resources having had committed fixed-term resources to the cause. This is evident by the progress made in the areas where capacity from within the Health Inequalities Team has directly	*"An established Prevention and Health Inequalities [forum] with a clear reporting and monitoring framework and dedicated leadership from across all NHS organisations. Having buy in from every organisation has led to a truly collaborative and constructive forum, where we are able to discuss opportunities for connecting work across system Providers and identify opportunities for shared learning and peer support."* *"Part of the work of the ICB Health Inequalities Team has been to identify and showcase the positive work taking*

	supported projects.	*place in our system. By doing so, we have been recognised by NHS England for the significant progress we have made in-year. 2/3 projects showcased at the event are ICS-based collaborative projects which have been led by members of the Health Inequalities Team. These projects came to fruition as the result of successful bids for external funding, facilitated and coordinated by the Health Inequalities Team."* *"More engaged and effective leadership established within the Trust to ensure ownership of the service. The new lead and their links to Finance, Health Inequalities, Quality and Performance - raising profile and value of the service internally via presentations, advocacy and now using the service data to demonstrate the value of the service in terms of savings and outcomes, internally and across the system."*
3. Training, education and shared learning	Project leads reported that opportunities to share learning, attend webinars and participate in training events at system, regional and national level has inspired progress and innovation in many project areas.	*"applying learnings and approach across other specialties, and also sharing that information across other transformation programmes [has enabled progress]".* *"[having opportunities to attend NHSE regional workshops on this area with powerful case studies on examples and some of the things that were discovered."* *"The number of cancer specific roles in general practice is growing. This group pulls together both cancer clinical leads and cancer care coordinators to share good practice, learning and issues related to cancer work in general practice. This is a key success and offers support and a safe environment to discuss issues and share learning and processes".*

4. Strong approaches to comms. and engagement	Some projects have developed excellent communications and engaged very effectively with stakeholders, reaching our most underserved communities and furthering progress toward project aims and objectives to reduce inequalities for Core20PLUS communities through tailored approaches. The role of our clinical partners cannot be understated with positive reports of clinical leadership and support of projects demonstrate collaborative working and health inequality messaging is reaching and will be making a difference at the front line in everyday interactions with NHS patients.	*"[the successful] development of [an] online training module for staff around dealing with people who have limited vision or no sight, which will help staff more widely across the system consider much more the needs of those individuals [has been] driven by a Local Eye Health Network and lots of positive contribution from members of the public in shaping it".* *"working collaboratively with professionals and CYP and Parent Carers to develop and implement plans – good examples of problem solving and working together"* *"Some excellent local and system comms and engagement to promote activities and make the service accessible, acceptable and relevant to our target groups. Good examples include the Facebook campaign and promotions in Bulgarian, for the Bulgarian community in Shropshire and the excellent radio interviews undertaken by Project staff and a very supportive local Councillor in Telford."*
5. Use of I.T. and digital	There are strong examples this past year where projects have used innovative IT and digital approaches to expand their reach and improve access to healthcare information. These methods have enabled further progress towards our aims and objectives by enhancing services or training offers and whilst we must always ensure we are not inadvertently excluding populations by moving to digital-based methods, utilising digital means to offer methods of access in addition to traditional means has enabled us to cater to some of our most marginalised communities.	Examples include: • Loaning blood pressure monitors either for 7 day monitoring in community settings or continuous management of blood pressure. • Using text messaging to promote available services or gather observations. • Co-development of videos in other languages to share healthcare information.

Barriers		
1. Capacity and workforce	The consistent theme running through most project areas relates to reduced and limited capacity. This is an unsurprising find considering the unprecedented pressures on the NHS for urgent, emergency, elective, general practice, treatment backlogs, financial positions and the crisis surrounding workforce recruitment and retention, a fact that has been significantly reflected in recent staff survey results which reflect increasing work pressures and high proportions of burnout amongst staff. Capacity issues are reflected across all organisations (ICB, Primary Care, Secondary Care, local authority partners and community services), with issues of capacity wide-ranging and relative to the following areas: • Leadership capacity to provide direction. • Capacity to manage and govern projects. • Capacity to carry out assurance monitoring and functions. • Capacity to deliver services and provide reports. • Capacity to provide support functions to projects. • Capacity to provide specialist input or technical capability (i.e. BI). • Capacity to organise or attend education and learning activities or events.	*"There is total agreement that this work is a priority, however GPs now have so many competing priorities, this may not always be at the forefront. We have seen the effects of COVID, StrepA, MMR and general winter pressures alongside increased workload due to delays in patient access to secondary care and practices concentrating efforts on supporting those that are most unwell."* *"Lack of capacity in an inadequately resourced team means it gets light touch attention when possible rather than meaningful focus and time. Too many priorities and pieces of work for the capacity available."* *"STW are a small system with very limited capacity, especially within our data and business intelligence teams. This limits the pace of progress we can make amongst many competing priorities."* *"Currently no project support for this project. Very little capacity to effectively manage project."*
2. Ownership and focus	This evaluation tells us that we have a strong sense of leadership and collaboration on system-based health inequalities projects, however, this is not the same in our wider functions or programme areas.	*"Lack of buy-in and/or headspace to properly contribute to the plan and actively drive it forward. [There is a general response that we] need to focus on keeping the hospitals running and seeing patients and recovering waiting lists, to look at [inequalities] later, but [we are] not recognising that*

	There are examples showing a lack of accountability, ownership, understanding, engagement and consistency in participation, often as a result of miscommunication and misunderstanding regarding core aims and deliverables, a lack of true awareness of health inequalities approaches and how these approaches should be integrated within current work as opposed to being considered as something 'additional' that is too time-intensive to consider amongst other significant demands and priorities. In a system significantly limited by resources and funding, any lack of accountability, ownership, focus or understanding of reducing health inequalities underpins all other barriers outlined earlier in this report.	*[inequalities-based approaches] should form part of that recovery."* *"So much time was lost for two years when leadership and ownership of this service was poor. The service is so far behind others [across the region] which have been actively developed and grown over 2 years whereas our team only appear to be functioning in fits and starts. Now with [a dedicated] Lead being involved and supportive, progress is being made but a high level of drive and the engagement needs to be maintained."* *"Once the early adopters have joined the programme it becomes more challenging to increase the no. of settings participating which requires even more efforts to identify persuasive narratives and enlist support from others to encourage participation."* *"Engagement with some partner organisations as a result of workforce pressures. Support is required to facilitate engagement."* *"It may be beneficial to have a health inequalities rep to attend steering groups to drive forward certain priorities"*
3. Data and intelligence	A key, consistent barrier to measuring the outcomes of the inequalities-based approaches has been the availability of local data and intelligence. Accurate and meaningful data is mission-critical in identifying inequalities, developing targeted action plans, and measuring impact.Key issues relative to the availability of local data include: • Issues extracting and sharing service data from Providers (both Secondary and Primary Care).	*"ESNs are unable to identify children with EHCPs in place as this is not flagged in their care records."* *"The NHS Digital Weight Management Programme is a national programme with very limited access to data for local systems. Limitations to granular-level referral activity data (by Practice) limits our ability to make targeted improvements for Core20PLUS populations. A lack of data on ineligible referrals further restricts our ability to make informed improvements to referral eligibility. To target*

	• Establishing formal data sharing agreements. • Having the right system infrastructure to enable data collection for key demographics i.e. establishing electronic patient flags in systems to identify patient inclusion groups for additional / targeted support. • Subsequent impact on completing robust, data-based impact assessments. • Challenges with nationally available data, such as time lag in updates, data quality, low number suppression and challenges in accessing data in a format that allows for meaningful analysis. This makes the drawing out of health inequalities themes at a granular level very challenging, thus inhibiting the ability to develop targeted plans and resources.	*improvements, we must cross-reference the data that is available to us with Practice demographics data, which is timely."* *"Local access to data/data-sharing is still very limited and national data sources are more out of date than is ideal (CVD Prevent data is 4 months out of date)."* *"The use of [digital platforms] to collect, store and aggregate data [can be impeded] by the complexity of IG and contracting barriers when trying to implement use for [integrated services being offered by] LA and VCSE partners."*
4. Lack of available funding	Many organisations within the system are experiencing significant financial deficit. Funding is a key barrier in its role in ensuring the capacity to meet population health needs, whether that be funding of pay or non-pay resources and provider contracts. Themes raised around finance are the prolonged and extensive use of fixed-term contracts and significant difficulty in accessing local funds through business case processes, or, lack of availability of relevant funding streams to facilitate projects which directly address inequality for Core20PLUS populations or support the 5 (10 in total) clinical priorities for adults and children and young people.	*"A business case was developed for the continuation of post attack reviews within the CCN service (SCHT) however this was not progressed due to current financial position."* *"Significant local financial deficit and limited funding available through the national programme (acknowledging that the project came to fruition originally as a result of a bid for national funding). Often, funding is available short-erm through national pilots, but this does not favourably support sustainability plans as it leaves little time to obtain the level of evidence needed to show return on investment, even more so when we are trying to make improvements in longer-term prevention and inequalities, which we would not expect to see until the medium to long term."* *"Funding would be useful to support campaigns to target non-attenders for screening etc."*

		"Funding has limited reach e.g. in the example of Tobacco Dependency service funding, Tobacco Dependency Advisors have been funded for priority settings (Acute, Maternity and Mental Health Inpatient) but the funding available did not stretch to enable implementation within community hospitals or other secondary care service providers."
5. Governance	Project leads have also shared the view that in some places there is a burden of reporting by way of duplication. Health Inequalities is the golden thread which runs through all current work programmes and in many instances, similar updates and assurance reports are being provided to multiple groups.	*"Integration of new governance which has oversight of many areas where governance is already in place. This includes the relationship between system Prevention and Health Inequalities initiatives focused primarily on NHS services, Place-based Boards and Programme Boards relative to the Key Lines of Enquiry (inclusive recovery, cancer, diabetes). We must, where possible, ensure we reduce duplication unless absolutely necessary."* *"There are various local reporting routes for this project, it would be helpful to have one."* *"there is overlap between the Project Group and Operational Group which requires review and change for Year 2."*

Appendix 3 – Examples of Best Practice

Examples of Best Practice and Case Studies

An example of successful partnership working –
Core20PLUS Connectors (STW Cancer Champions)

Shropshire, Telford and Wrekin (STW), in partnership with Local Authorities and Community Delivery Partners, Lingen Davies Cancer Fund and Qube Oswestry Community Action, were successful in their bid to be selected as one of 11 sites across the country to become a wave one pilot site to design and implement the NHSE Health Inequalities Core20PLUS Core Connectors programme (STW Cancer Champions).

The Cancer Champion project aims to increase the uptake of cancer screening invitations through raising awareness in underserved communities, by training volunteer champions from these communities. The project has engaged with more than 80 local community organisations and successfully recruiting over 220 Cancer Champions from a wide range of backgrounds including a broad range of healthcare staff, community outreach workers from many different services (e.g. veterans, refugees, drug and alcohol support workers etc), trusted members of our communities, migrant workers, people in contact with the justice system, religious leaders and even hairdressers!

Simultaneously, our Champions share what they know, or have learnt through their everyday conversations, about the barriers that make it more difficult for marginalised communities to access the healthcare they need. Insights gathered through the project include themes of fear, not understanding the importance of screening, difficulties with language and literacy and communication from healthcare staff. These insights have been fed back at a System, Regional and National level, with information specific to individual teams across the healthcare system being shared directly to support the development of tools and resources to improve access to cancer screening for those who most need it.

Some of those tools and resources have included the co-development of a series of multi-lingual videos which aim to share health information with communities who do not speak English as a first language, informing local toolkits for supporting people with Learning Disabilities or Autism to access screening and the piloting of a Cervical Screening Concerns Checklist within General Practice. Longer-term impacts are expected where our Cancer Champion's insights are being used to inform larger scale system strategy and action plans, including Digital and Cancer Strategies.

Whilst the project's pilot funding formally ended in March 2024, the interest and impact it has generated for our communities has led to its continuation. Moving forward, Cancer Champions will form part of Lingen Davies' and Qube's core business, whilst maintaining those fundamental relationships with healthcare decision-makers to continue feeding back our communities' insights to informing healthcare planning and improve service delivery.

Whilst there are many factors to success, the largest contributing factor is the accountability and ownership of all partner's involved in the project to bring their own expertise, skills and connections to the fore to support the project to succeed. In addition to this, having a fundamental understanding of which communities we aim to involve in the project, and why it is important that we persevere and do despite this taking time, is critical to us having the impact and reach that is needed to sufficiently implement an inequalities-based approach.

An example of addressing the intersection between mental and physical health and reducing healthcare inequalities for inclusion health groups through multi-agency – Providing Health Checks for People who are Homeless (Rough Sleeping) to Identify and Introduce Mental Health and Physical Health Interventions

Midlands Partnership Foundation University Trust's (MPUFT) Rough Sleepers Team has developed over the last six months with the aim of addressing healthcare inequalities specifically for people who are rough sleeping. The service has focused on both the mental and physical health needs of this population by working closely with established physical health pathways and offering a comprehensive outreach service.

The team comprises of three Band 7 Clinicians, a Band 5 Mental Health professional and there are plans to recruit a dedicated Social Worker. This range of working professionals ensure the team has expanded multi-disciplinary team knowledge, as well as social support and direct links into Local Authorities with plans to set up a local Task Force to offer personalised support address the wider needs of the population that sit outside healthcare provision.

Outreach clinics are held in discrete community locations across Shropshire, Telford & Wrekin, including the Ark. These clinics offer a wide range of health-based checks, including medication reviews, mental health examination, physical health checks (including blood pressure, BMI Hb1ac, lipids, bloods, ECG), smoking cessation advice and ongoing drug and alcohol support via SRP and Stars.

Additional key developments of the service:

- Key-worker approach to ensure prompt and timely interventions
- Care planning and PROMS to support the service users whole journey, including links with alcohol and drugs, prison services, Local Authorities, GP Practices, Reset Shropshire.
- Direct links with GP Mental Health Practitioners.
- Links into the Severe Mental Illness (SMI) pathway
- Dual-diagnosis training
- Advice and guidance for common physical health ailments including diabetes, foot care, Flu and Covid vaccinations.
- Ongoing development of a training package to offer to all partner agencies including drug and alcohol, rough sleepers, street pastors and temporary housing services.

An example of community involvement, co-design and co-development – New sight loss e-Learning launched in Shropshire, Telford and Wrekin

A new e-Learning resource for staff working in health and care services has been launched in Shropshire, Telford and Wrekin to help improve the lives of people living with sight loss.

The e-Learning is the result of a project initiated by the Shropshire Local Eye Health Network (LEHN), working with NHS Shropshire, Telford and Wrekin, which identified a gap in knowledge and understanding of sight loss and how it impacts people's lives.

The 'Understanding and Supporting People Living with Sight Loss e-Learning' is a collaboration between people with lived experience, sight loss experts and professionals from across the Integrated Care System. It involved people living with sight loss throughout its development, from design through to the development and launch of the content.

Recognising that sight loss will impact everyone at some point in their lives, either through work, personally or through a friend or loved one, the training is for all health and care –taff -

those who interact with people living with sight loss in their day-to-day work and those who provide specific eye care related services.

There are two levels to the training. The first is for those needing a basic understanding of the different conditions, their impact on people's lives and how we can make small changes to their day to day practice and services so they are more accessible.

The second is more in depth and provides information about where people can be signposted for support as they try to navigate their sight loss journey. The e-Learning includes 4 videos about the experiences of people living with sight loss and local services to make the modules more engaging and interactive:

- Sensory Impairment Service and Rehabilitation Officer for Visual Impairment
- Local Sight Loss Charity
- Low Vision Service
- Eye Care Liaison Officer

An example of leadership and accountability to drive progress at pace – Rapid Implementation of Alcohol Care Teams

The NHS Long Term Plan makes a commitment to support hospitals with the highest rate of alcohol dependence-related admissions to establish Alcohol Care Teams.

In April 2021, Shrewsbury and Telford Hospital NHS Trust (SaTH), with support from Telford & Wrekin Council, were successful in their bid for funding to establish an Alcohol Care Team at the Princess Royal Hospital in Telford & Wrekin. A total of £321,000 was awarded to see implementation over a 3-year period, with the aim of having a fully established Alcohol Care Team in place by March 2024.

Due to changes in local workforce and leadership, the sense of ownership and accountability for the project was lost and this subsequently led to additional issues, such as tracking down issued funds and resulting in significant delays. As a result of the service having experienced such significant delays to progress, and the likelihood that it would not achieve full establishment by March 2025, the project was escalated through system health inequalities governance.

This led to the appointment of a lead within the Trust who was tasked with progressing implementation of the service, at pace. Since this fundamental change in leadership, the service has made significant progress towards meeting its objectives, now being in a position whereby:

- Successful recruitment has taken place for Band 7, Band 6 and Band 2 staff.
- The service is submitting patient-level data submissions.
- An individualised detox pathway is in place.
- The profile of the service has been raised internally at the Trust and at ICS level.
- There are strengthened relationships between the Alcohol Care Team and Emergency Department.
- Quarterly reporting takes place internally to the Trust's Quality Oversight Committee, including data analysis of impact and outcomes.
- Preparation is now taking place for a future Business Case.

Due to this rapid improvement and confirmation that the service is meeting the minimum required implementation criteria, NHS England has awarded an additional allocation of funding to support the continuing development of the service throughout 2024/25.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin (STW) Health Inequalities Metrics End of Year 2023/24

Summary analysis in line with the NHS England Statement of Information

May 2024

Summary

The following slides provide a summary overview of the latest NHS England Statement of Information metric data, focusing on the latest figures for Shropshire, Telford & Wrekin, benchmarked against the England national average and where possible, a comparison at Place (Shropshire and Telford & Wrekin individually).

The data utilised for this review is based on national data sources aligned to the statement metrics, however, it is noted that the available data is commonly older and does not contain the granularity required.

As part of the national program of work, access and use of alternative data sources applying the national criteria are being developed. This approach is likely to provide more up to date data sources to support local trend improvement, and the granularity needed to provide a view of inequalities.

Where possible we have included references to local data sources to provide improved insights and show variance by demographic (age, ethnicity and deprivation quintile).

Shropshire, Telford & Wrekin continue to work collaboratively with National, Regional and Commissioning Support Unit (CSU) Health Inequalities and Analytical Teams to develop our local understanding of health inequalities and local Population Health Management Dashboard.

NHS England Statement of Information
Health Inequities Metrics

Domain	Indicator
Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex
Cardiovascular disease	Stroke rate of non-elective admissions) per 100,000 age-sex standardised)
	Myocardial infraction - rate of non-elective admissions (per 1000,000 age-sex standardised)
	Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold.
	Percentage of patients aged 18 and over with no GP recorded CVD a GP recorded QRISK score of 20% or more, on lipid lowering therapy
	Percentage of patients aged 18 and over with GP recovered atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy
Diabetes	Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes
	Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.
Elective recovery	Size and shape of waiting list; for those waiting longer than 18 weeks
	Size and shape of waiting list; for those waiting longer than 52 weeks
	Size and shape of waiting list; for those waiting longer than 65 weeks
	Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances
	Elective activity vs pre-pandemic levels for under 18s and over 18s
Learning disability and autistic people	Learning disability annual health checks
	Adult mental health inpatient rates for people with a learning disability and autistic people
Mental health	Overall number of severe mental illness (SMI) physical health checks
	Rates of total mental health act detentions
	Rates of restrictive interventions
	NHS Talking Therapies (formerly IAPT) recovery
	Childrens and young people's mental health access
Oral health	Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)
Respiratory	Uptake of COVID and flu by socio-demographic group
Urgent and emergency care	Emergency admissions for under 18s
Smoking Cessation	Proportion of adult acute inpatient settings offering smoking cessation services
	Proportion of maternity inpatient settings offering smoking cessation services

Additional Local Metrics or Analysis

Domain	Indicator
Cancer	Staging data for stage 1 and 2 **by deprivation and ethnicity**
Cardiovascular disease	Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold **by age, ethnicity and deprivation**
	Percentage of patients aged 18 and over with no GP recorded CVD a GP recorded QRISK score of 20% or more, on lipid lowering therapy **by age, ethnicity and deprivation**
Smoking	Smoking prevalence in adults (age 18+)
	Smoking Attributable Hospital Admissions (2019/20)
	% of hospital births where Smoking is reported at time of delivery
Elective Recovery	Waiting list profiles for 52 week waits by **age, ethnicity and deprivation**

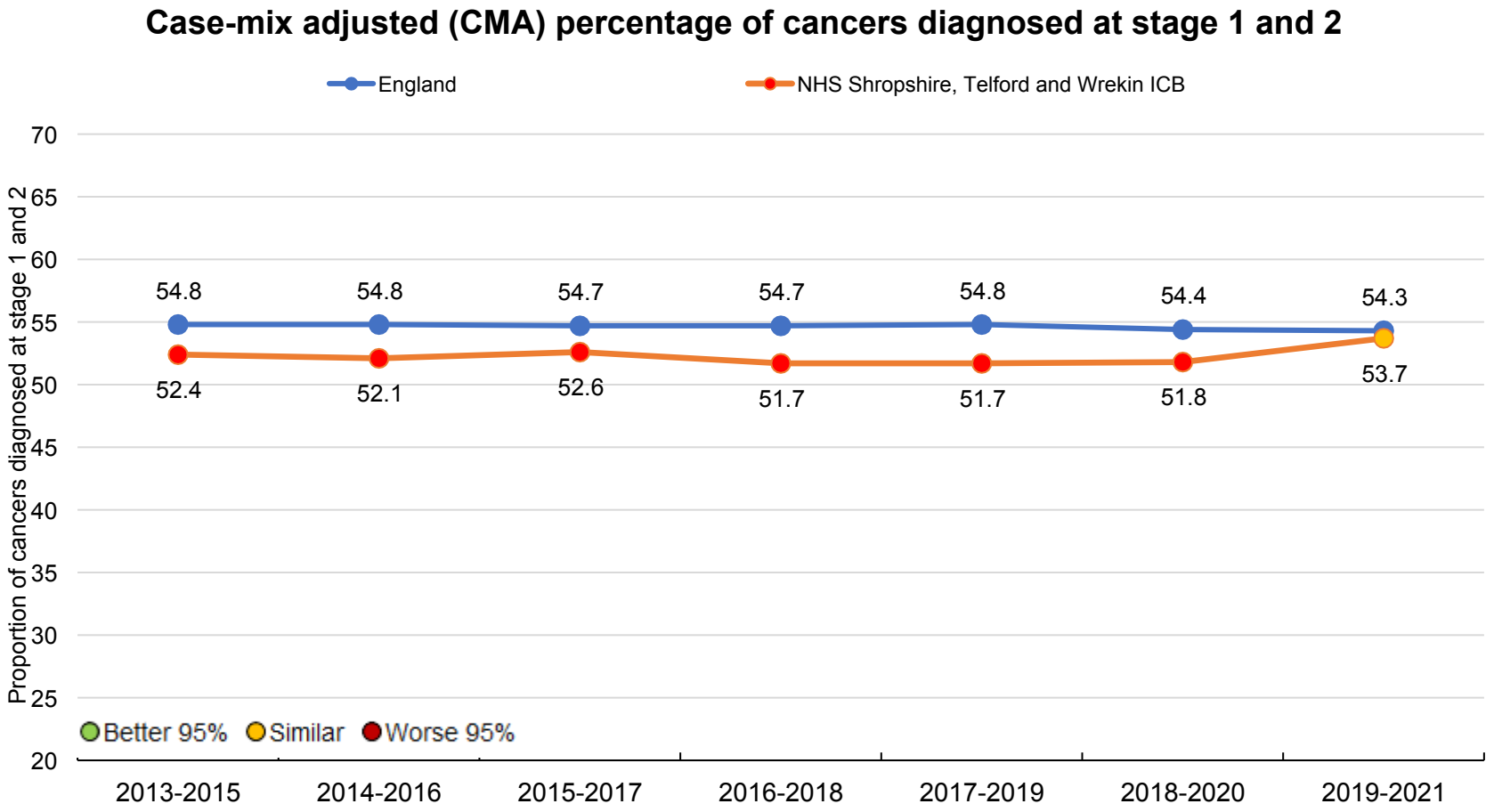
Key Headlines

- Both the ICB and the Telford and Wrekin authority have statistically higher stroke and heart attack admission rations than the England average.
- The ICB is below target for all three CVDPREVENT metrics, however do report improvement.
- Persons with Type 2/other diabetes are more likely to have received all 8 care processes than those with Type 1.
- Adult elective activity and day case attendances for persons aged under 18 have yet to return to their pre-pandemic levels.
- The ICB did not achieve “eliminating” waits of 65 weeks or more, however significant reduction in long waits is reported.
- The ICB is performing below the national average for learning disability health checks for persons aged 14-17 and 18+.
- The ICB has a higher adult mental health inpatient admission rate than the national average.
- The ICB is performing below the national average for delivering “all 6” physical health checks to persons with severe mental illness (SMI).
- The Telford and Wrekin authority has a higher preterm births (under 37 weeks) rate than the England average.
- Both local authorities have a higher rate of admissions for tooth extractions in children aged 10 or under, than the England average.
- COVID and Influence uptake rates are lowest among the most deprived neighbourhoods of the ICB and persons from non-white ethnicity found to have lower uptake levels than the white ethnic population.

Percentage of cancers diagnosed at state 1 and 2 (case-mix adjusted)

53.7% of cancer patients were diagnosed at either stage 1 or 2 (2019-2021)

This is in line with the England average (54.3%) and whilst it is an improvement on previous figures, the difference is not statistically significant.



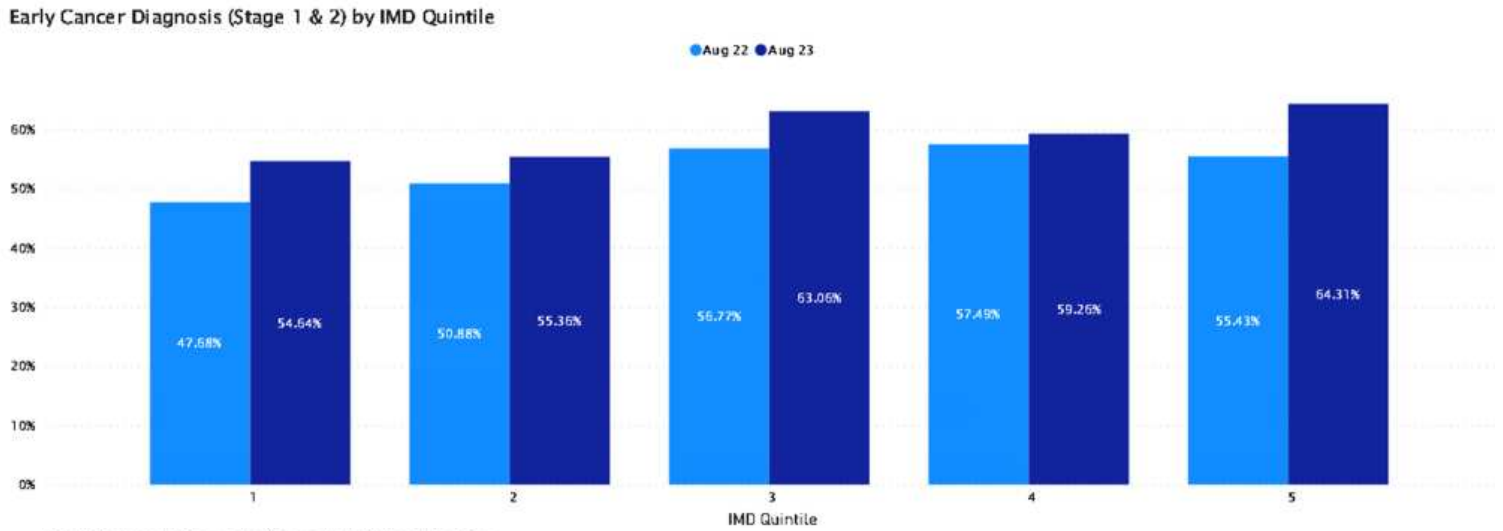
Data Source: https://digital.nhs.uk/ndrs/data/data-outputs/cancer-data-hub

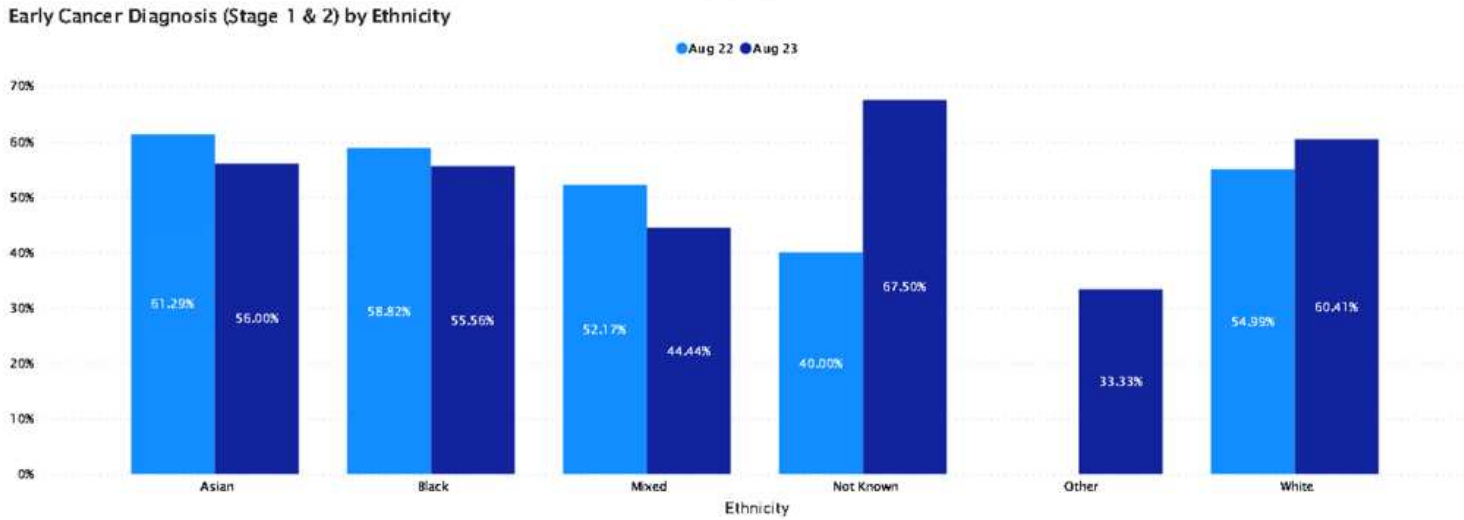
Cancer Early Diagnosis for Stages 1 and 2

Data over the last 12 months shows a 5% increase (54.7% - 59.8%) in the % of cancers diagnosed at stages 1 and 2.

Sociodemographic analysis shows that early diagnosis rates vary by 10% between the least and most affluent communities and 15% between people of white ethnicity and other ethnic backgrounds.

It should be noted that the data available reports very poor ethnicity capture (showing high proportions of ethnicity recorded as 'not known') and is therefore not fully representative of true variance between populations.





Source : Cancer outcome and services data set (COSD)

Cardiovascular Disease

Metrics stated as per the NHS England Statement of Information:

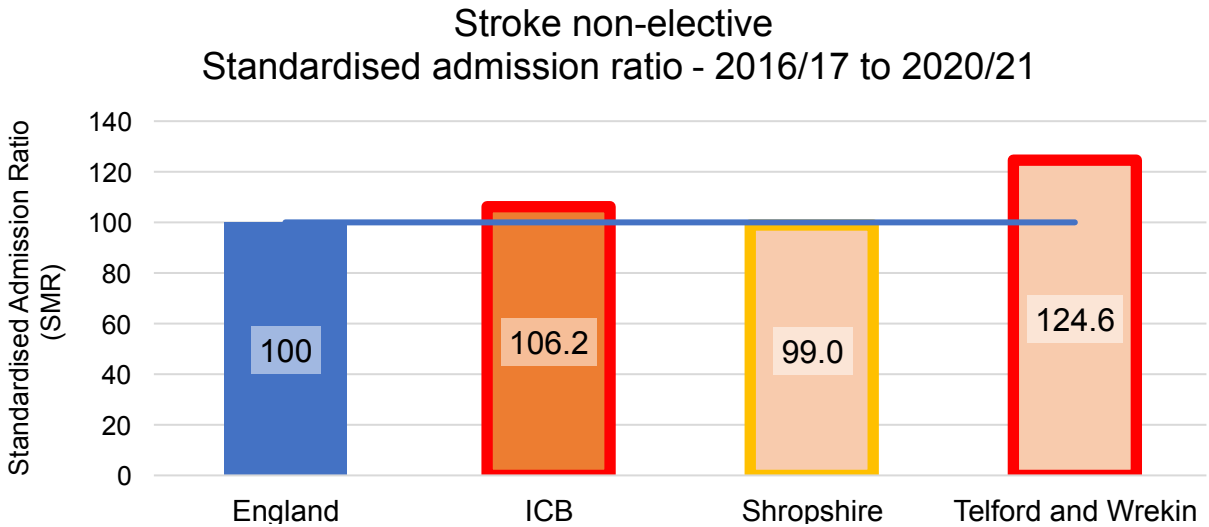
- Stroke rate of non-elective admissions per 100,000 (age-sex standardised)
- Myocardial infraction (heart attack) - rate of non-elective admissions per 1000,000 (age-sex standardised)
- CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold.
- CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD a GP recorded QRISK score of 20% or more, on lipid lowering therapy
- CVDP002AF: Percentage of patients aged 18 and over with GP recovered atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

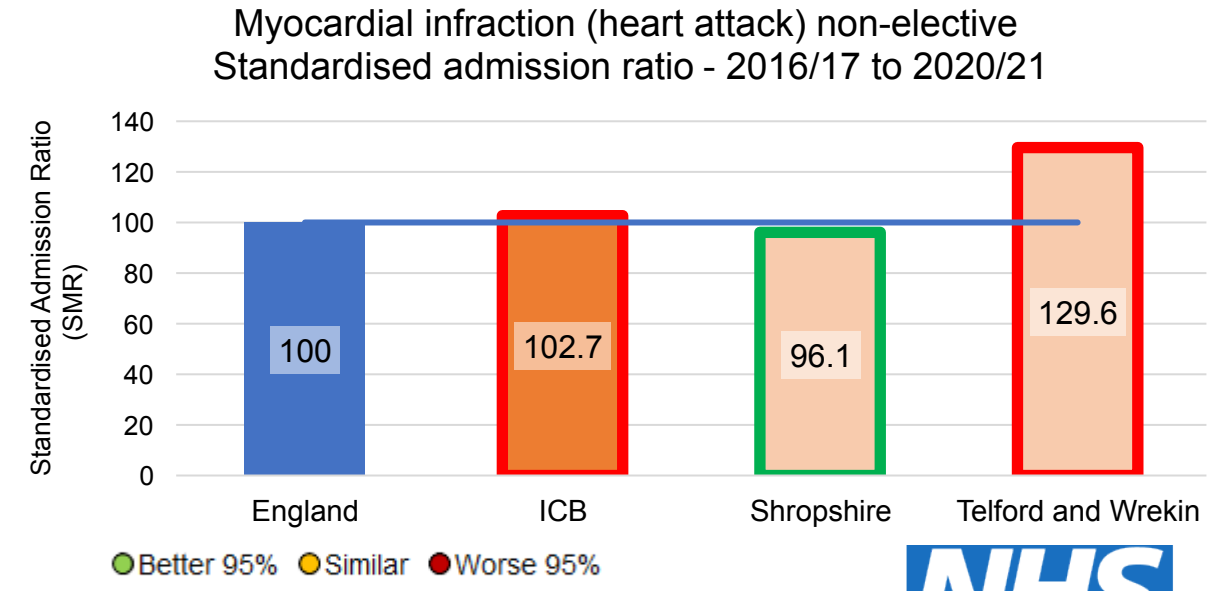
Non-elective Admissions Ratio for Stroke and Myocardial Infarction

Shropshire, Telford and Wrekin had a significantly higher ratio of heart attack and stroke compared to the England average.

A higher proportion of this activity can be seen in Telford & Wrekin, with Shropshire being in line or lower than national average for admissions ratio.

Local analysis found that over the past 6 years, the ICB has recorded an **average of 1,024 emergency admissions per year for Stroke** and an **average of 938 emergency admissions per year for myocardial infarction**. There has been little movement in admission rates over this period.





Data Source: Secondary Care Uses (SUS), NCDR and UDAL

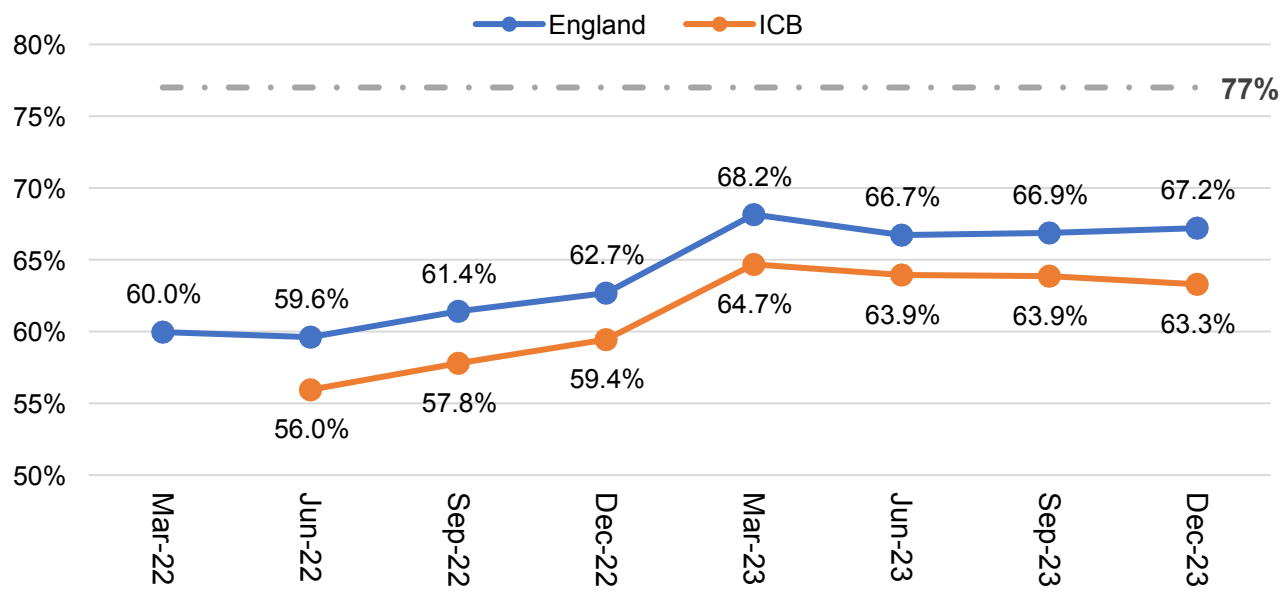
Optimal Treatment of Hypertension (CVDPREVENT **CVDP007HYP)**

As at December 2023, **63.3% of people in Shropshire, Telford & Wrekin aged 18+ were considered appropriately treated for their high blood pressure.** This is below national average but in line with recovery trends following huge declines in treatment during the Covid-19 Pandemic.

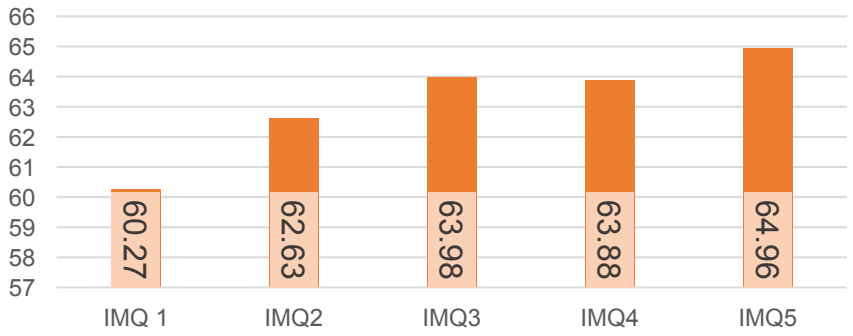
Social demographic analysis shows lower proportions of treatment for people from socio-economically deprived areas, black and mixed ethnic backgrounds and younger people.

Whilst the percentage of hypertension treatment shows no significant change between March and December 2023, it should be noted that the number of people being identified with hypertension has grown considerably, meaning more people are being treated appropriately for their high blood pressure.

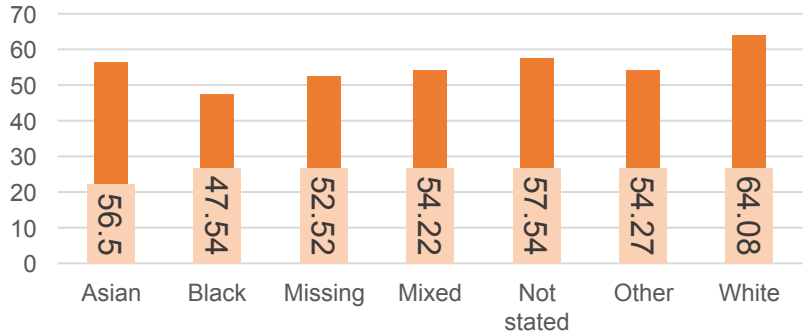
Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold



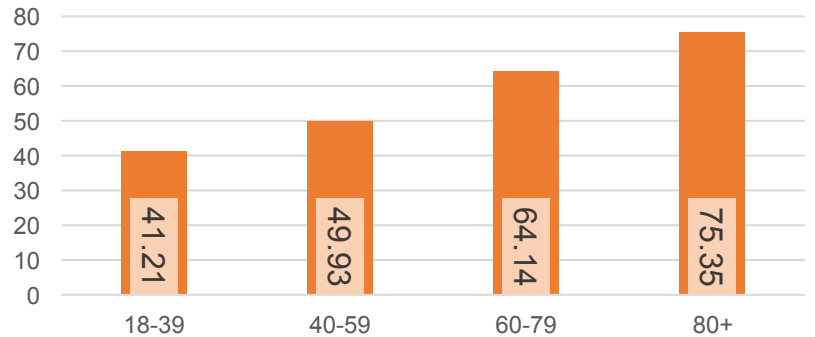
% of people treated to target (deprivation quintile)



% of people treated to target (ethnicity)



% of people treated to target (age)



Data Source: https://www.cvdprevent.nhs.uk/ (December 23 release)

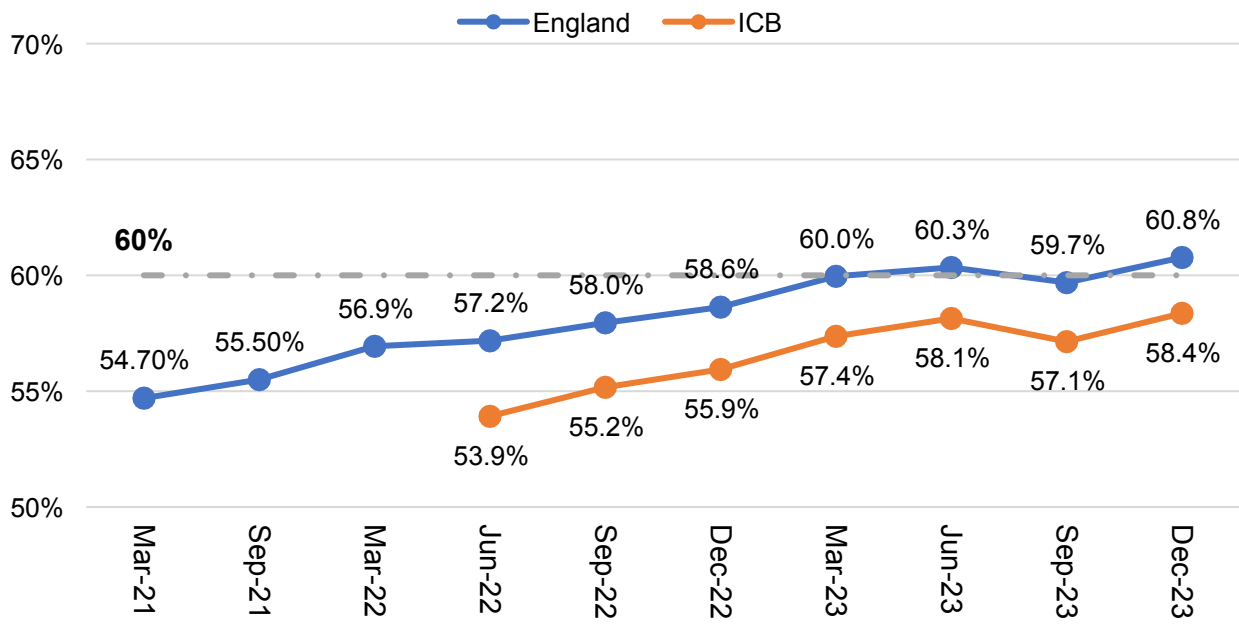
Cholesterol and Lipid Management (CVDPREVENT **CVDP003CHOL)**

The latest data shows that **58.4% of people aged 18+, with no recorded CVD and a QRISK score of 20% or more, were on lipid lowering therapy.**

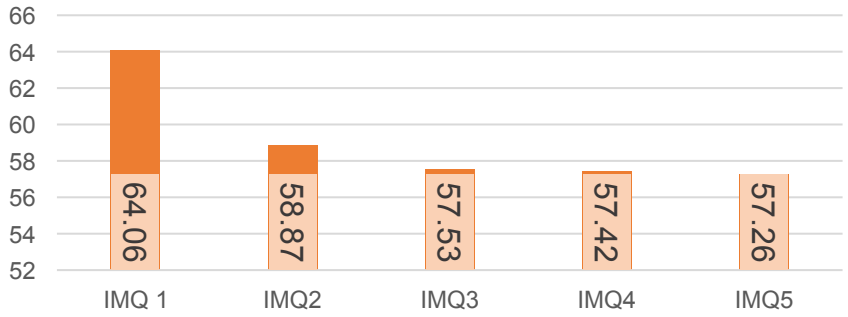
This is below the England average (60.8%) and just short of the national target of 60%. However, we can see that figures have been improving throughout the year in line with national trends.

Analysis found that the STW was meeting the 60% target for persons from the most deprived deprivation quintile (64.1%), for persons from an Asian or Asian British background (66.1%), for persons aged 40-59 (65.7%) and for persons aged 60-79 (61.9%).

CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD a GP recorded QRISK score of 20% or more, on lipid lowering therapy

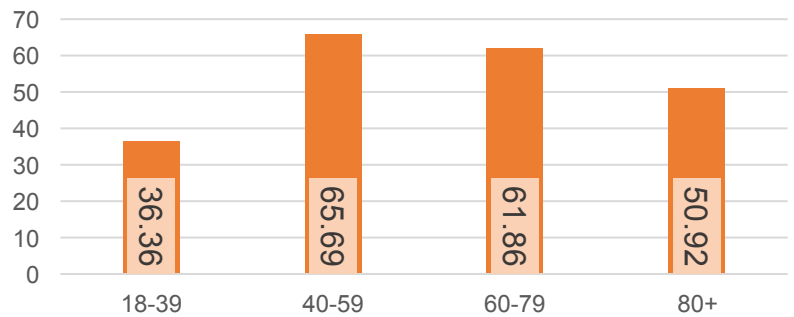


% of people treated to target (deprivation quintile)



% of people treated to target (ethnicity)

% of people treated to target (age)



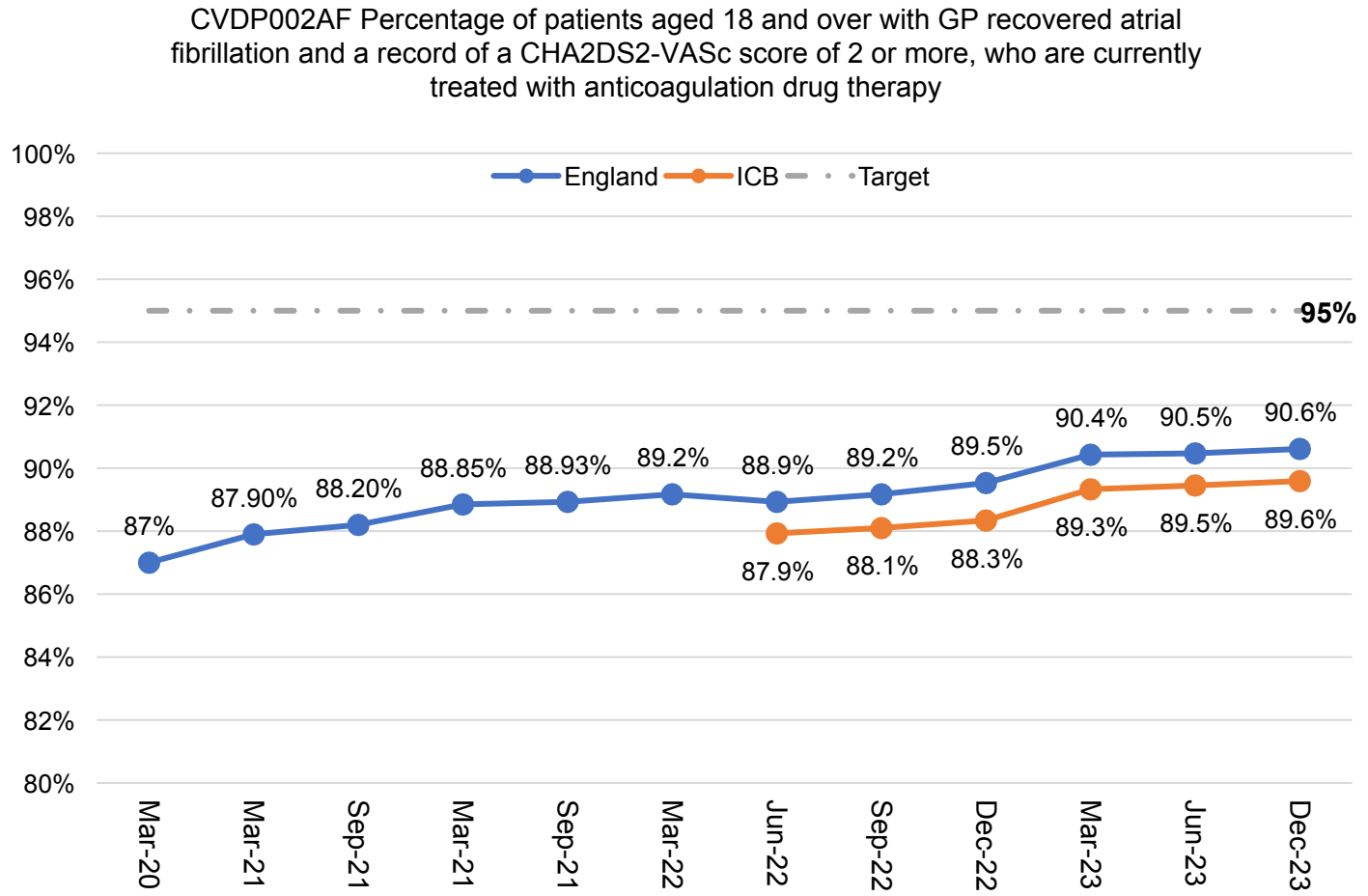
Data Source: https://www.cvdprevent.nhs.uk/ (December 23 release)

Atrial Fibrillation (CVDPREVENT **CVDP002AF)**

The latest data (December 2023) shows that **89.5% of persons aged 18+, with GP recorded AF and a record of CHA2DS2-VASc score of 2 or more, are currently being treated with anticoagulation drug therapy.**

This is below the England average of 90.6% and the national target of 95%. However, trend analysis does show that the ICB is heading towards this target and has broadly been following the national picture.

Social demographic analysis showed that there is a similar level of treatment between females (89.1%) and males (90.0%) with further analysis finding that the ICB was not meeting the target for any other cohort groups examined.



Data Source: https://www.cvdprevent.nhs.uk/ (December 23 release)

Diabetes

Two key metrics, one taken from the **National diabetes Audit (NDA)** and the other based on the **Healthier You : NHS Diabetes Prevention Programme (DPP)** :

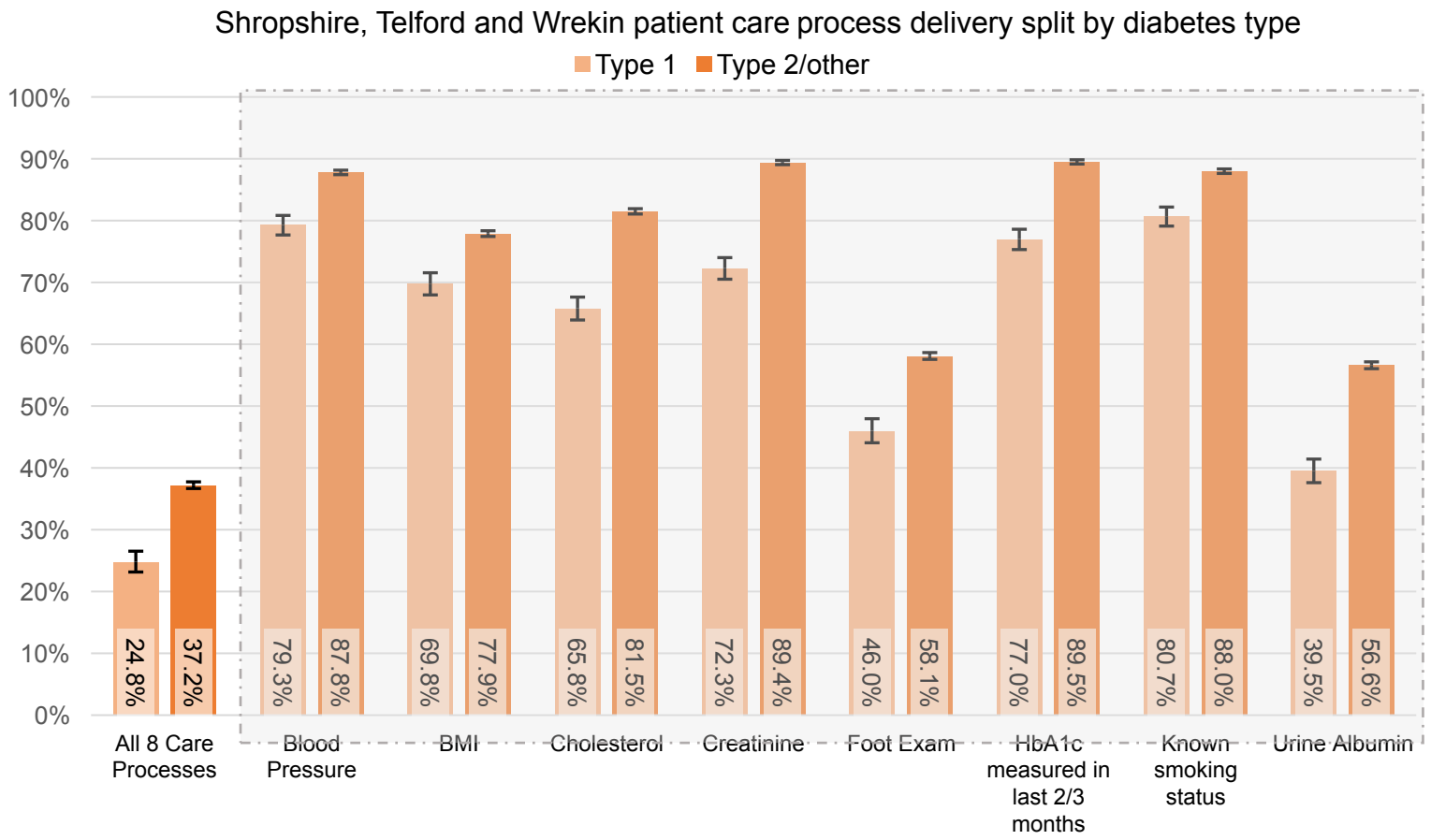
- Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes
- Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.

Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes

The latest nationally published figures (Quarter 3 2023/24) show that **people in Shropshire Telford & Wrekin with Type 1 Diabetes are less likely to have received all 8 diabetes care processes compared to people with Type 2 Diabetes.** This remains consistent when reviewing each care process individually.

STW has also achieved a smaller proportion of both Type 1 (24.8%) and Type 2/other (37.2%) patients receiving all 8 care processes compared to the England averages (34.8%, 51.3%).

Further analysis shows that **the ICB is below the England average for all but one measure – Type 1 Patients : HbA1c measured in the last 2/3 months.**



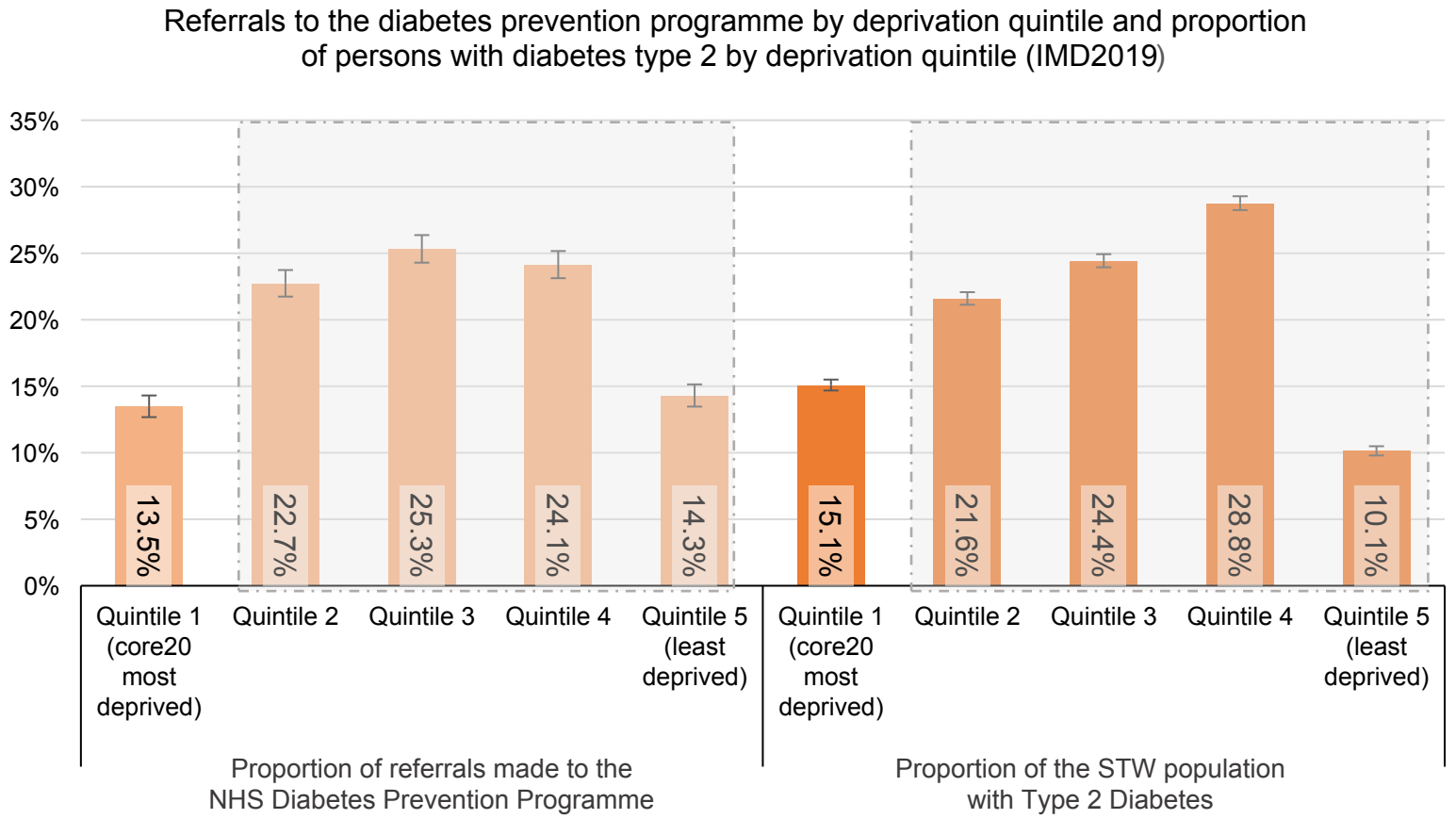
Data Source: National Diabetes Audit Dashboard

Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile

The latest nationally published figures (Quater 4 2023/24) show that a smaller proportion of referrals to the NHS Diabetes Prevention Programme were for people living in the highest areas of socio-economic deprivation (13.5% compared to 14-25% across more affluent areas).

This is slightly below the total proportion of persons with Type 2 Diabetes from Core20 geographical areas in Shropshire, Telford & Wrekin (15.1%).

The ICB was found to have the **3rd lowest proportion of total Type 2 referrals from the most deprived quintile across the Midlands**. Birmingham and Solihull recorded the highest proportion (57%) and Herefordshire and Worcestershire the lowest (13%).



Data Source: National Diabetes Prevention Dashboard

Learning Disabilities and Autism

Two key metrics one from the learning disabilities health check (LDHC) scheme, which is monthly publication based on the number of persons on the QOF learning disability register (aged 14+) receiving a health check. With evidence suggesting that providing health checks to persons with learning disabilities helps identified unrecognised health needs and can help reduce the burden of demand on secondary care services.

The second metric is based on adult mental health inpatient admission dates for persons with a learning disability and/or autism, collected as part of the Assuring Transformation collection. This data is collected to ensure that care for persons with a learning disability and/or autism improves and help to support a reduction in unnecessary and avoidable admissions.

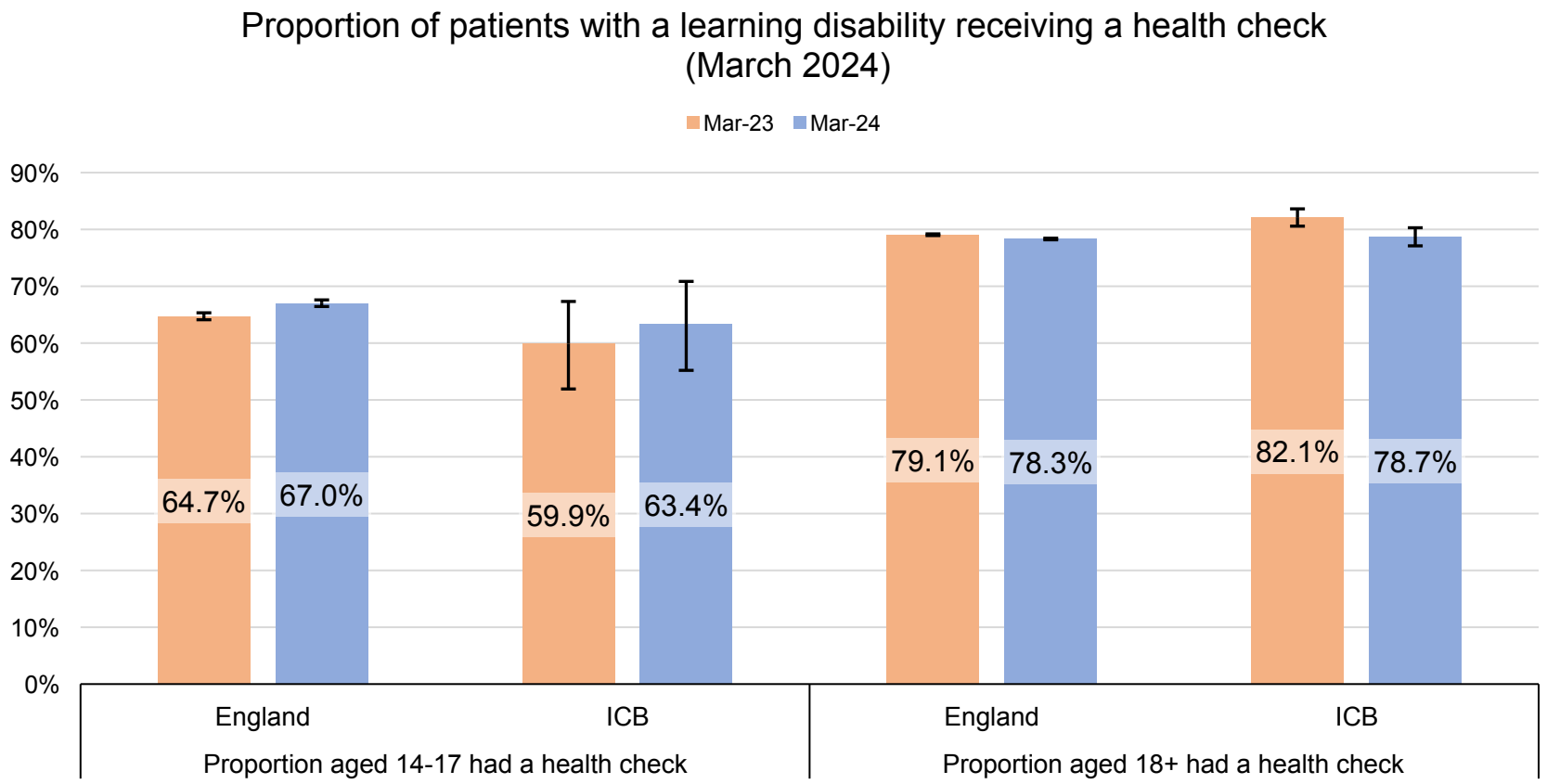
- **Learning disability annual health checks**
- **Adult mental health inpatient rates for people with a learning disability and autistic people**

Learning Disability Annual Health Checks

The latest data (March 2024) indicates that **78% of people aged 14+, with a learning disability, had received their annual health check** (63% of people aged 14-17 and 79% of people aged 18 and over). Both figures are statistically in line with the England average.

In actual terms, 2,094 people received their annual health check, meaning 483 people did not. 107 people declined their offer of a health check.

Trend analysis indicates that Shropshire, Telford & Wrekin reported a similar percentage of completed health checks the previous year.

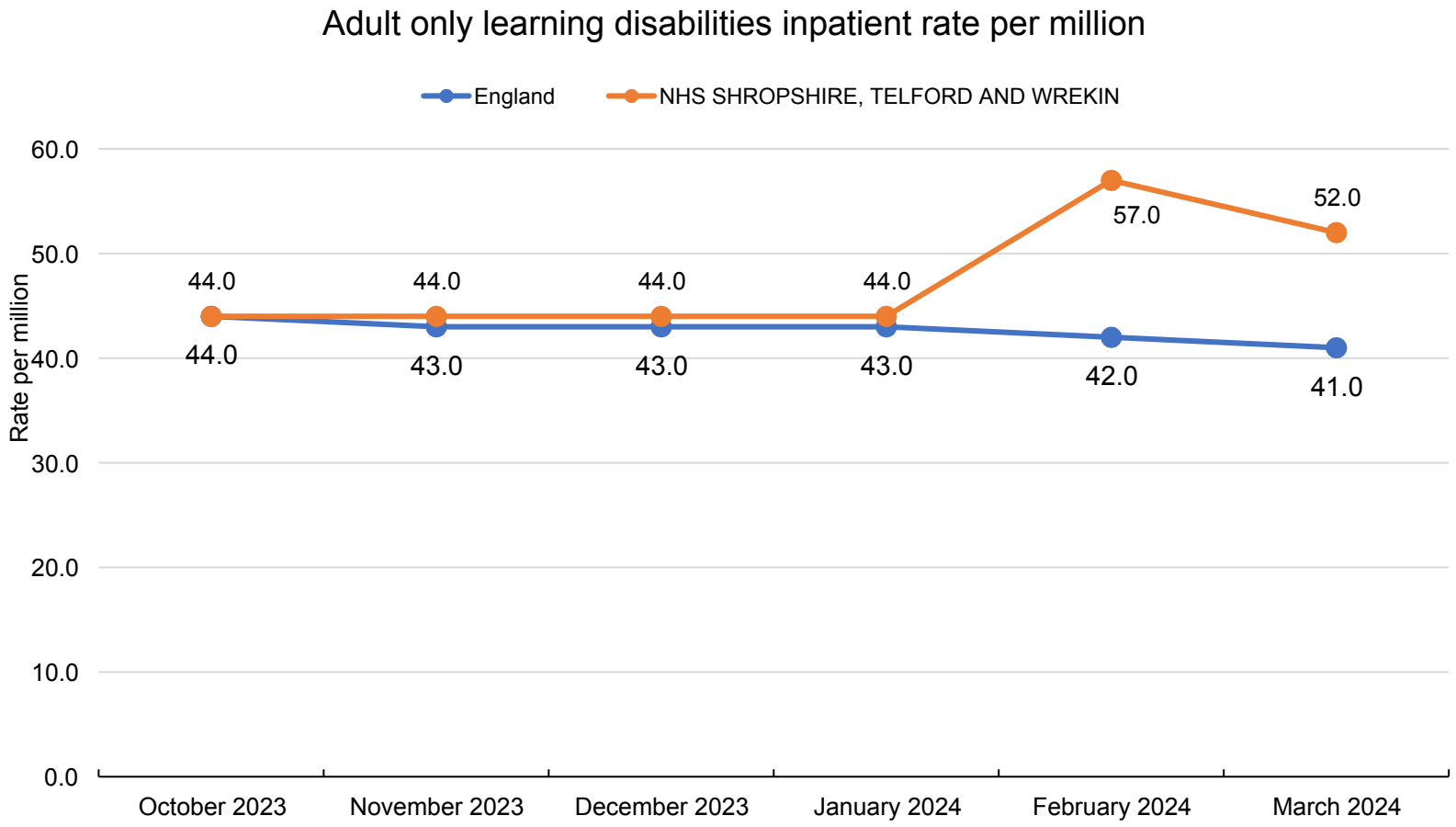


Data source : NHS England : [MI] Learning Disabilities Health Check Scheme (March 2024)

Adult Mental Health Inpatient Rates for People with a Learning Disability and Autism

NHS England's 'building the right support' guidance published in 2015 **aims to reduce the number of people with a learning disability and or Autism in a mental health inpatient setting** and to develop community alternatives to inpatient care in line with the National Service Model. Find out more here.

The latest adult mental health inpatient figures, show that following an increase in February 2024, the **ICB currently has a higher rate per million than the England average (52 V 41),** having spent 4 of the last 6 months reporting a similar rate to England.



Data Source: Learning Disability Services Statistics

Mental Health

Metrics stated as per the NHS England Statement of Information:

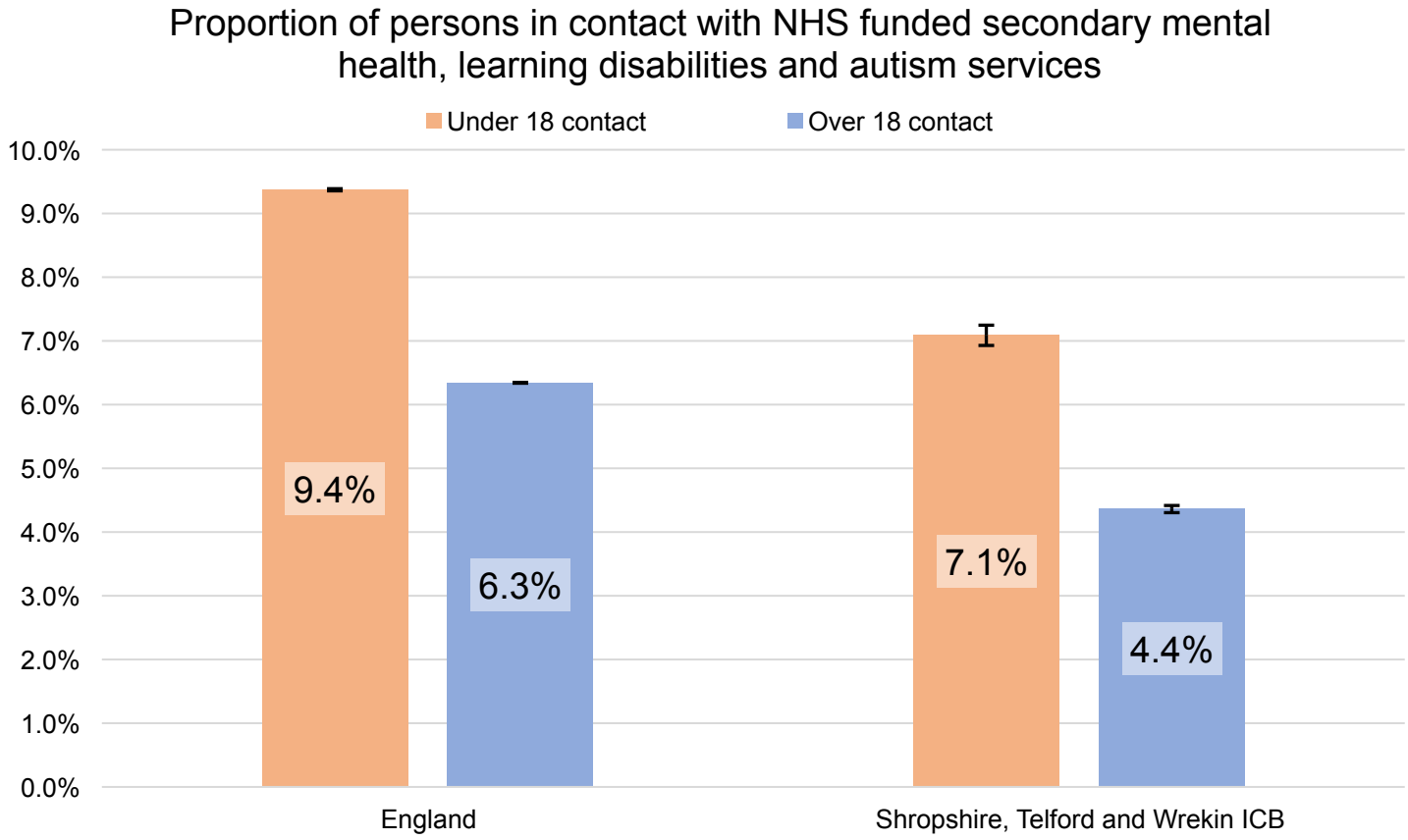
- Childrens and young people's mental health access
- NHS Talking Therapies (formerly IAPT) recovery
- Overall number of severe mental illness (SMI) physical health checks
- Number of restrictive intervention types per 1,000 occupied bed days
- Rates of total mental health act detentions

Childrens and Young People's Access to Mental Health Services

The latest nationally available data (financial year 2022/23) suggests that **a statistically lower proportion of people in Shropshire, Telford & Wrekin, who are under the age of 18, are in contact with NHS funded secondary mental health services (7.1%) compared to the national average of 9.4%.**

It can also be seen that a larger proportion of persons aged under 18 are in contact with mental health services than persons over at 18 at both a national and local level.

Please note that data availability is limited and we are unable to show trends in data over time.



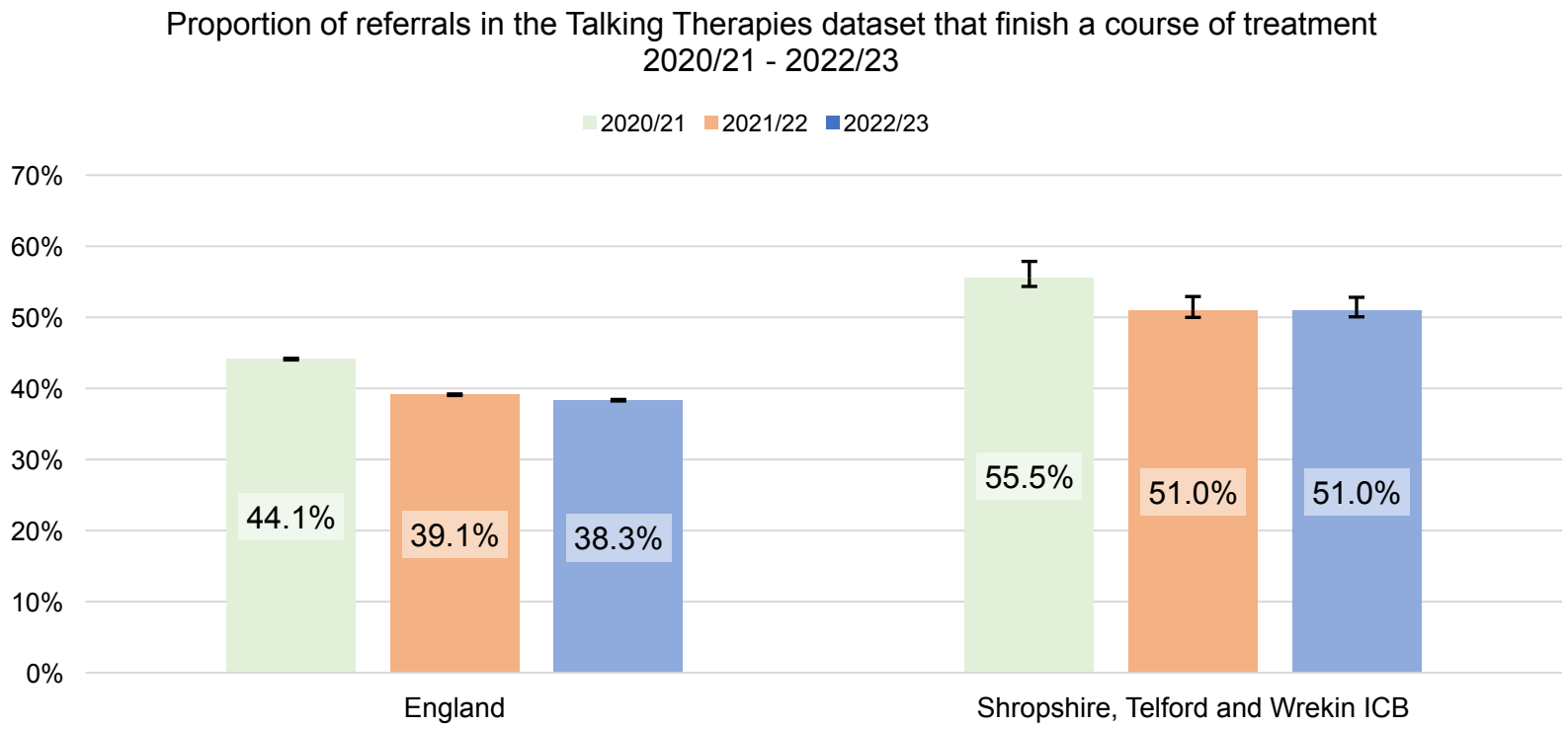
Source : NHS England : Mental Health Bulletin, 2022/23 Annual Report

NHS Talking Therapies (formerly IAPT) Recovery

NHS Talking Therapies was developed to improve and increase access to evidence-based, psychological therapies for depression and anxiety disorders within the NHS.

Figures for the 2022/23 period show that 11,425 NHS Talking Therapies referrals were completed during this period, with 5,825 persons completing their course treatment. Giving the ICB a rate of 51.0%. **This is above the England average of 38.3%.**

Trend analysis shows that the 2022/23 figures are in line with those recorded cover the 2021/22 period and below those recorded in 2020/21



Data Source: Psychology Therapies Annual Reports on the use of IAPT Services

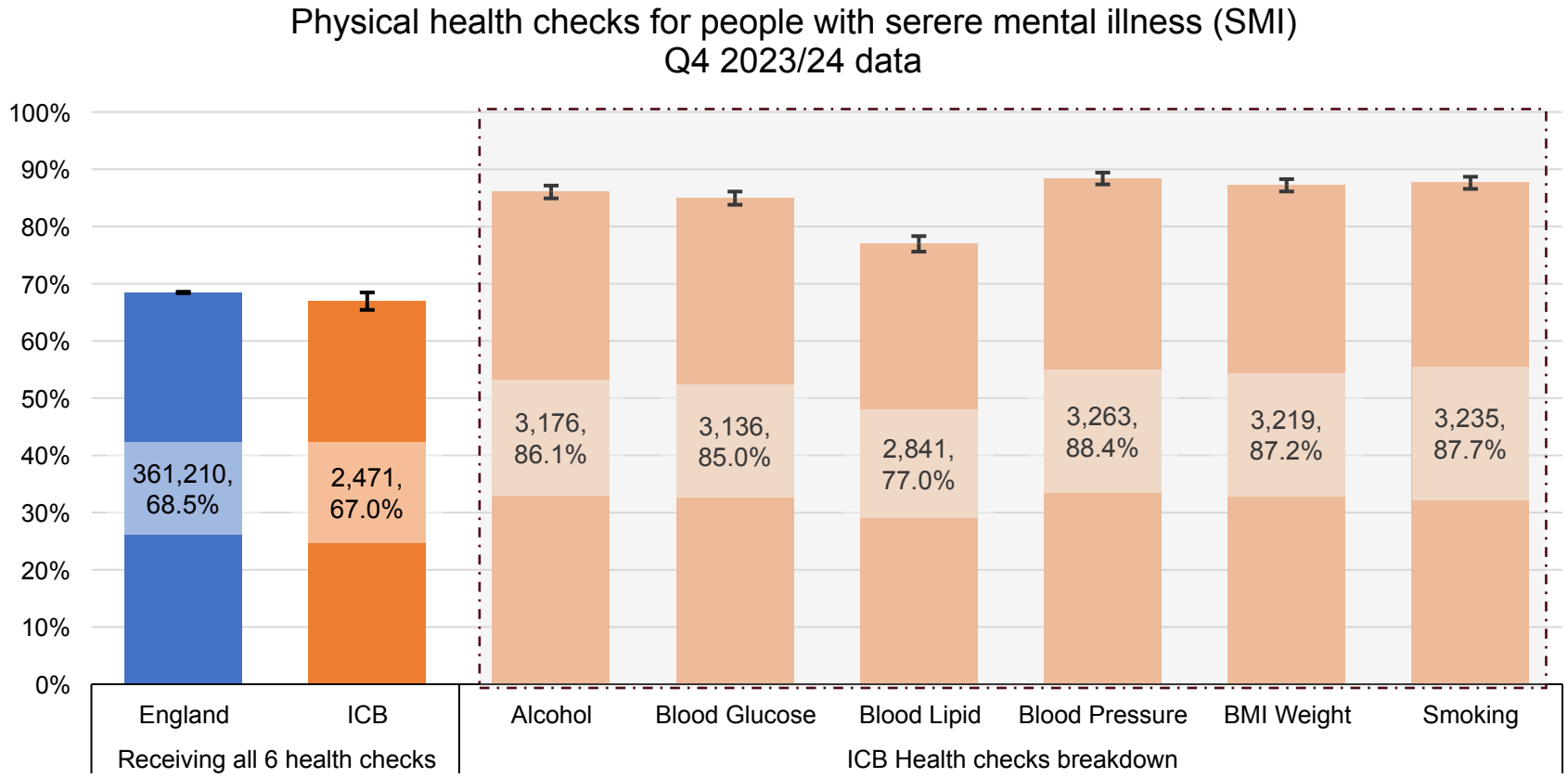
Overall number of Severe Mental Illness (SMI) Physical Health Checks

Quarter 4 2023/24 data indicates that **67% of people with a Severe Mental Illness (SMI) had received all 6 of their annual physical health checks.**

Further analysis has been undertaken to review completion of each individual health check. This data shows an increase in figures, with over two thirds of people on the SMI register receiving each health checks.

Whilst the data does not explain the possible reasons for the variation between the “All 6” and the individual health checks figures, it does highlight the importance of health care approaches such as Making Every Contact Count (MECC).

These figures represent an improvement in performance when compared to Q4 2022/23, with an additional 404 people receiving “All 6” health checks (2,067 in 2022/23 Vs 2,471 in 2023/24).



Source : NHS England Mental Health : Physical Health Checks for People with Severe Mental illness

Number of Restrictive Intervention Types per 1,000 Occupied Bed Days

Figures for the 2022/23 period, show that the Shropshire, Telford and Wrekin ICB had a higher crude rate of restrictive intervention bed days (29 per 1,000 of the population) than the England national average (23 per 1,000 of the population).

Please note that limited data is available and we are therefore unable to demonstrate trends in activity over previous years.

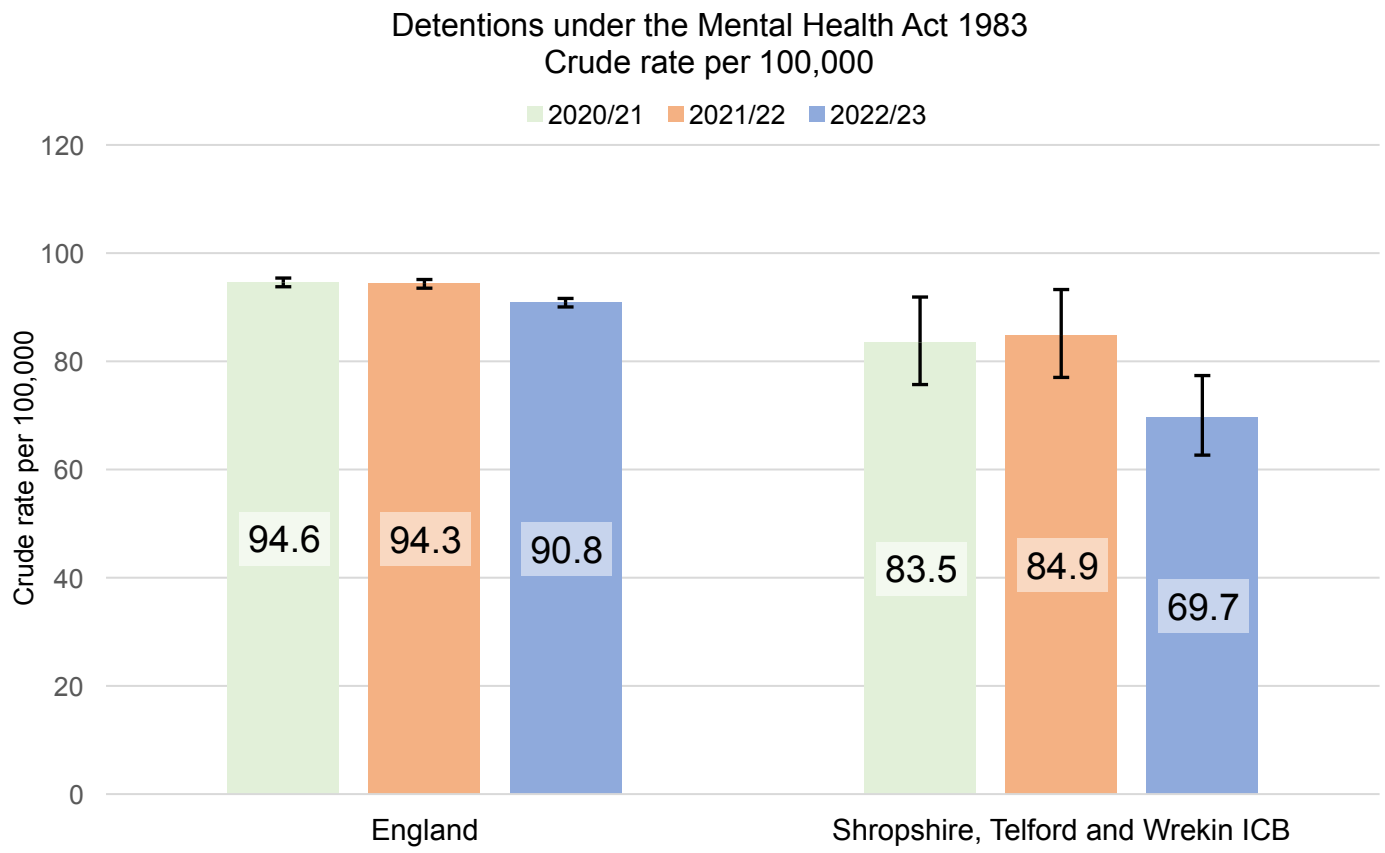
Data Source: NHS Digital Restrictive Interventions Dashboard

Rates of Total Mental Health Act Detentions

Detentions under the mental health act reduced by nationally and locally in 2022/23, with further analysis finding the ICBs detention rate (**69.7**) to be statistically lower than the England national average (**90.8**).

In real terms the ICB recorded **75 fewer detentions during the 2022/23 period compared to 2021/22** (355 Vs. 430)

Social-demographic analysis indicates that the highest rates of detention occur in persons aged18 to 34 (135.8 per 100,000), that females have a higher rate than males (83.7 Vs. 56.2), and that persons with a mixed ethnicity have a higher detention rate than those from an Asian, Black or White ethnicity. The neighbourhoods with the lowest levels of deprivation, where also those with the lowest detention rates.



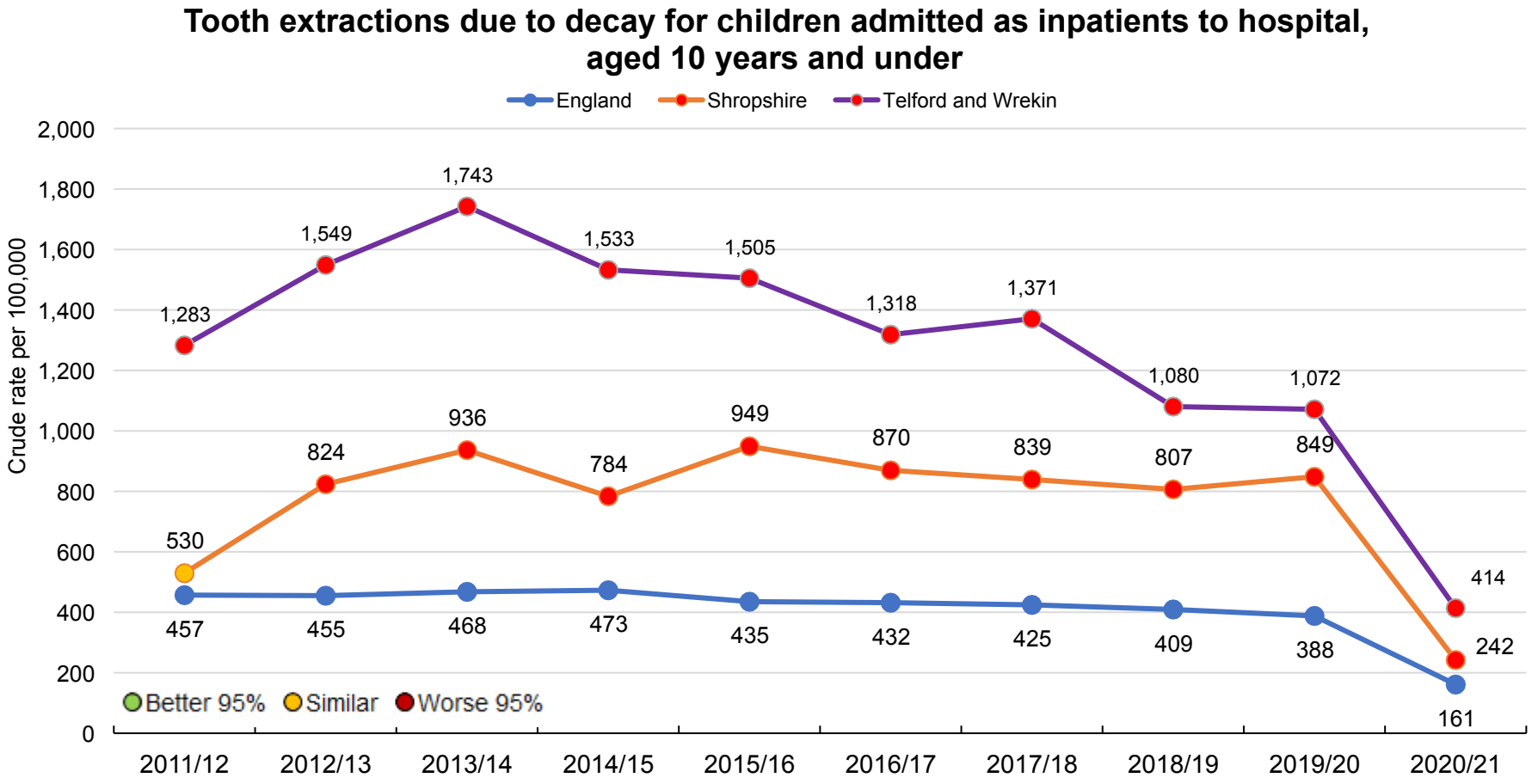
Data Source: NHS Digital Mental Health Act Statistics

Tooth Extractions due to Decay for Children Admitted as Inpatients to Hospital, Aged 10 Years and Under (number of admissions not number of teeth extracted)

The latest data (2020/21) indicates that there were **190** admissions for tooth extractions due to decay, for children aged 10 or under across the two local authority, with **both areas found to have statistically higher admission rates than the England average**.

Trend analysis indicates that both districts have an extraction admission rate that is **frequently statistically above the national average**.

NOTE: This metric is currently under review and may not be updated in future.



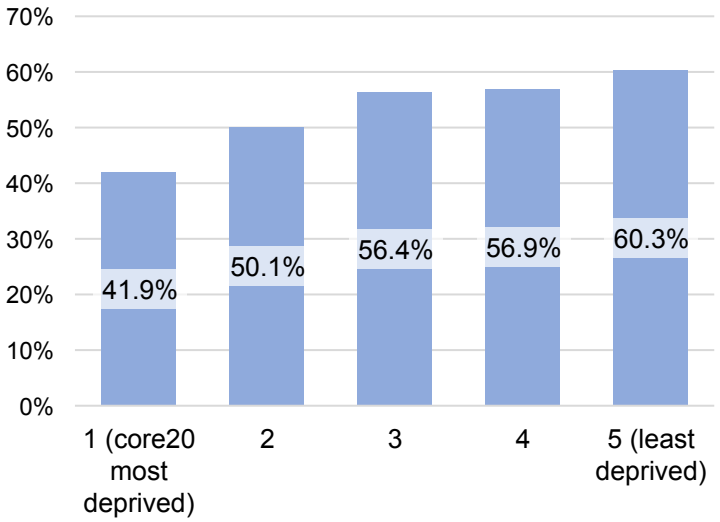
Secondary Care Uses (SUS) and Hospital Episode Statistics (HES) Data

Uptake of Influenza (Flu) Vaccination by Socio-demographic Group

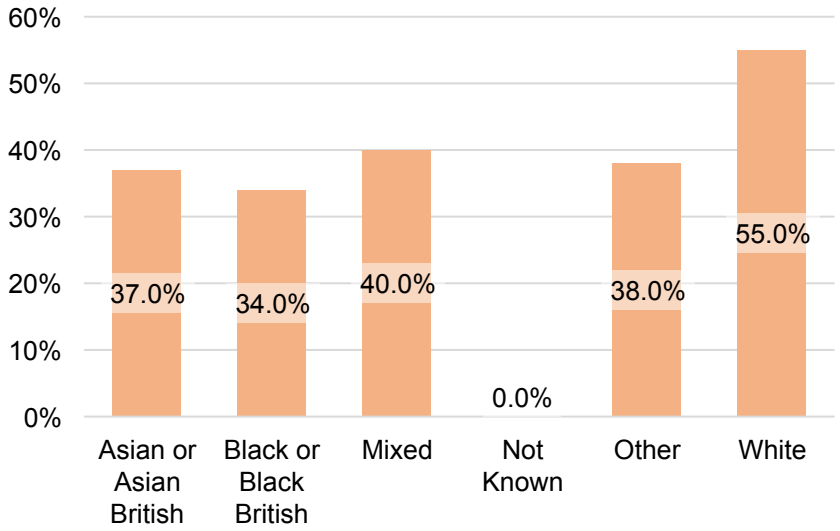
The latest influenza vaccination figures (April 8th 2024), for the **2023/24** season, show that the ICB had an update rate of **52.9%,** slightly above the England average of **50.0%.**

When broken down by socio-demographic characteristic uptake is found to be lowest among the most deprived neighbourhoods (quintile 1) and that persons with a white ethnicity have a much higher uptake rate than minority ethnic groups. Analysis by age –group corresponds with the vaccination programme targeting persons with certain long-term conditions, pregnant women, young children and older adults.

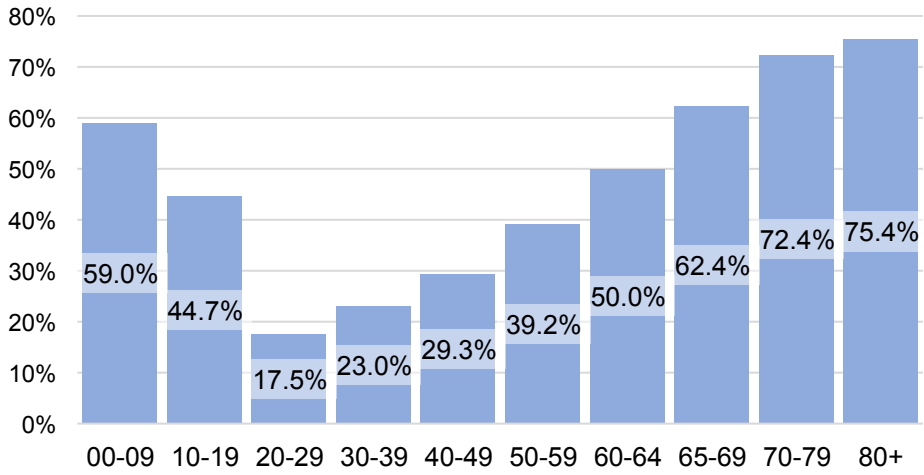
ICB Flu Vaccination uptake by deprivation quintile



ICB Flu Vaccination uptake by ethnicity



ICB Flu Vaccination uptake by age-group



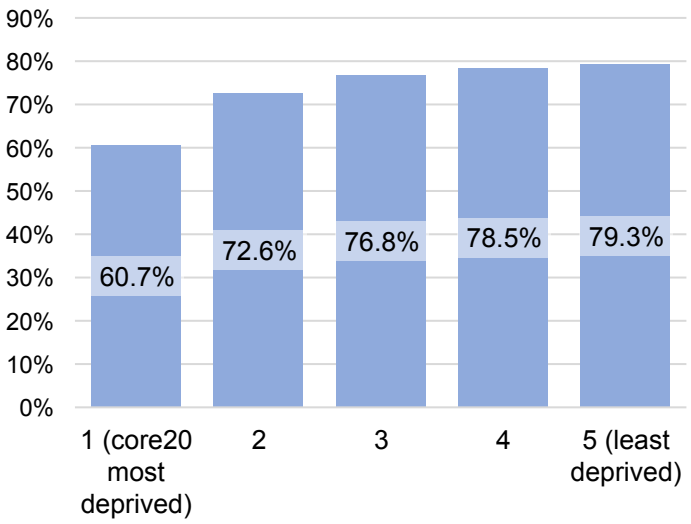
NHS England Healthcare Inequalities Improvement Dashboard

Uptake of COVID Vaccination by Socio-demographic Group (first dose only for adults aged 12+)

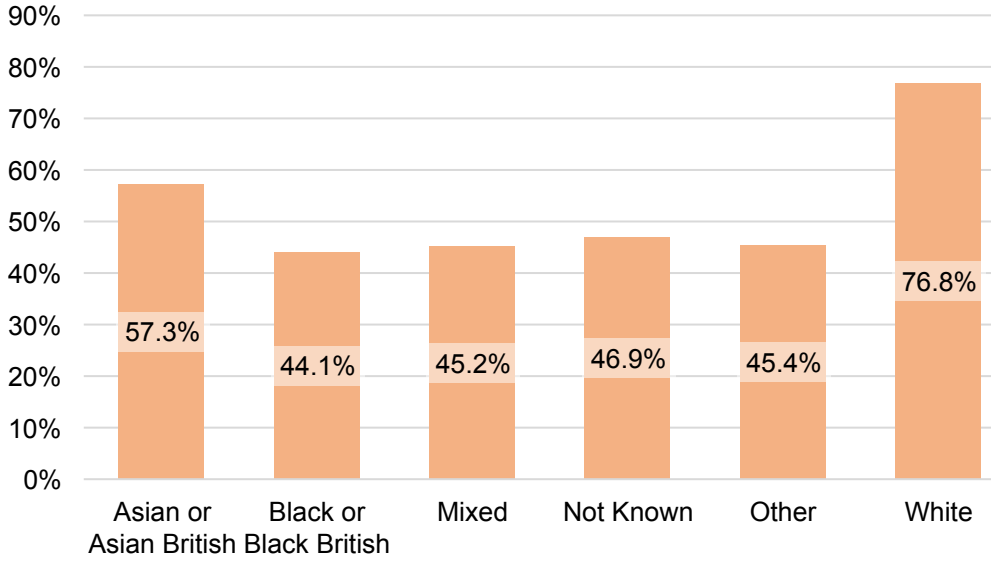
The latest influenza vaccination figures (January 2024), for the **2023/24** season, showed that the ICB had an update rate of **73.8%,** above the England average of **68.4%.**

When broken down by socio-demographic characteristic uptake is found to be lowest among the most deprived neighbourhoods (quintile 1) and that persons with a white ethnicity have a much higher uptake rate than minority ethnic groups. Analysis by age –group corresponds with the vaccination programme which as well as targeting persons with certain long-term conditions, pregnant women, and older adults.

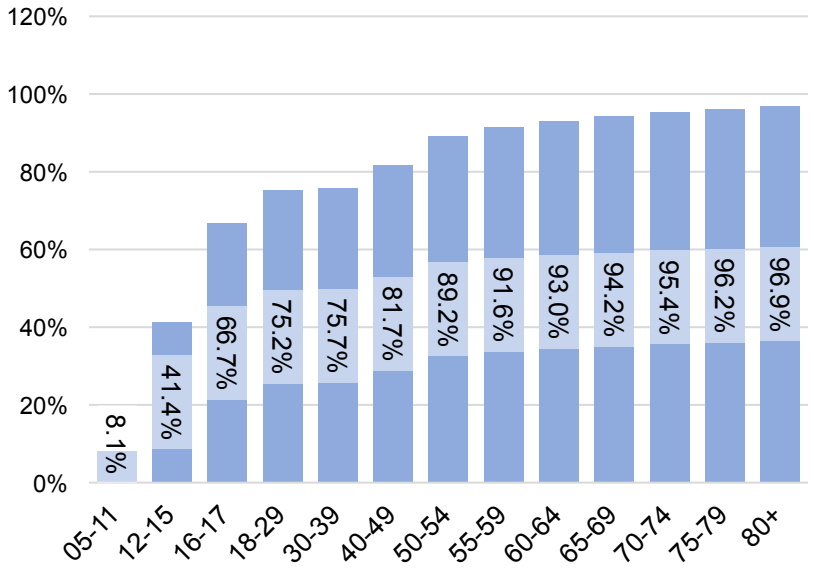
ICB COVID Vaccination uptake by deprivation quintile



ICB COVID Vaccination uptake by ethnicity



ICB COVID Vaccination uptake by age-group



COVID Vaccination & Vaccination Equality Tool (MSOA and Vaccination Site)

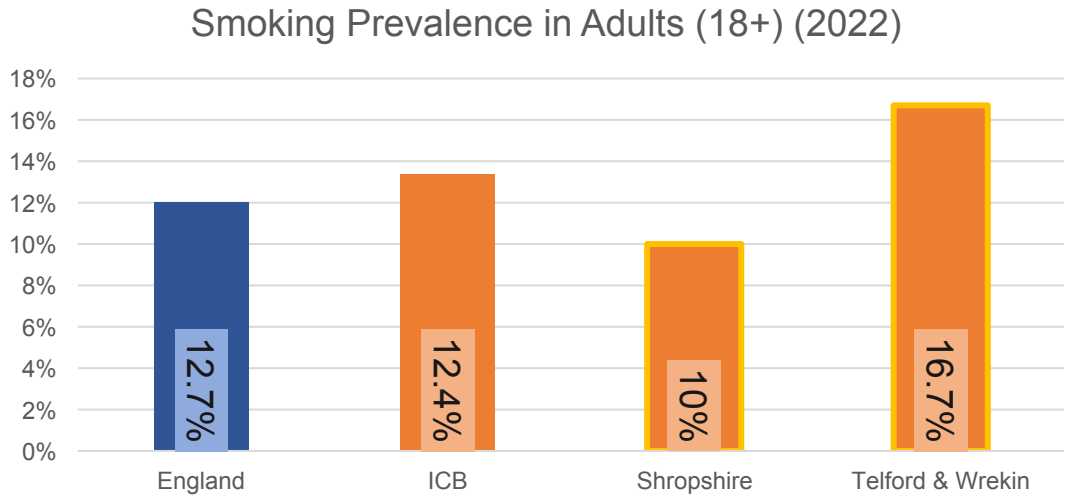
Smoking Prevalence and Proportion of Adult Acute Inpatient and Maternity Settings offering Tobacco Dependency Services

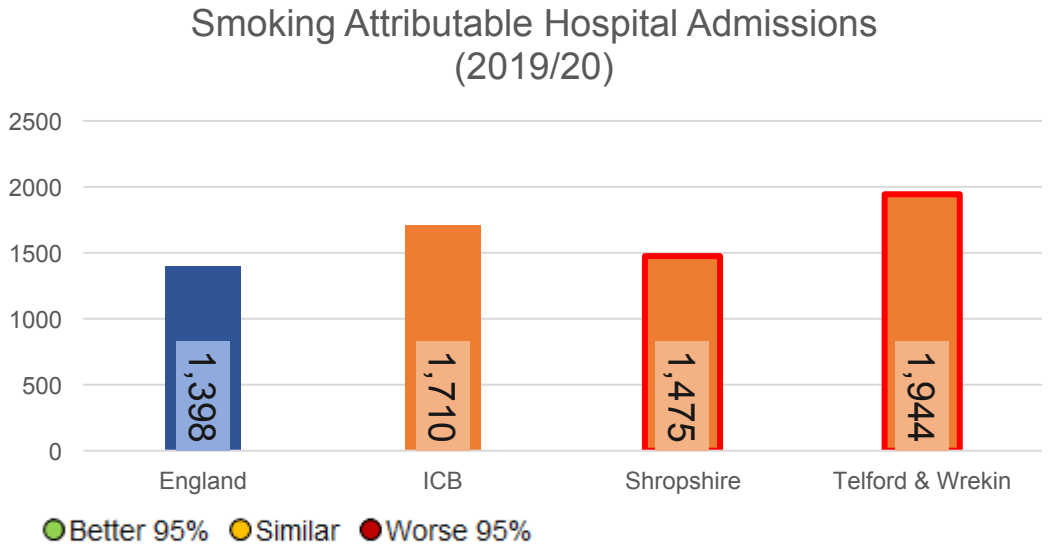
Shropshire, Telford & Wrekin has established Tobacco Dependency Teams within Shrewsbury Telford Hospital NHS Trust (SaTH) Acute Inpatient, Maternity Services and Midlands Partnership Foundation University Trust (MPUFT) Mental Health Inpatient services.

It is estimated that **12.4% of the Shropshire, Telford & Wrekin population (age 18+) are smokers (APS 2022),** in line with the national average of 12.7%. Trendline analysis indicates that the ICB has seen little movement in its estimated smoking prevalence, which was recorded as 12.6% in 2020 and 13.4% in 2021.

At a local authority level, it is estimated that 16.7% of adults in Telford & Wrekin and 10.0% of adults in Shropshire are smokers.

Smoking attributable hospital admissions, are hospital admissions that are estimated to have been caused by smoking. These figures are calculated using the estimated smoking prevalence and the relative risk of dying and or developing specific diseases, compared to persons who have never smoked. With the latest figures (2019/20) indicating that both local authorities have a higher admission rate than the national average.





Data Source: Fingertips Public Health Data

Smoking at Time of Delivery (SATOD)

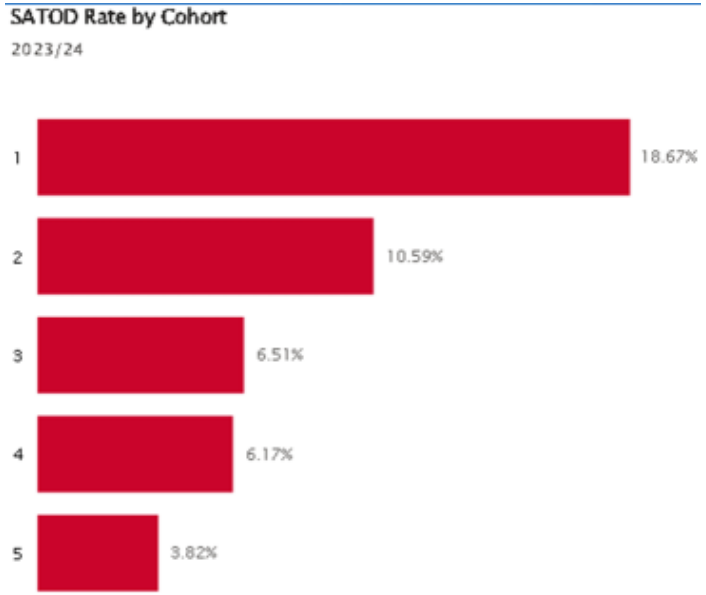
The following data shows the percentage of hospital births where the patient has been recorded as an active smoker at the time of delivery.

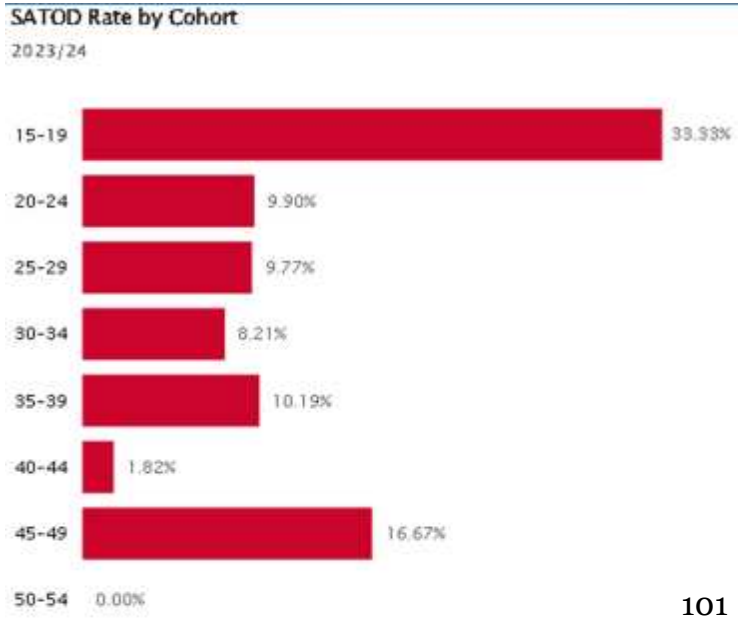
A 15% improvement can be seen overall since the previous year, however it should be noted that due to this data being based on small numbers, it may suggest greater variations in percentage, for example, 33% of people recorded as Smoking at Time of Delivery were age 15-19, but this refers to 2 people out of a total 6 recorded as this age group.

Please note that due to a combination of poor ethnicity reporting and small figures, there are data quality concerns when comparing Smoking at Time of Delivery by ethnicity.

Data shows that a much higher proportion of patients recorded as active smokers at the time of delivery are living in our most socio-economically deprived areas (18.7% compared to more affluent areas at 4%).

It is positive to see a reduction in Smoking at the Time of Delivery across all IMD Quintiles, but this rate is decreased at a much slower rate in a most deprived areas. (-11% for IMD Quintile 1 and -37% for IMD quintile 5 when compared to the previous year).



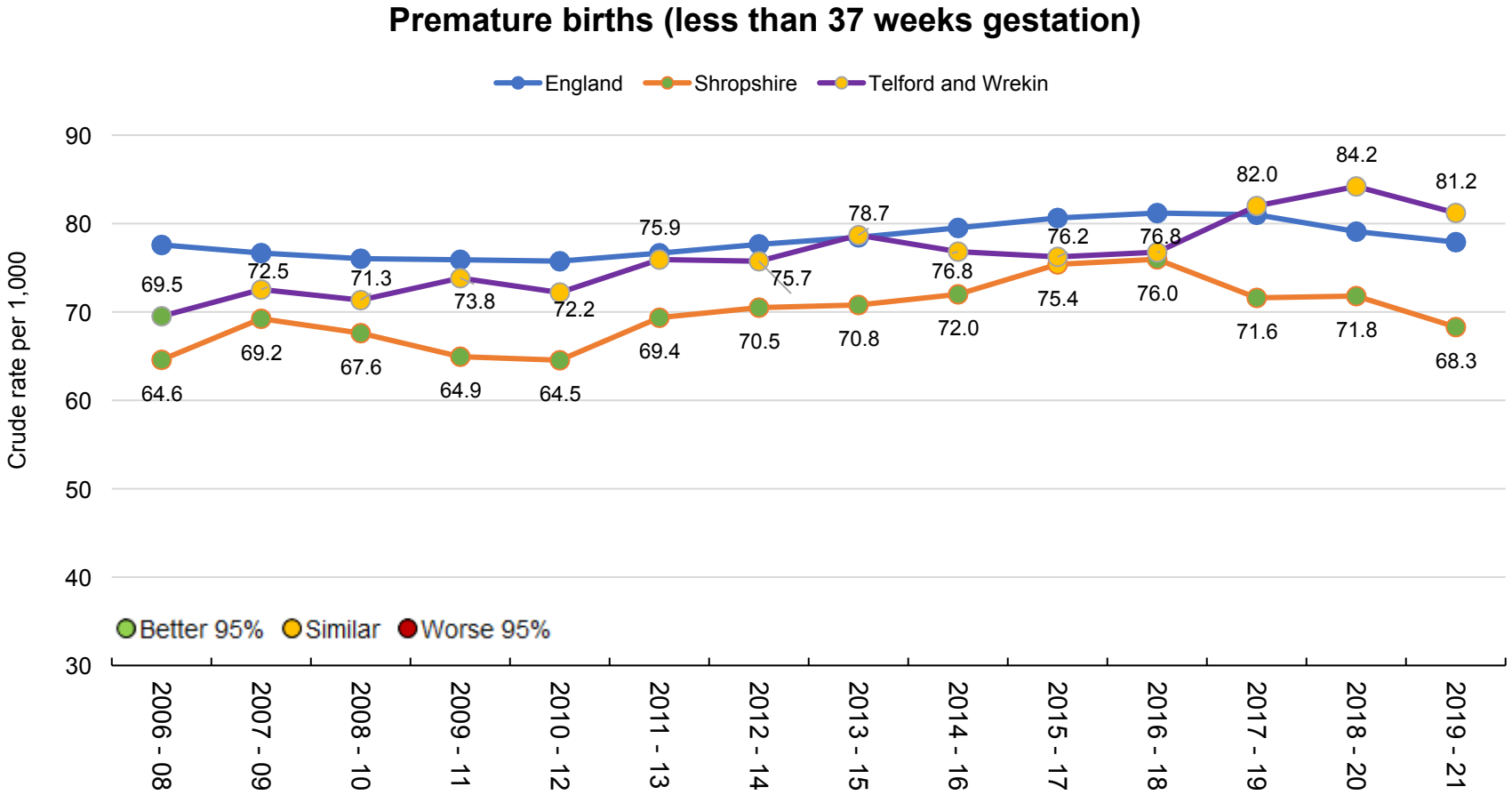


Source : NHS England Statistics on Women's Smoking Status at Time of Delivery

Preterm Births under 37 Weeks

Whilst Shropshire consistently reports a premature birth rate that is statistically below the England average, Telford and Wrekin is often found to be reporting a rate statistically in line with the national.

Whilst not statistically significant, the Telford and Wrekin rate has been above the England rate for the last three reporting periods (2017-19 to 2019-21).

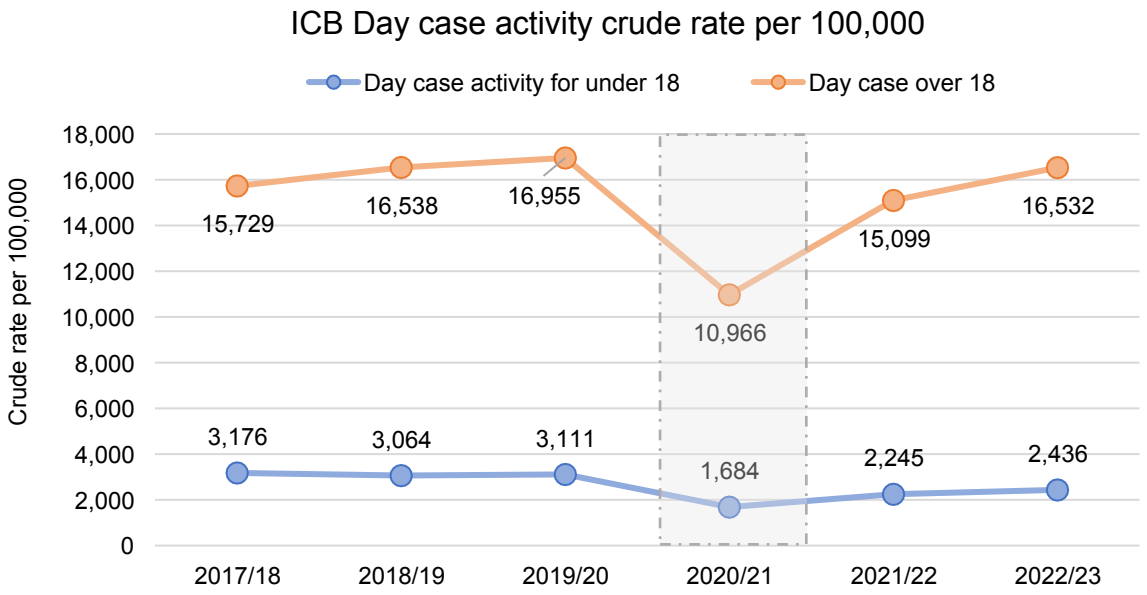


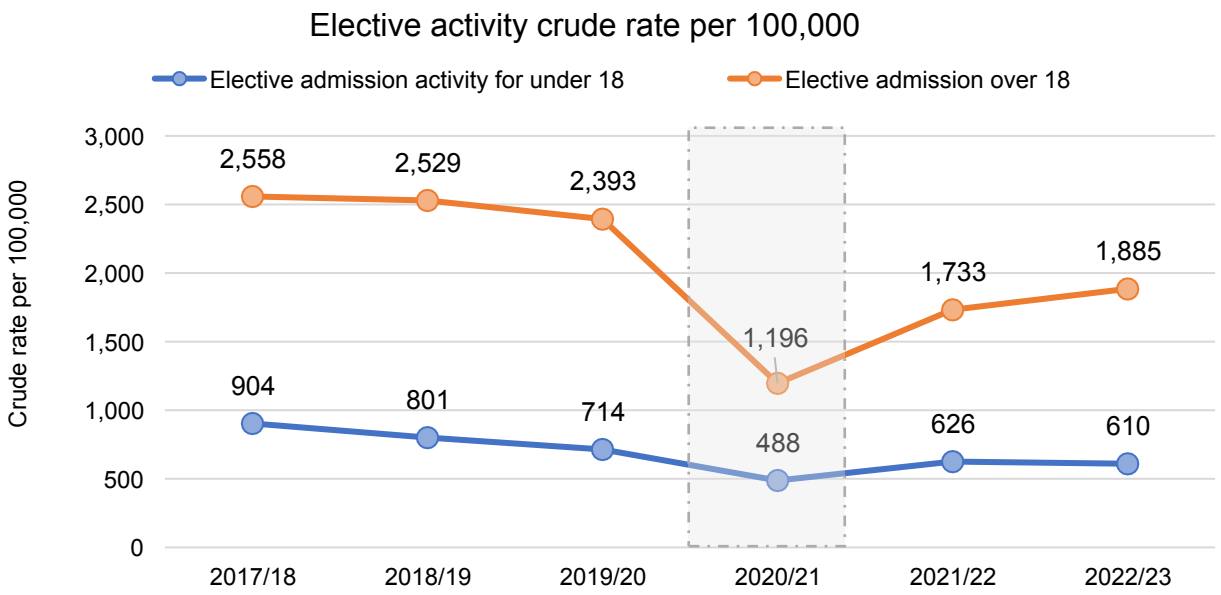
Data Source: Office for National Statistics – ad hoc table request - accessed via Office for Health Improvement and Disparities Fingertips tool

Elective Activity – Return to Pre-pandemic Levels

The COVID-19 pandemic had a destructive impact on NHS elective inpatient care resulting the cancellation and delay of millions of appointments, procedures and operations. As part of the NHS Blueprint for elective recovery ICB are to monitor the rate of day case and elective admissions, with the aim of activity volumes return to the levels seen prior the pandemic, which had its biggest impact on the 2020/21 financial period.

The below charts show that whilst adult (18+) day case attendances and aged under-18 elective admission activity are now broadly in line with their pre-pandemic levels. Aged under-18 day case activity and adult (18+) elective admissions are still below where they were prior to the pandemic.





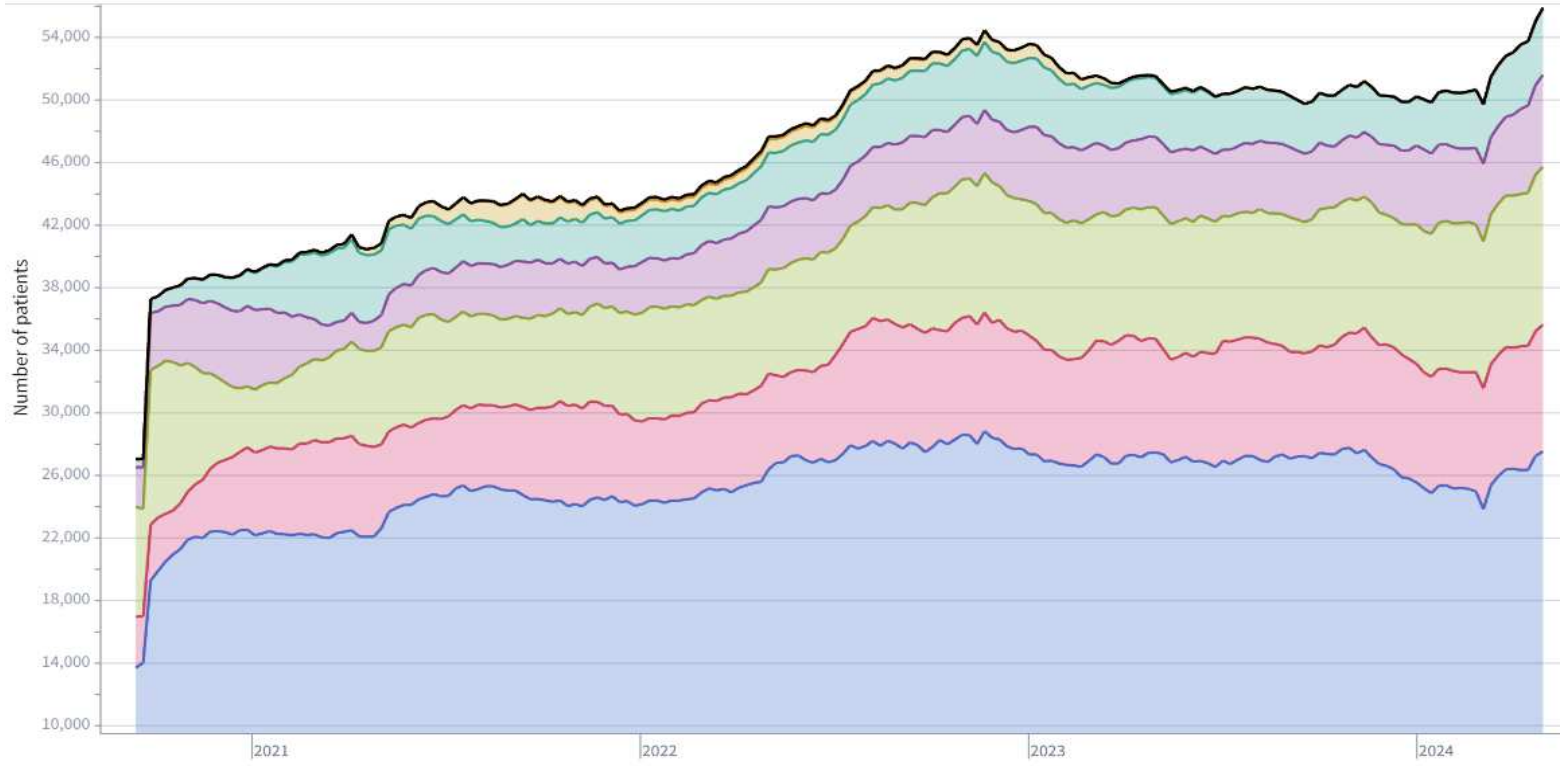
Data Source: Secondary Uses Service (SUS) hospital statistics data flow

Size and Shape of Waiting Lists

Reducing the elective care waiting list is key to returning hospital elective care to the levels seen prior the pandemic and to monitor progress ICBs have been ask to examine the “size and shape” of their waiting lists, to identify when patients may cross over certain thresholds or targets.

The latest data available via the Elective Recovery Dashboard (**April 28th 2024**) indicates that the ICBs total waiting list has increase and stands at **55,896** persons. Although further analysis does show that **5,549** patients do have a recorded “Decision to admit” (DTA) date.

It was a national target to have “*eliminated*” all waits longer than 65 weeks by March 2024 with the data indicating that the ICB providers have not achieved this goal and that there are several patients who have been waiting beyond 78 weeks.



Data Source: NCDR and UDAL Elective Recovery Dashboard

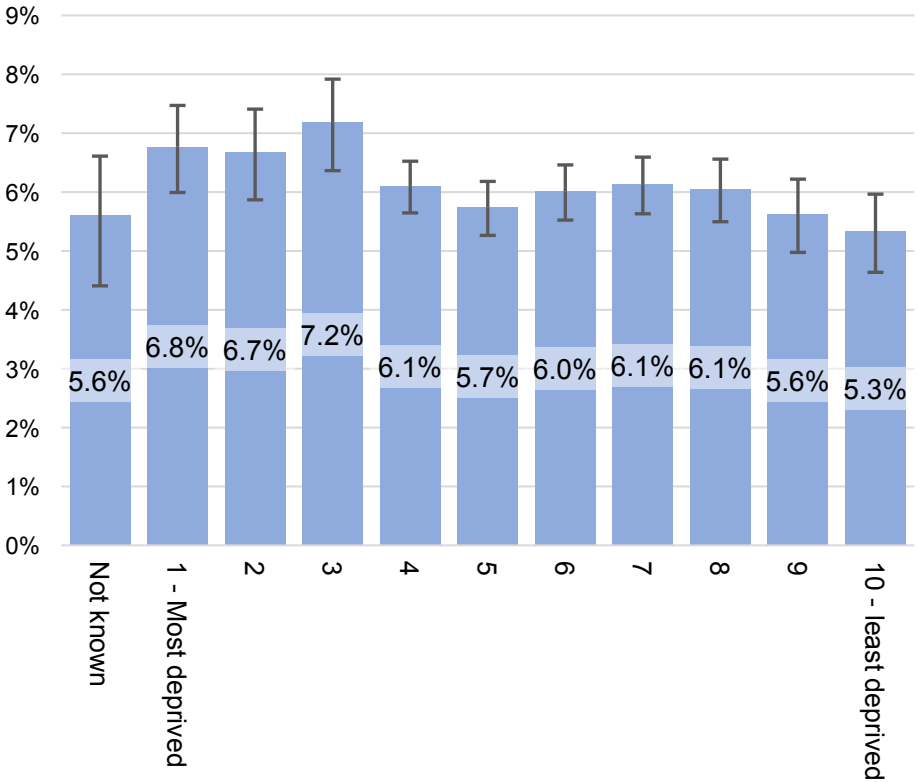
Waiting List Profiling – Patients Waiting Over 52 Weeks

Waiting list data tell us that people waiting 52 weeks or more are proportionately more likely to be:

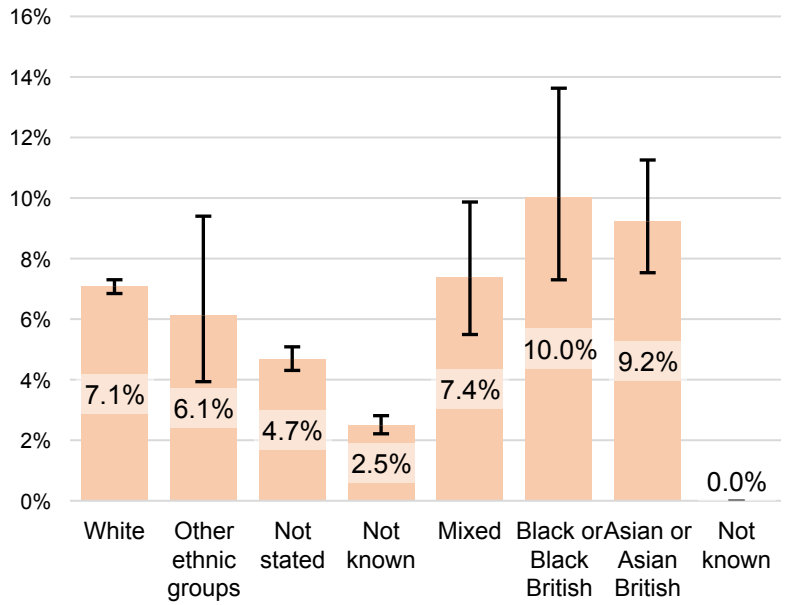
- Aged 0-17
- From the most socio-economically deprived neighbourhoods
- From Black or Asian ethnic backgrounds

Caution should be applied to these findings as waiting lists are prioritised based on clinical need and external factors, such as appointment cancellations, can extend a person's waiting time.

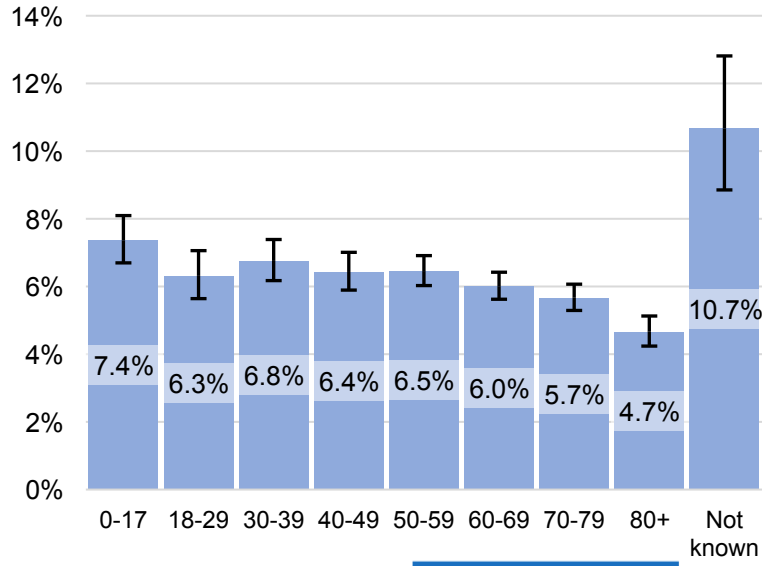
Proportion of the total patients on the waiting list, waiting 52 weeks or more by deprivation decile



Proportion of the total patients on the waiting list, waiting 52 weeks or more by ethnicity



Proportion of the total patients on the waiting list, waiting 52 weeks or more by age group

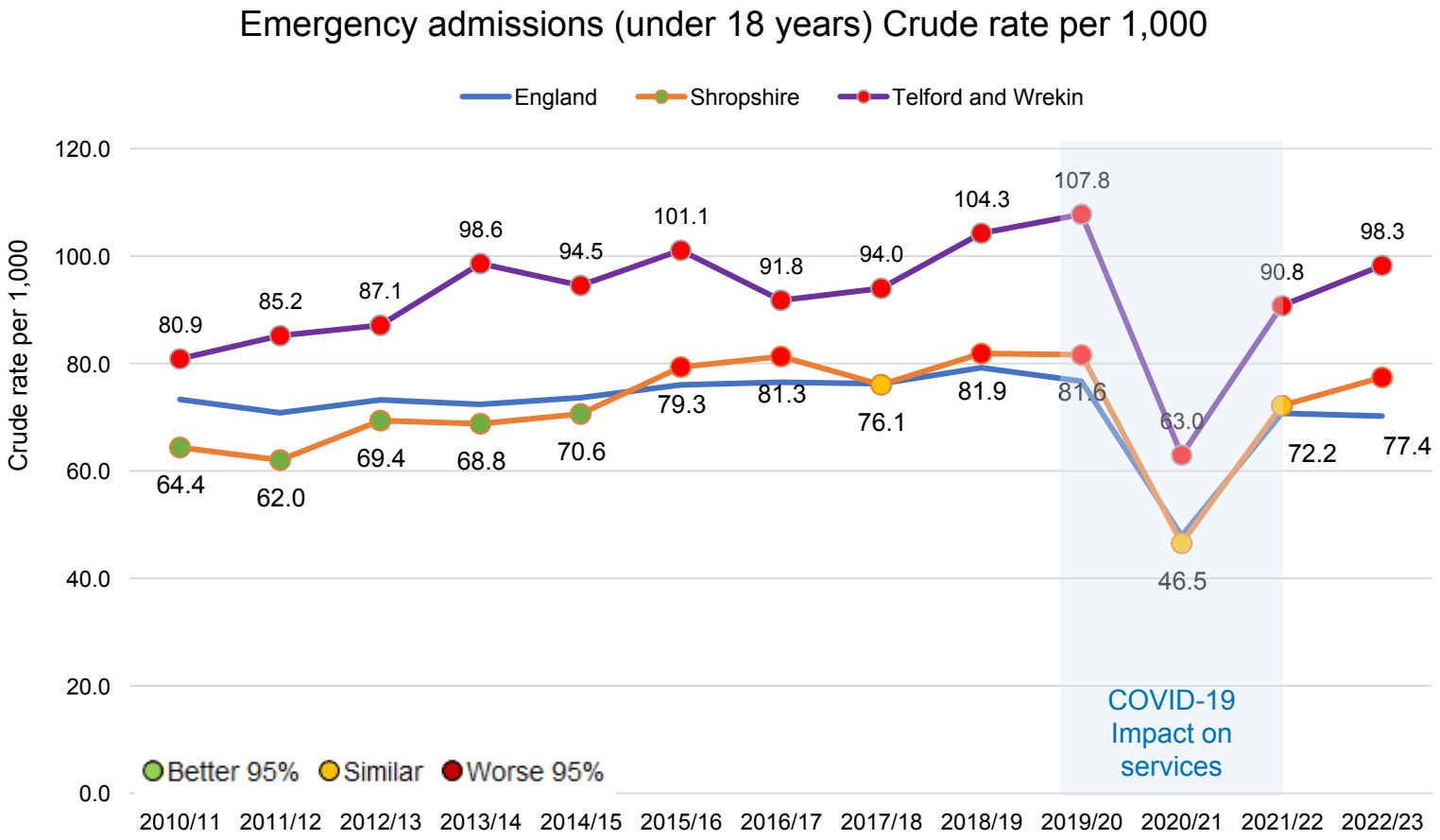


Data Source: National Waiting List Dashboard accessed via the Midlands and Lancashire Commissioning Support UNIT (CSU) Aristotle platform.

Emergency admissions for Under 18s

Nationally, figures for **2022/23 show that both the Shropshire (77.4) and Telford and Wrekin (98.3) recorded significantly higher crude emergency under-18 admission rates than the England average (70.2)**. With Trend line analysis find that whilst Telford and Wrekin have consistently reported a rate above the England average, Shropshire has moved from reporting a rate consistently below the national average to one that is now above it.

Local analysis, at an ICB level, focusing on the latest period (**2022/23**) finding that males (**91.8**) have a higher admission rate than females (**78.1**), that persons from the most deprived neighbourhoods had a higher rate (**98.4**) than those from the least deprived (**74.8**) and that persons aged 0-18 accounted for **16.2%** of all emergency admissions.

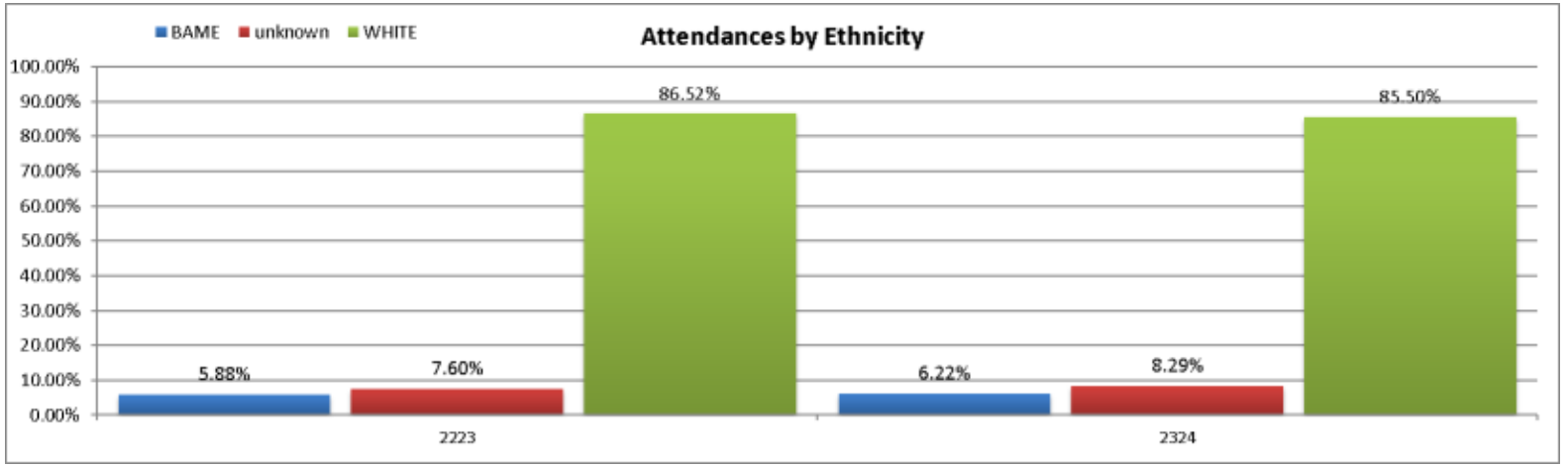


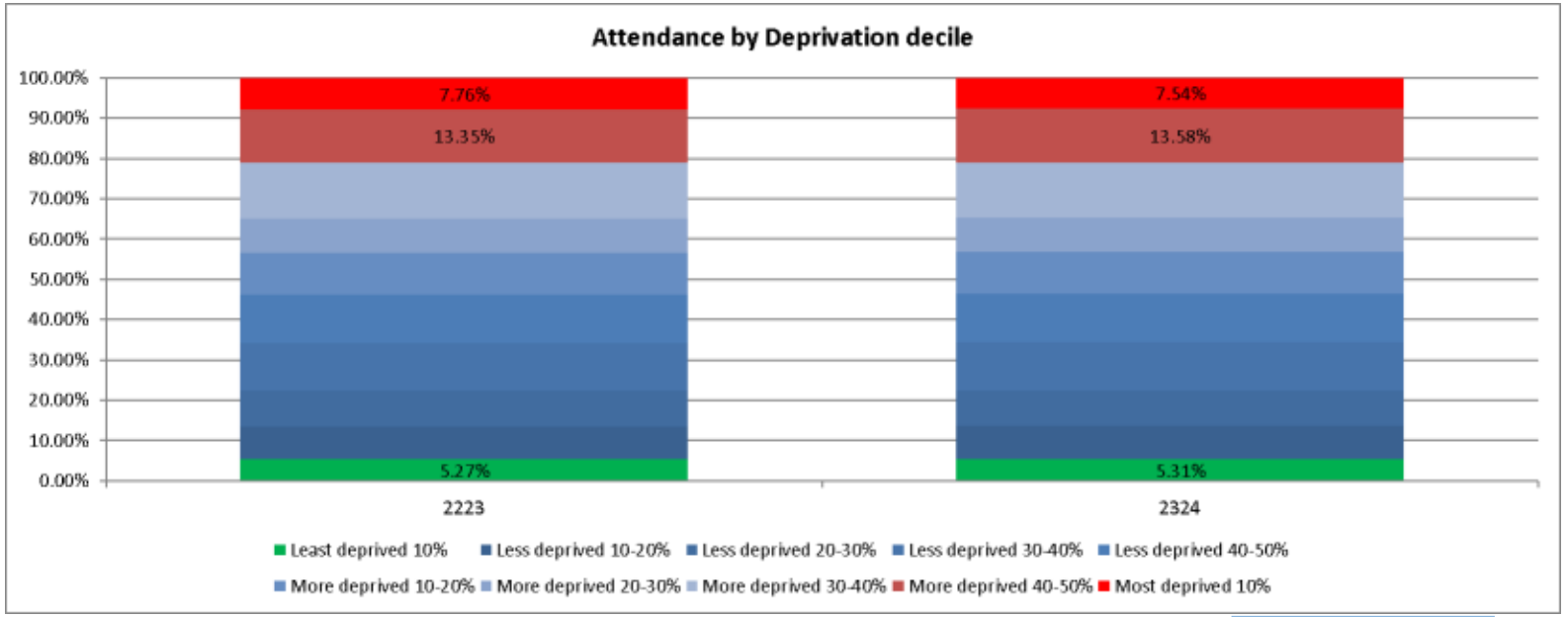
Data Source: OHID analysis of Hospital Episode Statistics (HES) data and local analysis of Secondary Care Uses (SUS) hospital statistics

Use of Emergency Care

A review of attendances across all Urgent and Emergency Care sites in Shropshire, Telford & Wrekin show there has been no significant change in attendances between 2022/23 and 2023/24.

Analysis shows a disproportionate use of emergency services across deprivation deciles.





Data Source: Emergency Care Data Set (ECDS) Dashboard

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Performance Report

June 2024

Operational Performance

The changeover of the Electronic Patient Record (EPR) at SaTH has had an impact on the systems ability to report our activity. This is turn has made it difficult to complete triangulation between activity, workforce and finance information. Work is ongoing to address these issues and minimise impact on future reporting.

The validated activity data month for the purposes of this report is April 2024 however, where possible more current unvalidated data from providers has been included. Some Mental Health Indicators may lag behind the April data month.

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

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

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

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

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

SPC Matrix		Assurance		
		Consistently Failing the Target	Inconsistently Achieving the Target/No Target	Consistently Achieving the Target
Variation	Concerning Variation	◆ UEC: A&E 4 hour performance achievement (Type1&3) - STW ◆ LDA: CYP with LDA in a MH Inpatient Unit (per million)	◆ Primary Care: Practices with digital telephony ◆ UEC: Total A&E attendances against Plan	
	Normal Variation	◆ Planned Care: Incomplete RTT pathways of 65+ weeks - STW ◆ Cancer: Referral to treatment <31 days % ◆ Primary Care: No. of GP appointments attended within 2 weeks ◆ LDA: Adults with LDA in a MH Inpatient Unit (per million) ◆ UEC: A&E 12 hour breaches	◆ UEC: Cat 2 Response Mean time ◆ UEC: Number of Super Stranded Patients ◆ Primary Care: Total Primary care appointments ◆ Primary Care: No. of GP appointments attended same or next day ◆ Primary Care: Direct Patient Care in Post (FTE) ◆ Primary Care: Appointments Booked/Cancelled online ◆ Primary Care: Practice with high quality online workflow tools ◆ Primary Care: GPs in Post (FTE) ◆ Mental Health: Talking Therapies patients reliably improved after 2+ contacts ◆ LDA: No. of Annual Health Checks for Persons aged 14 years (cyclical pattern - no concern)	◆ Community: 2hr Urgent Community Response
	Improving Variation	◆ Planned Care: All Diagnostics - < 6ww against target ◆ Planned Care: Diagnostic waits of 13+ weeks ◆ Cancer: 28 Day Faster Diagnosis Standard (STW) ◆ Cancer: Referral to treatment <62 days % ◆ Mental Health: OAP - Number of inappropriate bed days ◆ Mental Health: Dementia diagnosis rate ◆ Mental Health: CYP - persons U18 supported with at least 1 contact ◆ Mental Health: Adult CMH - number of people who receive 2+ contacts ◆ Mental Health: Adult SMI Physical Health Checks	◆ Planned care: Incomplete RTT pathways of 78+ weeks - STW ◆ Primary Care: Patients enabled to manage appointments on-line ◆ Mental Health: Talking Therapies reliable recovery after2+ contacts ◆ Cancer: Waits >62 days for treatment (SaTH)	◆ Mental Health: Patients accessing perinatal mental health
Insufficient data				◆ Planned Care: Outpatients - Virtual % of Total OPA - STW ** due to EPR system
Movement in Month		◆ Metric Performance improved from concerning to normal variation or from normal to improving variation	◆ Metric Performance decreased from improving to normal variation or from normal to concerning variation	◆ New metric

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

1. Primary Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Primary Care: Total Primary care appointments	Apr 24	261637				248,562
Primary Care: Practices with digital telephony	Apr 24	98%				98%
Primary Care: Practice with high quality online workflow tools	Apr 24	100%				100%
Primary Care: Patients enabled to manage appointments on-line	Mar 24	44.7%				41.9%
Primary Care: No. of GP appointments attended within 2 weeks	Apr 24	82.8%	88%			83.6%
Primary Care: No. of GP appointments attended same or next day	Apr 24	53.6%	54%			52.6%
Primary Care: GPs in Post (FTE)	Apr 24	303				301
Primary Care: Direct Patient Care in Post (FTE)	Apr 24	155				151
Primary Care: Appointments Booked/Cancelled Online	Mar 24	4234	2623			3,613

1.1 Year one of the National Primary Care Access Recovery Program (PCARP) is complete, each Primary Care Network (PCN) has successfully been awarded their final payment.

1.2 In line with the nationally updated plan published on the 9th of April 2024 and the progress to date, each PCN received has received a letter setting out further improvements and developments required by the ICB, in line with the National Delivery Plan 2024/25 and Modern General Practice.

1.3 Each PCN is required to continue to build on the progress made through 2024/25 it should be noted requirements of each PCN varies depending on the outcomes from 2024/25. However, requirements will be in relation to the one or more of the following three national measures: -

- patient experience of contact.
- ease of access and demand management; and
- accuracy of recording in appointment books.

1.4 PCN CAIP plans for this year are now under review by the primary care team and the PCN network to ensure that they address the improvements and developments required. Visits are being arranged to meet with each PCN and Clinical Lead to discuss and review these and their associated timescales for delivery. It is envisaged that the visits dependant on availability will be completed by the end of June 2025. Quarterly meetings are being scheduled with each PCN to seek assurance that plans are on track and mitigations in place if required, progress will also be monitored through the Primary Care Network meetings, held monthly.

1.5 A PCARP dashboard is now available and has been shared with general practitioners and their teams for comment before starting to be used more widely. Data is still not available for all metrics due to a lack of national definition and/or data flows. Validated Pharmacy First data is now available nationally, but NHSE need to obtain data sharing agreements before this is released to ICBs. The ICB are awaiting the completion of this, no date has yet been agreed. The measures available are now included in the primary care KPI summary above:-

1.5..1 Except for Patients enabled to manage appointments on line which is showing improving variation, all reported metrics are showing normal variation and inconsistently meeting the target.

1.5..2 The digital telephony metric has stalled at 98% with one PCN remaining to transfer. This is expected to be deployed during June/July.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

2. Urgent Emergency Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
UEC: Total A&E attendances against plan	May 24	13763				12,679
UEC: Number of Super Stranded Patients	May 24	98				107
UEC: Cat 2 Response Mean time	May 24	00:39:20	00:30:00			00:45:15
UEC: A&E 4 hour performance achievement (Type 1&3) - SATH	May 24	48.4%	76%			52.0%
UEC: A&E 12 hour breaches	May 24	2635	0			2,393
Community: 2hr Urgent Community Response	Apr 24	79.6%	70%			88.0%

2.1 The UEC tier 1 improvement programme continues to gain momentum with a robust performance management framework in place. Whilst none of the primary drivers (with the expecting of cat 2 response mean time and number of super stranded patients) are achieving the locally agreed plans, many of the actions were not expected to improve the performance of the services until June. It is likely that there are still data quality issues surrounding the implementation of SaTH's new EPR system, and the ICB is assured that this is being worked on

2.1.1 A&E Type 1 performance triggered cause for concern in May, this is being driven by type 1 resus performance and type 1 minors' performance which triggered a concerning trend in April and May. It is likely that there are still data quality issues surrounding the implementation of SaTH's new EPR system, and the ICB is assured that this is being worked on, so performance figures must be viewed with some caution at present. 12-hour breaches for patients with a decision to admit increased by 371 from May 2023 to May 2024. This demonstrates that patient flow through the hospital is not the only driver of the increase.

2.1.2 Ambulance metrics for Category 2 response times are within normal variation but inconsistently meet the target (30 minute) average.

2.1.3 Pre-hospital 2-hour Urgent Care Response (UCR) rate consistently achieves and exceeds the 70% target following the recalculation of the process limits to reflect the counting and coding change, shows normal variation.

3. Planned Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Planned Care: VWA - STW	Mar 24	105%	100%			103%
Planned Care: Incomplete RTT pathways of 78+ weeks - STW	Apr 24	5	0			93.4
Planned Care: Incomplete RTT pathways of 65+ weeks - STW	Apr 24	934	0			888
Diagnostics: Diagnostic waits of 13+ weeks	Apr 24	614	0			1,543
Diagnostics: All Diagnostics - < 6ww against target	Apr 24	73.1%	85%			70.5%
Cancer: Waits >62 days for treatment (SaTH)	May 24	320				367
Cancer: Referral to treatment < 62 days %	Apr 24	58.5%	85%			47.1%
Cancer: Diagnosis to First Treatment< 31 days	Apr 24	83.8%	96%			84.7%
Cancer: 28 Day Faster Diagnosis Standard (STW)	Apr 24	74.5%	77%			68.5%

3.1 Whilst Cancer services continue to be challenged, the system has received formal notification of exit from Tier 1. The system is currently over the 'fair shares' target, standing at 303 waiting over 62 days for May. Work is ongoing between SaTH and the ICB to meet the criteria for exit from Tier 2 during 24/25.

3.2 The latest data shows that the Faster Diagnosis Standard (FDS) has deteriorated slightly to 74.5% in May against the increased 24/25 target of 77% whilst Lower GI referrals with a FIT result have exceeded target for several months (92% in May). As performance of FDS improves, more patients will be seen within the referral to treatment (RTT) cancer waiting targets. May performance is 58.5% which whilst significantly below the current 85% target, is generally on an improving trajectory over the last six months.

3.3 The 2024-25 Operational Plan sets a target of zero patients waiting more than 65 weeks by September 24. Patients waiting over 65weeks rose to 934 at the end of April. This cohort was always expected to increase during the EPR change over as capacity was lost during the implementation. Revised forecast figures to the end of May have reduced, and validation of the waiting lists is anticipated to reduce the forecast further to the end of June.

3.4 A small number of 78-week breaches remain a concern with 5 at the end of April, all of which are complex cases and these are under investigation with the providers concerned. 2 breaches have been declared at the end of May (unvalidated).

3.5 The system VWA plan is set in 2024/25 as 106.8%. Reported performance is only available to the end of March due to issues surrounding the new EPR system. Performance at the end of March of 105% exceeded target of 100%, eliminating the financial risk of the ERF (Elective Recovery Fund) for 2023/24.

3.6 The ICS is in recovery against the overall 6 weeks standard for diagnostics but is showing sustained improving performance with the latest validated position for April of 73.1% against plan of 85%. The system has a reducing level of patients waiting over 13 weeks, with 614 patients waiting at the end of April. There is a national target to eliminate all >13wks during 24/25 and currently the system is planning to achieve that in all modalities except Audiology.

3.7 The ICB is working with SaTH on the demand and capacity issues of audiology and potential solutions. This is going through the new ICB Strategic Decision Making Framework later in June to prioritise this against our other clinical priorities and financial pressures.

4.0 Mental Health, Learning Disabilities and Autism

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Mental Health: Talking Therapies reliable recovery after 2+ contacts	Apr 24	52%	48%			46%
Mental Health: Talking Therapies patients reliably improved after 2+ contacts	Apr 24	75%	67%			68.4%
Mental Health: Proportion of Adult SMI having Physical Health Checks	Apr 24	63.6%	75%			50.9%
Mental Health: Patients accessing perinatal mental health	Mar 24	890	501			830
Mental Health: OAP - Number of inappropriate bed days	Mar 24	365	0			377
Mental Health: Dementia diagnosis rate	Apr 24	60.8%	66.7%			59.6%
Mental Health: CYP - persons U18 supported with at least 1 contact	Mar 24	5840	8341			5506
Mental Health: Adult CMH - number of people who receive 2+ contacts	Mar 24	4250	4984			4202
LDA: No. of Annual LDA Health Checks for persons aged 14 years	May 24	180	2080			177
LDA: CYP with LDA in a MH Inpatient Unit (per million)	May 24	40.1	10			26.5
LDA: Adults with LDA in a MH Inpatient Unit (per million)	May 24	45.8	30			48.0

4.1 NHS Talking Therapies has new metrics replacing the access metric. Reliable recovery and Reliable improvement for people who have completed treatment are both performing above target for April. Recruitment of both qualified and trainee Psychological Wellbeing Practitioners (PWP) is progressing at pace, referrals are increasing and waiting times are also reducing.

4.2 The number of physical health checks for serious mental illness (SMI) performance at April is 63.6% (2352 completed health checks over a 12 month period). Activity peaked in March (2471) but this is still a much improved performance than in previous years. Performance measurement has now changed to a % of people on GP SMI registers, and the national target is 75% by the end of 2024/25. Local plan is to achieve at least 67.6%.

4.3 Dementia diagnosis rates have been showing significant improvement but have reduced slightly for two consecutive months to 60.8%. Indicative figures for May are showing marked improvement – official figures available later in June.

An improvement plan includes an extension of the waiting list work, assessment of identified patients on drugs normally prescribed for dementia to go onto registers, and a proposal for a pilot into care homes.

4.4 A core NHS long term plan commitment is for children under 18 to receive at least 1 contact against a target of 8,341 by March 2024. Performance is showing significant improvement but remains behind plan in March. An improvement plan is in place but will take time to show in the metric due to it be being calculated on a rolling 12-month basis.

4.5 Psychiatric Intensive Care Unit (PICU) and Acute Out of Area placements demand is volatile but occupied bed days for inappropriate placements are circa 365 each month and remain above local plan of 180. The high demand is a national issue and is continually under review. Bed base review in progress across STW and Staffordshire Systems led by MPFT and supported by NHSE commenced in February and will report at end of June 2024.

4.6 Women accessing Perinatal Mental Health services continues to exceed target. Waiting times from referral to offering an appointment are low and have been sustained for several months - percentage of patients seen within 6 weeks is 100%.

4.7 Adult access to community Mental Health teams is showing sustained improvement at the end of March and is expected to increase further as Eating Disorders starts to flow into Mental Health Services Data Set (MHSDS) in 24/25. Official data for April performance is delayed due to a new version of the MHSDS being implemented.

4.8 Annual Health Checks (AHC) for patients with LD has an annual target of 75% of registered patients. Activity to May is in line with plan and is greater than the previous year equivalent. An improvement plan is underway, which seeks to further support patients to take up health checks offered, and reduce non-attendance (DNAs) as well as to improve patient experience.

4.9 Inpatient stays for adults with a Learning Disability (LD) are at 18 inpatients (45.8 per million population) at the end of May against a plan of 19. A root cause analysis is completed for all new admissions to determine how the admission could have been avoided and that the admission was clinically appropriate and unavoidable.

4.10 There are 4 children (40 per million population) with a LD or Autism in mental health inpatient beds at the end of May, following 3 admissions in April. The target is 2 by the end of Quarter 1. All admitted children currently have a diagnosis of ASD and have complex mental health needs.

5. Quality

A summary of quality indicators is provided at Appendix B.

5.1 Incidents of Clostridioides difficile (C diff) infection were above expected objective for SaTH, RJAH and SCHT as well as the system. A system action plan is in place and is reviewed monthly at the System IPC and Antimicrobial Resistance Group and SaTH have a specific plan with regional support.

5.2 Stillbirths are below the national average; however, the neonatal death rate is above the national average. An external review was commissioned by SaTH and undertaken in November 23 whilst the final report is awaited there are system workshops aimed at understanding key actions and work is ongoing. West Midlands Neonatal deaths are higher than the national average as a region.

5.3 CHC 28-day assessment compliance was below national standard at 60% in quarter 4, up from 32.3% in quarter 3. One assessment remained outstanding more that 12 weeks, a significant improvement from 52 outstanding by more than 12 weeks at the end of quarter 3. Whilst data is reported quarterly, it is monitored weekly and April and May evidences compliance with both national performance indicators, with more than 80% of assessments completed within 28 days and no referrals outstanding more than 12 weeks. NHSE regional support and oversight remains in place with monitoring at present, however, it is anticipated that the level of monitoring will reduce now that the performance has improved and is compliant with national standards.

5.4 There have been no reported never events in this period.

6. Finance

Month 2 Financial Position

Revenue:

6.1 At Month 2 the system has a year-to-date deficit of £22.7m, which is £0.2m adverse to plan, this variance is expected to be recovered and the year-end forecast is that the system deficit is delivered in line with the system revenue financial limit of £90m deficit.

6.2 Efficiency delivery at Month 2 is £8.1m which is £1m ahead of plan due to earlier delivery in the ICB compared to the plan phasing. Against the £89.7m annual efficiency plan value £79.6m is identified and £10.1m is unidentified, work is ongoing through the Financial Improvement Programme to address this, and additional resource is in the process of being secured to support.

6.3 At Month 2 the ICB £0.3m favourable variance to plan is due to efficiency being delivered ahead of plan offset by additional mental health PICU patient costs

6.4 At month 2, SaTH financial performance is in line with plan, however re-categorisation has taken place in the 12th June submission to ensure items such as income backed posts and the agreed ERF expenditure plan are shown within the pay/workforce plan.

6.5 At Month 2 SCHT delivered a surplus of £150k, this is £32k adverse to plan. The Trust is £297k favourable to plan against its Agency plan. £178k adverse on clinical supplies and £54k adverse on non-pay attributable to the Stoke Heath Prison service.

6.6 At Month 2 RJAH reported an actual £0.2m deficit, £0.5m adverse to plan. In month position £0.1m deficit, £0.3m adverse to plan. Main drivers are (£0.2m) adverse Low Value Agreement block overperformance, (0.2m) adverse expenditure driven by premium pay costs, (£0.1m) adverse outpatient performance - high volume of missed outpatient procedures, this will catch up for M3, Efficiency delivery is £14k adverse. Agency performance is £0.3m favourable to plan.

6.7 The gross risk for each organisation as per the 12th June plan submission totals £129.5m the increase due to additional efficiency risk at SaTH and SCHT and additional cost and income risk at RJAH. These risks are now being actively monitored to ensure that any mitigations can be fully identified and actioned to reduce the risk pressure over the coming months.

Capital:

6.8 The 24/25 Capital Framework for NHS STW providers means a 10% decrease to our operational capital from £28.8m reduced by £2.8m to £26m. ICB capital of £883k is not impacted.

6.9 We will work hard in year to live within the operational capital envelope however this does pose a risk to the system as some decisions will be necessary to either delay or not invest in programmes of work. This will directly impact on our ability to replace ageing equipment in a timely way and also manage our backlog maintenance. This will, particularly over an extended period of time (ie if we post a deficit for multiple years and the framework remains as is), impact on the quality of services we can provide.

7. Workforce

7.1 Our monthly ICS workforce dashboard enables us to track our trajectory of planned staff in post (WTE) and planned cost of that workforce against actual staff in post and actual cost, in addition to key workforce KPIs. Data is taken from the Provider Workforce Returns and Provider Financial Returns to NHSE. This report provides data for M1 and M2 of 2024/25.

The workforce dashboard does not contain Whole Time Equivalent (WTE) plan data for MPFT, and so it is therefore not possible to include MPFT in the actual vs plan part of the analysis.

7.2 **System:** The operational plan contains assumptions about activity, turnover and vacancy when developed. Workforce WTE and Cost variances from plan are influenced by several factors, including workforce unavailability, activity demands and workforce supply (recruitment and training).

- **Substantive WTE:** At the end of May 2024, when considering RJAH, SaTH, SCHT and MPFT combined, the planned workforce requirement submitted to NHSE on 12 June has been exceeded by +395 wte substantive staff

in April and +388wte substantive staff in May driven by an above plan position for MPFT. Excluding MPFT, RJAH, SaTH and SCHT are below plan for substantive workforce at –90wte in April24 and –42wte in May24.

- **Bank WTE**: At the end of May 2024, when considering RJAH, SaTH, SCHT and MPFT combined, the planned bank workforce has been exceeded by +51wte bank staff in April24 and +35wte in May24 driven by an above plan position for MPFT. Excluding MPFT, RJAH, SaTH and SCHT are below plan for bank workforce at –55wte in April24 and –72wte in May24.
- **Agency WTE**: At the end of May 2024, when considering RJAH, SaTH, SCHT and MPFT combined, the planned (anticipated) agency utilisation is below plan by -40wte agency staff in April24 and –49wte agency staff in May24 driven by an above plan position for MPFT. Excluding MPFT, RJAH, SATH and SCHT are below plan for agency by –85wte in April24 and –97wte in May24. For RJAH, SaTH and SCHT this represents an -£59k underspend in April24 and £284k underspend in May24.
- **Workforce Costs:** When considering RJAH, SaTH and SCHT total workforce costs are above plan by £2.96M in April 2024 and £2.12M in May 2024. This is driven by SaTH's workforce costs being above plan by £2.6M in April 2024 and £2.06M in May 2024. At the time of writing the report there is an outstanding query with SaTH regarding their workforce costs in particular workforce costs relating to substantive and bank workforce. Further intelligence is being gathered to understand the drivers of this.

7.3 **SaTH** is below plan for substantive (-7wte), bank (-129wte) and agency (-113wte) YTD. This may reflect an increased vacancy position from 2.1% in March 24 to 9% in April and May 24 and the impact of decisions made by the Trust vacancy control panel with 513 of 1,074 vacancy requests rejected since 9 December 2023.

7.4 **SCHT** is below plan for substantive (-68wte), bank (-4wte) and agency (-54wte) YTD. Again, this may reflect an impact of decisions made by the Trust vacancy control panel with 81 of 261 vacancy requests rejected since 9 December 2023. SCHT is still seeing a reducing vacancy rate currently 11.8% (May 2024) down from 16.2% in January 2024 because of ongoing recruitment to the sub-acute ward workforce

7.5 **RJAH** is below plan for substantive staff (-57wte) and marginally above plan for bank (+6wte) and below plan for agency (-15wte) YTD. The Trust continues to implement higher levels of scrutiny on bank utilisation. Whilst not captured in this data the Trust is also managing significant reduction in usage of the LLP workforce to achieve the NHSE mandated zero target of off framework agency by end June 2024. The Trust vacancy control panel at RJAH has rejected 51 of 209 vacancy requests since 9 December 2023.

7.6 **MPFT** has exceeded plan for substantive staff (+783wte), bank (+214wte) and agency (+93wte). Further intelligence is being gathered as to the drivers behind this above plan position.

7.7 Despite variances from the operational plan, trends show improving position for agency at system level with overall WTE and cost reducing from £4.5m in April 23 to £2.64m March 24

Vacancy Position

7.8 In M1 and M2, the vacancy rate for the system overall increased to 9.3% and 9.1% respectively (having seen an improving trend through 2023/24 and being at 5.6% in M12). At a system level, data for RJAH, SaTH and SCHT shows vacancy controls have resulted in 645 vacancy control requests out of 1,544 being rejected since 9 December 2023.

7.9 The combined rate in March 2024 rose primarily due to the increased vacancy position at SaTH. SaTH rates had reached a very low level of 2.1% in March 2024, but this has increased significantly to 9% in April and May 24 and is likely as a direct result of the decisions made by the Trust vacancy control panel with 513 of 1,074 vacancy requests rejected since 9 December 2023.

Sickness and Turnover Position

7.10 It has not been possible to fully report on sickness and turnover position for M1 and M2 due to issues with workforce reporting. The system position for sickness is 5.4% and for turnover is 10.6%. A full narrative will be provided in the next report.

Next Steps

7.11 Our workforce plan for 2024/2025 has identified seven critical workforce roles by profession with the greatest workforce deficits. Where there is capacity to do so the system people programmes will focus on these seven areas, recognising some actions will be immediate and targeted, and others will be medium to long term.

7.12 Through our system People Culture and Inclusion Committee, workforce and agency steering groups there will be greater oversight of workforce monitoring of changing trends or trajectories against plan and cost, escalation of risk and any necessary early required intervention to ensure this year's workforce plan remains on plan.

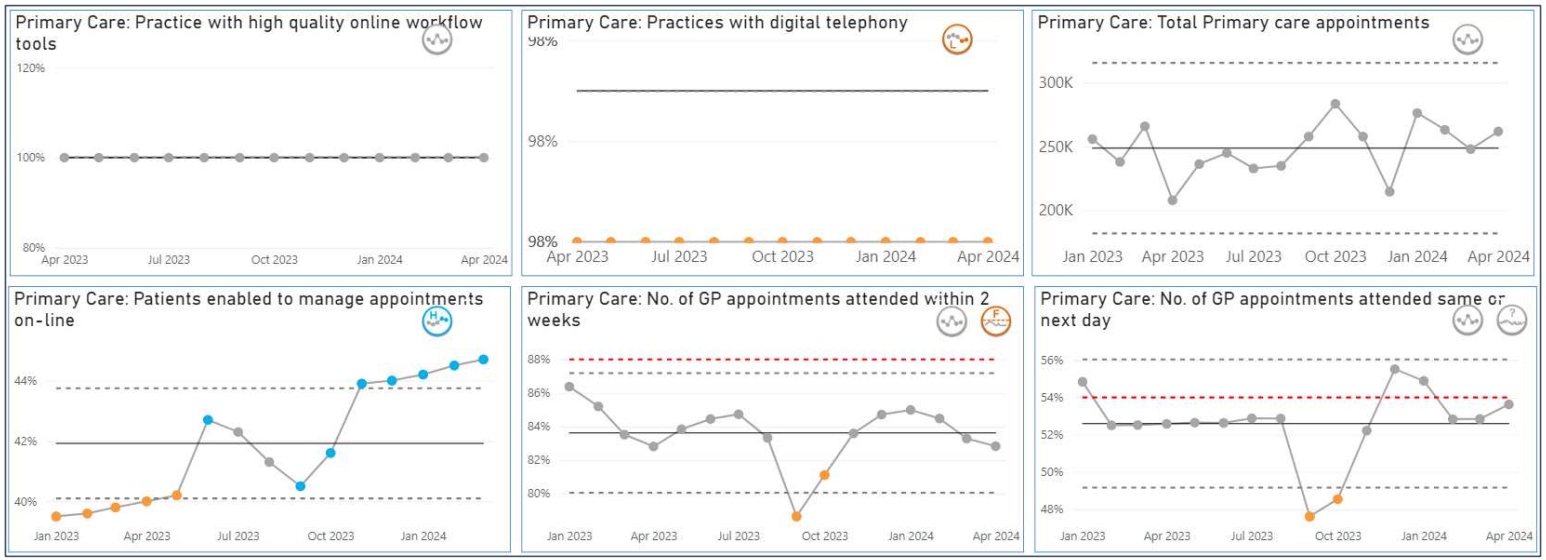
7.13 Trust and System vacancy controls will remain in place.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix A – Operational Metrics

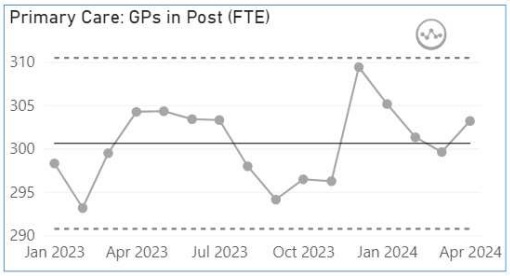
Primary Care

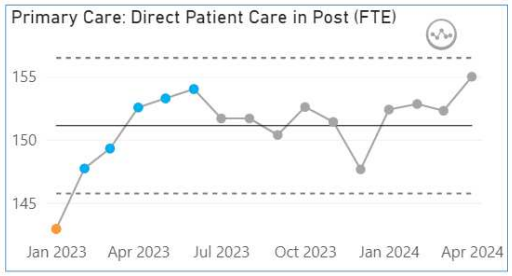


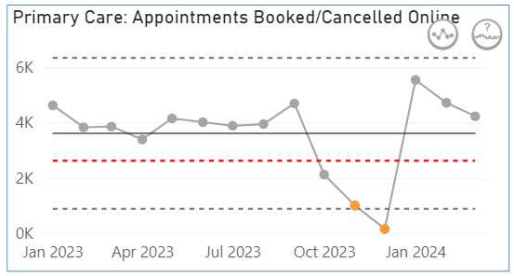
Integrated Care System

Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin



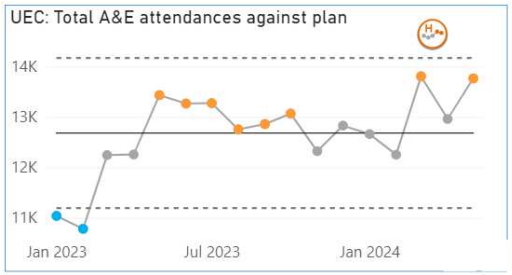


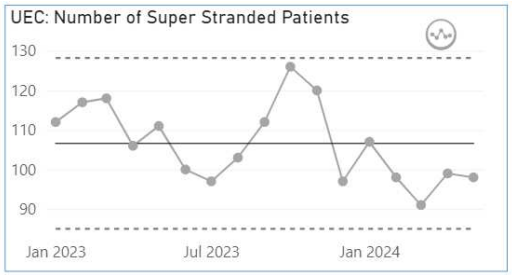


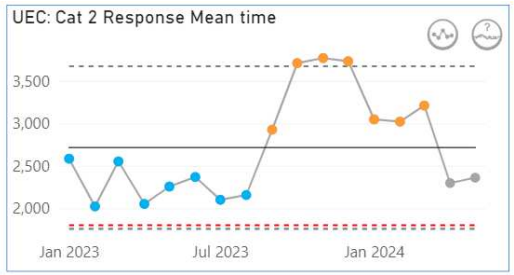
Integrated Care System
Shropshire, Telford and Wrekin

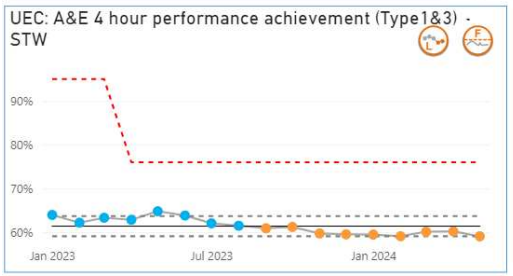
NHS
Shropshire, Telford and Wrekin

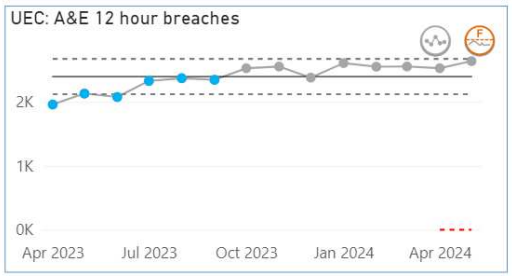
Urgent & Emergency Care

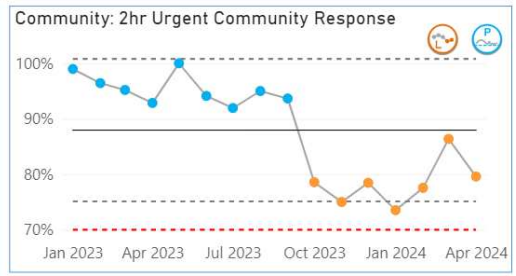








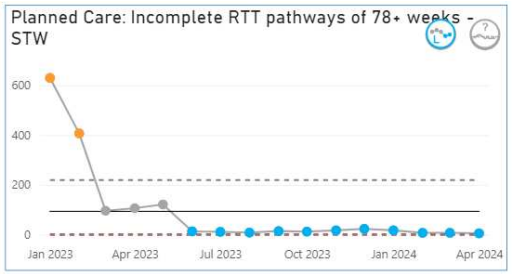


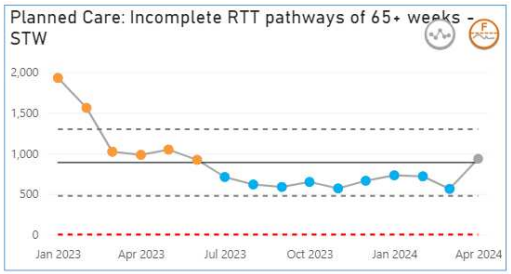


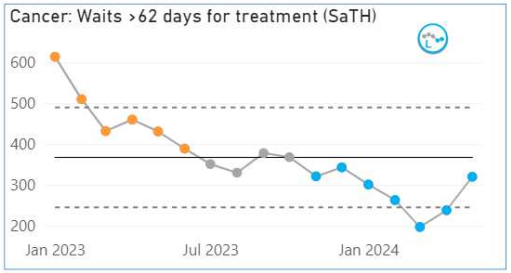
Integrated Care System
Shropshire, Telford and Wrekin

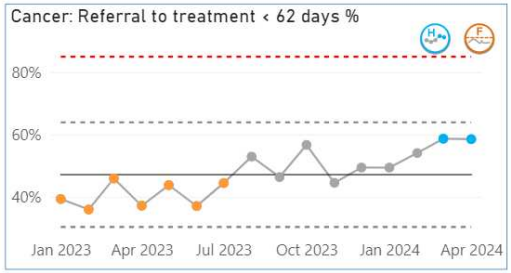
NHS
Shropshire, Telford and Wrekin

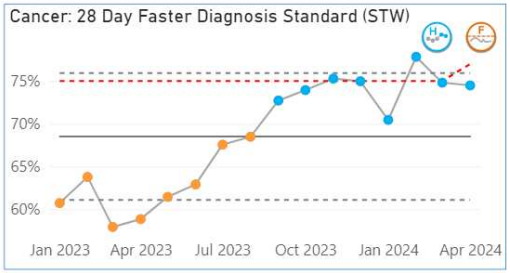
Planned Care – Elective





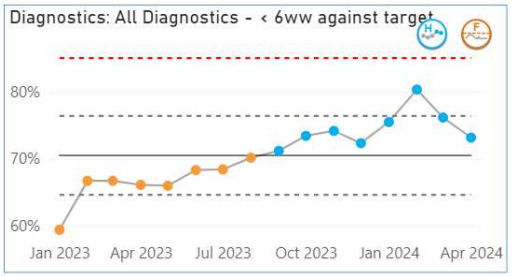


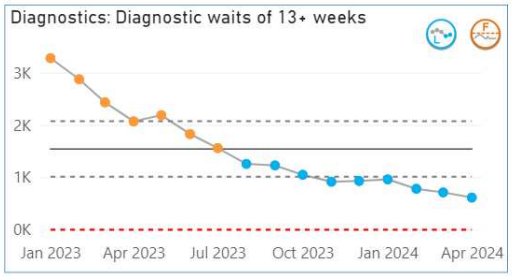


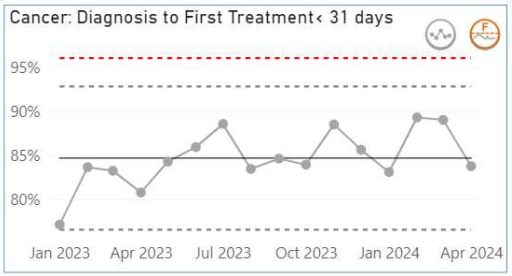


Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin



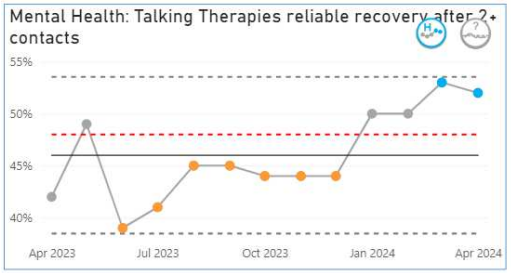


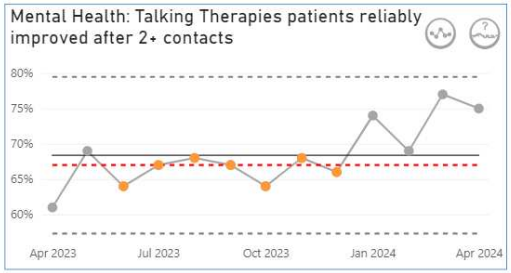


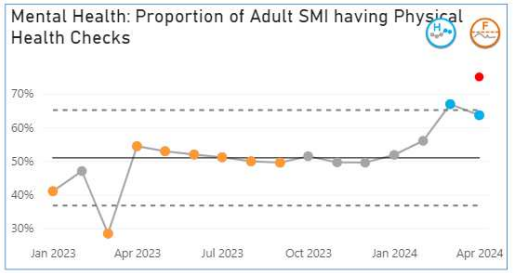
Integrated Care System
Shropshire, Telford and Wrekin

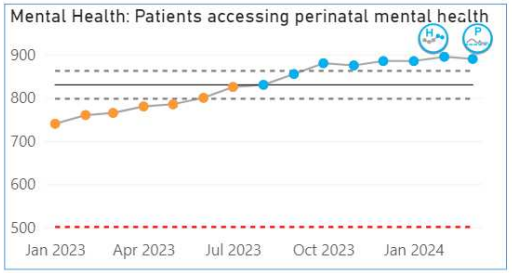
NHS
Shropshire, Telford and Wrekin

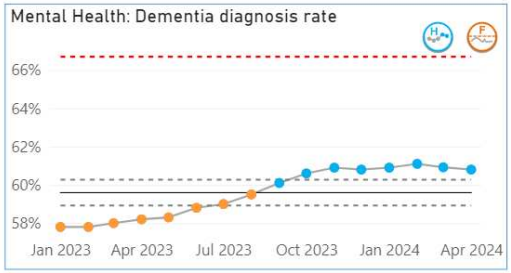
Mental Health, Learning Disabilities & Autism





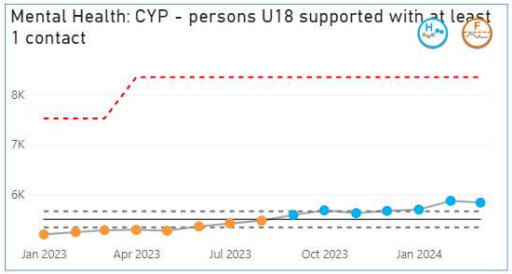


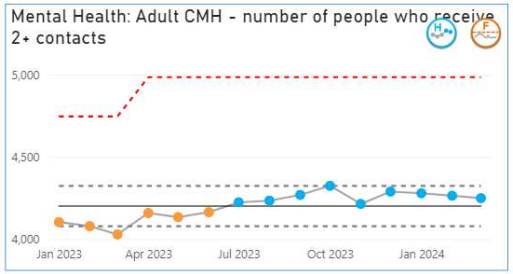


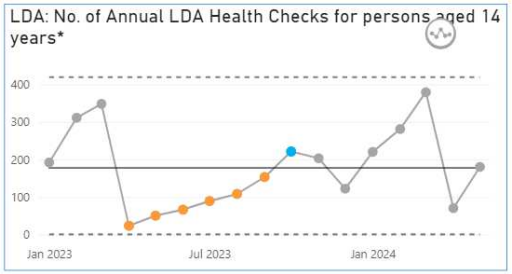


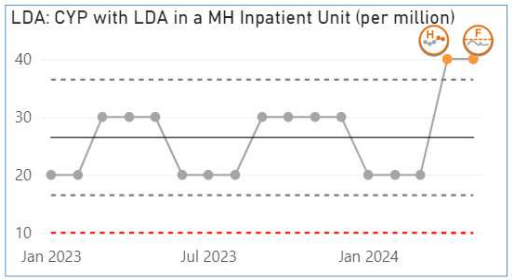
Integrated Care System
Shropshire, Telford and Wrekin

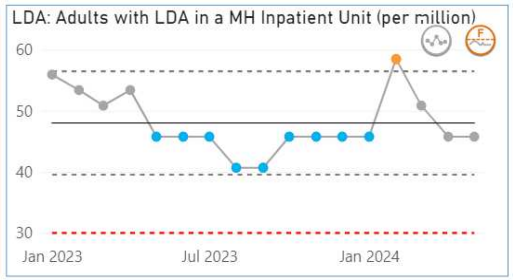
NHS
Shropshire, Telford and Wrekin











Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix B – Quality Metrics

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (Including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
IPC	C. difficile		Awaiting 2024/25 Plans	13	Cumulative Apr 24 - Apr-24	Awaiting 2024/25 Plans	8			1								
IPC	E.coli Bacteraemia		Awaiting 2024/25 Plans	43	Cumulative Apr 24 - Apr-24	Awaiting 2024/25 Plans	18			0								
IPC	Pseudonmonas aeruginosa Bacteraemia		Awaiting 2024/25 Plans	2	Cumulative Apr 24 - Apr-24	Awaiting 2024/25 Plans	1			0								
IPC	Klebsiella spp Bacteraemia		Awaiting 2024/25 Plans	6	Cumulative Apr 24 - Apr-24	Awaiting 2024/25 Plans	1			0								
IPC	MRSA Bacteraemia		Awaiting 2024/25 Plans	1	Cumulative Apr 24 - Apr-24	Awaiting 2024/25 Plans	1			0								
IPC	MSSA Bacteraemia		Awaiting 2024/25 Plans	13	Cumulative Apr 24 - Apr-24	No trajectory set	4			0								
Maternity	Stillbirths per 1,000 total births	3.3			2018 - 20	England = 3.9												
Maternity	Neonatal deaths per 1,000 total live births	3.2			2018 - 20	England = 2.8												

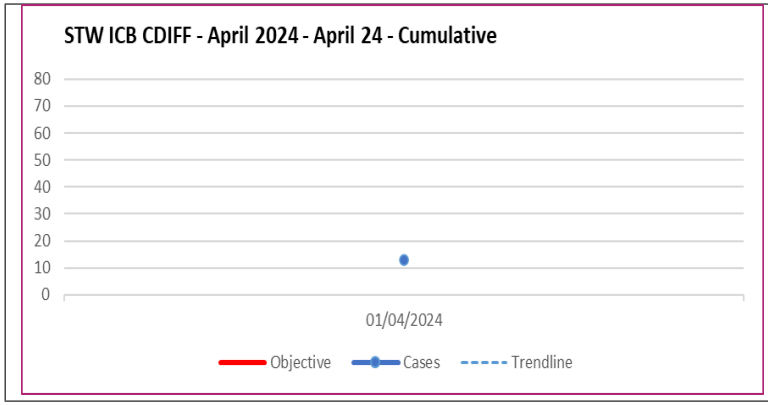
Clostridioides difficile continues to be above trajectory for SaTH and while RJAH is above annual objective they have regained monthly trajectory. Actions include review of antibiotic usage and deep clean as bed capacity allows. Gram negative and MRSA bacteraemia cases also remain higher than plan. Improvements to screening and Infection prevention and control practices are the areas of action.	Stillbirths are below the national average; however, the neonatal death rate is above the national average. An external review was commissioned by SaTH and undertaken in November 23 whilst the final report is awaited there are system workshops aimed at understanding key actions and work is ongoing. West Midlands Neonatal deaths are higher than the national average as a region.

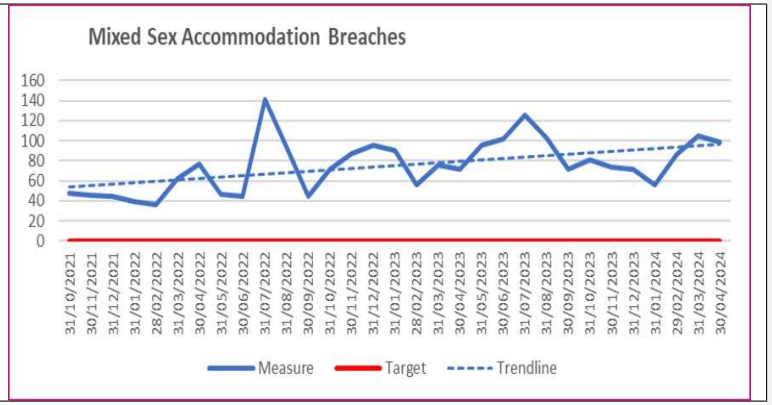
Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
CHC	% Referrals completed within 28 days			59.7%	2023/24 Qtr 4	England = 72.9%												
	Incomplete Referrals delayed >12 weeks			1	2023/24 Qtr 4													
Incidents	Number of Never Events				Cumulative Apr 24 - Apr-24	0	0			0								
	Number/Trend Serious Incidents				Monthly Apr 23 - Jun-23		1452			133			1557			45		
Friends & Family Test	Friends & Family Test - Inpatient				Apr-24 Public	Not applicable Higher is better	98.4%	1017		99.1%	343							
	Friends & Family Test - Maternity (Birth)				Apr-24 Public	Not applicable Higher is better	0.0%	4										
	Friends & Family Test - A&E				Mar-24 Public	Not applicable Higher is better	62.4%	534										
	Friends & Family Test - Mental Health				Mar-24 Public	Not applicable Higher is better							87.87%	338				
MSA	Mixed Sex Accommodation Breaches				Apr-24	Zero Lower is better	98											

Information from the Serious Incidents website (NRLS) - We have currently paused the publishing of this data while we consider future publications in line with the introduction of the Patient Safety Incident Response Framework (PSIRF) and the Learning from Patient Safety Event platform (LFPSE).





Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Overview:

•The Mixed sex accommodation breaches at SaTH follow an upward trendline. These remain high and the trust is taking action to reduce these further as part of an ongoing action

•Incidents of Clostridioides difficile (C diff) infection remain above the monthly trajectory for the system and all partner NHS organisations have breached their annual trajectories. A system action plan is in place and is reviewed monthly at the System IPC and Antimicrobial Resistance Group.

•There are no new never events to report in this period.

•Due to the implementation of the Patient Safety Incident Response Framework as part of the Patient Safety Strategy Serious Incidents have been replaced by Patient Safety Incident Investigations (PSII's). NHS STW ICS has transitioned to the new framework and partners are committed to embedding the changes outlined in the PSIRF Policy and Plan – future reporting to follow.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix C – Finance M2

Month 2 Financial Performance	YTD		
Organisation	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners			
NHS Shropshire, Telford and Wrekin	(10,020)	(9,744)	276
Total Commissioners	**(10,020)**	**(9,744)**	**276**
Providers			
The Shrewsbury and Telford Hospital NHS Trust	(12,976)	(12,930)	46
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	303	(161)	(464)
Shropshire Community Healthcare NHS Trust	182	150	(32)
Total Providers	**(12,491)**	**(12,941)**	**(450)**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(22,511)**	**(22,685)**	**(174)**

Key Data

£22.7m actual YTD System deficit, £0.2m adverse to plan YTD at M2.

The YTD position compares to the original 2nd May 2024 plan submission. Forecasts were not required as part of the Month 2 reporting submissions.

NHS STW ICS had submitted a 24/25 deficit plan of £99.0m. A final submission made on 12th June 2024 reported an improved deficit plan for the overall System of £90.0m.

£0.2m below the agency expenditure plan at M2 and £0.3m below the agency cap value (£6.4m cap ytd) for the system. ICB variance is due to efficiency being delivered ahead of plan offset by additional mental health PICU patient costs.

SaTH - Year to date at month two is in line with plan, however re-categorisation has taken place in the 12th of June submission to ensure items such as income backed posts and the agreed ERF expenditure plan are shown within the pay plan.

SCHT - YTD the Trust has delivered a surplus of £150k. This is slightly adverse to plan by £32k. The Trust is £297k favourable to plan against its Agency plan. £178k adverse on clinical supplies and £54k adverse on non-pay attributable to the Stoke Heath Prison service.

RJAH - YTD £0.2m deficit, £0.5m adverse to plan. In month position £0.1m deficit, £0.3m adverse to plan. Main drivers - £0.2m adverse Low Value Agreement block overperformance, - £0.2m adverse expenditure driven by premium pay costs, - £0.1m adverse outpatient performance - high volume of missed outpatient procedures for April/May due to process failure, this will catch up for M3, Efficiency delivery is £14k adverse, with total delivery of £588k, all recurrent. Agency performance is £0.3m favourable to plan YTD.

What have we done and next steps

All organisations continue to work through additional phased mitigation plans for the year to address risks in the position and improve wherever possible.

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

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Financial Risk

May 2nd

System Risk	24/25 Gross Risk £'000
NHS Shropshire, Telford & Wrekin ICB	35,470
Robert Jones & Agnes Hunt Hospital	16,468
Shrewsbury & Telford Hospitals	61,818
Shropshire Community Hospital Trust	8,050
Grand Total	**121,806**

June 12th

System Risk	24/25 Gross Risk £'000
NHS Shropshire, Telford & Wrekin ICB	33,870
Robert Jones & Agnes Hunt Hospital	18,297
Shrewsbury & Telford Hospitals	68,818
Shropshire Community Hospital Trust	8,550
Grand Total	**129,535**

The gross risk only for each organisation as per the 2nd May plan submission is presented above totalling £121.8m.

The gross risk only for each organisation as per the 12th June plan submission totals £129.5m with the increase due to additional efficiency risk at SaTH and SCHT and additional cost and income risk at RJAH.

These risks are not yet fully mitigated, an update will be provided in Month 3 reports.

Month 2 risks are being monitored and more detail is provided under each individual organisation with associated mitigations, work is ongoing to identify further mitigations and reduce the risk pressure over the coming months.

Commented [GJ(STAWIM1]: @WILLIAMS, Jane (NHS SHROPSHIRE, TELFORD AND WREKIN ICB - M2L0M) please check this with Angela - it seems the What have we done and next steps is missing??? Or is this a copy and paste issue???

Commented [JW2R1]: Copy & paste issue, it's because it's from a Powerpoint slide and it doesn't fit easily. Sam used to have the same problem. I've sorted now (squeezed it in!!)

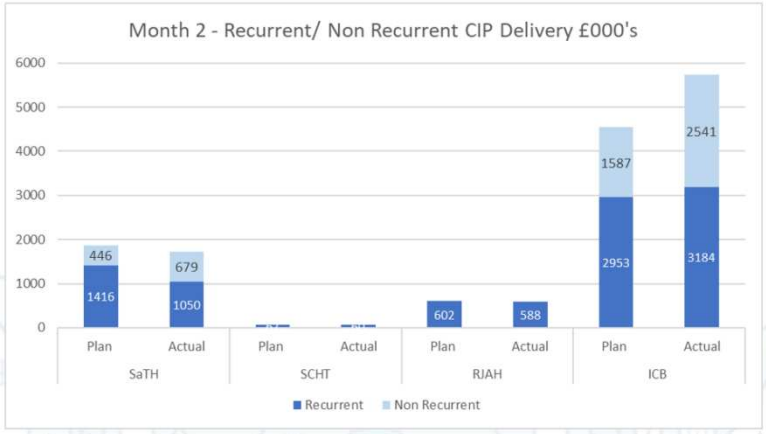
Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Efficiency Delivery – Month 2

Month 2 CIP Delivery against Plan

Organisation	2024/25 Plan £000's	M2 YTD Plan £000's	M2 YTD Actual £000's	M2 YTD Variance £000's	Forecast £000's
SaTH	44700	1862	1729	-133	44700
SCHT	3588	67	60	-7	3588
RJAH	5589	602	588	-14	5589
ICB	35787	4540	5725	1185	35787
Grand Total	**89664**	**7071**	**8102**	**1031**	**89664**



Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Finance – Capital

STW Organisation	Capital allocation	10% reduction	Revised Capital Allocation
RJAH	7,010	701	6,309
SATH	18,429	1,843	16,586
SCHT	2,500	250	2,250
Total	27,939	2,794	25,145
ICB	883	883	883
Total	28,822	2,882	26,028

- 2024/25 Financial Framework: Total planning gap still leaves a pressure on national budgets. Plans are going to be cash backed to avoid in year borrowing on a fair share deficit funding basis. The difference between the fair share of deficit funding and the Revenue Financial Plan Limit set for STW shows that STW has a deficit spending limit above the fair share of deficit funding.
  - 2024/25 = Deduction from the capital allocation in 2024/25 of 15% of the Revenue Financial Plan Limit and notional fair share value, capped at 10% of the core capital allocation. This is in addition to the repayment of prior year deficits already built into plans.
  - Future Years = The Revenue Financial Plan Limit or actual outturn (excluding the deficit support funding) if higher, less the value of the capital deduction from 2024/25 will be added to the system cumulative position to be repayable in future years in line with the business rules.

- Actuals/Forecasts are not available/required for Month 2 reporting.
- The revised 2024/25 Financial Framework for NHS STW due to our deficit means that providers have a 10% reduction in operational capital from £27.9m reduced to £25.1m, a reduction of £2.8m.
- ICB capital of £883k is not impacted.
- We will work in year to live within the operational capital envelope however this does pose a risk to the system as we are going to have to take some decisions to either delay or not invest in programmes of work. This will directly impact on our ability to replace ageing equipment in a timely way and also manage our backlog maintenance. This will, particularly over an extended period of time (ie if we post a deficit for multiple years and the framework remains as is), impact on the quality of services we can provide.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix D - Workforce

System Overview - WTE and Availability

13,200 WTE	9.5% Vacancy	10.6% Turnover	5.4% Sickness	78% AfC Appraisals	84% Medical Appr.	92% Mand. Training

Substantive WTE Actual vs Plan (SATH, RJAH and SCHT)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	10,299	10,318	10,349	10,356	10,348	10,336	10,438	10,411	10,367	10,335	10,303	10,273
Actual	10,206	10,237										
Variance	-93	-81										

			MPFT		RJAH		SaTH		SCHT		SYSTEM	
Metric	Staff Group	Data Period	Value	Variation	Value	Variation	Value	Variation	Value	Variation	Value	Variation
Sickness %	Total	May 2024	5.03%		8.33%		4.9%		5.59%		5.46%	
Turnover %	Total	May 2024	9.92%		8.23%		10.9%		11.8%		10.5%	
Vacancy %	Total	May 2024	15.8%		4.83%		8.90%		11.8%		9.73%	
Vacancy WTE	Total	May 2024	275		77.4		695		212		1,259	

Integrated Care System
Shropshire, Telford and Wrekin

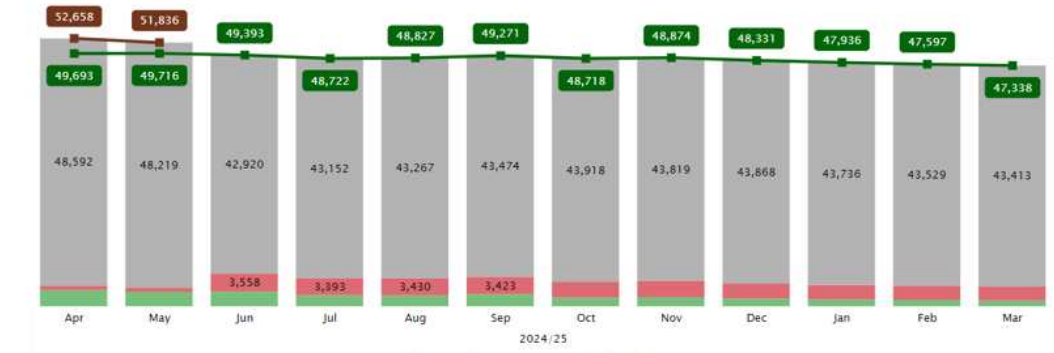
NHS
Shropshire, Telford and Wrekin

System Overview - Costs

Costs Actual vs Plan (SATH, RJAH and SCHT)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	49,693	49,716	49,393	48,722	48,827	49,271	48,718	48,874	48,331	47,936	47,597	47,338
Actual	52,658	51,836										
Variance	2,965	2,120										

Staff Costs Actual vs Plan – (£000)



System M2	Actual	Plan	Variance
Staff Costs (£000)	**£51,836**	**£49,716**	£2,120
Agency	£2,782	£3,066	-£284
Bank	£835	£3,587	-£2,752
Substantive	£48,219	£43,063	£5,156

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Due to the workforce information issues this month this slide has not been updated

Staff costs and WTE – Staff Group & Provider

Mar-24	GP, Medical and dental			Infrastructure and Administration			Nursing, midwifery and health visiting			Other			Scientific, therapeutic and technical			Support to clinical staff		
	Agency	Bank	Substantive	Agency	Bank	Substantive	Agency	Bank	Substantive	Agency	Bank	Substantive	Agency	Bank	Substantive	Agency	Bank	Substantive
RJAH																		
Staff Costs (£000)																		
Actual	£241.00	£136.00	£1,330.00	£2.00	£68.00	£1,856.00	£177.00	£256.00	£1,204.00	£0.00	£0.00	£92.00	£66.00	£136.00	£1,026.00	£0.00	£143.00	£698.00
Operational Plan	£50.00	£113.00	£1,503.00	£0.00	£40.00	£1,896.00	£144.00	£67.00	£1,280.00	£0.00	£0.00	£41.00	£0.00	£25.00	£1,047.00	£30.00	£72.00	£749.00
Difference	*£191.00*	*£23.00*	*-£173.00*	*£2.00*	*£28.00*	*-£40.00*	*£33.00*	*£189.00*	*-£76.00*	*£0.00*	*£0.00*	*£51.00*	*£66.00*	*£111.00*	*-£21.00*	*-£30.00*	*£71.00*	*-£51.00*
WTE																		
Actual	3.15	0.00	157.27	0.00	20.27	565.15	20.46	30.67	296.21	0.00	0.00	9.00	9.22	9.05	209.04	0.00	33.89	291.74
Operational Plan	0.00	0.00	156.30	0.00	4.00	567.15	2.00	11.90	315.68	0.00	0.00	8.00	0.00	4.33	215.33	0.00	0.00	298.30
Difference	*3.15*	*0.00*	*0.97*	*0.00*	*16.27*	*-2.00*	*18.46*	*18.77*	*-19.47*	*0.00*	*0.00*	*1.00*	*9.22*	*4.72*	*-6.29*	*0.00*	*33.89*	*-6.56*
SaTH																		
Staff Costs (£000)																		
Actual	£542.11	£671.31	£4,026.64	-£221.68	£374.24	£2,847.16	£978.86	£1,232.28	£7,660.66	£20.00	£0.00	£189.00	£0.00	£143.31	£3,001.63	-£7.82	£1,164.24	£7,222.14
Operational Plan	£497.50	£496.00	£4,128.00	£15.00	£237.00	£3,470.25	£856.50	£481.83	£7,002.33	£79.42	£0.00	£162.25	£54.75	£81.83	£3,383.33	£46.00	£369.00	£4,765.67
Difference	*£44.61*	*£175.31*	*-£101.36*	*-£236.68*	*£137.24*	*-£623.09*	*£122.36*	*£750.45*	*£658.33*	*-£59.42*	*£0.00*	*£26.75*	*-£54.75*	*£61.48*	*-£381.70*	*-£53.82*	*£795.24*	*£2,456.47*
WTE																		
Actual	49.50	78.35	845.82	2.92	92.29	1799.63	243.41	206.16	2013.18	0.00	0.00	9.51	24.96	35.07	741.43	0.00	276.94	1704.88
Operational Plan	72.57	82.11	613.65	10.75	67.74	1653.17	101.30	167.11	1857.29	0.00	0.00	150.23	24.70	30.92	751.48	15.14	213.26	1594.37
Difference	*-23.07*	*-3.76*	*232.17*	*-7.83*	*24.55*	*146.46*	*142.11*	*39.05*	*155.89*	*0.00*	*0.00*	*-140.72*	*0.26*	*4.15*	*-10.05*	*-15.14*	*63.68*	*110.51*
SCHT																		
Staff Costs (£000)																		
Actual	£199.00	£0.00	£166.00	£14.00	£31.00	£1,371.00	£347.00	£56.00	£2,186.00	£0.00	£0.00	£0.00	£94.00	£13.00	£962.00	£69.00	£53.00	£876.00
Operational Plan	£25.00	£0.00	£236.00	£1.00	£68.00	£1,452.00	£328.00	£97.00	£2,966.00	£0.00	£0.00	£0.00	£24.00	£11.00	£937.00	£72.00	-£62.00	£751.00
Difference	*£174.00*	*£0.00*	*-£70.00*	*£13.00*	*-£37.00*	*-£81.00*	*£19.00*	*-£41.00*	*-£780.00*	*£0.00*	*£0.00*	*£0.00*	*£70.00*	*£2.00*	*£25.00*	*-£3.00*	*£115.00*	*£125.00*
WTE																		
Actual	7.69	0.00	20.24	0.00	11.36	406.24	35.41	18.56	512.22	0.00	0.00	6.00	11.75	2.20	229.26	19.42	17.05	310.36
Operational Plan	1.64	0.15	26.38	0.33	18.81	410.40	12.05	25.70	576.49	0.00	0.00	0.00	4.97	4.18	239.26	26.56	18.44	316.13
Difference	*6.05*	*-0.15*	*-6.14*	*-0.33*	*-7.45*	*-4.15*	*23.36*	*-7.14*	*-64.27*	*0.00*	*0.00*	*6.00*	*6.78*	*-1.98*	*-10.00*	*-7.14*	*-1.39*	*-5.76*

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Due to the workforce information issues this month this slide has not been updated

Total Staff Costs and WTE by Provider

SATH M12	Actual	Plan	Variance
Staff Costs (£000)	**£34,356**	**£29,491**	**+£4,865**
Agency	£1,467	£1,715	-£248
Bank	£4,208	£2,045	+£2,163
Substantive	£28,681	£25,732	+£2,949
WTE	**8,124.05**	**7,405.79**	718.26
Agency	320.79	224.46	96.33
Bank	688.81	561.15	127.66
Substantive	7,114.45	6,620.18	494.26

RJAH	Actual	Plan	Variance
Staff Costs (£000)	**£7,431.00**	**£7,057.00**	374.00
Agency	£486.00	£224.00	262.00
Bank	£739.00	£317.00	422.00
Substantive	£6,206.00	£6,516.00	-310.00
WTE	**1,655.12**	**1,582.98**	72.14
Agency	32.83	2.00	30.83
Bank	93.88	20.23	73.65
Substantive	1,528.41	1,560.75	-32.34

SCHT	Actual	Plan	Variance
Staff Costs (£000)	**£6,437.00**	**£6,906.00**	-469.00
Agency	£723.00	£450.00	273.00
Bank	£153.00	£114.00	39.00
Substantive	£5,561.00	£6,342.00	-781.00
WTE	**1,607.76**	**1,681.48**	-73.72
Agency	74.27	45.55	28.72
Bank	49.17	67.28	-18.11
Substantive	1,484.32	1,568.65	-84.33

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Workforce KPIs by Provider

			MPFT		RJAH		SaTH		SCHT		SYSTEM	
Metric	Staff Group	Data Period	Value	Variation	Value	Variation	Value	Variation	Value	Variation	Value	Variation
Agency WTE	Total	May 2024	47.9		21.8		252		49.1		371	
Agency WTE %	Total	May 2024	2.96%		1.33%		3.15%		2.91%		2.87%	
Bank WTE	Total	May 2024	108		76.6		628		52.7		865	
Bank WTE %	Total	May 2024	6.66%		4.70%		7.86%		3.12%		6.69%	
Sickness %	Total	May 2024	5.03%		8.33%		4.9%		5.59%		5.46%	
Substantive WTE	Total	May 2024	1,460		1,534		7,117		1,586		11,698	
Turnover %	Total	May 2024	9.92%		8.23%		10.9%		11.8%		10.5%	
Vacancy %	Total	May 2024	15.8%		4.83%		8.90%		11.8%		9.73%	
Vacancy WTE	Total	May 2024	275		77.4		695		212		1,259	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

			MPFT		RJAH		SaTH		SCHT		SYSTEM	
Metric	Staff Group	Data Period	Value	Variation	Value	Variation	Value	Variation	Value	Variation	Value	Variation
Vacancy %	Allied Health Professionals	May 2024	40.7%		6.69%		18.8%		19.0%		19.3%	
	GP, Medical and dental	May 2024	28.2%		1.63%		10.0%		26.6%		10.4%	
	HCSW	May 2024	18.1%		10.3%		13.9%		9.80%		13.5%	
	Infrastructure and Administration	May 2024	12.1%		3.41%		2.98%		13.1%		5.51%	
	Nursing, midwifery and health visiting	May 2024	18.7%		7.39%		5.76%		10.1%		8.44%	
	Total	May 2024	15.8%		4.83%		8.90%		11.8%		9.73%	
Vacancy WTE	Allied Health Professionals	May 2024	48.4		11.9		92.3		41.5		194	
	GP, Medical and dental	May 2024	19.8		2.62		95.7		7.29		125	
	HCSW	May 2024	34.0		22.5		166		20.3		242	
	Infrastructure and Administration	May 2024	47.2		20.0		55.0		57.4		180	
	Nursing, midwifery and health visiting	May 2024	91.3		23.5		126		69.9		310	
	Total	May 2024	275		77.4		695		212		1,259	

NHS
Shropshire, Telford and Wrekin

Annual Report and Accounts

2023/24

Table of Contents

Performance Report **4**
Statement from Simon Whitehouse 4
Performance Overview 6
Statement of purpose and activities of the ICB 6
About us 6
Our mission statement and priorities 6
2023/24 Financial Position & Financial Review 10
Performance Analysis **16**
Performance Dashboard 16
Mental Health 17
Safeguarding 17
Children and Young People (CYP) safeguarding 17
Adult Safeguarding 18
ICB Statutory Responsibilities 19
Clinical Matters 20
Delivering our Plan and Priorities – Our Joint Forward Plan **21**
Delivering Person-centred care 23
The Big Health and Wellbeing Conversation 25
Tackling Health Inequalities 27
In-year Achievements 33
Medicines Management - Delivering a Person-Centred Approach 44
Place-Based Delivery 48
Hospital and Clinical Services 54
Service Transformation - Our Plans and Future Activity 57
Outpatients Transformation 58
Cancer 60
Eye Care Transformation 62
Musculoskeletal (MSK) Transformation 64
Cardiology Transformation 66
Learning Disability and Autism 68
Improving Quality 72

ICS quality developments 74
Enablers 78
Medicines Management 80
Greener NHS 86
Legal and Governance Matters 90
Patient Services 93
Accountability Report 98
Corporate Governance Report 98
Governance Statement 103
Other sources of assurance 119
Remuneration and Staff Report 130
Remuneration Report 130
Staff Report 135
Parliamentary Accountability and Audit Report 143
Annual Accounts 144

Performance Report

Statement from Simon Whitehouse

Chief Executive Officer of NHS Shropshire, Telford and Wrekin

As we reflect on the past year, NHS Shropshire Telford and Wrekin Integrated Care Board (ICB) has been integral to the health and social care system of our region.

Over the past year, our system has continued to face significant challenge and change. A combination of industrial action, system pressures, workforce challenges and demand for services has tested the resilience of the system repeatedly. At the same time the ICB has undertaken a significant change programme targeted at reducing the cost to run our organisation by 30% and ensuring that we are 'fit for purpose' to deliver the new system target operating model that the Board approved.

Despite these challenges, our team has continually demonstrated unwavering dedication, commitment, and innovation to ensure the safety and wellbeing of our communities. Working closely with colleagues in our NHS provider organisations, our local authority partners, local primary care services, and our communities, we have been able to navigate these challenges together. Our performance report provides a comprehensive overview of the pressures encountered and the collaborative responses undertaken by the ICB and our partners. I am proud of the way our teams collectively rose to the challenges presented.

The demand for health and care services has been steadily increasing due to factors such as an ageing population and a rise in individuals living with multiple long-term conditions. Consequently, the challenge to ensure that our services change and evolve to meet that demand is more important than ever. The challenges that we see for our local population are significant and of concern to all of us - wait times for some services are the longest they have been in 15 years, and the accessibility of essential services like primary care, children and young people's Mental Health Services, and urgent care falls short, at times of our expected standards. Despite this, we have seen improvements in some of our cancer services and our very longest waits have also reduced significantly over the past 12 months.

Despite encountering significant challenges during the 2023-2024 period, we have strengthened our partnerships with local stakeholders, enhancing collaborative efforts to address inequalities across our region and strive to deliver top-tier health and care services closer to our residents' homes.

It is important we involve and listen to our population to ensure we meet the need of the population. We have concluded 'The Big Health and Wellbeing Conversation' which was started last year, offering people across the county the opportunity to input into our future plans. The outcomes of the engagement activity have helped us to shape our Joint Forward Plan (JFP), and ensure we are following a person-centred approach to improving the health and wellbeing of local people.

Our JFP is an ambitious vision on how our system will work collaboratively to develop and review our system priorities, meet our distinct populations at ‘place’ and ‘neighbourhood’ localities and engage with our communities to ensure their needs are considered whilst understanding the systems challenges too.

As referenced earlier, we are particularly proud of our achievements to reduce wating times for elective and cancer care, but we know we have much more to do, and we will continue to focus our efforts on this with our provider collaborative.

Finally, I would like to thank our health and care staff across the system and our voluntary and community colleagues for their continued commitment and dedication. It remains our collective responsibility, as a partnership, to support our colleagues be the best that they can be, and to continually drive for improvements in outcomes for the population that we serve

Simon Whitehouse

Accountable Officer

XX June 2024

Performance Overview

Statement of purpose and activities of the ICB

This section of the Annual Report provides summary information on NHS Shropshire, Telford and Wrekin – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over the period 1st April 2023 to 31st March 2024.

About us

NHS Shropshire, Telford and Wrekin was created on 1st July 2022 and is responsible for planning and buying a wide range of health and care services for the whole of Shropshire, Telford and Wrekin. These include GP and primary care services such as optometry, pharmacy and dentistry, hospital care, community healthcare and mental health services. The principal location of the organisation during 2023/24 has been Halesfield 6, Telford, TF7 4BF but the Integrated Care Board relocated on 12th February 2024 to Wellington Civic Offices, Larkin Way, Wellington, Telford, Shropshire TF1 1LX.

An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in a geographical area.

Nationally, the expectation is that an ICS will:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

We also have a duty to monitor these services to ensure they provide a high level of care and are value for money. We are clinically-led and work closely with the 51 GP practices across the county. This means we can have closer links to our patients so we can develop more personalised local health services.

A governance structure chart is included on page 114 of this report.

Our mission statement and priorities

What we want to achieve as an ICS:

Together as one, we want to transform health and care across Shropshire, Telford & Wrekin by:

- Providing a greater emphasis on prevention and self-care
- Helping people to stay at home with the right support with fewer people needing to go into hospital

- Giving people better health information and making sure everyone gets the same high-quality care
- Utilising developing technologies to fuel innovation, supporting people to stay independent and manage their conditions
- Attracting, developing, and retaining world class staff
- Involving and engaging our staff, local partners, carers, the voluntary sector and residents in the planning and shaping of future services
- Developing an environmentally friendly health and care system

NHS Shropshire, Telford and Wrekin has a Joint Forward Plan for the next five years based upon the Integrated Care Strategy, which will include its mission statement and strategic objectives. This Plan was published on 30th June 2023.

Population challenges

We work across the 1,347 square miles of Shropshire, Telford and Wrekin, serving around 520,000 people.

The NHS Shropshire, Telford and Wrekin is responsible for buying NHS services for local people. In our area, we have:

- Two acute hospitals, less than 20 miles apart in Telford and Shrewsbury. These are run by one acute trust, the Shrewsbury and Telford NHS Trust (SaTH)
- A specialist orthopaedic hospital, the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), which provides elective orthopaedic surgery in the northwest of the county
- A community trust, the Shropshire Community Health Trust
- A mental health trust, Midlands Partnership University NHS Foundation Trust (who covers Shropshire and Staffordshire)
- An ambulance service, the West Midlands Ambulance Service University NHS Foundation Trust

Within our area, we have two unitary authorities – Shropshire Council and Telford & Wrekin Council. Shropshire Council covers 1,234 square miles, including 91.7% of the ceremonial county of Shropshire. This incorporates a number of towns, including Shrewsbury, Oswestry and Ludlow, but no major cities. The area covered by Shropshire Council has a population of around 320,000 people.

The rest of the area is covered by Telford & Wrekin Council. Around 185,000 live in this borough with around 165,000 living in Telford itself – making it the largest town that we cover.

Being on the Welsh-English border, we provide some hospital services for people from the Welsh health system who live outside of Shropshire or Telford and Wrekin. Some residents in mid-Wales rely on our services, particularly at our two acute hospitals and RJAH.

In Shropshire, Telford and Wrekin, there are particular population challenges in meeting the demand for health and social care services.

These include:

- Telford and Wrekin has a large, younger urban population with some rural areas. Telford is ranked among the 30% most deprived populations in England. Telford and Wrekin is home to around 185,000 people with the fastest growing population being aged 65+. This older group is growing at one of the fastest rates in the country.

- Shropshire covers a large rural population with problems of physical isolation and low population density (1.01 people per hectare compared to 4.34 in England) and has a mix of rural and urban aging populations. Shropshire has a population of approximately 320,000 people and a higher percentage of older people than the national average. (2021 Census).

- Shropshire, Telford & Wrekin has one of the least ethnically diverse populations in England: the lowest black and minority ethnic groups population levels across Midlands and East with 95.9% of the population identified as 'White British/Irish' (2011 Census).

- In Shropshire the population of people aged over 65 has increased by 25% in just 10 years. Over 44% of residents are over the age of 50 and around 23% of Shropshire's population are aged 65+, this compares with a West Midlands and England figure of 18% (2011 Census).

- The number of people with dementia or mobility issues which mean they are unable to manage at least one activity on their own is expected to rise significantly with the increase in the elderly population. Between 2017 and 2035 the number of people aged 65+ with dementia is expected to increase by 80%. Those people who are aged 65+ and unable to manage at least one activity on their own is projected to increase by 63%. Demand for services is shifting with greater need for services to support frailer people in the community with home-based health and wellbeing self-management and building resilience.

- Long-term conditions are on the rise due to changing lifestyles. This means we need to move the emphasis away from services that support short-term, episodic illness and infections towards earlier intervention to improve health and deliver sustained community based continued support.

- Along with an ageing population Shropshire, Telford & Wrekin has the third lowest fertility rates across Midlands and East (ONS Statistics: Gov.uk data June 2016).

Working with partners

NHS Shropshire, Telford and Wrekin forms part of the Shropshire, Telford and Wrekin Integrated Care System (ICS). An integrated care system (or ICS) is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Each ICS includes an integrated care board (as described above) and an integrated care partnership (as described below).

In its first two years of operation NHS Shropshire, Telford and Wrekin has been seeking to support the ICS to identify how partnership working will be further embedded across all partners and then to identify how the ICS needs to be structured and the ongoing support role the ICB will need to take to ensure that integration of services by all partners continues to be a key deliverable.

Shropshire, Telford and Wrekin ICS includes the following healthcare providers:

- The Shrewsbury and Telford Hospital NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Shropshire Community Health NHS Trust
- Midlands Partnership NHS Foundation Trust
- West Midlands Ambulance Service Foundation Trust
- 51 GP practices across eight Primary Care Networks.
- Community Pharmacy
- More recently, NHS Dentistry

There are also two local authorities within our ICS:

- Shropshire Council
- Telford & Wrekin Council

There is also involvement from our local voluntary community and social enterprise sector in Shropshire and Telford and Wrekin, along with both Healthwatch Telford and Wrekin and Healthwatch Shropshire.

You can find out more about the ICS here: Home - STWICS

An integrated care partnership (or ICP) is a statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

In our area our ICP is known as the Shropshire, Telford and Wrekin Integrated Care Partnership. You can find out more on the partnership's webpage:

Integrated Care Partnership (ICP) Meetings - STWICS

NHS Midlands and Lancashire Commissioning Support Unit

Midlands and Lancashire Commissioning Support Unit (MLCSU) provided a number of services through a contract ranging from financial management to human resources and information governance (IG). We continue to work with MLCSU in this period in terms of consistency of services provided.

2023/24 Financial Position & Financial Review

For 2023/24, the in-year reported financial outturn position is a deficit of £16.2m which is £16.0m adverse against the planned £0.2m deficit.

Late in the year, NHSE asked ICBs with historic system deficits to incorporate these into their reported position. For NHS STW this was a value of £65.2m. This is reported here but not included in the in-year position referenced in the table below, in line with NHSE reporting guidance.

	Year ended 31st March 2024		
	Budget £'000	Actual £'000	Variance £'000
In Year Allocation	1,216,769	1,216,769	0
Expenditure	(1,216,997)	(1,233,018)	(16,021)
Reported Deficit	(228)	(16,249)	(16,021)

There are a small number of key drivers of increased expenditure for the ICB which have continued throughout the year:

- Increases to independent sector ophthalmology activity driven through patient choice and long waiting times at our main provider.
- Continued expenditure with Local Authorities on additional discharge support that is no longer nationally funded through the Hospital Discharge Programme.
- Increased package prices in Individual Commissioning.
- Increased prescribing prices due to Category M (Cat M) and No Cheaper Stock Obtainable (NCSO) national adjustments.

Elective Recovery Funding has flowed into the System. Along with income for English patients, the ICB had included in its planning assumptions receipt of income for Welsh activity on behalf of the System providers. However, we were unable to attract any.

The ICB has been able to mitigate some of these overspends by offsetting benefits within Community, Running Costs and Pharmacy, Optometry and Dental (POD). In addition, efficiencies delivered in year exceeded the original plan value by £800k.

The full year financial position includes £26.8m of total efficiencies delivered in year, predominantly in Individual Commissioning and Medicines Management, of which £21.0m (78%) was recurrent.

Shropshire, Telford & Wrekin Integrated Care System (ICS)

The Shropshire, Telford and Wrekin Integrated Care System (ICS) is part of the National Recovery Support Programme – Level 4 of the NHS England and NHS Improvement (NHSEI) System Oversight Framework. The System and ICB is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering a deteriorating financial position.

A system financial framework was therefore developed and agreed by all organisations and all system partners have worked closely together to develop a roadmap for financial recovery.

All organisations have agreed to:

- the approach of 'one model, one consistent set of assumptions' and recognise that the position of each organisation will evolve and change transparently
- mobilise and deliver the plan to enable the development and delivery of the financial strategy and Financial Improvement Framework as part of an Integrated System Strategy
- ensure the transparent and agile approach to financial planning and management continues across the system
- recognise the financial control totals in the Financial Improvement Framework with a commitment to agree organisational control totals once operational planning has commenced
- work together to use our resources flexibly and effectively, to deliver the system vision.

To ensure that all decision-making is open and that changes are understood and approved by all, the system has been operating under the 'triple-lock' process and the 'moving parts' principles. This means that decisions are made at local, ICS and regional level (triple lock) and that new expenditure can only be committed if it is backed by new income or efficiency ('moving parts'). The principles are designed to ensure decisions are owned by each organisation and at system level, overseen by NHS England as required whilst the system remains in the Recovery Support Programme.

Further to this, in-year we have deployed additional System-wide controls for both pay and non-pay expenditure as part of an enhanced Triple Lock Process with the introduction of a system vacancy control panel and weekly review of non-pay expenditure above £10k.

The system medium to long term financial plan will be updated during 2024/25 to reflect the System Financial Improvement Programme and the Hospital Transformation Programme. The roadmap to financial recovery and financial sustainability will contribute towards exiting Level 4 of the National Recovery Support Programme.

System Capital Resource

As part of the Health and Care Act 2022 (the 2006 Act), ICBs, partner NHS trusts and NHS foundation trusts are required to prepare joint capital resource use plans. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders, on how the capital funding provided to ICBs is being prioritised and spent to achieve the ICB's strategic aims. This aligns with ICBs' financial duty to ensure that their allocated capital is not overspent and their obligation to report annually on their use of resources.

2023/24 is the second of a three-year ICS capital allocation. This means that we have a shared ICS level capital funding envelope for the full twelve months in 2023/24 and a baseline

envelope for 2024/25. A STW Capital Prioritisation and Oversight Group is established as a subcommittee of the Finance Committee to monitor the system capital programme against the capital envelope, gain assurance that the estates and digital plans are built into system financial plans and to ensure effective oversight of future prioritisation and capital funding bids.

The System Capital Resource Plan can be viewed on the ICB website at:

Joint Resource Capital Plans - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

	CDEL	Plan 2023/24 £'000	Expenditure 2023/24 £'000	Narrative on the main categories of expenditure
Provider	Operational Capital	28,051	26,534	The 2023/24 operational capital programme for STW is comprised of essential Estates backlog, improvements in digital infrastructure and key developments including the RJAH theatres project and a new Linac bunker at SaTH.
ICB	Operational Capital	878	801	Investment in Primary Care
	Total Operational Capital	**28,929**	**27,335**	
Provider	Impact of IFRS 16	7,079	3,666	The adoption of IFRS 16 means that leases are now held on the balance sheet and are included within the CDEL limits.
ICB	Impact of IFRS 16	4,767	5,074	
Provider	Upgrades & NHP Programmes	29,900	18,850	This relates to expenditure required to deliver the Hospital Transformation Programme Full Business Case and the enabling works that were aprroved as part of the OBC.
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)	21,934	53,124	This relates to national funding for the Elective Hub at PRH, the Community Diagnostic Centre at Telford and the additonal ward capacity at SATH. It also includes national digital funding to help the ICS reach the minimum digitial foundations standard.
Provider	Other (technical accounting)	-	-	
	Total system CDEL	**92,609**	**108,049**	

Adoption of going concern basis

The ICB's accounts have been prepared on a going concern basis.

In the year ended 31st March 2024 the ICB has reported a deficit of £16.2m. Late in the year, NHSE asked ICBs with historic system deficits to incorporate these into their reported position. For NHS STW this was a value of £65.2m. but this is not reported within the in-year position referenced, in line with NHSE reporting guidance.

The Shropshire, Telford and Wrekin System reported a £72.5m deficit in the year ended 31st March 2024 (excluding the historical deficit impact).

At the end of the financial period, it was judged that the going concern status of the organisation remained unchanged on the following basis:

- The ICB has taken steps to maintain business continuity for the finance function throughout the period in order that payments and collection of debt are not materially impacted. These steps include continuing with secure remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the

low value of the ICB's aged debt and its continued high achievement against the Better Payment Practice Code.

- There is a presumption that ICBs are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific ICB will be doing the function in future.

Although the financial position of the ICB and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the ICB's ability to continue as a going concern, the Governing Body, having made appropriate enquiries, have reasonable expectations that the ICB will have adequate resources to continue in operational existence for the foreseeable future.

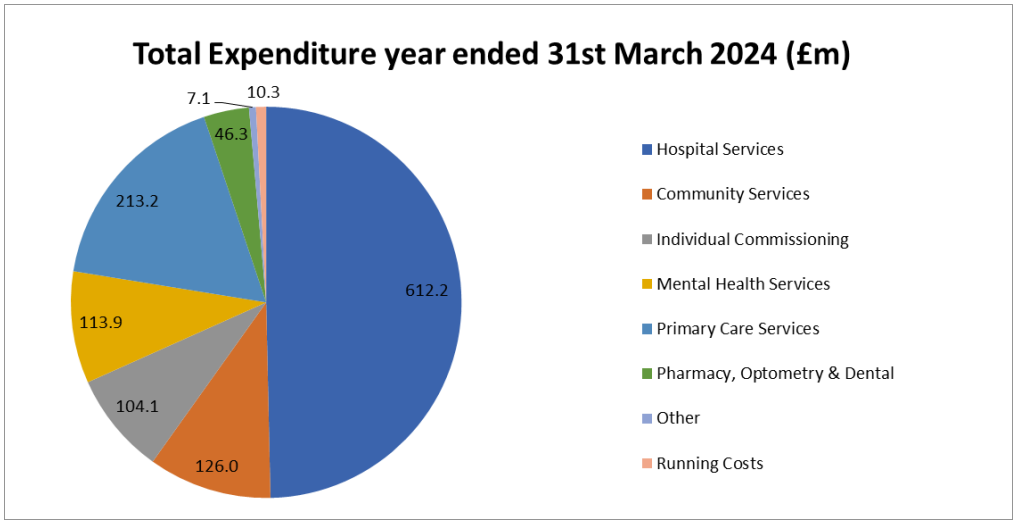
Further, the ICB submitted its 2024/25 financial plan covering the 12 month period for the ICB on 2nd May 2024 and also submitted a revision to this plan on the 12th June 2024 to reflect the agreed System financial plan value. This plan was based on the allocations notified by NHSE for the full financial year of 2024/25.

On this basis, the ICB has adopted the going concern basis for preparing the financial statements and has not included any adjustments that would result if it was unable to continue as a going concern.

Financial Review

In the year ended 31st March 2024 the ICB received a total allocation of £1,217 million to spend on the healthcare of its residents. The chart below shows a breakdown of the ICB's expenditure for the period by spend type totalling £1,233 million:

Expenditure year ended 31st March 2024 (£1,233 million)



Further analysis of expenditure, by type for the year ended 31st March 2024:

	Period ended 31st March 2024 Total £'000	Nine Months ended 31st March 2023 Total £'000
Pay	18,911	14,012
Purchase of goods and services		
Services from other ICBs and NHS England	3,948	5,239
Services from foundation trusts	180,122	124,713
Services from other NHS trusts	577,663	371,038
Purchase of healthcare from non-NHS bodies	206,629	116,570
General Dental services and personal dental services	28,727	
Prescribing costs	97,972	72,349
Pharmaceutical services	15,163	
General Ophthalmic services	6,642	655
GPMS/APMS and PCTMS	102,232	69,358
Supplies and services – clinical	2,012	1,349
Supplies and services – general	(2,463)	12,894
Consultancy services	511	296
Establishment	3,827	2,584
Transport	839	240
Premises	796	417
Audit fees	132	128
Other non statutory audit expenditure		
· Other services	24	18
Other professional fees	1,797	1,358
Legal fees	87	93
Education, training and conferences	547	712
Total Purchase of goods and services	**1,227,207**	**780,011**
Depreciation and impairment charges		
Depreciation	344	214
Total Depreciation and impairment charges	**344**	**214**
Provision expense		
Provisions	20	975
Total Provision expense	**20**	**975**
Other Operating Expenditure		
Chair and Non Executive Members	132	96
Grants to Other bodies	33	119
Expected credit loss on receivables	(44)	-
Other expenditure	9	-
Total Other Operating Expenditure	**130**	**215**
Total Expenditure	**1,246,612**	**795,427**

An analysis of the Statement of Financial Position, detailing assets and liability balances:

	31-Mar-24	31-Mar-23
	£'000	£'000
Total Non Current Assets	1,053	1,158
Current assets:		
Trade and other receivables	13,042	8,156
Cash and cash equivalents	518	286
Total current assets	**13,560**	**8,442**
Total assets	**14,613**	**9,600**
Current liabilities		
Trade and other payables	(85,720)	(61,001)
Lease liabilities	(1,073)	(913)
Provisions	(3,296)	(3,444)
Total current liabilities	**(90,089)**	**(65,358)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(75,476)**	**(55,758)**
Non Current Liabilities	-	-
Assets less Liabilities	**(75,476)**	**(55,758)**
Financed by Taxpayers' Equity		
General fund	(75,476)	(55,758)
Total taxpayers' equity:	**(75,476)**	**(55,758)**

Performance Analysis

Performance Dashboard

Key:
Better than Target
Within 10% of target
Greater than 10% off Target

Formatted against 23/24 planned trajectories

Key Performance Indicators 2023/24		National target	Local year-end target	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar
Cancer Waiting Times	28 Faster Diagnosis Standard	75%		58.8%	61.4%	62.9%	67.6%	68.5%	72.7%	73.9%	75.3%	75.0%	70.5%	77.8%	74.8%
	<31 days to treatment from a decision to treat	96%		77.5%	80.8%	86.0%	88.8%	84.3%	82.4%	83.9%	88.5%	85.6%	85.4%	89.3%	89.0%
	Suspected lower GI cancer referrals with FIT result[1]	80%		55.8%	56.0%	64.0%	78.2%	74.1%	73.9%	79.8%	80.6%	80.6%	82.2%	84.7%	87.2%
	Referral to treatment within 62 days	85%		44.0%	51.5%	47.1%	51.5%	56.2%	54.9%	56.7%	44.5%	49.4%	49.4%	54.1%	58.7%
RTT and Diagnostic Waits	All diagnostics within 6 weeks	85%	82%	66.1%	66.0%	68.3%	68.4%	70.1%	71.2%	73.4%	74.1%	72.3%	75.5%	80.3%	76.1%
	All diagnostics at 13 weeks+		0	2070	2188	1828	1560	1258	1229	1050	917	932	962	782	713
	Referral to Treatment waits <18 weeks	92%		58.8%	59.2%	59.0%	57.0%	57.2%	56.4%	56.8%	55.6%	52.3%	51.6%	50.6%	50.6%
	Referral to treatment waits 52 weeks+		2218	3721	3780	3416	3339	3163	3091	3099	3051	3078	3389	3743	3974
	Referral to treatment waits 65 weeks+		1769	982	1047	921	709	617	587	648	569	663	730	718	563
	Referral to treatment waits 78 weeks+		0	106	121	13	11	8	14	12	17	23	17	7	7
	Referral to treatment waits 104 weeks+		0	0	2	1	2	0	0	0	0	1	0	0	0
Primary Care	General practice appointments			207626	236126	244819	232678	234673	257662	283415	257652	214482	276183	263026	247769
	GP app'ts same or next day	54%		52.6%	52.7%	52.6%	52.9%	52.9%	47.6%	48.5%	52.2%	55.5%	54.9%	52.8%	52.9%
	GP app'ts within 2 weeks	88%		82.8%	83.8%	84.4%	84.7%	83.3%	78.6%	81.1%	83.6%	84.7%	85.0%	84.5%	83.3%
Community	2-hour Urgent Community Response[6]	70%		93.0%	100.0%	94.0%	92.0%	95.0%	94.0%	77.0%	75.4%	78.5%	73.5%	77.6%	86.4%
Learning Disability and Autism (LDA)	LDA patients aged 14+ having annual health check, cumulative YTD[4]	75%		2.5%	5.7%	10.3%	13.6%	17.7%	23.5%	31.9%	39.2%	43.7%	51.8%	62.8%	77.0%
	LDA patients aged 14+ having health check: monthly performance			2.5%	3.2%	4.6%	3.3%	4.1%	5.9%	8.3%	7.3%	4.5%	8.1%	11.0%	14.2%
	LDA patients aged 18+ inpatient in MH ward, per million	30		53	46	46	46	41	41	46	46	46	46	46	51
	LDA patients aged <18 inpatient in MH ward, per million	10		30	30	20	20	20	30	30	30	30	20	20	20
Mental Health (MH)	Inappropriate Out of Area bed days (to nearest 5, rolling 3 months)		180	355	370	365	370	370	370	370	365	370	370	365	due 14/06*
	Access to Talking Therapies, YTD[4]		12948	434	981	1500	2014	2474	2990	3550	4072	4460	5199	5716	6027
	Recovery after Talking Therapies	50%		45.0%	52.0%	41.0%	44.0%	48.0%	47.0%	45.0%	45.0%	48.7%	54.6%	53.3%	56.0%
	Talking Therapies waits <6 weeks	75%		34.8%	38.9%	32.1%	34.8%	40.5%	35.2%	36.8%	39.6%	38.2%	39.1%	40.9%	39.9%
	Dementia diagnosis rate	67%		58.2%	58.3%	58.8%	59.0%	59.5%	60.1%	60.6%	60.9%	60.8%	60.9%	61.1%	60.9%
	Access to perinatal MH services YTD[4] (to nearest 5)		540	780	785	800	825	830	855	880	875	885	885	895	890
	SMI[5] patients having 2+ contacts with MH services		4984	4160	4135	4165	4225	4235	4270	4325	4215	4290	4280	4200	4250
	SMI[5] patients having core health checks (rolling year)		2879	2014	1956	1922	1902	1861	1852	1929	1867	1878	1943	2094	2471
	MH patients aged <18 having 1+ contact (to nearest five, rolling year)		8341	5295	5280	5365	5425	5480	5595	5685	5630	5675	5700	5875	5840
	Timely access to treatment for eating disorders (urgent or routine)	95%		81.0%	87.0%	84.0%	60.0%	62.0%	74.0%	75.0%	79.0%	86.0%	89.0%	96.0%	88.9%
UEC[2]	SaTH ED attenders admitted/discharged/treated <4 hours	76%		54.3%	55.3%	53.6%	51.9%	51.6%	50.8%	51.5%	50.1%	51.4%	50.4%	49.9%	50.9%
	SaTH ED attenders admitted >12 hours from Decision to Admit		700	524	529	525	859	803	1026	1088	862	1068	957	860	844
	SaTH ED attenders have initial assessment within 15 minutes	50%		34.1%	34.2%	32.1%	32.4%	30.7%	28.9%	30.5%	37.2%	50.8%	50.9%	47.0%	45.5%
	4-hour performance, all providers, departments type 1 and 3 (SaTH)	76%		62.8%	64.8%	63.8%	62.0%	61.5%	60.9%	61.2%	59.7%	59.5%	59.5%	59.5%	60.1%
	Emergency Ambulance category 2 mean response minutes (WMAS all)	30		27.12	33.00	36.48	28.42	25.45	35.36	46.53	39.31	46.22	43.32	36.07	33.02
	Emergency Ambulance category 2 mean response in minutes (STW)	30		34.11	37.36	39.28	35.00	35.56	48.46	61.50	62.50	62.12	50.47	50.21	53.30

Notes: 1 - FIT=faecal immunochemical test; 2 - UEC=urgent and emergency care; 3 - CPCS=community pharmacy consultation service; 4 - YTD=year to date; 5 - SMI=serious mental illness; 6 - reporting changed mid-year; see narrative.

* Due to normal delay process in data availability , the figures for Out of Area beds days incur a 1 month delay. Therefore year end publication is due on 14th June 2024

As the NHS as a whole is still in recovery following the pandemic, many of the performance measures are RAG rated against the recovery trajectories for 23/24 including some local targets that are part of the overall recovery towards national targets. Sustainable improvements were made in planned care, cancer (including continued reduction in long waits), primary care and most mental health and learning disability and autism targets.

Further improvements are planned in 24/25 to continue our recovery of national targets in NHS STW. The system continues to be challenged regarding its urgent and emergency care (UEC) performance and is now in Tier 1 accessing national support to improve our system wide UEC performance during 24/25.

Please note as Note 6 above, there was a change to the methodology of the coding and counting of referrals to the 2hr Urgent Community Response (UCR) service from October 2023, which resulted in a drop in performance from>90% to >70%.

Mental Health

Financial Years	2023/24	2022/23
Mental Health Spend	£113,922	£101,253
ICB Programme Allocation	£993,361	£920,834
Mental Health Spend as a proportion of ICB Programme Allocation	11.47%	11%

Safeguarding

Children and Young People (CYP) safeguarding

The Safeguarding Children Team has continued to work in equal partnership with the Shropshire Safeguarding Community Partnership and the Telford and Wrekin Safeguarding Children Partnership (the Partnerships) through attendance at Board meetings and involvement in the continuing work streams of the two Partnerships.

The recognition of child neglect and appropriate early intervention has been a priority for both partnerships and a focus in Telford around the Independent Inquiry into Child Sexual Exploitation. There is a greater awareness of “think family” due to safeguarding concerns being identified with child and adults within the family unit.

The Safeguarding Children Team have contributed towards the child mortality working group covering Shropshire, Telford & Wrekin to establish the current position and identify high risk groups which may require more focused interventions.

National Review, panel reports and Independent Inquiry Recommendations

During 2023-2024, the Safeguarding Children Team have participated and contributed to Child Safeguarding Practice Reviews (CSPR) and Rapid Reviews where good practice and learning has been identified across the health economy. The Designated Nurses are panel members of the CSPR Panels for both Partnerships; actively contributing towards ensuring learning is embedded within practice.

The Independent Inquiry into Child Sexual Abuse in Telford recommendations have been progressed since its publication in July 2022. Recommendations for health included; Child Sexual Exploitation (CSE) training and awareness for all staff delivered in a variety of formats, trauma informed mental health services for CSE survivors and working with General Practitioners to identify children and adults who are at risk of or are survivors of CSE to ensure the appropriate flags and individualised care is provided. Furthermore, the ICB has worked closely with Telford & Wrekin Local Authority to fulfil the multiagency recommendations. There has been strong co-production with lived experience consultees

which will be continued moving forward to support coproduction of services for survivors. There will continue to be monitoring of the completion of recommendations through the ICB quality group and audits including the annual GP self-assessment audit.

The ICB contributed towards the consultation of the Working Together to Safeguard Children Document which was published in December 2023. Changes to the document are being discussed with the partnership and executive leads within the ICB to ensure clear structure and implementation.

Adult Safeguarding

Statutory Adult Safeguarding responsibilities have continued to be driven by our contractual assurance processes with our health provider services and through the partnership approach through the delivery of the statutory obligations in Section 44 of the Care Act. This partnership work has centred upon the relationship with both the Shropshire Safeguarding Community Partnership and the Telford and Wrekin Safeguarding Partnership.

There has been a considerable emphasis upon addressing the impact upon people caused by self-neglect including hoarding. There has been a new approach looking at professional curiosity and a multi-agency approach to addressing self-neglect with a focus upon partnership with the individuals effected and amongst organisation. This has also seen an increase in the accessible resources being made available

https://www.shropshiresafeguardingcommunitypartnership.co.uk/partnership-priority-areas/adult-safeguarding-and-protection-practice/self-neglect/#:~:text

The Safeguarding Accountability and Assurance Framework the Safeguarding Accountability and Assurance Framework (2022) has inspired a refresh of the adult safeguarding dashboards used with NHS Providers. These help us to identify key performance areas used to inform areas for attention. NHS Trusts have as a result undertake some focused work on MCA quality audits which have shown important improvements. We are also now collecting data on safeguarding supervision advice and support being sought and this helps address knowledge gaps and training.

In addition to the statutory duties as part of the safeguarding partnership the ICB also has a role to play in the Community Safety Partnership. Part of the key work this year has involved:

- Enhancing the Serious Violence Duty partnership work – which has provided detailed data allowing the key provider areas to be established.
- Commitment to the Domestic Abuse Local Partnership and the domestic abuse strategy The Domestic Abuse Strategy which has looked at training and the take up of the domestic ambassador role
- Training to support GPs and a domestic abuse resource pack.

Guidance Training and Policy

The ICB has been involved in partnership training through the section 42 adult safeguarding enquiry training it delivers with colleagues on behalf of the Partnership and specific training events for GPs which has included Safeguarding Adult Awareness, Domestic Homicide Reviews and the Mental Capacity Act. The ICB also has a set of policies looking at safeguarding and the MCA https://www.shropshiretelfordandwrekin.nhs.uk/news/type/safeguarding/

ICB Statutory Responsibilities

The ICB is an equal statutory partner within the partnerships alongside the Police and Local Authority, in line with the Working Together to Safeguard Children (2023). Since publication of the document, strategic meetings have been held to discuss implications and required changes to the partnership and decisions made around key roles and responsibilities. Local safeguarding arrangements include the Designated Nurses for Safeguarding Children, Chief Nursing Officer and Chief Executive Officer. The Designated Nurses play an active role within the Partnership meetings, subgroups and workstreams; chairing the CSPR panel in Shropshire and vice-chairing the CSPR Panel in Telford. The Local Safeguarding Arrangements are published at:

Telford & Wrekin Safeguarding Partnership	Partnership Arrangements Document - Telford and Wrekin Safeguarding Partnership (telfordsafeguardingpartnership.org.uk)
Shropshire Community Safeguarding Partnership	What is the Shropshire Safeguarding Community Partnership? — Shropshire Safeguarding Community Partnership

The safeguarding team contribute towards the Partnership's annual reports and Strategic Plans which can be located on the partnership websites:

Telford & Wrekin Safeguarding Partnership	Policies, procedures and key documents - Telford and Wrekin Safeguarding Partnership (telfordsafeguardingpartnership.org.uk)
Shropshire Community Safeguarding Partnership	Annual report archive — Shropshire Safeguarding Community Partnership

The ICB ensure practice follows the Safeguarding Accountability and Assurance Framework (2022) and Working Together to Safeguard Children Document (2023). Within this reporting period, the ICB have recruited 2 Designated Nurses for Safeguarding Children, meeting statutory responsibilities outlined in the documents cited.

Safeguarding Annual Report

NHS Shropshire, Telford and Wrekin publish a report(s) which details our safeguarding practice reviews, and how effective our arrangements have been in practice.

These are available on our website at the weblink below:

https://www.shropshiretelfordandwrekin.nhs.uk/about-us/how-we-are-run/safeguarding/

Clinical Matters

As an organisation, we hold a joint responsibility with our partner NHS trusts for the development and delivery of clinical services for the residents of Shropshire, Telford and Wrekin. We are also required to develop long-clinical strategies, and ensure that the decisions we make today ensure that local health and care services are fit to service the population and challenges of tomorrow. This year has seen a number of significant challenges, as referenced by Simon in his introduction, but also some success stories.

- Throughout the year, we, along with all ICBs, have needed to work closely and responsively with our partners to address the challenges brought on my industrial action, most recently in December 2023 and January 2024. Whilst this work ensured that our urgent and emergency care services were able to continue normal operations without a noticeable impact, we did see an increase in waiting lists for planned care, which is a key priority for us to address.

- In July 2022, the Telford Child Sexual Exploitation (IITCSE) report was published with 47 recommendations, five of which were assigned to the CCG. Although this commenced several years ago, addressing the recommendations is an ongoing process, and we have now recommended three for completion.
- Following the ICB Board in September, the system has developed a renewed approach to child mortality, involving a set of workshops with key colleagues from across the ICS to focus on learning from local, regional and national themes. The first workshop took place on 11th December 2023 and provided an overview of child mortality in Shropshire Telford and Wrekin followed by focussed group work to gain a baseline understanding of current activity.

- Our Research and Innovation collaborative has won the “Shining Research Star" award at the National Institute of Health Research Clinical Research Network awards 2023. This rounded off a hugely successful year in which saw successful bids for funding 4 research projects totalling £558,000 across a number of areas.

- During October – December 2023 Patient Safety Incident Response Framework (PSIRF) was approved for implementation by each local NHS trust board, and is now in place as the approach to learning from incidents and insight. PSIRF replaces the previous Serious Incident Framework and is widely regarded as the biggest change in safety culture in the NHS fostering psychological safety and allowing for a more comprehensive, understanding of safety incidents and a greater focus on learning and improvement. The System Quality Group (SQG) reporting the Quality and Performance Committee, has overseen system arrangements and policy. The SQG will now implement oversight arrangements on PSIRF priorities as well as system priorities

Delivering our Plan and Priorities – Our Joint Forward Plan

Our Joint Forward Plan (JFP) describes how we and our partner trusts intend to arrange and provide NHS services to meet the needs of everyone in Shropshire, Telford and Wrekin over the next five years.

It has been developed through a collaborative approach with all system partners and wider stakeholders, including our Health and Wellbeing Boards. We will be held to account for its delivery by our population, service users, their carers or representatives, and through the Integrated Care Partnership (ICP), Healthwatch and the local authorities' Joint Health Overview and Scrutiny Committees.

This plan was also developed in collaboration with the communities that we serve, through our Big Health and Wellbeing Conversation. Involving and engaging local people and groups is a core part of our purpose and informs our decision making across the organisation.

Importantly, our Joint Forward Plan remains flexible; our commitment to community engagement is ongoing and will continue to support the growth and delivery of our plan which will be updated on an annual basis. We understand that this is an ambitious plan, but we believe that it is achievable, and it is an important part of improving health and care services for our population.

The three key elements of our plan are:

- **Taking a person-centred approach (including proactive prevention, self-help and population health to tackle health inequalities and wider inequalities).**

  We are committed to working with service users, carers and partners to support our citizens to live healthy, happy and fulfilled lives. This will mean supporting people to proactively look after their own health, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it.

- **Improving place-based delivery, having integrated multi-professional teams providing a joined approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.**

  The Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined up and proactive care closer to home, supporting improved health and wellbeing for our population. This is encompassed by the Local Care vision of "adding years to life and life to years".

- **Providing additional and specialist hospital services through our Hospital Transformation Programme (HTP).**

The HTP is putting in place the core components of the acute service reconfiguration agreed as part of the Future Fit consultation. It is helping us to address our most pressing clinical challenges and establish solid and sustainable foundations upon which to make further improvements. The clinical consensus on this is clear and well-articulated. We need to make rapid progress on this to support the clinical sustainability of our services.

Enablers

NHS STW will focus on eight key enablers to the successful delivery of the JFP. These include Workforce Estates, Digital, Intelligence, Procurement, Communications and engagement, Research and innovation, Sustainability

In line with the Joint Forward Plan, we have structured this report to reflect the three key elements, and the enabling workstreams.

Delivering Person-centred care

Person-centred care moves away from professionals deciding what is best for a patient or service users, and places the person at the centre, as an expert of their own experience and lives. The person, and their family where appropriate, becomes an equal partner in the planning of their care and support, ensuring it meets their needs, goals, and outcomes.

With an emphasis on “doing with” rather than “doing to”, person-centred care runs through both individual and group settings, allowing users of services to be active not only in their own care but also in the design and delivery of services. This approach can improve both the experience and quality of care.

As an organisation, we believe that person-centred care relies on several aspects, including:

- putting people and their values at the centre of their care, considering people’s preferences and chosen needs.
- ensuring people are physically comfortable and safe.
- enabling emotional support involving family and friends.
- making sure people have access to appropriate care that they need, when and where they need it.
- ensuring people get all the information they need, in a way that is accessible for them, to make decisions for their care and support.

Person-centred care also recognises the strong and evidenced link between non-clinical, community support, and improvement in health and wellbeing. We will facilitate a strengths-based approach in our communities to utilise non-clinical resources, recognising that the wider determinants of health affect 90% of our health and wellbeing, with health and care services impacting only 10%.

Involving our Communities

As an organisation, we are committed to involving people and communities in what we do. This commitment stretches across the whole of the commissioning lifespan, with an ambition to embed and involve the patient voice at each stage to ensure that the decisions and changes we make are informed and led by the experiences of our residents.

To help improve services we need to effectively communicate and involve stakeholders, politicians and the public. ‘Communication’ can be defined as what to say (the message), who to say it to (the audience), and how to say it (which channels to communicate through, for example social media, web pages or local press).

Involvement and engagement is about actively gathering and listening to people’s input, and is an ongoing process which gives people the opportunity to contribute and voice their views. We recognise that the population we serve is diverse and faces challenges unique to our geographic location, and so we work hard to ensure that our engagement and involvement activity results in a representative perspective. We have strong links with organisations across the VCSE, and within much of our activity we ask a core set of demographic questions to understand who is

responding and if they meet the general demographics of the geographical or service area. The questions asked relate directly to the nine protected characteristics.

Public Sector Equality Duties

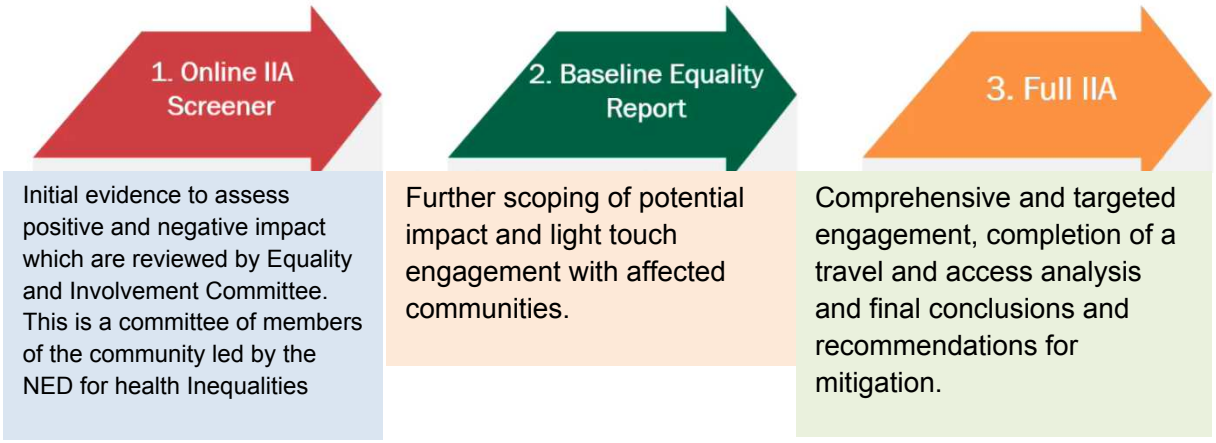
As a public sector organisation, NHS Shropshire, Telford and Wrekin (NHS STW) must comply with specific equality duties that require it to evidence how it pays due regard to the needs of diverse and vulnerable groups in the exercising of its responsibilities.

For the purposes of this annual report, this includes compliance with the Equality Act 2010, Human Rights Act 1998 and relevant sections of the Health and Care Act 2022.

We are committed to ensuring that we demonstrate due regard to the general duty when making decisions about policies and services. To meet legal duties and fully consider the impact that changes the system makes to services and policies has on the local population, over the course of the last two years we have collaboratively developed one system-wide Integrated Impact Assessment (IIA) which aims to provides consistency in our system approach to considering impact and involving the public.

The IIA widens the traditional Equality Impact Assessment (EQIA), addressing the 9 protected characteristics under the Public Sector Equality Duty (PSED) to include duties with regard to factors such as social exclusion, socially deprived communities, quality (including clinical effectiveness, patient safety and user experience), travel and access to services and climate change.

The assessment is comprised of three stages (as seen below).



All completed assessments are considered by our Equality and Involvement Committee (established in 2022/23). The committee is chaired by one of our Non-Executive Directors and establishes a role in ensuring we are meeting our duties to consider and address inequalities in our service design decision-making.

The Equality and Involvement Committee (EIC) includes members of the public, the VCSE and representation from public health. It acts as a 'critical friend' to review and advise on Integrated

Impact Assessments (IIA) for proposed service changes and plans to involve people and communities, with a particular focus on ensuring the ICB is addressing and reducing inequalities.

It is a formal committee of the ICB providing assurance to the Board that proposed policy or service changes have adequately and appropriately:

- considered and addressed the health and care needs and aspirations of residents in Shropshire, Telford and Wrekin who do, or may, experience inequalities in access to health services and health outcomes
- involved people who do, or may, use the services under consideration.

Examples of the work considered by the EIC include:

- The Shrewsbury Health and Wellbeing Hub
- The Musculoskeletal Transformation Programme
- The Local Care Transformation Programme
- The Hospitals Transformation Programme.

You can find more information about the EIC on our website.

The IIA tool is now live but continues under review to determine whether any further changes are required. Once fully integrated, all completed IIA screener tool submissions will be posted to our public website for complete transparency.

https://www.shropshiretelfordandwrekin.ics.nhs.uk/home/ourequalityobjectives/

Engagement assurance

The ICB has a number of committees where patient involvement is key:

Audit Committee – lay member chair
Remuneration Committee – two lay members attend, and one is chair
Primary Care Commissioning Committee – lay member chair
Quality and Performance Committee – lay member chair
Finance Committee – lay member chair
Joint Individual Funding Committee – lay member chair
Joint Individual Funding Appeal Panel – lay member
Strategic Commissioning Committee – lay member chair
Equality and Involvement Committee – lay member chair and public member co-chair

Engagement activities from 2023/2024

The Big Health and Wellbeing Conversation

To inform the development of the Joint Forward Plan, last year, the ICB launched the Big Health and Wellbeing Conversation. The engagement included a public survey, a number of listening events around the county, and targeted community engagement, inviting members of the public and staff to share their views and experiences of health and care services.

- Public events: Over 3000 leaflets and 500 posters were distributed in the areas of Bishops Castle, Ludlow, Market Drayton, Shrewsbury and Telford where the public events took place, attracting over 240 people.
- Targeted engagement: The targeted engagement took place with over 30 groups at risk of experiencing the greatest health inequalities. An example of the groups reached include older people, carers, people of different ethnicities, children and young people, veterans, street homeless, people experiencing domestic abuse, people with long term conditions and disabilities, people with drug and alcohol addition, and ex-offenders.
- Online survey: The online survey was promoted through the media, paid and organic social media as well as through partners in the Integrated Care System and VCSE, and received over 2600 responses.

The findings were analysed and collated into an engagement report and fed into our Joint Forward Plan. To maximise the impact of the insight people shared, individual insight packs were developed for providers highlighting people's views and experiences related to their organisations.

Musculoskeletal Chronic Pain Services

As part of the Musculoskeletal Transformation Programme, the ICB engaged with people attending clinics and support groups to understand their experiences and awareness of chronic pain (experience pain for 12 weeks or more) service.

This was part of a bigger programme of work where local NHS organisations are working together to transform services that support people with conditions that affect their joints, bones and muscles.

Through these conversations, the ICB aimed to understand:

- People's experiences of chronic pain services
- Their level of awareness and experience of the different services and support available
- Identify areas that worked well and areas that could` be improved.

The engagement team visited 17 locations, including clinics and groups, through February and March 2024 and spoke with close to 100 people. These conversations are now being analysed and themed to shape the future of the chronic pain service in Shropshire, Telford and Wrekin.

Advance Care Planning

As part of the Advance Care Planning (ACP) project, the ICB has established a co-design group to find ways to help the local system address the current need and to support and enable families, carers and communities to have conversations about death and dying, so that positive advance care planning can take place.

The group members include a wide range of people, including those with lived experience, VCSE and volunteers, chaplains, healthcare providers (including domiciliary care providers), nursing home providers, and the local authorities.

The group have met monthly since October 2023, working together to plan and deliver community engagement and two ‘Dementia and ACP’ workshops in December 2023 and February 2024.

Through the Dementia workshops, the engagement team spoke with 33 people online and 24 in person. Discussions identified personal and systemic barriers to completing ACPs, a need for clear and concise information and increased levels of support to enable someone to complete an ACP.

The community engagement included 9 carers groups, 1 Age UK group, 2 patient participation groups (PPGs), 2 long-term condition groups, and 2 specific interest groups.

The engagement has identified a gap in knowledge of ACP and the skills to enable these conversations within communities. In response, the co-design group, along with ACP leads, is planning the development and delivery of a workshop in the Spring of 2024 for community leaders. The aim is to empower community leaders to begin ACP conversations with people with whom they are in regular contact.

The next steps for the co-design group are to increase the diversity of the community group involvement, interconnect current work and continue to create a community movement and system change towards having conversations about death and dying, and advance care planning.

Working with our Partner Organisations

Working with partners across the system, including both Healthwatch and the VCSE, is also critical in enabling the ICB to engage with and understand the experiences of people within communities who are experiencing the greatest health inequalities. The ICB is continuing to develop contacts and relationships with different groups and organisations that represent the diversity of the population.

Tackling Health Inequalities

Tackling Inequalities in Access, Experience and Outcomes

Tackling inequalities in access, experience and outcomes of healthcare services is one of four key purposes of Integrated Care Systems (ICSs). It should be central to everything we do.

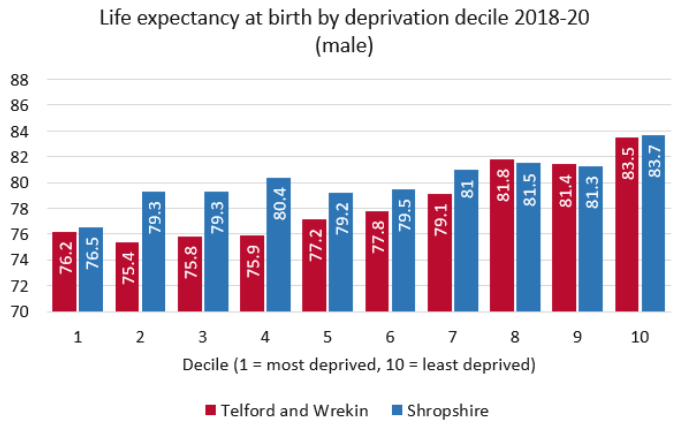
Health inequalities are **unfair and avoidable** differences in health across the population, and between different groups within society.

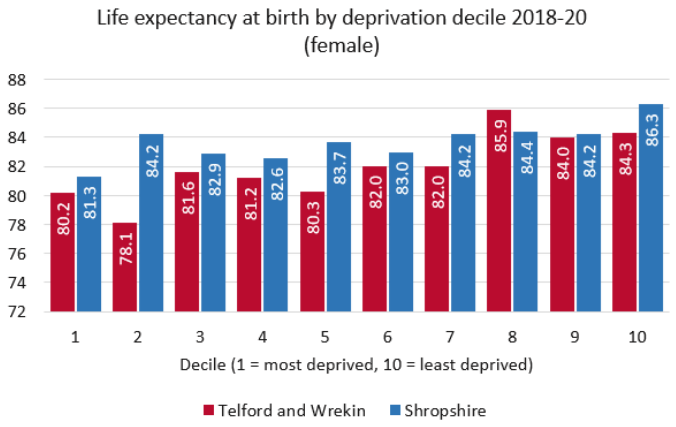
These include how long people are likely to live, the health conditions they may experience and people's experience of and access to care.

Research shows that **people living in areas of high deprivation**, those from **Black, Asian and minority ethnic communities** and those from **inclusion health groups**, for example the homeless, are most at risk of experiencing health inequalities.

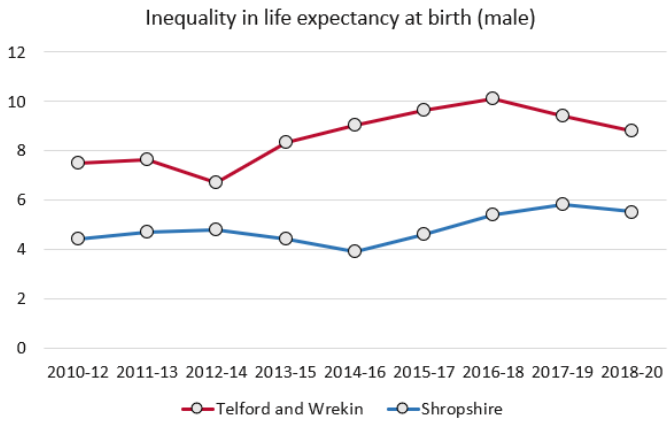
In Shropshire, Telford & Wrekin, life expectancy is lowest in areas considered to be in the 20% most deprived areas across England[1] (decile 1 & 2 in the graphs below). There is a gradient in life expectancy by deprivation in both Telford & Wrekin and Shropshire, meaning the more deprived the area, the lower the life expectancy.

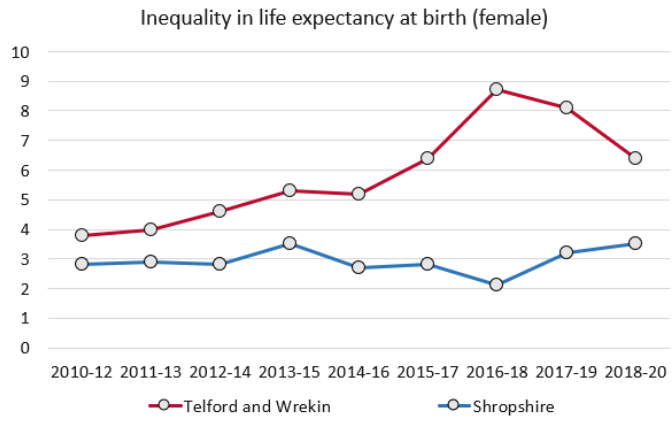
Inequality in life expectancy (the difference in years of life expectancy between most deprived and least deprived areas) is larger in Telford & Wrekin compared to Shropshire. This inequality has been increasing over the last decade, however, in 2016-18, inequality in life expectancy in Telford & Wrekin started to decrease.



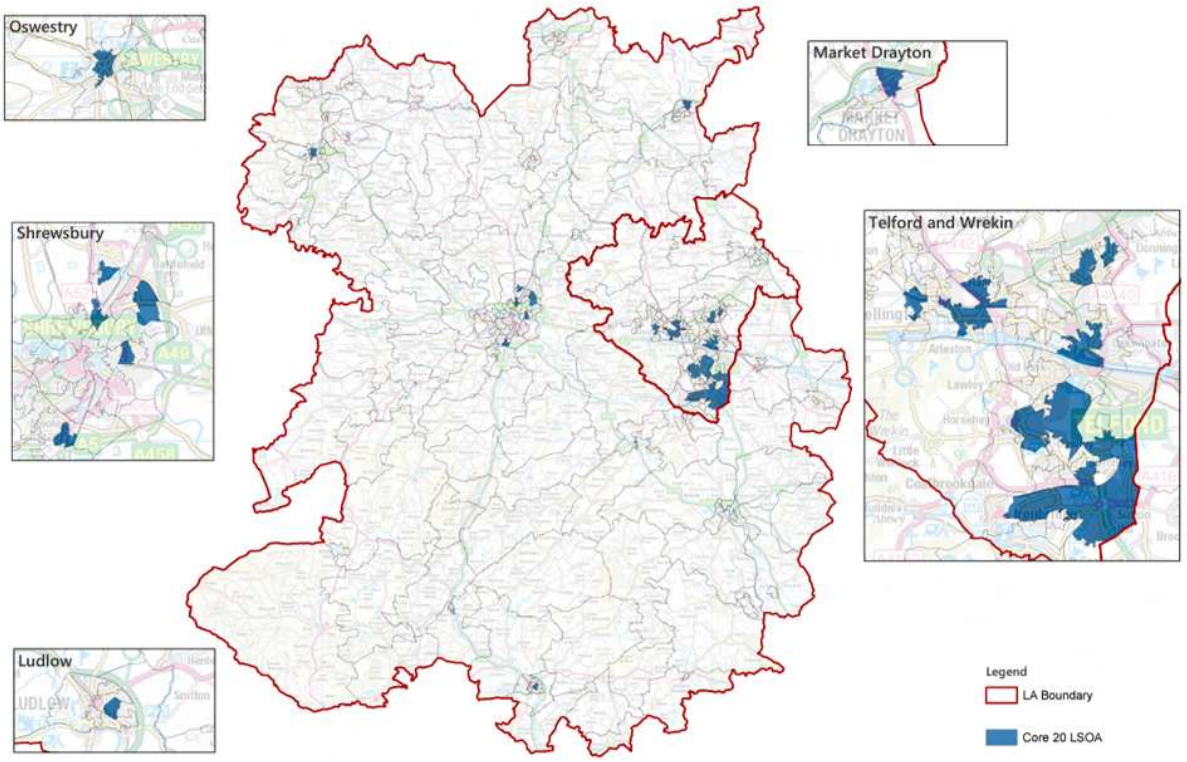


[1] The 20% most deprived areas are based on the National Index of Multiple Deprivation (IMD). https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019





According to the 2021 Census, 60,100 people in Shropshire, Telford & Wrekin live in geographical areas considered to be in the 20% most deprived areas across England. 45,400 of those people currently reside in in Telford & Wrekin and 14,700 live in Shropshire.



These areas are those to which the National 'Core20' approach to drive improvements in health and healthcare inequalities is targeted. The Core20PLUS5 Approach identifies priority populations who are most likely to experience inequality in access and experience of healthcare service, and in the health outcomes.

Health Inequalities Metrics – End of Year 2023/2024

The following data provides a summary overview of the latest NHS England Statement of Information metric data, focusing on the latest figures for Shropshire, Telford & Wrekin, benchmarked against the England national average and where possible, a comparison at Place (Shropshire and Telford & Wrekin individually).

The data utilised for this review is based on national data sources aligned to the statement metrics, however, it is noted that the available data is commonly older and does not contain the granularity required.

Key Headlines

- Both the ICB and the Telford and Wrekin authority have statistically higher stroke and heart attack admission rations than the England average.
- The ICB is below target for all three CVDPREVENT metrics, however do report improvement.
- Persons with Type 2/other diabetes are more likely to have received all 8 care processes than those with Type 1.
- Adult elective activity and day case attendances for persons aged under 18 have yet to return to their pre-pandemic levels.
- The ICB did not achieve “eliminating” waits of 65 weeks or more, however significant reduction in long waits is reported.
- The ICB is performing below the national average for learning disability health checks for persons aged 14-17 and 18+.
- The ICB has a higher adult mental health inpatient admission rate than the national average.
- The ICB is performing below the national average for delivering “all 6” physical health checks to persons with severe mental illness (SMI).
- The Telford and Wrekin authority has a higher preterm births (under 37 weeks) rate than the England average.
- Both local authorities have a higher rate of admissions for tooth extractions in children aged 10 or under, than the England average.
- COVID and Influence uptake rates are lowest among the most deprived neighbourhoods of the ICB and persons from non-white ethnicity found to have lower uptake levels than the white ethnic population.

Click here for the full “Summary analysis in line with the NHS England Statement of Information”, which contains a full picture of the data to support the above statements.

Our Progress In-year

There are five priority objectives which underpin the National Healthcare Inequalities Improvement Programme and remain central in the 2023/24 Operational Planning Guidance to ensure focused action continues to take place:

1. **Restore Services Inclusively**
   Using local data to plan the inclusive restoration of healthcare services, ensuring that waiting list performance reports are delineated by ethnicity and deprivation.
2. **Mitigating Against Digital Exclusion**
   Enabling robust data collection to identify which populations are accessing face-to-face, telephone and virtual consultations (broken down by relevant protected characteristic) and ensuring the impact of digital innovation is assessed, considered and mitigated.
3. **Ensuring Datasets are Complete and Timely**
   To improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.
4. **Accelerating Preventative Programmes**
   Driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.
5. **Strengthen Leadership and Accountability**
   Ensuring named executive leads are appointed for tackling health inequalities, improving awareness and knowledge of the workforce and supporting access to relevant training and development.

We undertook an evaluation of progress against these objectives in 2022/23. The evaluation identified that we needed to strengthen our coordinated leadership across Prevention and Health Inequalities with a view to improving governance and accelerating progress in 2023/24. This led to the following actions:

- ✓ The development of a high-level implementation plan. The plan identifies 20 local priority objectives and 37 programmes of work or projects.
- ✓ Coordinated applications for external funding from NHS England to support targeted inequalities-based initiatives within the plan. STW ICS has been successful in all applications to date and awarded funds have supported the establishment of our successful Core20PLUS Connectors, Hypertension Community Case-finding and reducing health inequalities in Cardiovascular Disease.
- ✓ A newly established Prevention and Health Inequalities Board chaired by the Director of Health and Wellbeing, Telford & Wrekin Council, with membership from Healthcare Inequality Senior Responsible Officers from health sector organisations.
- ✓ The development of a robust reporting and monitoring framework to provide oversight of progress made against actions and deliverables outlined in the high-level implementation plan, relevant risks and mitigations but also key highlights of best practice and successes taking place across the system to celebrate achievements.
- ✓ Improved collaboration and joint-working between NHS and Public health analytical departments to strengthen and develop local intelligence.
- ✓ Improved collaboration and joint-working between NHS and Public health analytical departments to strengthen and develop local intelligence.

As a system we have collectively reviewed the achievement against all 37 programmes of work as at Quarter 3 (December 2023).

At this time:

- 25 programmes of work reported as on track to deliver planned actions.
- 12 programmes reported delays or risks of delay.

	Objective	Work Programme / Project	RAG
1	Restore NHS Services Inclusively	Elective restoration programme	
2	Mitigate Against Digital Exclusion	2023/24 Digital Strategy	
3	Datasets are complete and Timely	System-wide data-sharing	
		Provision of baseline data and intelligence to support objectives (using a PHM approach)	
		Improved ethnicity recording	
4	Accelerating Preventative Programmes (objectives 6 – 20)		
5	Leadership and Accountability	Established senior roles across all organisations	
		Improved governance (system-level and Provider)	
		Improved HI awareness and training	
		Standardised approach to assessing impact	
		Equality, Diversity and Inclusion (EDI)	
6	Prevention: Alcohol Care Teams	Implementation of Alcohol Care Teams	
7	Prevention: Tobacco Dependency	Implementation of Tobacco Dependency Teams	
8	Prevention: Obesity/Weight Management	NHS Digital Weight Management Programme	
9	PLUS Group: Learning Disabilities	LD Physical Health Checks	
		LeDeR Action Plan	
10	PLUS Group: People Living in Rural Areas	Exploration of the impact of rurality	
11	Core20PLUS5 ADULT 1: Maternity	LMNS Equity and Equality Action Plan	
12	Core20PLUS5 ADULT 2: Severe Mental Illness	SMI Health Checks	
13	Core20PLUS5 ADULT 3: Chronic Respiratory Disease	Spirometry Services	
		Delivery of Flu and Covid-19 Vaccinations	
14	Core20PLUS5 ADULT 4: Early Cancer Diagnosis	STW Cancer Strategy Early Cancer Diagnosis Objectives	
		Early Cancer Diagnosis Improvement Plan	
		PCN Cancer DES	
		Core20PLUS Connectors (Cancer Champions)	
15	Core20PLUS5 ADULT 5: Hypertension and Lipids	Targeted secondary prevention Lipid Management	
		InHIP Hypertension Community Case-finding	
		Hypertension Treatment to Target	
16	Core20PLUS5 CYP 1: Asthma	CYP transformation for Asthma	
17	Core20PLUS5 CYP 2: Diabetes	Diabetes Transformation for CYP	
18	Core20PLUS5 CYP 3: Epilepsy	CYP Transformation for epilepsy	
19	Core20PLUS5 CYP 4: Oral Health	Oral Health workforce training	
		Provision of toothbrushes and toothpaste	
		Supervised toothbrushing for early years	
		Data analysis and audits of current waiting lists	
20	Core20PLUS5 CYP 5: Mental Health	Data analysis and audits of CYP MH access	
		National Mental Health Support Teams in Schools	
		Education and awareness of childhood trauma	

In-year Achievements

- Recruited 2.6 WTE fixed term project support roles
- New joint Population Health Analyst roles
- Identified Senior Responsible Officers for Healthcare Inequalities across NHS organisations
- Joint work with Diabetes UK to improve awareness of Diabetes Prevention in target communities.
- Established Prevention and Health Inequalities Board
- New monthly Health Inequalities Newsletter to staff to raise awareness, share information and celebrate local successes
- STW Talking Therapy Service highlighted as an area of good practice for adapting clinical systems to be more inclusive to LGBTQIA+ communities.
- 16 training sessions delivered to healthcare staff to increase knowledge and awareness of oral health in children and young people.
- 200 early years staff and 20 staff from housing associations have undertaken face to face asthma training.
- Ratified process for completing Integrated Impact Assessments to consider and mitigate impact on populations
- Equity profiling exercise undertaken to drive targeted work within Cancer Programmes.
- Use of more diverse imaging in local training
- New Health Inequalities Hub on the staff intranet
- Recruited Equality Diversity and Inclusion Champions across NHS organisations, including maternity settings.
- Local campaign materials developed to explain and promote the recording of Ethnicity
- Work with Sight Loss Shropshire and local communities to improve service pathways and communications in Elective Services
- Bottle-swap communication campaigns delivered in alignment with the development of local Family Hubs in our most deprived areas.
- Development of films and training for staff focused on supporting those with limited vision or sight loss
- Established Tobacco Dependency Services in Acute, Mental Health Inpatient and Maternity Services
- Integrated pathways between secondary care and community-based smoking cessation and lifestyle services
- Roll-out of the Civility, Respect, Inclusion and Kindness (CRIK) training for maternity services
- Introduction of Baby First Aid classes in Telford & Wrekin
- Successful pilot scheme offering free tennis lessons for people with Severe Mental Illness
- Local Asthma App developed to support young people with managing their asthma
- New data dashboards for Cancer, Mental Health and Urgent Care which identify healthcare inequality
- Public asthma campaigns specifically focused for homeschooled children, travelling communities, children's homes and young carers.
- Introduction of new technologies to support physical health checks
- Offering Flu and Covid-19 Vaccinations in community-based locations to improve access

- Over 30 local settings and 3200 children participating in the Brilliant Brushers Programme (supervised toothbrushing in early years settings)
- Train the Trainer Programme for trauma informed approaches to childhood trauma rolled-out to local community groups supporting young people at risk.
- Improved pathways for bowel cancer home-testing kits to remove barriers where people do not have a fixed home address
- Co-developed multi-lingual videos focused on improving cancer screening uptake
- Mental Health Support Teams established in local schools located in the most deprived areas.
- Targeted campaigns to improve late-stage diagnosis of Prostate Cancer in Black Men aged 40+
- Baby Friendly Initiative (BFI) Midwife recruited to drive progress towards Stage 1 Baby Friendly Initiative Accreditation.
- Recruitment of over 200 Cancer Champions from Ukrainian, Bulgarian, Hong Kong, Chinese, Iranian, Jordanian, Polish and Sikh communities.
- Joint work with Prostate Cancer UK to offer coaching to local Cancer Champions.
- 14 new Core20PLUS Ambassadors and 1 Health Inequalities Finance Fellow from across the health system.
- Over 600 blood pressure checks taken in the most deprived and rural communities.
- Successful application for £185,000 of national funding to enhance local work focused on reducing inequalities in cardiovascular disease.
- 70% of all schools in STW accredited as asthma friendly.

Our Progress against Prevention goals in the long-term plan

Priority	Success/Challenges/issues/concerns
Long-term Plan priorities 1. Number of maternity, inpatient and mental health sites delivering stop smoking services in line with the LTP plan 2. Count of referrals to Alcohol Care Teams (where funded this service is NHSE funded) 3. Referrals to digital weight management programme in the last 3 months	4. 3/3 TDT sites are live and fully established. Work is taking place with Community Pharmacy Leads to improve the geographical spread/availability of CPs and further liaise with Local Authorities about community-based provision on announcement of new grant funding. Challenges are that LAs do not currently provide NRT so community-based provision is limited and financial pressures. Our Acute Trust is piloting the use of Cytisine as part of the regional funding offer. 5. After significant delays in implementation, the ACT is now live, submitting data as of February 24 and 79 referrals have been made since January 24. Our multi-agency steering group takes place regularly with stakeholders from Acute, Local Authority, ICB and Community, there are 3WTE staff within the ACT as of Sep 23 with recruitment underway for a Clinical Lead, Nurse and Admin. The team have daily presence in our Emergency Department and anticipate full 7 day by end of March 24. Significant progress made / positive steps forward. 6. 241 eligible referrals were made in Quarter 3 2023/24. 1,492 referrals made to the DWMP since April 2023 by 47/52 GP Practices. 1,324 of these were eligible showing an 88.7% eligibility rate (exceeding the target of 85%) and achieving 70% of our 1,900 eligible referrals target. Final campaigns to GP Practices in Month 12 to encourage referrals. Successful approaches have been to consolidate all weight management and diabetes offers to provide a whole picture of local weight management offers.
Diabetes priorities 1. Referrals to NHS DPP, profile and actual 2. Number of patients referred to the T2DR programme	3. In the last 12 months the referral profile has been 2,024, with actual referrals of 1,725. 85% of people are reaching milestone 1. Challenges locally relate to capacity at both ICB and Primary Care. 4. The Type 2 to remission is due to launch in April 2024.
Cardiac priorities 1. Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 2. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60	3. CVD Prevention Clinical Lead, PMO and Medicines Management have been offering 1:1 support meetings with outlier GP Practices to discuss risk stratification resources, digital innovations and barriers to improvement as a means of working through sustainable improvements. Plans are to review outputs from all meetings to form plans for 2024/25. Health Innovation West Midlands are supporting with education offers. STW achievement for CVDP007HYP is 63.86% as at September 2023 maintaining a 12% increase required to achieve the 77% target by March 2024. Please note that whilst our treatment % remains relatively stable, our hypertension registered have increased by a few thousand since April 2023, meaning the number of people requiring optimal treatment to achieve target has increased 11,056. 4. STW achievement against CVDP003CHOL is 57.14% as at September 2023 with the equivalent of 830 patients to achieve the 60% target.

Health Inequality Equity of access to prevention programmes	• DWMP – Referrals range across all ages (18+) but the majority have been for those aged 50 – 70. The % of referrals for IMD1 has increased by 3.2% (17.1%). This now exceeds the % of referrals for IMD5 (12.6%). All other IMD quartiles range between 20 and 26%. The % of referrals for White British has reduced to 80.14% however a significant proportion of referrals are marked as 'ethnicity not recorded'. Further work required to improve ethnicity recording in-practice. Referrals for other ethnic groups have increased (Asian +0.33%, Black +0.97%, Mixed +0.02%). • TDT – Majority successful quits are reported for ages 60+ (38%) and increasingly for 18-34 year olds. The % of people living in IMD1 has increased to 44-45% for both referrals to and being seen by a TDT service. Quit rates reduce with only 37% of IMD1 patients successfully recorded as quitting after being seen by the service, but this remains proportionality higher than all other IMDs (by est. 16%). 93% of referrals recorded as British, 12% Not Known or Not Stated. • ACT – inequalities analysis not yet available.

Health Inequalities Case Studies

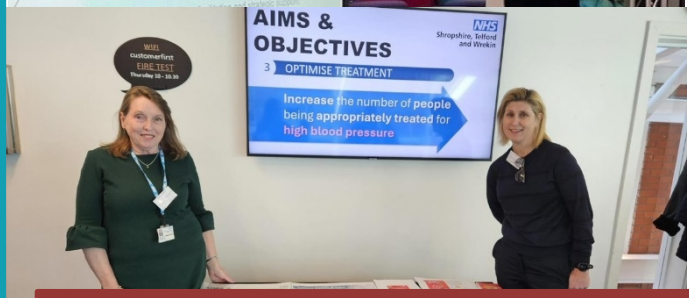
Midlands Health Inequalities Conference

On 29th November 2023, colleagues from Shropshire, Telford & Wrekin represented healthcare, Voluntary and Community Sector (VCSE) and the Local Authority (LA) at the NHS England Midlands Health Inequalities Conference.

Shropshire, Telford and Wrekin were selected to showcase three local pieces of work which demonstrate proactive work to reduce health inequalities for our local population.

- **Cancer Champions**
- **Community Blood Pressure Monitoring**
- **Children and Young People's Asthma**

ICB Health Inequalities Lead & Director of Mental Health, Learning Disability, Autism & Children and Young People, Tracey Jones joined a panel of senior colleagues in answering challenging questions from attendees and was also selected to attend a session with Bola Owolabi, Director for Health Inequalities England.



Core20PLUS Connectors (Cancer Champions)

In March 2022 Shropshire, Telford & Wrekin were successful as a wave 1 implementer site for the Core20PLUS Connectors Programme.

The project aims to empower our Core20PLUS communities to better understand cancer screening and spread awareness amongst families and friends through their everyday conversations.

- Delivered in partnership with Local Authorities an VCSE
- **200+ Cancer Champions**
- **85+ Organisations engaged**
- **100+ Training sessions delivered**
- Dedicated website
- Co-developed multi-lingual videos
- Insights reports which inform local across in Primary Care, Secondary Care and local Cancer Strategy.

Cancer Champions www.cancerchampions.co.uk

Community Hypertension Case-finding

As part of the Innovation for Healthcare Inequalities (InHIP) National Programme, Shropshire, Telford & Wrekin has been delivering blood pressure checks since August 2023 to our Core20PLUS communities with the aim of improving detection of high blood pressure in under-represented communities.

- Delivered in partnership with Local Authorities and VCSE
- Volunteer-led service model
- Models adapted to each Place
- Raising awareness of CVD-risk
- **90+** CVD Champions
- **200+** Blood pressures taken
- Digital innovations

Shropshire
Community Blood Pressure Checks

Healthylifestyles

Children and Young People's (CYP) Asthma

A system wide approach to supporting children with asthma across the STW footprint. Targeted intervention and focus on population groups, such as those living in deprivation, home-schooled children, travelling communities, young people's homes, and young carers.

Partnership working with housing authorities and associations is talk taking place with the development of training, resources, and engagement around policy to improve the standards of housing.

#AskAboutAsthma

Shropshire, Telford and Wrekin supports children with asthma

232 Asthma reviews since April 2023

200 Early Years staff and **20** housing associations asthma trained

200 CYP using the asthma app

70% of STW schools Asthma Friendly Accredited

Core20PLUS Ambassadors

As part of the National Core20PLUS5 Approach, NHS England developed the Core20PLUS Ambassador Programme. The programme is designed to support people working in the NHS in their commitment to narrow healthcare inequalities through improved knowledge, tools and confidence to discuss what they have learnt with peers. In 2023/24, this included the introduction of Health Inequality Finance Fellows, an extension to the programme specifically for those working in healthcare finance.

15 individuals from NHS Shropshire, Telford & Wrekin were successfully accepted into the programme, ranging across departments at ICB, Provider Trusts and Primary Care. This is an incredible achievement given the overwhelming interest the programme received and testament to the dedication of our staff in their applications.

Over the next 12 months Ambassadors will be supported to form local, regional and national networks with others who seek to improve healthcare inequalities and a range of development opportunities will be available to enable our ambassadors to develop their understanding of local inequalities and implement targeted actions which will improve the access and experience of healthcare services for our Core20PLUS populations.

"I decided to become part of the Health Inequalities Finance Fellow Network to support on the Health Inequalities Agenda. It was not area that I was familiar with, and a local presentation sparked many questions and thoughts in my head that it must be possible to make a dent in these issues locally.

I have since attended a superb presentation by the Health Economics Unit where it really brought to life the possibilities by a change in traditional thinking."

"I'm passionate about our NHS, its people and principles. This is a fantastic opportunity for us to make a difference, provide equitable access and experiences for all, working together to support our communities to live longer and healthier lives."

Examples of work from our Partners

Shrewsbury & Telford Hospital NHS Trust

Mitigating digital exclusion through outpatient transformation.

Investing in digital systems and improving digital maturity for better data accuracy and recording e.g., ethnicity recording and enabling improved reporting.

Enhanced health inequalities leadership through additional roles and EDI focused posts.

Preventions programmes for cancer faster diagnosis, CYP asthma, inpatient and maternity smoking and tier 3 weight management.

Midlands Partnership NHS Foundation Trust

Health improvement advice pilot as part of Patient Knows Best.

Inpatient smoking cessation.

Severe Mental Illness physical health checks.

Bespoke housing advice for SMI via a voluntary partner.

Co-located lifestyle advisors from Telford & Wrekin Local Authority with Mental Health Teams

Implementing National Standards for Food and Drink

Improving BAME access to community perinatal services.

Apprenticeship promotion in diverse settings.

Shropshire Community Health NHS Trust

Covid-19 Vaccination Programme

System focus on CYP Asthma.

Work in local schools to support CYP programmes as teachers know which families/children need more support.

Oral Health work in communities through the Healthy Smiles Team

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Review of DNA's to understand barriers to access.

Single STW MSK service, removing wait time disparity and allowing flexibility to move capacity around the system where it is most needed.

Optimising facilities in rural areas.

Work to improve datasets such as ethnicity recording and working through challenges with IMD analysis due to differences in scores between England and Wales.

The hospital is used as a community hub, particularly for those who experience isolation and loneliness. Charities utilise Trust spaces i.e., the dining room for Christmas dinners.

Shropshire Council

Task and finish group looking at Rural Proofing; considering closer to home services and travel support.

Healthy weight strategy

Health checks in farming communities.

Universal health checks working in GP Practices to focus on people with greater inequality and vulnerability.

RESET – MDT wraparound support for rough sleepers with drug and alcohol dependency.

Healthy Lives Service - *smoking cessation and weight management.*

Alcohol strategy

Digital inclusion with support to areas with no access.

First contact services team reach out to vulnerable maternity patients.

Measles MMR Action Plan, inequalities targeting.

Targeted MDT working for children taken into care age 0-5 and under 1.

Telford & Wrekin Council

Health inequalities is embedded into Health and Wellbeing Strategy.

Mental Health and Lifestyle Advisors have been co-located.

Work with MPFT, LA representation from Leisure and Energize Active Partnership looking at physical activity interventions.

Partnership work with partners and VCSE on Cancer Champions to support recruitment from underrepresented groups.

Blood pressure checks in underserved communities to enhance CVD Prevention awareness and intervention.

Primary Care Networks

Development of community hubs in partnership

Introduction of Mental Health Practitioners within local food banks Increased mental health support in Core20 areas

Free support and exercise spaces Health assessments and weekly dedicated clinics for asylum seekers

Working with Local Authorities to target health checks to higher risk populations

Supporting people to use digital tools Dedicated health support for vulnerable groups and people experiencing homelessness through frequented community bases

Increase blood pressure monitoring in Core20PLUS populations

Targeted campaigns for bowel and cervical cancer screening for vulnerable patients, homelessness, visually impaired and ethnic minority groups.

Improved SMI health checks Establishing MDT reviews for patients with long term conditions, frailty.

We are also committed to ensuring equity of access for members of the local community who are either serving or former members of the armed forces, along with our support and participation in the Refugee and Resettlement scheme.

Supporting our Veterans

There are currently 37/51 STW practices (73%) accredited as Veteran Friendly with the ambition to get all practices accredited compared to 28 practices 55% at 31 March 2023. This programme supports practices to deliver the best possible care and treatment for patients who have served in the armed forces.

We also confirmed our commitment to the armed forces community in November, by signing the Armed Forces Covenant. Our covenant carries two key principles:

- no member of the Armed Forces community should not face disadvantage in the provision of public and commercial services compared to any other citizen;
- in some circumstances special treatment may be appropriate, especially for the injured or bereaved.

By signing the covenant, we recognise the value that serving personnel, reservists, veterans and military families bring to the organisation, and to our country.

Refugee relocation and Resettlement

In November 2023, the Ministry of Defence notified the ICB that a military base in our area would be used as a temporary settlement base for families from Afghanistan who have leave to remain in the UK. Families would need access to Primary Care Health services. NHS STW worked closely with health service providers to put in place services and to register patients with a GP as appropriate. Current on site provision includes GP clinics, a community pharmacy service for minor ailments, immunisation and vaccination services, family support and sexual health advice. To date over 552 people have moved through this site before going to their permanent accommodation.

We also continue to support allocations from the Home Office. The GP practices in proximity to designated accommodation register new residents and provided initial health checks.

Our Legal Duty to Collect, Analyse and Publish Information in Health Inequalities

On 28th November 2023, NHS England released a Statement of information relating to the new legal duties for Integrated Care Boards (ICBs) and Foundation/Trusts to collect, analyse, publish, and use information on health inequalities under Section 13SA of the National Health Service Act 2006.

The domains of indicators included within the statement align to the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.

The purpose of exercising these powers is to:

i. Understand healthcare needs, including by adopting population health management approaches, underpinned by working with people and communities.
ii. Understand health access, experience and outcomes, including by collecting, analysing and publishing information on health inequalities set out in the Statement and relevant domains.
iii. Publish information on health inequalities within or alongside annual reports in an accessible format.
iv. Use data to inform action, including as outlined in the Statement.

NHS Shropshire, Telford & Wrekin has been leading the development of a Health Inequalities Outcomes Dashboard which will allow the opportunity to identify inequity in health outcomes and service provision but also the ability to monitor improvements in health outcomes over time and the indicative impact of programmes currently in place.

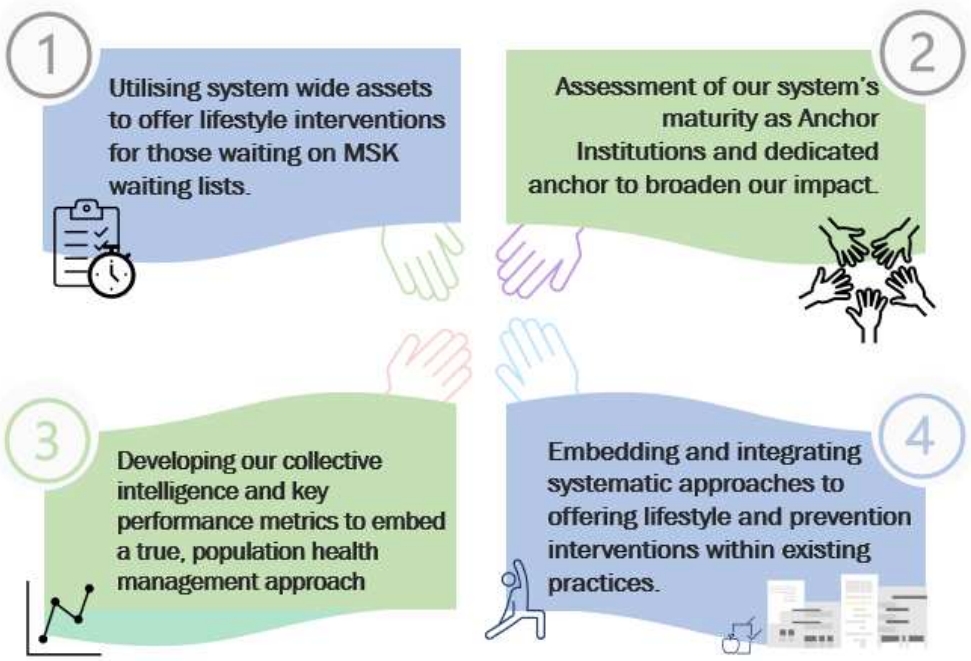
The dashboard currently identifies 61 draft indicators across four key cohorts (age, sex, ethnicity and socioeconomic status), which align with the objectives in the Operational Planning Guidance and the Core20PLUS5 for Adults and Children & Young People (those referenced in the Statement of Information).

Over the coming months the dashboard will continue to be developed and key metrics agreed which will act as the enabler for working with our Population Health Management Group to develop system-wide knowledge and intelligence.

Building on this Year's Successes

In December 2023 we held a collaborative workshop for Health Inequalities Senior Responsible Officers, Public Health Directors, and contributing Officers, to consider the work undertaken this year and identify opportunities for joined-up initiatives which would aim to reduce health inequalities, add greater value to services and impact positively on our population's health.

The following initiatives are those which will have greatest impact on our population and align with our aims to embed proactive and preventative approaches in our work, as well as evolve and optimise our impact as Anchor Institutions.



Key reflections from the workshop included the importance of working at scale efficiently, connecting existing work taking place across the system which contributes positively to reducing health inequalities and ensuring alignment with the priorities established in our Joint Forward Plan (JFP) and the Integrated Care Strategy. As such, those outputs generated the foundational blocks to a developing Health Inequalities Framework, which will propel and guide joined-up action for the forthcoming year.

Building blocks for collective Health Inequalities Action

Collective intelligence To enable us to fully understand our population.	**Inclusive community engagement** Local intelligence tells us 'what', engagement tells us why.	**Measuring the right impact** To ensure we are making the right difference to people.	**Wider Determinants** Using our role as Anchor Institutions to support people's wider needs, which impact health.
Good governance Tracking our success and challenges to continually improve	**Re-framing the narrative** Through embedded knowledge and awareness and championing the case for change.	**Collaborative Partnerships** Utilising our individual strengths as a collective alliance.	**Connecting Pathways** Understanding and utilising the vast work already taking place across our system.

We know from reviewing progress in-year that the provision of dedicated roles to support progress across the system is necessary to ensure robust oversight, coordination, and delivery of multiple agenda areas. To enact impactful change at scale, we must also embed a culture of understanding and approaches which see action on health inequalities as a lens to viewing service design and delivery, instead of an additional and separate entity. Lastly, the most impactful initiatives require us to work optimally as an Integrated Care System (ICS) to bring together key partners in addressing all determinants of health, including our role as Anchor Institutions and partnership working with Housing, Local Authorities and the Voluntary and Community Sector (VCSE).

The evaluation undertaken at the end of 2022/23 was pivotal to us understanding and implementing learning from 2022/23 projects within 2023/24 plans. As we look toward 2024/25, we are preparing to undertake a further evaluation of progress to understand and benchmark progress made in 2023/24 against the previous year. The 2023/24 evaluation will provide us with a further opportunity to identify learning from both in-year challenges and successes and better understand the views of our staff in terms of what they feel is needed to support them in their role to reduce healthcare and health inequalities.

The outcomes of the evaluation will be considered in our planning for 2024/25 to compliment the developing framework and enable us to refine and propel our approach to reducing inequalities in access, experience and outcomes for our Core20PLUS populations.

Medicines Management - Delivering a Person-Centred Approach

STOMP

STOMP, stopping over medication of people with a learning disability, autism or both with psychotropic medicines, and STAMP, supporting treatment and appropriate medication in paediatrics, are part of the NHS Long Term Plan, to help people with a learning disability, autism, or both to stay well, have a good quality of life and decrease health inequality.

The Medicines Management team has been collaborating with the Midlands Regional STOMP and STAMP team and will adapt their recently published Framework. A system wide collaborative approach has been taken with the implementation of clinical working groups, to ensure the development of:

- a clear clinical pathway of joint working between Primary and Secondary Care, with defined responsibilities in regular reviews and Medicines Optimisation of psychotropic medicines.
- clinical prescribing guidelines and guidance around potential treatment of behaviours of concern.
- easy read resources and leaflets to support people with learning disability, autism or both and their carer and families with the process of Medicines Optimisation.
- a campaign, driven by voices and aspirations of people affected, to create awareness.
- bespoke education sessions for Primary Care clinicians, Secondary Care clinicians and people affected, their carer, families, and support team.

The long-term aims are to:

- explore first alternatives before considering medication.
- ensure people with a learning disability, autism or both of any age and their circle of support are fully informed about their medication and are involved in decisions about their care.
- ensure all staff within organisations have an understanding of psychotropic medication, including why it is being used and the likely side effects.
- ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication.
- ensure that medication, if needed, is started, reviewed, and monitored in line with the relevant NICE guidance.
- work in partnership with people with a learning disability, autism or both, their families, care teams, healthcare professionals and others to stop over-medication safely.

Discharge Medicines Service (DMS)

An audit of NHS hospital discharges showed that 79% of patients were prescribed at least one new medication after being discharged from hospital. It is also known that discharge from hospital is associated with an increased risk of avoidable medicines-related harm.

By ensuring better coordination between hospital, community pharmacy and general practice, the NHS DMS aims to improve communication regarding changes to a patient's medication when they leave the hospital and helps prevent avoidable harm caused by medicines.

At the time of writing this report, three out of four NHS Trusts in Shropshire Telford and Wrekin are referring recently discharged patients who would benefit from extra guidance around prescribed medicines for provision of the DMS to their community pharmacy. The community pharmacist receives information about any medication changes made during the hospital stay and then supports the patient in understanding these changes, ensuring they take their medications correctly at home.

On average community pharmacy teams in Shropshire Telford and Wrekin are reviewing over 300 patients per month under the DMS service. Evidence suggests that for every ten DMS referrals completed by community pharmacy, one avoidable readmission is prevented. In addition, for patients who are readmitted, the average length of stay is reduced from 13 to 7 days. This represents a potential of over 360 avoidable admissions prevented per year, and almost 2800 hospital bed days saved each year.

Work continues to widen access to the Discharge Medicines Service as more settings are supported to start sending referrals, allowing more patients to benefit from this service and stay out of hospital for longer.

Polypharmacy - Structured Medication Reviews (SMRs)

Overprescribing is the use of a medicine where there is a better non-medicine alternative, or where the use is inappropriate for that patient's circumstances or is inconsistent with their wishes and can lead to problematic polypharmacy.

Problematic polypharmacy, where, for an individual taking multiple medicines, the potential for harm outweighs any benefits from the medicines, has been identified as one of the 16 National Medicines Optimisation opportunities 2023/24. SMRs can be used to review patients identified as having problematic polypharmacy.

Clinicians responsible for the care management of patients with chronic diseases undertake regularly clinical medication reviews to proactively manage people with complex polypharmacy, especially older people, people in care homes, and those with multiple co-morbidities. For patients aged 75 and over on 10 or more unique medicines, NHS Shropshire Telford and Wrekin (STW) is within the top performing Integrated Care Board's (ICB's) when compared to the similar 10 ICB's across England. This great performance is down to the hard work of General Practice and Primary Care Network Teams. The aim is now to focus on reducing problematic polypharmacy for all age patient groups with complex polypharmacy and to improve medicines safety and people's health.

The Medicines Management team are collaborating with Health Innovation West Midlands to implement the National Polypharmacy Programme. In addition, to support General Practice and Primary Care Network Teams with SMRs the Medicines Management team has been completing a series of measures including:

- producing a SMR best practice guide, and SMR Resources,
- delivering an education session,
- signposting to a series of free education and training sessions provided by the Health Innovation West Midlands to support clinicians to deliver high quality SMRs and address problematic polypharmacy in the process,
- identifying key priority areas which General Practices can use to focus SMR completion. For this, available National and Regional comparators and Local datasets were used, to identify areas where NHS STW may derive greater benefit from focussing on and to allow for optimal use of clinicians' resources and to have a positive impact on patient outcomes.

Cardiovascular Disease

Work has been ongoing to support the NHS Long Term Plan in reducing cardiovascular deaths, increasing the focus on prevention and management of cardiovascular disease (CVD) conditions and related risk factors.

Heart failure represents the only major CVD with increasing prevalence and carries a poor prognosis for patients, which highlights the clinical significance of this condition and clinical priority both locally and nationally.

During 2023/24, NHS Shropshire, Telford and Wrekin's Medicines Management Team implemented a Heart Failure Focus Project to support this key priority area. The aims of the project were to ensure that accurate and complete registers of Heart Failure patients exist in primary care with improved coding with a record of confirmed diagnosis. This would then further ensure treatment optimisation in-line with national and local evidence-based guidelines along with improved overall management of Heart Failure patients in primary care.

Support for practices included delivery of Heart Failure education sessions in collaboration with cardiology specialists from SaTH and Health Innovation West Midlands (HIWM), signposting to national and local guidelines, provision of a Heart Failure toolkit from HIWM and use of Eclipse vista pathways software to aid patient identification for therapy optimisation.

Early indications show that significant work has been undertaken in GP practices to review and address issues with system coding for Heart Failure which will improve accuracy of registers and additionally there has been system-wide improvement in optimising heart failure medication within primary care.

Other specific areas of good practice have also included "code-cleansing" of the Heart Failure register, ensuring diagnoses are confirmed by echo/specialist assessment, further improvements in therapy optimisation along with increased reviews involving an MDT approach and use of protected learning time to educate the practice team.

This work will be used to support and inform the cardiology transformation programme going forward.

There has also been continued focus on lipid management across Primary Care, following NHS Shropshire, Telford and Wrekin being awarded a grant bid for funding via The National System

Transformation Fund (STF). This has enabled work in 2023/24, to improve lipid management for patients with existing CVD, focussing on patients in GP practices where health inequalities may be present and that have outlier data in relation to cardiovascular outcomes. This has been a collaborative, multi-level approach with colleagues from SaTH, which also involved embedding cholesterol management for priority patients into the cardiac rehab clinic.

Interventions have included therapy and dose optimisation of existing medicines, initiation of additional/alternative medicines to improve lipid management alongside addressing non-compliance and providing diet and lifestyle advice. CVDPREVENT data for participating practices has shown improvement in one or both indicators for patients with CVD, treated with lipid-lowering therapies.

Place-Based Delivery

Place is defined by NHS England as being a geographic area that is defined locally.

In Shropshire, Telford & Wrekin Integrated Care System we define 'place' as the areas aligned with our two local authorities: Telford & Wrekin, and Shropshire. Both places have strong place-based integration boards – Shropshire Integrated Place Partnership (SHIPP) and Telford & Wrekin Integrated Place Partnership (TWIPP).

Both SHIPP and TWIPP are accountable to their local Health and Wellbeing Boards as well as the STW Integrated Care Board.

The role of SHIPP and TWIPP is to implement proactive prevention, reduce health inequalities, and improve outcomes for the local population. SHIPP and TWIPP reflect the identity of each of the places and benefit from the assets and strengths of the communities within that place. However, the places ensure that standards of access and quality do not vary and connect across STW to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

Primary Care

Primary Care acts as the 'front door' of NHS services, and is the first point of contact for many within Shropshire, Telford and Wrekin, often within their local community.

Primary care professionals, such as GPs, pharmacists, nurses and other members of multi-disciplinary teams withing general practice look after the basics of care, focusing on preventing illness, making diagnoses and treating conditions that don't need hospital care.

The ICB has 51 GP practices which make up the membership of 8 PCNs. These are:

- North Shropshire PCN
- Shrewsbury PCN
- South West Shropshire PCN
- South East Shropshire PCN
- Newport and Central PCN
- Wrekin PCN
- South East Telford PCN
- Teldoc PCN

STW PCNs have continued to develop and implement plans to meet the service requirements in the national PCN Directed Enhanced Service contract.

These include:

- Enhanced access providing additional routine and same day appointments on weekday evenings 6.30pm – 8.00pm and on Saturdays 9.00am – 5.00pm.
- Identifying and prioritising patients who would benefit from a Structured medication review (SMR).
- Enhanced Health in Care Homes which includes providing a lead GP for each care home; working with the community service provider to coordinate a multidisciplinary team to enable the development of personalised care and support plans; shared care agreements in place; providing a weekly home round; and establish a Care Home Enhanced Support team.
- Early cancer diagnosis including review of the referral practice for suspected and current cancers, improving screening, embedding FIT testing, trialling the use of teledermatology and focus on prostate cancer diagnosis.
- Providing patient access to social prescribing taking a personalised care approach to supporting patients' non-clinical needs.
- Cardiovascular disease (CVD) prevention and diagnosis: improving the diagnosis of hypertension and the number of blood pressure checks delivered by increasing testing and working with community pharmacy and improving identification of those at risk of atrial fibrillation and familial hypercholesterolaemia.
- Tackling health inequalities: improving Learning Disability registers and deliver an annual learning disability health check and action plan; record the ethnicity of patients; appoint a health inequalities lead; identifying a population within the PCN who are experiencing inequality in health provision and/or outcomes and deliver a plan to tackle their unmet needs.
- Anticipatory Care: contributing to the development of ICS delivery plans which will be delivered jointly.
- Personalised Care: contributing to a targeted programme of social prescribing to an identified cohort with unmet needs and improvements to shared decision making.

Access to General Practice

PCNs have also worked with their practices to improve patient experience and move towards a modern general practice access model. The ICB formulated a Primary Care Access Recovery Plan that was presented at a Board Meeting held in Public in November 2023.

As part of this each PCN was asked to produce a Capacity and Access Plan. Through the delivery of PCN Capacity and Access plans, PCNs are required to make changes in three areas.

I. patient experience of contact.
II. ease of access and demand management; and
III. accuracy of recording in appointment books.

Primary Care Workforce

Additional Roles Reimbursement Scheme

We have continued to support PCNs to develop their workforce plans to recruit into roles funded by the Additional Roles Reimbursement Scheme (ARRS). Clinical Pharmacists, Care Coordinators, Social Prescribing Link Workers, Paramedics and First Contact Physiotherapists have been with the main roles to be recruited. By the end of 23/24 PCNs will have utilised nearly all the ICB's ARRS allocation (an

improvement on previous years), resulting in over 320 ARRS-funded staff now in post within the system, supporting the delivery of PCN services.

Recruitment and retention of Primary Care Workforce

The STW ICB General Practitioner (GP) Strategy, which was produced in 2022 in consultation with practices and PCNs, aims to improve recruitment and retention of GPs. Responsibility for the delivery of the Strategy's Action Plan lies with the STW ICB Primary Care Workforce Lead, supported by a team of six "GP Leads", focusing on specific areas of the Strategy.

Actions and initiatives include the STW GP Fellowship scheme which supports over twenty newly qualified GPs, the GP mentoring scheme, funding the STW First 5 GP Network, supporting IMG doctors in their final exams and then in securing employment in local practices, encouraging practices to take Foundation Year doctors, supporting newly qualified GP Locums, providing information relevant to female GPs, and the development of a support network for "older" GPs.

Although all these initiatives will take time to have the desired impact, the data on GP numbers indicates some early success: although the number of GPs (headcount and WTE) fell between 2015 and 2020, numbers have broadly levelled out over the past two years with 308 (headcount) and 240wte at the end of December 2023.

Pharmacy First

On 31st January 2024, the Pharmacy First service was launched nationally. This service enables patients to be assessed and receive treatments for minor illnesses and seven common conditions from community pharmacies. NHS Shropshire Telford and Wrekin worked with system partners to support this service being available in 100% of community pharmacies across the area. Further work is continuing to support general practices to refer more patients to community pharmacy, helping more people get seen in a setting that is appropriate for them.

The launch of the national Primary Care Access and Recovery Plan in May 2023 has seen an increased focus on community pharmacies place within primary care. Three services launched or expanded to support patients access to primary care services. The community pharmacy blood pressure check service was relaunched enabling more residents to attend pharmacies for blood pressure checks and advice about heart health. The Pharmacy Contraception Service was expanded to allow women to access regular oral contraception from a pharmacy, without the need to visit general practice for a prescription first.

Primary Care Estates

New build GP premises

- Shifnal - Completion of the new building for Shifnal in December 2023
- Highley – Temporary accommodation provided for Highley Medical Practice to keep the GP service in the village and new premises, prior to the completion of a retrofit to accommodate the practice in future, in April 2024.
- Whitchurch – the development on the Pauls Moss site for a new health centre for Whitchurch is on track for completion in Autumn 2024

Building Improvements

- NHSE BaU capital funding used for projects this year to make improvements at 5 x GP practices, increasing clinical capacity and ensuring the premises continue to be fully compliant to current guidelines.

PC Estates Strategy

- PCN Estates Plans have now been completed and the revised PC Estates Strategy is on track for release in Q1 2024

Capital Funding Bids

- Almost £2.5m capital raised from s106 bids – funds likely to be drawn down from 2025 onwards.
- Around £650,000 capital raised from CIL bids for two key projects in Shropshire.
- Around 15x s106 bids currently being developed

Rates Rebates

- Over £220k revenue funds recovered this year so far in rates rebates

Place Collaboration and Engagement

'Place' involves commissioners, community services providers, local authorities, primary care, the voluntary and community sector, and public representatives working together to meet the needs of local people. They met in two Place alliances covering the whole of Shropshire, Telford and Wrekin, aligned to the footprint of the local authorities.

Place is a transformative work stream and aims to enable new models of care, integration and cost efficiencies by creating the environment and opportunity for organisations and the populations they serve to think, transform and work differently together, so that people can be well connected, and access coordinated services.

This way of working will inform and support the system leadership as it develops a new architecture and culture for system working which integrates good health and wellbeing support for those who live and work in Shropshire, Telford and Wrekin.

Place relies on organisations working better together to enable improved health outcomes for our population. Each Place alliance holds regular meetings, with a wide range of representation from principal system organisations and other relevant local organisations/groups.

Shropshire Council and Telford and Wrekin Council's Health and Wellbeing Boards (HWBB)

Our Chief Executive Officer, Simon Whitehouse, sits on the Health and Wellbeing Boards (HWBBs) of both local authorities and is co-chair for both Health and Well Being Boards. The HWBBs also form part of the ICS governance structure to ensure that partnership working is truly at the centre of the delivery of the ICS.

Both HWBBs have a Health and Wellbeing Strategy in place and this underpins the development work on the Joint Forward Plan.

The ICB has consulted each lead officer of the relevant Health and Wellbeing Boards in preparing this annual report.

TWIPP & SHIPP

Both of our 'places' have Integrated Place Partnership Boards in place, which have met regularly throughout the year. The purpose of these are to act as a partnership board of commissioners, providers of health and social care and involvement leads to deliver system outcomes and priorities are delivered at a place level.

The Telford & Wrekin Integrated Place Partnership (TWIPP) has been in its current format since March 2019 and comprises of senior officers from Telford & Wrekin Council, NHS Shropshire, Telford & Wrekin, Primary Care Networks, Midlands Partnership NHS Foundation Trust, Shropshire Community Health Trust, Shrewsbury and Telford Hospital Trust, Healthwatch, Shropshire Partners in Care and the Voluntary Community and Social Enterprise sector. The TWIPP vision is aligned to the Health and Wellbeing Strategy vision of: "Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"

Further information on TWIPP and its activity can be found here.

As a subgroup of the Health and Wellbeing Board and the Integrated Care Partnership, the Shropshire Integrated Place Partnership (SHIPP) aims to work collaboratively to deliver the system priorities. It does this by working in partnership with shared collaborative leadership and responsibility. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.

It is expected that through the programmes of SHIPP, and routine involvement and coproduction local people and workforce can feed ideas and information to inform and influence system strategy and priority development.

Further information on SHIPP and the Health and Wellbeing Board can be found here.

Shropshire Council and Telford and Wrekin Council & The Better Care Fund

The Better Care Fund (BCF) continues to be an important focus for our partnership working with Shropshire Council and Telford & Wrekin Council. Switching care from an acute setting to a community setting relies in part on the success of the BCF, and we have created programme support to ensure that we have the right skills and capacity to oversee this.

In addition, we continue to work collaboratively on our local neighbourhood working model which forms an important element of the ICS. This work allows us to explore, in a more meaningful way, how health and social care services can be delivered in more community settings, closer to people's homes. Ultimately, the aim is for services to be more integrated so we can support the whole person and not just a disease.

Joint Health Overview and Scrutiny Committee of Shropshire Council and Telford and Wrekin Council

Our interaction with the Joint Health Overview and Scrutiny Committee has continued during 2023/24. A number of areas have been discussed at the committee including:

- Calling for an Ambulance in an Emergency - Report from Healthwatch Shropshire & Healthwatch Telford and Wrekin
- NHS Winter Planning
- Shrewsbury and Telford Hospital Trust Performance
- Rural Proofing in Health and Care

Local Care Transformation Programme

Local Care is a system wide commitment to a range of community-based transformation programmes and initiatives. The programme reduces the need for unplanned health care, keeps people safe, well, and independent at home, and contributes to improved population health and wellbeing.

Local Care involves:

- Integrating health and care at place and neighbourhood levels to deliver more joined up' proactive and personalised care in local communities and in people's homes.
- Expanding the range of community-based services available to our population.
- Health and care professionals work together in a joined-up way across different settings focused on the person's needs, goals and wishes as part of a wider team with partners including working with the Voluntary Sector.

Admission to Hospital Avoidance

- Inputs at April 2023 (transfer to BAU):
  - c4,000 referrals into rapid response
  - c3,000 referrals into respiratory outreach
- Triangulated using output measures (between 21/22 and 22/23):
  - Reduction in A&E attendances of c11,000
  - Reduction in non-elective admissions of c2,500
- **Agreed impact: range of 34-45 beds, midpoint is 40 beds.**

Virtual Ward

- Inputs at January 2024 as per the NHSE monthly sitrep:
  - 135 beds open
  - 75% occupancy
  - 31 beds per 100,000 population (8th highest ICB)
- Will be triangulated using output measures in Q1 2024/25
- **Estimated impact: 50 beds plus an opportunity for 25 further beds with the appropriate clinical sponsorship.**

The impact of Local Care in 23/24 was measured as a cost avoidance benefit. The system has agreed to count this impact in beds, as this benefits both the system, and our patients. The Independent Review Panel for the Hospital Transformation Programme (HTP) has cited the criticality of Local Care to the HTP in terms of acute bed suppression.

Hospital and Clinical Services

As a system, how we utilise and make considered changes to our estates and infrastructure will collectively enable us to fully maximise the ambitions laid out in our Joint Forward Plan and Integrated Care Strategy. Our infrastructure should enable, support and empower collaborative delivery and system working, and must reflect our shared visions, objectives and priorities.

How we achieve this ambition is framed within the context of a number of national initiatives.

The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing whilst considering and working within the existing financial picture. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. It also sets out four major, practical changes to the NHS service model, to be delivered over the following five years:

1. Boosting 'out-of-hospital' care and joining up primary and community health services

2. Reducing pressure on emergency hospital services

3. Digitally enabled primary and outpatient care

4. Increasing focus by local NHS organisations on population health and local partnerships

Similarly, in October 2020, the NHS published the 'Delivering a Net-Zero National Health Service". This report presented two targets for NHS organisations to meet a net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For the emissions we control directly (the NHS Carbon Footprint), net-zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), net-zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Despite the vast amount of work to recover from the Covid-19 pandemic, health services continue to be significantly impacted in terms of delivering and providing timely elective care and, as a result, on the lives of many patients who are being referred for, or already waiting for planned treatment and procedures. This has been compounded further by ever increasing levels of demand on urgent and emergency health services, which then also creates a certain amount of negative impact on the smooth running and provision of planned care services.

Working with Our Partners

Earlier in 2022/23, we worked closely with provider partners to agree a 3-year plan that was fully aligned with the NHS England Long Term Plan on how to rise to the challenges of addressing the elective backlogs and long waiting lists and waiting times, through a combination of expanding capacity, prioritising treatment, reviewing and validating waiting lists, and transforming delivery of services. These priorities and pieces of work continue to form a vital part of the system-wide elective recovery and delivery plans that we have collectively worked to during 2023/24. This includes a lot of work to improve the running of services and waiting times in-year, but also longer-term large-scale transformation programmes to radically redesign how services are delivered, or clinical pathways.

One of the large-scale programmes for example, transforming the provision of Outpatient services also contributes to recovery from some of the post-Covid long waiting lists, and these approaches include:

- addressing health inequalities as part of waiting list recovery
- increased used of Advice and Guidance (and conversion to prevented face-to-face appointments)
- virtual consultations (and conversion to prevented face-to-face appointments)
- patient-initiated follow-ups (and conversion to prevented face-to-face appointments)
- improved capturing and reporting of the above in system data
- Validation and review of waiting lists
- One stop clinics
- Nurse-led telephone follow ups
- Remote reviews
- Looking at ways of reducing missed appointments

During 2023/24 our provider partners worked incredibly hard in very challenging circumstances to deliver increased levels of activity throughout the year, compared to 22/23, and ensured that the highest clinical priority patients; including patients on cancer pathways and those with the longest waits, were prioritised. Steps have also been taken to ensure health inequalities within waiting lists are considered where possible and any identified impact addressed, prevented or minimised.

Where there were challenges with throughput, particularly at Shrewsbury and Telford Hospital NHS Trust due to emergency care pressures, we also worked with several independent sector providers and utilised insourcing of support activity and diagnostics in particularly challenged specialities such as Gynaecology, Urology, ENT, and Trauma & Orthopaedics.

For Robert Jones & Agnes Hunt Orthopaedic Hospital the most challenged area has been spinal disorders due to the lack of capacity, case complexity and workforce challenges. To support with this, close working relationships continue to enable a safe & effective transfer of spinal patients to the Royal Orthopaedic Hospital and Walton Centre NHS Trusts. Similar inter-system provider mutual aid arrangements were also established for T&O patients between RJAH and SaTH for any Priority 2 patients/long waits where no HDU capacity was required by the patient.

In addition, to support with options around regional mutual aid in the West Midlands NHSE region, both SaTH and RJAH registered for the Digital Mutual Aid System (DMAS), where providers support each other with mutual aid and transfer of patients in our most challenged specialities.

As part of a national refresh of the Choice Framework, work was also undertaken from June 2023 onwards to implement something called a Patient Initiated Digital Mutual Aid System (PIDMAS). This is a real shift in maximising how informed and involved patients are in their own decision making and care. Implementing this means that provider Trust's now proactively identify and contact patients who have been waiting too long for their appointment, and where they meet certain criteria, to re-offer the opportunity to change provider and be able to go somewhere else with a shorter waiting time.

To further ensure the most efficient and effective use of available hospital capacity given the emergency care pressures, the ICS system was also asked to implement several recommendations made by the 'Getting it Right First Time' team (GIRFT) as part of the Midlands Elective Delivery Programme (MEDP). Good progress was made during the year in terms of deliverables such as the MSK transformation programme (provider collaboration for orthopaedics across the county, GIRFT best practice). The system

is performing well for day case rates within the model hospital/GIRFT data for most specialties however Orthopaedic day case rates, length of stay for primary hip replacements and primary knee replacements and urology procedures day case rates remain challenged. The system plans and programmes in place to address these challenges are being bolstered with the provision of GIRFT pathway redesign clinical toolkits and feedback from pilots in other Trusts and areas. These all form strengthened GIRFT improvement plans being finalised for 2024/25, some of which are intertwined with the existing transformation programmes as the vehicle for delivery.

- Theatre utilisation, which is essential to supporting activity, continued to be challenging at SaTH due to staffing, capacity, and equipment challenges. To support with productivity SaTH successfully recruited internationally, implemented new theatre software and are in the stages of implementing GIRFT recommendations for optimising theatre utilisation and efficiencies and best practice pathways.

  Radiology has also been a key challenge in supporting with elective recovery and both SaTH and RJAH had to increase capacity through external support such as mobile scanners, operating 7 days a week 12 hours a day to support with the demand and reduce the elective backlog. Through this extra capacity in the last three months of the year there has been a marked improvement in this diagnostics position at both providers.
  The local health system was taken out of Tier 1 monitoring with NHS England for elective care in October 2023, due to sustained improved performance for reducing and clearing the number of patients waiting 78 weeks and over 104 weeks. When considering 65 week waits, the ICB expects to have no patients waiting longer than 65 weeks by September 2024. Financial restrictions imposed by NHS England at the end of November 2023 severely impacted on SaTH's ability to reduce their number of patients waiting over 65 weeks due to restrictions to outsourcing and insourcing of services.
  During the year, there were also significant improvements in performance of cancer services at SaTH, although currently the service remains in Tier 1 NHSE monitoring and scrutiny. The challenged specialties all produced improvement plans which are monitored via the Tier 1 NHSE meetings, and over £1m funding was secured from the West Midlands Cancer Alliance to support further rapid improvements and dedicated resource in place to lead and deliver this. There were significant improvements in the 28-day Faster Diagnosis Standard (FDS) and it now meets and maintains the 75% standard, with national targets likely to be met. Colorectal urgent suspected cancer referrals now also regularly reach their 80% target. There is a continued challenge in maintaining the trajectory to meet the end of year 'fair shares' target of not more than 212 patients waiting over 62 days on a cancer pathway, and there remains a lot of further work to be done to improve performance against the 62 day referral to treatment standard. Urology remains the most challenged area.
  The county's first Community Diagnostic Centre (CDC) opened on 2nd October 2023, located at Hollinswood House in Telford. Phases one and two of the opening were completed and the service includes community-based provision of pathology services, radiology services (blood tests, CT scans and ultrasound scans), and MRI scanning along with non-complex dialysis. Phase three is slightly delayed but will soon be open for cardiorespiratory and tele-dermatology services.The planned opening of a ringfenced Elective Hub at SaTH was delayed from January to March 2024 due to legacy infrastructure challenges, with mitigations to deliver planned activity being progressed. This Hub will increase capacity and deliver elective activity that will help reduce the

surgery backlog. Within the Hub there are two theatres and an associated recovery area, which provides the theatres currently located within the SaTH day surgery complex which are often closed due to escalation/non-elective pressures from October to April every year. Approximately 24% of elective day case and inpatient activity is typically lost to winter surges in demand and lack of a protected elective capacity. This Hub will create a ring-fenced elective day-case facility bed base 52 weeks a year and addresses the fact that day surgery effectively stops between October and April year on year as the current bed base is used to support increases in non-elective bed pressures.

- Delays were encountered for Robert Jones and Agnes Hunt (RJAH) in the construction and opening of the new targeted investment fund additional theatre and recovery facilities, with the handover now planned for mid-May 2024. This capacity will enable RJAH to deliver approximately an additional 1,200 elective cases per annum thereafter.

In terms of waiting list administration, NHSE targets to validate, every 12 weeks, those patients on long waiting lists e.g. 104 weeks, 78 weeks, 65 weeks and 52 weeks were also met. Validation cycles of work on our waiting lists continues to ensure pathways are reviewed at regular intervals.

Robust governance and reporting structures exist within each of the provider organisations for the effective monitoring of this improvement and recovery work, as well as reporting into the NHS Shropshire, Telford and Wrekin and ICS committees and governance framework and NHSE assurance meetings. At an ICS level there remains a Planned Care Delivery Board in place which oversees and is accountable for the elective, cancer & diagnostics agenda for the whole STW ICS and has membership from all system partners. This provides high level assurance and reports into the Integrated Delivery Committee (IDC). For rigour and detail, the Director of Elective Care established a weekly Elective and Cancer Recovery and Delivery group for close monitoring and driving of progress.

Service Transformation - Our Plans and Future Activity

In the year ahead we intend to continue improving our elective recovery position, however this is dependent on a reduction in non-elective demand & pressures, workforce and staffing numbers improving, availability of independent sector capacity, Elective Hub implementation, CDC implementation, reduction in numbers of those in hospital who are medically fit for discharge but require ongoing community packages of care, provider collaboration and successful capacity deployment through the capital estates programme.

Linked to the NHS Long Term Plan, the broader programme of Elective Care Transformation is to lead and oversee transformative change on areas of elective care that will ensure individuals needing planned care see the right person, in the right place, at the right time (first and every time), and get the best possible outcomes, delivered in the most efficient way.

In addition, it sets out to address some of the known issues such as:

- suboptimal information flow and service pathways
- patients travelling to hospital, to wait for an appointment that may last only a few minutes, when we could save time, cost and stress by providing these services in a different way
- reducing the time to recovery for post-Covid-19 long waits that will help ensure the capacity we do have is utilised most efficiently, and that patients get to receive the care that they need, where when and how they need it.

Redesigning and transforming services where possible to be more efficient is a vital component in enabling effective recovery of the overall elective waiting list position. The programmes and the work underway or planned provides the opportunity to properly review and redesign elective care and move away from individual specialty appointments, and more towards patient pathways, experience and journeys. Always with the patient at the centre, making outpatients and accessing care simple, effective and efficient – Right Care, Right Person, Right Place, Right Time. As broad high-level aims, it is expected that through Elective Care Transformation for the system we would:

- better manage increasing demand for elective care services
- improve patient experience and access to care
- provide more integrated, person-centred care.

These high-level aims set the context for programmes of review, redesign, development and transformation, with additional aims to reduce the need for face-to-face outpatient appointments by a third over the next five years, along with a range of other benefits and intended outcomes including:

- improved utilisation of secondary care resource – physical space and clinical time
- optimised use of shared information and improved pathways
- improved clinical outcomes through patients receiving expert advice more quickly and follow-ups based on clinical need – rather than arbitrary schedules
- improved co-ordinated care for patients with multiple conditions
- improved patient experience through improved timely access to the right service, more informed and more empowered
- better use of patients' time through preventing what may be unnecessary trips to hospital
- reduced environmental impact, through decreasing journeys to hospital therefore emitting fewer CO2 emissions, resulting in reduced environmental damage and risk of preventable deaths through air pollution
- financial efficiency to patients through not having to travel, and to the system through improved efficiency and utilisation of existing resource.

Outpatients Transformation

This programme of work continues to progress in terms of its agreed scope and original planning and remains within timescales; to transform the provision of Outpatient services in the county to be more effective & efficient, whilst generating efficiencies that help enable recovery of long elective waiting lists and waiting times through reutilisation of freed up capacity.

The ambition of the programme is to:

- review and redesign services with service users and providers around patients' needs
- provide high quality citizen-centred services
- ensure timely, safe, effective, and sustainable care
- provide a seamless care experience
- ensure 'right time, right location, right person'
- ensure integration across primary, community and secondary care
- reduce duplication and improve resource efficiency, ensuring value for money

The programme is broadly structured into two core components:

- Continued focus on accelerated improvements around the utilisation of Advice & Guidance, Virtual Consultations and Patient Initiated Follow Ups. These alternative approaches enable effective pathways of care for patients who may not really require a hospital appointment, allowing patient access to care when it is needed as opposed to when the hospital will see you, and promoting the use of telephone and video consultations where clinically appropriate, and suitable for the patient, where it is beneficial to do so. Much work already underway to look at how these can be used effectively, and involving patients, public and clinical colleagues in those conversations. The work was overhauled during the second half of 2023 to strengthen the action plans with rigour, timescales, and improved discipline and accountability which helped drive and improvement in pace and progress. This continues into 2024/25.

- Longer term transformation opportunities to optimise the use of digital innovation, develop new and improved pathways and service delivery models, contribute to the 'left-shift' of more locally available services in communities or people's homes and alleviate some of the demand from the acute Trust by reducing unnecessary hospital-based appointments. A series of engagement sessions took place during 2023, and the outputs of these and comments captured have now been consolidated and analysed and will be converted into an evaluation report. These outputs will also be used to inform further transformation opportunities.

Some of the high-level benefits expected from this programme of work are as follows:

Patients & Carers	**Primary & Care & GP's**
Safer and quicker care	Manageable demand
Better experience and outcomes	Ability to target available resources
Seamless communication	Supported, sustainable teams
Care that fits around you	Seamless communication
Reduced travel/stress	Improved integrated working
Secondary Care/Hospital Colleagues	**Integrated Care System**
Safer care	Improved health & wellbeing of the local populati
Manageable demand	Better outcomes
Ability to target resources	Increased value
Supported, sustainable teams	Less waste
Seamless communication	More resources

As can be seen from this, the work to transform Outpatient services is intrinsically linked as a key enabler to recovery of the significant elective care waiting lists through being more effective & efficient.

The overall Outpatients programme forms an integral part of the broader transformation agenda and 'roadmap to recovery' which also consists of a few other initiatives also taking place in the background, with much work underway on:

- Validation of waiting lists through telephone and letter contact with patients resulting in a proportion of discharges or changed pathways such as converting to a virtual appointment;
- Focus on reducing the numbers of patients who miss appointments or do not attend;
- Where possible, re-offering choice to patients of alternative providers
- Where possible optimising the use of available independent sector capacity
- Work to drive through the targets of achieving zero 104+ week waits, 78+ week waits and 65+ week waits by March 2024.

Background targets to the Outpatient programme are to increase productivity/maximise capacity compared to 19/20 baseline, reduce follow up waiting lists by 25%, and prevent 33% face to face Outpatient activity compared to 19/20.

The programme continued to progress well, and a huge amount of progress was made in the areas described above. In parallel, the team undertook robust analysis of 3 years' worth of patient complaints and compliments relating to Outpatient services, ran a public survey, and hosted a number of engagement sessions to harness the feedback and opinions from colleagues, stakeholders, and the public on Outpatient services as well as suggestions for change and improvement. These were consolidated before undergoing thematic analysis, and will be used to produce an evaluation report, inform further transformation, and redesign opportunities.

With alternative approaches and ways of providing Outpatient services that mean you may no longer need to visit a hospital, this is also generating a number of other more environmental benefits including:

- Reduced miles travelled by patients, and their family and carers
- Reduced CO2 emissions
- Reduced hospital car park use
- Reduced time needed for appointments (for virtual/telephone consultations)
- Increase to quality-adjusted life years saved

Cancer

In line with the ambitions of the NHS Long Term Plan (2019), improving cancer pathways and outcomes continues to be a priority for STW and is at the heart of the ICS approach to recovery and ongoing development of cancer services.

Key actions have been undertaken during 2023/24, most of which are ongoing, and include the following.

Colorectal pathway

- Implementation of Faecal Immunochemical Testing (FIT) as an adjunct to the colorectal diagnostic pathway is now embedded across the system. In the past year, compliance with this element of the pathway has significantly increased such that in January 2024 almost 75% of referrals to the urgent suspected colorectal cancer (USC) pathway had an accompanying FIT result. This is in line with the national standard.
- Introduction of a straight to test (STT) flexible sigmoidoscopy pathway (December 2023) for those patients with a negative FIT but who are experiencing rectal bleeding

- Non-Specific Symptom (NSS) pathway (planned May 2024) for patients with a negative FIT who continue to experience symptoms which the GP is concerned about.

Collectively these approaches align with the national Best Practice Pathway (BPP) for colorectal and will refine referrals to the USC pathway, ensuring patients are directed to the pathway most suited to their health needs and reserving the USC pathway for those patients at the highest risk of a cancer diagnosis.

Skin

The Teledermatology pilot, based at a hub in the Royal Shrewsbury Hospital, went live with practices within the Shrewsbury Primary Care Network at the end of January 2023. The aim is to reduce inappropriate 2 week wait (now Urgent and Suspected Cancer – USC) referrals into secondary care by first taking dermatoscopic images in the hub which are then triaged by a secondary care clinician who may offer advice and guidance or recommend referral into the secondary care pathways. Initial uptake for this initiative was slow but in recent weeks referrals have increased and from February 2024 a further PCN has been invited to refer their patients in.

In tandem, the Community Diagnostic Centre (CDC) based in Telford will be a further pilot hub for patients, initially from some of the Telford & Wrekin PCNs, and this was from February 2024.

Evaluation of the pilot will be undertaken in conjunction with colleagues from SaTH to determine demand, capacity and the impact on referrals into the USC Skin pathway and a preferred approach going forward.

Breast pain

The Community Breast Pain Clinic established in November 2021, secured additional funding until the end of March 2024. This clinic has provided an additional pathway for patients presenting in primary care with breast pain without routinely referring into the USC pathway. The clinic has supported the service to meet the specific needs of those presenting with breast related symptoms and in turn has reduced the waiting times for patients being referred for suspected cancer by approximately 20%. The ICB is working in partnership with SaTH to determine options for the sustainability of this service once the enabling funding ceases.

Operational performance

STW remained within NHSE Tier 1 monitoring during 2023/24 with increased focus on reducing the backlog and to improve the Faster Diagnosis Standard performance. SaTH (as the main provider for cancer care in STW) have made extraordinary progress against the main NHS standards for cancer, improving compliance with the Faster Diagnosis Standard (FDS) from 59% in April 2023 to 75% in December 2023 (standard = 75%) and reducing the >62 day backlog from 470 to 343 in the same time frame.

Compliance with the 62 day standard (1st treatment after referral) has remained lower than average and this is acknowledged by SaTH and results from challenges being experienced within some specialties. The ICB are supporting with work being led by SaTH to recover this position.

Education and learning

Learning sessions involving the Cancer GP Lead and secondary care consultants were provided for primary care colleagues to provide information and education about existing cancer pathways, planned

changes and the clinical rationale for these. Sessions were well received and attended and will be continued during the coming year.

Cancer Programme Team

As an acknowledgement of the challenges facing STW with the provision of cancer care, the West Midlands Cancer Alliance provided non-recurrent funding to support the establishment of a small Cancer Programme Team who will take forward the implementation of a whole system programme and strategy of transforming cancer services for the county. The team was fully recruited and in place end March 2024, and look forward to working with system partners in the year ahead on collectively delivering programmes of work focused on improving outcomes and performance.

During the 2024/5 year the team priorities will be:

- Developing relationships with colleagues across primary, secondary and tertiary care along with organisations outside STW (WMCA, NHSE, voluntary and charitable sector) to understand system challenges and scope opportunities for improving outcomes and performance
- Providing support to FIT compliance, STT flexible sigmoidoscopy and NSS in the colorectal pathway to further refine USC referrals
- Providing support for ongoing delivery of Telederm pilot hubs and options appraisal for future service provision
- Providing support to Urology operational and clinical teams towards achieving best practice timed pathways
- Providing support to Gynaecology operational and clinical teams towards achieving Best Practice Timed pathways
- Providing support to operational and clinical teams for Head and Neck services teams towards achieving Best Practice Timed pathways
- Launching the national Targeted Lung Health Check (TLHC) project
- Providing education and training sessions for clinical and non-clinical colleagues across the system to provide a forum for discussion and aid understanding of specific pathways, changes and clinical rationale.

Eye Care Transformation

Planned to run up until 2025/26, this programme set out to review and redesign integrated end-to-end eye care services and pathways across the county, spanning primary, community and secondary eye care provision.

With a scope including the same principles as the outpatients transformation programme, it aims to improve referral processes and information sharing, shared decision-making, and reduce face-to-face outpatient activity and reduced unnecessary use of hospital for eye care appointments through methods including advice and guidance, remote consultations, one-stop clinics, community-based diagnostics, and nurse-led telephone follow-ups. It also includes several national recommendations around transforming eye care services and so has involved a clinically-led review and redesign of pathways; also considering learnings and recommendations that came out of stakeholder and public involvement and engagement sessions.

Some of the case for change and reasons why we need to improve eye care services includes:

- Importance of earlier detection and prevention

- Anticipating predicted increasing need for services
- Providing more services closer to home and in people's own communities, when it is needed,
- More joined up services across primary, community and secondary care
- Reducing unnecessary face to face Outpatient appointments
- Reducing travel to hospital and transport, which also reduces occupied parking spaces and CO2 emissions
- Making better use of new technologies and developments in eye care
- Making better use of data and tracking people's care.

The phases of the programme cover:

- Rethinking referrals and integrated eye care pathways (primary, community and secondary care)
- Outpatient transformation (eye care appointments)
- Multispecialty pathways (Giant Cell Arteritis and Hydroxychloroquine Monitoring etc)
- Low vision, dry eye, contact lenses and cataract direct to surgery listing (pre-op and consent in optometry)

All these phases will cut across eye care in general in terms of pathways, processes and ways of working, but include a specific focus on the following pathways:

- Cataract
- Glaucoma
- Medical retina
- Urgent eye
- Paediatric eye care

The programme launched November 2021 and undertook a period of comprehensive engagement, and this continues to form a continuous golden thread throughout the journey of the programme to ensure ongoing involvement, contribution and engagement.

This engagement has allowed us to harness comments and feedback on current eye care services, as well as suggestions and recommendations for change & improvement. That, combined with a patient survey, and analysis of 3 years worth of eye care complaints and compliments, and the national transformation recommendations, provided a wealth of information to help shape the design and development of a new improved integrated eye care model and pathways.

A piece of work was also completed to identify and analyse and associated inequalities, so that plans could be put in place to ensure these improvements to eye care would address any existing health inequalities and close gaps, and certainly ensure no new ones are created as a result.

Positive Impacts

Improved access to timely care and support for those with mobility and/or transport issues through new innovative ways of providing appointments, for example virtual appointments from your own home, removing the need for travel. Also, more locally available services through the provision of more eye care services from optical practices instead of hospital.

Enhanced experience of eye care services for all in an equitable way through new more effective and innovative ways of working, and more integration between primary, community and secondary care – ensuring the person is seen by the right person, in the right place, at the right time – first time.

Negative Impacts and mitigations

Potential risk of digital exclusion for those with limited or no access to technology and/or internet - the programme intends to provide virtual consultations by telephone also and ensuring that we still offer in-person traditional appointments.

For Phase 1 of the programme, a new proposed model of eye care and pathways were agreed by the Programme Team and stakeholders. However, the programme then had to be paused in May 2023, to allow for a broader Integrated Care Board review of its allocation of available resource to support the many competing priorities.

After a 6 month pause, the decision was made in December 2023 to restart the programme and see it through to completion from early 2024.

A business case for the proposed integrated improved eye care model and pathways is now being developed for consideration. This would provide a more cohesive and collaborative eye care service across primary, community and secondary care, including the independent sector, that benefits patients, carers, and those working in eye care because of the improved pathways that will be more slick, efficient, effective, clearer and easier to understand and navigate.

Prior to finalising the business case, the proposed model was shared in a further round of engagement to gain feedback and inform any necessary refining of the model before completion.

As a key enabler of improving eye care referral pathways and processes, and an enabler of this model in general, the Shropshire, Telford and Wrekin system agreed to be an early adopter and one of the 11 ICSs in the West Midlands for the implementation of electronic eye care referrals. The software and digital provider was commissioned by NHS England, with a project team and plan put in place locally for the implementation of this exciting change in how eye care referrals are made.

The system provides an improved flow of direct referrals between optometrists, the Referral Assessment Service (RAS) and Telford Referral and Quality Services (TRAQS), GPs and secondary care with the ability to transfer high resolution digital images directly from optometrists to secondary care consultants and enabling effective virtual consultations to take place without the need for the individual having to visit hospital. It also speeds up the process of optometrists gathering advice and guidance from consultants through a remote review, and the ability to make direct timely referrals into ophthalmology without the need for having burden the GP in processing the referral.

The Electronic Eye Care Referrals system has been successful implemented with most Optometry practices now actively using the system. Further work is ongoing with the remaining few practices.

Musculoskeletal (MSK) Transformation

Musculoskeletal (MSK) services are a key priority for the Integrated Care System in Shropshire, Telford and Wrekin.

In 23/24 we continued the drive of designing and implementing patient pathways and Services that meet our patient's needs, supports health care providers, and manages demand.

Introducing MSST

Working as a system, we integrated all the different community MSK services to have a single, streamlined service with clear accountability to improve patient experience, outcomes and service quality. This means one MSK model across Shropshire, Telford and Wrekin, including Therapies and MSK Interface. This

service is called MSST (usually spoken as 'must'). It fully launched in August 23, and is now embedded across STW. Having one single point of access (SPOA) and referral enables us to log and have oversight of all referrals in one place to ensure that everyone has equal access to the same high level of clinical care and treatment they need wherever they live in the county.

When the patient referral comes into MSST, it is triaged by our clinicians and forwarded to the right service, this supports our aim of Getting It Right First Time (GIRFT) for the patient and the clinician.

Within our new MSST service, the patient is referred between the relevant MSK services, appropriate to the persons need, and is no longer sent back to their GP to make new referrals. This makes the referral process more streamlined for the patient and avoid unnecessary work for the GP.

The care that people receive is organised through shared decision-making and patient choice. If the person moves to needing secondary care treatment, Orthopaedic and Rheumatology services, the person is given choice on what provider they would like to go to within our system or outside of STW.

MSK Digital Transformation

The MSK Transformation team has also been focusing on Digital Technology to support our MSK services and have been looking at ways it could support our patients further to self-manage their conditions and learn more about them. All which were highlighted as priorities from Primary Care Engagement, Patient involvement and based on the NHS England Plans for MSK services to:

- Develop MSK Community Hubs
- Self-referrals into Level 2 Therapies
- Self-management of MSK conditions
- Digital solutions to support productivity

MSK Transformation programme successfully put in three application forms to the HTAAF fund and successfully received £673,000 to develop:

- Good Boost (MSK aqua rehab and land-based exercise programmes in Leisure centres).
- My Recovery (App which includes information about MSK conditions and wider health management and can give guidance and advice to the patient which is tailored as they move through MSK Services. The app will also support waiting list patients to wait well)
- Strata (Digital solution to move patient information from two different systems, to make it quicker and less manual)

Self-Referrals

In the NHS England 2023/24 priorities and operational planning guidance PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk) , it shows a National NHS objective for Community Health Services, is to reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Expanding direct access and self-referrals empowers patients to take control of their healthcare, streamlines access to services and reduces unnecessary burden on GP appointments.

We are pleased that as part of the Transformation Programme, patients will be able to self-refer into MSK Level 2 therapies by April 24.

Giant Cell Arteritis (GCA) emergency pathway

Working across and in partnership with SaTH and RJAH we are close to implementing a single and recommended pathway for GCA. We aim to launch a GIRFT compliant GCA pathway for GCA by April 24.

What next

Other MSK Transformation projects have also started to be planned and designed ready for 24/25 are:

- Podiatry and Orthotics pathway redesign
- Enhance our orthopaedic services.
- Deliver one model of Rheumatology across STW (delivery 2024)
- Develop chronic pain pathways
- Deliver an outpatient's improvement project.
- Strengthen the support available for Primary Care (delivery 2024)
- Focus on population health management and equity in our MSK services.
- Emergency pathway in place for CES and GCA (delivery in 2024)

Cardiology Transformation

Launched in December 2022, the Cardiology Transformation Programme was established and scheduled to run until 2025/26 with the scope of working through the pathways that patients take from primary care through specialised services and back to primary and community care, from cardiovascular disease prevention and early diagnosis through to treatment and rehabilitation.

National context

An estimated 6.4 million people in England are currently living with cardiovascular disease (CVD). Mortality rates from CVD fell by 52% between 1990 and 2013 however CVD remains one of the biggest killers in the UK. Cardiovascular disease (CVD) is the second highest cause of premature death, after cancer, in England. Heart and circulatory diseases cause around a quarter (24 per cent) of all deaths in England; that's around 140,000 deaths each year – an average of 380 people each day or one death every four minutes.

The Cardiology transformation programme draws together the recommendations from the Cardiology GIRFT Programme National Specialty Report (Feb 2021), The Future of Cardiology, A Paper Produced by the British Cardiovascular Society Working Group on The Future of Cardiology, and significantly the Cardiac Pathways Improvement Programme. The Cardiac Pathways Improvement Programme (CPIP) brings together NHSE collective priorities set out in the Long-Term Plan, and by GIRFT, Specialised Commissioning, and the National Outpatient Transformation Programme. The CPIP team works in alignment with existing national programmes, focusing on key goals and priorities, and supports Cardiac Networks and Systems to deliver a comprehensive approach to whole pathway improvement and transformation.

Local Context

In Shropshire Telford and Wrekin there are around 66,000 people living with heart and circulatory diseases. These heart and circulatory diseases cause 110 deaths each month in Shropshire Telford and

Wrekin. Around 81,000 people in Shropshire Telford and Wrekin have been diagnosed with high blood pressure and 13,000 with Atrial Fibrillation.

Ambition

The ambition for the Cardiology Transformation Programme is to provide high-quality cardiology services for our patients, carers and their families in the right place, at the right time, in the right location delivering excellent patient experience.

Aims

The aims of the cardiology transformation work guided by NHSE's Cardiac Pathways Improvement Programme (CPIP) include:

- Reduce Cardiovascular disease related mortality
- Ensure high quality outcomes and safety of care across the pathway
- Improve and refine pathways and processes to provide clinically excellent cardiology services with restored services and reduced waits
- Improve integration of cardiology pathways across primary, community and secondary care to function collectively as one service with one common aim.
- Improved focus on preventative and proactive care
- Ensure value for money of commissioned services through provider collaboration.
- Providing increased support, development and accountability for the cardiology workforce
- Improve the flow, quality and use of information in order to optimise decision making; both operationally and strategically.
- Ensure the involvement and engagement of patients and public in the design and development of cardiology services
- Support the CVD prevention agenda

Since the commencement of the Cardiology Transformation Programme in December 2022, there is an identified Clinical Lead for the programme funded through NHSE's Cardiology Pathways Improvement Programme (CPIP). He links into the regional and national CPIP clinical programmes as well as providing clinical input and leadership for the STW Cardiology Transformation Programme.

The Shropshire Telford and Wrekin (STW) Cardiology Transformation Programme Delivery Group was put into place to work through the cardiology pathways that patients take from primary care through specialised services and back to primary and community care, from cardiovascular disease prevention and early diagnosis through to treatment and rehabilitation. The group collaboratively reviews, redesigns, develops and transforms cardiology services to ensure that high-quality cardiology services are provided for our patients, carers and their families in the right place, at the right time, in the right location delivering excellent patient experience.

In addition to a programme board group, plan and infrastructure, a clinical advisory group with multi-professional representatives from across the ICS was also established. The purpose of the Shropshire Telford and Wrekin (STW) Cardiology Clinical and Professional Advisory Group is to use its broad experience and expertise to provide clinical and professional advice to the STW Cardiology Transformation programme.

As with Eye Care Transformation, the Cardiology Programme was paused during the second half of 2023 to allow for a thorough review of the Integrated Care Board allocation of its resources to the many priorities.

It is absolutely understood and planned that Cardiology remains a system priority and is a programme of work earmarked to re-launch and re-start during 2024 to continue progressing at pace.

Other

Other pieces of large-scale work include the neurology service delivered at SaTH that was successfully transferred to The Royal Wolverhampton NHS Trust (RWT) in May 2021 after being challenged for many years, primarily due to workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close new referrals. Following system agreement that the local service could not be reopened in that form, agreement was reached between the CCG/ICB, SaTH and RWT to develop a sustainable neurology service across Shropshire, Telford and Wrekin.

The transfer was successful with ongoing monitoring throughout 2022 and 2023 prior to an evaluation and series of engagement sessions including clinical, patient and public and wider system stakeholders as an opportunity to undertake a full review and redesign, where necessary, of the local neurology service. This review and evaluation of the transfer is planned for 2024.

Work also continues on the review, redesign and recommissioning of audit hearing loss/audiology services in the county, including work being done in primary care around ear irrigation and wax removal.

Learning Disability and Autism

Our Annual Plan for 2023/24 – Key Programme Highlights

Special Educational Needs and Disabilities SEND

In Telford the Joint Local Area CQC and OFSTED SEND Inspection took place 20th - 24th March 2023, the outcomes of this inspection were published in July 2023. The inspection body evaluated the effectiveness of local arrangements to meeting the needs of children and young people with special educational needs and disabilities (SEND). The inspectors concluded that the Local Area's partnership's SEND arrangements typically lead to positive experiences and outcomes for CYP with SEND, due to the positive outcome the next full area SEND inspection will take place within the next 5 years. The local area were given 2 areas for improvement

- Leaders from NHS STW ICB need to work closely with other partnership leaders to improve the governance, monitoring and oversight of diagnostic pathways (including neurodevelopmental, mental health and speech and language therapy assessments) for children and young people with SEND, so that their needs are assessed and met consistently well and in a timely manner.
- Partnership leaders should improve communication with families, beyond the formal consultation routes, to share effective information and advice about the provision available to children and young people with SEND.

In Shropshire Local Area progress has been made with the Accelerated Progress Plan (APP) which was required to address limited progress in the areas of waiting times to access ASD and ADHD diagnostic assessment, speech and language therapy services and the quality of Education Health and Care Plans. The APP was deemed necessary after a SEND Local Area Re-inspection in November 2022.

SEND priorities for the forthcoming year are meeting the needs of CYP with neurodiversity including diagnostic pathways, meeting the needs of CYP with emotional wellbeing and mental health needs

including access to mental health services, meeting the needs of CYP with speech, language and communication needs including access to speech and language therapy. To support these areas additional funding has been secured through the 'Early Language Support for Every Child' initiative and 'Partnership for neurodiversity in schools' initiative. Additionally, Shropshire, Telford and Wrekin are part of a 2 year SEND Change Programme Partnership which has brought about additional funding to trial a range of initiatives, ELSEC being one of these.

Learning Disabilities and Autism Programme

The learning disabilities and autism programme came to the end of the 3-year road map (2021-2024) in March 2024.

Over the past 3 years we have worked with our system partners, our Parent Carer Forums and experts by experience on the key areas of:

- Reducing our reliance on specialist inpatient beds
- Building community infrastructure and support services
- Developing the housing and care market
- Improving outcomes for children and young people
- Driving a reduction in health inequalities and ensuring our workforce are supported and well trained

During the last twelve months we have worked to develop and enhance key services that add to our community offer.

- Our Keyworking service, delivered by Barnardo's is fully up and running, holding a full caseload of 36 children and young people. Several of the children and young people have shown improvements in presentation and a reduction in risk levels, allowing the service to close 15 cases.
- Our Adult Autism Hubs in Telford and Shropshire continue to support those on the waiting list for autism assessment, enabling them to 'wait well'. Both Hubs offer education workshops, one to one support and social opportunities for those pre and post diagnosis.
- We have developed several 'waiting well' initiatives for children who are waiting for autism assessment and their families. These include group sessions with an education psychologist and assistant psychologists embedded in our CAMHS service to provide early support, information and signposting.
- Preparing for Adulthood Navigators are placed with the Parent Carer Forums (Telford and Shropshire), working with families of young people aged 14 – 25 to support them through transition. Navigators offer one to one support, provide an information and training offer and develop peer support networks.

Work with our partners including our parent carer forums and experts by experience has been integral to the success of the programme over 2023/24. We have wide representation on our governance structures, and we have held coproduction workshops in relation to specific areas.

Earlier in the year we also held a very well attended in person workshop to coproduce the implementation of new guidance in relation to the Dynamic Support Register and Care (Education) and Treatment Reviews.

In February a system wide on person workshop was held as part of our review of the outcomes of the 3-year road map and to develop our plans for the coming year.

Next year we will continue to focus on admission avoidance and supporting the discharge of patients, while also seeking to further develop community infrastructure and services to enable individuals and families to receive support at the earliest opportunity.

Children and young people (CYP)

During the last year the system has developed several joint projects and services to drive improvement and capacity for services for CYP across STW. These include work to meet the NHS long term plan on CYP Long Term conditions, such as Diabetes, Epilepsy and Asthma. We have been recognised regionally for the provision of social prescribing for children and young people working developed jointly between the ICB, both local authorities and the voluntary sector.

System Governance

The ICB is in the process of establishing a strategic working group, which will include members from our partner organisations and local authority partners. Over the course of the 2023/24 year, CYP governance was delivered through the Mental Health, CYP & LD&A Board, which reports into our Integrated Delivery Committee. Additionally, we also have a Committee in Common which focuses on CYP, as a part of our provider collaborative activity.

CYP Transformation

We are currently reviewing our Children and Young Person's Mental Health Transformation Plan for Shropshire, Telford and Wrekin. As part of the review, we will be engaging with and taking into account the views and experiences of children and young people and their families and carers.

This working is planned to tackle the deterioration of mental and physical health of our CYP, and ensure that they have early, rapid and easy access to the care that is needed.

For further information on the programme, and activity to date, click here

CYP Mental Health Long Term Plan

As with many areas STW has seen an increase in the number of referrals to Mental Health services during the last year for both mental health support and Neuro assessments for ASD and ADHD. MPFT is now offering a waiting well initiative for all CYP waiting for an autism assessment. the feedback from parents and carers has been really positive.

During 2023/24 MPFT has reviewed and redesigned the crisis team and now offers a new 24/7 CYP crisis service, the eating disorder team has constantly met the national target and seeing all urgent referrals within one week and non-urgent within 4 weeks.

We now have another wave of Mental health support teams, and have 5 across the county supporting just over 50% of the schools in the county. These teams offer support to young people in school settings who are experiencing low mood and a range of anxiety difficulties.

Physical health CYP

Over 2023/24 the system has developed and actioned plans in a number of physical health services including diabetes, Epilepsy and asthma, STW ICB were successful in being awarded the asthma pilot funding to support meeting the national asthma bundle. A multi-agency asthma network has been developed and intelligence on impacts for air pollutions, asthma friendly schools, pathways developed for the care of CYP with asthma and heard the voice of CYP with asthma. The launch of the new Epilepsy bundle care for CYP has seen the system develop an epilepsy network and there has been an increase in CYP epilepsy nurses by 0.4 WTE to support the local development need to meet the bundle. The work will continue in 2024/25 to meet both the asthma and epilepsy bundles

Dementia

Work is progressing to implement the system wide dementia vision with system partners. The navigator function is being reviewed and options scoped for the delivery of this function. Demand for both the Admiral nurse service and the Alzheimer's link workers continues to grow. On going work continues with Primary care to develop the early help offer. Living plans have been implemented and are currently being evaluated. There have been a number of peer support group offered across the County.

Case Study Alzheimer's Society

- 84-year-old lady who was diagnosed with Vascular Dementia
- Client visited ILC – Independent Living Centre on Dementia Day.
- Dementia Link Worker visits weekly. No other services involved. Started to attend monthly coffee mornings and other groups were introduced slowly at the pace of the client and to enable client to feel comfortable and safe in the new environment. Also exploring other living accommodation

Outcome

- Client appreciated someone that was prepared to listen, non-judgmental and willing to look at different alternatives for groups to meet her needs.
- Confidence in joining the Lawley Court Coffee Morning and now has something to build on
- Alzheimer's Society having a presence monthly, can monitor carefully, also gives the client somewhere to have a meal and make new friends in a safe environment.

Mental Health

Over the past 12 months MPFT has proactively worked with partners and other NHS trusts:

- MPFT is progressing in the provider collaborative model. MPFT is the lead provider for adult eating disorder services, perinatal and a provider in forensics (reach out)
- MPFT continues to work with local authorities, housing associations, voluntary and community organisations to offer mental health support to members of the community including those who are vulnerable. Examples include the rough sleeper taskforce, led by Shropshire Council and Telford

& Wrekin Council, where MPFT provides rapid mental health support, for which they are early implementer in West Midlands
- The Telford & Wrekin Community Mental Health Service Depot Clinic won the Royal College of Psychiatrists Psychiatric Team of the Year; Outstanding Commitment to Sustainability / Green Care Award 2023
- MPFT's Early Intervention in Psychosis Service became the first accredited service in the UK and achieved level 4 (highest) in the National Clinical Audit of Psychosis
- Mental health workforce increased by 38.8% from December 2018 to October 2023

Key Achievements to Date

- Crisis Cafes in Shropshire and Telford & Wrekin
- Investment has been made to progress in the Rehab OOA placements and repatriations
- ARRs works developed in PCNs
- Partnership working with PCNS and including VCSE's
- Grown MH Liaison Team in RSH
- Debt and housing advisors for people with serious mental illness
- Staffing on wards - low staff numbers and high acuity - much more robust
- Reduction in restrictive practice on wards
- Real time data for suicide

Improving Quality

NHS Shropshire Telford and Wrekin works with partners to improve quality of services and support a culture of continuous learning and development of organisations who deliver care to our population. The quality governance structure of the ICS and quality function of the ICB works with information, organisations and senior leaders and regulators including the Care Quality Commission (CQC) and other external partners to address areas where quality improvement is required or where concerns have been identified. Current CQC ratings and conditions/concerns are listed in the table below.

Organisation	**Rating (as of 31st March 2024)**	**Conditions**
Shrewsbury and Telford Hospitals NHS Trust (SaTH)	Inadequate	1 condition relating to Regulated Activity: "Assessment or medical treatment 4 conditions relating to Regulated Activity: "Treatment of disease, disorder and injury"
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)	Good	None
Midlands Partnership NHS Trust (MPFT)	Good	None
Shropshire Community NHS Trust (SCHT)	Good	None

Primary Care

Overall rating	Outstanding	Good	Requires Improvement	Inadequate	Not inspected
51 Practices	3	43	4	0	1

NHS Shropshire Telford and Wrekin supports workstreams to improve and address areas of concern. In 2023/4 the following areas of collaborative work with partners has been undertaken with a focus on the Patient Safety Strategy and NHS Impact priorities.

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

- Collaboration in relation to the published and approved Patient Safety Incident Response Framework Policy and Plan including System agreement and setting of PSIRF priorities.
- Oversight of patient safety priorities in line with the PSIRF Policy and Plan to support shared learning across the system.
- Learning from Patient Safety Events (LFPSE) collaboration and oversight.
- Embedding of learning from infection prevention and control related incidents.

Shrewsbury and Telford Hospitals NHS Trust

- Maternity/Local Maternity and Neonatal services (LMNS) / Perinatal Quality – Oversight is maintained through several routes including SaTH attendance at LMNS / Perinatal Quality Surveillance Group NQSG monthly meetings, 3-year delivery plan workstream meetings, Contract Review meetings, Saving Babies Lives review meetings, Maternity & Neonatal Safety Champions meetings.
- Co-creation of a renewed harm review process relating primarily to urgent and emergency care ambulance off load delay with SaTH colleagues.
- Cancer harm review processes
- Collaboration in relation to the published and approved Patient Safety Incident Response Framework Policy and Plan including System agreement and setting of PSIRF priorities.
- Oversight of patient safety priorities in line with the PSIRF Policy and Plan to support shared learning across the system.
- Learning from Patient Safety Events (LFPSE) collaboration and oversight.
- The ICB is part of immediate escalation process and works with the system and Menal Health collaborative to ensure safe care at SaTH and appropriate Tier 4 bed.

Midlands Partnership NHS Trust

Increasing focused support to the Shrewsbury and Telford Hospital NHS Trust to address the concerns of the section 31 relating to the treatment of children and young people with acute mental health conditions as well as sustaining and continuing existing support, where relevant, is a continued priority going in to 2024/25.

- Collaboration in relation to the published and approved Patient Safety Incident Response Framework Policy and Plan including System agreement and setting of PSIRF priorities.
- Oversight of patient safety priorities in line with the PSIRF Policy and Plan to support shared learning across the system.

- Learning from Patient Safety Events (LFPSE) collaboration and oversight.
- Identification of quality priorities to support additional investment in children's services.
- Collaborative approach to addressing CQC recommendations and section 28.

Shropshire Community Health Trust (SCHT)

Focus on the local and national priority to support people to remain and receive the assessment and treatment they require in their own homes. This has resulted in the creation of Virtual Ward that provides consultant led hospital level care to a patient in their own home. SCHT has supported initiatives to prevent falls occurring or to support someone to remain at home after a non-injurious fall through prompt assessment and management.

SCHT have been commissioned to provide 2 Rehabilitation and Recovery (Sub Acute) Wards with 20 beds at PRH and a further 26 beds at RSH. The provision of the Rehab and Recovery beds strengthens acute and community patient pathways to support patients that no longer require acute hospital intervention but continue to require subacute inpatient care that cannot be provided at home. It complements the Virtual Ward programme and other interconnecting work streams such as Discharge to Assess.

Quality Lead has participated in Quality Monitoring visits.

- Collaboration in relation to the published and approved Patient Safety Incident Response Framework Policy and Plan including System agreement and setting of PSIRF priorities.
- Oversight of patient safety priorities in line with the PSIRF Policy and Plan to support shared learning across the system.
- Working towards the implementation of Learning from Patient Safety Events (LFPSE) collaboration and oversight.
- Collaborative working on pathways to avoid attendances to the emergency department and provide step down including strengthening urgent care response and virtual wards.

ICS quality developments

The Shropshire Telford and Wrekin Integrated Care System's quality function, with leadership from NHS STW, uses the NHSE publication on NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England (NHSE, January 2023) as its framework. Strategic quality requirements during 2023/24 have been undertaken though the implementation of national guidance including that on System Quality Groups and risk escalation. These have been fully embedded and utilised with partner support. Operational quality systems and assurance are in place through close liaison, and integration into quality functions in NHS trusts and at Place as well as through Safeguarding partnerships. Regular reporting against system risks and quality priorities are scheduled at both System Quality Group and the Quality and Assurance Committee of the ICB Board. These include patient safety and patient safety improvement programmes such as the NHS Patient Safety Strategy key deliverables - updated for 2023/24, Patient Incident and Response Framework (PSRIF), Learning from patient safety events (LFPSE), NHS IMPACT 2024/25 priorities

and operational planning guidance and Working Together to safeguard children (2023). Patient safety programmes led by the quality function of the ICS in 2023/24 have included:

- Supporting improvements to Palliative end of life care and in particularly identification of people at the end of life in the community.
- Quality Improvement projects to improve falls prevention referrals and provide timely response to those who fall.
- Quality Improvement project to improve compliance with deterioration training and action in care homes.
- Quality Improvement project to establish a meaningful experience of care function of the System Quality Group.
- Improving the quality of asthma annual checks in children.

NHS STW was selected as one of five national pilot sites to test the NHSE self-assessment tool to support national guidance on Improving experience of care: a shared commitment for those working in health and care systems (NQB, 2022). Through this the methodology and approach has been critiqued and co-produced and fed back nationally, and this work continues in the 2023/24. The project as co-produced a quality priority which is to be taken forward in 24/25 through System Quality Group.

Insight and feedback using locally, and nationally sourced data has been maintained including themes and trends from NHS-to-NHS concerns, complaints, and patient safety incidents. Through integration with the system governance processes, the effectiveness of quality functions involving Getting it Right First Time (GIRFT), NICE appraisals and guidance and national clinical audits have been assured. Additionally, there is quality representation on key programmes in line with the clinical strategy and long-term condition priorities. This includes diabetes, children, young people, and families and palliative and end of life care. Discharging Safeguarding responsibilities are monitored though the System Quality Group including the looked after children's agenda. Further information on Safeguarding is provided later in this report. In addition, the Child Death Overview Processes (CDOP) are currently under review in the system to ensure they are robust and have a supportive governance and escalation structure following the formation of the ICS. Challenges continue and are monitored through a joint quality and performance risk register which forms the basis of the agenda for the Quality and Performance Committee of the ICB Board.

Risks held on Quality risk register in 23/24

- Improving access to children and young people's mental health services including supporting Shrewsbury and Telford NHS Trust in meeting the requirements of its undertakings in relation to inpatient mental health paediatric care. Existing risk
- Ensuring safe and effective maternity and neonatal care. Existing risk
- Reducing delays to in Urgent and Emergency Care departments. Existing risk
- System governance of palliative and end of life care (de-escalated April 23)
- Improving the safety and effectiveness of diabetes care across the ICS. Existing risk
- Suspension of paediatric ophthalmology service (de-escalated April 23)
- Improving the safety of the acute paediatric pathway. (Risk reduced Jan 24 Existing Risk)
- Rising cases of *Clostridioides difficile* (risk escalated Aug 23)
- Tackling the backlog of elective care procedures (de-escalated May 24)

- Ensure we meet the statutory responsibilities with regards to Continuing Healthcare (escalated Jan 24)
- Individual Commissioning - Improving compliance of assessments undertaken within 28 days, (statutory function) (risk escalated Jan 24)

Learning Disabilities Mortality Review (LeDeR) Programme

LeDeR is an NHS service improvement programme 'Learning from lives and deaths for people with a learning disability and autistic people. NHS Shropshire Telford and Wrekin ICS continue to be fully committed to the LeDeR programme which key principles are to:

- Improve care, reduce health inequalities and to prevent people with a learning disability and autistic people from early deaths.

STW LeDeR reviews are undertaken by an external provider for the reporting period 1st April 2023 until 31st March 2024. The performance for STW has fallen below the national standard however there has been a remedial action plan and a change in provider for the 2024/25 contract.

LeDeR continues to report to the LD&A Operational planning group and System Quality Group.

Learning from LeDeR is shared through the LeDeR Steering Group which include members with lived experience and system partners.

There has been positive learning and areas of local challenge and improvement, please see table below:

Areas of good practice identified from LeDeR reviews	Key learning points of feedback to health and care partners	Areas requiring improvement identified from LeDeR reviews
Evidence of holistic and MDT approach to care and support Appropriate best interest decision making to support wishes and quality of life. Consistent reasonable adjustments to support home treatment and hospital admissions. Good communication with family members who were continuously informed, supported and included in all decisions. Care package provisions considering people's personalities and preferences.	To ensure MCAs are utilised for specific decisions. Completion of health action plans following an annual health check Reasonable adjustments are always identified, flagged, and implemented. Personalised recommendations on ReSPECT forms are always followed. All relevant age/gender screenings/vaccines are offered and supported with reasonable adjustments.	Promotion of MCA/BI training system wide. More support and information to be available to family carers around POA, appointee and deputyship. Promotion and training to understand the implementation and appropriate use of ReSPECT forms. Promote learning disability and autism awareness. Joint system working with primary and secondary care to drive forward areas of improvement

All deaths caused by aspiration pneumonia, sepsis, epilepsy, cancer, and dementia were considered priorities for 2023-24 and a focused review was undertaken. Other priorities for 2024-25 are being considered.

Enablers

At the heart of our work is a desire and purpose to improve the health of the diverse populations that make up Shropshire and Telford and Wrekin. We know that our geography and population demographics present us both opportunities and challenges, and that we must find new and innovative ways of working to enable the changes that need to take place to better serve these communities.

We know that we can only fully achieve this by working in partnership with others including local authorities, public health teams, health and social care staff, service providers, and residents themselves.

As an organisation, we have focused our efforts over the last year on working cross-organisationally on key programmes and projects to maximise our opportunities to develop and transform health and wellbeing services to improve the health of our population.

Key pieces of ongoing work that have supported this include:

- **People**

Our system workforce has been working collaboratively for many years, an approach underscored during the system's response to the Covid-19 pandemic. During this time relationships have formed between NHS, Local Authority, ICB (formerly CCGs), Primary Care, Social Care and Voluntary sector partners to tackle the workforce pressures at a system level. Our ICS People Committee draws its membership from a broad range of stakeholder organizations and continues to build on our collaborative approach towards delivering the National guidance for ICB People Functions to support a sustainable "One Workforce" within Health and Care - creating a 49 compassionate and inclusive culture and working collaboratively as a system to address our workforce challenges.

- **Population Health Management (PHM)**

Population Health Management (PHM) is a person centred, data driven approach that seeks to improve the physical and mental health of people over their lifetime. PHM allows our system to use all the digitally collated data, intelligence and insight from our area to make collective decisions and prioritise key issues and specific populations of people, depending on need and equity. It requires clinicians, professionals, frontline workers to expand their focus from treatment / assessment to considering the whole person and their health risk. System leaders in conjunction with local stakeholders and the public have set our ambitions and priorities for PHM over the next five years. We expect our priorities to evolve and respond to conversations with the public over the next five years.

- **Financial Sustainability & Productivity**

The Shropshire, Telford and Wrekin system has a significant underlying financial deficit which is one of the reasons that we are part of the Recovery Support Programme (RSP). The system and ICB is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering and making sustainable the financial position. A system financial framework was therefore developed in 2020/21 and agreed by all organisations and all system partners work closely together to deliver a roadmap for financial recovery.

- **Digital**

As an ICS we place our people at the heart of our digital journey and work together as a system to manage health and wellbeing services for our population. We promote a digital first, not digital only approach to improving care. Shropshire, Telford and Wrekin ICS are currently moving through the process of digitally transforming, to 'level up' and align with both ICS and national objectives. This means putting in place the right infrastructure that our impacted users expect. It means providing digital access to medical and care records. And it means ensuring information can be shared easily between our different care settings

Our clinical and professional teams work across the health system to transform and improve health services every day. There are a number of activities that support this work:

- Following the implementation of a fully managed domain within Primary Care, the ICB is underway with its deployment of SharePoint for all practices and PCNs utilising the NHS national tenancy. Implementing SharePoint enables substantial opportunities for improvements in collaboration, information management, and compliance. By providing a centralised, secure platform for document sharing and team collaboration, SharePoint helps the clinical and care teams more easily locate clinical information, reduce the risk of outdated guidance, enhance productivity across multi-disciplinary teams, and increasing the capacity for activities to improve patient care outcomes.
- All practices continue to offer Online Consultation through products procured via the national Digital First Primary Care Framework. Providing practices also with the ability for Video Consultations and digital tool such as 2-way SMS messaging allowing GPs to engage with citizens to gather more detail.
- Through the support of the Primary Care Team, Shropshire, Telford & Wrekin had the highest percentage of citizens using the registering with a GP surgery service.
- The ICB continues to encourage the use of the NHS App as the gateway to NHS services for viewing records, ordering repeat prescriptions, and is also working with the national team and suppliers to integrate SMS messaging into the app and is showing good levels of NHS App take-up with 49% of GP Patients 13+ registered for the NHS App.
- National PCARP cloud-based telephony funding has supported the remaining 15 practices who were on evergreen contracts or suppliers unable to provide advanced telephony functionality. Support with exit and implementation costs has allowed these practices to migrate to a supplier on the new mandated Better Purchasing Framework to provide the enhanced cloud-based telephony functionalities.
- Through the NHSE national pilot for Notes Digitisation the ICB received funding support for 7 practices in Shropshire, Telford & Wrekin to allow their Lloyd George notes to be scanned and digitised into the clinical system. This has now provided practices with ease of access to these records as well as providing additional space for practices to utilise.
- A new telephone system was procured for the Prescription Ordering Direct service to enable patients to order repeat prescriptions. Thie system introduced the keep my place in the queue which saves waiting times and returns calls.
- All systems now are using Multi Factor Authentication (MFA) in line with cyber security guidance. This is in place to keep all ICB information secure and safe from cyber-attack.

Medicines Management

Medicines optimisation looks at the value that medicines offer, making sure they are clinically effective (that they improve outcomes for the person taking them) and cost-effective (that they represent good use of NHS resources). It is about ensuring that people get the right choice of medicines, at the right time and are engaged in the process by their clinical team (shared decision- making).

Mission: To drive improvements in health outcomes and reductions in health inequalities for the population of Shropshire, Telford and Wrekin by leading on a system-wide collaborative approach, ensuring safe and effective medicines use is integral to all services, pathways and settings.

Vision: Transform the delivery of pharmacy creating an integrated workforce across the system, striving for innovation and collaborative change, that delivers seamless, patient-centred care at every point of the patient's journey.

System Wide Medicines Governance

We have been working with our provider colleagues to implement a shared governance framework for medicines and have launched our first ICS Medicines Strategy PowerPoint Presentation (shropshiretelfordandwrekin.nhs.uk).

We have strengthened our collaborative leadership model for pharmacy with the addition of an ICS Medicines Value Group to support delivery against the National Medicines Opportunities and have developed a pharmacy faculty to support in planning to address our significant workforce challenges.

From the 1st of April 2023, Integrated Care Boards (ICBs) took on the delegated responsibility for commissioning pharmacy services from NHS England. This supports NHS England's long-term ambition to put more decision making around services at a local level. In line with this delegated responsibility, NHS Shropshire Telford and Wrekin have increased their focus on community pharmacy and to enable this, we have introduced a community pharmacy lead role and a programme to promote and develop the role of community pharmacy.

Community Pharmacy Enabler section

The community pharmacy network in Shropshire Telford and Wrekin is made up of 81 pharmacies located in accessible locations across the Integrated Care Systems (ICS) footprint. In addition to supplying over half a million prescriptions items each month, the Shropshire Telford and Wrekin community pharmacy network undertakes several thousand pharmacy services each month. These community pharmacy services provide access to vital healthcare services to our residents in their own communities.

NHS Shropshire Telford and Wrekin are working with community pharmacies, other healthcare providers and non-health partners to enable more care to be delivered in the community, enhancing access, experience and outcomes for our residents.

This year work has continued to increase the utilisation of, and access to, the Discharge Medicines Service (DMS), Community Pharmacy Consultation Service (CPCS), and the Community Pharmacy Blood Pressure Check Service. In addition, this year has seen the expansion of existing services, and the creation of some new services. The Community Pharmacy Contraception Service pilot has been expanded

into a national service that allows women to access oral contraception from a community pharmacy without the need to visit a GP or sexual health clinic. CPCS has been expanded and relaunched as Pharmacy First, allowing 7 common conditions to be treated by community pharmacists without needing to visit their GP. Work is underway to launch the Community Pharmacy Independent Prescribing Pathfinder Programme in a small number of pharmacies across the region, this will see pharmacist prescribers treating patients in the community pharmacy setting.

As part of this work to expand service delivery in community pharmacy, NHS Shropshire Telford and Wrekin have worked with a variety of partners to integrate community pharmacy services and pathways into existing settings. Some of these partners include, General Practice, NHS Trusts, Urgent and Emergency Care teams, 111, Local Authorities, and the Voluntary Sector. Work has also taken place to strengthen existing relationships with a variety of local, regional, and national teams.

To ensure the community pharmacy offering is known by Shropshire Telford and Wrekin residents, the community pharmacy team has worked closely with local and regional communication teams on a variety of public facing campaigns that raise the profile of community pharmacy with the public.

The work that has been undertaken this year represents the first step to achieving the future vision of community pharmacy. This future vision will see enhanced access to care in the community, an increased focus on prevention and a reduction in healthcare inequalities for our residents.

Workforce

All areas within healthcare are currently undergoing challenges with workforce, the pharmacy sector is no exception. There are currently high levels of vacancies across all pharmacy providers in Shropshire Telford and Wrekin. While these challenges are mirrored in other areas, rurality and a lack of local training providers adds additional challenges locally. In addition, the national Initial Education and Training of Pharmacists Reform means that it is becoming more challenging for local providers to take on Foundation Pharmacists for their training year – a driver for recruitment.

Acknowledging these challenges and the significant risk a declining pharmacy workforce brings, NHS Shropshire Telford and Wrekin has worked with system partners to address some of these challenges.

An ICS Pharmacy Faculty has been set up to support the development of all pharmacy staff across Shropshire Telford and Wrekin. The faculty includes membership from all sectors of pharmacy and will work on key areas of training and education for pharmacists and pharmacy technicians. This will involve brining partners together to form joint cross sector placements for foundation year training placements, increasing the availability of undergraduate training placements, and developing an integrated and agile workforce fit to deliver the future vision of pharmacy.

Medicines Value

The Medicines Value Programme (MVP) is a national strategic priority for the NHS in England which aims to deliver measurable improvements in patient outcomes while maintaining an affordable medicines bill.

The programme covers the entire NHS system of primary and secondary care. Systems are integral to the implementation of the Regional and National Medicines Value priorities and driving the changes that are needed in prescribing and medicines use and delivering the programme's aims. The Medicines Value Programme Working Group for NHS STW was established in July 2023 to support the local health economy to implement strategies that enable Medicines Value priorities to be delivered.

The group has been instrumental in the review and delivery of the 23/24 cost improvement plans (CIP) for all system partners across NHS STW, with ICB cost-efficiencies projected to deliver savings of over £4.6 million by the end of the financial year.

Most recently, the group have been planning programmes for 24/25, identifying opportunities through local datasets and aligning priorities with regionally and nationally identified areas such as the National Medicines Optimisation Opportunities.

Antimicrobial Resistance

The System Antimicrobial Strategy and Oversight Group convenes bi-monthly to discuss how best to implement the **national 5-year action plan for antimicrobial resistance 2019 to 2024**, and to monitor and advise on local antimicrobial prescribing trends and patterns. The group forms a core pillar of medicines governance and membership includes partners from across the system representing primary care, secondary care and community teams.

The group have been instrumental in the design of our new outpatients service at SaTH. The Outpatients Parenteral Antibiotic Therapy (OPAT) service will allow patients requiring intravenous (IV) antibiotics, but who are otherwise medically fit, to be discharged from hospital earlier, getting back to their homes sooner, whilst receiving any IV antibiotics as outpatients and being provided with oral antibiotics in a safer and efficient manner.

Most recently, the group have been successful in bidding for a system wide guideline to be developed and utilised by all system partners when prescribing antimicrobial medicines. This will enable a standardised approach to the use of antimicrobials is adopted throughout Shropshire, Telford and Wrekin. The guidance will be developed in collaboration with the microbiology department of our local acute trust, ensuring local microbiological intelligence is adopted to keep antibiotics working for longer.

Local Commissioned service: Medicines Safety

In September 2022, the locally commissioned service for the safe prescribing of medicines was launched across all 51 GP Practices. We use a system called ECLIPSE Live Radar to help practices to identify patients at risk of harm from medicines.

The ECLIPSE Live Radar alert system is utilised by 78 NHS organisations nationally, with Shropshire Telford and Wrekin now ranked as the 5th best performing.

The service compliments GP practice systems for safe prescribing, ensuring medicines safety monitoring is completed in a timely manner, which reduces the risk and volume of medicine related hospital admissions.

The locally commissioned service has continued to demonstrate improvements and contributed to a 7.2% reduction in emergency hospital admission rates.

Medicines Safety in Care Homes, Home Care and Supported Living Enabler section

Our team support the safe use of medicines, which includes education and training, in care settings covering 180 Care homes 140 Domiciliary/Home care agencies, Childrens Services, Day Services and Supported Living.

The reporting of medication-related incidents via the Ulysses reporting system by care settings is increasing with 38 incidents reported via the system in 2023. Themes identified as a result of reporting have been embedded into education and training which is offered to all care settings across STW.

Oral Nutritional Supplement (ONS) prescribing has been identified as a quality improvement opportunity in Shropshire, Telford and Wrekin. Prevention of malnutrition is a complex process, best achieved through education, early intervention and food first approaches. We are working with a 3rd party organisation to identify opportunities in Primary Care to review and ensure appropriateness of patients' prescribed ONS as well as education to ensure regular monitoring and treatment goals are in place and a food first approach to malnutrition where appropriate.

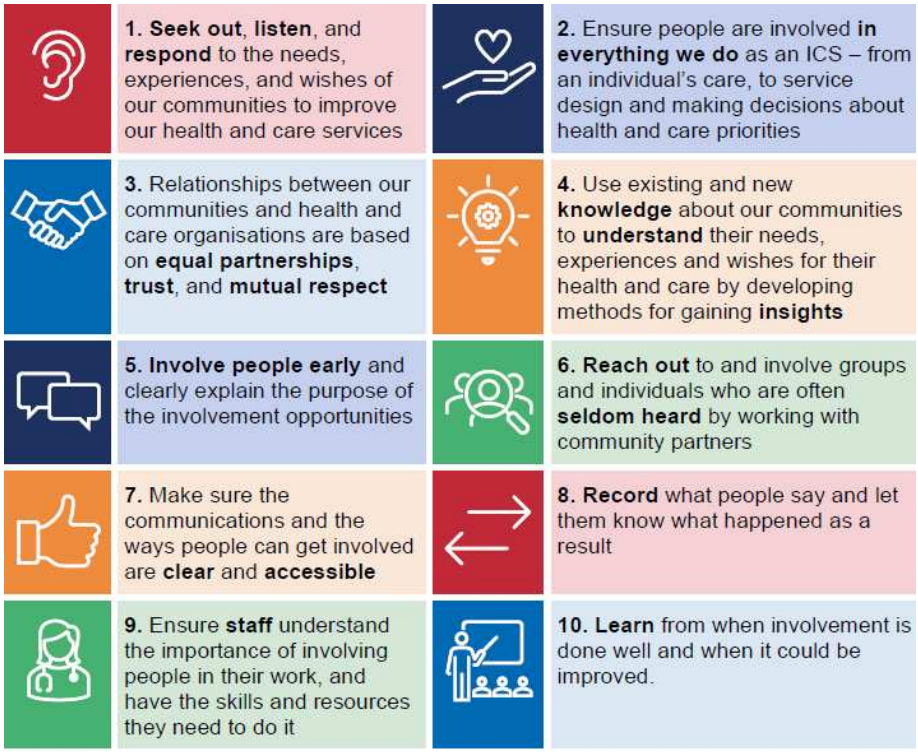
Engaging our Communities to Enable Change

The ICB has a legal duty under section 14Z45 of the Health and Care Act 2022 to involve individuals, their carers and representatives in the planning, development and consideration of changes which may impact upon them.

However, the ICB's desire to keep residents involved in planning, re-designing and commissioning goes much deeper than fulfilling statutory obligations.

The ICB's engagement strategy – Our Approach to Involving People and Communities – has been developed with partners across Shropshire, Telford and Wrekin Integrated Care System, this includes engagement and patient experience professionals, people from voluntary and community groups, Healthwatch, and patients and members of the public.

As part of the strategy development, ten principles for involving people and communities were co-designed which continue to inform the ICB's approach:



The approach to communication and engagement varies according to the subject of the engagement and who need to be engaged with. The ICB has developed a toolkit to support programme and project leads to plan and undertake communication and engagement activity appropriate to their work.

The ICB continues to regularly communicate and engage people through a number of established routes, including:

- Community outreach and engagement
- Insight and intelligence from surveys, focus groups, Patient Advice and Liaison Service (PALS) and complaints, and system partners
- Resident stories
- Experts by experience
- Board meetings held in public with opportunities for members of the public to ask questions
- Website and digital channels including Twitter, Facebook and LinkedIn
- Newsletters
- Media
- Political engagement
- The People's Network (see below)

The People's Network is a representative consultative body of local residents who have opted in to engage and feedback their views on health and care matters that affect the populations that make up Shropshire, Telford and Wrekin (STW).

There are around 400 members, who have been enrolled onto a bespoke platform developed internally to enable the ICB to engage in a range of different ways, to help inform decision making.

Since it was launched, the network has been engaged on a number of matters, including:

- Musculoskeletal services
- The development of two new sub-acute wards
- The Hospitals Transformation Programme

Voluntary sector

The ICB has a history of strong links with the voluntary sector in Shropshire, Telford and Wrekin, continuing to work closely with them in relation to plans, particularly with regard to Place. The ICB utilises their networks as well as its own direct contacts to reach out to more voluntary sector organisations and into diverse communities across the patch.

Patient participation group networks

The ICB works with patient participation group (PPG) networks, which bring together PPGs from across the county. The meetings provided a forum to inform patient representatives about national and local NHS developments and provide opportunities for involvement.

Shropshire, Telford and Wrekin Maternity and Neonatal Voices Partnership

The Maternity and Neonatal Voices Partnership (MNVP) is an independent team made up of women and their families, commissioners, service providers and local authorities.

The function of the MNVP is more than simply to listen. It brings people together to design and improve maternity care by discussing challenges and solutions across Shropshire (including Powys) and Telford and Wrekin.

Healthwatch

Healthwatch is an important partner for the ICB. They are regularly involved in formal and informal meetings including Governing Body and service transformation programmes.

Healthwatch have supported the ICB to establish processes that support involvement and feedback mechanisms for patients and members of the public. These help the ICB gather insight to feed into service learning and development. Healthwatch also regularly provide Patient Engagement Reports. These reports are a valuable source of information for service reviews.

Greener NHS

Sustainable Development

As an NHS organisation and spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare. Sustainability means spending public money well, the smart and efficient use of natural resources, and building healthy, resilient communities.

By making the most of social, environmental and economic assets, we can improve health both in the immediate and long term, even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

The NHS has set itself a much more ambitious target to become net carbon zero by 2040. Just one year after setting out these targets, the NHS has reduced its emissions equivalent to powering 1.1 million homes annually. NHS Shropshire, Telford and Wrekin ICB has accepted this challenge and established a Climate Change Group to work across organisations to deliver an ICS Green Plan which was approved by the shadow Shropshire, Telford and Wrekin ICB in April 2022. More information on these measures is available on the Greener NHS website.

During 2023/24 NHS Shropshire, Telford and Wrekin identified suitable estate In Wellington, Telford to consolidate its staff onto one site that meets modern building standards, with lower running costs and a better environment to support staff to work in an agile way, which will assist in meeting the NHS net carbon zero target. The relocation process was completed in February 2024.

Energy and Utility Costs 2022/23 and 2023/24

The ICB does not own or have control over any estate, other resources, natural capital or landowning that require reporting in this annual report.

Energy

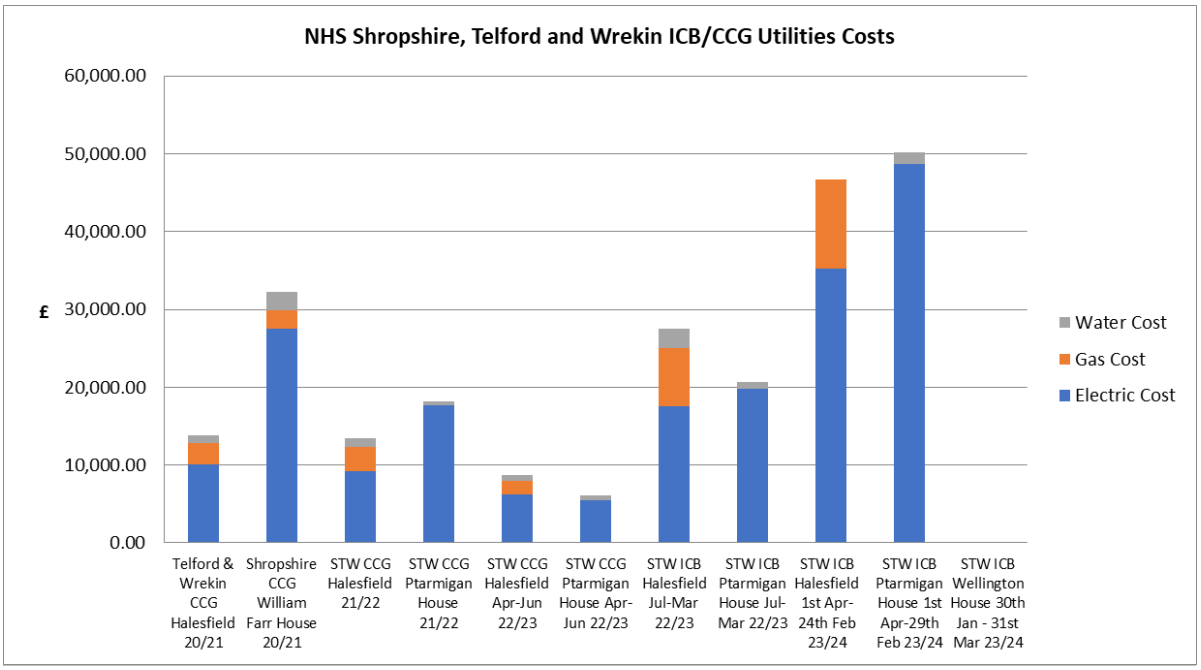
The ICB does not own or have control over any estate, other resources, natural capital or landowning that require reporting in this annual report.

The graph below shows the position for the year ended 31st March 2024, with comparative information for previous accounting periods of the ICB or CCG. In 2020/21 two sites were occupied by the then separate CCGs, Shropshire CCG at William Farr House and Telford and Wrekin CCG at Halesfield. In May 2021 following the two CCGs being dissolved, a single CCG was created, and staff based at William Farr House were moved to a new site at Ptarmigan House. From 1st July 2022 the CCG transferred all of its operations into the new ICB, and from March 2024 Halesfield and Ptarmigan leases were terminated with one new site at Wellington becoming the corporate centre for the ICB. There have been no charges for the new Wellington site in 2023/24.

The graph below shows there has been a similar level of usage of energy at the Halesfield site in water costs, gas and electricity costs between 2020/21 and 2021/22. Two accounting periods in

2022/23 for the two different organisations also make it difficult to draw direct comparisons with 2021/22.

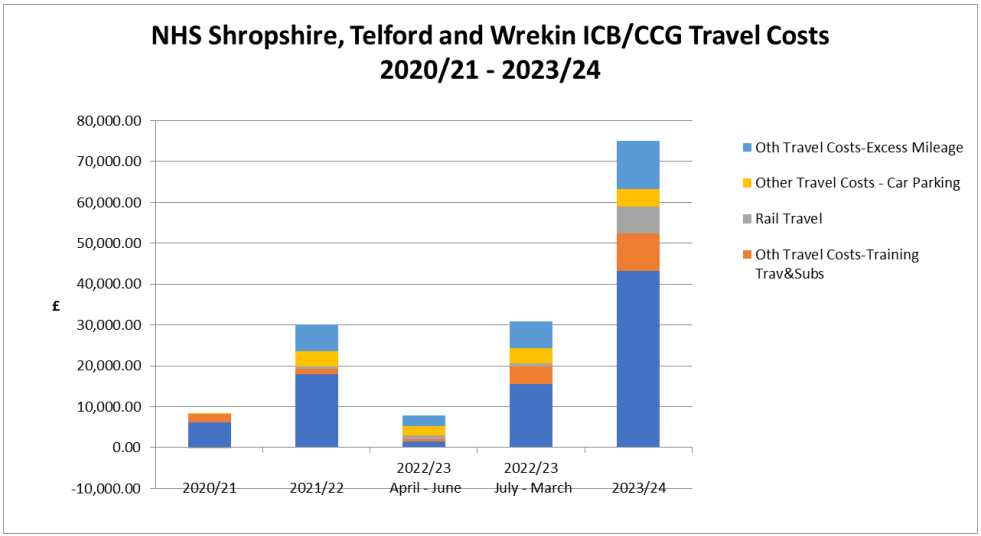
Utilities costs 2020/21 to 31st March 2024



Travel

The graph below shows an increase of travel costs from 2020/21 which reflects the relaxing of COVID 19 restrictions nationally. To support staff, the ICB has developed an agile working policy, which has enabled staff to continue to work from home wherever possible, to reduce staff travelling and enable them to have an improved work life balance.

During 2023/24 the ICB has not owned, hired or leased car fleets and none of our travel costs include any flights, either international or internal within the UK. However, for 2024/25 the ICB has introduced a lease car scheme for its staff which includes both traditionally fuel and electric/electric hybrids as options.



Consumables and waste management

During the period 1st July 2023 to 31st March 2024 the ICB used a total of 270 reams of paper, this is in comparison to 340 reams of paper used by the ICB and its predecessor: NHS Shropshire, Telford and Wrekin Clinical Commissioning Group in 2022/23.

Contracts for waste are overseen by landlords of each of the properties where ICB staff are based and so the ICB does not have access to waste management information for reporting purposes.

Environmental Impact of Medicines ('Green' medicines)

The ICB is not currently required to have a Green Plan, but it does contribute to the ICS Green Plan for system medicines. During 2023/24 continued work by the ICB's Medicines Optimisation team working with colleagues across the system has been ongoing to support the ICS Green Plan on improving respiratory outcomes while reducing the carbon emissions from inhalers.

To facilitate the rollout of the new asthma treatment guidelines for adults, the ICB delivered educational workshops for healthcare professionals. These sessions aimed to refresh and update skills on asthma management and implement quality improvement initiatives.

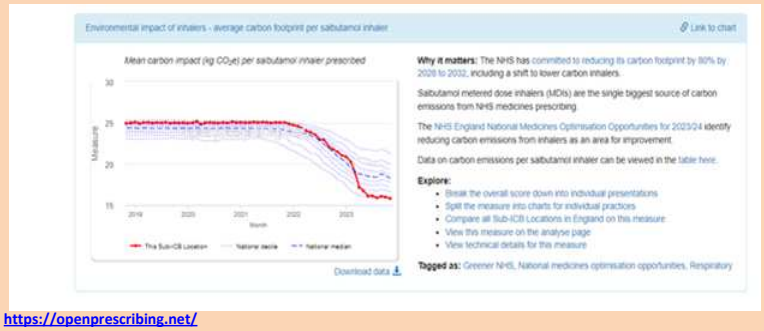
The ICB secured a non-promotional medicines service, 'The REACT Asthma Service.' This clinical therapy review service is designed to support practices in improving the therapeutic management of asthma patients. By implementing a systematic approach, to potentially reduce symptoms, the risk of asthma attacks, and preventable hospital admissions, through better asthma control. It complements the existing work of healthcare professionals in practices and helps address backlogs in chronic disease reviews caused by ongoing pressures in Primary Care. This service aligns with the ICB commitment to the Integrated Care System (ICS) Green Plan, aiming to meet NHSE targets for building a more sustainable NHS and reducing its environmental impact.

Collaboration with key stakeholders for Children and Young People (CYP) with Asthma to support the local system on the National Bundle for the management of asthma care, supporting the development of a systemwide Paediatrics Asthma and Wheeze Pathways to reduce avoidable harm to children and young people from asthma and improve their quality of life.

In a pioneering move towards environmental sustainability, the ICB has successfully surpassed NHSE targets on prescribing lower carbon Salbutamol MDI inhalers as a proportion of all Salbutamol

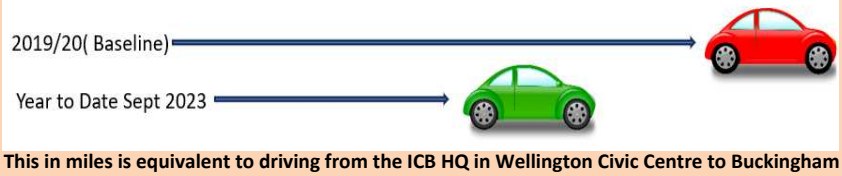
MDI prescribing. In September 2023, the ICB was commended by Open Prescribing for having the lowest national average carbon footprint per Salbutamol inhaler.

These initiatives represent our commitment to improving patient care while also contributing to environmental sustainability goals.



https://openprescribing.net/

STW Lower carbon salbutamol MDI as a proportion of all Salbutamol MDI prescribed.



This in miles is equivalent to driving from the ICB HQ in Wellington Civic Centre to Buckingham Palace, 55, 235 times.

STW Mean 
Carbon Emission Per Salbutamol Inhaler prescribed ($KgCO_2e$) NHSE Target <18 KgCO2e
2021/22 26.37$KgCO_2e$
2022/23 22.0 KgCO2e
2023/24 15.7 KgCO2e

https://www.prescqipp.info/our-resources/data-and-analysis/scorecards/scorecards-one-stop-shop/

Legal and Governance Matters

Procurement

The ICB through its procurement processes, ensures that all tenders issued have a sustainability clause included, and since the beginning of the year all authorities must include social value (which encompasses sustainability) in their tender evaluations (minimum weighting of 10 per cent). Clause SC18 Green NHS and Sustainability is in the NHS Standard Contract 2022/23 Service Conditions which the ICB uses to contract for its services.

Efficiency programme

In order to fund increases in activity, demography and any additional cost pressures, the ICB will need to deliver recurrent efficiency plans year on year.

As part of the development of the system financial sustainability plan, the aim is that in 2023/24 all system organisations work to deliver a 4.1% internal efficiency target. This is calculated as a percentage of the underlying startpoint budget. For the ICB, this equates to a £21.5m million efficiency target. On top of this, the ICB is also working with healthcare system partners on the system transformation programme to meet a further savings target of £4.4m.

Information Governance Incidents

NHS Shropshire, Telford and Wrekin has reported a total of 10 incidents during the period of 1st April 2023 to 31st March 2024. Of these incidents 9 were graded as non-reportable – very low risk with 1 being reportable to the Information Commissioner's Office (ICO) which was reported as a national cyber-attack on a provider organisation and was reported from all ICBs commissioning the service to the ICO, which did result in actions being taken to contact individuals where necessary.

Equality, Diversity and Human Rights Report

The NHS Equality Delivery System (EDS2) was launched in November 2013 to help monitor how the NHS is working towards these functions. It is a toolkit designed to help NHS organisations and members of staff review performance for people with characteristics protected by the Equality Act as well as identify how improvements can be made.

The nine protected characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership (ICB)
- Pregnancy and maternity
- Race including nationality and ethnic origin
- Religion or belief
- Sex

- Sexual orientation.

EDS2 can also be applied to people from other disadvantaged groups who may experience difficulties in accessing NHS services, including people who are homeless or live in poverty, those who are long-term unemployed, people in stigmatised occupations, drug users, and people with limited family or social networks or who are geographically isolated.

Organisations score themselves against the main functions within the assessment, more information of which can be found on the NHS England website.

NHS Shropshire, Telford and Wrekin's 2023 EDS2 submission report can be found here:

Equality, Diversity and Inclusion - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Emergency Preparedness Resilience and Response

Further to the Health and Care Bill being passed by Parliament and Integrated Care Boards (ICBs) being legally established on 1 July 2022, there was an associated amendment to the Civil Contingencies Act to designate ICBs as Category 1 responders where previously CCGs have been category 2 responders. This change has placed additional Emergency Planning, Resilience and Response (EPRR) responsibilities and accountabilities on ICBs.

The NHSE EPRR Strategic Framework is a national framework containing principles for health emergency preparedness, resilience and response for NHS-funded organisations in England including but not limited to NHS Trusts, Foundation Trusts, Care Trusts, providers of NHS-funded primary care, NHS commissioning organisations including NHS England and Integrated Care Boards.

As part of the NHS England EPRR framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

All NHS-funded organisations must meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract, the NHS Core Standards for EPRR and NHS England business continuity management framework.

Shropshire, Telford and Wrekin (STW) ICB has continued to implement its EPRR programme during 2023-24 focussing on its own internal resilience but also working in partnership with other organisations in the STW footprint to respond to incidents when they occur but also to engage in preparedness activities to ensure it can discharge its duties under the Act.

Whilst the ICB has demonstrated a robust approach to the response to, leadership in and co-ordination of incidents as they have occurred, we have identified a number of areas where improvements can be made to our planning and preparedness. To this end, during 2023-24 an improvement programme has been commenced to address this.

The ICB has continued to participate in the Local Resilience Forum, Local Health Resilience Partnership and the Midlands Health Resilience Partnership Board. We have a robust risk management process in place in relation to EPRR which is supplemented by a lessons learned process and training and exercising arrangements for staff.

Health and Safety

The ICB takes the health and safety of its employees very seriously and we have a policy in place to help ensure staff carry out their functions in a safe way. The policy requires staff to report health and safety incidents via an electronic system. These are then investigated, and action taken to help mitigate incidents reoccurring.

There were no health and safety incidents reported in the reporting period of 1st April 2023 to 31st March 2024.

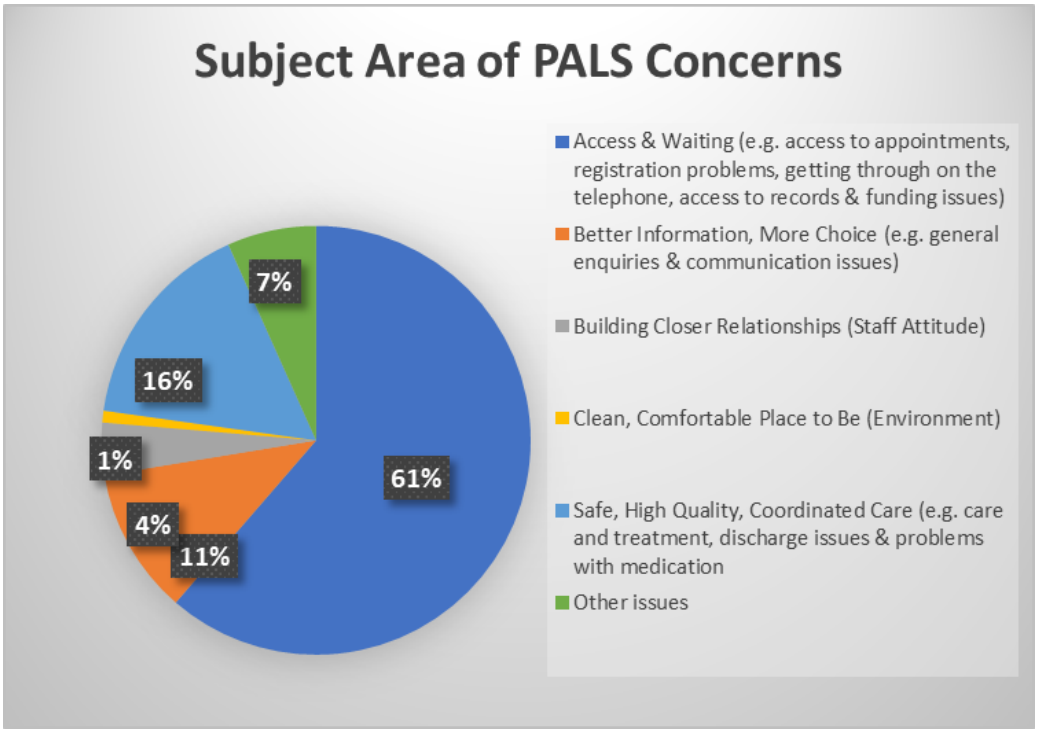
Patient Services

Patient Advice and Liaison Services (PALS)

PALS is integral to NHS Shropshire, Telford and Wrekin's commitment to working closely with patients and staff to improve services. It is an informal and impartial way to resolve the concerns of patients, relatives, carers and members of the public. The service is intermediary and a useful source of information, often signposting people to the healthcare they need. All enquiries received through PALS are recorded on a database and used to improve services.

During the financial year 2023/24, NHS Shropshire, Telford and Wrekin Patient Services Team received 1014 PALS enquiries. This is an increase on last year.

The chart below illustrates the domains of patient experience for the PALS enquiries received during 2023/24.



More than half (622) of the PALS enquiries received by NHS Shropshire, Telford and Wrekin were around accessing services.

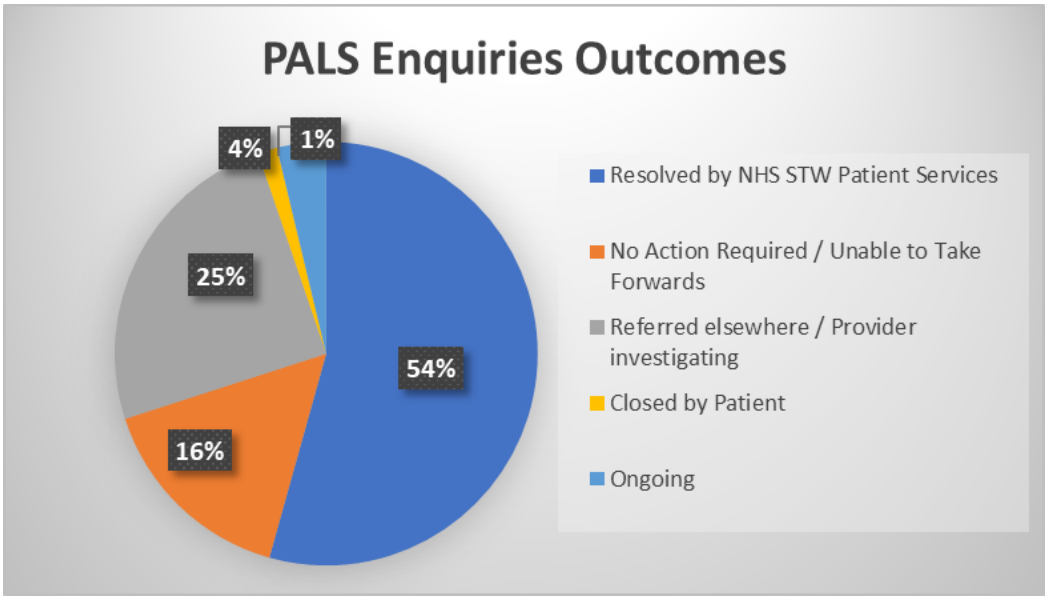
As of July 2023, the responsibility for managing enquiries/complaints relating to Primary Care was designated to ICBs by NHS England. This has led to an increase in the number of enquiries relating to Primary Care services. Of the total number of PALS enquiries received 366 related to GP Practices, 238 of which were around accessing appointments. The ICB also received 65 enquiries relating to Dentists, 55 of which are around accessing dental services.

There were 250 enquiries relating to hospital services, 127 of these were around access to appointments across several specialties and 62 related to the care received. Themes around specialties include,

Accident and Emergency, Cardiology, Gastroenterology, Cancer Services, Urology, Gynaecology and Musculoskeletal/Orthopaedics.

151 enquiries related to ICB services, with 38 related Medicines Management and access to various medications. 21 enquiries related to the Prescription Ordering Direct Service and 18 enquiries related to the Continuing Health Care process. The rest of the enquiries were around commissioning decisions, relating to various services. Themes within this were around access to the covid vaccination, access to breast reduction surgery and access to fertility services.

The chart below shows what happened with the queries and concerns received by NHS Shropshire, Telford and Wrekin Patient Services Team.

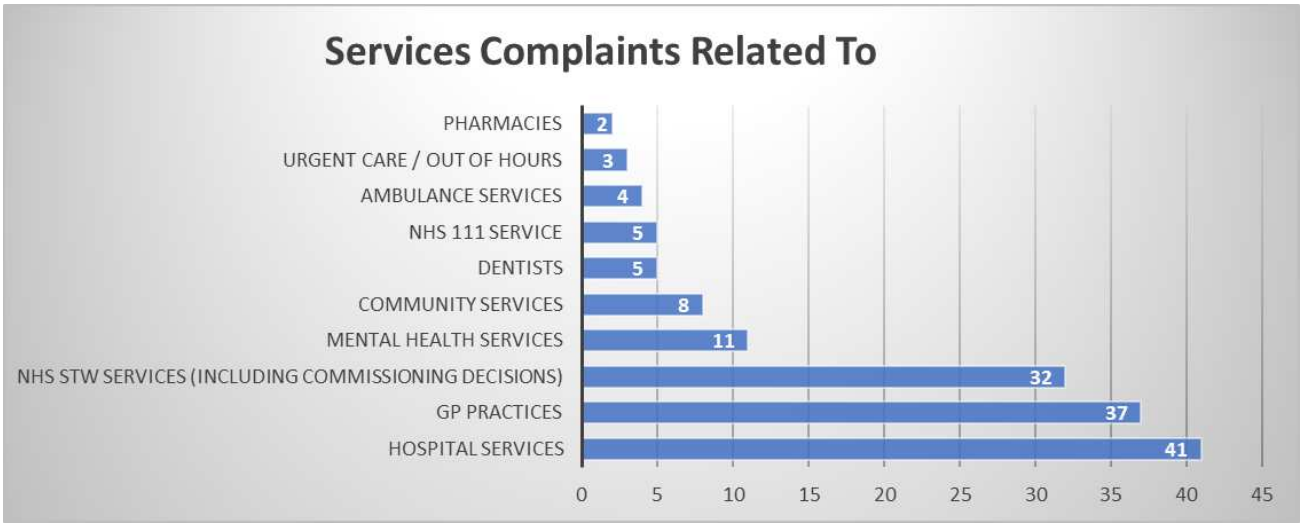


551 of the enquiries received were resolved by NHS Shropshire, Telford and Wrekin Patient Services Team; 251 were forwarded to the relevant provider to be resolved directly with the patient.

Complaints

Complaints are a valuable source of feedback and are used by NHS Shropshire, Telford and Wrekin to help improve services both within the organisation, and in the organisations that we commission. NHS Shropshire, Telford and Wrekin has a clear complaint policy in place, which is in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During 2023/24, NHS Shropshire, Telford and Wrekin received 148 complaints. As shown in the graph below, in addition to complaints about NHS Shropshire, Telford and Wrekin itself, many of the complaints relate to providers of services commissioned by NHS Shropshire, Telford and Wrekin.

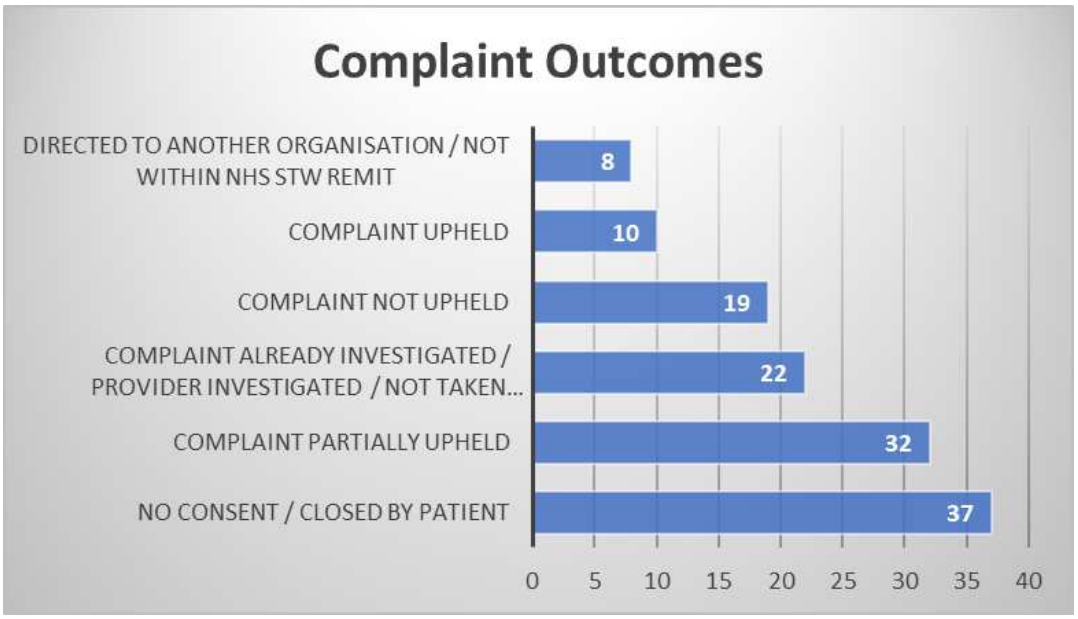


Of the complaints received by NHS Shropshire, Telford and Wrekin, 41 related to hospital services; 20 of these were around the care received and 18 of these were around accessing services.

There were 37 complaints relating to GP services, 18 of these were around access to services and 15 related to the care received.

32 complaints related to services provided by NHS Shropshire, Telford and Wrekin of these 16 related to the Continuing Health Care process.

Of the 148 complaints received during 2023/24, 56 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during 2023/24.



Ombudsman

The public have the right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with NHS Shropshire, Telford and Wrekin's response. NHS Shropshire, Telford and Wrekin has been contacted by the PHSO in relation to 1 case during 2023/24. This was just a request for information and no further action was taken by the PHSO following information being provided to them.

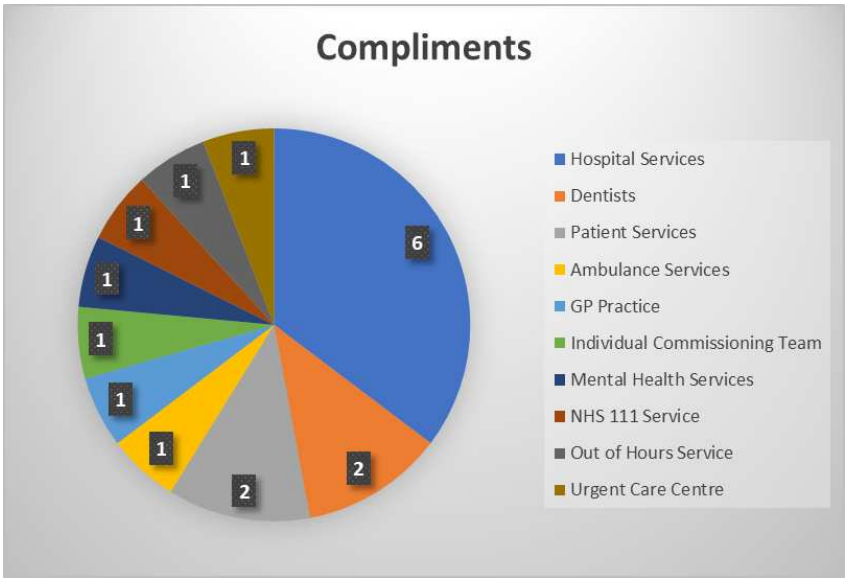
Data around the number of complaints received and accepted by the PHSO for all NHS organisations can be viewed on the PHSO website as follows: What our data tells us | Parliamentary and Health Service Ombudsman (PHSO)

MP letters

During 2023/24, NHS Shropshire, Telford and Wrekin received 102 letters/emails from local Members of Parliament (MPs) relating to the healthcare of their constituents. 36 of these enquiries related to services provided by NHS Shropshire, Telford and Wrekin and themes included issues with the Continuing Health Care process and access to various medications. 25 enquiries related to GP Services, 21 of which related to access, including getting through on the telephone and access to appointments. 18 Enquiries related to hospital services, 11 of which were around access to appointments. There were 9 enquiries around Mental Health Services, 7 of which were around access. Access to services was a theme throughout the MP enquiries received.

Compliments

In addition to managing complaints, concerns and enquiries, NHS Shropshire, Telford and Wrekin also receives positive feedback in the form of compliments. 17 compliments were received during 2023/24 and the chart below highlights the services that these compliments related to, along with number of compliments received for each service.



Learning from Feedback received

An important part of the complaint and PALS process is that lessons are learned, and improvements made to services based on feedback received from individuals. Below are some examples of where changes have been made to services following patients providing feedback to the ICB:

What we Heard	What has Happened
Poor Communication around transfer of patient between care homes The wife of a patient raised concerns that she was not informed that her husband was being moved to a different care home.	The Individual Commissioning Team have reminded staff of their responsibility to communicate and involve patients and their representatives in the decision-making process where a move is required. This will be monitored closely by the team management. The care home note that they did write to the patient's wife advising her of the planned move, however the letter was not received. The care home have undertaken a period of reflective practice and have agreed to send important mail such as this via recorded delivery in future.
Concerns regarding delays with referral for patient with other medical retina issues following being referred for cataract surgery Concerns were raised about the pathway for cataract care and delays when patients needed urgent referral onwards for other medical retina issues. The concerns involved Community Health and Eye Care, New Medica, GP Practice and the Referral Assessment Service.	Commissioners have discussed with the organisations involved and processes have been changed to ensure that issues such as this patient experienced do not happen again. The provider where the main delay occurred has changed their administration processes to prevent delays in referrals being rejected, where they have been sent to the service incorrectly.

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

NHS Shropshire, Telford and Wrekin is an Integrated Care Board with a unitary Board and is part of the Shropshire, Telford and Wrekin Integrated Care System.

NHS Shropshire, Telford and Wrekin Board composition during the period 1st April 2023 to 31st March 2024 was as follows:

Board members from 1 March 2023 to 31 March 2024	Board Role	Attendance
Sir Neil McKay (voting)	Chair	8 of 9
Simon Whitehouse (voting)	Chief Executive	9 of 9
Professor Trevor McMillan (voting)	Non-Executive Member and Deputy Chair	8 of 9
Roger Dunshea (voting)	Non-Executive Member	8 of 9
Dr Niti Pall (voting)	Non-Executive Member	1 of 9
Meredith Vivian (voting)	Non-Executive Member	8 of 9
Alison Bussey (voting) to 31st December 2023	ICB Chief Nursing Officer	5 of 9
Vanessa Whatley (voting) from 1st January 2024	Interim ICB Chief Nursing Officer	1 of 9
Gareth Robinson (voting)	ICB Executive Director for Delivery and Transformation	8 of 9
Claire Skidmore (voting)	ICB Chief Finance Officer	8 of 9
Mr Nicholas White (voting)	ICB Chief Medical Officer	8 of 9
Dr Ian Chan (voting)	Primary Care Member and GP in Telford and Wrekin	9 of 9
Dr Julian Povey (voting)	Primary Care Member and GP in Shropshire	9 of 9

Andy Begley (voting)	Local Authority Member and Chief Executive Shropshire Council	7 of 8
David Sidaway (voting)	Local Authority Member and Chief Executive Telford and Wrekin Council	6 of 9
Louise Barnett (voting)	Trust Member and Chief Executive, Shrewsbury and Telford Hospital NHS Trust	6 of 9
Neil Carr (voting)	Trust Member and Chief Executive, Midlands Partnership NHS Foundation Trust	7 of 9
Patricia Davies (voting)	Trust Member and Chief Executive, Shropshire Community Health NHS Trust	8 of 9
Stacey Keegan (voting)	Trust Member and Chief Executive, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	8 of 9
David Bennett (non-voting) from 8th December 2023	Associate Non-Executive Member NHS STW	3 of 9
Nigel Lee (non-voting) from 4th August 2023	Participant and Interim ICB Director of Strategy and Partnerships	2 of 9
Pauline Gibson (non-voting)	Participant and Non-Executive Director, Midlands Partnership NHS Foundation Trust	3 of 9
Tina Long (non-voting)	Participant and Interim Chair, Shropshire Community Health NHS Trust	3 of 9
Dr Catriona McMahon (non-voting)	Participant and Chair, Shrewsbury and Telford Hospital NHS Trust	6 of 9
Harry Turner (non-voting)	Participant and Chair, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	5 of 9
Cathy Purt (non-voting)	Participant, Chair of the ICB Strategy Committee and Non-Executive Director, Shropshire Community Health NHS Trust	4 of 9
Lyn Cawley (non-voting)	Healthwatch Observer and Chief Officer Healthwatch Shropshire	6 of 9
Simon Fogell (non-voting)	Healthwatch Observer and Chief Executive Healthwatch Telford and Wrekin	4 of 9
Jackie Jeffrey	VCS Observer and Vice Chair Shropshire, VCSA	4 of 9
Richard Nuttall	VCS Observer and Joint Chair, Telford & Wrekin Chief Officers Group (COG)	4 of 9
Jan Suckling	Healthwatch Observer and Lead Officer Healthwatch Telford and Wrekin	1 of 9

Primary Care General Medical Services

The organisation has delegated commissioning responsibilities for primary care general medical services on behalf of NHS England. This includes commissioning 51 GP practices located within the geographical area coterminous with the boundaries of Shropshire Council and Telford and Wrekin Council.

The practices are outlined below:

Practice name	Address
Albrighton Medical Practice	Shaw Lane, Albrighton, Wolverhampton, WV7 3DT
Alveley Medical Practice	Village Road, Alveley, Bridgnorth, WV15 6NG
The Beeches Medical Practice	1 Beeches Road, Bayston Hill, Shrewsbury, SY3 0PF
Belvidere Medical Practice	23 Belvidere Road, Shrewsbury, SY2 5LS
Bishop's Castle Medical Practice	School House Lane, Bishop's Castle, SY9 5BP
Bridgnorth Medical Practice	Northgate Health Centre, Bridgnorth, WV16 4EN
Broseley Medical Centre	Bridgnorth Road, Broseley, TF12 5EL
Brown Clee Medical Practice	Station Road, Ditton Priors, Bridgnorth, WV16 6SS
Cambrian Medical Centre	Thomas Savin Road, Oswestry, SY11 1GA
The Caxton Surgery	Oswald Road, Oswestry, SY11 1RD
Charlton Medical Centre	Lion Street, Oakengates, Telford, TF2 6AQ
Churchmere Medical Group	Trimpley Street, Ellesmere, SY12 0DB

Church Stretton Medical Practice	Easthope Road, Church Stretton, SY6 6BL
Claremont Bank Surgery	Claremont Bank, Shrewsbury, SY1 1RL
Cleobury Mortimer Medical Centre	Vaughan Road, Cleobury Mortimer, Kidderminster, Worcestershire, DY14 8DB
Clive Medical Practice	High Street, Clive, Shrewsbury, SY4 5PS
Court Street Medical Practice	Court Street, Madeley, Telford, TF7 5EE
Craven Arms Medical Practice	20 Shrewsbury Rd, Craven Arms, SY7 9PY
Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Highley Medical Centre	Bridgnorth Road, Highley, Bridgnorth, WV16 6HG
Hodnet Medical Centre	Drayton Road, Hodnet, Market Drayton, TF9 3NF
Hollinswood and Priorslee Medical Practice	Downmeade, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall Dale Road, Coalbrookdale, Telford, TF8 7DT
Knockin Medical Centre	Knockin, Oswestry, SY10 8HL
Linden Hall Surgery	Station Road, Newport, TF10 7EN
Marden Medical Practice	25 Sutton Road, Shrewsbury, SY2 6DL
Market Drayton Medical Practice	Maer Lane, Market Drayton, TF9 3AL
Marysville Medical Practice	Brook Street, Belle Vue, Shrewsbury, SY3 7QR
The Meadows Medical Practice	Turnpike Meadow, Clun, SY7 8HZ
Much Wenlock and Cressage Medical Practice	Kingsway Lodge, Kings Street, Much Wenlock, TF13 6BL
Mytton Oak Surgery	Racecourse Lane, Shrewsbury, SY3 5LZ
Plas Ffynnon Medical Centre	Middleton Road, Oswestry, SY11 2RB
Pontesbury and Worthen Medical Practice	Hall Bank, Pontesbury, Shrewsbury, SY5 0RF
Portcullis Surgery	Portcullis Lane, Ludlow, SY8 1GT
Prescott Surgery	Prescott Fields, Baschurch, Shrewsbury, SY4 2DR
Radbrook Green Surgery	Bank Farm Road, Shrewsbury, SY3 6DU
Riverside Medical Practice	Barker Street, Shrewsbury SY1 1QJ
Severn Fields Medical Practice	Severn Fields Health Village, Sundorne Road, Shrewsbury SY1 4RQ
Shawbirch Medical Practice	Brandon Avenue, Admaston, Telford, TF5 0DU
Shawbury Medical Practice	Poynton Road, Shawbury, SY4 4JS
Shifnal and Priorslee Medical Practice	Haughton Road, Shifnal, TF11 8DD
South Hermitage Surgery	South Hermitage, Belle Vue, Shrewsbury, SY3 7JS
Station Drive Surgery	Station Drive, Ludlow, SY8 2AB
Stirchley Medical Practice	Sandino Road, Stirchley, Telford, TF3 1FB
Teldoc	Church Road, Malinslee, Telford, TF3 2BF
Wellington Road Surgery	Wellington Road, Newport, TF10 7HG
Wem and Prees Medical Practice	New Street, Wem, Shrewsbury, SY4 5AF
Wellington Medical Practice	Chapel Lane, Wellington, Telford, TF1 1PZ
Westbury Medical Centre	Westbury, Shrewsbury, SY5 9QX
Woodside Medical Practice	Park Lane, Woodside, Telford, TF7 5NR

Composition of Governing Body

See Members Report

Committee(s), including Audit Committee

So that the Board of NHS Shropshire, Telford and Wrekin can provide strategic direction to the organisation and to assure itself of the ICB's internal control infrastructure, it has established a number of committees to undertake specific roles within the governance structure. A diagram showing the

governance structure and explaining the role of each committee can be found in the Annual Governance Statement later in this report.

The first year of operation of NHS Shropshire, Telford and Wrekin has been used to develop the committee's individual ways of working and starting to develop how the inter-relationships and inter-dependencies between the Board committees will function. As part of this work, we commissioned the Good Governance Institute to review our progress to date and to help identify improvements for the future. The output report from this work was presented to the Board on 31st January

The composition of the Audit Committee was as follows:

Mr Roger Dunshea	Chair and Non-Executive Member
Professor Trevor McMillan OBE	Non-Executive Member
Dr Niti Pall	Non-Executive Member
Mr Meredith Vivian	Non-Executive Member

The role of each Board committee, composition and attendance is detailed in the Annual Governance Statement which forms part of this Annual Report.

Conflicts of interest declared by our Board members and other committees where membership is different can be found on our website here:

Conflicts of Interest - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Modern Slavery Act

NHS Shropshire, Telford and Wrekin fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Shropshire, Telford and Wrekin Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Shropshire, Telford and Wrekin Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my ICB Accountable Officer Appointment Letter.

Disclosures:

> Section 30 letter issued by external auditors to the Secretary of State - NHS Shropshire and Telford ICB has reported a deficit of £16.2 million in its draft financial statements for the period ending 31 March 2024. This has resulted in the ICB overspending its revenue resource limit by £16.2 million. As a result the ICB has taken a course of action that is unlawful and has caused a loss. The external auditors are required to refer this matter to the Secretary of State.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Shropshire, Telford and Wrekin's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Simon Whitehouse

Accountable Officer

XX June 2024

Governance Statement

Introduction and context

NHS Shropshire, Telford and Wrekin is a body corporate established by NHS England on 1 July 2022 under the Health and Care Act 2022, which sets out the ICB's statutory functions.

The general function of NHS Shropshire, Telford and Wrekin is to arrange the provision of services for people for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2023 and 31 March 2024, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Shropshire, Telford and Wrekin's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Shropshire, Telford and Wrekin's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Shropshire, Telford and Wrekin is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that NHS Shropshire, Telford and Wrekin has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of relevant good governance as are relevant to it.

NHS Shropshire, Telford and Wrekin is led by a unitary Board comprising a Chair and Chief Executive, Executive Directors, Non-Executive Members and Partner Members composed of local GPs, local Trusts/Foundation Trusts and Local Authorities all located within the geographical area of Shropshire. The members of the Board are responsible for determining the governing arrangements of the organisation, which they are required to set out in NHS Shropshire, Telford and Wrekin's Constitution and Governance Handbook, which can be found on our website: Our Constitution - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk).

Attendance details refers to the full number of meetings held throughout the year. Where an individual was only a member for part of the reporting period, they may not have been required to attend every meeting.

Where an individual is marked as attending, there may be instances where a deputy attended in their place. If you require further detail on individual committees, please contact us through the normal channels.

Board

The composition of NHS Shropshire, Telford and Wrekin's Board is outlined in full within the Constitution.

The Board has met 8 times during the period 1st April 2023 to 31st March 2024 in total. The names of members and their-attendance are listed above at the beginning of the Corporate Governance section above.

Audit Committee

The Audit Committee provides assurance to the Board that the organisation's overall internal control/governance system operates in an adequate and effective way. The Committee's work focuses not only on financial controls, but also risk management and quality governance controls.

The Committee has met a total of 5 times during 2023/24, which is included in the attendance table below.

Audit Committee members	Meetings attended during 2023/24
Mr Roger Dunshea – Chair and Non-Executive Member	5 of 5
Professor Trevor McMillan – Non-Executive Member	3 of 5
Dr Niti Pall – Non-Executive Member	3 of 5
Mr Meredith Vivian – Non-Executive Member	4 of 5

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- financial sustainability.
- assurance gained from and further development of the Board Assurance Framework (BAF) and Executive Risk Register;
- assurance gained from overseeing the continued development and self-certification of the ICB against the Data Security and Protection Toolkit (DSPT);
- assurance on the ICB's emergency planning and business continuity processes;
- assurance on the counter fraud measures in place and on continuing work around preventing and addressing fraud;
- assurance gained from Internal / External Audit reports; and
- assurance on the content of the annual accounts and annual report audit by external auditors.
- EO Committee re Discharge Funding Gap
- Better Care Fund
- Investment Panel

Remuneration Committee

The Remuneration Committee has delegated decision making from the Board to approve appropriate salaries, payments and terms and conditions of employment.

The Committee has met a total of 4 times during 2023/24, which is included in the attendance table below.

Remuneration Committee members from 1st April 2023 to 31st March 2024	Meetings attended during 2023/24
Professor Trevor McMillan – Chair of the Committee and Non-Executive Member	4 of 4
Sir Neil McKay – ICB Chair	2 of 4
Dr Niti Pall – Non-Executive Member	4 of 4
Meredith Vivian – Non-Executive Member	4 of 4

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- ICB Chief Executive Officer Substantive Appointment
- ICB Chief Executive Officer (CEO) Pay Review 2023 – 2024
- ICB Chief Nursing Officer Remuneration and Appointment Process
- ICB Chief Nursing Officer (CNO) Temporary Appointment
- ICB Chief Medical Officer (CMO) Pay Case Update
- Executive Director and Director Annual Pay Review 2023 – 2024
- Interim Chief People Officer Role
- Update on Clinical Lead Personalised Care
- On Call Review Paper
- Proposal to implement a VSM2 (Very Senior Manager 2) category with a pay band equivalent to Agenda for Change Band 9
- Temporary Implementation of Purchase of Annual Leave
- Very Senior Manager (VSM) Local Pay Framework
- Approval Process for Potential Redundancies

Remuneration Committee – To Manage Conflicts of Interest

There were no meetings held of the Remuneration Committee, where the membership of the Committee would need to be amended to avoid any conflicts of interest.

Extraordinary Remuneration Committee members from 1st April 2023 to 31st March 2024	Meetings attended during 2023/24
Sir Neil McKay – ICB Chair	0 of 0
Claire Skidmore – ICB Chief Finance Officer	0 of 0
Dr Julian Povey – Partner Board Member and GP in Shropshire	0 of 0
Simon Whitehouse – ICB Chief Executive Officer	0 of 0
Andrew Begley – Partner Board Member and Chief Executive of Shropshire Council	0 of 0
Patricia Davies – Partner Board Member and Chief Executive of Shropshire Community Health NHS Trust	0 of 0
Stacey Keegan – Partner Board Member and Chief Executive of Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	0 of 0
Neil Carr – Partner Board Member and Chief Executive of Midlands Partnership University NHS Foundation Trust	0 of 0

Quality and Performance Committee

The QPC Committee oversees and provides assurance on performance and quality of commissioned services. The committee met 10 times as required during the period 1st March 2023 to 31st March 2024. No meetings were held in August 2023 and December 2023.

Quality and Performance Committee members	Meetings attended during 2023/24
Meredith Vivian – Chair and Non-Executive Director Member	10 of 10
Alison Bussey – ICB Chief Nursing Officer to 31st December 2023	5 of 10
Vanessa Whatley – ICB Interim Chief Nursing Officer from 1st January 2024	9 of 10
Nick White – ICB Chief Medical Officer	2 of 10
Claire Parker – ICB Director of Partnerships and Place	1 of 10
Julie Garside – ICB Director of Planning and Performance	9 of 10
Liz Noakes – Director of Public Health representing Telford Local Authority	5 of 10
Rachel Robinson – Director of Public Health representing Shropshire Council	0 of 10
Hayley Flavell – Director of Nursing and Midwifery at Shrewsbury and Telford Hospital NHS Trust	3 of 10
Rose Edwards – Associate Non-Executive Director at Shrewsbury and Telford Hospital NHS Trust (from January 2023)	10 of 10
Liz Lockett – Member Chief Nurse at MPFT	1 of 10
Jacqueline Small – Member Non-Executive Director MPFT (to 31st December 2022)	0 of 10
Simmy Akhtar – Non-Executive Director MPFT (from 1st January 2023)	2 of 10
Clare Hobbs – Director of Nursing at Shropshire Community Health NHS Trust	1 of 10
Tina Long – Non-Executive Director at Shropshire Community Health NHS Trust (to 28th February 2022) no longer part of the committee	0 of 10
Jill Barker – Member Associate Non-Executive Director at Shropshire Community Health NHS Trust	9 of 10
Sara Ellis Anderson – Chief Nurse representing Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust – now with SCHT representing Clair Hobbs.	1 of 10
Ruth Longfellow – Medical Director at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust – deputising for Sara Ellis	3 of 10
Chris Beacock - Non-Executive Director at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust – no longer a committee member	0 of 10
Sonya Miller Assistant Director for Children's Social Care and Safeguarding – Shropshire Council – Senior Leadership representative	0 of 10
Jo Britton Executive Director of Children's Services, Telford and Wrekin Council – Senior Leadership Representative	0 of 10
Lynn Cawley – Shropshire Healthwatch	3 of 10
Simon Fogell – Telford and Wrekin Healthwatch	3 of 10

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- Performance Exception Reports
- Health Protection Board Update
- Primary Care Access Implementation Plan
- Local Maternity and Neonatal Services
- Mental Health
- Learning Disability & Autism

- Infection, Prevention & Control
- SOAG Exception Report
- Deep Dive – Primary Care
- Deep Dive – Urgent and Emergency Care
- Deep Dive – Children and Young People
- IAPT – Improving Access to Psychological Therapies
- System Quality Metrics
- System Risk Register
- Diabetes
- Palliative Care and End of Life Services
- Quality Insight
- Safeguarding Adults and Children Annual reports

Finance Committee

The Finance Committee Section One and Section Two oversees and provides assurance on the financial delivery of commissioned services. The committee met 10 times during 2023/24 as required during the period 1st April 2023 to 31st March 2024.

Finance Committee members	Meetings attended during 2023/24
Section One – Financial assurance for ICB as a statutory body	
Professor Trevor McMillan – ICB Non-Executive Member and Chair	9 of 10
Claire Skidmore – ICB Chief Finance Officer	8 of 10
David Bennett – ICB Associate Non-Executive Member – from 8th December 2023	1 of 10
Section Two – Financial assurance for ICS	
Professor Trevor McMillan – ICB Non-Executive Member and Chair	9 of 10
Claire Skidmore – ICB Chief Finance Officer	9 of 10
David Bennett – ICB Associate Non-Executive Member – from 8th December 2023	2 of 10
Helen Troalen – Director of Finance for Shrewsbury and Telford Hospitals	6 of 10
Sarah Lloyd – Director of Finance for Shropshire Community Health Trust	6 of 10
Craig McBeth – Chief Finance Officer for Robert Jones, and Agnes Hunt Hospitals Trust	4 of 10
Chris Sands – Chief Finance Officer for Midlands Partnership NHS Foundation Trust	3 of 10
Sarfraz Nawaz – Non-Executive Director for Robert Jones, and Agnes Hunt Hospitals Trust	3 of 10
Richard Miner - Non-Executive Director for Shrewsbury and Telford Hospitals Trust	3 of 10
Peter Featherstone – Non-Executive Director for Shropshire Community Health Trust	7 of 10
James Walton – Partner Organisation of Shropshire Local Authority	0 of 10
Michelle Brockway – Partner Organisation of Telford & Wrekin Local Authority	1 of 10
Richard Minor – Non-Executive Director for Shrewsbury and Telford Hospital	3 of 10

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- Monthly Position Update
- Finance Risk Register (System Board Assurance Framework)
- 2023/24 Plan Update
- Intelligent Fixed Payment Group Update - including Terms of Reference sign off
- Capital Plan Update
- ICB 2023/24 Efficiency Plans Update

The Strategy Committee

The Strategy Committee oversees the development of ICS 5 Year Forward Plan taking into account the Integrated Care Strategy. The Committee has met 11 times during the period 1st April 2023 to 31st March 2024 as required.

Strategy Committee members	Meetings attended during 2023/24
Cathy Purt – Chair of Strategy Committee	7 of 11
Nigel Lee – Interim ICB Executive Director of Strategy and Partnerships from 4th August 2023	6 of 11
David Brown – Non-Executive Director of Shrewsbury and Telford Hospitals	6 of 11
Liz Noakes – Director of Public Heath, Telford and Wrekin Council	6 of 11
Mark Large – Non-Executive Director of MPFT	5 of 11
Professor Paul Kingston – Non-Executive Director for Robert Jones, and Agnes Hunt Hospitals Trust	1 of 11
Peter Featherstone – Non-Executive Director for Shropshire Community Health Trust	5 of 11
Rachel Robinson – Director of Public Health, Shropshire Council	4 of 11
Claire Skidmore - ICB Chief Finance Officer or Deputy	3 of 11
Nick White - ICB Chief Medical Officer or Deputy not yet nominated (from 1st February 2023)	4 of 11
Ian Chan - One representative of general Practice Primary care Providers vacancy – not yet nominated - (from 1st February 2023)	2 of 11
One representative from the VCS - vacancy – not yet nominated (from 1st February 2023)	
Sara Lloyd, Senior Executive strategy lead from Shropshire Community Healthcare NHS Trust (from 1st February 2023)	2 of 11
Nia Jones - Managing Director for Planning and Strategy, Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	8 of 11
Steve Grange Senior Executive strategy lead from Midlands Partnership Foundation Trust	2 of 11

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- Joint Forward Plan
- Clinical Strategy
- HTP update
- System Utilisation Review
- NOF 4 Exit Criteria
- Health Inequalities
- Population Health Group

- Provider Collaborative Development
- Local Care and Transformation Programme
- Strategic Commissioning intentions
- STW General Practitioner (GP) Strategy 2023/24
- Histopathology Transformation
- Digital Strategy
- Procurement Working Group

Primary Care Commissioning Committee

The Primary Care Commissioning Committee oversees the commissioning of primary care standard general medical services (GMS) under delegated decision-making authority from NHS England.

The Primary Care Commissioning Committee has met 3 times during the period 1st April 2023 to 31st March 2024 as required.

Primary Care Commissioning Committee members	Meetings attended during 2023/24
Dr Niti Pall – Non-Executive Director, Chair	3 of 3
Nick White – Chief Medical Officer (Deputy Chair)	2 of 3
Simon Whitehouse – ICB Chief Executive Officer	1 of 3
Claire Skidmore – ICB Chief Finance Officer	2 of 3
Gareth Robinson – ICB Director of Delivery & Transformation	3 of 3
Nigel Lee – Interim ICB Director of Strategy & Partnerships from 4th August 2023	0 of 3
Alison Bussey – ICB Chief Nursing Officer to 31st December 2023	0 of 3
Vanessa Whatley – Interim ICB Chief Nursing Officer from 1st January 2024	0 of 3
Roger Dunshea – Non-Executive Director	3 of 3

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- Changes to Primary Care Commissioning Governance
- Finance Report
- Primary Care Workforce & Training Hub Report
- Primary Care Teamwork Programme
- General Practice Nurse Strategy
- GP Delivery Plan
- GP Strategy
- GPN Strategy
- Digital Programme & Budget
- System Digital Strategy Development
- GP Access – GP Access Recovery Plan; GP Patient Satisfaction Survey; GP Access Performance report
- Asylum Seeker Update
- Risk Register
- Shrewsbury Health & Wellbeing Hub
- Lantum Contract
- Prioritisation Process for PCN Estates Strategy Capital Programme
- Hodnet Medical Practice Boundary Change
- Delegation of POD and Changes to Terms of Reference
- GP Occupational Health Service – Direct Award of Contract
- Practice Patient Participation Group Audit and Improvement Action Plan
- Results of GP Surveys
- Results of Primary Care Ethnic Diversity Survey
- NHS Long Term Workforce Plan

Integrated Delivery Committee

The Integrated Delivery Committee provides assurance oversight and support to the development and delivery of system transformation programmes and efficiency programme.

The Integrated Delivery Committee has met 12 times during the period 1st April 2023 to 31st March 2024 as required (this does not include the meeting scheduled for 21 March 2024). *

Integrated Delivery Committee	Meetings attended during 2023/24
Harry Turner – Chair of the Committee and Chair of Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	5 of 12
Gareth Robinson – Vice Chair of the Committee and ICB Director of Delivery & Transformation	12 of 12
Claire Skidmore – ICB Chief Finance Officer	5 of 12
Tanya Mills – Director of Adult Social Care, Shropshire	1 of 12
Jonathan Rowe – Director of Adult Social Care, Telford and Wrekin Council (to January 2024)	5 of 12
Simon Froud – Representing Telford & Wrekin Council (from 12 June 2023)	4 of 12
Angie Wallace – Chief Operating Officer of Shropshire Community Health NHS Trust	0 of 12

Mike Carr – Chief Operating Officer of Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	7 of 12
Sara Biffen – Chief Operating Officer of Shrewsbury and Telford Hospitals	9 of 12
Alison Bussey – ICB Chief Nursing Officer (to 31st December 2023)	0 of 12
Vanessa Whatley – Interim ICB Chief Nursing Officer (from 1st January 2024)	1 of 12

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- IDC Chair's Report
- Local Care Update
- Financial Improvement/Efficiency Programme Update
- Financial Efficiency Planning Update
- Planned Care Board Update
- UEC Board Update
- Investment Panel Update
- IDC Draft Forward Plan
- TWIPP Chairs Report
- SHIPP Chairs Report
- MH LD&A Board Chairs Report
- Outpatients Deep Dive
- Digital Update
- Local Care – Virtual Ward update
- HTP Update/LCTP impact
- 78 Week Waits Performance Update
- Vaccination Programme Update
- Planned Care Update
- Operational Plan Delivery Dashboard
- LCTP Governance & Reporting Framework
- Virtual Ward Update
- Baricitinib Policy
- MH LDA Deep Dive
- Annual Procurement Plan
- MSK Transformation Terms of Reference
- Local Care Transformation
    - Governance Model
    - Highlight & Risk Report
    - VW Escalations
- System Operational Plan Dashboard
- MSK Strategy Engagement Outputs
- Digital Delivery
- Local Care Transformation – Cohort 1 update
- Primary Care Improvement & Transformation Board
- MSK Transformation
    - Board Development Session
    - Reporting
- System GP Access Improvement/Recovery Plan

- ICELS Mobilisation
- Rapid Response Update
- Medicines Management Policy
- VBC Policy
- CGM Commissioning Policy: Adults and CGM Commissioning Policy: CYP
- MSK Update

System People, Culture and Inclusion Committee

The System People, Culture and Inclusion Committee provides assurance and oversight of the development and delivery of the system's People Plan.

The System People Committee has met 3 times during the period 1st April 2023 to 31st March 2024 as required.

System People, Culture and Inclusion Committee Members	Meetings Attended During 2023/24
Catriona McMahon – Chair and Chair of Shrewsbury and Telford Hospital NHS Trust	3 of 3
Professor Trevor McMillan – ICB Non-Executive Director	0 of 3
Teresa Boughey - Non-Executive Director Shropshire Community Health NHS Trust	2 of 3
Pauline Gibbons – Non-Executive Director Midlands Partnership University Foundation Trust	0 of 3
Professor Paul Kingston – Non-Executive Director for Robert Jones, and Agnes Hunt Hospitals Trust	0 of 3
Cathy Purdy – Non-Executive Director Shrewsbury and Telford Hospital NHS Trust	0 of 3
Stacey Keegan - Vice Chair and Chief Executive Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1 of 3
ICS Chief People Officer/Vacant	0 of 3
Alex Brett – Chief People Officer Midlands Partnership University Foundation Trust	0 of 3
Rhia Boyode – Director of People and OD Shrewsbury and Telford Hospital NHS Trust	3 of 3
Denise Harnin– Chief People Officer and Culture Officer Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2 of 3
Clair Hobbs – Director of Nursing, Clinical Delivery and Workforce	0 of 3

Throughout the period 1st April 2023 to 31st March 2024, the Committee has received reports on the following:

- Draft People, Culture & Inclusion Governance & Operating Model
- Refresh of the Terms of Reference and Title of this Meeting
- People Delivery Committee Chairs' Report September 2023
- System Workforce Metrics to end August 2023
- AOB previously noted to the Chair
- 2023/2027 People Strategy Delivery
- SRO Report Retain
- SRO Report Reform
- SRO Report Transform

- Pharmacy Faculty

Integrated Care Partnership (ICP)

The Integrated Care Partnership is a joint committee created by NHS Shropshire, Telford and Wrekin, Shropshire Council and Telford and Wrekin Council. The role of the ICP is to bring together multiple system partners to develop an integrated care strategy for the whole population using best available information.

The Integrated Care Partnership has met once during the period 1st April 2023 to 31st March 2024 as required.

Integrated Care Partnership members	Meetings attended during 2023/24
Cllr Shaun Davies, Leader of Telford & Wrekin Council (Co-Chair)	1 of 1
Cllr Lezley Picton, Leader of Shropshire Council (Co-Chair)	1 of 1
Sir Neil McKay, Chair of the Integrated Care Board	1 of 1
Cllr Andy Burford, Chair of Telford and Wrekin's Health & Wellbeing Board	1 of 1
Cllr Cecilia Motley, Chair of Shropshire Health & Wellbeing Board	1 of 1
Simon Whitehouse, Chief Executive of the Integrated Care Board	1 of 1
David Sidaway, Chief Executive of Telford and Wrekin Council	1 of 1
Andy Begley, Chief Executive of Shropshire Council	1 of 1
Vacancy - Primary Care representative from Shropshire Place Based Partnership	0 of 1
Vacancy - Primary Care representative from Telford and Wrekin Place Based Partnership	0 of 1
Liz Noakes, Director of Public Health of Telford and Wrekin Council	1 of 1
Rachel Robinson, Director of Public Health of Shropshire Council	1 of 1
Tanya Miles, Executive Director People, Shropshire Council	0 of 1
Jo Britton, Director of Children's Services for Telford and Wrekin Council	1 of 1
Karen Bradshaw, Director of Children's Services for Shropshire Council	0 of 1
Simon Froud, Director of Adult Social Care for Telford and Wrekin Council	0 of 1
Louise Cross, Telford and Wrekin VCS	0 of 1
Jackie Jeffery, Shropshire VCS	1 of 1
Heather Osborne, Shropshire VCS	1 of 1
Lynn Cawley, Healthwatch Shropshire representative	1 of 1
Simon Fogell, Healthwatch Telford and Wrekin representative	0 of 1

Throughout the period 1st April 2023 to 31st March 2024, the partnership has received reports on the following:

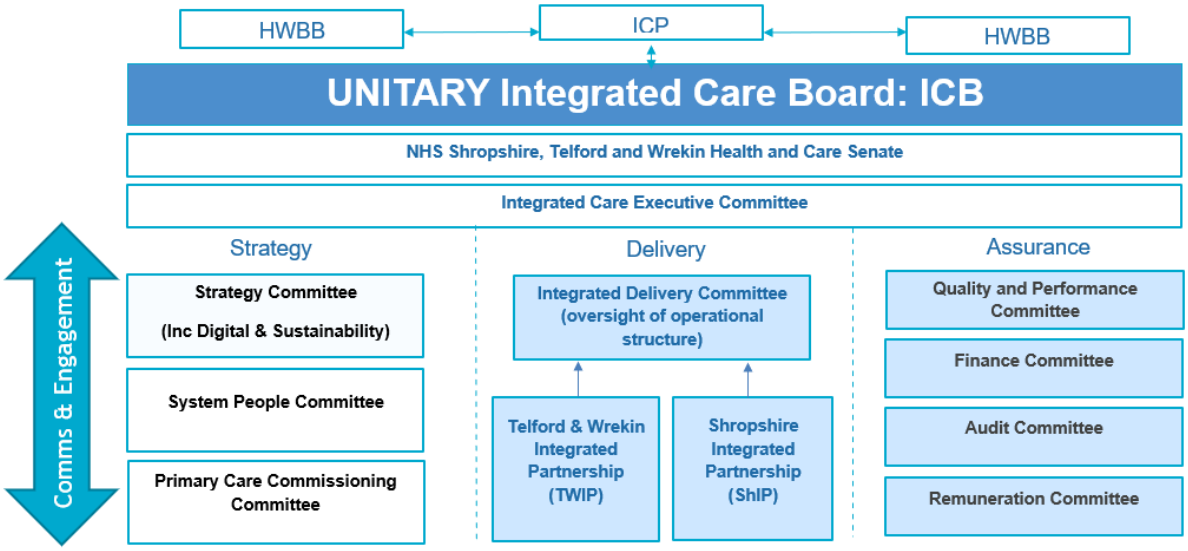
- Briefing on the content of the current Joint Strategic Needs Analysis and Health and Wellbeing Strategies for the respective local authority areas.
- Development and approval of the Integrated Care Strategy
- Update on development of the Joint Forward Plan and the engagement plan and delivery with the public and stakeholders.

Membership of the committees and sub-committees of the Board is outlined in respective terms of reference which are included in the Constitution and Governance Handbook. Attendance at these meetings is recorded in the minutes of each meeting.

The governance structure for NHS Shropshire, Telford and Wrekin (as described in the Constitution) is shown on the next page.

The organisation has reflected on its own effectiveness and performance as part the monthly assurance checkpoints undertaken by NHS England during 2023/24 and as part of the transition arrangements to the ICB and Good Governance Institute report on “Making Meetings Matter”. The outcomes of these reflections have been reported to the Board.

Governance Structure



UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code.

Discharge of Statutory Functions

NHS Shropshire, Telford and Wrekin has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the organisation is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the organisation’s statutory duties.

Risk management arrangements and effectiveness

Corporate governance is the system by which the Board directs and controls the organisation at the most senior level, to achieve its objectives and meet the necessary standards of accountability and probity. Using a risk management mechanism, the Board brings together the various aspects of

governance: corporate, clinical, financial, and information to provide assurance on its direction and control in a coordinated way across the whole ICS and across the ICB as standalone organisation.

During 2023/24 the ICB and system have adopted a revised Risk Management Policy and risk appetite and a new system board assurance framework and strategic operational risk register that covers both system and ICB only strategic operational risk.

NHS Shropshire, Telford and Wrekin received a limited assessment from its Internal Auditors which reflects that an Assurance Framework has been established but is not sufficiently complete to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks across all the main business activities. There were also two areas recommended by internal auditors for action which are being actioned in quarter 1 and 2 of 2023/24 financial year.

The coordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the Board. In addition, the other committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

NHS Shropshire, Telford and Wrekin prevents risk arising wherever possible by:

- applying policies and procedures for staff and contractors to follow;
- the Constitution and Governance Handbook;
- standing orders and standing financial instructions;
- the use of technical support external to the organisation (for example, legal, Information Governance and human resources advice); and
- internal audit.

The organisation also employs deterrents to risk arising (for example fraud and IT deterrents).

The system of risk control forms part of the organisation's system of internal control and is defined in the Integrated Risk Management Policy, which is reviewed annually. The policy defines the risk management responsibilities and common methodologies for the identification and assessment of risks for the whole organisation. It requires that risks are managed to a reasonable level, within the parameters of a defined risk appetite, rather than requiring the elimination of all risk of failure to achieve the organisation's objectives.

The risk control system facilitates the assessment of risk by:

- identifying and prioritising the risks to the achievement of the organisation's objectives
- evaluating the likelihood of those risks being realised and the impact should they be realised, and managing them efficiently, effectively and economically.

The Risk Management Policy applies to all risks, whether these are financial, quality, performance, governance, etc.

The risk appetite was determined and approved by the Board and the strategy outlines the processes for maintaining and monitoring the System Board Assurance Framework and the Strategic Operational Risk Registers for the System and ICB with due regard to this appetite.

Our risk appetite is outlined in our Risk Management Policy which can be found here.

Risk management is embedded in the activity of the organisation and can be demonstrated through:

- completion of equality impact assessments for reviewed or new policies

- incident and serious incident reporting is encouraged by the organisation and evident through the Ulysses reporting system
- Information Governance (IG), raising concerns and ensuring fraud awareness and training has been provided to senior managers and staff
- training for staff and Board members is mandated for particular areas: health and safety, IG, safeguarding, safer recruitment, fire safety, business continuity/emergency planning, Integrated Single Finance System (ISFE) and conflicts of interest
- intelligence gathering through quality and performance contracting processes with providers
- complaints and Patient Advice and Liaison Service (PALS) enquiries
- NHS-to-NHS concerns reporting via Ulysses
- national reviews, inspections and guidance.

Risks are identified, assessed and recorded in accordance with the Risk Management Policy. The principal processes and the matrix described in this document is applied to all risk registers, incident management and risk assessment activity across the organisation. The Policy outlines the processes used to identify risk within the ICB and across the system.

Capacity to Handle Risk

Leadership is given to the risk management process by the Accountable Officer whose role is to own the System Board Assurance Framework (SBAF). The SBAF, which documents the principle risks to the system's objectives not being delivered, is underpinned by the Strategic Operational Risk Register (SORR) for the system and for the ICB as a corporate entity. This outlines the lower-level risks to each executive lead not meeting their specific remit objectives and, specifically, risks to the organisation not fully discharging primary care commissioning under its delegation from NHS England effectively. Each executive lead, or members of their respective teams, will inform the Strategic Operational Risk Register. Both the Accountable Officer and directors are supported by the Director for Corporate Affairs. NHS Shropshire, Telford and Wrekin staff are provided with a risk assessment code of practice and receive support and training on risk management from the Director of Corporate Affairs where required.

A summary of the major risks identified in the SBAF during 2023/24 is set out below, and the actions being taken to mitigate the risks. The major risks to the ICS and the organisation have been reviewed and revised bi-monthly where necessary.

Description of major risks added to the Board Assurance Framework during 2023/24	Existing controls	Further actions
Strategic Risk No.1: Unable to sustain a culture of strategic collaboration and partnership working and secure delivery of integrated cares on priorities	Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook / Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy • Joint 5 year forward plan • People Priorities Partnerships and Services • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIPP	1. Complete self-assessment against NHSE/CQC regulatory framework - Q4 2a Interim ICS Director of Strategy le leading development of STW Provider Collaborative – Q3 2b. Creation of dedicated Director level role to support development of Provider Collaborative2c. Establishment of Provider Collaborative Committees in Common 2d. CB CEO co-chair of HWBB's 2e. Director of Partnerships and Place supporting delivery of JFP priorities and integrated place working

	• Health and Wellbeing Boards • ICS People Strategic Workstreams 2024 - 2027 Governance & Engagement Structures • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivery Committee • STW Mental Health Collaborative • GGI Review of ICB/ICS governance structures • ICB Strategic Partner on development of ICB version 3.0 • ICB Strategic Partner on development of ICB version 3.0 • People Culture and Inclusion Committee	

Strategic Risk No.2: Risk of not delivering sustainable services within available resources.	Strategies and Plans
	• System Financial Strategy, incorporating:
	  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
	  ○ Triple Aim framework
	  ○ Value based decision making approach
	• Financial Revenue Plan
	• Financial Capital Plan
	• Joint 5 year forward plan
	• Efficiency and Transformation Plans
	• General Practice Estate Programme
	
	Partnerships and Services
	• ShIPP
	• TWIPP
	• ICS Digital Delivery Group
	• Estates Board
	• People Board
	• Planned Care Board
	• UEC Delivery Board
	
	Governance & Engagement Structures
	• Finance Committee
	• Investment Panel
	• Integrated Delivery Committee
	• Audit Committee
	• Provider Collaborative Committees in Common
		1. Develop financial sustainability plan
		
		2. Complete self-assessment against NHSE/CQC regulatory framework

Strategic Risk No.3: STW is seeing a growing and ageing population; services and the workforce will need to adapt and shape to meet these needs. There is a risk that this capacity and capability will not be sufficient to meet population needs nor be able to focus on tackling identified and emergent health inequalities in every instance.	Strategies and Plans • 5 Year Forward Plan • System Development Plan • Inequalities Implementation Operational Plan • Primary Care Winter Plan • Integrated Care Strategy Partnerships and Services • CEO Group • Urgent and Emergency Care Board • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group Governance & Engagement Structures • Integrated Care System CEO Group • ICB Board • ICB Strategy Committee • ICB Quality and Performance Committee • ICB System People Committee • ICB Strategy Committee • Integrated Care System Health Inequalities Board • Population Health Board	Complete self-assessment against NHSE/CQC regulatory framework CQC - timeframe yet to be published nationally.
Strategic Risk No.4: Inability to recruit, retain and keep our ICS Workforce well.	Strategies and Plans • One People Plan Recommendations and Insights Report • workforce information dashboards to consider workforce information (sickness, turnover, vacancies, staff in post, Agency and bank usage etc) • 5 year Joint forward Plan Partnerships and Services • People related workstreams being led by the ICS People Team Governance & Engagement Structures • System People Committee provides oversight of the development of our system people strategy and annual programmes and strategic direction of travel • System People Committee oversight of Annual operational workforce planning process to set direction of travel for next 12 months	1 Finalise our ICS People Strategy and priorities by September 2023 4 GGI Making Meetings matter review includes System People Committee – due to report in September 2023 1/2/3/CEO decisions on system people collaborative approach, structures and resources – following discussion papers taken to CEOs meetings and HRD meetings for consideration. 4. Refresh of the System People Committee as the oversight function. 5. Refresh of the People Delivery Committee as the operational delivery programme board. 2. see (4) above
Strategic Risk No.5: Lack of capacity and strategy to develop and use digital	Strategies and Plans • Integrated Care Strategy	1. ICS Digital Strategy and portfolio for Board approval scheduled March 2024

and data systems to enable efficient and effective care across the ICS	• Joint Forward Plan • Population Health Roadmap • Joint Strategic Needs Assessments • Digital Strategy Partnerships and Services • Population Health Management Board • ICS Digital Delivery Group • TWIPP • ShIPP Governance & Engagement Structures • Integrated Delivery Committee • Strategy Committee • System Digital Governance Model	2. Develop information and data strategy across ICP 3. Complete self-assessment against NHSE/CQC regulatory framework 4. Consideration of system resources for support delivery of the Digital Strategy 5. Develop system digital operating model following adoption of the Strategy and portfolio
Strategic Risk No.6: Inability to respond strategically to ICS objectives due to the impact of external factors beyond the influence of the ICS. for example, EPRR, Climate change, economic and political changes	Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Health and Wellbeing Strategies • Local Authority Strategies • NHS EPRR Framework • NHS England Incident Response Plan • Local Authorities EPRR Response Plans • ICB Incident Response Plan • ICB EPRR Policy • ICB Business Continuity Plans (Corporate & Directorate) • ICB EPRR Communications Plan • ICB On Call Policy • STW Health Protection Strategy • Regional ICB Mutual Aid Agreement • ICS Green Plan • Individual NHS organisations Green Plans • ICB Risk Management Policy Partnerships and Services • Integrated Care Partnership • Local Resilience Forum • Local Health Resilience Partnership • Health Emergency Planning Operational Group • Population Health Board • ShIPP • TWIPP • Primary Care Networks • ICS Climate Change Group Governance & Engagement Structures • Integrated Care Partnership • Health and Wellbeing Boards • Local Resilience Forum • Local Health Resilience Partnership • Health Emergency Planning Operational Group (HEPOG) • Themed HEPOG sub groups	1. ICB CEO to write out to partner CEOs with request for operational lead 2. Escalated to CEOs for decision 3. Action to complete plans included in EPRR annual work programme 23/24 4. Complete self-assessment against NHSE/CQC regulatory framework
Strategic Risk No.7: Inability to contribute effectively as a system to support broader social and economic development	Strategies and Plans • Integrated Care Strategy • 5 year Joint Forward Plan • Health and Wellbeing Strategies Partnerships and Services • TWIPP • ShIPP • Provider Collaboratives • ICS Chief Executives Group • Networks Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours • Health and Wellbeing Boards	1. Population health management approach needs to be adopted. 2. GGI review of meetings and governance structure – phase 1 October 2023
Strategic Risk No.8: Patient and Public Involvement	Strategies and Plans • Integrated Care Strategy • 5 Year Forward Plan • Big Health and Wellbeing conversation comms and engagement plan socialised and approved by Board • Communications and Engagement Strategy for STW ICB approved by the Board Partnerships and Services • Presence of Healthwatch for both areas at Board meetings and Quality and Performance Committee • System Involvement and Engagement Network established • Communications and Engagement teams working jointly across ICB, ICS and Providers providing more capacity and expertise in planning and delivery	1a) CSU comms and engagement capacity is used when required. 1b) People's network established to enable ongoing engagement on a regular basis

	• Board meetings are held in public and board papers published to the ICB website to increase transparency. • Substantive ICS Director of Comms and Engagement now appointed and overseeing ICB and ICS functions • System-wide Integrated Impact Assessment (IIA) tool developed to streamline the way we identify the impact of change on equality groups Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • Reports to Governing bodies/Committees require section completing on Patient involvement • Equality and Involvement Sub-Committee as part of ICB Governance • Non Executive Director for Inequalities in place on Board to act as specific check and balance with regard to patient involvement	

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place to ensure the organisation delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. There is appropriate monitoring of risks and the courses of action being employed to mitigate them.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Our Risk Management Strategy defines our commitment to ensuring that the organisation has in place structures that will effectively manage risks of all kinds, in line with aims set out in our Constitution. We will take all reasonable steps to manage risks in commissioned services, staff, visitors, reputation, organisational assets and any other issue as an integral part of our management processes.

The following control mechanisms are in place:

- risk management
- Constitution
- security management
- Counter Fraud Annual Plan
- Internal Audit Annual Plan
- performance monitoring of ICS providers and the organisation itself
- Data Security and Protection Toolkit submission
- incident and serious incident reporting
- quality and financial reporting
- contract/quality performance monitoring arrangements with providers
- policies and procedures
- risk assessments
- governance reporting between the Board and its committees/sub-committees
- adult and children's safeguarding annual reports
- emergency and business continuity planning/core standards
- external regulator reports on providers.

Annual audit of conflicts of interest management

The organisation has a Conflicts of Interest Policy which governs the process for employees, Board members, Committee members, contractors and others undertaking functions on behalf of the organisation to declare their interests where these may conflict with those of NHS Shropshire, Telford and Wrekin. The Policy outlines a process for individuals both employed by the organisation or those not employed but acting on behalf of the organisation, to declare these interests to ensure that decisions made on behalf of NHS Shropshire, Telford and Wrekin are not compromised. The policy and registers can be found on the website: Conflicts of Interest - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

The organisation has carried out its annual internal audit of conflicts of interest at the end of 2023/24 and the audit provided moderate assurance, with some recommendations for further action. All recommendations have been fully accepted by the organisation and recommendations are being actioned in quarter one of 2024/25. Register of interests have been updated for Committees and Place based partnership meetings and newly published national training is being rolled out to staff and key decision makers in the organisation.

There have been no breaches of the Conflicts of Interest Policy which require reporting to the Audit Committee during this period.

Data Quality

The Board relies on the data quality elements in its contracts with providers that requires them to quality assure their data prior to submission. The organisation also uses NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) for provider information performance, quality and finance and therefore the organisation's contract with MLCSU outlines information reporting expectations. The data sources used by MLCSU is the national UNIFY system and Secondary Uses Service (SUS) data which is verified via the contracting process with providers.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, particularly personal identifiable information. The framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the organisation, other organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively. The Data Security and Protection Toolkit submission is not due until 30th June 2023 and therefore final compliance cannot be reported in this annual report.

The organisation places high importance on ensuring there are robust information governance (IG) systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed processes and procedures in line with the DSPT. We have ensured all staff undertake annual IG training and provide a staff IG handbook to ensure everyone is aware of their roles and responsibilities.

There are processes in place for incident reporting and the investigation of serious incidents. We have reported a total of 7 incidents during the period 1st April 2023 to 31st March 2024 and 6 of these

incidents were graded as non-reportable – very low risk, with 1 reportable to the Information Commissioner's Office (ICO). We have developed an information asset register which enables the organisation to identify high-risk assets through data flow mapping, and this ensures that an information risk culture is embedded throughout the organisation.

NHS Shropshire, Telford and Wrekin receives an Information Governance service from MLCSU. This enables us to receive a full, specialised service, which as a small organisation we could not reproduce in-house.

A work programme has been undertaken by MLCSU to ensure that the organisation is compliant against General Data Protection Regulations. As part of this, our information has been audited and staff training has been delivered.

Business Critical Models

The organisation relies on centrally provided NHS business planning models to help it plan future strategy. NHS Shropshire, Telford and Wrekin has no business-critical models that it would be required to share with the Analytical Oversight Committee.

Third party assurances

Third-party assurances are received annually from MLCSU for particular financial functions that are part of a service level agreement. Processes are in place to ensure that the CSU Internal Audit function shares its own audit findings of these functions with the ICB's internal auditor, who includes a precis of the findings in the Head of Internal Audit Opinion, which is part of this statement.

Raising Concerns – Freedom to Speak up

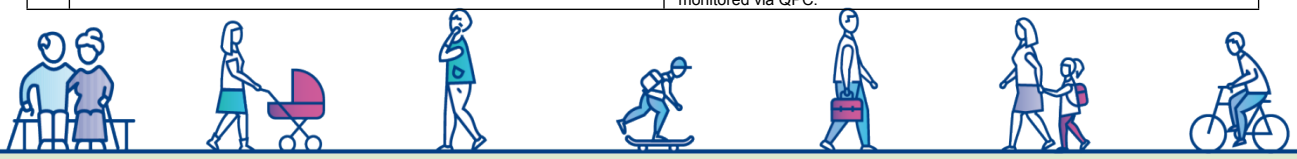
NHS Shropshire, Telford and Wrekin has a policy in place to support staff to raise concerns (sometimes referred to as 'whistleblowing'). There have been no concerns raised by staff to designated officers for investigation during the period 1st April 2023 – 31st March 2024. However, three members of staff have raised concerns directly with the Freedom to Speak Up Guardian during the period, one of these members of staff chose to subsequently raise the concern with their line manager and the two chose not to take any further action. The organisation has appointed a Freedom to Speak Up Guardian and also has a Senior Freedom to Speak Up Lead and Board level Non Executive Member to support staff to raise concerns under the policy moving forward.

The Audit Committee gets an annual report on any concerns raised and action taken, protecting anonymity where required.

Control Issues

The significant control issues that the organisation has been managing during the period 1st April 2023 to 31st March 2024 that would require reporting in this Annual Governance Statement are as follows:

1.	Quality and Performance - Accident and Emergency	Harm review process in place- multiagency involvement TOR agreed and weekly oversight.
2.	Quality and Performance - Regulators (including patient safety)	SATH CQC report pending. Awaiting report for factual accuracy by end of January 2024. ICB will review finding in consultation with SATH. PSIRF implemented for all 4 NHS trust boards Dec 2023. Plans to roll-out with primary care in line with national guidance.
3.	Quality and Performance - Ambulance Services	Offload delays and response delays. Senior leaders meeting 3 times a week to address risk and discuss mitigations, e.g. additional sub-acute beds.
4.	Quality and Performance - Mental Health and Dementia	Increased waiting lists for BEEU, talking therapies and adult ADHD. Risks monitored via QPC.



5.	Quality and Performance - Infection prevention control (IPC)	Strategic measles management plan in place.
6	Quality and Performance - Asylum seekers	Plan for mobile TB screening for asylum seekers, working with primary care.
7	Quality and Performance - Critical Incidents	Senior leaders meeting 3 times a week to address risk discuss mitigations.
8	Quality and Performance - Maternity	Monthly oversight via ORAC/MTAC/QSAC and LMNS board.
9	Quality and Performance - Childrens Services	Paediatric transformation at SATH. Working ongoing to address paediatric audiology and child mortality. Continue to support the independent inquiry into child sexual exploitation (IITCSE).
10	Finance, Governance and Control - Finance and Procurement	23/24 Financial Position is a significant deficit and adverse variance to the submitted plan. ICB has agreed a revised FOT position to be reported at M9 with NHSE via the FOT change protocol. Longer term financial recovery plan and strategy development underway including system transformation programme.
11	Finance, Governance and Control - Information Governance, inc data breaches	On the 19th of September 2023, Baywater Healthcare was the subject of a cyber incident. The supplier provides long term condition support therapies including oxygen services for patients with chronic conditions. The threat attacker targeted a specific folder, which was copied and removed from their environment. This has resulted in a breach of confidentiality but not availability. Baywater Healthcare has provided a report to ICBs Nationally and NHS Wales and NHS Scotland which summarises the impacted data. NHSE has shared guidance on the process of risk assessment for patients within ICB areas which is being considered for additional action.
12	Quality and Performance - Accident and Emergency	Performance in December has continued to be challenged across the system, similarly as the rest of the NHS, experiencing extreme pressure following the festive period, further compounded by Junior Doctor Industrial Action. This resulted in a large number of ambulance handover delays, long waits within both A&E departments and an increased number of patients waiting for beds (DTAs Decision to Admit). This has led to an increased number of unconventional care spaces being utilised. However, a series of actions have taken place which when combined with lower levels of demand have allowed the system to be in a significantly improved position. These are: • System Winter Flow Summit held to specifically agree actions to mitigate risk 13through the system, this has led to several key actions being agreed with associated impact, these are tracked through the SCC and weekly winter flow dashboards. • Further embedding of System Control Centre (SCC) into all process' and daily cadence across the system. This has been enhanced by moving into a 7-day service from November 2023 and having dedicated staff in post. • Additional 16 beds opened boxing day at Robert Jones and Agnes Hunt Orthopaedic Hospital to increase flow. • Accelerated opening of 20 sub-acute beds at PRH, further plans to expedite the opening of 20 beds at RSH. There are wider plans to expand this bed base. • A Multiple-Agency Discharge Event (MADE), involving all stakeholders was held, further dates planned. • Focus on Virtual Wards (VW) utilisation and improved pathways. A total of 251 patients were cared for under the VW in October which allowed patients to be treated for higher acuity needs whilst being able to stay in their own home. Further focus will be on developing additional clinical pathways for frailty and respiratory conditions. • The Urgent Care Response (UCR) team continue to support patients to remain out of an acute setting by providing a 2- hour response. Performance is significantly above the 70% national standard and continues to remain above 90%. • The 3 UEC Improvement programmes, Appropriate Access to Care, Early Flow and Discharge have all been reviewed following feedback from recent review visits from NHSE and DHSC. The delivery priorities have been aligned to programmes that will have the most impact on Category 2 Ambulance performance, A&E 4-hour waiting targets and reduction in NCTR patients. Delivery of all these programmes will be overseen by the UEC Board • Approved 7 winter schemes for 2023/24. The schemes are in mobilisation phase with reporting and monitoring key performance indicators being developed with the leads of the schemes.

Review of economy, efficiency & effectiveness of the use of resources

The Finance Committee, Integrated Delivery Committee and Quality and Performance Committee give detailed consideration to the organisation's financial and performance issues to provide the Board with assurance that all issues are being appropriately managed and escalated where necessary. This includes the determination of key financial assumptions to underpin the organisation's medium-term financial strategy and scrutiny of monthly financial reporting, including delivery of transformation schemes through the system Investment Panel, performance against central management costs and efficiency controls.

These committees report to the Board via a chair's exception report at each meeting. In addition, the Board receives summary financial, quality and performance reporting at each meeting.

The Internal Audit Plan also provides reports to the Audit Committee throughout the year on financial systems and financial management provided by the organisation and supported by MLCSU. Outcomes from these internal audit reviews are detailed in the Head of Internal Audit Opinion.

Delegation of functions

NHS Shropshire, Telford and Wrekin has a Scheme of Reservation and Delegation that sets out delegated areas of responsibility and authority and clearly defined limits that properly reflect roles and responsibilities.

It is underpinned by a comprehensive system of internal control, including budgetary control measures, and ensures that there are sufficient safeguards and management mechanisms in place to maintain high standards in terms of effective, efficient and economic operation of the group. The scheme captures the decision-making roles of the Accountable Officer, directors, Board and committees, and is linked to the terms of reference of each committee.

The Audit Committee maintains an oversight of delegated functions and responsibilities to ensure that resources are used efficiently and economically and that there are effective processes in place to guard against fraudulent usage.

The organisation, in accordance with its Constitution, reviews its Scheme of Reservation and Delegation annually. Amendments to the overarching Scheme of Reservation and Delegation are taken to the Board for approval. The organisation remains accountable for all its functions – including those that it has delegated.

External audit fees, work and independence

The ICB's external auditors are Grant Thornton UK LLP, Colmore Plaza, 20, Colmore Circus, Birmingham, B4 6AT. The contract value was £110,000k excluding VAT. The contract included the core audit work of the financial statements and work on the economy, efficiency and effectiveness in the ICB's use of resources (Value for Money).

Counter fraud arrangements

Counter fraud arrangements are contracted by the ICB from 360 Assurance who provide the services of an Accredited Local Counter Fraud Specialist (LCFS), contracted to undertake counter fraud work proportionate to the ICB's identified risks.

The Government's Functional Standard (Govs13: Counter Fraud) was launched in October 2018 and is being implemented across all government departments and arms-length bodies, including the NHS who moved to adopt the new standards in 2021. The ICB Audit Committee receives a regular report from the LCFS which details activities undertaken against each of the Standards, and the LCFS produces an annual report detailing the year's activities. There is executive support and direction for a proportionate proactive work plan to raise awareness of the zero tolerance to fraud and to address identified risks.

The Chief Finance Officer, who is a member of the ICB Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption and oversees that appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations. In addition, the LCFS role is further supported by a nominated Counter Fraud Champion who provides a senior voice within the organisation to champion the counter fraud agenda, and to enable and support the counter fraud programme of work.

Our Workforce – Delivery and Assurance

The STW ICS People Strategy 2023-2028 is underpinned by four key programmes:

1. ATTRACT and TRAIN
2. RETAIN
3. REFORM
4. TRANSFORM

These align with the NHSE People Plan and Promise, the NHS Long Term Workforce Plan, and the directives set forth in the NHSE Annual Operating Priorities and Guidance. Our People Strategy, while guided by NHS national directives, also integrates principles from the 2022 Local Government Partners in Health strategy.

Each programme is managed by a Senior Responsible Officer at the Director level, who is pivotal in ensuring the programme's or project's successful execution in meeting agreed in year strategic priorities and expected outcomes. Delivery of each programme is driven through transformation leads through partnership and collaboration with provider partners across health , local authority, independent care providers and NHS partners.

For 2023-2024, the ICS People Collaborative, which assures and oversees the Board on essential drivers, has been chaired on a rotational basis by the four SROs. This governance will be enhanced in 2024-2025 with an Executive level SRO assuming the chairmanship. The principal drivers are:

a) workforce metrics
b) workforce supply and retention
c) progress in implementing the 2023-2028 ICS People Strategy,
d) progress towards the 10 people outcomes
e) evidencing exiting segment four of NHSE oversight framework relative to workforce and the people element.

The People Collaborative reports to the STW ICS People Committee, which is a subcommittee of the Board. Additionally, workforce-specific metrics, particularly the annual workforce plan and its associated costs, are reported to the Integrated Performance Report.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

My opinion is provided on the basis of an objective assessment of the framework of governance, risk management and control. To provide my opinion, I have considered:

- the arrangements for Strategic Risk Management and the Board Assurance Framework
- Internal audit plan outturn

- the implementation of internal audit actions
- third party assurances.

The work undertaken within the Internal Audit Plan for the 2023/24 financial year is limited to the scope agreed with the organisation's executive officers and approved by the Audit Committee and as detailed within our final reports.

This opinion will remain open until the required submission of the 2023/24 final annual report and accounts and may be subject to revision should there be any changes within the organisation's control environment, specifically in relation to any work within your Internal Audit Plan for 2023/24 which is currently being finalised.

Any assignments issued since the 2022/23 opinion have been considered. I have also considered findings and recommendations from reviews undertaken on an advisory basis that have not included a formal opinion.

As part of the Internal Audit Plan, your nominated audit team has delivered an agreed staged rolling programme of work throughout the year to support our year end opinion. We have continued to work with the organisation to ensure your plan has remained relevant and have agreed any adjustments with the Audit Committee.

I **anticipate giving a Limited Assurance Opinion** that there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.

Strategic risk management and Board Assurance Framework – I anticipate giving a Limited Opinion on this area. There was a gap in the Board Assurance Framework in the earlier part of the year whilst it was being developed and aspects of the Board Assurance Framework have not been used effectively. Strategic risk arrangements at the ICB have not followed the ICB's Policy and have been inconsistent throughout the governance structure of the organisation. These weaknesses should be referenced in the Annual Governance Statement.

Internal Audit outturn – I anticipate providing Moderate Assurance for this element of the opinion however should any of our remaining work highlight significant weaknesses we reserve the right to update this element. The workplan is relatively limited in terms of days and coverage, and governance and risk issues have been identified as a theme in several areas of our work.

Implementation of Internal Audit Actions – As 31st March 2024, the ICB had an implementation rate of **83%** and one medium risk historic action. This therefore currently equates to a Significant assurance opinion for this element.

Limitations to the opinion

It is management's responsibility to develop and maintain a sound system of governance, risk management and control. This draft opinion is based on the work undertaken, the scope of which has been agreed with management. Where good levels of control are concluded, there are still instances where this may fail, for example, poor judgement in decision-making, human error, control processes being deliberately circumvented, management overriding controls and the occurrence of unforeseeable circumstances. As our scope of work is limited, there may be weaknesses in control systems that we are not aware of.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of a risk-based plan generated from an organisation-led Assurance Framework, which is one component that the Board considers in making its Annual Governance Statement.

During the period, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
System Board Assurance Framework: Audit found inconsistency of Committee oversight for some risks and a discrepancy between what reporting was required for Board between the Risk Management Policy and custom and practice. Management is currently developing an action plan to address all issues in the first quarter of 2024/25.	Limited
Policy Management Framework	Moderate
Financial Ledger and Reporting	Significant
Financial Systems	Significant
Continuing Healthcare (CHC) VFM: Audit found the following areas needed addressing and management has agreed to action in the first two quarters of 2024/25: • Completion of CHC case reviews • Management of appeals • Timely completion of funding assessments • Delivery against the Individual Commissioning Recovery Plan is reported through to Quality and Performance Committee • Update standard operating procedures • Develop a CHC Policy	Limited
Better Care Fund – Discharge Enablement Funding	Advisory
Delegated Direct Commissioning	Advisory
Ophthalmology Service Contracts	Advisory
Additional review at the request of the Chair of Audit Committee	Advisory

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- the Governing Body
- the Audit Committee
- the Finance Committee
- the Quality and Performance Committee
- internal audit
- other explicit reviews/assurance mechanisms.

The Head of Internal Audit Opinion contained within this report sets out a limited assurance position for the ICB as a result of weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives. Although the internal audit outturn was rated as moderate assurance, the strategic risk management and Board Assurance Framework was rated as limited due to a gap in the Board Assurance Framework at the beginning of the year as a result of the ICB developing a new Board Assurance Framework, with some aspects of which have not been used effectively and the Risk Management Policy has not been adhered to with inconsistency of application.

In response the ICB is developing a number of actions to address the issues raised in the Head of Internal Audit Opinion during quarter 1 of 2024/2025, with Internal Audit undertaking a further review in quarter 2 to provide an assurance position update to the Audit Committee.

Conclusion

In conclusion, my review of the effectiveness of governance, risk management and internal control and the Head of Internal Audit Opinion have confirmed that the ICB maintains a limited system of internal control which has been designed to meet the organisation's objectives, but controls are not being applied consistently. Accepting the control issues identified above, and the actions that are being taken to address these and the results of the internal audit reviews undertaken during the year, I am confident that the organisation understands the mechanisms that need to be in place to deliver good governance and that there is a plan to rectify these gaps in assurance.

Mr Simon Whitehouse

Accountable Officer

xx June 2024

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee was established by NHS Shropshire, Telford and Wrekin ICB to recommend approval of the remuneration and terms of service for the Executive Directors, other staff employed with Very Senior Manager (VSM) pay terms and conditions and lay appointments to the CCG Board.

The composition and responsibilities of the ICB's Remuneration Committee can be found in the Governance Statement.

Percentage change in remuneration of highest paid director - Audited

Year ended 31st March 2024	Salary & Allowances	Performance Pay & Bonuses
Highest Paid Director: % change from nine months to 31st March 2023	2.74%	0.00%
All Staff: % change from nine months to 31st March 2023	4.59%	0.00%

Nine months to 31st March 2023 2022-23	Salary & Allowances	Performance Pay & Bonuses
Highest Paid Director: % change from three months to 30th June 22	-2.67%	N/A
All Staff: % change from three months to 30th June 22	-1.56%	N/A

The increase in the highest paid director salary reflects the annual pay award received for 2023/24.

The increase in all staff reflects the annual pay award received for 2023/24.

As at 31st March 2024, remuneration ranged from £22k to £189k based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pay ratio information

Remuneration of NHS Shropshire, Telford and Wrekin's staff – Audited.

Year ended 31st March 2024	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,147	£42,618	£57,755
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£25,147	£42,618	£57,755

Nine Months ended 31st March 2023	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£37,506	£54,619
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£37,506	£54,619

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in Shropshire, Telford and Wrekin ICB in the year ended 31st March 2024 was £185k to £190k and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile Salary ratio	Median total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio	75th percentile salary ratio
Year ended 31st March 2024	7.5	7.5	4.4	4.4	3.2	3.2
Nine months to 31st March 2023	7.6	7.6	4.9	4.9	3.3	3.3

In the year ended 31st March 2024 no employees received remuneration in excess of the highest-paid director/member.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The remuneration of the Chief Executive Officer, Executive Directors, Chair and Non-Executive Director who serve on the board is determined by the Remuneration Committee, with reference to recognised national ICB Executive Pay Ranges and Guidance and benchmarking with other ICBs. The Remuneration Committee is also responsible for determining pay for all other non-agenda for change roles with reference to national guidance and benchmarking.

Midlands and Lancashire Commissioning Support Unit (MLCSU) provide independent advice and support to the ICB and the Remuneration Committee in relation to employment and remuneration matters.

Remuneration of Very Senior Managers

Remuneration for Very Senior Managers at the ICB is agreed with reference to the national ICB Pay Framework. Where full time salaries exceed the threshold appropriate approval is sought via NHS England and the Department of Health and Social Care.

Senior manager remuneration (including salary and pension entitlements)

Salary and Pension Benefits 2023/24 – NHS Shropshire, Telford and Wrekin ICB – Audited

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Bennett*	David	Associate Non Executive Director (from 8th December 2023)	08/12/23 to 31/03/24	0-5	-	-	-	-	0-5
Bussey *	Alison	Chief Nursing Officer (retired 31st December 2023)	01/04/23 to 31/12/23	115-120	-	-	-	0-2.5	115-120
Chan	Ian	Partner Member for Primary Care/Clinical Lead	01/04/23 to 31/03/24	65-70	-	-	-	-	65-70
Dunshea *	Roger	Non Executive Director	01/04/23 to 31/03/24	10-15	-	-	-	-	10-15
McKay *	Neil	Chair and GP/Healthcare Professional	01/04/23 to 31/03/24	60-65	-	-	-	-	60-65
McMillan *	Trevor	Non Executive Director	01/04/23 to 31/03/24	10-15	-	-	-	-	10-15
Pall *	Navnit	Non Executive Director	01/04/23 to 31/03/24	10-15	-	-	-	-	10-15
Povey *	Julian	Partner Member for Primary Care	01/04/23 to 31/03/24	15-20	-	-	-	-	15-20
Robinson	Gareth	Executive Director of Delivery & Transformation	01/04/23 to 31/03/24	160-165	-	-	-	42.5-45	205-210
Skidmore	Claire	Chief Finance Officer & Deputy Chief Executive Officer	01/04/23 to 31/03/24	165-170	-	-	-	-	165-170
Vivian *	Meredith	Deputy Chair, Lay Member for Patient & Public Involvement	01/04/23 to 31/03/24	10-15	-	-	-	-	10-15
Whatley	Vanessa	Chief Nursing Officer (appointed 1st December 2023)	01/12/23 to 31/03/24	105-110	-	-	-	15-17.5	120-125
White	Nicholas	Chief Medical Officer	01/04/23 to 31/03/24	135-140	-	-	-	202.5-205	340-345
Whitehouse	Simon	Chief Executive Officer	01/04/23 to 31/03/24	185-190	-	-	-	-	185-190

* Not in the NHS Pension scheme in this employment

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Salary and Pension Benefits – nine months ended 31st March 2023 – NHS Shropshire, Telford and Wrekin ICB – Audited

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)	Full Year Equivalent Salary £
Bussey *	Alison	Chief Nursing Officer	01/07/22 to 31/03/23	110-115	-	-	-	0-2.5	110-115	149,450
Chan	Ian	Partner Member for Primary Care/Clinical Lead	01/07/22 to 31/03/23	50-55	-	-	-	257.5-260	305-310	69,208
Dunshea *	Roger	Non Executive Director	01/07/22 to 31/03/23	5-10	-	-	-	-	5-10	13,000
Dymond	Nicola	Executive Director of Strategy & Integration	01/07/22 to 31/03/23	105-110	-	-	-	557.5-560	665-670	145,000
McKay *	Neil	Chair and GP/Healthcare Professional	01/07/22 to 31/03/23	45-50	-	-	-	-	45-50	65,000
McMillan *	Trevor	Non Executive Director	01/07/22 to 31/03/23	5-10	-	-	-	-	5-10	13,000
Pall *	Navnit	Non Executive Director	01/07/22 to 31/03/23	5-10	-	-	-	-	5-10	13,000
Povey *	Julian	Partner Member for Primary Care	01/07/22 to 31/03/23	45-50				-	45-50	65,480
Robinson	Gareth	Executive Director of Delivery & Transformation	01/07/22 to 31/03/23	110-115	-	-	-	35-37.5	145-150	147,000
Skidmore	Claire	Chief Finance Officer & Deputy Chief Executive Officer	01/07/22 to 31/03/23	115-120	-	-	-	140-142.5	260-265	157,583
Vivian *	Meredith	Deputy Chair, Lay Member for Patient & Public Involvement	01/07/22 to 31/03/23	5-10	-	-	-	-	5-10	13,000
White	Nicholas	Medical Director	01/07/22 to 31/03/23	95-100	-	-	-	157.5-160	255-260	132,222
Whitehouse	Simon	Chief Executive Officer	01/07/22 to 31/03/23	135-140	-	-	-	230-232.5	365-370	180,249

* Not in the NHS Pension scheme in this employment

Pension benefits

Please note that the cash equivalent transfer value was calculated by the NHS Pensions Agency.

Pension entitlements of Senior Managers 2023/24 – NHS Shropshire, Telford and Wrekin ICB – Audited

Surname	Forename	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31st March 2024 £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bussey	Alison	Chief Nursing Officer (retired 31st December 2023)	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Chan*	Ian	Partner Member for Primary Care/Clinical Lead	0	0-2.5	10-15	0-5	155	15	187	0
Robinson	Gareth	Executive Director of Delivery & Transformation	2.5-5	0-2.5	15-20	10-15	160	54	253	0
Skidmore*	Claire	Chief Finance Officer & Deputy Chief Executive Officer	0	37.5-40	55-60	160-165	863	229	1,201	0
Whatley	Vanessa	Chief Nursing Officer (appointed 1st December 2023)	0-2.5	0-2.5	35-40	95-100	712	17	849	0
White	Nicholas	Chief Medical Officer	7.5-10	65-67.5	60-65	170-175	877	431	1,416	0
Whitehouse	Simon	Chief Executive Officer	0	42.5-45	70-75	190-195	1,170	268	1,562	0

Ian Chan, Claire Skidmore and Simon Whitehouse are affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

Shropshire, Telford and Wrekin ICB does not have any to report during the year ended 31st March 2024.

Payments to past directors

In the year ended 31st March 2024 Shropshire, Telford and Wrekin ICB made no payments to a Director requiring special approval from Treasury.

Staff Report

Employee benefits 2023/24 – Audited

Employee benefits	Year ended 31st March 2024		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	13,934	1,440	**15,374**
Social security costs	1,311	1	**1,312**
Employer Contributions to NHS Pension scheme	2,147	-	**2,147**
Other pension costs	-	-	**-**
Apprenticeship Levy	48	-	**48**
Other post-employment benefits	**-**	-	**-**
Other employment benefits	**-**	-	**-**
Termination benefits	30	-	**30**
Gross employee benefits expenditure	17,470	1,441	18,911
Less recoveries in respect of employee benefits (note 4.1.2)	(30)	**-**	**(30)**
Total - Net admin employee benefits including capitalised costs	17,440	1,441	18,881
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**17,440**	**1,441**	**18,881**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. This has continued for the ICB in 2022/23 and 2023/24. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4

Staff Analysis by Gender

	Headcount by Gender			
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**
Board Member	3	9	6	**18**
Other Senior Management (Band 8C+)	29	5	0	**34**
All Other Employees	217	44	0	**261**
Grand Total	**249**	**58**	**6**	**313**

**Unknown pertains to Board Members without a pay record in the ICB Electronic Staff Record (ESR) system*
Named Individuals categorised as Unknown are :-

Louise Barnett
Andy Begley
Neil Carr

Patricia Davies
Stacey Keegan
David Sidaway

Staff composition

Pay Band	Headcount
Ad Hoc / Local	0
Band 1	0
Band 2	2
Band 3	66
Band 4	22
Band 5	20
Band 6	51
Band 7	41
Band 8 - Range A	38
Band 8 - Range B	21
Band 8 - Range C	10
Band 8 - Range D	6
Band 9	3
Medical	9
VSM	18
Board (off payroll)	6
Grand Total	**313**

Board (off payroll) pertains to Board Members without a pay record in the ICB Electronic Staff Record (ESR) system
Named Individuals categorised as such are :-

Louise Barnett
Andy Begley
Neil Carr
Patricia Davies
Stacey Keegan
David Sidaway

Sickness absence data

Staff sickness absence 2023	2023 Number
Total Days Lost	2653.27
Total Staff Years	248.22
Average Working Days Lost	10.69

The sickness absence data for the ICB in 2023 was whole time equivalent (WTE) days available of 55850.2 and WTE days lost to sickness absence of 2653.27 and average working days lost per employee was 10.69 which was managed through the absence management policy.

Staff turnover percentages

ICB Staff Turnover 2023-24	2023-24 Number
Average FTE Employed 2023-24	253.03
Total FTE Leavers 2023-24	33.25
Turnover Rate	13.14%

The ICB Staff Turnover Rate for 2023-24 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The ICB's Total FTE Leavers in year was 33.25. The ICB's Average FTE Staff in Post during the year was 253.03. The ICB Staff Turnover Rate for the year was 13.14%

Trade Union Facility Time Reporting Requirements

For the period 1st July 2022 to 31st March 2023, we had no Trade Union officials within NHS Shropshire, Telford and Wrekin.

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
0	0

Percentage of time spent on facility time

Percentage of time spent on facility time	Number of employees
0%	0
1-50%	0
51-99%	0
100%	0

Percentage of pay bill spent on facility time

Percentage of pay bill spent on facility time	Figures
Provide the total cost of facility time	0
Provide the total pay bill	0

Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100
0

Other employee matters

The ICB recognises that discrimination and victimisation is unacceptable and that it is in the interests of the organisation and its employees to utilise the skills of the total workforce. It is the aim of the organisation to ensure that no employee or job applicant receives less favourable facilities or treatment (either directly or indirectly) in recruitment training/career progression or employment on the grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex or sexual orientation.

To support this commitment and to ensure we comply with both the Equality Act 2010 and the Human Rights Act 1998, the ICB requires all its staff to undertake regular mandatory training on equality, diversity and human rights and to comply with our Equal Opportunities Policy.

We are committed to communicating and engaging with staff on a consistent and frequent basis, through one-to-ones, team meetings, staff consultation events, ICB staff briefings and staff newsletters.

The ICB has a recruitment policy which is based on NHS best practice. We use the recruitment service of MLCSU to ensure that recruitment is carried out robustly and transparently in line with our policy and there is a clear audit trail of recruitment decisions and employee checks. We have a Training and Development Policy which seeks to ensure that all staff have equal opportunity and access to training and development required by their role through identification with their managers in appraisals and regular one-to-one meetings.

Employees with a disability

Employing people with a disability is important for any organisation providing services for the public, as they need to reflect the many and varied experiences of the public they serve. In the provision of health services, it is perhaps even more important, as people with disabilities make up a significant proportion of the population, and those with long-term medical conditions use the services of the NHS.

The ICB's commitment to people with disabilities includes:

people with disabilities who meet the minimum criteria for a job vacancy are guaranteed an interview
the adjustments that people with disabilities might require to take up a job or continue working in a job are proactively considered

the ICB's mandatory equality and diversity training includes awareness of a range of issues impacting people with disabilities.

Expenditure on consultancy

The ICB spent £511,154 on consultancy services in the year ended 31st March 2024. The majority of this spend related to payments to a consultancy firm for Running Cost transformation projects and Primary Care Support implementation fees.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, ICBs must publish information on their highly paid and/or senior off-payroll engagements. The tables below show the existing arrangements as of 31 March 2024.

For all off-payroll engagements agreed in the year ended 31st March 2024, for more than £245 per day:

	Number
Number of existing engagements as of 31st March 2024	0
Of which, number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a senior civil servant.

Shropshire, Telford and Wrekin ICB can confirm that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax.

For all off-payroll engagements between 1st April 2023 and 31st March 2024, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1st April 2023 and 31st March 2024	0
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2023 and 31st March 2024

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements	14

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit packages agreed in the year ended 31st March 2024 – Audited.

Year ended 31st March 2024

Exit packages agreed in the financial year	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Redundancy and other departure costs have been paid in accordance with the provisions of NHSE guidance. Exit costs in this note are accounted for in full in the year of departure. Where the Shropshire, Telford & Wrekin ICB has agreed early retirements, the additional costs are met by the Shropshire, Telford & Wrekin ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	-	-

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice.

There have been no non-contractual payments made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

The ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this Annual Report.

Annual Accounts

Please find a full copy of our annual accounts appended following this page

Simon Whitehouse

Accountable Officer

XX June 2024

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31st March 2024	2
Statement of Financial Position as at 31st March 2024	3
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2024	4
Statement of Cash Flows for the year ended 31st March 2024	5

Notes to the Accounts

Accounting policies	6-11
Other operating revenue	12
Revenue	12
Employee benefits and staff numbers	13-15
Operating expenses	16
Better payment practice code	17
Other gains and losses	18
Finance costs	18
Net gain/(loss) on transfer by absorption	18
Property, plant and equipment	19
Right of Use Assets and Leases	20-21
Trade and other receivables	22
Cash and cash equivalents	23
Trade and other payables	24
Provisions	25
Contingencies	26
Financial instruments	26-27
Operating segments	27
Joint arrangements - interests in joint operations	28
Related party transactions	29
Events after the end of the reporting period	30
Third party assets	30
Financial performance targets	30
Analysis of charitable reserves	30
Losses and special payments	30

Statement of Comprehensive Net Expenditure for the year ended 31st March 2024

	Note	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Income from sale of goods and services	2	(13,164)	(14)
Other operating income	2	(641)	(360)
Total operating income		**(13,805)**	**(374)**
Staff costs	4	18,911	14,012
Purchase of goods and services	5	1,227,207	780,011
Depreciation and impairment charges	5	344	214
Provision expense	5	20	975
Other operating expenditure	5	130	215
Total operating expenditure		**1,246,612**	**795,427**
Net Operating Expenditure		**1,232,807**	**795,053**
Finance expense	8	14	7
Other Gains & Losses	7	198	-
Net expenditure for the Year		**1,233,019**	**795,060**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**1,233,019**	**795,060**
Comprehensive Expenditure for the year		**1,233,019**	**795,060**

Statement of Financial Position as at 31st March 2024

	Note	31st March 2024 £'000	31st March 2023 £'000
Non-current assets:			
Property, plant and equipment	10	-	-
Right-of-use assets	11	1,053	1,158
Total non-current assets		**1,053**	1,158
Current assets:			
Trade and other receivables	12	13,042	8,156
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	13	518	286
Total current assets		**13,560**	8,442
Non-current assets held for sale		-	-
Total current assets		**13,560**	8,442
Total assets		**14,613**	9,600
Current liabilities			
Trade and other payables	14	(85,720)	(61,001)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	11.2	(1,073)	(913)
Provisions	15	(3,296)	(3,444)
Total current liabilities		**(90,089)**	(65,358)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(75,476)**	(55,758)
Non-current liabilities			
Lease liabilities		-	-
Total non-current liabilities		**-**	**-**
Assets less Liabilities		**(75,476)**	(55,758)
Financed by Taxpayers' Equity			
General fund		(75,476)	(55,758)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(75,476)**	(55,758)

The notes on pages 6 to 30 form part of this statement

The financial statements on pages 2 to 30 were approved by the Board on 26th June 2024 and signed on its behalf by:

Chief Accountable Officer
Simon Whitehouse

Statement of Changes In Taxpayers' Equity for the year ended 31st March 2024

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Year ended 31st March 2024				
Balance at 1st April 2023	(55,758)	-	-	(55,758)
Changes in ICB taxpayers' equity for Year ended 31st March 2024				
Net operating expenditure for the financial year	(1,233,019)	-	-	**(1,233,019)**
Net Recognised ICB Expenditure for the Financial year	**(1,233,019)**	**-**	**-**	**(1,233,019)**
Net funding	1,213,300	-	-	**1,213,300**
Balance at 31st March 2024	**(75,476)**	**-**	**-**	**(75,476)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Nine month Period ended 31st March 2023				
Balance at 1st July 2022	-	-	-	**-**
Transfer of assets and liabilities from closed NHS bodies	(60,378)	-	-	**(60,378)**
Adjusted balance at 1st July 2022	**(60,378)**	**-**	**-**	**(60,378)**
Changes in ICB taxpayers' equity for Nine month Period ended 31st March 2023				
Net operating costs for the financial year	(795,060)			(795,060)
Net Recognised ICB Expenditure for the Nine month period	**(795,060)**	**-**	**-**	**(795,060)**
Net funding	799,680	-	-	799,680
Balance at 31st March 2023	**(55,758)**	**-**	**-**	**(55,758)**

The notes on pages 6 to 30 form part of this statement

Statement of Cash Flows for the year ended 31st March 2024

	Note	**Year ended 31st March 2024 £'000**	Nine month Period ended 31st March 2023 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,233,019)	(795,060)
Depreciation and amortisation	5	344	214
Impairments and reversals		-	-
Non-cash movements arising on application of new accounting standards		-	(250)
Interest paid / received		14	7
Release of PFI deferred credit		-	-
Other Gains & Losses		198	-
(Increase)/decrease in trade & other receivables	12	(4,886)	(8,156)
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	14	24,719	61,002
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	15	(168)	-
Increase/(decrease) in provisions	15	20	1,225
Net Cash Inflow (Outflow) from Operating Activities		**(1,212,778)**	(741,018)
Cash Flows from Investing Activities			
Interest paid / received		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(1,212,778)**	(741,018)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,213,300	799,680
Repayment of lease liabilities		(291)	(218)
Non-cash movements arising on application of new accounting standards		1	(2)
Net Cash Inflow (Outflow) from Financing Activities		**1,213,010**	799,460
Net Increase (Decrease) in Cash & Cash Equivalents	13	**232**	58,442
Cash & Cash Equivalents at the Beginning of the Financial Year		**286**	-
Movement due to transfer by Modified Absorption		-	(58,156)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**518**	286

The notes on pages 6 to 30 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICB's) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The accounts are prepared for a twelve month period to 31st March 2024. The prior year comparatives are for a nine month period to 31st March 2023 following the transfer of assets into the ICB on 1st July 2022.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Where assets and liabilities transfer under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

1.4 **Pooled Budgets**

The ICB has entered into a pooled budget arrangement with Telford and Wrekin Local Authority [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for Better Care Fund (BCF), and the Transforming Care Programme (TCP). The TCP pool is hosted by the Local Authority and the BCF pool is jointly hosted.

The ICB has also entered into a pooled budget arrangement with Shropshire Council under a Section 75 partnership agreement. This was for the purpose of commissioning health and social care services under the Better Care Fund (BCF). The host Partner for the agreement is Shropshire Council.
The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of these pooled budgets, identified in accordance with the pooled budget agreements. Note 19 to the accounts provides details of the income and expenditure for these arrangements.

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the financial statements continued

1.7 **Employee Benefits continued**

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the financial statements continued

1.10 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements continued

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.12 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.26% (2022-23: 3.27%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.03% (2022-23: 3.20%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 4.72% (2022-23: 3.51%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 4.40% (2022-23: 3.00%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.14 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Notes to the financial statements continued

1.16 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.16.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.16.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.17.2 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements continued

1.18 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.20 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 **Critical accounting judgements in applying accounting policies and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed and the only items worthy of note are disclosed below.

1.21.1 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in adjustment to the carrying amounts of assets and liabilities within the next financial year.

Accruals - Continuing Health Care (CHC): The value of expected claims for CHC is estimated based on the number of days a patient has spent in a care home, multiplied by the daily charge of that provider. An estimate of future patients (accounting for expected growth), that are not yet in the ICB's CHC database is also made based on the number of days in a given month multiplied by the average monthly cost of existing patients included in the database.

Accruals - Prescribing: The ICB recognises the cost of drug prescribing based on data received from the NHS Business Services Authority (NHSBSA). Reports are received on a monthly basis, but are two months in arrears. March costs are estimated using historical levels of expenditure. The NHSBSA uses a methodology for forecasting prescribing expenditure that is based on national averages and does not necessarily reflect local issues. Therefore consideration is given to the use of local knowledge to determine the appropriate level of expenditure to be included in the accounts. This review is undertaken and full disclosure of any proposed adjustments shared with the auditors.

1.22 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 **New and revised IFRS Standards in issue but not yet effective**

There are no new or revised IFRS standards which are relevant or material to the ICB.

2 Other Operating Revenue

	Year ended 31st March 2024 Total £'000	Nine month Period ended 31st March 2023 Total £'000
Income from sale of goods and services (contracts)		
Prescription fees and charges	**5,214**	-
Dental fees and charges	**7,482**	-
Income generation	**-**	-
Other Contract income	**438**	14
Recoveries in respect of employee benefits	**30**	-
Total Income from sale of goods and services	**13,164**	14
Other operating income		
Other non contract revenue	**641**	360
Total Other operating income	**641**	360
Total Operating Income	**13,805**	374

3 Contract Revenue

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Patient transport services £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Income generation £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue						
NHS	-	-	-	-	59	30
Non NHS	-	5,214	7,482	-	380	-
Total	**-**	**5,214**	**7,482**	**-**	**438**	**30**

	Patient transport services £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Income generation £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue						
Point in time	-	5,214	7,482	-	438	30
Over time	-	-	-	-	-	-
Total	**-**	**5,214**	**7,482**	**-**	**438**	**30**

3.2 Transaction price to remaining contract performance obligations

The ICB did not have any contract revenue in the year ended 31st March 2024 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1. Employee benefits	Total Permanent Employees £'000	Other £'000	Year ended 31st March 2024 Total £'000
Employee Benefits			
Salaries and wages	13,934	1,440	**15,374**
Social security costs	1,311	1	**1,312**
Employer Contributions to NHS Pension scheme	2,147	-	**2,147**
Other pension costs	-	-	**-**
Apprenticeship Levy	48	-	**48**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	30	-	**30**
Gross employee benefits expenditure	**17,470**	**1,441**	**18,911**
Less recoveries in respect of employee benefits (note 4.1.1)	(30)	-	**(30)**
Total - Net admin employee benefits including capitalised costs	**17,440**	**1,441**	**18,881**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**17,440**	**1,441**	**18,881**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. This has continued for the ICB in 2022/23 and 2023/24. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4

	Total Permanent Employees £'000	Other £'000	Nine month Period ended 31st March 2023 Total £'000
Employee Benefits			
Salaries and wages	9,580	2,058	11,638
Social security costs	928	-	928
Employer Contributions to NHS Pension scheme	1,417	-	1,417
Other pension costs	-	-	-
Apprenticeship Levy	28	-	28
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	1	-	1
Gross employee benefits expenditure	11,954	2,058	14,012
Less recoveries in respect of employee benefits (note 4.1.1)	-	-	-
Total - Net admin employee benefits including capitalised costs	11,954	2,058	14,012
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	11,954	2,058	14,012

4.1.1 Recoveries in respect of employee benefits

The ICB has recognised one recovery in respect of employee benefits in the year ended 31st March 2024. This is from Shropshire Community Healthcare Trust (SCHT) for a seconded employee whose substantive role at SCHT was made redundant. There were none in the Nine month Period ended 31st March 2023.

4.2 Average number of people employed

	Year ended 31st March 2024			Nine month Period ended 31st March 2023		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**252.70**	**21.19**	**273.89**	235.13	35.00	270.13
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

There have been no agreed Exit packages in the financial year.

	Nine month Period ended 31st March 2023 Compulsory redundancies		Nine month Period ended 31st March 2023 Other agreed departures		Nine month Period ended 31st March 2023 Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	-	-	1	82,367	1	82,367
£150,001 to £200,000	2	320,000	-	-	2	320,000
Total	2	320,000	1	82,367	3	402,367

There have been no departures where special payments have been made in the financial year (Nine month period ended 31st March 2023 - nil).

Analysis of Other Agreed Departures

	Year ended 31st March 2024 Other agreed departures		Nine month Period ended 31st March 2023 Other agreed departures	
	Number	**£**	Number	£
Contractual payments in lieu of notice	-	-	1	82,367
Total	**-**	**-**	1	82,367

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

5. Operating expenses

	Year ended 31st March 2024 Total £'000	Nine month Period ended 31st March 2023 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	3,948	5,239
Services from foundation trusts	180,122	124,713
Services from other NHS trusts	577,663	371,037
Purchase of healthcare from non-NHS bodies	206,629	116,569
General Dental services and personal dental services	28,727	-
Prescribing costs	97,972	72,349
Pharmaceutical services	15,163	-
General Ophthalmic services	6,642	655
GPMS/APMS and PCTMS	102,232	69,358
Supplies and services – clinical	2,012	1,349
Supplies and services – general	(2,463)	12,894
Consultancy services	511	296
Establishment	3,827	2,584
Transport	839	240
Premises	796	417
Audit fees	132	128
Other non statutory audit expenditure	-	-
· Other services	24	18
Other professional fees	1,797	1,358
Legal fees	87	93
Education, training and conferences	547	712
Total Purchase of goods and services	**1,227,207**	**780,011**
Depreciation and impairment charges		
Depreciation	344	214
Total Depreciation and impairment charges	**344**	**214**
Provision expense		
Provisions	20	975
Total Provision expense	**20**	**975**
Other Operating Expenditure		
Chair and Non Executive Members	132	96
Grants to Other bodies	33	119
Expected credit loss on receivables	(44)	-
Other expenditure	9	-
Total Other Operating Expenditure	**130**	**215**
Total operating expenditure	**1,227,701**	**781,415**

The above includes expenditure dealt with under pooled budget arrangements as set out in Note 19.

Commissioning for pharmacy, ophthalmology and dentistry (POD) services from NHSE was transferred to the ICB with effect from 1st April 2023 and all expenditure is included in the above note.

External Audit Fees are inclusive of VAT and include the following:
Statutory audit fees for the year ended 31st March 2024 is £132k

The auditor's liability for external audit work carried out for the year ended 31st March 2024 is limited to £1million.

The full year fee paid to external auditors disclosed within Other Services (review of MHIS compliance statement) was £30k plus VAT.

Internal audit and counter fraud services are provided by 360 Assurance who are part of an NHS Trust. The cost of these services was £68k (excl VAT) in the year ended 31st March 2024, and is included within other professional

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	Year ended 31st March 2024 Number	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 Number	Nine month Period ended 31st March 2023 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	41,546	324,203	28,907	225,759
Total Non-NHS Trade Invoices paid within target	41,370	316,713	28,755	217,907
Percentage of Non-NHS Trade invoices paid within target	**99.58%**	**97.69%**	99.47%	96.52%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,086	770,938	649	506,926
Total NHS Trade Invoices Paid within target	1,063	770,782	635	506,015
Percentage of NHS Trade Invoices paid within target	**97.88%**	**99.98%**	97.84%	99.82%

The Better Payment Practice Code requires the ICB to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Amounts included in finance costs from claims made under this legislation	0	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**0**	**-**

7. Other gains and losses

	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Loss/(Gain) on disposal of right-of-use assets other than by sale	198	-
Total	**198**	**-**

The loss relates to the early termination of the Halesfield and Ptarmigan IFRS16 leases, and associated dilapidations costs, in February 2024.

8. Finance costs

	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on lease liabilities	14	7
Interest on late payment of commercial debt	-	-
Other interest expense	-	-
Total interest	**14**	**7**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**14**	**7**

9. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

NHS Shropshire, Telford & Wrekin ICB received the balances summarised below on the 1st July 2022 from the predecessor clinical commissioning group of NHS Shropshire, Telford & Wrekin CCG.

	Year ended 31st March 2024				Nine month Period ended 31st March 2023
	Total £'000	NHS England Parent Entities £'000	NHS England Group Entities (non parent) £'000	Non NHSE Group £'000	£'000
Transfer of property plant and equipment	-	-	-	-	-
Transfer of Right of Use assets	-	-	-	-	1,044
Transfer of intangibles	-	-	-	-	-
Transfer of inventories	-	-	-	-	-
Transfer of cash and cash equivalents	-	-	-	-	104
Transfer of receivables	-	-	-	-	2,910
Transfer of payables	-	-	-	-	(62,216)
Transfer of provisions	-	-	-	-	(2,220)
Net loss on transfers by absorption	**-**	**-**	**-**	**-**	(60,378)

As NHS Shropshire, Telford & Wrekin ICB is the recipient in the transfer of a function, it has recognised the assets and liabilities as at the transfer date. These balances are disclosed within the Statement of Financial Position as at 1st July 2022.

10. Property, plant and equipment

31st March 2024	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1st April 2023	-	-	-	-	0	-	195	39	234
Disposals other than by sale	-	-	-	-	(0)	-	(195)	(39)	(234)
Cost/Valuation at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Depreciation 1st April 2023	-	-	-	-	0	-	195	39	234
Disposals other than by sale	-	-	-	-	(0)	-	(195)	(39)	(234)
Depreciation at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Book Value at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Fully depreciated assets transferred in from the previous organisation have been cleared as there are no records of the assets to which they relate to.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 1st April 2023	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

11. Leases

11.1 Right-of-use assets

For local accounts use

31st March 2024	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 1st April 2023	-	1,438	-	-	-	-	-	-	1,438	983
Additions	-	965	-	-	-	-	106	-	1,071	-
Reclassifications	-	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	(1,438)	-	-	-	-	-	-	(1,438)	(983)
Cost/Valuation at 31st March 2024	**-**	**965**	**-**	**-**	**-**	**-**	**106**	**-**	**1,071**	**-**
Depreciation 1st April 2023	-	280	-	-	-	-	-	-	280	191
Charged during the year	-	342	-	-	-	-	2	-	344	245
Reclassifications	-	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	(606)	-	-	-	-	-	-	(606)	(436)
Depreciation at 31st March 2024	**-**	**16**	**-**	**-**	**-**	**-**	**2**	**-**	**17**	**-**
Net Book Value at 31st March 2024	**-**	**949**	**-**	**-**	**-**	**-**	**104**	**-**	**1,053**	**-**

NBV by counterparty	
Leased from DHSC	-
Leased from the NHS England Group	-
Leased from NHS Providers	-
Leased from Executive Agencies	-
Leased from Non-Departmental Public Bodies	-
Leased from other group bodies	-
Net Book Value at 31st March 2024	**-**

11. Leases cont'd

11.2 Lease liabilities

	31st March 2024 £'000	31st March 2023 £'000
Lease liabilities at 1st April 2023	(913)	-
Additions purchased	(1,071)	-
Reclassifications	-	-
Interest expense relating to lease liabilities	(14)	(7)
Repayment of lease liabilities (including interest)	291	218
Disposals on expiry of lease term	-	-
Derecognition for early terminations	634	-
Transfer (to) from other public sector body	-	(1,125)
Other	-	1
Lease liabilities at 31st March 2024	**(1,073)**	**(913)**

11.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31st March 2024 £'000	**Of which: leased from DHSC group bodies £000**	31st March 2023 £'000	Of which: leased from DHSC group bodies £000
Within one year	(89)	-	(285)	(194)
Between one and five years	(609)	-	(641)	(438)
After five years	(650)	-	-	-
Balance at 31st March 2024	**(1,348)**	**-**	**(926)**	**(632)**
Balance by counterparty				
Leased from DHSC		-		-
Leased from the NHS England Group		-		-
Leased from NHS Providers		-		-
Leased from Executive Agencies		-		-
Leased from Non-Departmental Public Bodies		(1,348)		(294)
Leased from other group bodies		-		(632)
Balance as at 31 March 2023		**(1,348)**		**(926)**

11.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Depreciation expense on right-of-use assets	344	214
Interest expense on lease liabilities	14	7

11.5 Amounts recognised in Statement of Cash Flows

	Year ended 31st March 2024 £'000	Nine month Period ended 31st March 2023 £'000
Total cash outflow on leases under IFRS 16	291	218

12. Trade and other receivables	Current 31st March 2024 £'000	Non-current 31st March 2024 £'000	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000
NHS receivables: Revenue	229	-	863	-
NHS prepayments	-	-	-	-
NHS accrued income	3,701	-	885	-
Non-NHS and Other WGA receivables: Revenue	442	-	4,923	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,252	-	799	-
Non-NHS and Other WGA accrued income	345	-	117	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	6,091	-	-	-
Expected credit loss allowance-receivables	(18)	-	(62)	-
VAT	1,000	-	629	-
Other receivables and accruals	(0)	-	2	-
Total Trade & other receivables	**13,042**	**-**	**8,156**	**-**
Total current and non current	**13,042**		**8,156**	
Included above:				
Prepaid pensions contributions	-		-	

12.1 Receivables past their due date but not impaired

	31st March 2024 DHSC Group Bodies £'000	31st March 2024 Non DHSC Group Bodies £'000	31st March 2023 DHSC Group Bodies £'000	31st March 2023 Non DHSC Group Bodies £'000
By up to three months	81	241	(323)	4,338
By three to six months	50	1	10	5
By more than six months	-	1	(13)	-
Total	**131**	**243**	(326)	4,343

12.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	**£'000**	**£'000**
Balance at 1st April 2023	**(62)**	**-**	**(62)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	44	-	**44**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Amounts written off	-	-	**-**
Other changes	-	-	**-**
Total	**(18)**	**-**	**(18)**

13. Cash and cash equivalents

	31st March 2024	31st March 2023
	£'000	£'000
Balance at 1st April 2023	286	-
Transfer from other public sector body under absorption accounting	-	104
Adjusted balance	**286**	104
Net change in year	232	182
Balance at 31st March 2024	**518**	286
Made up of:		
Cash with the Government Banking Service	518	286
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**518**	286
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	-
Balance at 31st March 2024	**518**	286
Patients' money held by the integrated care board, not included above	-	-

The ICB does not hold any significant cash and cash equivalent balances that are not available for use by the organisation.

14. Trade and other payables	**Current 31st March 2024 £'000**	**Non-current 31st March 2024 £'000**	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	4,416	-	1,341	-
NHS accruals	2,425	-	3,324	-
NHS deferred income	-	-	-	-
Non-NHS and Other WGA payables: Revenue	20,591	-	18,540	-
Non-NHS and Other WGA accruals	45,284	-	15,140	-
Non-NHS and Other WGA deferred income	-	-	70	-
Social security costs	174	-	152	-
VAT	-	-	-	-
Tax	171	-	138	-
Payments received on account	-	-	-	-
Other payables and accruals	12,659	-	22,296	-
Total Trade & Other Payables	**85,720**	**-**	**61,001**	**-**
Total current and non-current	**85,720**		**61,001**	

Other payables include £921k outstanding pension contributions at 31st March 2024 (£1,059k at 31st March 2023).

Individual Commissioning accruals have been reclassified from Other payables and accruals in 2022/23 to Non-NHS and Other WGA accruals in 2023/24.

15. Provisions

	Current 31st March 2024 £'000	**Non-current 31st March 2024 £'000**	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000
Legal claims	170	-	154	-
Continuing care	3,126	-	3,040	-
Other	0	-	250	-
Total	**3,296**	**-**	**3,444**	**-**
Total current and non-current	**3,296**		**3,444**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 1st April 2023	**-**	**-**	**-**	**-**	**-**	**-**	**154**	**3,040**	**250**	**3,444**
Arising during the year	-	-	-	-	-	-	167	392	-	**559**
Utilised during the year	-	-	-	-	-	-	-	-	(168)	**(168)**
Reversed unused	-	-	-	-	-	-	(151)	(306)	(82)	**(539)**
Balance at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**170**	**3,126**	**0**	**3,296**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	170	3,126	0	**3,296**
Balance at 31st March 2024	**-**	**-**	**-**	**-**	**-**	**-**	**170**	**3,126**	**0**	**3,296**

The legal claims provision relates to ongoing legal cases outstanding at 31st March 2024, with the estimated costs to conclusion provided by the ICB's legal advisors. The ICB has no claims currently lodged with NHS Resolution.
A continuing care provision has been created which reflects the estimated cost of continuing care appeals currently awaiting processing. The provision is based on the number of appeals outstanding at the 31st March 2024 and these are expected to be processed within the new financial year.
The Other provision relates to Dilapidations arising in relation to one of the IFRS16 leased properties which was terminated in February 2024.

16. Contingencies

The ICB has no confirmed contingent assets or liabilities to disclose. The organisation has commenced an organisationsal restructure and Management of Change programme in February 2024 for which there could be some unquantified financial implications arising in the 2024/25 financial year.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the ICB and internal auditors.

17.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The ICB borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, the organisation has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

17. Financial instruments cont'd

17.2 Financial assets

	Financial Assets measured at amortised cost 31st March 2024 £'000	**Equity Instruments designated at FVOCI 31st March 2024 £'000**	**Total 31st March 2024 £'000**	Financial Assets measured at amortised cost 31st March 2023 £'000	Equity Instruments designated at FVOCI 31st March 2023 £'000	Total 31st March 2023 £'000
Trade and other receivables with NHSE bodies	570	-	570	1,634	-	1,634
Trade and other receivables with other DHSC group bodies	3,705	-	3,705	631	-	631
Trade and other receivables with external bodies	6,534	-	6,534	4,526	-	4,526
Cash and cash equivalents	518	-	518	286	-	286
Total at 31st March 2024	**11,327**	**-**	**11,327**	7,077	-	7,077

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31st March 2024 £'000	**Other 31st March 2024 £'000**	**Total 31st March 2024 £'000**	Financial Liabilities measured at amortised cost 31st March 2023 £'000	Other 31st March 2023 £'000	Total 31st March 2023 £'000
Trade and other payables with NHSE bodies	776	-	**776**	914	-	914
Trade and other payables with other DHSC group bodies	6,146	-	**6,146**	3,752	-	3,752
Trade and other payables with external bodies	79,528	-	**79,528**	56,889	-	56,889
Total at 31st March 2024	**86,450**	**-**	**86,450**	61,555	-	61,555

18. Operating segments

As stated in IFRS8, the "Chief Operating Decision Maker" is responsible for allocating resources to and assessing the performance of the operating segments of an entity. At Shropshire, Telford and Wrekin ICB this function is performed by the Board. The ICB considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Board as one segment. These Statements are produced in accordance with this position.

The values relating to this operating segment can be found in the SoCNE (page 2), and SoFP (page 3), and are summarised in the table below:

Year ended 31st March 2024	**Gross expenditure £'000**	**Income £'000**	**Net expenditure £'000**	**Total assets £'000**	**Total liabilities £'000**	**Net assets £'000**
Shropshire, Telford & Wrekin ICB	1,246,238	(13,775)	**1,232,463**	14,614	(90,090)	**(75,476)**
Total	**1,246,238**	**(13,775)**	**1,232,463**	**14,614**	**(90,090)**	**(75,476)**

Nine month period ended 31st March 2023	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Shropshire, Telford & Wrekin ICB	795,213	(374)	794,839	9,601	(65,359)	(55,758)
Total	795,213	(374)	794,839	9,601	(65,359)	(55,758)

18.1 Reconciliation between Operating Segments and SoCNE

	Year ended 31st March 2024 £'000	Nine month period ended 31st March 2023 £'000
Total net expenditure reported for operating segments	1,232,463	794,839
Reconciling items:		
Depreciation & Amortisation	344	214
Finance cost - IFRS16	14	7
Loss on Disposal of RoU Assets	198	-
Total net expenditure per the Statement of Comprehensive Net Expenditure	1,233,019	795,060

19. Joint arrangements - interests in joint operations

ICBs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

19.1 Interests in joint operations

			Amounts recognised in Entities books ONLY Year ended 31st March 2024				Amounts recognised in Entities books ONLY Nine month Period ended 31st March 2023			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	Assets	Liabilities	Income	Expenditure
			£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Shropshire LA	Commissioning of health and social care services under better care fund	-	-	-	26,030	-	-	-	26,277
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Telford & Wrekin LA	Better care fund promoting integrated working	-	-	-	26,927	-	-	-	17,304
Transforming care programme S75 arrangement	Shropshire, Telford & Wrekin ICB and Telford & Wrekin LA	The transforming care programme for people with learning disabilities	-	-	-	-	-	-	-	1,742

Expenditure on LD&A was not transacted under a S75 Agreement in 2023/24 due to Telford LA withdrawing from the agreement. Discussions are ongoing to agree the programme arrangement for 2024/25.

19.2 Pooled budgets under the Better Care Fund

The ICB's contribution of the total value of these pooled budgets in the period ended 31st March 2024 was £53m. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

A summary of the schemes with each local authority is given below:

Shropshire Local Authority	**Year ended 31st March 2024 £'000**	Nine month Period ended 31st March 2023 £'000
Assistive Technologies	2,123	1,507
Care navigation/Co-ordination	2,097	1,489
Enablers for Integration	4,870	3,464
Integrated Care Planning	4,088	2,894
Intermediate Care Services	3,758	2,668
Personalised Healthcare at Home	305	217
L A Schemes	8,789	14,038
Total	**26,030**	26,277

Telford & Wrekin Local Authority	**Year ended 31st March 2024 £'000**	Nine month Period ended 31st March 2023 £'000
Management Charges	290	155
Shropshire Community Health Trust	4,368	3,100
Shrewsbury and Telford Hospital	2,112	1,499
LA Schemes	20,122	12,526
GP Practice Support	35	25
Total	**26,927**	17,305

20. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ian Chan GP - Partner: Teldoc	72,707	-	-	-
Ian Chan - Clinical Director: Teldoc PCN	9,483	-	-	-
Roger Dunshea - Black Country Healthcare NHS FT: Non-Executive Director	149	-	-	-
Sir Neil Mckay - Associate with PA Consulting	233	-	-	-
Sir Neil Mckay - Strategic Adviser and Health Strategy Board Chair: Browne Jacobson LLP	14	-	-	-
Julian Povey - Partner: Pontesbury & Worthen Medical Practice	19,292	-	(2)	-
Julian Povey - Pontesbury & Worthen Medical Practice: Shrewbury PCN	27,092	-	-	-
Nicholas White - Consultant Plastic Surgeon: University Hospitals Birmingham NHS FT	4,070	-	-	-
Simon Whitehouse Spouse - Senior Staff Nurse: University Hospital of North Midlands	10,178	-	-	-
DHSC Related Party - Leeds Teaching Hospital NHS Trust	36	-	-	-
DHSC Related Party - Accurx Ltd	292	-	-	-
DHSC Related Party - Alzheimers Society	284	-	-	-
DHSC Related Party - NHS England	135	2,888	-	15
DHSC Related Party - Milton Keynes University Hospital NHS Trust	17	-	-	-

The Department of Health and Social Care is regarded as a related party. During the period the ICB has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS Business Services Authority
NHS England
NHS Midlands & Lancashire CSU
NHS Property Services Limited
Midlands Partnership University NHS Foundation Trust
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
University Hospital of North Midlands NHS Trust
West Midlands Ambulance Service NHS Trust

In addition, the ICB has had a number of transactions with other government departments and other central and local government bodies. The majority of these transactions have been with Shropshire Council, Telford & Wrekin Council and Welsh Government Bodies.

Payments were also made to GP practices in the period to 31st March 2024 in respect of GMS/PMS/APMS and enhanced services. Two general practitioners within these practices are also members of the ICB's Board.

21. Events after the end of the reporting period

There are no events after the end of the reporting period to report which would impact the financial statements. Commissioning for Specialised Commissioning (SpecComm) services from NHSE has been transferred to the ICB with effect from 1st April 2024.

22. Third party assets

The ICB does not hold any third party assets

23. Financial performance targets

The ICB has a number of financial duties under the NHS Act 2006 (as amended).
The ICB performance against those duties was as follows:

	Year ended 31st March 2024		Nine month Period ended 31st March 2023	
	Target	**Performance**	Target	Performance
	£'000	**£'000**	£'000	£'000
Expenditure not to exceed income	1,230,544	1,246,793	773,917	795,433
Revenue resource use does not exceed the amount specified in Directions	1,216,769	1,233,019	773,543	795,060
Revenue administration resource use does not exceed the amount specified in Directions	10,331	10,331	8,195	8,194

24. Analysis of charitable reserves

The ICB does not hold any charitable reserves.

25. Losses and special payments

The ICB did not incur any losses or special payments in the nine month period to 31st March 2024.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Grant Thornton UK LLP
17th Floor, 103 Colmore Row, Birmingham B3 3AG

26th June 2024

Dear Grant Thornton UK LLP

NHS Shropshire Telford and Wrekin Integrated Care Board
Financial Statements for the year ended 31 March 2024

This representation letter is provided in connection with the audit of the financial statements of Shropshire Telford and Wrekin ICB ('the ICB') for the year ended 31 March 2024 for the purpose of expressing an opinion as to whether the ICB's financial statements give a true and fair view in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2023/24 and applicable law.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities for the preparation of the ICB's financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2023/24 ('the GAM'); in particular the financial statements are fairly presented in accordance therewith.

ii. We have fulfilled our responsibilities for ensuring that expenditure and income are applied for the purposes intended by Parliament and that the financial transactions in the financial statements conform to the authorities which govern them.

iii. We have complied with the requirements of all statutory directions affecting the ICB and these matters have been appropriately reflected and disclosed in the financial statements.

iv. The ICB has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

v. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

vi. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include GP prescribing. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative, methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the ICB ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a. there are no unrecorded liabilities, actual or contingent

b. none of the assets of the ICB has been assigned, pledged or mortgaged

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have only accrued for items received before the year-end.

xii. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The ICB's financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xiii. We have considered the unadjusted misstatements schedule included in your Audit Findings Report. We have not adjusted the financial statements for these misstatements brought to our attention *as* they are immaterial to the results of the ICB and its financial position at the year-end. The financial statements are free of material misstatements, including omissions.

xiv. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xv. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xvi. There are no prior period errors to bring to your attention.

xvii. We have updated our going concern assessment. We continue to believe that the ICB's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

a. the nature of the ICB means that, notwithstanding any intention to liquidate the ICB or cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements

b. the financial reporting framework permits the entry to prepare its financial statements on the basis of the presumption set out under a) above; and

c. the ICB's system of internal control has not identified any events or conditions relevant to going concern.

We believe that no further disclosures relating to the ICB's ability to continue as a going concern need to be made in the financial statements.

Information Provided

xviii. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the ICB's financial statements such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your audit; and

c. access to persons within the ICB via remote arrangements, where/if necessary, from whom you determined it necessary to obtain audit evidence.

xix. We have communicated to you all deficiencies in internal control of which management is aware.

xx. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xxi. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xxii. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the ICB and involves:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the financial statements.

xxiii. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

xxiv. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxv. We have disclosed to you the identity of the ICB's related parties and all the related party relationships and transactions of which we are aware.

xxvi. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Governance Statement

xxvii. We are satisfied that the Governance Statement fairly reflects the ICB's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

Annual Report

xxviii. The disclosures within the Annual Report fairly reflect our understanding of the ICB's financial and operating performance over the period covered by the ICB's financial statements.

Approval

The approval of this letter of representation was minuted by the ICB's Board at its meeting on 26th June 2024.

Yours faithfully

Name **Simon Whitehouse**

Position **Chief Executive Officer**

Date **26th June 2024**

Signed on behalf of the ICB

The Audit Findings for NHS Shropshire Telford and Wrekin ICB

For the year ended 31 March 2024

June 2024

Richard Anderson

Director

T 0121 812 7658

E richard.j.anderson@uk.gt.com

Terry Tobin

Senior Audit Manager

T 0121 232 5276

E terry.p.tobin@uk.gt.com

Nokubonga Mkhize

In-charge auditor

T 0121 232 5427

E: nokubonga.g.mkhize@uk.gt.com

Grant Thornton

NHS Shropshire and Telford and Wrekin ICB
Wellington Civic Offices
Larkin Way
Tan Bank
Wellington
Telford
TF1 1LX

Private and confidential

Grant Thornton UK LLP
17th Floor
103 Colmore Row
Birmingham
B3 3AG

T 0121 212 4000
www.grantthornton.co.uk

June 2024

Dear Claire

Audit findings for NHS Shropshire and Telford and Wrekin ICB for the period ended 31 March 2024

This Audit Findings presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process and confirmation of auditor independence, as required by International Standard on Auditing (UK) 260. Its contents will be discussed with management and the Audit Committee.

As auditors we are responsible for performing the audit, in accordance with International Standards on Auditing (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We encourage you to read our transparency report which sets out how the firm complies with the requirements of the Audit Firm Governance Code and the steps we have taken to drive audit quality by reference to the Audit Quality Framework. The report includes information on the firm's processes and practices for quality control, for ensuring independence and objectivity, for partner remuneration, our governance, our international network arrangements and our core values, amongst other things. This report is available at www.grantthornton.co.uk/en/about-us/leadership-and-governance/transparency-report/

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Yours sincerely

Richard Anderson
Director
For Grant Thornton UK LLP

Contents

Section	Page
Headlines	4
Audit Findings	6
Value for money	20
Other statutory powers and duties	21
Independence and ethics	22
Appendices	25
Communication of audit matters to those charged with governance	26
Action Plan	27
Fees and non-audit services	29
Audit Approach	30
Audit opinion	311

1. Headlines

This table summarises the key findings and other matters arising from the statutory audit of the Integrated Care Board ('the ICB') and the preparation of the ICB's financial statements for the year ended 31 March 2024 for consideration by those charged with governance.

Financial statements

Under International Standards of Audit (UK) (ISAs) and the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion:

- the ICB's financial statements give a true and fair view of the financial position of the ICB's income and expenditure for the period; and
- the ICB's financial statements, and the parts of the Remuneration and Staff Report to be audited, have been properly prepared in accordance with the Department of Health and Social Care (DHSC) group accounting manual 2023/24 (GAM).
- expenditure has been incurred "as intended by Parliament".

We are also required to report whether other information published together with the audited financial statements in the Annual Report, is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated and whether the income and expenditure included in the financial statements has been applied for the purposes intended by Parliament (the regularity opinion).

Our audit work was completed during May and June 2024. Our findings are summarised from page 8 . The only audit adjustments to the financial statements identified which impact your reported Comprehensive Expenditure figure was GP Prescribing and Community Dental. The actual spend for GP prescribing was £470,000 lower than that accrued in your accounts. In addition, our recalculation of community dental payments from contracts provided was £1.3 million lower than in the accounts. Management has decided not to adjust as these are not material. Were you to adjust for this, your deficit would decrease by £1.8 million We have also identified several audit adjustments and disclosure issues, which are detailed on pages 17 to 19 and management has amended for. We have also raised some recommendations for management as a result of our audit work in Appendix B.

Our work is nearly complete and there are no matters of which we are aware that would require modification of our audit opinion subject to the following matters;

- final quality review by Senior Manager and Director
- receipt of final letter of representation
- review of final version of Accounts and Annual Report

We have concluded that the other information to be published with the financial statements, is consistent with our knowledge of your organisation and the financial statements we have audited.

Our anticipated audit report opinion will be unqualified.

We are also required to report on whether the income and expenditure included in the financial statements has been applied for the purposes intended by Parliament (the regularity opinion). Failure to meet statutory financial targets automatically results in a qualified regularity opinion. Comprehensive net expenditure in the financial statements was £16.25 million more than the amount specified in Directions. We are therefore proposing to issue a qualified regularity opinion in this regard.

1. Headlines

Value for Money (VFM) arrangements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the ICB has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are required to report in detail on the ICB's overall arrangements, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the ICB's arrangements under the following specified criteria:

- Improving economy, efficiency and effectiveness;
- Financial sustainability; and
- Governance

As part of our work, we considered whether there were any risks of significant weakness in the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources. In undertaking this work, we have also considered the role of the ICB within the wider health sector, as well as considering its own arrangements. We identified one risk of significant weakness in our audit plan.

We have completed our VFM work and have issued our Auditor's Annual Report. We identified a significant weakness in how the ICB plans and manages its resources to ensure it can continue to commission its services. This was in relation to unidentified savings gaps in its financial plan that threaten its delivery, persistent failure to meet savings plans and achieve financial targets and the absence of a robust, fully worked up cost improvement plan, including over the medium term.

We recommended that the ICB needs to work with partners to move the system into financial balance. To do this the ICB needs to lead on identifying realistic and credible recurrent savings opportunities which can be delivered in the medium term and are:

- clinically supported
- risk assessed
- triangulated with other priorities and plans (for example, workforce, clinical and estates).

We also recommended that progress against delivery should be reported to the Finance Committee with any slippage being identified and remedial action taken as soon as possible.

Statutory duties

The Local Audit and Accountability Act 2014 ('the Act') also requires us to:

- report to you if we have applied any of the additional powers and duties ascribed to us under the Act; and
- to certify the closure of the audit.

Due to the ICB's expenditure exceeding its annual allocation in 2023/24, we were required by statute to report this matter to the Secretary of State.

We expect to certify the completion of the audit at the same time as issuing our audit opinion.

Significant matters

We did not encounter any significant difficulties or identify any significant matters arising during our audit. However, on page 14 we set out some areas to help further improve the process next year.

Our approach to materiality

As communicated in our Audit Plan dated March 2024, we determined materiality at the planning stage as £16m based on 1.4% of forecast gross operating costs. At period-end, we have left this unchanged.

A recap of our approach to determining materiality is set out below.

Basis for our determination of materiality

This was equivalent to approximately 1.4% of the ICB's forecast operating expenses in 2023/24. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue

Reporting threshold

We will report to you all misstatements identified in excess of £300,000, in addition to any matters considered to be qualitatively material.

Materiality area	Amount (£)	Qualitative factors considered
Materiality for the financial statements	16,000,000	This was equivalent to approximately 1.4% of the ICB's estimated operating expenses in 2023/24. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue. On receipt of accounts, we decided to leave that unchanged.
Performance Materiality for the financial statements	12,000,000	The performance materiality has been set at 75% of financial statements materiality. This reflects our risk assessed knowledge of potential for errors occurring including the stability of finance staff. Performance materiality is used for the purpose of assessing the risks of material misstatement and in determining the nature, timing, and extent of further audit procedures. It is the amount we set at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.
Trivial matters	300,000	We will report to you all misstatements identified in excess of £300k as this is the reporting threshold for any errors identified as part of our work on the National Audit Office's Whole of Government Accounts (WGA) exercise.
Senior officer remuneration and pension disclosures.	5,000	Due to the public interest in senior officer remuneration disclosures, and based on the code, we apply specific audit procedures to this work and set a lower materiality level for this area. We design our procedures to detect errors in specific accounts at a lower level of precision which we have determined to be applicable for senior officer remuneration disclosures. We evaluate errors in the remuneration report for both quantitative and qualitative factors against this lower level of materiality. We will apply heightened auditor focus in the completeness and clarity of disclosures in this area and will request amendments to be made if any errors exceed the threshold we have set or would alter the bandings reported for any individual. Materiality for this has been set at £5,000 as this would capture any changes by more than one band.

Overview of significant audit risks identified

The below table summarises the significant risks discussed in more detail on the subsequent pages.

Significant risks are defined by ISAs (UK) as an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum due to the degree to which risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement if that misstatement occurs.

Other risks are, in the auditor's judgment, those where the risk of material misstatement is lower than that for a significant risk, but they are nonetheless an area of focus for our audit.

Risk title	Risk level	Change in risk since Audit Plan	Fraud risk	Level of judgement or estimation uncertainty	Status of work
Management override of controls	Significant	↔	✓	Low	●

↑ Assessed risk increase since Audit Plan
↔ Assessed risk consistent with Audit Plan
↓ Assessed risk decrease since Audit Plan

● No adjustment or change in disclosure required
● Non-material adjustment or change to disclosures within the financial statements
● Material adjustment or change to disclosures within the financial statements

Financial Statements - Significant risks

Risks identified in our Audit Plan	Commentary
ISA 240 improper revenue recognition (rebutted) Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue	**Auditor commentary** In our planning we have rebutted this presumed risk for the ICB because: • revenue does not primarily involve cash transactions; and • funding is principally an allocation from NHS England which is not accounted for in the Statement of Comprehensive Net Expenditure. • Revenue received from Pharmacy, Optometry and Dental was not material We therefore did not consider this to be a significant risk for the ICB. We still consider this is appropriate. Our audit work has not identified any issues in respect of revenue recognition.
ISA 240 expenditure (rebutted) Practice Note 10 states that as most public bodies are net spending bodies, then the risk of material misstatements due to fraud related to expenditure may be greater than the risk of material misstatements due to fraud related to revenue recognition.	**Auditor commentary** We have rebutted this risk for the ICB because: • expenditure is primarily driven by agreed block payments to providers; and • opportunity to manipulate contract variations is low in the current NHS financial regime. We therefore do not consider this to be a significant risk for the ICB. However, we continued to review material expenditure transactions as part of our audit, ensuring that it remains appropriate to rebut the risk of expenditure recognition. Our audit work has not identified any issues in respect of expenditure recognition.

Financial Statements - Significant risks

Risks identified in our Audit Plan	Commentary
Management override of controls In accordance with ISA (UK) 240, we have identified a risk of fraud in respect of management override of controls.	**Auditor commentary** • evaluated the design effectiveness of management controls over journals • analysed the journals listing and determined the criteria for selecting high risk unusual journals • challenged management's key judgements and estimates and considered whether these judgements and estimates are individually or cumulatively indicative of management bias; • tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness • evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions Our audit work has not identified any issues in respect of management override of controls. However, there is a system weakness whereby users can self-authorise their own journals and senior staff can post journals (although in practice this does not happen). This year an additional task has been added to the month end timetable for a review to be made of all posted journals. We consider that this system weakness does increases the risk of fraud or error and Those Charged With Governance should confirm that they are satisfied with this approach. We have included a recommendation to this effect in Appendix B.

2. Financial Statements - key judgements and estimates

This section provides commentary on key estimates and judgements in line with the enhanced requirements for auditors.

Significant judgement or estimate	Summary of management's approach	Audit Comments	Assessment
Key estimates and judgements include: • GP Prescribing • Pension entitlements of senior officers in the remuneration report • Accruals • Continuing Health Care Accruals • Pharmacy	The ICB made estimates for known 2023/24 liabilities.	We have reviewed the ICB's estimates and judgements and concluded that they have been compiled in accordance with the GAM. We have completed substantive testing of the estimates and judgements used in relation to accruals and have concluded that they are reasonable. Therefore, the policy as shown in the financial statements is correctly stated. The ICB made an accrual for prescriptions dispensed in February and March where the actual figures were not yet available. The difference in actual spend compared to estimate over trivial. (£470,000 lower) Please see page 18 for more detail. We have reviewed the pension entitlements of senior officers in the remuneration report and found them to be reasonable. .	● Grey
Provisions	The ICB made provisions in the Balance Sheet at 31 March 2024 .	Shropshire Telford and Wrekin ICB has provisions totalling £3,296k, the majority of which are in respect of CHC in its financial statements. To challenge the reasonableness and completeness of its provisions we reviewed the disclosure against 13 other ICBs. All bar one of the other ICBs had some form of provision, 10 others provided for CHC (11 in total, 79%) with a smaller number providing for legal (50%), redundancy (43%), restructuring (14%) and other provisions (57%). Importantly the total average provision represented approximately 0.16% of total spend. In the case of CHC/Redundancy provisions Shropshire, Telford and Wrekin ICB's provision represents 0.25% of total spend vs an average of 0.06% for CHC and 0% of total spend vs an average of 0.03% for redundancy. We have undertaken further work in the areas of Legal/Other to gain assurance that these are in accordance with IAS37 and are satisfied that the disclosures are reasonable as well as there not being a risk of material understatement.	● Grey

Assessment

- ● Dark Purple We disagree with the estimation process or judgements that underpin the estimate and consider the estimate to be potentially materially misstated
- ● Blue We consider the estimate is unlikely to be materially misstated however management's estimation process contains assumptions we consider optimistic
- ● Grey We consider the estimate is unlikely to be materially misstated however management's estimation process contains assumptions we consider cautious
- ● Light Purple We consider management's process is appropriate and key assumptions are neither optimistic or cautious

Other findings – Information Technology

This section provides an overview of results from our assessment of Information Technology (IT) environment and controls which included identifying risks from the use of IT related to business process controls relevant to the financial audit. This includes an overall IT General Control (ITGC) rating per IT system and details of the ratings assigned to individual control areas.

IT application	Level of assessment performed	Overall ITGC rating	ITGC control area rating			Commentary on issues identified (amber or red ratings only)
			Security management	Technology acquisition, development and maintenance	Technology infrastructure	
Common Controls	ITGC assessment (design, implementation and operating effectiveness)	●	●	●	●	None
Oracle	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	See issue on journals in Appendix B
Electronic staff record	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	None

Assessment
- ● Significant deficiencies identified in IT controls relevant to the audit of financial statements
- ● Non-significant deficiencies identified in IT controls relevant to the audit of financial statements/significant deficiencies identified but with sufficient mitigation of relevant risk
- ● IT controls relevant to the audit of financial statements judged to be effective at the level of testing in scope
- ● Not in scope for testing

Other findings

Matter	Commentary	Auditor view
Service Auditor Reports Under ISA 315R, auditors are required to understand and assess relevant internal controls of the systems relevant to the preparation of financial statements. This includes systems provided by service organisations. An independent auditor produces a service auditor report to provide management with assurance over the internal control environment of the system they use and as external auditors we review these service auditor reports when undertaking our work. The following systems used by the ICB are provided by service organisations. The data from these systems are relevant to preparation of the ICB's financial statements. • NHS Business Services Limited: Finance and Accounting Services • The Electronic Staff Record Programme (ESR) • Prescription Payments Process System • Dental Payment Process (DPP) System • Capita Primary Care Support Services • Midlands and Lancashire CSU-Finance and Payroll	**NHS Shared Business Service Limited: Finance and Accounting Services** An unqualified opinion was issued by the Service Auditor. No impact on our audit at the ICB. **NHS Business Services Authority: The Electronic Staff Record Programme,** An unqualified opinion was issued by the Service Auditor. No impact on our audit at the ICB **NHS Business Services Authority: Prescriptions** An unqualified opinion was issued by the Service Auditor. No impact on our audit at the ICB **NHS Business Services Authority: Dental** An unqualified opinion was issued by the Service Auditor. No impact on our audit at the ICB Midlands and Lancashire CSU-Finance and Payroll An unqualified opinion was issued by the Service Auditor. No impact on our audit at the ICB Capita Primary Care Support Services A qualified opinion was issued by the Service Auditor relating to one out of 15 control objectives.. Controls should be in place to ensure in instances where users had access to the finance role in PCSE online for external users is granted to the user with appropriate approval form. During the period 1 April 2023 to 31 March 2024 this access could not be evidenced in 8 out of 40 selected instances. (Control 11.07) The same issue was raised by the Service Auditor in the previous year.	The audit team have considered the issues identified and do not consider them significant enough to have an impact on the audit opinion of the ICB. These qualifications are relevant to the controls operating at the third party and not the ICB. We are satisfied that the ICB has compensating controls to mitigate against any increase area of risk. The ICB has updated the Annual Governance Statement to reflect these reports.

Other findings

Issue	Commentary
Matters in relation to fraud	We have previously discussed the risk of fraud with management and the Audit Committee. We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedure
Matters in relation to related parties	We are not aware of any related parties or related party transactions which have not been disclosed. However we do recommend that the ICB review the related parties included in the accounts as they do not fully meet the definition in the GAM, with many of the related parties disclosed not having control or joint control over the other party. See Appendix B.
Matters in relation to laws and regulations	You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work.
Written representations	A letter of representation has been requested from the ICB which will be presented alongside this report.
Accounting practices	We have evaluated the appropriateness of the ICB's accounting policies, accounting estimates and financial statement disclosures. A number of minor amendments were made to the accounting policies to enhance the transparency of the disclosures within the Accounts.
Confirmation requests from third parties	We requested from management permission to send confirmation requests to your bank. This permission was granted and the requests were sent and have been received as part of our final accounts work.

Other responsibilities under the Code

Issue	Commentary
Disclosures	Our review found no material omissions in the financial statements, but our review identified several smaller amendments, which have been correctly processed by the ICB in the updated financial statements.
Audit evidence and explanations	All information and explanations requested from management was provided. However, see below where improvements can be made for next year.
Significant difficulties	There were no significant difficulties in carrying out your audit. In the second-year of the ICB audit we noted several improvements in quality of evidence and evidence of quality control. There were areas we noted for further improvement which we thought would be helpful to share. Some initial evidence provided at audit was insufficient to support transactions and further requests had to be made but this was less than in the previous year. The ICB set up some onsite days to expedite obtaining further evidence which were very helpful. Also, the central finance team was very responsive to requests. In future initial evidence provided should be improved (to match the quality of the final evidence provided this year). In addition, the detailed transaction listings we were provided with for several accounts balances from which we initially select samples to test contained many unexplained contra entries (e.g. debit balances in a creditor balances listings). This created additional work for both officers and auditors. The most significant example was for payables where the ICB was unable to provide a breakdown of all the balances to test and instead provided a huge list of all transactions during the year on this balance which led to a large amount of additional work on both sides. In addition, in Appendix B we refer to difficulties we had obtaining audit evidence to audit Pharmacy, Optometry and Dentistry as well as the Better Care Fund.
Regularity Opinion	We are required to give a regularity opinion on whether the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them (the regularity opinion). Failure to meet statutory financial targets automatically results in a qualified regularity opinion. Comprehensive net expenditure was £16.25 million more than the amount specified in Directions. We are therefore proposing to issue a qualified regularity opinion.
Other information	We are required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. No inconsistencies have been identified. We plan to issue an unmodified opinion in this respect.
Auditable elements of Remuneration Report and Staff Report	We are required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. We have audited the elements of the Remuneration Report and Staff Report and have identified some amendments, which have been correctly processed by the ICB in the updated Report. Please see page 18. At this stage, we propose to issue an unqualified opinion on the Remuneration Report and Staff Report subject to audit.

Other responsibilities under the code

Issue	Commentary
Matters on which we report by exception	We are required to report on several matters by exception: • the Annual Governance Statement does not comply with guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit, • the information in the annual report is materially inconsistent with the information in the audited financial statements or apparently materially incorrect based on, or materially inconsistent with, our knowledge of the ICB acquired in the course of performing our audit, or otherwise misleading. • if we have applied any of our statutory powers or duties. • where we are not satisfied in respect of arrangements to secure value for money and have reported significant weaknesses. Comprehensive net expenditure was £16.25 million more than the amount specified in Directions. We therefore reported this matter to the Secretary of State (a Section 30 report). We will also report a value for money significant weakness in relation to financial sustainability.
Review of accounts consolidation schedules and specified procedures on behalf of the group auditor	We are required to give a separate audit opinion on the ICB accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these schedules under group audit instructions. In the group audit instructions, the ICB was selected as a non-sampled component. We have completed the specified procedures required under the group instructions. The ICB consolidation schedules were consistent with accounts included in the Annual Report.
Certification of the closure of the audit	We intend to certify the closure of the period end 31 March 2024 audit by the end of June 2024 at the same time as issuing the audit opinion.

Other responsibilities

Issue	Commentary
Going concern	In performing our work on going concern, we have had reference to Statement of Recommended Practice – Practice Note 10: Audit of financial statements of public sector bodies in the United Kingdom (Revised 2020). The Financial Reporting Council recognises that for particular sectors, it may be necessary to clarify how auditing standards are applied to an entity in a manner that is relevant and provides useful information to the users of financial statements in that sector. Practice Note 10 provides that clarification for audits of public sector bodies. Practice Note 10 sets out the following key principles for the consideration of going concern for public sector entities: • the use of the going concern basis of accounting is not a matter of significant focus of the auditor's time and resources because the applicable financial reporting frameworks envisage that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist, and so a straightforward and standardised approach for the consideration of going concern will often be appropriate for public sector entities • for many public sector entities, the financial sustainability of the reporting entity and the services it provides is more likely to be of significant public interest than the application of the going concern basis of accounting. Our consideration of the ICB's financial sustainability is addressed by our value for money work, which is covered elsewhere in this report. Practice Note 10 states that if the financial reporting framework provides for the adoption of the going concern basis of accounting on the basis of the anticipated continuation of the provision of a service in the future, the auditor applies the continued provision of service approach set out in Practice Note 10. The financial reporting framework adopted by the ICB meets this criteria, and so we have applied the continued provision of service approach. In doing so, we have considered and evaluated: • the nature of the ICB and the environment in which it operates • the ICB's financial reporting framework • the ICB's system of internal control for identifying events or conditions relevant to going concern • management's going concern assessment. On the basis of this work, we have obtained sufficient appropriate audit evidence to enable us to conclude that: • a material uncertainty related to going concern has not been identified • management's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Audit adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Impact of adjusted misstatements

There were no adjusted misstatements identified at the date of issuing our Report. We will provide an update to Management and the Audit Committee should any issues be identified from the remaining testing.

Misclassification and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

Disclosure omission	Auditor issues	Adjusted?
Note 23-financial performance targets	We found that the deficit stated in the financial performance target note was overstated by £65 million as the allocation figure incorrectly included an adjustment for previous year deficit. This was adjusted to show a deficit in year of £16.25 million. The ICB used an incorrect target figure in the note. This included allocations adjusted for the previous year's deficit and not the 2023/24 allocations only.	Yes

Audit adjustments (continued)

Disclosure omission	Audit issue	Adjusted?
Various	Nil values and blank lines were removed in several places. These included Note 5 Operating expenses Note 7,8,10,11 Note 15 Provision Note 17 Financial Instruments	Yes
Note 18 Operating Segments	No prior year comparators were initially included in draft statements. These have been added to the final version of the accounts.	Yes
Accounting policies	Note 1: Incorrect reference made to GAM 2022/23. Note 1.1 Going concern - Paragraph relating abolition of CCG included in the template accounts when not relevant to going concern basis. Note 1.21.1 Sources of estimation Uncertainty - As material uncertainty is not there, it has been removed. Note 1.23 New and revised IFRS standard – disclosures in this note were not relevant/material and have therefore been removed Several notes, (1.9 PPE, 1.10 Depreciation, leases, 1.17.1 Financial Guarantee Contracts) were not required as these related to immaterial areas of the accounts. These have been removed	Yes
Remuneration Report Disclosure Checklist	The following items were initially not disclosed in the Annual report as required by GAM: 1. The average percentage change from the previous financial year in respect of employees of the entity 2. Prior year comparatives not provided for each percentage change. 3. Explanation of significant changes in the ratios between current and prior year not included. These explanations have been added to the final version of the Annual Report.	Yes
Remuneration Report	In relation to all pension related benefits – the banding for one officer was amended to be "0" as he was affected by service pension remedy and calculations returned negative amounts that are not disclosed per GAM. Some Annual Report finance elements were included in the accounts and this needed to be corrected.	Yes

Audit adjustments

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit of the year to 31 March 2024 which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Net Expenditure	Statement of Financial Position	Impact on adjusted net expenditure	Reason for not adjusting
Prescribing expenditure & accrual				
GP Prescribing estimate-we have seen that the actual spend was £470,000 lower than that accrued. Though this is above our trivial threshold, this demonstrates that the estimate was materially accurate. Management has decided not to adjust as this is not material. Were you to adjust for this, your deficit would decrease by £470,000. We request that your letter of representation sets out that those charged with governance have formally considered this and why they decided not to alter the accounts.	Reduction of comprehensive net expenditure by £470,000	Reduction of accruals by £470,000 million	Reduction of net expenditure by £470,000	Not material estimation difference
Community dental				
A difference of £1 343 217 has been identified between the figure shown in the ledger and accounts for General Dental Services and Personal Dental Services and our recalculations of the contract value based on the contract and the annual uplifts. We request that your letter of representation sets out that those charged with governance have formally considered this and why they decided not to alter the accounts.	Decrease of comprehensive net expenditure by £1.3 million	Increase of general fund balance by £1.3 million	Decrease of net expenditure by £1.3 million	Not material.

3. Value for money

Approach to Value for Money work for the period ended 31 March 2023

The National Audit Office issued its latest Value for Money guidance to auditors in December 2021. The Code requires auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Improving economy, efficiency and effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services.

Governance

How the body ensures that it makes informed decisions and properly manages its risks.

We have now issued our Annual Auditors Report. We identified a significant weakness in how the ICB plans and manages its resources to ensure it can continue to commission its services. This was in relation to unidentified savings gaps in its financial plan that threaten its delivery, persistent failure to meet savings plans and achieve financial targets and the absence of a robust, fully worked up cost improvement plan, including over the medium term.

We recommended that the ICB needs to work with partners to move the system into financial balance. To do this the ICB needs to lead on identifying realistic and credible recurrent savings opportunities which can be delivered in the medium term and are:

- clinically supported
- risk assessed
- triangulated with other priorities and plans (for example, workforce, clinical and estates).

We also recommended that progress against delivery should be reported to the Finance Committee with any slippage being identified and remedial action taken as soon as possible.

4. Other statutory powers and duties

We set out below details of other matters which we, as auditors, are required by the Act and the Code to communicate to those charged with governance.

Issue	Commentary
Public Interest report	There was no report in the public interest.
Written recommendations	There were no written recommendations.
Referral to the Secretary of State	Due to the ICB's expenditure exceeding its annual allocation in 2023/24, we were required by statute to report this matter to the Secretary of State (a Section 30 Report) . This referral was made on 13 May 2024.

Independence and non-audit services

Auditor independence

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant facts and matters that may bear upon the integrity, objectivity and independence of the firm or covered persons. relating to our independence. We encourage you to contact us to discuss these or any other independence issues with us. We will also discuss with you if we make additional significant judgements surrounding independence matters.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Financial Reporting Council's Ethical Standard (Revised 2019) and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements. Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in May 2020 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

We confirm that we have implemented policies and procedures to meet the requirements of the Ethical Standard. For the purposes of our audit, we have made enquiries of all Grant Thornton UK LLP teams providing services to the ICB.

Other services

Other services provided by Grant Thornton relate to MHIS compliance – further details are provided in the table on the following page.

The amounts detailed are fees agreed to-date for audit related and non-audit services to be undertaken by Grant Thornton UK LLP in the current financial year. These services are consistent with the ICB's policy on the allotment of non-audit work to your auditors. Any changes and full details of all fees charged for audit related and non-audit related services by Grant Thornton UK LLP and by Grant Thornton International Limited network member Firms will be included in our Audit Findings report at the conclusion of the audit.

None of the services provided are subject to contingent fees.

Transparency

Grant Thornton publishes an annual Transparency Report, which sets out details of the action we have taken over the past year to improve audit quality as well as the results of internal and external quality inspections. For more details see Transparency report 2020 (grantthornton.co.uk)

Independence and non-audit services

Service	Fees £	Threats	Safeguards
Audit related			
Review of the ICB's compliance with the Mental Health Investment Standard	£30k plus VAT (£20k plus Vat in previous year)	Self-Interest (because this is a recurring fee) Self-Review Management	We have carried out this review for 2022/23 recently. The level of this recurring fee taken on its own is not considered a significant threat to independence as fees for 2023/24 work were expected to be £30,000 (plus VAT) in total in comparison to the total 2023/24 fee for the audit of £110,000 and in particular relative to Grant Thornton UK LLP's turnover overall. Further, it is a fixed fee and there is no contingent element to it. These factors all mitigate the perceived self-interest threat to an acceptable level. The work was performed after conclusion of the 2022/23 audit and entailed testing expenditure in the ICB's statement to supporting evidence that it has been correctly categorised as mental health spend, which is entirely separate to the testing required for purposes of the audit. The scope of the work does not include making decisions on behalf of management or recommending or suggesting a particular course of action for management to follow. We may make recommendations to improve the operation of systems for producing the MHIS compliance statement, but it would be for management to decide whether to implement our recommendations. If errors are found in the MHIS completion statement, then we will discuss them with informed Management and they will decide whether or not to amend the statement. If they choose not to, then our report will be modified accordingly, and the issues will be reported to NHS England and NHS Improvement. We will agree the factual accuracy of our report before issuing it.

5. Independence and ethics (continued)

As part of our assessment of our independence we note the following matters:

Matter	Conclusion
Relationships with Grant Thornton	We are not aware of any relationships between Grant Thornton and the ICB that may reasonably be thought to bear on our integrity, independence and objectivity.
Employment of Grant Thornton staff	We are not aware of any former Grant Thornton partners or staff being employed, or holding discussions in respect of employment, by the ICB as a director or in a senior management role covering financial, accounting or control related areas.
Business relationships	We have not identified any business relationships between Grant Thornton and the ICB.
Contingent fees in relation to non-audit services	No contingent fee arrangements are in place for non-audit services provided.
Gifts and hospitality	We have not identified any gifts or hospitality provided to, or received from, a member of the ICB's board, senior management or staff.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention and consider that an objective reasonable and informed third party would take the same view. The firm and each covered person and network firms have complied with the Financial Reporting Council's Ethical Standard and confirm that we are independent and are able to express an objective opinion on the financial statements

6. Appendices

A -Communication of audit matters to those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	•	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks	•	
Confirmation of independence and objectivity	•	•
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	•	•
Significant findings from the audit		•
Significant matters and issue arising during the audit and written representations that have been sought		•
Significant difficulties encountered during the audit		•
Significant deficiencies in internal control identified during the audit		•
Significant matters arising in connection with related parties		•
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		•
Non-compliance with laws and regulations		•
Unadjusted misstatements and material disclosure omissions		•
Expected modifications to the auditor's report, or emphasis of matter		•

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Findings, outlines those key issues, findings and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

Distribution of this Audit Findings report

Whilst we seek to ensure our audit findings are distributed to those individuals charged with governance, we are also required to distribute our findings to those members of senior management with significant operational and strategic responsibilities. We are grateful for your specific consideration and onward distribution of our report to all those charged with governance.

B-Action Plan

Set out here are any recommendations made as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendations
● Medium	Journals authorisation Our audit work has not identified any issues in respect of management override of controls. However, there is a system weakness whereby users can self-authorise their own journals and senior staff can post journals (although in practice this does not happen). We consider that this increases the risk of fraud or error and Those Charged With Governance should confirm that they are satisfied with this approach This year an additional task has been added to the month end timetable for a review to be made of all posted journals. If any instances are identified where journals have been entered and approved by the same team member or entered by a senior member of the team (band 8D and above) they will be signed off by a different approver.	Audit Committee to confirm it is satisfied with this approach and accepts increased risk of fraud and/or error due to lack of independent authorisation.
● Medium	Joint Arrangements **There was no active signed Section 75 agreement in place between the ICB and Shropshire Council for 2023/24.** To improve contract management performance of these arrangements, the ICB should ensure a signed agreement is in place at the commencement of the year. We were able to gain sufficient and appropriate audit evidence for these payments by direct confirmation with the Council.	Management should ensure signed Section 75 agreements are in place at the start of each financial year
● Medium	NHS England delegated responsibility to all ICBs for pharmaceutical, general optometry and dental (primary, secondary and community services) in 2023/24. The ICB has an agreement with a regional primary care team hosted by another ICB to process journals into the ICB's ledger. We experienced difficulties in obtaining evidence from the regional team to allow us to test the accuracy of payments and income We noted that the ICB had very limited input into the financial information entered into the ledger and relied on the regional primary care team to provide an understanding of the processes and support the audit. We were also unable to establish any robust complementary user controls at the ICB to assure itself on the accuracy of payments being entered into its ledger. We were able to gain sufficient and appropriate audit evidence for these payments from evidence we obtained from the regional primary care team.	Management should ensure that it has appropriate oversight and understanding of all material income and expenditure streams in the ICB's financial statements.
● Medium	In our IT work, we noted that service auditor reports did not cover several material systems such as CHC, EPACT2 and Eden.	Management should assess how it gains assurance over the controls operating in IT systems for which there are no available service auditor reports..

Key

- ● High – Significant effect on control system
- ● Medium – Effect on control system
- ● Low – Best practice

B-Action Plan

Set out here are any recommendations made as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendations
● Medium	Healthcare contracts In our testing of secondary care contracts, we identified several material NHS contracts which had not been signed. To improve contract management performance of these arrangements, the ICB should ensure a signed agreement is in place at the commencement of the year. Some other large contracts were only signed after year end.	Management should ensure signed agreements are in place with all trusts at the start of each financial year.
● Medium	Related parties note We noted that some related parties included in Note 20-related parties did not strictly meet the definition of a related party as per the GAM. Many of the related parties do not have control or joint control over the other party.	Management should review the contents of the related party note for 2024/25.

Key

- ● High – Significant effect on control system
- ● Medium – Effect on control system
- ● Low – Best practice

C. Fees

We confirm below our final fees charged for the audit and provision of non-audit services. The following tables below sets out the total fees for non-audit services charged from the beginning of the financial period to current date.

Audit fees	Proposed fee	Final fee
ICB Audit	£110,000	£110,000
Total audit fees (excluding VAT)	£110,000	£110,000

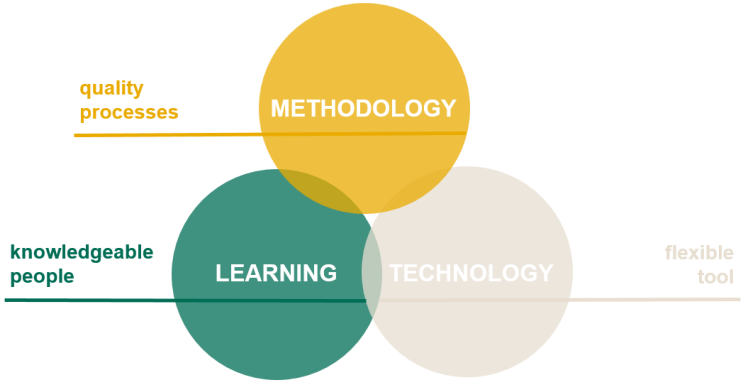
Non-audit fees for other services	Proposed fee	Final fee
2022/23 Mental Health Investment Standard	£30,000	£30,000
2021/22 Mental Health Investment Standard	£20,000	£20,000

D-Our Audit approach

As a Firm, we have significantly developed our use of audit, data interrogation and analytics software

LEAP

- A globally developed ISA-aligned methodology that re-engineers our audit approach to focus on quality and effectiveness
- LEAP empowers our engagement teams to deliver even higher quality audits, enables our teams to perform effective audits which are scalable to any client, enhances the work experience for our people and develops further insights into our clients' businesses
- The LEAP approach allows us to tailor the audit programme to help engagement teams respond quickly to any changes as they occur, keeping quality high through responsiveness and flexibility



IDEA

- We use one of the world's leading data interrogation software tools, called 'IDEA' which integrates the latest data analytics techniques into our audit approach
- We have used IDEA since its inception in the 1980's and we were part of the original development team. We still have heavy involvement in both its development and delivery which is further enforced through our chairmanship of the UK IDEA User Group
- In addition to IDEA, we also other tools like ACL and Microsoft SQL server
- Analysing large volumes of data very quickly and easily enables us to identify exceptions which potentially highlight business controls that are not operating effectively

Inflo

Cloud based software which uses data analytics to identify trends and high risk transactions, generating insights to focus audit work and share with clients.

REQUEST AND SHARE
- Communicate and transfer documents securely
- Extract data directly from client systems
- Work flow assignment and progress monitoring

ASSESS AND SCOPE
- Compare balances and visualise trends
- Understand trends and perform more granular risk assessment

VERIFY AND REVIEW
- Automate sampling requires
- Download automated work papers

INTERROGATE AND EVALUATE
- Analyse 100% of transactions quickly and easily
- Identify high risk transactions for investigation and testing
- Provide client reports and relevant benchmarking KPIs

FOCUS AND ASSURE
- Visualise relationships impacting core business cycles
- Analyse 100% of transactions to focus audit on unusual items
- Combine business process analytics with related testing to provide greater audit and process assurance

INSIGHTS
- Detailed visualisations to add value to meetings and reports
- Demonstrates own performance and benchmark comparisons

E- Audit opinion

Our anticipated audit report opinion will be unqualified and our regularity opinion will be qualified. We draw your attention to where we identified a significant weakness in how the ICB plans and manages its resources to ensure it can continue to deliver its services

Independent auditor's report to the members of the Board of NHS Shropshire and Telford and Wrekin Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Shropshire Telford and Wrekin ICB (the 'ICB') for the year ended 31 March 2024, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Audit opinion

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2023-24 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Audit opinion

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The ICB reported a deficit in its financial statements of million for the nine months ending 31 March 2024. The ICB thereby breached two of its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that annual expenditure does not exceed income and revenue resource use does not exceed the amount specified by direction of NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 13 May 2024 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS Shropshire Telford and Wrekin ICB's breach of its revenue resource limit for the year ending 31 March 2024

Audit opinion

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page(s) x to x, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24).
- We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

Audit opinion

- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of fraud in expenditure recognition and the risk of management override of controls. We determined that the principal risks were in relation to:
  - Journals with a specific focus on those which altered the financial performance of the ICB for the year an those posted by senior officers
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual journals which included**;**
    - journals posted by senior finance officers
    - large value journals
    - journals posted in March and post period-end
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
  - agreeing expenditure transactions, on a sample basis, to supporting evidence; and
  - evaluating and challenging the estimates and the judgments made by management at year end
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates

Audit opinion

- understanding of the legal and regulatory requirements specific to the ICB including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2024.

We have nothing to report in respect of the above matter except:

On 19 June 2024 we reported our combined Annual Auditor's Report for the years 2023/24 to Those Charged With Governance. We reported that the ICB has not been able to achieve financial balance in 2023/24, has set a deficit plan for 2024/25 which includes unidentified savings and does not have a fully developed medium term financial plan to address its underlying deficit.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Audit opinion

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements-audit certificate

We certify that we have completed the audit of Shropshire and Telford and Wrekin Integrated Care Board for the year ended 31 March 2024 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Appendix 1
Year End Report on PCARP 2023/24 and Planning for 2024/25.

1. Introduction

1.1 Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care boards (ICBs) were required to develop system-level access improvement plans. This aligns with leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

1.2 National guidance was published at the end of July 2023 detailing the required contents of the system level plan.

1.3 The STW Primary Care Access Improvement Plan 23/24 set out our ambition to improve local access to general practice, maintain and improve patient satisfaction and work to streamline access to care and advice.

1.4 The 24/25 planning process builds on the progress from 23/24 and highlights any areas of variation within and across PCNs.

1.5 Since the launch of the PCARP program in May 2023 there have been significant improvements across the county in digital telephony, the expansion of ARRs roles, engagement with the General Practice Improvement Program and better mapping and understanding of appointments in general practice.

1.6 At the same time, we have seen two practices merge and one PCN change into two PCNs meaning that across STW we now have 50 practices across 9 PCNs.

1.7 This is a two-year program so this reviews progress in year one and planning for year two.

2. Review 2023/24

2.1 The program provided several actions and timelines for completion by the ICB. We have completed most actions and where these have not been completed these have sometimes been outside our control i.e., nationally prescribed telephony provider not having the capacity to install before the deadline, but dates are booked, and contracts are signed. (For the whole set of actions see table 1).

2.2 We are making slow progress around the implementation of self-referral pathways although we are in the process of expanding this offer to patients. The ask of ICBs from NHSE changed in year from implementing the seven pathways to increasing the use by 50% of any pathways that have been implemented and this will be our focus in 2024/5.

2.3 Some of the national metrics for primary care access are still not agreed and it may be October before these are available. This has made month on month tracking difficult, but we continue to monitor areas where we have targets.

2.4 The mechanism for securing the payment of 30% of the CAP funding has changed this year and PCN CDs are being asked to self-declare for their constituent practices.

2.5 All PCNs and practices received the full CAP funding for 2023/24 following the ned of year review by an ICB panel.

Table 1

Title	**2023/24 End of year position**	**Target achieved where applicable Y/N**
Establish the following self-referral pathways as set out in 2023/24 guidance	Services have been designing and planed as below	NA
Selected community MSK services	June 2024 for STW base self-help app release and then 1st PCN as pilot for Self-referral to MSK Therapy from app. July 2024 to start roll out.	Target will be achieved by March 2025
Audiology for older people including hearing aid provision,	Implementation planned for June 2024	Target will be achieved by March 2025
Community Podiatry	No plans to introduce self-referral for community podiatry	N
Falls Response	Implementation planned for July 2024	Target will be achieved by March 2025
Wheelchairs	as previous - not feasible	N
Community Equipment	as previous - not feasible	N
Weight Management	There continues to be disparity between the Shropshire and T&W LA offer to patients.	N
Ensure pathways are in place between community optometrists and ophthalmology	90% of optometry practices across STW are now accessing EeRS to make referrals and request advice and guidance. Referrals for all non-urgent ophthalmology pathways can now be made via EeRS. Self-referral will be in place by March 2025 as part of system eyecare transformation programme.	Target will be achieved by March 2025

Sign up practices ready to move from analogue to digital telephony, and co-ordinate access to specialist procurement support through NHS England's commercial hub.	50/51 practices on digital telephony. Remaining practice scheduled to move in July 2024 (delays due to national procurement and provider capacity).	N
Select digital tools from the Digital Pathway Framework lot on DCS product catalogue (published in August), using user research and preview to be published by June. ICBs to work with PCNs and practices to decide which tools will best enable them to shift to the Modern General Practice Access model.	Digital Framework was not shared. ICB working with practices and regional team to progress with digital tools to support modern general practice service delivery.	NA
Develop and implement a process for undertaking the diagnostic Support Level Framework with the aim being for all practices to have had a facilitated discussion using the SLF in the next 18 months (requires 2 facilitators and x 1 3-hour online session) Facilitator training required and provided nationally	10 completed nationally as part of GPIP. 3 completed locally as part of GP Support offer.	N
Nominate practices and PCNs for national intensive and intermediate transformation support matched to needs using the Support Level Framework where possible to understand support needs. Prioritise practices with greatest challenges, and with data from digital telephony already in place, and nominate further practices as they	Allocation achieved; 8 practices completed intermediate GPIP 2 practices completed intensive	Y

implement digital telephony.		
CBs to establish and/or build on current local peer to peer learning infrastructure to develop local communities of practice to support shared learning and data driven improvement which includes enabling Modern General Practice.	Monthly PCN Development meetings are in place where PCNs have shared progress, issues, and good practice. National webinars and resources have been shared and promoted. The Primary care Team will look to further this offer to practice level in 2024/25.	Y
ICBs to put in place a strategy for auditing usability and accessibility of all general practice websites using the GP website benchmark and improve tool. All GP websites to be audited in 23/24 and an improvement plan agreed. Practices offer accessible and easily usable websites. Implement 'what good looks like' guidance using the NHSE tool to review sites, identify best practice examples in their systems, and target areas for improvements.	ICB audit carried out early in 2023. PCNs have led practices with the use of the national audit tool to audit the quality and ease of access of practice websites as part of the Capacity Access Improvement Work. All practices have made improvements to their websites and will continue to work on this during 2024/25 to be compliant with the audit tool guidance.	Y
Fund or provide local hands-on support to 850 practices nationally (ICBs should work with regions to determine population appropriate share of target). We would expect the level of support to be like the national intermediate offer, and offered alongside wider or ongoing support for	Local allocation 7 practices. GP Support Team continues to offer localised and flexible support to practices. Modular offer being developed for 2024 in line with NHSE advice of support criteria. 10 practices are currently supported via this process. This is at varying levels dependent on practice need.	Y

practices and PCNs where required, using the outputs of the SLF to help guide specific support needs		
Agree and distribute transition cover and transformation support funding (£13.5k / qualifying practice) to support practice teams seeking to implement Modern General Practice Access model Guidance on distribution to be published soon	Open offer to all practices to apply. Funding was agreed for 29 practices in 2023/24 with full in year budget committed. This offer continues into 2024/25.	Y
Care Navigator training - all practices to nominate staff to attend.	End of year national data has not been shared. At February 2023 data showed that over 40 practices nominated staff to attend the national training with 78 modules completed. Local training has also been provided through the training hub with over 33 practice staff attending. National offer closed on 31st March 2024.	Awaiting numbers from NHSE
Digital and Transformation PCN leads training	National data shows 2 PCN digital leads have signed up to cohort 3.	N
Leadership Improvement Training (GPIL)	National data shows no practice sign up to GPIL.	N
QI Capability improvement training.	National data shows no practice sign up to this training.	N
Understand and sign off PCN/practice capacity and access IIF CAIP baseline using guidance	Complete.	Y
Agree with practice/PCN support needs (digital telephony, online tools,	Ongoing conversations alongside national procurement framework and guidance.	Ongoing

training, capacity backfill, intensive support, etc)		
Co-develop and sign off PCN/practice access improvement plans leveraging example practice access improvement plans published by NHS England by 9 June	Complete.	Y
Assess improvement and pay 30% CAP IIF funding at the end of year using progress against baseline and access improvement plans, as well as improvement activity across all three areas over the year as per template in guidance.	All PCNs were successful in gaining the full 30% CAIP following review of end of year reports by the ICB CAIP Review panel.	Y
Set up process for practices to inform of diversion to 111 and monitor exceptional use when over capacity	An informal process has been developed in 2023/24 through the generic primary care email account. This needs to be formalised in 2024/25.	Y
Develop system level access improvement plans which include summary of practice/PCN improvement plans, challenges, wider support needs and barriers and ICB actions (including leading local improvement communities, leveraging and promoting universal support offer, and improving the quality of core digital patient journeys for patients and staff and usability of practice websites supported by the national website audit tool).	Complete. reported to Public Board in October 2023.	Y

Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal	STW PCNs have been supported to utilise their full ARRS budget allocations for 23/24, with a final financial assessment due by the ICB's finance team in April. In addition, PCNs are supported to ensure that they accurately report their staff cohorts via NWRS.	Y
Further expand GP speciality training (pending NHS workforce plan)	The ICB has no direct control or influence over the number of doctors joining the STW GP Speciality Training Scheme - applications and appointments are made by NHSE. However, the STW ICB GP Marketing Lead works with Foundation Year doctors and local practices to encourage these doctors to apply to join the GP training scheme.	Y
Encourage experienced GPs to stay in practice through the pension reforms /create simpler routes back to practice for the recently retired	Although the ICB has no direct control over national policies around pensions and return to practice schemes, the STW ICB Refreshed GP Leads are developing a range of activities, information and networking opportunities for mid to late career GPs with a view to encouraging them to stay in the profession rather than retiring early.	Y
Ensure the ICB is maximising the opportunities to access Section 106 and CIL monies related to housing developments to improve primary care estates/infrastructure	Overall ICB PC wrap around and prioritisation to be completed in April 2024. External consultant continuing to work through s106 opportunities. CIL application has been accepted by Shropshire Council for additional capital funding for Shifnal new build project. Awaiting transfer of funds from Council. Highley new build project proceeding to construction phase and expected completion now mid-April 2024 due to some last-minute delays with furniture and snagging issues Opening scheduled for 20 April 2024.	Y
Report in public board updates and plans for improving the primary–secondary care interface (four focus areas below)	Primary Secondary Care Interface group was launched in October 2023 and has meeting monthly. Attendance has varied but the group have now agreed a positive way forward and are planning dedicated time together to build relationships and work through the priority areas.	Y

ICB chief medical officers to establish the local mechanism, which will allow both general practice and consultant-led teams to raise local issues, to jointly prioritise working with LMCs, and to tackle the high-priority issues including those in the AoMRC report.	A joint Primary/Secondary Care Group has been established and has met four times. An assessment of the four STW providers against the four areas has been jointly completed and returned to NHSE and will be used as the baseline for measurement of change. A joint discharge letter is currently being designed between Primary and Secondary Care to address some of the current interface issues reported from all providers. All providers have been asked to identify their Primary Care Co-ordinators an provide these at the next meeting.	Y
1) Onward referrals: if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them,		N
2a) Complete care (fit notes and discharge letters): trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need,		N
2b) Providers of NHS-funded secondary care services should have implemented the capability to issue a fit note electronically.		N
3) Call and recall: for patients under their care, NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments.		N
4) Clear points of contact: ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly:		Y

Encourage practices to sign up for the easy-to-use online patient registration service	STW practices have engaged well with this with 26 practices signing up in 2023/24 (there was no target set).	Y
Co-ordinate system comms to support patient understanding of the new ways of working in general practice including digital access, multidisciplinary teams and wider care available. This messaging should include system specific services and DoS (Directory of local services). Needs to link to planned national comms campaign	Activity for this month has consisted of the launch an external social prescriber campaign to raise awareness of this unique roles (communications including an external blog from a SP explaining the role and how it can help patients as well as a cancer specific SP blog for the system newsletter as well as a dedicated webpage as part of MDT info). Upcoming activity to include video case studies from SPs and patients who have benefitted from the service. PCARP social media activity has also performed well for March with MDT video posts and pharmacy messaging being the top performing posts across all ICB social channels.	
Maintain an up-to-date DoS	This is an ongoing task with the DOS checked and kept up to date by the regional lead.	Y
Deliver training to all practices/PCNs on DoS.	Covered as part of care navigation processes.	Y
Support Practices to enable prospective online access for patients to their records	50/51 practices enabled bulk transfer by the deadline of October 2023. The remaining practice has also now enabled this. There are several practices with compliance issues due to being slightly over/under the recommended variation. Practices have been asked to review and update their safeguarding coding accordingly.	Y
Allocate System Development Funding in line with guidance published 22.5.23. NHSE expects systems to use a large part of this to support primary care transformation.	Complete.	Y
Launch Pharmacy First, subject to consultation completion	Complete - continuing to support practices and pharmacies.	Y
Expand the number of community pharmacies on the blood pressure check advanced service	Working with LPC to support the provision of ABPMs from community pharmacy. Working to understand and mitigate against any barriers. Engagement with local authorities on the linking of CP BP check service to existing outreach clinics.	Y

Expand the number of community pharmacies managing ongoing oral contraception (subject to findings of initial pilots and consultation)	Work has been focussed towards embedding pharmacy first. Future work to focus on increasing sign up and delivery.	N
Support practices and community pharmacies to increase the number of referrals to CPCS	Continuing to engage with practices based upon internal prioritisation list. Collaborating with Medicines Management, Primary Care and LPC to ensure practices and pharmacies are offered support to increase the number of referrals Awaiting release of national Pharmacy First activity data held by NHSE for targeted engagement. Pharmacy First was launched in 100% of STW community pharmacies in January 2024. In the first 4 months of the service, 3706 referrals were made from 67% of STW practices to community pharmacy to be seen under this Service.	Y
Practice digital telephony systems are utilising call back, queuing and call routing, and integration with clinical systems features	Practices are now using a variety of messaging functions to offer self-book appointments and improve communication with patients for example a text service to share appropriate test results and reminders for appointments. Most practices have the queuing functionality and some also having the call back feature with the intention of all practices adding both features in 24/25.	Target will be achieved by March 2025
All practices are providing online consultations	All practices are signed up to offer Online Consultations. The vast majority are with AccuRX Patient Triage.	Y

Planning for 2024/25

To gain the 2024-25 full CAIP payment, all practices need to have in place the following.

MGPA priority domain	**All PCN practices to have following components in place and these continue to remain in place**
1) Better digital telephony	Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.

2) Simpler online requests	Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours. Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the *submissions via online consultation systems in general practice* publication.
3) Faster care navigation, assessment, and response	Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

2024/25 Summary of Recovering Access Targets

April 9 Letter from Amanda Doyle – see Appendix 2

A. Empowering Patients
B. Implementing Modern General Practice Access
C. Build Capacity
D. Cutting Bureaucracy

3. Next Steps

3.1 Letters sent to all PCNs after review of 23/24 progress setting areas for focus for 24/25 plans. These include a request for PCNs to reflect in their plans to address inequalities in provision and patient access.

3.2 Start to include pharmacy, optometry and dentistry access recovery plans and progress in addition to general practice.

3.3 Develop the PCITG and PCSCIG to function effectively to continue to oversee improvements in access and reduce bureaucracy across organisational boundaries freeing clinical and admin capacity and simplifying the patient journey.

4. Conclusion

4.1 The PCARP program has completed the first of a two-year program and progress has been made in every practice and therefore PCN against the improvement areas outlined above.

4.2 This has released the final 30% of the Capacity Access Funding into general practice which will be utilised to continue with the improvements required.

4.3 The Board are asked to note the progress made in recovering access to Primary Care across the county.

5. Recommendations

5.1 The Board write to PCNs to acknowledge the progress made in 2023/24 and commend the improvements that have been made.

Appendix 2

Classification: Official
Publication reference: PRN01226

Dear colleagues,

Delivery plan for recovering access to primary care: update and actions for 2024/25

The NHS is determined to make it easier and quicker for patients to see their GP and members of the primary care team.

That is why in May 2023, along with the Department of Health and Social Care (DHSC), we published a two-year delivery plan for recovering access to primary care while taking pressure off general practice.

Since the plan's publication, we have delivered:

- Record numbers of general practice (GP) appointments with more than 360 million appointments – excluding those for Covid vaccinations – delivered in the 12 months up to February 2024, an additional 57.5 million appointments than before the pandemic (Pressure on NHS services remains high – NHS England). This includes 3 in 5 GP appointments delivered face-to-face, over half booked and attended on the same day or next day, and nearly 9 in 10 appointments attended within two weeks of booking (for appointments not usually booked in advance).
- The biggest expansion of services in pharmacy for years – making it easier for patients to access treatment for common conditions through their local pharmacy.
- More than 36,000 additional direct patient care roles now compared to 2019 (Appointments in General Practice, September 2023 – NHS England Digital, Expanded NHS support available for patients in GP practices across the country – NHS England)
- 90% of practices enabling patients to use the NHS App to send messages, book appointments and order repeat prescriptions.

The fact that these achievements, and others (as set out in Annex 2) have been achieved against the backdrop of sustained, significant demand on primary care, is testament to everyone's commitment to providing high-quality care.

But we need to go further.

So, continuing to improve timely access to primary care is an NHS priority and a core part of recovery in the NHS planning guidance for 2024/25.

The second year of the delivery plan for recovering access to primary care is about realising the benefits to patients and staff from the foundations we have built since launch in the following four priority areas.

Empowering patients

We'll continue to break down the barriers patients face and make it easier for them to access care, while taking pressure off general practice.

The number of patients viewing their records on the NHS App will increase from 9.9 million to 15 million a month, and the number of patients using the NHS App to order repeat prescriptions will increase from 2.7 million to 3.5 million per month, by March 2025.

It will be become more common for patients to self-refer, with the number of self-referrals across all pathways increasing by a further 15,000 patients a month by the end of March 2025.

And we will continue to realise the potential of community pharmacies, growing the monthly patient volumes across all three pharmacy services by March 2025 by at least 71,000 blood pressure check consultations; 25,800 oral contraception consultations; and 320,000 Pharmacy First clinical pathways consultations.

Implementing Modern General Practice Access

Over the next year, we will support practices to make full use of digital telephony capabilities, including callback functionality and ensuring that practices meet capacity and access improvement payment (CAIP) payment criteria. This will include implementing a single view of all requests whether online, phone or walk-in through the use of digital tools, each of which includes structured data to support the assessment and streaming to the appropriate response.

And we will begin to share data on the number of calls to 111 in core hours with primary care networks (PCN) clinical directors, to support quality improvement, so practices only divert to 111 in exceptional circumstances.

For 2024/25 we will strengthen locally owned delivery of transformation support, alongside continuing to provide funding and national support through the General Practice Improvement Programme.

Build capacity

The NHS needs more GPs. That's why in the NHS Long Term Workforce Plan (LTWP), the NHS and Government pledged to increase the number of GP training places by 50% to 6,000 by 2031/32.

This year we will take another step towards meeting that ambition and, through the LTWP, will focus on growing GP specialty training by 500 places in 2025/26, timed so that more of these newly qualifying doctors can train in primary care.

Cut bureaucracy

We want GPs and their teams to spend more time treating patients and less time managing paperwork.

That's why this year we have already changed the GP contract to suspend and income protect 32 out of the 76 Quality and Outcomes Framework (QOF) indicators.

A new online patient registration service will be expanded to all practices by 31 December 2024 saving time for patients and practices.

Improving the primary-secondary interface will be a key focus in 2024/25 and we are looking for significant progress on implementation, recognising the benefits for patients and staff including in general practice.

Next steps

The detailed actions for 2024/25 are included in Annex 1. with an update on delivery of Year 1 actions in Annex 2.

Funding for 2024/25 is set out in Annex 3, with more details given in the recent letter to the profession on the 2024/25 general practice contract.

We are asking integrated care boards (ICBs) to continue to report progress against all the elements of the delivery plan in their October or November 2024 public boards.

We will issue further guidance, but this report should outline the local plans to improve access, progress against the primary and secondary care interface, and include:

- a breakdown of the use of the funding streams for primary care in 2023/24
- projected use in 2024/25, including for service development funding (SDF) for high quality online consultation software and transformation funding
- an update on how many PCNs have claimed the 30% CAIP payments

In the meantime, please contact your regional NHS England representative or england.pccsdeliveryunit@nhs.net if you have any questions.

Thank you for your continued support and hard work in improving our services for patients.

We look forward to continuing to work with you and building on the achievements made in the first year of the delivery plan.

Yours sincerely,

Dr Amanda Doyle OBE MRCGP, National Director for Primary Care and Community Services, NHS England.

Dr Claire Fuller MBBS DRCOG MRCGP, National Medical Director for Primary Care, NHS England.

Annex 1: The NHS delivery plan for recovering access to primary care 2024/25

A. Empowering patients

NHS App and digital access

Latest data shows 84.1% of practices have enabled patients to view prospective records compared to around 21% in May 2023 and feedback from patient groups is positive (for more details on access see: NHS England » Millions more people given access to their GP records online).

In addition, 94.3% of practices offer patients the ability to book/cancel some specific appointments online and 98.9% offer patients the ability to order online repeat prescriptions, although we estimate only 2.7 million (around 11%) of repeat prescriptions per month are ordered this way.

Our 2 goals for 2024/25 are firstly, to encourage more patients to use the online repeat prescription function; and secondly, to increase patient use of their digital health record, resolving any outstanding issues with any practice that has not enabled access to prospective records for their patients (prospective record access from 31 October 2023 is a GMS contractual requirement).

We are setting ourselves the goal of increasing the number of patients using the NHS App or online channels to order repeat prescriptions to 3.5 million per month. We will be sharing repeat prescription data with primary care networks (PCNs) and will be working with practices and patient groups to understand how we can help overcome any barriers to adoption.

We have been asked how offering patients the ability to book specific appointments online fits with Modern General Practice Access where all requests are assessed around the need for a face-to-face appointment.

Appointments available for patients to book directly online are for regular routine appointments that do not require prior assessment, such as booking for a regular B12 injection or where a practice has assessed the patient's needs and identified the right type of appointment can be offered (for example, with a specific healthcare professional or as part of a particular clinic).

As software improves, many practices are also now texting patients a link so they can choose and book an appointment online after the assessment of their request determines an appointment is required. Both approaches can reduce pressure on administrative staff and improve flexibility and experience for patients.

Expanding self-referral

By March 2024, we are on track to increase by 50% the number of people self-referring to the 7 community services prioritised where general practice involvement may not be necessary – an additional 15,000 patients a month.

However, there remains variation across integrated care boards (ICBs), pathways and providers; and therefore opportunity exists for more people to benefit from self-referral in these services, as well as others where self-referral may be clinically appropriate.

Our goal for 2024/25 is to further increase self-referrals across all pathways by at least a further 15,000 patients a month by the end of March 2025, by working with ICBs to reduce

variation and ensuring healthcare staff and patients can readily understand availability of self-referral locally.

Expansion of pharmacy services

In 2023/24 we have successfully expanded the existing blood pressure and oral contraception services and launched Pharmacy First, where pharmacists can now supply some prescription-only medicines where clinically appropriate to treat 7 common health conditions.

We have been asked how Pharmacy First reduces practice workload if practices still need to review pharmacy actions as part of approving the patient record update. It is important that practices are updated on the outcome of any consultations that take place elsewhere in primary care to inform later clinical decision-making. The GP is also the data controller for the patient record.

We have delivered a range of digital enhancements that make it easier for pharmacists and practice staff to capture outcomes from these new clinical pathways. Pharmacy systems now capture complete, structured data linked to the patient.

Over the coming months, this data will start to be surfaced directly into practice workflows. This means practice staff will no longer have to match records to patients, manually code or transcribe from emails.

Instead, they will be able to review consultation information, including notes and details of medications issued, and add the data to the patient record with one click. Designed with GPs and practice staff, this is a significant enhancement to existing processes, and will provide a template for improving post consultation messages from other care settings.

Our goals for 2024/25 are to grow the monthly patient volumes across all 3 pharmacy services by March 2025 by at least 71,000 blood pressure check consultations; 25,800 oral contraception consultations; and 320,000 Pharmacy First clinical pathways consultations. We will review the ambition of this trajectory in September, when public uptake of the service in the first 9 months is understood. We will continue to monitor uptake by Distance Selling Pharmacies, which have an important role to play in providing wider access to patients via video consultations.

Greater flexibility

Recognising pharmacists and pharmacy technicians each have expertise in medicines, DHSC has taken forward commitments in the delivery plan to release pharmacists' time for more patient-facing services including:

- consultations on enabling the use of patient group directions by pharmacy technicians and modernising pharmacy legislation on pharmacy supervision
- amending legislation to increase dispensing efficiency

The Medicines and Healthcare products Regulatory Agency (MHRA) has reclassified eligible medicines, so they are more easily available to patients in pharmacies, and elsewhere, without requiring an appointment and prescription. In 2024/25, DHSC will continue to work with stakeholders and partners to support and progress these commitments further.

B. Implementing Modern General Practice Access

Better digital telephony

The delivery plan set out the key elements of a Modern General Practice Access Model starting with digital telephony. All bar a small number of practices are already, or soon will be, operating digital telephony – over 99% of practices have signed the necessary contractual arrangements.

An increase from 55% of practices in an October 2022 audit and around 70% in May 2023 (for some, their telephony supplier has moved installation dates into April/May 2024 due to capacity constraint reasons. We currently expect 99% of practices to be live by May 2024).

Our goals for 2024/25 are to encourage the full use of digital telephony capabilities, including callback functionality, and for PCNs to review the key telephony metrics across their practices (including number of calls, average wait, abandonment time, average call length) to support quality improvement in demand management and planning of care navigation.

Separately, we plan to share data on the number of calls to 111 in core hours with PCN clinical directors to support quality improvement. Practices should only divert to 111 in exceptional circumstances and should inform their local commissioner (ICB primary care team).

Simpler online requests

The second component aims to make digital communications and access easier for those patients who can use and prefer these channels. The functionality of existing and new digital tools has continued to improve over the last year, and this is set to continue next year. We expect digital channels to be available to patients as a minimum during core hours ensuring parity across phone, walk-in and digital access.

Practices who have focused on this are receiving more requests online and are able to easily ask clarifying questions to patients. This supports effective assessment of need and care navigation, supports practices to determine the right next steps and (where functionality is installed) to send a link for patients to self-book an appropriate appointment if required. This also frees up phone lines for patients who need them.

To support practices to access high quality online consultation, messaging and booking tools, we have raised the standards and minimum functionality that we expect suppliers of these key tools to be able to meet. This will form part of future digital frameworks and further detail on the 'digital pathway framework' to support general practice will follow in due course.

However, many existing suppliers are already introducing enhancements to their products based on these higher standards. ICBs will be funded to support practices to secure the high-quality tools they need (see Annex 3 for more details).

Our aim for 2024/25 is to increase the use of these higher quality digital tools and we will be tracking and reporting on the number of patients using digital access throughout the year.

Faster care navigation, assessment and response

The third component aims to ensure every patient knows on the day how their request will be handled. The delivery plan described the role of care navigation to self-care and other primary care services, and we have made care navigation training available for every practice in

England. To date, over 6,100 staff have registered and over 3,375 have completed the training available in 2023/24.

In 2024/25, using the digital tools and funding outlined in this letter, we want to support practices to implement a single view of all requests whether online, phone or walk-in, each of which includes structured data to support the assessment and streaming to the appropriate response.

This means general practice staff do need to collect key data from patients who phone or walk-in. Practices which do this well use a team approach to streaming, often led by an experienced GP.

Transformation support

Over the last 9 months, more than 1,650 practices have benefited from the national general practice improvement programme (GPIP), with over two-thirds of these practices benefiting from 'hands on' support. With GPIP support, practices have seen reduced call wait times, fewer abandoned calls, and significantly increased use of digital access routes by patients, while also reducing avoidable appointments (phase A practice-level GPIP support). The programme has grown the national primary care improvement community to over 12,000 members.

Our goal for 2024/25 is to scale the learning from GPIP and strengthen locally owned delivery of transformation support in partnership with ICBs. This approach will enhance the critical role of systems and enable those closest to local challenges to lead engagement, and to shape, target and deliver support.

NHS England will continue to provide an online support offer making this knowledge and best practice available to all alongside flexible, hands-on support to a proportion of practices identified as most benefitting by their ICB, as part of the transition to a system-owned delivery model.

Funding for Modern General Practice Access

For 2024/25 we are making 3 funding sources available to support practices implement what we know is a major transformation. First, through support for high quality online software (for example, online consultation tools, messaging systems and appointment booking tools) (see Annex 3).

Second, we will continue to provide a one-off transformation fund (an average of £13,500 per practice) to any practice that has not already claimed this to cover the additional resource needed to make the switch from an appointment book approach to Modern General Practice Access.

Third, in the 2024/25 contract we are continuing to income protect most investment and impact fund (IIF) indicators to create a capacity and access payment (CAP) of £292 million to support implementation. This is covered in paragraphs 28 – 31 in the contract letter.

As in 2023/24, 70% of funding will be paid to PCNs without any conditions, with the remaining 30% available to PCNs once all practices within a network have put in place the components of the Modern General Practice Access Model, which each attract a third of the overall capacity and access improvement payment (CAIP) funding.

This funding will be available from confirmation, so practices who have already implemented all 3 elements should confirm this with their ICBs from April 2024, and will receive monthly funding thereafter.

C. Build capacity

Empowering patients and improving Modern General Practice Access will make a significant contribution, but the increased level of demand on primary care needs to be underpinned by more investment in the primary care workforce as set out in the Long Term Workforce Plan (LTWP).

The delivery plan focused on delivering the manifesto commitment of over 26,000 more direct patient care staff and 50 million more appointments by March 2024. Latest data shows we have delivered both and exceeded staff roles, with over 36,000 additional direct patient care roles now compared to 2019 (Appointments in General Practice, September 2023 – NHS England Digital, Expanded NHS support available for patients in GP practices across the country – NHS England) meaning an expanded team of health professionals are now available to help patients get the right care when they need it, in addition to seeing their GP or practice nurse.

Our goals for 2024/25 are to support the achievement of the LTWP ambitions. This includes initially growing GP specialty training by 500 places in 2025/26, timed so that more of these newly qualifying doctors can train in primary care. Further expansion of GP specialty training places will then take place with 1,000 additional places (5,000 in total) in 2027/28 and 2028/29.

Planning policy

As described in the plan, DHSC will continue to work with the Department for Levelling Up, Housing and Communities (DLUHC) on how reforms to planning policy could better support funding of primary care estate, including new areas of housing development.

D. Cutting bureaucracy

Primary-secondary care interface

The delivery plan asked ICB chief medical officers (CMOs) to focus on and report their progress against 4 main recommendations on how to improve the interface from the Academy of Medical Royal Colleges (AoMRC) report, including:

- onward referrals
- complete care (fit notes and discharge letters)
- call and recall
- a point of contact for clinicians

The importance of these commitments are reinforced by the RCGP interface guidance and we suggest systems work through producing their local version of the guidance. Good progress has been made in some local areas, but there remains more to do in all systems.

Our goal for 2024/25 is provide more support to ICB CMOs with national leadership co-led by the NHS England national medical directors for primary and secondary care. We have already asked ICBs to report progress through their public board in April or May and will again ask ICBs to do this in October or November 2024. This will be a focus for 2024/25 and we are looking for significant progress on implementation, recognising the benefits for patients and staff alike.

In 2023/24 we developed an assessment tool at the request of many ICBs. In 2024/25 we are asking all ICBs to use this across their secondary care NHS providers, to baseline, improve and report on progress as they implement the AoMRC recommendations and RCGP interface guidance. Themes from the assessment tool will inform future support and guidance including content for October or November board reports.

Progress in this area is dependent on this being a joint endeavour between secondary care and primary care, and we are expecting all trusts to have identified a lead clinician for this important area of work.

Roll out of easy-to-use online registration

Conventional patient registration processes can be complex and resource intensive for practices and patients with around 6.8 million processed annually. A new online patient registration service and paper form has been co-developed and tested with relevant groups including general practice staff.

The commitment for 2,000 practices to be using this service was met in November 2023, one month ahead of schedule. More than 1 million patients have used a national online service to register with a GP since its launch 18 months ago. In 2024/25, we will roll this out to all practices by 31 December 2024.

Building on the Bureaucracy Busting Concordat

DHSC has worked with other government departments to reduce unnecessary bureaucracy and administrative burdens placed upon general practice and free up time for patients. In 2024/25, DHSC will seek to reduce bureaucracy building on ongoing work taking place across government.

NHS delivery actions for 2024/25

A. Empower patients		
1	Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.	Increase NHS App record views from 9.9m to 15m per month by March 2025. Increase NHS App repeat prescription numbers from 2.7m to 3.5m per month by March 2025.
2	Continue to expand Self-Referrals to appropriate services.	Increase number of self-referrals across appropriate pathways by a further 15,000 per month by March 2025.
3	Expand uptake of Pharmacy First services.	Increase PF pathways consultations per month by at least 320,000 by March 2025 Increase oral contraception prescriptions coming directly from a Community Pharmacy by at least 25,800 by March 2025. Increase Community Pharmacy Blood Pressure check appointments by at

		least 71,000 per month by March 2025 as part of our ambition to deliver a further 2.5 million blood pressure checks in community pharmacy.
B. Implement Modern General Practice Access		
4	Complete implementation of better digital telephony.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
5	Complete implementation of highly usable and accessible online journeys for patients.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
6	Complete implementation of faster care navigation, assessment, and response.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
7	National transformation/improvement support for general practice and systems.	Programme milestones including sharing evidence, standards, best practice and support tools; which in turn enhance system-led targeted support to practices and PCNs.
C. Build capacity		
8	Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP).	As per the LTWP.
D. Cut bureaucracy		
9	Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations.	Baseline in April 2024 using assessment tool and monitor ICB progress against implementation of AoMRC recommendations based on NHS Trust provider returns every 6/12.
10	Make online registration available in all practices.	More than 90% of practices using the on-line registration system by 31 December 2024.

Annex 2: Update on delivery actions for 2023/24

A. Empower patients			
1	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.	**Partially complete**	Latest data shows achieved appointments (94.3%) and repeat prescription (98.9%) and prospective records at (84.1%).
2	Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.	**On track**	41k monthly referrals in Nov 23 against goal of 45k by end March 2024 for in scope pathways.
3	Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience	**Complete**	Launched December 2023.

	for millions of patients, subject to consultation.		
4	Launch Pharmacy First so by the end of 2023 community pharmacies can supply prescription medicines for seven common conditions.	**Complete**	Launched January 2024.
5	Greater flexibility to release pharmacists' time for patient-facing services.	**On track**	Public consultations delivered and legislative changes.
B. Implement Modern General Practice Access			
6	Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign-up by July 2023.	**Implementation nearing completion**	All practices due to transition have signed contracts. Over 90% have implemented and remaining practices will complete by May 2024.
7	Provide all practices with the digital tools and care navigation training for modern general practice access.	**Complete**	All practices have had access to funding to support procurement of digital tools.
8	Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme.	**Complete**	All practices offered opportunity for support with > 1,650 practice supported.
C. Build capacity			
9	Make available an extra £385 million in 2023/24 to deliver 26,000 more direct patient care staff employed and 50 million more appointments by March 2024 (versus 2019).	**Complete**	We have delivered both and exceeded staff roles with over 36,000 additional Direct Patient Care roles compared to 2019.
10	Further expand GP specialty training.	**Complete**	Work underway in line with LTWP.
11	Change local authority planning guidance to raise the priority of primary care estates.	**On track**	Work underway with Department for Levelling Up, Housing and Communities.
D. Cut bureaucracy			
12	Reduce time spent liaising with hospitals by improving the interface with primary care, especially the four areas highlighted by the Academy of Medical Royal Colleges report, in a public board update in Autumn.	**Complete**	All ICBs reported to public boards.
13	Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – re-target £246 million –	**Complete**	This has been completed and approach will continue in 2024/25.

	and protect 25% of Quality and Outcomes (QOF) clinical indicators.		
14	Reduce unnecessary bureaucracy and administrative burdens placed upon General Practice to free up time for patients through the bureaucracy busting concordat.	**On track**	DHSC work ongoing with other government departments.

Annex 3: 2024/25 funding streams

Further funding will be available to in 2024/25 to support the continued delivery of the delivery plan for recovering access to primary care including

- transition cover and transformation support
- General Practice Improvement Programme (GPIP)
- support the uptake of digital tools through digital pathways (DP framework)
- funding to support the continued roll-out of Pharmacy First

Confirmation of allocations (where applicable) and further detail of funding flows will follow as soon as possible.

In addition, there a number of funding streams which are available to PCNs and which support their role in primary care transformation:

Maximum network funding available (per Ready Reckoner)

Funding available per registered patient (unless otherwise stated)	**23/24**	**24/25**
1. Core PCN Funding (in 24/25 Clinical Director Funding and Leadership and Management Support are combined into a single Core Funding Payment).	£2.913	£2.916
2. Additional Roles Reimbursement sum (on a weighted patient basis).	£22.671	£22.894
3. PCN Care Home Premium £120 per bed (£10 per bed per month), based on CQC data on beds within services registered as care home services with nursing (CHN) and care home services without nursing (CHS) in England.	£120.000	£120.000
4. Enhanced Access (PCN Adjusted Population basis).	£7.578	£7.674
5. Impact and Investment Fund based on 90% achievement and £198 per point. Actual income will depend on PCN performance).	£0.947	£0.206
6. PCN Capacity and Access Support Payment (based on funding of £204.4m and is paid per PCN Adjusted Population at 1 January 24).	£2.765	£3.248
7. PCN Capacity and Access Improvement Payment (paid to PCNs according to the requirements of the PCN DES Specification. Indicative maximum figures in the calculator tab are based on funding of £87.6m divided by England total PCN Adjusted Populations at 1 January 2024).	£1.185	£1.392

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

LeDeR: Learning from Lives and Deaths of People with a Learning Disability and Autistic People

Shropshire, Telford & Wrekin

Annual Report

1st April 2023 – 31st March 2024

Document Version Control			
Version	Draft	V0.1	12.04.2024
	Draft	V0.2	30.04.2024
	Draft	V0.3	19.05.2024
	Final	V1.0	13.06.2024
Document History	**LeDeR Steering Group:** 12.04.2024 & 19.05.2024		
	System Quality Group: 23.05.2024		
	Quality Performance Committee: 30.05.2024		
	Shropshire Telford & Wrekin Integrated Care Board: 26.06.2024		
Approved by			
Date approved			
Author(s)	**Jen Morris**, Quality Lead Learning Disabilities & Autism, Deputy Local Area Contact (LAC) STW LeDeR Programme **Tracey Slater**, Interim Deputy Chief Nursing Officer, Local Area Contact (LAC) STW LeDeR Programme		
Senior Responsible Lead (SRO)	**Vanessa Whatley**, Chief Nursing Officer		

Table of Contents

Title	Page(s)
Executive Summary	4
Credits and Acknowledgements	5
Glossary of abbreviations	6
Introduction to LeDeR	7
Life expectancy & Health inequalities	8
LeDeR process	9
LeDeR reviews	10
LeDeR Governance Panel & Steering Group	11
Governance process	12
Child Deaths	13
Equality impact and Demographic data	14
Summary of death notifications in 2023/24	15
Notifications by month	16
Who is reporting deaths to LeDeR	17
Level of Learning Disability	18

Title	Page(s)
Focused reviews 2023/24	19
Ethnicity	20
Gender	21
Diagnoses	22
Age at death	23
Median age at death	24
Place of death	25
Lead cause of death	26
Long term conditions	27
End Of Life Care (EOL)	28
DNACPR/ReSPECT	29
Poor use of MCA/BI/ReSPECT	30
Comparison of notifications and median of age since the start of LeDeR.	31
Quality of Care from reviews	32
Availability & Effectiveness of services from reviews	33

Title	Page(s)
Improving Care	34
Learning opportunities from local reviews 2023/2024	35
Positive Practice from local reviews 2023/2024	36
Key themes from reviews	37
STW System Wide: LeDeR Priorities Action Plan	38
Clive Treacey	39
Oliver McGowan	40
Annual Health Checks	41
Updates and key progress from2022-23	42
Challenges	43
STW Priorities for 2023/24	44
Recommendations and Next Steps for 2024-25	45
Conclusion	46
Appendices & Resources	47-50

Executive Summary

Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) is a service improvement programme for people with a learning disability and autistic people established in 2017.

The programme seeks to:

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

Throughout 2023-24, Shropshire Telford & Wrekin Integrated Care Board (NHSSTW) has worked with a range of stakeholders to continue delivery of the LeDeR programme across our county. This has been done by carrying out a review after the notification of the death of any individual with a learning disability and/or autistic person then using the learning from each review to drive improvements in care for our people.

Each LeDeR review we have completed during 2023-24 has looked at key episodes of the individual's life and death to identify any challenges in access, provision, and delivery of care. Understanding the lived experience of people with learning disabilities and/or autistic people is central to the LeDeR programme, and our reviewers have actively sought to engage with family members and carers in each of the reviews they have carried out.

During 2023-24 NHSSTW was notified of 21 adult deaths of people with a learning disability and or/autistic people who lived in Shropshire Telford & Wrekin. A total of 21 LeDeR reviews were progressed during the year. The median adult age of death was 50 years a reduction from 2022/23. The report also shows a reduction in LeDeR notifications received compared to 2022-23. It should be kept in mind that a referral to the LeDeR programme, although strongly recommended, is not mandatory so does not have complete coverage of all deaths of people with a learning disability and autistic people and the numbers are small so must be interpreted with caution; findings and comparisons must be considered indicative rather than conclusive. A priority for the LeDeR programme for 2024-25 is to work with system partners, parents and carers groups and the voluntary sector to increase to number of notifications.

Findings from 2023/24 shows the lead cause of death as aspiration pneumonia, this accounts for 19% of all deaths reviewed. 14% of deaths were linked to bronchopneumonia and 9% of deaths were linked to epilepsy and 9% were linked to cancer. Level of disability linked to reviews showed 16% of individuals had a mild learning disability, 37% a moderate learning disability, 32% a severe learning disability, 10% profound learning disability and 5% the level was not documented. Ethnicity linked to reviews shows 90% of individuals were white British, 5% Bangladeshi and 5% Chinese.

During 2023/24 we have continued to work with a range of partners to co-produce activities that respond to the learning from reviews, and this is set out in the sections below. During 2023-24 we have worked with system partners to collate a systemwide action plan for the Clive Treacey recommendations, further detail is in the slides below and Clive Treacey recommendations are aligned to our local priorities and will continue to be a focus for 2024-25.

We can demonstrate our ongoing commitment to learn from LeDeR reviews and implement meaningful change and improvement initiatives to meet the aim of the LeDeR programme. The aim remains for people with a learning disability and autistic people across STW to enjoy good health and good care, and to no longer experience health inequalities or die from preventable causes.

Credits and Acknowledgements

We would like to thank the families, friends, carers and health and social care professionals who have provided critical contributions to each LeDeR review. Their support has been invaluable and without their input, the reviews and learning would not have been possible.

Special thanks to:

- Members of the LeDeR Steering Group and Governance Panel
- Primary Care colleagues across Shropshire Telford and Wrekin
- Our provider trusts: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH); The Shrewsbury and Telford Hospital NHS Trust (SaTH); Shropshire Community Health NHS Trust (SCHT); and Midlands Partnership University NHS Foundation Trust (MPUFT)
- Shropshire Telford & Wrekin Child Death Overview Panel (CDOP)
- Shropshire Council and Telford & Wrekin Council
- NHS South Central and West Clinical Support Unit
- NHS England national & regional teams
- Marilyn Jones, parent care and member with lived experience
- Rob Gough as parent care and member with lived experience
- Mrs J Hampton-Pidgeon as LeDeR programme administration support.

Glossary of abbreviations

A	Autism
AHC	Annual Health Check
CDOP	Child Death Overview Panel
CIPOLD	Confidential inquiry into premature deaths of people with learning disabilities
CLDT	Community Learning Disability Team
CYP	Children & Young people
DNACPR	Do not attempt cardiopulmonary resuscitation
GP	General Practitioner
HAP	Health Action Plan
ICB	Integrated Care Board
ICS	Integrated Care System
LAC	Local area contact
LD	Learning Disability
LeDeR	Learning from Lives and Deaths of People with a Learning Disability and/ or Autism
NHSE	National Health Service England
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SaLT	Speech and Language therapist
SCW CSU	South Central & West commissioning support unit
SMART	Specific, measurable achievable, realistic and timebound actions
STW	Shropshire Telford and Wrekin
QA	Quality Assurance

Introduction to LeDeR

LeDeR was established in 2017 and was one of the key recommendations of the confidential inquiry into premature deaths of people with learning disabilities (CIPOLD). CIPOLD reported that some people with learning disabilities were dying sooner than they should. Some of the reasons for this were related to the standard of health & social care that individuals received. The learning from deaths – people with a learning disability and autistic people (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and autistic people and reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives. The scope of LeDeR is that every adult aged 18 and over with a learning disability or with a clinical diagnosis of autism is eligible for a LeDeR review when they die.

The key principles of the programme are to:

Life expectancy & Health inequalities

Life expectancy

On average women with a learning disability die 23 years younger than women in the general population and men with a learning disability die 19 years younger than men in the general population (LeDeR, 2023; ONS, 2022). Nationally there is not accurate data for the life expectancy for autistic people.

LeDeR is part of the system and national wide context linked to the NHS Long Term Plan, which aims to improve people's health. A number of barriers are preventing people with a learning disability and or autism from getting good quality healthcare.

Health inequalities

Are the unfair differences in the status of people's health and wellbeing that frequently arise from the disparities and difficulties for people with a learning disability and/ or autistic people when they attempt to access health and/ or social care. These are known to result in poorer outcomes. These inequalities are what damage the level and effectiveness of care that people receive and reduce the opportunities for them to lead not only healthy but also their best lives.

LeDeR Process (see appendix 1)

1) Notifying a death: When a person with a learning disability or an autistic person dies a LeDeR death notification should be completed.
2) Allocation to reviewer for completion: At this stage it is assigned as an initial or a focused review (see next slide for further information)
3) The reviewer will then prepare for the review and access information relating to individuals care and treatment.
4) The reviewer will then contact family members & professionals
5) The reviewer will conduct the review
6) The review to be quality assured (QA) by a senior reviewer
7) The completed review is then sent to the LAC/deputy LAC for QA
8) If it is an initial review, following the QA by the LAC/deputy LAC, the review can be signed off on the LeDeR platform
9) If a focused review, following the QA by the LAC/deputy LAC the review is presented at ICS Governance Panel.

Where to notify a death

Report the death of someone with a learning disability or an autistic person (leder.nhs.uk)

LeDeR Policy

NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021

LeDeR reviews

Types of reviews

- **Initial Review:** The initial review is intended to be a short assessment to see if there is a need to progress to a focused review.
- **Focused review:** The focused review builds on the initial review. It asks for more information about known medical conditions and the social care the person received. There is also an opportunity to describe challenges or good practice around the care the person received.

Categories for a Focused review

- All autistic people who do not have a learning disability aged 18 and above
- People from ethnic groups other than white British (including travellers, Jewish people and other white backgrounds)
- People who have been in a detained setting in the criminal justice system /or who have been under a Mental Health Act restriction within five years of death
- Following an initial review where there is likely to be significant learning from the life of the person to inform service improvements
- Local priorities for focused reviews
- Where the family have requested a focused review
- Where there are any concerns about the care the person received.

LeDeR Governance Panel & Steering Group

Table 1

Core Membership
Family members who are carers or a family member who are members with lived experience.
Local Area Contact (LAC) and deputy LAC – who will have a key role in chairing the panel.
The Shrewsbury and Telford Hospital NHS Trust (SaTH),
Shropshire Community Health Team (SCHT)
The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH).
Midlands Partnership University NHS Foundation Trust (MPUFT).
ICB including Individual Commissioning Team
Primary Care
Shropshire Council and Telford & Wrekin Council

The LeDeR Governance Panel meets monthly and is chaired by the deputy LAC. The LeDeR Steering Group originally met bi-monthly, but it was felt that priorities needed to be discussed more frequently, therefore from January 2024 they are held monthly and chaired by the LAC.

Table 1 lists the core representatives that attend the LeDeR Governance Panel and the LeDeR Steering Group

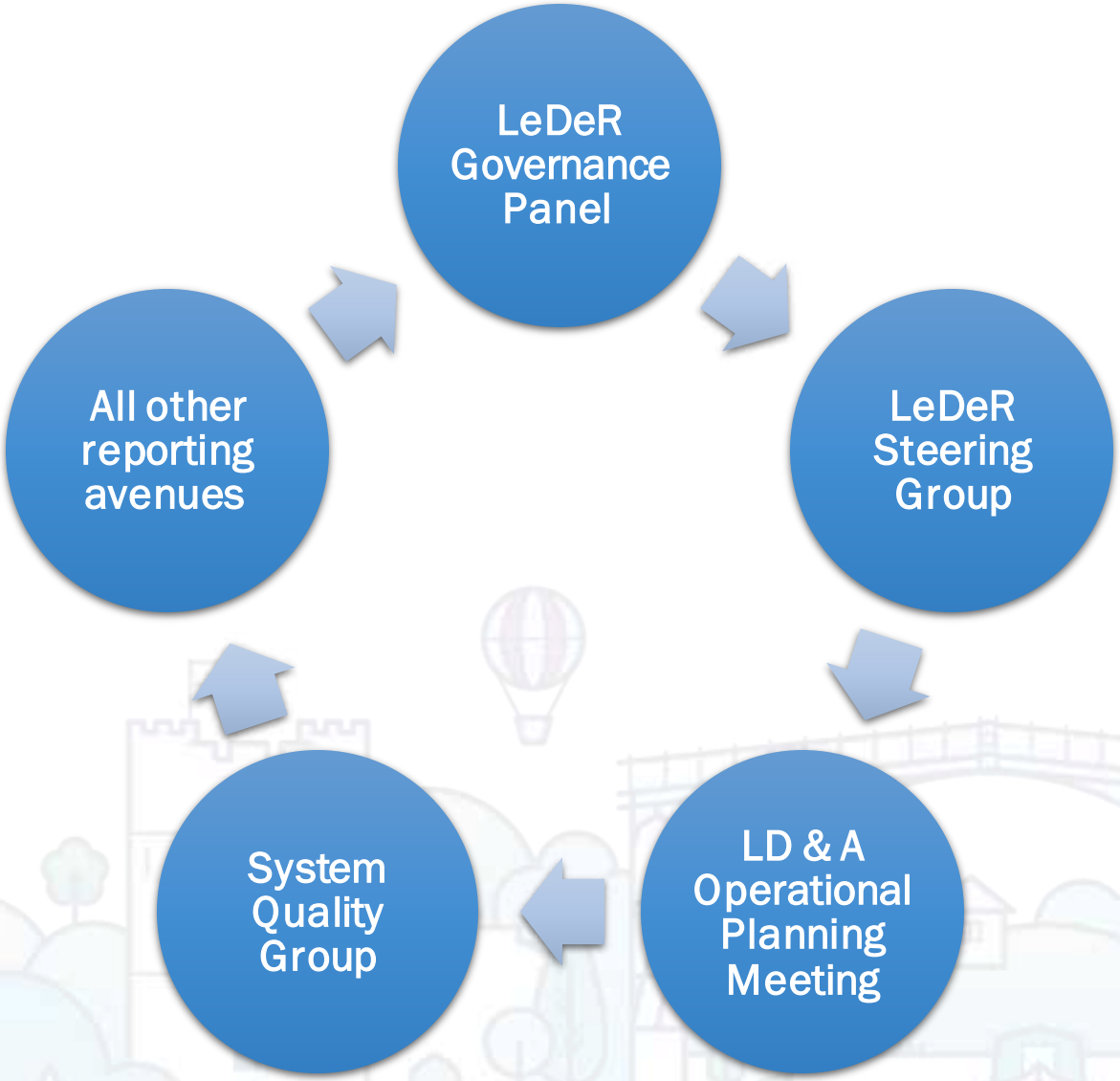
System partners who are members of both groups are expected to attend all meeting or to send a deputy who has decision making powers for the organisation they are representing.

Table 2 lists the 'as required' members who are invited to the LeDeR Governance panel should a case include the teams listed.

Table 2

As required
West Midlands Ambulance Service University NHS Foundation Trust (WMAS)
Screening Services
Police representative
Mental Health Team Providers
Senior Reviewers and respective reviewers as per the listed reviews on the agenda
Any other teams linked to specific cases

Governance Process



All focused reviews are presented at the LeDeR Governance Panel who sign off the quality of the reviews and in discussion with the reviewer, agree specific, measurable, achievable, realistic and timebound (SMART) actions.

SMART actions feed into the system wide LeDeR Priorities Action Plan which is the responsibility of the LeDeR Steering Group.

Updates are reported to the:

- STW Learning Disabilities & Autism Operational Planning Meeting
- STW System Quality Group

Updates also feed into:

- STW Health Inequalities implementation plan
- NHS England quarterly reports

Child Deaths

From the 1st July 2023 the LeDeR policy regarding the review of deaths of children and young people aged 4 to 17 changed and there was no longer a requirement for deaths of children to be notified to the LeDeR programme.

This change was made because it was felt that the deaths of children with a learning disability and autistic children are reviewed by the national mandated processes that look at the deaths of all children.

Autism was also added to the national child mortality review child notification which will enable more in-depth analysis of the deaths of autistic children and young people for the first time.

The deputy LAC in NHS STW has close links into the CDOP process and attends panels when requested .

Equality impact and Demographic data

Table 3

According the office of national statistics following the 2021 census:	
Population of Shropshire Telford & Wrekin	509,100
Population of Shropshire	323,600
Population of Telford & Wrekin	185,500

Table 4

Data from the general practice registers shows:	
People aged 14 and over registered with a learning disability in STW.	2684
People across STW with autism,	5595 (2384 of which are under the age of 18.)

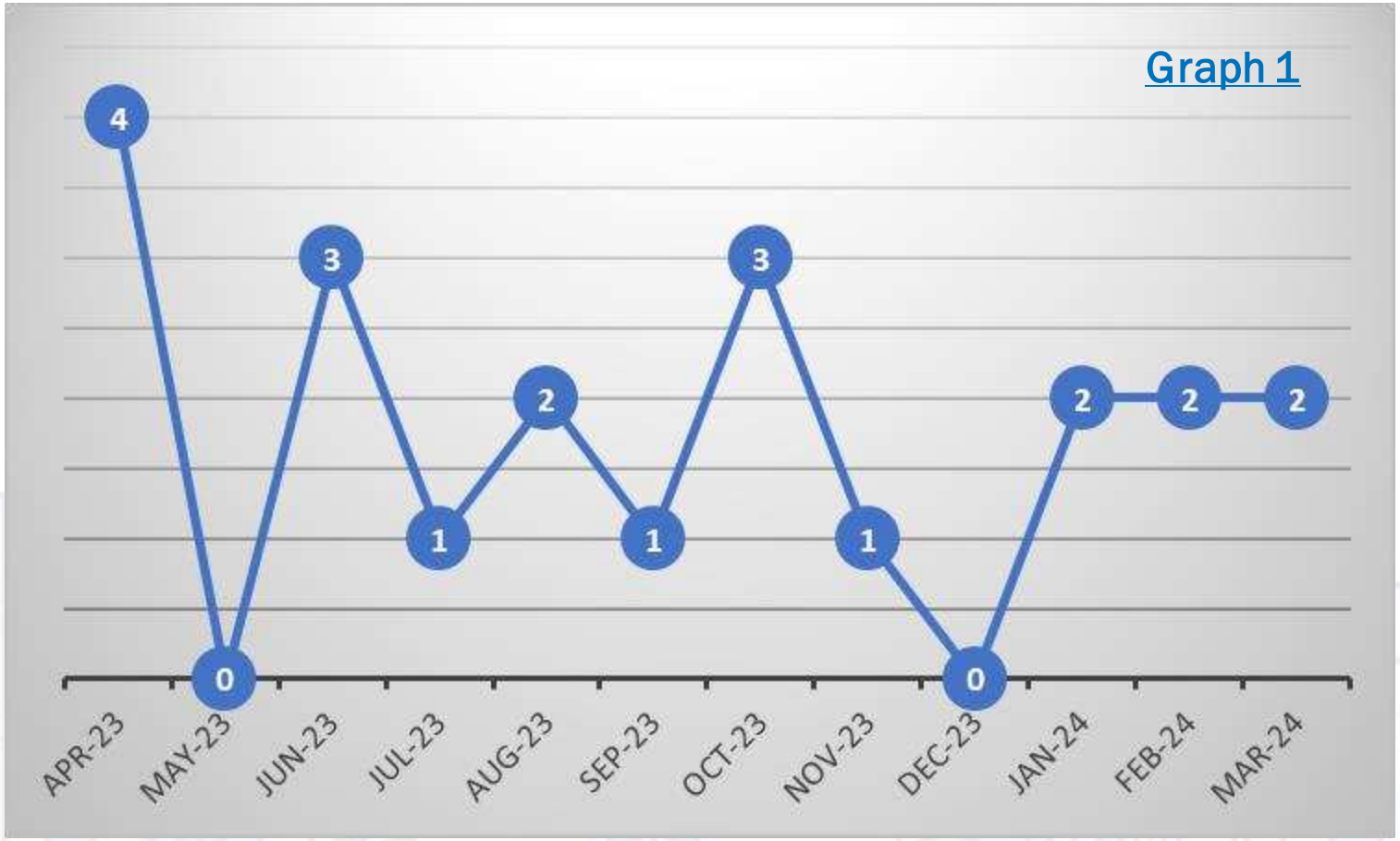
Summary of death notifications in 2023/24

Table 5

Total adult notifications 1st April 2023 – 31st March 2024	21
Total child death notifications 1st April 2023 – 31st March 2024	1
Completed reviews in 2023/24 (excluding child deaths) **please note some reviews completed in this period may have been carried forward from previous years.**	21
Number of initial reviews completed	6
Number of focused reviews completed	15
Number of reviews on hold	3

Notifications by month

The highest number of LeDeR notifications received for 2023-24 was in April 2023 (4), closely followed by June 2023 (3) and October 2023 (3). There were no notifications received in May 2023 or December 2023. As per slide 33, STW have seen a decline in notifications for 2023-24 compared to previous years.



Who is reporting deaths to LeDeR

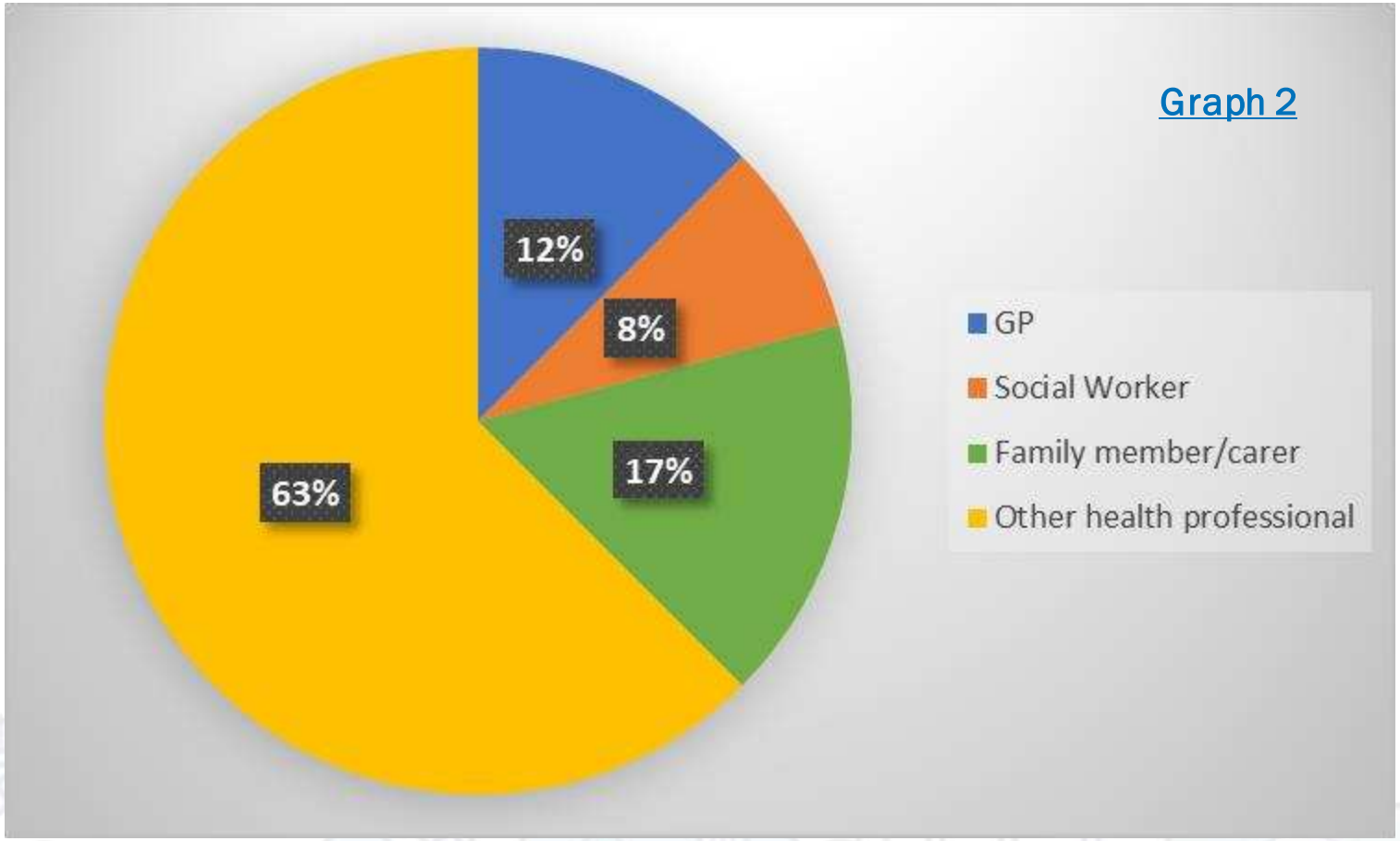
Table 6 Out of the 21 completed cases:

Notifier	No of notifications
GP's	3
Social Workers	2
Family members/carers	4
Other health professionals	15

Other health professionals could be:

- Clinical lead
- Nurse Specialist
- Mental Health Nurse
- Acute Liaison Nurse
- Assistant Psychologist
- Learning Disability Nurse
- Nurse Practitioner
- Speech and Language Therapist
- Learning from Deaths Lead

Graph 2



Please note the number of notifications will equal more than 21. This is due to more than 1 person submitting a notification to LeDeR for 4 of the cases.

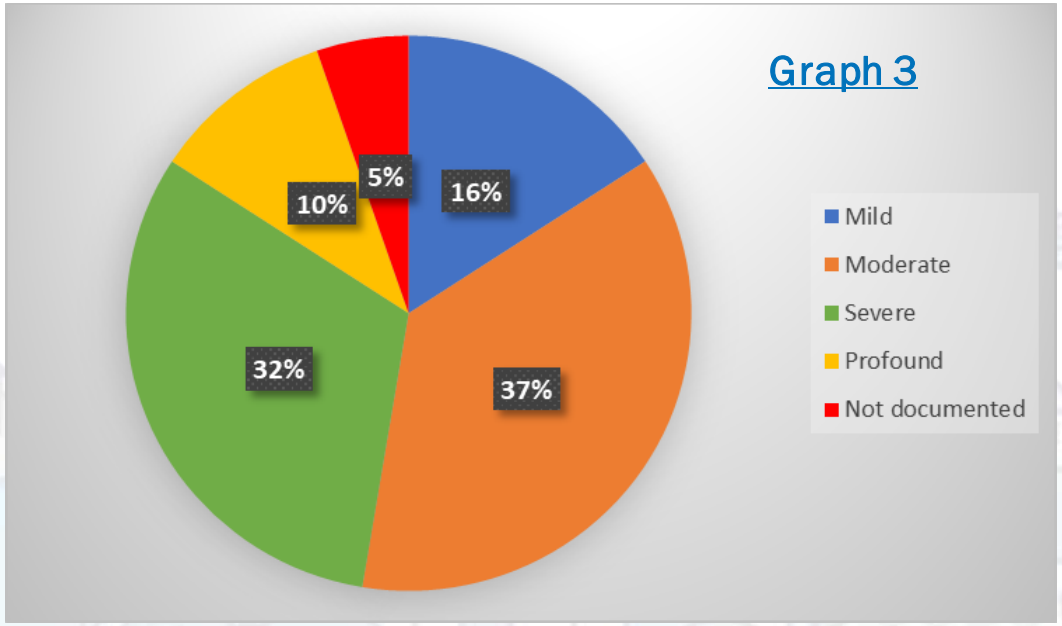
Level of Learning Disability

Table 7

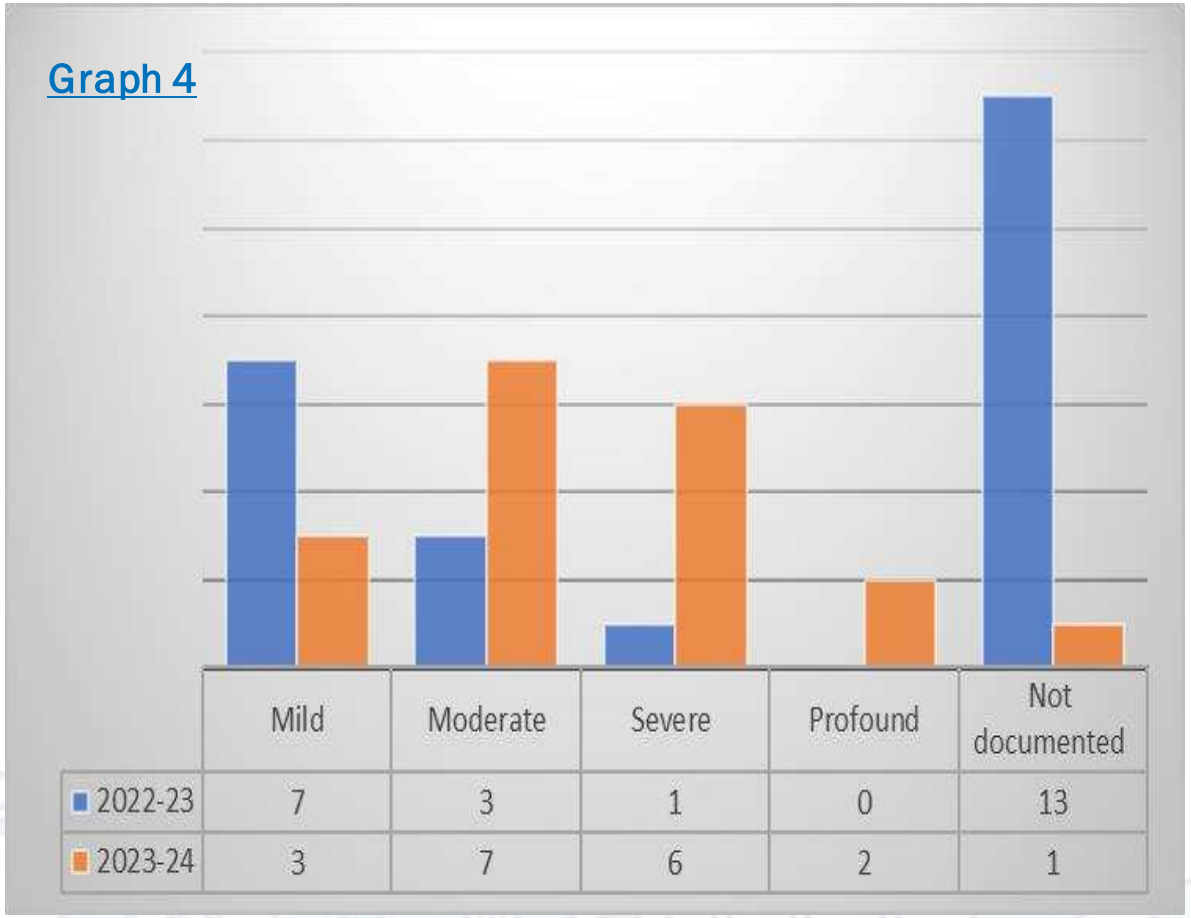
Level of learning disability	Number of people	Percentage
Mild	3	16%
Moderate	7	37%
Severe	6	32%
Profound	2	10%

1 case did not document the level of the learning disability.

Graph 3

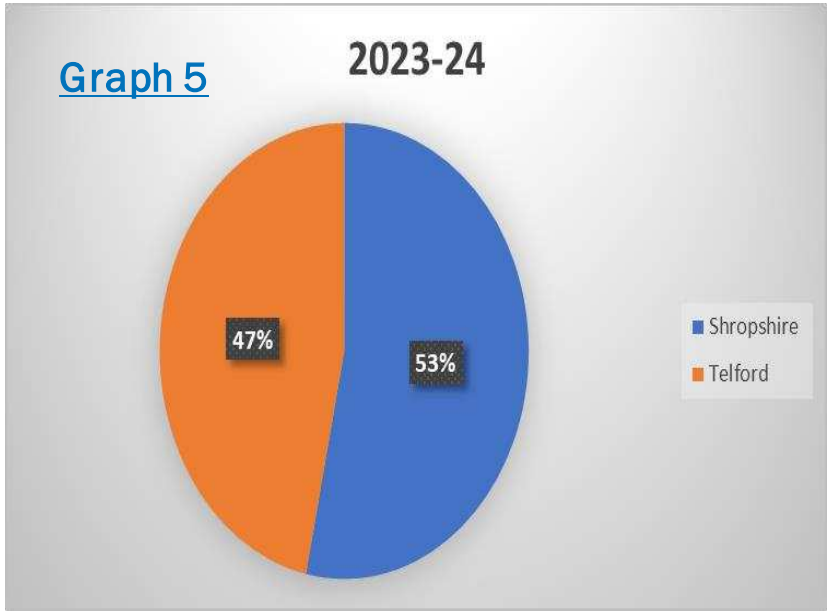


Graph 4



Graph 4 shows a comparison of this data to last year. This year's data is showing a significant improvement in the level of learning disability reporting.

Focused reviews 2023/24

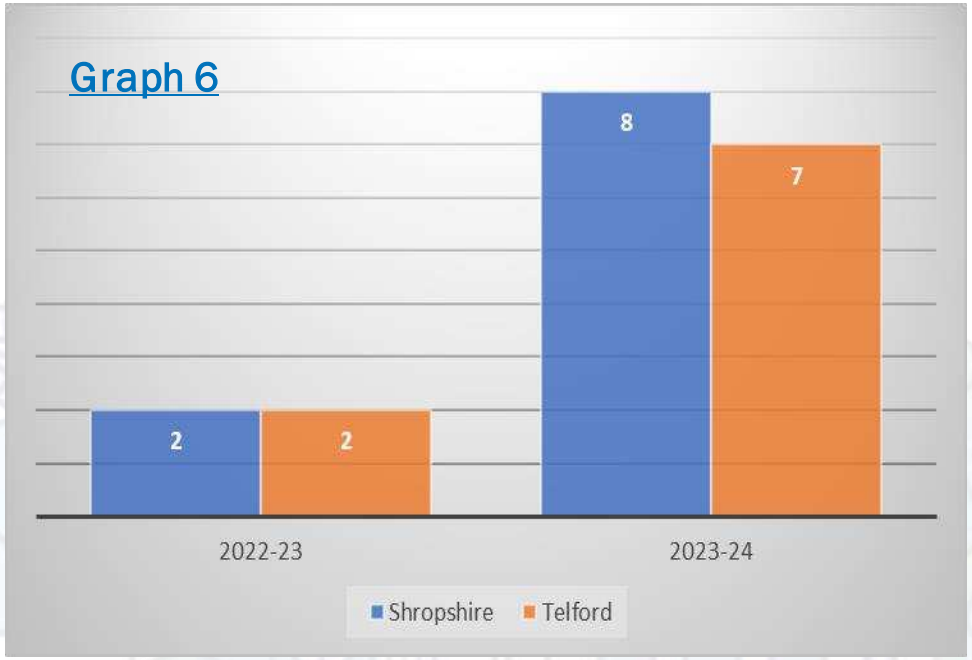


The number of focused reviews completed in 2023-24 was **15**.

Compared to last year where only **4** of the reviews completed were focused reviews.

Graph 5 shows that, 8 of the 15 reviews were from Shropshire (**53%**) and 7 of the 15 reviews were from Telford & Wrekin (**47%**).

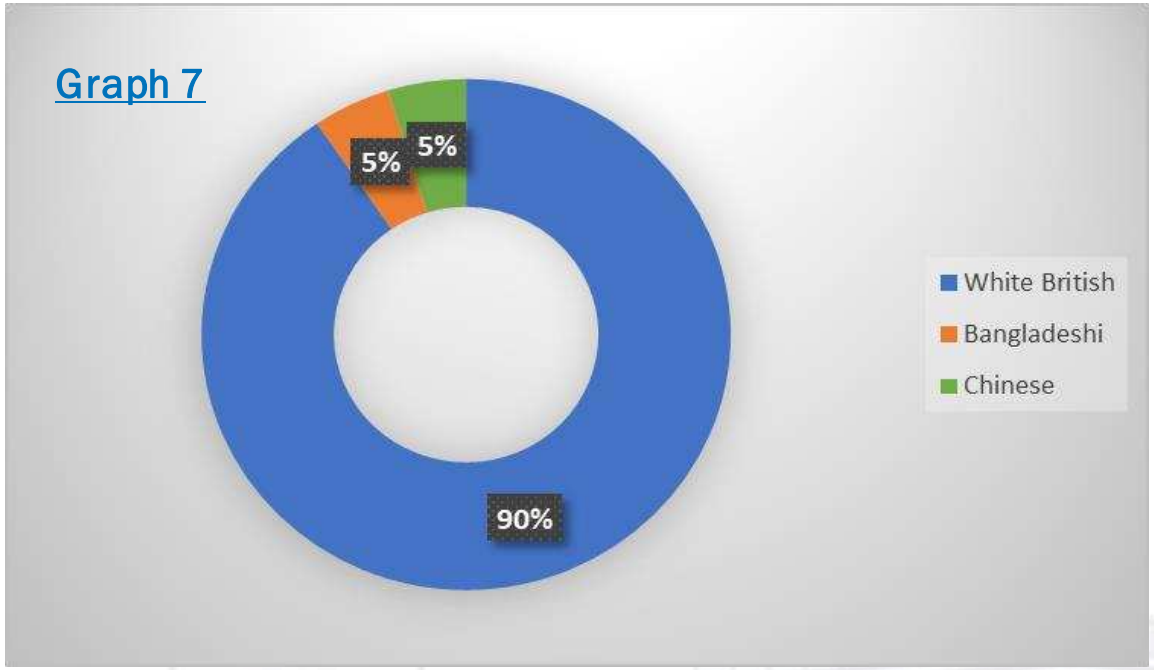
Graph 6 shows last year's data was a **50-50** ratio of reviews per locality with **2** linked to Telford & Wrekin and **2** to Shropshire.



Ethnicity

As per graph 7, of the 21 completed reviews, 19 (90%) were white British. 1 was Bangladeshi and 1 was Chinese.

Graph 7



As an ICS we need to do more to ensure we are receiving notifications for our whole community to try to understand more about the potential impact of ethnicity on health inequalities of people with a learning disability or autistic people.

Table 8

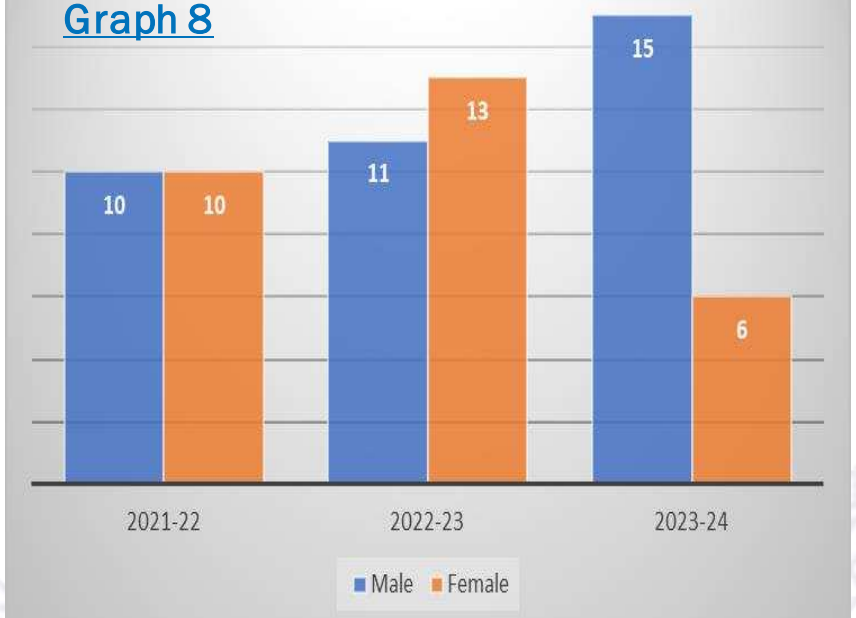
Ethnicity	2021-22	2022-23	2023-24
White British	14	22	19
Other	5	2	2

An individual's ethnicity was not recorded as part of the LeDeR review until 2021, therefore we do not have this data prior to then. In 2021 a platform development occurred for this data. The ethnicity from a majority of LeDeR cases from 2021 was recorded as white British, where the table states other, this could mean another ethnicity, the information was not available or not disclosed.

Gender

Nationally there are more deaths of males than females. As shown in graph 9, across Shropshire Telford & Wrekin there are significantly more male deaths (**71%**) than female deaths (**29%**) compared to last year where there were slightly more female deaths than male deaths.

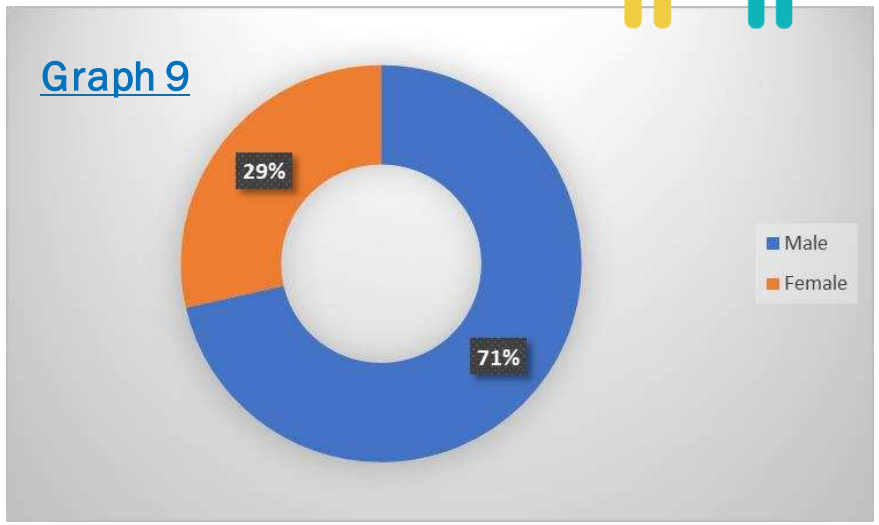
Graph 8



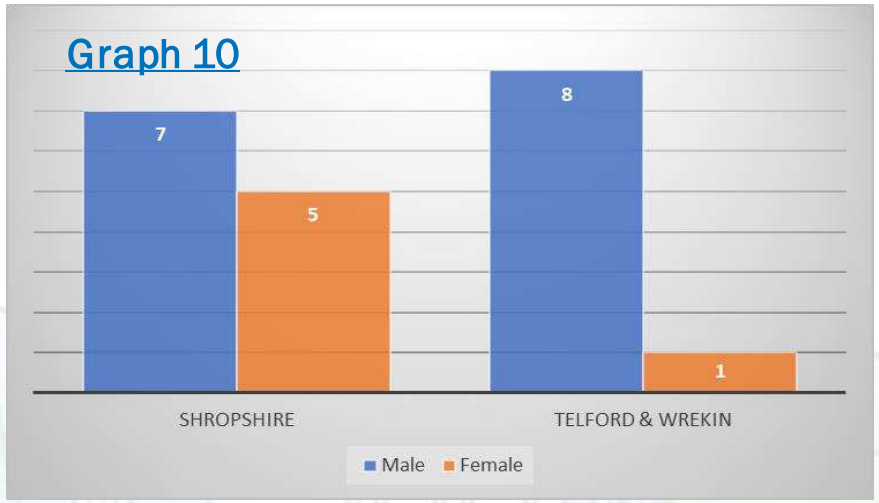
A breakdown of gender was not recorded as part of the LeDeR review until 2021, therefore we do not have this data prior to then. As a comparison from 2021, there has been an increase in male deaths as shown in graph 8.

With a further breakdown of region, more females died in Shropshire than in Telford & Wrekin and slightly more men died in Telford & Wrekin than Shropshire as shown in graph 10.

Graph 9

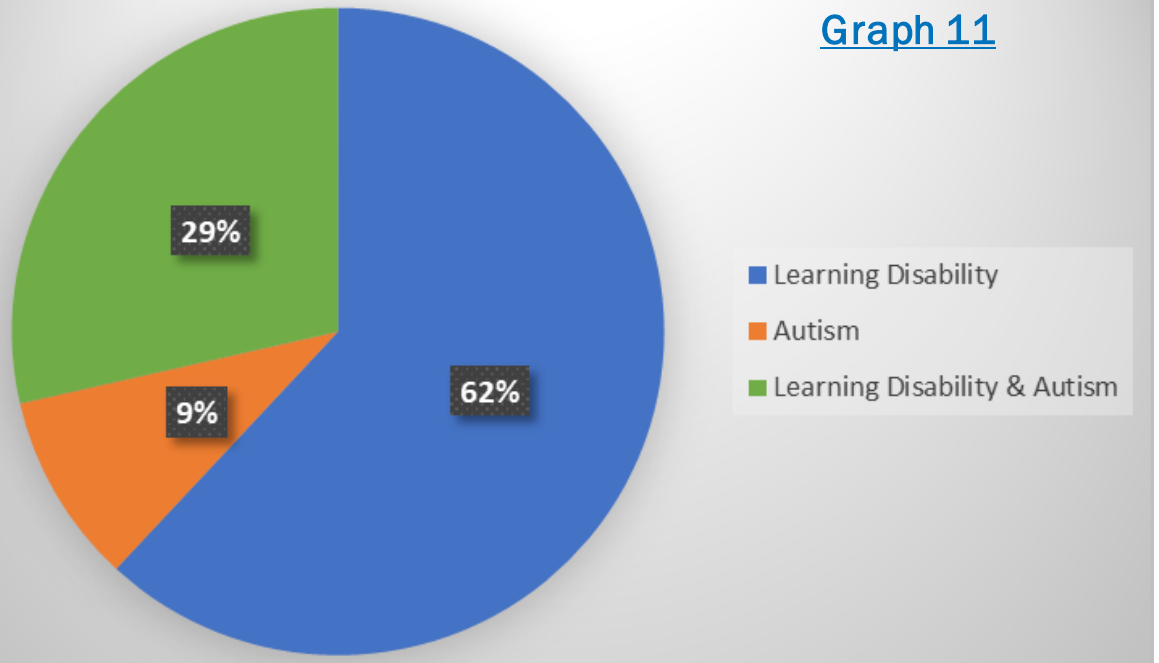


Graph 10



Diagnoses

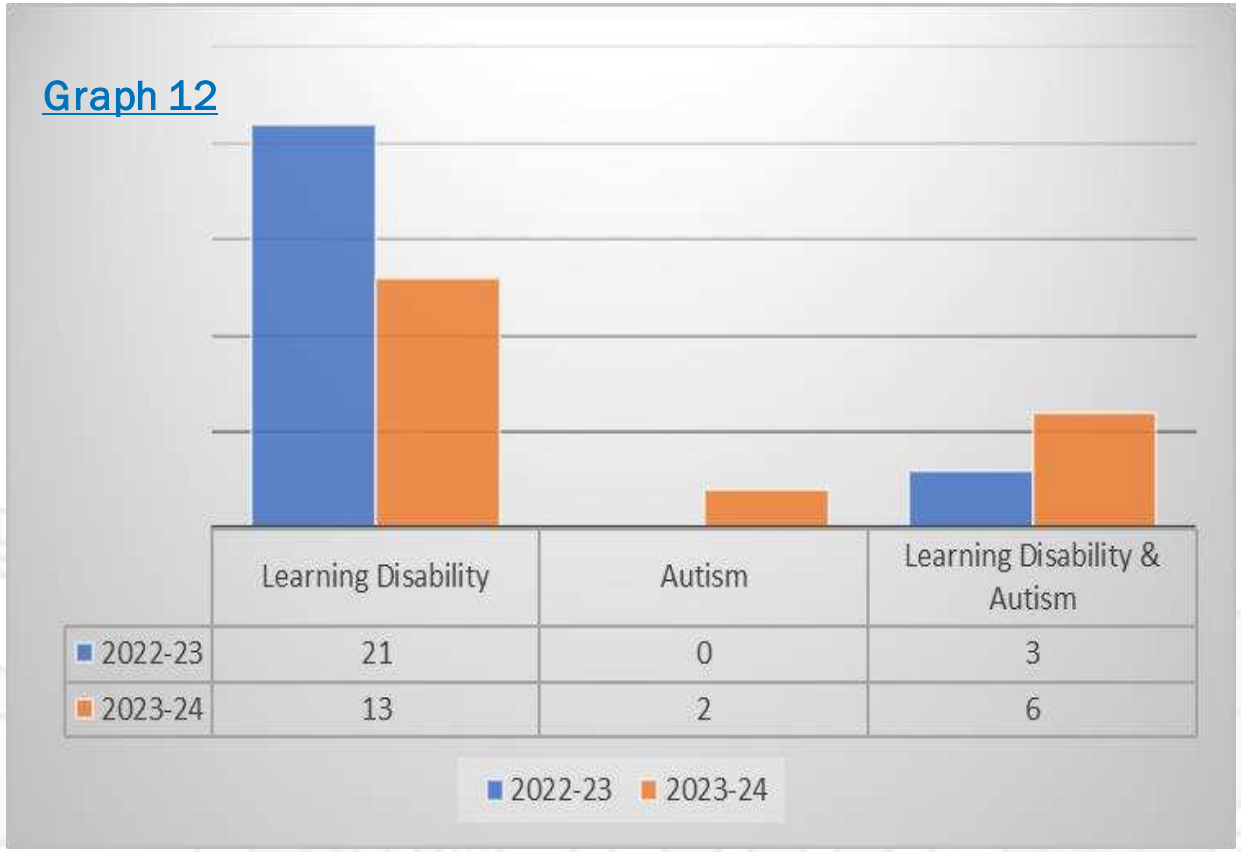
Graph 11



As per graph 11, 13 people (**62%**) had a learning disability only diagnosis, 6 people (**29%**) a diagnosis of both a learning disability and autism and 2 people (**9%**) had a diagnosis of autism only.

Graph 12 shows a comparison from 2022-23, this data was not reported for the period of 2021-22.

Graph 12

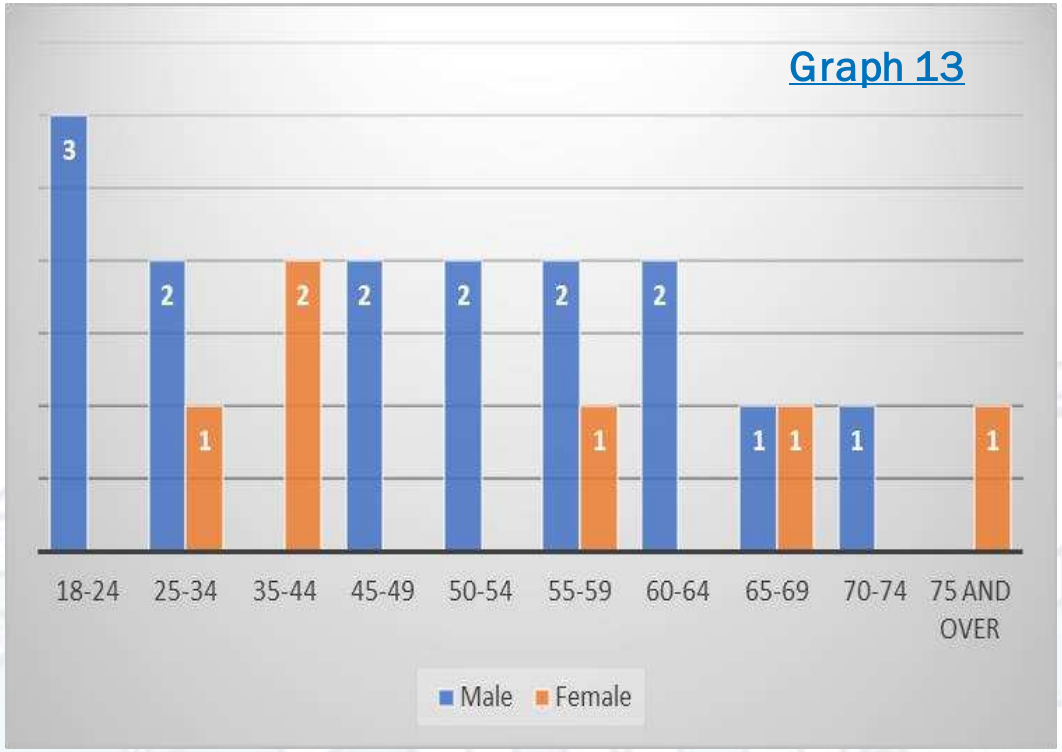


	Learning Disability	Autism	Learning Disability & Autism
2022-23	21	0	3
2023-24	13	2	6

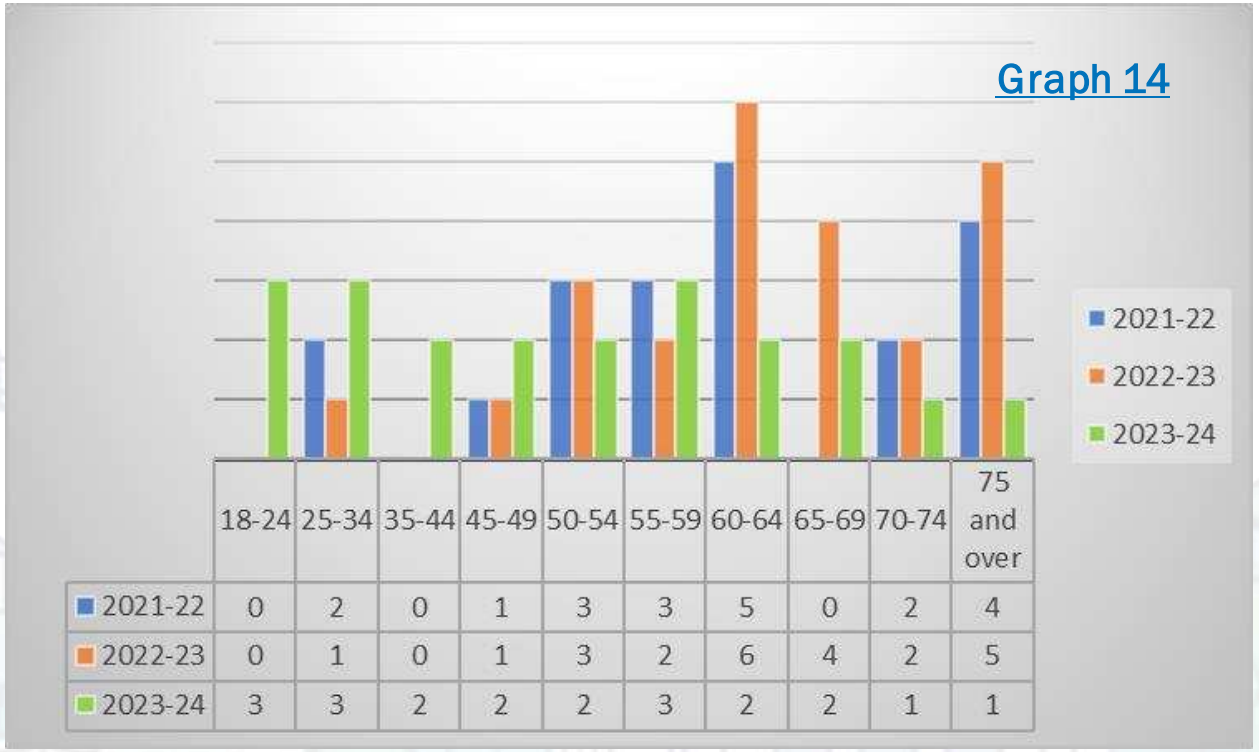
Age at death

Graph 13 shows the age range of all 21 reviews that were completed. The age of death was not recorded for completed LeDeR reviews until 2021, therefore we do not have this data prior to then. Graph 14 shows a comparison from 2021, which shows an increase in individuals dying younger in STW.

Graph 13



Graph 14



	18-24	25-34	35-44	45-49	50-54	55-59	60-64	65-69	70-74	75 and over
2021-22	0	2	0	1	3	3	5	0	2	4
2022-23	0	1	0	1	3	2	6	4	2	5
2023-24	3	3	2	2	2	3	2	2	1	1

Median age at death

Table 9

No	Age ranges
1	18
2	21
3	22
4	27
5	32
6	33
7	35
8	43
9	45
10	49
11	50
12	54
13	55
14	55
15	55
16	62
17	62
18	68
19	69
20	70
21	79

Nationally the median age of death for the reporting period 2022-23 for a person with a learning disability is **62.9** years. Data for 2023-24 is not yet available, the median age for STW for 2022-23 was **62**.

As shown in table 9, In 2023-24 the median age of death in STW is **50.** This shows a significant decline compared to 2022-23.

Table 10

Male ages	Female ages
18	27
21	35
22	43
32	55
33	69
45	79
49	
50	
54	
55	
55	
62	
62	
68	
70	

Median age for males in STW = **50** years of age

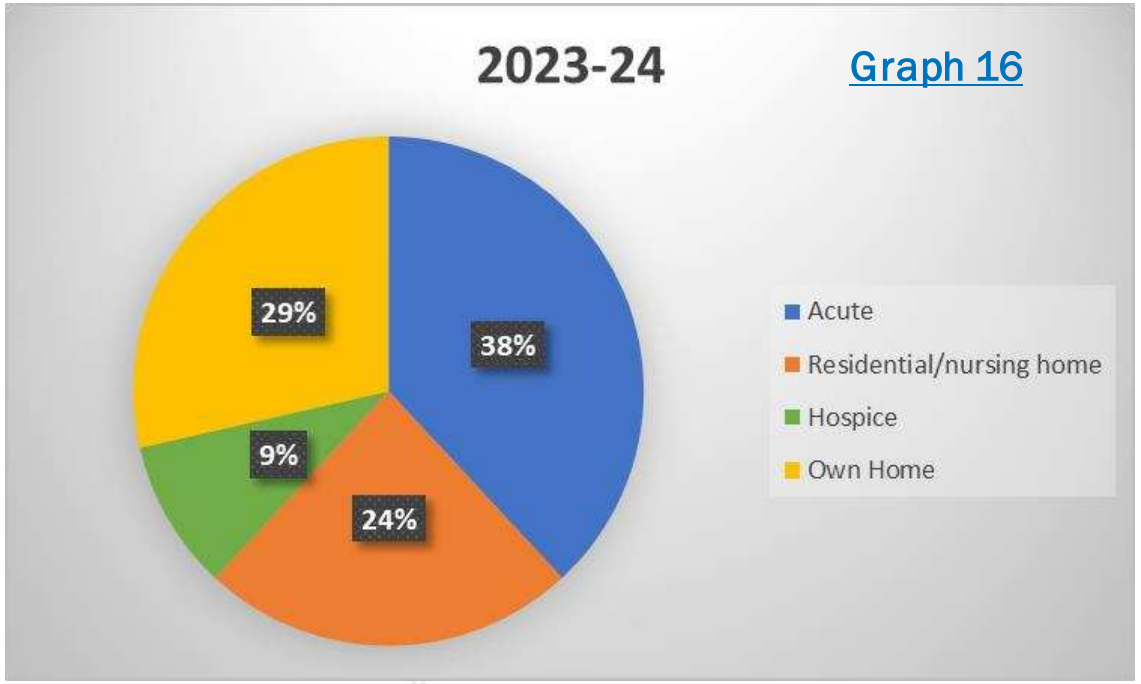
Median age for females in STW = **49** years (43+55 = 98/2)

8 out of the 15 male deaths (**53%**) in STW were ages **50** and under

3 out of the 6 female deaths (**50%**) in STW were aged **50** and under

Place of death

Eleven people (**53%**) died in their usual place of residence, i.e., either their own home (including supported living) or a residential/nursing home. This an increase to 2022-23 where **42%** died in their usual place of residence.



The place of death was not recorded for completed LeDeR reviews until 2021, therefore we do not have this data prior to then. The table to the left shows a comparison from 2021.

Lead cause of death

Table 11 shows the lead causes of death for STW since the start of LeDeR. This highlights that Pneumonia and Dementia have been the lead causes of death since the start of LeDeR.

Table 11

Year	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Cause of Death	Generalised Pneumonia	Pneumonia	Pneumonia	Dementia	Dementia	Aspiration Pneumonia

Table 12

Cause of Death		No. of cases
Aspiration Pneumonia		4
Epilepsy		2
Cancer		2
Sepsis		0
Dementia		0

Table 12 highlights the local priorities for 2023-24 for STW. These were decided based on previous years leading causes of death. As shown for this reporting period the cause of death for **4** cases was Aspiration Pneumonia, **2** cases was epilepsy and **2** was cancer.

Table 13 shows the leading causes of death for this reporting period were **4** as Aspiration Pneumonia and **3** Bronchopneumonia.

Table 13 - Lead cause of deaths 2023-24

Cause of Death	No. of cases
Aspiration pneumonia	4
Bronchopneumonia	3

Long term conditions

Tables 14 & 15 show information taken from the LeDeR platform regarding long-term conditions had reported in the 21 reviews completed.

Table 14

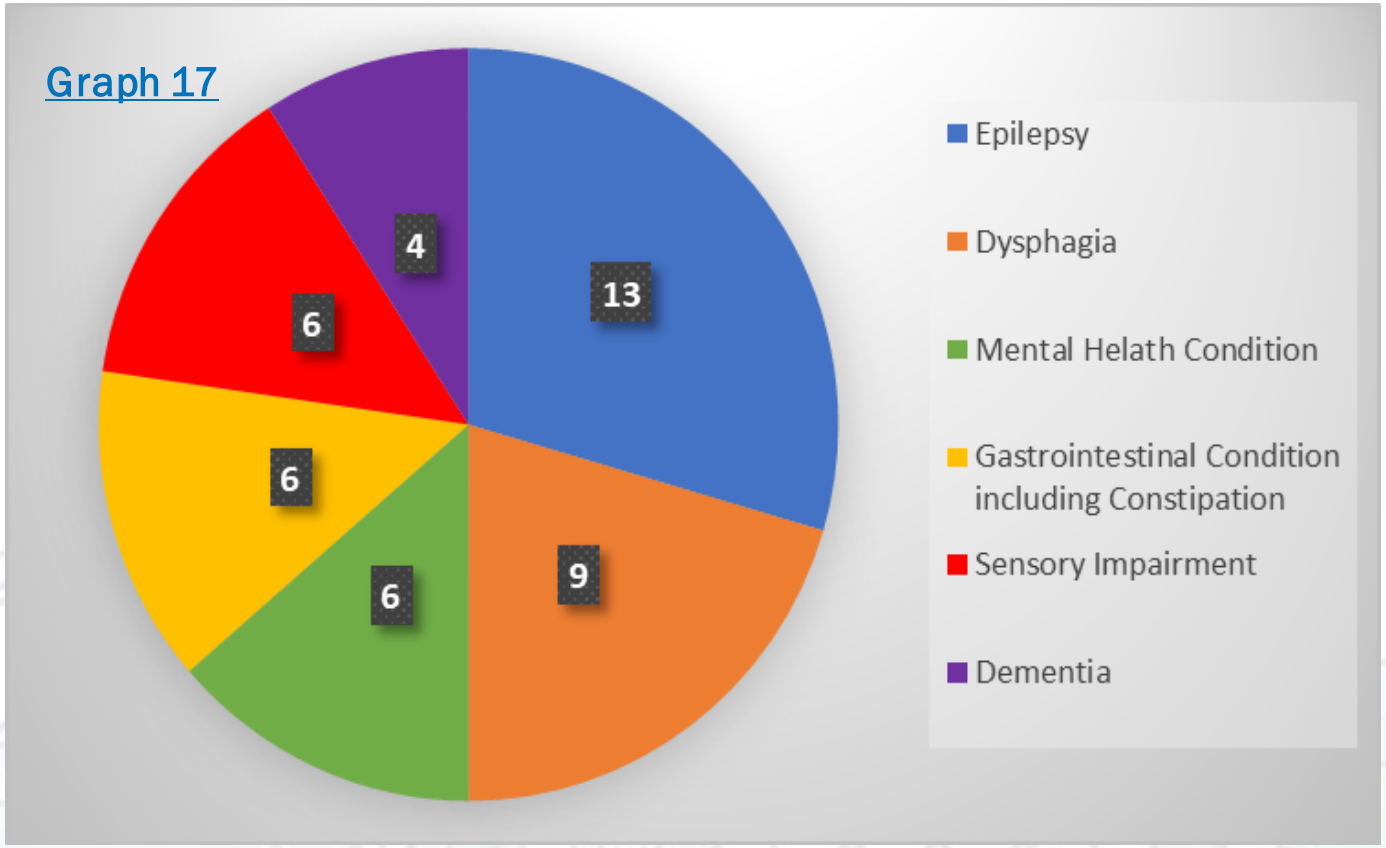
Long term condition	No of cases
Epilepsy	13
Dysphagia	9
Mental Health Conditions	6
Gastrointestinal conditions including constipation	6
Sensory impairment (vision or hearing	6
Dementia	4
BMI over 30	3
Cerebral Palsy	3
Hypertension	3
Asthma/COPD	2
Cancer	2

Table 15

Long term condition	No of cases
Cardiovascular Disease	2
Significant Scoliosis	2
BMI under 18.5	1
Hirschsprung Disease	1
Stroke	1
Hirschhorn Syndrome	1
Chronic Kidney Disease	1
Disorder of Glycoprotein	1
Non-diabetic Hyperglycaemia	1

With Graph 17 showing the most prevalent long-term conditions reported.

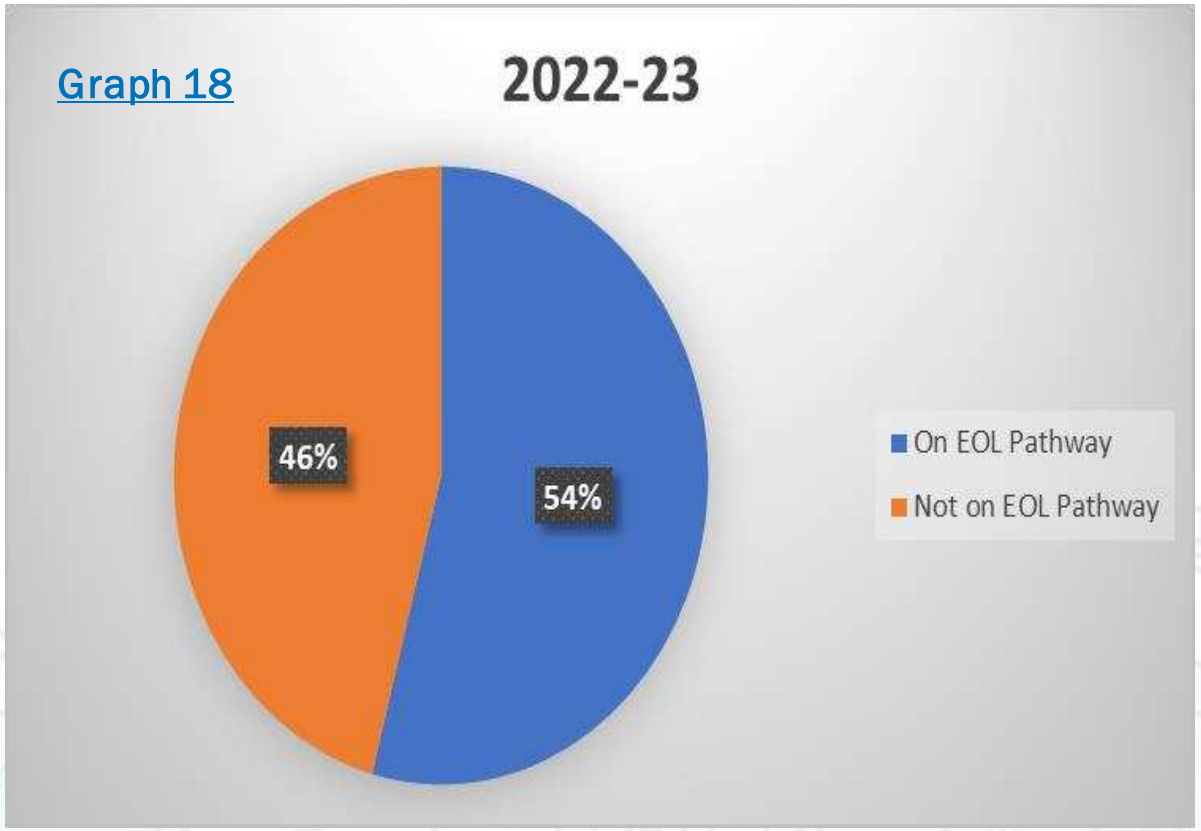
Graph 17



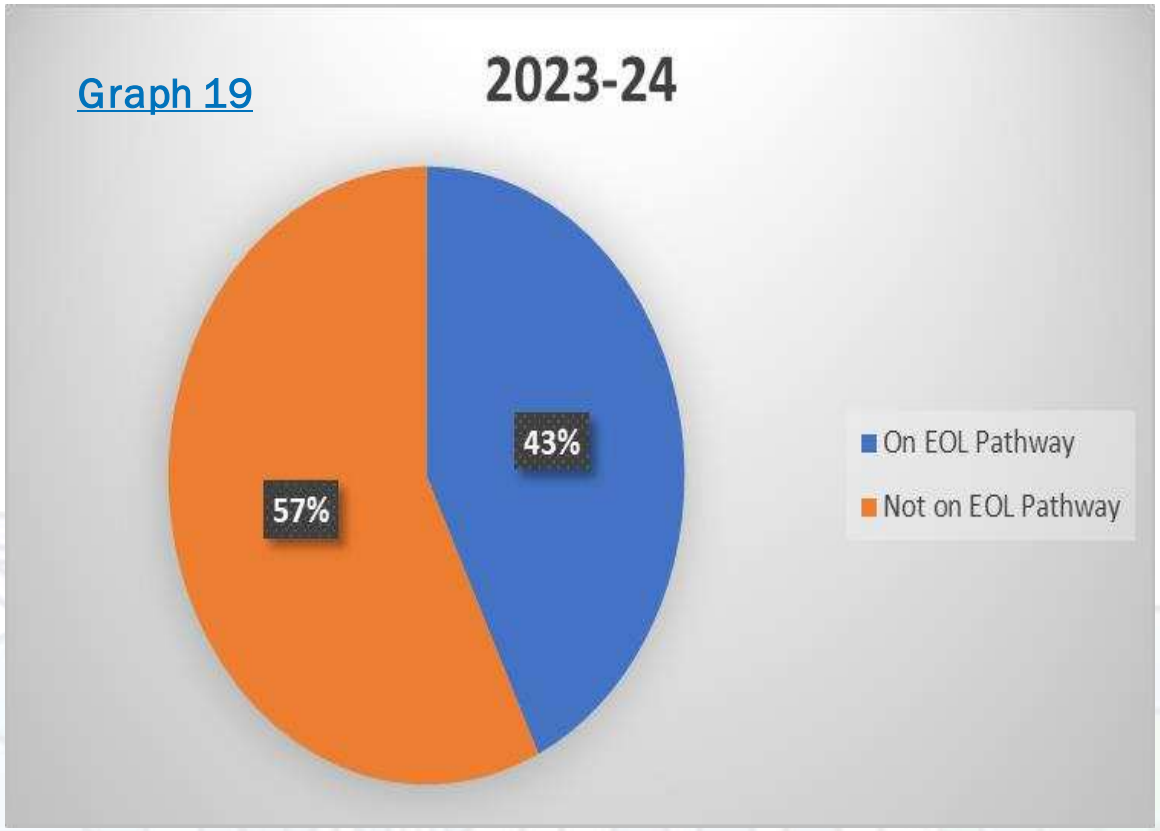
End Of Life Care (EOL)

9 (43%) of the individuals out of the 21 completed reviews were on the End-of-Life Pathway, compared to last year where **13** (54%) of the individuals out of the 24 completed reviews were on the End-of-Life Pathway.

Graph 18



Graph 19



DNACPR/ReSPECT

For 2023-24, **13 (62%)** individuals out of the 21 completed reviews had a ReSPECT document in place and **11 (52%)** of the individuals had a DNACPR in place, which shows a decline from last year 2022-23, where **23 (96%)** individuals out of the 24 completed reviews had a ReSPECT document in place and **22 (92%)**of the individuals had a DNACPR in place.

Poor use of MCA/BI/ReSPECT

Below demonstrates concerns raised from some of the 21 completed reviews.

- Individual had no ReSPECT/DNACPR in place, family/carer felt one would have been beneficial to highlight the individuals care and treatment preferences.
- Recommendations within the ReSPECT document not always followed by healthcare professionals.
- Mental capacity assessment not utilised accordingly when individual was deemed as not having capacity.
- No consideration of completion of ReSPECT document when individual was presenting as well.
- No evidence of appropriate MCA/BI when ReSPECT form completed
- No family/carer awareness of ReSPECT document.
- Evidence of poor example of a ReSPECT document, not signed or reviewed by clinicians.
- Best interest decisions not regularly reviewed
- Evidence of limited knowledge around the mental capacity act with health professionals
- Inappropriate ReSPECT document completed with no physical health reason.
- Mental capacity assessments not always completed properly and or task specific.

Comparison of notifications and median of age since the start of LeDeR.

Table 16

Year	Notification No	Difference	Median Age	Difference
2018-19	29	-	58	-
2019-20	20	9 less	50	Minus 8 years
2020-21	25	5 more	55	Plus 5 years
2021-22	28	3 more	60	Plus 5 years
2022-23	30	2 more	62	Plus 2 years
2023-24	21	9 less	50	Minus 12 years

The low numbers of notifications means that the outcome of should be taken as trends over time on which to initiate quality improvement rather than an absolute number. Age is tracked to ensure that we ensure we are paying attention to all parts of our population. As a system we are only aware of the deaths that are notified to LeDeR, which is why it is important that all deaths are notified to LeDeR by anyone to ensure we get a true picture for Shropshire, Telford & Wrekin.

Quality of Care from reviews (see appendix 2)

Table 15 highlights the grading of the quality of care from all 15 completed focused reviews in 2023-24 and table 16 highlights this for 2022-23. Grading is discussed and decided by all members of the LeDeR Governance Panel, prior to approval and closure of any case on the LeDeR platform.

Table 17

2023-24	
Grading	No of cases (15)
6	0
5	6
4	3
3	3
2	1
1	2

40% of the cases in 2023-24 were graded as a 5 (good care) 20% of cases were graded as a 4 (satisfactory care) and as a 3 (fell short of expected good practice). 7% of the cases were graded as a 2 (fell short of expected good practice and may have contributed to cause of death) and 13% of the cases were graded as a 1 (fell short of expected good practice and contributed to the cause of death)

In 2022-23 75% of the 4 completed focused reviews were graded as a 5 (good care) and 25% were graded as a 4 (satisfactory care).

Table 18

2022-23	
Grading	No of cases (4)
6	0
5	3
4	1
3	0
2	0
1	0

Availability & Effectiveness of services from reviews (see appendix 2)

Table 19 highlights the availability & effectiveness of services from all 15 completed focused reviews in 2023-24 and table 20 highlights this for 2022-23.

Table 19

2023-24	
Grading	No of cases (15)
6	3
5	4
4	2
3	3
2	1
1	2

20% of the cases in 2023-24 were graded as a 6 (excellent) 27% were graded as a 5 (good) 13% of cases were graded as a 4 (fell short of the expected standards in some areas). 20% were graded as a 3 (fell short of the expected standards which impacted on the persons wellbeing). 7% of the cases were graded as a 2 (fell short of the expected standards which impacted on the persons wellbeing & or had the potential to contribute to cause of death) and 13% of the cases were graded as a 1 (fell far short of the expected standard & this contributed to the cause of death)

In 2022-23 75% of the 4 completed focused reviews were graded as a 5 (good) and 25% were graded as a 4 (fell short of the expected standards in some areas).

Table 20

2022-23	
Grading	No of cases (4)
6	0
5	3
4	1
3	0
2	0
1	0

Improving Care

From reviews where care fell short, it was identified that in these cases:

- Illnesses were not recognised until the individual became so unwell, admission to hospital was required.
- There were significant safeguarding concerns relating to drug errors or omissions.
- Despite clear guidance in place and the individuals' presentation/symptoms (indicating deterioration) no medical attention was sought.
- Due to individuals decline to be examined, their worsening condition was not identified in a timely manner resulting in fatality.

To improve the care for people with a learning disability and or autistic people we need to ensure the quality of services is of the best standard.

To do this as a system we need to:

- Understand the uptake of effective education and training available to all care providers
- Ensure regular and consistent monitoring and oversight by commissioners
- Promote the importance and raise awareness of reporting significant concerns in a timely manner to ensure individual are receiving the input required effectively.

Learning opportunities from local reviews 2023/2024

NHS STW are committed to extracting learning from LeDeR, implementing actions and demonstrating change with ongoing commitment to sustainability of change.

To ensure ReSPECT documents are regularly reviewed	Further education with care providers around the importance of Annual Health Checks.	Any reasonable adjustments should be identified, flagged and implemented within all systems.	Further support for family's & implementation of family support forums locally within STW.	To ensure the completion of Health Action Plans following all Annual Health Check.	Autism training to be provided for family carers	Annual Health Checks to always be completed face to face
Health professionals to always utilise and refer to supporting documents such as hospital passport and pain profiles	Clear guidance, further and up to date training and education around MCA/BI and ReSPECT documents including family carers and all health and care professionals.	Quality assurance processes need to be shared widely (including family and carers) to incorporate the triangle of care principle	Care providers to have processes in place to ensure staff members are familiar with all person specific documentation	To ensure everyone is aware of the differences between a learning disability and a learning difficulty	More information and support to be provided to family carers around power of attorney, appointee and deputyship.	The right skills and training to be provided for all team members who care for individuals with learning disabilities and or autism
Learning Disability and or autism not to be used as cause of death on a death certificate	To ensure the correct terminology is always used for individuals	More LeDeR awareness amongst wider organisations	Joint working amongst system partners to support specific pathways to support individuals with a leanring disability and or autism	The benefits of vaccinations and age appropriate screenings to always be discussed with individuals using accessible information	All Mental Capacity Assessments to be task specific and appropriate paper work to always be completed	To promote the importance of discussions and completion of ReSPECT forms when an individual is presenting as well.

Positive Practice from local reviews 2023/2024

Some evidence of good health and social care support throughout individuals' lives.	Indication of individuals social and emotional needs being met with a good Multidisciplinary team approach.	Transition from child to adult services well planned and effective to support individuals	Examples of good post diagnosis multidisciplinary team working to support individual emotionally and physically	Some evidence of good communication and advice offered to support individuals and their families.	Indication that appropriate and timely specialist medical and social referrals made.
Effective use of system partners adapting their communication strategies to support individuals.	Some evidence of Individuals' quality of life being the main focus following best interest meetings.	Some evidence of the inclusion of family members who were fully informed throughout.	Indication of care package provisions considering individuals personality and preferences.	Some good examples of consistent and appropriate reasonable adjustments	Some effective referral pathways made to specialists in a timely manner

Key themes from reviews

Table 21

Theme	Actions to be taken	No of cases linked to.
ReSPECT Document	• Promotion of appropriate completion of ReSPECT documents, raising awareness amongst key organisations of the benefits of proactive use of RESPECT documents. • Education and training to be completed by all health and social care professionals, carers and family members and to remain up to date.	6
Learning Disability as cause of death	• Promote and raise awreness that Learning disability/learning difficulty to never be included in part 1 as cause of death, on death certificates.	2
Reasonable Adjustments	• Any reasonable adjustments to always be identified, flagged and implemented amongst all organisations including incorporation into individual support/care plans	2
MCA/BI/DoLS	• Mental Capacity Assessments and best interest decisions to always be task specific • Inclusive of individuals, family members/carers • Paperwork always appropriately completed. • Guidance to always be followed, • Training and education to be completed and in date.	9
Supporting documentation	• To ensure all supporting documentation is in place including hospital passports, pain profiles and utilised to easily identify any changes in presentation to ensure appropriate actions are taken to support individual needs in all key organisations.	5
Annual Health Checks	• To always be completed on time and face to face. • To ensure enough time is given to include discussions around vaccinations, age-appropriate screenings, social prescribing • To include provision of accessible information and if any declines to be documented as to why. • A health action plan to always be completed following an annual health check for individuals, family members carers to follow. • The importance of Annual Health Checks shared with carers/care providers.	7
Learning Disabilities & Autism	• To ensure anyone supporting individuals with a learning disability and or autistic person have the right skill set, training and education to support individual needs fully.	5
Quality of Care	• To have oversight of the quality of care supported individual are receiving, more accountability to be established • Processes for this oversight to be in place including the triangle of care.	5

STW System Wide: LeDeR Priorities Action Plan

ReSPECT
Recommended Summary Plan for Emergency Care and Treatment

STW currently have 11 priorities on the LeDeR Priorities Action Plan. Using the data we are seeing from our LeDeR reviews as a baseline for 2024-25 we want to focus on specific priorities to enable us as a system to make a tangible change and really drive this forward.

Hospital passport 	Mental Capacity Assessment (MCA), Best Interest (BI) Decisions and Deprivations of Liberties (DoLs)	Training & education
Reasonable adjustments	Healthy Lifestyles	Inclusion of family members/carers
EOL, Palliative Care, ReSPECT & DNACPR	Reduce health inequalities for those with LD&A from ethnic diverse groups	Care act reviews 
Epilepsy Management	Managing deteriorations and early detection of deterioration	

Clive Treacey

Following the death of Clive in 2017, his care and treatment was the subject of an independent review commissioned by NHS England, in line with the principles of the LeDeR programme methodology. From this review, 10 key findings were found and 52 recommendations to drive systemic change.

Update: For STW, there is now a system wide action plan in place, highlighting all recommendations following the Clive Treacey independent review. The system have come together and met face to face to dicsuss how to move forward with this action plan. The recommendations ate also linked to a number of priorities on the LeDeR Priorities Plan. Nationally, SUDEP Action developed a commissioning checklist and guidance to provide a concise but comprehensive tool to help deliver safe, effective epilepsy care for people with a learning disability and/or autism. NHS England are also in the process of implementing a conscience manual to support the next steps linked to the key findings and recommendations. STW are committed to attending any events linked to Clive Treacey to drive tangible change locally.

Challenges: Variable commitment system wide has resulted in delays linked to recommendations updates. Each system partner will have their own Clive Treacey Action Plan, which means each system will be at different stages regarding specific recommendations, making it difficult to to deliver informed system wide updates.

<u>It is important to work together as a system to ensure systemic change occurs.</u>

Oliver McGowan

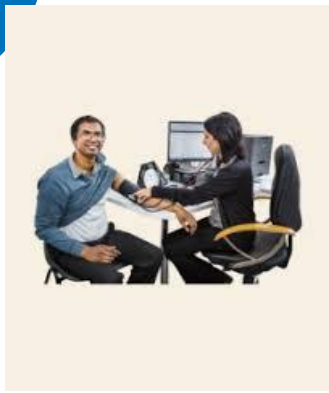
The Health and Care Act 2022 introduced a requirement that providers registered with the CQC must ensure their staff receive learning disability and autism training appropriate to their role. Staff working in health and social care need to understand the needs of autistic people and people with learning disabilities, to provide improved services, reduce health inequalities and eliminate avoidable deaths.

Update: System partners within in STW continue to complete the e-learning element of this training. Guidance has been circulated who should be completing which tier The Oliver McGowan Mandatory Training on Learning Disability and Autism: Tier guidance for employers (hee.nhs.uk) (the second part of this training) tier 1 is a 1-hour webinar following the completion of the e-learning and tier 2 is a full day face to face training session following the completion of the e-learning. The deputy LAC for the LeDeR programme sits within the stakeholder group who meet monthly for any updates linked to Oliver McGowan.

Challenges: The amount of people in STW who are required to complete the tier 2 face to face training outnumbers the number of sessions available for people to attend. The training team continue to work hard to put on more training sessions and work closely with national partners to support the roll out of this training.

The Oliver McGowen training programme plays a pivotal role in our commitment as a system to provide the highest quality care and support to individuals with learning disabilities and autism.

Annual Health Checks



The aim is for the uptake of Annual Health checks (AHC's) for any individual with a learning disability aged 14+ is at least 75%.

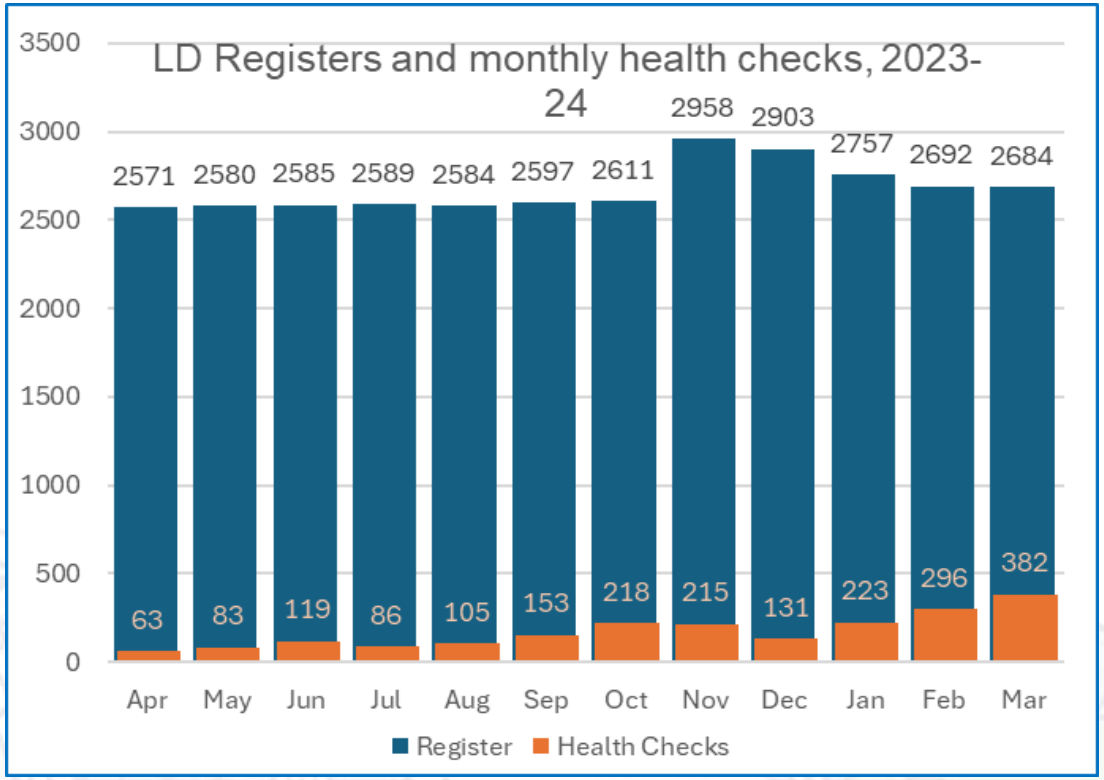
Update: This year the uptake of Annual health Checks (AHC's) reached within Shropshire Telford & Wrekin was 77.3%, which is over the target set by NHS England.

Challenges: From LeDeR reviews in some cases there is evidence that some AHCs are outdated for individuals, no Health Action Plans are in place following the AHC and in some cases the AHC was completed over the phone with a family member/carer.

We need to ensure that all AHCs should be completed face to face, and any reasonable adjustments required to support an individual's needs should be identified, flagged and implemented.

The system relies heavily on the learning disability register to be correct to ensure all individuals receive all support available to them, this highlights the importance of coding within GP practices together with the correct use of terminology.

Graph 21



Review of 2022-23 recommendations	Updates and key progress
Strengthen links with and reduce inequalities for people from minority ethnic communities.	One of our LeDeR panel members feeds into the EDI working group
Widen the membership of the LeDeR Steering Group and LeDeR Governance Panel to include people with lived experience and representation from a minority ethnic community.	New LeDeR panel member with lived experience and representation linked to out EDI population.
Make improvements in all key areas we have identified this year through a robust strategic plan that is led by our LD&A working group.	A one-minute brief is produced monthly and shared system with a LeDeR specific topic linked to themes from LeDeR reviews. Established Aspiration Pneumonia working group to complete a quality improvement project around this. .
To ensure that we continue to focus on delivering the recommendations from the Oliver McGowan and Clive Treacey reports.	This is linked to slides 39 & 40 within this report
Explore the term reasonable adjustments and its meaning and what people need compared with what they can expect and continue to explore the barriers individuals experience and support them to access what can make the difference to them.	All systems have a responsibility to flag reasonable adjustments ready for implementation of the reasonable adjustment digital flag nationally.
Increase the training around reasonable adjustments and healthy living across the STW system partners that incorporates Healthwatch/Treat me well.	There has been an Increase in joint working across the system and e-learning is in place to support the roll out of the reasonable adjustment digital flag.
Work with GPs across Shropshire Telford and Wrekin to ensure GP records include the number of individuals with a diagnosis of autism to improve our database for people with autism.	GPs have a coding list to refer to support this from NHS England.
NHS STW to carry out an audit on the adherence of mental capacity act and DoLS and the use of DNACPR and ReSPECT documents.	New ReSPECT lead in post and the policies and processes are being reviewed to include system partners.
To explore and develop a regional interlinked system to identify people with a learning disability and autism when accessing health and social care services.	The introduction of electronic systems within our acute system partners will support with this.
To improve on the use of hospital passports across the STW system, for the work to be undertaken to use the One Health and Care Integrated Care Record to identify a person with a learning disability and/or autism and the hospital passport/reasonable adjustments so that no matter where the individual is in the system, this information can be accessed.	There is now an established LeDeR task & finish group to look at a quality improvement project around hospital passports and the previous point is also linked to this recommendation.
Improve opportunities for personalised end of life care.	Established end of life working group led by Shropshire Community Health team.

Challenges

1. Postponement of new electronic systems within one of our system providers leading to delays in improving processes for individuals with Learning disabilities and or autism such as flagging of reasonable adjustment, relevant documents such as health passports.
2. Balance of responsibilities due to resources, capacity and at times changing priorities resulting in a variable commitment and core membership system wide linked to the LeDeR Programme and Clive Treacey Action Plan.
3. Capacity to work proactively and preventively when all services are overstretched and firefighting
4. Not all system partners have dedicated learning disability and or autism teams
5. Some services being disparate and separate risking duplication and gaps system partners are unaware of
6. Too many goals/targets in the context of the current capacity pressures
7. As a system we have faced challenges and barriers including breaching and quality of reviews and extracting learning from reviews in a timely manner. We sought a remedial action plan from our provider to improve the performance as seen above. The contract with our current provider ended on 31.03.2024 and STW changed the provider undertaking the reviews from 01.04.2024.
8. At points throughout this reporting period the LeDeR platform was inaccessible to the LAC/deputy LAC delaying quality assurance and closure of LeDeR cases.

Shropshire Telford & Wrekin Priorities for 2023/24

The local priorities for STW for 2023-24 were:

- **Aspiration Pneumonia**
- **Epilepsy**
- **Cancer**
- **Dementia**
- **Sepsis**

If the cause of death was linked to any of the above, then it would be reviewed as a focused review. This resulted in a higher rate of focused reviews compared to previous years.

Plan for 2024-25

Given that Aspiration Pneumonia is our lead of cause of death during 2023-24 in STW, it will remain a priority moving forward. All other LeDeR cases with be reviewed on a case-by-case basis by the LAC and deputy LAC to determine if the case should be a focused review. This will be considered if there would be significant learning from a review, there are quality of care concerns, evidence of lack of reasonable adjustments and any gaps in any education and training.

Recommendations and Next Steps for 2024-25

- Target the promotion of LeDeR to increase the number of LeDeR notifications utilising our LeDeR Steering Group members.
- To promote the appropriate completion of DNACPR's and ReSPECT documents, liaising with the ReSPECT Lead for SaTH.
- Improve joint working to achieve priority health/social care goals for example Clive Treacey
- Agree a smaller number of high priority goals to deliver on in 2024/25 and discuss and receive informed updates for all at The LeDeR Steering Group monthly.
- Continue to utilise the learning management system to promote learning from all LeDeR reviews with monthly one-minute briefs.
- Continue to utilise opportunities to promote learning from all LeDeR reviews.
- The implementation of a communications plan and user friendly ICB website incorporating resources and links associated with LeDeR and the learning disability and autism programme.
- Putting learning from reviews into action and undertake quality improvement projects linked to our LeDeR priorities to ensure we make tangible change for individuals with a learning disability and autistic people across Shropshire, Telford & Wrekin.

Conclusion

The LeDeR programme in Shropshire Telford and Wrekin has seen strong engagement with stakeholders across the system who are committed to achieve the aims and objectives of the LeDeR programme. We have identified a number of areas where there are opportunities for quality improvement, and we continue to see examples of good practice within our reviews which demonstrate positive learning and our drive to improve at all times.

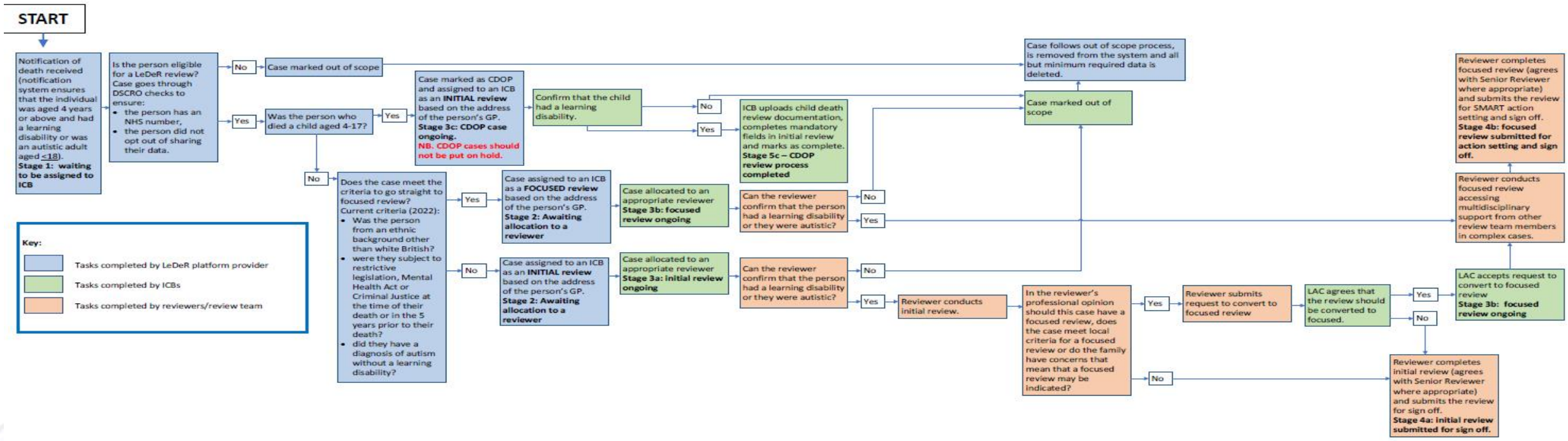
This year has seen the age of death decrease but this is against a backdrop of lower notifications. Previous years have been comparable to nationally published data which is available each September. We will commit to driving up the profile of LeDeR to get as many notifications as possible to strengthen our data and drive our improvements.

Appendices

- Appendix 1: LeDeR process chart
- Appendix 2: Grading of care table

Appendix 1

Overview of review process



Appendix 2

Grading care (4)

Grade	Quality of care – overall, on balance…..	Availability and effectiveness of services – overall, on balance…..
6	This was excellent care (it exceeded expected good practice). Please identify in learning and recommendations what features of care made it excellent and consider how current practice could learn from this.	Availability and effectiveness of services was excellent and exceeded the expected standard
5	This was good care (it met expected good practice). Please identify in the review learning and recommendations any features of care that current practice could learn from.	Availability and effectiveness of services was good and met the expected standard
4	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing). Please address these issues in your recommendations for service improvement, and identify in learning and recommendations any features of care that current practice could learn from	Availability and effectiveness of services fell short of the expected standard in some areas but this did not significantly impact on the person's wellbeing.
3	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death. Please address these issues in your recommendations for service improvement, and identify any features of care that current practice could learn from.	Availability and effectiveness of services fell short of the expected standard and this did impact on the person's wellbeing but did not contribute to the cause of death.
2	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.	Availability and effectiveness of services fell short of the expected standard and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.
1	Care fell far short of expected good practice and this contributed to the cause of death.	Availability and effectiveness of services fell far short of the expected standard and this contributed to the cause of death.

Resources

- easyreadfullreport.pdf (bristol.ac.uk)
- The Triangle of Care explained (youtube.com)
- Clive-Treacey-Independent-Review-Final-Report-9.12.21.pdf (england.nhs.uk))
- NHS England-funded project is lasting legacy to Clive | SUDEP Action
- (Oliver McGowan | Oliver's Campaign |)
- The difference between Learning Disability and Learning Difficulty (youtube.com)
- Resources for Healthcare Professionals | Mencap

S

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 25th April, 2024

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW (part only)
Vanessa Whatley	Interim CNO NHS STW (Part Chair)
Julie Garside	Director of Performance and Delivery, NHS STW
Jill Barker	Associate Non-Executive Director, SCHT
Sara Reeve	Deputy Director of Quality, MPFT
Sharon Fletcher	Interim Deputy Chief Nurse NHS STW
Tracey Slater	Interim Deputy Chief Nurse Local Area Contact (LAC) STW LeDeR programme
Mahadeva Ganesh	Medical Director SCHT
Anne Maclachlan	Clinical and Care Director, Shropshire Care Group, MPFT
Clare Hobbs	Director of Nursing, Clinical Delivery & Workforce, SCHT

Attendees:

Sharon Clennell	Head of Urgent & Emergency Care & Transformation & Commissioning, NHS STW attending as an observer
Sue Bull	LMNS Programme Manager NHS STW
Sara Bailey	Deputy Director of Nursing Deputising for Hayley Flavell, Director of Nursing SaTH.
Lisa Rowley	PA to CNO, note taker, NHS STW

1.0 Minute No. QPC-24-04.48- Welcome/Apologies by: Meredith Vivian

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

Minute No. QPC-24.04.49 Apologies:

Meredith Vivian – part only
Liz Lockett - Sara Reeve Representing
Ruth Longfellow - RJAH
Hayley Flavell - SaTH
Paul Kavanagh Fields – RJAH – Kirsty Foskett representing

3.0 QPC-24-04.50 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

4.0 Minute No. QPC-24-04.51 - Minutes of Meeting held on 28th March 2024

4.1 The minutes of the meeting held on 28th March 2024 were reviewed and accepted as an accurate record of the meeting.

5.0 Minute No. QPC-24-04.52 - Matters Arising and Action Log

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

6.0 Minute No QPC-24-04.53 – Performance Exception Report –

The report was taken as read, a discussion with committee members ensued and Julie Garside highlighted the following key points: -

6.1 Progress against primary care action plans are on track; There will be a panel meeting in early May to assess delivery against the plans for last year. There will be a Primary Care Planning and Performance lead post in the new structure but is a gap at present. However, there will be a member of the team on the panel to assure the process in terms of assessing the delivery. Primary Care deep dive will be presented to QPC in May. UEC is still struggling in all areas with around the 50/55% utilisation of virtual wards.

6.2 There has been a statistically significant improvement in relation to 111 diversions to ED. Ambulance performance and CAT 2 response times and over hour ambulance delays is within normal variation.

6.3 The improvement in time to initial assessment is being maintained; the four hour and number of patients over 12 hours metrics are in an adverse position and are consistently failing with a concerning variation, the Tier 1 and GIRFT improvement plan is needed to improve this position.

6.4 Flow metrics continue to show signs of improvement in terms of variation and occasionally achieving the target for No Criteria To Reside (NCTR); there is a sustained improvement in the reduction in length of stay of the patients with No Criteria To Reside, this needs to be sustained and improved further going into 2024/25.

6.5 Mental Health and LDA are slowly improving and sustaining that improvement. MPFT are looking at a system piloted in Derbyshire called Diadem to help with improving our dementia diagnosis rate; A paper is expected by the ICB soon which will be reviewed to see if Diadem can be piloted, particularly supporting patients in care homes with their diagnosis of dementia.

6.5 In Q4 there has been improvement in LDA and SMI health checks. However, this remains a challenge and further work is required with primary care to ensure more even phasing of these checks and more rapid data entry onto general practice systems.

6.6 Elective & Cancer -this is a continued good news story, there were 5 over 78 weeks at the end of March, appropriate validation is in place to prevent this happening again in 2024/25. There was an over achievement against the over 65-week backlog which continues to decrease, the aim is to get to 0 by September.

6.7 There is an improving position regarding diagnostics with just over 80% achievement in the DM01 target in 2023/24 against a target of 85%. The plan

for 24/25 is subject to obtaining funding for the endoscopy business case which, would get an indicative system achievement of DM01 levels of approx. 87%. Over 13-week waits are also decreasing well, these need to be eliminated by the end of March 25.

6.8 With regard to outpatients there is still a struggle with virtual take up which is thought to be due to some extent to a cultural issue with some clinicians. Some significant OD work is required and learning from exemplars from NHSE to move this forward in 2024/25.

6.9 With regard to Cancer, FDS standards are being delivered, we are consistently achieving over 80% of lower GI referrals with an accompanying FIT test, the fair shares target was overachieved for the over 62 day backlog at the year end.

6.10 CHC is showing statistically significant improvement and achievement against the recovery plans. There continues to be a challenge with getting comparative data against that fast-track profile, but this is being closely monitored.

6.11 SF asked how performance is being linked to patient safety and asked whether there would be an opportunity to look at Performance areas with a patient safety lens as there may be some models that can be looked at that might support some of the performance work that's already ongoing,

Action, Julie Garside, Sharon Fletcher and Angie Parkes to meet to discuss potential for patient safety and performance to work differently together.

6.12 VW commented that plans are in place to merge the quality metrics with the performance report it is hoped that by July 2024 the first draft will be ready.

6.13 Dr Ganesh commented that there is a missing link with the LeDeR and primary care annual health surveillance of people with a learning disability and asked whether as a health economy there an opportunity is was to have a specific discussion with primary care at GP Forum.

Action: Julie Garside to pick up Dr Ganesh's comment with Jane Williams, planning and performance lead regarding annual health checks being discussed at GP Forum.

The Committee:

- Noted the content of the report regarding performance of key metrics against national.
- standards and local targets.
- Where performance falls short of national standards and locally agreed targets,
- Noted the actions being taken and that risks are being appropriately mitigated and
- Noted that The Performance Report continues to evolve to improve the way data and actions are presented to provide assurance to the Committee.
- fed back on the report presentation to ensure the report meets the needs of the Committee.

7.0 <u>Minute No QPC-24-04.54 - System Risk Register</u> including **System BAF and SORR 2024/25**

System & ICB BAF, STW Risk Update Report – The papers were taken as read and Sharon Fletcher highlighted the following points:-

7.1 There are no significant changes to risks in month to report.

7.2 Ongoing quality improvement work is being carried out in the background supporting risk owners with quality improvement methodology and ongoing mitigation of risks on the risk register. There is an ongoing piece of work in relation to alignment of risk matrixes across the ICS. However, at the last SQG meeting a discussion was held regarding a new risk which will go to SQG in May relating to shared prescribing.

7.3 The ICB Risk register was reviewed. Following an audit, it was found that there is a delay between updating and some duplication from old risks, other than that there had been no feedback on QPC risks. No additional comments were received on the risk register or BAF.

The Committee:

- Discussed the risks for ongoing progress/action.
- A discussion at SQG is required to further examine mitigations with partners in relation to the new risk.

8.0 **Minute No QPC-24-04.55 - System Quality Metrics**

The paper was taken as read and Tracey Slater highlighted the following points:-

8.2 ADHD was discussed, and it was recognised that a significant amount of work has taken place with triage to reduce this risk to individuals but he waiting list remains too long and risk is only manged on the day of the assessment. 102 co-morbid patients have been identified that need to be transferred to MPFT; a meeting is scheduled imminently to finalise the safe data transfer. The pathway has been agreed by both providers, health &well-being and MPFT.

The Committee:

- Considered additional assurance required in relation to the metrics.

9.0 **Minute No QPC-24-04.56 - System Quality Exception Report Chairs Report**

The paper was taken as read and Vanessa Whatley highlighted the following points:

9.1 The System Quality Group met at the beginning of April where a new risk was discussed around shared care and prescribing for patients that are on shared care arrangements. as no representative was present at SQG to have a detailed discussion about what partners could do to help mitigate any actions or risks. Therefore, this has been deferred to the May SQG meeting for discussion and will then be presented to QPC as part of the risk register.

9.2 C diff cases continue to be high; This is an issue across the country about higher rates of C diff, Sath, SCHT and RJAH have reported higher than expected cases of C. diff. There will be a review by the regional lead on 26th April at SaTH. A discussion was held at the IPC/AMR system meetings regarding the new national recommendations about cleaning and what cleaning

materials should be used during different periods of the year rather than just using hyper chloride. There will be new guidance published to help refresh C diff. An assurance paper will be written following the review to advise what is being done regionally and in other parts of the system including antimicrobial prescribing in the Community and primary care.

9.3 The immunisation for HPV in both Shropshire and in Telford are both low Shropshire 79.50% and Telford & Wrekin 71.4% - this is 2021/22 data; both local Authorities are trying to improve this. It tends to be lower in boys than girls, evidence is emerging there is good benefit for boys. However, when this was first launched, the benefit was for girls. There are some issues around this vaccination that both local authorities are looking at and this came from the sexual health update. Vaccinations across the board is a challenge however this vaccination could lead to some longer-term impacts for the health and care system.

9.4 The Chair asked for clarity on who is responsible for shared care.

9.5 VW explained that it is medicines that are prescribed in one organisation and given by another but controlled by the prescriber; Often they are mental health medications.

9.6 Anne MacLachlan added that it is ADHD medication as well, such as melatonin, largely mental health medication. There have been many returns of people rejecting shared care agreement drugs and sending them back to MPFT.

9.7 The Chair asked what the impact was on virtual wards since a lot of the prescribing will be in that scenario where there are two organisations involved.

9.8 Vanessa Whatley explained that some shared care patients that get deferred from their GP, there is nowhere for them to go and sometimes the community providers pick up the patients. There should be a proper pathway and agreements in place and there is a risk which needs to be looked at further to see the data, how many patients this affects and where patients are coming from. It is thought that some patients come from specialist studies and most commonly from mental health a lot of the patients come from outside of tertiary centres.

9.10 Sharon Fletcher commented that after looking at this risk, the risk owners are Dr Priya George, Nick White, Clare Stallard and Liz Walker have been invited to SQG in May, following which it is hoped by April QPC there will be more information around risk mitigation and impact?

9.11 The Chair queried CDiff and asked if all those involved in the flow of patients across the system are buying into managing CDiff and not just a SaTH problem.

9.12 CDiff tends to linger in healthcare environments, and it is hard to remove the spores using normal cleaning methods, therefore thrives in inpatient settings. The drivers can be the overuse of PPI's preventing ingestion which is commonly used; often get prescribed with other drugs to prevent side effects. The system are low prescribers to patients of PPI (protein pump inhibitors) but do give high dose PPI as a proportion so it's Some antibiotics drive C diff will select C diff more than others. However, CDiff has to be in the environment.

The Committee

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

10.0 **Minute No QPC-24-04-57 – UEC Deep Dive – Sharon Clennell**

The paper was taken as read and Julie Garside & Sharon Clennell highlighted the following points: -

10.1 It was explained that there remain significant challenges within UEC, Shropshire Telford & Wrekin are the worst in the region and one of the worst nationally in terms of Urgent care performance. A visit has been carried out by the tier one national team and GIRFT who have carried out a piece of work looking at the system and areas where improvement is needed; six work streams have been identified. Documents summarising those projects are being worked through and what the impact will be delivering those projects on patient care and urgent care performance.

10.2 STW for urgent emergency care has been placed into Tier 1 meaning that there needs to be a significant improvement in urgency, emergency care.

10.3 There will be a system review of all services in all organisations to make sure that they are accurate up to date and they've got all the relevant information, that it will also highlight where there are pathways will need to be looked at. This programme has been amalgamated with the Care Coordination Programme, which previously Betty Lodge was the SRO for. Both of those programmes have been moved into one and Claire Horfield will be taking this forward.

10.4 The second focus area is frailty. A further area of focus is around acute medicine and IPS, (inter Professional Standards) which is being led Dr Lawrence Ginder and a further area of focus around performance and improving the 4-hour performance locally, which is currently circa 50% and it needs to get to 76%. There is also a focus piece of work around system discharge for all the programmes, Louise Barnett is the executive sponsor.

10.5 These programmes of work will form part of the UEC improvement programme for 2024/25, these programmes of work will be presented to UEC Board for ratification and approval.

10.6 Each Programme of work will be led by the identified Senior Responsible Office supported by NHS Emergency Care Improvement Support Team (ECIST) and the Getting It Right First Time (GIRFT) team.

10.7 Each SRO is finalising their plans and progressing with the implementation of the programme with stakeholders. Governance and performance monitoring will be via the Tier One Enabling Group with exception reporting to the UEC Delivery Board monthly.

10.8 The progress of the each of the programmes will be monitored through Tier 1 operational group, which was previously UEC Operational Group and then that will feed into the Board who will maintain oversight in terms of reporting. These programmes of work will form part of the UEC improvement programme for 2024/25, these programmes of work will be presented to UEC Board for ratification and approval.

10.9 A discussion ensued regarding the importance of frailty care and that efficient and effective frailty care is needed at the front door and ensuring that across primary care and community care the frailest of people have been assessed and the right action has been taken; frailty needs to be a priority which does not just apply to the elderly, in Telford there are Frail young people. Clare Hobbs referred to the Black Country's freed pathway, which is an all-encompassing

Pathway and suggested this is explored further. Going forward particularly for frailty, lifted experience and experience of care will be looked at.

The Committee:

- Noted the content of the report and associated Appendix One
- Noted the update of STWs Tier One position and associated programs.
- Were assured that the metrics and assurance for monitoring each program has been identified.

11.0 <u>Minute No. QPC-24-04.58 – Health Protection Board Assurance Report</u>
The paper was taken as read and the following points were highlighted:

11.1 There is an issue with having appropriate TB service to meet the population need due to significant population changes which is a rising risk. This risk is being reviewed to see how it's scored; it is expected to score over 15 and will be added to the risk register. The TB team will take a whole look at the service spec and its commissioning. Nurses are having to deal with six-month treatment programmes for numerous patients at a time, particularly within the Eastern European population.

11.2 There was a death in December 2023 due to TB in STW which has highlighted the seriousness of TB. Screening has been done amongst hotel resident migrants but with a 30% attendance rate, appropriate controls, mitigations and actions have been put in place for those testing positive but the demand on a small service is high.

11.3 It was highlighted that Simon Whitehouse and relevant execs, and DPHs in the system are aware of this issue and it has been recognised and the need to recommission the service,

Action: Vanessa Whatley to look further into recommissioning the TB Service.

11.4 There is a plan in place for commissioning this work an SaTH are working internally regarding providing support ensuring that patients have their treatments,

11.5 SaTH have TB on their risk register and have appointed an additional nurse to help in to ensure that patients receive timely treatment and also have a pathway for their workforce.

11.6 Dr Ganesh questioned how well asylum seeker children who attend schools are being screened and that Primary Care could pick these up earlier.

11.7 Vanessa Whatley commented that the SaTH maternity team are very good at Immunising at birth, Children are immunised within 28 days that are at risk. If a family or their grandparents or other close relatives come from countries on the list where TB is prevalent than those children who get a vaccination. In the outbreaks seen where children are involved, they have had that vaccination which prevents dangerous cases of TB. To summarise, a risk is being developed, which will have the relevant actions and the steps to control the risk.

The Committee:

- Noted the contents of the report.

12.0 Minute NO QPC-24-04-59 – LMNS Programme Board & Perinatal Quality Update

The paper was taken as read and Sue Bull highlighted the following points: -

12.1 Maternity Workforce, at the LMNS Board in April SaTH highlighted the current workforce unavailability in maternity because the current workforce returns showed they are over staffed however they have high rates of unavailability. The Trust have mitigations in place, their senior leadership team carried out a review of their specialist workforce which has allowed a release of 1.9 wte to move back into the clinical workforce to maintain patient safety. The ICB Quality Team are working closely with the Trust to understand the impact on patient safety.

12.2 With regard to CNST The Trust has received external approval and ratification of their year five submission. The Trust have also fully achieved the 100% against the saving babies lives care bundle; SaTH are the only Trust within the region to achieve this.

12.3 Trust is moving at good pace for overall implementation of the first Ockenden report and the second report with 92% overall for the first report and 91% overall for the second report. There still are still some recommendations outstanding, the way the Trust is proposing to move forward is to move away from the assurance committee currently in place and move towards using an assurance tool. This tool will allow oversight and an ongoing review of all recommendations.

12.4 The Quality Review dashboard for maternity shows the delivery suite acuity was 58% in February which was one of the lowest acuity reporting months to date. The mitigation put in place supports the narrative around how the Trust are managing this, and it also gets triangulated against other areas such as red flags and datix, There is no associated negativity on patient safety even though acuity was low. Reassurance has also been noted that 1:1 care in labour demonstrates 100% compliance. The rate for Induction of labour the rate in February was 36.2% a slight decrease however remains above the average range of 29.2% which aligned with saving babies lives care bundle.

12.5 Term admission rates in February were 5.8% which is below the national target for term admissions of 6%. The Term admissions reporting as avoidable and non-avoidable were elements of care not being met resulting in admissions to neo natal units; These are areas that will be looked at through the Board where assurance will be sought.

12.6 Smoking rate at delivery has shown a slight increase to 10.2%; the healthy pregnancy support service is working closely with families towards a target rate of 6%. This is an area of work that will be explored further as part of the workstreams set up by LMNS.

12.7 Breast feeding rates are 64.7% which is below the target of 70% There is a baby friendly initiative midwife in post and are working towards the accreditation and will be closely monitored as part of the working groups within LMNS.

12.8 Births ratio was 1-25 this month, no change has been seen month on month.

12.9 The LMNS Board members had previous concerns about the quality of data in the neonatal dashboard. However, at the April LMNS Board the neonatal team expressed confidence that this had been resolved and therefore the data submitted from March onwards is reliable. There are issues with the roll out of the full EPR and Badgernet within the neonatal unit as they do not have the ability to use this system in its entirety in the same way as maternity do, this is being investigated, there is a digital data workstream within the LMNS where this will be highlighted and discussed.

12.10 The Maternity neonatal voices Partnership (MVNP) co-lead for MVNP left their post on 30th March after 3 years which has caused some capacity issues, The raining co-chair has taken over the lead for MNVP, reassurance was given that the ICB are working closely with MNVP and commitment is in place to ensure users are at the heart of decision making, governance processes are being put in place to ensure user feedback is presented in the system and acted upon. A Task and Finish Group has been set up to develop the MNVP workplan for 2024/25 which is in its final stages together with the communication and engagement action plan.

12.11 The maternity and neonatal senior advocate has been a long-standing role but unfortunately the person who left this post in March 2024, approval to go out to advert was delayed however the advert for this post has now been approved.

12.12 The three-year delivery plan which is what LMNS is working towards, the eight workstreams have been set and are underway, good engagement from internal and external partners, the equity & equality plan is part of these workstreams. The next steps are to agree priorities and put action plans in place to demonstrate and agree outcomes required from the workstreams.

12.13 LMNS Dashboard - A project to develop a regional dashboard that allows benchmarking against peers on activity and quality metrics was put in place, this project has now closed, and the dashboard is now up and running and should be fully functional by March. A demonstration of this dashboard will be presented to the LMNS Programme Board. This will allow all of the system to have oversight of performance as a maternity and neo-natal system.

12.14 Finance & Commissioning- Funding has been received for 2024/25 for LMNS; work will commence in getting clear spending plans from providers. The ICB does not have a Maternity Commissioner in post, this position is within the new structure and this post will be filled for 2024/25.

12.15 Tracey Slater referred to the smoking rate at the time of delivery, and asked what the link is with Primary Care and pharmacies and what opportunities are there for making every contact count with other health care providers.

12.16 The LMNS workstream has partners within the LMNS, the providers who have their own public health service that they provide a preventative service it would be good to link further into the system.

Action: SB to link in with TS to see who these contacts are in primary care and Pharmacies in relation to smoking rate at the time of delivery.

The Committee:-

- Noted the contents of the report.

13.0 Minute No 24-04.60 - Virtual Ward Update –

The report was taken as read; Sara Bailey highlighted the following points: -

13.1 Clare Hobbs opened the discussion by advising the Committee that once further work has been carried out on the impact of virtual wards around readmissions and benchmarking with other virtual wards, and that it is important to monitor the length of stay of inpatients and the impact of virtual ward development. But also, ED attendances which is missing from the report presented.

13.2 From and equality and performance perspective, workforce is an issue. The Rapid Response Team in the Virtual Ward Team do work together. The utilisation rate now in virtual ward is around 50-55%, Virtual wards for example drop down to 98 patients, but rapid response numbers have gone up to 50, this is a theme often seen.

13.3 Work is ongoing with ICB and SATH colleagues to review data regarding A&E attendances and length of stay in the acute setting to determine whether virtual ward has had desired impact.

13.4 A Review has been undertaken of patients re-admitted within 30 days to determine whether there is any learning.

13.5 SCHT continue to work with colleagues to develop new pathways.

13.6 Face to face communication tends to be where majority of referrals come from. The average length of stay on a virtual ward is 14 days and 8% of patients are readmitted after 30 days.

13.7 With regard to patient experience from a quality perspective, There is more work to be done. SCHT have undertaken a virtual ward patient story, which has been shared across the system. Clare Hobbs stated that she would like to work with Healthwatch partners to get some objective data in regarding patient experience of virtual wards, they have carried out their own internal bespoke survey, but did not receive many responses.

13.8 The Chair referred to the number of patients readmitted after 30 days an asked whether this was to the virtual Ward or into SaTH.

13.9 Dr Ganesh confirmed that the patients are readmitted back to the Virtual ward and that a small number of patients are readmitted to SaTH and said there are multiple reasons for the readmissions and that a deep dive needed to take place to provide the correct information as he did not feel that readmissions were at 8%.

The Committee:

- Noted the contents of the presentation provided.

14.0 Minute No QPC 25-04.61 - Healthwatch Shropshire Update

The Chair advised that he had received an update from Lynn Cawley to provide an update in her absence.

14.1 Healthwatch Shropshire are focusing on cancer at the moment, looking at getting people's experiences for cancer services and will provide an update on this in May and will be looking for feedback and comments.

14.2 Healthwatch Shropshire are looking at their priorities for the year ahead, so they would welcome thoughts and ideas and suggestions upon which to attach their programmes of work.

Action: Meredith Vivian to forward to Committee members Lynn Cawley's note

The Committee:

- Noted the verbal update.

15.0 Minute No QPC-25-04.62 - Healthwatch Telford & Wrekin Update

15.1 There was no representative from Healthwatch Telford & Wrekin present to provide an update.

16.0 Minute No QPC-25-04-63 - Items for Escalation/Referral to Other Board Committees

16.1 Not for escalation but he is concerned about TB and noted that Vanessa Whatley, Rachel Robinson and Helen Onions as well as commissioning colleagues will be looking at this closely going forward.

16.2 The Chair commented that no items were requested to be escalated or referred to other Board Committees.

17.0 Minute No. QPC-25-04.64 Any Other Business (AOB)

17.1 Meredith Vivian referred to Quality in primary care which he said was a wide subject and said it would be a very good opportunity to look at the quality and that he plans to write to you all with a little set of questions to help us inform our approach to how the committee does what it's what it does and things that we want to explore in particular and by that not just the subject matter, but the nature of inquiry.

Date and Time of Next Meeting

The Next meeting is scheduled to be held on 30th May 2024 starting at 2.00pm to 4.00pm via Microsoft Teams

SIGNED ……. DATE ……

S

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 28th March, 2024

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Julie Garside	Director of Performance and Delivery, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Jill Barker	Associate Non-Executive Director, SCHT
Sara Reeve	Deputy Director of Quality, MPFT
Helen Onions	Director of Public Health, Telford Local Authority
Sharon Fletcher	Interim Deputy Chief Nurse & Patient Specialised NHS STW
Tracey Slater	Interim Deputy Chief Nurse Local Area Contact (LAC) STW LeDeR programme
Dr Ian Chan	Primary Care GP, Teldoc
Dr Ganesh	Designated GP for Safeguarding Shropcom
Anne Maclachlan	Clinical and Care Director, Shropshire Care Group, The Redwoods Centre

Attendees:

Sara Ellis-Anderson	Deputy Director of Nursing – Quality & Deputy DIPC – deputising for Deputising for Clair Hobbs
Sara Bailey	Deputising for Hayley Flavell, Director of Nursing.
Lisa Rowley	PA to CNO, note taker, NHS STW

1.0 Minute No. QPC-24-03.33- Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made. The Chair highlighted that the meeting was not quorate due to annual leave of the voting Members. Therefor no decisions could be made however, The Committee agreed to carry on with the meeting.

Commented [WV(STAWIM1]: Please can you say why not quorate?

Minute No. QPC-24.03.34 Apologies:
Anne Maclachlan, Clinical & Care Director MPFT - Sara Reeve representing
Liz Lockett - Sara Reeve Representing
Dr Ganesh - Shropcom
Clair Hobbs - Shropcom
Ruth Longfellow - RJAH
Tracey Slater - STW
Hayley Flavell - SaTH
Paul Kavanagh Fields - RJAH
Vanessa Whatley Interim Chief Nursing Officer& Director of Quality and Safety/Deputy Chief Nurse, NHS STW

3.0 QPC-24-32.35 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

4.0 Minute No. QPC-24-03.36 - Minutes of Meeting held on 29th February 2024

4.1 The minutes of the meeting held on 29th February 2024 were reviewed and accepted as an accurate record of the meeting subject to:-
4.2 Lynn Cawley to be added to the attendance list.
4.3 Minute 16.0 re diabetes, Escalation diabetes of to the Board the diabetes was considered, and it was agreed to wait until after April QPC

5.0 Minute No. QPC-24-03.37 - Matters Arising and Action Log

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

6.0 Minute No QPC-24-03.38 – Performance Exception Report – Julie Garside

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

6.1 The Committee were informed that good progress is being made in relation to the development and monitoring of the primary care recovery access plans which is limited by national progress. There are 5 measures where there are no definitions or data flows, it has been promised that this will be rectified however, no date when this will happen has been provided. The Primary Care Team within the ICB are carrying out practice visits and year end reviews will be carried out in May. PCN's and Practices are being supported in terms of providing them with evidence showing improvements they have made.
6.2 With regard to patient access and digital telephony, the reason why this could not be at 100% by the end of March was due to capacity of the provider and not within general practice or the ICB.
6.3 Regarding access into primary care from the public perspective, primary care access arrangement needs to be picked up with the Comms team to see how to roll out Digital telephony across practices to re-enforce to the public that there is good access.
6.4 A recommendation was made to prompt a programme of work around primary care access. It was commented that there are two clear messages that should go out to the public one being around the positiveness about the digital telephony as people's perception of this would mean booking appointments on line, and it was suggested that this split to provide for clarity for the public needs to be managed.
6.5 The Healthwatch Shropshire access survey will be presented to the LA Health and Wellbeing Board in June with an update from ICB's Primary Care team in terms of the access plan where the discussion could be expanded to include how best to communicate with the most excluded group.
6.6 Health inequalities focus needs to be given on areas of deprivation because the variation of 111 usage is higher in deprived areas and the use of services and demand are also higher in those areas; the funding in practices does not cater or factor in deprivation which is creating inequality in terms of access, this needs to be considered in terms of the long term strategy plan.
6.7 The detailed plan around Core20plus4 plan is a detailed plan around the most deprived areas which is a national definition and this will be explored further through the prevention and inequalities board in more detail.
6.8 It was highlighted that there are a number of patients on waiting lists who are at a high risk of amputation of limbs due to diabetes, these patients are not engaging with

general practices and it was asked whether support from the Council would help tackle this issue and to drive integration.

Action: Julie Garside to discuss with Helen Onions the support for primary care in terms of public and patient Comms and engagement plans JG to have a discussion with Edna Boampong re plans going forward with Edna and whether this could be linked with those PCM visits in April/May. Following which an update will be provided to QPC. Meredith Vivian to be linked into the email exchange with Comms.

6.9 UEC continued improvements are still being seen in terms of initial time to triage; length of stay is down to an average of around 3.5 days, and in some weeks it has come down 2.5 days, however when measuring those benefits in flow, it is not translating into benefits in terms of a reduction in escalation capacity within SaTH and also the benefit in terms of the number of patients in EDs for over 12 hours and the four hour performance is not being seen; the GIRFT and tier one support is needed to get underneath this as there is clearly something that is not coming through the normal analysis route. There has been an improvement in associated metrics, but it is not translating through into patient experience and risk of harm.

6.10 The system is on track to achieve the LD inpatient target by the end of the year; there has been a number of late admissions which has set back achieving the target, these patients are continuously assessed for the appropriateness of those admissions.

6.11 Julie Garside extended her thanks to provider colleagues regarding the planned care position despite challenged circumstances in terms of industrial action. The reduction in the over 65 weeks target is going to be over-achieved. There has been improvement in the 62 day cancer backlog which is down to 187 against a target of 212 as at end of March. It is expected to rise slightly during April due to the Easter holidays. The team, the providers and the cancer team are working on a plan with NHS England to be out of Tier 1 for cancer, by the end of quarter one. There are draft plans in place for next year to support this.

Commented [WV(STAWIM2]: Please add who from

6.12 With regard to cancer care the fit test percent of suspected lower GI cancers with a fit test of 84.7% which is an improvement however it is being looked into whether this is having any impact on the number of referrals which should show a reduced number of referrals and a higher number of conversions.

6.13 Balancing of the metrics is being developed and the consequence of this is to be able to reduce the number of endoscopy procedures. In terms of referrals, SaTH are struggling with the EPR transfers and the BI work is being carried out with Anna Martin at SaTH to get the metric around the what is happening in terms of the volume of endoscopy procedures. Referral information is awaited from SaTH in order to see if GPs are making the right referrals so patients are seeing the right person at the right time. The symptoms pathway is due to go live within the next couple of weeks where benefits are expected to be seen.

Commented [WV(STAWIM3]: Can you sort the formatting out from here on please

6.14 It was highlighted that during a recent meeting of the Commissioning Working Group the number of pressures and multiple priorities was discussed and decisions to change pathways that have an impact on primary care but the ICB do not get to get involved in that discussion or have that ability to agree it, and then work out how it will be implemented. The Group took the action to pick that up as part of the new Primary Care Transformation and Delivery Group. Other system partners support will be needed to support this as part of the development to provide a collaborative to ensure primary care are part of those collaborative discussions and are at the table to agree priorities that are missing; the number of priorities that are being put to primary care that do not come out via the ICB or the Primary Care Team, there may be a need to look at contractual arrangements with providers in a supportive way to ensure a discipline is put in place ensuring that primary care are at the table when matters are decided.

6.15 There are a number of issues around integration, how it can work better for the patient and how things can be streamlined to reduce unnecessary activity going to secondary care.

6.16 It was pointed out by Dr Ian Chan that General Practices are not adequately communicated with since the transition from a CCG to the ICB.

Commented [WV(STAWIM4]: Would you add who from? Was it Ian Chann maybe?

6,17 MPFT have extended some of the dementia waiting list contracts further. A part time Medic Aid has been employed until the end of April and will provide support with assessments . There are issues with Bloods for people over 50. Bloods are awaited from primary care which is causing a delay over the 18 week waits.

6.18 The AI in relation to Talking Therapies is working well. MPFT are struggling to recruit into admin posts and retention is low due to the complexity of the role. Waiting lists are reducing, MPFT are benchmarking well compared to the rest of the region's waiting lists for Tier 3, the more complex therapies are down.

6.19 Reference was made to the audiology service review having been on hold but is now being put through the new ICB Strategic Decision Framework in order to push forward the capacity issues and possible solutions. This is so that it will appropriately assessed as part of ICB's clinical prioritisation of the resources and given the current financial position any investment that the system wishes to make would need to be scrutinised and has to be approved by NHS England.

The Committee:

- Noted the content of the report regarding performance of key metrics against national standards and local targets.
- Where performance falls short of national standards and locally agreed targets,
- Noted the actions being taken and that risks are being appropriately mitigated and provide the necessary.
- Noted that the Performance Report continues to evolve to improve the way data and actions are presented to provide assurance to the Committee. The Committee is asked to feed back on the report presentation to ensure the report meets the needs of the Committee.

7.0 Minute No QPC-24-03.39 - System Risk Register – Sharon Fletcher

The paper was taken as read and the following points were highlighted: -

7.1 It was highlighted that Vanessa Whatley and the Quality Team are working on an ongoing quality improvement project with John Costello at MPFT to develop a framework which will support improvement projects at various levels and ensure that all risk content are based on a quality improvement methodology and all risk owners will be supported in applying this methodology. When updates are requested for the next SQG a short survey will be put together that will influence where the quality improvement needs to be.

7.2 The risk of diagnosis of the ADHD is being worked on and being progressed as a new risk.

7.3 System risk 1 CYP mental Health Services- this risk has been reviewed; Key actions remain around the Section 31 action plan, and system oversight for CYP is currently in development. It is still rated as a 16 and actions are progressing.

7.4 The update regarding the governance element of this risk it is expected to be presented to QPC as part of the deep dive update in May 2024.

Action: Sharon Fletcher to ensure that this is built into updates to ensure SQG are aware.

7.5 Safe & effective Maternity Care – the rating changed for this risk to a 10 following agreement at SQG based on the progress made on Ockenden and other benchmarking processes. The CQC report for SaTH is still awaited.

7.6 CAMHS – Concerns were raised at the Health & Wellbeing Board there are some key areas where oversight is needed at this group around some elements of commissioning.

Action: Sharon Fletcher to link in with Helen onions regarding CAMHS RISK in order that Helen can provide an update at the next Health & Wellbeing Board.

7.7 It is intended that this risk will reduce further to a score of 9 by April and it was questioned whether this is on trajectory. it was highlighted that it was unlikely that this would happen until May/June of this year.

Action: Sharon Fletcher to obtain an update on this risk from the risk owner and provide feedback to QPC at a later date.

7.8 UEC risk remains an extreme risk with key areas of concern being acute medicine, frailty, emergency medicine and care co-ordination improvements, these programmes are being established however the challenges in relation to workload is understood. 4 new GIRFT workstreams have been devised and are progressing which are going through the UEC Route for reporting but will be updated in UEC deep dives.

7.9 The UEC Improvement plan is going to the UEC Delivery board for sign off on 16th April 2024. A deep Dive for UEC is scheduled to be presented at QPC in for April with a recommendation was made that the deep dive focusses on sharing the improvement plan in order to provide QPC Committee to have sight of this plan in order to provide assurance which would resonate with the timings of the deep dives.

7.10 In relation to risk SQG 4 it was highlighted that a target had not been set and a recommendation was made that targets are set as it is important to have the aim rather than leaving blank. It was pointed out that this aligns with the work around the quality improvement methodology, the initial aim of the Risk Register which had been put together at a time that required a way of articulating risks across the system; however with the introduction of the QI Methodology will change that aim which will provide clear focus points with clear methodology and steps around how impact will be measured. The clearer language within the risk Register will not be seen until June of this year, there is an aim and commitment to ensure that the risk register is clear and less vague.

7.11 Given the challenges within SaTH Clinicians teams and operational teams are fully committed to within SaTH to make improvements to UEC in terms of process.

7.12 An example of work carried out within the ICB is a good piece of co-produced work with SaTH in relation to harm reviews on a QI methodology, a review of delayed ambulance offloads is being looked on a weekly basis and 12-hour trolley breaches are reviewed on a monthly basis. This is an evolving process, there is good engagement with SaTH. Looking at how we look at the introduction of other parts of the system and looking at themes rather than specific individual patients who are usually looked at on the day. This is reported up to UEC Board providing a quantitative perspective.

7.13 From a patient safety regional response, It is a hot topic in the regional patient safety meetings around the strategy and multiple regions are attempting to mitigate some of the risks in lots of different ways and the regional team are pull those connections together some of the ICBs are working patient safety specialist to patient safety

specialist to ensure we find the pockets an our model of the UEC harms review process, this is being held up as a really good example of collaborative working.

7.14 The diabetes risk had not been reviewed and remains an extreme risk and will be picked up as part of the system quality updates. An update on the diabetes risk will be made available at the next QPC meeting.

7.15 Diabetes update in April and it would be nice to see if it ties up with what is in the risk register in terms of actions.

Action Sharon to cross reference the Diabetes report against what is in the risk register.

7.16 The Acute Paediatric Pathway risk has been reviewed following a previous discussion at QPC. There has been a reduction in this risk and good progress through the paediatric transformation assurance committee within SaTH, also some of the wider contract work which will support this, from April metrics and information that relates 4 key clinical pathways including torsion, asthma and epilepsy will be received. So hopefully we will be able to triangulate some of the quantitative data against qualitative approach across the ICS.

7.17 C-diff risk has been reviewed; cases continue to be high across the system there is a lot of work ongoing. Kirsty Morgan from NHSE have visited SaTH recently and has fed back that SaTH are working hard to do all that they can despite challenges of not being able get rooms empty for cleaning and decontamination due to capacity challenges. There has been discussion around this risk whether it needs to be rescoped to include other infection risk across the system. This will be discussed at SQG and a further update will be provided to QPC in May.

7.18 SaTH updated that Kirsty Morgan, Regional IPC nurse specialist looked around ED predominantly around the spaces to isolate particularly for Children with measles where space is a challenge; interim measures have been put in place in terms of where a temporary segregated the waiting area so we can have some cohorting of isolation rather than a single side room whilst the work by the UEC spaces to completed. Kirsty was assured by what she saw in terms of cleanliness and processes in place and triage. It was a positive visit and SaTH are awaiting the formal response.

7.20 It was discussed that this does add an element of complexity, but it does also offer if using the human factors of the SEPS model for greater opportunity across the system for areas to be identified which have not explored which could be reframed and refreshed. Work is being done with Minesh Parbat Chief Pharmacist and the IPC team in relation to vaccinations and how to procure an emergency preparedness response. There is an after-action review after the UKHSA report mid Apil, it is intended to pull together a system wide after-action review to discuss any opportunities which will support any changes and any wording or scope of that risk.

7.21 ADHD is rated as a 16, STW Task & Finish Groups have been established as a subgroup of SQG to help drive this risk. A paper that covered risks around long waits associated with adult ADHD and ASD was presented to the commissioning working group and a follow-on meeting has taken place due to the complexity of this risk, not least because of the issues around the financial position and the ability to put extra investment into managing the waiting lists and to bring the backlogs down. A way forward was agreed and commissioners will be supported to bring the papers through the process, this is a process that enables the commissioning of correct capacity to meet the current demands so the current waiting list is not added to and a backlog position was agreed as a way forward. How the backlog issue and also looked at and how to balance that financial risk against the quality and risk for patients. This will continue to be monitored through this group to ensure progress continues.

Commented [WV(STAWIM5]: Remove as this doesn't make sense, can you renumber the below then please

7.22 Individual Commissioning remains an area of focussed work rated as a red risk of 15. There are multiple strands of work taking place across the system.
7.23 It was commented that it would be helpful to have all gaps in the risk register filled and as much detail included as for assurance purposes.

Action: Sharon Fletcher to liaise with Risk Owner to help fill in gaps where needed.

The Committee:

- Noted the contents of the report.

8.0 Minute No QPC-24-03.40 - System Quality Metrics – Tracey Slater

8.1 There is good working partnership working in relation to the harm reduction processes. There is a piece of focused quality QI work happening with staff looking at postpartum haemorrhage.
8.2 Progress has been made in relation to the remaining Ockenden recommendations, in particular the development of a regional dashboard.
8.3 Falls admissions have decreased, impacted by the increase in activity of the Falls project, which was the outer hospital project and the increase in activity in stability classes.
8.4 A paper on falls will be presented at the Commissioning Working Group on the 17th April. Funding for falls needs to be prioritised, falls is featured high on the list of priorities and there is confidence that falls will feature high enough up that list of priority and a recommendation will be made at the commissioning working group to fund this service which will then enter into the ICB and NHS England triple lock process,
8.5 Falls was highlighted in Healthwatch Shropshire's ambulance report. Shropshire Council also have a falls service and it was asked whether this service was aligned with Shropshire's or if it is they are separate.
8.6 The fall services are fragmented. The falls paper being presented at the Commissioning Working Group will look at how a county wide integrated full service could be achieved.

The Committee:

- Considered additional assurance required in relation to the metrics

9.0 **Minute No QPC-24-03.41 - System Quality Exception Report Chairs Report – Sharon Fletcher**

9.1 The March meeting included a draft of the schools' asthma policy and comments were requested, Policy is due to be signed off by the end of Q1.
9.2 It was highlighted that childhood asthma it is not included within the risk register, however there is a focussed piece of work to get children having high numbers of inhalers having good quality regular asthma checks via their GP practices ongoing. This is feeding into the Child Mortality Workshop and Lynette Charles, the Consultant respiratory Nurse at SaTH has been leading There has been 2 recorded asthma deaths in recent years and CDOP has made recommendations. The number of patients attending the Children's Assessment Unit is more with asthma in Shropshire compared to in other counties. There was a pilot project which was initiated where patients who have been discharged from hospital had support from the Community children's Nurses to ensure that education was given to parents to help prevent

Commented [WV(STAWIM6]: Please can you clarify this - I cant work it out.

readmission, following this pilot readmissions decreased however the pilot project needs to be revisited as it proved to be very useful.

9.3 Referrals for asthma have increased into secondary care which could be avoided if better education in both the education sector as well as parents should be implemented. The question was asked what the aim was moving forward as unfortunately as alluded to previously there have been some mortalities which could have been avoided.

Following Discussion, The Committee
- Considered the alerts in this report and further assurance required.
- Accepted the report

10.0 Minute No QPC-24-03-42 – Insight Report – Sharon Fletcher

10.1 It was highlighted that this report triangulated information from weekly safety huddles and exec huddles, therefore if there were areas of concern or feedback this report acts as a barometer. The report is triangulated with other qualitative information, which links into the quality improvement work that is ongoing across the whole of the ICS.

10.2 The report shows the increase in relation to whole numbers of access points which is down to the devolution of NHS England's work. There is a monthly update from the ICB's weekly Safety Huddle and a monthly update from the Patient Services Team which enables the Quality Team to respond quickly to anything that needs to be responded to; there are areas where feedback has been received saying that this is a good pathway for them to be able feed back into the system from a quality point of view quickly.

10.3 There is no NHS-to-NHS detail within this report; there is an ongoing project around the NHS to NHS concerns project which will be launched across the system where the NHS to NHS concerns process will be changed to a provider partner feedback model, where a triage approach will be encouraged for feedback, conversations are taking place across the system in line with PSIRF. A GP newsletter has been sent out to primary care, presenting themes around NHS-to-NHS feedback working with multiple partners across the ICS to try and make it more meaningful so that it is not just a list of concerns raised with no real responses. There is a full quality improvement ongoing and from a patient involvement feedback part, it would be helpful if either Healthwatch could give a view on the work that has already been done by way of a collaborative approach.

10.4 Healthwatch have been advocating for a joined up approach looking at concerns and complaints across the ICS. Healthwatch would be supportive of this approach and would like to be involved in all the conversations.

Action: Lynn Cawley and Sharon Fletcher to meet to discuss this collaborative approach to the report

10.5 It was highlighted that when Healthwatch Shropshire had first been set up, information sharing agreements with providers were in place where they would have regular quarterly meetings where feedback received about individual services would be shared. It was noted that Healthwatch Shropshire would be keen to reinstate these meetings which would be relevant to Healthwatch as they provide the independent health complaints advocacy service.

10.6 It was suggested that both Healthwatch Shropshire and Telford & Wrekin contribute to future Patient Insight report and get some of the new provider partner feedback information included. It was also suggested that Healthwatch could contribute to the Quality & Performance report in relation to their feedback around referral issues.

Action: Julie Garside and Lynn Cawley to meet following planned annual leave to discuss Healthwatch's contribution to the Quality & Performance Report.

The Committee:
- Considered the contents of the report for ongoing progress/action

11.0 Minute No. QPC-24-03.43 – Deep Dive – Primary Care

11.1 This paper has been deferred to April or May QPC meeting So that Dr Ian Chan can be present as it was noted that Dr Chan will be on annual leave for the April meeting.

The Committee:
- Noted and agreed to defer this paper to a later meeting.

14.0 Minute NO QPC-24-03-44 – Healthwatch Shropshire Update

14.1 Healthwatch Shropshire have a new member of staff commencing on the 8th of April who is going to be the new entrant view Officer and it is hoped that entrance view can be picked up again.

14.2 The main piece of work now continues to be the living well with cancer project; they are also carrying out a piece of work around end of life. Organisations are asking people who are living with cancer and service users their experiences, but they're not seeing any outcomes from that which makes it harder for Healthwatch to engage with them,

14.3 Healthwatch Shropshire have not yet produced their Domiciliary Care report, however this will be produced within the next month or two.

14.4 Healthwatch asked that they are informed of the ICB's priorities for 2024/25 so they can ensure that any engagement they do supports what the ICB is doing.

14.5 Healthwatch confirmed that they are included within the steering group for he for end of life. (PEoLC) meetings.

The Committee:
- Noted the verbal Update

15.0 Minute No 24-03.45 Healthwatch Telford & Wrekin Update

15.1 No Representative from Healthwatch Telford & Wrekin were present at the meeting to provide an update.

16.0 Minute No QPC-24-03-46 - Items for Escalation/Referral to Other Board Committees

16.1 No items were requested to be escalated or referred to other Board Committees.

17.0 Minute No. QPC-24-03.47 Any Other Business (AOB)

17.1 No other business was raised.

The meeting closed at 14:02pm

.

Date and Time of Next Meeting

Thursday 25th April 2024 2.00pm to 4.00pm via Microsoft Teams.

SIGNED ..... **DATE** .....

NHS Shropshire, Telford and Wrekin
Audit Committee Meeting

Wednesday 17 April 2024 at 8.30 a.m.
Via Microsoft Teams

Present:	
Mr Roger Dunshea (Chair)	Non-Executive Director, NHS STW ICB
Mr Trevor McMillan	Non-Executive Director, NHS STW ICB
Mr Meredith Vivian	Non-Executive Director, NHS STW ICB
Mrs Niti Pall	Non-Executive Director, NHS STW ICB
In Attendance	
Mr Trevor Purt	Non-Executive Director, SaTH – ICS Observer
Mrs Claire Skidmore	Chief Finance Officer, NHS STW ICB
Miss Alison Smith	Director of Corporate Affairs, NHS STW ICB
Mr Angus Hughes	Associate Director of Finance, NHS STW ICB
Mrs Angela Szabo	Deputy Director of Finance, NHS STW ICB
Ms Lisa O'Brien	Audit Manager, CW Audit Services
Ms Sarah Swan	Assistant Director, CW Audit Services
Mr Paul Westwood	Head of Counter Fraud Services, CW Audit Services
Mr Terry Tobin	Grant Thornton – External Audit
Mrs Sara Spencer	Operational IT & IG Manager
Mrs Chris Billingham	Corporate PA (Minute Taker)
Apologies:	
Mr Richard Anderson	Director, Grant Thornton – External Audit

Minute No. AC-24.04.21 – Introductions & Apologies

1.1 Mr Dunshea welcomed Committee members to the meeting.

1.2 Apologies received were as noted above.

Minute No. AC-24.04.22 – Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests available to view on the website at: Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

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

2.3 No additional conflicts of interest were declared, and no existing interests were raised that may conflict with an agenda item.

Minute No. AC-24.04.23– Minutes from Previous Meetings

3.1 The minutes of the Extra Ordinary Audit Committee held on 4 January 2024 were approved as a true and accurate record of the meeting.

3.2 The minutes of the Audit Committee held on 17 January 2024 were approved as a true and accurate record of the meeting.

Minute No. AC-24.04.24 – Matters Arising and Action List

4.1 The Action Log was updated as appropriate.

4.2 The Chair requested an update from Mrs Skidmore regarding the situation with the Better Care Fund and the Local Authorities.

4.3 Mrs Skidmore advised that discussions are ongoing. Support had been requested from representatives from the national team to mediate a conversation.

4.4 The Chair had considered his action regarding the capture of information and data by the Business Intelligence team. He believed that this could be the subject of a review in 2025/26 due to the complexity of the information and suggested that it should be removed from the action list and placed on the forward planner as a possible internal audit for 2025/26.

4.5 The Chair then requested an update regarding EPRR. Mrs Skidmore advised that an individual had been appointed to support EPRR.

4.6 Mr Purt took the latest SaTH EPRR plan to their Audit Committee and an action plan is in place regarding all outstanding issues. It will be rag rated every quarter and will be submitted to the Board twice this year. He was confident that all of the areas in which SaTH were not compliant will be resolved by the time of the next submission.

ACTION: Alison Smith to ask Sam Tilley to provide a briefing note which picks up the points made by Mr Purt regarding EPRR, and other issues across the system.

Minute No. AC-24.04.25 – System BAF & Strategic Operational Risk Registers

5.1 Miss Smith presented the latest versions of the System Board Assurance Framework and the Strategic Operational Risk Register which had been submitted to the Board at the end of March.

5.2 The Chair referred to strategic risk number 2 which related to services, resources, and money and asked - bearing in mind the actions that must be taken in terms of freezing vacancies – how that featured in the actions on this particular assurance framework.

5.3 Mrs Szabo advised that the ICB has a set allocation for running costs which it must operate within. Any vacancies arising as a result of the Management of Change process had already been taken into account and the vacancy freeze is not expected to impact our ability to recruit to those.

5.4 Mr Dunshea referred to reference within the papers to a long-term demand and capacity model and medium-term financial plan and asked when they would be available.

5.5 Mrs Skidmore advised that the documents would be refreshed as soon as the 2024/25 plan had been submitted. A timeline is being developed internally to have them available by the end of Q2.

5.6 The meeting discussed the potential loss of colleagues from the organisation and the risk around corporate memory which Mrs Skidmore will include in the next iteration of these documents. Concerns were also expressed regarding the impact of diminished capacity and increased demand on quality and performance, a concern which Mr Vivian had already raised at the ICB Board.

5.7 The Chair believed that three issues needed to be assessed in terms of assurance: -

- The way in which actions are logged in terms of ownership and dates.
- The risks of not recognising the interdependencies between various risks and overlaps between them.
- The way in which we as an ICB are managing risk and Board assurance, and how well the Committees are engaged in this process, particularly challenge, oversight, and scrutiny.

ACTION: Alison Smith to pick up the actions relating to the way in which actions are logged on the System BAF and SORR, the risks of not recognising the interdependencies between various risks and overlaps between them, and the risk around Board assurance and how well Committees are engaged in this process.

Resolve: ***The Committee reviewed the current System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR) and requested further actions as outlined above.***

Resolve: ***The Committee noted the risk around Board assurance and how well Committees are engaged in this process.***

Minute No. AC-24.04.26 – MHIS Report to ICB Board

6.1 Mrs Szabo and Mr Tobin provided an update regarding the 2022/23 audit. Mr Tobin set the context of the report.

6.2 In 2010, NHSE set out a commitment to increase mental health spend which is now a key target.

Approximately five years previously NHSE asked CCGs (now ICBs) to publish a compliance statement but at the same time they also wanted assurance from auditors to be placed alongside that.

Mr Tobin's report provided that assurance and confirmed that the ICB had met the standard and had complied with the relevant guidance.

Any issues identified were set out in Appendix A. There were material issues that would have potentially overstated the position and some understated. The net impact of those was £163k over statement which was well within our materiality threshold and allowed the report to be issued.

6.3 Mrs Skidmore confirmed that MHIS was currently heavily ring-fenced. There was no evidence to suggest there would be any changes in the audit regime and it is assumed that it will continue.

Resolve: ***The Committee noted the contents of the report.***

Minute No. AC-24.04.27 – Estates Strategy Update Presentation

7.1 Simon Taylor and Zoe Watts, NHS Property Services (NHSPS), joined the meeting to present the draft Estates Strategy. They were accompanied by Mr Gareth Robinson, Director of Delivery & Transformation, NHS STW ICB.

7.2 The Chair welcomed all three guests to the Audit Committee, advising that the Committee were looking for assurances around the current position, how much is known, gaps in our knowledge, and how well the strategy of the system can help determine the estates requirement going forward.

7.3 Mr Robinson introduced Zoe Watts who presented the draft Estates Strategy which NHSPS had developed and written on behalf of the system. Ms Watts advised that the Strategy is a mandatory document requested by NHSE that provides an overview of the ICS in terms of their infrastructure now, their target infrastructure, and how it will be achieved over the next ten years.

7.4 To help establish key infrastructure objectives and key themes, NHSPS undertook 18 stakeholder interviews and ran two workshops with representatives from the acute community, primary care, and wider public sector. The feedback from each interview was relatively consistent, with stakeholders highlighting the need for greater partnership working and collaboration, an overarching estates lead to offer some strategic direction, and a clear governance structure – mainly in terms of estates – to enable all parties to work towards one estates governance structure, improve building utilisation, service integration and patient accessibility and create a better link between estates and other infrastructure components such as sustainability, digital, workforce, and improving the patient and workforce environments.

Using this feedback, NHSPS compiled the following infrastructure objectives: -

- To work more collegiately as a system to ensure that a clear estates leadership is in place and regular estates forums are held with stakeholders.
- To include digital access as a key part of our infrastructure plans.
- The creation of integrated flexible spaces across our clinical estate to enable multiple services to be delivered in one location.
- Improving the utilisation of existing space and clinical space, thus avoiding vacant space.
- Delivering an estate that is affordable and fit for purpose.

7.5 A snapshot of the infrastructure strategy was contained within the presentation. The document had been produced in accordance with NHSE guidance.

7.6 The strategy was presented to the ICB Executive team on 16 April 2024, and to the ICB Audit Committee on 17 April 2024. Feedback will be requested from both groups and the strategy will be amended to reflect any requested changes. It will then be shared with wider stakeholders to receive their feedback.

7.7 Two key milestone dates are 31 May 2024 when NHSE require the first draft of the Infrastructure Strategy to be provided. Thereafter, comments will be returned, and amendments made. The final document must be submitted on 31 July 2024.

7.8 The Chair thanked colleagues from NHSPS for their impressive work in creating the draft strategy.

Minute No. AC-24.04.28 – Internal Audit

Review and approve annual Internal Audit Plan 24/25

8.1 Ms Swan outlined the process followed to create the plan. She met with all of the Executives individually and compiled a list of areas of focus for inclusion in the plan. The focus should be on prioritisation and where resource is best directed to provide assurance.

8.2 Specific requests were received regarding the Additional Roles Reimbursement Scheme which she planned to pick up in Quarter 1.

8.3 She had also been asked to focus on complaints and engagement relating to CHC.

Resolve: ***The Committee approved the draft Internal Audit Plan, subject to minor amendments.***

Ophthalmology Contract Management Report

8.5 Ms O'Brien advised that this was an advisory review. It was included in the plan for 2023/24 in order to look at the contract management arrangements in place with independent sector organisations for the outsourcing of ophthalmology services primarily for contract cataract surgery to patients across the Telford, Shropshire and Wrekin footprints.

8.6 Provision of this type of surgery is primarily driven by choice and as waiting lists are much shorter in the independent sector, this is a popular choice for patients. However, with this comes significant spend for the ICB and as such the Audit Committee had requested additional assurance around how these particular contracts were being managed.

8.7 This was a high-level review that focused on areas within the ICB's remit, given that national contracts and funding of additional activity to independent sector providers is done through the elective recovery fund.

8.8 Contract management meetings were held frequently and there was good evidence to support scrutiny and challenge over IS activity and billing. Actions arising from these meetings were being addressed promptly.

8.9 The review identified the potential for the Terms of Reference that support these meetings to be reviewed and aligned to provide consistency and ensure they reflect current practice, e.g., the frequency of meetings and the arrangements for reporting the meeting outcomes to relevant meeting groups within the ICB. It was unclear where outcomes of these were being presented or discussed, and this was not able to be evidenced.

8.10 Scope to enhance quality visits was identified, ideally on a more proactive basis. Currently these tend to be undertaken on a more *reactive* basis when issues or concerns have been notified to the ICB. One visit had been undertaken to one IS provider during 2023/24.

8.11 The NHS standard contract stipulates the need to have in place local agreements with IS providers with the aim of tackling waiting lists and allowing a more equitable process around patient choice for this type of surgery. Whilst it was noted that formal agreements are not in place, that work was evidenced and discussions remain ongoing in this area. This includes the implementation of PIDMAS, the Patient Initiated Digital Mutual Aid System which, once in place, should allow patients who have been waiting more than 40 weeks on NHS waiting lists to move provider more easily.

It was also noted that certain peer ICBs have proposed a methodology that shares the complexities of different cases with this surgery in order to help prevent the cherry picking of activity by certain IS providers which would leave NHS organisations with the more complex treatment. This approach is now under review by NHSE.

8.12 Suggested actions for the ICB to consider are included in the report in order to ensure that oversight and focus remains over these key areas of development.

8.13 Scope was noted to improve the level of oversight by Board over ophthalmology activity spend and any associated developments or to ensure that is evidenced more clearly through upwards reporting from relevant committees, and in particular progress with the Ophthalmology Transformation Programme and finances or arrangements under the ERF as this is a risk to the ICB if the funding via the ERF ceases. However, we understand that this is to continue through the remainder of the year.

8.14 Mrs Skidmore wished to review the report with her team as she had responsibility for contracting, and believed there were some interesting links into commissioning as we move forward.

ACTION: Mrs Skidmore to liaise with Mr Robinson and his team to make sure there is an appropriate response to the recommendations made around ophthalmology.

8.15 Discussion took place regarding complex patients and long waits around their onward referral to providers, during which reference was made to the use of digital and automated processes. Ms O'Brien confirmed this was not part of the scope.

8.16 Mr Vivian and Mr Dunshea both referred to the service aspect of the contract and reference in the report to the Ophthalmology Transformation Project.

Mr Dunshea queried whether the HTP build at SaTH and PRH would remove the need for referrals to the independent sector.

8.17 Mr Purt advised that because SaTH were now subject to the same recruitment ban as the ICB they are very cautious about which services are recruited to. This would not be a clinical priority against some of the other areas on the waiting lists that SaTH are currently trying to prosecute and whilst opportunities exist to use private sector partners it seems a sensible way of driving forward in certain areas.

In response to a question from Mr Dunshea as to whether HTP would provide SaTH with the capacity for bringing ophthalmology in house, Mr Purt replied that HTP does not provide the hospital with any more beds, nor does it improve discharges and flow through the hospital.

8.18 Mrs Skidmore commented that several options were available to the ICB when considering the developing provider collaborative and suggested that at a point in the future, she and Mr Purt should discuss whether SaTH would wish to be lead provider in that area. The independent sector does not have the waiting list pressures experienced by the NHS and can provide a faster service for patients. Cataract treatment is currently very expensive for the NHS in terms of volume of patients and money spent in that area could potentially be prioritised elsewhere.

ACTION: Mr Robinson and Mrs Skidmore to provide a briefing around options for ophthalmology in terms of commissioning contracting, value for money and affordability whilst considering the overlap with Mr Purt's SaTH Committee on performance and Finance.

ACTION: Mrs Skidmore to create space on the forward agenda for deep dive areas for some of the more significant risks.

Resolve: ***The Committee noted the 2023/24 Ophthalmology report and the associated level of assurance.***

The Chair welcomed Mr Trevor McMillan to the meeting. Mr McMillan joined the meeting at 9.30 a.m. because of another commitment.

Head of Internal Audit Opinion / Second Interim Opinion

8.19 Ms Swan referred to the interim opinions which were imminent within the next few days, after which the current draft submitted to Audit Committee would be updated, agreed, and finalised.

The Stage 2 opinion was agreed.

8.20 Ms Swan wished to discuss the framework of strategic risk management. In the Stage 2 opinion a gap in terms of the BAF was identified whilst the system BAF was being developed.

The ICB is an organisation with many high-level risks but very few were identified in the SBAF and there were very few specific actions and time scales. That led us to form an opinion in the draft report that that aspect is limited.

8.21 Mr Dunshea requested Miss Smith's opinion as to how valid she found this view on the findings from Ms Swan.

8.22 Miss Smith replied that the report was very helpful, particularly the comments relating to the opinion regarding the Committees, the mapping of which had been particularly helpful in identifying shortfalls and inconsistencies.

8.23 Discussion took place regarding further action to be taken by Non-Executive Directors and the Board to address the situation. Actions identified included: -

- The Executive team taking responsibility for their team's input and engagement with the process.
- The Corporate Governance team facilitating and supporting people in those discussions.
- Chairs to make sure that the schedule for their committees has a regular discussion around the BAF and the SORR, and the lead officer who sits with them to make sure that that also happens on an operational basis.
- The governance team will take forward work in terms of training and awareness and ensuring consistency.

8.24 Miss Smith confirmed her intention to consider the report in detail and compile proposed actions to be taken to both the Exec meeting and Senior Leadership Team. Mr McMillan expressed his agreement with her proposal, stating that a written response from management was required as to how the ICB intends to respond.

8.25 The Chair suggested that the management response should be discussed at the next meeting of the Non-Execs/Execs.

ACTION: Non-Execs and Execs to discuss the management response to the need for improved reporting of strategic risks in the SBAF.

8.26 The Chair requested confirmation that the review of the GP Board was now complete.

8.27 Ms Swan confirmed that she would be meeting with Ms Pyrah, Associate Director of Primary Care, before issuing the reports.

8.28 The Chair requested that the report should be issued to Committee members before the next meeting.

Resolve: ***The Committee noted the Stage 2 and Stage 3 draft Interim Head of Internal Audit Opinion reports.***

Minute No. AC-24.04.29 – Draft Annual Accounts 2023/24 & Draft Annual Report 2023/24

Draft Annual Accounts 2023/24

9.1 Mrs Skidmore thanked the Finance team for their hard work in preparing the accounts.

9.2 She was pleased to report that we were able to meet our reforecast position, and invited questions.

9.3 There were no questions regarding the annual accounts.

Resolve: ***The Committee noted the draft annual accounts for 2023/24 and draft disclosure notes.***

Draft Annual Report 2023/24

9.4 Miss Smith intimated that not all of the required information had been available. Any draft information was highlighted within the report.

9.5 She thanked Martin Rogers for his hard work in pulling the report together.

9.6 As signalled at the January meeting, the joint forward plan was used as the infrastructure to describe our performance during the year to try to meet the Audit Committee's request that the report should have less pages and more engaging content that members of the public would find helpful.

9.7 The document submitted to the Committee was in draft. However, there was still time to make any changes requested by Committee members.

9.8 In light of the draft Head of Internal Audit opinion and with Committee approval, Miss Smith intended to amend the narrative in the Chief Executive Officer's review of the year which referred to our governance performance prior to submission to NHS England and our external auditors.

9.9 The Committee agreed with the narrative being amended to reflect the interim opinion.

9.10 Mr Vivian commented that the numbers shown for individuals' attendance at meetings appeared to be incorrect and did not accurately reflect his own attendance.

ACTION: Mr Vivian to email Miss Smith with his comments regarding individuals' attendance at meetings and she will follow up his comments with those responsible.

Resolve: ***The Committee noted the content of the draft NHS Shropshire, Telford and Wrekin Annual Report (including the Annual Governance Statement) for 2023/24, acknowledging that some information is not yet available but will subsequently be added and then shared with the ICB's external auditors prior to the final version being shared with the Audit Committee at its Extra Ordinary meeting to be held in June.***

Resolve: ***The Committee assured itself that the content of the draft NHS Shropshire, Telford, and Wrekin Annual Report (including the Annual Governance Statement), 2023/24, is accurate and sufficiently reflects the position of NHS Shropshire, Telford and Wrekin.***

Resolve: ***The Committee approved the draft NHS Shropshire, Telford, and Wrekin Annual Report for 2023/24 and draft Annual Governance Statement 2023/24 of NHS Shropshire, Telford, and Wrekin prior to submission to the external auditor and NHS England.***

Minute No. AC-24.04.30 – External Audit – 2023/24 Audit Plan & Fees

10.1 Mr Tobin introduced the Audit Plan for 2023/24 and highlighted key points. These were: -

- Management override of controls
- Fraudulent transactions
- Fraudulent expenditure recognition
- Risk relating to Pharmacy, Optometry and Dentistry (POD) in its first year of delegation.

10.2 Materiality is higher this year - £60m - reflecting the fact that we are now dealing with 12 months of expenditure as opposed to 9 months last year. Any errors over £300,000 - the National Audit Office reporting threshold - will be reported to the ICB in the audit funds report.

10.3 Value for money planning had been carried out, the results of which were outlined within the Audit Plan.

10.4 One significant risk of financial weakness was identified and that is in relation to financial sustainability due to the ICB's system deficit. Specific additional work will be carried out to respond to that risk.

10.5 It is planned to issue our audit opinion before the end of June. We also plan to issue the final Auditors Annual Report at the same time.

10.6 Mrs Skidmore confirmed that she was comfortable with the contents of the report.

Resolve: ***The Committee noted the contents of the External Audit report.***

Minute No. AC-24.04.31 – Counter Fraud

Progress Report

11.1 Mr Westwood advised that no new incidents had been reported since the previous Audit Committee.

11.2 One ongoing issue was reported via an intelligence bulletin from the Counter Fraud Authority which has been reviewed by the contracting team. An audit of the contract was carried out, they are comfortable that there are no issues, and the item is closed.

11.3 Several intelligence bulletins have been received, further details of which are outlined in the report.

11.4 Page 3 of the report provides an overview of the rag rated assessments against the 13 requirements of the counter fraud functional standard. One is rated as Amber.

11.5 Page 10 of the report refers to a national procurement exercise issued by the Counter Fraud Authority which is currently being reviewed to assess the implications for the ICB.

11.6 Page 11 of the report refers to two intelligence alerts. One has been closed, and work is being undertaken with the GP Practice Manager on a data breach.

11.7 Page 12 reports closure of the issue relating to suspected contract mismanagement.

Resolve: ***The Committee noted the contents of the Counter Fraud progress report.***

2024/25 Draft Counter Fraud Plan

12.1 Mr Westwood introduced the draft plan for consideration and approval.

12.2 The Counter Fraud Group for ICBs had discussed national risks, including personal health budgets and credit card usage.

12.3 The fraud risk assessment had been shared with the Chief Finance Officer and the Director of Finance and a decision was made to carry out work on credit card usage in PHBs within the year.

12.4 Mr Westwood requested approval of the plan by the Committee.

12.5 Mrs Skidmore confirmed that use of the ICB's corporate credit card is relatively small, and the card can only be used by a small number of people. She would expect that to be a short piece of work to provide assurance that the processes are working as they should be.

Resolve: ***The Committee approved the draft Counter Fraud Plan.***

Minute No. AC-24.04.32 – Information Governance Update

IG DSPT Progress Report

13.1 Key points of the IG DSPT report were: -

- Mandatory training had reduced slightly to 85% and a plan is in place to improve this figure. Line managers have been asked to remind staff to complete their training and is also being escalated to heads of departments to ensure the training percentage increases.

- The baseline DSPT submission was submitted at the end of February. It covered 58 assertions, which is in line with previous years and means that the ICB is on track to meet the 30 June target.

- There was a low response from staff to the training needs analysis. Managers are being asked for the training needs of teams. That information will be included in next quarter's report.

- The information risk programme continues and is on track with only two more teams still to confirm that they are actively recording all of their information risks.

- There were three breaches in the last quarter.

13.2 There were no questions in relation to the IG DSPT report.

Resolve: ***The Committee noted the contents of the IG service report.***

Minute No. AC-24.04.33 – Losses, Special Payments and Waivers

14.1 Mr Hughes confirmed that two waivers were reported in the period since the last Audit Committee. No losses have been reported.

14.2 Attached as Appendix 1 was an action from the last Audit Committee regarding three waivers that were reported to the January Audit Committee and were unfortunately excluded from the pack.

14.3 There were no questions from members of the Committee.

Resolve: ***The Committee noted that there were no losses and no special payments in the period 18th January 2024 – 5th April 2024.***

Resolve: ***The Committee noted that there have been two waivers signed off by the CFO in the period 18th January 2024 – 5th April 2024.***

Minute No. AC-24.04.34 – Update on Actions Arising from the Internal Audit of Policy Management

15.1 Miss Smith referred to Mrs Eggby-Jones' report and the table of actions contained in Appendix 1.

15.2 One outstanding action was highlighted in the report relating to policies due for review. An IT solution is being sought to help with capacity issues for the tracking recommendation and IT colleagues from CSU have provided a quote for developing a process for the policy review. A formal quote and formal proposals have now been requested. Once approved, budget approval to progress will be sought.

Resolve: ***The Committee noted the update on actions arising from the Internal Audit of Policy Management, and work in progress to complete the one remaining outstanding action.***

Minute No. AC-24.04.35 – Discharge of Audit Committee Responsibilities

Audit Committee Self-Assessment of Effectiveness

16.1 Miss Smith advised the meeting that it is good practice for the Audit Committee to self-assess and also advised of a requirement in the Terms of Reference of this Committee that an annual report is produced.

16.2 She confirmed that the checklist was completed based on herself, Mrs Eggby-Jones, Ms Swan, Ms O'Brien, Mr Westwood, etc. from our own particular perspectives for consideration and approval by the Committee

16.3 We have prepared the Audit Committee annual report which is a summary of activity over the year for consideration by the Committee. It can then be included in the Chair's report to the Board.

16.4 There were no comments from members of the Committee.

Resolve: ***The Committee noted the responses to the checklist questions and was assured that they are an accurate reflection of the current practice of the Audit Committee.***

Resolve: ***The Committee noted the Annual Report of NHS Shropshire, Telford, and Wrekin Audit Committee for the period of April 2023 to March 2024 and was assured that the Committee has discharged its responsibilities in accordance with the agreed Terms of Reference (TOR) and reviewed its work and performance during 2023/24.***

Minute No. AC-24.04.36 – Governance Issues / Concerns from Other Committees

17.1 No issues or concerns were raised by members of the committee.

Minute No. AC-24.04.37 – Any Other Business

There was no other business.

ICB 26-06-054
Finance Committee Minutes

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 26th March 2024, at 2.00pm
Via Microsoft Teams

Present:

Name	**Title**
Trevor McMillan (Chair)	Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW

Attendees:

Angela Szabo	Interim Director of Finance NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

David Bennett	Non - Executive NHS STW
Gareth Robinson	Directory of Delivery and Transformation NHS STW

1.0 Minute No. SFC-24-03.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **TMcM** stated apologies as noted for the meeting,

2.0 Minute No. SFC-24-03.002 – Declarations of Interests

2.1 No declarations of interest were noted.

3.0 Minute No. SFC-24-03.003 – Minutes from the Previous Meeting held on:
22nd February 2024.

3.1 **TMcM** asked if there were any points to be raised about the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-24-03.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

5.0 Minute No. SFC-24-03.005 - ICB M11 Financial position

Report received as read.

5.1 **AS** highlighted that at M11 the ICB is reporting a £11.8m deficit which is a £11.8m adverse position against the year–to-date plan.

AS reported the main reasons for the adverse variance in the ICB position remain in line with reporting so far this year, significant overspends continue in discharge expenditure (shown in community), individual commissioning and prescribing (particularly due to inflation) and a lack of elective recovery income received from Wales. **AS** added that

these pressures are partially offset with an underspend in dental within the POD budget and a number of non-recurrent underspends due to the allocations approval and prior year balance policies implemented in 23/24.

AS explained that the full year forecast outturn has been revised at month 11 and is now reported as £16.2m – this follows the distribution of national funds to offset the original planned deficit. The ICB share of the system allocation being £11.6m.

AS highlighted, that at Month 11 efficiency savings are forecast to achieve £0.8m better than plan (£26.7m delivery v's £25.9m plan) due to several non-recurrent savings identified as part of the ICB's ongoing budget review.

AS explained that at month 11, most risk has now either been reduced, removed, or has now materialised in the position, there remains overall unmitigated risk of £1.6m relating to the CHC and prescribing position. If pressures in these areas were to materialise, there is currently no identified mitigation.

The ICB Finance Committee noted:

- the M11 headlines for the ICB financial position (£11.8m YTD deficit, £11.8m adverse position to plan)
- that the ICB is forecasting a deficit of £16.2m by the end of the year now that the planned deficit has been funded.
- the small level of financial risk remaining if a new cost pressure could not be mitigated which is currently reported alongside the forecast position (£1.6m)

6.0 Minute No. SFC-24-03.006 ICB M11 Efficiency update

Report received as read.

6.1 **KO** highlighted that £24.5m of savings have been delivered against a YTD plan of £23.5m providing a positive variance of +£1m.

KO explained the positive position in Month 11 is a continuation from last month where additional non-recurrent savings were identified within the UEC and Mental Health budgets and the delivery of savings within the medicines management programmes (DOAC and DOLCV) were over and above plan. **KO** stated that overall, this provides a positive forecast position which is now reported to deliver £26.7m of efficiencies against an original plan of £26m providing a positive variance of £800k**.**

KO reported that the ICB has made significant progress in identifying further savings opportunities to meet the stretch targets set at the beginning of the year.

The ICB Finance Committee noted:

- Month 11 Efficiency delivery and the progress that has been made in bridging the gap in the unidentified savings plans.
- The revised efficiency forecast position of £26.7m that has been reported.

TMcM queried if year on year are they the same things that are looked at regarding efficiencies. **KO** stated that there tend to be ongoing opportunities for savings in Medicines Management and within CHC.

KO also noted that we now have a Systems Medicines Value Group, which is chaired by the systems' chief pharmacist. **KO** added that there has been a number of efficiency opportunities put forward to that group for review and delivery.

7.0 Minute No. SFC-24-03.007 – ISFE2 and No PO No Pay

Report received as read.

7.1 **AS** explained that the No PO (Purchase Order) No Pay Policy is a key element of the ICB's internal control environment and is designed to assist budget holders and managers in the discharge of their responsibilities. All NHS organisations are required to adopt and enforce a No Purchase Order, No Pay Policy. This is being driven as part of the implementation of the new ISFE2 finance ledger. The ICB plans to move forward with adopting this policy as soon as possible.

AS highlighted that the policy means that every purchase of goods or services needs to have an official purchase order, which a supplier will subsequently quote on the invoice, providing full governance, traceability, and auditability. There are certain exemptions which are identified in the policy document.

AS stated, that the policy is designed to strengthen compliance to the ICB's Standing Financial Instructions and will ensure prompt matching of invoices to purchase orders for payment.

The ICB Finance Committee:

- Approved the new PO No Pay Policy which will now be disseminated to all budget holders, promoted via the staff huddle, and made available to all staff via the intranet.

8.0 Minute No. SFC-24-03.008 – Any Other Business

There was nothing noted under this agenda.

Meeting closed at 14.49.

Date And Time of Next Meeting

Monday 29th April 2024, 9.30am via Teams.

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 26th March 2024 at 3.15pm
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillian OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Sarah Lloyd	Chief Finance Officer SCHT
Peter Featherstone	Non-Executive SCHT
Helen Troalen	Director of Finance SATH
Mark Salisbury	Deputy Chief Finance Officer – RJAH
Richard Miner	Non-Executive – SATH
Michele Brockway (part)	Interim Director Finance & Human Resources- T&W Council

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Kate Owen	Head of PMO NHS STW
Angela Szabo	Director of Finance NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Chris Sands	Chief Finance Officer – MPFT
Glenn Head	Deputy Chief Finance Officer – MPFT
David Bennett	STW Non-Executive Director NHS
Sarfraz Nawaz	Non-Executive - RJAH
Craig MacBeth	Chief Finance Officer – RJAH

1.0 Minute No. SFC-24-03.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted,

2.0 Minute No. SFC-24-03.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

3.0 Minute No.SFC-24.03.003 Minutes of the Previous Meeting held:
Thursday 22nd February 2024.

3.1 **TMcM** asked if there were any points to be raised on errors or accuracy within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-24.03.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly. **PF** requested whether more information could be provided in reports of comparison of performance/delivery (i.e. benchmarking). **CS** mentioned the work that Julie Garside and the productivity group are doing and also how the ICB is involved in regional work to benchmark CHC costs.

5.0 Minute No. SFC-24.03.005 - ICS M11 Finance Overview

5.1 **Report received as read.**

CS highlighted that at Month 11 the ICS has a deficit of £71.1m, which is £65.2m adverse to plan (this includes the cost of industrial action).

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

CS highlighted that in Month 11 the system received a national allocation of £57.1m to fund the planned deficit. This was allocated according to the distribution of the deficit in the plan with £45.5m moved to SaTH and £11.6m retained in the ICB. This therefore means that the reported forecast is now £72.7m (reduced from £129.8m) which now also includes funding for the additional costs of industrial action for which an allocation has been received.

Regarding capital, **CS** mentioned that the system was in receipt of an allocation to fund IFRS16 impact. Costings suggests that there is £1.5m risk for the STW system based on current forecasts as costs exceed the allocation distributed. This may be mitigated through the exclusion of internal leases within the DHSC group or, if not, will have to be covered through use of slippage within the SCHT operational capital position. Dialogue with the region is ongoing.

CS reported that Providers operational capital forecasts are predominantly in line with the full year allocation, though a small amount of slippage is expected.

The System Finance Committee noted the following:

- The M11 headlines for the system financial position (£71.1m YTD deficit, £65.2m adverse to YTD plan).
- That the system is now reporting a forecast deficit of £72.1m, reduced from £129.8m deficit following receipt of a national allocation of £57.1m to fund the planned deficit - this was allocated to SaTH (£45.5m) and the ICB (£11.6m).
- The small level of financial risk remaining if a new cost pressure could not be mitigated which is currently reported alongside the forecast position (£5.2m)

6.0 Minute No. SFC-24-03.006 ICS M11 Efficiency Update

Report received as read.

6.1 **K.O** highlighted that £47.6m of savings have been delivered against a YTD plan of £57.7m and therefore the system reports an adverse variance to plan of £10.1m.

KO explained, the main underperformance falls within SaTH (-£11.7m YTD) and, as previously reported, the majority of slippage directly relates to escalation costs. SaTH are also reporting an underperformance of core efficiencies within corporate services, nurse recruitment and corporate estates.

KO highlighted that each partner organisation has remained committed to identifying further opportunities stretching existing plans where possible and further non recurrent savings have since been identified which has improved the overall forecast position to £54.6m (77% of original plan) this represents a further improvement of £500k since last month.

KO stated that each partner organisation continues to oversee its own CIP delivery which is managed through local sustainability working groups and monthly reporting is sent through to the financial improvement programme group for oversight of system delivery.

KO emphasised that focus is now drawn to developing a robust set of plans for next year and beyond which will help to deliver longer term sustainability, these will need to be ambitious and will require collaboration across all system partners and teams.

HT stated for the record that SATH did not commit to deliver the stretch target at the beginning of the year.

The System Finance Committee noted:

- Month 11 efficiency delivery and the adverse YTD variance to plan of £10.1m
- A revised efficiency forecast position of £54.6m which is an improvement from last month of £0.5m
- That focus is now drawn to ensuring that robust sustainability plans are in place for next year and beyond.

7.0 Minute No. SFC-24.03.007 Any Other Business

7.1 There were no items raised as A.O.B.

Meeting closed at 16.26.

Date and Time of Next Meeting

Monday 29th April 2024, 13,15pm via Team

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Monday 29th April 2024, at 9.30am
Via Microsoft Teams

Present:

Name	**Title**
Trevor McMillan (Chair)	Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW

Attendees:

Angela Szabo	Interim Director of Finance NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

David Bennett	Non - Executive NHS STW
Gareth Robinson	Directory of Delivery and Transformation NHS STW

1.0 Minute No. SFC-24-04.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **TMcM** stated apologies as noted for the meeting,

2.0 Minute No. SFC-24-04.002 – Declarations of Interests

2.1 No declarations of interest were noted.

3.0 Minute No. SFC-24-04.003 – Minutes from the Previous Meeting held on: 26th March 2024 were agreed as a true and accurate record.

3.1 **TMcM** asked if there were any points to be raised about the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-24-04.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

5.0 Minute No. SFC-24-04.005 - Finance Risk Register/BAF review

Report received as read.

5.1 AS explained that there had been a minor change to the wording under finance risk in the BAF. This now reflects the transaction of the individual fixed payment reversal and income rebasing. **AS** stated, that there had not been any other changes to the narrative and the risk levels in the report haven't changed.

AS highlighted the primary risks in the risk register for the attention of the System Finance Committee. The first is the delivery of our agreed 23/24 ICB targets. That action has now been closed for 23/24 and a new action is now open for 24/25 which has the same controls

and the same actions around the finance strategy, the recovery plan, the medium- and long-term plan. Which is outlined in the risk register with clear timelines of what is being taken forward.

AS stated, that the risk about finance team capacity has been updated to reflect actions in the management change process. **AS** added that the narrative explains that we have secured additional resource for finance and PMO, within the management of change structure.

AS explained that now that the income rebase is complete, we are now looking at the contract income versus the national tariff and cost-based reviews. **AS** stated, that she has added some additional narrative around the work that has been done to the risk register.

TMcM queried about the section in the report regarding Culture of Strategic Collaboration. **AS** replied that it may go through the Strategic Committee in the new operating structure. **CS** added that we could get a perspective from provider colleagues in section two of the System Finance Committee if that was felt to be appropriate.

TMcM queried about sustainable services and asked where the Financial Improvement Programme Board report to. **KO** stated that they report to the new Strategic Transformation Group.

TMcM queried the workforce item in the BAF noting that some timescales had lapsed. He asked that this be brought up to date.

Action: CF *to liaise with Alison Smith and request for the workforce section in the BAF to be reviewed and updated.*

TMcM noted that risk 6 in the BAF (impact of external factors) provided information on EPRR but did not cover the impact of climate change, economic change, and political change. He asked for this to be reviewed as well.

Action: CF *to liaise with Alison Smith to see whether the impact of climate change, economic change and political change can be captured and be reflected within the BAF report (risk 6 – impact of external factors).*

The ICB Finance Committee:

- *Reviewed the current system SBAF and SORR and considered and accepted the changes suggested.*
- *Recommendations were made for the management team to seek to improve the narrative in the workforce and impact of external factors BAF risks.*

6.0 Minute No. SFC-24-04.006 - ICB M12 ICB Finance update

Report received as read.

6.1 **AS** highlighted that at month 12 the ICB delivered a £16.2m deficit in line with the agreed M11 FOT, which is a £16.0m adverse position against the full year revised plan. **AS** added that a national allocation reduction of £65.2m, representing the 2022/23 historic System deficit, was assigned to the ICB in month 12.

AS explained the main reasons for the adverse variance in the ICB position remain in line with reporting so far this year, being significant overspends in discharge expenditure (shown in community), individual commissioning and prescribing (particularly due to inflation) and a lack of elective recovery income received from Wales. **AS** added that these pressures are partially offset with an underspend in dental within the POD budget

and a number of non-recurrent underspends due to the allocations approval and prior year balance policies in place throughout 23/24.

AS highlighted, that at Month 12 efficiency savings delivered £0.8m better than plan (£26.7m delivery v's £25.9m plan) due to several non-recurrent savings identified as part of the ICB's ongoing budget review.

AS stated, that the ICB had also hit its running cost spend target.

TMcM asked about late local authority invoices. **AS** explained that these were in relation to jointly funded packages. **AS** added that, we are currently undertaking a significant piece of work looking at individual commissioning, part of which is to consider the forecasting processes within the operational team within CHC.

The ICB Finance Committee noted:

- *The ICB has delivered the agreed reforecast ICB deficit of £16.2m.*

7.0 Minute No. SFC-24-04.007 – ICB M12 Efficiency update

Report received as read.

7.1 **KO** highlighted at M12 reporting £26.7m of savings have been delivered against the plan of £25.9m providing a positive variance of +£0.8m.

KO explained the positive position is due to efforts from all teams to stretch savings targets wherever possible. There have been significant savings reported within the medicines management team with the pricing of DOAC generic switching and further cost savings through the Script switch and the Optum programme. **KO** added that the individual commissioning team have continued to report benefits within the review programme and through Fast Track referrals.

KO highlighted that throughout the year weekly meetings have been established within the Delivery and Transformation team to review, check and challenge overall spend and budgets and to consider further opportunities for savings programmes. Action plans have been in place with 1-1 weekly meetings arranged to track progress which has helped to meet the stretch targets set.

KO mentioned that the Sustainability Working Group have maintained detailed oversight on the delivery of all programmes throughout the year including risk and year to date delivery against plan.

The ICB Finance Committee noted:

- *Month 12 Efficiency delivery and the progress that has been made in bridging the gap in the unidentified savings plans.*
- *The efficiency position of £26.7m that has been reported.*

8.0 Minute No. SFC-24-04.008 – Terms of Reference

Report received as read.

8.1 **AS** highlighted that in January 2024 NHS STW Board received and approved a report,

from the Good Governance Institute (GGI) on recommended changes to STW Governance. As a result, the Finance Committee Terms of Reference have been updated to reflect the changes agreed to the roles and functions of the Board sub-committees.

AS noted, new paragraphs regarding onward escalation and reporting of risk. This is now standardised for all Board Sub-Committees.

AS stated, that the membership of the Finance Committee has been updated to reflect updated responsibilities as a result of the ICB Management of Change restructure which now reflects the following changes:

- ICB Deputy CFO updated to Director of Finance – both sections
- Removal of the ICB Executive Director of Strategy and Integration – both sections
- Addition of the ICB Chief Delivery Officer to the System section
- Amendment in job title for the Vice Chair to ICB Independent Associate Non-Executive Director – Finance

AS also highlighted various other changes to the Terms of Reference, including changes to the Sub-Committee structure.

The ICB Finance Committee:

- *Approved the updates made to the Finance Committee Terms of Reference.*

9.0 Minute No. SFC-24-04.009 – A.O.B

TMcM asked that for future meetings, he would like to see the draft minutes and Chairperson's report to the Board before they are submitted. This will be built into the monthly reporting timetable (for section 1 and 2 meetings).

Action: CF *to ensure that from now on, draft minutes and Board reports are shared with the Committee Chair prior to submission for papers. This will be built into the monthly reporting timetable.*

Date And Time of Next Meeting

Thursday 30th May 2024, 13.00 via Teams.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

People Strategy

People Programmes Annual Report.

2023-2024

Contents...

Introduction 3

Statement from Stacey-Lea Keegan 3
A welcome from Alison Trumper 3
Our People Team 4
STW ICS People Governance 4
Our People Promise 6

Part 1

Train | Growing For The Future 8
Reform 18
Retain 20
Transform - Equality Diversity and Inclusion | Leadership, Organisational Development and Culture 24
Celebrating our success 30

Part 2

Train | Growing For The Future 33

ICS Educators' Collaborative Event – 15th Feb 2024, hosted by Telford College. 34
Learning Management System (LMS) 36
Managing Deterioration 38
The Joint Training mission 39
Sight Loss eLearning Project 40
Growing for the Future (11-17yrs) 42
Springpod 45
Futures Cards. 46
Next Gen & Talent foundry Schools Workshop 47
Skills Show 48
Step Into Work 49
T-Levels 50
Social and Healthcare Partnership Training Academy 52
OSCAT 55
Growing Our Workforce 56

Reform 58
Workforce Sharing Agreement. 59
Our local authority and Independent Care provider Workforce. 60
Key Messages 61

Retain 64
Springboard Preceptorship 66
Monthly Retention Data Snapshot. 68

Transform - Organisational Development, Leadership and Culture | Equality Diversity and Inclusion (EDI) 70
Organisational Development, Leadership & Culture 2023/24 71
Equality Diversity and Inclusion (EDI) 2023/24 72
Cultural and Diversity Event – September 2023 73
Equality Diversity and Inclusion (EDI) 2023/24 continued 74

Introduction.

Welcome to Shopshire Telford and Wrekin's (STW) Integrated Care System (ICS) People annual report 2023-24. This report outlines the progress made to support workforce transformation. The past year has rightly focused on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, retain them, train our people, and work together differently to deliver care. We have seen some positive progress but there is still more to do.

Our people across all providers within Shropshire Telford and Wrekin ICS do extraordinary things for our patients, residents, and communities but this is only possible if the safety, health, and wellbeing of our people is recognised as a key priority. If we don't look after ourselves and our colleagues, we cannot deliver safe, high-quality care and services that we strive to.

Thank you.

Stacey-Lea Keegan
Chef Executive Officer The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust CEO SRO for People

Our 2023/24 ICS People Team Annual Report...

Welcome to Shropshire, Telford & Wrekin Integrated Care System People Team, annual report 2023 to 2024.

It is difficult to single out achievements in a year, I hope this report demonstrates they have been significant in terms of both breadth and number delivered by the core people team which is small with some turnover due to short term funding.

Despite this it has been a credit to both the team and to system partners who , particularly over the last year have shaped our positive , compassionate and inclusive people culture with everyone having an important part to play for the benefit of our people who make up our workforce and for the population we serve.

Alison Trumper
Head of STW ICS
People Programmes

Sara Hayes
STW ICS Deputy
Chief People Officer
up to Oct 2023

The county of Shropshire is a large beautiful rural county. It is well known that there are a significant number of health and care roles identified on the national skilled worker occupational shortage list, but our beautiful county also experiences geographical disparity, with available health and care workers located predominantly within larger urban areas and cities.

This compounds our challenge as providers of health and care within Shropshire, Telford & Wrekin, Integrated Care System, to both attract and retain its workforce to be able to deliver optimal health outcomes and good experiences of care to the people we serve.

Lower workforce availability perpetuates individual providers' ability to attract new and to retain its existing people who make up its workforce.

This united challenge also providers united opportunity.

An opportunity for Providers to work together collectively, in partnership, sharing and spreading best practice, pooling expertise and innovation, taking collective responsibility and decision making, learning together, and sharing collective successes.

Cognisant to our system pressures our People Promise Priorities for 2023-2024, developed with system partners, are intended to be our collective strategic enablers to improve our offer for people w who are part of our current workforce and those who will the next new generation of wonderfully diverse workforce.

Our People Team.

TRAIN | Growing for the Future

Executive SRO
Clair Hobbs

Director of Nursing, Clinical Delivery and workforce

Shropshire community Health Trust

Tom George

Head of Education Infrastructure & Assurance

Shrewsbury and Telford NHS Trust ICS Education & Learning Lead 0.4wte *STW ICS*

Tracy Newbold

Widening Participation Lead

Project Manager Growing for the Future 0.4wte

Shrewsbury and Telford NHS Trust *Post ended 31/3/2024*

Carol Bagnall

People Transformation Lead- Growing for the Future

STW ICS

Sarah Morgan

People Project Officer Growing for the Future

STW ICS

Post ends end May 2024

Jo Bayliss

People Transformation Manager- Train 1wte

STW ICS

Sandra Williams

Operational Manager & Lead Educator HCSW Academy 1wte

STW ICS

Ruth Field

Industry Placement Co-ordinator- T-Levels 1wte

STW ICS

Post ends end March 2025

Vanessa Roberts

People Transformation Manager STW ICS

Post ended October 2023

REFORM

Executive SRO
Rhia Boyode

Director of People and Organisational Development

Shrewsbury and Telford NHS Trust

Simon Balderstone

Deputy Director of People Operations. Shrewsbury & Telford Hospitals NHS Trust

Progress against our four strategic priorities reports to the System People Collaborative , the System People Culture and Inclusion Committee and ultimately Integrated Care Board'

The people team have convened a number of steering groups, as enablers to support progressing our strategic priorities.

Steering groups are well supported with excellent representation from provider partners.

RETAIN

Executive SRO
Denise Harnin

Chief People and Cultural Officer

The Robert Jones Agnes Hunt Orthopaedic Hospital

Mandee Worrall

People Transformation Lead for Retention, Health and Well-being

EDI Post ended March 2024

Juliet Doman

People Transformation Manager for Health and Well-being

Post ended July 2023

Alison Lester

People Transformation Manager for Retention, Health and Well-being

TRANSFORM | Organisational Development, Leadership and Culture. | Equality Diversity and Inclusion (EDI)

Executive SRO
Alex Brett

Chief People Officer

Midlands Partnership University NHS Foundation Trust

Jane Rook

Transformation Lead; Organisational Development, Culture and Leadership 0.2 wte

Deborah Hammond

Transformation Manager; Organisational Development, and Leadership. 1 wte

Emma Neen

Organisational Development Practitioner. 0.8 wte

STW ICS core People Team is a small team, initially funded by investment from the then Health Education England but as investment discontinued the team are now employed by NHS Shropshire Telford Wrekin.

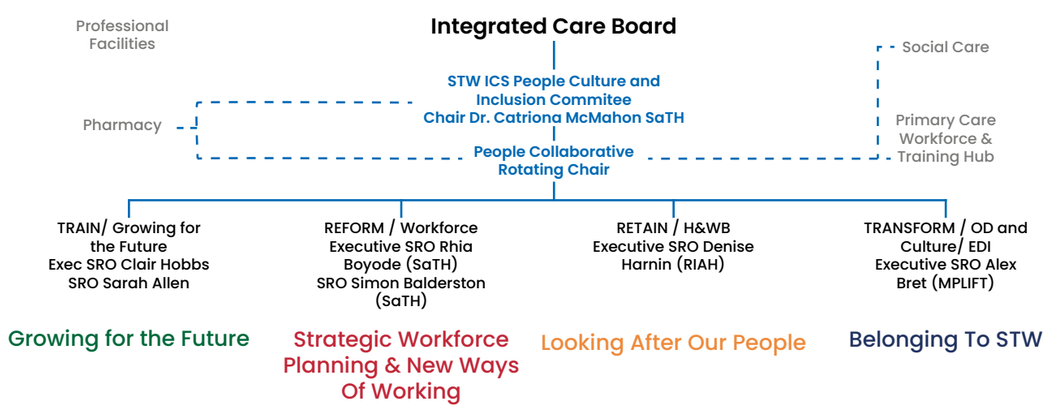
We know more capacity and capability is needed to support progress on our people transformational programmes.

Our provider partners are seeking ways to increase to strengthen leadership to deliver each of our strategic priorities across the four portfolios'.

We have already tested out how it feels to be employed by one organisation and lead on both employing organisation and system programmes with success so far and aim to expand on this model during 2024-2025.

Over the last year, our system governance reporting structure now has strengthened reporting and accountability to Shropshire. Telford Wrekin Integrated Care Board.

STW ICS People Governance



Our People Promise.

We are **compassionate** and **inclusive -**

We do not tolerate any form of discrimination, bullying or violence.

We make the STW a place where we all feel included and respected.

We are **recognised** and **rewarded -**

A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

We each have a **voice that counts -**

We all feel safe and confident to speak up. And we take the time to really listen – to understand the hopes and fears that lie behind the words.

We are **safe** and **healthy -**

We look after ourselves and each other.

Well-being is our business and our priority – and if we are unwell, we are supported to get the help we need.

We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

We are **always learning -**

Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.

We have equal access to opportunities.

We attract, develop, and retain talented people from all backgrounds.

We work **flexibly -**

We do not have to sacrifice our family, our friends, or our interests for work.

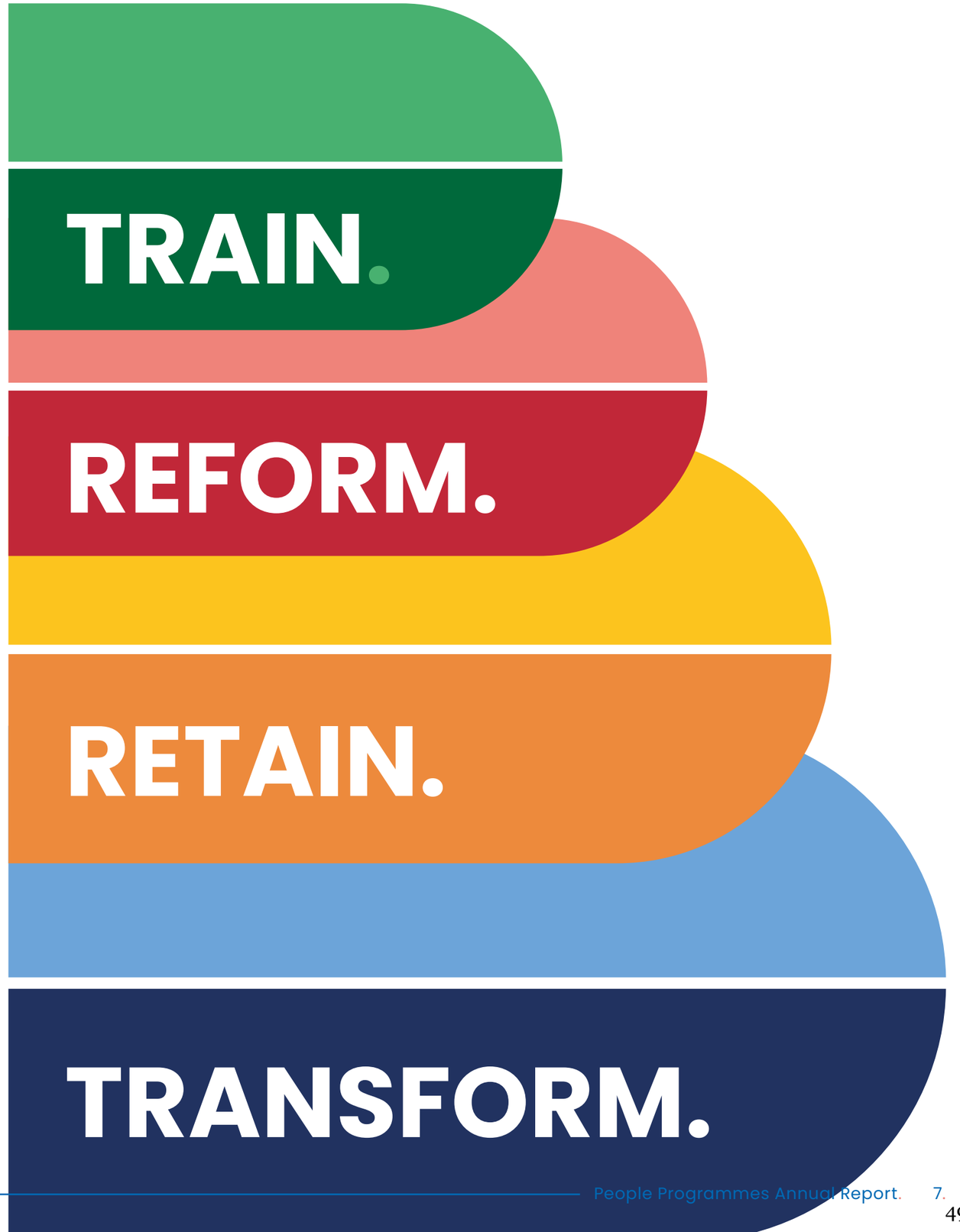
We have predictable and flexible working patterns – and, if we do need to take time off, we are supported to do so.

We are a **team -**

First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best care.

We learn from each other, support each other and take time to celebrate successes.

Our People Team Highlights.



Train.

Train.

Intended outcomes

Co-ordination, implementation and allocation of investments aligned to LTWP / MeTIP / CPD/ WDF /apprenticeships and other short term NHSE training investment to meet workforce needs aligned to system workforce plan.

One system approach to local delivery of training utilising available subject matter experts increasing access to high quality training for all ICS workforce.

Develop a more transferable workforce to meet provider partner needs linked to future workforce transfer/ collaborative bank system.

Intended impact

Investment prioritised to meet workforce development needs – current /long term plan.

One system training resource repository through the ICS Learning Mangement System (LMS) , a) to deliver equitable access to training b) workforce training data monitoring at system level

Efficient utilisation of available subject matter experts, standardised learning outcomes linked to competencies.

Have a more 'portable' workforce across NHS/ health and social care aligned to future collaborate bank and workforce transfer schemes.

Be responsive to skilling/upskilling / reskilling of workforce.

Assurance to the quality of education delivery

Assurance that Education meets required national local strategic priorities.

Assurance and evidence that the ICB is meeting its legislative duty under Health and Care act 2022 14Z41 Duty to promote education and training.

Improved safety quality and health outcomes for the people of Shropshire Telford and Wrekin

Growing For the Future.

Intended outcomes

To Develop and attract a sustainable new workforce pipeline from within STW aligned to local workforce plan and to meet the future workforce needs.

Develop & strengthen partnerships with local FE/HE colleges to create accessible, diverse, creative, sustainable employment pathways into ICS providers.

Promote the diverse careers, STW ICS has to offer the next generation.

Attract domestic pipeline, people looking for a career change.

Intended impact

11- 16-year-olds - increase interest amongst next generation into health / social care careers

19+ year olds - conversion of people participating on sustainable step into work /pre-employment programmes, into permanent employment.

A co-ordinated system approach to 'marketing / attracting /raising profile of all careers across STW ICS

A system sustainable pipeline to meet the needs of the Shropshire Telford and Wrekin Integrated Care System workforce.

TRAIN.

What we set out to do

What we achieved

Review and refresh the system Education and Training Steering group

'The System Education and Training Steering Group continued to meet throughout 2023-24

We plan to make this more strategic and will review membership in readiness for 2024-25

In February 2024, we successfully hosted our first event to develop the ICS education strategy.

Over 50 delegates from various ICS partner organisations actively participated, contributing valuable insights. Networking facilitated the exchange of expertise and a deeper understanding of roles within the system. Participants left with renewed enthusiasm, ready to contribute to a comprehensive educational strategy.

We aimed to enhance the ICS Learning Management System (LMS) by expanding user access, enriching content, streamlining training event management with the Signup Tool, and leveraging the LMS to support key initiatives and store vital materials

The LMS now supports over 4,821 users—a substantial increase—and hosts approximately 9,952 modules, including 91 newly developed local modules by subject matter experts. This growth highlights the ongoing need for an accessible, high-quality digital education and training platform.

The platform's dynamic Signup Tool has streamlined the registration and management of numerous local events and training sessions.

We aim to advance a 'one workforce' approach to education, maximising the opportunities provided by our local further and higher education colleges. Additionally, we recognise the absence of the value of further education within the NHS Long Term Plan.

We have established on-site steering groups with Shrewsbury and Telford Colleges. Our particular partnership with Telford College is based on its adult education offerings and opportunities.

Currently, we support our educator workforce by providing them with the opportunity to obtain a BTEC Level 3 education and training qualification. This initiative enhances our ability to deliver even higher standards of education for our workforce. To date, over 50 multi-professional educators (including GPs) have successfully qualified.

Additionally, we address numeracy challenges within our workforce through the 'Multiply Maths' programme. So far, 45 students have participated, with 38 continuing their professional development studies. Six individuals have already achieved a Level 2 qualification.

In response to the unlikely workforce development investment from 2024-2025, we are further collaborating with the colleges to enhance their offerings for the health and care workforce. We plan to launch a prospectus and communication campaign across our provider partners. This comprehensive approach will encompass digital, business, finance, and higher technical qualifications, as well as apprenticeships for all workforce members—not just those who are patient/client-facing.

What we set out to do

What we achieved

In response to the Health and Care Act 2022, our objective was to deliver The Oliver McGowan Mandatory Training for our CQC registered providers.

Oliver's training plays a pivotal role in supporting the development of a health and social care system where compassion, knowledge, and understanding serve as the bedrock of care for all individuals. This aligns with the ICB's strategic objectives to address health inequalities in outcomes, experiences, and access while enhancing population health and healthcare outcomes

NHS Shropshire Telford and Wrekin ICB established a system-wide Oliver McGowan Mandatory Training Stakeholder Group to develop and support the delivery of training across health and social care partner organisations across the STW.

In partnership with Joint Training within Shropshire Council Local Authority we have now commenced delivering the required training across STW. The training is delivered, by our accredited trios of trainers using a the nationally approved standardised framework.

We received some short-term investment which meant we were able to progress delivery and by 31 March 2024 we have successfully trained 101 individuals, to complete Tier 1 training.

As an Integrated Care System, we have not achieved the NHS England key performance metric of ensuring that 10% of eligible staff complete either tier one or tier two training, as appropriate to their role. This shortfall is attributed to the challenges in developing sufficient sustained training capacity to meet the needs of approximately 30,000 staff across CQC-regulated providers within Shropshire, Telford, and Wrekin. However, the regional team has acknowledged the progress made, which surpasses that of other systems in the West Midlands region

To address urgent care pressures and to support keeping people well at home, we are aiming for an integrated, cross-provider approach to recognising and managing the deteriorating patient/client

During quarter 4 of 2023-24, the Integrated Care System (ICS) established a project group bringing together key ICS health and social care partners, and education teams.

This project group is reviewing current training provisions, the access to and uptake of training, pathways, tools, and trainers to assess the potential impact on reducing emergency calls, admissions, and hospital bed days. The goal is to align training offerings to ensure they are delivered effectively across various settings.

In response to pharmacy workforce shortages across the community and NHS , we wanted to develop a local training offer to avoid our workforce having to travel long distances to train or to train on line.

In partnership with NHSE, the pharmacy faculty and Telford college, we have developed a level 5 pharmacy technician qualification which meets proficiencies for registration onto the General Pharmaceutical Council.

This will enable our local workforce with better opportunities to progress their careers to become a pharmacy technician and will better support the expanded pharmacist roles into community expanded pharmacist roles particularly in responses to the community pharmacist role and services.

The training is expected to start in Q 3 2024/25

Growing for the Future.

What we set out to do	What we achieved
Convene a system Widening Workforce Access and Participation (WWAP) steering group to work together to take collective responsibility in the co-ordination of activities and projects to attracting new and our next generation workforce.	The system wide WWAP steering group has been reviewed and refreshed and has continued to meet throughout 2023-24 and has good representation from across the system.. Development of school career events to ensure a co-ordinated, targeted approach to engagement with head teachers avoiding a silo disjointed approach. Development of an 'ICS directory to support future workforce in understanding our different provider partners. Established a ''step into work'' training programme with Telford college, Department of Work and pensions and provider partners supporting work placement.
Increase the number of school children we showcase our careers to.	Delivered on our first 'Talent Foundry ' workshop for schools identified as under-represented to promote careers across STW – places booked within an hour of release. Delivered two work related learning weeks, delivered by multi professionals from across the system, with over 20 children attending as part of their work experience from school. Held our second skills show at Telford international centre , represented by many of our system partners where over 3000 people interested in working in health or care visited our stands.

What we set out to do	What we achieved
Support the NHSE universal family programme by strengthening the education offer and employment opportunities too young people who are care experienced.	Through partnership work across both local authorities and Telford college, we have successfully secured a fixed term funding to appoint our first co-ordinator for care experienced young people up to 25 who are not in employment , education or training (NEET). We aim to attract 12 people into the programme and hopefully ultimately into a job within our system.
Increase the employability for our student nurses on the Shropshire placement circuit by supporting them to achieve their technical proficiencies. We also wanted to provide an opportunity for our existing workforce to refresh their technical proficiencies."	Partnership with the University of Chester we developed Outreach Skills Clinic for Assessment & Training programme (OSCAT) to support students on the Shropshire circuit and staff across STW ICS to practice skills in a simulated environment, delivered on one of the sites or via the Mobile Training Unit (MTU).
Engage with local colleges to support T-levels within health.	In partnership with both Telford and with Shrewbury college , Department of Education and our NHS provider partners , attracted 56 young people onto the first T-level cohorts . These are our next generation who are interested in mental health and adult nursing and midwifery. Our next cohort is September 2024. We have been inclusive in our approach to our next generation with 25% from BAME heritage. Successfully bid and received investment from the Department of Education for a T-level placement co-ordinator who supports our 16 years olds into NHS placements with an aim to avoid any drop out from programme. Worked with Telford college to fund a T-level placement support worker in readiness for our Sept cohort where there will be over 100 16-17 year olds on placement across STW as part of their training. We have been invited by the Department of Education to present or partnership approach to T-levels to regional groups where STW was described as "pioneering'.

Social and Healthcare Partnership Training Academy.

The Social & Health Care Training Academy was set up in 2022 by a collaboration between STW ICS & Telford College and their commitment to support the recruitment, retention and career pathways across the NHS and Social Care. With a specific focus to reduce the number of Healthcare Support Worker Vacancies across STW ICS to Zero.

What we set out to do

As part of our centralised approach to marketing and recruiting local people who are new to care, we wanted to develop a standardised approach to induction and education for our Health care support workers.

What we achieved

As a system partnership approach, we now have a standardised HCSW induction programme, aligned to the Care Certificate learning outcomes, delivered through the STW ICS HCSW Academy based at Telford College.

All learning is recorded on our centralised Learning Management System ultimately increasing opportunity and making it easier for our HCSW's to work across providers.

Since the start of the HCSW academy in January 2022, 27 cohorts have been delivered with over 800 people having gone through the programme and commenced employment within our ICS.

Vacancies were reduced to such, NHS providers asked us to stop the centralised recruitment as they had no vacancies to place them in.

Agency usage reduced zero (with the exception of the newly opened recovery and rehabilitation wards).

In collaboration with Partners In Care, two of their educators supported some of the training on the HCSW academy programme, as well as supporting candidates throughout the two weeks and supporting candidates who came from social care back in practice.

Janet Davies

Clinical Educators, Partners in Care

Shona Holmes

Clinical Educators, Partners in Care

Janet and Shona, two retired community nurses, exemplify legacy nurses who returned after retirement to bolster the care staff workforce with their clinical skills, knowledge, and wisdom.

Partners in care are proud to have worked in collaberation with the ICB across four project areas during 2023 2024 These being:

What we did...

The Clinical Practice Education Project aimed to reduce illness and unnecessary hospital attendance for care home residents due to Urinary Tract Infections (UTIs) through improving hydration awareness and practices among care home staff. A total of 19 care homes across Shropshire, Telford and Wrekin participated with an additional 17 care providers receiving in home training towards the end of the project. The project had a potential impact on approximately 1,800 residents. A total of 1,062 learners attended a session on hydration and of these 454 attended an additional session on UTIs.

....the outcome

Across the 19 project homes, there was a reduction in UTI hospital admissions of 36% between April-September 2023 in comparison to April-September 2022.

The average length of hospital stay for a UTI admission from our project homes was 11 days. A 36% reduction in UTI admissions equals 12 fewer admissions. This amounts to 132 fewer hospital bed days over six months.

Quarterly UTI admissions went from 1.4 admissions per project home in April-June 2022 to 0.9 admissions per project home in July-September 2023.

There was a 42% reduction in the number of individuals receiving antibiotics for UTIs during July-September 2023 compared to the start of the project, suggesting improvements in the assessment and management of UTIs in the project homes. This is a reduction of approximately one UTI per month per care home.

There was a strong relationship between involvement in the project and reductions in falls: a 25% reduction in total falls and a 45% reduction in hospital admissions due to traumatic injuries in the project homes. This is a reduction of approximately three falls per month per care home.

What we did...	....the outcome
The Falls Project aimed to increase the number of people assisted off the floor within half an hour of falling in a care home and to increase home care providers' access to lifting equipment in the community. Through a programme of training, the project generated positive outcomes, the equipment and associated app were viewed as user friendly, and training was successfully cascaded.	Over the life of the project there were 226 falls in total. Combining homecare/ domiciliary care and care home providers, there were 51 lifts with the Mangar cushion and 17 calls to 999. On the assumption that each lift using the cushion would have previously been a call to 999 this meant a potential total of 68 calls previously, thus a reduction in 999 calls of 75%. Average figures for the time people were waiting to be lifted reflected a significant difference in timescales. The average wait for an ambulance was 2¼ hours compared to 14½ minutes when the cushion was used. As a result of delivering the project and having access to its resources, Partners in Care have promoted alternative methods of raising a person to that of calling 999 including the use of the Mangar lifting cushion, the iStumble app, and clinical support via Rapid Response in other areas such as Moving and Handling training.
The Dementia project delivered a wide range of dementia related training for care providers within Shropshire, Telford & Wrekin. This training was designed to increase skills, knowledge, and confidence to deal with challenging situations within the care settings rather than resorting to an ambulance call out. The impact of training has been further enhanced through working with a small number of care homes to provide intensive on-site support for staff caring for people living with dementia.	Recognising and reducing sensory overload and the development of monthly activities more suited to people living with dementia, resulted in a calmer lounge environment and greater engagement in a wider range of activities. Swapping lunch and evening meals so that residents enjoy a lighter lunch and main evening meal, resulted in less sleeping during the day, increased engagement in activities during the afternoon, greater socialising during the evening meal and a positive change in sundowning behaviour.

Mobile Training Unit.

We have used the Marches Education simulated program to be able to offer a more responsive learning environment. Over 400 people have been trained using this facility to date.

In particular, we have used the mobile training unit for cross-provider, multi-professional, integrated training to recognise and manage the deteriorating patients.

This unit enables greater access for our workforce to simulated learning environment as a safe space to practice and learn new skills.

Reform.

Our reform portfolio has concentrated on developing and monitoring our NHS workforce plan during the year.

Our people priorities are enablers to having the right workforce in the right place at the right time.

Reform.

What we did...	....the outcome
Convened our ICS workforce planning group.	Our operational managers have had opportunity to attend workforce planning workshops to develop skills, expertise and knowledge in this complex subject.
Support the growth of our NHS workforce.	By growing our NHS workforce we have been able to provide new services to our local communities, including: • Community Diagnostic Centres • Rehabilitation and Recovery Words • Virtual Ward • Elective Hub • Integrated Discharge Team • New Operating Theatres
Implemented a workforce sharing agreement.	Our Workforce sharing agreement is intended to help us be a bit more flexible as employers, and to offer our people a wider range of employment experiences. It is the start of something different, creating a sense of one workforce for our system. The Agreement enables people employed by one of the signatory organisations to work in another but without having to do their employment checks and mandatory training again. Workforce Sharing Agreement

Reform.

What we did...	....the outcome
Our ICS Workforce Dashboard Working collaboratively with the ICB Business Intelligence Team, we have developed a system NHS workforce dashboard built in PowerBI.	Enables sharing and visibility of our workforce data that can be filtered by NHS Trust, by substantive bank and agency workforce (wte and %) and by Staff Group including: • Staff in post wte history, • Turnover, sickness, vacancies, • Actual staff in post wte against the operational workforce plan, • Actual cost of workforce against the operational financial plan, • Agenda for change appraisals, medical appraisals and statutory & mandatory training compliance. • Metrics for critical roles to demonstrated impact of interventions including health care support workers and allied health professionals.

The dashboard is updated monthly and key data is shared/reported through the Integrated Performance Report to ICB Board along with the ICB Quality & Safety Committee and both the ICB People Collaborative and ICB People, Culture and Inclusion Committee

Our NHS Workforce Plan 2023-2024.

Reform

What we planned to deliver	What we delivered
For 2023/24 we planned to grow our total substantive NHS workforce by 427wte (staff in post).	In March 2024, we are 378 WTE above the plan for our substantive NHS workforce. While this has been an achievement, it has increased beyond the planned figures and financial envelope . Greater rigor in monitoring the 2024/25 plan will be applied through the refreshed ICS System Workforce Planning and Assurance Steering Group, reporting to the People Collaborative, People Culture and Improvement Committee, and Integrated Performance Committee.
We planned to maintain the existing vacancy rate of 8.7%	In March 2024 our current NHS system vacancy rate is 5.4% (better than planned)

Reform

What we planned to deliver	What we delivered
We planned for a system turnover rate of 11.9% by March 2024, reduced from 13% in March 2023	March 24 - turnover was 10.7%, sickness was 5.4% (better than planned)
We planned for a system sickness rate of 5.3% by March 2024, reduced from 5.7% in March 2023	In January 2024 our current system sickness rate is 5.5% (on plan) and was at 5.1% in March 24

Retain.

Retain.

Intended outcomes

Support delivery of the NHS Long-term workforce plan

Provide assurance of project delivery via the approved ICB governance model

Facilitate the implementation across STW of the 5 high impact Workforce retention actions:

Complete the Nursing and Midwifery retention self-assessment tool.

Implement the national preceptorship framework.

Implement legacy mentor schemes.

Facilitate a one system approach to implement the following strategic actions identified from NHSE Self-assessment retention tool:

- Develop effective use of data and diagnostics to understand the workforce profile.
- Meet the needs of a modern workforce.
- Recruit and retain existing and experienced workforce.
- Improve STW ICS workforce flexibility and consistency.
- Support workforce movement across STW
- Standardisation of roles across all system providers
- Support the reduction of vacancies, absences, and leavers across STW.
- Embed an inclusive culture to improve retention across STW.

Intended impact

Successful delivery of the NHSE 5 high impact retention actions.

Targeted interventions for different career stages:

Early career

Experienced workforce

Later career

Staff will feel recognised and rewarded fairly.

We will embed the right culture, supporting staff to lead transformation, to provide

sustainable, high-quality services.

Adopting a robust approach to understanding our data – this will highlight any hot spot areas.

Retaining and supporting our workforce is a key priority across Shropshire, Telford and Wrekin as outlined in the National People Plan and the NHS Long Term Plan.

Ensuring that our workforce feel valued and can develop in their career is crucial to retention. We believe staff should have access to support, development and opportunities and be encouraged to achieve their individual ambitions within the workplace.

Based on the evidence we have, there are two important principles which support the workforce retention:

- Targeted interventions for different career stages: early career, experience at work and later career. There are different risk points related to job satisfaction and our vison is to respond and all support will be tailored accordingly.
- Bundles of high-impact actions are more effective than single actions. We support a bundle approach to deliver sustained gains, applied to the different career stages, informed by evidence that drives job satisfaction, experience and therefore retention.

Health and well-being.

Intended outcomes

Looking after our people's health and well-being.

Support and facilitate a system-wide workforce Health and Wellbeing offer.

Improve STW ICS workforce mental health support.

Encourage staff to attend National pension seminars.

Support/develop a menopause policy or add to existing policies.

Intended impact

Staff will have opportunities for regular conversations to discuss their well-being and ways to retain them in the workplace.

Supporting the management of any day to day stressors that can affect an individual's work and home life will ensure their ongoing wellbeing and happiness is maintained

Retain.

In 2023/24 we planned to deliver...

Refresh system retention governance framework and plans.

Design and implement a systemwide data dashboard

Design and implement a systemwide retention strategy in line with the NHSE 5 High impact retention actions to deliver:

- **Targeted intervention for different career stages: early career, experience at work and later career.**
- **Implement the National Preceptorship Framework**
- **Implement legacy mentoring schemes.**
- **Encourage staff to attend national pension seminars on pensions and flexible retirement options.**
- **Develop a menopause policy / guidance or add to existing policies.**

Support all system partners with bespoke retention improvement plans.

In 2023/24 we delivered...

Developed a workforce data dashboard providing an improved live up-to-date data picture.

Facilitated the implementation of:

- Targeted intervention for different career stages: early career, experience at work and later career's including rotational posts across the system and standardised itchy feet conversations.
- National Preceptorship Framework
- Legacy mentoring schemes.
- Staff to attend national pension seminars on pensions and explored flexible retirement and return options using all communication platforms.
- Menopause policy/guidance to support existing policies.

STW ICS had the second highest reduction in leavers in the previous 12 months

Previous 12 Months' Leaver Rate Change by ICS

ICB	Leaver rate (%)	Change	Percentage point change
NHS BLACK COUNTRY INTEGRATED CARE BOARD		▼	-0.8%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD		▼	-0.9%
NHS BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD		▼	-1.3%
NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD		▼	-1.4%
NHS LINCOLNSHIRE INTEGRATED CARE BOARD		▼	-1.4%
NHS COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD		▼	-1.4%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD		▼	-1.6%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD		▼	-1.7%
NHS HEREFORDSHIRE AND WORCESTERSHIRE INTEGRATED CARE BOARD		▼	-1.9%
NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD		▼	-2.2%
NHS NORTHAMPTONSHIRE INTEGRATED CARE BOARD		▼	-2.3%

STW ICS had the second highest reduction in leavers in the previous 12 months. Whilst it is difficult to quantify any one thing that is supporting our people to remain in STW, we can draw conclusions that the bundle of interventions may be having a positive impact.

Health and well-being.

In 2023/24 we planned to deliver...

Co-design and create a systemwide wellbeing vision.

Develop health and wellbeing systemwide strategic objectives in line with the People Strategy.

Implement Health and Wellbeing National Framework

Implement a revised systemwide staff psychological wellbeing Hub – evolving to meet demand.

Revise and refresh systemwide health and wellbeing offer

Rebrand STW wellbeing offer.

Racial inclusion work to address health inequalities.

In 2023/24 we delivered...

Co-designed and created a system wellbeing strategy.

Systemwide collaborative offer and on-going support within the current allocated funds.

Implemented the national framework via Task and Finish revised governance model.

Amalgamation of both the Health and Wellbeing Steering Group with the Workforce retention steering group in line with the revised People Hub governance model.

Implementation of a review of menopause champions across providers

Implemented a systemwide Staff Psychological wellbeing Hub including referrals from neighbouring ICS partners.

Ongoing funding business case of the System wide Staff Psychological Wellbeing Hub.

Staff Group Consultation Menopause business case. Approved at People Collaborative. Awaiting approval and funding of pilot (April 2024).

Workforce analysis through a population health inequalities lens.

Collaborated with all Health and Social care providers sharing good practice models and policies.

Transform.

Organisational Development (OD), Culture, Leadership.

Intended outcomes

High Potential Scheme

1. Inclusive talent pipeline, through the initiative of the HPS Scheme, to ensure a cohort of ready leaders for STW. This programme will support the talent pipeline for Executive Director vacancies, increase the diversity of senior leaders and retain leaders with high potential while accelerating their careers into Executive roles.
2. Building on HPS, consult and enable the production of a system-wide talent management plan.

OD, Leadership & Culture

3. Deliver inclusive leadership development for the ICB Executive Team and enable the procurement of an external consultant to design the ICB redesign implementation plan.
4. Deliver an ICS Leadership and Management Competency Framework
5. Creation of a system-wide OD, Leadership & Culture Collaborative

Intended impact

High Potential Scheme

- A more diverse talent pool of ready now individuals to occupy Senior Leader vacancies within the system whose values align to the ambitions of the People Promise.
- Embedded inclusive talent management practices, informed by the 6 EDI High Impact actions, to grow an inclusive talent pipeline for a stronger and more diverse cohort of aspirant leaders.

OD, Leadership & Culture

- Support of the ICB workforce, while in a state of flux, paving the way for the OD strategic partner.
- An ICS-wide core set of Leadership & Management competences now provides a level of standardisation across the system as well as access to development for those who have not had this available to them in the past
- OD, Leadership & Culture Collaborative will provide focus on collective OD improvement consultancy, programme & project management skills, coaching and culture to enable innovation & transformation in collaborative system programmes.

Equality diversity and Inclusion.

Intended outcomes

Continue to facilitate the implementation across STW of the NHS EDI improvement 6 high impact actions.

Deliver our STW improvement plan. Build on the values of everyone counts, dignity and respect, compassion, improving lives, working together for patients and commitment to quality.

We will acknowledge the contributions, expertise and lived experience shared with us by staff, staff networks, managers, and system leaders.

Understanding of outcomes in the Perceptions and experience of Racism report and implement relevant actions

Embed recommendations from WREI, WRES and WDES reports.

Embed learning from the Michelle Cox Tribunal

Intended impact

Begin to shift behaviours and attitudes towards all 9 protected characteristics across STW ICS

Work towards achieving a positive experience of Equality, Diversity, Inclusion and Belonging for all in STW ICS

To abide by the legislation outlined in the Equality Act 2010

Implement positive change across the System in a collaborative manner

Timely completion of required reports allowing collation of ICS data to be shared regionally and nationally

Improve staff experience across all protected characteristics

Achieve a diverse workforce in an inclusive environment to improve staff engagement, decrease turnover and enhance innovation

Rhia Boyode - EDI event interview

Organisational Development, Leadership & Culture 2023/24.

In 2023/24 we planned to deliver...	In 2023/24 we delivered...	The high-level impacts of High Potential Scheme (HPS)...
High Potential Scheme (HPS) Cohort 2 in partnership with the National Leadership Academy via a buddy-model joining STW with SSoT **Informed by the 6 EDI High Impact Actions and the requirement to have a system talent pipeline plan with emphasis on growing a more diverse and inclusive leadership representative of the communities we serve**	HPS Roadshows for engagement / communication with stakeholders Unconscious bias training for all assessors 10 x Assessment centres run to select candidates via interview and EDI scenarios Large scale Launch Event (f-2-f) 6 x Participant development workshops 10 x Executive 'On the Sofa' masterclass sessions Participant Action Learning Sets (ALS), Coaching and Mentoring sessions Communities of Practice for ALS Leaders, Coaches and Mentors 6 x Placement Panel Briefings 19 x Placement Panels (for rounds 1 and 2) 3 x Placement Manager Briefings Tri-Sector Challenge participation Individual triumvirate (3-way) participant progress meetings HPS Succession Planning workshop for Sponsors HPS Schwartz Round (f-2-f) Animation of an HPS Storyboard to articulate the purpose and benefits of HPS as a talent management vehicle	HPS supports the talent pipeline for filling Executive Director vacancies, while increasing the diversity of senior leaders and retaining leaders with high potential. The HPS programme builds on the capacity for recruitment and retention in our system and supports the wider system inclusion work being undertaken in tackling both workforce and health inequalities. HPS provides opportunities for scale and spread across with neighbouring systems to embed core principles of the NHS People Plan to enable a sustainable, engaged, and enthused workforce for the future. HPS supports the creation of a Talent and Succession Pipeline, collaborating with regional partners over applying HPS methodology as a launch pad, extending its infrastructure for developing and embedding system-wide talent structures and processes.

In 2023/24 we planned to deliver...	In 2023/24 we delivered...	The high-level impacts
ICS OD, Leadership & Culture Collaborative	ICS OD, Leadership & Culture Collaborative – seeks to link up the strategic ambitions of our partner organisations. A first large-scale engagement meeting is booked for Friday 22nd March 2024	This group will ascertain the level of OD skill / capacity across system, help build relationships and provide the opportunity for collaboration on key OD, Leadership & Culture initiatives
STW ICS Leadership & Management Competency Framework	Suite of Leadership & Management offers- created in liaison with partner organisations – now positioned on the system LMS to allow access for all ICS staff	An ICS-wide core set of Leadership & Management competences now provides a level of standardisation across the system as well as access to development for those who have not had this available to them in the past
Action Learning Sets (ALS) Skills Dissemination	Facilitation and training of Action Learning Sets for My Home Life England Leadership Programme (commissioned in early 2023) to create self-sustaining groups going forward	Dissemination of ALS skills allows leaders to apply these skills in their own workplaces, making them more self-sufficient leaders
OD Plan to support STW ICB Executive Team, SLT and wider ICB staff	Preparation and facilitation of February 2023 ICB all-staff development day Creation of interim OD plan and calendar of events for 2023 in preparation for the procurement of OD strategic partner Specification bid for OD strategic partner procurement co-designed, written, and shaped, plus involvement in procurement panel interviews Facilitation of Board and SLT sessions to help articulate ICB Aim and Purpose Preparation and delivery of Change Ambassadors development, plus SDI profiling facilitation for this group	Our programmes have helped to support the ICB workforce, while in a state of flux, and helped pave the way for the OD strategic partner Our ICB Change Ambassadors are now able to support our staff with Change Model concepts

Equality diversity and Inclusion.

In 2023/24 we planned to deliver...

Implement a review of the EDI Steering group including attendance, Chair and Terms of Reference. To realign the structured reporting process to ensure all risks of non-delivery are mitigated and escalated where appropriate.

The intention for the steering group structure is the formation of Task and Finish Groups, each with a chair who will oversee the objectives of the group. The chair will utilise system EDI experts to deliver and standardise the plan.

In 2023/24 we delivered...

EDI Plan on a page shared with steering group

Submission of WREI self-assessment from a system wide perspective in June and November 2023

Review of Terms of Reference, Meeting Governance and formation of Task and Finish Groups to support the EDI Steering Group

New Chairperson of the EDI Steering Group commenced in September 2023

Zero tolerance to racism poster agreed to be piloted by SaTH for future implementation across ICS organisations

Workshop delivered in January 2024 with EDI steering group members to start to build the accountability and collaborative working approach that is needed to become a proactively anti discriminatory ICS and meet the statement and commitments to EDI set out by ICS STW.

EDI Workshop outcomes communicated to the steering group with next steps

In 2023/24 we planned to deliver...

Review and refocus of EDI priorities

Continue delivery of an EDI steering group with representation from organisations across the System

Adhere to National guidance and report completion

In 2023/24 we delivered...

EDI Steering Group meeting - a focus on Race Equality. A face-to-face meeting with Simon Whitehouse at the Princess Royal Hospital concentrating on the Perceptions and Experience of Racism Report, proposed action plans and next steps.

Executive sponsorship agreed by SRO for EDI Alison Bussey (ICB Chief Nurse up to December 2023) , CNO and Simon Whitehouse CEO NHS STW

Northern Care Alliance commissioned to deliver 5 sessions lasting 3 hours Sept-Nov for Managers to increase confidence in identifying and managing risk relating to equality in the workplace with 44 participants across STW

Cultural and Diversity Event held in September 2023 with 91 attendees. Key speaker Michelle Cox in attendance

EDI Workshop outcomes communicated to the steering group with next steps

Discussions with system partners regarding future management of system EDI priorities commenced in March 2024

TRAIN.

REFORM.

Celebrating our success.

‘The Misson Attracted Me & The People Kept me .’

RETAIN.

TRANSFORM.

Train.

This section provides more detail on the work undertaken in 2023/24

ICS Educators' Collaborative Event – 15th Feb 2024, hosted by Telford College.

Highlights from the ICS Educators' Collaborative Event, February 2024.

In February 2024, the Integrated Care System (ICS) Education and Learning Group embarked on an ambitious journey to bring together expert educators from across the health and social care sectors in Shropshire, Telford, and Wrekin (STW). The ICS Educators' Collaborative Event was not just a meeting of minds but a vibrant workshop aimed at shaping the future of healthcare education and training across the ICS. This gathering was a testament to the power of collaboration, strategic development, and innovation in education.

A Vision of Collaboration and Strategy.

With over 50 delegates attending from our diverse ICS partner organisations, the event set the stage for networking and collaboration and provided the opportunity for delegates to shape the ICS Education, Learning, and Development Strategy. With engaging sessions designed to provoke thought and offer practical takeaways, attendees were immersed in a day of learning, networking, and strategy development.

The event was hosted by Tom George, Head of Education Infrastructure & Assurance at Shrewsbury and Telford Hospital, and ICS Education & Learning Lead. Ali Trumper, ICS Head of People Programmes, and Katie Donegan from Partners in Care offered an engaging overview of the ICS and its objectives and initiated a crucial dialogue on envisioning the future landscape of STW ICS. This was complemented by a practical presentation on how to apply Improvement Methodology by James Owen, Deputy Director of Education and Improvement at Shrewsbury and Telford Hospital NHS Trust.

Goals and Achievements.

The primary aim was to deepen understanding of the ICS, its partners, and the pivotal role of further and higher education in shaping a sustainable local workforce. Attendees gained insights into existing workstreams, such as OCSAT, T-levels, and the offers available at Telford College and explored the potential of the system LMS and access to education for the social and independent care workforce.

Through interactive exercises, participants contributed to the vision for an ICS Education, Learning, and Development quality framework strategy, discussing how success can be measured and how to become a quality kitemark-endorsed education provider.

Interactive and Engaging.

Networking emerged as a powerful component, with attendees valuing the opportunity to connect, share expertise, and understand each other's roles within the system. The event's success was evident in the enthusiastic participation, the wealth of ideas generated for the strategy, and the positive feedback on the organisation and delivery of the day. This vibrant engagement set the tone for a constructive and forward-looking discussion on the future of healthcare education and training.

Participants left with a renewed sense of purpose, equipped with new knowledge and insights, and ready to contribute to the development of a cohesive and comprehensive Education, Learning, and Development strategy and supporting framework. The positive feedback and the commitment to future participation underscored the event's success in achieving its objectives and laying the groundwork for ongoing collaboration, innovation, and celebration.

Looking Ahead.

The event not only highlighted the critical importance of collaborative efforts but also set the stage for future initiatives that will continue to drive improvements in workforce development and patient outcomes. Together, we are shaping a future where education and training are at the heart of excellence in health and social care.

Learning Management System (LMS).

We have a Learning Management System that hosts training and development, accessible for all our workforce across health and social care. Our aim over the next two-to-three years is to grow one central Learning Management System for our workforce, moving away from the multiple systems currently in place. We feel this will be a more efficient use of funding to have one learning platform rather than multiple learning platforms.

Revolutionising Learning with the ICS Learning Management System (LMS).

The Learning Management System (LMS) is a comprehensive learning platform that offers e-learning, webinars, events, and workshops to all health and social care staff across the Shropshire Telford & Wrekin (STW) Integrated Care System (ICS).

The digital platform aims to serve as a central hub where all partner organisations within the ICS can host, report on, and share learning resources. Selected and procured by the ICS Education and Learning Group, the LMS is managed by the Integrated Care Board People Team and is instrumental in implementing the ICS People Plan and developing the Education, Learning, and Development Strategy.

In addition to providing access to the full catalogue of e-Learning for Health courses, the LMS also features content from Skills for Care and locally developed materials tailored specifically for the STW health and social care workforce. It further promotes learning opportunities hosted by other organisations, for example, the NHS Leadership Academy and Versus Arthritis ensuring a broad spectrum of resources is available.

The LMS provides quality-assured learning resources produced by local Subject Matter Experts and allows individual health and social care organisations to manage learner access and compliance reporting functionality for employees via an Administrator role, which also includes tracking progress and reviewing assessment scores. Users have found the platform easy to use and access learning materials from various devices, and the modules/content have received positive feedback from staff working across the sectors.

Moreover, the LMS includes an Eventbrite-style sign-up portal that is accessible to both internal and external users. This portal simplifies the event/classroom registration process by capturing essential information such as the organisation name and job role, thereby allowing administrators to generate comprehensive reports and streamline the management of educational events and workshops.

Data for 2023-24 Period:

Total Number of Users: Increased to 5,845 from 4,307 as of 31st March 2023, marking a 35.7% increase. This growth reflects our ambition to increase the number of users and organisations using the LMS by 20% within the year.

Total Number of Modules: Rose to 9,848 from 8,173 as of 31st March 2023, a 20.5% increase, indicating an expanding repository of learning resources.

Total Number of Organisations: Grew to 970 from 812 as of 31st March 2023, a 19.5% increase, demonstrating wider adoption across health and social care sectors.

Total Number of Local Developed Modules: Now at 95, up from 84 as of 31st March 2023.

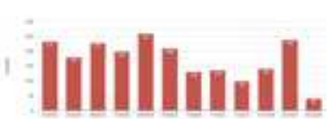
Total Number of Visits for OMMT e-Learning in the Last 7 Days: Reached 1,817, a significant rise from 0 as of 31st March 2023.

Total Number of Classrooms Hosted in the Last Year: 136, down from 256 between 31/03/2022 - 31/03/2023, a 36.33% decrease due to reduced capacity within the People Team to establish and host classroom sessions and events.

Number of new users April 2023 -March 2024:

Number of classroom sessions/ events April 2023 -March 2024:

Number of modules started April 2023 -March 2024:



What We've Achieved.

We have successfully introduced and rolled out the new Oliver McGowan Learning Disability and Autism Mandatory training using the LMS's functionality. The innovative STW sign up tool—a bespoke version of Eventbrite—has streamlined the management and delivery of facilitated sessions, showcasing our ability to meet specific training needs with versatility.

The LMS also played a significant role in driving other key projects forward, such as the STW Eye Transformation project. We developed two new modules aimed at enhancing understanding and support for people living with sight loss. This effort, a joint venture with individuals with lived experience and professionals, seeks to boost service accessibility and support for those navigating sight loss.

Furthermore, the LMS has supported the response to recommendations from the independent inquiry into Telford child sexual exploitation by providing essential training materials for local staff. It further aids in delivering the LeDeR Programme, serving as a vital source of information and lessons learned.

The development and success of the STW sign up tool, mirroring an Eventbrite-style portal, have simplified the registration process for events and classrooms significantly. This innovation has improved the delivery of essential training, such as the Oliver McGowan Mandatory Training, making a real difference in how we educate and empower our healthcare professionals.

OLIVER'S CAMPAIGN

Oliver McGowan

Looking Ahead.

As we reflect on the past year, our achievements underscore the power of collaboration, innovation, and a shared vision. The LMS stands as a testament to our commitment to enhancing education and learning within the health and social care sectors. With continued dedication and partnership, we move forward, inspired by the possibilities that lie ahead in elevating the standards of care and professional development across our system.

Enhancing Education and Learning with the LMS.

In an era of rapid transformation and emerging challenges within health and social care sectors, the Integrated Care System (ICS) Education and Learning Group has continued to pursue its vision to develop and provide a cohesive approach to education and learning. The role of our shared Learning Management System (LMS) has helped in achieving these objectives, showcasing significant strides toward a unified, system-wide educational framework.

Our LMS has seen remarkable growth, now supporting 4,821 users across 969 different ICS partner health and social care organisations. The platform's content has evolved dramatically, hosting approximately 9,952 modules, including 91 locally and collaboratively developed modules by subject matter experts, alongside comprehensive resources from the Skills for Health e-LfH platform. This vast repository underscores our commitment to providing accessible, high-quality education and training solutions.

Additionally, the LMS has been praised for its user-friendly design, enabling staff to easily access a wide range of learning materials from various devices. Staff working across the sectors have provided positive feedback on both the modules and the content available, and the quality of the educational resources.

Managing Deterioration.

A Systematic Approach to Recognising and Managing Deterioration.

During quarter 4 of 2023-24, the Integrated Care System (ICS) began leading an important initiative to improve the early detection and management of a person's deterioration. This collaborative project involves bringing together key ICS health and social care partners, education teams, and the ICS Learning Management System (LMS). The aim is to equip ICS staff with the knowledge, skills, and confidence required to effectively recognise and address a person's deterioration.

Establishing a Solid Framework.

Currently, the project group is in the process of defining its governance, reporting structures, and objectives. Areas of focus include:

- Assessing existing training opportunities and resources for staff.
- Standardising training content and terminology across workforce and services.
- Developing consistent pathways for the identification and management of patient deterioration.

Project Components and Objectives.

This project plans to review current training provision, the access to and uptake of training, pathways, tools, and trainers to assess the potential impact on reducing emergency calls, admissions, and hospital bed days. The goal is to align training offerings to ensure they are delivered effectively across various settings.

Supported by the ICS Learning Management System (LMS) and in collaboration with existing trainers and health and social care partners, the project group aims to expand its engagement. This includes efforts to involve Primary Care partners via the Shropshire Telford & Wrekin Training Hub (STWTH) and Council partners.

Looking Forward.

The immediate next steps involve drafting a detailed project brief with explicit aims and objectives, setting the foundation for the development of an action plan. This plan will facilitate the establishment of a comprehensive, system-wide approach for managing a person's deterioration across the STW health and social care settings. The project group aims to achieve this ambitious goal within the next year.

Good practice.

Shrewsbury and Telford Hospital opened their SERII (Education Research Innovation Institute) building in November bringing integrated education, innovation and research under one roof.

A Systematic Approach to Recognizing and Managing Deterioration.

Recognizing signs of deterioration early is crucial for several reasons:

- It enables timely interventions that can prevent severe illness and reduce the need for emergency care.
- It aids in identifying disease progression, allowing for the timely update of management plans.
- It assists in recognizing when a ``person may be nearing the end of life, ensuring appropriate care plans can be established.

The project acknowledges the challenges in detecting deterioration across various settings and aims to maximize the opportunity to create standardized detection pathways and tools.

Some key focus areas of the project include:

- Specific Examples: Utilizing case studies to demonstratethe impact of early recognition of a person's deterioration.
- Testimonials and Case Studies: Sharing experiences from staff who have employed early detection strategies, providing insight into both benefits and encountered challenges.
- Partnership Opportunities: Highlighting ways for local health and social care providers to collaborate on this initiative.
- Metrics for Success: Establishing clear metrics to measure the project's impact and achievements.

The Joint Training mission.

The Joint Training mission is to:

-Develop and deliver learning and development opportunities for all organisations involved in health and social care, including Family Carers and people who use services.

-Develop knowledge and skills to positively influence improved experience of health and social care support for the people of Shropshire.

This supports the Priorities and Aims of our funding partners:

-The Shropshire Plan Priorities: Healthy people, Healthy economy, and a Healthy organisation.

-Midlands Partnership University Foundation Trust Aims:Making everyone matter. To empower and engage our workforce. To be an effective partner.

-Integrated Care Board Aims: To improve people's health, deliver high-quality care and get better value for money.

We also generate income by selling our training courses and expertise.

Centre of Excellence
Valid until 01/2026

New Development, we are currently part of a Transformation Project to:

Provide joined up learning across both Adults and Children's services. Joint Training is now part of a Transformation Project aiming to bring learning and development opportunities for people working with adults, children, and young people together into the same place, with one point of access via the Shropshire Council web site.

This responds to:

- New demand - over recent years Joint Training has increasingly been asked to provide training for workers supporting children and young people as well as adults. We have begun to expand our training offer in response to this e.g., Mental Health First Aid Youth, Suicide First Aid: Children and Young People, Mental Capacity Act awareness for staff and parents of young people in transition to adulthood, Restrictive Intervention, de-escalation model for education. Supporting All Age Strategies e.g., Autism.
- Safeguarding – children, young people and adults exist in families and community groups. A shared understanding of the risks and complexities of safeguarding needs to be developed to maximise opportunities to reduce risks and potentially save lives.
- Co-ordinated approach – this will support the development of an even more joined-up approach to learning which will maximise resources and provide opportunities to income generate to support the training offer. This will bring together exiting new opportunities to extend our learning offer over a wide range of subjects to a wider learner group.

Transformation Project progress to date includes:

- Crisis Prevention Institute now available to Education and Foster Parents
- New All Age Safeguarding Post
- Newley emerging team with wider range of expertise
- Developing a wider range of courses
- Attracting a wider reach of learners
- Learning already available with an All-Age approach include:
- Mental Health First Aid Youth
- CYP Self-Harm
- Autism in Young people – Trauma and Life Transitioning
- Working with Childhood Trauma and Abuse
- Safeguarding Children and Young People Aware
- Please see our web site for further information - Joint Training

Sight Loss eLearning Project.

Revolutionising Care Through Digital Learning

Spearheaded by the collaborative efforts of the Local Eye Health Network, experts with personal experience of sight loss, and the wider health system, this project aimed to educate our local health and social care workforce about the unique challenges faced by individuals living with sight loss, ultimately enhancing the care and services they receive.

From Inspiration to Aspiration

Inspired by Dan Williams' work at Visualise Training Consultancy, alongside the Local Eye Health Network and My Sight Nottinghamshire, our journey in Shropshire Telford, and Wrekin (STW) has a twofold mission: to improve the standard of care for those with sight loss and to improve their experiences within health and social care locally.

Why It Matters

With an estimated 19,500 individuals experiencing sight loss within our county, it is imperative that all health and social care professionals possess the knowledge and skills to offer effective support to those with a sight loss. This initiative prioritises a personalised approach in both service design and daily interactions, aiming to significantly enhance the quality of life and experiences of individuals with sight loss.

A Collaborative Endeavour

The development of the two sight loss eLearning modules was significantly enhanced by the contributions of individuals living with sight loss. Through focus groups, these participants provided invaluable insights that directly influenced the content of the modules. Now available to the health and social care workforce across STW, the modules include personal stories and overviews of local services, spotlighting the Sensory Impairment Service, Rehabilitation Officer for the Visually Impaired (ROVI), local sight loss charities, the Low Vision Service, and the Eye Care Liaison Officer.

Developing Understanding and Support for People with Sight Loss

This eLearning resource is a bespoke tool developed to address the knowledge gap regarding sight loss. It is designed to meet the specific needs of our local community members affected by sight loss, enhancing every interaction and service they encounter. The development of this resource was guided by feedback from individuals with sight loss and is based on best practice standards.

eLearning Unveiled

The eLearning modules, inclusive of four informative videos, are designed to provide comprehensive insights into the various conditions, their impacts, and available support pathways, aiding those navigating their sight loss journey.

Broadening Horizons

Since their introduction in September 2023, the modules targeted specific professional groups initially, with plans in place to extend access to a wider audience. Hosted on both the STW ICS Learning Management System and Shrewsbury and Telford's (SaTH) Learning Management System, the modules are designed to reach and benefit all health and care workers in STW.

An Invitation to Participate

We are continually working on inviting health and social care colleagues to view the modules and for them to explore how they can enhance their practice and improve care and services for those with sight loss. This project demonstrates the powerful outcomes that can be achieved through collaboration, innovation, and a shared ambition to make a tangible difference in the lives of our local population.

The Journey and Impact

From initial connections in March 2022 to the co-production of learning resources, the project has evolved through collaborative efforts with experts, insights from focus groups, and ongoing feedback. With a phased roll-out across various health and social care sectors, the feedback from people with sight loss has been clear: communication and respect are paramount.

Vision for the Future

This project goes beyond educational efforts; it directly contributes to the ICB's goal of reducing health inequalities, particularly for those with sight loss. By fostering awareness and understanding among the health and social care workforce, we are moving towards creating a health and social care environment that is more inclusive, empathetic, and efficient for individuals living with sight loss.

A Call to Action.

We encourage all health and social care staff to engage in this training to support and understand those living with sight loss and consider how they can apply their learning in their work. To access the training directly, scan the provided QR code.

eLearning Screenshots

Growing our Future.

This section provides more detail on the work undertaken in 2023/24

Growing for the Future (11-17yrs).

Widening Workforce Access and Participation.

As we strive for a healthcare workforce which is representative of the communities we serve, we have delivered a variety of engaging and inspirational widening access and participation initiatives within our communities. This has included activities specifically for those who are under-represented or from lower socioeconomic and deprived areas across our county.

Our engagement with schools and colleges supports the Gatsby Benchmarks framework which forms part of the Government's Careers Strategy, especially Benchmark 5 - Encounters with employers and employees as well as supporting the development of a sustainable pipeline to meet the requirements of the NHS long term workforce plan.

Careers events.

Over the last 12 months we have attended over fifty careers' events at schools, colleges, and jobcentres throughout the county. Having representation at as many of these events as possible has been a focus for us this year as it allowed us to be able to inspire, dispel myths, and promote the varied routes and pathways into a career within health and social care.

Our Organisational Directory has been an invaluable resource at these events as it has enabled us to promote the different organisations, signpost to opportunities, and where to gain information, advice and guidance regarding health and social care careers throughout Shropshire, Telford, and Wrekin.

Work related learning programme.

This one-week programme was specifically designed for Year 10 students (aged 14 – 15 years of age) who are interested in a career in health or social care but were unable to undertake a work experience placement within organisations due to health and safety restrictions or due to lack of capacity of placement availability. During the programme over 20 students from a variety of schools across the county, met staff from an array of different departments including pathology, radiotherapy, and a variety of therapy roles. The students participated in immersive and interactive activities relating to the various jobs, as well as discussing the different training opportunities which are available such as apprenticeships.

Virtual work experience.

In the absence of work experience placements within health care settings due to the Covid-19 pandemic, engaging with our local schools and colleges remained a priority for us. As such STW ICS commissioned Springpod, an immersive online careers and university exploration platform, to devise and deliver three online work experience programmes for Medicine, Allied Health Professionals, Nursing & midwifery. Embedded in each programme was the opportunity to discover other careers including pharmacy, healthcare science and dentistry.

Participants were able to access the programmes during their school/colleges work experience weeks or within their own time if they had a particular interest in a career. Feedback from one participant stated:

"I enjoyed learning more about the Allied Health Professionals and their roles, as well as the key communication points needed when working in these professions."

Springpod

The success of the programmes was reviewed on completion of the year long project in June 2023, with the following results.

Programme	Enrolment	Gold Completed 70% +of the programme	Silver Completed 35%-70% of the programme	Bronze Completed >35% of the programme
Nursing	268	101	107	60
Medicine	316	223	70	23
Allied Health Professionals	290	114	102	74
Total	874	438	279	157

The results demonstrated the value of the programmes with large number of students enrolling and completing the programmes. The information gathered during these programmes would have supported the students with further applications for university, apprenticeships, or employment.

Work Experience.

For many organisations face to face work experience placements recommenced during the summer term of 2023. Placements take place in a variety of clinical and non-clinical settings, on dedicated weeks or at the request of the applicant.

We are currently developing a STW ICS work experience online platform which will allow applicants to explore opportunities across several organisations with an increased number of requests for placements fulfilled.

Growing for the Future (11-17yrs).

Futures Cards.

Development of a new **Futures cards** initiative; a tangible learning tool, easily accessible at schools/college/events which aims to help our future workforce learn more about specific career paths and raise the profile of careers across the STW-ICS. With 15 Future Card careers in total, each career card will link via QR code to a comprehensive talking heads video, providing a more in-depth understanding of the role and the local options available within this sector.

Which will be held on our **STW-Healthcare careers website.**

We are continuing to work on developing and expanding the STW-Healthcare website aspiring to help widen access to careers within STW-ICS and build on our every growing pipeline. Part of this focus is also on more social media engagement, specially targeted at our younger future workforce in a way that is health literate and accessible.

Next Gen & Talent foundry Schools Workshop.

In conjunction with the Talent Foundry, who were procured by NHSE Next Gen, we were the first system to host the schools work shop. Together we developed and launched a very successful Workshop in December 2023, held In the VR suite at Telford College. We engaged with a range of qualifying local schools to host year 9/10 students into a hands-on/virtual/ interactive health and social care experience.

The event was delivered by a number of our health and social care professionals which allowed young people to experience these roles first hand.

They were able to ask questions and gather information and inspiration about some of these STW-ICS career routes.

Feedback showed how these workshops helped to inspire the children and develop confidence, along with their desire to think big about a potential future employment within the STW-ICS health and social care sector; thus continuing to develop our local workforce pipeline.

Parental consent underneath photo of children

Parental consent underneath photo of children

Feedback from both the students and teachers was "amazing", with quotes such as:

Teacher quotes:

What would you say to another teacher thinking of booking their students onto this workshop/programme?

"Do it! The program was amazing, the staff and exhibitors were great and were really approachable. The tasks were pitched well and students felt like they could ask any questions."

"We as staff have been talking about it non-stop since we got back and the kids have a real buzz about them."

"This was a brilliant afternoon filled with lots of interesting workshops. Pupils left feeling knowledgeable about careers with the NHS. It was an insightful experience which pupils greatly benefited from."

Student quotes:

How could we make the workshop/programme better?

"Get even more people from the NHS"

"Nothing, maybe longer on the VR, it was amazing!"

"It's perfect"

Something you learnt.

"I didn't realise how many jobs there were"

"Midwifery is more fun than I thought"

"It has made me think about joining AHP"

How has taking part benefited you.

"I know what subjects to study"

"Benefited me by showing me all the careers"

Growing for the Future (17yrs to Adult).

Skills Show.

16th March 2023 saw the success of the Apprenticeship, Employment and Skills Show at The Telford International Centre. As a sponsor we had a prime location situated just inside the main entrance for the event. 3000 people registered for event 1500 of which were young people from local schools

16/03/23

16/03/23

We are now just days away from embarking upon this year's bigger and better Skills Show event (which is the largest in the region), where we will once again be a co-sponsor. Bringing our impressive revamped hub to attract over 3000+ attendees, we aspire to once again engage with our community to showcase our wide range of clinical and non-clinical career opportunities, apprenticeships, work experience, step into work programmes and various training opportunities etc. along with a plethora of career advice and signposting from our engaged partner professionals, who are very much part of the event and bring their own interactive activities and stands to engage and attract.

This Years Skill Show ran in march 2023 and attracted over 3000 attendees to our ICS stand

Step into work.

Our Step into Work programme is proving to be a successful way of helping our local community get into work by gaining sustained employment within STW-ICS social and healthcare sector. Our programme, developed in partnership with Telford College, includes targeted Level 1&2 training and a subsequent work placement within our partners vacancies. We have seen several recent success stories, with lots of positive feedback and an increasing momentum for this package moving forward. Working with our local Department of Work & Pensions to highlight potential candidates, affords our partners the ability to increase in their diversity and improved representation of minority groups in their workforce.
The programme can be life-changing for some, with candidates advising of increased aspirations and self-confidence.

Feedback from candidate.

"I thoroughly enjoyed my step into work programme and would not have received my new job without the programme! I am extremely grateful to have been given the opportunity to partake."

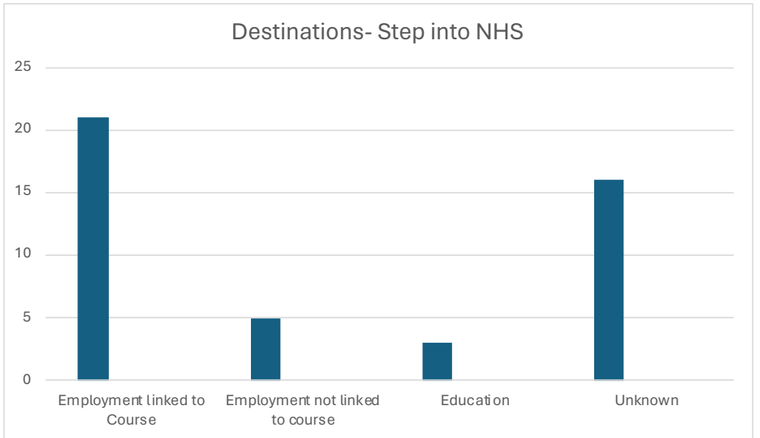
Care Experienced Young People.

Working with, Telford College we are creating an opportunity for care experienced young people to do a course in a non-educational environment to improve their confidence, employability skills and gain customer service qualification, alongside this they will gain work experience within STW ICS with the pastoral support while on the program. Working with NHSE Universal Family Program and how that links in with the Care Leaver Covenant. We hope to be able to implement Care experienced as a protected characteristic when applying for positions with in STW ICS ensuring if the minimum criteria is met they will automatically be called for interview.

Step into NHS.

This course is aimed at those looking for work or a career change. It is fully funded And referrals are either by the job centre or individuals can self refer.

This course started in Sept 2023, since then nearly 50 students have completed the programme, with some positive success stories, with 5 progressing onto the healthcare support worker academy and into employment within the ICS.



Good practice.

In partnership with Shrewsbury college , Shrewsbury and Telford developed an "Intern training and work placement programme" specifically for people living with Learning Disability and /or autism. With 12 people on programme , the aim at the end is to support their first cohort into paid employment.

T-Levels.

T-LEVELS
THE NEXT LEVEL QUALIFICATION

May 2023
A steering group was set up to include all 4 NHS trusts and both Telford College and Shrewsbury colleges group across STW ICS. This collaboration of organisations across the ICS ensures consistency for the students

June 23
T-level event for local employers.

July 23
Shrewsbury college held a welcome event for potential T-Levels students. NHS trusts started to raise awareness of T-Levels through their own communications teams.

August 23
Industry placement co-ordinator (IPCO) employed, only 7 ICS trust were awarded the grant from the Department of Further Education for this role.

September 23
First Students enrolled on the course

November 23
T-Level students completed HCSW Academy, adult nursing T-levels

What is a T-Level.

T levels are a new two-year course which are taken after GCSE's and are broadly equivalent in size to three a-levels. They have been developed in collaboration with employers and education providers so that the content meets the needs of industry and prepares students for entry into skilled employment, an apprenticeship, related technical study through further or higher education. T levels offer students practical and knowledge base learning at a school or college and on the job experience through an industry placement of at least 315hrs approximately 45 days.

The Academy

December 23
Students feedback on the placement so far.

I really love ward 15&16 which if I actually have a chance I don't want to change ward next year but unfortunately I have to move clinical area. The people in my ward are very nice the way they welcomed me on my first day and how they still treat me as first is marvellous, they ensure that I am learning everything that I need to they are all very careful with me and explain everything that I found new to do and always give me a try to participate in anything that goes on in the ward apart from stuffs that are beyond me. Sharon the manager is very kind and understands my situation in getting into the ward but she always makes sure I am having the best experience and always with a HCA and a nurse to upgrade my knowledge more. There's so much I can't even tell but am very happy because I always feel like a staff in the ward. EVERYONE treats me like their co-workers which makes me very confident and trust them in terms of me not understanding anything.

I am finding my placement the best thing I could ever do and I think it is the best opportunity I will ever have in a lifetime. I have really enjoyed working with different staff members and getting know the different job within the healthcare service and what their job involves and also getting to know the different staff that come on the ward. I am just so thankful for this opportunity as I know it is a once in a lifetime experience and it can get me where I want to get to in the future to come.

I am really enjoying my placement. Many of the staff I have worked with are supportive and polite to me. I like caring for the patients and helping them out with needs they need support with. There is nothing I don't really enjoy; I just wish our lunch time was slightly longer as I am not able to re fuel myself enough.

January 24
Midwifery and Mental Health students commenced first placement. Department of Education conference with local authorities to talk about how we have implemented T-levels in health. Midpoint reviews for placement carried out. Evaluations mid placement from placement areas on how students are progressing.

February 24
On 8th Feb we celebrated T-Level Awareness Day

Facebook –
678 accounts reached with 63 engagements including 6 shares

Twitter –
283 views with 2 re shares and 3 link clicks

Instagram –
444 accounts reached with 27 reactions including 2 saves

Linked In –
458 impressions against 205 views with 15 clicks

The DFE Local Authority Talk

Callum's DFE Visit

Department for Education

DFE highlighted STW as an exemplar project and presented to the DFE steering group, the national ICS t-levels network meeting and the Gatsby Foundation

What's next...

Expanding into Allied Health Professionals

Telford college looking to start a T-Level in Science with a specialism of Laboratory science

Continue to grow the number and type of placements for T-level students in the future

Showcase T-Levels within schools to ensure future students are aware

Look at pathways with universities and employers that T-Levels will be able to follow

Look at the Buddy system for HCAs at SATH and see how we can bring this out within the ICS to all health areas that will support T-Level students

A focus on non clinical / care T-Levels to attract young people into future roles such as our labs, administration, management, IT

Social and Healthcare Partnership Training Academy.

Introduction.

The Social & Health Care Training Academy was set up in 2022 by a collaboration between STW ICS & Telford College and their commitment to support the recruitment, retention and career pathways across the NHS and Social Care. With a specific focus to reduce the number of Healthcare Support Worker Vacancies across STW ICS to Zero.

The HCSW Academy is a two-week enhanced induction programme, within the frame work of the Care Certificate. Through centralised marketing and recruitment campaigns over 800 people, new to care have been recruited into the ICS

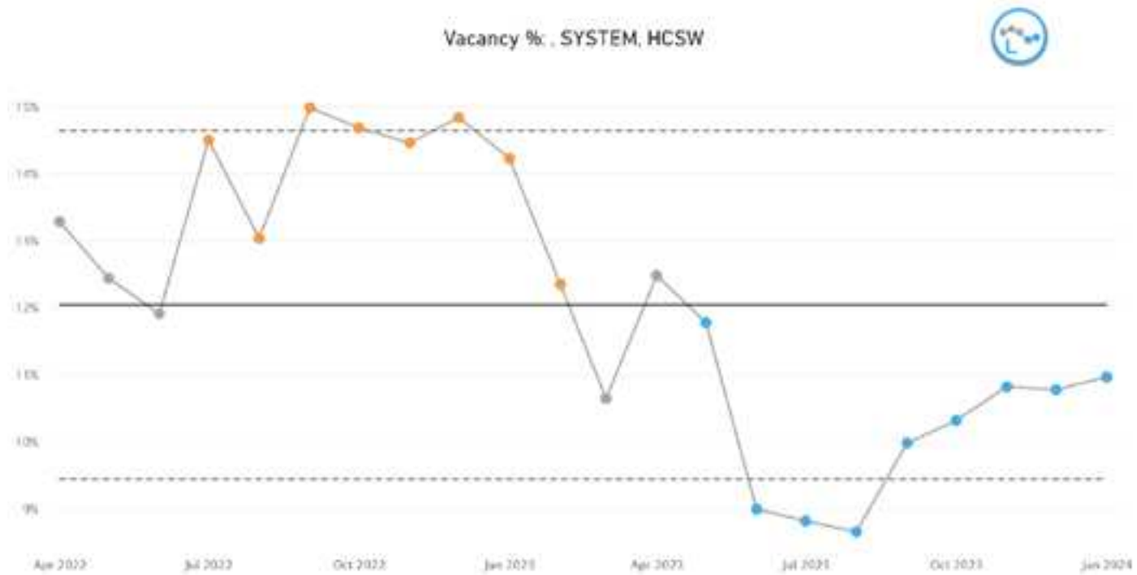
People from different age groups, gender, diverse background and heritages have been attracted.

Impact on our NHS HCWS Workforce.

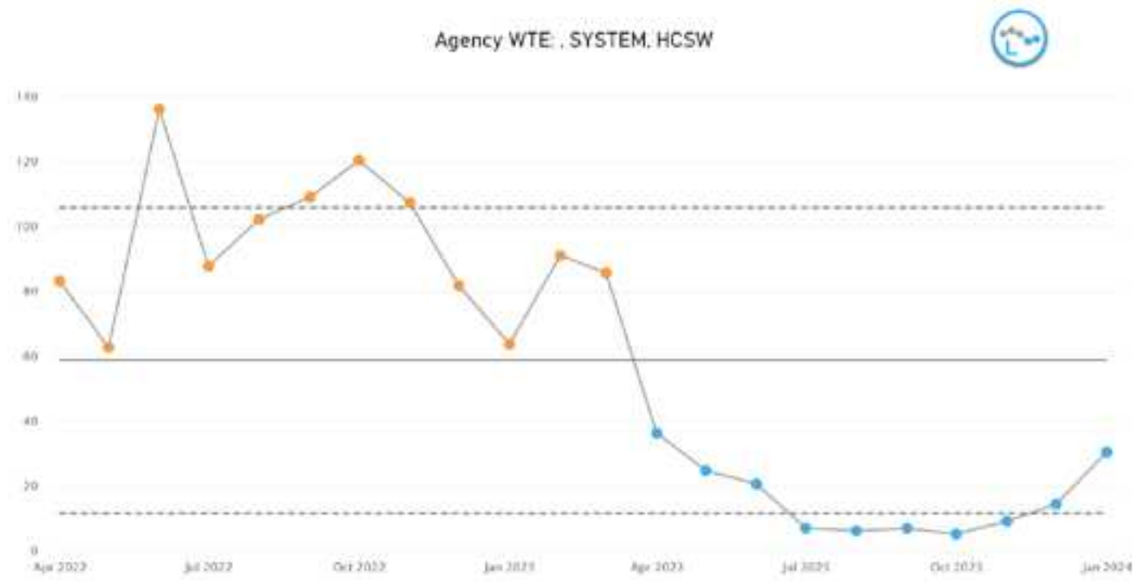
We have more to do as a system team, our social/independent care partners currently experiencing 1650 vacancies. We will be adapting the academy to better fit social care providers' needs.

Workforce Has Increased

Vacancies Have Decreased



Agency Utilisation Decreased Overall



In November 2023 we supported our first group of T-Level students (15 from Shrewsbury College Group and 32 from Telford College) through the HCSW Academy preparing them for their first clinical placement.

T-Level students feedback on HCSW academy program

How prepared did you feel about your clinical placement **before** commencing the HCSW Academy T-Level Induction Programme?

43% answered **Very prepared**

How prepared did you feel about commencing your placement **after** the HCSW Academy T-Level Induction Programme?

100% answered **Very prepared.**

"The trainers did a very great job and they had a lot of patience with us and they were funny too."

"I most enjoyed the practical sessions as I was able to put my learning to practice."

"I just wanted to thank you for giving me this opportunity as it is one in a lifetime chance."

"I don't think there is anything that can be improved because we were taught everything we needed to know and what we might come across in the wards which is a good thing."

Feedback from HCSW.

How prepared did you feel for the role of the HCSW **prior** to commencing the programme?

54% answered **Somewhat prepared.**

How prepared did you feel for the role of the HCSW **following** completion of the programme?

100% answered **Very prepared.**

What is your overall thoughts of the HCSW Academy?

"Very deep, covered all my modules to equip HCSW to carry out their duties."

"Really helpful but a lot of information in a short amount of time."

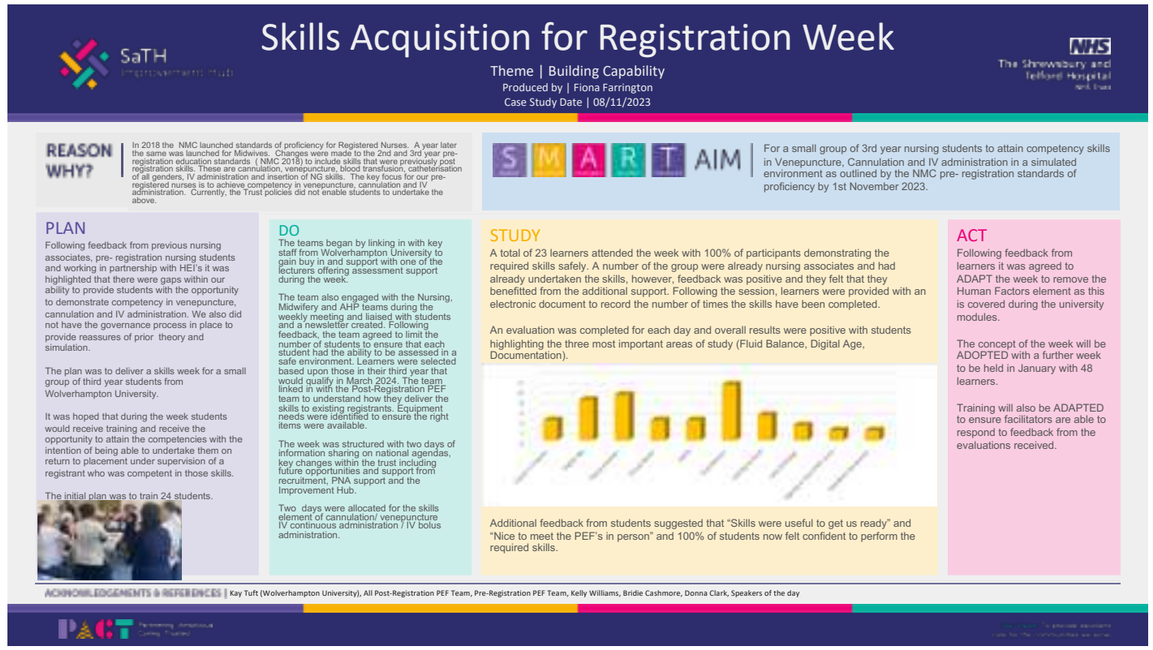
"Great to work alongside other people. Others willing to help when needed."

"Very good, useful and efficient training that you definitely need it before you start your journey at hospital."

OSCAT.

The aim of this project is to support our student nurses who are on placement on the Shropshire Telford and Wrekin placement circuit, to attain their technical nursing skills as part of their proficiencies registration. The OSCAT clinics enable our students to use their practical technical skills in a simulated learning environment.

To date, sixty students have attended clinics from August to January. We will better monitor the impact of these clinics to see whether this improves retaining our student nurses within Shropshire Telford and Wrekin following qualification.



We will be joining the OSCAT service with the good practice from Shrewsbury and Telford hospital acquisition weeks to further improve our offer to attract and retain nurses in Shropshire Telford and Wrekin.

Growing our workforce.

We want to improve the quality and experience of the people we care for and reduce our reliance on agency workforce.

We have been hugely successful in international recruitment and have attracted

- 205 Nurses
- 10 Midwives
- 10 Diagnostic Radiographers
- 2 Therapeutic Radiographers
- 2 Breast Imaging Radiographers

Our medical and dental workforce turnover at our largest acute NHS provider is reducing and is now at 7.9 %

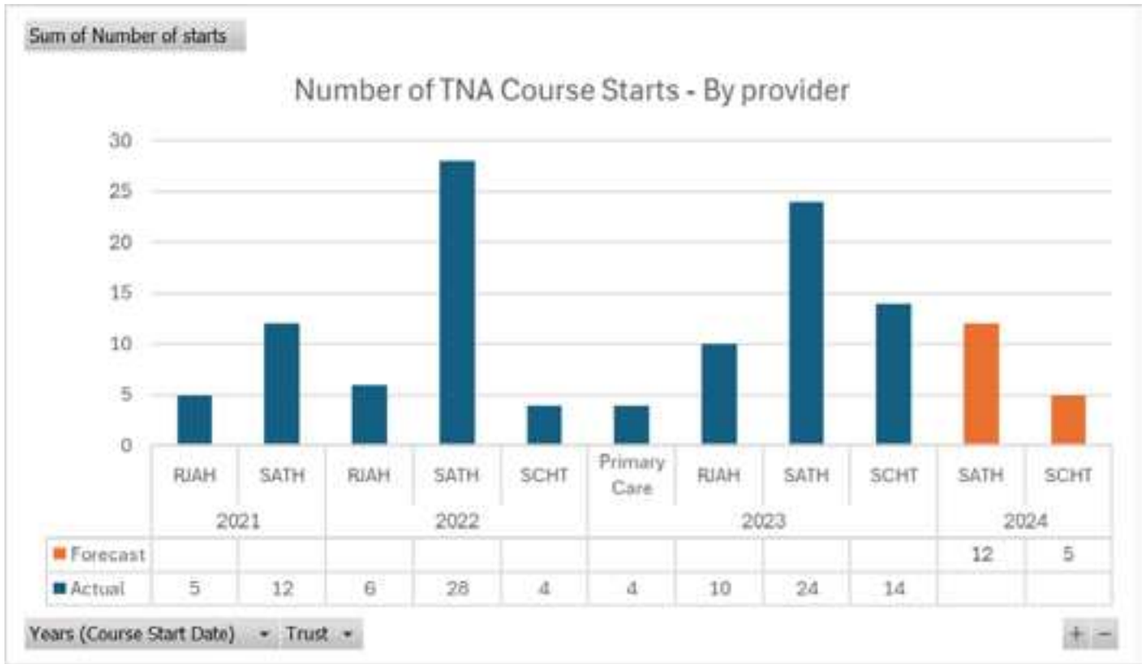
Apprenticeships.

In line with the long term workforce plan we are growing our Apprenticeship offers of training for our workforce.

We know over 350 apprentices are currently on programme, and we need to improve this. We have now convened a system apprenticeship group led by one of our providers partners . We have used the system apprenticeship Levy sharing agreement and supported two Trainee Nurse Apprenticeships from the care sector.

Trainee Nurse Apprenticeships.

We have grown year on year our TNA's across our NHS provider partners



Reform.

This section provides more detail on the work undertaken in 2023/24

Workforce Sharing Agreement.

Impact so far

Three of NHS partners have a number of situations where the workforce sharing agreement has enabled people to work across different sites.

This has supported people to experience different working environments either through rotation programmes or a direct temporary move.

This has enabled people to share skills, develop new skills and experiences and support where there may be critical workforce gaps.

Our first non-NHS partner Hope House hospice for children , has joined the workforce sharing agreement and will be embarking on working with NHS partners during 24-25.

Our local authority and Independent Care provider Workforce.

Monitoring workforce trends across social and independent care providers is more challenging. Information about the local authority and independent sector adult social care workforce is taken from the national Skills for Care Adult Social Care Workforce Data Set and is always retrospective data by several months.

Overall we can see that our care sector is challenged with 1,500 vacancies and a turnover of 29.4% as of 23/24 Q4 . There have been improvements with the filled posts and vacancy rates on an improving trajectory .

Recruitment and Retention by ICB

Filled posts % change since March 2023 for independent sector only

2022/23	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
14,000	1.8%	3.1%	4.6%	4.3%

Vacancy Rate by ICB

Vacancy rate as % since March 2023 for independent sector only

2022/23	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
10.1%	9.9%	8.1%	7.0%	6.7%

Key messages.

NHS Substantive Workforce Growth (April 2023 to January 2024).

-Our system total substantive NHS workforce has grown by 842wte..

-Our system Nursing, Midwifery and Health Visiting workforce has grown by 249wte.

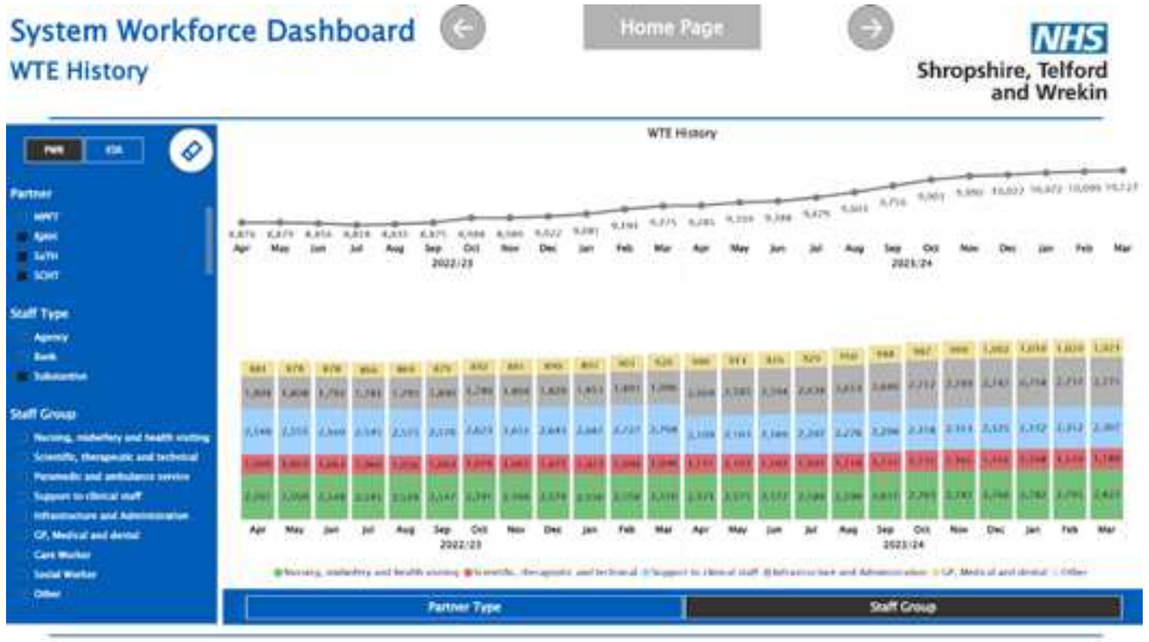
-Our system GP, Medical and Dental workforce has grown by 114wte.

-Our system Support to Clinical workforce has grown by 198wte.

-Our system Scientific, Therapeutic and Technical workforce has grown by 69wte.

-Our system Infrastructure and Administration workforce has grown by 202wte.

-All of the NHS Trusts have seen an improvement in sickness rates



			MPFT	RJAH	SaTH	SCHT	ICB	STW ICB	Acute	Community & MH
Metric	Staff Group	Date Period	Value	Value	Value	Value	Value	Value	Value	Value
Sickness%	Total	Jan 2024	9.6%	7.7%	11.1%	12.2%	13.2%	13.2%	10.5%	10.9%
Turnover%	Total	Jan 2024	4.9%	4.9%	5.6%	5.5%	4.9%	4.9%	5.4%	5.2%

By growing our NHS workforce we have been able to provide new services to our local communities, including:

- Community Diagnostic Centres
- Rehabilitation and Recovery Wards
- Virtual Ward
- Elective Hub
- Integrated Discharge Team
- New Operating Theatres

Our ICS Workforce Planning Group

Our operational managers have had opportunity to attend workforce planning workshops to develop skills, expertise and knowledge in this complex subject.

Our ICS Workforce Dashboard

Working collaboratively with the ICB Business Intelligence Team, we have developed a system NHS workforce dashboard built in PowerBI that enables sharing and visibility of our workforce data that can be filtered by NHS Trust, by substantive, bank and agency workforce (wte and %) and by Staff Group including:

- Staff in post wte history,
- Turnover, sickness, vacancies,
- Actual staff in post wte against the operational workforce plan,
- Actual cost of workforce against the operational financial plan,
- Agenda for change appraisals, medical appraisals and statutory & mandatory training compliance
- Metrics for critical roles to demonstrate impact of interventions including health care support workers and allied health professionals.

The dashboard is updated monthly and key data is shared/reported through the Integrated Performance Report to ICB Board along with the ICB Quality & Safety Committee and both the ICB People Collaborative and ICB People, Culture and Inclusion Committee.

Retain.

This section provides more detail on the work undertaken in 2023/24

Retaining and supporting our workforce is a key priority across Shropshire, Telford and Wrekin as outlined in the National People Plan and the NHS Long Term Plan.

Ensuring that our workforce feel valued and can develop in their career is crucial to retention. We believe staff should have access to support, development and opportunities and be encouraged to achieve their individual ambitions within the workplace.

Based on the evidence we have, there are two important principles which support the workforce retention:

- Targeted interventions for different career stages: early career, experience at work and later career. There are different risk points related to job satisfaction and our vison is to respond and all support will be tailored accordingly.
- Bundles of high-impact actions are more effective than single actions. We support a bundle approach to deliver sustained gains, applied to the different career stages, informed by evidence that drives job satisfaction, experience and therefore retention.

Summary of delivered projects.

- System Health & Care Apprenticeship
- GP Fellowship
- High potential scheme
- Scope for growth conversations
- System workforce sharing agreement
- NHS staff survey and Pulse
- Talent management career conversations
- System rotational posts
- Leadership development within social care
- GP retention posts
- Flexible working
- System workforce planning
- Menopause champions review
- Preceptorship framework

Springboard Preceptorship.

The aim of this project is to support our newly qualified nurses and allied healthcare practitioners. It is an integrated preceptorship program and is deemed to be exemplar by NHS England. We will be monitoring the impact of this program during the forthcoming year.

Your Preceptorship Journey to Success Key Elements.

Standardised preceptor preparation to ensure understanding of the role and requirements to effectively support newly registered staff.

Core generic preceptorship development days to aid transition, development in role and enable peer support.

Standardised preceptorship passport, including meeting templates and documentation to record your progress

Springboard – Your Preceptorship Journey to Success Definition and Aim.

Preceptorship is the springboard to enabling the transition from students to newly registered practitioners as they begin the next phase in their professional journey.

We aim to provide an individualised, structured approach that empowers the preceptee to develop their resilience, well-being and to grow in confidence and competence through lifelong learning.

Benefits of a collaborative ICS approach.

Enhance existing preceptorship programmes within individual organisations.

Standardize preceptorship and ensure access for all newly qualified

Work together across nursing and Allied Health professions to offer multi-professional programmes: inter-professional learning together

Opportunity to build networking and understanding of roles across the health economy.

Attract and retain our future Shropshire workforce through robust early career support.

Opportunity to benchmark against the National Framework (due to launch September 2022).

What's next.

When Springboard was introduced we commenced with 2 cohorts:

Cohort 1 ran from October 2022 – September 2023 – 28 preceptees

Cohort 2 ran from April 2023 – completing next week on 21st March 2024 – 33 preceptees

The delivery of cohorts after this has taken place with delivery across the ICS as follows:

SaTH – delivering Springboard independently utilising the resources developed collaboratively

RJAH - delivering Springboard independently utilising the resources developed collaboratively

Shropshire Community Trust/Primary care/social care/hospices – delivering Springboard collaboratively utilising shared resources

Integrated Care System
Shropshire, Telford and Wrekin

Springboard
Your **Preceptorship** Journey to Success

NHS

DEVELOPMENT OF A MULTIDISCIPLINARY PRECEPTORSHIP PROGRAMME ACROSS AN **INTEGRATED CARE SYSTEM**

Background and Purpose

Background

Preceptorship is a structured period for newly qualified practitioners. The importance of this support is recognised as a strategic measure to enhance recruitment and retention but also critical to enable the practitioner to realise their potential to deliver the highest quality care (Scholes et al 2017).

To address this national requirement in Shropshire, Telford and Wrekin (STW) development of an Integrated Care System (ICS) preceptorship programme was commenced, with representation across multiple organisations and disciplines.

Purpose

To develop a programme to enhance and standardise preceptorship for newly qualified practitioners from nursing, midwifery and the Allied Health Professions, building upon existing programmes.

In addition, with recent implementation of the National Preceptorship Framework for Nursing (2022) this provided an opportunity to review and benchmark the new ICS programme against the recommended National standards.

Methods

In January 2022 a multidisciplinary working group assembled, consisting of preceptorship leads from across the ICS, to begin development of the following components of the project:

- Preceptorship definition and aim
- Preceptor preparation workshops
- A formal generic structured programme (5 days) over 12 months
- Preceptorship Passport - developed on a digital Learning Management System allowing data extraction
- Memorandum of Understanding to be agreed and signed by all parties
- Development of our Springboard logo and branding to provide an identity for resources
- Evaluation forms for preceptees and preceptors

Discussion

- Implementation of the programme commenced with the first cohort in October 2022 representing three ICS organisations. Inclusion of all members in the delivery phase posed the greatest challenge due to logistics and timelines.
- Development and planning is ongoing with adherence to the recommended National framework.
- This project is continuing with phased member involvement and a process of evaluation. Effects on future workforce trends and the preceptees' experience of preceptorship will be measured.
- The Springboard brand is central to our preceptorship vision.

Development Process

- Partner representatives across the STW ICS from Nursing and Allied Health Professions contributed to the development of an ICS preceptorship framework via an established steering group reporting into STW ICS Social and Healthcare Nursing and Health Care Support Worker Council and Allied Health Care Professionals Council.
- The framework is developed against the National preceptorship framework and delivers an integrated process of support for transition from student to registrant for both Nurses and Allied Health Care Professionals.
- There was also representation from the STW ICS preceptorship working group to attend the Regional preceptorship forum lead by the Assistant Director of Nursing & Quality NHS England - Midlands offering the opportunity to share best practice

Benefits of a collaborative ICS approach

- Enhance existing preceptorship programmes within individual organisations
- Standardize preceptorship and ensure access for all newly qualified
- Offer inter-professional learning across nursing and Allied Health professions
- Opportunity to build networking and understanding of roles across the health economy
- Attract and retain our future Shropshire workforce through robust early career support
- Opportunity to benchmark against the National Framework (launched September 2022) and National Preceptorship Interim Quality Mark (launched January 2023)

Springboard - Your Preceptorship Journey to Success Definition and Aim

Preceptorship is the springboard to enabling the transition from students to newly registered practitioners as they begin the next phase in their professional journey.

We aim to provide an individualised, structured approach that empowers the preceptee to develop their resilience, wellbeing and to grow in confidence and competence through lifelong learning.

Springboard - Your Preceptorship Journey to Success Key Elements

- Standardised preceptor preparation to ensure understanding of the role and requirements to effectively support newly registered staff
- Core generic preceptorship development days to aid transition, development in role and enable peer support
- Standardised preceptorship passport, including meeting templates and documentation to record progress and development accessed via an online platform

Springboard
Your **Preceptorship** Journey to Success

Sample Evaluations

Nice to talk to others and feel not on my own with emotions relating to transition.	Great discussions and group work made the day interesting - Thank you.
Well delivered and team are passionate about preceptorship.	Made me feel like I'm not alone.
Really enjoyable day. Makes me feel well supported.	Reassuring to know there is a journey and pathway to follow.

Challenges

- The introduction of this new collaborative process was at risk of generating negative reactions from those organisations who already have a robust, successful preceptorship programme in place
- Decision making and consensus can be more complex across multiple stakeholders
- Some decision making was more complicated, and this affected project milestone timelines
- Delivery of sessions collaboratively has timing and logistics implications

Future Considerations

- Confirm Key Performance Indicators and implement robust measurement of outcomes
- Expand cohort numbers from across other ICS organisations
- First cohort completes in September 2023 - evaluation of outcomes
- Develop an action plan with member organisations in relation to working towards submission for an ICS wide Preceptorship Quality Mark
- Ensure appropriate governance and quality measurement processes are in place

References:

Scholes, J, et al. Managing Support for Newly Qualified Practitioners; Lessons Learnt from One Health Care Region in the UK. Journal of Nursing Management 25(2), 2017, doi:10.1111/jonm.12446.

https://www.england.nhs.uk/publication/National-Preceptorship-Framework-for-Nursing/, NHS England, 10 Oct. 2022,

https://workforceskills.nhs.uk/projects/nhse-i-national-preceptorship-programme-2022/national-preceptorship-interim-quality-mark//, National Workforce Skills Development Unit, 15 March 2023.

Authors:
Alison Lester, Transformation Manager, STW ICS
Catherine Chaplin, Clinical Educator
Sarah Yewbrey, Lead Nurse for Education and Quality at SCHT
Shropshire Community Health NHS Trust

Monthly Retention Data Snapshot.

It is difficult to quantify the impact of any one activity within the retention and health and well-being bundle. Enclosed data illustrates the improving trajectory for workforce turnover within our NHS provider partners.

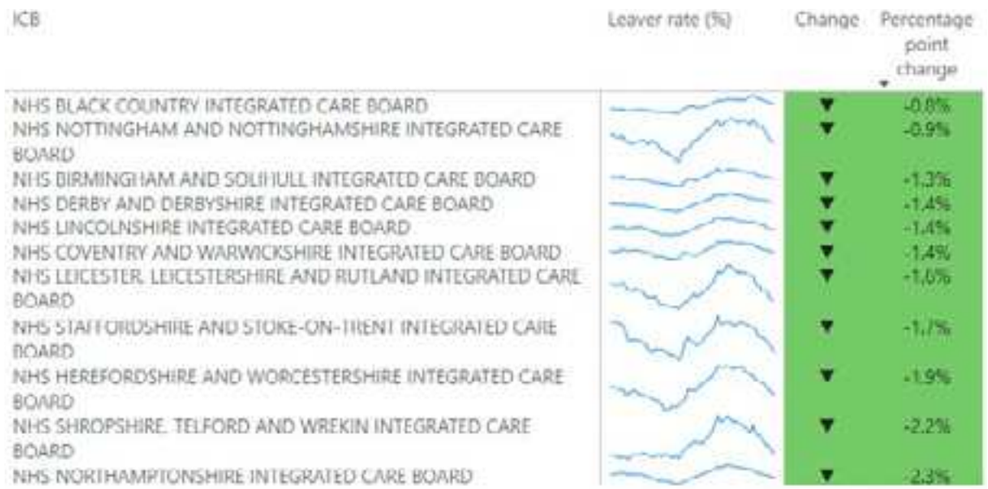
Month: November 2023
ICS: STW

National NHS Leaver Rate for all Staff	**7.7%** *Declining trend since April 2023 from 8.9%*
Midlands NHS Leaver Rate for All Staff	**6.7%** *Declining trend since April 2023 from 8.1%*
ICS NHS Leaver Rate for All Staff	**6.5% (608 WTE)** *Below regional rate/below national rate* *Declining trend since Apr 23 from 8.6%*

Previous 12 Month's Leaver Rate Trend Analysis by ICB.

Previous Month's Leaver Rate Change and WTE Leaver Trend.

Previous 12 Month's Leaver Rate Change by ICS.



Transform.

Organisational Development, Leadership and Culture

Equality, Diversity and Inclusion.

This section provides more detail on the work undertaken in 2023/24

Organisational Development, Leadership and Culture.

We are delighted to share the work we have been leading in this portfolio, including the transformational journey of the High Potential Scheme national pilot, to establish a culture of collaboration and delivery across Shropshire Telford and Wrekin. This activity would not have been possible without system co-production, as we work together with our system partners to develop our compassionate, capable, and diverse leaders of the future.

The Organisational Development, Leadership & Culture portfolio, including the High Potential Scheme and its talent management infrastructure, sits within the TRANSFORM element of People, Culture, and Inclusion.

Our enabling groups are the OD & Leadership Collaborative and the High Potential Scheme Steering Group.

Equality Diversity and Inclusion (EDI) 2023/24.

Workplace Equality, Diversity and Inclusion strategies focus on valuing every employee as an individual. There is a requirement to positively impact groups and individuals in accordance with the terms and definitions of all protected characteristics as stated in the Equality Act 2010.

NHS Shropshire Telford and Wrekin is committed to support the ICS to implement national, regional and local initiatives to ensure equality, diversity and inclusion for all.

Workforce Race Equality & Inclusion Strategic Objectives

1. Collaborative approach across system
2. Access to Inclusive and compassionate health and well-being support
3. Building accountability
4. Eliminating racism and bias in disciplinaries
5. Inclusive recruitment and talent progression
6. Leading with compassion and Inclusion
7. Removing barriers to help staff speak up
8. Tackling racism and other type of discrimination NHS Trust.

National EDI Requirements

NHS Equality Diversity and Inclusion Improvement Plan

6 High Impact Actions:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives, to which they will be individually and collectively accountable
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity
3. Develop and implement an improvement plan to eliminatze pay gaps
4. Develop and implement an improvement plan to address health inequalities within the workforce
5. Implement a comprehensive induction, on-boarding and development programme for internationally recruited staff
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Cultural and Diversity Event – September 2023.

Aims.

To increase awareness of the importance of equality, diversity and inclusion (EDI) for our staff, patients and our communities.

Celebrate diversity, network and share the wealth of services that support EDI across our system.

Talk about the challenges, our journey and action plan.

Provide an inclusive and supportive platform for people to share what organisations and the system can do to enhance the EDI agenda.

Learn from our staff what they think we should be measuring, as a system, to demonstrate what *"success"* looks like.

Event Format.

The event was chaired by Simon Whitehouse, Chief Executive, NHS Shropshire Telford and Wrekin Integrated Care Board.

15 registered to attend across Health and Care organisations.

Format – presentations, panel discussions with presenters, including Rhia Boyode, Director of People and Organisational Development, The Shrewsbury and Telford Hospital NHS Trust.

Delegates participated in interactive table discussions, experienced cultural performances by African Drumming, Ukrainian Dancing and Singing, visiting partners information stalls, and had networking opportunities throughout the day.

Outcomes.

91 people attended and were provided with a feedback form -
44 completed responses were received -
48% response rate.

95% very satisfied or satisfied,
5% neutral with the events organisation.

95% were also satisfied or very satisfied with the time allocated to discussions. Two of the feedback responses indicated dissatisfaction with the time allocated with one commenting that the time for this was "too short".

98% of respondents were confident or somewhat confident that the outcomes from this engagement will influence future equality, diversity, and inclusion plans. One respondent remained neutral.

ICS wide EDI Education offer commissioned from Northern Care Alliance

Developed for 2023 - Leadership session: Leadership and management of equality-related workforce issues

Objective

The session was designed for managers to increase their confidence in dealing with equality related issues.

Feedback from HR colleagues and international recruits, along with recent research and staff experience data, informed the design of the session.

There were 5 three-hour sessions available facilitated by an NCA representative.

Next Steps

Further clarification of EDI roles are required to support further work against the EDI portfolio priorities across the ICS

Further development of the EDI steering group and associated task and finish groups

Further implementation of the current and forthcoming EDI priorities.

The STW High Potential Scheme is part of inclusive System Talent Management. For the groups identified below we set targets to help promote fair progression for historically disadvantaged or under-represented groups.

The impact of setting these targets is that it has encouraged even more BAME and female staff to apply and gain places on the scheme beyond expectations

Characteristic	STW Proposed	STW Actual
Target	14%	16%
Disability	16%	10%
Gender (Female)	60%	75%
LGBT+	10%	8%

Shropshire, Telford and Wrekin

People Programmes Annual Report.

2023-2024

STW ICS People Team: Enabling our Integrated Care System to collaborate and achieve a confident, diverse and sustainable workforce.

' The Misson Attracted Me & The People Kept me. '

End Of Report.