NHS
Stoke-on-Trent
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

Quarter one 2022/23

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We want our patients, carers, staff and partner organisations to be able to understand our information in the format that is most accessible to their individual needs. This includes identifying and reasonably removing barriers for people accessing our information, services, premises, any employment or engagement opportunities. This may involve responding to our anticipatory equality duty to make reasonable adjustments, from requests received.

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Chair's introduction

It has been my absolute privilege to have been Chair of Stoke-on-Trent CCG, and to witness the transition to Staffordshire and Stoke-on-Trent Integrated Care System (ICS).

The ICS will formally bring together the NHS, local government and other organisations including the voluntary, community and social enterprise sectors. We've been building to this point for several years through our Sustainability and Transformation Partnership, Together We're Better. The ICS will retain the name.

I am optimistic for the future, and after just over a decade from inception, I feel that the CCG has left a positive legacy and has brought clinicians, and especially GPs, a more positive leadership role in clinical commissioning.

We have changed markedly during that decade, including the scale at which we work, with the six original CCGs in Staffordshire and Stoke-on-Trent working together for some time now, under one management team, and their Governing Bodies meeting in common.

An ongoing challenge will be to work as a Staffordshire and Stoke-on-Trent system, but retain place-based decision-making that reflects the differing needs of our communities. The CCGs leave a strong legacy of place-based focus and engagement, as well as partnerships with providers and communities that we can be proud of.

The last two years have been dominated, globally and locally, by COVID-19. The disease is still very much with us, and that is not going to change any time soon. The standout success is the COVID-19 vaccination programme – and I thank everyone involved in this incredibly challenging but rewarding project.

COVID-19 has also had a massive impact on how primary care operates. We had to adapt quickly to be able to continue to provide services, which has taken time for both staff and patients to get used to. As we move towards 'living with COVID-19' and recovering from the impacts of the pandemic, the NHS is now prioritising the backlog of patients waiting for treatment.

Despite recruitment drives, workforce challenges continue to restrict our capacity. Part of the answer is the new professionals we are bringing into general practice, particularly throughout primary care networks (PCNs) working together. There is now a much wider range of expertise available through GP practices – a very exciting time for primary care.

I encourage you to follow and get involved with the projects being led by the ICS to transform a range of health and care services to ensure they can meet current and future needs.

Dr Lorna Clarson
Chair
NHS Stoke-on-Trent CCG

Performance Report

Performance overview

This overview provides information about the CCG including its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

A statement from the Accountable Officer

This ‘Annual’ Report actually only covers the first quarter of 2022/23, as the CCGs were replaced by the Staffordshire and Stoke-on-Trent Integrated Care Board on 1 July 2022. This was the final stage of our transition to a new Integrated Care System.

Over the last decade, the CCGs have seen many changes and challenges. I want to thank every member of staff for their dedication and determination to do their ‘day job’ whilst also responding to the COVID-19 pandemic and planning for the NHS reorganisation.

Looking back on the legacy of the CCGs, there is much to be proud of.

In the wake of COVID-19, the CCG teams have supported the urgent and emergency care system, maintained cancer and urgent elective care, kept the doors of primary care open, recovered elective waiting lists, achieved financial balance and delivered the largest mass vaccination programme the NHS has ever seen.

The CCGs have only been as good as their people and none of this would have been achieved, in the most challenging of circumstances, without the CCGs’ staff. Thank you all for the tremendous job you have done over the years.

I am delighted that the vast majority of CCG staff have found a new home in the ICB, and TUPE transferred (Transfer of Undertakings – Protection of Employment) as part of the NHS’ continued employment commitment. However, many governing body colleagues have not.

Thank you to all of the clinical chairs, lay members, clinical leaders and executive colleagues for all you have contributed this journey. Best wishes for whatever the future holds.

Thank you also to our GP memberships across the six CCGs. General practice, the bedrock of the NHS, never closed during the pandemic and you delivered over

two-thirds of the vaccinations against COVID-19. Thank you for your continued endeavours and support.

Peter Axon
Interim Chief Executive Officer
Staffordshire and Stoke-on-Trent Integrated Care Board

29 June 2023

Purpose and activities of the organisation

NHS Clinical Commissioning Groups (CCGs) have been responsible for planning and buying local healthcare services since April 2013. CCGs combine the expertise of clinicians including family doctors (GPs), nurses and NHS managers.

CCGs are here to make a difference to people's lives through improving the health and wellbeing of individuals and their families and taking action to reduce the inequalities in health that exist across Staffordshire and Stoke-on-Trent. Staffordshire and Stoke-on-Trent has a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation.

In Stoke-on-Trent, we have a population of 296,761 – compared to 1,166,953 in Staffordshire and Stoke-on-Trent (figures as at October 2021).

We need to consider the following factors:

- An ageing population – this puts more pressure on our health and care services
- People's health varies – with different levels of poverty, deprivation and health inequalities
- A diverse population – 8.8% of people in Staffordshire and 17.8% in Stoke-on-Trent identify themselves as non-White British[1]
- Lifestyle factors that lead to health needs – more people have diabetes, strokes or heart disease than the national average[2], and obesity is also significantly worse than the national average
- Long-term conditions – the number of people with long-term conditions is increasing, with more than half of over-65s having two or more long-term conditions
- Early deaths – for example, people in Stoke-on-Trent have a lower life expectancy than in other parts of the country. More people under the age of 75 die from cancer than the national average
- Deprived and ethnic minority communities are at a greater risk of exposure to COVID-19 and are more likely to have poorer outcomes due to existing

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[1] ONS Data / Population characteristics research tables: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationcharacteristicsresearchtables

[2] Quality and Outcomes Framework, 2019/20 – NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20

poor health and adverse lifestyle factors. The control measures that have been implemented during the pandemic such as lockdown, social distancing and changes to routine care have resulted in disproportionately worse economic, social and health impacts on disadvantaged populations.

Our membership is made up of GP practices – as GPs are best placed to understand what services their patients need. This means that health professionals with current patient experience are leading the decisions we make. Our GP practices are organised into groups known as primary care networks (PCNs), which work together with a range of local providers, including those across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

To support these aims, 25 PCNs are already established across Staffordshire and Stoke-on-Trent, and seven across Stoke-on-Trent CCG, with eight clinical directors appointed.

The CCG is the delegated commissioner of general medical services, which means the organisation is responsible for managing the national General Medical Services (GMS) / Personal Medical Services (PMS) contracts with GP practices.

There are 143 general practices across the whole of Staffordshire and Stoke-on-Trent, and 37 in Stoke-on-Trent CCG.

We commission healthcare and work with a number of providers, including the following.

- Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)
- Mental health trusts including North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT)
- NHS community trusts, including MPFT
- Vocare (urgent care services)
- West Midlands Ambulance Service University NHS Foundation Trust (WMAS)
- NHS elective services provided to the local population by non-NHS providers
- Voluntary, community and social enterprise (VCSE) partners
- A diverse market of nursing, residential home and domiciliary care providers.

We work closely with our partners and providers to prevent poor health, improve wellbeing and involve and empower our population. Across Staffordshire and Stoke-on-Trent, the local authorities are Stoke-on-Trent City Council (a unitary authority) and Staffordshire County Council, which is split into eight districts and boroughs: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth.

Our objectives and strategies

Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

Stoke-on-Trent CCG is a key partner in the local Integrated Care System (ICS) along with other neighbouring NHS organisations, local authorities, and the voluntary sector. The partners have a clear shared ambition to work with local people, communities, and staff to improve the health and wellbeing of individuals and to use their collective resources more effectively.

The key four aims of all ICSs are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS to support broader social and economic development.

The Staffordshire and Stoke-on-Trent ICS Board has agreed that their vision is “to make Staffordshire and Stoke-on-Trent the healthiest places to live and work”.

For local people, this means:

- more joined-up and better care – as we work together to bridge gaps between services
- everyone has access to high-quality services wherever they live and whatever their background – helping to reduce inequalities
- being empowered and supported to take an active role in their health and wellbeing – as we put an emphasis on preventing ill health
- being put at the heart of decisions made about health and care services
- services brought closer to the people who use them
- being helped to live independent and healthy lives – as we promote community-centred care
- health and social care professionals have access to more data and technology to inform decisions
- one system with one strategy – to connect everyone who uses, delivers and manages health and care services
- the best use of money and resources – as we work closely as a health and care system.

System partners recognise that not one organisation working in isolation can solve the demand pressures that the system is currently facing. Stark health inequality challenges remain across the system and there is an urgent need to improve outcomes for our population whilst living within our collective resources.

During the first quarter of 2022/23, partners continued to work on the ICS Development Plan that was reviewed by NHS England and NHS Improvement. In anticipation of new legislation (the Health and Care Bill), all parts of the ICS

worked in partnership to streamline the commissioning approach and to develop system-wide strategic commissioning across health and care.

Partners also worked together to support the transition to an ICB, which included recruitment of both Executive and Non-Executive Directors to the Board. Read about the appointments on the ICB website.

The move to put ICSs on a statutory footing was delayed from 1 April 2022, which provided Staffordshire and Stoke-on-Trent ICS with an opportunity to prepare and operate in shadow form with as much of the new infrastructure, arrangements, and meetings as possible.

On 1 July 2022, the anticipated Staffordshire and Stoke-on-Trent NHS Integrated Care Board (ICB) was formed as a statutory organisation and the clinical commissioning groups (CCGs) abolished.

The Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) is a statutory committee responsible for developing and implementing a single Integrated Care Strategy, which will set the long-term direction for local health and care services. Throughout 2022/23, partners will work together, involving staff and local residents, to inform the strategy by March 2023.

National guidance indicates that an ICP and an ICB are core components of all integrated care systems.

We are championing the need for local delegation, and are supporting the development of partnerships at Place. With a focus on **horizontal** integration (across geographies), these partnerships will plan and deliver services to meet the needs of local communities.

Our Provider Collaborative Board is also established, which aims to support our providers to work more closely together to support integration **vertically**. This supports greater efficiency and innovation across our priorities.

For more information about the ICS' vision, purpose and charter, visit their new website www.staffsstokeics.org.uk.

Principal risks and issues

In view of the COVID-19 pandemic, the CCG decided to 'mothball' its business-as-usual corporate risk register and created a COVID-19 risk register to enable the CCG to focus on the work and risks of the pandemic.

Details of these risks can be found in the Governance Statement section.

Financial review

Summary of quarter one 2022/23 financial performance

Throughout the first quarter of 2022/23, we have received a funding allocation to spend on healthcare services for our population based on a national statistical formula to determine health needs. NHS England provided a non-recurrent adjustment to the CCG's allocation to ensure that the CCG ended the period reporting a break-even financial position.

The six Staffordshire and Stoke-on-Trent CCGs ended the first quarter of 2022/23 with a total allocation to spend on healthcare of £537.2 million. Included in this allocation is a separate financial allocation to spend on running costs (employing staff, running the organisation and buying support services). The running costs allocation was determined as approximately £4.63 per head of CCG population – or £5.4 million for the Staffordshire and Stoke-on-Trent CCGs.

The financial rules set by NHS England for CCGs are such that:

- We must not over-spend our total allocation, as this would be a breach of our statutory duty under the Health and Social Care Act 2012
- We are expected to under-spend our total allocation (healthcare allocation plus running costs allocation)
- We can use any under-spend on our running costs allocation to fund expenditure on healthcare
- We cannot use an under-spend on our healthcare to over-spend on running costs.

As an individual CCG, our actual financial performance for the first quarter of 2022/23 is summarised in the following table.

Summary quarter one 2022/23 financial performance

Area of expenditure	Budget £'000	Actual £'000	Over/under spend £'000
Patient services	129,568	129,568	0
Corporate / running costs	1,332	1,332	0
Total	**130,900**	**130,900**	**0**

The highlights from our financial performance are as follows:

- The actual position we have reported at the end of the first quarter of 2022/23 is of financial break-even
- To achieve the break-even position, NHS England reduced the CCG's notified allocation by £2.56 million. This means that the allocation available to the successor organisation to the CCG from 1 July 2022 – Staffordshire and Stoke-on-Trent Integrated Care Board – will be increased by that amount.

Historic expenditure by area of healthcare expenditure

Area of expenditure	2020/21 £'000	2021/22 £'000	Q1 2022/23 £'000
Acute	205,331	211,448	51,813
Mental health	69,870	76,254	17,811
Community	88,756	93,699	19,303
Prescribing	54,376	54,702	13,487
Primary care other	15,091	16,727	3,407
Primary care co-commissioning	41,929	45,209	11,508
Continuing care and funded nursing care	35,977	43,480	11,583
Other programme services	2,218	1,367	656
Corporate / running costs	5,254	5,411	1,332
Total	**518,801**	**548,298**	**130,900**

The highlights from our historic expenditure are as follows:

- During the first quarter of 2022/23, overall expenditure was approximately in-line with historic trends
- Growth in continuing care has continued to be greater than consumer price inflation.

The CCG's accounts for the first quarter of 2022/23 will be audited later on in the 2022/23 financial year with an expectation that the audit opinion will be published alongside that of the opinion concerning the Staffordshire and Stoke-on-Trent ICB accounts for the remainder of 2022/23. It is anticipated that those opinions will be published during the summer of 2023.

Future financial plans

After two years of working under a temporary financial regime as a result of the COVID-19 pandemic, the NHS issued planning guidance for 2022/23 that set out our priorities and the financial regime for the year ahead. This guidance reconfirmed the ongoing need to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic.

Staffordshire and Stoke-on-Trent Integrated Care System estimated an underlying deficit of circa £200 million before the pandemic. Over the past year, the system has implemented a financial strategy which has started the process of financial improvement, and the latest estimate of the underlying deficit is £136 million at 30 June 2022. The system financial strategy has helped contain activity growth which has supported this improvement.

Achieving financial sustainability continues to be a significant control issue in the short-term. We are working with system partners to manage this by continuing with the system strategy to contain activity growth and reduce the underlying

deficit further. In addition, the system will work to maximise the significant opportunities for productivity improvements across all areas, which will be used to drive out the remaining deficit over the next three years. Whilst these medium-term strategies are delivered to achieve a sustainable financial position, the system will use short-term, non-recurrent measures to mitigate the underlying deficits.

Following the Royal Assent of the Health and Social Care Act, the six Staffordshire and Stoke-on-Trent CCGs were abolished on 30 June 2022. They were succeeded by the Staffordshire and Stoke-on-Trent Integrated Care Board from 1 July 2022.

Mental Health Investment Standard (MHIS)

The Mental Health Investment Standard is measured across the entirety of a financial year and therefore an assessment of achievement against the standard during the first quarter of 2022/23 is not available.

Going concern

We have undertaken an assessment of our status as a going concern. In conjunction with the ICS, we and our providers across the system have produced a financial strategy and are currently working on the development of a medium-term financial recovery plan that is targeted with the objective of returning the system to an in-year financial balance.

This is based on having established an Integrated Care Board supported by local Places and Provider Collaboratives, which enables all of the system partners within the health economy to focus on delivering a collaborative transformation plan.

This has been supported by strengthened system governance measures, including the establishment of a System Transformation and Savings Group, to enable the CCG and system to make progress with their journey to a position of financial sustainability.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Bill allowed for the establishment of Integrated Care Boards (ICBs) across England, and abolished NHS clinical commissioning groups (CCGs) from 30 June 2022. ICBs will take on the commissioning functions and will have transferred across to them all of the assets and liabilities of the CCGs.

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.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of

financial statements. If services will continue to be provided, the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

Performance overview

As a statutory body, we recognise the importance of providing assurance to our stakeholders and the public so that they have confidence in our ability to commission safe, high-quality sustainable services within the resources that we have available.

The COVID-19 pandemic has continued to impact a number of our normal key performance measures in the first quarter of 2022/23. We are working hard to rise to the challenge of restoring services, meeting the new care demands and reducing care backlogs as a direct consequence of the pandemic. There has been and will continue to be, increased demand for service among in acute, community and mental health providers. The health and care system will continue to go through a process of recovering from the impact of COVID-19 on patients and performance.

As part of our process of assurance, NHS England (NHSE) regularly assesses our operational effectiveness. Our performance is assessed against a wide range of indicators that reflect whether standards set out in the NHS Constitution and the NHS Oversight Framework (NHSOF) are being delivered and whether health outcomes are improving for local people.

Annual Assessment

As part of the oversight process, each CCG is assessed annually against five key domains in the NHS Oversight Framework. We are not expecting a formal annual assessment from NHS England covering the first quarter of 2022/23.

COVID-19 impact on performance

The COVID-19 pandemic has continued to evolve and present significant challenges across the system. It has and continues to test our health and care services across Staffordshire and Stoke-on-Trent.

From April to June 2022, high levels of COVID-19 infections were seen across the country, caused by increases in infections compatible with the Omicron sub-variants BA4 and BA5. At the end of June 2022, the estimated number of people in England testing positive for COIVD-19 was around 1 in 25 people[3].

Reported cases for Staffordshire and Stoke-on-Trent were slightly below the average for England. Vaccine uptake has continued to be good: at the end of June

[3] Data taken from Office of National Statistics (ONS) weekly survey 8 July, for the week ending 29 June 2022

84% of the eligible population across Staffordshire and Stoke-on-Trent had received their COVID-19 booster dose, and 79% of eligible people had received a spring booster.

Despite this, the new strain has proved to be more infectious and the recent wave has led to an increase in the number of beds occupied by patients with COVID-19, although the number of Intensive Care beds occupied by COVID-19 patients remained relatively low. At the University Hospitals of North Midlands NHS Trust the number of beds occupied by COVID-19 patients during April exceeded levels seen in January 2022.

The increased prevalence of COVID-19 has led to an increase in staff absence due to sickness and self-isolation across all partners, which has contributed to significant pressures across health and care services.

Patient demand has continued to be very high across all services; our Primary Care teams continue to see high numbers of people requesting appointments, whilst our community and domiciliary teams, nursing, and residential home staff, mental health care, ambulance crews and other vital services have also seen significant demand. Emergency departments have seen high numbers, including other illnesses as well as COVID-19.

Acute trusts have been required to continue delivering elective care though waiting lists for surgery and treatment are still high. This is partly due to the overall backlog resulting from the pandemic and also operational capacity and productivity, which have also been affected by staff sickness and absence related to COVID-19.

Stoke-on-Trent CCG has contributed extensively towards working in an integrated way, leading and providing support to addressing the continuing pressures across all care pathways.

The CCG continues to work collaboratively with ICS partners across Staffordshire and Stoke-on-Trent to deliver solutions to support immediate and longer-term workforce needs. A system-wide Workforce Cell has been in place since March 2020 and functions as a hub to support workforce challenges and recruit staff to deploy where needed across the system.

Restoration and recovery

The national operational planning guidance for 2022/23 published by NHS England and Improvement (NHSEI) renewed the focus on restoring services and recovering elective activity. The guidance outlined clear ambitions around recovery, specifically for elective care, diagnostics and cancer. These ambitions were underpinned by robust workforce plans that seek to grow the substantive workforce whilst actively supporting the health, well-being and safety of staff. In addition to the operational planning guidance, a range of recovery ambitions were outlined in the national Delivery plan for tackling the COVID-19 backlog of elective care published on 8 February 2022.

Systems were asked to develop plans to significantly increase elective and diagnostic activity to above pre-COVID-19 levels whilst eliminating long waits for

treatment and improving performance against cancer waiting times standards. Systems were also asked to expand capacity in primary and community care and improve mental health services and services for people with a learning disability and/or autism.

Delivery on these ambitions will depend on us doing things differently, accelerating partnership working and increasing our capacity and resilience.

The six CCGs across Staffordshire and Stoke-on-Trent have worked with partner organisations to produce ambitious activity, workforce and finance plans to maximise service delivery and support recovery. It must be noted, however, that this was against a backdrop of the continued existence of COVID-19. Whilst the objectives for 2022/23 were based on COVID-19 returning and remaining at a low level, the new Omicron variant impacted recovery through infection prevention and control measures to protect staff, patients and the public restricting available capacity for outpatient clinics and diagnostic and planned procedures.

The NHS is taking the opportunity to use what we have learned from the pandemic to work differently and better. The requirement to provide services remotely has highlighted numerous opportunities to roll out digital technologies in patient care. Examples include virtual wards to monitor patients' conditions at home, outpatient appointments delivered via video call and the NHS app. Across Staffordshire and Stoke-on-Trent GP practices have been supported to utilise digital support methods for appointments and prescriptions including patient access, Electronic Prescribing Service (EPS) and the NHS app.

The focus for the remainder of 2022/23 will continue to be the restoration of services and where possible exceeding activity delivery against the 2019/20 pre-COVID-19 baseline.

Constitutional Standards

The NHS Constitution, published in 2009, contains several key standards covering a range of NHS access points, including urgent and emergency care services, diagnostic testing, planned and routine operations, cancer screening and treatment.

During the first quarter of 2022/23, a number of constitutional standards were not achieved due to the continued impact of COVID-19 on health and care services locally and nationally.

Stoke-on-Trent CCG's main acute services contract is with University Hospitals of North Midlands NHS Trust (UHNM) and performance by this provider largely determines our ability to meet NHS Constitutional standards.

Collectively, these providers determine our ability to meet NHS Constitutional Standards and deliver services for our population. The CCG is also an associate commissioner for various other providers in the area. This report highlights those providers relevant to the area.

Key Performance Indicators

The table below summarises Stoke-on-Trent CCG's performance against the NHS constitutional standards during the first quarter of 2022/23.

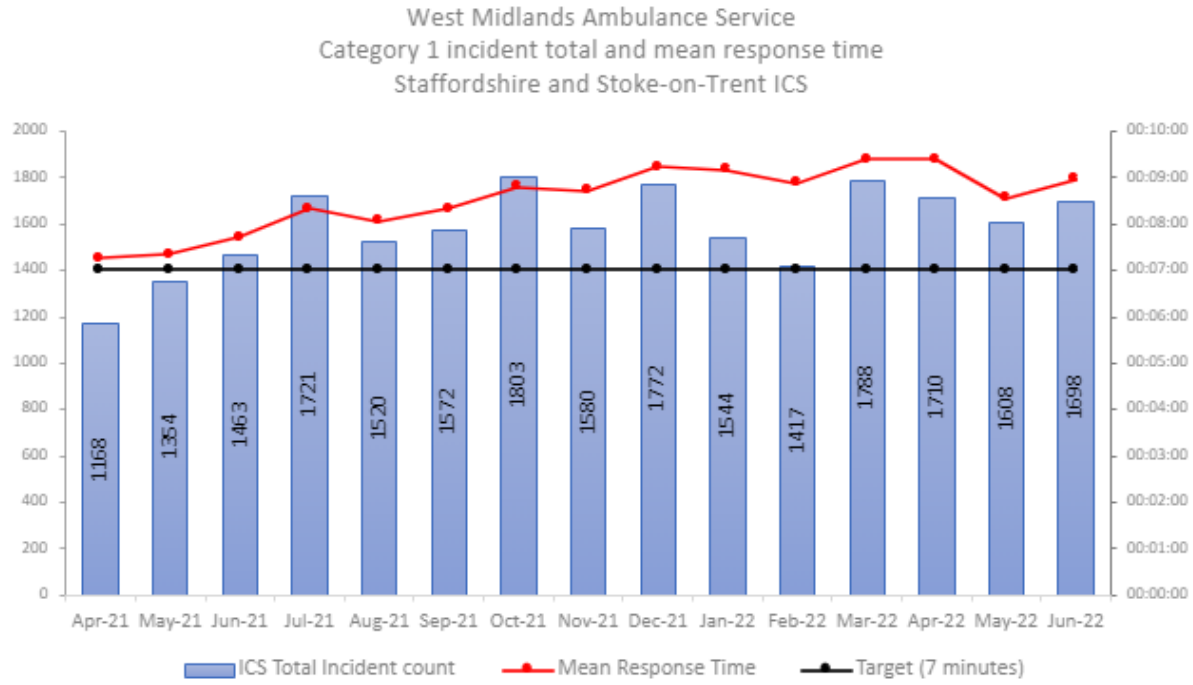
Indicators	Target	Stoke-on-Trent CCG				
		22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance
Healthcare Acquired Infections						
MRSA	0	0	0	0	0	
C.difficile	43/48/63	22	4	9	9	
Referral to Treatment Times						
RTT Admitted	n/a	53.46%	53.8%	54.8%	51.8%	
RTT Non-Admitted	n/a	71.79%	75.3%	70.7%	69.6%	
RTT incompletes	92%	56.73%	54.9%	57.7%	57.6%	
RTT 52 week + waiters (Incompletes, all Providers)	0	2,042	2,182	2,133	2,042	
Diagnostic test waiting times						
Diagnostics 6 weeks +	99%	64.5%	63.0%	65.2%	65.1%	
Cancer waits						
Cancer 2 week wait	93%	43.2%	43.6%	41.3%	44.7%	
Cancer Breast Symptoms 2 week wait	93%	30.6%	17.5%	46.4%	35.3%	
Cancer 31 day first definitive treatment	96%	87.2%	94.0%	85.3%	82.6%	
Cancer 31 day subsequent treatment - surgery	94%	62.5%	68.4%	52.6%	70.0%	
Cancer 31 day subsequent treatment - drug	98%	91.7%	100.0%	92.9%	85.0%	
Cancer 31 day subsequent treatment - radiotherapy	94%	94.6%	97.6%	95.0%	91.7%	
Cancer 62 day standard	85%	51.5%	55.1%	48.1%	50.7%	
Cancer 62 day screening	90%	53.1%	57.1%	40.0%	53.8%	
Cancer 62 day upgrade	0%	76.7%	88.0%	75.9%	69.4%	
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation Breaches	0	0	0	0	0	

Accident and Emergency provider performance – University Hospitals of North Midlands NHS Trust

Target	2022/23 year to date	April 2022	May 2022	June 2022
A&E 4-hour target: 95%	62.7%	62.9%	62.8%	62.3%
12-hour trolley breaches: 0	1,823	878	390	555

West Midlands Ambulance Service performance

Ambulance services are measured by the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. The chart below shows the average (mean) response times in minutes to Category 1 (life-threatening) ambulance calls across the Staffordshire and Stoke-on-Trent ICS. The number of calls is also shown. The target response time is seven minutes.



During the first quarter of 2022/23, response times have exceeded seven minutes. This coincides with a sustained increase in the number of calls. Further details on performance against the constitutional standards and other key targets are outlined in the Performance Analysis section.

Performance analysis

Urgent and emergency care

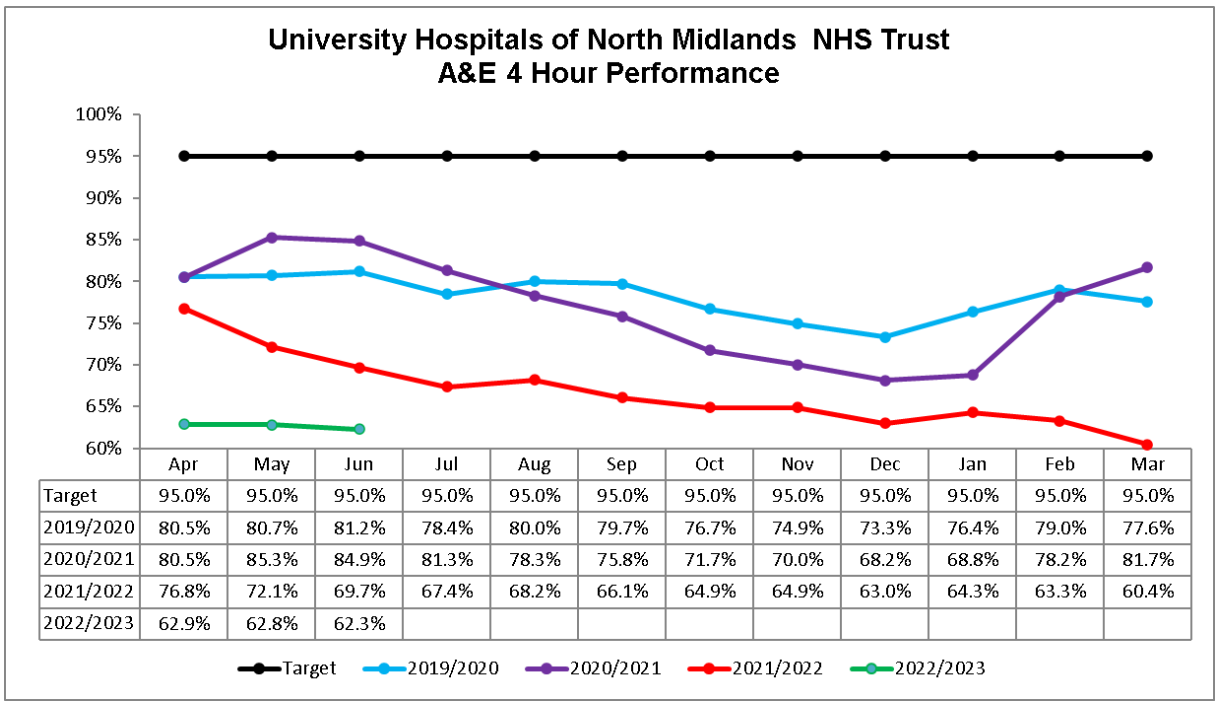
The ICS urgent care system has remained under sustained pressure during the first quarter of 2022/23. There have been challenges linked to increased demand and COVID-related capacity restrictions. Hospital Emergency Departments (ED) and acute care were highly compromised by a number of factors:

- Impact of the Omicron COVID-19 variants
- Infection, Prevention and Control restrictions
- Unplanned absences for staff related to COVID-19
- Lack of capacity to discharge patients into care homes due to closures and COVID-19 outbreaks
- Increased demand following a temporary lull over the spring Bank Holiday period
- Patients presenting at ED have been generally more unwell, leading to increases in length of stay.

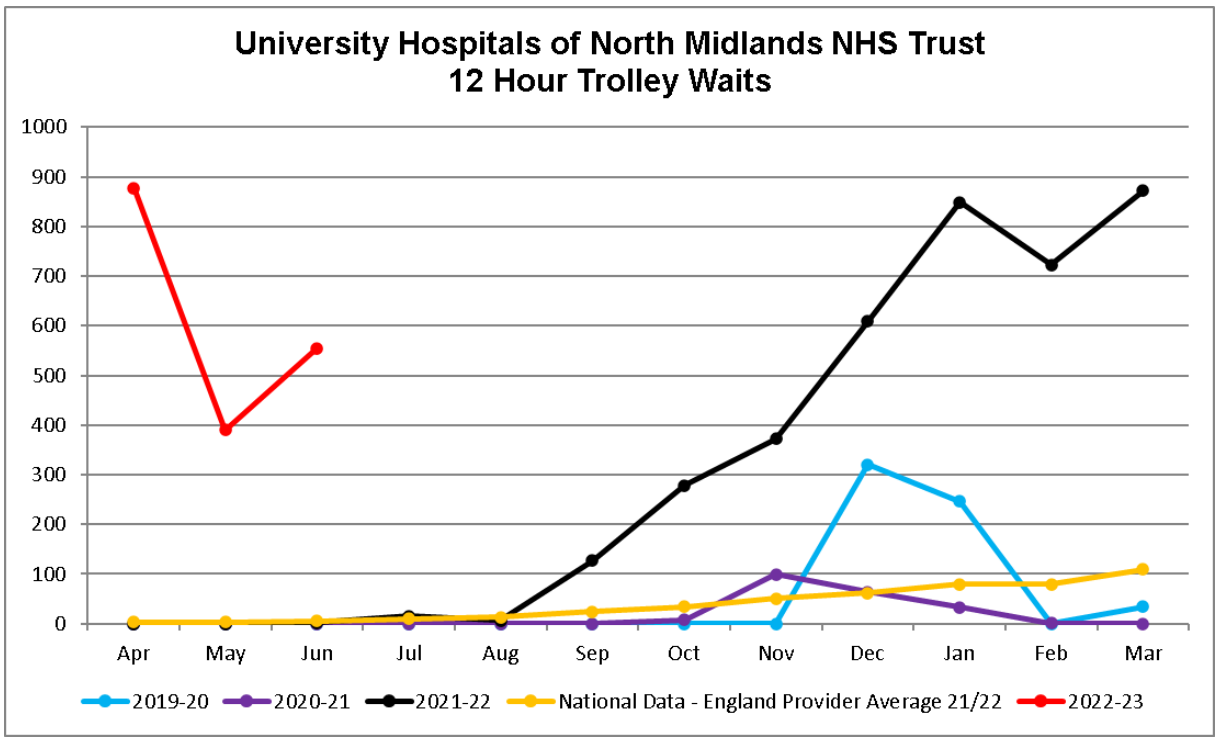
These continuing challenges are reflected in the performance against the urgent care constitutional standards – the proportion of emergency department patients seen within four hours of arrival, and the number of patients waiting on a trolley for 12 hours or more.

A&E performance is reported at the provider trust level, rather than CCG.

Stoke-on-Trent CCG's main acute provider, University Hospitals of North Midlands NHS Trust has seen an increase in 12-hour trolley breaches. Performance against the four-hour A&E standard (Four hours from booking into A&E to being admitted, discharged or transferred to another facility) has continued to prove challenging. The target of seeing 95% of patients within four hours was not achieved during the first quarter of 2022/23.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2019/2020	80.5%	80.7%	81.2%	78.4%	80.0%	79.7%	76.7%	74.9%	73.3%	76.4%	79.0%	77.6%
2020/2021	80.5%	85.3%	84.9%	81.3%	78.3%	75.8%	71.7%	70.0%	68.2%	68.8%	78.2%	81.7%
2021/2022	76.8%	72.1%	69.7%	67.4%	68.2%	66.1%	64.9%	64.9%	63.0%	64.3%	63.3%	60.4%
2022/2023	62.9%	62.8%	62.3%									



The CCGs' Quality and Safety Committees in Common (QSCC) meet throughout the year to monitor and review all quality and safety risks.

The CCGs continue to work with health and social care partners to progress initiatives and actions that support performance improvements. Further rapid improvements have taken place and learning has been incorporated:

- Improved collaboration and partnership working was evident
- Daily communication between partners ensures collaboration and mutual support

- Community services assist paramedics to navigate alternative community services, prior to patients presenting at the emergency department
- A resilience plan is created in preparation for Bank Holiday periods and partners work together to ensure clear and robust plans are in place.

An ICS approach to surge planning for winter is being developed which will encompass all partners in the urgent and elective care pathway to develop a clear capacity plan and associated triggers.

Elective care

Providers have worked hard to improve elective capacity and tackle backlogs, however, pressures on our health and care services across Staffordshire and Stoke-on-Trent due to COVID-19 have continued to impact the recovery of activity to pre-pandemic levels.

COVID-19 has had a significant impact on plans to recover planned care activity. During the lockdowns in 2019/20 fewer patients were seeing their GP and being referred to secondary care for treatment; these patients are now coming forward. There are existing backlogs on hospital waiting lists resulting from the postponement of elective surgery and some outpatient consultations during the same period. Total urgent care demand for beds has impacted theatre and ward capacity to support elective care patients.

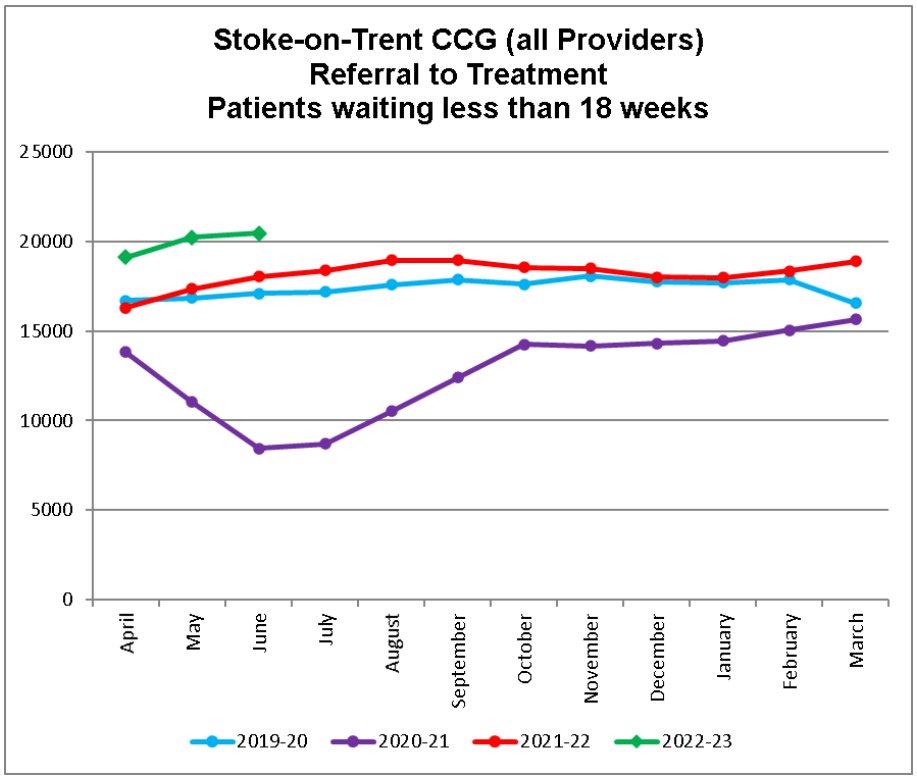
The above factors, along with staffing pressures, has meant that our patients are having to wait significantly longer for treatment. This has also meant that our acute providers have failed to meet the referral to treatment standards this year.

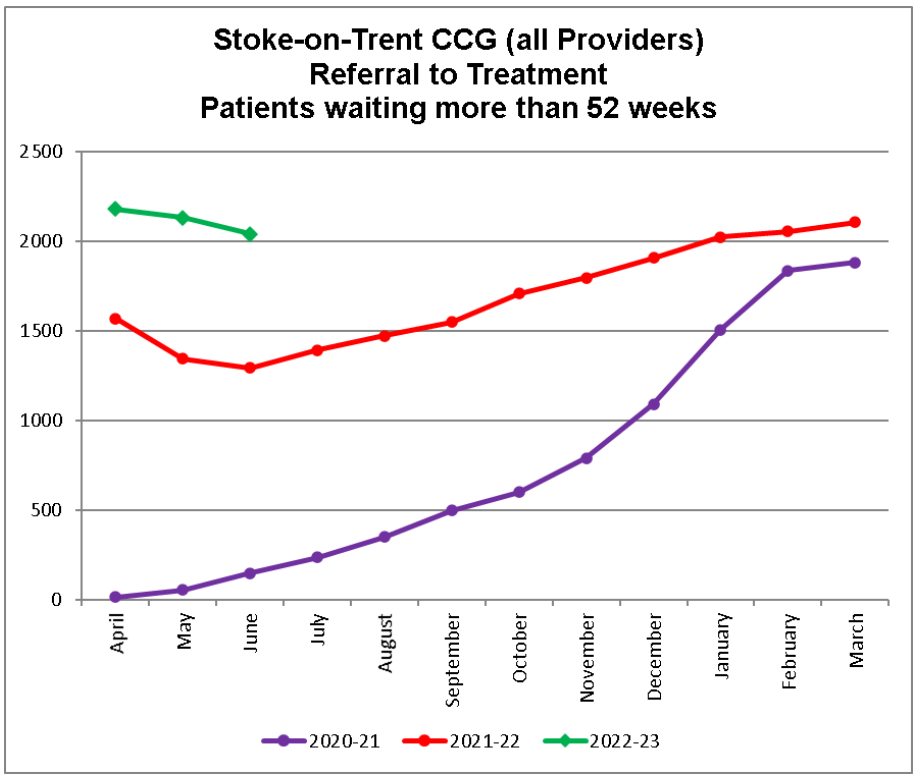
The Referral to Treatment (RTT) standard is part of the NHS Constitution and requires that 92% of patients should wait no more than 18 weeks from referral to the start of their treatment and that no patients should wait over 52 weeks for treatment.

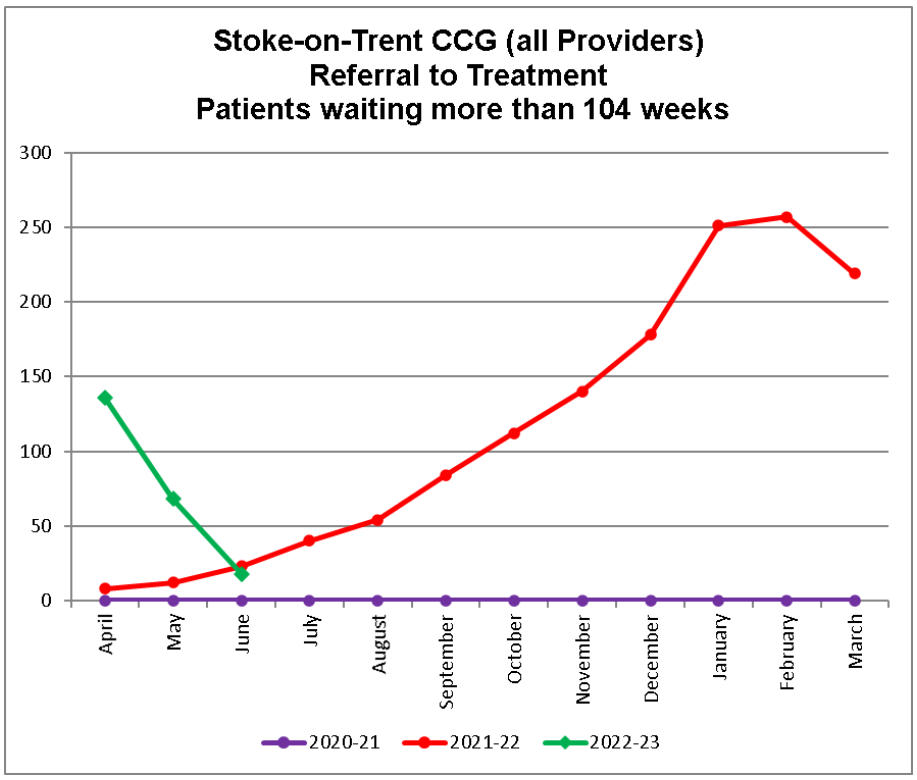
During 2022, providers, supported by the ICS, have focused efforts on eliminating very long waits of 104 weeks or more. This has resulted in a significant drop in the number of patients waiting over 104 weeks as demonstrated by the graphs below.

In June 2022, a total of 2,042 patients were waiting over 52 weeks for Stoke-on-Trent CCG and 18 were waiting over 104 weeks.

Referral to Treatment – total percentage of Stoke-on-Trent CCG patients seen within 18 weeks, and number of patients waiting over 52 weeks and 104 weeks







All breaches of 52 and 104 weeks are subject to a harm review by the provider and a meeting attended by the CCG Quality team to identify if any harm has occurred, plus any learning and improvement to be applied to patient pathways. Providers continue to ensure that patients who have already had an extended wait for treatment can be prioritised alongside more urgent patients.

Outpatient services

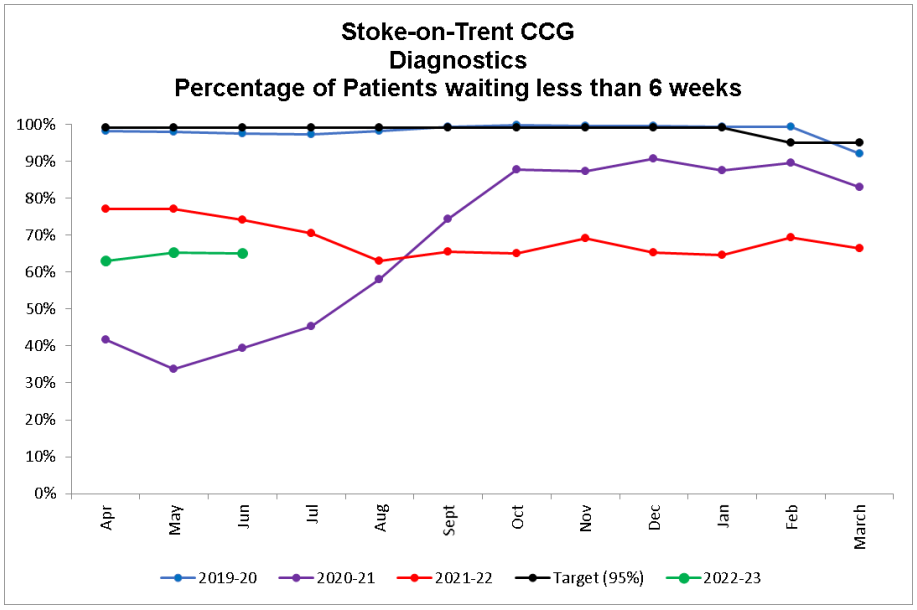
The system and providers are working collectively to transform outpatient services and reduce waiting times. For example, many outpatient consultations are held via video call so patients do not always have to travel to hospital. Work is underway to reduce the number of follow-up appointments, for example, in certain services patients with long-term conditions are being empowered to contact the hospital when they experience a flare-up in their condition so they can receive an appointment quickly through patient-initiated follow-up (PIFU).

Diagnostic services

Diagnostic services have been affected throughout the year by the continued impact of COVID-19, particularly in terms of staffing, as tests must be delivered in person by a trained operative.

The diagnostics standard is for patients to wait less than six weeks for a diagnostic test. The target has been set at 95% from February 2022.

For Stoke-on-Trent CCG, performance for the first quarter of 2022/23 was 64.5%.



As with other activity, diagnostic capacity has been affected by recent pressures.

Stoke-on-Trent CCG is working closely with our core acute provider, University Hospitals of North Midlands NHS Trust, to support them to manage pressures in elective care with a focus on reducing harm to patients.

Fortnightly meetings are held with trusts to review those patients waiting the longest, and providers continue to ensure that patients who have already had extended wait for treatment can be prioritised alongside more urgent patients.

Our independent sector partners have also supported us in providing additional capacity to treat patients. Patients currently sitting on acute NHS trust waiting lists are being offered the opportunity to receive care in those facilities.

Cancer

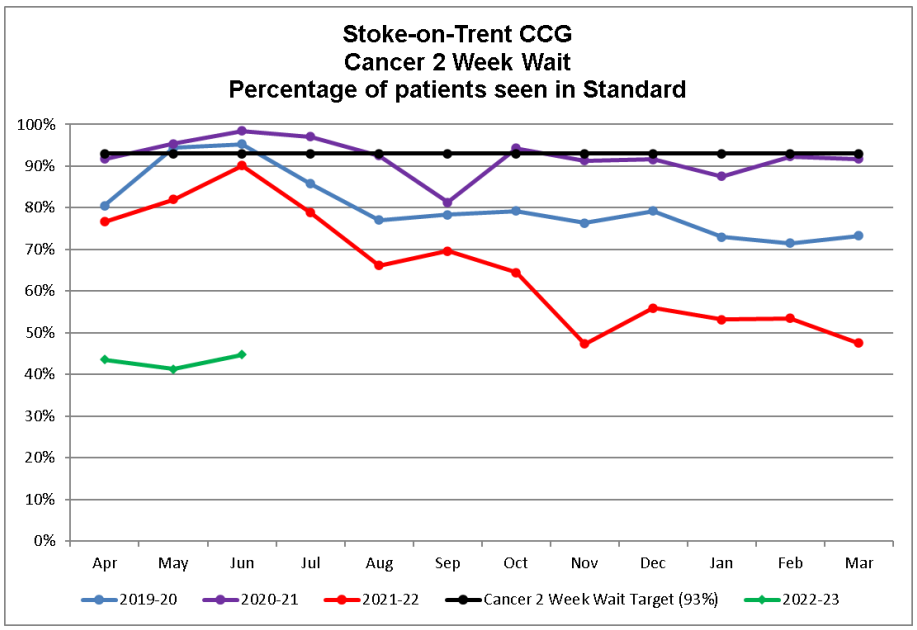
Performance in cancer standards across Stoke-on-Trent CCG has been variable throughout the first quarter of 2022/23. Relatively small patient numbers in some standards can lead to large fluctuations in performance month-on-month.

The overall number of patients attending their GP practice has returned to pre-COVID-19 levels and is starting to exceed levels seen in 2019. This has led to increased numbers of two-week wait referrals and patients attending screening.

Total number of Stoke-on-Trent CCG patients seen as part of the two-week wait cancer standard by all providers

This standard covers patients seen by a specialist in secondary care following an urgent GP referral for suspected cancer. The standard states that 93% of patients should be seen within 14 days of the referral.

The 93% target has not been met in the first quarter of 2022/23. Performance has steadily declined and is currently below 50%. Performance is largely dependent upon the performance of our six providers.

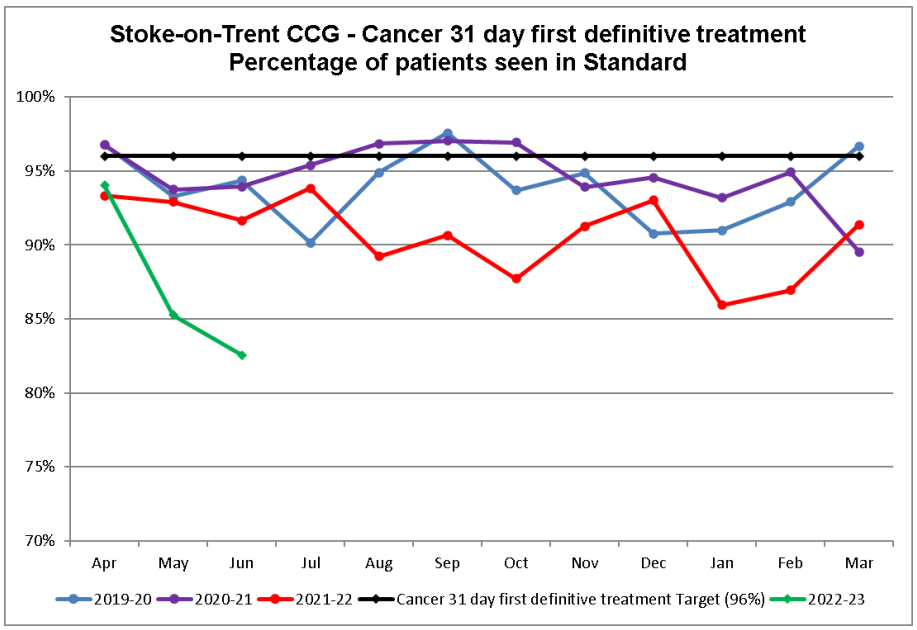


Total number of Stoke-on-Trent CCG patients seen as part of the 31-day decision-to-treat to first treatment standard by all providers

The standard covers patients starting a first definitive treatment for a new primary cancer within one month of a cancer diagnosis. The standard states that 96% of patients should receive a first definitive anti-cancer treatment within 31 days of the diagnosis date.

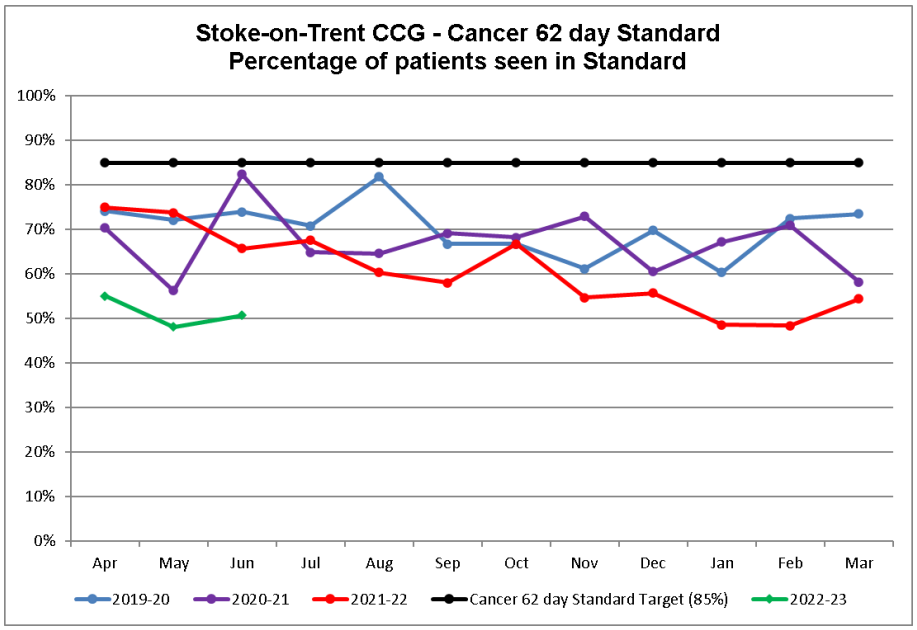
Performance against the 31-day decision to treat to first treatment standard has been variable since the pandemic started in 2020.

As of June 2022, University Hospitals of North Midlands NHS Trust (UHNM) reported 83.3% performance against the 96% standard.



Total number of Stoke-on-Trent CCG patients seen as part of the 62-day cancer standard by all providers

The standard covers patients starting a first definitive treatment for a new primary cancer following an urgent GP referral for suspected cancer. The standard states that 85% of patients should receive a first definitive anti-cancer treatment within 62 days of the urgent referral date.



Performance has been variable across the six core providers for the 62-day urgent referral to the first treatment standard since the first lockdown in April 2020. During the first quarter of 2022/23, none of the main providers achieved the 85% target against this standard.

The standard states that 90% of patients should receive a first definitive anti-cancer treatment within 62 days following a referral from an NHS cancer screening programme (breast, cervical or bowel).

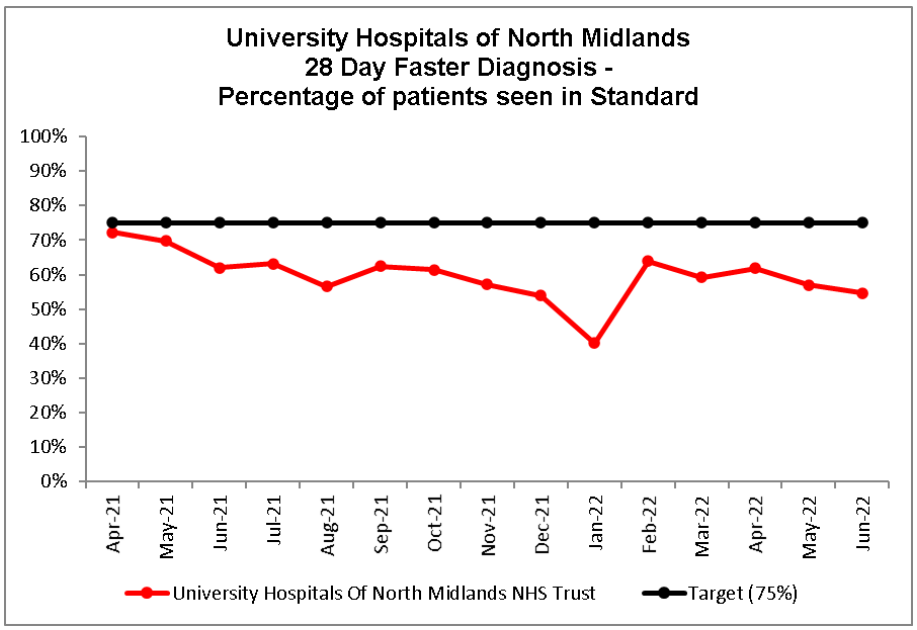
28 Day Faster Diagnosis

The Faster Diagnosis Standard (FDS) was introduced in April 2020 to ensure patients who are referred for suspected cancer have a timely diagnosis. The standard states that at least three-quarters (75%) of patients should be told whether or not they have cancer within 28 days of an urgent referral from their GP or a cancer screening programme.

Total number of Stoke-on-Trent CCG provider patients seen as part of the 28-day Faster Diagnosis standard

Please note that this data is currently reported at provider level. Performance for the 28-day faster diagnosis standard has remained variable across the six main providers covering Staffordshire and Stoke-on-Trent.

As of June 2022, Stoke-on-Trent CCG's main provider, The University Hospitals of North Midlands has not met the 75% target.



Mental health

Mental Health and Learning Disabilities and Autism (LDA) services continue to receive extremely positive feedback both regionally and nationally for coordination and performance.

Despite ongoing challenges and pressures, performance across the main provider for Stoke-on-Trent CCG, North Staffordshire Combined Healthcare Trust, has continued to improve, and Staffordshire and Stoke-on-Trent mental health services remain one of the best performing across the Midlands.

Please note the latest available data for mental health performance is May 2022.

Access rates for many adult and children's mental health services have improved. For example, adults waiting times for Early Intervention in Psychosis have significantly improved. in May 2022 the ICS achieved 87.5% of people with a first episode starting treatment within two weeks of referral, exceeding the national ambition of 60% and above the Midlands average (56.6%).

Stoke-on-Trent CCG achieved 94.7%.

COVID-19 has had a significant impact on the workforce and also capacity across inpatient wards. Despite these challenges, people have not been placed inappropriately out of the area, with out-of-area placements falling significantly throughout 2022.

Stoke-on-Trent CCG had zero patients placed out of area during the last eight months.

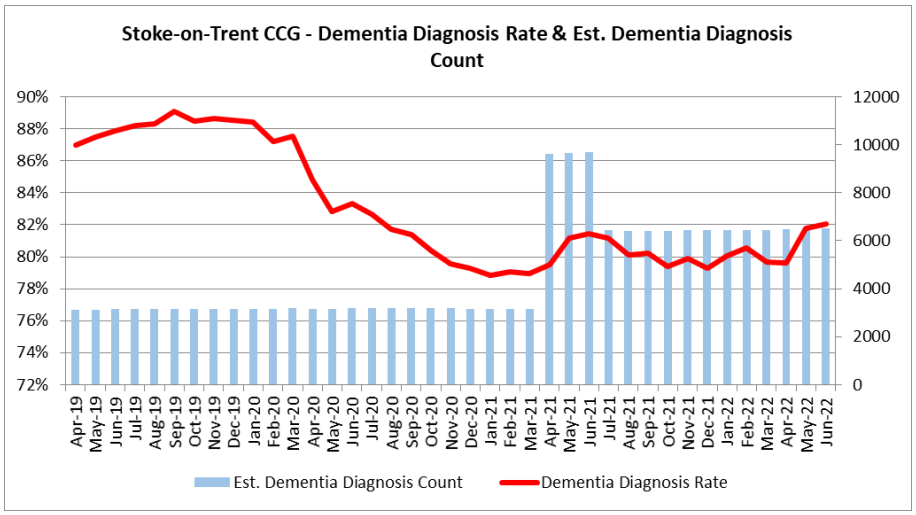
Improving Access to Psychological Therapies (IAPT) referrals remain below target due to the impact of COVID-19 but there has been a significant increase in referrals. Pathways are established with long COVID clinics, and training of all IAPT staff on assessment and treatment of long COVID.

Dementia diagnosis

The dementia diagnosis rate has improved across all six CCGs during the first quarter of 2022. The overall number of patients receiving a dementia diagnosis is rising, which has resulted in an increase in demand for local services.

The charts below show the number of dementia diagnoses made and the rate – the diagnosis rate is calculated as the number of patients aged 65+ diagnosed as a percentage of the estimated dementia diagnosis count.

Despite a notable increase in demand, Stoke-on-Trent CCG has consistently exceeded the 65% target - diagnosis rates hit 82% in June 2022.



The six CCGs in Staffordshire and Stoke-on-Trent have enhanced the Hospital Avoidance Function that currently has been successful in supporting people with dementia avoiding admission to a mental health hospital and receiving their care and treatment at home (or in their usual place of residence).

Children and young people (CYP)

The ICS achieved the CYP access target in 2021/22 and is achieving the monthly target for 2022/23 – 14,364 children and young people with a diagnosable mental health condition to have at least one contact with an NHS-funded community mental health service. This target has been exceeded in May and June 2022, with 14,620 and 14,745 children and young people seen across the ICS.

Learning Disabilities and Autism

People with a learning disability often have poorer physical and mental health than those without a learning disability. An annual health check can improve people's health by spotting problems earlier. The primary care team and community LD nurses are providing targeted support to GP practices, individuals and families to encourage uptake and make recommendations on reasonable adjustments to enable access to annual health checks and meet patients' needs, particularly for younger patients.

The six CCGs are focused on improving the uptake of annual health checks to reduce health inequalities, and are working to increase the rate of health checks for people aged 14 and over on a GP LD register towards the NHS Long Term Plan ambition to achieve 75% in 2023/24. The ICS as a whole is on track to achieve 75% of all people with LD having had an annual health check during 2023/24.

Learning from lives and deaths – people with a learning disability and autism (LeDeR)

The learning from lives and deaths of people with a learning disability (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 to improve the health of people with a learning disability and reduce health inequalities.

As of 1 January 2022, the programme also includes autism. Nationally, life expectancy is improving, and the focus is on ensuring all patients with learning disabilities and autism receive the same quality of care.

Partners continue to promote partnership and collaborative working, which has resulted in good engagement and information sharing. The programme has successfully implemented a ‘Health Passport’ for patients with learning disabilities which are now used in over 300 care / residential homes and all acute and community services across the system.

Reducing health inequalities

There are significant inequalities across Staffordshire and Stoke-on-Trent, with Stoke-on-Trent being the 14th most deprived CCG out of all 191 CCGs in England. Half of all neighbourhoods within Stoke-on-Trent CCG are classed being the most deprived 20% nationally[4].

Early childhood indicators are poor across Stoke-on-Trent, with the CCG having the highest infant mortality rates in England[5], highlighting some of the health disparities that exist compared to the rest of England.

There are stark differences in health outcomes based on socio-economic factors. Life expectancy for the most deprived residents in Stoke-on-Trent upper-tier local authority (UTLA) is about nine years lower than the least deprived residents[6]. Mortality rates in 2021 for Stoke-on-Trent CCG were twice as high for residents from the most deprived quintile compared to those from the least deprived quintile[7].

There are also variations in utilisation of healthcare services. Residents from more deprived areas have higher rates of non-elective and emergency admissions[8], whilst there are also differences in flu and COVID vaccination uptake by deprivation and ethnicity[9].

Reducing these gaps will have a major impact on health outcomes for the population and achieve a major reduction in the demand for health and care services.

The Marmot Review, published in 2010, highlighted the role of wider determinants of health by emphasising the strong link between social inequalities and disparities in health outcomes[10].

The COVID-19 pandemic has brought health inequalities back into sharp focus and has exacerbated health inequalities that existed before the COVID-19 pandemic. National evidence shows that there have been disparities in the risk

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[4] English indices of deprivation 2019. Ministry of Housing, Communities & Local Government. Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[5] Infant mortality, crude rate per 1,000 by CCG, 2018-20. ONS. Accessed via OHID Fingertips available at: https://fingertips.phe.org.uk/
[6] Slope of index of inequality in life expectancy (2018-2020) for Stoke-on-Trent UTLA. OHID. Available at: https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/
[7] Local analysis using age-standardised rates for 2014-2021 based on deaths register data by CCG and deprivation decile. Data sourced from MLCSU.
[8] Local analysis using age-standardised rates for 2018 – 2021 based on SUS emergency inpatient admissions by CCG and deprivation decile. Data sourced from MLCSU.
[9] Health Inequalities Improvement Dashboard, NHS England.
[10] Fair Society, Healthy Lives (The Marmot Review). Available at: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

and outcomes from COVID-19 based around age, geography, deprivation, ethnicity, socially excluded groups, occupation, and comorbidities[11].

Reducing the risk of worsening health inequalities

Staffordshire and Stoke-on-Trent have five key priorities to our approach to addressing health inequalities:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete and timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership and accountability.

Given the impact of COVID-19 on health inequalities and as we restore NHS performance to pre-COVID-19 levels we are actively ensuring that this is not made worse. We therefore continue to expand the use of linked data so that we can consider population risk and health inequalities in reaching our decisions about how services are delivered and restored.

Population management approach to addressing health inequalities

We are adopting a population health management (PHM) approach to ensure the right data and intelligence are used to identify and address existing health inequalities. This will allow system partners both to develop a shared understanding of population need and to plan targeted interventions that will meet people's needs and result in better health outcomes.

Accelerating preventative programmes

Proactively reducing health inequalities and supporting the recovery of services in the community will involve community and social engagement and interventions for:

- preventative measures for COVID-19 including social distancing and hand hygiene
- promoting the uptake of COVID-19 vaccinations by communities at greatest risk
- promoting the uptake of the seasonal flu vaccination, childhood immunisations and vaccinations and accessing health services appropriately
- cardiovascular disease (CVD) prevention programmes as a key component of the NHS Long Term Plan and associated risks with COVID-19

[11] COVID-19: review of disparities in risks and outcomes. PHE. Available at: https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

- promoting non-medical models to improve wellbeing
- smoking cessation and other brief intervention advice to improve health.

Update on preventative programmes

The acceleration of preventative programmes, which proactively engages those at greatest risk of poor health outcomes is a key ambition for the Staffordshire and Stoke-on-Trent ICS.

As part of our response to treating tobacco dependency in 2021/22, we have started to develop the initial building blocks which will support this work to implement the recommended models across all inpatient and maternity settings. This includes the development of a governance structure including a multiagency ICS Tobacco Steering Group and Tobacco Dependency Delivery Groups across providers which is chaired by the CCGs.

Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters

There are no issues to report for the first quarter of this financial year, which is the last report for Stoke-on-Trent Clinical Commissioning Group following the closure of CCGs and the formation of the Staffordshire and Stoke-on-Trent Integrated Care Board.

Further information regarding these matters can be found in this report's dedicated Governance Statement section, including reference to Modern Slavery Act requirements for the CCGs. We also produce an annual Equality and Inclusion Report.

We have an accredited Counter Fraud Specialist in place to undertake counter-fraud work proportionate to identified risks and this service is provided by RSM. We also have Counter Fraud Champions who are available for concerns to be raised with and who would prefer not to go directly to our Counter Fraud Specialists. Our Champions will act as the link with Counter Fraud.

Finally, all officers of the CCG and relevant decision makers are required to sign a declarations of interest form stating any relationships with other colleagues and organisations as well as declaring any gifts and hospitality they may have been offered.

Sustainable development

As an NHS organisation spending 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 services. Sustainability means spending public money well, using natural resources smartly and efficiently, 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 costs of natural resources.

The CCG continues to demonstrate a commitment to actively promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner. We recognise that everything we do has an impact on the environment, which in turn affects people's health and wellbeing.

All six CCGs in Staffordshire and Stoke-on-Trent are working together to make the most efficient use of our resources, including the estate. We continue to maintain other offices in Edwin House, Burton, and Smithfield One in Hanley, we have now also secured a hub in Stafford Education and Enterprise Park, Stafford – albeit with reduced staff footfalls and energy consumption as the CCG introduced its Agile Working Policy.

With the development of our Agile Working framework, all staff continue to work from home but attend one of the hubs as work dictates. We continue to conduct all business meetings through Microsoft Teams, significantly reducing our carbon footprint by removing the need to travel and use utilities in buildings. Costs have fallen accordingly, with only the most essential journeys undertaken in a few isolated cases where homeworking was impossible.

All our offices are situated in purpose-built office blocks, designed to high environmental standards to reduce the carbon footprint of the CCGs.

Our ICS has collected and developed its first consolidated system-wide strategy, which has been submitted for review regionally. We are following NHSE/I Green Plan guidance to create an integrated document that describes our journey, governance arrangements and core local ambitions towards national net zero targets. As part of the initial work towards this, every NHS organisation and our ICS have confirmed a board-level net zero lead with accountability for this work, with our NHSE/I regional team.

Full details of how we operate can be found in our 2021/22 Annual Report.

Statutory duties

The CCG has a number of statutory duties under section 14Z15(2)(a) of the Health and Social Care Act 2012 and section 116B(1)(b) of the Local Government and Public Involvement in Health Act relating to:

- improving the quality of services (Duty 14R)
- reducing inequalities (Duty 14T)
- public involvement and consultation (Duty 14Z2)
- contributing to the delivery of any joint health and wellbeing strategy
- section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

The CCG also has statutory duties relating to safeguarding adults and children which are as follows:

- The Children Act 1989
- The Children Act 2004
- The Adoption and Children Act 2002
- The Care Act 2014
- Working Together to Safeguard Children 2018.

The following sections of this report focus on quality, partnerships and public and patient involvement, and explain how the CCG has discharged its statutory duties in these areas during 2022/23.

The CCG certifies that we have complied with the statutory duties laid down in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Maintaining and improving the quality and safety of services

The Staffordshire and Stoke-on-Trent CCGs work closely together. This is reflected in the joint governance through Quality and Safety Committees in Common (QSCC). The committee continued to meet (virtually) throughout 2021/22. During February 2021, due to system pressures and to enable the focus on managing the COVID-19 pandemic to continue, the QSCC agenda was refocused to prioritise patient safety and areas of risk across the system.

Quality is everyone's business, and the patient journey today often involves multiple providers. It is therefore important that all organisations and individuals involved have strong relationships and work together in a systematic way to understand patients' needs and ensure that care is safe, effective and provides a positive experience. It is only when all strands of quality come together that high-

quality care is achieved. We have well-established working relationships, and we continue to work proactively with our main providers via Clinical Quality Review Meetings (CQRMs), to ensure that our vision for quality patient care is delivered.

The quality team works in partnership with providers to identify emerging quality concerns and assist with prompt resolutions. These have taken the form of CQRMs or touch-point meetings with a clear focus on patient safety.

The CCGs are committed to continually working with all providers as we move into 2022/23 and through the transition into the Integrated Care System. We aspire to maintain and continue to improve the high levels of quality and safety of care provided for our local population. The CCGs recognise the importance of working together to achieve the best health and wellbeing outcomes for the people of Staffordshire and Stoke-on-Trent, building on the progress and work currently being undertaken.

General quality improvement

The Nursing and Quality Directorate in the CCG has continued to work tirelessly and in partnership to ensure the delivery of high-quality service provision for local people. We have continued to review the processes and mechanisms we use, and continued to build relationships with our respective stakeholders and providers of healthcare, which are:

- University Hospitals of North Midlands NHS Trust (UHNM)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- Midlands Partnership NHS Foundation Trust (MPFT)
- Vocare – Integrated Urgent Care
- Independent hospitals, independent care homes and domiciliary care providers

We also work with some out of area providers, as detailed below.

The following summaries present an overview of the discussions the Quality team has had with key providers during the last year, and the improvements that have been identified.

All Patient-Led Assessments of Care Environment (PLACE) scores for providers from which the CCG commissions services can be found on the NHS Digital website.

North Staffordshire Combined Healthcare NHS Trust (NSCHT)

North Staffordshire Combined Healthcare Trust (NSCHT) have worked as a valued system partner during the COVID-19 major incident response. We recognise the impact the pandemic has had on staffing and services since mid-January 2020. NSCHT remains rated as ‘outstanding’ by the Care Quality Commission (CQC). The CCG continue to work alongside the Trust to support it to maintain its strong reputation.

With the support of the Trust and Healthwatch Stoke-on-Trent, the CCG continues to complete virtual quality visits to provide real-time assurance on the quality of services provided. Vacancy management has been a major factor for the provider.

The Trust has devised a number of innovative recruitment projects, working closely with other providers and local universities, including the co-production of a joint bid to recruit international nurses and the continuation of the Nurse Preceptee course.

The Trust launched a Regroup-Reflect-Recharge campaign in April 2021 to seek the views of staff. Five key themes were captured including agile and flexible working, health and wellbeing, a move away from the perceived 'always on' culture with protected time and rest breaks, staff engagement and away days, as well as an estates and facilities review. A number of actions have been taken in response.

Projects continued throughout the year, including Project Chrysalis, which delivers the eradication of dormitory-style wards, anti-ligature work and the introduction of a co-produced Wellbeing College. Regroup-Reflect-Recharge also initiated the commencement of the three-year Community Mental Health Transformation Programme, giving service users the opportunity to get involved in the transformation of community mental health services in Stoke-on-Trent and North Staffordshire.

Midlands Partnership NHS Foundation Trust (MPFT)

The Trust has encountered many challenges with the ongoing COVID-19 pandemic and the variations of the virus, which has meant that the Trust has had to react quickly to the demands on their services, ensuring patient safety remained a top priority. The Trust undertook a significant piece of work around learning from experience during 2020/21, engaging with staff to understand what could be done differently to ensure that the right skill mix was in the right place and at the right time. Throughout this period, the CCG and Trust continued to hold bimonthly Clinical Quality Review Meetings. Or, where capacity was limited, either Touch Point meetings or Patient Safety Focus meetings, enabling continued assurance around the quality, safety and care for service users.

The Trust has continued to undertake a comprehensive Health Care Associated Infections (HCAI) programme of work relating to COVID-19, managing outbreaks effectively even with the staffing challenges of COVID-related illness. The HCAI team have also worked as system partners with regards to the vaccination programme with the Trust's Chief Executive Officer being the Senior Responsible Officer for the programme.

The Trust has undertaken a programme of virtual Quality Standards Assurance visits (QSAV), which have proved to be very successful and has enabled both the CCG and Trust the opportunity to have open and transparent discussions with staff from different care groups. The virtual QSAVs have given the Trust and CCG the opportunity to hear and gain assurance of the good work that has taken place across the service areas and support teams where there have been challenges.

The Trust was nationally recognised for their people and organisation development work and was shortlisted for two Healthcare People Management Association (HPMA) Excellence in People awards, which recognises and celebrates the work of human resources (HR), organisational development (OD) and workforce professionals in healthcare across the UK:

- The Capsticks Award for innovation in HR for the 'Big Shout Out', a virtual celebration and 'thank you' to staff for their efforts throughout 2020 and the challenges of the COVID-19 pandemic. The event included three virtual festival tents and over 40 hours of digital content, based on the themes of compassion, collaboration and celebration
- The Academi Wales Award for excellence in OD for an OD initiative or project that had significantly benefited the organisation through improved effectiveness or viability, for the Trust's innovative collaboration programme and hub, 'In Our Gift'. The programme aims to capture the art of the possible by harnessing the talents of staff from across the organisation. It uses a digital platform to enable colleagues to connect, influence and collaborate to improve the experiences of staff and service users.

The Trust was also shortlisted for the Health Service Journal (HSJ) Mental Health Provider of the Year 2021, in recognition of the organisation's commitment to partnership and quality improvement alongside a strong focus on staff engagement and involvement in research.

University Hospitals of North Midlands NHS Trust (UHNM)

UHNM had a second very challenging year due to the COVID-19 pandemic dominating 2021/22. Throughout the year and following relaxation of government restrictions, UHNM has seen an increase in emergency department (ED) attendances and has received high volumes of referrals for patients with suspected cancer. The ED has had times throughout the year when the Trust were moved to escalation level 4 and they declared a major incident during mid-September 2021 and January 2022 due to the Omicron variant of COVID-19.

During these times of high demand, 12-hour trolley breaches occurred along with ambulance handover delays as seen nationally. The Trust has undertaken harm reviews for the affected patients and has held panels with the CCGs' Quality Leads in attendance. These have continued throughout the year. Due to the number of ambulance handover delays and in order to maintain safety, the Trust introduced a standard operating procedure to monitor patients and escalate into ED when required. UHNM has worked with system partners to undertake initiatives to try to reduce ED attendances and improve hospital flow.

Due to the high inpatient numbers during the second COVID-19 surge, a major incident was declared, which resulted in further cancellations of elective work. This has inevitably led to significant backlogs. Throughout the pandemic, the Trust has prioritised cancer work and urgent patients with the triage of referrals and clinical prioritisation of waiting lists. The Trust has undertaken harm reviews for those patients who waited longer than 52 weeks to complete their treatment. The CCGs' Quality Leads attended panels to review cases by speciality. The Trust has continued to utilise the independent sector hospitals for suitable elective patients.

In January 2022, the UHNM workforce was significantly impacted by the Omicron variant, with high sickness levels across the Trust. Many staff were either testing positive or self-isolating due to being in contact with a positive case. The Trust redeployed staff from elective areas and had support from the army to ensure patient care and safety were maintained. The Trust's COVID-19 vaccination programme, led by the Infection Prevention and Control team, continues to

administer booster vaccines as per national guidance, to UHNM staff with over 8,000 vaccines administered to date.

UHNM had a CQC inspection in August and October 2021, and the report was published in December 2021. The Trust received an overall rating of 'Requires Improvement' with rating changes for the 'Caring domain' from 'Good' to 'Outstanding'; and the 'Well Led' domain from 'Requires Improvement' to 'Good'.

Integrated urgent care

Urgent care centre and emergency department front door model

Vocare work as an active system partner alongside the urgent care centre (UCC) and the emergency department at Royal Stoke University Hospital, working collectively to ensure there is a robust model of care in place to meet the needs of patients. Members of a joint working group chaired by the CCG work together to improve patient flow and patient experience, ensuring the model of care is clinically safe and strive to resolve system problems to mitigate risk to patient safety.

A number of changes and improvements have been made, including the introduction of a nurse navigator as a safety step which allows ambulatory patients to be immediately assessed and signposted to the most appropriate care setting. This includes sending patients direct to the UCC where they will be assessed as requiring primary care and ensuring patients are not transferred without appropriate clinical information being recorded on an appropriate auditable IT system.

NHS 111 kiosks have been installed at the front door of the accident and emergency department, which patients can use with the support of staff if required, to seek direction to the most appropriate care setting.

Independent hospitals

During 2021/22, the CCG continued close working with all the independent hospitals within the Staffordshire and Stoke-on-Trent footprint, as well as with key partners such as the CQC and NHSE/I. Work continued to strengthen and further develop quality monitoring systems and processes for assurance for all stakeholders and service users.

On two occasions and with two of the independent hospitals, the CCG was required to have clear oversight and management of challenging situations for patients. Relocation was needed to be safely and appropriately facilitated by relevant placing commissioners.

In June 2021, a high dependency rehabilitation service was issued with an urgent notice of suspension of registration by the CQC with all patients required to be transferred within a six-week period. The CCG supported the provider of care and the placing commissioners in the safe management of closure and the safe relocation of 24 patients with complex needs. Following the closure, the CCG worked closely with NHSE/I in a debrief process to ensure clear lessons were learned and the learning shared appropriately. Unfortunately, those lessons were then required to be used soon after, to facilitate the closure of another independent mental health hospital, this time in Leek.

Following a poor CQC outcome, the CCG supported the hospital in Leek with their improvement plan, however the Board of Directors for the hospital made the decision to close the hospital, giving 12 weeks' notice. The CCG's Quality Team again supported the providers and placing commissioners in the safe management and safe relocation of all patients with complex needs, working closely with NHSE/I, the CQC and all system partners.

These events have led to the development and ongoing review of several processes, including clear oversight arrangements for CCG commissioned inpatient care for independent hospital review, a host commissioner escalation process and a Staffordshire system Memorandum of Understanding for failing independent hospitals.

As a host commissioner, the CCG continues to ensure appropriate communication processes are in place to share soft intelligence, working closely with NHS England with meetings continuing throughout the year, despite pandemic pressures.

Due to the ongoing COVID-19 pandemic, several independent hospitals had COVID-19 outbreaks which were managed via a system-wide approach with assistance from key stakeholders as required, including NHSE/I and the UK Health Security Agency (previously Public Health England).

The CCG continue with the quarterly meetings with independent hospitals and stakeholders, including NHSE/I, Healthwatch, Asist and safeguarding, to share intelligence, good practice and lessons learned.

As part of the quality improvement work initiated in 2021/22, quality visits have occurred for all independent hospitals. Where required, action plans have been developed and monitored.

The CCG has also worked closely with NHSE/I to develop the national template used to support Safe and Well reviews for all children, young people and adults with a learning disability and autism. The 'Five Eye' review demonstrates the collective input and view of those involved with the individual. The aim is to ensure there is a system in place to receive intelligence and feedback regarding the quality of care from placing commissioners in decision making from provider service surveillance.

Out of area providers

A number of residents in Staffordshire and Stoke-on-Trent access services managed outside the area. In these instances, the six CCGs are associates to the contract held by another CCG (the lead commissioner) and work in partnership with the relevant trust and lead commissioner to support quality improvements for our residents.

The CQC inspected a number of these services recently, including:

The Dudley Group NHS Foundation Trust

The CQC carried out an unannounced focused inspection of the emergency department at Russells Hall Hospital in February 2021 (findings published April 2021). The inspection framework focused on key lines of enquiry under Safe, Responsive, and Well-Led domains and covered aspects of care that included

care of the critically ill patient, infection prevention and control, patient flow, workforce, leadership, and culture. The CQC identified no 'must do' actions and four 'should do' actions to improve services. The full report is available on the CQC website.

University Hospitals Birmingham NHS Foundation Trust (UHB)

UHB had an unannounced inspection from the CQC in June 2021 (findings published October 2021). The inspection focused on urgent emergency care, medical care, cancer services and surgery as well as the Well-Led domain. The Trust's overall CQC rating and Safe and Responsive domains were all changed from 'Good' to 'Requires Improvement'. The CQC identified areas of outstanding practice within cancer services as well as areas for improvement. The full report is available on the CQC website.

University Hospitals Derby and Burton NHS Foundation Trust (UHDB)

UHDB had an announced focused inspection from the CQC in April 2021 (findings published in June 2021) to look at infection prevention and control. The inspection was not rated. The CQC identified one 'must do' action relating to the storage of equipment in patient bathrooms. The full report is available on the CQC website.

Walsall Healthcare NHS Trust (WHT)

The CQC carried out an unannounced focused inspection of the medical services at Manor Hospital in March 2021 (findings published May 2021). The inspection was in response to concerns around the safety and quality of services. Following the inspection, WHT was issued with a section 29a warning notice and the rating of the services changed to 'Inadequate'.

Further, the CQC carried out an unannounced focused inspection of the maternity service at the Manor Hospital in July 2021 (findings published October 2021). The inspection was in response to concerns around safety and governance. WHT were issued with two requirement notices.

The full reports are available on the CQC website. Black Country and West Birmingham CCGs have provided significant support to WHT and maintained oversight of the issues identified by the CQC.

General practice quality

The Primary Care team continue to monitor the quality and safety in general practices working closely with the CCGs' Quality team and other stakeholders including the Care Quality Commission.

Across Staffordshire and Stoke-on-Trent, 99% of practices are currently rated by the CQC as 'Good' or 'Outstanding', with work ongoing for those practices rated as 'Requires Improvement'. We currently have no practices rated 'Inadequate'.

A quality visit programme took place in 2021/22 as a two-way conversation on areas such as workforce and access. Themes and trends will be gathered once the programme is completed early in 2022/23 to share learning and identify any additional support for practices.

Incident investigation processes are supported also by the Quality team including the sharing of wider learning.

The General Practice Nurse Evidence Based Practice (GPN EBP) Group

The CCG continues to work collaboratively with Keele University to support the General Practice Nurse (GPN) Evidence Based Practice Group. The Group has been operational since 2015 with aims to review the most up-to-date evidence to deliver high-quality, safe and effective patient care with a focus on minimising unwarranted clinical variation.

The outcome is that evidence-based research translates into evidence-based practice. This is achieved through a partnership with primary care clinicians and clinical academics at Keele University. The group are very successful in supporting a change in practice where the evidence is available to promote more up to date ways of performing patient care and have further supported new studies where the evidence was lacking.

Since the group began, nurse participants have developed their leadership skills including co-authoring publications, presenting at conferences and lecturing on nurse education programmes. Many members of the group were also recognised by the Queen's Nursing Institute and received the Queen's Nurse award; an award that is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice.

The group continues to flourish and highlights the value of the general practice nursing workforce with a focus on leadership, career framework, professional roles, innovation and quality improvement.

Suicide Prevention Strategy Programme

The Staffordshire and Stoke-on-Trent Suicide Prevention Programme provides the opportunity to bring multiple organisations around the table to discuss suicide-related matters and national guidance at a strategic and operational level. The partnership, chaired by the CCGs, coproduced and maintain a strategy and action plan with a primary aim of reducing the rate of suicide in Staffordshire and Stoke-on-Trent.

The core membership of the partnership is made up of multiple organisations who play a key role in suicide prevention including Stoke-on-Trent City Council Public Health, Staffordshire County Council Public Health, National Rail, Samaritans, the six Staffordshire and Stoke-on-Trent CCGs, Staffordshire Police, Staffordshire Fire Service, the Coroner's Office, Brighter Futures, North Staffordshire Combined NHS Trust, Midlands Partnership NHS Foundation Trust, Survivors of Bereavement by Suicide (SOBS), local universities, Changes and North Staffs User Group.

A series of thematic workshops led by Public Health and Prevention at Staffordshire County Council focuses on areas such as:

- targeting elevated risks or vulnerable groups
- reducing the risk of suicide for people in the criminal justice system
- ensuring a consistent approach to suicide mitigation
- assessment and safety planning across mental health (primary and secondary care)

- services for adults and children
- reducing access to means of poisoning (for example safer prescribing of painkillers and antidepressants)
- reducing the risk of suicide for people who misuse drugs and alcohol and for people who self-harm
- ensuring safe and appropriate access only, to certain physical locations of concern such as bridges and trainlines
- partnership response to emerging clusters of suicides
- ensuring timely updates of local and national data
- timely review of new publications to maintain best practice.

As part of the #TalkSuicide campaign, suicide awareness and prevention training is available to small groups, using Zoom. The half-day online training is free and designed to:

- tackle misconceptions and stigma regarding suicide
- recognise the signs that someone may be at risk
- have open and honest dialogue about suicide
- use a simple four-step suicide intervention
- signpost to local support services.

So far, nearly 1,700 people have been on the half-day suicide prevention awareness training, and both Staffordshire and Stoke-on-Trent local authorities will continue to fund this for the next year.

The Suicide Prevention Community Champion programme will continue to be funded into the coming year.

The draft specification for the NHS England-funded Postvention (suicide bereavement) service is currently being shared with survivors of bereavement by suicide for their feedback and discussions to begin the procurement for the service will take place over the next month.

A national consultation (‘conversation’) has just finished to inform the development of the national Suicide Prevention Plan which is expected sometime in early 2023.

Quality visits

During the pandemic, in recognition of the pressures faced by providers and respecting COVID-19 safety measures, routine planned quality visits were paused. However, responsive quality visits continued with appropriate adherence to COVID-19 precautions. Quality visits have been undertaken virtually in collaboration with providers during periods of reduced pressure.

As part of our quality assurance and quality improvement process, the Quality team agreed to virtually attend provider internal assurance meetings. This ensured robust scrutiny and assurance that appropriate learning and actions were embedded in order to drive quality improvement and ensure patient safety. These internal meetings have included harm reviews, as well as reviews of pressure

ulcers, falls, 12-hour trolley breaches and NHS Constitution breach panels, for issues such as waits over 52 weeks.

Delivery of the Quality and Patient Safety Strategy

Our key role is to commission the best possible services and achieve the best health outcomes for the population that we serve, within available resources. We will always champion quality and patient safety as a central principle, demonstrating that it should, and can, be maintained and improved alongside financial sustainability.

The Quality and Patient Safety Strategy 2019-21 described a systematic quality assurance structure to ensure that performance concerns and risks around quality are escalated appropriately and openly. The structure incorporated the provider CQRMs and the Quality and Safety Committees 'in Common' (QSCC). In accordance with the National Quality Board guidance, a System Quality and Safety Committee was established in July 2021 to run in parallel with the CCG's existing meetings. The PSIRF launch is anticipated in September 2022 as part of the NHS Patient Safety Strategy. Implementation will be in six parts over a period of 12 months with the first three months being about orientation to the process and understanding systems.

The CCG is clinically led and committed to engaging with clinicians so that those who deliver care directly to patients can use their clinical knowledge and experience to inform and influence service provision and commissioning decisions.

Patient feedback continues to be received, evaluated and triangulated with other data at the QSCC. This has informed the CCG quality assurance response, which included virtual quality visits and onsite visits to some providers.

The patient journey often involves multiple providers across Staffordshire and Stoke-on-Trent, requiring many patients to travel outside of their immediate area. It is therefore important that all organisations and individuals involved have strong relationships and work together in a systematic way to understand patient needs and ensure that care is safe, effective and provides a positive experience. Furthermore, where the experience is found to be less than positive, mechanisms exist to ensure early warnings, shared learning and continuous improvement.

Patient feedback

The CCG understands how fundamental patient feedback is to the monitoring and influencing of high-quality and safe patient care that the CCG commissions. The patient voice and patient stories have the potential to identify any gaps and best practice in the quality of commissioned services. The patient feedback received by the QSCC was evaluated and triangulated, which informs CCG quality visits to providers or quality improvement work that is subsequently undertaken between the CCG and providers.

The Quality team gathers patient feedback from a variety of sources, including:

- patient group meetings at the QSCC
- Patient Engagement and Experience Reports

- Healthwatch and Soft Intelligence Reports
- CCG quality visits
- joint CCG and provider collaborative working
- GP 60-second reporting
- the Maternity Voices Partnership.

Patient feedback was communicated via the lay member representatives at the QSCC. If any quality or safety issues re-identified, they were reviewed at the QSCC, which also heard patient stories and received patient engagement and experience reports.

Patient Experience Report

The QSCC received a six-monthly Patient Experience Report which included an overview of the key themes and trends of patient feedback relating to all providers. The report also included an overview of actions taken by providers in response to patient and public complaints, Members of Parliament letters, Patient Advice and Liaison Service (PALS) contacts and complaints received directly by the CCG.

Annual complaints analysis

All patients who are unhappy about a service that is funded or provided by the NHS have a right to make a complaint. We actively encourage patients and their families to complain when they are not satisfied with the service, care or treatment they receive.

People within the six Staffordshire and Stoke-on-Trent CCGs use a range of services in local hospitals, health centres or in their own homes and could choose who they make their complaint to. People can decide to complain directly to the provider of their care services or to the commissioner, in this case the CCGs.

During the height of COVID-19, the team were very busy with increased PALS enquiries related to the impacts of the pandemic as well as many enquiries regarding the vaccine and testing. Calls of this nature are now reducing but it is clear that the ongoing impact of COVID-19 is still being felt, with people highlighting waiting times and delays to treatment in some of their enquiries.

In addition to this, providers continue to feel the effects of COVID-19 with response times still longer than their pre-pandemic level although very recently we have started to see a small improvement in this area.

A breakdown of the numbers and type of contacts received from April to June 2022 is outlined below.

Types of feedback received across the six Staffordshire and Stoke-on-Trent CCGs

Feedback type	Q4 2021/22	Q1 2022/23
PALS	365	219
MP letters	51	38
Complaints	49	38

Compliments	4	4
Total	**469**	**299**

Themes and trends across the six Staffordshire and Stoke-on-Trent CCGs

The services with the highest amount of feedback from April to June 2022 are detailed below:

- **General practice services** – issues raised appear to focus on registration issues, particularly in relation to where there are new housing developments, problems contacting the practice particularly by phone as well as issues in securing an appointment
- **University Hospitals of North Midlands NHS Trust** – about accessing appointments, delays in treatment follow up care, waiting times to be seen, and clinical treatment across all the hospitals' specialities and wards
- **Midlands Partnership NHS Foundation Trust** – about the commissioned community services and in particular relating to accessing those services and securing an appointment
- **CCG Commissioning Decisions** – about changes to prescribing, fertility services, and treatments not routinely commissioned.

Complaint outcomes across the six Staffordshire and Stoke-on-Trent CCGs

The table below shows the outcome of complaints from April to June 2022. This is for cases closed, rather than received for this period.

Outcome	Number of complaints
Complaint upheld	3
Complaint partially upheld	12
Complaint not upheld	7
Complaint already investigated	3
Referred to other PALS team	3
Information provided	3
No Consent so Closed	1
Unable to Proceed	10
Not recorded	11
Total	**53**

Lessons learned from complaints and PALS

Complaints are viewed positively by the CCG, as they provide us with the opportunity to constantly review our processes to ensure that we continue to meet the needs of our service users. Investigating officers are provided with an

investigation report detailing the objectives of their investigation and the issues which require a response.

As part of that process, investigating officers tell us about changes or improvements they have made or plan to make and lessons learned where appropriate. We include this detail in our responses providing as much detail as possible.

Parliamentary and Health Service Ombudsman (PHSO)

Where a complainant remains dissatisfied following the CCG's attempts to resolve the issues raised to their satisfaction, the second stage of the NHS Complaints Regulations enables complainants to refer their complaint for independent review by the Parliamentary and Health Service Ombudsman (PHSO).

During the first quarter of 2022/23, we were not advised of any new cases being investigated. Currently the PHSO has requested case files on four cases and is considering whether investigation is required. Two cases from one complainant are currently being investigated collectively by the PHSO and we await the outcome of this process.

Cases transferred to the Integrated Care Board

On closing down the CCGs at the end of June 2022, the following number of open cases were transferred to the ICB for continuation:

Feedback type	Number of cases
Complaint	53
PALS	30
MP letter	16

Soft intelligence

Monitoring soft intelligence allows patients, the public and healthcare professionals to provide their feedback to the CCG about healthcare services in their local area. Soft intelligence is triangulated with other forms of quality data, to inform the quality team of any areas of quality and safety and good practice which require further attention.

Soft intelligence is reported on our Datix system and reviewed on a weekly basis by clinicians, to identify any themes or trends. Potential Serious Incidents and Never Events are acted upon immediately and processed via the most appropriate governance safety process. Soft intelligence is triaged by the Quality team and shared with Providers, where appropriate. All soft intelligence is presented to the Datix Monitoring Group for the purpose of reviewing themes and trends, and, where appropriate, undertaking a multidisciplinary review to propose further actions.

The group has representation from General Practice, Medicines Optimisation, the Primary Care team, patient representatives, members of the Nursing and Quality Directorate and lay members. The group meets monthly with the aim of improving patient care and safety and ensuring robust governance and assurance. A

quarterly soft intelligence report is completed and reviewed by the group's membership prior to wider circulation to stakeholders.

Serious Incidents (SIs)

The Serious Incident function transferred from the Midlands and Lancashire Commissioning Support Unit to the CCGs on 1 June 2021 in readiness for system-wide operating once the ICS is established. The Serious Incident (SI) team have undertaken work to streamline processes across all functions to ensure a focus on lean methodology and to work more collaboratively with providers to ensure robust assurance.

The SI process supports the implementation of learning to prevent recurrence of harm and promote high quality, safe and effective patient care. Investigations are undertaken to identify how and why serious incidents happen, which result in recommendations and action plans to effectively and sustainably address system factors and help deliver safer care for patients.

The SI team continues to work closely with providers and quality leads and support the administration required for the Serious Incident Review Group and Serious Incident subgroup meetings held across the CCG's footprint. These meetings monitor the completion rate, discuss any concerns detailed in the investigation and address any learning, which requires support or wider dissemination across the system.

Work to transfer the SI function into the CCGs, has enabled the team to be able to provide a more responsive service that better meets the needs of the system.

Learning Disabilities Mortality Review (LeDeR)

The 'Learning from lives and deaths – People with a learning disability and autistic people' (LeDeR) programme has remained integral to the work of health and social care partners across Staffordshire and Stoke-on-Trent. With the introduction of autism to the LeDeR programme in January 2022, we plan to continue to uphold the programme's aims of tackling the causes of early morbidity and preventable deaths in people with a learning disability and autism, through:

- improving the quality of health and social care service delivery for people with learning disabilities and autism
- reducing premature mortality and health inequalities among these groups
- positively influencing practice at individual, operational and strategic levels which affects the lives of our population with a learning disability and autism
- ensuring a positive patient and carer experience.

We are committed to ensuring effective communication and good working relationships with our reviewers and stakeholders. The system had secured a contract with the South Central and West Commissioning Support Unit in February 2021. This was paused in May, as advised by NHSE/I, to allow time for the implementation of a new national LeDeR platform. The contract continued in July 2021 and has supported and enabled a new review allocation, completion and reporting process which has enhanced the overall delivery of the programme. It has also enabled prompt access to records with reviewers critically identifying any

local issues and learning that will need to be put into action. This arrangement has enabled a quicker turnaround of reviews, resulting in a greater number of reviews being undertaken by the programme.

The programme worked collaboratively with the North of England Commissioning Support Unit, commissioned by NHSE/I, to complete all “stacked” backlogged reviews which occurred as a result of suspending the programme. This supportive collaboration ensured that all outstanding “stacked reviews” were completed, quality assured and closed before the end of the deadline set by NHSE/I.

The local LeDeR Steering Group meets monthly and includes membership from all our system partners. They have been instrumental in implementing actions from the findings and recommendations that arise from our LeDeR reviews. The group has ensured an active shift in focus from reporting on data, to providers reporting demonstrable actions and impact, captured on a slide deck which can in turn be used by each of our partners within their own organisations.

The national LeDeR Policy, published in March 2021, identified a number of actions to be delivered by 1 April 2022. These included the production of a three-year strategy, setting out the ambitions for our LeDeR programme up to 2024 and the establishment of a Governance Panel to identify and monitor actions that arise from focused reviews. Our three-year strategy was produced in September 2021. Reports are being produced quarterly to demonstrate progress against the Strategy and plans for further implementation going forward. The LeDeR Governance Panel is currently at an advanced stage with the first meeting scheduled for February 2022 ahead of the April 2022 deadline date mandated in the LeDeR Policy.

All systems have received an allocation to support ‘Learning into Action’. We are using that funding to develop a Digital Patient Hospital Passport. All system partners are involved with the project at an advanced stage and very near completion. The aim is to produce hard copies as well as digitalising the document via a QR (Quick Response) matrix barcode which can be accessed via a smart device. A training module will be developed to support the document as well as promotional activities to maximise its effectiveness.

Inclusion, collaboration and co-production remain priorities of the LeDeR programme. The attendance of a lady with lived experience at our Steering Group meetings is invaluable and uplifting. We will continue to champion the inclusion of families, carers and people with lived experiences as well as our Ethnic Diverse Group population within the LeDeR programme, ensuring they are appropriately represented within the programme activities.

Special Educational Needs and Disabilities (SEND)

In 2021/22, the CCG has strengthened its collaborative working relationship with the local authorities and parents and carers to ensure that co-production principles are embedded across the local area and all workstreams. The aim is to deliver a robust response to the requirements of the SEND reforms (2014) and to ensure that the initiative lives up to its intended ambition.

The reforms were ambitious, aiming to place children and young people at the heart of the system with the role of health providers and the meshing of the two systems being pivotal. A Parliamentary Select Committee Report (2019) has

confidently stated that the reforms were the right ones, while acknowledging the challenges for partners in delivering them. We are anticipating the publication of the long-awaited SEND Review which will be published in Quarter 1 of 2022 alongside a green paper with proposals and will make recommendation on how the system needs to be overhauled and improved upon. Alongside this a new Inspection framework will also be launched with a focus on strategic leadership and governance, joint commissioning and co-production.

The CCG's Executive Director of Nursing and Quality has overall responsibility for SEND at Board level and has overseen a number of quality initiatives during 2021/22 as follows:

- maintaining CCG representation across the partnerships at both an operational and strategic level
- continued improvements in the EHCP (Education, Health and Care Plan) process including quality markers that support co-production principles
- delivering targeted training to health providers in conjunction with all partners to ensure a continuous cycle of improvement
- preparing and responding to the re-inspection of Staffordshire with regards to the Local Area Review in 2018 and the subsequent Written Statement of Action.

In Staffordshire and Stoke-on-Trent, there are clear governance processes to support the implementation of the SEND agenda, with the SEND inclusion and partnership groups being pivotal in scrutinising delivery of distinct improvement programmes. The CCG jointly chairs key meetings and are represented at all levels of the SEND agenda to support joint working and joint commissioning. SEND governance processes are reviewed regularly, and at least annually, to ensure processes continue to be efficient and equitable.

Infection prevention and control (IPC)

IPC work during 2021/22 has continued to be dominated by the COVID-19 pandemic. Working closely with colleagues across local authorities, UKHSA, NHSE/I and other NHS colleagues, we have supported the wider health and social care systems in maintaining systems to facilitate specialist IPC advice and support, not only in health but across the wider care services across Staffordshire and Stoke-on-Trent. Working together has enabled the maintenance of expected standards and the ongoing provision of safe IPC care across services during a time of frequent guidance changes and concerns.

The response to supporting a system-wide approach commitment to IPC during 2021/22, is seen in the examples set out below:

- Investment into MPFT's IPC service provision allowing the team to provide wider IPC services across Staffordshire and Stoke-on-Trent care services, in particular supporting outbreak management with specialist advice and review of IPC practices. This builds on the achievement to provide IPC training to a consistent standard, to all our care homes during 2020/21, following a national directive

- Continued additional investment from the CCG and both local authorities for the provision of a Strategic Improvement Lead for IPC for a further 24 months, hosted by the CCGs.

IPC leads, and associated roles, from across commissioning and provider organisations, including local authorities, have continued to show a commitment to joint working and shared learning throughout the pandemic. A well-established weekly IPC meeting has enabled a considered approach to new guidance, sharing and concerns of specific issues as well as professional support, in an open and informal forum.

The review of incidence of health care associated infections (HCAIs) continues and enables themes to be identified and learning shared within the wider health and social care systems, resulting in improved practice. This shared learning also supports the national ambition to reduce the incidence of gram-negative blood stream infection and other healthcare associated infection with a commitment for a collaborative approach and focussed workstreams.

Quality Impact Assessments (QIAs)

We remain committed to evaluating the impact on the quality of care for patients for any proposed service changes, either temporary or permanent. A single QIA policy and process for all six Staffordshire and Stoke-on-Trent CCGs has been in place and reviewed annually over a number of years. The process includes a single QIA sub-group, which has a range of members including lay members of the Governing Bodies and members of the Quality team.

The sub-group continues to scrutinise commissioning activities and challenge decision making so that staff who propose the change can ensure that quality is not compromised and, if necessary, mitigate against actions that would impact on the residents that the CCG serves. The subgroup meets at least monthly, and will flex to meet more often, if needed, in response to the fluctuation in QIAs as they arise.

During 2021/22, the CCG further embedded the improvements made in 2020/21 as well as continued to be flexible to the demands within the system. This is supporting plans to develop a system-wide QIA process as we move into 2022/23 and the introduction of an Integrated Care System (ICS).

In recent times, the process was scaled back and QIA sub-groups were cancelled to accommodate the national response to COVID-19. Over this period, the CCGs enacted a ‘short form’ QIA process that analysed the quality impacts of any changes enforced on the system by COVID-19. Later, the sub-groups resumed and the ‘short form’ QIA process was incorporated into the sub-group’s oversight function. During 2021/22, the full QIA process has resumed with the sub-group members meeting virtually.

QIA development to enable a system-wide QIA process with partners across the local NHS footprint continues, following pauses in response to COVID-19. A working group has now been established with representation from partners across the ICS footprint. Changes include a more robust review of the impact on quality, identified mitigations and aspirations, and oversight using pathway mapping to identify where the change sits within the system. Feedback to the CCG is via the Quality and Safety Committees in Common (QSCC) and the newly formed System

Quality and Safety Committee (SQSC). This work will continue into 2022/23, as we design an overarching ICS to ensure quality for patients remains at the heart of the work we do.

Maternity Transformation Programme (MTP)

The CCGs in Staffordshire and Stoke-on-Trent actively support the recommendations within Better Births (2016), Saving Babies Lives Care Bundle Version 1 and 2 (SBLCB v1/v2), the Neonatal Critical Care Review, the NHS Long Term Plan (2019) and Phase 3 COVID-19 priorities through the Staffordshire and Stoke-on-Trent Maternity Transformation Programme (MTP) and Local Maternity and Neonatal System (LMNS). The LMNS membership includes the six CCGs, both Staffordshire and Stoke-on-Trent local authorities, NHS maternity providers, NHS providers, NHSE/I, and women who use maternity services.

NHSE/I provided transformation funding for 2021/22 with revised targets and deliverables which were echoed within the operational and planning guidance of March 2021. These deliverables will be carried over into 2022/23, with realigned trajectories to reflect the ongoing position and are set out below:

Pandemic recovery

Including reopening all services, supporting staff to recover and implementation of four actions to minimise risks for black, Asian and minority ethnic women. An operational policy has been developed and proactive communication via social media routes has promoted early presentation for women when concerned and COVID-19 vaccinations for all pregnant women and maternity staff.

While restrictions have been lifted across the whole maternity pathway in order to support attendance at appointments and visiting arrangements, our maternity services continue to allow the attendance of only one birth partner during labour. The intermittent redeployment of registered staff to support clinical services has also resulted in suspension of some elements of maternity services, for example home births, ‘continuity of carer’ teams and birth care at the free-standing midwifery led birthing units during the duration of Q3 and Q4. All our providers remain committed to supporting the reinstating of these services and, with the support of the LMNS and Together We’re Better strategy team, will engage with the public to coproduce and strengthen the proposed clinical models.

Ockenden actions

The Chief Operating Officer’s letter of 14 December 2020 included the expectation that LMNS would oversee the implementation of immediate and essential actions (IEAs) as set out in the Ockenden report. In addition, the operational planning guidance set out specific changes which were required for LMNS Governance in response to Ockenden, including strengthening ICS oversight and the LMNS role in quality surveillance and learning. The maternity programme governance framework has been reviewed and updated in line with these recommendations and the revised perinatal quality surveillance model implemented.

Maternity transformation

LMNSs were asked to take responsibility – with accountability to ICSs – for ensuring universal implementation of initiatives, in view of the local and national variation in implementation highlighted by the Ockenden report. The CCG remains

committed to ensuring women receive 'continuity of carer' as set out in Better Births, the Long Term Plan and the National Guidance on planning implementing and monitoring 'continuity of carer' as published during 2021.

Co-production and transformation of maternity services via the MVP (Maternity Voices Partnership) has continued to progress, with the MVP providing feedback on the Postnatal Improvement Plan, MTP Plan, Neonatal Critical Care Review and leaflets.

Bi-monthly meetings are now taking place, as opposed to quarterly meetings. This provides more focused discussion and engagement from champions and stakeholders. A quarterly service user feedback report, 'You said, we did', has been produced. This allows for champions to feel their opinion is valued and provides feedback to service users and families. Each LMNS workstream now has MVP Champion representation, which has supported even greater co-production of services.

Safeguarding children and vulnerable adults

Safeguarding is a statutory responsibility for the CCG, led by the Executive Director of Nursing and Quality and supported by the Designated Safeguarding Nurses for Children, Looked after Children and Adults. CCG safeguarding responsibilities are covered in key legislation. During this unprecedented period of the COVID-19 pandemic, safeguarding duties and responsibilities remained high priorities for the CCG with the Safeguarding team maintaining a 'business as usual' approach.

The CCG is a statutory partner of both the Adult and Children's Local Safeguarding Boards (or equivalent meeting) with the safeguarding arrangements of our most vulnerable remaining as a key priority. The Designated Nurses for Safeguarding Children, Looked after Children and Adults remain committed to working with multi-agency partners and neighbouring CCGs to ensure that children and adults at risk are protected from harm.

Robust governance and contractual arrangements are in place for reporting and responding to safeguarding issues which fulfil the national and local safeguarding requirements. The CCG's Safeguarding Dashboards, with agreed trajectories for each metric, are now fully embedded within provider organisations and reviewed by the Safeguarding Leads, enabling a full view of performance, quality and trends, and the identification of targeted areas requiring action.

Safeguarding Children priorities

The Designated Nurses, Doctors and Named GPs for Safeguarding Children have prioritised safeguarding workstreams across Staffordshire and Stoke-on-Trent. This has included:

- partnership working with multi-agencies on the Domestic Abuse Strategic Commissioning Board and associated working groups
- partnership working with multi agencies on the Violence Reduction Executive Board and Delivery Groups

- developing and supporting the Domestic Abuse Strategy, the Serious Violence Strategy, Violence Against Women and Girls Strategy and child exploitation task groups, including county lines and modern slavery
- developing the Child Sexual Exploitation Strategy and the Female Genital Mutilation Steering Group agenda
- steering and contributing to the workstreams and contributing towards the Staffordshire and Stoke-on-Trent priority agenda for neglect.

The Designated Nurses have continued to support and guide the CCG regarding their statutory safeguarding duties. Policies for safeguarding children have been developed and updated including the Safeguarding Children Policy, Safeguarding Children Supervision Policy, and the Managing Safeguarding Allegations Against Staff and Domestic Abuse Policy.

The Designated Nurses remain committed to implementing the changes in 'Working Together to Safeguard Children' (2018), stipulated as part of the CCG's responsibilities outlined in the Children and Social Work Act 2017. This work is ongoing and involves development of a revised Safeguarding Executive Partnership in Stoke-on-Trent and an associated Quality and Assurance group, a Safeguarding Children Board in Staffordshire and associated Scrutiny and Assurance group, a Child Death Overview Panel, and two Child Safeguarding Practice Review subgroups.

The newly formed Safeguarding Children Health Forum began in November 2019 with the aim of enabling and coordinating the health economy to improve the wellbeing of children and families. It remains committed to the former joint Safeguarding Children Board's arrangements, ensuring that the relationships and co-production around priorities are owned and valued by all partners across the wider partnership. It specifically seeks to achieve the following goals:

- Provide a communication network for safeguarding children's health professionals, reinforcing relationships and sustaining reciprocal communication and collaboration between the Staffordshire and Stoke-on-Trent Safeguarding Children Board / Partnership and health provider safeguarding teams
- Facilitate the sharing of best practice and encourage members to promote this within their organisations
- Discuss, share and reflect on current areas of safeguarding work, and identify areas of concern, gaps and themes that require local attention and multi-agency problem solving
- Provide scrutiny and challenge to the Safeguarding Children Scrutiny and Assurance Group, and report to the Staffordshire and Stoke-on-Trent Safeguarding Children Board / Partnership
- Escalate matters that require further scrutiny or investigation to the appropriate forums.

The Designated Professionals chair the Child Safeguarding Practice Review sub-groups of the Staffordshire Safeguarding Children Board and Stoke-on-Trent Executive Children's Partnership, and act as Vice Chair of the CDOP (Child Death

Overview Panel) for Staffordshire and Stoke-on-Trent. Both Designated Nurses remain officers of the respective Local Safeguarding Children Boards (or equivalent). Learning from reviews is shared across the wider health system and robustly monitored and tested.

As part of its improvement plan, Stoke-on-Trent City Council has introduced a new model of working, which the Designated Nurses have supported as a health reference group. This group are now members of the Children's Advice and Duty Service (CHADS) working group.

The Safeguarding Partnership has developed a performance framework to enable assurance and monitoring of the newly commissioned Graded Care Profile 2 (GCP2) and Restorative Practice.

The CDOP Nurse Practitioner became an employee of the CCG and a valued member of the Safeguarding Team in 2020. This role provides assurance that providers of health services are compliant with the child death overview processes and deliver valuable training and information pertaining to the prevention of child deaths across Staffordshire and Stoke-on-Trent. The Safeguarding Team enabled a secondment opportunity in 2021 for an experienced Specialist Health Visitor to join the team to deliver the CDOP duties whilst the CDOP Nurse Practitioner commenced her secondment at NHS England. This has proved to be a positive developmental experience, enhancing skills, knowledge and confidence.

The Designated Nurse for Looked after Children has embedded processes across Staffordshire and Stoke-on-Trent, working in partnership with the Local Authority and provider organisations. A robust quality assurance system is in place to monitor the quality of health assessments and this role continues to be an expert source of advice and guidance to medical staff completing the required assessments.

The Designated Nurse and Doctors for Looked after Children are core members of the Corporate Parenting Boards for Staffordshire and Stoke-on-Trent.

Safeguarding adults

The Designated Nurse for Safeguarding Vulnerable Adults for the CCGs in Staffordshire and Stoke-on-Trent, co-ordinates the adult team. They ensure delivery against the statutory duties and responsibilities detailed within the Care Act 2014 and in accordance with the NHS England Safeguarding Accountability Framework, to demonstrate the CCG's compliance with statutory safeguarding functions.

The Designated Nurse is vice chair of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB). Together with the Senior Nurse for Adult Safeguarding, they provide leadership and support to the sub-groups of the Board. The CCG has received the SSASPB Annual Report, which has been discussed in detail at the CCGs' Safeguarding Group, a sub-group of the Quality and Safety Committees in Common (QSCC).

The Safeguarding Group, chaired by the Clinical Chair and Non-executive GP Lead for Adult Safeguarding, agree the workstreams and work plans for the safeguarding team. It discusses safeguarding issues for adults, children and young people in detail, and escalates relevant matters to the QSCC. This has

strengthened safeguarding throughout the CCG and ensured robust governance and reporting.

The Designated Nurse, supported by the Senior Adult Safeguarding Nurse and Named GP for Adult Safeguarding, have undertaken Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs), statutory reviews that the Safeguarding Team undertake on behalf of Primary Care General Practice.

The Adult Safeguarding Roles and Competencies for Healthcare Staff intercollegiate document was published in August 2018 and is endorsed by NHSE/I and the Royal Colleges. It was designed to guide professionals and the teams they work with to identify the competencies they need to ensure that people receive personalised and culturally sensitive safeguarding support. The adult safeguarding team has worked with NHS Providers to ensure action plans derived from this document have been delivered, and demonstrate compliance.

Across the six CCGs, there have been a high number of Section 21a Deprivation of Liberty Challenges. These have been overseen by the Safeguarding Team in collaboration with external providers and NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

The Adult Safeguarding Team is working with the Executive Director of Nursing and the Commissioning Team to prepare for the implementation of the MCA (Mental Capacity Act) Amendment Act (2019). This will see a change in the CCG's duties when authorising the arrangements enabling the care or treatment of people who lack capacity to consent to the arrangements, which gives rise to a deprivation of their liberty.

The Designated Adult Nurse also ensures that the Prevent agenda and requirement set out in the Counter Terrorism and Security Act (2015) is achieved by all NHS commissioned services.

The Designated Adult Nurse is a member of the NHSE/I Safeguarding National Network, which is a clinical reference group influencing national policy and developing key partnership working at a national level.

Hospices

End of life (EOL) care remains one of the priority areas for the CCG. A palliative and end of life cell (PEOLC) was developed in 2020/21, linking with the CCG's EOL operational cell. As part of the Palliative Care and EOL Strategy, developed at the end of November 2019, the EOL cell was created to support a system-wide approach to delivering improvements in EOL care during COVID-19. The group is made up of partners from the community services, acute hospitals and the voluntary and community sectors. This cell reports to the COVID-19 response governance structure which then reports into the CCG's Governing Body.

The Quality team representative for the EOL cell is the Designated Nurse for Safeguarding Vulnerable Adults. Due to the escalation of the COVID-19 pandemic, the EOL cell met weekly to focus on operational issues that arose. The Quality team has not conducted quality visits in adult and children's hospices during the pandemic. However, regular communication through the EOL cell and reporting mechanism has ensured ongoing engagement.

Nursing homes

Quality improvement in nursing/care homes remains one of the CCG's priorities. To accomplish this, the local system Nursing Home Quality Assurance and Improvement Group (NHQAIG) meet monthly to ensure the safety and wellbeing of the residents in care homes with nursing provision and other care providers who have residents or service users in receipt of NHS funded care across the local economy. This is achieved through working with key partners, principally the local authorities and regulatory bodies, using new and established governance systems and new innovations to provide strategic oversight of reporting of exceptions, trends and patterns. The main functions of the group are to seek assurance and drive improvement in respect of the safety and quality of nursing care in all areas commissioned through the CCGs and to inform the commissioning process and the market management of care homes with nursing.

The Provider Improvement Response Team (PIRT) has been operational since March 2019, and is an integrated service jointly funded by Staffordshire County Council and the six Staffordshire and Stoke-on-Trent CCGs, with the aim of working with care home services identified as being in urgent need of support. The PIRT works collaboratively with providers across the health and social care system who have triggered PIRT criteria, with a predominant focus on ensuring safe, effective, evidence-based and high-quality care to patients and residents.

The team's aims and intended outcomes are to:

- improve patient safety and quality of life by ensuring care home providers meet individuals' needs
- improve market quality by working with care homes that have an escalated level of risk and those which have continuously struggled to improve the quality of their service
- reduce unnecessary hospital admissions by identifying issues, understanding hospital admission difficulties and working with the care homes to reduce unnecessary non-elective hospital admissions. The aim is to ensure a timely response to care needs from the right care professional in the right setting
- ensure greater market choice with more services with a CQC 'Good' or 'Outstanding' rating to improve the standards of patient care
- avoid urgent closures by the regulator under Section 30 of the Health and Social Care Act 2008. The aim is to minimise the impact on people and their families and carers in the event of a care home closing (CQC, 2020)
- use quality interventions to reduce the duration of contractual suspensions, increasing the available capacity within the market.

Through their input and collaborative working, the PIRT has been able to demonstrate considerable impact by:

- preventing urgent care home closures
- reducing the need for multi-agency processes including large scale enquiry and quality improvement processes

- enhancing timely response to quality assurance action plans
- supporting referrals to training resources to enhance staff knowledge and adherence to training standards.

To support information sharing, a localised version of MiDoS named 'MiDoS for Care Homes', which is a directory of information and services, has been designed as an online information hub for care homes in Staffordshire and Stoke-on-Trent. It provides access to elements of the NHS Directory of Services (DoS) and a wide range of supportive information, which includes links to various community teams and associated key guidance. The platform itself is a collaboration between the six Staffordshire and Stoke-on-Trent CCGs, West Midlands Ambulance Service and the Staffordshire County Council Quality Assurance team.

There is a wide range of information that can be accessed on the platform, some of which includes:

- contact details for community teams, contract management teams, care review requests and care brokerage services
- contact details for dentists, pharmacies, GPs, opticians and hospitals
- referral links for safeguarding, serious incidents and regulatory notifications
- key information pages for NHS.net
- guidance around safeguarding referrals, mental capacity and other associated guidance
- links to organisations that provide supportive guidance to care homes.

There is a rolling programme of reviews that see the content refreshed and updated, following feedback and the availability of new resources. Promotional work on MiDoS for Care Homes continues to support frontline professionals including, community teams and PCN care coordinators, who work with care homes to have access to the system which enables staff to signpost to appropriate resources.

Care at Home (Domiciliary Care)

The Care at Home (Domiciliary Care) workstream oversees those in receipt of NHS Continuing Healthcare (CHC) and where care is brokered by Midlands and Lancashire Commissioning Support Unit (MLCSU) or MPFT's Palliative Care Centre (PCC).

There are many challenges with this area of work, including a large supplier base, transient workforce and lack of robust intelligence sharing between commissioners of these services. In 2021, it was recognised that the assurance provided to care homes, is not in place for care at home. A Care at Home Monitoring Group, therefore, was establishment in September 2021.

The Care at Home Monitoring Group has representation from the CCG's Nursing and Quality team (Corporate Nursing and Safeguarding), MLCSU, the Primary Care Commissioning Committee and the Care Quality Commission (CQC). All intelligence received by members is shared, discussed and contributes to a discussion about the safety of patients and the continuation, pausing or suspending of services.

A Standard Operating Procedure (SOP) has been developed and includes making recommendations, where appropriate, to the CCG's Executive Director of Nursing and Quality or Deputy Director where it is agreed actions need to be taken to keep people safe. Signed approval is submitted to the monthly CHC Quality Performance and Operations meeting and reported up to the Individual Patient Activity Board (IPA). Any actions are reviewed monthly and aligned to discussions that take place at the system wide monthly Quality and Safeguarding Information Sharing Meeting (QSISM), chaired by Staffordshire County Council.

The group continues to grow in knowledge and breadth, increasing the intelligence received into the CCG, and thereby increasing the level of assurance about care delivery.

Engaging people and communities

Developing the future approach to working with people and communities

Community engagement and involvement has always been recognised as a key enabler in supporting effective health and social care planning and delivery across Staffordshire and Stoke-on-Trent.

There is now an opportunity as an Integrated Care System (ICS) to strive further and harder than ever before to ensure people and communities are at the heart of everything being done. That includes developing a new approach to community engagement.

The core requirements of the ICS guidance around working with people and communities was for the Integrated Care Board (ICB) to develop a system-wide strategy describing its principles and arrangements. It was also to set out the ICB's approach to working with partners to ensure that Integrated Care Partnerships (ICPs) and partnerships at Place have representation from local people in priority-setting and decision-making forums.

To develop a system-wide strategy for the ICB in Staffordshire and Stoke-on-Trent that is transparent, effective, and meaningful, we have been working collaboratively with partners, the public, Healthwatch and the voluntary, community and social enterprise sector (VCSE). We recognised and wanted to build on established relationships and the work already being done by partners across the system to involve and engage with people and communities.

Initially we reviewed how we had all been involving people in the work we do, including seldom heard groups or groups representing communities with protected characteristics and vulnerabilities. We then collectively developed a core set of principles that reflect how the public would like to be engaged and would empower people to become active participants in their own health and wellbeing.

In December 2021, the local principles, which are set out below and echo the principles that were set out within the ICS guidance, were agreed by the ICS Partnership Board, and these principles were used to shape the ICB strategy for engaging with people and communities.

The local principles for working with people and communities are:

- Health and wellbeing are everyone's business – engagement needs to be inclusive and accessible to all
- Put the public voice at the heart of decision making
- Don't make assumptions – ask how best to engage
- Recognise the different needs of the population, especially those who could be excluded
- Do it once and do it well – shared intelligence between partners
- Allow enough time to engage properly, adapting the approach where necessary
- Be honest, open and transparent – authentic involvement
- Clear communication that can be understood by all – be clear on what you are asking and consider your audience
- Commit to feedback – explain what impact engagement has made in simple terms
- Build on what is already there – utilise existing knowledge, relationships, experience and local assets, including the community and voluntary sector.

One of the areas of development that was identified within the strategy was to establish a system-wide People and Communities Assembly that would bring together a range of public and community representatives from across Staffordshire and Stoke-on-Trent.

The purpose of the Assembly would be to advise the ICB on its statutory duty to engage and to hold the ICB to account in its responsibility to secure public involvement in the consideration, planning and development of proposals for change and any decisions affecting the operation of commissioning arrangements.

Having a diverse membership would enable the Assembly to act as an advisory board and critical friend to the ICB on its approach to involvement and engagement, including targeted engagement with seldom heard communities. It would also ensure the ICB meets the requirements of the public sector equality duty to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people.

During the first quarter of 2022/23, proposals for the People and Communities Assembly were discussed with existing patient and public forums and further events are planned for September 2022 to finalise the detail.

Further engagement with people and communities was also undertaken to shape the final version of the strategy submitted to NHS England in July 2022. The strategy received positive feedback with nine areas identified as best practice, but there is recognition that there is still more we want to build on as we progress through this transitional year.

Transformation

One of the key areas of engagement for the ICS this year has been the clinically-led transformation programme that started in 2019 with a listening exercise but was paused in 2020 in response to the COVID-19 pandemic.

Involvement work was restarted in autumn 2021 with a refresh of previous activity to understand if anything had changed, if there was anything new, and what impact the pandemic had had on experiences of health services.

Five programmes are currently underway:

- Clinical policy alignment – this programme was formerly known as 'Difficult Decisions', and is designed to create a consistent policy criteria and patient eligibility across five areas of care:
    - Assisted conception
    - Hearing aids for non-complex hearing loss
    - Male and female sterilisation
    - Breast augmentation and reconstruction
    - Removal of excess skin following significant weight loss.
- Community diagnostic centres – these will increase capacity and availability of planned appointments for blood tests, X-rays, MRI scanning and other diagnostic tests
- Inpatient mental health services in south east Staffordshire – this will identify the long-term solution for services previously provided by the George Bryan Centre in Tamworth
- Maternity – this will support the national roll-out of the continuity of carer and on-demand models of care
- Urgent and emergency care – this will support the national mandate to replace walk-in centres (WICs) and minor injury units (MIUs) with urgent treatment centres (UTCs) to help people access the treatment they need at the most appropriate location, without the need to attend emergency departments unnecessarily.

The programme for inpatient mental health services in south east Staffordshire is the most advanced, with the business case now complete and currently progressing through the NHSE assurance process. We hope to have an update in late September which will guide the next steps in the continuing work to find a long-term solution for inpatient mental health services previously provided by the George Bryan Centre.

Work is continuing behind the scenes for the other four programmes, and you can read more about each of these programmes on the ICB website by clicking the links above.

The pandemic created several challenges and opportunities for the system, particularly in relation to engaging with the public. One example is the requirement to shift to a 'Digital First' approach instead of face-to-face discussions and involvement opportunities (retaining the use of traditional methods where possible). Recognising the barriers this approach might have created for some people, we developed a series of robust approaches, including:

- using the 'Accessibility Approach' – a process to manage and monitor how to support people for who English is not their first or preferred language, or

who live with barriers to online routes to involvement because of infrastructure and geographic connectivity, access to devices or skills

- working with voluntary sector partnerships to build on existing relationships with partners to either:
  - reach their networks with communications and updates, including invitations to participate in involvement activity
  - support their events by attending to provide an update, hear views and answer questions
  - host voluntary sector partners to translate online meetings and events, either in live scenarios or with translated recordings of presentations with updates being shared during discussions
  - access the extensive network of translation partners to provide materials in a range of alternative formats spanning languages, large-print, Braille, BSL and others as requested
- learn from COVID-19 and use the approaches developed during the system's approach to the pandemic to reach diverse communities via the established network of 'Trusted Voices and Trusted Faces' – people who are already living and working in the county, and in many cases in contact with communities that have historically struggled to be reached. This approach has helped understand communities better, appreciate their different cultural priorities and concerns, and benefit from an increased use of networks and community relationships.

As this work continues during 2022/23, alternatives continue to be reviewed to provide virtual events to allow groups of people in face-to-face environments to participate, and the best methods to deploy continue to be reviewed, based on current guidance and the audience involved.

Online

Digital communications

Digital communications have continued to be developed and strengthened, partly due to changes introduced due to COVID-19, but also because of positive feedback from stakeholders. During joint engagement with Staffordshire County Council to develop a strategy for children with Special Educational Needs and Disabilities, for example, parents and carers fed back that they welcomed the online approach as for many it was a more accessible way to engage.

This activity also supports the Digital Communication Strategy, which involves using a variety of digital assets and innovative methods to share our messages and engage with the local population as well as internal colleagues and GP practices. However, it is recognised that digital channels are not accessible to all and therefore there maintains a focus on non-digital communications as well.

Social media

Social media continues to be a key channel of communication, supporting the use of more innovative and accessible methods of sharing information. Videos and infographics have enabled more effective explanation of complex information and

to target key messages more effectively, particularly using paid-for advertisements on channels such as Facebook.

As social media channels have developed, and the digital audience expanded additional channels such as Spotify, pay-per-click adverts (PPC) and Snapchat have been used. A tester budget was used to reach younger demographics on Snapchat. This achieved 439,913 impressions and 1,009 link clicks over a four-week period. The vaccination campaign was targeted at 18 to 29-year-olds and surpassed other platforms used for this campaign that are favoured by older age groups, such as Facebook.

By using platforms such as Spotify, it has been possible to target audience through other senses bedsides visual, in this case audio, allowing key local NHS messages to be pushed through various sensory routes in addition to widening accessibility opportunities. Assets have also been tailored to meet the needs of different communities using interpreters to translate information into different languages or using British Sign Language (BSL) interpreters.

Storytelling has been used through Facebook carousels to push several key health messages at once, allowing the audience to understand important, key messages and action all at once. Training was also provided to the team around organic targeting, which has allowed specific audience demographics to be targeted, preventing over-saturating of channels by using a more targeted approach.

Innovation will continue on social media and digital strategies and implementations through learnings from the past year.

Live meetings and webinars

The use of virtual meetings and webinars has continued to support communication and engagement with stakeholders of all levels across the system. This has included virtual focus groups to support engagement on several projects including the SEND joint strategy, the clinical transformation programme and the mental health transformation for community services.

The joint Annual General Meeting (AGM) was held as a live webinar again this year where attendees could hear about achievements and focus for the next year. Feedback from the previous year's event was used to improve the format and approach to this year's meeting and received positive feedback from those who attended.

The Governing Body meetings and the Primary Care Commissioning Committee meetings have continued as virtual meetings in public with videos of these events and meetings made available for people to watch after the event on the website. Whilst operating in shadow form, the Integrated Care System Partnership Board was also held online – with members of the public invited to attend.

GP-led sessions have been supported as on-line webinars and the communications and engagement team have provided further technical support and training for other departments to hold their own virtual meetings, such as unconscious bias training and protected learning time (PLT) sessions with GP practices.

Internally, live meetings and webinars have supported the transition process for staff as preparations progressed for the establishment of the new Integrated Care Board. Weekly live conversations, known as the Team Brief, have taken place between senior leaders and staff about the organisational development work programme, as well as interactive development sessions with all staff throughout the year.

E-newsletters

E-newsletters have been used to support communication around key activities across the integrated care system. Regular bulletins have continued to be delivered to stakeholders that provide updates on the work of the partnership, including the development of plans to support the transition from CCGs to an Integrated Care Board and Integrated Care Partnership.

Internally there continues to be delivered twice-weekly bulletins to staff within the CCGs. This is supported by a weekly webinar hosted by the Accountable Officer and other members of the executive team to provide updates from different departments within the organisation. There is also a continuous feed of information through other mediums such as social media, websites, Microsoft Teams chats and intranets.

Websites and intranets

Websites are central to providing meaningful public information and feedback in accessible formats, especially during a period of change. In anticipation of the change in legislation, a new fully integrated website has been developed to support both the Integrated Care Board and the wider integrated care system, with increased functionality for the user.

The staff intranet also continues to be the one-stop host of resources for staff including news, training opportunities and resources. This year the intranet was moved to a SharePoint platform to aid easier access for staff, and the use of features to connect with the Microsoft package. The GP intranet, developed in response to COVID-19, has also now been moved to a SharePoint platform and has been developed to incorporate primary care news, forms, operational procedures and other resources.

Face-to-face

Engagement with our various patient groups has continued using online mechanisms put in place due to social distancing restrictions. Feedback has also been responded to from some of the groups to introduce Zoom meetings where required to support engagement with those who were struggling to use Microsoft Teams.

As COVID restrictions have been relaxed, face-to-face engagement has started to be reintroduced – especially in areas where members of the community would not be able to access digital channels. One example is the attendance at local coffee mornings that support people who are deaf or hard of hearing – supported by BSL interpreters to facilitate the conversation.

Clinical and Professional Leadership

NHS England and NHS Improvement released guidance in September 2021 around implementing effective clinical and professional leadership within integrated care systems (ICSs). ICS and designate Integrated Care Board (ICB) leaders have been asked to agree on a local framework and associated development plan, as well as to ensure that leaders from all clinical and care professions are involved and invested in the vision, purpose, and work of their ICS as it matures.

Clinical and care professionals will be involved in decision-making at every level of the system and the ICS has been engaging with multiple partners to inform the emerging framework and model. This includes the development of communication materials to explain the vision and five core principles for clinical and professional leadership at a local level.

During 2021/22, the first multi-organisation and multi-professional networking event for clinical and care professionals across Staffordshire and Stoke-on-Trent was held. The event enabled clinical and care professionals to understand what the framework is and how they can connect and contribute towards the panel as well as highlighting opportunities or challenges. The event also allowed attendees to shape and inform the evolution of the local clinical and professional leadership approach.

A survey was run alongside the event and feedback from both is currently being collated and analysed to inform the approach going forwards.

Overview and Scrutiny Committee

The Health and Care Overview and Scrutiny Committee is responsible for scrutiny of matters relating to the planning, provision and operation of health services in the local authority's area. This includes public health, in accordance with regulations made under the Health and Social Care Act 2001 and subsequent guidance.

The Committee has the power to make reports and recommendations to NHS bodies conferred by the Health and Social Care Act 2001 and may respond independently to health-related consultations from government and external agencies.

The Committee takes the lead in scrutinising the work of the CCG, which has been actively engaged with the Committee throughout the year in formal meetings and informal briefings. This is to make sure that Committee members can scrutinise our plans and proposals in a public forum.

Going forward, the committee will continue to take the lead on scrutinising the work of the ICB and the ICP.

Health and Wellbeing Strategy

The Health and Wellbeing Board is a statutory partnership, which brings together senior leaders from Stoke-on-Trent City Council, NHS commissioners and health service providers, Healthwatch, voluntary sector organisations, education providers and emergency services.

It meets to understand local needs, agree priorities, and ensure NHS organisations and the council work more closely together to improve the health of local people and ensure fair access to services.

One of the key functions of the Health and Wellbeing Board is to prepare, consult on and publish a Joint Health and Wellbeing Strategy. The strategy is the city's plan for reducing health inequalities and improving health and wellbeing for residents of all ages. It is used by local health and care partners to inform plans for commissioning services and shape how we work together to meet health and social care needs and address the social determinants of health.

The Board's key functions are:

- to undertake a Joint Strategic Needs Assessment (JSNA)
- to prepare, consult on and publish a Joint Health and Wellbeing Strategy
- to develop local evidence-based priorities for the commissioning of local services
- to ensure that the commissioning plans and activities of CCGs and the council are consistent with the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy
- to support the development of joint commissioning, integrated delivery and pooled budgets
- to assess the need for pharmaceutical services in its area, and publish a statement of its first assessment and of any revised assessment
- to encourage integrated working under the Health and Social Care Act 2012.

Examples of the contribution to the Health and Wellbeing Board include the following:

- Clinical and Executive representation from the CCG
- Regular updates have been provided to the Health and Wellbeing Board on the system's response to the COVID-19 pandemic
- During 2021/22, the NHS, working closely with the local authorities, has continued to manage the largest vaccination programme in the history of the NHS. Regular updates have been provided to the board and any feedback has been shared with the programme to inform the approach to the programme
- During the second half of the year, the Health and Wellbeing Board have been actively engaged in the development of plans for the Integrated Care System.

This information has been developed in conjunction with the Health and Wellbeing Board and was agreed to be included in this year's Annual Report.

Accountability Report

Corporate Governance Report

The Corporate Governance Report seeks to explain the composition and organisation of the CCG's governance structures and how they support achievements.

Member profiles

Dr Lorna Clarson is Chair of Stoke-on-Trent CCG.

Marcus Warnes is the single Accountable Officer for Cannock Chase CCG, East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG.

Stoke-on-Trent CCG member practices

Practice Name	Address	Post Code
Adderley Green Surgery	Longton Health Centre, Drayton Road, Longton, Stoke-on-Trent **Branch Surgery:** 28-30 Weston Street, Adderley Green, Stoke-on-Trent	ST3 1EQ ST3 5DQ
Apsley House Practice	Cobridge Primary Care Centre, Church Terrace, Cobridge **Branch Surgery:** 62 Knypersley Road, Norton, Stoke-on-Trent	ST6 2JN ST6 8HZ
Baddeley Green Surgery	988 Leek Road, Stockton Brook, Stoke-on-Trent	ST9 9PB
Belgrave Medical Centre	116 Belgrave Road, Dresden, Stoke-on-Trent	ST3 4LR
Birches Head Medical Centre	Diana Road, Birches Head, Stoke-on-Trent **Branch Surgery:** Hulton House Surgery, 1479 Leek Road, Abbey Hulton	ST1 6RS ST2 8DA
Blurton Medical Practice	Blurton Health Centre, Ripon Road, Blurton, Stoke-on-Trent	ST3 3BS
Borse and Partners	Meir Primary Care Centre, Weston Road, Meir, Stoke-on-Trent	ST3 6AB
Brinsley Avenue Medical Practice	11 Brinsley Avenue, Trentham, Stoke-on-Trent **Branch Surgery:** The Health Centre, Old Road, Barlaston, Stoke-on-Trent	ST4 8LT ST12 9EP
Brook Medical Centre	98 Chell Heath Road, Bradeley, Stoke-on-Trent **Branch Surgery:**	ST6 7NN

	Smallthorne Site Surgery, 2 Baden Road, Smallthorne, Stoke-on-Trent	ST6 1SA
Cambridge House Surgery	Cambridge House, 124 Werrington Road, Bucknall	ST2 9AJ
Cobridge Surgery	Cobridge Community Health Centre, Church Terrace, Cobridge	ST6 2JN
Dunrobin Street Medical Centre	Dunrobin Street Medical Centre, Dunbrobin Street, Stoke-on-Trent	ST3 4LN
Furlong Medical Centre	Furlong Road, Tunstall	ST6 5UD
Glebedale Medical Practice	Glebedale Road, Fenton, Stoke-on-Trent **Branch Surgery:** Merton Street, Longton, Stoke-on-Trent	ST4 3AQ ST3 1LG
Goldenhill Medical Centre	High Street, Goldenhill, Stoke-on-Trent	ST6 5PQ
Harley Street Medical Centre	Harley Street, Hanley **Branch Surgery:** Student Health Services, Coalport Building, Leek Road, Stoke-on-Trent	ST1 3RX ST4 2YJ
Hartshill Medical Centre	Ashwell Road, Hartshill, Stoke-on-Trent	ST4 6AT
Haymarket Health Centre	Dunning Street, Tunstall	ST6 5BE
Honeywall Medical Practice	Stoke Health Centre, Honeywall, Stoke-on-Trent	ST4 7JB
Longton Hall Surgery	186 Longton Hall Road, Blurton, Stoke-on-Trent	ST3 2EJ
Lucie Wedgwood Health Centre	Chapel Lane, Burslem, Stoke-on-Trent	ST6 2AB
Mayfield Surgery	54 Trentham Road, Longton, Stoke-on-Trent	ST3 4DW
Meir Park and Weston Coyney Medical Practice	Meir Park Surgery, Lysander Road, Meir, Stoke-on-Trent **Branch Surgery:** Meir Primary Care Centre, Weston Road, Meir, Stoke-on-Trent	ST3 7TW ST3 6AB
Middleport Medical Centre	Newport Lane, Middleport	ST6 3NP
Dr P D Miles and Dr R Valasapalli	Meir Primary Care Centre, Weston Road, Meir, Stoke-on-Trent	ST3 6AB
Millrise Medical Practice	Millrise Road, Milton, Stoke-on-Trent	ST2 7BW
Moorcroft Medical Centre	Botteslow Street, Hanley **Branch Surgery:** Moss Green Branch Surgery, Bentilee Neighbourhood Centre, Dawlish Drive, Bentilee, Stoke-on-Trent	ST1 3NJ ST2 0EU
Norfolk Street Surgery (merged with Snowhill Medical Centre 01/05/22)	Shelton Primary Care Centre, Norfolk Street, Shelton	ST1 4PB
Orchard Surgery	Knypersley Road, Norton, Stoke-on-Trent	ST6 8HY

	Branch Surgery: Endon Surgery, Station Road, Endon	ST9 9DN
Potteries Medical Centre	Beverley Drive, Bentilee, Stoke-on-Trent	ST2 0JG
Prima Care Surgeries	Abbey Surgery, 77 Woodhead Road, Stoke-on-Trent **Branch Surgery:** Hanley Health Centre, Upper Huntbach Street, Hanley **Branch Surgery:** Foden Street Surgery, 32 Foden Street, Stoke-on-Trent	ST2 8DH ST1 2BN ST4 4BX
Drs Shah and Talpur	Hanford Health Centre, New Inn Lane, Hanford	ST4 8EX
Snowhill Medical Centre (merged with Norfolk Street Surgery 01/05/22)	Shelton Primary Care Centre, Norfolk Street, Shelton	ST1 4PB
Trent Vale Medical Practice	876 London Road, Stoke-on-Trent	ST4 5NX
Trentham Mews Medical Centre	Eastwick Crescent, Trentham	ST4 8XP
Trinity Medical Centre	Uttoxeter Road, Blythe Bridge, Stoke-on-Trent	ST11 9HQ
Tunstall Primary Care	Tunstall Primary Care Centre, Alexandra Park, Scotia Road, Tunstall **Branch Surgery:** Packmoor Medical Centre, Thomas Street, Packmoor	ST6 6BE ST7 4SS
Willow Bank Health Centre	Meir Primary Care Centre, Weston Road, Meir	ST3 6AB

Composition of the Governing Body

Voting	Number
Board Nurse/Secondary Care Consultant	2
GPs	5
Officers	4
Lay Members – statutory	3

Governing Body members

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Dr	Lorna	Clarson	Chair		
Dr	Doug	Robertson	Secondary Care Consultant		
Mrs	Margy	Woodhead	Lay Member for PPI		
Mr	John	Howard	Lay Member for Governance		
Mr	Tim	Bevington	Lay Member		
Dr	Steve	Fawcett	Medical Director		
Dr	Waheed	Abbasi	Clinical Director		
Dr	John	Gilby	Director for Primary Care		
Dr	Latif	Hussain	Non-Executive GP		
Mr	Marcus	Warnes	Accountable Officer		
Mr	Paul	Brown	Chief Finance Officer		
Mrs	Heather	Johnstone	Executive Director of Nursing and Quality/Chief Nurse		
Mrs	Cheryl	Hardisty	Executive Director of Commissioning and Operations		
Ms	Jane	Moore	Executive Director of Strategy, Planning and Performance		

**Dates will only be included if there has been a change in-year*

Committee(s) including Audit Committee

Audit Committee

This is a committee held in common with Cannock Chase CCG, East Staffordshire CCG, North Staffordshire CCG, South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG. Only Stoke-on-Trent CCG members vote on Stoke-on-Trent issues.

Stoke-on-Trent CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	John	Howard	Lay Member for Governance		
Mr	Tim	Bevington	Lay Member		
Dr	Doug	Robertson	Secondary Care Consultant		

Cannock Chase CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	John	Howard	Lay Member for Governance		
Mr	Paul	Gallagher	Lay Member for Patient and Public Involvement (PPI)		
Dr	Doug	Robertson	Secondary Care Consultant		

East Staffordshire CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	David	Harding	Lay Member for Governance		
Ms	Anne	Heckels	Lay Member for PPI and Quality		
Dr	Doug	Robertson	Secondary Care Consultant		

North Staffordshire CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*

Mr	John	Howard	Lay Member for Governance		
Dr	Doug	Robertson	Secondary Care Consultant		
Mr	Tim	Bevington	Lay Member		

South East Staffordshire and Seisdon Peninsula CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Ms	Anne	Heckels	Lay Member for PPI		
Mr	John	Howard	Lay Member for Governance		
Mr	Paul	Gallagher	Lay Member for Quality		
Dr	Doug	Robertson	Secondary Care Consultant		

Stafford and Surrounds CCG representatives on Audit Committee

Title	First name	Surname	Position	Date of joining the committee*	Date of leaving the committee*
Mr	John	Howard	Lay Member for Governance		
Mrs	Diana	Smith	Lay Member		
Mr	Paul	Gallagher	Lay Member		
Dr	Doug	Robertson	Secondary Care Consultant		

**Dates will only be included if there has been a change in-year.*

Remuneration Committee

The Remuneration Committee did not meet in the period from 1 April 2022 to 30 June 2022.

Details of membership can be found in the Remuneration and Staff Report.

Further details of the sub-committees of the Governing Body can be found in the Annual Governance Statement.

Register of Interests

We record details of company directorships and other significant interests held by members of the Governing Body which may conflict with their management responsibilities, as well as details of how these conflicts are managed.

Please see the Governance Statement for more information.

Personal data-related incidents

Please see the Governance Statement for more information.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual 'Slavery and Human Trafficking Statement'. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. Income earned by NHS bodies from government sources, including CCGs and local authorities, is considered to be publicly funded and is therefore outside the scope of these reporting requirements.

After discussion with our Auditors, the CCG does not consider that it has any activities that requires it to be treated as a commercial organisation for the purpose of the Modern Slavery Act 2015. We do not engage in profit-making activities, and so do not trigger the mandatory reporting requirements.

However, we fully support the government's objectives to eradicate modern slavery and human trafficking. Even though we do not meet the requirements for producing an annual statement, as best practice, the six Staffordshire and Stoke-on-Trent CCGs have provided a combined Modern Slavery Act statement.

Statement of Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England appointed Mr Marcus Warnes to be the Accountable Officer of Stoke-on-Trent CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group 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 Clinical Commissioning Group 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
- prepare the accounts on a going concern basis.

The CCG has complied with its financial duties under Section 223H to 223J of the National Health Service Act 2006 (as amended) and has made a surplus. In all other respects to the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as 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 the CCG's auditors are aware of that information
- the Annual Report and Accounts as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Peter Axon
Interim Chief Executive Officer
Staffordshire and Stoke-on-Trent Integrated Care Board

29 June 2023

Governance Statement

Stoke-on-Trent CCG is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG 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 local population.

As of 30 June 2022, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 my CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG 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 CCG as set out in this Governance Statement.

Governance arrangements and effectiveness

The Governing Body has continued to ensure that the group has made appropriate arrangements for ensuring it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

This has been achieved by the following.

Key features of the CCG's constitution for governance

The CCG promotes good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties. The principles of good governance are established in our Constitution.

The CCG will at all times observe these generally accepted principles in the way it conducts its business. These include:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business

- the Good Governance Standard for Public Services
- the standards of behaviour published by the Committee on Standards in Public Life (1995), known as the 'Nolan Principles'
- the seven key principles of the NHS Constitution
- the Equality Act 2010.

Information about the Governing Body, the Locality Commissioning Board and the committees

The Governing Body, Membership Board and committees have continued to meet throughout the period from 1 April 2022 to 30 June 2022. These consist of the following:

Committees of the Governing Body (all held in common)

- Audit Committee
- Remuneration and Terms of Service Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Communication, Engagement, Equality and Employment Committee.

Full details of each of the above committees can be found in our 2021/22 Annual Report.

Joint arrangements with other CCGs

The six CCGs in the Staffordshire and Stoke-on-Trent area continued to work together up to the cessation of CCGs on 30 June 2022.

Meetings of the Governing Body

Our Governing Body continued to meet during the first quarter of 2022/23. Full details can be found in our 2021/22 Annual Report.

Performance of the Membership Board and Governing Body, including their own assessment of their effectiveness

The CCG's Governing Body and Membership Board continued to meet virtually and have helped support the Due Diligence work required to provide a seamless handover at the end of June 2022, to the incoming Integrated Care Board/Integrated Care System.

Highlights of the work of all the above committees, sub-committees and joint committees

Membership Board

Full details of all our committees and sub-committees can be found in our 2021/22 Annual Report.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon Good Governance Institute best practice.

Discharge of statutory functions

The CCG continued to honour its discharge of its statutory duties as required in line with legislation.

As CCGs will be abolished on 1 July 2022 in line with national policy, all current responsibilities for quality need to be handed over to successor bodies or cease. As part of the transition arrangements, we are required to carry out due diligence to ensure effective transitioning of all current assets and liabilities and key areas of work between CCGs to ICBs and to produce a legacy document.

In this regard to help with this work, our Audit Committee held a series of Due Diligence meetings looking at:

- Finance
- Human Resources (HR)
- Quality and Safety
- Information Governance (IG)
- Information Technology (IT)
- Strategy, Planning and Performance
- Business Interruption (BI)
- Commissioning
- Primary care.

To help support and provide a detailed and robust legacy document to record the CCG's achievements, systems, processes and governance arrangements to aid the transition to the ICB for ICB colleagues to refer to as required.

The legacy document records the achievements, systems, processes and governance arrangements to aid the transition to the ICB.

The six Staffordshire and Stoke-on-Trent CCGs have been noted as being of a challenged system for many years, primarily in terms of difficult relationships, the financial position and performance in key areas such as urgent and emergency care. All six CCGs have played a leading role in changing that perception, and indeed the reality.

We have significantly improved in many areas and are now often referred to not as ‘a challenged system’, but as ‘a system with challenges’. This is a testament to the incredible commitment and dedication shown by everyone within the CCGs, the chairs, executives, lay members, clinical leaders and member practices. But most of all, our fabulous staff.

Risk management arrangements and effectiveness

With the assistance of Internal Auditors RSM, we implemented best practices in relation to our Board Assurance Framework (BAF) development. Senior executive leads reviewed their objectives, which were renewed and rewritten as ‘SMART’ objectives.

In conjunction with the work on the BAF, a refresh of our approach to risk management was undertaken. Risk owners, with support from the Governance team, were requested to carry out a full review of their COVID-19 risks as well as their existing corporate risks and where appropriate, align them to BAF risks/objectives.

Senior executive management continued to receive the BAF and Risk Register on a monthly basis during the first quarter of 2022/23.

The BAF and Risk Register are also presented to the Audit Committee in full, with risks scoring 15 or above being reported to the Governing Body and associated committees responsible for their area of risk.

Our Internal Auditors then reviewed the arrangements formally and overall, found reasonable assurances with the re-modelled and re-aligned approach, which was positive. Full details of their audit opinion can be found in our 2021/22 Annual Report.

The administration of both the BAF and Risk Register is undertaken by the Governance team who continue to provide support on the completion of the registers.

We have auditor-assured and adequate risk management control frameworks, with clear reporting lines and regular review of the CCG’s identified risks.

We have ensured that risk management has remained fully embedded in the CCG’s core business activity (including interlinked areas such as undertaking Equality Impact Assessments with in-built risk assessment checks, or to support all incident reporting to be carried out openly).

Capacity to handle risk

The CCG Governing Body is responsible for the organisation’s systems for internal control, including risk management. The Accountable Officer is designated with overall responsibility for ensuring the implementation of external assurances covering risk management and reporting to the Governing Body. The Accountable Officer delegates some of these responsibilities to senior officers of the CCGs.

Single leadership team

The role of the single leadership team covering all six CCGs in Staffordshire and Stoke-on-Trent is to have oversight of the BAF and the encompassing risk register for all risks. Executive directors through their ‘Start the Week’ weekly meeting

were responsible for validating and managing risks within their designated remit of work, including COVID-19 response.

Audit Committee (held in common)

The Audit Committee ensures that effective systems of integrated governance, risk management and internal control are maintained.

The Audit Committee reviews the risk register and BAF.

The sub-committees of the Governing Bodies are responsible for overseeing the risks relating to their workstreams. The Audit Committee has oversight of all risks.

Accountable Officer

The Accountable Officer has overall responsibility to ensure appropriate systems of internal control are in place for all aspects of governance, including financial and risk management as well as plans for dealing with emergencies that may impact on the CCGs.

Day-to-day management of risk management processes is delegated to the Executive Director of Corporate Services, Governance and Communications.

Executive directors

The relevant executive director ensures that all risks are identified, managed and mitigated for their workstreams and that the risk owner carries out their duties effectively. The attribution of risks is aligned with the programme portfolios. Executive directors led the interim risk review process throughout the COVID-19 response.

Risk owners

The risk owners will ensure that their risks are continuously managed. They will check that the risk register is updated on at least a monthly basis or as deemed appropriate by their executive director.

The directors are:

Executive leads	Area of work
Chief Finance Officer	Finance, Governance and Senior Information Risk Owner
Executive Director of Quality and Safety – Chief Nurse	Quality, Safety, Safeguarding, Caldicott Guardian
Executive Director of Corporate Services, Governance and Communications	Corporate Governance, Human Resources, Organisational Development, Equalities and Communications and Engagement
Executive Director of Primary Care	Primary Care and Medicines Optimisation
Executive Director of Strategy, Planning and Performance	Performance, Information, Planning and Strategy, as well as formal processes for ICC incident response
Executive Director of Strategic Commissioning and Operations	Commissioning and Operations, including the operational cells' work in COVID-related areas

Risk assessment

A review of the Risk Register was undertaken to record legacy risks that would be transferred from the CCG to the ICB, a total of 15 high-scoring risks were recorded.

In addition, it is also important to note that as a result of the close monitoring of risks the CCGs closed down two risks during the period 1 April 2022 to 30 June 2022:

Risk Ref	Description	Reason for closure
1066	**Cancer activity UHDB:** There is an overall increase in the number of two-week wait (2ww) referrals, which have increased. During the pandemic, a number of referrals missed the 2ww window. Post COVID, the number of referrals has increased. This delay could lead to unfavourable outcomes for some patients. There is an increase in referrals for dermatology, including urgent skin cancer referrals, a proportion of which are inappropriate. This is impacting on the delivery of 2ww referral treatment. There is an influx of breast cancer referrals above pre covid levels due to external publicity which again is causing capacity issues across the Midlands. Referrals are being booked at 16-21 days which is potentially impacting diagnosis and delaying start of treatment. **Cancer activity UHB:** There is a risk is still getting patients into secondary care following 2ww referral or confirmed cancer diagnosis- patients choosing not to access for diagnostics or treatment following confirmed cancer diagnosis. Breast cancer booking is fragile, they are seeing a significantly high level of referrals from across the country. Also seeing an impact on referrals from celebrity deaths. Endoscopy wait (6-8 week cancer 2ww) struggling to get back to pre-COVID levels. Workforce issues with sickness within teams, staff burnout, work overload and BREXIT fallout causing an impact. Concerns with in-house capacity for booking endoscopy and currently the Trust is not looking at routine endoscopy.	**4 April 2022:** Risk recommended for closure as managed via in line with executive direction.

	Impact: Delayed diagnosis and treatment, and poorer survival rates. An increase in referrals needs to be managed in order to manage diagnostic capacity.	
966	The long-term consequences to patients and staff of Staffordshire and Stoke-on-Trent following the demands placed upon the system in response to COVID-19 are not yet known. There is a potential unintended consequence which will have significant impact on physical/emotional patient wellbeing and optimal treatment outcomes across all commissioned services.	**12 May 2022:** Discussion at CCGs' Quality and Safety Committees 'in Common' and agreement to close the risk as the consequences are known and are being managed as business as usual (BAU).

Other sources of assurance

Internal control framework

Work has commenced to refresh the BAF to develop the objectives for 2022/23, which includes taking forward elements from the CCG BAF that remain outstanding.

Assessment of CCG effectiveness

RSM's opinion is limited to the internal audit work for the three-month period of 1 April 2022 to 30 June 2022, it also takes into consideration their cumulative knowledge of the CCG and supported by the work completed in 2021/22 that formulated their opinion with the 2021/22 Head of Internal Audit annual report issued June 2022.

Annual audit of conflicts of interest management

Our annual audit of conflicts of interest is detailed in our 2021/22 Annual Report.

RSM, will present their audit plan for the ICB to the ICB Board for approval. Their plan will set out the proposed audits for the 2022/23 financial year as the ICB establishes itself.

Headlines/summary of findings

RSM have based their opinion on the work undertaken in quarter one of 2022/23. This includes:

- Data Security Protection Toolkit – advisory
- Operational Planning – substantial assurance

- Medicines Management – reasonable assurance – positive opinion
- Due Diligence workstreams:
  - Finance, completed in two phases, Commissioning and HR

NHS England conflicts of interest and conflicts of interest training

Despite having some difficult challenges, robust management of conflicts of interest has enabled us to ensure that all colleagues attending our Governing Body and committee meetings have completed a declaration of interest and completed the training.

A conflicts of interest register is presented at the start of every meeting and members are asked to declare if they have a conflict regarding any items on the agenda. Spot checks of the conflicts register are undertaken by the Governance team by reviewing information on the register with Companies House for accuracy.

The Conflicts of Interest Policy has been reviewed and transferred to the ICB and will publish the register of interests on the website

Data quality

The Governing Body agrees that the data, information and intelligence brought to its attention and the attention of the Membership Board and its committees are fully acceptable and fit for purpose.

Information Governance (IG)

As a CCG, we have a strong IG culture and robust systems and processes in place. Whist the CCG was not required to submit a baseline audit submission or a submission on the DSPT Toolkit, Stoke-on-Trent CCG decided to do these submissions.

Personal data-related incidents

There have not been any personal data breaches during the period 1 April 2022 to 30 June 2022.

Freedom of Information (FOI) requests

The CCG has a robust process in place for answering FOI requests and has not had any breaches, with the majority of responses being provided well before the deadline. The same system and process will transfer into the ICB.

Subject Access Requests (SAR)

Again, the CCG has a robust process in place for Subject Access Requests. However, the CCGs do not receive patient medical records or hospital notes and are therefore unable to provide this information under Subject Access. Instead, these have to be obtained from the relevant hospital trust or GP practice.

The CCG is able to provide information relating to Continuing Healthcare (CHC) and Personal Health Budget (PHB) funding and/or Individual Funding Requests.

During the period 1 April 2022 to 30 June 2022, the CCG did not receive any such requests.

Business-critical models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, we confirm that an appropriate framework and environment are in place to provide quality assurance of business-critical analytics and modelling.

Third party assurances

The CCG commissions its back-office support from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). Monthly performance reviews are scheduled with MLCSU.

MLCSU's Internal Audit support is provided by Deloitte. The CCG is awaiting the outcome of the MLCSU's Service Auditor Reports, and will include any identified weaknesses in controls within the final submission.

Control issues

No material issues requiring reporting beyond the underlying financial position were identified via the Month 9 Governance Statement return to NHSE. However, we face an ongoing control issue relating to the COVID-19 pandemic.

The financial framework for 2022/23 is returning to a population-based funding method. The system operating plan is still under development with a publication date of 28 April 2022. This plan will describe the system response to all operational requirements. The accompanying financial plan is based on the latest system allocations and is currently showing that the system will have a financial deficit in 2022/23. This financial forecast is under discussion with NHSE/I and an agreed plan will be published as soon as agreements have been reached.

While it was determined that this issue did not prejudice the achievement of the other organisational priorities or undermine the integrity or reputation of the CCG and/or wider NHS, advice and opinions were sought by both internal and external audit and provided to the Audit Committee, including briefings on the financial position by the Chief Finance Officer throughout the year.

At the time of writing the external audit, opinion on the financial statements is expected to be unqualified; therefore, delivery of the standards expected of the Accountable Officer are not deemed to be at risk. Furthermore, the issue has not made it harder for us to resist fraud or other misuse of resources, and has not diverted resources from another significant aspect of the business.

Review of economy, efficiency and effectiveness of the use of resources

Financial planning and in-year performance monitoring (such as details about the CCG's recovery planning process) are covered within the Performance Report section.

Central management costs are provided in the Financial Performance Targets note in the Accounts section.

Our Governing Body in Common and the Finance and Performance Committee and Audit Committees meeting in Common have been kept fully abreast of the CCG's financial position, and have provided both support and challenge as would be expected.

The CCG's QIPP delivery and monitoring function has been paused and revised during this financial year due to COVID-19 national requirements. In addition, business processes have been restructured to enable the Finance and Performance Committee to scrutinise and lead the COVID-19 financial agenda within standard business processes.

Delegation of functions

The key financial systems (general ledger, accounts payable, accounts receivable and payroll) are operated by Shared Business Support under contract to MLCSU. These systems undergo a separate regime of Internal Audit assessment which is provided by Deloitte. Their Service Auditor Reports are published twice a year, presented to the Audit Committee and reviewed by our external auditors in terms of informing the overall audit opinion.

For details on internal delegations, please refer to our Constitution.

Counter fraud arrangements

The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake counter fraud work proportionate to identified risks. This service is provided by RSM. The CCG seeks to ensure that a comprehensive counter fraud and anti-bribery culture exists throughout the CCG.

The CCG has counter-fraud as part of the mandatory training and all staff are required to complete this module. The CCG also has Counter Fraud Champions in place. These roles provide a link to our Local Counter Fraud Specialists (LCFS), if individuals feel they cannot raise their concerns directly with LCFS they can raise them with the Champions who can then provide that link with the LCFS.

Head of Internal Audit Opinion

Review of the effectiveness of governance, risk management and internal control

For the three months ended 30 June 2022, as at 26 September 2022, our head of internal audit opinion for the six Staffordshire and Stoke-on-Trent CCGs is as follows:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

Peter Axon
Interim Chief Executive Officer
Staffordshire and Stoke-on-Trent Integrated Care Board

29 June 2023

Remuneration report

Remuneration Committee

The CCG has a Remuneration and Terms of Service Committee in Common, which is a sub-committee of the Governing Bodies in Common. The Chair of the Remuneration Committee is the Lay Member for Governance and its members are the Clinical Chairs of each CCG, lay members and secondary care consultants.

The purpose of the committee is to advise the Governing Bodies about appropriate remuneration and terms of service for the Accountable Officer, Director of Finance and other senior employees, on Very Senior Manager contracts, including:

- all aspects of salary
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms
- discipline and dismissal of officer members of the Governing Body.

The Director of Corporate Services, Governance and Communications and HR support the meeting with the Chair, the Accountable Officer and the Director of Finance being asked to attend as appropriate.

Remuneration Committee members

Name	Position	Date joining the committee*	Date leaving the committee*
Alison Bradley	Chair		30/06/2022
Lorna Clarson	Chair		30/06/2022
Paul Gallagher	Lay Member		30/06/2022
Rachel Gallyot	Chair		30/06/2022
Paddy Hannigan	Chair		30/06/2022
Ann Heckels	Lay Member		30/06/2022
John Howard	Lay Member		30/06/2022
Gary Free	Chair		30/06/2022
Doug Robertson	Secondary Care Consultant		30/06/2022
Jan Toplis	Lay Member		30/06/2022
Tim Bevington	Lay Member		30/06/2022

Details of the Remuneration Committee can be found in the Annual Governance Statement.

Pay multiples (subject to audit)

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.

For the majority of staff, costs are shared across the six Staffordshire and Stoke-on-Trent CCGs in proportion to their Running Cost Allocation. To report the salary band of the highest paid director/member for each individual entity based upon the share of basic salary costs paid by each CCG would result in an abnormally low figure. Therefore, to maximise transparency and to show a true and fair view of the pay multiple across the six Staffordshire and Stoke-on-Trent CCGs, the banded remuneration of the aggregate total salary cost of the highest paid director/member for the six Staffordshire and Stoke-on-Trent CCGs is shown and used as the basis for the pay multiple calculation.

The banded remuneration of the highest paid director / member in the organisation in the financial year 2022/23 was £150,000 - £155,000 (2021-22, £150,000 - £155,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23	**25th percentile**	**Median salary ratio**	**75th percentile**
Total remuneration (£)	33,706.00	48,526.00	68,598.86
Salary component of total remuneration (£)	33,706.00	48,526.00	68,598.86
Pay ratio information	4.52	3.14	2.22
2021/22	**25th percentile**	**Median salary ratio**	**75th percentile**
Total remuneration (£)	32,306.00	47,126.00	65,664.00
Salary component of total remuneration (£)	32,306.00	47,126.00	65,664.00
Pay ratio information	4.72	3.24	2.32

Note: Salary movement for all pay scales reflects incremental movement only. Also while this Annual Report covers the period 1 April 2022 to 30 June 2022, the figures above are annualised for comparator purposes.

There has been no increase in the salary of the highest paid director and a 3% increase to average of employees' salary when compared to 2021/22. Salary movement during the reporting period reflects incremental movement only.

In 2022/23, 0 (2021/22, 0) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £5,760 to £155,544 (2021/22 £3,707 to £155,544).

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

Senior Managers are paid under one of three national frameworks.

The Accountable Officer and the Director of Finance were paid under remuneration guidance for Chief Officers (where the Senior Manager also undertakes the Accountable Officer role) and Chief Finance Officers, published in 2012.

The following posts were paid on the Very Senior Manager pay scale:

- Director of Strategy, Planning and Performance
- Director of Commissioning and Operations
- Director of Nursing and Quality, and Chief Nurse
- Director of Corporate Services, Governance and Communications
- Director of Primary Care and Medicines Optimisation
- Managing Director – North Staffordshire
- Managing Director – East Staffordshire
- Managing Director – South Staffordshire.
- Agenda for Change – see next paragraph.

Agenda for Change

All other staff except medical and dental staff are paid through the Agenda for Change pay structure.

Lay member remuneration was based on the rate for PCT non-executive directors set by the former Appointments Commission in accordance with national policy.

No senior managers have been paid/will be paid through a performance-related pay mechanism in quarter one 2022/23.

Everything relating to the remuneration and terms and conditions of the Accountable Officer, Director of Finance and Very Senior Managers is subject to approval by the Remuneration Committee.

Remuneration of Very Senior Managers

In accordance with the Department of Health and Social Care Group Accounting Manual paragraph 3.90, we can confirm Marcus Warnes, Accountable Officer is paid more than £150,000 per annum.

A letter from Amanda Pritchard, Chief Operating Officer NHS England and Chief Executive NHS Improvement was received by the Remuneration Committee in July 2021 outlining a recommendation for a 3% pay rise for Very Senior Managers. This recommendation was adopted/approved by the CCGs Remuneration Committee meeting of 7 July 2021.

The outcome of adopting this recommended pay rise was to increase the overall remuneration of the Accountable Officer above £150,000 per annum.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

All CCGs: 1 April 2022 to 30 June 2022

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits To the nearest £1,000 £000	(f) TOTAL (a to e) (bands of £5,000) £000
Marcus Warnes - Accountable Officer	35-40	2,100	0-0	0-0	0-0	35-40
Paul Brown - Chief Finance Officer	30-35	2,000	0-0	0-0	7.5-10	35-40
Jane Moore - Director of Strategy, Planning and Performance	15-20	0	0-0	0-0	0-0	15-20
Heather Johnstone - Director of Quality and Safety	30-35	0	0-0	0-0	7.5-10	35-40
Lynn Millar - Director of Primary Care	25-30	1,100	0-0	0-0	82.5-85	110-115
Sally Young - Director of Corporate Services, Governance and Communications	25-30	0	0-0	0-0	10-12.5	40-45
Cheryl Hardisty - Director of Strategic	25-30	0	0-0	0-0	0-0	25-30

Commissioning and Operations						
Craig Porter - Locality Director South	25-30	0	0-0	0-0	5-7.5	30-35
Mark Seaton - Locality Director North	25-30	0	0-0	0-0	0-2.5	25-30
Nicola Harkness - Locality Director East	25-30	1,600	0-0	0-0	5-7.5	30-35
Lorna Clarson - CCG Chair	5-10	0	0-0	0-0	25-27.5	30-35
Lorna Clarson - Joint Clinical Director	5-10	0	0-0	0-0	0-0	5-10
Stephen Fawcett - Joint Medical Director	15-20	0	0-0	0-0	0-0	15-20
Waheed Abbasi - Clinical Director	10-15	0	0-0	0-0	2.5-5	15-20
Latif Hussain - Joint Non Exec GP Board Member	0-5	0	0-0	0-0	0-0	0-5
Douglas Robertson - Secondary Care Specialist	0-5	0	0-0	0-0	0-0	0-5
John Gilby - Clinical Director	10-15	0	0-0	0-0	0-0	10-15
John Howard - Lay Member for Governance	5-10	0	0-0	0-0	0-0	5-10

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Capitated: 1 April 2022 to 30 June 2022

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits To the nearest £1,000 £000	(f) TOTAL (a to e) (bands of £5,000) £000
Marcus Warnes - Accountable Officer	5-10	500	0-0	0-0	0-0	5-10
Paul Brown - Chief Finance Officer	5-10	500	0-0	0-0	0-2.5	10-15
Jane Moore - Director of Strategy, Planning and Performance	0-5	0	0-0	0-0	0-0	0-5
Heather Johnstone - Director of Quality and Safety	5-10	0	0-0	0-0	0-2.5	5-10
Lynn Millar - Director of Primary Care	5-10	300	0-0	0-0	20-22.5	25-30
Sally Young - Director of Corporate Services, Governance and Communications	5-10	0	0-0	0-0	0-0	5-10
Cheryl Hardisty - Director of Strategic Commissioning and Operations	5-10	0	0-0	0-0	0-0	5-10

Craig Porter - Locality Director South	5-10	0	0-0	0-0	0-2.5	5-10
Mark Seaton - Locality Director North	5-10	0	0-0	0-0	0-2.5	5-10
Nicola Harkness - Locality Director East	5-10	400	0-0	0-0	0-2.5	5-10
Lorna Clarson - CCG Chair	5-10	0	0-0	0-0	25-27.5	30-35
Lorna Clarson - Joint Clinical Director	0-5	0	0-0	0-0	0-0	0-5
Stephen Fawcett - Joint Medical Director	10-15	0	0-0	0-0	0-0	10-15
Waheed Abbasi - Clinical Director	5-10	0	0-0	0-0	0-2.5	5-10
Latif Hussain - Joint Non Exec GP Board Member	0-5	0	0-0	0-0	0-0	0-5
Douglas Robertson - Secondary Care Specialist	0-5	0	0-0	0-0	0-0	0-5
John Gilby - Clinical Director	5-10	0	0-0	0-0	0-0	5-10
John Howard - Lay Member for Governance	0-5	0	0-0	0-0	0-0	0-5

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Further information – annual salary

- Marcus Warnes - Accountable Officer | annual salary - £152k
- Paul Brown - Chief Finance Officer | annual salary - £145k

- Jane Moore - Director of Strategy, Planning and Performance | annual salary - £116k | Left the organisation 31/05/2022
- Heather Johnstone - Director of Quality and Safety | annual salary - £124k
- Lynn Millar - Director of Primary Care | annual salary - £116k
- Sally Young - Director of Corporate Services, Governance and Communications | annual salary - £116k
- Cheryl Hardisty - Director of Strategic Commissioning and Operations | annual salary - £116k
- Craig Porter - Locality Director South | annual salary - £107k
- Mark Seaton - Locality Director North | annual salary - £107k
- Nicola Harkness - Locality Director East | annual salary - £107k
- Lorna Clarson - CCG Chair | annual salary - £35k
- Lorna Clarson - Joint Clinical Director | annual salary - £25k
- Stephen Fawcett - Joint Medical Director | annual salary - £77k
- Waheed Abbasi - Clinical Director | annual salary - £49k
- Latif Hussain - Joint Non Exec GP Board Member | annual salary - £11k
- Douglas Robertson - Secondary Care Specialist | annual salary - £18k
- John Gilby - Clinical Director | annual salary - £49k
- John Howard - Lay Member for Governance | annual salary - £28k

Senior manager remuneration 2021/22 (including salary and pension entitlements)

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100) £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer *	35 - 40	1700	0 - 0	0 - 0	10 - 12.5	45 - 50
Paul Brown - Chief Finance Officer *	30 - 35	800	0 - 0	0 - 0	7.5 - 10	40 - 45
Jane Moore - Director of Strategy, Planning and Performance *	25 - 30	0	0 - 0	0 - 0	7.5 - 10	35 - 40
Heather Johnstone - Director of Nursing and Quality *	25 - 30	0	0 - 0	0 - 0	7.5 - 10	35 - 40
Lynn Millar - Director of Primary Care *	25 - 30	1000	0 - 0	0 - 0	5 - 7.5	35 - 40
Sally Young - Director of Corporate Services, Governance and Communications *	30 - 35	0	0 - 0	0 - 0	7.5 - 10	35 - 40
Cheryl Hardisty - Director of Strategic Commissioning and Operations *	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
Craig Porter - Locality Director South *	25 - 30	0	0 - 0	0 - 0	5 - 7.5	30 - 35
Mark Seaton - Locality Director North *	25 - 30	0	0 - 0	0 - 0	10 - 12.5	35 - 40
Nicola Harkness - Locality Director East *	25 - 30	1600	0 - 0	0 - 0	0 - 2.5	25 - 30
Lorna Clarson - CCG Chair **	35 - 40	0	0 - 0	0 - 0	65 - 67.5	100 - 105
Lorna Clarson - Joint Clinical Director ***	10 - 15	0	0 - 0	0 - 0	0 - 0	10 - 15
Stephen Fawcett - Joint Medical Director ***	40 - 45	0	0 - 0	0 - 0	0 - 0	40 - 45
Waheed Abbasi - Clinical Director ***	25 - 30	0	0 - 0	0 - 0	10 - 12.5	35 - 40
Latif Hussain - Joint Non Exec GP Board Member ***	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10
Douglas Robertson - Secondary Care Specialist *	0 - 5	0	0 - 0	0 - 0	0 - 0	0 - 5
John Gilby - Clinical Director ***	25 - 30	0	0 - 0	0 - 0	0 - 0	25 - 30
John Howard - Lay Member for Governance *	5 - 10	0	0 - 0	0 - 0	0 - 0	5 - 10

Note: Taxable expenses are expressed to the nearest £100.

The three locality directors have been included within the tables above as they have significant influence over the decisions of the entity, however they are not governing body members.

All expense payments in the tables above and below relate to benefits in kind in relation to lease cars.

NHS Stoke-on-Trent CCG shares a single leadership team with five other Staffordshire and Stoke-on-Trent CCGs. The remuneration of those senior officers is apportioned on a capitated basis unless stated otherwise.

The table above shows the costs apportioned to NHS Stoke-on-Trent CCG associated with the remuneration of the senior management team.

*Note: NHS Stoke-on-Trent CCG pays 24.45% capitated basis of the highlighted individuals' costs.

**Note: NHS Stoke-on-Trent CCG pays 100% capitated basis of the highlighted individuals' costs.

***Note: NHS Stoke-on-Trent CCG pays 56.28% capitated basis of the highlighted individuals' costs.

The table below shows the costs of the individuals 100% attributable to the six Staffordshire and Stoke-on-Trent Clinical Commissioning Groups for 2021/22.

Name and title	a) Salary (bands of £5,000) £000	b) Expense payments (taxable to nearest £100) £	c) Performance pay and bonuses (bands of £5,000) £000	d) Long-term performance pay and bonuses (bands of £5,000) £000	e) All pension-related benefits (bands of £2,500) £000	f) Total a-e (bands of £5,000) £000
Marcus Warnes - Accountable Officer	145 - 150	6900	0 - 0	0 - 0	40 - 42.5	195 - 200
Paul Brown - Chief Finance Officer	135 - 140	3400	0 - 0	0 - 0	30 - 32.5	170 - 175
Jane Moore - Director of Strategy, Planning and Performance	115 - 120	0	0 - 0	0 - 0	35 - 37.5	150 - 155
Heather Johnstone - Director of Nursing and Quality	115 - 120	0	0 - 0	0 - 0	32.5 - 35	150 - 155
Lynn Millar - Director of Primary Care	110 - 115	4300	0 - 0	0 - 0	25 - 27.5	145 - 150
Sally Young - Director of Corporate Services, Governance and Communications	120 – 125	0	0 – 0	0 – 0	30 – 32.5	150 – 155
Cheryl Hardisty – Director of Strategic Commissioning and Operations	115 – 120	0	0 – 0	0 – 0	0 – 0	115 – 120
Craig Porter – Locality Director South	105 – 110	0	0 – 0	0 – 0	27.5 – 30	135 – 140
Mark Seaton – Locality Director North	105 – 110	0	0 – 0	0 – 0	45 – 47.5	150 – 155
Nicola Harkness – Locality Director East	100 – 105	6500	0 – 0	0 – 0	7.5 – 10	115 – 120
Lorna Clarson – CCG Chair	35 – 40	0	0 – 0	0 – 0	65 – 67.5	100 – 105
Lorna Clarson – Joint Clinical Director	25 – 30	0	0 – 0	0 – 0	0 – 0	25 – 30
Stephen Fawcett – Joint Medical Director	75 – 80	0	0 – 0	0 – 0	0 – 0	75 – 80
Waheed Abbasi – Clinical Director	45 – 50	0	0 – 0	0 – 0	20 – 22.5	70 – 75
Latif Hussain – Joint Non Exec GP Board Member	10 – 15	0	0 – 0	0 – 0	0 – 0	10 – 15
Douglas Robertson – Secondary Care Specialist	5 – 10	0	0 – 0	0 – 0	0 – 0	5 – 10

John Gilby – Clinical Director	45 – 50	0	0 – 0	0 – 0	0 – 0	45 – 50
John Howard – Lay Member for Governance	20 – 25	0	0 – 0	0 – 0	0 – 0	20 – 25
Margaret Woodhead – Lay Member for PPI	15 – 20	0	0 – 0	0 – 0	0 – 0	15 – 20
Tim Bevington – Lay Member	20 – 25	0	0 – 0	0 – 0	0 – 0	20 – 25

Note: Taxable expenses are expressed to the nearest £100.

The three locality directors have been included within the tables above as they have significant influence over the decisions of the entity, however they are not governing body members.

All expense payments in the tables above and below relate to benefits in kind in relation to lease cars.

Pension benefits (subject to audit)

1 April 2022 to 30 June 2022

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 30/06/22 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 30/06/22 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 31/03/22 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 30/06/22 £000	(h) Employers Contribution to partnership pension £000
Marcus Warnes - Accountable Officer	0-0	0-0	50-55	110-115	1,121	0	841	0
Paul Brown - Chief Financial Officer	0-2.5	0-0	35-40	80-85	795	9	816	0
Jane Moore - Director of Strategy, Planning and Performance	0-0	0-0	65-70	0-0	1,115	2	1,129	0
Heather Johnstone - Director of Quality and Safety	0-2.5	0-2.5	40-45	75-80	769	11	791	0
Lynn Millar - Director of Primary Care	2.5-5	0-0	35-40	60-65	517	48	573	0
Sally Young - Director of Corporate Services, Governance and Communications	0-2.5	0-0	35-40	110-115	907	0	696	0

Craig Porter - Locality Director South	0-2.5	0-0	10-15	0-0	145	4	153	0
Mark Seaton - Locality Director North	0-2.5	0-0	25-30	75-80	667	0	513	0
Nicola Harkness - Locality Director East	0-2.5	0-0	35-40	70-75	665	7	680	0
Lorna Clarson - Joint Clinical Director / CCG Chair	0-2.5	0-2.5	25-30	45-50	378	19	402	0
Waheed Abbasi – Clinical Director	0-2.5	0-0	10-15	20-25	244	2	250	0

Pension benefits 1 April 2021 to 31 March 2022 (subject to audit)

The Cash Equivalent Transfer Values contained in the table below relate to the total value accrued by the individual across all six Staffordshire and Stoke-on-Trent CCGs. The total amount is shown due to not being able to reliably estimate the split of the CETVs by individual CCG.

Name and title	a) Real increase in pension at pension age (bands of £2,500) £'000	b) Real increase in pension lump sum at pension age (bands of £2,500) £'000	c) Total accrued pension at pension age at 31.03.22 (bands of £5,000) £'000	d) Lump sum at pension age related to accrued pension at 31.03.22 (bands of £5,000) £'000	e) Cash Equivalent Transfer Value at 31.03.21 £'000	f) Real increase in Cash Equivalent Transfer Value £'000	g) Cash Equivalent Transfer Value at 31.03.22 £'000	h) Employer's contribution to stakeholder pension £'000
Marcus Warnes - Accountable Officer	2.5 - 5	0 - 2.5	55 - 60	110 - 115	1,046.41	48.55	1,121.39	0
Paul Brown - Chief Financial Officer	2.5 - 5	0 - 2.5	35 - 40	80 - 85	733.01	39.05	795.48	0
Jane Moore - Director of Strategy, Planning and Performance	2.5 - 5	0 - 0	65 - 70	0 - 0	1,046.61	45.88	1,114.91	0
Heather Johnstone - Director of Nursing and Quality	2.5 - 5	0 - 2.5	40 - 45	75 - 80	714.37	33.73	768.86	0
Lynn Millar - Director of Primary Care	0 - 2.5	0 - 0	30 - 35	60 - 65	478.88	18.87	516.72	0
Sally Young - Director of Corporate Services, Governance and Communications	0 - 2.5	2.5 - 5	35 - 40	105 - 110	835.09	49.81	906.97	0

Craig Porter - Locality Director South	0 - 2.5	0 - 0	10 - 15	0 - 0	114.82	14.39	144.53	0
Mark Seaton - Locality Director North	2.5 - 5	2.5 - 5	25 - 30	75 - 80	597.39	51.53	666.66	0
Nicola Harkness - Locality Director East	0 - 2.5	0 - 0	35 - 40	70 - 75	637.40	10.26	664.72	0
Lorna Clarson - Joint Clinical Director/CCG Chair	2.5 - 5	2.5 - 5	25 - 30	45 - 50	322.26	44.65	378.00	0
Waheed Abbasi - Clinical Director	0 - 2.5	0 - 2.5	10 - 15	20 - 25	218.23	17.81	243.81	0

**Column E disclosed the growth of all pension-related benefits during the year. It reflects pension-related benefits and is sourced from the Greenbury information.

Please note the pension values for Lorna Clarson includes the pension for her CCG Chair role and Joint Clinical Director role due to not being able to reliably estimate the split of the pension by individual role.

John Howard, Margaret Woodhead and Tim Bevington are all lay members who are not eligible to opt into the pension scheme.

Cheryl Hardisty, Stephen Fawcett, Latif Hussain, Douglas Robertson, and John Gilby chose not to be covered by the pension arrangements during the reporting year.

NHS Pensions are using pension data from their systems without adjustment for potential future legal remedy required as a result of the McCloud judgement. This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.

Given the considerable uncertainty, this means that the benefits and related CETVs presented do not allow for a potential future adjustment arising from the McCloud judgment.

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 of for loss of office

No payments have been made in respect of compensation on early retirement. Payments paid or payable in respect of loss of office are summarised within the notes relating to Exit Packages.

Payments to past directors

No payments have been made in relation to Exit Packages.

Staff report

Number of senior managers

A senior manager is defined by NHS Business Services Authority as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS organisation.

For the purposes of this report, we believe those persons in Band 8a and above are senior managers.

Senior staff analysis by Band (based on staffing at 30 June 2022)

Pay Band	Headcount
Apprentice	1
Band 1	0
Band 2	4
Band 3	2
Band 4	27
Band 5	24
Band 6	36
Band 7	31
Band 8 - Range A	59
Band 8 - Range B	31
Band 8 - Range C	21
Band 8 - Range D	8
Band 9	7
Medical	31
Very Senior Manager (VSM)	26
Governing Body (off payroll)	0
Grand total	**308**

Staff numbers and costs (subject to audit)

The table below shows the average number of people employed on 30 June 2022 in NHS Stoke-on-Trent CCG:

Staff numbers

Average number of people employed 30/06/22	Permanently employed	Other	Total
Administration and Estates	47.57	0.52	48.09

Medical and Dental	2.09	0	2.09
Nursing, Midwifery and Health Visiting Staff	4.51	0	4.51
Other	1.00	1.14	2.14
Scientific, Therapeutic and Technical Staff	5.18	0	5.18
Total	**60.35**	**1.66**	**62.01**

The table below shows the associated staff costs for NHS Stoke-on-Trent CCG:

Staff costs

Staff costs 30/06/2022	Permanently employed £000	Other £000	Total £000
Salaries and Wages	£849	£15	£864
Social Security Costs	£94	£0	£94
Employer Contributions to NHS pension scheme	£100	£0	£100
Total	**£1,043**	**£15**	**£1,058**

Staff composition

Headcount by gender (based on staffing at 30 June 2022)

Staff grouping	Female	Male	Totals
Governing body	16	22	**38**
Other senior management (Band 8C+)	36	19	**55**
All other employees	179	36	**215**
Grand total	**231**	**77**	**308**

Percentage by gender (based on staffing at 30 June 2022)

Staff grouping	Female	Male
Governing body	42.1%	57.9%
Other senior management (Band 8C+)	65.5%	34.5%
All other employees	83.3%	16.7%
Grand total	**75.0%**	**25.0%**

Sickness absence data

Staff sickness absence 2022	2022 number
Total days lost	1,133.26
Total staff years	254.30
Average working days lost	4.46

The sickness absence data for the six Staffordshire and Stoke-on-Trent CCGs in 2022 was whole time equivalent (WTE) days available of 57,218.57 and WTE days lost to sickness absence of 1,133.26. Average working days lost per employee was 4.46, which was managed through the Absence Management policy.

Staff turnover percentages

CCG staff turnover 2022/23	2022/23 number
Average FTE employed	251.76
Total FTE leavers	11.51
Turnover rate	4.57%

The CCG staff turnover rate for 2022/23 has been calculated by dividing the total full-time equivalent (FTE) leavers in-year by the average FTE staff in post during the year. The six Staffordshire and Stoke-on-Trent CCGs' total FTE leavers in year was 11.51. The CCGs' average FTE staff in post during the year was 251.76. The CCGs' staff turnover rate for the year was 4.57%.

Staff policies

The CCG has continued to work with the Staff Engagement Group (SEG), Staff Network/support Groups, Staff Side Representatives and the Communications, Engagement, Equalities and Employment (CEEE) committee to align all HR policies across the six CCGs in Staffordshire and Stoke-on-Trent. As part of the due diligence process for the transition of staff to the ICB on 1 July 2022, a review of all policies is ongoing to ensure they are fully aligned at the point of TUPE transfer (Transfer of Undertakings – Protection of Employment). However, the policies in common across all six CCGs are used by managers and staff for consistency. All reviewed policies have an accompanying Equality Impact Assessment (EIA).

Our rolling programme of training for current staff and new starters on mandatory equality and diversity includes awareness of a range of issues impacting on people with disabilities. The CCGs introduced independent mandatory training for all staff on invisible disabilities and unconscious bias. We also ensure that any employee who needs training (either because they work with people with disabilities, or because they have acquired an impairment or medical condition) receives the necessary support through workplace risk assessments and health and wellbeing conversations.

Through unconscious bias training, all interview panel members must have attended the training, and each panel has a band-related equality question to ask all candidates.

Staff can easily access HR policies and documents by using the staff intranet, 'Information and News', known by staff as IAN.

Trade Union Facility Time Reporting Requirements

We have one local representative across the six CCGs in Staffordshire and Stoke-on-Trent. However, as we continue to work across the Staffordshire and Stoke-on-Trent system, we have utilised a system of local representative as well as continuing to engage and consult with regional representatives from various trade unions. The percentage of facility time internally is not monitored.

Health and safety

Midlands and Lancashire Commissioning Support Unit (MLCSU) provides advice and support on all health and safety-related matters. However, from October 2021, the majority of CCG staff had a change of base to home and relevant display screen equipment (DSE) assessments are reviewed annually. Those staff who are still office-based continue to be supported by the Buildings Management team, where they are based. The staff that continued to work in the office had additional safety precautions in place along with the appropriate personal protective equipment (PPE) and distancing guidance.

All staff are asked annually to undertake a DSE assessment for their home office set up, and this was sent to the HR team for inclusion in their personnel records..

MLCSU's Health and Safety team have also kept the CCGs updated on any changes in government guidance and health and safety legislation during this time – and continue to do so.

There were no health and safety-related incidents reported to the MLCSU Health and Safety Officer and no RIDDOR incidents.

Other employee matters

Agile working

Agile working is about what you do, and not where you do it. We have developed our agile working principles and framework to provide an opportunity to modernise our working practices – moving away from assumptions of traditional office working about where, when and how work should be done, to a culture of working wherever, whenever and however is most appropriate to get the work done.

It is not just about working hours, locations and workstyles – it is about being responsive and adaptive to service needs and advancements in technology. Agile working aims to provide greater flexibility, particularly in relation to the time and location our staff can work, subject to the requirements of the service and individual job.

The 'Back to the Future Programme' brought together and co-ordinated a broad range of changes around digital transformation, estates, corporate governance, human resources, wellbeing and organisational development. April 2022 saw the opening of the three designated 'hubs' for staff to use, utilising two existing office

hubs and one new hub in Stafford. These are supported by the Agile Framework which continues to be monitored and developed to create a new work culture and approach to agile and hybrid working.

Staff development days

Development days have occurred virtually throughout the first quarter, embracing new technology and new ways of getting staff together to hear key messages and provide feedback from previous events. Some of the events were recorded through Microsoft Teams, so staff who may have missed the event could watch back. Several equality, diversity and inclusion related topics and themes have been presented and discussed during these sessions – some of which have influenced the wider equality agenda across the six CCGs.

- 27 April 2022
- 25 May 2022
- 28 June 2022.

Staff training

The commitment to organisational development by the Governing Bodies remains strong and work will progress for 2022/23, with the release of the Training and Development catalogue. A broad range of training has been delivered, from nationally-recognised accreditation such as Prince 2 and Managing Successful Programmes, to ILM5 coaching and mentoring.

Health and wellbeing support to staff

The CCGs' HR lead has continued to ensure health and wellbeing is a priority for the culture of our workforce, ensuring that all staff are signposted to local and national services and support, apps and the system Psychological and Wellbeing Hub. The introduction of the Coaching Culture app with various support modules has also been launched.

Our job adverts state that all staff will receive a health and wellbeing conversation with their line manager, and staff are signposted to support via two Wellbeing Guardians.

A significant number of staff are also trained Mental Health First Aiders, and we have recently appointed volunteer staff, Change Ambassadors, Menopause Ambassadors and Domestic Abuse Ambassadors.

Whistleblowing

For our corporate whistleblowing obligations, we have a dedicated policy in place. We have appointed Freedom to Speak Up Guardians, and all our staff are assured that they can speak up freely to raise any concerns they may have.

Governing Body Organisational Development session

Governing Body meetings are held in common for all six CCGs, with six Governing Body meetings in common held in public and a confidential meeting.

No OD sessions were held in quarter one.

Staff Engagement Group

The six CCGs have successfully maintained a formal Staff Engagement Group (SEG) while working virtually, which includes core members and various volunteers from all directorates and reports directly to the Communications, Engagement, Equality and Employment Committees in Common (CEEE). During quarter one 2022/23, the group have continued to support staff events, supported charity and health awareness days, initiated investment in Mental Health First Aiders refresher training and provide monthly feedback on key issues.

The group have supported the business cycle review of a significant number of aligned HR policies and standing items have been introduced on the Equality, Diversity and Inclusion (EDI) and People Plan.

Staff Survey

The Staff Survey ran between October and November 2021. Overall there was a response rate of 85%. The average response rate for similar organisations is 79%.

A Staff Survey Task and Finish Group has been established to review the feedback from the NHS Staff Survey to form an action plan to recognise the achievements, investigate areas of concern and seek new opportunities of support for staff.

We will ensure that the action plan tracks progress towards the seven elements of the People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

All members will be sent a copy of the free text submitted anonymously, which will be aligned to the People Promise, Bench Mark report of the CCGs to comparable organisations and responses broken down by directorates where the numbers in the teams are greater than 11.

The action plan will be shared with the ICB Chief People Officer to deliver during 2022/23 from 1 July 2022.

Staff diversity and inclusion (best practice disclosures)

These best practice disclosures are as follows.

Changes to staff composition of under-represented groups at the entity over time, both for the workforce as a whole and for management and/or senior management positions, are provided in separate, nationally-published 2021 Workforce Race Equality Standard (WRES) reports and Combined CCG Staff Workforce Diversity Profile Review. In July 2021, the CCGs published a Gender Pay Gap Report.

The Equality and Inclusion Action Plan features a comparison of staff composition of under-represented groups against any diversity and inclusion targets that the

CCG has. Alongside this are explanations of what the CCG has done to meet those to improve the diversity and inclusiveness of its workforce, including outputs and publications in respect of responsibilities under other legislation to report on the diversity and inclusiveness of the workforce and to promote equality of opportunity.

Further data is published in our WRES reports, Combined CCG Staff Workforce Diversity Profile Review 2021 and 2021 Public Sector Equality Duty (PSED) Annual Report (available on the CCG website). The CCGs' 2021/22 PSED Annual Report will be published in June 2022.

The CCGs are working with NHS provider partners around a system-wide staff ethnic minority, disability and neurodiversity, and LGBTQ+ groups; and in developing the Midlands EDI Strategy and Six High Impact Actions on race inclusion.

The six CCGs have mandated unconscious bias and invisible disability training for all its staff and an 'Introduction to EDI' session is incorporated within the new staff induction programme.

Expenditure on consultancy (subject to audit)

For the three-month period ending 30 June 2022: £5k (2021/22: £58k). Expenditure classified as consultancy relates to the provision to management of objective advice and assistance relating to strategy, structure, management, or operations of an organisation in pursuit of its purposes and objectives.

Off-payroll engagements

The Staffordshire and Stoke-on-Trent CCGs operate under a single management structure, meaning that most employees are contracted to work across more than one CCG and their costs have been attributed accordingly. In relation to the off-payroll workers, the figures represent the number of engagements rather than the Full-Time Equivalent (FTE) of each contractor. For example, if an individual is contracted by all six CCGs irrespective of the hours worked, they will be represented within each CCG's tables as a whole single engagement.

A £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The CCG did not have any highly paid off-payroll engagements during the period 1 April to 30 June 2022.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 30 June 2022, for more than £245 per day:

Highly paid off-payroll engagements	Number
Number of existing engagements as of 30 June 2022	0
Of which, the 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

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April and 30 June 2022, for more than £245 per day:

Temporary off-payroll engagements	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	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: number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April and 30 June 2022:

Off-payroll engagements / senior official engagements	Number
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 includes both on payroll and off-payroll engagements	17

Exit packages, including special (non-contractual) payments

Table 1: Exit packages

Exit package cost band (Inc. any special payment element	Number of compulsory redundancies (whole numbers only)	Cost of compulsory redundancies (£s)	Total number of exit packages (whole numbers only)	Total cost of exit packages (£s)
Less than £10,000	0	0	0	0
£10,000 - £25,000	0	0	0	0
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	0	0	0	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,000	0	0	0	0
Totals	**0**	**0**	**0**	**0**

HM Treasury requires the disclosure of exit package information in the Annual Report and Accounts. In the first quarter of 2022/23, the CCG did not incur any

expenditure arising from exit packages (compulsory or voluntary redundancies or other agreed staff departures).

When incurred, redundancy and other departure costs are paid in accordance with the provisions of the NHS Agenda for Change agreement. Where the CCG agrees early retirements, the additional costs are met by the ICB and not by the NHS Pension Scheme. When incurred, ill-health retirement costs are met by the NHS Pension Scheme.

Table 2: Analysis of other departures

Analysis of other departures	Agreements (number)	Total value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	**0**	**0**

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 Table 1 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 nil relating to non-contractual payments in lieu of notice.*

No non-contractual payments were 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

Stoke-on-Trent CCG 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 report between pages 5 – 24 of the Annual Accounts. An audit certificate and report is also included in this Annual Report between pages 1 – 6 of the Independent Auditor's Report.

Peter Axon
Interim Chief Executive Officer
Staffordshire and Stoke-on-Trent Integrated Care Board

29 June 2023

Independent auditor's report to the members of the Governing Body of NHS Staffordshire and Stoke-on-Trent ICB in respect of NHS Stoke-on-Trent CCG

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Stoke-on-Trent (the 'CCG') for the period ended 30 June 2022, 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 the Accounts Directions issued under Schedule 15 of 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 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 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

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 CCG 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.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Stoke-on-Trent CCG transferred to NHS Staffordshire and Stoke-on-Trent ICB on 1 July 2022. When NHS Cannock CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Staffordshire and Stoke-on-Trent ICB.

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 CCG'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.

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 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks

associated with the continuation of services provided by the CCG. 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 CCG and the CCG'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 CCG'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.

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 2022-23; 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.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, 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.

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 CCG, or an officer of the CCG, 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 CCG 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.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 73 to 74, 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 CCG'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 CCG 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 CCG 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 2022-23).
- We enquired of management and the audit committee, concerning the CCG'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.
- We assessed the susceptibility of the CCG'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 management override of controls. We determined that the principal risks were in relation to:
  - Material manual year end journals and unusual manual journals
  - Reasonableness of year end accruals
- 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 material year end journals and unusual manual journals
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of year end accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item
- 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 year end accruals.
- 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 CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG 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 CCG'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 CCG's control environment, including the policies and procedures implemented by the CCG 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 CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG'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 CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer was responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG'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 CCG 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 CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022..

We have undertaken 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 CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had 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 have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Stoke-on-Trent CCG 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 Governing Body of Staffordshire and Stoke-on-Trent ICB, as a body, in respect of the CCG, 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 Governing Body of NHS Staffordshire and Stoke-on-Trent ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law,

we do not accept or assume responsibility to anyone other than NHS Staffordshire and Stoke-on-Trent ICB and the CCG and the members of the Governing Bodies of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

29 June 2023

NHS Stoke-on-Trent CCG - Accounts for period ending 30 June 2022

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Notes to the Accounts

Statement of Comprehensive Net Expenditure for the period ended 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Income from sale of goods and services	2	(571)	(1,089)
Total operating income		**(571)**	**(1,089)**
Staff costs	4	1,058	4,057
Purchase of goods and services	5	130,383	547,597
Depreciation and impairment charges	5	-	50
Provision expense	5	-	677
Other Operating Expenditure	5	30	1,033
Total operating expenditure		**131,471**	**553,414**
Net Operating Expenditure		**130,900**	**552,325**
Comprehensive Expenditure for the period		**130,900**	**552,325**

The financial statements and accompanying notes are prepared covering period 1st April 2022 to 30th June 2022.

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Current assets:			
Trade and other receivables	8	1,697	3,897
Cash and cash equivalents	9	4,592	73
Total current assets		**6,289**	3,970
Total assets		**6,289**	3,970
Current liabilities			
Trade and other payables	10	(37,529)	(44,200)
Provisions	11	(584)	(677)
Total current liabilities		**(38,113)**	(44,876)
Assets less Liabilities		**(31,824)**	(40,907)
Financed by Taxpayers' Equity			
General fund		(31,824)	(40,907)
Total taxpayers' equity:		**(31,824)**	(40,907)

The notes on pages 5 to 29 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 29th June 2023 and signed on its behalf

Peter Axon
Chief Accountable Officer

29 June 2023

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for the period		
Balance at 01 April 2022	(40,907)	**(40,907)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for period		
Net operating expenditure for the financial period	(130,900)	**(130,900)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial period.	**(130,900)**	**(130,900)**
Net funding	139,982	**139,982**
Balance at 30 June 2022	**(31,824)**	**(31,824)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(37,580)	**(37,580)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(552,325)	(552,325)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(552,325)**	**(552,325)**
Net funding	548,998	548,998
Balance at 31 March 2022	**(40,907)**	**(40,907)**

The notes on pages 5 to 29 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	**2022-23 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(130,900)	(552,325)
Depreciation and amortisation	5	0	50
(Increase)/decrease in trade & other receivables	8	2,201	912
Increase/(decrease) in trade & other payables	10	(6,671)	1,324
Provisions utilised	11	(93)	0
Increase/(decrease) in provisions	11	0	677
Net Cash Inflow (Outflow) from Operating Activities		**(135,463)**	(549,362)
Net Cash Inflow (Outflow) before Financing		**(135,463)**	(549,362)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		139,982	548,998
Net Cash Inflow (Outflow) from Financing Activities		**139,982**	548,998
Net Increase (Decrease) in Cash & Cash Equivalents	9	**4,519**	(364)
Cash & Cash Equivalents at the Beginning of the Financial period		**73**	436
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial period		**4,592**	73

The notes on pages 5 to 29 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups 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 2021-22 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 clinical commissioning groups, 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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].***

The Health and Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and abolished clinical commissioning groups (CCG). ICBs have now taken on the commissioning functions of CCGs and as such the CCGs functions, assets and liabilities have transfer to an ICB.

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.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

The CCG has referred to the Department of Health Manual of Accounts 2022-23 (pages 101-102), which outlines the following in respect of the going concern assumption:

IAS 1 presentation of financial statements: preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

The following is clear evidence that the CCG meets the requirement highlighted above and as set out in section 4.18 - 4.28 of the Department of Health Manual of Accounts:

- NHS Stoke-on-Trent CCG (the CCG) was established on 1 April 2013 as a separate statutory body;
- the CCG has an agreed Constitution which it is operating to for the governance of its activities;
- the CCG and, pending legislation, its successor organisation the Staffordshire and Stoke-on-Trent ICB have been allocated funds from NHS England for 2022/23; and submitted a financial plan to NHS England for 2022/23.
- the CCG is allocated a cash drawdown which is based on the cash requirements of the CCG

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 absorption accounting. 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, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

Notes to the financial statements

1.4 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the NHS Act 2006, the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Following the Care Act 2014 that amended the NHS Act 2006 to provide the legislative basis for the delivery of the Better Care Fund (BCF), the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups entered, from 2019/20, into a Section 75 and Section 256 Pooled Budget agreement with Stoke City Council (SCC).

The BCF is a key catalyst for Health and Social Care working with other partners, to establish a complementary approach to whole systems working that builds upon approaches and infrastructures that are already part of the Staffordshire and Stoke-on-Trent landscape. BCF affords the opportunity to develop shared positions, to adopt agreed objectives and to drive changes that are systems wide.

The accounting treatment for the pooled budget agreement varies from scheme to scheme. For some schemes SCC acts as the principal and, in these cases, the CCG reports transactions and balances with SCC and SCC accounts for expenditure and balances with the end providers. For some schemes the CCG has not transferred any resources to SCC as these relate to current CCG contractual commitments. Until the current CCG contractual commitments are decommissioned and then re-commissioned jointly through the BCF these transactions are excluded from pooled budget arrangements and, as before, accounted for in the CCGs accounts. The CCG has transferred some of its resources to SCC for it to be used to protect social care services and to implement the Care Act. These transfers are recorded as expenditure in the CCG accounts. There are also some schemes for which SCC controls and expends all resources. None of the expenditure on such schemes is recorded in the CCG accounts. Finally there are some schemes for which resources are transferred to other CCGs and the CCG reports transactions and balances with those CCGs and the other CCGs account for expenditure and balances with the end providers. To ensure comprehensive disclosure in respect of BCF, ‘Note 14' discloses the accounting treatment of all the schemes included in the Section 75 agreement between Staffordshire and Stoke-on-Trent CCGs and SCC.

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 clinical commissioning group.

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 clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

- The clinical commissioning group 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 clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group 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 clinical commissioning group 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.

Notes to the financial statements

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.

1.7.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website.

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 clinical commissioning group 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 **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 **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 clinical commissioning group;
- 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.

Notes to the financial statements

1.10.2 **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.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **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 clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

Notes to the financial statements

1.12 **The Clinical Commissioning Group 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 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year 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.

1.13 **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 clinical commissioning group’s cash management.

Notes to the financial statements

1.14 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group 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 0.47% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.70% (2021-22: 0.70%) 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 0.95% (2021-22 0.95%) 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 0.66% (2021-22: 0.66%) 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 clinical commissioning group 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.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group 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 clinical commissioning group.

1.16 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group 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.

1.17 **Financial Assets**

Financial assets are recognised when the clinical commissioning group 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.

1.17.1 **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.

Notes to the financial statements

1.18 **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, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group 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.

1.19 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group 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.

1.20 **Value Added Tax**

Most of the activities of the clinical commissioning group 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.

1.21 **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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.22.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Management has made no critical accounting judgements in the process of applying the clinical commissioning group's accounting policies.

1.22.2 **Sources of estimation uncertainty**

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the clinical commissioning groups financial statements. Estimations have been made in respect of a number of accruals; these accruals have been calculated based on the best available information when preparing the financial statements, and on historic experience, principally in respect of certain elements of GP prescribing and the Continuing Healthcare service.

1.23 **Adoption of new standards**

On 1 April 2022, clinical commissioning groups adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases. Following review of the CCG's operating leases, it was determined that no operating lease qualified for this adoption.

1.24 **New and revised IFRS Standards in issue but not yet effective**

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2. Other Operating Revenue

	2022-23 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	20
Non-patient care services to other bodies	**456**	82
Other Contract income	**115**	988
Total Income from sale of goods and services	**571**	**1,089**
Total Operating Income	**571**	**1,089**

3.1 Disaggregation of Revenue - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue		
NHS	11	-
Non NHS	445	116
Total	**456**	**116**

	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue		
Point in time	456	116
Over time	-	-
Total	**456**	**116**

4. Employee benefits and staff numbers

4.1 Employee benefits

	Total		2022-23
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	849	15	**864**
Social security costs	94	-	**94**
Employer Contributions to NHS Pension scheme	100	-	**100**
Gross employee benefits expenditure	1,043	15	**1,058**

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	2,942	196	**3,137**
Social security costs	339	-	**339**
Employer Contributions to NHS Pension scheme	568	-	**568**
Apprenticeship Levy	13	-	**13**
Gross employee benefits expenditure	3,862	196	**4,057**

4.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**60.35 #**	**1.66 #**	**62.01** #	59.38 #	2.45	61.83

4.3 Pension 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.

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:

4.3.1 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.3.2 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 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS pensions website.

5. Operating expenses

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	734	3,421
Services from foundation trusts	19,814	76,912
Services from other NHS trusts	60,223	245,395
Purchase of healthcare from non-NHS bodies	17,094	77,060
Purchase of social care	2,045	23,537
Prescribing costs	13,556	55,597
General Ophthalmic services	852	2,697
GPMS/APMS and PCTMS	13,765	52,965
Supplies and services – clinical	53	213
Supplies and services – general	576	1,893
Consultancy services	8	129
Establishment	171	1,417
Transport	644	2,283
Premises	764	3,629
Audit fees *	35	57
Other non statutory audit expenditure		
· Internal audit services	-	39
· Other services	3	14
Other professional fees	3	110
Legal fees	41	183
Education, training and conferences	2	48
Total Purchase of goods and services	**130,383**	**547,597**
Depreciation and impairment charges		
Depreciation	-	50
Total Depreciation and impairment charges	**-**	**50**
Provision expense		
Provisions	-	677
Total Provision expense	**-**	**677**
Other Operating Expenditure		
Chair and Non Executive Members	30	113
Expected credit loss on receivables	-	920
Total Other Operating Expenditure	**30**	**1,033**
Total operating expenditure	**130,413**	**549,356**

* Audit fees for the period total £47k inc of VAT. £35k has been accounted for during the reporting period with the remainder accounted for within the Staffordshire and Stoke-on-Trent ICB accounts.

The auditor's liability for external audit work carried out throughout the year is limited to £2m

6.1 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the period	3,531	43,471	13,438	159,244
Total Non-NHS Trade Invoices paid within target	3,449	44,027	13,240	141,626
Percentage of Non-NHS Trade invoices paid within target	**97.68%**	**101.28%**	**98.53%**	**88.94%**
NHS Payables				
Total NHS Trade Invoices Paid in the period	91	81,698	471	335,784
Total NHS Trade Invoices Paid within target	90	81,123	447	334,992
Percentage of NHS Trade Invoices paid within target	**98.90%**	**99.30%**	**94.90%**	**99.76%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target for the CCG to be compliant is to pay 95% of invoices, in terms of value and volume.

7. Property, plant and equipment

2022-23	Information technology £'000	Total £'000
Cost or valuation at 01 April 2022	248	248
Disposals other than by sale	(248)	(248)
Cost/Valuation at 30 June 2022	**-**	**-**
Depreciation 01 April 2022	248	248
Disposals other than by sale	(248)	(248)
Depreciation at 30 June 2022	**-**	**-**
Net Book Value at 30 June 2022	**-**	**-**

7.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	0

8.1 Trade and other receivables

	Current 2022-23 £'000	Current 2021-22 £'000
NHS receivables: Revenue	524	128
NHS prepayments	4	10
NHS accrued income	30	2,125
Non-NHS and Other WGA receivables: Revenue	1,243	1,368
Non-NHS and Other WGA prepayments	341	635
Non-NHS and Other WGA accrued income	601	669
Expected credit loss allowance-receivables	(1,088)	(1,088)
VAT	42	49
Total Trade & other receivables	**1,697**	**3,897**
Total current and non current	**1,697**	**3,897**

8.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	-	-	128	134
By three to six months	-	125	-	-
By more than six months	-	30	144	-
Total	**-**	**155**	**272**	**134**

8.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2022	(1,088)
Total	**(1,088)**

9. Cash and cash equivalents

	2022-23 £'000	2021-22 £'000
Balance at 01 April 2022	73	436
Net change in period	4,519	(363)
Balance at 30 June 2022	**4,592**	**73**
Made up of:		
Cash with the Government Banking Service	4,592	73
Balance at 30 June 2022	**4,592**	**73**

10. Trade and other payables	**Current 2022-23 £'000**	Current 2021-22 £'000
NHS payables: Revenue	12	1,355
NHS accruals	3,984	4,371
Non-NHS and Other WGA payables: Revenue	4,270	7,979
Non-NHS and Other WGA accruals	25,328	23,932
Other payables and accruals	3,935	6,562
Total Trade & Other Payables	**37,529**	**44,200**
Total current and non-current	**37,529**	**44,200**

Other payables include £252k outstanding pension contributions at 30 June 2022 (£365k as 31 March 2022).

11. Provisions

	Current 2022-23 £'000	Current 2021-22 £'000
Redundancy	89	89
Legal claims	42	42
Continuing care	189	189
Other	264	357
Total	**584**	**677**
Total current and non-current	**1,261**	**677**

	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2022	**89**	**42**	**189**	**357**	**677**
Utilised during the year	-	-	-	(93)	**(93)**
Balance at 30 June 2022	**89**	**42**	**189**	**264**	**585**
Expected timing of cash flows:					
Within one year	89	42	189	264	**584**
Balance at 30 June 2022	**89**	**42**	**189**	**264**	**584**

Other provisions relate to GP Premises Rent Reviews covering any premises that have not been reviewed to ascertain their current market rental value within the last three years.

12. Financial instruments

12.1 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 NHS clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

12.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk

The clinical commissioning group 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 clinical commissioning group therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group 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.

12.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

12.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating 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.

12. Financial instruments cont'd

12.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Financial Assets measured at amortised cost 2021-22 £'000
Trade and other receivables with NHSE bodies	534	208
Trade and other receivables with other DHSC group bodies	621	2,714
Trade and other receivables with external bodies	1,243	1,369
Cash and cash equivalents	4,592	73
Total at 30 June 2022	**6,990**	**4,364**

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000
Trade and other payables with NHSE bodies	575	2,140
Trade and other payables with other DHSC group bodies	3,974	3,679
Trade and other payables with external bodies	32,980	38,380
Total at 30 June 2022	**37,529**	**44,199**

13. Operating segments

IFRS 8 defines an operating segment as follows. An operating segment is a component of an entity:

- That engages in business activities from which it may earn revenues and incur expenses (including revenues and expenses relating to transactions with other components of the same entity)
- Whose operating results are reviewed regularly by the entity's chief operating decision maker to make decisions about resources to be allocated to the segment and assess its performance and
- For which discrete financial information is available.

The term 'Chief Operating Decision Maker', per IFRS8, identifies a function, not necessarily a manager with a specific title. That function is to allocate resources to and assess the performance of the operating segments of an entity. The CCG's chief operating decision maker is its group of executive and non-executive officers (the Governing Body). The CCG considers it has only one operating segment: commissioning of healthcare services. Finance and performance information is reported to the Governing Body as one segment and these financial statements have been prepared in accordance with this reporting.

14. Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	**2022-23 Expenditure £'000**	2021-22 Expenditure £'000
Better care fund	Stoke on Trent City Council	Protection of Adult Social Care	2,822	23,494
Better care fund	Staffordshire County Council	Protection of Adult Social Care	45	389

During 2021-22 additional non recurrent funding was invested into the BCF for Winter Funding and additional Discharge Support with particular regard to maintaining capacity post the end of the Hospital Discharge Programme Funding.

15. Related party transactions

Details of related party transactions with individuals are as follows:

	2022-23				2021-22			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Moorcroft Medical Centre	744	0	109	0	2,058	0	407	0
Brook Medical Centre	652	0	85	0	2,185	0	140	0
The Village Surgery	0	0	0	0	0	0	0	0

Dr Steve Fawcett, CCG Clinical Director and Joint Medical Director, is a GP Partner at Moorcroft Medical Centre.

Dr, John Gilby CCG Clinical Director, is a GP Partner at Brook Medical Centre.

Dr, Waheed Abbassi, CCG Clinical Director, is a GP Partner and Principal at the Village Surgery.

NHS Stoke-on-Trent CCG operates a Joint Management structure with five other Staffordshire CCGs included in the list below (*) from 1st April 2018.

The Board posts as detailed in the Remuneration report are shared equally between each CCG.

The Department of Health and Social Care is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority;
- NHS Business Services Authority.
- NHS Clinical Commissioning Groups.

Of those entities listed above, our main areas of expenditure has been with:

*NHS South East Staffordshire & Seisdon Peninsula CCG
*NHS Stafford & Surrounds CCG
*NHS Cannock Chase CCG
*NHS North Staffordshire CCG
*NHS East Staffordshire CCG
University Hospital of North Midlands NHS Trust
Midlands Partnership Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
West Midlands Ambulance Service NHS Foundation Trust
NHS Midlands and Lancashire CSU
NHS Property Services

16. Events after the end of the reporting period

Under the Health and Care Act 2022, Clinical Commissioning Groups (CCGs) are to be abolished and be replaced by Integrated Care Boards (ICBs). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to the newly established NHS Staffordshire and Stoke On Trent ICB.

17. Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2022-23 Target	**2022-23 Performance**	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	131,471	131,471	553,558	553,414
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	130,900	130,900	552,469	552,325
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	1,332	1,332	5,445	5,411

18. Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2022-23 Number	**Total Value of Cases 2022-23 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs	-	-	2	71
Total	**-**	**-**	**2**	**71**