Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Thursday 20 June 2024

1.00pm-3.00pm

Via MS Teams

[A = Approval / R = Ratification / S = Assurance / D = Discussion / I = Information]

	Agenda Item	Lead(s)	Enc.	A/R/S/D/I	Time	Pages
1.	Welcome and Apologies • Leadership Compact	Chair	Enc. 01	S	1.00pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 16 May 2024 and Matters Arising	Chair	Enc. 03	A		5-17
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		18
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	1.05pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	I	1.10pm	19-28
8.	2024/25 Recovery Plan	PB	Enc. 06	S	1.25pm	29-42
9.	System OD Plan	MI/PG	Enc. 07		1.40pm	43-57
	System Governance and Performance					
10.	Fit and Proper Person Test Update	PW	Enc. 08	S	1.55pm	58-66
11.	Quality and Safety Report • Quality Committee Assurance Report	HJ JS	Enc. 09 Enc. 10	S	2.05pm	67-70 71-73
12.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB/PS MN	Enc. 11 Enc. 12	S	2.20pm	74-83 84-89
13.	Conflicts of Interest Policy	PW	Enc. 13	R	2.45pm	90-127
	Any other Business					
14.	**Items notified in advance to the Chair**	All		D		
15.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.50pm	
16.	**Meeting Effectiveness**	Chair				
17.	**Close**	Chair			3.00pm	
18.	**Date and Time of Next Meeting** 18 July 2024 at 12.30pm held in Public – Royal Stoke University Hospital, Trust Boardroom, University Hospitals of North Midlands NHS Trust, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG					

ICS Partnership leadership compact

Trust

- We will be **dependable**: we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency**, working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be **open to changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness and honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by example

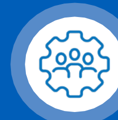
- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respect

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to understand others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness and compassion

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion**.



System first

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire and Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking forward

- We will **focus on what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution**.

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2024-2025
INTEGRATED CARE BOARD (ICB)
AS AT 12 JUNE 2024

Key Declaration completed for financial year 2024/2025
Declaration for financial year 2024/2025 to be submitted

Note: **Key relates to date of declaration**

Date of Declaration	Title	Forename	Surname	Role	Organisation	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
3rd April 2023	Dr	Buki	Adeyemo	Chief Executive	North Staffs Combined Healthcare Trust	Nothing to declare	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	**Nothing to declare**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
13th March 2023	Mr	Jack	Aw	ICB Partner Member with a primary care perspective	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Principal Partner Loomer Medical Partnership Loomer Road Surgery, Haymarket Health Centre, Apsley House Surgery (2012 - present) 2. Clinical Director - About Better Care (ABC) Primary Care Network (2019 - ongoing) 3. Staffordshire and Stoke-on-Trent ICS Primary Care Partner Member (2019 - present) 4. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 5. Director North Staffordshire GP Federation (2019 - ongoing) 6. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 7. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 8. Clinical Advisor Cegedim Healthcare Solutions (2021 -	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. North Staffordshire Local Medical Committee Member (2009 - ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a GP at Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke-on-Trent ICS (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st April 2023	Mr	Peter	Axon	CEO ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
8th April 2024	Mr	Paul	Brown	Chief Finance Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014- March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
1st April 2023	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	University Hospitals of North Midlands NHS Trust (UHNM)	Nothing to declare	1. Lay Member of Keele University Governing Council (November 2019 - November 2023) 2. Governor of Newcastle and Stafford Colleges Group (NSCG) (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
26th July 2023	Mr	Neil	Carr OBE	Chief Executive Officer	Midlands Partnership University NHS Foundation Trust	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
6th December 2023	Mrs	Claire	Cotton	Director of Governance	University Hospitals of North Midlands NHS Trust (UHNM)	1. Employee of University Hospital of North Midlands NHS Trust (UHNM) (2000 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
10th April 2024	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Employed session a week (0.1 wte) by MPFT as Head of SSoT PH Alliance (as a locum public health consultant) (June 2024 - ongoing)	1. Fellow of the Faculty of Public Health (FFPH) and registered with the GMC (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
4th January 2024	Mr	Patrick	Flaherty	Chief Executive Officer and ICB Board Member	Staffordshire County Council	1. Chief Executive Officer of Staffordshire County Council (July 2023 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
24th April 2024	Mrs	Gillian (Gill)	Hackett	Executive Assistant	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
3rd April 2023	Mrs	Julie	Houlder	Non-Executive Director Chair of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner of Elevate Coaching (October 2016 - ongoing)	1. Chair of Derbyshire Community Health Foundation Trust (January 2023 - ongoing) (Non-Executive since October 2018) 2. Non-Executive George Eliot NHS Trust (May 2016 - ongoing) 3. Director Windsor Academy Trust (January 2019 - ongoing) 4. Associate Charis Consultants Ltd (January 2019 - ongoing)	1. Owner Craftykin Limited (July 2022 - ongoing)	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on ICB conflicts register
4th May 2023	Mr	Chris	Ibell	Chief Digital Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
12th July 2023	Ms	Mish	Irvine	ICS Director of People	ICS/MPFT (hosted)	Nothing to declare	Nothing to declare	1. Trustee (NED) of the YMCA, North Staffordshire (July 2023 - ongoing)	Nothing to declare	(h) recorded on conflicts register.

25th April 2024	Mrs	Heather	Johnstone	Chief Nursing and Therapies Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	Nothing to declare	1. Spouse is employed by UHB at Heartland's hospital (2015 - ongoing) 2. Daughter is Marketing Manager for Voyage Care LD and community service provider (August 2020 - ongoing) 3. Daughter-in-law volunteers as a Maternity Champion as part of the SSOT maternity transformation programme (2021 - ongoing) 4. Brother-in-law works for occupational health at UHNM (ongoing) 5. Step-sister employed by MPFT as Staff Nurse (ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
3rd April 2023	Mr	Shokat	Lal	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Local government employee (West Midlands region) and there are no direct or indirect interests that impact on the commissioning arrangements of the ICB (ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
17th April 2024	Ms	Megan	Nurse	Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Hospital Manager for Mental Health Act reviews, MPFT (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association, member of Audit Committee and Renumeration Committee (September 2022 - ongoing)	1. Chair Acton Academy Governing Body, part of North-West Academies Trust (September 2022 - December 2023) Declaration to be removed from Register end June 2024	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register
8th April 2024	Mr	David	Pearson	Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Non-Executive Chair Land based College linked with Chester University (2018- 31st March 2024 retired) Entry to be removed from register September 2024	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing)	(h) recorded on conflicts register.
4th October 2022	Mr	Jon	Rouse	Local Authority Partner Member and CEO of Stoke City Council	Stoke-on-Trent City Council	1. Employee of Stoke-on-Trent City Council, local authority may be commissioned by the ICS (June 2021 - ongoing) 2. Director, Stoke-on-Trent Regeneration Ltd, could be a future estates interest (June 2021 - ongoing) 3. Member Strategic Programme Management Group, Staffordshire & Stoke-on-Trent LEP, may have future financial relationship with the ICS (June 2021 - ongoing)	Nothing to declare	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
11th April 2024	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. I sometimes do shifts for MPFT that I am not paid for (ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - March 2024) (Declaration to be removed from register September 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance Service (WMAS) (February 2021 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
9th April 2024	Mr	Phil	Smith	Chief Delivery Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
17th April 2024	Mrs	Josie	Spencer	Independent Non-Executive Director	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Non-Executive Director Leicestershire Partnership Trust (May 2023 - ongoing) 2. Non-Executive Director for Coventry and Rugby GP Alliance (December - 31/05/2024 (To be removed from register November 2024)	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - 31/05/2024) (To be removed from register November 2024)	Nothing to declare	Nothing to declare	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the conflicts register.
17th May 2023	Mr	Baz	Tameez	Healthwatch Staffordshire Manager	Healthwatch Staffordshire	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
9th April 2024	Mr	Paul	Winter	Associate Director of Corporate Governance and DPO	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required

ANY CONFLICT DECLARED THAT HAS CEASED WILL REMAIN ON THE REGISTER FOR SIX MONTHS AFTER THE CONFLICT HAS EXPIRED

1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the ICB)*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child etc) close friend or business partner*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the ICB role with which the interest conflicts (e.g. membership of an ICB commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any ICB decision)
(b) Not to appoint to an ICB role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the ICB believes the conflict cannot be effectively managed
(d) All staff with an involvement in ICB business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key ICB decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other members (but only for immaterial conflicts)
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the ICB Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

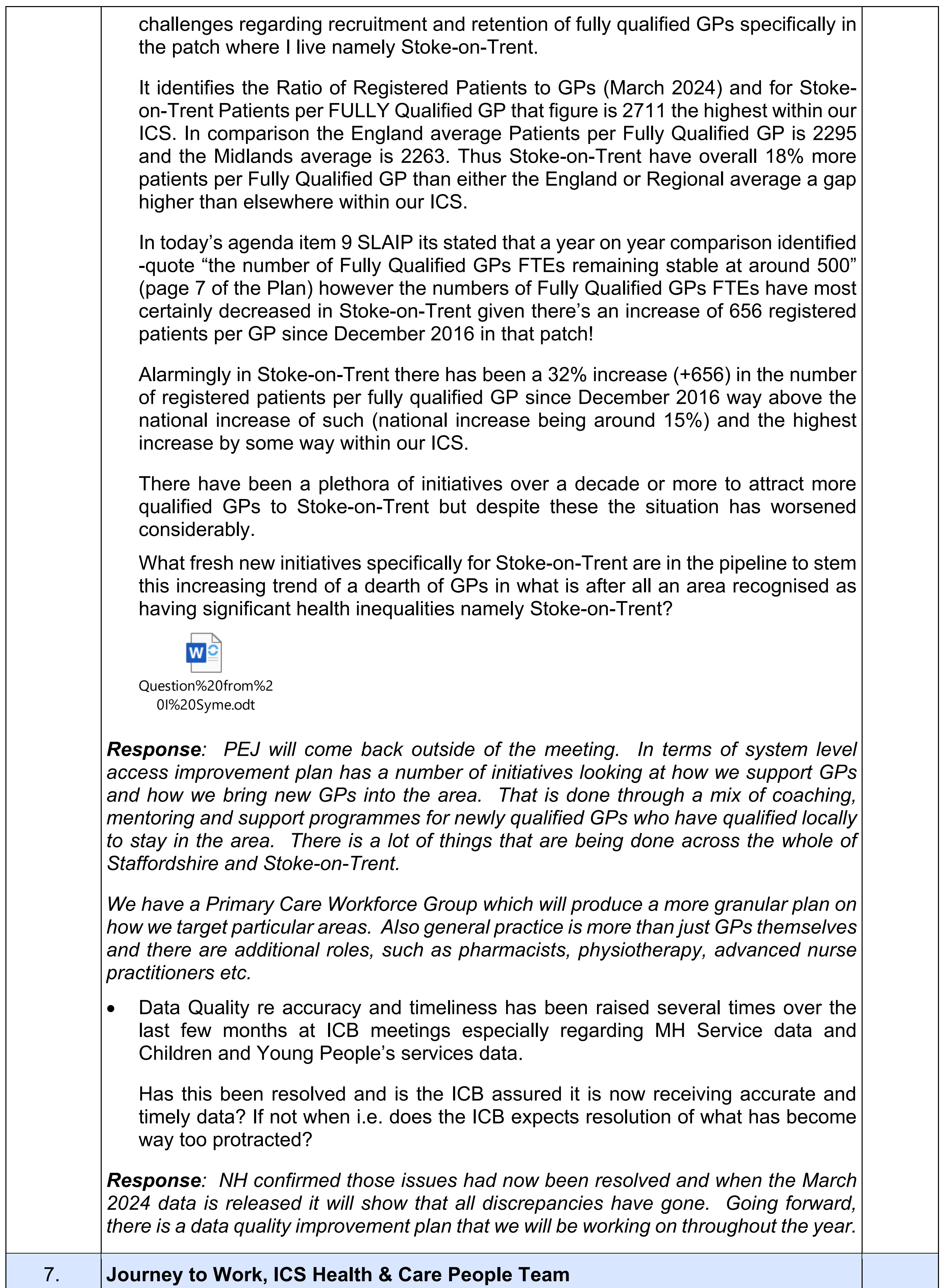
Staffordshire and Stoke-on-Trent Integrated Care Board Meeting HELD IN PUBLIC

Minutes of the Meeting held on Thursday 16 May 2024 12.30 pm - 2.30pm Via MS Teams

Members:	**Quoracy**	**18/04/24**	**16/05/24**	**20/06/24**	**18/07/24**	**26/09/24**	**17/10/24**	**21/11/24**	**19/12/24**	**16/01/25**	**20/02/25**	**20/03/25**
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (CMO) or the Director of Nursing & Therapies (CNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members: with ideally at least one from each of the three cohorts	✓	✓									
Peter Axon (PA) Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		✓	✗									
Paul Brown (PB) Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Phil Smith (PSm) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Julie Houlder (JHo) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Megan Nurse (MN) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓									
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	✗									
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council		✓	✗									
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓									
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands NHS Trust		✓	✓									
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		✓	✗									
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓									
Steve Granger (SG), Midlands Partnership NHS University Foundation Trust		✗	✓									
Nicky Harkness (NH), Interim Chief Transformation Officer, Staffordshire & Stoke-on-Trent Integrated Care Board		✗	✓									
Participant Members:												
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓									
Baz Tameez (BT), Support Staffordshire		✓	✗									
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✗	✓									

Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		×	✓											
Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		✓	✓											
Mish Irvine (MI), Chief People Officer, Staffordshire & Stoke-on-Trent ICB (People Directorate, Midlands Partnership University NHS Foundation Trust)		✓	✓											
Katie Weston (KW), Staffordshire & Stoke-on-Trent ICB		✓	×											
Claire Cotton (CC), University Hospitals of North Midlands NHS Trust		✓	×											
Gemma Treanor (GT), Head of ICS People Team, Staffordshire & Stoke-on-Trent ICB		×	✓											
Sarah Jeffery (SJ) Staffordshire & Stoke-on-Trent ICB		×	✓											
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓											

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Public Board meeting. DP advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP reminded members of the importance of the Leadership Compact document which was used in all of the meetings transacted by the ICB and it guided the way they conducted business and he would return to that at the end of the meeting It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Neil Carr (Steve Grange attending), Jon Rouse and Patrick Flaherty and Peter Axon (Paul E-J attending)	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	**Minutes of the Meeting held on 18 April 2024**	
	The minutes of the meeting held on 18 April 2024 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED.**	
5.	**Action Log**	
	There were no actions to review.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	Ian Syme • I recognise the considerable work and achievement within Primary Care 2023/24 as enunciated in today's Chair and Chief Executives report para 1.1. I have also read and understood agenda item 9 enclosure 7 'Systems Level Access Improvement Plan' (SLAIP) A data dashboard by the House of Commons Library 'Constituency Data GPs and GP practices' was published 25th April 2024 does however highlight considerable	



	challenges regarding recruitment and retention of fully qualified GPs specifically in the patch where I live namely Stoke-on-Trent. It identifies the Ratio of Registered Patients to GPs (March 2024) and for Stoke-on-Trent Patients per FULLY Qualified GP that figure is 2711 the highest within our ICS. In comparison the England average Patients per Fully Qualified GP is 2295 and the Midlands average is 2263. Thus Stoke-on-Trent have overall 18% more patients per Fully Qualified GP than either the England or Regional average a gap higher than elsewhere within our ICS. In today's agenda item 9 SLAIP its stated that a year on year comparison identified -quote "the number of Fully Qualified GPs FTEs remaining stable at around 500" (page 7 of the Plan) however the numbers of Fully Qualified GPs FTEs have most certainly decreased in Stoke-on-Trent given there's an increase of 656 registered patients per GP since December 2016 in that patch! Alarmingly in Stoke-on-Trent there has been a 32% increase (+656) in the number of registered patients per fully qualified GP since December 2016 way above the national increase of such (national increase being around 15%) and the highest increase by some way within our ICS. There have been a plethora of initiatives over a decade or more to attract more qualified GPs to Stoke-on-Trent but despite these the situation has worsened considerably. What fresh new initiatives specifically for Stoke-on-Trent are in the pipeline to stem this increasing trend of a dearth of GPs in what is after all an area recognised as having significant health inequalities namely Stoke-on-Trent? Question%20from%20l%20Syme.odt ***Response**: PEJ will come back outside of the meeting. In terms of system level access improvement plan has a number of initiatives looking at how we support GPs and how we bring new GPs into the area. That is done through a mix of coaching, mentoring and support programmes for newly qualified GPs who have qualified locally to stay in the area. There is a lot of things that are being done across the whole of Staffordshire and Stoke-on-Trent.* *We have a Primary Care Workforce Group which will produce a more granular plan on how we target particular areas. Also general practice is more than just GPs themselves and there are additional roles, such as pharmacists, physiotherapy, advanced nurse practitioners etc.* • Data Quality re accuracy and timeliness has been raised several times over the last few months at ICB meetings especially regarding MH Service data and Children and Young People's services data. Has this been resolved and is the ICB assured it is now receiving accurate and timely data? If not when i.e. does the ICB expects resolution of what has become way too protracted? ***Response**: NH confirmed those issues had now been resolved and when the March 2024 data is released it will show that all discrepancies have gone. Going forward, there is a data quality improvement plan that we will be working on throughout the year.*	
7.	**Journey to Work, ICS Health & Care People Team**	

	A short video was played which showed the work that the People Team had been doing across the system. It was noted that the People Team were intending to take the video into schools and colleges and hoping to address the wider issues within the whole borough across Staffordshire. JHo stated that the video showed how good things could be when everyone worked together. She asked about the age profile of existing volunteers and how they were connected with those volunteers. GT confirmed that they were working with VAST and Support Staffordshire and one of the schemes they were running at the moment was a volunteer companion role within the people hub. They had also supported VAST in a bid they had submitted to foster the volunteer workforce across Staffordshire and Stoke-on-Trent so that would be linked to that pathway. JS had met with a group of students and she found that they struggled with seeing themselves in a role in the NHS, so a video like this would be very helpful. TS asked on behalf of members of the public if there was someone who they could contact to get more involved with this. GT confirmed that the People Team would be doing a full communication marketing plan in order to get it out there in the public domain. SG referred to the marketing campaign about getting into health and it would also be very reinforcing to demonstrate what opportunities were in health if you were already in the NHS. He mentioned that they had just appointed a new consultant psychiatrist in the Trust who had started their career in healthcare support. PEJ added that during the covid pandemic, they had 30 leisure staff who had volunteered and all had gone on to continue in healthcare. DP reiterated that the video would be available on the ICB website. The Staffordshire and Stoke-on-Trent Integrated Care Board **SUPPORT** and **ENDORSE** the approach, encourage Trusts and partner organisations to continue to support the scheme and projects applicable to their area of Health and Social Care and workforce.	
8.	**ICB Chair and Chief Executive Update**	
	DP pointed out the importance of the Primary Care stock take detailed in the report. He felt it was a helpful summary, describe the pressures in Primary Care and they would hear that amplified for Enclosure 9, later during the meeting. DP reported that the Sexual Safety Charter had now been signed off and the ten key commitments were underway with training and other resources wrapped around it. DP mentioned the extraordinary achievement of MPFT for winning the award for terms and services at the national Positive practice in mental Health Awards 2024. DP recently visited University Hospitals of North Midlands NHS Trust (UHNM) and was kindly hosted for the day by their Chair, David Wakefield. During his tour of the site, he was particularly impressed with the level of healthcare technology that the Trust had embraced. Throughout the day the level of commitment and enthusiasm of all the staff he met was also very noticeable. David would like to put on record his thanks to all the staff that he met on the day for their warm hospitality, in particular he mentioned Sarah Jamieson, Director of Midwifery, as he was blown away with the interest and drive with all the members of staff. DP also mentioned the work that Leanne Borden did in the West Building and commended all the staff for their work in a busy and difficult environment. Following that he went to A&E and met with Richard Hall who was the lead consultant who shared his vision for how young people access A&E and their	

	experience. DP stated that he came away from the visit, despite the negativity in the press, feeling humbled and inspired to see the enthusiasm from the staff. TB thanked DP for his report following his visit to UHNM and she would feed that back to the team. She added that Sarah Jamieson had also just got a part time role working with the National Maternity Improvement team. HJ had also been several times to the Midwifery unit at UHNM and also felt there was a palpable feeling of inclusivity and that stemmed from Sarah, Anne Marie and everyone's leadership. PEJ highlighted some of the statistics for primary care and emphasised an 8% increase in the number of GP appointments across primary care over the last year and they were one of the few systems in the country that supported the extra winter appointments which provided an extra 80,000 over the winter period which did make an impact. PEJ referred to the question asked at the beginning of the meeting around the increase in workforce and stated that there were some really good statistics around Mental Health, Learning Disabilities and Autism and the practise friendly schemes etc. For Finance, PEJ highlighted the amount work that was done by collectively by the system Chief Finance Officers, chief People Officers and Chief Operating Officers over the last few months to bring the control total to just under £91m. JHo felt that it would also be useful to correlate the information on the use of pharmacists etc. within the table as well. SF asked how many more GPs and medical practitioners there were and would it reassure the public that the ICB were doing what they said they would. PEJ confirmed that he would look at that outside the meeting. The Staffordshire and Stoke-on-Trent Integrated Care Board **RECEIVED** the report and were assured the leadership are working on each topic as raised.	
9.	**System Level Access Improvement Plan**	
	SJ reported that general practice was seen as the bedrock of the healthcare system and it remained the first point of contact for many people seeking health services in their local community. It played an important 'gatekeeper' role, ensuring as many people as possible received the care they needed close to home. GPs and their teams made up the vast majority of NHS contacts that take place, in Staffordshire & Stoke on Trent (SSOT) more than six million appointments took place last year. SJ stated that general practice was under extreme pressure with intense workload and workforce challenges and was struggling to maintain a level of service that met the demand and accessibility needs for the patient population. People wanted to be able to get through on the telephone and know how their appointment was going to be dealt with. She reiterated that the ICB's ambition was to enable people to have more choice around when, where and how they access general practice, to have greater continuity where this was needed and to have a positive experience. SJ advised that a national Delivery Plan for Recovering Access to Primary Care was published by NHS England in May 2023 to help to address those challenges and ensure that general practice would keep at pace with the growing demand and be sustainable and resilient now and in the future. The System-Level Access Improvement Plan had been written in response to the national plan and worked through the 4 national ambitions which were to empower people, to build modern general practices, to cut bureaucracy and build capacity.	

	A draft System Level Access Improvement Plan was presented to the ICB Public Board in November 2023 with a requirement for an update of the plan to be presented to the ICB Board in May 2024. SJ advised that the Improvement Plan provided an update of the work undertaken, progress towards the national ambitions and ongoing focus for 2024-25. SJ advised that the ICB had the most comprehensive communication campaign in the region. They had undertaken public surveys, testing campaign messaging and imagery with members of the public, developing materials with practices, and asking for feedback from local voluntary sector partners and Healthwatch. The ICS People's Panel was used for patient/public feedback and an online session was held with GPs. 131 responses from members of the People's Panel. She added that public views had improved and enhanced their public messaging. A number of campaigns were launched following the same methodology and formed part of the improving access communication delivery plan. Their next steps was to develop a patient friendly summary of the plan for publication on the ICB website and develop patient FAQs to explain to patients what they could expect from the delivery of the plan including timelines. SJ confirmed that they would continue to deliver the whole SLAIP with key areas of focus for 2024-25: • Empowering patients through the increased use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions, expand Self-Referrals to appropriate services and expand uptake of Pharmacy First services • Implementation of Modern General Practice Access – digital telephony, usable and accessible online journeys for patients and faster care navigation, assessment and response • Building Capacity - continue with the expansion and retention commitments in the Long Term Workforce Plan (LTWP) • Cutting Bureaucracy - further progress on implementation of the four Primary Care Secondary Care Interface recommendations and make online registration available in all practices SJ added that 2024/25 was an important year for actions from Primary Care Access Recovery Plan which would build the foundation for the next phases of implementation of the Fuller Review in May 2022, which would focus on Integrated Neighbourhood Teams, Personalised Care and Prevention. DP stated that it was key that accurate information was sent out through the communication plan and asked if primary care colleagues received feedback as well. SJ responded that they have drafted a letter to GPs to thank them for their achievements at a Primary Care Network collaborative to recognise that. JS was a little unclear how they were getting patient feedback for things such as pharmacy first. SJ admitted that they were not capturing that information routinely enough and they would link in with Comms & Engagement colleagues. SL asked how far were they in meeting the demand for appointments. He also added that the most venerable in the community was where English may not be their first language. SJ confirmed that they were working with community leaders and patient champions on how it was communicated and translated.	

	JA stated that IT in primary care was hugely transformed and the use of digital telephony and online consultations had helped them to get branded detail. JHo asked about patient experience and how was it triaged. PB confirmed that they were developing system collaboratives and the next step was the greater integration in that journey. BA felt it was critical that they did not create gaps, especially for mental health. CI confirmed that they had been investing in digital technology and highlighted that UHNM, MPFT and NSCHT had been working on patient engagement platforms. He picked up the point raised by SL about people with different languages and he confirmed that he had seen some demonstrations on being able to converse digitally in the language of choice which would automatically be responded to in that language. MN referred to social prescribing and asked how far were they in gathering data to evidence the impact that it was having. SJ advised that they were looking at that now and already had case studies that demonstrated the value, but not the granular impact and they would be developing that going forward. TB asked what the full capacity was on demand and did the demand meet the shortfall. SJ confirmed that they had access to the capacity available in the clinical systems and confirmed that they would take that away for some further work. JA added that was part of a national piece of work and there was a mapping exercise that was started last year. SF stated that receptionists had a very poor reputation that there were opportunities to re-educate people on what their role was now and perhaps they could put some positive messages on recordings for when patients are on hold on the phone. He added that on the digital platforms for alternative languages, he asked that the ICB did not assume people had the literacy skills equally to be able to use them and make things as accessible as possible. It was noted that this would be overseen and monitored through the Primary Care Portfolio Board. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the plan and key priorities for 2024-25.	
10.	**Quality and Safety Report**	
	HJ took the report as read, but highlighted the following:- She referred to the adverse media in respect of maternity services at the moment which she felt undermined the progress that had been made at UHNM and the positive visit that she described in relation to the improvement that had been made. HJ reported that the Quality & Safety Committee (QCS) received a deep dive presentation outlining the system's transforming care programme which continued to see improvement. She added that the QSC approved the terms of reference for the Health Safeguarding and Looked after Children Oversight Group which would be looking at the ongoing looked after children backlog. She reiterated that this was a regional and national issue and were working on how they take those assessments and were developing a strong business case to ensure the business capacity.	

	HJ asked the Board to ratify the policies that had been approved at QSC. MN referred to infection and control and asked if they were mirroring the national rise. HJ confirmed that information would be available and confirmed that PEJ was now the lead on IPC. The Staffordshire & Stoke-on-Trent ICB Board: • **RECEIVED** the report and sought clarification and further action as appropriate • **WERE ASSURED** in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System. • **RATIFIED** the decisions of the Quality and Safety Committee with regards to: o ICS ReSPECT Policy o Safeguarding Children & Young People Policy o Managing Allegations Policy o Safeguarding Children & Adults Supervision Policy o Safeguarding Training Policy o Adult Safeguarding Policy.	
11.	**Finance and Performance Report**	
	Finance PB advised that following the H2 planning process being completed, a revised control total of £91.4m deficit was agreed by NHS England. As a result, the system moved its forecast outturn to reflect that deficit. The system was able to stay on track and deliver within the control total with a year-end position of £90.9m deficit for 2023/24 submitted in the draft accounts which were subject to audit sign off. Their capital plan was overcommitted as expected, although mitigations had brought the overcommitment down to £1.1m, pressures in International Financial Reporting Standard (IFRS)16 where the revised allocation fell short of the systems requirement for this technical accounting change PB referred to the CHC work which was the most material cash improvement and one of the most material things in terms of patient care. **Performance** SP gave a brief overview of performance:- • March's Computer Aided Dispatch (CAD) data from West Midlands Ambulance Service (WMAS) showed a 6.3% increase in Category 2 incidents over the previous month. This was 2.5% up on the same period last year with the 3-month average also reporting 6.1% higher than last year. Category 2 response had improved through the second half of March after a pressured start with the latest 4-week average of 38m 22s (w/e 7th April 2024) placing the ICB 4th out of 11 in the Midlands region, and 23rd out of 42 nationally. • Category 3 incidents within the WMAS CAD report showed a decrease of 21.5% against the previous month (March 2024 vs February 2024), and 1% down on the same month last year, with a 92% increase in Category 5 calls • NHS111 service provision had transferred over to Derby Health United (DHU) Healthcare from Totally Group • 4hr Emergency Department (ED) performance at UHNM (University Hospitals of North Midlands NHS Trust) has improved to 70.2%, up from 63.7% the previous month, as additional focus was placed on emergency department pathways. The increased performance was achieved in the face of a 9% overall increase in attendances at UHNM, which compared to March 2023 was equivalent to 27 more patients per day through March 2024.	

	• Continued daily monitoring of 4hr ED performance remained in place with NHSE targeting 77% by the end of April 2024 through breach reduction.
	• 12hr Performance improved with a reduction to 8.6% from 9.5% which kept UHNM in the 2nd quartile regionally. Royal Stoke was primarily responsible for this improvement with a 1½ percentage point improvement over the previous month and the best performance reported for the site of the last 6 months. When compared to the same period last year March 2024 was 1.9 percentage points better.
	• Infection Prevention and Control (IPC) concerns relating to diarrhoea and vomiting remained consistent through March removing beds from the bed base
	• Eliminating 104+ and 78+ week waiters (ww) remained a system focus; five patients remain in the 104+ ww category at ICB level in February and 207 in the 78+ ww category. Both increased from January.
	• UHNM have exceeded the monthly target in 52+ ww in February.
	• 65+ ww at UHNM have decreased in February to 942, from 1,084 in January – a decrease of 142. The national expectation was that these were at zero by the end of September 2024
	• ICB Diagnostic performance against the 7-core test plan (of 78.0% of patients to be seen in <6 weeks in February) was above plan at 79.0%. The planning guidance outlines the national ambition was 95% by March 2025 for this target.
	• The activity count decreased in all [7] tests, by 1,949, with the greatest decreases in Computed Tomography (of 1,026) and Ultrasound (of 950). The plan was exceeded in Magnetic resonance imaging (MRI) and Gastroscopy only.
	• The latest UHNM position (w/e 31st March, weekly recovery pack) reports the [Cancer] 62-day backlog has decreased to 222.
	• The ICB 28-day faster diagnosis pathway saw 76.9% of patients told within 28 days (across all providers) above the national standard of 75%. The planning guidance will increase this target to aim for 77% by March 2025.
	• The 104-day Cancer backlog at UHNM (w/e 31/03, weekly recovery pack) remains at 79; this total remained just below the revised trajectory (of approximately 80 for this period). Largest backlog was in Colorectal (28) and Urology (19).
	• GP appointments for February 2024 exceeded the monthly plan by 119,361 appointments (27.2%) and remained well above plan overall for 2023-24.
	• Community Pharmacist Consultation Service (CPCS) referrals from General Practice exceed the overall YTD target by 490 [referrals] (April 23 to January 24). No new data is available since the move to Pharmacy First on the 31st January. They were awaiting confirmation from NHSE on when new data would be available.
	• Additional Roles Reimbursement Scheme (ARRS) FTE and budget utilisation continued to increase
	• National objective was to increase the percentage of appropriate patients on lipid lowering therapies; the national target of 60% has not been met in February 2024 with 57.6% achieved
	• Reduced the emergency admissions for Long Term Conditions (LTC), including diabetes, epilepsy and asthma in the under 18-year-old population.
	  • Year to Date (YTD), asthma and diabetes admissions were below the equivalent period in 2019/20.
	  • YTD, epilepsy admissions increased on 2019/20. There were 184 admissions in 2019/20 v 203 in 2023/24, which is an additional 19 admissions, and a 10% increase. Admissions increased in CYP aged 5-10 and 11-17 but not in the 0-4's
	• Inappropriate adult acute Out of Area Placement (OAP) bed days are over plan (of zero) by 185 this year, to January (0 for the last 2 months). A business case was approved at the February System Performance Group (SPG). Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT) would be picking up all Psychiatric Intensive Care Unit (PICU) activity from April.	

	• Access to NHS Talking Therapies stood at 23,705 year to date (up to February). 78.2% of planned activity has taken place. Local data indicated that this position would improve to 84% by year end. • The Dementia diagnosis rate at 71.9% in February, continued to exceed the national target of 66.7%. • Autism assessment waits for Children and Young People (CYP) remained 27 weeks at MPFT and 38 weeks at NSCHT. 14 weeks over plan at MPFT and 2 weeks within plan at NSCHT MN advised that the Finance & Performance Committee received the System Recovery Programme report and the recommendations going forward and a helpful discussion around the importance of developing our system needs financial plan and then to have the 1 year operational plans which would take place over the summer. SG raised a declaration of interest in respect of the CHC agenda as the programme was entering a commercial process. He advised that there was £40m saving associated with the programme and a further stretch for an additional £33m. DP referred to the winter surge plan learning where it noted the important contribution from the voluntary, community and social enterprise sector and asked how they were managing the contracts going forward and ensuring that they were handled equitably as any other provider across the system. DP stated that given the industrial action and other issues that had impacted the 78 week, asked for assurance to get to zero. TB advised that they had gone through very granular detail about each week and they also manage it through the Tier 1 national discussions with national colleagues as well. She added that the numbers impacted during the industrial action was now very low and were now working through what happened day to day to ensure they were lined up and also confirmed that they had a trajectory in place to achieve zero. The Staffordshire & Stoke-on-Trent ICB Board • **NOTED** the headlines, escalation and exceptions highlighted • **NOTED** the M12 summary and outturn financial position. • **TOOK ASSURANCE** from the conversations taken at F&P Committee.	
12.	**2024/25 Operating Plan**	
	PB advised that they had now agreed the plan on Friday with Regulators. He added that they had triangulated with HR colleagues, finance and operational delivery. He stated that the plan was complaint operationally and in terms of workforce. PB mentioned the work of the Clinical Senate which was chaired by Rachel Gallyot which had been very helpful. He reiterated that they had worked collectively together to come to a solution which was reflected in the financial position. They were now focussing on delivering the £90m and added that there was a lot of risk and with £80m costs they did not have mitigations for. PB reiterated that there was a lot of risk but as a system they were committed to work together to try and deliver, with step 2 to stabilise things and stop the growth of cost and bring the system back into recurrent balance over time. SG thanked PB for facilitating a lot of what were sometimes very difficult conversations. DP echoed that comment and added that there were a lot of systems were struggling at the moments to get to balance. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the update	
13.	**Health & Care Senate Terms of Reference**	

	PEJ advised that the paper was asking the ICB Board to consider a Health & Care Senate request for the delegation from Board to Senate of certain ICB statutory powers. Specifically, the power to approve clinical strategies and policies on behalf of the Board. Also to formalise the Senate's informal role in sponsoring emerging ICB-ICS Clinical Pathways, via the Portfolios. These would empower the Senate to act on the Board's behalf at key stages of the formal decision-making process. PEJ confirmed that this would not include those powers already delegated to the Quality & Safety Committee for policies, strategies, etc within their remit – e.g. for Safeguarding; Infection Prevention & Control; CHC and certain other areas that were currently in the final stages of being agreed and finalised between the Q&S Committee and Senate Leaders and were provided as an updated appendix to the Terms of Reference document. JS confirmed that, as Chair of the QSC together with HJ and PEJ, they had met as a group and were content with the process. JHo agreed that clinical decisions should be made in that forum. MN agreed that it was the right direction. SF asked if it would be using any element of the public voice in terms of its decision making. PEJ confirmed that there would be a public voice in the design process and then once that policy/procedure was brought together. TS added that the review of the pathway comes from the public. Everything needs a QIA JA was supportive, but felt there was a lack of direct GP representation in the standing order members in order to engage . PEJ agreed that they would take a look at that. The Staffordshire & Stoke-on-Trent ICB Board • **APPROVED** the requested delegation of certain clinical policy / strategy approvals powers on behalf; • **ACKNOWLEDGED** that such approval is pending the finalisation of two tables of Approvals Powers Inclusions & Exclusions to appear in the final Senate (and updated Q&S Committee) Terms of Reference, once agreed, by the end of May 2024. • **RATIFIED** the updated Health & Care Senate's Terms of Reference, that reflected the requested internal delegation of powers • **NOTED** the further work to be undertaken by the Governance Team to reflect the ancillary paperwork to enact the delegation	
14.	**People Culture and Inclusion Committee Report**	
	MI advised that the report provided a summary of workforce position, challenges, risks and mitigation via People Culture and Inclusion programme activities considered at ICB People Culture and Inclusion Committee (PCI). She confirmed that the Risks were summarised and that they were reviewing all of their risks to ensure that they were mitigated and they also needed to consider the impact on the workforce. The Staffordshire & Stoke-on-Trent ICB Board • **NOTED** the workforce position, operating plan submission, risks and mitigations in place to address • **TOOK ASSURANCE** from the conversations taken at the PCI Committee	
15.	**Audit Committee Assurance Report**	

	The Board noted that the ICB would be issued with a Section 30 Referral to the Secretary of State because the ICB had failed to meet its' statutory duty to break even. This was anticipated and the Board was fully sighted on the financial position and the action being taken to return to break even. It was also agreed that in the future, the covering report to the statements would be more explicit regarding the nature of and conclusions in the Governance Statement, Internal Audit Opinion and review of the ICB as a Going Concern The Staffordshire & Stoke-on-Trent ICB Board **TOOK ASSURANCE** from the conversations taken at the Audit Committee	
16.	**Any Other Business**	
	<u>Birth Trauma Enquiry Report</u> HJ highlighted the recently published All Party Parliamentary report into Birth Trauma and assured members of the Board that this would be reviewed and the local maternity and neonatal system board would receive a self-assessment of the performance of local services in respect of the findings of this important document. A further update would be presented to Quality and Safety Committee in June and this would come back to Board once complete. **ACTION**: HJ to bring a further update to Board in more detail once the review was complete. TB confirmed that any report that came into their organisation, they would conduct the usual gap analysis and were already underway working through the recommendations and action plans and would bring them into one action and then feed into a system action plan. No other items of business raised.	**HJ**
17.	**Questions from the floor relating to the discussion at the meeting**	
	Ian Syme At UHNM there are around 7000 births per year, yet the CQC are saying that at Queens Hospital there are 2700 births and he is unable to get information from either UHDB or Derbyshire ICB board papers and asked what was happening at the Queens hospital following the CQC review, as there must have been an action plan? *Response:* *Queens Hospital and UHDB were aligned a couple of years ago and confirmed that was being led by Derby & Derbyshire ICB and was linked in with the National Maternity Safety Support Programme (MSSP) and she was currently having discussions on how they can strengthen those links to make sure that we all get the same map of data as they do for UHNM.* UHNM reinstated home births – what is the situation in the south and why is continuity of care a lower priority to home births in the southeast. *Response:* *The continuity of care guidance change that came out was better. When it was first published there was a requirement for all maternity services to implement continuity of care across the board and there were significant challenges in getting that to work. There are lots of reasons and HJ was around historically in the days of changing childhood where there was a very similar demand in terms of what was expected of our continuity. The guidelines changed mid COVID and it was one of the lower priorities during COVID because of keeping mums and babies and families safe. However, since COVID, the priority around continuing care is very much part of certain groups such as black minority ethnic families. They have looked at reports into how*	

	these individual groups of people are not getting the same level of service. So quantitative care is a priority for those groups. The Halo model is heavily reliant on agency – WMAS have moved non substantive Halo to front line, but WMAS are saying they do not employ agency staff. *Response:* *We were paying top up to provide 24/7 Halo cover we still receive that payload support within those core hours from the ambulance service, but we are just employing our own staff short term agency staff to support us through those other hours of the day.* Ian Syme asked about notice given to SOT City Council on some of their contracts *Response:* *What Stoke City council have signalled at this time regarding Home First is their intention to withdraw their contribution from that contract, but there is still a level of funding invested through the better care fund to Home First anyway, so this is not about removing the Home First offer for residents. Stoke has stated that their intention is to reinvest that money in developing a broader range of pathways.* **Derek Hoey** Access to GP appointments – The worrying situation is that patients are not even getting that far and many are being told to book online. Are you making the default situation as having to book appointments online. *Response:* *The ICB was not aware of that, there is nothing to say that patients have to book online and if there are any specific examples asked that they be shared offline. It was also noted that the ICB were improving the telephone systems at practices in order to avoid such situations.*	
18.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact.	
19.	**Close**	
	There being no further business, the Chair closed the meeting.	
20.	**Date and time of Next Meeting**	
	20 June 2024 at 1.00pm held in Public via MS Teams	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

Staffordshire and Stoke-on-Trent Integrated Care Board

Staffordshire and Stoke-on-Trent ICB Board Meeting
HELD IN PUBLIC

Date of Meeting 20/06/2024

Open Actions

Reference Number	Meeting Date	Agenda Item	Agenda No	Action	Due Date	Responsible Officer	Outcome/update (Completed Actions remain on the Live Action Log for the following committee and are then removed to the 'Closed Actions' Worksheet)
2024-24/001	18/05/2024	AOB - Birth Trauma Enquiry Report	16	HJ to bring a further update to Board in more detail once the review was completed by QSC.	26/09/2024	HJ	Due in September 2024

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**10 June 2024**					
Title:	Chair and Chief Executive Officer Report					
Presenting Officer:	David Pearson, Chair, and Peter Axon, CEO					
Author(s):	David Pearson, Chair, and Peter Axon, CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☒	**Discussion (D)**	☐	**Assurance (S)**	☐
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent system that are not reported elsewhere on the agenda.

Specifically, the paper details a high-level summary of the following areas:
1. System and General Update
2. Finance
3. Planned Care
4. Urgent Care
5. Key figures from our population
6. Quality and safety

7.0 Vaccinations

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
N/A	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions

CQC or Patient Safety	This report type may assist the 2024 ICS CQC inspection
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	N/A for the report
Workforce or Training	N/A – no specific training implications; workforce matters are inherent to each topic
Equality & Diversity	N/A in terms of Equality Act 2010 or Public Sector Equality Duty
Due Regard: Inequalities	Access to services and reducing inequalities is implicit throughout
Due Regard: wider effect	N/A – no decisions are required for the paper itself: it is to raise awareness

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	**BAF8**	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

Click or tap here to enter text.

(7) Recommendations to Board / Committee:

To receive the report and be assured the leadership are working on each topic as raised.

1.0 System and general update

1.1 People team

1.1.1 ICS People Culture and Inclusion 2023/24 Annual Report

The 2023/24 Integrated Care System's People Culture and Inclusion Annual report, developed in collaboration with system partners, has now been ratified by the People Collaborative. The report will be shared with stakeholders using various communication channels. The report captures the achievements, challenges and future focus for the programmes across our system. Highlights include.

- Progress in delivering the Long-Term Workforce Plan
- Securing our future supply pipeline
- Supporting system recovery
- Looking after our people
- Connecting with local communities to promote and enable access to health and care careers.
- Looking after and developing our people
- Creating an inclusive and compassionate culture and keeping our residents at the heart of everything we do.

ICS Annual Report 2023_24 - ICS Annual Report 2023_24 (pagetiger.com)

1.1.2 NHS Confederation Expo

Mish Irvine, Interim Chief People Officer, Gemma Treanor, Head of the Integrated Care System's People Function, and Amy Duffy, Senior Commissioning Officer, Staffordshire County Council, attended the Expo on 12 June to share experiences in working across organisational boundaries and creating 'One Workforce'. The system was approached to present on our collaboration across sectors, our journey towards integration and solving our workforce challenges at place. Coming together at the Expo to showcase our work on areas such as retention, workforce development, widening participation, access and outreach, was a testament to the cross-sector partnerships developed over time and the success of the different programmes.

1.1.3 National T-Levels Pilot

The system is representing the Midlands in the National T-Levels pilot in conjunction with the Department for Education. The aim of the pilot is to increase uptake of T-Levels, expand placements across the system, and test innovative approaches to T-Levels in health and care.

A case study that has been created in conjunction with University Hospitals North Midlands NHS Trust and Stoke Sixth Form College, has been promoted both regionally and nationally, across organisations, schools, and colleges.

The case study reflects on the usefulness of partnerships and the resulting head-start to a career in healthcare. In this case, it demonstrates this through Maisie's journey switching from A Levels to T Levels, partnering with the college to purchase the relevant equipment, and the team at University Hospitals North Midlands NHS Trust providing mentorship. Maisie has now been offered a place to study Radiography at the University and remains on the hospital's bank.

1.2 HSJ Digital Awards 2024

Congratulations to our partners who were successful at the recent HSJ Digital Awards, in the following categories.

Digital Clinical Safety Award:

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Winner – Midlands Partnership University NHS Foundation Trust (MPFT) - "A Cultural Shift and Collaborative Approach in Digital Innovation"

Enhancing Workforce Engagement, Productivity and Wellbeing through Digital:

Winner – University Hospitals North Midlands NHS Trust (UHNM) and other Trusts, University of Derby and other universities, NHS England and Sim4Med "Midlands Imaging Training Academy"

Moving Towards Net Zero through Digital:

Winner – MPFT "Leading the Way in Digitising Secondary Care Prescriptions for a Greener Future"

Finalist – MPFT "Staffordshire Community Dental Services – Moving to Net Zero"

Improving Mental Health through Digital:

Finalist – MPFT "Transforming Mental Health Care through Electronic Prescribing Service"

Improving Back-Office Efficiencies through Digital:

Finalist – MPFT "Enhancing Back-Office Processes Through Advanced Automation"

Finalist – MPFT "Staffordshire Community Dental Services – Digitisation"

Digital Organisation of the Year:

Finalist – MPFT "From reactive chaos to successful delivery of our co-produced MPFT Digital Transformation Strategy"

Digital Team of the Year:

Finalist – MPFT "From reactive chaos to successful delivery of our co-produced MPFT Digital Transformation Strategy"

Finalist – UHNM and other Trusts, University of Derby and other universities, NHSE and Sim4Med "Midlands Imaging Training Academy"

Digital Literacy, Education and Upskilling Award:

Finalist – MPFT "Digital Angels"

1.3 Primary care

1.3.1 Cloud Based Telephony (CBT)

The CBT project is now entering the closing stages and the benefits realisation activities have begun. The Primary Care Digital function has been asked by NHS England to collate a list of GP practices who would be happy to accommodate a ministerial visit, post-election, to share their experiences of the benefits of implementing digital cloud-based telephony. This is a huge achievement for the Digital function to support the delivery of the Primary Care Access Program and celebrate excellent outcomes for our population.

1.3.2 Additional Roles Reimbursement Scheme (ARRS) Utilisation

In 2022-23, 21% (£4m) of the (ARRS) Additional Roles Reimbursement Scheme budget was not utilised by Primary Care Networks (PCNs) in Staffordshire and Stoke-on-Trent. In 2023-24 the Additional Roles

Reimbursement Scheme budget increased by £7.5m and a dedicated task and finish group was set up to ensure that PCNs used as much of the money as possible through recruiting new roles to deliver additional capacity within primary care and a multi-agency plan was devised and delivered. At the end of 2023-24, PCNs utilised 93.2% of the Additional Roles Reimbursement Scheme budget and claims are still coming in, so this total may rise further. This equated to a workforce increase of 214 WTE posts over 12 months.

1.3.3 System Level Access Improvement Plan

An updated plan was presented to the Integrated care boards Public Board in May 2024, and this was positively received. The next steps include the development of a patient friendly summary and frequently asked questions to support the contents of the plan.

1.3.4 Local incentive scheme (Quality Improvement Framework)

Focusing on a number of system priorities e.g., Cardiovascular Disease, End of Life, Chronic Kidney Disease, Diabetes management, the Quality Improvement Framework has been issued to all practices to aim to improve patient outcomes.

1.3.5 Referrals to the Digital Weight Management Programme

The ICB finished seventh nationally for achieving our target number of eligible referrals to the Digital Weight Management Programme in 23/24. The online programme supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

1.3.5 Communications

The focus for recent communication activities in Primary Care has been to promote the Pharmacy First services, the Adoption and utilisation of the NHS App, the General Practice Improvement Programme, and the Stone and Eccleshall PCN Wellbeing and Community event. There has also been a number of organisational development sessions promoted and held.

1.4 Clive's Way' conference

On 9 December 2021 NHSE/I Midlands published the final report of an independent review looking at the care, treatment and death of Clive Treacey. Clive was an individual from Staffordshire with a learning disability who suffered from complex epilepsy. He spent much of his life moving between many care providers who struggled to meet his needs and support him to live the life he wanted. He sadly died in January 2017, aged 47, at a privately run hospital for people with learning disabilities following an epileptic seizure.

In her final report, the Independent Chair, identified a breadth of opportunities for learning from Clive's life and makes over fifty recommendations for system-wide improvement at a local, regional and national level. In April, NHS England co-chaired 'Clive's Way' conference for health and social care professionals. This conference was an opportunity for health and care professionals to come together to see how they are, and can, tangibly implement the recommendations in the report and improve outcomes for people with a learning disability. This event was attended by senior members of the ICB's Learning Disability and Autism portfolio and learnings from the event have been discussed at the portfolio's Board.

The conference was an opportunity to reflect on how people with learning disability and autistic people live a full and valued life locally. Even though our system has made huge progress since 2017, through the integration of the Small Changes campaign concentrating on reducing health inequalities by encouraging staff to make reasonable adjustment, and the delivery of the Oliver McGowan training, there is still much to do to prevent anyone else having an experience like Clive, in our system.

1.5 Tracy Bullock retirement

After 40 years' service within the NHS, Tracy Bullock, CEO of University Hospital North Midlands, retires from the NHS at the end of this month. It is with enormous gratitude that we acknowledge all that Tracy has achieved both within our system but also across her illustrious career prior to arriving in Staffordshire. On behalf of the entire Board, thank you Tracy!

We would also like to extend a warm welcome to Simon Constable, who will be taking over as the new CEO of university Hospital North Midlands.

1.6 Gill Hackett retirement

This is also the last time that Gill Hackett will be administering the ICB Board before she retires at the end of the month. Gill has been a great asset to the ICB, and the CCGs before that, making sure everything runs smoothly and on track. On behalf of the Board, we would like to thank Gill and wish her all the best for the future.

2.0 Finance

The system was able to stay on track and deliver within the control total with a year-end position of £90.9m deficit for 2023/24 submitted in the draft accounts, subject to audit sign off, which is progressing well.

Moving to 2024/25, the system has an approved deficit of £90m which is cash backed. There is a resubmission on 12 June, which will not change the agreed deficit position but will update progress on efficiencies and risk. Due to the financial deficit in 2023/24 and 2024/25, the operational capital allocation for the system has been reduced by £1.5m to £42.6m, which has compounded an already over committed plan with potentially further risks that are being worked through. This has required a re-prioritisation of capital plans, which impacts on operational capital investment around backlog maintenance, equipment replacement and other smaller scale capital developments. The constraints on capital have been noted as a high risk within the Integrated care board and providers risk registers moving forward.

3.0 Planned Care

Further to the Operational Planning submission on 2 May, and subsequent meetings held during May 2024, all systems were asked to make a final re-submission to conclude the 2024/25 Planning Round by 12:00 noon on Wednesday the 12 June 2024. Systems were asked to submit revised templates for Finance, Workforce and Activity and Performance, built from the 2 May submission but incorporating any local feedback. There was no requirement to submit a revised narrative template. Systems were sent an individual letter outlining the process and any system specific points to address.

Staffordshire and Stoke-on-Trent ICB was asked to ensure our resubmission was in line with our revenue financial plan limit of £90.0m, which includes additional PFI funding of £7.6million. We were also asked to reflect the outcomes from the 10 May meeting within our plan in addition to the following areas identified:

1. Development of the elective recovery programme to maximise revenue opportunities for the system. To include a review of opportunities to further improve elective activity with a minimum 4% increase in planned value weighted activity.
2. Reflect the increase in elective activity to address the 52-week wait trajectory at University Hospitals North Midlands NHS Trust and repatriation from the independent sector.
3. Continuation of the work to de-risk the plans to support delivery of the revenue finance plan limit, including a full identification of efficiency schemes by 31 May 2024.

The submission was made successfully in line with the deadline of 12 June.

3.1 Elective Waits (104, 78 and 65 week waits)

The Integrated Care Board and system partners continue to address the backlog of patients on the elective waiting list, with the ambition of treating all those waiting more than 78 weeks by the end of Quarter 1, and 65 weeks by the end of Quarter 2, in accordance with the national planning guidance. However, despite progress being made, the rate of improvement has been impacted upon by the ongoing Industrial Action by both junior doctors and consultants. The above ambitions apply to all providers across the system. The Independent Sector continues to support our recovery.

NHS England have confirmed that the system will remain in Tier 1 for Elective Care and Cancer, with the addition of Diagnostics added within the weekly oversight.

Current position is as follows:

There was one breach for 104-week waits in May and zero forecasted breaches for June where the breach is attributable to University Hospitals North Midlands NHS Trust (UHNM). However, there were four additional breaches reported at the end of May and there is a forecasted position at the end of June of two patients. These extra patients are Corneal transplant patients that UHNM have accepted as mutual aid from The Royal Wolverhampton NHS Trust (RWT). It was agreed that UHNM submit these as part of their active waiters, but nationally and regionally they would be excluded and reported under Birmingham and Black Country ICB. There were zero breaches at the end of May for patients who are outside of the system.

For patients waiting beyond 78 weeks for treatment, the number of breaches across the system at the end of May was 37 (32 at UHNM, one at Ramsay and four at Medefer). The forecast position for the end of June is 17 (all at UHNM), with a forecasted position of zero breaches for July.

As previously reported the ICB continues to track long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System. In the latest unvalidated data (2nd June), there are 11 patients waiting over 78 weeks outside of the system, six (four of these are at University Hospitals of Derby and Burton (UHDB)) are on the admitted part of the pathway and five (four of these is at UHDB) are on the non-admitted part of the pathway. UHDB are on Tier 1 elective oversight and are subject to weekly monitoring by NHS England.

Good progress is being made overall on the 65-week-wait cohort. The revised target is now September 2024, where previously it was March 2024. The number of breaches across the system at the end of May was 1,236 (1,207 at UHNM, one at Nuffield, one at Ramsay, 27 at Medefer). The forecast position for the end of June is 1,337 breaches (1,321 at UHNM, 16 at Medefer), with a forecasted position of 1,664 (1,656 at UHNM and eight at Medefer) for July.

For providers outside of the system, in the latest unvalidated data (2 June 2024) the potential cohort of patients who could breach 65 weeks if not treated, by the end of June is 746 patients, 352 of these are on the admitted part of the pathway and 394 on the non-admitted pathway.

3.1.1 Cancer Performance

University Hospitals of North Midlands NHS Trust has seen a continued steady reduction in the 62-day backlog since September, however, there have been increases at some points over this time. As of 2 June, the 62-day backlog was 231, this is compared to 248 as of 28 April. University Hospitals of North Midlands NHS Trust are currently under their fair share allocation.
The 104+ day backlog has also seen a downward trend, with some increases at some points. As of 6 June, the 104+ backlog was 59, this is compared to 60 as of 28 April.
The position of 28-day faster diagnosis standard for cancer has seen a steady improvement since November but did see a slight decline in January. April's position was 69.14% against a Trust trajectory of 74.04%, May provisional position is 80.4% against a Trust trajectory of 74.5%.
May provisional data for 31 day combined is 89.5% against a target of 96%, and a 62-day combined is 61.1% against a target of 85%.

4.0 Urgent and Emergency Care (UEC)

Unvalidated four-hour performance in May achieved 71.4%, up on the validated position of 70.7% reported for April, the third consecutive month of above 70% performance, and an improvement towards the target of 77% through the year, and 78% by March 2025, as defined in national guidance. Type 3 activity locations continued to perform well with an overall performance of 98.18%, with most breaches down to individual days of high pressure rather than consistent levels through the month. Leek Hospital reported a single breach for the first time since February 24. When comparing the overall performance to the same period last year, the improvement was 2.1 percentage points and is the highest overall performance since the 72.2% reported for May 2021. This improved performance was achieved whilst average daily patient attendances remained the same as April, and Emergency Admission via emergency department reduced by the equivalent of 28 patients per day.

Twelve-hour performance during May reduced to 7%, down from 8.6% in April and the lowest reported level since August 2023. When compared to the same period last year the reduction was 0.6 percentage points for May 24. Following on from the previous periods where County Hospital was being utilised to share risk which resulted in degraded 12hr performance both sites have reported improvements for May, which is expected to continue into June.

Long Length of Stay performance reported reduced levels in all three cohorts, 7+, 14+ and 21+ with the biggest reduction being in 21+ days where a 1.6 percentage point reduction down to 13.6% of occupied beds was reported; this equates to approximately 43 patients per day through the month. When compared to the same period last year the 7+, 14+ and 21+ cohorts were 1.8, 1.6 and 1.9 percentage points respectively lower in May 2024. The system surge multidisciplinary team continues to meet and monitor the de-escalation of winter capacity in line with the bed model.

Category 2 Response Times through May remained around the 30-minute mark with the latest 4-week average (w/e 2 June) of 29min 16s placing the system in the second quartile (13th out of 42) nationally, and fourth out of 11 regionally. The average for 2024/25 so far remains just over one minute above the 30-minute target at 31mins 4secs.

Medically Fit for Discharge increased overall during May, with the latter half of the month providing the main driver for the increase. This was mostly located at Royal Stoke Hospital. County Hospital saw variable levels ranging from the highest number in almost 12 months to the lowest in almost six months.

Minimal Flu cases were reported during May with only two instances of single beds being occupied by patients with Influenza.

COVID-19 bed numbers started May on an upward path that began in the middle of April but, having plateaued by the second week of the month, began a gradual decline falling to 62 from 93 by the end of the month, and continuing the downward trend into June. Even though the numbers have reduced infection prevention control (IPC) concerns continue to place additional pressure within the system. Burton hospital saw continual but low levels of cases, never exceeding eight, and ending the month with three beds occupied by patients with COVID-19.

Staff absences due to COVID-19 fell in line with the reduction in beds occupied, whilst overall absences increased through the last week of the month, having reduced to the lowest percentage of total staff absence since August 2023.

5.0 Key figures from our population

		Last 3 to 4 months in current financial year				Comparator month		Change on same month previous year		
		Jan-24	Feb-24	Mar-24	Apr-24	Mar-23	Apr-23			
	A&E and Walk in Centre attendances (UHNM)	20,776	19,952	21,864	21,419		19,495	1,924	9.9%	↑
	A&E and Walk in Centre attendances (other providers)	17,669	17,584	18,860	18,660		16,434	2,226	13.5%	↑
	Non elective admissions (UHNM)	8,140	7,578	7,866	7,958		6,982	976	14.0%	↑
	Non elective admissions (other providers)	6,675	6,528	6,620	6,534		5,722	812	14.2%	↑
	Elective and Day Case spells (UHNM)	7,678	7,552	7,396	7,752		5,690	2,062	36.2%	↑
	Elective and Day Case spells (other providers)	8,435	8,447	8,248	8,453		7,204	1,249	17.3%	↑
	Outpatient procedures (UHNM)	4,913	5,206	5,049	5,329		4,066	1,263	31.1%	↑
	Outpatient procedures (other providers)	9,838	9,755	9,785	9,905		7,619	2,286	30.0%	↑
	GP Appointments (all)	596,636	558,380	538,690	546,734		425,635	121,099	28.5%	↑
**	Physical Health Community Contacts (attended)	143,115	133,790	141,770	148,950		121,860	27,090	22.2%	↑
**	Mental Health Community Contacts (attended)	47,370	41,165	37,885		47,940		-10,055	-21.0%	↓

Most datasets are subject to change following refresh

NHS 111 - Due to the switchover to DHU, part way through April 2024, it is not currently possible to identify 111 call volumes from National data. A local solution is currently being investigated.

**Physical and Mental health contacts - latest month is provisional and subject to change and both datasets are sometimes one month behind the other datasets depending upon timing of publication

The comparison with the same month the previous financial year is the same month for most measures, apart from measures that lag one month behind. The month being compared is indicated by the absence of dark grey shading.

Variation in Planned Care type activities (e.g. Elective/ Day Case admissions, OP/ GP appointments) is influenced by a variety of factors, including the number of working days in the month (activity in some months is affected by bank holidays). We will flag up if variation in these activities is abnormal.

6.0 Quality and safety

6.1 Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)

The ICB Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) Programme Team hosted an action planning event supported by all healthcare and social care providers across the system, including Healthwatch, Primary Care and local advocacy services. The event showcased the work undertaken by the programme, such as the recently launched easy read breast cancer screening service video. The video has been developed and delivered by experts by experience to inform and encourage people with a learning disability or autism to attend their preventative screening appointments. The video and associated information has been nominated for an Innovation and Improvement in Reducing Healthcare Inequalities HSJ Award. Plans are in place to make similar videos relating to bowel, lung, and cervical cancer screening services as part of the LeDeR system wide action plan for 24/25.

6.2 The nursing, quality and therapy

The nursing, quality and therapy directorate is pleased to confirm that the Maternity and Neonatal Independent Senior Advocate (MNISA) is now fully operational and working alongside women, birthing people and their families. The pilot role, launched in response to the immediate and essential actions outlined in the Investigation into Maternity Services at Shrewsbury and Telford NHS Trust, has recently been extended to continue until late 2025. The role offers support to families who have experienced loss,

bereavement or a significant health complication related to their maternity or neonatal care. The MNISA can support families to navigate some of complex investigation processes which follow and advocate for them to ensure that the impact is acknowledged for them, their voice is heard and used to improve care for future families.

7.0 Vaccinations

The Spring COVID-19 vaccination programme continues until 30 June 2024 for all those aged 75 and over (including those turning 75 by 30 June 2024), residents in an older adult care home or immunosuppressed individuals aged 6 months to 74 years.

Staffordshire and Stoke-on-Trent have seen a very positive uptake this campaign with 91,334 vaccinations being undertaken within vaccination sites in Staffordshire and Stoke-on-Trent. For the Staffordshire and Stoke-on-Trent registered population, 54.06% of the ~161,000 individuals who are eligible have been vaccinated so far during the programme. This is the third highest ICB within the Midlands NHS England Region.

Care home residents have been the priority for sites and >95% of care homes have been visited with most residents vaccinated with their COVID-19 Spring dose.

NHS England are currently undertaking an Expression of Interest process for COVID-19 vaccination programme providers from September 2024 to March 2026. This is open to all healthcare providers this time so may see additional sites from the traditional GP practices/PCNs, NHS Trusts and Community Pharmacies. JCVI are yet to announce detailed recommendations for the Autumn/Winter COVID vaccination programme this year, but this is expected shortly.

David Pearson, ICB Chair

Peter Axon, ICB Chief Executive Officer

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 06

Report to:	**Integrated Care Board**
Date:	**20 June 2024**
Title:	**System Recovery Programme 2024/25**
Presenting Officer:	Paul Brown – Chief Finance Officer
Author(s):	Alex Robinson – TDU Manager
Document Type:	Report

Action Required (select):						
	Information (I)	☒	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes / No**	YES
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.
Any financial impacts: ICB or ICS?	**Yes / No**	YES *If Y, are those signed off by and date:* The financial impacts are as outlined in the body of the report.
Appendices:	Performance Report	

(1) Purpose of the Paper:
The purpose of this paper is to provide a summary of the recovery programme received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC).

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (I)	29/05/2024
System Finance and Performance Committee (S,D)	04/06/2024

(3) Implications:	
Legal or Regulatory	Monitoring performance is a statutory duty of the ICB.
CQC or Patient Safety	N/A
Financial (CFO-assured)	As outlined in the body of the report.
Sustainability	N/A
Workforce or Training	N/A
Equality & Diversity	N/A
Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☒	**BAF5**	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	**BAF6**	Sustainable Finances	☒
BAF3	Proactive Community Services	☒	**BAF7**	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The report outlines at a high level our efficiency target for 2024/25 of £203m.

The report sets out the work undertaken during April and May 2024 to establish the 5 system collaboratives and an overview of the five system collaboratives covering collaborative scope, ambition and underpinning workstreams. Detail on the emerging delivery metrics has been taken through System Finance and Performance Committee, the Provider Collaborative Board and the Health & Care Senate. These will be built into future reporting to measure delivery.

From 1st June 2024, we will move into delivery and monitoring with the weekly recovery meeting to be reconvened to manage interdependencies and co-dependencies on three levels: 1) across the collaboratives; 2) with the existing Portfolios; and with individual Providers themselves.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Note the progress to date on our system recovery programme.

Staffordshire and Stoke-on-Trent
Integrated Care System

System Recovery Programme 2024/25

Integrated Care Board June 2024
Prepared by the Transformation and Delivery Unit

Introduction

- We have agreed a system efficiency target of £203m for 2024/25. This will enable the system to deliver a £90m deficit position as at 31st March 2025, as agreed with NHSE.
- This £203m will be delivered through organisational specific cost improvement plans (CIP) and five system collaboratives (System Recovery Programme for 2024/25). Circa 30% of the system efficiency plan is aligned to these five system collaboratives.
- Together, these system collaboratives form a cohesive approach for our capacity challenges, harnessing the collective expertise, resources, and commitment of stakeholders.
- During April and May 2024, each System Collaborative has focused:
  1. Defining its scope and ambition and any underpinning workstreams and/or projects;
  2. Agreeing activity and financial metrics for measuring success;
  3. Securing stakeholder buy in and clinical leadership;
  4. Identifying any emerging risks to delivery;
  5. Completing the relevant impact assessments such as Quality Impact Assessment, Equality Impact Assessment and Data Protection Impact Assessments
  6. Setting out critical milestones to support delivery.
- The following slides provide overview of the five system collaboratives. Detail on the emerging delivery metrics has been taken through System Finance and Performance Committee, the Provider Collaborative Board and the Health & Care Senate. Once finalised the underpinning metrics will be built into future reporting to measure delivery.
- From 1st June 2024, we will move into delivery and monitoring. The weekly recovery meeting will reconvene to manage interdependencies and co-dependencies on three levels: across the collaboratives; with the existing Portfolios; and with individual Providers themselves.

Staffordshire and Stoke-on-Trent Integrated Care System

Continuing Healthcare

Recovery 2024-25

Continuing Healthcare (CHC)

Collaborative Scope and Ambition

- To reach the full £109m by the end of 2025/26 as part of a 3-year scheme.
- This includes delivering the £40m FYE from 23/24 and delivering an additional £33m in 24/25

SRO Supporting Statement (Steve Grange)

- The CHC Provider collaborative has been established to provide strengthened clinical leadership and oversight with the aim to review and improve patient pathways, journey, and experience.
- This is against a backdrop of improving the way that we use our resources and ensuring that we develop new ways to work together as system partners for to benefit of local people.

Collaborative Underpinning Workstreams

1a: To create a **provider collaborative** aimed at bringing together the knowledge, leadership and intelligence of the system to focus on ensuring quality patient outcomes and the financial sustainability of CHC provision

1b: To build and develop long term sustainable working relationships with the **market**

1c: To pool the system's **data** into one location to create a single source truth to feed system reporting and other work streams allowing evidence based decisions and targeted interventions

1d: To drive out cost and ensure the most appropriate and **least restrictive care** is provided to patients

1e: To deliver a streamlined, personalised **end of life pathway**, that is timely, efficient and effective ensuring individuals with a rapidly deteriorating condition, that may be entering a terminal phase of life, are supported in the preferred place of care as quickly as possible

1f : To redesign the current **specification** to ensure it reflects the requirements of the CHC framework, the ICB, system partners and patients and families

1g: To ensure the comprehensive and robust application of the **CHC framework**

Staffordshire and Stoke-on-Trent Integrated Care System

Demand Management

Recovery 2024-25

Demand Management

Collaborative Scope and Ambition

This collaborative effort will require close coordination and communication between all stakeholders involved, including patients, the acute trust, VCSE and Vol sector, community providers, social care services, and other key partners. By working together towards a common goal, we can ensure that patients receive the right care in the right place at the right time, leading to better outcomes for all involved.

Key strategies for achieving this goal may include:

1. Establishing **clear pathways for patient flow**, including improved communication and coordination between all points of care.
2. Ensure we have a **consistent offer to Care Homes**.
3. Implementing **alternative care models**, such as virtual consultations and home-based care, to reduce the reliance on acute care beds.
4. Enhancing **community support** services to provide patients with the necessary resources and assistance to manage their health outside of the hospital.
5. Monitoring and evaluating progress towards **reducing bed numbers and improving patient flow**, with regular reporting and feedback mechanisms in place.

By working together towards these shared objectives, we can drive meaningful change in the healthcare system, ultimately leading to better outcomes for patients and a more efficient use of resources across the system.

SRO Supporting Statement (Simon Evans)

Through the development of a highly focused collaborative we will deliver changes that will shift the provision of care outside of our hospitals supporting patients in the community in an efficient and effective way. The use of our services and resources will change such that those that have the greatest impact will grow and extend to meet the needs of patients. By doing this we will reduce decompensation of vulnerable patients, harm caused through poor access to emergency services and provide a wholly better experience to patients more of which are able to choose a local, community or home-based support. We will make some difficult decisions on services that don't meet this brief swiftly and we may reduce, delay or suspend some so that we are able to focus our resources and efforts on those that have greatest impact. In order to do all of this we will devise a mechanism of connecting patients (SpOA) that will improve the way our services interact with each other and reduce delay.

Collaborative Underpinning Workstreams

2a - Active Case Management
2b - Care Homes Offer
2c - Single Point of Access
2d - Alternative Response Services

Staffordshire and Stoke-on-Trent Integrated Care System

Contracts

Recovery 2024-25

Contracts

Collaborative Scope and Ambition

- Ensuring **maximum productivity** (including ERF income) and **driving value from contractual arrangements**: by managing T&Cs, outcomes/ outputs;
- Regaining control of growth and inflation pressures;
- Delivering phase 2 plans around **appropriate/sustainable use of Independent Sector provision** via robust pathway management

SRO Supporting Statement (Helen Ashley)

Historically the CCGs and subsequently ICB has engaged in a number of external contracts in order to provide additional capacity to supplement NHS provision.

Whilst additional capacity has an immediate short term gain , it introduces additional overheads and costs into an already challenged financial environment.

Through the development of the system collaborative we will seek to ensure that we drive value for money from our contracts, and develop medium term sustainable plans to address any capacity shortfalls that currently exist.

Collaborative Underpinning Workstreams

- Base Efficiency Programme
- Independent Sector Partner Programme
- Stretch Target Deep dive contract review

Staffordshire and Stoke-on-Trent
Integrated Care System

Clinical Value & Medicines

Recovery 2024-25

Clinical Value & Medicines

Collaborative Scope and Ambition

To promote **value based personalised care** together.

SRO Supporting Statement (Rachel Gallyot)

The Clinical Value and Medicines Collaborative will focus on protecting resources through the **promotion of clinical value: prioritising outcomes and reducing low value clinical interventions**.

This will be delivered through targeted, specific programmes of work, identified and supported by data and evidence with a quality improvement approach.

The Collaborative will promote clinical value through medicine, interventions, clinical pathways and policy.

There will be a continuous focus on scoping new opportunities to maximise clinical value and building a culture of value based clinical practice.

Collaborative Underpinning Workstreams

The Collaborative will focus initially on the following four areas:

- **Medicines** - Prioritise medicines offering best value on specified clinical pathways.
- **Interventions** - Reduce the number of low value clinical interventions and overuse of specific diagnostics.
- **Pathways** - Design and implement value-based clinical pathways.
- **Policy** - Supporting clinical implementation, analyse existing policies with restricted and excluded criteria, addressing areas where clinical practice deviates from guidance.

Staffordshire and Stoke-on-Trent
Integrated Care System

Enabling Functions

Enabling functions

Collaborative Scope and Ambition

Our ambition is, where appropriate, to work **collaboratively to maximise opportunities for working collectively through our enabling functions** which include corporate back office, estates & digital efficiencies and savings across the ICS.

SRO Supporting Statement (Paul Brown)

The collaborative has three parts and each will have a nominated SRO. We will be looking to build on the work of the system estates group to capitalise on the opportunities of under-utilised estate and the digital collaboration forum to ensure best value from our digital investments.

The collaborative will deliver cash-out contributions from estates and corporate posts to contribute towards the £203m system efficiency programme. These targets are contained within the CIP targets of the 4 organisations. The digital programme is delivering non-cash benefits that will enable more cost effective delivery of services across the system.

Collaborative Underpinning Workstreams

- **Estates** – extracting savings from underutilised estate and selling surplus assets to generate capital receipts. The targets for 24/25 are relatively modest and the goal is to complete the work so that there is a larger contribution from 25/26
- **Workforce** – monitoring the delivery of organisational specific CIP Plans regarding Corporate Vacancies and in collaboration, where possible, identifying further opportunities to work collaboratively to deliver additional efficiencies
- **Digital** – improving productivity and containing costs by maximising the use of RPA processes and Artificial Intelligence

Staffordshire and Stoke-on-Trent
Integrated Care System

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure No: 07

Report to:	**Integrated Care Board**					
Date:	**20 June 2024**					
Title:	**SSOT ICS Organisational Development Plan**					
Presenting Officer:	Pauline Grant					
Author(s):	Pauline Grant					
Document Type:	Strategy	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)** ☒	**Discussion (D)** ☒	**Assurance (S)** ☐			
	Approval (A) ☐	**Ratification (R)** ☐	*(check as necessary)*			
Is the decision within SOFD powers & limits	**Yes / No**	Choose an item.				
Any potential / actual Conflict of Interest?	**Yes / No**	Choose an item. *If Y, the mitigation recommendations* – Not at this stage				
Any financial impacts: ICB or ICS?	**Yes / No**	Choose an item. *If Y, are those signed off by and date:* Not at this stage				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:
To provide an overview of the proposed approach to coproducing the ICS Organisational Development (OD) Plan and approach and inform the Board on progression to date.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
ICS Organisational Development Community of Practice: Information, Discussion and sharing and gathering system level strategic insights to inform thinking and draft development and next steps	17/04/2024
NHS Providers / ICB: Codesign and development Workshop 1 for Discussion, refinement, alignment with individual organisational priorities and context (short and long terms)	04/06/2024

(3) Implications:	
Legal or Regulatory	Click or tap here to enter text.
CQC or Patient Safety	Click or tap here to enter text.
Financial (CFO-assured)	Click or tap here to enter text.
Sustainability	Click or tap here to enter text.
Workforce or Training	Click or tap here to enter text.
Equality & Diversity	Click or tap here to enter text.
Due Regard: Inequalities	Click or tap here to enter text.

Due Regard: wider effect	Click or tap here to enter text.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☒	☐	This will take place as part of the planned co-design and development of the strategy

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	BAF5	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☐	BAF6	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	BAF7	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☐	BAF8	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

INTRODUCTION:
This draft ICS Organisational Development (OD) Plan intends to build on existing individual Organisation approaches to prioritising employee happiness and well-being in order to support improvements in engagement and experience efforts. Set within the strategic context of the NHS Long Term Workforce Plan, the Hewitt Review, the Fuller Stocktake, the NHS People Promise and The Future of HR and OD, it aims to cultivate a system wide culture of connection, collaboration and consistency with compassion, inclusion and belonging central to everything we do. The Plan will strategically shape our ICS Organisational Development approach and activities, guiding the focus for ICB Board Development and associated leadership and modelling of system culture and collaboration, as well as setting the scope and direction of agreed ICS strategic OD priorities. The Plan aims to identify and build on existing good practice, sharing learning, sourcing opportunities to scale, spread and innovate, in order to reduce duplication, whilst maximising efficiency.

OUR PRIORITIES:
Our ICS People Priorities for 2024/25 place Equality, Diversity and Inclusion, Culture and Leadership as central functions of its core business system priorities and this plan seeks to align these with the organisational priorities of system partners which centre on Health and Wellbeing and Positive and Inclusive Cultures.*

THE PUROSE AND CONTEXT OF OUR OD PLAN
Alignment of strategic priorities and recognising the current context is critical to the success of the Plan therefore we will prioritise initiatives for action where there is the greatest potential for working together as a system, based on learning from existing initiatives where we have already seen success working together at system, as well as any gaps identified as priority areas for action. Our Mandate for Change emphasises psychological safety, leading by example, building relationships, sharing best practice, centring OD and inclusion as part of everyone's business as well as support and building capability of our OD professionals*.

OPPORTUNITIES AND CHALLENGES
Existing relationships, examples of joint initiatives and previously embedded organisational approaches highlight our strengths as an ICS and there are a number of additional opportunities for us to ensure the effective functioning and continuous improvement of our system through joint working, particularly in

regards priority areas such as talent management and succession planning, building on our established communities of practice and harnessing opportunities for greater consistency across our practices and processes. Equally, we face a number of challenges, including the need to gain financial stability, whilst balancing the well-being and aspirations of our people. We know there is a need to take action to reduce duplication of effort and improve efficiency, effectiveness and outcomes.

APPLYING A STRENGTHS BASED APPROACH
The Plan emphasises the use of strengths-based approaches and best practice evidence & data to target innovation whilst adopting evidence based frameworks and methodologies to drive improvement. Central to our approach is psychological safety, cultural intelligence and positive practices, building on areas already prioritised within our partner organisations such as 'Just and Restorative, Belonging, Kindness and Joy in Work'*.

SHAPING OUR CULTURE AND BEHAVIOURS
Our Leadership Compact sets out the foundational values and behaviours expected of our leaders needed to lead across systems driving Staffordshire and Stoke on Trent ICS forward and this OD plan builds on many of these principles. Reviewing and refreshing our Leadership Compact as part of the development and implementation of our OD plan and approach, will support our leaders at all levels, including our Board, clinical and operational leaders, to exhibit the system leadership behaviours required to influence complex systems, working across organisational boundaries, collaborating with stakeholders across sectors, to effectively address systemic issues. Culture has been identified as a priority area for improvement, and our Leadership Compact will be central to this*.

OUR ACHIEVEMENTS
We already have a number of areas of success, where we are working collaboratively across our ICS that we can build on, including a variety of inclusion and belonging initiatives such as our innovative WRES Champions Programme, Reciprocal Mentoring, and Inclusion School, the High Potential Scheme, our Coaching and Mentoring Partnership and the Psychological Well-being Hub.

INFORMING OUR SYSTEM OD PRIORITIES
Development of our OD Plan is an evolving endeavour and we are working with the senior OD and Inclusion leads across our system partners to codesign and coproduce this OD Plan and approach. To date, there have been a number of early initial individual conversations with Chief People Officers, Human Resource and OD Leads, various senior leads from across different organisations and within our OD Community of Practice. It is also a recurring agenda item on our ICS Talent and Leadership Steering groups whose membership includes representation from ICS OD, EDI and Talent leads, Local Authority, Higher Education, Deputy CPO's, EDI, leadership and talent leads from NHS Provider organisations and our Primary Care Network. We also have GP presentation. Insights have been further informed from engagement and learning from Board development sessions, system workshops and initiatives and desktop research of existing data.

This has led to the emergence of some overarching cross cutting themes related to the continued need to build shared purpose and values, stronger alignment between our overall strategies and approach, greater clarity on the purpose and function of our structures and more communication across all partners and all levels of our organisations. There is a desire for a more positive culture and behaviours, together with greater consistency of decision making, OD, leadership and talent practices and better coordination of initiatives best achieved and prioritised as a system. These themes have helped form the basis for more in-depth conversations, to better collectively understand and align our priorities. This early initial and ongoing engagement has also highlighted and informed understanding of the individual and unique challenges faced by our different sector partners and the complexities involved in developing a shared OD plan and approach.

Initial conversations are being followed up with the development and roll out of a number of codesign workshops bringing together networks of individual organisations to provide input into shaping our final plan ensuring that individual organisations:

- priorities and strategic drivers are reflected

- have the opportunity to articulate what they need from a system OD plan
- can shape what a system OD function might look like and what needs to be in place for it to work

Workshop 1 took place on June 4th, with our NHS Provider organisations and additional workshops are in planning, to take pace with other system partners across our Councils, Local Authority and Primary Care. We will also ensure the voice of our patients and carers and staff networks is captured within our finalised plan. There is a proposal that our year one priorities (2024-25) focus on:

- Culture and Psychological Safety*
- Systems Leadership*
- Inclusive Talent Management*
- OD Practitioner Development*

Following the series of engagement workshops and agreed priorities, collaboration will continue with system partners to identify opportunities for sharing learning, innovating and scaling and spreading existing good practice as well as being clear of where our gaps are as a system.

OWNERSHIP & ENGAGEMENT FOR TRANSFORMATIONAL CHANGE
Transformational change is underscored by senior leadership taking ownership for driving sustainability and ensuring long-term success. It signals and supports clear governance, prioritisation of resources and effective implementation of initiatives aimed at fostering collaboration, innovation and continuous improvement.

There is an inherent challenge in bringing together a multitude of different provider organisations into one Integrated Care System and in shaping our OD approach. It is recognised that successful delivery is predicated on creating mindsets for change, emphasising readiness for change, collaboration, focusing on common goals, facilitating innovation and continuous improvement.

*These are the key themes or priority areas that have come out of workshop one. These will continue to involve as we engage more widely across our different groups of stakeholders ensuring our OD Plan and approach reflects the priorities and needs of all system partners.

(7) Recommendations to Board / Committee:

There is a need to work together as system partners to clarify our approach to OD, determine how an overarching strategic plan is operationalised and implemented, as well as clarifying the underlying principles to our approach and agreeing a mandate for change.

We ask that the Board:
- consider the draft OD Plan, endorsing the principles and approach outlined, recognising their importance in addressing current challenges and fostering System resilience.
- assume ownership and leadership of the Organisational Development Plan when finalised aligning the necessary resources, including financial, human and technological, to support successful implementation of the Strategic OD plan.

NEXT STEPS
Over the next 3 months (June – August) we will continue the codesign, coproduction, refinement, engagement, socialisation and development of the OD plan and approach, guided and defined by the ICS and provider organisation strategic objectives, local plans and priorities. This will inform the agreed activities we prioritise and undertake, the intended impact and anticipated measurable outcomes the plan will seek to deliver.

Final engagement sessions will take place during September prior to finalising the plan. An updated and final version of the Plan will be presented back to October Board.

Staffordshire and Stoke-on-Trent
Integrated Care System

Organisational Development Strategic Plan and Approach 2024 - 2027

DRAFT

Introduction

Research consistently shows that when work aligns with our values and beliefs, it significantly enhances individual performance and organisational outcomes. Prioritising happiness and well-being in the workplace is linked to increased job satisfaction, improved mental health and higher levels of employee retention.

Strategic Context

In June 2023, the NHS published its **Long Term Workforce Plan** setting out an ambitious 10 year vision for healthcare in England, focusing on training and growing the workforce, embedding the right culture, improving retention and reforming the way we work and train our people**.** **The Hewitt Review** 2021 and **The Fuller Stocktake** set priorities for improving culture, collaboration and systems leadership, whilst the **NHS People Promise** sought a pledge that we work together to improve the experience of working in the NHS for everyone. **The Future of HR and OD** recognises the people profession are a critical factor in enabling change and provides a framework towards building a shared commitment for enhancing capabilities across the profession, increasing collaboration across team and organisational boundaries, supporting organisations as they address and progress key issues.

Purpose

This Organisational Development Plan will strategically shape our ICS Organisational Development approach and activities, guiding the related focus for ICB Board Development and associated leadership and modelling of system culture and collaboration, as well as setting the scope and direction of agreed ICS strategic OD priorities. The primary focus for implementation will be to identify and build on existing good practice, sharing learning, sourcing opportunities to scale, spread and innovate in order to reduce duplication whilst maximising efficiency.

Aims

This Plan aims to cultivate a system wide culture of connection, collaboration and consistency with compassion, inclusivity and belonging being central to everything we do.

Underpinning the Plan with Strengths-based approaches will enable us to engage in conversations about our successes and aspirations, aligning our priorities for action, fostering trust, building relationships and ensuring a sense of shared purpose.

Transformational change begins with our leaders who are the catalysts for organisational evolution

Leaders set the tone, direction and pace for change, inspiring and mobilising others to embrace new ideas and approaches whilst modelling the behaviours and values necessary to drive improvement and innovation. Leading by example, they empower teams to embrace change, adapt to new challenges and realise their full potential.

We will deliver our aim through positive leadership and an unwavering commitment to the well-being of all our people.

We aspire to:

- ✓ *continually invest in and nurture our talented workforce*
- ✓ *develop our leaders with intent to building a positive organisational and system culture, with an engaged workforce*
- ✓ *create working environments where all of our people can experience inclusion and belonging and do their best work*

People Promise

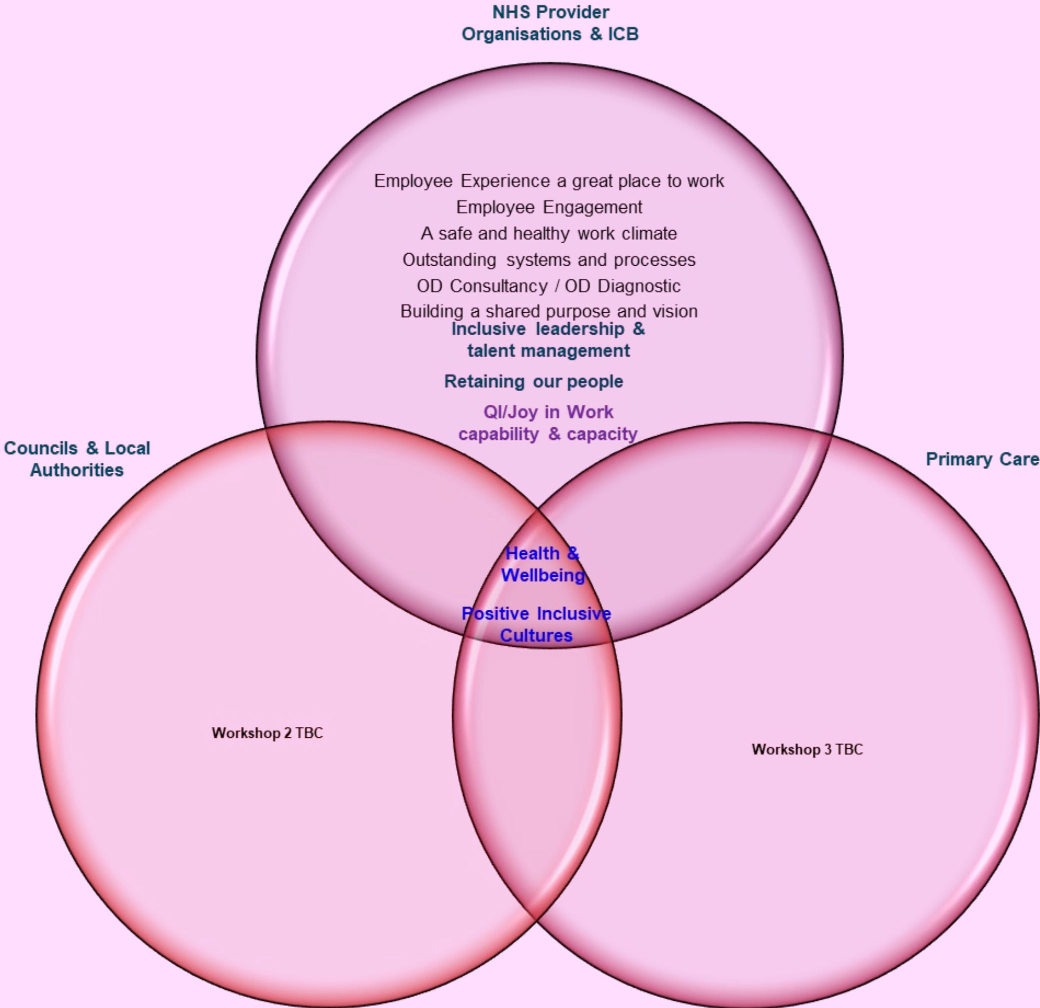
We are compassionate and inclusive · We are recognised and rewarded · We each have a voice that counts · We are safe and healthy · We are always learning · We work flexibly · We are a team

Our Priorities

Staffordshire and Stoke on Trent Interim People Plan 2022-23 and Beyond, prioritises workforce activities required to progress the ICS towards being a more integrated, inclusive, supportive system for our people. The People Plan prioritises working together to build compassionate and inclusive cultures, striving to affect positive change across the whole workforce, collaborating, widening participation, developing a broader talent pipeline and ensuring our workforce reflects our population.

Our System People Priorities 2024/25

Our System Partners Organisational Priorities:



Our system partners have made significant progress to date in the areas of organisational development, equality, diversity and inclusion, staff engagement and talent and leadership. and staff engagement across their individual organisations. Health and Wellbeing and Positive Inclusive cultures are identified as collective priority areas of focus across providers. The OD action plan will identify areas of good practice that can be built upon, scaled and spread.

PURPOSE AND KEY REQUIREMENTS FOR OUR ICS OD PLAN

A high-level strategic plan and approach across the system that connects to organisational priorities and challenges and aligns to delivery of system strategic objectives

Builds a shared purpose, culture and commitment to collaboration and facilitates shared learning

Sets direction and positions OD and EDI as golden threads in everything we do, ensuring they are seen as everybody's business

Consistency and efficiency of approach, builds on existing good practice, identifying opportunities to scale and spread rather than a singular focus on creating new initiatives

Prioritises activities that are best undertaken as a system, identifying opportunities for joint initiatives and innovation, enables transformational change that demonstrates impact and measurable outcomes

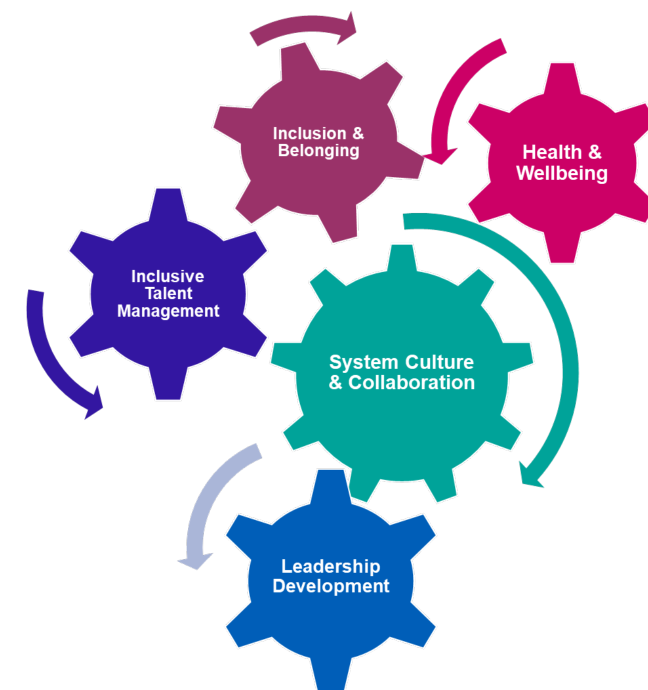
Supports development of system OD professionals and resources

The Purpose and Context of our OD Plan

No matter the strength of strategic plans for improvement, success in fostering the cohesion and resilience required for the transformative organisational and system design and development needed to impact better health and care delivery, is dependent on senior leadership and the cultures they create.

Senior leaders are the face and voice of culture change, authentically modelling the mindset and intent needed and genuinely supporting the desired transformation critical for success.

Our OD Focus



We have identified these five areas of existing OD activity and will prioritise initiatives for action where there is the greatest potential for working together as a system based on learning from existing initiatives such as our WRES Champions Programme, the High Potential Scheme, our Coaching and Mentoring Partnership and the Psychological Wellbeing Hub, as well as gaps in existing provision identified as priority areas for joint working

Our Mandate for Change

System and OD Strengths, Development, Opportunities and Challenges

Strengths	Development areas
• Existing relationships (OD Community of Practice) • Proof of concepts in People Programme • Broad OD skill set • Specialist knowledge • Governance structure in place • Existing examples of OD work in organisations and at system level • Embedded OD approaches within organisations • NHS have shared guiding principles/plans (LT Workforce plan, People Promise) • NHS have robust data sets Staff survey, ESR, Occupational Health data.	• Readiness for change • Psychological safety • Understand the 'what's in it for me' • Identify what is going to influence leaders at all levels • Build a compelling narrative 'Club and Country' • Work with the willing • Celebrate and showcase what we are doing across the system • Shared decision making and responsibility • Understanding the priorities and approaches • Shared definition of OD • Communities of Practice • Consistency in psychometric tools • Systems thinking leadership • Existing Governance structure • Communication and Engagement
Opportunities	**Challenges**
• Identify a consistent OD diagnostic approach • Use NHS Impact for people workstream • Defining the problem • Develop a practical OD toolkit • Talent and succession planning • Communities of Practice • Stakeholder mapping and engagement • Club and Country • Links with Quality Improvement • Digitalisation • A future focused approach	• Move away from 'bring in some OD' • Engage to make it real • Co-production with non-healthcare partners and staff • Defining OD collectively / an agile approach • Resourcing the work • Financial restrictions • Taking OD 'out of the box' • PESTLE influences • Culture change for 'club and country' – tuning into systems thinking

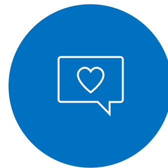
Our Approach

Applying a Strengths Based Approach

There is wealth of empirical evidence that positive practices improve individual health, performance, cognitive functioning and relationships, buffering against trauma and helping organisations amplify good practices. Positive practices such as *Just and Restorative, Belonging. Kindness and Joy in Work* are already being prioritised and implemented across some of our system partners and are known to influence employee motivation and productivity, build better team collaboration and communication, fostering cooperation and inclusivity and contributing to better organisational cultures and more productive and positive working environments.

. Evidence and Underpinning Principles

Create a psychologically safe learning environment



Use a Strengths based approach

Compassion, Inclusion and Belonging as golden threads in all we do

Use best practice evidence & data to target innovation

Cocreate and Coproduce to generate change

Adopt frameworks/ methodologies to drive improvement

Positive leadership inspires and empowers, creating supporting environments, fostering trust, optimism and a sense of purpose.

The principles of Justice, Equality, Diversity, Inclusion and Belonging (JEDI-B) are not exclusive to marginalised groups but are essential for the well-being and success of all individuals within society.

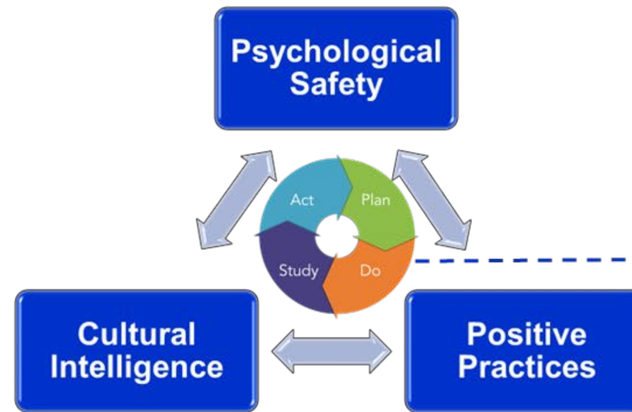
By prioritising equity, organisations can ensure that every member of their workforce has the opportunity to thrive and contribute meaningfully.

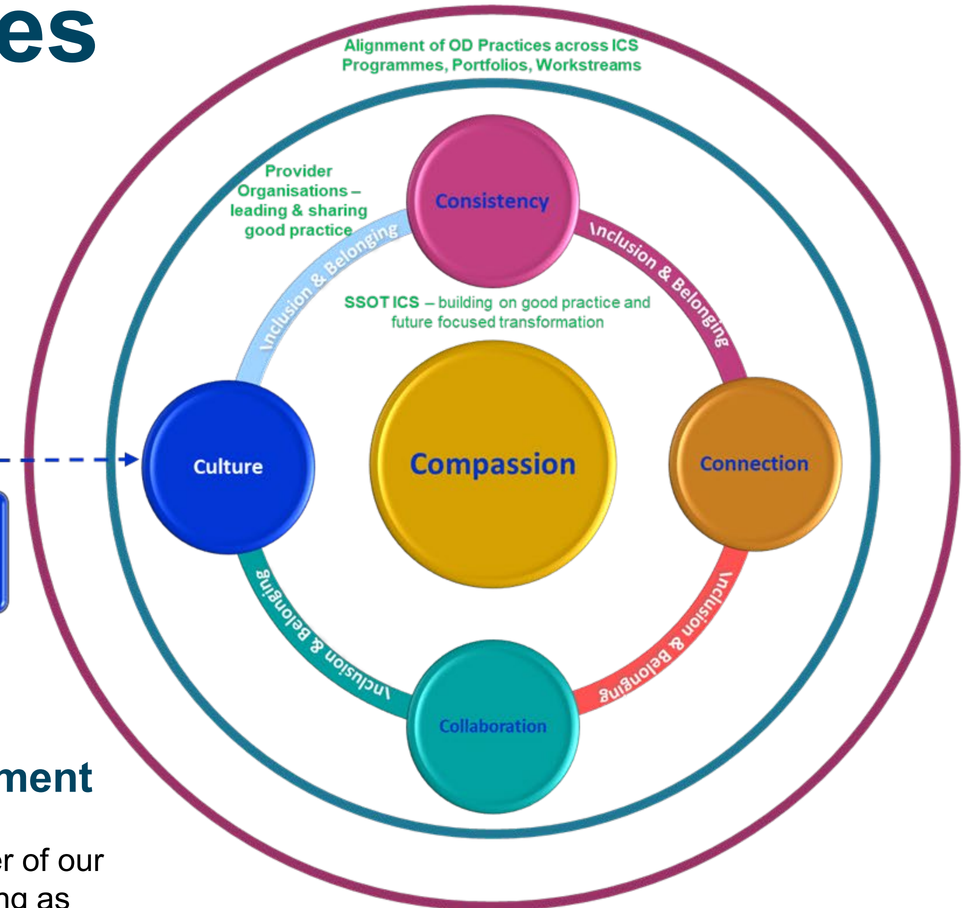
Evidence and Guiding Principles

Building on existing priorities and approaches

4 evidence-based Frameworks and methodologies underpin our approach to driving positive behaviours and improvement:

- **Psychological Safety** – empowering our people to openly communicate, innovate and learn from mistakes, fostering strong relationships and helping us to deliver on our system priorities and objectives.
- **Cultural Intelligence** – enhancing interpersonal connection, effective communication and trust, promoting adaptive leadership, building capability to navigate system complexities, fostering innovation and success across diverse teams and organisations.
- **Positive Practices** – fostering a culture of empathy and energy that unlocks the full potential of our people, encouraging them to thrive, driving engagement, innovation and excellence throughout our integrated care system.
- **Quality Improvement** – enhances a culture of data driven continuous improvement driven .





5Cs for Organisational Development

5Cs consisting of culture as the critical enabler of our identified priorities, with inclusion and belonging as golden threads in everything we do, compassion, positioned as being at the heart of everything we do, connection as a key ingredient of building trusting relationships, consistency in our approach and staff experience and collaboration built on existing best practice and sharing learning, provide a framework and focus for our collective efforts in effecting change across our Integrated Care System.

Alignment with Priority Areas

Priorities resulting from this OD Plan will set the direction for aligning OD activities and support across our various People workstreams and portfolios of work.

Shaping our Culture and Behaviours

Our Leadership Compact sets out the foundational values and behaviours expected of our leaders, needed to lead across systems, driving Staffordshire and Stoke on Trent ICS forward and this OD plan builds on many of these principles.

It challenges our leaders to embody trust, courage and integrity while fostering an environment that is open, honest, and psychologically safe.

It recognises each of us as ambassadors of our shared vision, committed to collaborative working and continuous improvement.

By embracing these principles, we ensure that our leadership is not only effective but also reflective of the compassionate and inclusive culture we aspire to cultivate across our health and care system.

Launched in our Integrated Care Board, this Leadership Compact will be refreshed and reviewed with System Partners as part of the development and implementation of our OD approach supporting our leaders at all levels, including our Board, clinical and operational leaders, to exhibit the system leadership behaviours required to influence complex systems, working across organisational boundaries, collaborating with stakeholders across sectors to effectively address systemic issues.

NOTE: As our plan continues to evolve, through wider engagement across our stakeholder groups, we will continue to update this content around the values and behaviours expected of our leaders ensuring our refreshed Leadership Compact provides alignment between the NHS People Promise areas and the behavioural drivers of other sector partners.

Our Achievements working collaboratively

Building on existing priorities and approaches

We are fortunate to have a number of existing examples of good practice to draw upon where we are already working together as a system and have achieved success. Our collaborative efforts have included improvements in:

Inclusion and belonging

Changing mindsets and culture

- ***Inclusion School*** (over 200 attendances - included both in person and online sessions in 23-24)
- ***Comfortable Being Uncomfortable*** programme (around 300 leaders participated, 95% reporting increased in having conversations on race, in being a race ally and to make positive difference at work.

Taking Positive Action

- **Differently Abled Buddy Scheme** (450 people educated on disability inclusion; at least 91 confidential discussions)
- ***New Futures*** positive action on race development programme (36 Global Majority Heritage participants).
- **WRES Champions** (20 champions) and **Reciprocal Mentoring** approaches (12 pairings)

Delivering Change

- Significant progress in improving the ethnic diversity and representativeness of our ICS workforce (Increased our Global Majority Heritage workforce from 14% to 16%
- Increased the proportion of our workforce that are confident to declare disabilities and neuro-difference (from 3% to 5%)
- Improved belief in equal opportunities by Global Majority heritage colleagues
- Improved feeling valued, satisfaction with work adjustments and engagement in differently abled colleagues

Leadership and Talent

High Potential Scheme

Our Achievements to date

- **36%** of Cohort 2 participants promoted since starting scheme in Jan 2023
- **73%** of participants progressed 1 year after graduating Cohort 1, of which 71% are female
- **Over 100** stretch opportunities offered
- **244** stakeholders involved in delivering the programme cross the systems
- **3** teams of 6 taken to WME Trisector challenge, all mentioned in a shortlisted category; one individual winning Shining Star Award for team leadership.

Our Deliverables for 2024-25

- **28** participants completing their second stretch assignments and showcase panels, amongst other activities before December 2024.
- HPS graduation event to take place 23rd January 2025.

Coaching and Mentorng Partnership

- 4 NHS providers joint members of West Midlands Coaching and Mentoring Pool along with **36** other subscribing organisations
- **18** trained coaches in external pool across SSOT ICS
- **43** internal coaches in pool across SSOT ICS
- **16** career development mentors across SSOT ICS registered in WME pool
- 17% increase in staff accessing coaching from 22/23-23/24.
- Pool membership saved us circa 82K in 23/24 for total cost of coaching hours accessed by staff

Staff Psychological Wellbeing Hub

The Hub provides a safe and confidential space for staff to prioritise their wellbeing and get themselves back on track so that they can be their best selves both at home and in the workplace

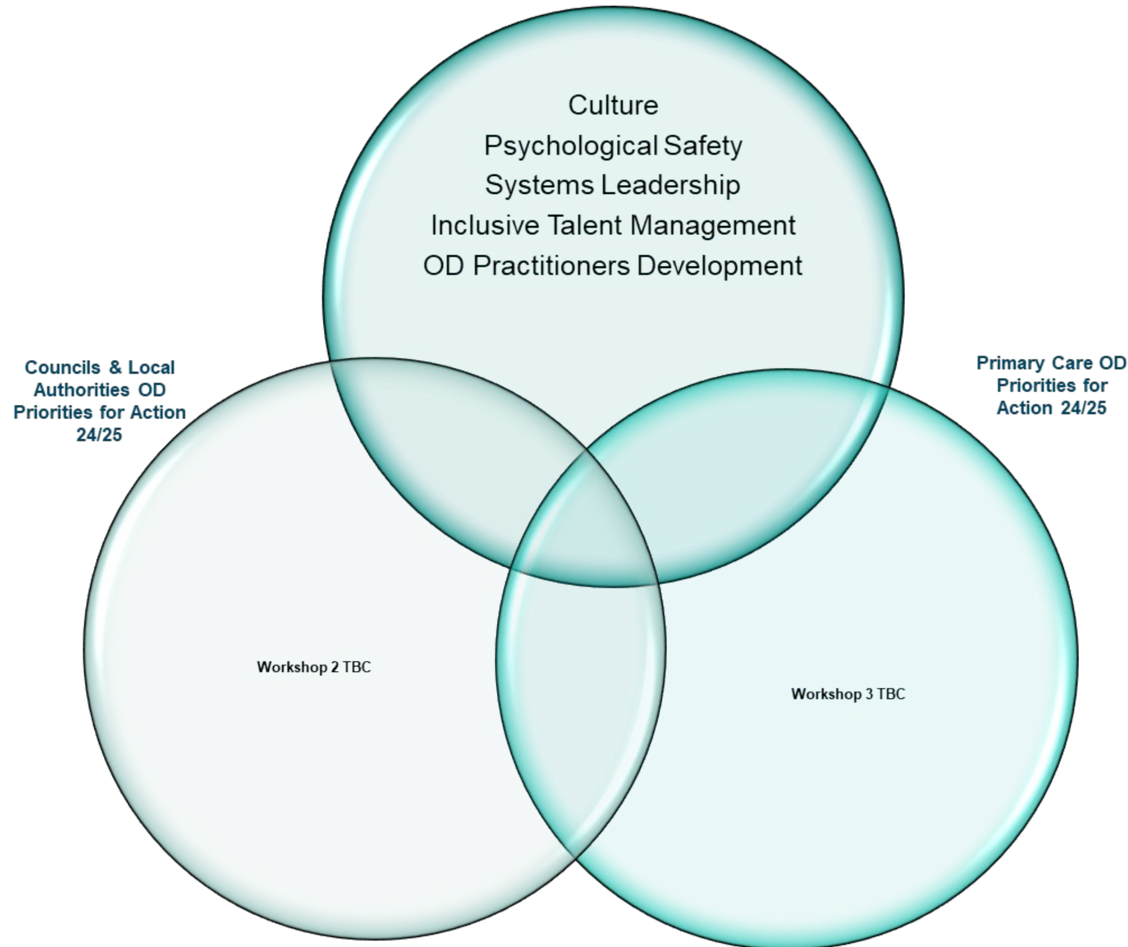
May 2021 - February 2024

Hub Referrals: **1416**
Assessments completed: **1169**
Staff referred on to support services: **978**
Engagement Sessions carried out: **200**
Workshops designed: **48**
Workshops facilitated: **200**
Attendees welcomed: **3166**

Informing our System OD Priorities

Unfolding Themes

1. **A shared purpose and set of shared values** driving behaviours towards a compassionate and inclusive culture, providing greater consistency of staff experience
2. **Stronger alignment** between our overall strategies, approach, structures and governance
3. **More clarity** on the purpose and function of our structures and more communication across all Partners and all levels of our organisations
4. **Greater consistency** in our cultures and behaviours, OD and leadership practices, and better coordination of leadership offers and how we manage talent
5. **Clear standards and expectations** for our leaders and managers.



"Poor management leads to lost customers and lost profits, but it also leads to miserable lives. Gallup's research into wellbeing at work finds that having a job you hate is worse than being unemployed - and those negative emotions end up at home, impacting relationships with family. If you're not thriving at work, you're unlikely to be thriving at life."

State of the global workplace 2023 report: The voice of the world's employees

Gallup

Staff Engagement Theme Score
7.1 (7.0 in 2022). Scoring higher than the Midlands and **National average on sub-scores.**

Morale Theme Score
6.2 (6.0 in 2022) Scoring higher than the and National average on sub-scores.

Ownership & Engagement for Transformational Change

Board Ownership of our OD Agenda

Transformational change is underscored by senior leadership taking ownership for driving sustainability and ensuring long-term success. it signals and supports clear governance, prioritisation of resources, and effective implementation of initiatives aimed at fostering collaboration, innovation and continuous improvement.

Codesign, Coproduction, Engagement and Socialisation

Our OD plan and approach will continue to evolve as we engage with stakeholders across our ICS to shape and coproduce the plan ensuring all contributions are recognised, that our people feel valued and their voices heard.

Engagement with staff across the system will continue throughout coproduction and into delivery via a variety of approaches to include:

- connecting with staff networks
- discussions within teams and organisations
- Response from national, regional and system surveys

Leading Transformational Change

We have acknowledged the inherent challenge in bringing together a multitude of different provider organisations into one Integrated Care System and in shaping our OD approach, this plan recognises that successful delivery will be predicated on creating mindsets for change by:

- **Assessing Readiness for change:** critically analysing our system resolve, fit and capacity to successfully deliver the benefits of our proposed OD plan and approach
- **Emphasising Collaboration**: encouraging collaboration and participation from all stakeholders, providing an inclusive approach that builds trust, fosters good relationships, and promote a sense of ownership and commitment
- **Focusing on Common Goals:** Facilitating discussions around shared values, aspirations and priorities, helping to identify common ground and aligning our diverse organisations around a common purpose and vision. Emphasising what unites rather than divides our organisations promoting a sense of unity and collective action.
- **Facilitating Innovation:** Encouraging creativity, exploration, and experimentation, stimulating innovation and generating new ideas for addressing complex challenges that require cross-sector collaboration, creating supportive environments for learning, adaptation and continuous improvement

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 08

Report to:	**Integrated Care Board**					
Date:	**20 June 2024**					
Title:	**Fit and Proper Person Test (FPPT) ~ Update**					
Presenting Officer:	Tracey Shewan, Director of Corporate Governance					
Author(s):	Tracey Revill, Governance Manager/IG Operational Lead					
Document Type:	Report					
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☒	**Assurance (S)**	☐
	Approval (A)	☒	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	NO				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Policy					

(1) Purpose of the Paper:
To provide an update on the Fit and Proper Person Test for members of the ICB Board and to provide assurance that all members have received satisfactory FPPT checks.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Click or tap here to enter text.	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	It is now a legal requirement for all Board members to have checks to assess their suitability to sit on the Board.
CQC or Patient Safety	The introduction of the FPPT takes into account the requirements of the CQC in relation to directors being fit and proper for their roles.
Financial (CFO-assured)	There could be financial ramifications if a board member is found not to be fit and proper for their roles in relation to decisions made by the board which may have a financial impact.
Sustainability	Considered and not applicable
Workforce or Training	All board members are required to carry out all mandatory training and is documented as part of the FPPT.

Equality & Diversity	Reviewed as part of the FPPT.
Due Regard: Inequalities	Reviewed as part of the FPPT
Due Regard: wider effect	Reviewed as part of the FPPT

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	**DPIA**	☐	☐	☒	*If N, why Not applicable in relation to this report.* *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	A Stage 1 EIA has been completed, awaiting outcome.
	QIA	☐	☐	☒	*If N, why Not applicable in relation to this report.* *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Not applicable in relation to this Report

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	**BAF5**	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	**BAF6**	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	**BAF7**	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	**BAF8**	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

All Fit and Proper checks have been carried out on all ICB Board members and these have been signed by the Chair for the Chief Executive Officer and the Chair and CEO have signed off for the ICB Exec Directors and the NEDs.

The Chair's FPPT has been signed off by the Senior Independent Director.

The Chair has received assurance from partner organisations that each representative from their respective organisation has undergone FPPT and is therefore, sit and proper to sit on the ICB Board.

(7) Recommendations to Board / Committee:

The Board is asked to receive the FPPT update and noting that all board members have received an FPPT and that the Chair is assured that they are fit and proper for their roles on the board, but to also note that confirmation is still awaited in relation to the representative from Staffordshire County Council.

Fit & Proper Person Test
Executive Update

1.0 Background

Following the introduction of the Fit and Proper Person Test (FPPT) and guidance provided by NHS England the ICB has implemented the testing requirements of the FPPT Framework. All Board Directors are required to be tested against a set of standard competencies, with a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations.

The ICB has developed a SOP for the purposes of monitoring and renewing the FPPT which must be completed annually. The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The SOP is appended to this update.

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

NHSE advise that the approach should be proportionate, with the ICB Chair deciding the level of assurance required from Partner organisations etc.

2.0 Progress to date

The Governance Team has led the process and all Board directors have received a Self-attestation form to complete. Following the return of the forms the HR team have completed the checks required. These consist of:

General HR questions regarding Name, Organisation, Job title etc.

- Employment history
- Training/Development
- References
- Appraisals
- Any disciplinaries, grievances, whistleblowing claims unacceptable behaviours
- DBS check
- Professional registration

Directorship Checks

- Insolvency
- Disqualification – Director's register
- Disqualification – Charity Trustee
- Employment Tribunal Judgements

Social Media Checks

- Google
- FaceBook
- Instagram

The ICB has now completed these checks which have been signed off by the Chief Executive Officer and the Chair.

The ICB Chair has written to their partner organisations requesting confirmation that their representatives at the ICB Board also meet the standards of FPPT. Responses to date have been received from:

- Midlands Partnership NHS Foundation Trust
- North Staffordshire Combined Healthcare NHS Trust
- Stoke-on-Trent City Council
- University Hospitals of North Midlands NHS Trust
- Staffordshire County Council

All future new appointments to the Board will be subject to the FPPT requirements and will be carried out by the recruitment team.

3.0 Next Steps

The FPPT process should be completed annually and therefore, next steps for the ICB will be for all Directors and NEDs to have completed their appraisals. Once these have been completed, Self-Attestation forms will be sent to the Directors/NEDs for completion for the annual review at the end of June 2024.

The annual FPPT should be carried out at the same time of year as the annual appraisal. However, NHSE have confirmed that for 23/24, if Appraisal has already been completed it will not need to be repeated. From 2024/25 the FPPT will need to be aligned with the appraisal.

The evidence from the FPPT should be provided to the Chair or CEO to consider as part of the appraisal.

4.0 Annual NHS FPPT submission reporting template

The annual submission template has been completed for sign-off by the Chair for submission with the Chair's annual appraisal.

5.0 Governance arrangements

The FPPT process will be audited in 2027, as guidance states a review should be held at least every three years but will be continuously monitored to identify any learning / best practices.

NHS England

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Staffordshire and Stoke-on-Trent ICB	David Pearson	May 2024

Part 1: FPPT outcome for board members including starters and leavers in period

		Confirmed as fit and proper?			Leavers only	
Role	**Number Count**	**Yes**	**No**	**How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? ***	**Number of leavers**	**Number of Board Member References completed and retained**
Chair/NED board members	5	Yes		None	0	
Executive board members	9	Yes		None	0	
Partner members (ICBs)	6	Yes		None	0	
Total	20	Yes			0	

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Part 2: FPPT reviews / inspections

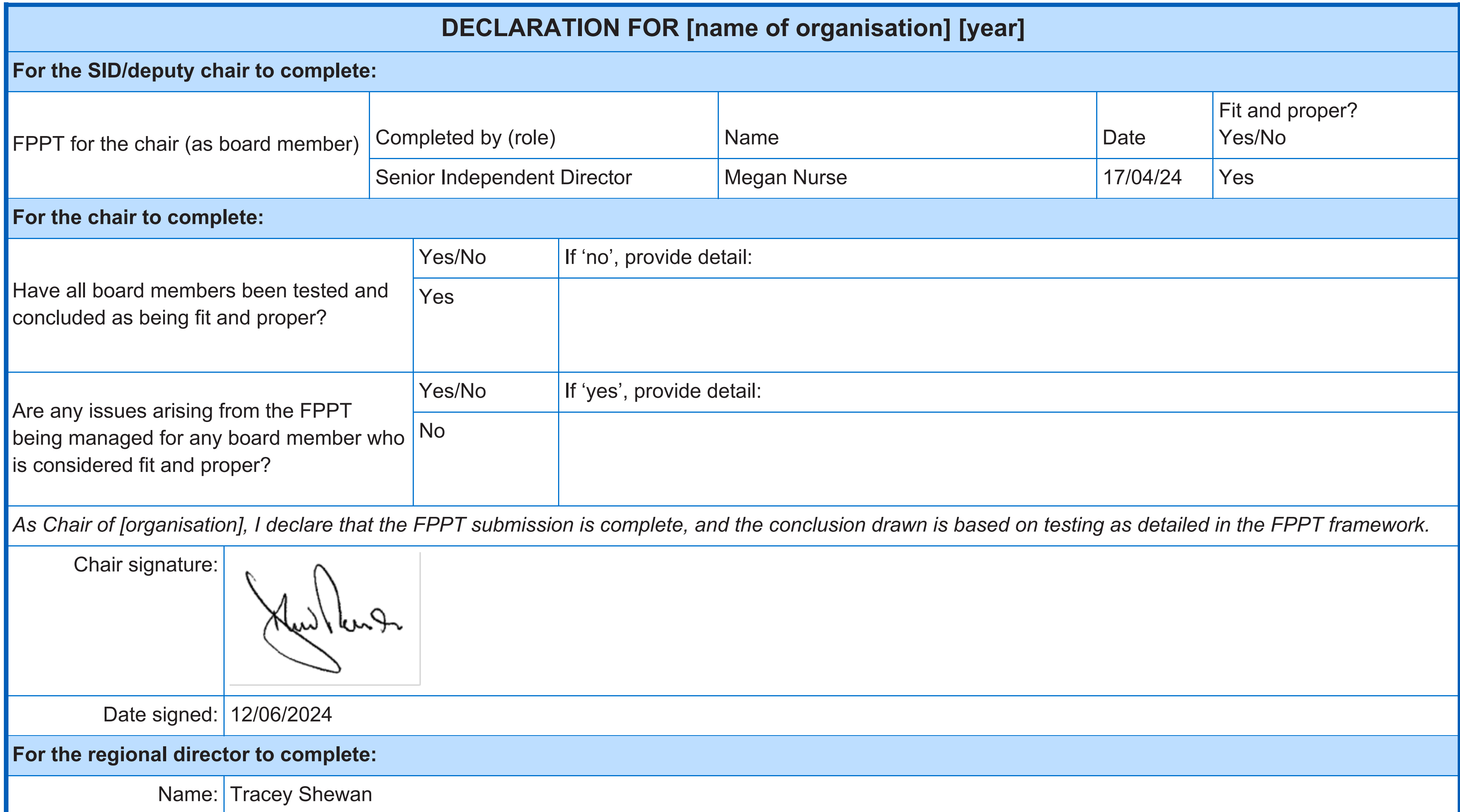
Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.	20/06/2024			
Executive Meeting	16/05/2024	Approved		
Audit Committee	01/07/2024	As the Audit Committee has not had a BAU meeting since March 2024 the process will be submitted to the committee at the next BAU meeting to be held on the 1st July 2024.		
Committee Effectiveness Review	2023/24	Our committees undertook an effectiveness review of the business undertaken during the last year.		

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Committee Effectiveness Review	2023/24	It was agreed that the committees were well run/structured and that they were briefed on key issues sufficiently to enable them to provide support and challenge. The committees provide a good forum for debate. Main concerns were around "heavy" agendas. Further details can be found in our Annual Report for 23/24 once it is published.		
SID/Chair	17/04/2024	SID and Chair met to sign off the Chair's FPPT		
Chair/Senior Managers/ HR/CEO/SID	19/04/2024	SOP produced for the process of FPPT which was approved.		

Add additional lines as needed

Part 3: Declarations



DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director	Megan Nurse	17/04/24	Yes
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If ‘no’, provide detail:		
	Yes			
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If ‘yes’, provide detail:		
	No			
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:	[signature]			
Date signed:	12/06/2024			
For the regional director to complete:				
Name:	Tracey Shewan			

Signature:	
Date:	

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 09

Report to:	**Integrated Care Board**					
Date:	**20 June 2024**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Heather Johnstone, Chief Nursing and Therapies Officer (CNTO)					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)**	☐	**Discussion (D)**	☐	**Assurance (S)**	☒
	Approval (A)	☐	**Ratification (R)**	☐	*(check as necessary)*	
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail June 2024.					

(1) Purpose of the Paper:
To provide assurance to the Integrated Care Board regarding the quality, safety, experience, and outcomes of services across the entire health economy.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
This paper is a combination of corresponding papers (D/S/I) presented and discussed at Quality and Safety Committee.	12/06/2024
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Risks identified and managed via the Board Assurance Framework and Corporate Risk Register.
CQC or Patient Safety	Updates provided against relevant organisations. Continuous Quality Improvement update aligns to known links between providers and systems.
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	Details contained within the report relating to providers by exception.
Equality & Diversity	Details contained within the report.
Due Regard: Inequalities	Update contained within the report.

Due Regard: wider effect	Quality Impact Assessment update supports the ICB, and system partners, having due regard to all likely effects of decisions.

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	BAF5	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☐	BAF6	Sustainable Finances	☐
BAF3	Proactive Community Services	☒	BAF7	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☒	BAF8	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

The paper summarises the items received by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in May & June 2024. The Committee fulfilled its role as defined within its terms of reference. Where appropriate, actions and oversight arrangements are identified within Appendix A.

Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:

- Updates from System Partners.
- Local Maternity and Neonatal System

(7) Recommendations to Board / Committee:

Members of the Integrated Care Board are asked to:

- Receive this report and seek clarification and further action as appropriate.
- Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail June 2024

1. Updates from System Partners (from SQG)

1.1 Midlands Partnership University NHS Foundation Trust (MPFT)

1.1.1 MPFT won or was highly commended in 15 awards at the national Positive Practice in Mental Health Awards 2024. The annual awards identify, share, and celebrate positive practice in mental health. Further, MPFT's 0-19 services have maintained UNICEF UK's Baby Friendly Initiative Gold status following a progress monitoring review.

1.2 North Staffordshire Combined Healthcare NHS Trust (NSCHT)

1.2.1 Football Communities Combined – NSCHT, Port Vale Foundation and Stoke City Community Trust – were Silver runners-up in the 'Best Not for Profit Working in Partnership with the NHS' category at the Health Service Journal Partnership Awards 2024.

1.3 University Hospital of North Midlands NHS Trust (UHNM)

1.3.1 UHNM continue to progress with their implementation of the Johns Hopkins Activity and Mobility Programme. The work on eight adult inpatient wards across Royal Stoke University Hospital and County Hospital has been accepted for presentation at the #EndPJparalysis Global Summit in July 2024. A region wide campaign is planned to raise awareness of the importance of moving.

1.4 Staffordshire and Stoke-on-Trent ICB

1.4.1 A substantial number of residents in South Staffordshire access healthcare at providers outside of Staffordshire. In these instances, Staffordshire & Stoke-on-Trent ICB is an associate to the contract held by another ICB and work in partnership with partners to collaboratively support quality improvements for our residents. The ICB's Quality Leads have long established working relationships with NHS Birmingham & Solihull ICB, NHS Black Country & West Birmingham ICB & NHS Derby & Derbyshire ICB. Where there has been CQC inspection activity the ICB has been notified and received updates on any improvement actions identified. Further, our Local maternity and neonatal system (LMNS) routinely receives updates on the quality and oversight of maternity services at The Royal Wolverhampton NHS Trust and University Hospitals of Derby & Burton NHS FT.

1.4.2 The latest NHS Oversight Framework 2023-24 segmentation levels were published by NHS England in May 2024. The segmentation is based on a quantitative and qualitative assessment of the five national and one local priority themes contained within the NHS Oversight Framework including an assessment of the quality of care, access, and outcomes. The segmentation levels for our main NHS providers remain unchanged as follows:

Inter-System Providers	
Midlands Partnership University NHS Foundation Trust	2
North Staffordshire Combined Healthcare NHS Trust	1
University Hospitals of North Midlands NHS Trust	3
Intra-System Providers	
The Royal Wolverhampton NHS Trust	3
University Hospitals of Derby & Burton NHS Foundation Trust	3
West Midlands Ambulance Service University NHS Foundation Trust	2

1.4.3 The NHS Patient Safety Strategy includes the ambition for all safety-related clinical governance committees (or equivalents) in NHS organisations to include one or more Patient Safety Partners (PSPs). PSPs will advocate for patients, carers, and families to ensure that their perspectives and considerations are prioritised. Following review, consistent with other volunteer roles, the decision has been taken to recruit 2 volunteer PSPs who will report directly to the ICB's Patient Safety Specialist, support the work of the ICB and collaborate with PSPs across system partners.

1.4.4 All NHS system partners implemented the Patient Safety Incident Response Framework (PSIRF) on 1st December 2023 following the delivery of accredited oversight and/or investigator training to support improving patient safety through a systems approach. Six months on, NHS providers are reporting that learning response reviews have given then a rich mixture of learning to support improvements in patient safety, clinicians involved in reviews have given positive feedback and patient safety learning newsletters are in place to share key themes with all services. The ICB has received 'substantial assurance' from the internal auditors following a review of the delivery of PSIRF. The ICS held our first Bi-Annual PSIRF Learning Event on 13th May 2024. The event, designed to share feedback from the implementation of PSIRF and learning from completed learning responses, was very well attended by NHS Trusts both in and out of system, non-NHS organisations, Black Country ICB and Health Innovation West Midlands (HIWM). HIWM, who have role to test and accelerate the adoption and spread of innovative ideas supportive delivery of the NHS Patient Safety Strategy, celebrated the significant work in the system which is leading the way for the region and continue to promote and share resources created in the system as best practice. Planning is already underway for the next Bi-Annual PSIRF Learning Event scheduled in October 2024, including extending the invite to wider system partners and a focus on a pragmatic approach to PSIRF for non-NHS organisations including primary care.

1.4.5 There are an increasing number of people waiting over 18 weeks for a wheelchair and a corresponding increase in service user feedback. Plans are in place to recover performance to 95% within 18 weeks over the next 12 months. The ICB has worked with the provider to strengthen their quality governance arrangements including sharing best practice from NHS system partners to update the duty triage guidelines to include reprioritisation and clinical harm review. A quality visit was undertaken by the ICB, supported by the National Clinical Director, in May 2024 to discuss the implementation of the updated guidelines. Further, the ICB have received positive feedback from a system partner confirming the actions being taken to support referrers and service users. The provider has appointed a National Customer Relations Manager who has reviewed complaints processes and is proactively seeking to work with the Parliamentary & Health Service Ombudsman Stakeholder Engagement Team.

1.4.6 The Mental Health Host and Home ICB guidance sets out the enhanced responsibilities of a Host ICB for the quality oversight and monitoring of specialist non-secure mental health inpatient NHS and independent provision in their geographic are. It also makes clear the expectations of the role of the Home ICB for the oversight and care of people they place in a mental health unit outside of the ICB geography where the person is ordinarily resident. The ICB, supported by North Staffordshire Combined Healthcare NHS Trust, have agreed to be part of a national pilot implementing the guidance. A task and finish group has been set up involving relevant system stakeholders and information governance specialists to develop a robust implementation plan. It has been agreed that the System Quality Group will provide the oversight and governance for the escalation of any quality issues.

2 Local Maternity and Neonatal System (LMNS)

2.1 The All-Party Parliamentary Group on Birth Trauma report Listen to Mums: Ending the Postcode Lottery on Perinatal Care sets out practical recommendations to reduce the rate of birth trauma. These include, integrating principles of trauma informed care across maternity settings and ensuring that women's rights are respected before, during and after birth. A benchmarking exercise is taking place in collaboration with all stakeholders to identify areas for improvement within the current service provision.

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 10

Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 12th June 2024

Key Discussion Topics	**Summary of Assurance**	**Action including referral to other committees and escalation to Board**
Risk Register	The committee Approved the addition of the proposed new risks 1363, 1369 and 1373. Approved the proposed decrease and closure of risk 1268. Approved the proposed decrease of risks 1241 and 1278. Approved the closure of risk 1315. The committee were assured in relation to the report.	
Stoke-on-Trent SEND Strategy	The committee approved the Stoke-on-Trent SEND Strategy and recommended ratification by the Board.	
Listen to Mums: Ending the Postcode Lottery on Perinatal Care. A report by The All-Party Parliamentary Group on Birth Trauma	The paper provided assurance to the committee that the recommendations within the report were subject to a benchmarking exercise with all key stakeholders to identify gaps within the current service provision. These gaps will be explored and proposed actions will be presented to the committee at its August meeting. Following this, a further update will be provided to the ICB Board in September.	
Local Maternity & Neonatal System (LMNS)	The committee were assured in relation to key quality assurance, improvement and patient safety activities being undertaken across maternity and neonatal services in Staffordshire and Stoke-on-Trent.	
Looked After Children Health Assessments	The committee noted the update on statutory guidance for looked after children and the ICBs current performance against the Initial Health Assessment (IHA) and Review Health Assessments (RHA). The current trajectory for meeting the targets for IHA's is July 2025, the team are still working on an improvement trajectory for RHA's. The committee were concerned about the length of the IHA improvement trajectory but were assured in relation to the data quality that underpinned it. The committee also supported the ongoing transformation	

	work in this area. The committee asked to receive bimonthly updates to monitor the delivery of the targets.	
Safeguarding Policies	The committee approved the following safeguarding policies and recommended ratification by the Board. • Domestic Abuse and Serious Violence Policy for ICB Employees Policy (subject to confirmation of an equality impact assessment having taken place) • Prevent Policy The policy in relation to: • Mental Capacity Act Policy To be brought back to the August meeting.	
Safeguarding Adults & Children Report	The committee were assured in relation to the highlights and exceptions provided in relation to safeguarding adults and children. The committee noted the further work in relation to increasing the number of MARAC (domestic abuse) referrals from health partners.	
All Age Continuing Care	The committee were assured on the progress to date in relation to All Age Continuing Care particularly the positive impact on patient experience as a result of the improved performance.	
Working with People and Communities	The committee were assured the ICB has measures in place to fulfil their duties to engage with local populations across Staffordshire and Stoke-on-Trent	
Health Inequalities	The committee noted the progress being made regarding the collaborative development of the ICS Health Inequalities Strategy for Staffordshire and Stoke-on-Trent.	
Continuous Quality Improvement	The committee noted the updates contained within the report which demonstrated the work being undertaken within the Continuous Quality Improvement Sub-Group.	
System Quality Group	The committee were assured in relation to the key areas of risk and concern from the System Quality Group meetings held on the 10th of May and 7th June 2024 where partners from health, social care and the wider ICS were in attendance. The committee also approved the ICB Patient Safety Incident Response Framework Policy.	
Quality Impact Assessment	The committee were assured in relation to the update provided on the Quality Impact Assessment work programme and the actions being taken to ensure the ICB fulfils its statutory duty to have regard to all likely effects of decisions.	
Planning Guidance – Quality & Patient Safety	The committee noted the report which provided a summary of the quality and patient safety deliverables contained within the 2024/25 priorities and operational planning guidance.	

	The committee were assured that actions are underway to implement all objectives and actions.	
Quality Oversight Dashboard	The committed noted the final iteration of the Quality dashboard as at Month 12 (March 2024) and supported a deep dive discussion in July 2024.	
North Staffordshire Combined Healthcare NHS Trust (NSCHT) Quality Account Statement	The committee received for information the NSCHT Quality Account Statement which had been approved by the ICB Chief Medical Officer/Deputy Chief Executive, and the ICB Assistant Chief Nursing & Therapies Officer.	

Risk Review and Assurance Summary

The Board can take assurance regarding the reports provided and the discussion which took place at the committee.

The Board are asked to **ratify** the approval of the following items as indicated above:

- Stoke-on-Trent SEND Strategy
- Domestic Abuse and Serious Violence Policy for ICB Employees Policy (subject to confirmation of an equality impact assessment having taken place)
- Prevent Policy
- The ICB Patient Safety Incident Response Framework Policy.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 11

Report to:	**Integrated Care Board**
Date:	**20 June 2024**
Title:	**Report to the ICB Board on Performance**
Presenting Officer:	Paul Brown – Chief Finance Officer
Author(s):	Colin Fynn – Head of Intelligence and Analytics
Document Type:	Report
Action Required (select):	**Information (I)** ☒ **Discussion (D)** ☐ **Assurance (S)** ☒ **Approval (A)** ☐ **Ratification (R)** ☐ *(check as necessary)*
Is the decision within SOFD powers & limits	**Yes / No** — YES
Any potential / actual Conflict of Interest?	**Yes / No** — NO *If Y, the mitigation recommendations –* Click or tap here to enter text.
Any financial impacts: ICB or ICS?	**Yes / No** — YES *If Y, are those signed off by and date:* The financial impacts are as outlined in the body of the report.
Appendices:	Performance Report

(1) Purpose of the Paper:

The purpose of this paper is to provide a summary of performance report received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). In line with previous years there is no formal month 1 reporting for the ICS financial position. Therefore, the finance section is not contained within this summary.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (I)	29/05/2024
System Finance and Performance Committee (S,D)	04/06/2024

(3) Implications:

Legal or Regulatory	Monitoring performance is a statutory duty of the ICB.
CQC or Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team and pursued through the Clinical Quality Review Meeting (CQRM).
Financial (CFO-assured)	As outlined in the body of the report.
Sustainability	N/A
Workforce or Training	N/A

Equality & Diversity	N/A
Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:					
		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Approved by QIA Panel on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:					
BAF1	Responsive Patient Care - Elective	☒	BAF5	High Quality, Safe Outcomes	☒
BAF2	Responsive Patient Care - UEC	☒	BAF6	Sustainable Finances	☒
BAF3	Proactive Community Services	☒	BAF7	Improving Productivity	☒
BAF4	Reducing Health Inequalities	☒	BAF8	Sustainable Workforce	☒

(6) Executive Summary, incl. expansion on any of the preceding sections:

The report contains:

1. An executive summary of performance across our One Collective Aim, Urgent and Emergency Care (UEC), Tackling Backlogs (Planned Care), Diagnostics, Cancer, General Practice/Primary Care, Prevention and Health Inequalities, Children and Young People (CYP), Mental Health and Learning Disabilities.
2. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operational plan
3. Escalations presented and considered at the system finance and performance committee, along with exception reporting against our One Collective Aim and 4 system priorities.
4. In line with previous years there is no formal month 1 reporting for the ICS financial position.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Note the headlines, escalations and exceptions highlighted

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Performance Report

20th June 2024

Prepared by the Transformation Delivery Unit and ICB Intelligence Team

Overview

This report contains for discussion:

1. An executive summary outlining key performance headlines and escalations.
2. An overview of portfolio exceptions.
3. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operating plan.
4. Exception reporting against our One Collective Aim and 4 system priorities.

Please note:

1. In line with previous years there has been no formal month 1 reporting process for the ICS financial position. Therefore, the finance section will not be within this summary. At SPFC the updates were around the 2024/25 operational plan and the system recovery plan.

Ctrl and click on any underlined text for further detail.

Executive Summary – Headlines (1/2)

Headlines	Points to note
One Collective Aim	• April's West Midlands Ambulance Service (WMAS) CAD (Computer Aided Despatch) data indicates reductions in both Category 2 and Category 3 incidents in relation to March 2024 of 1.1% and 3% respectively. When compared to the same period last year Category 2 reported growth of 4.8% whilst Category 3 saw a reduction of 8.1%. • Category 2 response started April below the 30-minute target level but gradually increased through the month resulting in the latest 4-week average of 32m 48s (w/e 12th May) placing the system 7th out of 11 in the Midlands region, and 22nd out of 42 nationally. The 2024/25 YTD average of 31m 48s is a full 9 minutes below the 2023/24 average. • NHS111 data through Derbyshire Health United (DHU) Healthcare is not currently available due to delays in the local reporting process through the Lead Commissioner.
Urgent and Emergency Care (UEC)	• 4hr Emergency Department (ED) performance at University Hospitals of North Midlands NHS Trust (UHNM) fell slightly from 70.23% the previous month to 70.18% for April but focus on emergency department pathways continues. The small fall in performance was due in part to a 2.37% daily increase in attendances at UHNM, and when compared to April 2023, the 6.9% increase in attendances was equivalent to 30 more patients per day through April 2024. • 12hr Performance continued to improve with a slight reduction from 8.6% to 8.5% during April. This kept UHNM in the 2nd quartile regionally where they have been since July last year. • Localised reporting of Pathway 3 Discharges utilising new NHS guidance indicates the percentage of discharges designated as Pathway 3 through April were 0.51%, below the 1% national guidance and supporting the drive towards Pathway 0 designation of 80%, for which April reported 78.14%. • Whilst Infection Prevention and Control (IPC) concerns relating to diarrhoea and vomiting have reduced, Covid has increased through April with 93 beds occupied by the 12th May.
Tackle Backlogs (Planned Care)	• Eliminating 104+ and 78+ week waiters (ww) remains a system focus; 3 patients remain in the 104+ ww category at Integrated Care Board (ICB) level in May (w/e 12/05) and 27 in the 78+ ww category. • UHNM have exceeded the monthly target in 52+ ww in March, by 261. • 65+ ww at UHNM have decreased in March to 713, from 942 in February – a decrease of 229. The national expectation is that these are at zero by the end of September 2024.
Diagnostics	• ICB Diagnostic performance against the 7-core test plan (77.1% of patients to be seen in <6 weeks in March) was below plan at 74.5%. The planning guidance outlines the national ambition is 95% by March 2025 for this target. • The activity count decreased in all [7] tests, by 262, with the greatest decreases in Computed Tomography (of 2,382) and Ultrasound (of 1,474). The plan was exceeded in Magnetic Resonance Imaging (MRI) and Gastroscopy only.
Cancer	• The latest UHNM position (w/e 12th May, weekly recovery pack) reports the [Cancer] 62-day backlog has increased to 268. • The ICB 28-day faster diagnosis pathway saw 76.9% of patients told within 28 days (across all providers) above the national standard of 75%. The planning guidance will increase this target to aim for 77% by March 2025. • The 104-day Cancer backlog at UHNM (w/e 12/05, weekly recovery pack) is now at 65; this total remains below the revised trajectory (of approximately 80 for this period). Largest backlog is in Colorectal (27) and Urology (20).

Ctrl and click on any underlined text for further detail.

Executive Summary – Headlines (2/2)

Headlines	Points to note
General Practice/Primary Care	• GP appointments - the overall number of appointments has exceeded the 2023/24 plan by 10.1%, delivering an additional 586,463 appointments [above plan]. This includes additional appointments commissioned over winter/Easter. • Community Pharmacist Consultation Service (CPCS) referrals from General Practice exceed the overall YTD target by 490 [referrals] (April 2023 to January 2024). No new data is available since the move to Pharmacy First on the 31st January. We are awaiting confirmation from NHSE on when new data will be available. • Additional Roles Reimbursement Scheme (ARRS) FTE (Full Time Equivalent) has continued to increase reaching 556.7 for March 2024, utilising 91.9% of the 2023/24 budget by year-end.
Prevention and Health Inequalities	• The national objective is to increase the percentage of appropriate patients on lipid lowering therapies; the national target of 60% has not been met in March 2024 with 58.1% achieved.
Children and Young People (CYP)	• Reduce the emergency admissions for Long Term Conditions (LTC), including diabetes, epilepsy and asthma in the under 18-year-old population. • Year to Date (YTD) to February (latest data), asthma and diabetes admissions were below the same period in 2019/20. • YTD to February (latest data), epilepsy admissions increased on 2019/20. There were 184 admissions in 2019/20 versus 203 in 2023/24, which is an additional 19 admissions and a 10% increase. Admissions increased in CYP aged 5-10 and 11-17 but not in the 0-4's.
Mental Health and Learning Disabilities	• Inappropriate adult acute Out of Area Placement (OAP) bed days are over plan (zero) by 185 this year, to February, but have been 0 over the last 3 months. • Access to NHS Talking Therapies was 25,605 at year end. 16% below plan but 3% higher than last year (24,790). • The Dementia diagnosis rate was 72.2% at year end. Exceeding the national target of 66.7% and improving on 2022/23 (69.9%). • Autism assessment waits for Children and Young People (CYP) increased by one week at both trusts to 28 weeks at Midlands Partnership Foundation Trust (MPFT) and 39 weeks at North Staffordshire Combined Healthcare Trust (NSCHT). 15 weeks over plan at MPFT and 1 week within plan at NSCHT.

Ctrl and click on any underlined text for further detail.

Overview of key underpinning deliverables

Ctrl and click on the portfolio heading box for further detail on programme delivery and performance.

Children and Young People / Maternity

- Design and Implement Long Term Conditions Programme:
  - Asthma
  - Epilepsy
  - Diabetes
- Implement Children with Complex Needs Project
- Implementation of the national delivery plan for maternity and neonatal care

Planned Care, Diagnostics & Cancer

- Ongoing implementation of Patient Initiative Follow Up (PIFU)
- Trajectory for eliminating 65 week waits delivered
- Meeting 85% /theatre utilisation
- Meeting 85% day case utilisation
- Introduce Community Diagnostic HUBs
- Optimal use of lower GI 2 week pathway

Improving Population Health

- Systematic implementation of the Core20 approach
- Implement NHS Long Term Plan prevention programmes
- Utilise population health management techniques

Urgent and Emergency Care

- Implement Capital Investment Case
- 76% of patients seen within 4 hours in A&E
- Bed occupancy 92% or below
- Full review and priority setting for virtual wards.
- Development of a fully integrated Single Point of Access.
- Deliver a fully integrated discharge "hub"

Mental Health, Learning Disabilities and Autism

- Improve the crisis pathways including 111 and ambulance response
- Undertake a Psychiatric Intensive Care Unit (PICU) Options Appraisal
- Minimise waiting times for autism diagnosis
- Improving Access to Talking Therapies
- Increased number of people with a Serious Mental Illness (SMI) having annual physical health check

Primary Care

- % Appointments within 14 days of booking
- Patient Experience (GPPS & FFT positive responses)
- Deliver Additional Roles Reimbursement Scheme (ARRS) – Budget utilisation %
- Direct Patient Care FTE per 10,000 pop. vs. National
- Digital Pathways
- GP Referrals to Community Pharmacy Consultation Service (CPCS).
- Deliver recovery of dental activity (UDA's)

End of Life, LTCS and Frailty

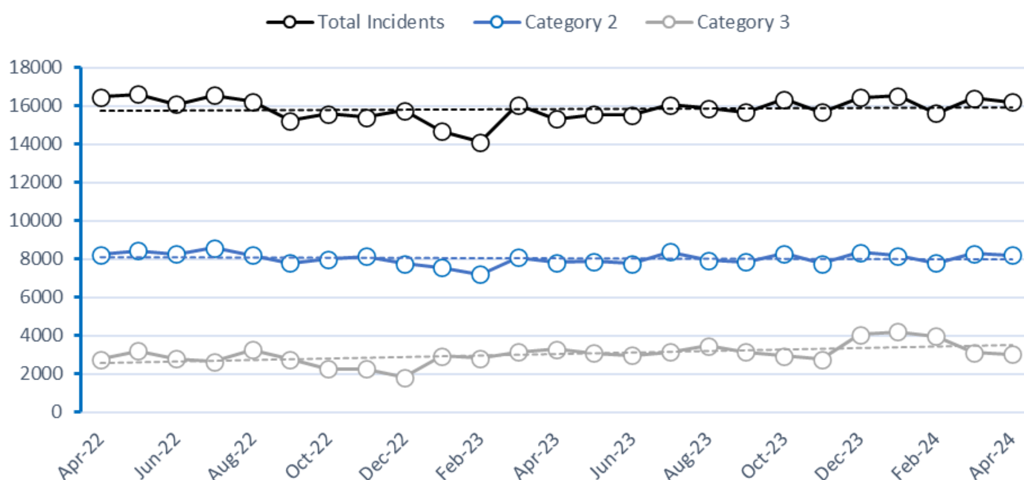
- The creation of a Palliative End of Life Care (PEoLC) strategy
- Identification of Patients in the last 12 months of life recorded on Palliative Care Registers in Primary Care
- The creation of a Long Term Conditions (LTC) strategy
- Transformation programme around Cardiovascular (CVD), Respiratory and Diabetes
- Delivery of the frailty strategy

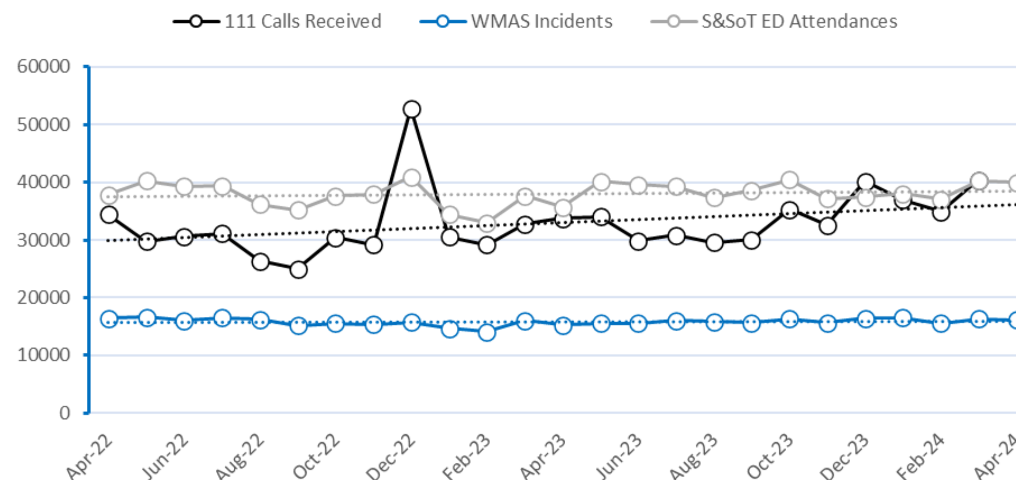
TRAFFIC LIGHT KEY:

- On track
- Mitigations identified but unlikely to improve position in year
- Measure of success under review by the portfolio
- Behind schedule but mitigations should improve in year position
- Complete

Our One Collective Aim

One Collective Aim	Points to note
Reduce the number of Category 2 and 3 ambulance calls *The data provided here are the incidents derived from calls to West Midlands Ambulance Service (WMAS) for our ICB only.* *Charts run from April 2022.*	• WMAS CAD data for Category 2 incidents for April indicates a 1.1% reduction over the previous month, however, there were 4.8% more incidents than the same period last year. The primary causes for the reduction over the previous month are reductions in Chest Pain, Cardiac Back Pain and Breathing Problems, most likely due to the lessening of the prevalence of winter viruses. Covid however continued to be an issue through the month, mitigating a degree of the potential reduction, alongside increased calls for Stroke, which rose 9.9% over the previous month. • Monitoring against contractually agreed trajectories for Category 2 Response saw the latest 4-week average of 32m 48s (w/e 12th May 2024) placing us 7th out of 11 in the Midlands region, and 22nd out of 42 nationally. • WMAS CAD data for April's Category 3 shows a 3% reduction on the previous month and reduction of 8.1% on the same period last year. Reductions were seen across a wide range of symptoms; however, the largest reductions were seen in areas such as Trauma, Mental Health and Breathing Problems. Conversely, increases were seen through the month for Fall related incidents, calls relating to Concerns for Welfare, Suicide, and Overdoses. • The total number of NHS111 calls answered during April 2024 is not currently available pending local reporting solutions though the Lead Commissioner of the new Service Provider.





Please note: A WMAS incident could have multiple calls and not all incidents result in a conveyance.

Our 4 system priorities (1)

System Priority	Key points this month or actions and observations for the coming months
1. Urgent & Emergency Care **Focus on prevention, hospital avoidance and appropriate and timely discharge**	• ED front door - Internal rapid handover protocol (risk stratification across Trust) having been agreed has been enacted through the month when required, with 1 off load every 15 mins until the pressure has reduced. • Emergency Department – WMAS Demand through the month grew beyond predicted volumes resulting in level 4 actions being taken on multiple occasions. Same Day Emergency Care (SDEC) activity increased once again by a further 5% over the previous month whilst Non-Elective Demand continued to report 5% above 2019/20 levels. • Discharges – At the MPFT Regional discharge meeting with NHSE, excellent feedback was received relating to the complex discharge processes in the system. Localised reporting of Pathway 3 Discharges utilising new NHS guidance indicates achievement of the below 1% national guidance and supporting the drive towards Pathway 0 designation of 80%. • Surge update - Plans to start de-escalating community capacity have begun leading to closed beds, whilst Ward 7 at County Hospital has now closed for maintenance work, and UHNM Winter Capacity is now integrated into base beds (Ward 120/123)
2. Tackle Backlog (Planned Care) **Backlog reduction**	• UHNM are achieving the Patient Initiated Follow Up target, but this is not resulting in a reduction in follow-ups to the national target. Analysis of new to follow up ratios (March 2022/23 compared to March 2023/24) shows 19 specialities (of 55, 45.5%) having a greater first to follow-up ratio and 30 with a reduction (54.5%). • 65+ week waits at UHNM were 713 in March, 713 above the plan of 0. • 78+ week waits; decreased to 58 at UHNM in March's monthly data. A total of 27 are forecast for the end of May and 0 are forecast at the end of June (latest forecast reported w/e 12th May in the UHNM Weekly recovery pack). • 104+ week waits: 3 at UHNM in May, w/e 5th May. UHNM forecast for there to be 3 104+ ww at the end of May and 0 at the end of June (latest forecast reported w/e 12th May in the UHNM Weekly recovery pack). • Diagnostic activity was below plan in March (across the 7 core tests) by 7.4%. MRI and Gastroscopy the only tests to exceed the plan. The percentage of patients seen in <6 weeks across the 7 core tests (at 74.5%) decreased (from February), was below the monthly plan (of 77.1%) and above the National Standard of 75%. • 28-day faster diagnosis standard (FDS) both UHNM and the ICB exceeded the National Standard, at 75.8% (UHNM) and 76.9% (across the ICB for all Providers), respectively.

Our 4 system priorities (2)

System Priority	Key points this month or actions and observations for the coming months
3. General Practice / Primary Care **Ensuring that residents have appropriate, timely and equitable access to services**	• GP appointments the overall number of appointments has exceeded the 2023/24 plan by 10.1%, delivering an additional 586,463 appointments above plan. This includes additional appointments commissioned over winter/Easter. • The March 2024 Did Not Attend (DNA) rate was 4.3% - a decrease of 0.1% from February, in-line with previous seasonal trends. • The number of completed referrals to Community Pharmacist Consultation Service (CPCS) from General Practice remained stable for January 2024.The overall YTD target is being exceeded by 490 referrals (April 2023 to January 2024). No new data is available since the move to Pharmacy First on the 31st January. Dates for the availability of the data have not been provided, the ICB is awaiting an update from NHSE. • The Scheduled Units of Dental Activity (UDAs) increased during March 2024, but remain below the contracted number. The overall ICB delivery for 2023/24 stands at 78.7% (407,419 UDAs below contracted). A Dental Strategy is in development which aims to prevent poor oral health, boost access and activity and support and develop dental workforce. A Heath Equity Assessment is being undertaken and its outcomes will be used to reduce inequity of provision and outcomes will be used to develop a local plan. • Additional Roles Reimbursement Scheme (ARRS) stands at 556.7 Full Time Equivalent (FTE) for March 2024 and remains below plan. Monthly underspend has been reducing, utilisation of the cumulative budget was 91.9% at year end.
4. Complex Individuals **Improving access to high quality and cost-effective care for people with complex needs, which requires multi-agency management.**	• Access to Children and Young People (CYP) community mental health remains below the planned trajectory by 24% (4,193). NSCHT submitted data corrections in April, however the publication of March data has been delayed due to operational issues, so the impact cannot currently be assessed. • The Dementia diagnosis rate was 72.2% at year end. Exceeding the national target of 66.7% and improving on 2022/23 (69.9%). • Access to NHS Talking Therapies was 25,605 at year end. 16% below plan but 3% higher than last year (24,790). • The number of people with Severe Mental Illness (SMI) having an annual physical health check in Q4 was 8% below the plan target of 6,268 (a shortfall of 475 patients). However, this is a much-improved position on Q3 (a 30% increase). 74.5% of people had a health check and the number of health checks increased by 15% on the same period last year. [No further update available currently]. • Patients with Learning Disabilities and Autism (LD&A) with an Annual Health Check (AHC): the year-end target of 75.3% was exceeded in March (82.3%). [No further update available currently].

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 12

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	4 June 2024

Key Discussion Topics	**Summary of Assurance**	**Action including referral to other committees and escalation to Board**
PART A		
Integrated System Performance and Programmes Highlight Report	The Committee noted the Month 12 performance position against the key metrics in the Operating Plan. The Committee received escalations from the Portfolios and in particular noted the following: • The latest UHNM position (w/e 12 May) reports the Cancer 62-day backlog has increased to 268 but year to date remains improved. • Access to Children and Young People community mental health remains below the planned trajectory by 24%. NSCHT submitted data corrections in April, however the publication of March data has been delayed due to operational issues, so the impact cannot currently be assessed • Autism assessment waits for Children and Young People increased by one week at both Trusts • WMAS demand through the month grew beyond predicted volumes resulting in Level 4 actions being taken on multiple occasions. Same Day Emergency Care (SDEC) activity increased by 5% over the previous month whilst non-elective demand continued to report 5% above 2019/20 levels	Stoke on Trent City Council are leading a session with system partners to support the development of a broader range of discharge pathways for Stoke residents. Concern remains over the timescale for design and mobilisation of pathways. Interim arrangements are in place to provide 24/7 HALO cover at RSUH, pending a formal model being agreed.
Escalation from System	The paper provided details of three	The Committee approved the

Capital Group	potential risks associated with over commitments against the System capital allocation that were escalated to the Committee following the System Capital Group meeting on 17 May. The paper also detailed a further risk that has emerged following the release of the NHS Financial Framework 2024/25 Update on 24 May. The Committee noted that work is in progress to clarify and mitigate the risks as far as possible and an update will be provided to the next Committee meeting.	inclusion of the risks/updates in the System Risk Register.
2023/24 Q4 Operational Plan End of Year Assessment (Stocktake)	The paper provided detail of Portfolio deliverables and their position at the end of Q4 against the 2023/24 Operational Plan. The Committee noted that across all Portfolios there were 214 deliverables for 2023/24 of which: • 41% of the deliverables are complete • 35% of the deliverables are partially compliant or ongoing • 23% of the deliverables are for 2024/25 delivery or for longer-term delivery • 1% of the deliverables are no longer required The Committee noted that for 2024/25, there will be gateway reviews at Month 4 and Month 8 with each Portfolio, and these will be presented as a stocktake to future Committee meetings.	Board to note the significant progress achieved through the Portfolios in 24/25 and additional gateway reviews in 25/26 to strengthen governance and oversight.
Draft 2024/25 System Operational Plan	The draft System Operational Plan has been developed in partnership and outlines the annual priorities and actions we will take during 2024/25 to address the challenges we face. Each of the Portfolios have mapped their deliverables against the 2024/25 two aims and five priorities, the JFP and the 5 Ps within the ICP Strategy. Progress on the goals and objectives will be reported to the Committee as part of the gateway reviews and presented as a twice a year stocktake.	The draft plan will be taken through each Provider Board to ensure alignment with the plans of individual organisations and the final version presented to a future ICB Board meeting for approval. Monitoring of the 24/25 operational plan will have a greater level of detail and in year milestones to enable increased monitoring of performance against plan during the year.
Monitoring the System Efficiency Plan for 2024/25	The paper set out the plan for monitoring delivery of the System Efficiency Plan of £203m, which is required in order to achieve the £90m deficit control total. This £203m will	c40% of the plans remain categorised as high risk, primarily affecting the ICB and UHNM. and this will be followed up in depth at Month 2. This

	be delivered through organisational specific CIP plans and by the five System Collaboratives (which currently have 29% of the efficiency target). The data reported monthly to NHSE will be utilised to review the entirety of CIP plans alongside the System Recovery Programme to avoid the risk of double counting. The Committee approved this approach.	primarily affects the ICB and UHNM.
System Recovery Programme 2024/25	The paper provided an update on how the System Recovery Programme is being developed for 2024/25. Progress to date by the five System Collaboratives includes: • Defining their scope and ambition and any underpinning workstreams and/or projects • Agreeing activity and financial metrics for measuring success and how they will be phased over the remainder of 2024/25 • Securing stakeholder buy in and clinical leadership where appropriate • Identifying any emerging risks to delivery • Completing the relevant impact assessments such as QIA, EIA and DPIA • Setting out their critical milestones The Committee noted that the Stage 2 Full Case for Change document for the CHC Collaborative will be available after the conclusion of the procurement process. For Corporate Back Office and Estates, this will be available once we have completed a further diagnostic and identified further stretch opportunities in addition to what is already sitting in individual organisation CIP plans. The Committee approved the aims and ambitions of each of the five System Collaboratives and their contribution to the £203m efficiency plan for the System.	Board to note the progress made in establishing the collaboratives and key metrics / milestones. Full Case for Change documents have slipped against timetable for CHC and Corporate / Back Office / Estates.
Elective Care/Elective Recovery Plan	The Committee discussed the current position for 104ww, 78ww and 65ww and the actions being taken to mitigate the position.	Industrial Action in June will have an impact upon waiting times.

	The Committee was pleased to note that for 104ww, there were zero breaches in April. For 78ww, the number of breaches is reducing and the forecasted position is zero breaches after Q1. Good progress has been made for the 65ww and a route to zero by the end of September has been provided by UHNM. The Committee noted the position for long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System.	
Provider/Partner Updates		UHNM reported that NHSE has requested they take an additional 20 FY1 Junior Doctor posts at a full year cost of £300k. This is being taken forward as a 'triple lock' intervention, with NHSE recognising the impact on our financial position. It was noted that Black Country ICB is seeking a substantial increase in funding, and that the SSOT ICB is disputing the extent of this.
System Transformation and Service Change Update	The Committee noted that the West Midlands Clinical Senate panel review of the proposal for the Freestanding Midwifery-led Birthing Units took place on 26 April and the final report is awaited. The templates for the designation of proposed standalone Urgent Treatment Centres have been submitted to NHSE.	
ICS Green System Ambitions and Quarterly Green Plan Update	The paper described the year end position against the ICS Green Delivery Plan and the 2023/24 System ambitions and provided an overview of the objectives for 2024/25. Meaningful and achievable local ambitions will be developed via the Greener Delivery Group. A case study for our successful programme: Measuring the carbon impact of Virtual Wards was included as an appendix. The ICB completed a self-assessment using the NHSE Greener NHS Maturity Matrix and the	Progress against our Green System ambitions and Delivery Plan will form part of QSRM going forward. While it is a positive classification, our 'maturing' system rating brings a reduction in support from the NHSE regional lead.

	Regional Team have confirmed that the ICS is classed as Tier 3 – Maturing.	
System Risk Register	There are 24 risks on the System Risk Register of which 15 are high scoring. The Committee approved one new risk, the closure of three risks and a reduction in risk score for one risk. The Committee has good sight of the top risks for finance, performance and transformation.	
ICS Oversight Framework/QSRM Update	The Committee received the letter detailing the findings of the Quarter 4 Segmentation Review for the ICB and NHS provider organisations and noted that there will be no change to the ICB and provider segments. The Committee also received the feedback letter following the QSRM held on 19 April.	
PART B		
ICB Efficiency 2024/25	The paper provided an update of the progress to date against the ICB's £102.2m efficiency programme. The Efficiency Oversight Group has approved £72.9m of in-year PIDs with a full year effect of £84.9m. This represents a strong start to the year, whereby the level of PIDs cover 92% of the original £79.2m efficiency target prior to the additional stretch. However, to date, £29.3m remains as un-identified efficiency and presents a key risk. The improvement of £23m to the financial plan has been assumed to be delivered 50% recurrently and 50% non-recurring. Therefore, reducing the recurrent efficiency target for 2024/25 to £90.7m. This is an extremely important indicator as any shortfall will deteriorate the ICB's underlying deficit of £106.3m further. The Committee noted that reporting against delivery will commence next month.	FPC will continue to receive a monthly report on efficiency performance.
Better Care Fund Plan 2023 - 2025	The paper provided an end of year update in respect of the first year (2023/24) of the two-year BCF plans for both Staffordshire and Stoke-on-Trent. The Committee noted that updated plans are due to be submitted to the Region by 10 June 2024, work is	The committee requested a further report on key actions, risks and issues in the development of BCF for 2025 onwards.

	progressing and on track to meet the deadline. It noted that here is an urgent requirement to complete a line-by-line review of BCF plans in 2024/25 to inform future plans and proportion of spend and activity split by local authority footprint. Stoke on Trent City Council are progressing discussions with partners around the development of new discharge pathways. Staffordshire County Council has issued a formal request to review the ICB discharge allocation split.	
Primary Care Forum Report	In order to have governance oversight, the Committee received a summary report of the meeting that took place on 14 May.	
ICB Risk Register Report	There are 9 risks on the ICB Risk Register of which 3 are high scoring (12 and above). The Committee approved two new risks and the proposed increase in score for one risk.	
ICB Undertakings	The paper updated the Committee regarding formal ICB Undertakings with NHSE, including the areas of focus that fall within the Terms of Reference of the Committee, as a core part of the overall organisational response.	The committee approved the role of FPC in monitoring Undertakings.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions that took place at the Committee. Specific risks are highlighted above, and in the FPC Risk Register.

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 13

Report to:	**Integrated Care Board**					
Date:	**20 June 2024**					
Title:	**Conflicts of Interest and Gifts & Hospitality Policy**					
Presenting Officer:	Tracey Shewan, Director of Corporate Governance					
Author(s):	Tracey Revill, Governance Manager/IG Operational lead					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	**Information (I)** ☐	**Discussion (D)** ☐	**Assurance (S)** ☐			
	Approval (A) ☐	**Ratification (R)** ☒	*(check as necessary)*			
Is the decision within SOFD powers & limits	**Yes / No**	YES				
Any potential / actual Conflict of Interest?	**Yes / No**	NO *If Y, the mitigation recommendations –* Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	**Yes / No**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.				
Appendices:	No appendices to this Front Cover					

(1) Purpose of the Paper:
To seek ratification of the Revised Conflicts of Interest and Gifts and Hospitality Policy as approved by the Audit Committee members.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
The paper is only presented to ICB Audit Committee	Click or tap to enter a date.
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	It is a requirement that the ICB have in place a Conflicts of Interest and Gifts & Hospitality Policy for all staff.
CQC or Patient Safety	Considered and not applicable
Financial (CFO-assured)	Can have financial implications if a member of staff is found to have not made a declaration or have received gifts/hospitality as part of their role.
Sustainability	Considered and not applicable
Workforce or Training	Part of mandatory training for all staff
Equality & Diversity	Applies to all staff

Due Regard: Inequalities	Applies to all staff
Due Regard: wider effect	Reputational if a member of staff is found not to have submitted a declaration

(4) Statutory Dependencies & Impact Assessments:

		Yes	No	N/A	Details
Completion of Impact Assessments:	DPIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, Reported to IG Group on Click or tap to enter a date.
	EIA	☐	☐	☒	Click or tap here to enter text.
	QIA	☐	☐	☒	*If N, why* Click or tap here to enter text. *If Y*, signed off by QIA on Click or tap to enter a date.
Has there been Public / Patient Involvement?		☐	☐	☒	Click or tap here to enter text.

(5) Integration with the BAF & Key Risks:

BAF1	Responsive Patient Care - Elective	☐	BAF5	High Quality, Safe Outcomes	☐
BAF2	Responsive Patient Care - UEC	☐	BAF6	Sustainable Finances	☐
BAF3	Proactive Community Services	☐	BAF7	Improving Productivity	☐
BAF4	Reducing Health Inequalities	☐	BAF8	Sustainable Workforce	☐

(6) Executive Summary, incl. expansion on any of the preceding sections:

The attached policy has been updated from the former CCG policy following NHSE's guidance that ICBs are required to have a Conflicts of Interest and Gifts & Hospitality policy in place.

The policy, was approved by the Audit Committee members virtually, the policy was sent to members for approval via email on the 25th April 2024 no additional comments were received and was therefore, approved. The policy is currently available on the ICB's intranet and website, marked "Subject to Approval", awaiting ratification by the Board.

(7) Recommendations to Board / Committee:

The ICB Board is asked to Ratify the attached policy.

Staffordshire and Stoke-on-Trent Integrated Care Board

CONFLICTS OF INTEREST POLICY
Including
Gifts & Hospitality Policy

Subject to Approval

Policy Number	Corporate Governance
Version:	4.1
Ratified by:	Integrated Care Board
Date ratified:	
Name of originator/author:	Deputy Director of Corporate Services & Governance
Name of responsible committee/individual:	Audit Committee (approved virtually)
Date approved:	25th May 2024
Date issued/Effective Date:	27th June 2019
Review date:	June 2027
Date of first issue	2013
Target audience:	All ICB employees, directors, non-executive directors, temporary staff, contractors

CONSULTATION SCHEDULE		
Name and Title of Individual	**Groups consulted**	**Date Consulted**
Chief Financial Officer		
Chief Operating Officer		
Director of Corporate Governance Director of Quality?	Internal	

RATIFICATION SCHEDULE	
Name of Committee approving Policy	**Date**
Audit Committees in common	
Integrated Care Board	1st July 2022

VERSION CONTROL			
Version	**Version/Description of amendments**	**Date**	**Author/ amended by**
1	New policy		
2	Revised Policy for the six South Staffordshire CCGs, policy aligned to the North Staffordshire CCG policy.	January 2019	Jane Chapman
3	Removal of duplicate wording	November 2021	Jane Chapman
4	Amended for ICB use	June 2022	Jane Chapman
5	Policy revised following NHSE advice for ICBs, including review by RSM	May 2024	Tracey Revill

IMPACT ASSESSMENT ~ *available on request*			
	Stage	*Complete*	*Comments*
Equality Impact Assessment	Stage 1	22nd January 2024	Approved
Quality Impact Assessment			N/A
Privacy Impact Assessment			N/A

Please also see the Anti-Fraud and Bribery Policy, Disciplinary Policy and Standard Business of Conduct

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1.0 Introduction

1.1 Effective handling of conflicts of interest is crucial to give confidence to patients, taxpayers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair, transparent and offer value for money. ICBs are also required under the NHS Act 2006 (as amended by the Health and Social Care Act 2022) to manage conflicts of interest robustly and appropriately.

1.2 It is more important than ever that ICBs have robust processes in place for the ongoing management of conflicts of interest as the new arrangements mean that providers and commissioners will have a joint role in decision-making around the provision of local services. While it should not be assumed that individuals have a conflict of interest based on their capacity within any organisation, the possibility of actual or perceived conflicts remains and these should be managed appropriately, including appropriate record-keeping and ongoing oversight.

2.0 Aims & Objectives

2.1 As per the Health and Care Act 2022, each ICB is required to set out its own conflicts of interest policy and register of interests which staff and board/committee members are required to comply with, this includes co-opted members and /or appointed deputies who may only be involved in committees for a limited time.

2.2 This policy sets out the approach for Staffordshire and Stoke-on-Trent Integrated Care Board (referred to as the ICB) to identify, manage and record any potential or actual Conflicts of Interest that may arise as part of the commissioning of healthcare for the residents of Staffordshire and Stoke-on-Trent whilst providing services locally.

2.3 Those who are members of ICB sub-/joint-/committees of the ICB board (or individual given delegated decision-making authority by the ICB board) must comply with the ICB's conflicts of interest policy, including the registration of interests – this may include those employed by other organisations/contractors such as Midlands and Lancashire Commissioning Support Unit. Agency staff are also required to declare conflicts. Where this is the case, the individuals should take into account both the ICB's and their employing organisation's policies on conflicts of interest and declare requirements accordingly.

2.4 The ICB is committed to upholding the principles of openness, transparency, fairness and integrity in its role as a commissioner. This will ensure that high standards of corporate governance and personal conduct are displayed by all staff and demonstrate that the principles of good governance as described in the Nolan principles are adhered to.

2.5 The ICB recognises that a potential conflict of interest between the roles of commissioner and provider is a key risk that requires careful management whether this is an indirect conflict, pecuniary or otherwise. These issues need to be overcome to ensure that the ICB is able to commission a range of community-based services to improve quality and outcomes for patients. The provider of services may be a GP practice. The ICB will need to demonstrate that these services:-

- Clearly meet local health needs and have been planned appropriately.
- Go beyond the scope of the GP contract.
- Are appropriately procured in line with legislation.

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2.6 In accordance with the revised statutory guidance on managing conflicts of interests for ICBs issued by NHSE in September 2023, the ICB has reviewed and revised its conflict of interest policy.

2.7 In addition to complying with the statutory guidance, ICBs also need to adhere to relevant guidance issued by professional bodies on conflicts of interest, including the British Medical Association (BMA)[1], the Royal College of General Practitioners[2] and the General Medical Council (GMC)[3], and to procurement rules including The Public Contract Regulations 2015[4] and the National Health Service (procurement, patient choice and competition) (no.2) regulations 2013[5], as well as the Bribery Act 2010[6] and also the Health and Care Act 2022.

2.8 This policy also needs to be read in conjunction with the ICB's constitution and the section *Standards of Business Conduct and Managing Conflicts of Interest),* along with the Anti-Fraud and Bribery Corruption Policy.

2.9 The aim of this policy is to:
- Avoid potential conflicts of interests.
- Manage conflicts of interests where unavoidable.
- Set out the arrangements for managing potential financial conflicts of interest.
- Ensure equity.
- Support openness and transparency.
- Adopt appropriate and proportionate safeguards.
- Build on existing guidance on procurement and competition.
- Ensure that assurance can be given to NHS England when services are commissioned from GP practices that the appropriate processes have been put in place to ensure fairness.

3.0 Scope of the Policy

3.1 The policy applies to:

3.2 **All ICB employees, including:**
- All full and part time staff.
- Any staff on sessional or short term contracts; i.e. Locality Leads, Clinical Associates.
- Co-opted Board members.
- Any students and trainees (including apprentices).
- Agency staff; and
- Seconded staff.

3.3 In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this policy, as if they were ICB employees. This includes **any** Commissioning Support Unit staff.

3.4 **Members of the ICB Board:**
All members of the ICB's committees, sub-committees / sub-groups, including:
- Co-opted members.
- Appointed deputies; and

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[1] *BMA guidance on conflicts of interest for GPs in their role as commissioners and providers* http://www.bma.org.uk/support-at-work/commissioning/ensuring-transparency-and-probity
[2] Managing conflicts of interest in clinical commissioning groups:http://www.rcgp.org.uk/~/media/Files/CIRC/Managing_conflicts_of_interest.ashx
[3] *GMC | Good medical practice (2013)* http://www.gmc-uk.org/guidance/good_medical_practice.asp and http://www.gmcuk.org/guidance/ethical_guidance/21161.asp
[4] *The Public Contract Regulations 2015*http://www.legislation.gov.uk/uksi/2015/102/regulation/57/made
[5] *The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013* http://www.legislation.gov.uk/uksi/2013/500/contents/made
[6] *The Bribery Act 2010* http://www.legislation.gov.uk/ukpga/2010/23/contents

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- Any members of committees / groups from other organisations.

Where the ICB is participating in a joint committee alongside other ICBs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating ICB.

4.0 Definition of an interest

4.1 NHSE guidance defines a conflict of interest as “a set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest being hold”.

4.2 A conflict of interest may be:

Actual	Potential
There is a material conflict between one or more interests	There is the possibility of a material conflict between one or more interests in the future.

4.3 Any loyalty interests should be declared by staff involved in decision making for example (but not limited to holding a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role. Sitting on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.

4.4 Staff may hold interest for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct. The perception of an interest can be as damaging as an actual conflict of interest.

4.5 Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out of hours commissioning and involvement with integrated care organisations, as clinical commissioners may here find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment to procurement exercises, to contract monitoring.

4.6 Interests fall into the four categories outlined below. A benefit may arise from the making of a gain or the avoidance of a loss:

i. **Financial interests:** This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model;
- A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;

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- A management consultant for a provider; or
- A provider of clinical private practice.

This could also include an individual being:

- In employment outside of the ICB (SEE 79-81 secondary employment (13.1-13.2)
- In receipt of secondary income.
- In receipt of a grant from a provider.
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider.
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

ii. **Non-financial professional interests:** This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients.
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared).
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE).
- Engaged in a research role.
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or.
- GPs and practice managers, who are members of the Governing Body or committees of the CCGs, should declare details of their roles and responsibilities held within their GP practices.

iii. **Non-financial personal interests:** This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider.
- A volunteer for a provider.
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
- Suffering from a particular condition requiring individually funded treatment.
- A member of a lobby or pressure group with an interest in health and care.

iv. **Indirect interests:** This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-

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financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner.
- Close family member or relative e.g., parent, grandparent, child, grandchild or sibling.
- Close friend or associate.
- Business partner.

4.7 The above categories and examples are not exhaustive and a common-sense approach will be adopted. The ICB will exercise discretion on a case-by-case basis, including in relation to new model care arrangements, having regard to the principles set out in the next section of this policy, in deciding whether any other role, relationship or interest which would impair or otherwise influence the individual's judgement or actions in their role within the ICB. If so, this should be declared and appropriately managed.

5.0 Principles

5.1 This section sets a series of principles for those who are serving as members of ICB Boards, ICB committees or take decisions where they are acting on behalf of the public or spending public money.

5.2 All staff should observe the principles of good governance in the way they do business. These include:

- The Nolan Principles[7] (as set out in 6.3 below).
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA)[8].
- The seven key principles of the NHS Constitution[9].
- The Equality Act 2010[10].
- The UK Corporate Governance Code[11] .
- Standards for members of NHS Boards and ICB Boards in England[12].

5.3 All individuals with a position in public life should adhere to the seven principles of public life, which are:

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[7] *The 7 principles of public life* https://www.gov.uk/government/publications/the-7-principles-of-public-life
[8] *The Good Governance Standards for Public Services , 2004, OPM and CIPFA http://www.opm.co.uk/wpcontent/uploads/2014/01/Good-Governance-Standard-for-Public-Services.pdf*
[9] *The seven key principles of the NHS Constitution*
http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx
[10] *The Equality Act 2010* http://www.legislation.gov.uk/ukpga/2010/15/contents
UK Corporate Governance Code https://www.frc.org.uk/Our-Work/Codes-Standards/Corporate-governance/UKCorporate- Governance-Code.aspx
[11] *UK Corporate Governance Code* https://www.frc.org.uk/Our-Work/Codes-Standards/Corporate-governance/UKCorporate- Governance-Code.aspx
[12] *Standards for members of NHS boards and CCG governing bodies in England*
http://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-and-clinicalcommissioning-group-governing-bodies-in-england

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

5.4 In addition, to support the management of conflict of interests, the ICB will ensure they:

- **Do business appropriately**: Conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.

- **Be proactive, not reactive:** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity.

- **Be balanced and proportionate**: Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome.

- **Be transparent:** Document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.

- Create an **environment and culture** where individuals feel supported and confident in declaring relevant information and raising any concerns.

5.5 In addition to the above, the ICB needs to bear in mind:

- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring.

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- If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.

- For a conflict of interest to exist, financial gain is not necessary.

6.0 Review of the Policy

6.1 This policy will be reviewed on an annual basis by the ICB's Governance Lead to ensure it is still fit for purpose and any revisions will be reported to the Audit Committees for approval prior to the policy being recommended to the Board for ratification.

7.0 Roles and Responsibilities

Accountable Officer

7.1 The Accountable Officer has overall accountability for the ICB's management of conflicts of interest.

ICB Board

7.2 All those responsibilities set out in section 6 apply to all members of the Board as well as the following:

- Ensure that the ICB's policies and procedures accurately reflect national guidance and instructions particularly in relation to the procurement of services.

- Ensure that arrangements for audit and audit reporting are open, robust and effective.

- Create and support an environment in which all individuals involved directly or indirectly with the ICB feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts.

All employees of the ICBs

7.3 It is the responsibility of each employee of the ICB to:

- Ensure that they read and understands the ICB's prime financial policies, constitution and how they apply to them.

- Ensure that they do not place themselves in a position where private interests and NHS duties might conflict.

- Avoid undertaking duties, remunerated or otherwise, outside of their employment with the ICBs if there is any actual or potential conflict with, or prejudice of, the standards set out in this document.

- Refuse to accept any casual gifts or inducement by declining politely. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude to the value not exceeding **£10** from patients or their relatives, need not necessarily be refused. If in doubt, the line manager should be consulted. If small gifts are accepted a record of this should be made in the gifts and hospitality register which is maintained by the Governance Team. Gifts and hospitality declaration forms are also available from the Governance Team.

- Refuse offers of hospitality or entertainment, although modest working lunches such as would be offered by the ICBs would be acceptable.

- Offer any modest hospitality such as a working lunch in the course of working visits. Alcoholic beverages must not be provided.

- Maintain appropriate confidentiality at all times in respect of information to which they have access in the course of their duties. In particular, they will observe the strict

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rules relating to patient confidentiality and will not misuse official 'commercial in confidence' information, nor will they make it available to other people without consulting the line manager.

- Ensure that they always conduct themselves and provides services in such a way as to up-hold the good name of the NHS and the ICB.

- Adhere to the ICB's disciplinary rules as set out in its disciplinary policy and procedure.

- Be aware and comply with the provisions of the Bribery Act 2010, as amended from time to time.

- Understand that failure to follow this policy may damage the ICB and its hard work and so may be viewed as a disciplinary matter, to be dealt with under normal disciplinary procedures, and the penalty could include dismissal.

7.4 Individuals must not:

- Use a present or past official position to obtain preferential rates for private deals.

- Attempt to influence the awarding of contracts by any factors other than those set out in standing orders and prime financial policies or otherwise designed to ensure that value for money is obtained.

7.6 Director of Corporate Governance

On behalf of the Accountable Officer the Director of Corporate Governance will have responsibility for:

- The day-to day management of conflicts of interest matters and queries.

- Maintaining the ICB register(s) of interest and the other registers referred to in this policy.

- Supporting the Conflicts of Interest Guardian to enable them to carry out the role effectively.

- Providing advice, support, and guidance on how conflicts of interest should be managed.

- Ensure that appropriate administrative processes are put in place.

- Oversee the arrangements for the management of conflicts of interest and will advise the ICB Board as required.

- Review this policy on an annual basis and make recommendations to the Audit Committee and IC Board for any required changes.

- Ensure that the register(s) of interest is reviewed regularly and updated as necessary.

- Ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflicts of interest or potential conflicts of interest, to ensure the integrity of the group's decision-making process.

- Ensure the gifts and hospitality register is maintained and report to the Audit Committee at least annually on the register.

- Ensure the declarations of interest are published on the ICB website.

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7.7 **Conflict of interest Guardian**

- To strengthen the scrutiny and transparency of the ICB's decision-making processes the ICB has nominated the Audit Committee Chair as the Conflict-of-Interest Guardian.

- In collaboration with the Governance Lead, the Conflicts of Interest guardian will:
  - Be a safe point of contact of employees or workers of the ICB to raise any concerns in relation to this policy.
  - Support the rigorous application of conflict-of-interest principles and policies.
  - Provide independent advice and judgement where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
  - Provide advice on minimising the risks of conflicts of interest.

7.8 Whilst the Conflicts-of-Interest Guardian has an important role within the management of conflicts of interest, executive members of the ICB's Board have an on-going responsibility for ensuring the robust management of conflicts of interest, and all ICB employees, Board and committee members will continue to have individual responsibility in playing their part on an ongoing and daily basis.

8.0 Gifts and Hospitality

8.1 All staff should ensure that they are not placed in a position that risks or appears to risk compromising their role of the ICB's public and statutory duties or reputation. Staff must not, or be perceived to, secure valuable gifts and hospitality by virtue of their role. "All staff should be aware that gifts and hospitality can be used as a subterfuge for bribery and, if this is suspected it should be reported immediately to the Local Counter Fraud Specialist."

The Bribery Act 2010 makes it a criminal offence to give/offer a bribe, or to request, offer to receive or accept a bribe. The Act reformed the criminal law of bribery, making it easier to tackle this proactively in both the public and private sectors. It introduced a corporate offence which means that commercial organisations, including NHS Bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

8.2 *Gifts*

8.2.1 Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression or gratitude. We should be proud that our services are so valued, but situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. ICB staff and members should be mindful that even gifts of a small value may give rise to perception of impropriety and might influence behaviour if not handled in an appropriate way.

8.2.2 A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.

8.3 **Overarching principles**

- ICB staff should not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances.

- Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the governance team who maintains the register of gifts and hospitality and recorded on the register.

8.5 **Gifts from suppliers or contractors**:

- Gifts from suppliers or contractors doing business (or likely to do business) with the ICB should be declined, whatever their value (subject to this, low cost branded

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- promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6). The person to whom the gifts were offered should also declare the offer to the governance team so the offer which has been declined can be recorded on the register.
- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason why it was deemed acceptable to accept should also provided along with the actual or estimated value for recording on the register.

8.6 **Gifts from other sources** (e.g. patients, families, service users):

- ICB staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the ICB and not in a personal capacity. These should be declared by staff and the following options are suggested:
  - Share the gift with all staff.
  - Raffle the gift for charity.
  - Donate the gift to charity or,
  - Make a donation to charity and keep the gift.
- A common-sense approach should be applied to the valuing of gifts (using an actual amount if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

8.7 If there is any doubt about the appropriateness of accepting a gift, staff should either politely decline or consult their line manager for the Governance team.

9.0 Hospitality

9.1 Delivery of services across the NHS depend on working with a wide range of partners (including industry and academia) in different places and, sometimes outside of traditional working hours. As a result, ICB staff will sometimes, appropriately, receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

9.2 Hospitality means offers of meals, refreshments, travel, accommodation and other expenses in relation to attendance at meetings, conferences, education and training events etc.

9.3 **Overarching principles**

- ICB staff should not ask for or accept hospitality that may allow or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercises when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these.

9.4 **Meals and Refreshments**

- Under a value of £25 may be accepted and need not be declared.
- Of a value between £25 and £75 may be accepted and must be declared.
- Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the ICB's registers(s) of interest as to why it was permissible to accept.

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- A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

9.5 **Travel and accommodation**

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest or are of a type that the ICB itself might not usually offer, need approval by senior staff (e.g. the ICB governance lead or equivalent), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the ICB's registers (s) of interest as to why it was permissible to accept travel and accommodation of this type.
- A non-exhaustive list of examples includes:
  - Offers of business class or first-class travel and accommodation (including domestic travel); and
  - Offers of foreign travel and accommodation.

9.6. **Sponsored Events**

- Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefitting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.

9.7 When sponsorships are offered, the following principles must be adhered to:

- Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the events will result in clear benefit for the ICB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation; no information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the ICB's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content of the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- The ICB will make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to the ICB.

9.8 **Other forms of sponsorship**:

- Organisations external to the ICB or NHS may also sponsor posts or research. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition. There needs to be transparency and any conflicts of interest should be well managed.

- Further information is available Managing conflicts of interest in the NHS: Guidance for staff and organisations.

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10.0 Declaring interests and gifts of hospitality

Statutory requirements
ICBs must make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision(s) to be made by the Group as soon as they become aware of it and in any event within 28 days. The ICB must record the interest in the register(s) as soon as they become aware of it [13]

10.1 The ICB need to ensure that as a matter of course, declarations of interest are made and regularly confirmed or updated.

10.2 Declarations of interest and gifts and hospitality should be made by the following.

All ICB employees, including

- All full and part time staff.
- Any staff on sessional or short term contracts; i.e. Locality Leads, Clinical Associates.
- Any students and trainees (including apprentices).
- Agency staff; and
- Seconded staff.

In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this policy, as if they were ICB employees. This includes **any** Commissioning Support Unit staff.

Members of the ICB Board:
All members of the ICB's committees, sub-committees / sub-groups, including:

- Co-opted members.
- Appointed deputies; and
- Any members of committees / groups from other organisations.

10.3 GPs who undertake work on behalf of the ICB and are employed by the ICB are required to declare offers/receipts of gifts and hospitality to the ICB.

10.4 Individuals should record any declaration(s) on the declaration of interests form for ICB members and employees (Appendix A).

10.5 All persons referred to in paragraph 11.2 below must declare any interests. Declarations of interest must be made available as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing). Further opportunities to make declarations include:

On appointment:
Applicants for any appointment to the ICB or its Board or any committees will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will again be made and recorded.

[13] National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) Section 140 (3)

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At meetings:
All attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the item is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed. Declarations of interest should be recorded in minutes of meetings (see 18 for further advice on record keeping).

When prompted by their organisation:
Because of their role in spending taxpayers' money, ICBs should ensure that, at least annually, staff are prompted to update either declarations of interest, or make a nil return where there are no interests or changes to declare.

On changing role, responsibility or circumstances:
Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship, starts a new project/piece of work or may be affected by a procurement decision e.g. their role may transfer to a proposed new provider)), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event ***within 28 days***. This could involve a conflict of interest ceasing to exist or a new one materialising.

If any individual's circumstances change, it is the individual's responsibility to make a further declaration as soon as possible and in any event ***within 28 days***, rather than waiting to be asked.

Individuals must formally notify the Associate Director of Corporate Governance and/or the Governance Manager/IG Operational Lead by completing and submitting an updated declaration of interest form.

11.0 Register(s) of interests and gifts and hospitality

11.1 It is a statutory requirement for ICBs to maintain one or more registers of interest of: the members of the group, members of its Board, members of its committees or sub-committees of its Board and its employees. All Board members and senior managers are to declare conflicts of interest on appointment, quarterly, at meetings and on changing role, responsibility or circumstances.

11.2 The ICB must publish and make arrangements to ensure that members of the public have access to these registers on request.

11.3 Register(s) of interest will be maintained for all those individuals who fall within the scope of this policy, as detailed at 10.2.

11.4 All interests declared will be promptly transferred to the relevant ICB register(s) by the governance lead who has designated responsibility for maintaining registers of interest.

11.5 The register of interests will record the following:-

- Name of the person declaring the interest.
- Position within, or relationship with, the ICB (or NHS England in the event of joint committees).
- Type of interest e.g., financial interests, non-financial professional interests.

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- Description of interest, including for indirect interests details of the relationship with the person who has the interest.
- The dates from which the interest relates; and
- The actions to be taken to mitigate risk - these should be agreed with the individual's line manager or a senior manager within the ICB.

11.6 **Register(s) of Gifts and Hospitality**

11.6.1 The ICB will maintain a register for the individuals listed in paragraph 11.2, the register will record the following:-

- Recipient's name.
- Current positions(s) held by the individual (within the ICB)
- Date of offer and/or receipt.
- Details of the gift or hospitality.
- The estimated value of the hospitality;
- Details of the supplier/offeror (e.g. their name and the nature of their business).
- Details of previous gifts and hospitality offered or accepted by this offeror/supplier.
- Action taken to mitigate against a conflict, details of any approvals given and details of the officers reviewing. Approving the declaration made and date.
- Whether the offer was accepted or not; and
- Reasons for accepting or declining the offer.

11.7 **Publication of registers**

11.7.1 All staff listed in paragraph 11.2 should declare interest and offers/receipts of gifts and hospitality, but the ICB recognises that some staff are more likely than others to have a decision-making influence on the use of taxpayers money, because of the requirements of their role. For the purpose of this policy these people are referred to as **'decision making staff'.**

11.7.2 The ICB has defined decision making staff as those staff that have a material influence on how taxpayers' money is spent. The following is a list of those individuals who likely to be decision makers.

- All Board members.
- Executive and Non-Executive Directors (or equivalent roles) who have decision making roles which involves the spending of taxpayers' money.
- Those at Agenda for Change band 8d and above.
- Members of advisory groups which contribute to direct of delegated decision making on the commissioning or provision of taxpayer funded services as working people groups involved in service redesign or stakeholder engagement that will affect future provision of services.
- Members of other committees of the ICB e.g. audit committee, remuneration committee, planning and commissioning committee etc.
- Members of new care models joint provider/commissioner groups/ committees.
- Management, administration and clinical staff who have the power to enter into contracts on behalf of the ICB.
- Management, administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devises or equipment and formulary decisions.

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- As per the ICB's Scheme of reservation and delegation.

11.8 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available registers (s). Where an individual believes that substantial damage or distress may be caused to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be in writing. Decisions not to publish must be made by the Conflict-of-Interest Guardian for the ICB, who should seek appropriate legal advice where required and the ICB will retain a confidential un-redacted version of the registers(s).

11.9 The ICB will ensure all decision-making staff are aware in advance of publication that the register(s) will kept, how the information on the registers(s) may be used or shared and the register (s) will be published.

11.10 Staff who are not decision-making staff but are still required to make a declaration of interest(s) or a declaration of gifts or hospitality will be made aware that the register(s) will be kept and how the information on the register(s) may be used or shared.

11.11 The ICB will ensure all staff are aware of its fair processing notice and the contact details of the data protection officer.

11.12 An interest (including offers of gifts and hospitality) of decision-making staff shall remain on the public register for a minimum of **six** months after the interest has expired.

11.13 The ICB is required to retain a private record of historic interests for a minimum of six years after the date on which it expired.

11.14 The ICB's published register of interests will state that historic interests are retained by the ICB for the specified timeframe; a request for this information should be made to the Governance lead.

11.15 The register of interest and gifts and hospitality must be published as part of the ICB's annual report and annual governance statement. A web link to the ICB's registers is acceptable.

12.0 Appointments and roles and responsibilities in the ICB

12.1 Everyone in the ICB has a responsibility to appropriately manage conflicts of interest.

12.2 Appointing Board or committee members and senior employees - On appointing Board, committee or sub-committee members and senior staff, the ICB will need to consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will need to be considered on a case-by-case basis, but the ICB's constitution should reflect the ICB's general principles.

12.3 The ICB will need to assess the materiality of the interest, in particular whether the individual (or any person with whom they have a close association could benefit whether financially or otherwise) from any decision the ICB might make. This will be particularly relevant for Board, committee and sub-committee appointments, but should also be considered for all employees and especially those operating at senior level.

12.4 The ICB will also need to determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual shall not be appointed to the role.

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12.5 Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to either ICB (whether as a provider of healthcare, including 'new care model' providers, or healthcare commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the ICB, in particular if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role. Specific considerations in relation to delegated or joint commissioning of primary care are set out below.

12.6 The ICB has set out in it's constitution a statement on the conduct expected of individuals involved in the ICB, e.g. members of the Board, members of committees, and employee, which reflects the expectations set out in the Standards for Members of NHS Boards[14] .

12.7 **ICB Non-Executive Directors**

12.7.1 Non-Executive Directors play a critical role in ICBs, providing scrutiny, challenge and an independent voice in support of robust and transparent decision-making and management of conflicts of interest. They chair a number of ICB committees, including the Audit Committee and Finance and Performance.

12.7.2 By statute, the ICB must have at least three Non-Executive Directors, (one of whom must have qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters[15] and serve as the chair of the audit committee[16]; and the other, knowledge of the geographical area covered in the ICB's constitution such as to enable the person to express informed views about the discharge of the ICB's functions[17]).

12.8 **Outside employment**

12.8.1 Outside employment means employment and other engagements, outside of formal employment arrangements, (for more information please refer to the ICB's Secondary Employment Policy). The ICB will take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract with them are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with the ICB (for example in relation to new care model arrangements). The purpose of this is to ensure that the ICB is aware of any potential conflict of interest. Examples of work which might conflict with the business of the ICB, including part-time, temporary and fixed term contract work, include:

- Employment with another NHS body.
- Employment with another organisation which might be in a position to supply goods/services to the ICB including paid advisory positions and paid honorariums which relate to bodies likely to do business with the ICB.
- Directorships e.g. of a GP federation or non-executive roles.
- Self-employment, including private practice, charitable trustee roles, political roles and consultancy work in a capacity which might conflict with the work of the ICB or which might be in a position to supply goods/services to the ICB. Staff should not actively

[14] Standards for Members of NHS Boards and Clinical Commissioning Groups
http://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-and-clinical-commissioning-group-governing-bodies-in-england

[15] Section 12(3) NHS (CCG) Regulations 2012
http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf

[16] Section 14(2) NHS (CCG) Regulations 2012
http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf

[17] Section 12(4) NHS (CCG) Regulations 2012
http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf

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solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursed on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain. Staff should also obtain permission from the organisation if in their professional role, they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

12.9 The following principles and rules will be adhered to:

- The ICB will require individuals to obtain prior permission to engage in outside employment and reserve the right to refuse permission where it believes a conflict will arise which cannot be effectively managed.

- Staff must declare any existing outside employment on appointment, and any new outside employment when it arises.

- ICBs should ensure that they have clear and robust organisational policies in place to manage issues arising from secondary employment. In particular, it is unacceptable for pharmacy advisers or other advisers, employees or consultants to the ICB on matters of procurement to themselves be in receipt of payments from the pharmaceutical or devices sector.

13.0 Managing conflicts of interest at meetings

Statutory requirements *ICBs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making.*

13.1 The ICBs have reviewed their governance structures and policies for managing conflicts of interest to ensure that they reflect NHSE guidance and are appropriate. The CCGs have considered the following:-

- The **make-up of their Board and committee structures** and processes for decision-making.

- Whether there are sufficient management and internal controls to detect **breaches** of the ICBs conflicts of interest policy, including appropriate external oversight and adequate provision for **raising concerns under this policy**.

- How **non-compliance** with policies and procedures relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into); and

- Identifying and implementing **training** or other programmes to assist with compliance, including participation in the training offered by NHS England.

13.2 **Chairing arrangements and decision-making processes**

13.2.1 The chair of a meeting of the ICBs Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

13.2.2 In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

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13.2.3 In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member of the Board.

13.2.4 It is good practice for the chair, with support of the ICB's Associate Director of Corporate Governance or equivalent and if required, the Conflicts of Interest Guardian, to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

13.2.5 To support chairs in their role, they will have access to a declaration of interest checklist prior to meetings, which will include details of any declarations of conflicts which have already been made by members of the group.

13.2.6 The chair will ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group must declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the ICB's relevant register of interests to ensure it is up to date.

13.2.7 Similarly, any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be included on the ICB's register of gifts and hospitality to ensure it is up to date.

13.2.8 It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interest, but which has not been declared then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

13.2.9 When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting.
- Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting.
- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict.
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery.
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where,

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for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared.

- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

- Where the conflict of interest relates to outside employment and an individual continues to participate in meetings pursuant to the preceding two bullet points, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes. Where it is appropriate for them to participate in decisions they must do so if they are acting in their ICB role.

14.0 Joint Working Arrangement/Delegation

14.1 As ICBs establish ways of working, through new joint working arrangements or delegation to other statutory bodies, managing real or perceived conflicts of interest will continue to be an important aspect of ensuring robust governance arrangements.

14.2 The guiding principle for NHS organisations in dealing with these conflicts will be that decisions must be made in the public interest, avoiding any undue influence from other interests. The significant NHS provider involvement within each ICB's membership will require any conflicts of interest to be assessed on a case-by-case basis, in line with the principles set out in this policy.

14.3 Under s65Z5, delegation and joint exercise of function arrangements can only be made between relevant bodies, NHS, local authorities and/or combined authorities. NHS organisations convening joint committees will be able to determine the membership of committees – which organisations are represented and on what basis. Committees could include individuals who are not employees of the 'convening organisations'. For example, the joint committee could include a clinician who has expertise relevant to matters delegated to the committee but who is not an employee of any of the bodies participating in the joint committee. As with any internal committees of an ICB, a joint committee should ensure the appropriate management of conflicts of interest relating to any of its members.

For example, an individual from a social enterprise that provides mental health services may give a reasoned and evidence-based opinion that a certain type of online therapy is better for supporting people who experience anxiety – but it might also be that the social enterprise is currently the only provider of that service in the ICS footprint. This should not mean that individual's contribution is discounted – but their conflicting interest should be recognised and taken into account when considering the final decision.

14.4 **Principles for ICBs managing conflicts of interest**

14.4.1 Decision-making must be geared towards meeting the statutory duties of the ICBs at all times, including the triple aim.[18] Any individual involved in decisions relating to ICB functions must be acting clearly in the interest of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interest.

[18] The triple aim is a common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services, (trusts and foundation trusts). It will oblige these bodies to consider the effects of the decisions on: the health and wellbeing of the people of England; the quality of services provided or arranged by both themselves and other relevant bodies; the sustainable and efficient use of resources by both themselves and other relevant bodies.

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14.4.2 ICBs have been created to give trust/foundation trust, local authority and primary medical services (general practice) provider nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle and while it should not be assumed that they are personally or professionally conflicted, just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interest arising will remain. For all decision, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not these outweigh the value of the knowledge the bring to the process.

14.4.3 The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision-taking need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and in any event, within 28 days of them becoming aware. This is already standard practice in existing NHS organisations. This includes being clear and specific about the nature of any interest and about the nature of any conflict that may arise regarding a particular decision.

14.4.4 If an interest is declared but there is no risk a conflict arising, then no further action need be taken, although the interest will still need to be recorded. However, if a material interest is declared, then it should be considered to what extent it affects the balance of the discussion and decision-making process. In doing so the ICB should ensure conflicts of interest (and **potential** conflicts) do not and do not **appear** to, affect the integrity of the ICB's decision-making processes.

14.4.5 ICBs should consider the composition of decision-making forums and clearly distinguish between those individuals who should be involved in formal decision-taking and those whose input informs decisions. In particular, ICBs should consider the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in the decision, including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction. For example, where independent providers (including the VCSE sector) hold contracts for services, it would be appropriate and reasonable for the ICB to involve them in discussions, eg about pathway design and service delivery, particularly at place level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

14.4.6 Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation could include:

- Including a conflicted person in the discussion but not in decision-making.
- Excluding a conflicted person from both the discussion and the decision-making.
- Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes.
- excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

14.4.7 The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made. In particular, when adopting a specific

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approach to mitigate any conflicts of interest (including perceived conflicts), ICBs should ensure that the reason for the chosen action is documented in minutes or records.

14.4.8 These factors should be read in conjunction with other relevant NHS England statutory guidance, including guidance on joint working and delegation arrangements and when published on the provider selection regime and guidance. In relation to the provider selection regime, as is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process. (Note: the secondary legislation that will establish the new procurement rules must address the management of conflicts of interest.)

15.0 Minute-taking

15.1 It is imperative that the ICB ensures complete transparency in their decision-making processes through robust record-keeping.

15.2 If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- **Who has the interest.**
- **The nature of the interest and why it gives rise to a conflict**, including the magnitude of any interest.
- The **items on the agenda** to **which the interest relates.**
- **how the conflict was agreed to be managed**; and
- **evidence that the conflict was managed as intended** (for example recording the points during the meeting when particular individuals left or returned to the meeting).

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16.0 Managing conflicts of interest throughout the commissioning cycle

16.1 Conflicts of interest need to be managed appropriately throughout the whole commissioning cycle. At the outset of a commissioning process, the relevant interests of all individuals involved should be identified and clear arrangements put in place to manage any conflicts of interest. This includes consideration as to which stages of the process a conflicted individual should not participate in, and, in some circumstances, whether that individual should be involved in the process at all.

The ICB must also identify as soon as possible where staff might transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest and the ICB must ensure they manage the potential conflict.

16.2 Designing service requirements

16.2.1 The way in which services are designed can either increase or decrease the extent of perceived or actual conflicts of interest. Particular attention should be given to public and patient involvement in service development.

16.2.2 Public involvement supports transparent and credible commissioning decisions. It should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring. ICBs have legal duties under the Act to properly involve patients and the public in their respective commissioning processes and decisions.

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16.3 **Provider engagement**

16.3.1 It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community and mental health sectors and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. The ICB needs to be particularly mindful of these issues when engaging with existing/potential providers in relation to the development of new care models.

16.3.2 Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

16.3.3 As the service design develops, it is good practice to engage with a range of providers on an on-going basis to seek comments on the proposed design e.g., via the commissioner's website and/or via workshops with interested parties (ensuring a record is kept of all interaction). NHS Improvement21 has issued guidance on the use of provider boards in service design[19].

16.3.4 Engagement should help to shape the requirement to meet patient need, but it is important not to gear the requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

16.3.5 The ICB needs to ensure they meet any obligation to document their decisions including but not limited to, any obligations they have under the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and the Public contract s Regulations 2015.

16.4 **Specifications**

16.4.1 Commissioners should seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services. However, they also need to ensure careful consideration is given to the appropriate degree of financial risk transfer in any new contractual model.

16.4.2 Specifications should be clear and transparent, reflecting the depth of engagement, and set out the basis on which any contract will be awarded.

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[19]NHS Improvement is the organisation which brings together Monitor and the NHS Trust Development Authority, and is a combination of the continuing statutory functions and legal powers vested in those two bodies, including Monitor's functions in relation to the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (PPCCR)

18.0 Procurement

18.1 Mixed Procurement

18.1.1 These are relevant healthcare services that also incorporate other goods or services and are procured together (for example, patient transport which includes health care services). To qualify as mixed procurement and be procured under the PSR, the main subject-matter must be the healthcare services, and the authority must believe that the other goods or services cannot reasonably be supplied under a separate contract. Full details of the new procurement process are set out in the Non-Healthcare Procurement Policy and the Healthcare Procurement Policy.

18.2 Procurement Processes:

The PSR provides five distinct routes to market for procuring healthcare services, but only one which provides for competition as we know it under the current Regulations:

18.3 **Direct Award Process A (one capable provider):** Used when there is an existing provider for the healthcare services and there is only one capable provider. The authority awards the contract without competition and submits a notice of the award for publication.

18.4 **Direct Award Process B (patient choice):** when patients have the freedom to choose their provider and there are no restrictions on the number of providers. The authority awards the contract without competition and submits a notice of the award for publication.

18.5 **Direct Award Process C (incumbent extension):** Applicable when the authority assesses the existing provider's ability to satisfy the proposed contract and the proposed new contract has no considerable changes. The authority submits a notice of intention to make an award to the existing provider. After the standstill period, the contract is awarded and a notice of the award is published.

18.6 **Most Suitable Provider Process:** The authority submits a notice of intention to follow this process and identifies potential providers, assesses them based on key criteria, and selects the most suitable provider. After the standstill period, the contract is awarded and a notice of the award is published.

18.7 **Competitive Process:** Utilised when the relevant authority determines criteria, invites offers from providers, assesses the offers, and makes a decision on the successful provider. After the standstill period, the contract is awarded and a notice of the award is published.

18.8 1Framework agreements can only be concluded using the competitive process.

18.8 Basic Selection Criteria and Information Management:

18.8.1 Under routes 3-5 above, providers must meet the basic selection criteria, which may include suitability, economic and financial standing, and technical and professional ability. The authorities can impose specific requirements related to authorisations, memberships, turnover, financial capacity, and technical resources.

18.8.2 Authorities must maintain records of contract details, decision-making processes, conflicts of interest, and more. They are also required to publish an annual summary of contracting activity and an annual report on compliance.

18.9 Conclusion:

18.9.1 By understanding the PSR and the various processes involved, clients can navigate the system effectively and ensure compliance with the requirements.

18.9.2 The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 201323 state:

> *ICBs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and*
>
> *ICBs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it has entered into. [As set out in paragraph 113 below, details of this should also be published by the ICB.]*
>
> *The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*

18.9.3 Paragraph 24 of PCR 2015 states: "Contracting authorities shall take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures so as to avoid any distortion of competition and to ensure equal treatment of all economic operators". Conflicts of interest are described as "any situation where relevant staff members have, directly or indirectly, a financial, economic or other personal interest which might be perceived to compromise their impartiality and independence in the context of the procurement procedure".

18.9.4 The Procurement, Patient Choice and Competition Regulations (PPCCR) place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, run a fair, transparent process that does not discriminate against any provider, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. Furthermore the PPCCR places requirements on commissioners to secure high quality, efficient NHS healthcare services that meet the needs of the people who use those services. The PCR 2015 are focussed on ensuring a fair and open selection process for providers.

18.9.5 An obvious area in which conflicts could arise is where either ICB commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the ICB has a financial or other interest. This may most often arise in the context of co-commissioning of primary care, particularly with regard to delegated commissioning, where GPs are current or possible providers.

18.9.6 ICBs will be required to make the evidence of their management of conflicts publicly available, and the relevant information from the procurement template will be used to complete the register of procurement decisions. Complete transparency around procurement will provide:

- Evidence that the ICB is seeking and encouraging scrutiny of its decision-making process.
- A record of the public involvement throughout the commissioning of the service.
- A record of how the proposed service meets local needs and priorities for partners such as the Health and Wellbeing Boards, local Healthwatch and local communities.
- Evidence to the audit committee and internal and external auditors that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route and in addressing potential conflicts.

18.9.7 External services such as commissioning support units (CSUs) can play an important role in helping ICBs decide the most appropriate procurement route, undertake procurements

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and manage contracts in ways that manage conflicts of interest and preserve the integrity of decision-making.

18.9.8 Officers must assure themselves that a CSU's business processes are robust and enable the ICB to meet its duties in relation to procurement (including those relating to the management of conflicts of interest). This would require the CSU to declare any conflicts of interest it may have in relation to the work commissioned by the ICB.

18.9.9 The ICB cannot, lawfully delegate commissioning decisions to an external provider of commissioning support, the ICB will need to:

- Determine and sign off the specification and evaluation criteria.
- Decide and sign off decisions on which providers to invite to tender; and
- Make final decisions on the selection of the provider.

19.0 Register of Procurement Decisions

19.1 ICBs need to maintain a register of procurement decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. This must include:

- The details of the decision.
- Who was involved in making the decision (including the name of the ICB's clinical lead, the ICB's contract manager, the name of the decision-making committee and the name of any other individuals with decision-making responsibility).
- A summary of any conflicts of interest in relation to the decision and how this was managed by the ICB; and
- The award decision taken.

19.2 The register of procurement decisions must be updated whenever a procurement decision is taken. The Procurement, Patient Choice and Competition Regulations 9(1) place a requirement on commissioners to maintain and publish on their website a record of each contract it awards. The register of procurement decisions should be made publicly available and easily accessible to patients and the public by:

- Ensuring that the register is available in a prominent place on the ICB's website; and
- Making the register available upon request for inspection at the ICB's headquarters

19.3 Although it is not a requirement to keep a register of services that may be procured in the future, it is good practice to ensure planned service developments and possible procurements are transparent and available for the public to see.

20.0 Declarations of interests for bidders / contractors

20.1 As part of a procurement process, it is good practice to ask bidders to declare any conflicts of interest. This allows commissioners to ensure that they comply with the principles of equal treatment and transparency. When a bidder declares a conflict, the commissioners must decide how best to deal with it to ensure that no bidder is treated differently to any other.

20.2 It will not usually be appropriate to declare such a conflict on the register of procurement decisions, as it may compromise the anonymity of bidders during the procurement process. However, commissioners must retain an internal audit trail of how the conflict or perceived conflict was dealt with to allow them to provide information at a later date if required. Commissioners are required under regulation 84 of the Public Contract Regulations 2015 to make and retain records of contract award decisions and key decisions that are made during the procurement process (there is no obligation to publish

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them). Such records must include "communications with economic operators and internal deliberations" which should include decisions made in relation to actual or perceived conflicts of interest declared by bidders. These records must be retained for a period of at least three years from the date of award of the contract.

21.0 Contract Monitoring

21.1 The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.

21.2 Any contract monitoring meeting needs to consider conflicts of interest as part of the process i.e., the chair of a contract management meeting should invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this guidance. This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other ICBs under lead commissioner arrangements.

21.3 The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

21.4 Officers must be mindful of any potential conflicts of interest when they disseminate any contract or performance information/reports on providers and manage the risks appropriately.

22.0 ICB Improvement and Assessment Framework

22.1 As part of the framework, the ICB is required on an annual basis, to confirm via self-certification:

- That the ICB has a clear policy for the management of conflicts of interest in line with the statutory guidance and a robust process for the management of breaches.
- That the ICB has a minimum of three Non-Executive Directors.
- That the ICB audit chair has taken on the role of the Conflict-of-Interest guardian.
- The level of compliance with the mandated conflicts of interest on-line training, as at 31 January annually.

23.0 Internal Audit

23.1 The ICB is required to undertake an audit of conflicts of interest management as part of their internal audit on an annual basis. The ICB also undertakes an audit of its Counter Fraud arrangements.

23.3 The results of the audit will be reflected in the ICB's annual governance statement and will be discussed in the end of year governance meeting with NHS regional teams.

24.0 Raising Concerns and Breaches

24.1 It is the duty of every ICB employee, Board member, committee or sub-committee member to speak up about genuine concerns in relation to the administration of the ICB's policy on conflicts of interest management, and to report these concerns. These individuals should not ignore their suspicions or investigate themselves, but rather speak to the designated ICB point of contact for these matters; this is:

- Conflict-of-Interest Guardian; Julie Houlder; Julie.houlder@staffsstoke.icb.nhs.uk,
- Head of Governance; Lia Pitarokoili; Vasileia.pitarokoili@staffsstoke.icb.nhs.uk,
- Fraud Champion; Tracey Revill; tracey.revill@staffsstoke.icb.nhs.uk.
- Concerns can also be raised with the Counter Fraud team at RSM, details of which can be found on the Counter fraud section on IAN; COUNTER FRAUD - USEFUL LINKS (sharepoint.com)

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24.2 Any non-compliance with the ICB'S Conflicts of Interest Policy should be reported in accordance with the terms of that policy, and ICB's Freedom to Speak Up whistleblowing policy (where the breach is being reported by an employee or worker of the ICB) or with the whistleblowing policy of the relevant employer organisation (where the breach is being reported by an employee or worker of another organisation).

24.3 Effective management of conflicts of interest requires an environment and culture where individuals feel supported and confident in declaring relevant information, including notifying any actual or suspected breaches of the rules. In particular, the team or individual designated by the ICB to provide advice, support, and guidance on how conflicts of interest should be managed, should ensure that organisational policies are clear about the support available for individuals who wish to come forward to notify an actual or suspected breach of the rules, and of the sanctions and consequences for any failure to declare an interest or to notify an actual or suspected breach at the earliest possible opportunity.

24.4 All reports of concerns and breaches will be investigated in accordance with the Staffordshire and Stoke-on-Trent ICB's Raising Concerns at Work Policy.

24.5 Anonymised details of breaches will be published on the ICB's website for the purpose of learning and development.

25.0 Reporting Breaches

25.1 If any employees, Board members, committee or sub-committee members suspect or are aware of any known breaches of the ICB's Conflicts of Interest Policy, they should contact the ICB's designated Conflicts of Interest Guardian, or Freedom to Speak Up Guardian in the first instance to raise any concerns.

Any contact with the Conflicts of Interest Guardian or Freedom to Speak Up Guardian, is on a strictly confidential basis.

25.2 Anyone who wishes to report a suspected or known breach of the policy, who is not an employee or worker of the ICB, should be aware of their own organisation's whistleblowing policy, since most such policies should provide protection against detriment or dismissal.

25.3 All such notifications will be treated with appropriate confidentiality at all times in accordance with the ICB's policies and applicable laws, and the person making such disclosures can expect an appropriate explanation of any decisions taken as a result of any investigation.

25.4 Furthermore, providers, patients and other third parties can make a complaint to NHS Improvement in relation to a commissioner's conduct under the Procurement Patient Choice and Competition Regulations. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

26.0 Fraud or Bribery

26.1 Any suspicions or concerns of acts of fraud or bribery can be reported to the ICB's Local Counter Fraud Specialist or online via [Report NHS fraud | Help fight fraud within the NHS | Report your fraud concerns and suspicions using a confidential online form (cfa.nhs.uk)] / or via the NHS Fraud and Corruption Reporting Line on 0800 0284060 (available 24/7).

26.2 This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

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27.0 Impact of non-compliance

27.1 Failure to comply with the ICB's policies on conflicts of interest management, pursuant to this statutory guidance, can have serious implications for the ICB and any individuals concerned.

28.0 Disciplinary Implications

28.1 The ICB will ensure that individuals who fail to disclose any relevant interests or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest are subject to investigation and where appropriate, to disciplinary action. This may include:

- Informal action- such as reprimand or signposting to training and/or guidance.
- Formal action- such as formal warning, the requirement for additional training, rearrangement of duties, redeployment, demotion or dismissal.
- Referring incidents to regulators.
- Contractual action against organisations or staff.

29.0 Professional Regulatory Implications

29.1 Statutorily regulated healthcare professionals who work for or are engaged by ICBs are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest). ICBs should report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result.

30.0 Civil Sanctions

30.1 If conflicts of interest are not effectively managed, the ICB could face civil challenges to decisions they make. For instance, if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

31.0 Criminal sanctions

31.1 Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for ICBs and linked organisations, and the individuals who are engaged by them.

31.2 The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation.
- Fraud by failing to disclose information; and,
- Fraud by abuse of position.

31.3 In these cases an offender's conduct must be dishonest and their intention must be to make a gain or cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of ten years imprisonment and / or a fine and can be committed by a body corporate.

31.4 Under the Bribery Act 2010 it is an offence to:

- Promise, offer or give a bribe.
- Request, agree to receive or accept a bribe.
- Bribe a Foreign Official.

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31.5 The offences of bribing another person or being bribed carries a maximum sentence of ten years imprisonment and / or a fine Court. In relation to a body corporate the penalty for these offences is a fine

32.0 Conflicts of Interest Training

32.1 The ICB will provide training to all employees, Board members and members of ICB committees and sub-committees on the management of conflicts of interest. This is to ensure staff and others within the ICB understands what conflicts are and how to manage them effectively.

32.2 All such individuals will have training on the following:

- What is a conflict of interest.
- Why is conflict of interest management important.
- What are the responsibilities of the organisation you work for in relation to conflicts of interest.
- What should you do if you have a conflict of interest relating to your role, the work you do or the organisation you work for (who to tell, where it should be recorded, what actions you may need to take and what implications it may have for your role).
- How conflicts of interest can be managed.
- What to do if you have concerns that a conflict of interest is not being declared or managed appropriately.
- What are the potential implications of a breach of the ICB's rules and policies for managing conflicts of interest?

32.3 NHS England has developed an online training package for ICB staff, Board and committee members. This will be rolled out 1st March 2024 and will be available via ESR. This will need to be completed on an annual basis to raise awareness of the risks of conflicts of interest and to support staff in managing conflicts of interest.

32.4 The annual training will be **mandatory**.

33.0 Equality Impact Assessment

33.1 The ICB is committed to ensure that it treats all employers fairly, equitably and reasonably and that it does not discriminate against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs or sexual orientation. An equality impact assessment has been completed to go with this policy.

33.2 This policy will be monitored for effectiveness by the number of declarations submitted in line with the policy it will also be monitored in relation to how many gifts and hospitality are declared and accepted etc. Registers for conflicts of interest and gifts and hospitality can be found on the ICB's website; Our publications and policies - Staffordshire and Stoke-on-Trent (icb.nhs.uk) and also on IAN; under "Resource Centre" "Conflicts of Interest".

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Staffordshire and Stoke-on-Trent Integrated Care Board

APPENDIX A ~ DECLARATION OF INTEREST FORM – ICB STAFF/BOARD MEMBERS

INTEGRATED CARE BOARD (ICB) ~ DECLARATION OF INTEREST FORM
FINANCIAL YEAR 20XX/20XX

FULL NAME:			
JOB TITLE:		**BAND:**	
ORGANISATION:			

Detail of Interests held (complete all the boxes that are applicable), please include start and end dates

Type of interest e.g. Financial Non-Financial Professional Non-Financial Personal Indirect	**Description of Interest**	**Date interest relates from and to**	**Actions to be taken to mitigate the risk** ***(Governance use only)***

Please ensure your form is signed by your line manager prior to sending it to the governance team, thank you.

This form is required to be completed in accordance with the ICB's Constitution, Section 14O of the NHS Act 2006 and the NHS Procurement, Patient Choice & Competition Regulations 2013. Submitted information will be held by the ICB for personnel or other reasons specified on this form and to comply with ICB policies. Information may be held in both manual and electronic form in accordance with the Data Protection Act 1998; and may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in ICB registers.

If you are unsure of what you should declare, please refer to the notes page 3 of this document or contact the governance team for further advice. Please be aware that any declared conflict will remain on the ICB's registers for six months after the conflict ceases.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB, as soon as is practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

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I do / do not *(delete as applicable) give my consent for this information to be published on registers that the ICB holds. If consent is NOT given, please give reasons why:*

Signed		***Date:***	
Signed/Position *(Line Manager or Senior ICB Manager)*		***Date:***	

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NOTES FOR COMPLETING THE DECLARATION OF INTEREST FORM

The types of interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

Type of Interest	*Description*
Financial Interests	*Where an individual may get direct benefit from the consequences of a commissioning decision, e.g. being:* *a) A Director / Non-Exec Director or senior employee in a private company or public limited company or other organisation which is doing, or is likely / possibly seeking to do business with the ICB* *b) A shareholder (or similar owner interest), or partner / owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or is likely / possibly seeking to do business with the ICB* *c) A management consultant for a provider* *d) In secondary employment (including on a part-time, temporary, fixed-term contract basis) with another NHS body, an organisation supplying or likely to supply goods / services to the ICB: including self-employment / private practice, Directorship of a GP Federation* *e) In receipt of secondary income / a grant / any payments (e.g. honoraria, one-off payments, day allowances, travel or subsistence payments) from a provider* *f) In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role* *g) Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider)*
Non-Financial Professional Interest	*Where an individual may obtain non-financial professional benefit from the consequences of a commissioning decision: e.g. increasing their professional reputation / status or promoting their professional career, and where the individual is:* *a) An advocate for a particular group of patients* *b) A GP with Special Interests: e.g. in dermatology, acupuncture etc* *c) A member of a particular specialist professional body (routine GP membership of the RCGP, BMA or a Medical Defence Organisation would not usually by itself amount to an interest needing to be declared)* *d) An advisor for the CQC or NICE* *e) A medical researcher*
Non-Finance Personal Interests	*Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, e.g. where the individual is:* *a) A Voluntary Sector champion or volunteer for a provider* *b) A member of a Voluntary Sector Board or has any other position of authority in or connection with a Voluntary Sector organisation* *c) Suffering from a particular condition requiring individually funded treatment* *d) A member of a lobby or pressure group with an interest in health*
Indirect Interests	*Where an individual has a close association with an individual with a financial, non-financial professional interest or non-financial personal interest in a commissioning decision (as the categories above), e.g. being:* *a) A spouse / partner* *b) A close relative: e.g. parent, grandparent, child, grandchild or sibling* *c) A close friend* *d) A business partner*

For further assistance in completing this form, please contact the Governance Team:

Tracey Revill; tracey.revill@staffsstoke.icb.nhs.uk

Paul Winter; paul.winter@staffsstoke.icb.nhs.uk

*The completed form should be sent by email, signed **and** counter-signed by your Line Manager to: Generic Governance Inbox; governance@staffsstoke.icb.nhs.uk*

Thank you.

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NHS Staffordshire and Stoke-on-Trent Integrated Care Board

APPENDIX B ~ Gifts and Hospitality Declaration Form

Declaration of Offers and Receipt of Gifts & Hospitality Form

Return completed form to: *ICB Governance Inbox;* governance@staffsstoke.icb.nhs.uk

SECTION ONE: Recipient Details					
Title		**Surname**		**Forename**	
Job Title			**Telephone**		

SECTION TWO: Receipt / Offer of Hospitality & Gifts			
Details of gifts/hospitality Offered		**Date offered**	
Value/Estimated Value			
Company or individual from which offer received		**Date of Event**	
Details of previous offers or acceptances by this company or individual			
Was the Gift / Hospitality accepted? [YES / NO]		**Date refused/accepted**	
Reason for accepting/declining offer			
Signed		**Date**	

SECTION THREE: Authorisation (for completion by Line Manager)					
Title		**Surname**		**Forename**	
Job Title			**Telephone**		
Signed			**Date**		

SECTION FOUR: Authorisation (for completion by ICB Chief Finance Officer)			
Signed		**Date**	
Job Title		**Telephone**	
For Governance Use Only:			
Date entered onto CCG Register		**Reference Number**	

I understand that if I knowingly make a false declaration or fail to make a declaration when required, then action may be taken against me. This may include internal disciplinary action or referring the matter to the Trust's Local Counter Fraud Specialist which may result in criminal or civil action being taken against me.

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