NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 21 March 2024

12.30pm-2.30pm

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	12.30pm	2
2.	Quoracy		Verbal			
3.	Conflicts of Interest		Enc. 02			3-4
4.	Minutes of the Meeting held on 15 February 2024 and Matters Arising	Chair	Enc. 03	A		5-14
5.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		15
6.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	12.35pm	
	Strategic and System Development					
7.	ICB Chair and Chief Executive Update	DP/PA	Enc. 05	I	12.40pm	16-22
8.	NHSE Specialised Service Delegation	CB	Enc. 06	A	12.50pm	23-98
9.	Joint Forward Plan	CB	Enc. 07	A	1.00pm	99-158
10.	Intelligence Strategy	CI	Enc. 08	A	1.10pm	159-176
	System Governance and Performance					
11.	Quality and Safety Report • Quality Committee Assurance Report	HJ JS	Enc. 09 Enc. 10	S	1.20pm	177-181 182-184
12.	Finance & Performance Report • Finance & Performance Committee Assurance Report	PB/PS MN	Enc. 11 Enc. 12	S	1.30pm	185-197 198-204
13.	2024/25 Planning Update	PB	Enc. 13	I/S	1.40pm	205-214
14.	ICB Budget Setting	PB	Enc. 14	A	1.50pm	215-221
15.	People Culture and Inclusion Report • People Culture and Inclusion Committee Report	MI SL	Enc. 15 Enc. 16	S	2.00pm	222-236 237-242
16.	ICB Constitutional changes required by NHSE	TS/PW	Enc. 17	A	2.05pm	243-246
17.	Freedom to Speak Up Report	TS	Enc. 18	I	2.10pm	247-251
	Committee Assurance Reports					
18.	Audit Committee Report	JHo	Enc. 19		2.15pm	252-254
	Any other Business					
19.	**Items notified in advance to the Chair**	All		D		
20.	**Questions from the floor relating to the discussions at the meeting**	Chair			2.20pm	
21.	**Meeting Effectiveness**	Chair				
22.	**Close**	Chair			2.30pm	
23.	**Date and Time of Next Meeting** 18 April 2024 at 1.00pm held in Public – via Microsoft Teams					

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**.

NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2023-2024
INTEGRATED CARE BOARD (ICB)
AS AT 14 MARCH 2024

Kev

Declaration completed for financial year 2023/2024
Declaration for financial year 2023/2024 to be submitted

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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	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.
1st April 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 - ongoing)	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
6th April 2023	Mr	Chris	Bird	Chief Transformation Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim Chief Transformation Officer, NHS Staffordshire & Stoke-on-Trent ICB until 31.07.23. Substantive role - Director of Partnerships, Strategy & Digital , North Staffordshire Combined Healthcare NHS Trust (April 2023 - July 2023)	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (April 2023 - March 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.
2nd August 2023	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	No action required
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. 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.
3rd April 2023	Dr	Paul	Edmondson-Jones	Chief Medical Officer and Deputy Chief Executive	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Charity Trustee of Royal British Legion Industries (RBLI) who are a UK wide charity supporting military veterans, the unemployed and people with disabilities (December 2022 - ongoing)	Nothing to declare	Nothing to declare	(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.
1st April 2023	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
1st April 2023	Dr	Paddy	Hannigan	Clinical Director for Primary Care	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Salaried GP at Holmcroft Surgery integrated with North Staffordshire Combined Healthcare Trust and contract responsibilities taken over by NSCHT (1st January 2020 - 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.
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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	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*
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.
21st April 2023	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		(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.
19th April 2023	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 - 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
1st April 2023	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 - ongoing) 2. Membership of the Royal College of Nursing (RCN) (1978 - ongoing) Membership cancelled with effect from 30/11/2022 (declaration to be removed from the register in May 2023)	Nothing to declare	1. Spouse and daughter work for North Staffs Combined Health Care NHS Trust (2018 - ongoing: redeclared 21.11.21)	(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 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.
4th April 2023	Mrs	Tracey	Shewan	Director of Corporate Governance	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Works shifts on Chebsey ward at MPFT (December 2022 - ongoing)	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (August 2019 - 06 November 2023) (Declaration to be removed from register May 2024) 2. Sibling is a registered nurse with MPFT (August 2019 - ongoing) 3. Daughter works for West Midlands Ambulance	(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 April 2023	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
1st December 2023	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 - ongoing	1. Company Director for Coventry and Rugby GP Alliance (December 2023 - ongoing)	1. Chief Executive Coventry and Rugby GP Alliance (May 2022 - 31st August 2023) (Declaration to be removed from the register February 2024)	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
3rd April 2023	Mr	Paul	Winter	Associate Director of Corporate Governance / ICB Data Protection Officer	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 15 February 2024 1.00 pm - 2.30pm Via MS Teams

Members:	Quoracy	20/04/23	18/05/23	15/06/23	20/07/23	21/09/23	19/10/23	16/11/23	21/12/23	18/01/24	15/02/24	21/03/24
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		✓	✓	✓	✓	✓	✖	✓	✓	✓	✓	
Chris Bird (CB) Chief Transformation 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		✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	A	✓	✓	✖	✓	✓	✓	
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✓	✓	✖	A	✖	✖	✖	✓	✓	✓	
John Henderson (JH) Chief Executive, Staffordshire County Council		✖	✖	✓								
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	✓	✓	✓	✓	✓	✖	✓	
Patrick Flaherty, (PF) Chief Executive, Staffordshire County Council					A	✓	✓	✖	✓	✓	✓	
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) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✖	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Participant Members:												
Simon Fogell (SF), Stoke-on-Trent Healthwatch		✓	✓	✓	✓	✓	✖	✓	✖	✓	✖	
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Alex Brett (AB) Chief People Officer, 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		✖	✓	✓	✓	✓	✓	✓	✓	✓	✖	
Steve Grange (SG), Midlands Partnership University NHS Foundation Trust		✓	✓	✖	✓	✖	✖	✖	✖	✖	✖	
Helen Ashley (HA), University Hospitals of North Midlands NHS Trust			✓	✖	✖	✓	✖	✖	✖	✖	✖	
Claire Cotton (CC), University Hospitals of North Midlands NHS Trust		✓	✓	✖	✓	✓	✖	✖	✖	✖	✓	
Lynn Tolley (LT) Acting Chief Nurse and Therapies Officer, Staffordshire & Stoke-on-Trent ICB						✓	✓	✓	✓	✖	✖	
Richard Harling (RH) Staffordshire County Council								✓	✖	✖	✖	
Chris Sands (CS), Chief Finance Officer, Midlands Partnership University NHS Foundation Trust				✓				✓	✖	✖	✖	
Helen Dempsey (HD) Director of Finance & Performance, Staffordshire & Stoke-on-Trent ICB				✓					✖	✖	✖	
Mish Irvine, Chief People Officer, Staffordshire & Stoke-on-Trent ICB (People Directorate, Midlands Partnership University NHS Foundation Trust)				✓	✖	✖	✓	✓	✓	✓	✓	
Karen Webb (KWe), Deputy SRO Learning Disability and Autism, Staffordshire & Stoke-on-Trent ICB					✓						✖	
Katie Weston (KW), EPRR Strategic Lead, Staffordshire & Stoke-on-Trent ICB					✓						✖	
Jacqui Charlesworth, Deputy Finance Director, Staffordshire & Stoke-on-Trent ICB							✓	✓	✖		✖	
Rachel Gallyot, Staffordshire & Stoke-on-Trent ICB							✓				✖	
Becky Scullion, Director of Nursing Staffordshire & Stoke-on-Trent ICB										✓	✖	
Nicola Bromage, Staffordshire & Stoke-on-Trent ICB											✓	
Hayley Allison, Staffordshire & Stoke-on-Trent ICB											✓	
Gill Hackett (GH), Executive Assistant, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✖	✓	✓	✓	✓	✓	✓	

		Action
1.	**Welcome and Introductions**	
	JHo 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. JHo reminded member 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 Phil Smith (Hayley Allison attending) Chris Bird (Nicola Bromage attending) and Paul Winter and David Pearson.	
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 January 2024**	
	The minutes of the meeting held on 18 January 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 Urgent and Emergency Care (UEC) - Enclosure 5 Chair and Chief Executives gives an analysis of UEC situation within our ICS and challenges including severe pressures. UHNM recently declared a Critical Incident with the almost unheard of Ambulance diverts to neighbouring trusts Mid Cheshire, RWT and Burton. Highlighted is Ambulance cat2 performance which is worse than last year and several initiatives now in place to improve or mitigate overall UEC 'performance'. Ambulance Handover delays at Royal Stoke ED are also increasing significantly and are above 70 mins on average. It's acknowledged throughout Care Systems that Ambulance Handover delays can and do create significant detriment to individuals including impacts such as 'excess deaths'. This issue of ambulances stuck outside an ED thus not available to respond to further community need seems to be a significant sticky challenge for our ICS despite a swathe of initiatives being undertaken to address the situation. In fact in December 2021 I questioned UHNM Board as to whether significant Ambulance Handover Delays were in fact becoming 'normalised' this being minuted at 184/2021 of UHNM Board papers. • Ambulance Handover delays are problematic in the vast majority of English ICSs. However some ICS do seem able to curtail delays to a much lower levels than in our ICS. Are there lessons to be learned from those ICS s and if so what has been identified that can be further implemented locally to sustainably reduce delays in Handover at Royal Stoke ED? ***Response:*** *HA gave some context – we focus on ambulance delays throughout the system. We have plans on how we ultimately reduce them. We work closely across other ICBs and NHSE encourage us to share and use best practice. Why are we an outlier in terms of or delivery and specific ambulance delays. We are currently validation some of the areas that are highlighted. RS sees more ambulance runs than any other areas across the midlands mainly to our geography, population driven, we have a higher number of over 75s. The reasons for hand over delays are very often for the number arriving at any time and also the flow through hospital. We use GIRF. We very much share and learning as standard piece of work.* *JHo asked if that comparison work would come back to Board. HA confirmed that this will be included in the UEC plan over the next few months.* *HJ added that harm review is shared far and wide and best practice for quality for patient experience.* • CRIS Teams, Acute Care at Home along with Virtual Bed usage were key Capacity metrics in our ICS UEC winter surge planning. Work force challenges previously identified have likely impacted on the capacity contribution those initiatives now make to the Winter Plan. What is the situation regarding those work force challenges and possible improvements to workforce recruitment and retention? ***Response:***	

	The Acute Care at Home offer comprises specific areas and is part of our surge plan. We have been able to redeploy staff from other organisations to support the workforce model. We also have the People Hub across the ICS and are able to align people from the hub to the Acute Care at Home. We are also reviewing the function of Acute Care at Home to work through what would give us the most sustainability for that service. *JHo confirmed that the work on the comparisons would go the EUC Board, then F&P and then to Board.*	
7.	**ICB Chair and Chief Executive Update**	
	PA acknowledged the pressure in the system and that UHNM declared a critical incident this week. He added that UEC was complex, it had a number of multi-faceted moving parts and it was an ongoing challenge to ensure those parts kept moving. He believed that the comparative piece discussed earlier was very important. PA advised that the specialist commissioning delegation was linked to the wider Midlands collective, they had learnt lessons from the recent POD delegation and the work was still ongoing but it would come to the Board next month with a clearer position. JHo acknowledged the sad death of Paul Draycott, which had been a huge shock to Combined Healthcare and in the short time she had known him, his influence and style made an impact on her on the times they had met. On behalf of the System, she passed on their condolences to his family. MN noted that Covid vaccinations were down to 52% of the population and asked what could be done to encourage the take up of the vaccinations. PA felt it was important in a public forum to encourage people to get their jabs. PEJ added that it was disappointing for both flu and covid vaccinations. He stated that they were above the national and regional totals, but it did mean that 48% of the population were unvaccinated. He continued to say that there was an increasing number of people who say it was just another cold but the ICB would continue to work on how they get out to people, locally. He added that it would get more important, as they now had shingles and a number of other viruses and for children, there was the MMR vaccine and the ICB would put a programme in place to address that. MN asked if they were working fast enough to put communications in place about measles. JHo also asked if the ICB were taking learning from our colleagues in terms of the East Midlands, where this was more prominent. PEJ confirmed that they had weekly meetings which included the East Midlands. There were also comms going out aimed at children and their families, schools etc. as well as regular comms through general practice. He agreed that the biggest learning was coming from Birmingham. JHo asked how the undertakings would be monitored and reported. PA confirmed that the Board would sign the undertakings off in March and they would be monitored through F&PC then up to the Board through the committee reports. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report for information.	
8.	**Electronic Patient Record Programme Business Case**	
	CI advised that this paper was regarding information sharing and to give assurance that they had followed due process on reaching the decision. He confirmed that the business case had also been through SPG and FPC. He explained that there was a digital road map aligned with national directives against the pillars that they worked to. A lot of the initiatives were long standing and they were seeking to deliver digital transformation over the next 3-5 years.	

	For the Electronic Patient Record (EPR) they had have been looking at a capacity of having the best system patient record. He added that there were challenges both on the clinical and digital side. CI explained that they had many different systems across at the acutes alone and that EPR needed to be replaced by 2027. He reported that they had been working on a Business Case for costs and were looking to implement it across primary care, secondary and acute care and empower patients to their systems. During the development of the business case, four options were identified CI advised that the preferred option was 3a which would support all functions across the system. He confirmed that they had worked through the revenue and capital associated with each option and it was agreed that individual organisations would be staggered over time, starting with acute in 2027. CI explained that they had worked out the programme funding which was separate to the overall implementation and licencing of the solution. In 2024/25 they had a net funding requirement of £892k and that was the ask to FPC. The funding had already been pre-approved but had not been received and would be using that allocation to fund phases 3 and 4. CI pointed out that they could not go into procurement until funding was approved and they would not progress to any supplier until the end of the test period. FPC provided approval for phases 3 and 4 subject to a number of recommendations including ensuring there were clear stage gates for the various organisations to be able to review and assess progress as they worked through the full business case. SL referred to the governance piece and stated that cost challenges were often not assumed and with long timelines, he asked how that would be managed because. SL also asked about digital inclusion for patients and the end service users who were often excluded and had challenges in managing their way through electronic systems. CI responded in regard to the governance and especially managing potential cost challenges if they arose and stated that they were talking of 100s of millions of pounds. He reassured members that the necessary conversations had taken place within the ICB, local authorities and Trust levels and they were preparing all organisations to this. He confirmed that they would ensure they had the appropriate governance in place for such a huge programme. CI agreed that digital was not for everyone and there was the potential for people to be excluded. To avoid this, they had been doing a lot of work around patient engagement platforms with care providers etc., and confirmed this was on their radar and part of their strategy. JA echoed the concern around financial governance. With regard to digital exclusion he felt it was the most advanced within the current system. However, he had more concern about health care workers' digital literacy and reiterated that there was work to be done to upscale the workforce. He added that they could not have envisaged things from the covid outbreak and a commitment of 10 years was a long process and something could change over the course of 1-2 years. CI commended MPFT, who had formed a digital angels team of support workers to go out in the system to hold people's hands. They had have also signed up to the digital skills network and there were a variety of internal training courses to help people on a variety of different skills. CI confirmed that 10 years was the maximum for the procurement period and it needed to be run for that length of time to get longevity on the investment.	

	JHo summarised that there was a need for strong financial governance, digital exclusion and the potential for upscaling of the workforce. She added that members could take assurance of the work being done and the slides set out the case for change, and an EPR would help support in terms of improving the patient experience, digital maturity and financial efficiencies downstream as well as the significant cost. CI agreed to run through the finer details separately with the NEDs. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the report.	
9.	**Quality and Safety Report**	
	HJ highlighted that the measles update referred to by Megan earlier was set out in the quality report together with updates on inspections of local authorities including SEND and children's services. HJ highlighted the extraordinary update on a review that was undertaken for LeDeR where they had previously outsourced their services and had identified a backlog of reviews and they were taking immediate action undertaking the training to support the backlog. She reassured members that their commitment was to would ensure that the backlog was reduced as soon as possible. CQC activity – MPFT were now rated good for their inpatient wards and West Midlands Air Ambulance were rated as outstanding. JHo asked how the children's services OFSTED was reflected in planning. HJ responded that from a safeguarding point of view she gave reassured that for all follow up action points there would be an improvement board where all would be reviewed and would link back to the portfolios. The Staffordshire & Stoke-on-Trent ICB Board **RECEIVED** the report and sought clarification and further action as appropriate and **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**.**	
10.	**Finance and Performance Report**	
	Finance PB ran through the M10 position and confirmed that they now had agreement to a control deficit of £91.4m. He added that there were a few risks that they were managing but alerted the Board that the majority concerned system provider contracts but he believed they could manage those within the budget. PB reported that there was a national issue that affected us locally as well which was regarding Band 2 staff that had been upgraded to Band 3, which would have a substantial cost. He confirmed that those were the risks at this stage and they were confident they would achieve the £91.4m target. SL asked about the additional costs related to the industrial action. PB confirmed that was the cost for the back filling for the rotas and there was an element of financial risk around that too. **Performance** HA highlighted a couple of areas within the report.	

	Planned care – They had an ongoing challenge with long waiters and had a cohort of patients in the 78 week category awaiting treatment. She explained that their route was to zero, but they were expecting further industrial action at the end of February which would affect their position to get zero. NHSE had indicated that the timeline to clear the 78 week waiters was extended to the end of April. Urgent care – As mentioned earlier in the meeting they have had a challenging few weeks with a critical declaration from UHNM during that time which increased attendance and ambulances into hospital. HA advised that although the Category 2 response time had deteriorated, the regional position had improved to 6 out of 11 in the Midlands, which was an improvement from recent weeks. All winter schemes were operational now and they would be reviewing the de-escalation of some of that capacity but would not switch anything off ahead of the Easter period. HA stated that they already had comparative piece of work they were undertaking and there was some ongoing progress improvement work which was being undertaken within the providers, specifically UHNM who had some NHSE support at the moment. JHo asked if the winter surge was due to stop before or after the Easter break. HA confirmed that they would be looking at de-escalation after Easter and would not close anything off where was still required. MN brought attention to increase in the number of Category 2 and 3 calls across all metrics. She added that the F&P committee had asked for further analysis to come back to the next meeting. JR stated that with regard to the children's mental health provision, the data was wrong because of data quality issues, particularly in relation to Combined Healthcare. He asked if those had been resolved and did the Board have the full picture of access waiting times. HS confirmed that would be corrected for the next report. JR reiterated that this had been going on for some time and needed to be resolved. PA confirmed that everyone needed to be aware of the issue and they would update the Board with a solution and corrected data at the next meeting. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the report.	
11.	**2024/25 Planning**	
	PB reported that they were wating for annual operational planning guidance but had a clear indication from the Centre what was required. He advised that they held an event on 24th January where they looked at different elements of the system where they could make an improvement. The essence of that event was that they needed to do fewer things, but bigger things. One of those was programmes was they were looking at a single point of access and which would allow them to use the out of hospital services already in place. It was also identified that there was a need for improved productivity as well as the money and were there services that they could spend less on. Having agreed those principles, the System Strategy Directors worked together to construct a process to allow the system to decide what those priorities were that they needed to focus on.	

	They now had a process and discussed that at the System CEOs group where they also received good feedback from the Local Authorities and were now working on ensuring it was a whole system plan. PB reported that the most challenging area was performance in terms of activity meeting the pressures of ambulances, mental health etc. He reiterated that they would meet the control total of £91.4m. PB advised that the timescale was day by day and by the end of February, they were required to produce a flash return then, by the end of March they were required to submit a final plan. PB confirmed that they would have a clear update for the board meeting in March and would be asking the Board to approve the plan for the year. MN commented that the system was working really well together, as she had observed at the event on 24th January, across Staffordshire and Stoke-on-Trent planning for the next year. MN asked whether they were able to transform and improve performance that was needed to be done at the same time as delivering cash out savings and the expectation they were able to deliver those two things together. PB confirmed that they could take cash out and improve performance, but felt that the timescale could be difficult. PB agreed that was the challenge in doing both together. SL referred to productivity and stated that they had seen an increase in the clinical workforce and the challenge in productivity, and asked how significant was that gap and was there a level of understanding about productivity across the system. PB responded that the work around the single point of access would make a big difference to productivity and will create the system productivity that was needed. He added that acute productivity had seen a fall by 20% and they were trying to develop a solution that was system orientated rather than acute orientated. JR had confidence that the DOFs, DOSs and COOs were working well to guiding the Board. JR made a note of appreciation that it was very difficult for all DOFs to balance the books and this should be recognised as a Board to navigate our way through this period. TB referred to the board risk appetite and felt it would be useful if they knew what the appetite was on certain things. She added that, in relation to the discussion around staffing, there had been an increase in headcount in 2019 and UHNM did not foresee taking headcount out. However, they did need to work on productivity, but quality and safety was more important than some things. JHo agreed that the risk appetite was very important and to ensure that was addressed at Board level. PA reiterated the point on the challenge on certain individuals across the system and they were not alone in resolving the problem. He added that the Kings Fund published a report on the transformation of community services and they needed to acknowledge that they were in a wider pack in trying to resolve the problem. The Staffordshire & Stoke-on-Trent ICB Board:- • **NOTED** the recap of the core documents • **NOTED** the summary of the additional JFP Guidance • **NOTED** the outline of the JFP strawman	

	• **NOTED** the progress to date and next steps	
12.	**Board Assurance Framework**	
	CC reported on the latest updates and thanked the team for pulling the BAF together with the executive team. She confirmed that it had already been through various committees and robust scrutiny. CC advised that with the support of the Exec team across the system it was agreed to develop the BAF at system level rather than ICB and they would be holding a system wide workshop in March. CC explained that the BAF was subject to audit which was currently underway and the outputs of that audit would be brought back to the Board in due course. They would be using the BAF to inform the committees and would be bringing a summarised version to the Board. JHo thanked everyone for bringing the BAF to life. HJ reported that they have seen an improvement on maternity from when the BAF was published for the Board. HS welcomed the planned workshop session to move towards a system BAF and added that they could align the BAF with the ICS Green plan reaching out into the Local Authorities and voluntary sectors. She stated that she would be happy to assist at the workshop. JHo stated that this linked to the 2024/25 planning and the context of the financial pressure and that was where the risk appetite was important. The Staffordshire & Stoke-on-Trent ICB Board • **CONSIDERED** whether the Quarter 3 risk scores and assurance assessments are an accurate reflection of the current position. • **WERE ASSURED** that the Committees have oversight of the BAF where they are the lead committee. • **CONSIDERED** whether the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance. • **AGREED** if there are any procedural or other changes required to the way the committee conducts its business: e.g. Terms of Ref amends etc.	
13.	**Committee Assurance Reports**	
	People, Culture and Inclusion Committee SL advised that the committee had a discussion around financial framework on the operational workforce plan. The Staffordshire & Stoke-on-Trent ICB Board **NOTED** the contents of the reports.	
14.	**Any Other Business**	
	No other items of business raised.	
15.	**Questions from the floor relating to the discussion at the meeting**	
	David Jones Does the eventual EPR include community, pharmacy and dentist.	

	CI referred to community and mental health and advised that he did not have that information and would go back to check if they have representations from that question. **Ian Syme** 1. Referred to the control total of £91.4m and the impact of the industrial action and asked what would happen to the underlying deficit of the system. *PB confirmed that the deficits were repayable. The challenge for 2024/25 was the start of 2023/24.* 2. System priorities – complex individuals was severe at 77% below target of (1637 patients) and asked what the problem was here. *HS confirmed that was a similar data reporting issue. Health checks were taken by health teams and that needed to come back to the primary care. She agreed that she would come back to the next meeting regarding the data.* **Derek Hoey** Referred to performance in non-urgent patient transport. On several occasions he has received feedback from patients in the community on the lack of performance from ERS to which he gave an example. He asked how could members of the public reassure themselves of improvements on their performance. *HA agreed that was a shocking example – however, she did not have the up to date data on the patient transport service and asked Mr Hoey if he would like to send her any specific examples, she would investigate them. She reiterated that they had regular contract discussions with the PTS and would report directly back to Me Hoey on more information.* The were no further questions received from the floor.	
29.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact.	
30.	**Close**	
	There being no further business, the Chair closed the meeting.	
31.	**Date and time of Next Meeting**	
	21 March 2024 at 12.30pm held in Public – via MS Teams	

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Date of Meeting 21/03/2024

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)
				THERE WERE NO ACTIONS FROM THE MEETING HELD ON 15 FEBRUARY 2024			

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 05

Report to:	**Integrated Care Board**					
Date:	**21 March 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

(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 Health Inequalities

On 30 January, partners from across the system came together to develop a Health Inequalities strategy. Dave Heywood, Chief Executive of South Staffordshire Council, opened the day, which was attended by over 70 people, and Dr Giri Natarajan, Regional Deputy Director of Public Health, providing the keynote speech. Dr Natarajan outline the huge opportunity of working together as a system to tackle health inequalities, particularly as most people's health and wellbeing is influenced by the communities in which people live, their lifestyles and behaviours, and the wider determinants of health such as housing, education and work.

The agenda was carefully constructed to ensure key partners, rather than the Integrated Care Board (ICB), were leading and influencing the conversation, including the two Upper Tier Local Authorities and the Voluntary, Community and Social Enterprise (VCSE) Alliance.

Key themes from the day included working in collaboration where it makes sense, building an equal platform for the voluntary sector and working at locality level to develop our communities. The strategy is currently being drafted with further engagement planned.

1.2 People

In January, the workforce included 24,043 whole time equivalents (wte): in NHS providers there were 2,872 wte, in Primary Care there were 610 wte, and in social care there were 20,000 wte. In addition, there are numerous people who are volunteers or carers in our community.

Our workforce is our biggest asset. We are starting to see the positive effects of being less reliant on agency workforce and seeing improvements in our vacancy, turnover and sickness absence. The merits of improvement of grip and control are vital to ensure we are using our resources in a sustainable way and continuing to strive for improvement in this, whilst ensuring that impact to patients is positive.

We are currently amid the financial year 2024-2025 (FY24-25) NHS Operational Planning process. To commence the operational planning process, a high-level plan was submitted to NHS England in February 2024. This detailed a planned modest increase in establishment of +115 wte (+0.5%) and +315 wte (+1.3%) in staff in post. We are assured that many of these increases are relating to income backed activity at this early stage. In March 2024 we will develop the plan to a granular level to ensure that the recruitment pipeline is accurately reflective of planning requirements across activity, finance, and workforce.

The week commencing 5 February 2024 was National Apprenticeship Week. Multiple events were held to promote entry level and higher-level apprenticeship opportunities in Health and Social Care settings. The events included Staffordshire University Apprenticeship fair, Stafford Job centre drop-in session and numerous secondary school events both in person and online, reaching thousands of students across Staffordshire and Stoke-on-Trent.

As a system we were finalists in the Widening Participation Recognition Category at the FE Week and AELP AAC Apprenticeship Awards 2024 and winners of the "Promoting Apprenticeships Recruitment Campaign" at the Newcastle and Stafford College Group Employer Awards.

2.0 Finance

At month 10, at a system level, we are reporting a £69.5m adverse variance against plan. The adverse position drivers are consistent with prior months across Continuing Health Care (CHC) and prescribing inflationary pressures, slippage on efficiency programmes, the ongoing retention of escalation beds due to urgent and emergency care (UEC) demands throughout the financial year. Our original break-even plan included a number of upside assumptions. Unfortunately, a number of these assumptions have not come to fruition and last month we notified regional and national teams as part of the financial reset return of a forecast out turn of £91.4m. All organisations are increasingly confident of delivering their risk adjusted

forecast and managing the residual risks. However, the position includes risks around the fixed and variable aspects of the Elective Recovery Fund (ERF), and we hold firm on our assumptions and bills related to overperformance associated to Urgent and Emergency Care (UEC), (Non-elective stay (NELs) and A&E attendances) amounting to £8.1m. On this basis, as a system, we still believe that a deficit of £91.4m is our most likely position.

3.0 Planned Care

3.1 Elective Waits

The Integrated Care Board (ICB) 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 April 2024, in accordance with the national planning guidance (extended from March 2024). However, despite progress being made, the rate of improvement is being hampered by the ongoing industrial action by both junior doctors and consultants.

Current position is as follows:

3.1.1 104-week waits

One patient breached at the end of February at University Hospitals of North Midlands NHS Trust (UHNM), due to a new clock start not being applied, the patient has a TCI in March. There are no further 104-week breaches predicted. There were two breaches at the end of February who are outside of the system. One patient is at Sandwell and West Birmingham NHS Trust, under the specialty of Ear, nose and throat (ENT) and is expected to come in on 8 March. The other patient is at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) under the specialty of Rheumatology; they had plans for injections w/c 4 March.

3.1.2 78-week waits

For patients waiting beyond 78 weeks for treatment, the number of breaches across the system at the end of February was 164 154 at University Hospitals of North Midlands NHS Trust (UHNM), and 10 at Nuffield). The forecast position for the end of March is 83 (71 at UHNM and 12 at Medefer), with a forecasted position of 22 breaches for April (15 at UHNM and 7 at Medefer). However, work is continuing to reduce these further. As previously reported the ICB does continue to track long-waiters that receive their elective care outside of the Staffordshire and Stoke-on-Trent System. In the latest unvalidated data (25 February), there are 70 patients waiting over 78 weeks outside of the system, 41 are on the admitted part of the pathway, of which 34 are at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), and 29 are on the non-admitted part of the pathway, of which 18 are at UHDB. UHDB are on Tier 1 elective oversight and are subject to weekly monitoring by NHS England.

3.1.3 65-week waits:

Good progress is being made overall on the 65-week-wait cohort. Numbers have continued to improve with the potential cohort of patients breaching 65 weeks by the end of March now standing at c1,900 on 25 February, this is compared to over 37,000 at the start of the financial year. This is an improvement of c1,900 patients since 21 January. As at 4 March, there were 1,097 breaches at the end of February (1,068 at UHNM, 28 at Nuffield, 1 at Ramsay), with a forecasted position for the end of March of 1,084 breaches (1,039 at UHNM, 1 at Nuffield and 44 at Medefer). The forecasted position for April is 836 (818 at UHNM and 18 at Medefer). For providers outside of the system, in the latest unvalidated data (25 February) the potential cohort of patients who could breach 65 weeks if not treated, by the end of March is 991 patients, 479 of these are on the admitted part of the pathway and 512 on the non-admitted pathway.

3.2 Cancer Performance

University Hospitals of North Midlands NHS Trust (UHNM) have seen a continued steady reduction in the 62-day backlog since September but did see an increase during December. As of 3 March, the 62-day backlog was at 274, this is compared to 365 as of 21 January. The 104+ day backlog also saw an increase during December but has seen a steady reduction since the beginning of January. As of 3 March, the 104+ day backlog was at 79, this is compared to 96 as of 21 January.

The position of 28-day faster diagnosis standard for cancer has improved in February after a slight decline in January. December position was 70%, January position was 67%, with February currently being at 76.8%, to note that February is currently only 94.5% complete.

4.0 Urgent and Emergency Care (UEC)

Four-hour performance in February remained steady with a marginal increase to 63.7% from 63.4% in January. Whilst this performance is down on the same period last year, it hides the variation within the month which ranged from a low of 53.7% to a high of 77.2% with improved performance over the second half of the month allowing significant recovery of the position. Whilst overall attendances for the month were down by 4% the shorter month saw an increase in the attendances per day of an extra 18 patients, split equally between Type 1 and Type 3. In comparison to the same month last year, overall attendances were up 9%, 37 patients per day when accounting for the extra day. Continued load balancing across sites through the earlier half of the month saw County Hospital continue to be pressured on performance with a new 17% point reduction on the same period last year.

Twelve-hour performance improved to 9.5% in February, from 10.7% the previous month. Royal Stoke Hospital reported an individual improvement from 18.4% to 16.8% during the month, 0.6 percentage points above the same period last year. With reduced load balancing in effect between sites, County Hospital also saw an improvement from 5.1% to 3.3% which was 2.7 percentage points better than the same period last year.

Long Length of Stay (LoS) performance reported little variation over the previous month with each of the 7+, 14+, and 21+ measures indicating changes of between 0.3 and 0.8 percentage points, however, each reported significantly below the levels reported for the same period last year. This includes an average of 34 fewer patients per day in beds for the 14+ days measure, and 32 fewer per day for 21+ days.

Category 2 performance through the start of February was significantly challenged initially breaching the 1-hour average mark before reducing significantly to just above the 30-minute average target by the last week of the month. The 4-week average of 46mins 54secs saw improvement both regionally and nationally and the latest weekly average response of 30mins 24secs placed the system in the highest quartile regionally and second quartile nationally.

Medically Fit for Discharge (MFFD) decreased across both sites during February, and with the KPMG Test of Change commencing during the final week of the month and the Trust Manual for Discharge standardising procedures, there is the opportunity for the Immediate Focus Plan to deliver real improvements.

COVID-19 bed numbers reported a small uptake through the middle of February at University Hospitals of North Midlands NHS Trust (UHNM), however, they resumed their downwards path by the 3rd week of the month and continued to trend downwards through into March, reporting lower than the same period in each of the previous three years. The monthly average of 93 indicates the pattern of change with the end of month figure reporting as 69 beds. Our Community Hospitals also reported reducing numbers achieving 0 beds by the end of the month. Staff absences due to COVID-19 reduced to 0.3% of all staff for Providers within the system, indicating a low but sustained level of infection. Flu bed numbers followed the patterns reported nationally reducing though February, reaching as low as 10 at the end of the month equating to approximately 6% of G&A bed base occupied by the end of the month.

During March, the system is focusing on achieving 76% for the 4-hour performance. For March we are to time at 70.3% as of 7 March. This is an improvement from February which was 63.7%, however there is still work to be done to achieve 76%. Type three attendances have only had breaches in Enhanced Primary Care (EHPC) whereas the Walk in Centres (WIC's) have achieved 100%. Both Royal Stoke University Hospital (RSUH) and County continue to struggle however additional focus on performance and validation is hoping to with a newly developed action plan improve the position during March.

5.0 Key figures for our population

		Last 3 to 4 months in current financial year				Same month in previous financial year		Latest month v same month in previous financial year		
		Oct-23	Nov-23	Dec-23	Jan-24	Dec-22	Jan-23			
*	111 calls received	35,316	32,553	40,198	37,000		30,580	6,420	21.0%	↑
	Percentage of 111 calls abandoned	5.7%	6.3%	7.1%	13.0%		8.3%	4.7%	56.5%	↑
	A&E and Walk in Centre attendances (UHNM)	21,360	19,592	19,877	20,461		18,739	1,722	9.2%	↑
	A&E and Walk in Centre attendances (other providers)	18,311	17,350	17,307	17,367		15,730	1,637	10.4%	↑
	Non elective admissions (UHNM)	7,947	7,637	7,655	8,208		6,954	1,254	18.0%	↑
	Non elective admissions (other providers)	5,952	5,965	5,746	6,190		5,479	711	13.0%	↑
	Elective and Day Case spells (UHNM)	7,168	7,272	6,561	7,782		6,811	971	14.3%	↑
	Elective and Day Case spells (other providers)	8,432	8,869	7,410	8,468		7,790	678	8.7%	↑
	Outpatient procedures (UHNM)	5,229	5,912	4,598	4,681		4,213	468	11.1%	↑
	Outpatient procedures (other providers)	10,019	9,616	7,440	9,175		7,782	1,393	17.9%	↑
	GP Appointments (all)	621,388	562,056	466,525	596,636		523,005	73,631	14.1%	↑
**	Physical Health Community Contacts (attended)	140,975	140,675	122,865	139,760		136,805	2,955	2.2%	↑
**	Mental Health Community Contacts (attended)	46,070	46,465	37,150		37,120		30	0.1%	↑

Most datasets are subject to change following refresh

*NHS 111 - latest month is provisional and subject to change
**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 Chief Nursing and Therapies Officer – Return to work

We are delighted to welcome back our Chief Nursing and Therapies Officer, Heather Johnstone, after a period of sick leave. Throughout this difficult period, the Directors of Nursing, Lynn Tolley and Becky Scullion, have continued to lead the directorate and to attend all key meetings on behalf of Heather. We would like to record our thanks to them both for sustaining the high standards we expect from the team.

6.2 Paramedic Students

The Integrated Care Board (ICB) is continuing to work in partnership with Staffordshire University to develop a new alternative placement for paramedic students across the ICS. Following the successful pilot with one student last year, the ICB will be facilitating three third year paramedic students for the week commencing 11 March 2024. This is a unique opportunity for the students to experience different elements of the urgent care pathway. They will experience NHS111, both in hours and out of hours and will spend time with the Community Rapid Intervention Service (CRIS), the Acute Visiting Service (AVS) and finally with the ICB's Urgent Care Team (UCT). The aim of this week is to increase awareness of other services and the pressures that they face, promote the alternative recruitment opportunities for the

paramedic role and to break down traditional barriers between services. The students will leave this week with a greater understanding of the wider system and their place within it. This will have a positive impact on their clinical practice moving forward.

The placement in 2023 was well received with positive feedback and recognition of the benefits of continuing to take this forward. There was significant work by Vicki Graham to make this happen and ensure paramedics can receive a valuable rounded experience.

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:	**21 March 2024**					
Title:	**NHS England Specialised Service Delegation**					
Presenting Officer:	Chris Bird, Chief Transformation Officer					
Author(s):	Chris Bird, Chief Transformation Officer					
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**	YES *If Y, the mitigation recommendations –* Potential Conflict for NHS Provider Chief Executives where the Trust provide specialised services. This is mitigated by those Board members representing NHS provider sectors not individual Trusts.				
Any financial impacts: ICB or ICS?	**Yes / No**	Choose an item. *If Y, are those signed off by and date:* Yes – ICB financial allocation will increase to reflect additional commissioning responsibilities. Financial allocations agreed with ICB Chief Financial Officer				
Appendices:	Delegation Agreement					

(1) Purpose of the Paper:

This paper sets out the proposed delegation of 59 specialised services approved by the NHS England Board as being suitable and ready for delegation to Integrated Care Boards in the Midlands Region at their meeting of 6th December 2023

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Finance & Performance Committee	05/03/2024
Provider Collaborative Board	26/02/2024

(3) Implications:

Legal or Regulatory	NHS England will retain legal accountability for all specialised services – the ICB will become operationally responsibility for the commissioning and performance of the services
CQC or Patient Safety	A Quality Assurance Framework has been established to support ICB oversight of the new services
Financial (CFO-assured)	ICB financial allocations will increase to reflect additional commissioning responsibilities.
Sustainability	None arising directly from this report

Workforce or Training	None arising directly from this report
Equality & Diversity	The delegation of these services will improve integration and support equality of access across services in Staffordshire and Stoke-on-Trent
Due Regard: Inequalities	None arising directly from this report
Due Regard: wider effect	None arising directly from this report

(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?		☐	☐	☒	Delegation of specialised services is part of national policy as set out in the NHS Long Term Plan

(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:

NHS national policy requires ICBs to work in collaboration with NHS England and other relevant partners regarding Specialised Services.

The proposed delegation is a matter for each statutory ICB Board and will transfer the commissioning and monitoring of 59 specialised services to the ICB.

This delegation will benefit the care provided to patients across care pathways, improve access and reduce inequalities by aligning commissioning responsibility to ICBs and enabling a whole population approach.

The report sets out the due diligence that has been completed to support these proposals and in particular amplifies aspects of quality, finance and resources that are required to support a safe transition.

ICBs across the Midlands have been working in partnership with NHS England to co-design an architecture to support delegation and continue to enable joint working on other retained services. These are detailed in the report.

Specifically, the Delegation Agreement is a nationally mandated document setting out the formal requirements of delegation which the ICB Board is invited to consider. This Agreement is attached as an Appendix to the report.

The report concludes by describing the future governance arrangements via a Joint Committee together with topic specific sub-groups focussing on finance, quality and commissioning.

(7) Recommendations to Board / Committee:
The ICB Board is asked to: i) approve the delegation of the defined set of 59 specialised acute services to the ICB from 1st April 2024 ii) delegate the final signature of the national Delegation Agreement to the Chair and Chief Executive of the ICB in the context of the collective ICB position across the Midlands region

NHS England Specialised Services Delegation to ICBs

Introduction

Since April 2023, the Midlands ICBs and NHS England have operated under statutory joint working arrangements to commission specified specialised services. This has included 59 Acute Specialised Services identified in the Specialised Commissioning Roadmap (May 2022) as suitable and ready for delegation.

Following an agreed due diligence process it is recommended that the 11 Midlands ICBs support formal delegation of the 59 services in April 2024. This is in line with the ICB readiness submission to NHS England though the pre-delegation assessment framework and the subsequent NHS England Board approval in December 2023.

National policy requires ICBs to work in formal collaboration regarding Specialised Services. This responsibility, it is proposed, will be enacted through the East and West Midlands Joint Committees. However. the decision to move from joint working to formal delegation is a decision for each statutory ICB Board. Given the NHS England Board decision and policy direction, all Boards who do support the recommendation will be enabled to progress.

All ICBs are expected to receive the delegation of all agreed Specialised Services (Acute, Mental Health and Learning Disabilities, and Vaccinations) by no later than April 2025. The proposed phasing of delegation, with 59 services proceeding in April 2024, provides the Midlands ICBs with the opportunity to build experience in commissioning these services with a developmental safety net of a transitional year. NHS England will provide significant support to ICBs from 2024 to 2025 as they take on these delegated functions.

The delegation of the 59 Acute specialised services is too individual ICBs, however, the formal Delegation Agreement requires ICBs to collaborate in a multi-ICB partnership. The Delegation Agreement must therefore be supported by a Collaboration Agreement and Commissioning Standard Operating Framework, which includes NHSE as a partner in their continued role in commissioning retained services. The approach; supports the requirement to consider the cross-system population needs that support safe and sustainable care in specialised provision

The Midlands have developed a joint Memorandum of Understanding as a part of the suite of delegation documents, setting out our collaborative commitment to working together to maximise the benefits of delegations for patients, populations and across complex pathways.

Responsibilities and Accountabilities

The delegation of specialised commissioning does not change the accountability for these services as this remains with NHS England.

Upon delegation the services become the responsibility of the 11 Midlands ICBs. As noted, the ICBs are required to commit to working together to commission these services. NHS England remains a partner in this process and is responsible for the commissioning of retained specialised services.

Benefits of delegation

The primary purpose of delegation is to benefit the care provided to patients across their care pathways, improve access and reduce inequalities for whole populations. There is a significant opportunity to ensure that the disconnect between the commissioning of specialised services through NHS England and the local commissioning bodies is removed.

The clinical leaders across ICBs and NHSE have identified the delegation benefits as follows:

- **Equity of access for all patients:** There is good evidence that this varies across geographies with those further from specialised provision less likely to have access. Delegation provides the opportunity to understand access and consider outcomes and value across pathways.

- **Whole pathway approach:** Joining up the whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing pressure on specialised services.

  In addition, this ensures any proposed changes in specialised services are planned with interdependent local services; this could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.

- **Facilitation of whole pathway transformation** across ICS footprints as new services are introduced: It will allow implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

An example of the benefits of delegation is set out below:

Renal Services

The need for **renal dialysis** can be reduced by ICBs focusing on identifying those at risk for developing kidney disease and its progression. New treatments are now available to delay progression which if systematically implemented should reduce population dialysis and transplantation needs.

Currently planning and delivery are separate between primary and tertiary care and more local solutions could be developed. More integrated commissioning of specialised renal services would make innovations easier by:

- The same people and organisation being responsible for commissioning both the specialised (e.g. dialysis) and non- specialised (GP led) parts of the patient pathway ensuring complete clinical join up of pathway.
- Budgets could be pooled which creates more of an incentive to prevent renal progression, promotion of home therapies to reduce transportation costs and prompt referral for renal transplantation.
- Wider service provision could be included more easily e.g. psychological support and welfare support.
- Services can be tailored around the needs of local populations helping to

Summary of the due diligence process

The 11 ICB and NHS England have been working together throughout 2023/24 through formal joint working arrangements. This has enabled ICB specialised services leads to understand and work alongside NHSE teams, making informed decisions on finance, quality and commissioning and contracting.

The approach to the transition process for delegation has been led through joint working groups covering finance, governance, clinical quality, strategic commissioning, and planning. This approach was informed by the design principles and operating model set by ICB CEOs.

The comprehensive national safe delegation checklist, which all regions utilise to provide joint ICB and NHS England assurance on deliverables for safe delegation, has guided the approach to due diligence. In addition, learning from the POD delegation, an additional process was agreed and led in the Midlands including ICB and NHSE leads.. The summary due diligence reports have focussed on four key domains and have been received by the East Midlands and West Midlands Joint Committees. The due diligence domains are set out below:

- **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in 24/25
- **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
- **Resources** – staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role.
- **Benefits and opportunities** – Clarity on the benefits of proceeding with delegation in 24 /25. This assessment must also consider the missed opportunity that may accrue through delay to delegation.

There has been a level assurance met against each of these domains.

The joint working groups have co-produced several key documents that support the delegation of these services, these include:

Delegation Agreement: Nationally mandated document setting out the formal legal requirements of delegation – this is attached at Appendix One

Memorandum of Understanding (MoU) and Collaboration Agreement 2024/25

The MoU sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHS England Midlands. The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process. The Collaboration Agreement, which is between the 11 ICBs and NHS England sets on how ICBs will make joint decisions through delegation of responsibility to the existing Joint Committees in the East and West Midlands, how they will commission the services and the financial framework in which they operate including the operation of a pooled fund between the 11 ICBs to manage financial risks across the Midlands. The agreement also sets out how NHS England will work with the ICBs on services that have been identified as suitable for future delegation but are not yet being delegated. The initial agreement is for one year in which it will be reviewed prior to further service delegation.

Commissioning Team Agreement and Operating Framework

This document described the multidisciplinary team (finance, clinical and quality, commissioning, and support teams) who will work on behalf of the 11 ICBs and NHS England. These staff will continue to be employed by NHS England for 24/25. The document describes who the teams are, what they do and how they work.

Service Portfolio Reports

These documents have been developed regionally to ensure an appropriate baseline position related to specialised service lines including:.

- A clear understanding of the services provided within each individual ICB.
- Organisational memory on quality issues captured, written down and communicated formally to receiving bodies.
- Identification of the top issues/risks along with mitigating actions - captured for handover.

The service portfolio reports will continue to be developed and subsequently form the detailed functional documents to enable commissioning for ICB populations and across multi-ICBs.

Future arrangements

Decision Making

On agreement of individual ICBs to accept the delegation of the 59 Specialised Acute service lines, Boards are asked to support the delegation authority for decisions related to these specialised services through to the Joint Committees, established through the Joint Working Agreement in operation in the East and West Midlands. Terms of Reference have been amended from the Joint Working Agreement arrangements to reflect this change. The committees have authority to establish appropriate subsidiary arrangements to support the efficient operation of those services, which will include establishing appropriate delegations to enable day-to-day decision making through sub-groups, details of these subsidiary arrangements are summarised in the Collaboration Agreement and will be formally ratified by the Joint Committees at their first meeting after 1 April 2024.

Finance Subgroup - A Joint Finance and Contracting Subgroup reporting to the Committees that will oversee the financial framework.

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services which will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this is articulated in detail in the Collaboration Agreement.

NHS England will commit to continue to regularly review the overall financial position and risks with ICBs and ensure the retained services and 59 acute delegated services are reviewed together.

Quality Subgroup - Quality will be overseen by the Specialised Commissioning Quality Group. The group will provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues, and risks that are recurrent and/ or have an impact wider than individual ICSs.

Midlands Specialised Services Commissioning Subgroup – A multi-disciplinary group that oversees the design, development, planning, transformation, improvement, and reduction of inequalities for the effective delivery of services.

During 2024/25 the ICBs and NHS England will continue to develop and share expertise through a clearly defined joint workplan to including quality, finance commissioning and planning.

In line the agreed governance framework ICBs should add the following to their SFI's

'Delegated Specialised Commissioning - Decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.'

Recommendation

In summary ICBs have been jointly working with NHS England throughout 23/24 to commission acute specialised services and gain an understanding of the risks and issues.

It is proposed that Midlands ICBs work together and receive an initial delegation of 59 Acute Specialised in 2024/25. This will enable ICBs to have the benefit of learning and developing their approach in a phased manner before the full delegation of further specialised services (including Mental Health and Learning Disabilities) and immunisation and vaccination services in 2025/26.

The ICB is asked to approve the following:

i) approve the delegation of the defined set of 59 specialised acute services to the ICB from 1st April 2024

ii)

ii) delegate the final signature of the national Delegation Agreement to the Chair and Chief Executive of the ICB in the context of the collective ICB position across the Midlands region

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS STAFFORDSHIRE AND STOKE ON TRENT ICB INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Staffordshire and Stoke on Trent ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Staffordshire and Stoke on Trent ICB
Area	The county of Staffordshire, including the city of Stoke-on-Trent
Date of Agreement	[Date]
ICB Representative	[Insert details of name of manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 31);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

DALE BYWATER

REGIONAL DIRECTOR - MIDLANDS

(for and on behalf of NHS England)

Signed by **NHS Staffordshire and Stoke on Trent Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] NHS Staffordshire and Stoke on Trent Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with Schedule 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.4 consider how in performing their obligations they can address health inequalities;

5.1.5 at all times exercise functions effectively, efficiently and economically;

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England

from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England

for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements;

10.15.2 the payments to be made by each partner and how those payments may be varied;

10.15.3 the specific Delegated Functions which are the subject of the arrangements;

10.15.4 the Delegated Services which are subject to the arrangements;

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.15.6 the arrangements in place for governance of the pooled fund; and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this

agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 15 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.6, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS

England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in

relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Schedule 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement;

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably

practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 *(Termination)*) except that the provisions referred to in Clause 29 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance and Sharing Provisions*).

30. COSTS

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. SEVERABILITY

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term "including" or "includes" will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

"Administrative and Management Services"	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
"Agreement"	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
"Agreement Representatives"	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
"Annual Allocation"	means the funds allocated to the ICB annually under section 223G of the NHS Act;
"Area"	means the geographical area covered by the ICB;
"Assurance Processes"	has the definition given in paragraph 3.1 of Schedule 3;
"Best Practice"	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in

	the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and

	the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.5 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;
"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement;

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services;

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

8.5.2 effective introduction of new medicines;

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 Individual Funding Requests

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

17.3.2 robust and defensible, with conflicts of interests appropriately managed;

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

1.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4. The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1. NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

6.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1. Clinical Commissioning Policies;

6.2.2. National Specifications, including National Standards for each of the Specialised Services.

7. Clinical Networks

7.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

7.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

7.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2. NHS England shall manage all complaints in respect of the Reserved Services.

9. Commissioning and optimisation of High Cost Drugs

9.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.1.5. provide input into national procurement, homecare and commercial processes;

9.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

9.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

9.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18. Provider Selection and Procurement

18.1. In relation to procurement, NHS England shall be responsible for:

18.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

18.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

19.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

19.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

20.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

20.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

21.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2. Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific

and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4. Lawful basis for sharing

4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7. Governance: Staff

7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Parties shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Party becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection

Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7. In particular, each Party shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10. The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in

accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

10.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

None – local terms are described as part of the Collaboration Agreement and Operating Framework which includes a pooled budget established by the ICBs

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

SCHEDULE 9: Developmental Arrangements

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

Finance
Ringfencing – Delegated specialised commissioning allocations will be ringfenced to be spent only on specialised commissioning services. This includes reserves and discretionary growth funding as well as existing contractual spend, both block and variable elements. This does not determine which specialised services those allocations are spent on. Any variation of this condition would need to be to be approved by the regional Director of Commissioning or Director of Finance.

Review
Review and removal of the delegation arrangement is the responsibility of the Regional Director of Finance and Regional Director of Commissioning Integration. This will be carried out based on the regional and individual ICB financial position and following and agreed assurance process.

SCHEDULE 10: Administrative and Management Services

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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:	21 March 2024					
Title:	**Joint Forward Plan**					
Presenting Officer:	Chris Bird – Chief Transformation Officer					
Author(s):	Vicki Inch – Associate Director of Planning and Intelligence					
Document Type:	Business Plan	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:	Joint Forward Plan Update 2024 - 2025					

(1) Purpose of the Paper:
The Joint Forward Plan (JFP) update attached provides the Board with the final draft of our JFP for discussion and approval. The JFP plays a vital role in realising the ambitions set out in the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Health & Wellbeing Board – Staffordshire approach in developing the JFP update and the strawman (D)	07/03/2024
Stoke-on-Trent Health and Wellbeing Board Development session approach in developing the JFP update, and the strawman (D)	01/02/2024

(3) Implications:	
Legal or Regulatory	The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts to prepare a plan setting out how they propose to exercise their functions in the next five years. These should be reviewed and/or revised before the start of each financial year.
CQC or Patient Safety	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Financial (CFO-assured)	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Sustainability	Where any impacts arise from the delivery of the Joint Forward Plan, once

	agreed, these will be considered via the appropriate routes.
Workforce or Training	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Equality & Diversity	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Due Regard: Inequalities	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.
Due Regard: wider effect	Where any impacts arise from the delivery of the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.

(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?		☐	☐	☒	It has also been just under 12 months since the publication of our first full Joint Forward Plan (JFP) in June 2023, therefore there are no significant revisions to our plan which require involvement at this stage. We will continue to hold conversations with local partners, people and communities to inform future iterations of the plan

(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 Staffordshire and Stoke-on-Trent Joint Forward Plan (JFP) 2024-2025 Update draft document, attached, follows on from the first JFP published in June 2023. The expectation is that our plan is refreshed yearly and published.

National guidance published in December 2023 outlined that systems continue to have the same level of flexibility to determine how the JFP is developed and structured. However, the guidance and supporting materials indicated that we should pay particular attention to areas such as some of the statutory duties eg financial duties, duty to improve quality, as well as broader updates on areas such as workforce. The role of NHSE was outlined in the guidance as "providing support and guidance on the revision of the JFP" and to "review and comment on updated draft JFPs". There is no formal assurance required from NHSE on the plan.

Given the level of work and depth of detail outlined in our first JFP we have chosen to develop an update which builds on our ambitions set out in our first JFP. This update recognises progress over recent months and to reflect the areas outlined in the national guidance. Our long-term priorities have remained

unchanged from our 2023/28 JFP. This updated plan is intended to be read as a companion piece to the full JFP.

Within the plan we have updated on our challenges, the ongoing development of our Operating Model including the developing Communities Approach to Improving Health and Wellbeing Outcomes, prevention and targeting Health Inequalities. After the JFP was published some key national guidance and documents were published and the local response to these is reflected in our update including the Delivery Plan for Recovering Access to Primary Care, delegation of key services from NHS England and the NHS Long Term Workforce Plan. Key additions have been made including updates around some of ICB statutory duties e.g., quality and finance, more detail on developing our wider infrastructure around Estates, Digital and Delivering a Net Zero NHS.

The content has been developed with the full engagement and input of relevant leads from Staffordshire County Council and Stoke-on-Trent City Council. The approach to developing the JFP was discussed at the Stoke-on-Trent Health and Wellbeing Board (HWB) Development Session and the Staffordshire Health and Wellbeing Board. The JFP will be circulated to the Staffordshire Health and Wellbeing members after the ICB Board for final agreement, with the Chair having delegated authority to endorse the JFP and provide the statement of support on behalf of the HWB. The JFP will be presented to the Stoke-on-Trent Health and Wellbeing Board on 27th March and to request the signed statement of support from the HWB.

The approach to developing the JFP was discussed with NHS England and a draft of the JFP shared on 4th March. They gave positive feedback on our openness, good engagement and constructive collaboration with the regional team. Areas where they felt the JFP could be strengthened have been addressed but where minor changes rather than wholesale change. Other feedback received already from our Local Authorities and other system partners has also been addressed where appropriate.

The publication of this JFP update for Year 2 (2024/2025), is just the continuation of our journey. We will continue to hold conversations with local partners, people and communities to inform future iterations of the plan.

(7) Recommendations to Board / Committee:

1. Approve this final draft of the Joint Forward Plan, with the caveat that a fully designed document will be developed for the 6th April publication date

2. Agree delegated approval to the ICB Chairman, David Pearson and ICB Chief Executive Officer, Peter Axon for sign-off by allowing for any final feedback from the Health and Wellbeing Boards.

Staffordshire and Stoke-on-Trent Integrated Care System

Joint Forward Plan Update 2024 - 2025

FINAL DRAFT 14th March 2024

Contents

Foreword

Welcome to the Joint Forward Plan (JFP) 2024-2025 update for Staffordshire and Stoke-on-Trent.

Our ambition and hopes for our population and communities were first set out in our Integrated Care Partnership Strategy (ICPS), published in 2023. It has also been just under 12 months since the publication of our first JFP in June 2023. This means that at this point there are no significant revisions to the following plan and it should be read as a companion piece to the full JFP.

We continue to face challenging times across both the NHS and our Local Authorities, around increased demand for many of our services and financial constraints. This comes alongside challenges being faced by many in our population due to increasing inequalities and economic hardship driven by the cost-of-living crisis. We acknowledge that together we all play critical roles in driving the improvement of health, wellbeing, and equality for all people living in Staffordshire and Stoke-on-Trent.

Our uniquely positioned partnership between local people and communities, the NHS, local authorities and the voluntary and community sector enables us to improve all aspects of health and care - including the wider determinants and primary and secondary prevention. We will continue to strengthen how we work together as an integrated multidisciplinary team of partners, to focus on addressing the challenges set out in our JFP and in developing our wider plans.

Coordination and co-production between our communities and a range of partners is critical to our development. It will happen through collaboration and integration with local authorities at County, Unitary and district / borough level.

During 2024/25 and beyond we will be particularly focusing on joining up with our partners to support and develop a communities approach to Improving Health and Wellbeing Outcomes, prevention and targeting Health Inequalities. This will involve building upon existing assets around the eight districts and boroughs across Staffordshire and the four localities in Stoke-on-Trent. As system partners we our aims are to ensure transformation, delivery and engagement happening at the most appropriate level of the system and are bespoke to meet the needs of specific groups of our population.

We continue to be committed to work as ‘One Workforce’ where ‘operating as a whole is greater than the sum of the parts’, under an anchor employer model. We know we need to harness the collective effort of our workforce to meet the demands we face. We know that we will have greater impact through what we can achieve together, reducing duplication and working across boundaries to support integrated multi-disciplinary team working.

We have started to make significant developments in our progress with the shared care record. Ensuring that direct care is improved through access to the right information, enhancing and enriching the data that is available to clinicians and residents to support better care. We will work together across the system to develop our approaches and operating models underpinned by local insights and data to support evidence-based decision making at all levels. A Data and Intelligence Strategy to be published in June 2024, will set out more broadly where we want our data, business intelligence infrastructure and capability to be.

Since the JFP was published the Integrated Care System (ICS) has been assessed by NHS Regional Green Team as a 'maturing system' against the maturity matrix self-assessment. We are now much clearer on our steps and areas of focus to reaching Net Zero Carbon for our direct emissions (NHS Carbon Footprint) by 2040 and our indirect emissions (NHS Carbon Footprint Plus) by 2045 at the latest.

In conclusion, our aim has been to look at and update the JFP. In particular we have focused on a reflection of our ongoing challenges, the ongoing development of the way we work, developments aligned to some of our statutory duties and national expectations set out since our first plan.

The publication of this JFP update for Year 2 (2024/2025), is just the continuation of our journey. We will continue to hold conversations with local partners, people and communities to inform future iterations of the plan.

David Pearson

Chair - Staffordshire and Stoke-on-Trent Integrated Care Board & Joint Chair of the Staffordshire and Stoke-on-Trent Integrated Care Partnership

Peter Axon

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

Health and Wellbeing Boards

We have involved both our Health and Wellbeing Boards (HWBs), covering Staffordshire and Stoke-on-Trent, in preparing our JFP update. This has included sharing a draft with each HWB and asking whether the update takes proper account of their health and wellbeing strategy.

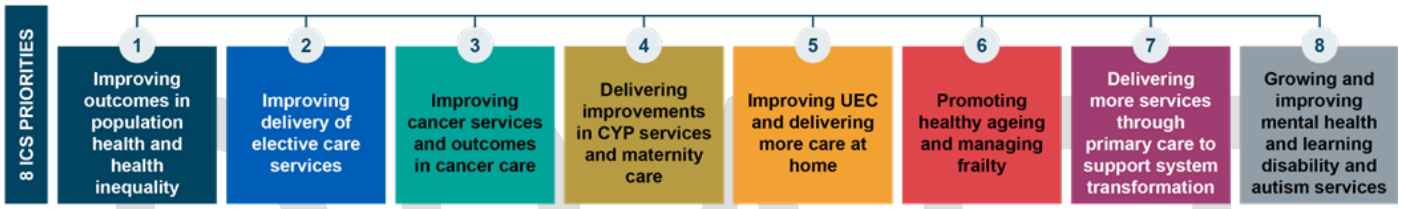
{DRAFTING NOTE: Draft HWBB statements to be agreed with LA {The Staffordshire Health and Wellbeing Board can confirm that the draft addendum to the Joint Forward Plan as part of the 2024/25 refresh, has been presented to the Board on the 7th March 2024. The JFP takes into account the Staffordshire Health and Wellbeing Strategy 2022-2027 and the joint priorities outlined in the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy.	{DRAFTING NOTE: Draft HWBB statements to be agreed with LA The Stoke-on-Trent Health and Wellbeing Board can confirm that the draft addendum to the Joint Forward Plan as part of the 2024/25 refresh, has been presented to the Board on the 27th March 2024. The JFP takes into account the Stoke-on-Trent Health and Wellbeing Strategy 2022-2027 and the joint priorities outlined in the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy.}
Signed: {DRAFTING NOTE: Insert signature}	Signed: {DRAFTING NOTE: Insert signature}
Councillor Mark Sutton Chair of the Staffordshire Health and Wellbeing Board Staffordshire County Council	**Councillor Jane Ashworth OBE** Chair of the Stoke-on-Trent Health and Wellbeing Board Stoke-on-Trent City Council

Introduction

The Joint Forward Plan (JFP) plays a vital role in realising the ambitions set out in the Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy. Our JFP will be refreshed and published every year, so that we can share some of the progress we have made and we can make changes to reflect any new strategic direction developed - either nationally or locally. It is an inclusive plan that has been co-developed with our system partners and shared as it has progressed, with our partners including the Health and Wellbeing boards and NHS England. Given the level of work and depth of detail outlined in our first JFP (published in June 2023), we have chosen to develop an update to that JFP.

This update should be read as a companion piece to the full JFP published in June. We have not gone into detail about achievements during 2023/24 as these will be set out in the various annual reports of the Integrated Care Board (ICB) and system partners which are publicly available.

Our long-term priorities have remained unchanged from our 2023-28 JFP.



ICS Long Term Priorities

We have split our JFP into two distinct parts.

From reading **Part 1** of this plan, you will get an overview of our ongoing challenges and how we have built on our ambitions, progress over recent months and updated national guidance. Within each section, where relevant we have included Operational Case Studies which demonstrate examples of work we are doing – these are shown in blue boxes. Throughout the document there are underlined words or sentences. By clicking on any underlined text you will be taken to relevant external document or the page within the update.

Part 2 of the plan is a series of appendices which provide an overview and some further detail of key areas of development since the publication of the JFP in June 2023 and a summary of which elements of our plan support meeting the statutory requirements placed upon the ICB.

Part 1

This section will give you an overview of:

- how the Integrated Care Board (ICB) and its system partners will coordinate the delivery of NHS services to achieve our objectives
- our ongoing challenges
- how we have built on our ambitions, progress over recent months and to reflect updated national guidance.

Our Ongoing Challenges

The **COVID-19 pandemic** continues to strain health and care resources, with potential further waves of infections and the need for ongoing vaccination campaigns, boosters, and public health measures. The long-term effects of COVID-19 on healthcare delivery include backlogs in elective waiting list and increased demand for services such as mental health. Managing and reducing these impacts remains a significant challenge.

Inequalities persist across different demographics and regions and we know with certain groups experience poorer health outcomes due to socioeconomic factors, ethnicity, or geographic location. Addressing these inequalities and ensuring equitable access to health and care services remains a priority.

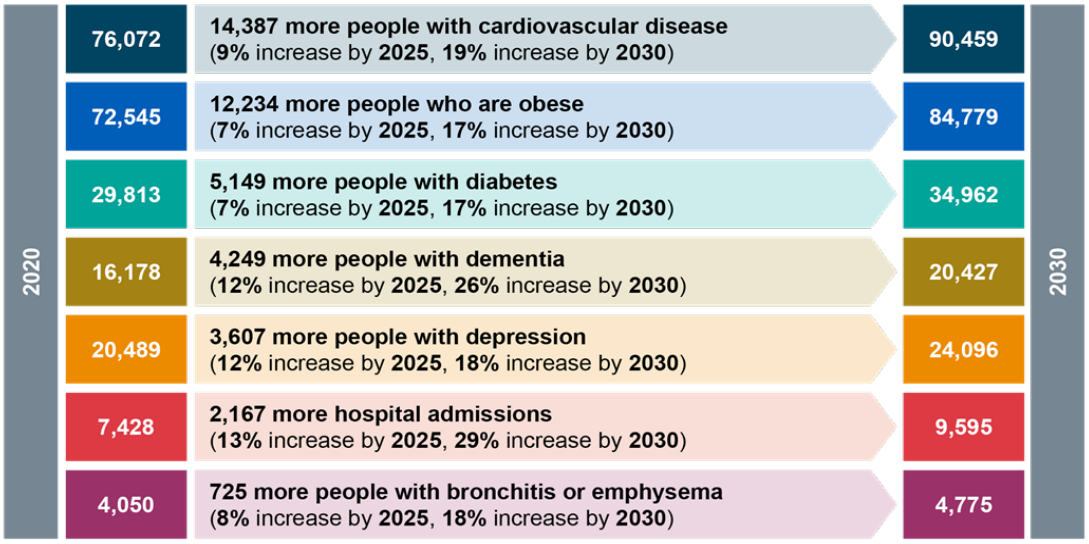
Recruiting and **retaining a skilled workforce** presents an ongoing challenge. Our workforce is our greatest asset in providing high-quality care for local people, but we recognise the significant workforce challenges we face across both health and care.

Our people have worked tirelessly and passionately to deliver services despite the challenges with **workforce** supply, operational pressures and the ongoing impacts that working in health and care has on their health and wellbeing. While these system pressures have impacted significantly on workforce availability and resilience, our people and leaders have continued to work together - forging strong relationships to develop innovative approaches to support our people and deliver services to our population.

We are operating within a **constrained financial environment**, with increasing demand in both volume and level of need for services. Balancing the budget while maintaining high-quality care and investing in essential infrastructure and technology poses a significant challenge.

In 2023/24 the NHS System recorded a financial deficit for the first time since 2019/20 and we enter 2024/25 with an underlying deficit of £240m which represents 7% of the NHS resources allocation to Staffordshire and Stoke-on-Trent. These figures exclude the financial pressures on local authority partners in the delivery of their statutory functions, but we of course recognise these pressures.

Our aging population and demographic places additional strain on health and care services, as it is strongly linked to the increased demand for **long-term care, chronic disease management, and end-of-life care**. It is a challenge to make sure services remain sustainable while we adapt them to meet the complex needs of older adults. If we do nothing, the long-term condition projections for over-65s in 2030 are shown in the below diagram.



Long Term Condition Projections for 2023 in people aged 65 and over
Source: POPPI v15.0 17 November 2020. www.poppi.org.uk data sources: Institute of Public Care (IPC) and ONS (Office for National Statistics). Crown copyright 2020.

Mental Health impacts on our communities and this continues to be exacerbated by factors such as social isolation, economic uncertainty, and the impact of the cost-of-living crisis. Meeting the growing demand for mental health services, including early and timely access to the right help and support including at crisis point, is a challenge. Across the ICS, prevalence of depression, dementia and severe mental illness (SMI) have all increased since 2021/22, with depression reported in 2022/23 as 15.23% (up from 14.47%), dementia, 0.94% (up from 0.87%) and SMI, 0.82% (up from 0.78%). All three have increased nationally, however, depression and dementia prevalence is higher in Staffordshire and Stoke-on-Trent than found nationally.

Reducing unwarranted variation in the quality of the arrangements in services, for **child safeguarding and care experienced by children and young people** is a key area of focus for system partners. These are some of society's most vulnerable children and as partners, we recognise the challenges facing us as partners and the importance of ensuring that their needs are seen, and their voices are heard. There is a high level of concern for **children and young people in complex environments and situations**.

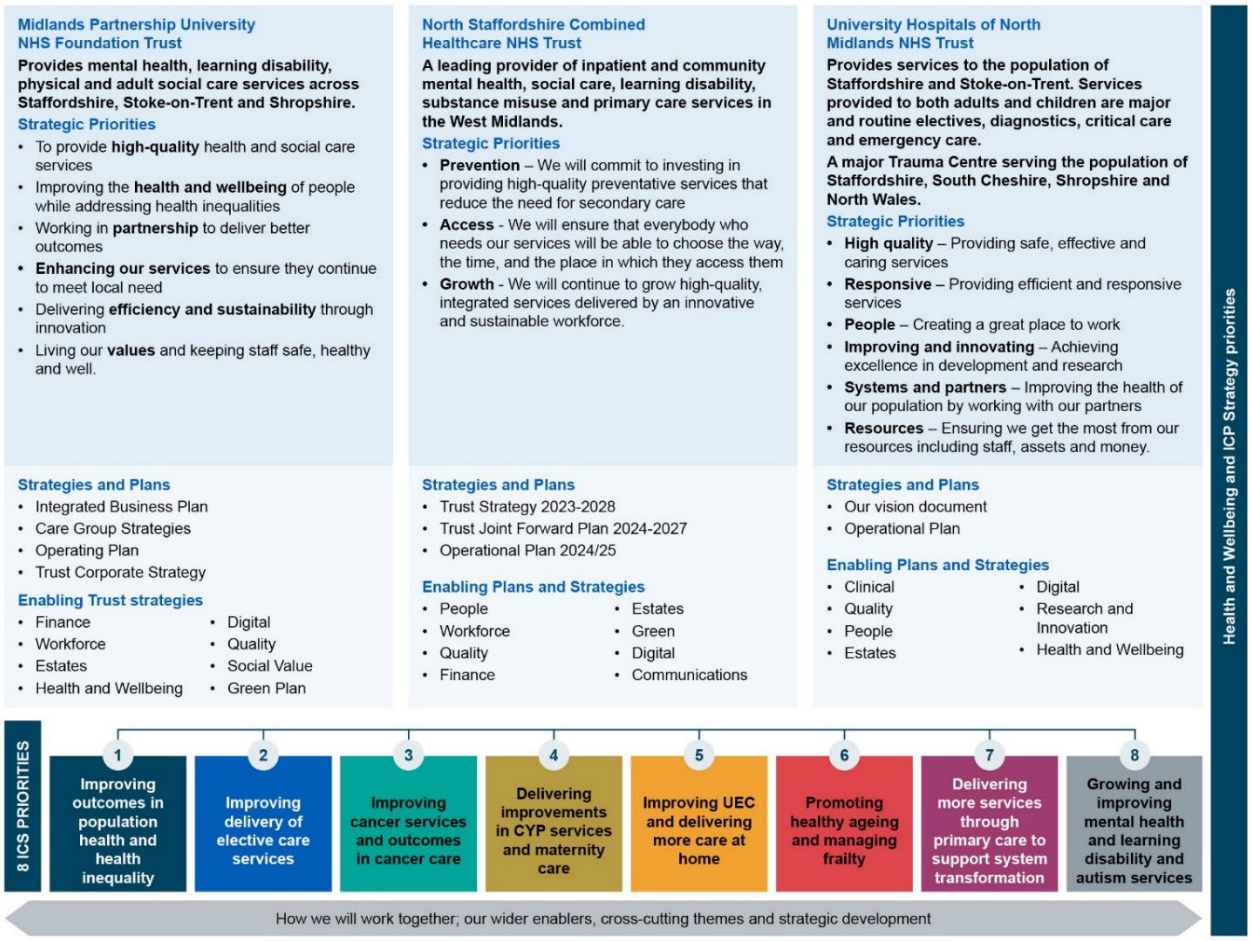
Social determinants are known to be a larger factor in someone's health than the quality and amount of health care they receive. An individual's employment status, wellbeing, living conditions and income all have a greater impact on their health than the accessibility and quality of care provided by health services. Factors in the **UK economy** have had a significant impact on individuals, families, and communities locally. It exacerbates existing inequalities, with low-income households disproportionately affected. Those on fixed incomes, such as pensioners or individuals receiving benefits, may struggle to afford necessities, pushing more people into poverty or deeper into financial hardship. Anxiety, depression, and other mental health issues may worsen as individuals struggle to make ends meet or worry about their financial future. Local NHS and social care organisations have a connection to the local economy not only as a potential employer for local people but also, they can impact indirectly on local businesses and help to provide economic opportunity for local people.

The environmental changes taking place now, and in the future, present the biggest global threat of the twenty-first century. **Climate change** is cited as a major factor that directly contributes to cardiovascular disease, asthma, and cancer in NHS England's Delivering a 'Net Zero' National Health Service report. We need to act now to reduce the burden of disease through air pollution.

Our Providers

While our JFP reflects the plans and five-year strategies for each of our main acute, mental health and community NHS providers in the ICS, it purposely seeks not to replicate them.

The diagram below outlines the high-level priorities and ambitions of our NHS providers within the ICS footprint, which have been refreshed since the JFP was published.



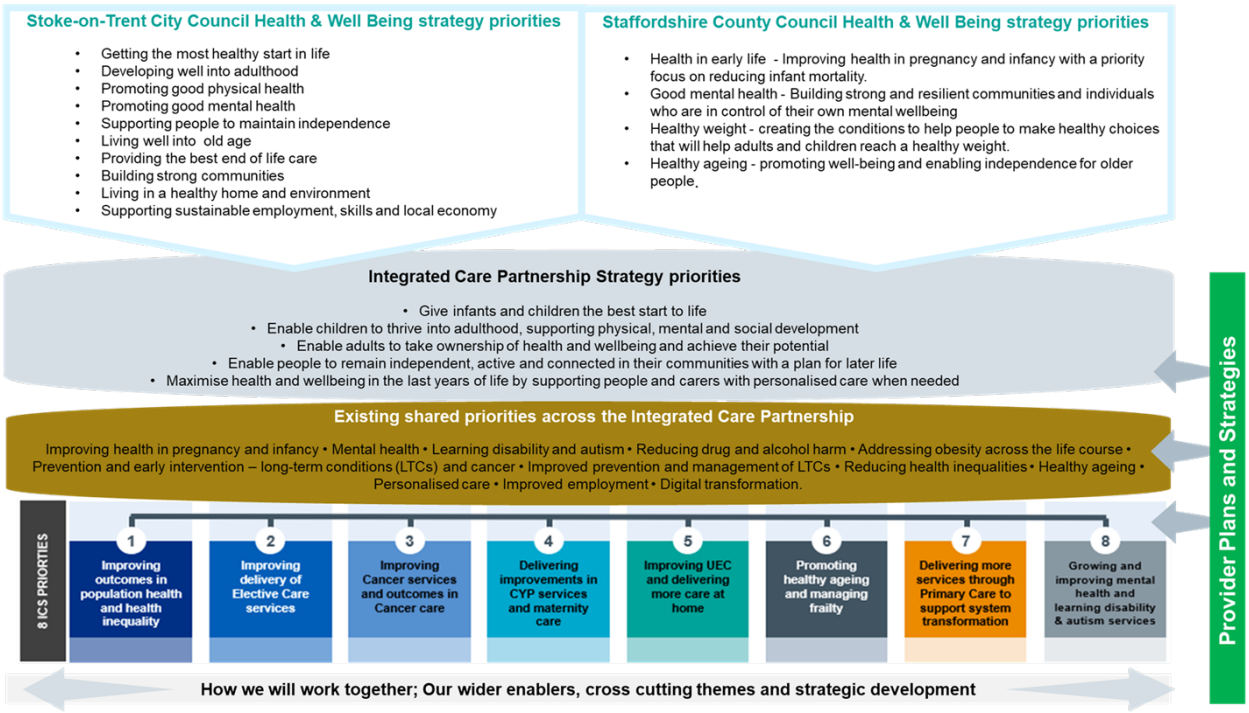
High-level priorities and ambitions for our NHS providers within the ICS footprint

Some of our population (in particular South Staffordshire residents) receive acute services from University Hospitals of Derby and Burton NHS Trust (UHDB) and the Royal Wolverhampton NHS Trust (RWT), as well as services from other acute and community providers that sit outside out area (such as Birmingham Hospitals). The table below gives a summary of the vision and goals of our two major out of ICS providers servicing our population.

University Hospitals of Derby and Burton NHS Trust (UHDB)	Royal Wolverhampton NHS Trust (RWT)
The strategic goals of UHDB are currently under development as part of refreshing their 5-year strategy which will be published in May 2024 but comprise of; • Quality and safety - To improve patient outcomes and experience by providing safe, high-quality, consistent and equitable care, delivered in the right place at the right time.	RWT have launched their vision for the future at RWT comprising of four strategic aims. 1. Excel in the delivery of Care - We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

University Hospitals of Derby and Burton NHS Trust (UHDB)	Royal Wolverhampton NHS Trust (RWT)
• Quality and safety - To improve patient outcomes and experience by providing safe, high-quality, consistent and equitable care, delivered in the right place at the right time. • People and culture - To build a compassionate and inclusive culture which engages and empowers our people, with the right structure and support to enable them to provide safe, high-quality care for our patients. • Value and sustainability - To get the best value from our resources by improving the way we work, both internally and with our system partners, and reducing waste and variation to achieve better outcomes and experiences for all. • Education and learning - To support our people to learn, teach and thrive in a culture of continuous learning and development, ensuring we meet the needs of patients, now and into the future. • Research and innovation - To encourage a curious mindset in our people and provide the right opportunities to engage in research and innovation to achieve breakthroughs, design more effective treatments and drive better outcomes for our patients.	2. Excel in the delivery of Care - We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement. 3. Support our Colleagues - We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting diversity of our populations. 4. Improve the health of our Communities - We will positively contribute to the health and wellbeing of the communities we serve. 5. Effective Collaboration - We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

Our Local Authorities



Health and Well Being Strategy Priorities for our Local Authorities within the ICS footprint

Stoke-on-Trent City Council's current Health and Wellbeing Strategy comes to an end in 2025. Work is currently underway to start to develop a new joint Health and Wellbeing Strategy. It is anticipated that the focus will be on the wider determinants of health (including employment and housing), and the modifiable factors that affect premature deaths in the under 75's. These are predominantly due to cancer or respiratory disease, but also drug and alcohol misuse - which still aligns with the existing priorities. We will be working closely with Stoke-on-Trent City Council to make sure our plans and strategies remain aligned and we will use mechanisms such as Place (Strategic approach) and the Joint Commissioning Boards as appropriate to support our population. The Joint Strategic Needs Assessment (JSNA) was reviewed in 2023 where the approach taken was changed to include a more interactive dashboard approach. As part of the strategy development work the following key issues have been identified:

1. The cost of living
2. Infant mortality
3. Health inequalities
4. Lack of physical activity
5. Obesity
6. Premature deaths (under 75's).

Staffordshire County Council five-year Health and Wellbeing Strategy (2022-2027) was published in 2022. The JSNA has been reviewed and consequently, Staffordshire County Council, the ICB and other partners are working together to develop an interactive platform for JSNA data. This will allow for better use and interpretation of health needs to inform local decisions and activity. The most recent JSNA (Joint Strategic Needs Assessment) identified the local key issues in Staffordshire as:

1. Wider Determinants (education/exclusions, crime, housing & fuel poverty)
2. Healthy Lifestyles (excess weight, physical activity)
3. Mental Health
4. Alcohol Misuse
5. Parental and Infant Health (infant mortality)
6. Ageing Well
7. Social Care Demand
8. The COVID-19 impact on services and outcomes

As partners with our two local authorities, we recognise that we need to work together on how to better meet the needs of **children and young people in complex environments and situations** for our population. To support this process, we have carried out a specific needs assessment. This has contributed alongside a number of other needs assessments across the region to establish an evidence base about the nature and profile of need and how well teams, organisations and the system are responding. The Pan-Midlands Needs Assessment on Children and Young People with Complex Needs draws on the learning from these needs assessments with the aim of identifying key areas across the Midlands, encouraging further collaboration across the region and to support the sharing of effective practice. This will be a key area of focus over the period of the JFP especially through one of our System Collaboratives which will be developed on behalf of the system and with partners, by Staffordshire County Council.

Our continued focus on inequalities

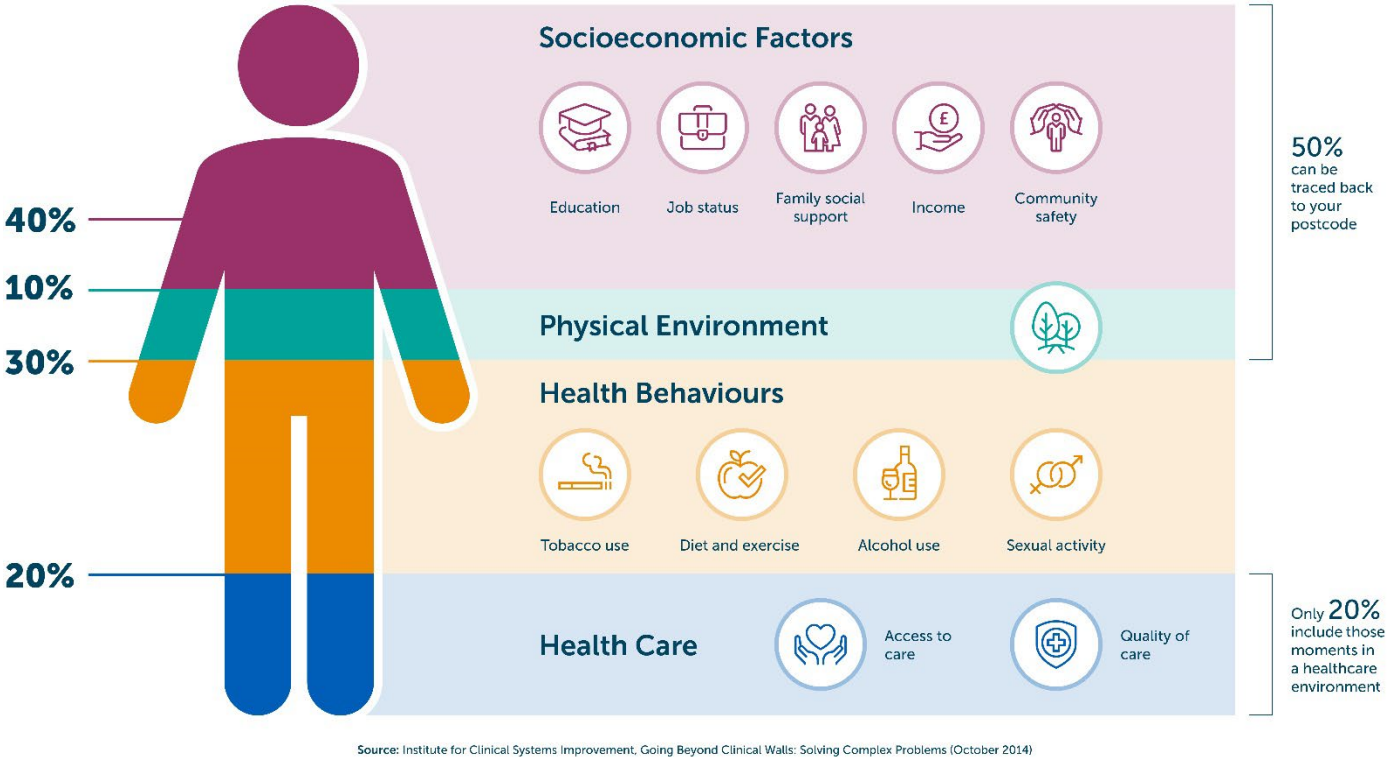
Tackling and priorities of the Integrated Care System (ICS) as an anchor institution and supports one of the NHS quadruple aims (the health of populations). The Integrated Care Board (ICB) has an important role in leading and coordinating action taken across the system and this approach is embedded in our Integrated Care Partnership Strategy. We have started to put the building blocks in place and a range of initiatives are in place to support the tackling of inequalities in our population. Examples of these include

- Social Prescribing
- Community Mental Health Transformation
- Southeast Staffordshire Healthy Communities projects
- Stoke Health Champions
- Community Lounges

- Core 20 Connectors.

Within Staffordshire there is a two-tier administrative structure where Staffordshire County Council are responsible for functions such as education, strategic planning and social care and the eight districts, namely: South Staffordshire, Cannock Chase, Lichfield, East Staffordshire, Tamworth, Stafford, Newcastle-under-Lyme and the Staffordshire Moorlands who are responsible for functions such as local planning and housing. As Stoke-on-Trent City Council is a unitary authority, all functions are the responsibility of the local authority.

It is well documented that health and wellbeing outcomes are impacted by a whole range of factors related to the circumstances in which we are born, grow, live, work and age. These are known as the 'wider determinants' of health. We recognise that there are many factors that impact on the wider determinants of health including socioeconomic factors, physical environment, health behaviours and health care. The biggest factor is socioeconomic where we need to collectively develop the building blocks to have the biggest impact. These building blocks are education, employment, family/social support, income and community safety.



Social Determinants of Health Infographic
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

We know that inequalities can start before birth and can affect all stages in life ('across the life course'). They can impact on outcomes across housing, education, employment, healthy lifestyles, dental, mental health, physical health and loneliness.

Health inequalities in Staffordshire

Staffordshire County Council has recently undertaken a piece of work to analyse data to compare the outcomes of people living in the most deprived areas with the most affluent against the Staffordshire average.

It showed that someone living the most deprived area is:

- 90% more likely to have parents who smoke

- 12% more likely to have a low birth weight
- 2.5 times more likely to be in poverty
- 2.5 times more likely to claim unemployment benefits
- 49% more likely to experience fuel poverty
- 49% more likely to be living alone as an older adult.

Someone living in the most affluent area is:

- likely to live 3.7 years longer
- 47% less likely to have a hospital admission for dental decay
- 21% less likely to be overweight or obese (in year six)
- 41% more likely to achieve English and Maths grades
- 10% less likely to be admitted to hospital because of alcohol harm
- 46% less likely to die from coronary heart disease before the age of 75.

Health inequalities in Stoke-on-Trent

Figures for Stoke-on-Trent show:

- Ranked 13th out of 317 across the country for deprivation
- More than half of Stoke-on-Trent areas are in the two most deprived deciles
- The number of people in fuel poverty is higher than the England and West Midlands average
- 29% of children live in absolute low-income families
- The highest rate of infant deaths when compared to England and the West Midlands. This includes neonatal (in the first 28 days after birth) and post-neonatal (28-365 days after birth) deaths, premature births (born before 37 weeks), and low birth weight
- 1 in 6 women smoke through pregnancy (ranked 5th highest in England)
- The number of premature deaths is higher than the England and West Midlands average, with the main reasons being lung cancer, cardiovascular disease and respiratory.

As an ICS we are developing a Health Inequalities Strategy with a set of priorities and actions to increase our influence more effectively as a collective than we could as individual organisations. A workshop held in January 2024 identified a number of key themes where we should focus our collective efforts including clear links to our policy drivers for implementation, namely Core20Plus5 (adults) and Core20Plus5 (Children and Young People) and the national priority areas where work continues. A Health Inequalities Working Group has been established to develop this Strategy, which will then inform a financial framework for investment of our ring-fenced Health Inequalities funding allocation. The strategy and a supporting delivery plan are anticipated to be agreed through the Integrated Partnership Board in June 2024.

We have used local intelligence to identify the Inclusion Health Groups for our local area and we continue to focus on these groups, against the principles for action in the NHS Inclusion health framework. An example of this is the Specialist Homeless Health Integrated Service below.

Specialist Homeless Health Integrated Service

Coordinates care for the most vulnerable and complex people who are homeless (including rough sleepers) in the towns of Stoke-on-Trent and in and around Newcastle-under-Lyme town Centre. The Service Provider collaborates with the local authorities and specialist services, such as the Rough Sleeper Outreach Service and other Rough Sleeper Initiative programmes, to promote self-care and fosters a recovery-based approach focusing on strengths and realistic person-centered goals. Locally, a dedicated welfare officer from the Defence Medical Welfare Service (DMWS) works in partnership with University Hospital of North Midlands NHS Trust (UHNM) to provide a range of supportive services to veterans and their families to support access, treatment and timely discharge from health care.

Case study: Rough Sleeper Outreach service and Defence Medical Welfare Service

Reducing unwarranted variation in the quality of the arrangements in system health services, for child safeguarding and Looked After Children is a key area of focus, as acknowledged in the Not Seen, Not Heard report (Care Quality Commission 2016). Core20PLUS5 is an NHS England approach to reduce health inequalities at both national and system level. 'Core20' refers to the most deprived 20% of the national population (as identified by the national Index of Multiple Deprivation) and the 'PLUS' population specifically refer to the inclusion of young carers, Care Experienced Children and Young People and those in contact with the justice system.

Using population level data helps us to make decisions at a local level and ICS partners are developing an interactive platform for JSNA data that will allow stakeholders to interpret health needs to inform local decisions and activity. We are working with Optum (our Strategic Partner to deliver the Population Health Management programme) to create a more comprehensive view of a person's health and care needs, so that we can continuously improve our care within our available resource. As part of our legal duty, work is also underway to develop a dashboard to be able to identify the needs of communities experiencing inequalities in access, experience and outcomes.

The voices of local people and communities is essential as part of how we design and redesign services. We have worked as partners to undertake an appreciative enquiry approach to our asset-based community development and co-produced solutions where appropriate. An example of this is the Core20PLUS connectors work, which is led by the Voluntary, Community and Social Enterprise (VCSE) sector.

Core 20 Ambassadors

As part of our Core20PLUS5 implementation, we currently have six Core20 Ambassadors who are a mix of professionals from General Practitioner to a social prescriber, with one of the six ambassadors being a Healthcare Financial Management Association (HFMA) lead. A pilot Health Inequality Finance Fellowship programme launched in 2023 in the West Midlands. Over 40 fellows have been recruited for the 2023/24 programme including from Staffordshire and Stoke-on-Trent. The fellowship provides an opportunity to harness the ambition of the finance community in supporting the health inequalities agenda while investing in finance staff who are passionate and already working in this area. These Fellows will support CORE20PLUS Ambassadors who may struggle to make improvements without understanding the important role finance plays.

Case study: Core20 Ambassadors

As part of our approach to addressing women's health needs, as identified within the guidance published in January 2024, a comprehensive needs assessment has been undertaken and a model has been developed which aligns with the Women's Health Strategy for England. Elements of this model is currently being procured and is expected to be in place in 2024.

Ongoing Development of our Operating Model (the way we work)

Despite our significant challenges, we believe that collaborative efforts at all levels are the most effective approach to co-producing and delivering our plans. Each of our partners have positive impacts on our population – some providing care, others involved in planning services, and others impacting on wider determinants of health and care (such as housing and education).

We will continue to work with local partners to strengthen how we work together and how we make decisions. The establishment of our portfolios leadership model and development of provider collaboratives in 2023 started the ball rolling. Our operating model will evolve over time as collaboratives and the communities approach continue to mature which will support solving complex problems that require multi agency effort and responses.

Communities Approach to Improving Health and Wellbeing Outcomes, prevention and targeting Health Inequalities

Our uniquely positioned partnership between local people and communities, the NHS, local authorities and the voluntary and community sector enables us to improve all aspects of health and care - including tackling the wider determinants, preventing ill health and secondary prevention. With hundreds of health and care organisations serving more than a million local people, we must make sure that we are utilising each to the fullest and ensure that work is done, and decisions are made, at the most appropriate level.

Groups of partners coming together within partnerships are crucial for how we will deliver. Together they play critical roles in driving the **improvement of health, wellbeing, and address health inequalities** for all people living in Staffordshire and Stoke-on-Trent.

To effectively improve the health and wellbeing of our local population, we need to look beyond health and care services to understand the barriers and opportunities to people living a healthier life. We know that access to healthcare only accounts for around 20% of health outcomes across Staffordshire and Stoke-on-Trent. The other 80% is influenced by other factors, or 'wider determinants', such as the communities we live in, the education we have and the choices we make.

We recognise that there can be significant variation between the needs of the population, and that the way that wider determinants affect people is likely to differ according to where people live. This means that we need to shift to a more tailored and targeted approach to improving health and wellbeing outcomes, one that is sensitive to the diverse populations we serve. We need all partners and communities to work together.

Working at a more local level will allow us to focus on smaller populations and provide greater flexibility to find tailored solutions to challenges. We will do this in partnership with the local authorities, the VCSE and the communities themselves. It is important to recognise and build on the relationships that are already established and to work collaboratively with partners - acknowledging the contributions that each can make and respecting roles and responsibilities across the system.

Information gathered from local populations will be utilised to support the refresh of our plans including the Integrated Care Partnership Strategy.

Progress on Our Communities Approach

Since our JFP was published in June 2023 we have been working closely to join up with partners to develop a more tailored approach to improving health and wellbeing outcomes. We remain committed to the principle of subsidiarity and are looking to build upon existing frameworks and assets to better align decision-making as close to the communities where outcomes occur, this will translate through place (strategic approach), localities (planning footprint) and communities (delivery).

The eight districts and boroughs across Staffordshire and the four localities in Stoke-on-Trent are outlined below.

Staffordshire County Council District and Borough Councils	Stoke-on-Trent Localities
• Cannock Chase District • East Staffordshire Borough • Lichfield District • Newcastle-under-Lyme Borough • South Staffordshire District • Stafford Borough • Staffordshire Moorlands District • Tamworth Brough	• North • Central • South East • South West

Within each area, we will codesign a unique set of priorities based on the health and social care needs of the community – focusing on prevention, supporting people to take control of their own health and wellbeing, and supporting independence. Joint Strategic Needs Assessment (JSNA) data, produced by both our local authorities (Staffordshire County Council and Stoke-on-Trent City Council), Population Health Management (PHM) data, the Research Engagement Network outputs and local intelligence will help us to do this. Priorities will be guided by local intelligence using a diagnostic data pack that will provide a detailed picture of the community. This will include health, but also wider determinants such as housing, employment, facilities, and education. We are developing an interactive platform for JSNA data so that in the future. This will allow for better use and interpretation of health needs to inform local decisions and activity.

By focussing on smaller populations, we will be able us to develop a detailed understanding of what causes poorer outcomes and health inequalities. We will also be able to prioritise and make decisions with local communities to tailor proactive and preventative solutions that are specific to their needs. It will identify the priorities that matter to the residents in each area and help to treat communities as active partners, rather than passive recipients of services.

We will build on our existing relationships and ways of reaching our communities to test our intelligence. This will help us to gain a more detailed understanding of the local barriers and opportunities to people living a healthier life in a particular area. We will then develop multi-disciplinary, integrated teams, involving all relevant partners, to deliver against the priorities identified, utilising community assets as well as local services.

Voluntary Community and Social Enterprise Alliance led by VAST and Support Staffordshire

In Staffordshire and Stoke-on-Trent, there is a broad and diverse Voluntary, Community and Social Enterprise (VCSE) sector, who are a critical partner within the system. They contribute to the setting of strategies and deliver services for some of our most vulnerable population. Many of the organisations focus on the health and wellbeing of individuals and local communities from prevention through to bereavement.

A range of services are delivered or supported through the VCSE sector. Examples of this include: -

Services supported through VCSE sector

Locally the VCSE Healthy Communities Alliance was established in 2021. It enables the VCSE sector to have representation and engagement on various boards, committees, steering groups and partnerships of our ICS, including the ICS Partnership Board. Since our JFP was published, VCSE representatives have been elected to all seven system level portfolios. Their role is to: -

- Collaboratively support the development and work of the board, committee, steering group or partnership
- Develop a greater knowledge of the issues, plans and agencies which affect the work of the board, committee, steering group or partnership

A Memorandum of Understanding is in place between the ICB and the VCSE Alliance which includes the following four priority areas of work:

1. Commissioning and Procurement
2. Communications and Engagement
3. Volunteering and Prevention
4. Social Prescribing.

Examples of how this has worked in practice include:

- Ensuring NHS contracts and requirements are equitable and proportionate to the level of funding given to the sector to provide a service, as part of a commissioning framework
- Ensuring that we utilise the VCSE sector unique positioning and skills as part of our communication and engagement planning
- Encouraging volunteering as part of our NHS Long Term Workforce Plan
- Ensuring the role of preventative services and social prescribing is embedded within portfolios.

The NHS Long Term Workforce Plan also sets out steps to make sure the impact of volunteering is fully recognised – supporting the workforce now and in the future. The system will continue to work in partnership to improve volunteering opportunities in health and care settings. We want to reach as many of our local communities as we can to encourage our population to take up volunteering as a key role. We recognise that volunteering is also a route into health and care careers, and we want to explore alternative and attractive volunteering roles which support our services and provide fulfilling opportunities for people. In addition, we will align to national and regional programmes including NHS Cadets, NHS and Care Responders, and the recruitment portal.

Volunteer Centre Quality Accreditation

Support Staffordshire has recently achieved the Volunteer Centre Quality Accreditation (VCQA), demonstrating the quality of their offer and impact in supporting local voluntary, community and social enterprises across Staffordshire. Accreditation is awarded for three years and is provided following independent assessment of a portfolio of evidence provided against a set of criteria based around the Five Functions of Volunteer Centres. In achieving the VCQA, Support Staffordshire has demonstrated it delivers each of these functions to a high standard, that it is responsive to, and embedded within the needs of the local voluntary, community and social enterprise sector, and is committed to working in partnership. The VCQA is a quality mark that provides confidence to local communities, voluntary and community organisations and local strategic partners, funders and commissioners. We are very pleased to share that Support Staffordshire's assessment showed its strengths in Good Practice Development. The accreditation process provides opportunities to gain invaluable insights into organisational strengths and areas for development.

Case study: Support Staffordshire

Volunteering for Health Grant Funding

Partners recognise the vital role played by volunteers and how they should be included in workforce plans going forward, strengthening and extending integrated care, particularly in times of surge. However, there is an ambition to capitalise further on the role volunteering can play. A bid to access Volunteering for Health funding is being led by VAST on behalf of the ICS to support the development of high-quality volunteering infrastructure within the system. Volunteering for Health is a £10m programme that is being delivered through a partnership between NHS Charities Together, NHS England, and CWplus.

Case study: VAST

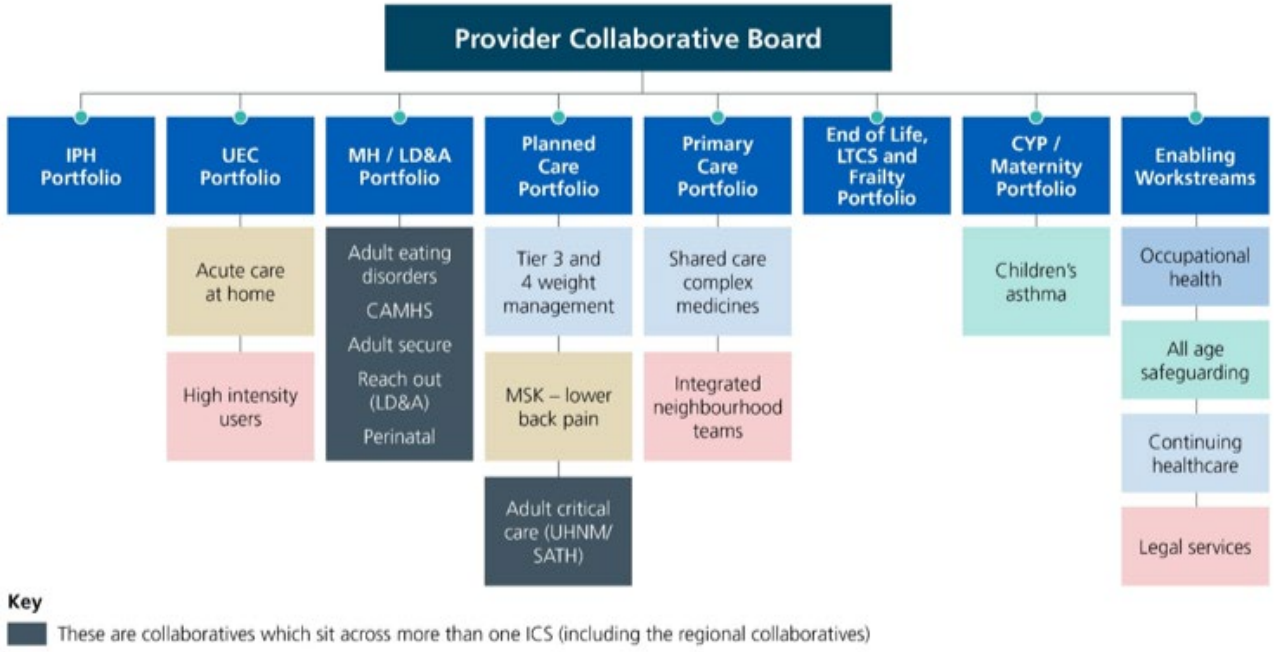
Provider and System Collaboratives

Provider collaboratives bring providers together to achieve the benefits of working at scale. This will help to improve quality, efficiency and outcomes, and to address inequalities in people's access to, and experience of, different providers. Our acute and mental health providers have a track record in collaborating and developing various forms of collaboration both in and out of the system – including strategic collaboration and lead provider collaboratives spanning ICSs and outside of our region. They share a significant interdependency with Place and our portfolios.

At the point of drafting this update, we are in the midst of the 2024/25 planning round. Alongside a challenging efficiency programme, we are working up six recovery themes, aimed to deliver cash out through cost reduction, demand management and a clear focus on clinical value. We have agreed to establish six system collaboratives covering our recovery priority areas, with all system partners engaged in either leading or supporting project delivery. The six collaboratives are:

Six System Collaboratives Diagram

Provider collaboratives are continuing to develop across most of our system portfolios and enabling workstreams, as the vehicle for delivering transformation at scale involving two or more in-system providers. This work is overseen by a Programme Board which has executive representatives from acute providers (both within and outside our system), community providers, Place, ICB, local authority and general practice. The diagram below provides a summary of the collaborations currently in place, which report to the Provider Collaborative Board.

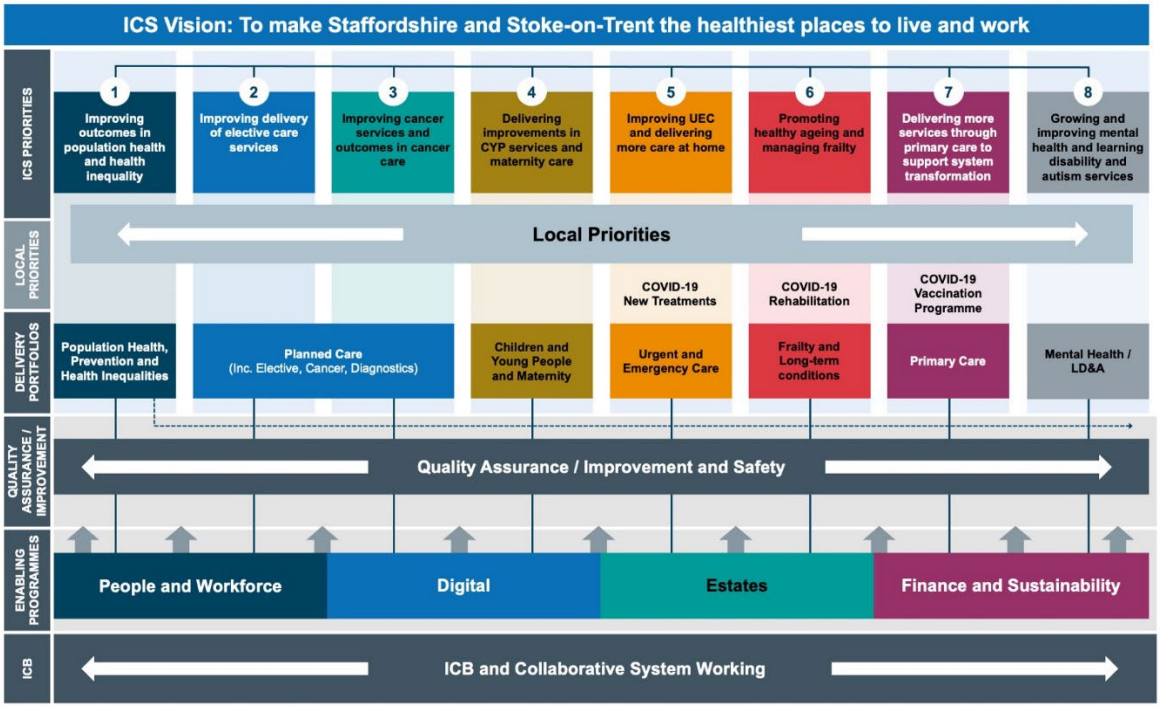


Overview of provider collaboratives currently in place

It is acknowledged that provider collaboratives will continue to develop and evolve into 2025/26 and beyond, where opportunities to delegate ICB functions could be explored where it makes sense to do so and where it is consistent with national policy. The form the collaboratives will take will evolve as they develop and will be supported by the Provider Collaborative Programme.

Our Portfolios

Our seven portfolios are Improving Population Health; Planned Care (includes elective, cancer and diagnostics); Children and Young People and Maternity and Neonates (as one portfolio); Urgent and Emergency Care; End of Life, Long Term Conditions and Frailty; Primary Care; and Mental Health and Learning Disabilities and Autism.



Our seven portfolios and ICS priorities

As a newly-formed statutory body, we have worked hard to ensure that structures are effective and enable staff across the ICS to be fully focused on delivering for our population. The portfolios cannot be successful if they work in isolation, as many of our actions require involvement from more than one portfolio or partner.

We continue to ensure our portfolios are a balance of the implementation of transformation and redesign and the maintenance of business as usual. It is vital that we support partnerships of providers in and out of the system (NHS, local authority, Independent Sector) to work together at scale to focus on the delivery of our plans.

Throughout 2023/24, each portfolio successfully developed an agreed dashboard of metrics (measures to track programme progress) and, where identified, outcome measures to support them. A quarter two stocktake was completed as part of an annual planning cycle, and a quarter four stocktake exercise will be completed at the end of the financial year. The stocktake exercises enable portfolios to perform a self-assessment on where they are up to, against their planned priorities and deliverables. This formed the basis of our One Year NHS England facing Operational Plan submission and our local System Operational Plan.

This plan is intended to be read as a companion piece to the full JFP published in June and our Operational Plans. Further details about our portfolios and their plans were set out in detail in that document. At the time of publishing our JFP update, as a system, we are developing our local 2024/25 Operational Plan in response to national guidance. The plan will be published in May 2024, and will outline our response to any revised national targets across our portfolios and providers.

A learning organisation – Our Governance and Partnerships Review

According to national policy, ICBs should undertake a local self-assessment after their first year of operation. The ICB Chair makes the decision following local discussion with system partners as appropriate and their

NHS England Regional Director. They are discretionary, as part of wider development led by ICB Chair and their Board. Self-assessment is designed to focus on the ICB as the 'customer'.

The ICB undertook its first formal Governance and Partnerships Review in Winter 2023/24, which culminated in a Board Development session at the end of January 2024. The review focused on all four focus areas below as they were all felt to be equally important and integrated.

- Role and function of the ICB Board
- Assignment of decisions to system, place and provider
- Commissioning decision-making
- NHS system management decision-making by the ICB and its partners.

The review confirmed a small number of important actions that currently form part of an ongoing implementation plan. These were:

- How we work together as a Board (on strategy, leadership etc)
- ICB Committee and Sub-Committee procedural rather than structural changes
- How we communicate post-event / post-Board to others.

Wider Effect of Decisions

As an ICB, the alignment of the organisational priorities with the triple aim is a key priority in decision making. Organisational priorities are reflected in the Board Assurance Framework which outlines the key strategic risks for the organisation, and all decisions are linked to specific elements of that framework. The triple aim is also embedded through the use of community stories at the ICB Board meetings to inform decision making and provide a clear, practical link to the three aims.

We continue to focus on our duty to have regard to the wider effect of decisions through our processes including Quality Impact Assessments and Equality and Health Inequality Impact Assessments (EHIA). The ICB's Quality Impact Assessment (QIA) Policy outlines how they will have regard for all likely effects of decision-making in relation to the quality of service. The ICB are committed to collaborating with NHS partners. NHS partners have agreed that as they are all part of one system, they do not want separate QIAs for system transformation work and associated engagement. In 2023, the partners adopted a collaborative approach to undertaking QIAs to support formal service change proposals to NHS England. This approach will continue throughout 2024.

Equality and Health Inequality Impact Assessments are a well-established and embedded tool within the ICB that support compliance of the Equality Act and Public Sector Equality Duty. This tool helps to ensure decisions, practices and policies are fair and mitigate discrimination against protected or vulnerable/excluded groups, consider equality of opportunity and the fostering of good relations. An important and integral part of the EHIA process is to ensure stakeholder engagement. A stakeholder is an individual or group that has an invested interest and a voice that informs the organisation's decision-making process and can include staff, patients, the public, voluntary, community and social enterprises, internal and external support groups/networks, or business partners.

Ongoing Strategy Development and Delivery

Since the publication of the JFP, we have made progress in several key strategic priority areas and continued to progress setting out or delivering our longer-term underpinning strategies.

Key strategic decisions

The ICB agreed a proposal in December 2023 for a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre. The proposal was developed through a programme of work by Midlands Partnership University NHS Foundation Trust (MPFT), who had provided the services at the George Bryan Centre until its temporary closure in 2019, and the ICS. In December 2023, the ICB Board also agreed the interim aligned assisted conception policy for Staffordshire and Stoke-on-Trent. This policy replaced the three policies that were in place under the former clinical commissioning groups (CCGs).

During 2023/24, NHS England approved business cases for the implementation of community diagnostic centres (CDCs) across Staffordshire and Stoke-on-Trent.

The CDCs will help achieve the following ambitions:

- To improve population health outcomes by diagnosing health conditions earlier, faster and more accurately
- To increase capacity in the diagnostic service by investing in new facilities, equipment and training new staff, contributing to recovery from COVID-19 and reducing pressure on acute hospital sites
- To improve productivity and efficiency by streamlining the way we provide acute and elective (planned) diagnostic services where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication
- To contribute to reducing health inequalities by ensuring everyone has the same access to care and the same health outcomes
- To deliver a better diagnostic service and more personalised experience by providing a single point of access to a range of services in the community
- To support more joined-up care across primary, community and secondary care.

In April 2023, the ICB Board approved and published a GP Five-year Strategy. The strategy sets out how the health, care and wellbeing needs of the local population are to be met through a positive, ambitious vision for the future of general practice. This will include the support we will we put into place for GPs and their teams to achieve it. It brings a renewed focus on our model of care which builds on the Fuller Stocktake Report around population health management and integrated teams – while continuing to develop and deliver on the ongoing work programmes that already exist. The strategy focuses less on organisations and boundaries, and more on people (patients and workforce) and Places. The strategy and its implementation will be overseen by the Primary Care Collaborative - a collective of senior leadership across general practice including Primary Care Networks (PCNs) and Local Medical Committees (LMCs).

During 2023, a total of 118 leaders from across Staffordshire and Stoke-on-Trent came together for the inaugural system-wide workforce summit, 'Aiming Hire and Higher'. Attendees at the summit included clinical and operational leaders from across the NHS, local authorities, the voluntary sector, primary care, social care, education providers and NHS England. The aim of the summit was to collectively find solutions to the biggest workforce related challenges in Staffordshire and Stoke-on-Trent. It also looked at how we will locally meet the ask of the NHS Long Term Plan outlined further in this document, as well as the ambitions of primary care and social care.

Longer Term Underpinning Strategy Documents

The progress and development of a range of enabling strategies are set out below which put the building blocks in place for future delivery.

Since the JFP was published across the ICS, partners have led, co-produced and published a range of new strategies including:

- A joint Strategy between Staffordshire County Council (SCC) and Staffordshire and Stoke-on-Trent ICB Living My Best Life: A Joint Strategy for Disabled and Neurodivergent people in Staffordshire (2023-28). It complements national and local strategies and good practice including SEND (special educational needs and disabilities) and carers' strategies
- A Research and Innovation Strategy was agreed in September 2023 setting out six core objectives
- An ICB Quality Strategy (2023-26) which describes our quality aims for next three years, outlines our quality risk response following the National Quality Board guidance, and is underpinned by our delivery plan

We are in the process of defining our local approach to developing and engaging on system strategies, focusing on:

- A Long-Term Conditions Strategy to help system partners understand how they can best support people with long-term health conditions, to empower people to manage their own conditions and to ensure people know how and where to seek professional help or support
- A local needs assessment focused on end of life and palliative care to support delivery of the national ambitions for palliative and end of life care
- A Health Inequalities Strategy to bind us as a system behind a set of priorities and actions that we can influence as a collective more effectively than we could as individual organisations
- An ICS Alcohol Strategy to strengthen the partnership approach to improving outcomes and quality of life in people at risk of or experiencing alcohol harm, informed by current evidence on existing and emerging trends in population alcohol use, and effective integrated approaches to preventing alcohol harm
- A Cyber Security Strategy that will enable us to keep our data and infrastructure safe while providing our residents with the data they need to support the management of their health and care
- An Infrastructure Strategy will be published in spring 2024, which sets out our high-level, system-wide approach coordinating and influencing the development of all estate directly used in the provision of NHS delivered health and care
- A Data and Intelligence Strategy to be published in June 2024, which sets out sets out where we want our data, business intelligence infrastructure and capability to be
- System-wide Employee Experience and Health and Wellbeing Strategy which supports our whole workforce (to be launched 2024/25)
- Urgent and Emergency Care Strategy to demonstrate how the system will support our local population should they need care that cannot be met in a planned care environment
- A refresh of the Healthy Ageing and Managing Frailty in Older Age Strategy (2021-25) to take place in 2024/25, which will include social care, ensuring all relevant data and innovative frailty practices are shared across system partners. This will support the delivery to our frail patients across health and social care and enable them to live a full life, for longer.

The following strategies have been updated since the JFP was published in light of new guidance or terminology:

- A multi-agency Staffordshire and Stoke-on-Trent Violence Reduction Strategy (2024-29)
- Staffordshire and Stoke-on-Trent Domestic Abuse Strategy (2021-24) setting out our joint aim and approach to addressing domestic abuse and the outcomes we expect to see. The strategy is being updated in accordance with the Domestic Abuse Act 2021 and requirements in relation to the Sexual Safety Charter and our approach to Safe at Home, and it will be published in 2024.

What else is new since our JFP published in June 2023

National Expectations and Developments

After the JFP was published, NHS England set out the requirement for a '**Delivery Plan for Recovering Access to Primary Care' (PCARP)** to address access challenges and to make sure that the growing demand on general practice can be sustained - to be resilient now and in the future.

On response to PCARP, the System-Level Access Improvement Plan (SLAIP) aligns to the four national ambitions: to empower people, build modern general practices, cut bureaucracy and build capacity. The primary care portfolio will continue to develop this work. The local plan sets out our actions to deliver to deliver against the national requirements and on key areas to support improved patient experience of general practice locally (Appendix 1: System Level Access Improvement Plan). The multifaceted approach to the SLAIP has developed substantially since being launched and it will be presented to the ICB Board in May 2024 for approval. We will continue to work closely with all stakeholders to ensure the important steps in reducing the pressure within general practice and tackling 'the 8am rush' will provide a strong footing as we progress to deliver the wider Fuller Stocktake vision as part of our GP 5-year strategy.

The responsibility for commissioning **pharmaceutical, general ophthalmic and dental (POD (Pharmaceutical Ophthalmic and Dental))** was delegated to ICBs on 1st April 2023. This created an opportunity to provide better support for our populations ensuring that services meet the needs of the local population. When we wrote the first JFP, we were still understanding how **dental services** were delivered and looking at the baseline activity. We have set out some of the challenges facing us in dental services, and some of the actions that will support delivery of our objectives – in particular the National Dental Recovery Plan. The three key areas for action including prevention, operational interventions and workforce / wider reform. Our local approach is outlined in more detail in (Appendix 2: Dental).

Since 2013, NHSE has held legal and operational responsibility for **commissioning specialised services** including: planning services, setting clinical standards, allocating resources, contracting with, and reimbursing providers and monitoring service performance. In 2022 NHSE set out the roadmap for how the commissioning model for specialised services would evolve in the coming years. From 2024/25, ICBs will be asked to agree the set of specialist services delegated to them - along with specialist commissioning budget allocated based on population figures. By delegating services, we will have an overview of the available resources for our population, meaning we can see how best to invest in improving quality and outcomes, reducing health inequalities and improving value. The key programmes of work are currently in progress focus on the agreement of and then the subsequent safe delegation of specialised services. This involves working alongside the NHS England regional team and joint work with NHS England, the other ICSs in the West Midlands, and locally in Staffordshire and Stoke-on-Trent. We have also received the 2024-25 NHS Midlands Operational Plan for specialised which will inform our operational plan in 2024/25. The overarching priorities set out in the plan are:

- Achieving financial sustainability

- Empower and support local systems to deliver on their responsibilities, as well as adopting a more collaborative approach in delivering our collective ambition in improving the health and wellbeing of the Midlands population.
- Tackling and reducing health inequalities
- To improve access to safe and high-quality services across the region specifically Mental Health and Maternity.

In March 2023, for **Maternity and Neonatal Services** NHS England published their Three Year Delivery Plan for Maternity and Neonatal services which encompasses all the plans and requirements up to that point. The plan is made up of four themes, each with three objectives. Since the publication of our JFP, work has been underway, with the support from the Local Maternity Neonatal System (LMNS). This work is being led by the Children and Young People and Maternity Portfolio and is bringing together partners across the system. Further details about our local approach please see (Appendix 3: Maternity).

Ongoing work at system level

This section is primarily focused on the statutory duties where additions have been made to the guidance and ICB's have been asked to review and update as appropriate within the refresh plan. This section should be read in conjunction with the first JFP published. A table of the statutory duties can be found in (Appendix 4: Matrix of Statutory Duties).

Quality and Patient Safety, Assurance and Improvement

We recognise the essential role all ICS partners have overseeing the quality of care given, and in creating and sustaining a culture of openness, learning and continuous improvement. Our System Quality Group is now well established and routinely involves wider partners including the Care Quality Commission, Healthwatch organisations, and NHS England. This forum facilitates engagement, intelligence-sharing, learning and quality improvement across the ICS.

Since our JFP was published, the ICB has published our Quality Strategy. This has been co-produced by the ICB and NHS partners and complements the ambitions and priorities of the ICS with quality and safety being the golden thread running throughout. The Strategy describes our aims for improving quality over the next three years, the quality outcomes and how we will know we have made an impact. It also supports our delivery of the NHS Patient Safety Strategy and NHS IMPACT (Improving Patient Care Together), outlines our quality risk response following the National Quality Board guidance. A comprehensive Quality Strategy Delivery Plan will be developed following stakeholder and staff engagement to determine the detailed actions required to achieve the aims of the Quality Strategy. This plan will be an addition to this strategy and will be used as a marker for achievements and presented to the Quality and Safety Committee bi-monthly to demonstrate adherence with actions required and any blocks to achieving the aims of the strategy.

The Patient Safety Incident Response Framework (PSIRF) was implemented across the ICS. This framework outlines how all NHS organisations should respond to patient safety incidents for the purpose of learning and improvement. All partners have received accredited oversight and/or investigator training to support improving patient safety through a systems approach. Monthly touchpoints and bi-annual system-wide learning events are in place to maximise learning from patient safety incidents to identify how improvements can be made. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

PSIRF four main objective for change

Source: ***[The Patient Safety Incident Response Framework]***

All NHS partners in the ICS have undertaken the NHS IMPACT baseline assessment and continue to use the NHS IMPACT self-assessment framework to guide plans on embedding improvement. The ICS Continuous Quality Improvement Subgroup routinely shares organisational updates on development work linked to NHS IMPACT and has begun to explore areas of collaboration at an ICS level. Partners from the ICS are part of a National Peer Support programme that enables systems to learn from each other's successes, and to explore opportunities to accelerate system-wide adoption.

The Financial Planning Context for Revenue and Capital

2024/25 is the final year of the current comprehensive spending review period and as such the NHS can only see the level of resources available for this one-year period. We are currently in the process of setting 1-year plans with a view to updating both our Medium-Term Financial Strategy and three-year capital plan throughout 2024/25 in readiness for the 2025/26 operational planning round.

Our financial arrangements and the current financial outlook

In the JFP set out details of the **Medium-Term Financial Strategy,** our financial operating model within the system (the Intelligent Fixed Payment System) and our overall system governance arrangements.

Our financial strategy, set in Autumn 2022 was broadly set around maintaining our costs level and managing our non-elective demand to the levels experienced in 2019/20 with a view to eliminating the underlying deficit of approximately £160m. The strategy we described a six-step plan to deliver financial sustainability while releasing resource that could be invested transforming services and addressing inequalities.

Together, the NHS partners set a balanced financial plan for 2023/24. However, it was clear from the that from the start of the financial year that the demand for services and inflation would rise above the fending received. In summer 2023 we estimated a most likely deficit for the year of £143m and set up a formal recovery process to mitigate this. We are currently forecasting delivery of an in-year deficit of £91.4m and our underlying deficit has increased to approximately £240m.

At the time of writing, we are in the midst of the 2024/25 planning round. The system is committed to delivering the best financial position possible however, it is not year clear whether breakeven can be delivered. Alongside a challenging efficiency programme of identifying and making efficiencies, we are

working up six recovery themes. These aim to release cash through cost reduction, demand management and a clear focus on clinical value.

Given the financial pressures also faced by our local authority partners, the recovery plan identifies programmes which can deliver financial improvement for all system partners. The recovery plan themes are outlined in the Provider/System Collaborative section earlier in this document.

As a system we are committed to building on our existing bed model to provide a holistic view of the capacity within the system. This will sit alongside productivity tools being developed by NHS England and will enable us to better understand the interplay between organisations as we transform and integrate services. A delivery plan for the resourcing model will be developed in the first quarter of 2024/25.

Our capital plans

Alongside the revenue plan for 2024/25, we will publish the Joint Capital Resource Use Plan (JCRUP) which is the plan for capital spend. This is the final year of the current planning period for capital. The plan has been developed to refresh the existing capital plans, taking into account any slippage in timetables, the impact of inflation and any new anticipated public dividend capital.

The capital schemes submitted in our system financial plan, including both internally funded and public dividend capital (PDC) funded schemes, total £95.6m {DRAFTING NOTE: number to be confirmed following the CIG on 15 March}. As per previous years, our capital spend is driven by maintenance, medical equipment and digital schemes – outside of new builds and large-value individual schemes. The JCRUP will be published on the ICB website in summer 2024.

Personalised Care and Choice

Our ICP Strategy sets out our strategic commitment to delivering personalised care, and that we will work with people as equal partners to deliver coordinated care centred on an individual's physical, mental and social needs. Our June 2023 JFP set out our approach to the widest delivery of patient choice – which was a golden thread throughout the plan across our delivery portfolios. As an ICB, we are committed to giving patients greater choice and control over how they receive their health care, in line with the NHS Constitution and the NHS Choice Framework.

The ICB works with referrers, including GPs, to ensure they are aware of patients' right to choose, and that appropriate information is available at the point of referral to ensure that an informed choice can be made. In using tools such as the NHS e-Referral Service (e-RS), national digital platform patients are able to be referred into elective care services. Arrangements are in place for providers to qualify for and secure NHS Standard Contracts for the provision of elective services – where the legal rights to choice apply.

Victims of Abuse and Safeguarding

We have continued to develop our approach to support Victims of Abuse and our approach to Safe in our Communities, Safe at Home and Safe at Work.

The ICS and partners have developed and published the latest multi agency Staffordshire and Stoke-On-Trent Violence Reduction Strategy (2024-2029). Based on the National Serious Violence Strategy, serious violence includes homicide, knife crime and gun crime, and areas of criminality where serious violence or its threat is inherent - such as in country lines drug dealing and other form of serious assault. While this is the focus of the strategy, there will be a focus on building connectively with aligned work streams such as domestic abuse, sexual abuse, exploitation and public place violences against women and girls (VAWG).

Our local strategy builds on achievements made to date and is underpinned by a public health approach with continued focus on the five priority areas of attitudinal change, primary prevention, secondary prevention, tertiary prevention and enforcement and criminal justice. As part of the approach to the Serious Violence Duty there will be a focus on recognising and understanding the signs and symptoms of trauma and Adverse Childhood Experiences, responding, preventing and reducing trauma through early intervention.

Our local, multi-agency Staffordshire and Stoke-on-Trent Domestic Abuse Strategy (2021-24) is informed by national and local evidence. It responds to the need to prevent and addresses domestic abuse where agencies, communities and businesses harness their collective efforts to make a positive change. It sets out our joint aim and approach to addressing domestic abuse and the outcomes we expect to see as a result through four priority areas are preventing violence and abuse, provision of services, perpetrators and provision of safe accommodation. The strategy is being updated in accordance with the Domestic Abuse Act 2021 and requirements in relation to the Sexual Safety Charter and our approach to Safe at Home. It will be published in 2024.

The ICB are updating the Domestic Abuse Policy for ICB employees to include sexual violence recognising the requirements from the domestic Abuse Act 2021 and the Sexual Safety Charter. It is anticipated to be published by May 2024, and will include those individuals who are being or who have been sexually abused and the range of behaviour this presents itself such as harassment, stalking, exploitation, coercive control and non- fatal strangulation. Local services are available for children and adults affected by this and work has begun in understanding the data associated with this behaviour.

Members of staff who experience domestic abuse and / or sexual violence may choose to disclose, report to or seek support from a staff side representative, a manager, or colleague. The ICB have staff members who are identified as Domestic Abuse Ambassadors or Mental Health First Aiders. We developed the policy in line with the Equality Impact Risk Assessment process to ensure fair and equitable access to services – no matter where they live, their age, gender, ethnicity or sexual orientation.

As part of the Safe at Work principle the ICB have a statutory responsibility to maintain the safety of their workforce. This includes their psychological and sexual safety along with their physical safety. The ICB signed up to the NHS Sexual Safety Charter in 2023.

Safeguarding

As part of our statutory duties, we are required to make sure relevant safeguarding provisions are in place. Safeguarding refers to the processes and policies to keep people safe, recognise vulnerabilities at the earliest opportunity (such as those individuals with special educational needs and disabilities and care experienced children and young people) and promote wellbeing and resilience.

The Working Together to Safeguard Children 2023 provides the ICS with the statutory guidance to inform and enable collaborative, multi-agency working within a statutory safeguarding framework. Each individual within the ICB accountability structure will work with their counterparts in the police, local authorities, education and VCSE organisations that form the safeguarding children and adult partnerships.

The Child Death Overview Process (CDOP) supports the ICS infant mortality reduction objectives and part of that includes the development and delivery of the safe sleep programme. Safe sleep resources for parents and carers are now available including a safe sleep video, education booklets, room thermometers and the roll out of the ICON programme **Babies cry, you can cope**. We will continue our strategic approach to ensure Safe sleep messages are being disseminated across social media platforms and throughout hospitals and GP Practices in Staffordshire and Stoke-On-Trent.

Research and Innovation

As part of meeting our statutory requirements around research, since publishing our JFP, a Research and Innovation Strategy has been produced and agreed through the Staffordshire and Stoke-on-Trent, Shropshire Telford and Wrekin Health and Care Research Partnership (SSHERPa). This was agreed in September 2023 and sets out six objectives:

The Research and Innovation Strategy six objectives

Executive leadership and the hosting arrangements of Staffordshire and Stoke-on-Trent, Shropshire Telford and Wrekin Health and Care Partnership (SSHERPa) is in place with a provider executive sponsor and programme management support. We have a dedicated ICB lead for Research (Deputy Chief Medical Officer) who provides senior leadership between SSHERPa and the ICB; with a Research and Innovation committee reporting into the Improving Population Health portfolio board.

Work has continued to develop and enhance partnerships across the health, care and the voluntary, community or social enterprise (VCSE) sector to advance research and innovation. The establishment of voluntary and community sector research coordinators and the development of a research connectors network across our region has enabled us to reach wider underserved communities who do not currently have the opportunity to engage in research.

To develop the local research infrastructure, members from the VCSE are key partners of SSHERPa and a dedicated patient, public and community involvement and engagement workstream is in place. This brings together those working in public engagement across all settings and enables community engagement with VCSE. It allows us to share new studies in development, along with the established National Institute for Health and Care Research (NIHR) portfolio studies, across the widest population.

As of February 2024, more than 9000 people have been recruited to take part in research studies in the ICS, and we are looking for ways to extend these opportunities further through community networks. There is ongoing development of a research bus (led by MPFT) which is to be launched in 2024.

As a partnership, we are developing a collaborative approach to integrated research, while also addressing the health and care priorities of our region. Our application to be part of a national programme around dementia biomarkers was successful, and we are working to establish a NIHR Mental Health Research Group (led by Keele University but with NHS partners and the VCSE sector as co-applicants).

On a regional level SSHERPa partners are part of West Midlands Secure Data Environment Network workstreams. We have strong links with local research infrastructure and stakeholders to make sure that staff, organisations and our local population can be involved in research to support health and care priorities.

Workforce and Education

NHS England's NHS Long Term Workforce Plan was released after our JFP was published. It sets out the national workforce ambitions and is a comprehensive framework to support strategic workforce planning, put staffing on a sustainable footing, and improve patient care.

Since then, we have continued to work with our NHS, local authority, ICB, primary care, social care and VCSE partners to tackle the workforce pressures at a system level. Progress has been made in several areas – as highlighted in the following infographic which captures achievements in programmes where we have worked across boundaries to address the challenges, scale up our work and impact, and create efficiencies.

ICS People Achievements in programmes across boundaries
Source: ICS People Culture and Inclusion Annual Report 202323 – You Tube

NHS Long Term workforce Plan – Local delivery

The NHS Long Term Workforce Plan (LTWP) sets out a strategic direction for the long term, as well as action to be taken locally, regionally, and nationally in the short to medium term to address workforce challenges including the workforce gap. It details the actions that will be taken in the coming years to address the identified shortfall in addition to, and building on, actions and investment already committed.

The actions fall into three priority areas: Train, Retain, and Reform – supported by strategic workforce planning.

TRAIN	RETAIN	REFORM
• Medical and Dental education • Reduce International Recruitment • 'New 2 Care' • Engage with seldom heard communities • Trainee pipeline intelligence & planning • Education / training commissions and workforce development funding • Clinical Placement Capacity • Grow Education provider partnerships • Alternative training / education models • Apprenticeship expansion	• Health and Wellbeing offers • Staff Psychological and Wellbeing Hub long-term funding • Employee Value proposition • Expansion of Flexible Working practice • Equality, Diversity & Inclusion activities • Health Inequalities focus in activities • Experience & wellbeing data and intelligence • Culture, Leadership and Talent activities • Digital Staff Passport	• Reduction in agency • Increase contingent workforce • Delivery of ICS People Digital Plan • Upskilling workforce • Attraction of digital workforce • Future workforce for digital and AI • Delivery of People Services at Scale • Engage Professional bodies • ICS Portfolio workforce planning • Transformation inc new roles & skills • Cultural and Leadership for reform • ICS career pathway & rotational offers

NHS Long Term Workforce Plan priority areas

The plan reiterates the need to ensure the right people, with the right skills, are in the right place, at the right time to provide high quality care, while improving outcomes and experience.

A significant challenge is affordability and growth on the scale outlined in the LTWP, which will contribute to the financial deficit, in the backdrop of a national requirement to increase capacity in priority areas including urgent and emergency care (UEC), elective and mental health to contribute to system recovery. Therefore, work is underway to align the national assumptions with local planning and trajectories.

In 2024/25 and beyond, integrated and transformational planning will be essential to reduce demand on services where possible. This includes ensuring that the current workforce is used effectively.

Productivity will be key, alongside designing new workforce models and roles aligned to clinical pathways, improving access routes (T-Levels and Apprenticeships), retention, medical expansion and reform, clinical expansion and reform (non-medical). Examples include our system rotational apprenticeship schemes, our 'New 2 Care' inclusive recruitment model which supports our communities to access entry level jobs with support, and the creation of one occupational health contract for NHS organisations.

In addition, the ICB have established a Primary Care Workforce Implementation Group with multidisciplinary representation from practice, PCN, system, training hub and regional partners. This group is in the process of developing a Primary Care Workforce Local Delivery Plan in response to the NHS LTWP. The plan will focus on all three elements of the NHS LTWP (Train, Retain and Reform), and will consider clinical and non-clinical roles within general practice and additional roles reimbursement scheme (ARRS) roles within the PCNs.

The NHS LTWP excludes social care but assumes that the social care workforce will remain static. However, Skills for Care forecast estimates that there will need to be an increase of total posts by 28%. We will continue to work closely with our partners in adult social care (ASC) to understand the social care workforce, required growth, and in implementing the priorities within the NHS LTWP. We await the national ASC Long Term Workforce plan, and once it is published, we will work with partners to analyse and integrate into our local LTWP.

People Programme Priorities 2024/25

Given the current context, a shift in focus for the ICS People Programmes is necessary to support the achievement of the system priorities and recovery. A review of delivery plans associated with the LTWP, programme work, and core business was undertaken, and activities realigned to support the financial framework and the aims of the Operating Plan.

Over the coming years, we will work in partnership to implement the recommendations of the Delivering People Services at Scale framework. These will support several system aims, including productivity, reducing waste and duplication, digital advancements, enhanced employee experience – all leading to improved quality and service user experience.

Partners will consider areas such as recruitment and improvement of 'time to hire', portability of employment checks across NHS trusts, and exploring digital enablers such as a Digital Staff Passport. We will also consider opportunities to explore more standardised employment offers, enabling working across sector boundaries and levelling-up to create 'one workforce'.

At the heart of all we do together is our commitment to look after our people, aligning to the NHS People Promise commitments. This will be enabled by the development of a system-wide Employee Experience and Health and Wellbeing Strategy (to be launched in 2024/25), which supports our whole workforce. We will continue to strengthen our system-wide compassionate culture enabled through the development of a system-wide Organisational Development (OD) Plan, leadership compact, and development offers.

Equality, diversity and inclusion will be a 'golden thread' throughout all programmes, building on the successes of existing programmes including Inclusion Schools, WRES Champions and Differently Abled Buddy scheme, and addressing the findings of the 'Too Hot to Handle? report locally.

The infographic below sets out our 'Journey to Work' model which captures our long-term approach to engaging our communities; attracting and supporting local people into health and care volunteering, jobs and careers; and looking after people through the employment lifecycle.

Journey to work: Our long term approach to achieve our People Programme Priorities 2024/25

Education and Training

The Education, Training and Development workstream has progressed significantly since we published our JFP. Under the leadership of an Executive Clinical Sponsor, partners are working collaboratively to drive forward specific projects including understanding our future pipeline, clinical education landscape, strengthening our work with universities, clinical placement capacity, career pathways and improving the quality of education.

We have undertaken an analysis of the Long-Term Workforce Plan, proposed growth and review of the ambitions, and work is ongoing to map the national expansion to local operational plans, Multi-Professional Educational and Training Investment Plans (METIP) and pipeline data. Achieving the proposed growth is a significant challenge for our system, so we will need to redesign traditional workforce models to meet the future demands and clinical pathways within our available budget.

Our approach to education and training will focus on reform - creating innovative workforce solutions, designing and attracting a different workforce for the future by developing new roles, and routes into health and care careers, skill mixing and working in integrated teams across organisational boundaries.

We will continue to work with NHS England and higher education to understand the trainee pipeline, aligning with operational and long-term planning. We will mitigate risks to future education supply through local targeted activities for clinical, social and education pathways. Additionally, we will work in partnership to maximise the value of the education tariff and ensure high quality education provision.

There will be a specific focus on widening participation and inclusion including but not limited to expansion of workplace learning schemes and development of entry level, non-registered routes. This will build on our successful apprenticeship pathways and delivering the national T-Levels Pilot programme for the Midlands.

We will be working with our local communities to promote health and care careers, improving access to jobs through training and shadowing opportunities, working with colleges to develop entry level courses and support. Our work with schools as a 'Cornerstone Employer' will continue to grow through increased promotion of health and care careers in Primary and Secondary education and joined up working with colleges to create attractive pathways into further education and careers.

Our overarching ambition is to raise aspirations, create accessible career pathways and support the overall health and wellbeing of our young people by aligning our approach with the ICS Children and Young Peoples Strategy: Getting the Right Start.

The Education, Training and Development Steering group has developed a set of priorities for the workstream to focus on during 2024-25. Although ambitious, partners are signed up to this collaborative plan with key stakeholders from across the system leading individual workstreams to drive forward the programmes of work. Those leads include NHS, Social Care, Primary Care, University, College and NHS England.

The Education, Training and Development Steering Group Priorities 2024/25

Our Strategic Transformation and Service Change programmes

The Strategic Transformation and Service Change programme, alongside other transformation programmes that are embedded within the portfolios, support the delivery of a sustainable health care future across the ICS.

Service change programmes are conducted in accordance with the Planning, assuring and delivering service change for patients guidance from NHS England. The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services so they can influence ICB decisions at the level of participation they choose.

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

- eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities.

For each programme, we undertake stakeholder analysis and mapping. In line with our statutory duty to involve, we ensure we are engaging with the public and with key patient groups who may have an interest in a given programme.

We also work closely with the Consultation Institute (tCI) for advice on our approach to involvement within the programmes and ensure any involvement process meets best practice guidelines. Our portfolios are supported by our strategic transformation and service change function to undertake the options appraisal process where required, and to ensure that business cases stand up to the rigour of NHS England's assurance process.

The table below summarises the key areas of focus for the transformation and change programme:

Programme and portfolio
Urgent and emergency care (urgent treatment centre designation) *Urgent and emergency care (UEC) portfolio*
Cannock transformation programme *Primary care, UEC, Planned care portfolios*
Maternity *Children and young people and maternity portfolio*

In summer 2021, we started a conversation about how we could improve diagnostic services across Staffordshire and Stoke-on-Trent. Currently, most diagnostic services (tests to work out what is causing a person's illness or symptoms) are provided in hospitals, but it is now recommended that NHS organisations across England move to providing these in community diagnostic centres (CDCs). We believe this will give patients across the county access to diagnostic services such as blood tests, scans, X-rays and imaging more quickly and nearer to home.

Progress on Developing the Wider Infrastructure

We are progressing our ambitions to create stronger, greener, smarter, better, fairer health and care infrastructure – together with efficient use of resources and capital to deliver them. The ICS and its partner organisations play a pivotal role in shaping the future of infrastructure in Staffordshire and Stoke-on-Trent.

We cannot default to doing the things we have done in the past. We need appropriate and sustainable solutions; driven by increased creativity and greater innovation. We need to apply this way of working to improving the things we already do, to developing new infrastructure and more broadly, in collaboration shaping our future for the next 15 years.

This collaborative effort will design holistic solutions that not only meet clinical requirements, but also integrate seamlessly with broader community initiatives and make best use of technology.

Infrastructure Strategy

Following the publication of the first JFP in June 2023, we have co-produced a draft Infrastructure Strategy which will be published in Spring 2024. The strategy will set out our high-level, system-wide approach to coordinate and influence the development of all estate directly used in the provision of NHS delivered health and care.

The strategy will be underpinned by a time-phased Infrastructure Plan, which has been co-produced with partners and will set out more detailed specific initiatives and projects. For the initial years, this will include proposed timelines, resource allocation, responsibilities, and milestones to track progress. We recognise already that our timelines will need a significant lead in period of five to 10 years – in particular given timing for some our Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) concession periods and our journey to deliver net-zero by 2040.

Over the next five to 10 years, our vision for the health and social care infrastructure in Staffordshire and Stoke-on-Trent is to have the right network of NHS and partner infrastructure in place that enables us to deliver our strategic and operational objectives. This will include:

- Establishing a system-wide infrastructure baseline through a comprehensive assessment, incorporating key metrics related to the age, backlog risks, and 10-year profiles of the infrastructure
- Understanding how our all our space is utilised to enable us to maximise the clinical value we deliver from our infrastructure
- Implementation of planned developments including community diagnostic centres (CDCs) for enhanced diagnostics, urgent treatment centres (UTCs) for timely care, and community hubs to enhance community engagement and preventive care
- Upgrading existing facilities to deliver fit for purpose clinical space
- Investigating new opportunities, particularly in the use of commercial estate
- Strengthening the skills we will need across our infrastructure workforce as we move to an increasingly green, sustainable, data-driven and digital NHS and align this to our Workforce Strategy
- Developing a framework for governing and executing multi-partner, place-based projects
- Reflecting national guidance produced by NHS England
- Assessing the digital tools and systems we need (today and into the future) to support us to use and manage our buildings more effectively.

To support delivery of the strategy, we must be able to jointly:

- manage strategic risks, engaging local perspectives and foster leadership across our infrastructure workforce
- establish new investment principles to prioritise and identify development opportunities
- promote sustainable practices
- maximise the use of our estate for clinical purposes through integrating digital health solutions and creating flexible workspaces for non-patient facing activities
- enable integration (within organisations, between providers to support sustainability of services and functions, across clinical pathways, between physical and mental health, across tertiary, secondary and primary care, between health and social care, and between physical and digital services and infrastructure).

The success of the Infrastructure Strategy critically depends on collective ownership and support from the system and its partners. Stakeholders have endorsed a Strategic Framework, relying on activity-driven infrastructure planning utilising environment, infrastructure, smart, and workforce parameters. Strategic workstreams will shape priorities for various care areas, facilitating key service transformation plans.

Digital

Since the JFP was published, we have continued to progress steps to digitise, connect and transform. This aims to increase digital maturity and ensure a core level of infrastructure, digitisation and skills.

Our actions contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care and reducing digital inequity and supporting net zero objectives.

We have identified the following activities which will allow us to tackle the challenges ahead.

- It is important to understand and capitalise on the emergent artificial intelligence (AI) technology to support our staff by removing simple, repetitive tasks and allowing them to focus on more complex activities. AI has now been added as our 12th initiative
- The ICS digital teams are progressing our Electronic Patient Record programme focusing on interoperability and system-wide working. Our priority is now on the procurement process and embedding the identified solution in our first trust, UHNM
- As highlighted in the Digital Maturity Assessment (DMA) we are working to enhance patients' access to their digital data. Significant investments have been provided to further develop patient portals and reduce digital inequalities

- Development of a programme approach to enable the delivery and realisation of our Data and Intelligence Strategy to support our system to become a more data enabled system. Digital will be investing in capacity to support this
- Align Digital People plans and activities at system level to address supply, retention, development, and future pipeline challenges, as well as enhancing digital literacy of the wider workforce.

North Midlands Integrated Stroke Delivery Network

The North Midlands Integrated Stroke Delivery Network (ISDN) in collaboration with Medtronic, have been educating more than 50 clinicians across the Midlands region in the interpretation of computed tomography (CT) scans in relation to stroke. Professor Indira Natarajan, Clinical Director for Stroke Services, opened the session by taking delegates through a stroke patients journey into a comprehensive stroke centre – giving information on what acute sites can do to make transfers more time efficient. This comes at an optimal time due to the national roll out of artificial intelligence to aid in CT interpretation

Case study: North Midlands Integrated Stroke Delivery Network

Climate Change Sustainability

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. We therefore view sustainability actions as part of our preventative health and wellbeing actions.

Building on the wealth of good practice at the local organisational level and aligning with local plans and strategies, we work with all our partners to collaborate as an 'anchor system' to use our assets for social, economic and environmental benefit. Operating as an anchor system, we will continue to develop, but have an initial focus around the areas described below.

Environmental protection, tackling climate change and restoring nature are intrinsically linked to the health of our communities

Sustainability not only supports the delivery of the JFP, but also addresses some of the underlying causes of ill health. For instance, if the UK hits its climate change targets, we could save up to 144,000 lives a year through more active lifestyles, less vehicle pollution, and healthier, carbon-friendly diets – thereby improving outcomes in population health and healthcare. These outcomes alone tackle an array of health issues we face including obesity, diabetes, cardiovascular disease, respiratory disease, cancer, and mental health and wellbeing.

Placing a significant focus on the roles of education and training in the supply and retention of the workforce alongside the valuable role we can perform as an anchor organisation

We aim to implement and embed the Journey to Work concept with our partners, communities, schools and colleges to build a robust offer of support to increase our pipeline, create opportunities for everyone, and make sure our workforce represents our local population.

Estates decisions should benefit patient experience or outcomes and staff working conditions and be efficient for the healthcare and public sector system

Making use of all public estate in a functional and useful way is a necessity so the One Public Estate (OPE) agenda is recognised and incorporated in our planning and thinking about how we maximise healthcare outcomes and return on public sector investment. Decisions will demonstrate the commitment to Net Zero Carbon, social awareness and value for money.

Delivering a Net Zero NHS

Our vision is to achieve net zero healthcare within Staffordshire and Stoke-on-Trent ICS, in line with the Delivering a Net Zero NHS which is now issued as statutory guidance. This sets out two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

In 2022, in preparation for developing our system Green Plan for 2023-25, we identified the following additional themes:

- Leadership and system governance
- Data analysis and baselining
- Workforce development
- Energy management
- Community impact.

In 2023/24, the ICS developed a strategic Delivery Plan which looks at our overall system arrangements, including our governance and leadership. The ICS Green Delivery Plan provides a framework to embed social value and sustainability principles and priorities, so that they become a part of the day-to-day activities carried out across the ICS enabling it to meet the overarching Green Plan objectives. The ICS Green Delivery Plan is themed and aligned to the nine areas of focus as set out in the Greener NHS Programme to ensure a clear emphasis on social value and reducing health inequalities.

The ICS has been assessed by NHS Regional Green Team as a 'maturing system' against the System maturity matrix self-assessment. Areas where we need to focus are aligned to our ICS Delivery Plan and working groups are in place or been established to progress our priorities. The groups are made up of system partners – ICB, NHS providers, local authorities, and VCSE organisations – with the purpose of working collaboratively to plan and deliver objectives and monitor benefits and impacts. Building on progress over the last year, we are now looking focus on the areas below aligned to the national guidance:

Nine areas of focus

We want to develop greener health and social care systems which deliver high-quality services and improve the health and wellbeing of the population through addressing the nine areas of focus set out in the national guidance:

1. Workforce and system leadership: Building awareness of our Net Zero targets and obligations through education and training of our workforce, and broadening involvement to include VCSE partners
2. Sustainable models of care: Developing a plan to support all staff within primary care with sustainability and look to adopt and embed the Green ED framework
3. Digital transformation: We are beginning to quantify the carbon impact of remote monitoring schemes starting with Virtual Wards
4. Travel and transport: Review the national Net Zero Travel and Transport Strategy and develop an ICS action plan which will include the coordination of system-wide travel surveys and target setting on low emission vehicle (LEV), ultra-low emission vehicle (ULEV) and zero emission vehicle (ZEV) targets
5. Estates and facilities: Progress heat decarbonization planning and assess future readiness for low carbon heating within the system. Having baselined the existing infrastructure and opportunity to install Solar panels across the Staffordshire and Stoke-on-Trent estate, we will be developing an implementation plan to expand this
6. Medicines: Continue work to reduce nitrous oxide emissions and emissions from inhalers against our 2019/20 baseline
7. Supply chain and procurement: All new procurements will conform to Procurement Policy Note (PPN) 06/21 requirements and require carbon reduction plans and we will look to embed sustainability impact assessments

8. Food and nutrition: Meet or exceed targets outlined in the ICS Green Plan
9. Adaptation: Produce an adaptation plan which includes assessment of risks, identification of impacts, and identification of adaptation solutions for adjusting our systems and infrastructure to continue to operate effectively in response to the changes in climate.

Part 2

In this section of the plan is a series of appendices which:

- provide an overview of other key areas of development since the publication of the JFP in June 2023
  - System Level Access Improvement Plan (SLAIP)
  - Dental
  - Maternity
- summarise how we will meet the statutory requirements placed upon the ICB
- include a glossary of terms and abbreviations

1. System Level Access Improvement Plan

The Fuller Stocktake Report built a broad consensus on the vision for integrating primary care with three essential elements:

- Streamlining access to care and advice
- Providing more proactive, personalised care from a multidisciplinary team of professionals
- Helping people stay well for longer.

Before the Integrated Care Board (ICB) can fully implement the wider reforms necessary to achieve this vision, it is acknowledged there is a need to take the pressure off general practice and tackle the '8am rush'. Although this plan supports all three elements of the Fuller Stocktake Report's vision, it makes no excuses for focusing on the first, with financial support provided by NHS England.

Part of this initial focus was the development of PCN access improvement plans, which were assured by the ICB and NHS England in July 2023. These have included the general practice elements of PCARP and focus on key areas to support improved patient experience of general practice:

- Patient experience of contact
- Ease of access and demand management
- Accuracy of recording in appointment books.

Some specific examples that Staffordshire and Stoke-on-Trent PCNs have identified within their plans are captured below. This is not an exhaustive list but provides a sense of the actions being taken locally:

PCN area	Action being taken
North Staffordshire and Stoke-on-Trent	A pilot project is taking place with a focus on backend workflow turnaround, i.e., dealing with administration such as patient letters/tasks etc. Actioning the workflow within a specific time period following receipt has seen a reduction in telephone calls, appointment requests, patient queries and tasks. Staff satisfaction and morale has also increased due to a reduction in patient complaints and queries.
North Staffordshire	Digital Inclusion sessions are being held in GP practices within the PCN to support people to access information digitally where appropriate.
South Staffordshire	A General Practice Team leaflet has been produced for people who do not have online access, detailing the varied skill mix available in general practice.
South West Staffordshire	Consistent messaging on websites across the PCN to inform people of services available in addition to general practice and consistent advice on usage of services.
South East Staffordshire	Use of a web-based community connectivity app that is used by the public and health professionals and links directly into our GP systems. The app enables health and social care professionals to link citizens to local services and demonstrate outcomes.

The skill mix of the general practice workforce has continued to develop within Staffordshire and Stoke-on-Trent. 616 Whole Time Equivalent (WTE) Additional Role Reimbursement Scheme (AARS) posts as part of the PCN Directed Enhance Service (DES) have been recruited to. This includes roles such as first contact physiotherapists, mental health nurse specialists, advanced nurse practitioners, paramedics and many more. We expect to see further roles recruited to by the end of March 2024.

Patient empowerment is an important deliverable to support the Staffordshire and Stoke-on-Trent PCARP, and the below details current initiatives demonstrating our commitment to this crucial work:

- **Self-Referral Pathways:** Progress has been made for several self-referral pathways to help empower people and encourage them to take control of their own health. These pathways are community musculoskeletal and podiatry, audiology for older people including hearing aid provision, Weight

Management Service, self-referral pilot – digital weight management plans, Wheelchair Services, Community Equipment Services, Falls Services, and Reactive Falls Pathway.

- **Digital Empowerment and Pathways:** 95% of practices in Staffordshire and Stoke-on-Trent are now offering Full Prospective Access (FPA) – meaning all local practices currently have access to solutions which enable the booking of routine appointments and to other digital pathways such as online triage, short message service (SMS) messaging and video consultations. In Staffordshire and Stoke-on-Trent, 100% of practices will be using digital telephony systems by 31 March 2024 to further improve the patient journey.

- **Pharmacy First:** This service went live on 31 January and enables Staffordshire and Stoke-on-Trent pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) without the need to visit a GP. Staffordshire and Stoke-on-Trent GPs are prominent users of pharmacy support services as seen through repetitive high usage of the recently retired Community Pharmacy Consultation Service (CPCS).

PCNs and practices have committed to providing Modern General Practice (MGP) by accessing support and training for care navigation, digital transformation and capacity backfill. The ICB continues to work with GP practices to support the identification and implementation of their MGP models throughout 2023/24 and 2024/25, in line with the two-year plan.

A major part of the access challenge is the rise in administrative workload, particularly for experienced GPs, potentially meaning less time for them to be available to see patients. The ICB has developed a single Primary Care and Secondary Care Consensus Agreement that has been signed up to by all organisations across Staffordshire and Stoke-on-Trent. The Consensus Agreement aims to facilitate effective working between primary and secondary care organisations and details responsibilities to support this. The ICB will work with local authorities and other partners including national agencies to support the adoption of the Bureaucracy Busting Concordat, reducing the administrative burden for GP practices.

Since the launch of PCARP, the ICB has shared the primary care campaign plans at regional meetings between NHS England and the ICB, have been highly commended as best practice for communicating the contents of the delivery plan. In terms of engagement and communications efforts to deliver on the communications objective set out in the delivery plan, ongoing monitoring will continue to build on these plans to ensure they are effective in terms of messaging and reach.

Campaign	Timescales
Use of national NHS application campaign materials	Ongoing, national campaign began February 2024
Use of national pharmacy promotion campaign materials	July – ongoing
National pharmacy oral contraception programme campaign: Initial comms to GPs Communicate to ICB staff Public campaign materials in use	 March May August – ongoing
Local Primary Care Access Campaign (paid-for activity): Phase one (access/care navigators/ARRS roles/staff abuse/other ways to access care) – social media adverts (Facebook and Instagram), audio adverts via Spotify, out-of-home adverts, partner toolkit, primary care toolkit, webpage and press release Phase two (as above) – social media adverts, continuation of webpage, printed materials to 142 GP practices in SSOT Phase three (ARRS roles) – suite of videos (explaining individual roles, also available in British Sign Language (BSL) and translated captions on YouTube), updated webpage, social	 Summer 2022 Autumn/winter 2022 Summer 2023

media adverts (Facebook and Instagram), radio adverts, out-of-home adverts, partner toolkit, primary care toolkit, podcasts and press releases	
Self-referral programmes: Digital weight management Audiology Podiatry/physio/falls service/wheelchairs/other equipment services	 Spring – summer 2023. Expected to restart for autumn/winter 2023 October – ongoing Communication to take place once these services launch locally
Use of national materials to promote patient records being available on NHS application	November 2023 onwards
Use of national NHS111 updated campaign materials	November onwards
Use of national pharmacy 'common conditions' campaign materials	February 2024 onwards
Use of national GP online consultations campaign materials	Expected 2024/25

2. Dental

Why is this important to our population?

In the UK, tooth decay is the most common childhood disease and tooth extraction is the most common reason for children to receive a general anaesthetic. Nationally, 12% of three-year-olds and 25% of five-year-olds have cavities (form of tooth decay), and in 2019, 6% of children under 16 in England required time off school due to dental health issues, affecting their learning. During 2019-20, there were 37,000 hospital admissions to remove children's decayed teeth. This costs the NHS £50 million per year, and it is largely preventable.

In Stoke-on-Trent, a study showed that 35% of five-year-olds had visible tooth decay, compared to a West Midlands average of 23.8% and an England average of 23.7%.

What do we know about people's local experiences?

Access to NHS dental services is reported in terms of the count of unique patients seen in the previous 24-month period. During the COVID-19 pandemic, the numbers of unique patients accessing a dentist declined due to infection control and related challenges that the pandemic created falling to a low point in February 2022 when 180,776 fewer patients had been seen within Staffordshire and Stoke-on-Trent. While this position started to increase from March 2022, Staffordshire and Stoke-on-Trent , in common with all ICBs in the Midlands, are now seeing smaller increases in the numbers of unique patients seen, linked to the ongoing shortfall in the capacity to deliver services.

How do we plan to make a difference?

The responsibility for dental commissioning was delegated to ICBs on 1 April 2023, which created an opportunity to provide better support for our populations ensuring that dental services meet the needs of the local population. Locally there is an Oral Health Improvement Service, with several initiatives already in place to prevent tooth decay and extraction. The include oral health training for the wider professional workforce, supervised toothbrushing in children's settings, targeted provision of toothbrushes and toothpaste by health and social care professionals, and mouth care in care homes. As part of the ICB's commitment to improving access and minimising health inequalities, Staffordshire and Stoke-on-Trent ICB is working with other ICBs in the West Midlands to develop a range of initiatives. Some will be in place in the immediate term, and some will be to support the transformation of services.

This includes:

- Completion of an ICB Dental Services Health Equity Audit and oral needs assessment

- The ICB is contributing towards the development of a Dental Strategy for the ICBs in the West Midlands (anticipated to be presented in April) focusing on a number of key priorities including recruitment and retention, health prevention and strengthening community relationships. A local improvement delivery plan will then subsequently be formed
- Additional children's specialist support to provide expert advice to local practices to help to manage patients closer to home, improve outcomes and relieve pressure on specialist services, NHS111 and accident and emergency (A&E).

As part of the National Dental Plan, there are three key areas for action including prevention, operational interventions and workforce / wider reform. Over the forthcoming months, the results from the Health Equity Audit, oral needs assessment and the (NHS Dental Recovery Plan) recommendations will be considered alongside the Regional Dental Strategy and subsequent improvement plan.

3. Maternity

In March 2023, NHS England published their overarching plan for maternity and neonatal services, a plan which would encompass all the plans and requirements up to that point; the Three Year Delivery Plan for Maternity and Neonatal services. The plan is made up of four themes, each with three objectives.

Since the publication of the JFP in 2023, work has been underway, with the support from the Local Maternity Neonatal System (LMNS) to ensure the implementation of two key aspects of the LMNS work. This includes:

1. The review of the LMNS governance process, including the monthly Quality and Safety Oversight Forum (QSOF) which reports into the monthly LMNS Partnership Board with representation from all those involved with the LMNS, and who provide maternity and neonatal services to women and families in Staffordshire and Stoke-on-Trent. This has resulted in having a focus on the outputs from the Three Year Delivery Plan

2. Alignment of key actions from the Care Quality Commission (CQC) inspection, undertaken in June 2023, against the Three Year Delivery Plan – which resulted in confirmation that the actions had been addressed by the Trust.

Implementation Plan and progress to date

Theme	Outcome measure	Evidence	Relevant regulation and incentivisation	Progress Measures	Progress Update
Theme 1 **Listening to, and working with, women and families with compassion**	Indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey; aggregated at trust, ICB, and national levels and at a national level analysed by ethnicity and deprivation.	Feedback on personalised care gathered via Maternity and Neonatal Voices Partnerships (MNVPs) from a wide range of service users. Local evidence of working with women and families to improve services including co-production.	CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections. NHSE Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme which encourages the use of MNVPs.	Perinatal pelvic health services and perinatal mental health services in place. Number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard. Proportion of maternity and neonatal services with UNICEF Baby Friendly Initiative (BFI) accreditation.	UHNM CQC Maternity Survey Summary and Action Plan presented annually to the Local Maternity and Neonatal System (LMNS) Quality and Safety Oversight Forum (QSOF). Perinatal pelvic health services funding allocated to UHNM and Derby and Derbyshire ICB. Perinatal mental health services established and monitored via QSOF. Both provider organisations within the ICS; UHNM and QHB have UNICEF BFI accreditation. CNST compliance reviewed and monitored

Theme	Outcome measure	Evidence	Relevant regulation and incentivisation	Progress Measures	Progress Update
Theme 2 **Growing, retaining, and supporting our workforce**	NHS England Staff Survey, the National Education and Training Survey (NETS), and the General Medical Council (GMC) National Training Survey.	Progress against workforce, retention, succession, and training plans. Local staff feedback mechanisms. Progress against the nursing and midwifery high-impact retention interventions.	CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development. NHS Resolution CNST maternity incentive scheme incentivises the Trust to evidence that training accordance with the core competency framework is in place.	Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data. Annual census of maternity and neonatal staffing groups to facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists. Assess retention, through monitoring staff turnover, staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.	Staff Survey results and action plan submitted to the LMNS QSOF. NETS results submitted to the monthly Strategic Quality Group (SQG). GMC National Training Survey results submitted to the monthly SQG. Monthly Provider Workforce Return data received from NHS England. CNST compliance reviewed and monitored.

Theme	Outcome measure	Evidence	Relevant regulation and incentivisation	Progress Measures	Progress Update
Theme 3 **Developing and sustaining a culture of safety, learning and support**	Achieving meaningful changes in culture will take time and progress measures difficult to identify and can have unintended consequences. So primarily determined by listening to the people who use and work in frontline services.	Assurance from Trust Boards that they are using an appreciative enquiry approach to support progress with plans to improve culture. Trust Boards regularly sharing and acting on learning. Staff feedback on how incidents and issues of concern are managed.	CQC review of Trust's learning and responsive culture, strong leadership, and robust governance.	Midwives' and obstetric and gynaecology specialists' experience from the Staff Survey, the NETS and GMC National Training Survey.	Organisational development (OD) updates from reports on the implementation of the Vitality programme (culture) in reports to QSOF. Updates on Serious Incidents (SIs) and, more recently, implementation of Patient Safety Incident Response Framework (PSIRF). CQC visits, published reports and updates on subsequent action plans currently monitored via a monthly System Maternity Oversight and Assurance Group (SMOAG) lead by the ICB and NHS England. Staff Survey results and action plan submitted to the LMNS QSOF. NETS results submitted to the monthly SQG. GMC National Training survey results submitted to the monthly SQG.

Theme	Outcome measure	Evidence	Relevant regulation and incentivisation	Progress Measures	Progress Update
Theme 4 **Make better use of digital technology in maternity and neonatal services**	Focus on clinical outcomes for maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth and preterm births, and monitor by ethnicity and deprivation.	Clinical audits of implementation of shared standards. A standardised tool is provided for assuring version 3 of the Saving Babies' Lives (SBL) care bundle. An ICB-wide dashboard to support benchmarking and improvement. Progress against locally planned improvements.	NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions. CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.	Local implementation of version 3 of the SBL care bundle using a national tool. Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care. The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme. A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.	Published MBRRACE data reviewed alongside current trust mortality data within re-established Neonatal Improvement and Mortality Group. SBL reviewed and compliance agreed. LMNS dashboard shared at LMNS Partnership Board showing UHNM and QHB data. CNST compliance reviewed and monitored. CQC visits, published reports and updates on subsequent action plans currently monitored via a monthly SMOAG lead by the ICB and NHS England. ATAIN reports shared at QSOF. ICB Digital Midwives funded to provide updates.

4. Matrix of Statutory Duties

Staffordshire and Stoke-on-Trent ICB will exercise its statutory duties through a range of approaches as outlined in the full JFP as below:

Statutory duty	First full JFP (published June 2023)	JFP update (published April 2024)
Describing the health services for which the ICB proposes to make arrangements	Covered throughout document. Our Joint Forward Plan sets out how we will meet the needs of our population, across key pathway and population groups, driven by our understanding of population health need, patient/public feedback and service challenges and opportunities	-
Duty to improve quality of services	See Quality assurance and improvement section	See Quality and patient safety, assurance and improvement section
Duty to reduce inequalities	See Improving population health section	See Our continued focus on health inequalities section
Duty to promote involvement of each patient	See in Personalised care section	
Duty as to patient choice	See Personalised care section, Urgent and emergency care portfolio section, Planned care (elective, cancer, diagnostics) section, End of life, frailty and long-term conditions (ELF) section, Primary care, Working in partnership with people and communities section	-
Duty to obtain appropriate advice	See Governance framework, functions and decision map section	-
Duty to promote innovation	See Research and innovation section	-
Duty in respect of research	See Research and innovation section	See Research and innovation section
Duty to promote education and training	See People plan section	See Education and training section
Duty to promote integration	See Provider collaboratives section, Better Care Fund and integration ambitions section, UEC Strategy section, System development overview section	-

Statutory Duty	First full JFP (published June 2023)	JFP update (published April 2024)
Duty to have regard to wider effect of decisions	See Finance, Estates, Sustainability and Green plans, Governance framework sections	-
Duty as to climate change	See Sustainability section, Delivering a net zero NHS section, Procurement section	See Sustainability section, Delivering a net zero NHS section, Procurement section
Duty to involve the public	See Working in partnership with people and communities section, Our transformation programme and service change section, and Why do we need a forward plan section	-
Addressing the particular needs of children and young persons	See Children and young people portfolio section, Mental health, learning disabilities and autism portfolio section, Serious violence and safeguarding section	See Victims of abuse and safeguarding section
Addressing the particular needs of victims of abuse	See Serious violence and safeguarding section	-
Implementing any joint local health and wellbeing strategy	See Introduction, Our approach to developing our priorities section, Addressing our population's health and care needs section	-
Financial duties	See Our Finance Strategy section	See Our Finance Strategy section
Workforce	-	See Workforce and education section
Digital and data	-	See Digital section

5. Glossary

Term	Definition
Anchor Institution	Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use.
Clinical Commissioning Group (CCG)	Clinical commissioning groups were NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in each of their local areas in England. On 1 July 2022 they were abolished and replaced by integrated care systems as a result of the Health and Care Act 2022.
Health and Wellbeing Board (HWB)	A forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to discuss how to work together to improve the health and wellbeing outcomes of local people.
Health and wellbeing strategies	Jointly agreed and locally determined set of priorities for local partners (between ICBs and local authorities) to use as basis of commissioning plans.
Health inequalities	The gap in access to health services between different groups, social classes and ethnic groups and between populations in different geographical areas.
Integrated Care Board (ICB)	An integrated care board is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Integrated Care Partnership (ICP)	An Integrated Care Partnership is a statutory committee jointly convened by local authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.
Integrated Care System (ICS)	Integrated care systems are partnerships of organisations that come together to plan and deliver joined-up health and care services, and to improve the lives of people who live and work in their area.
Joint Strategic Needs Assessment (JSNA)	A document which analyses the health needs of a population to inform the commissioning of health, wellbeing and social care services. This document is updated annually.

NHS England (NHSE)	NHS England leads the National Health Service in England. It has seven integrated regional teams that support the commissioning of healthcare services for different parts of the country.
Place-based approach	A place-based approach brings together health and care organisations and teams, including the voluntary and community sector, with local people in a particular area to better join up services to meet their needs.
Planned care	Planned care is any treatment that is not an emergency. It is where a patient is referred for treatment and planned appointments.
Primary care	Primary care is used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services.
Plan for Recovering Access to Primary Care (PCARP)	The Delivery Plan for Recovering Access to Primary Care (PCARP) published in May 2023 sets out how the NHS will make it easier for patients to get the help they need
Primary care networks (PCNs)	PCNs are groups of GP practices in an area that work together, and with hospitals, social care, pharmacies and other services, to care for people with long-term conditions and prevent people becoming ill.
Provider	An organisation and legal entity, acting as a direct provider of health care services via an NHS contract. The following organisations may act as healthcare providers: • GP practice • NHS trust • NHS foundation trust • Registered non-NHS provider (e.g. Independent Sector Healthcare provider) • Unregistered non-NHS provider • Care trust • Local authorities with social care responsibilities • Other agencies.
Secondary care	More specialised care usually after referral from GP (primary care). This can be provided in a hospital or in the community.
Social care	A range of non-medical services arranged by local authorities to help people.
Urgent Care Centre (UCC) or Urgent Treatment Centre (UTC)	A centre which provides care and treatment for minor illnesses and injuries that require urgent attention.

Voluntary, community and social enterprises (VCSE)	Not-for-profit organisations set up to offer services to specific groups in society. VCSE organisations can include charities, public service mutuals, social enterprises, and many other not-for-profit organisations.

6. Abbreviations and acronyms

Abbreviation / Acronym	Description
A&E	Accident and Emergency
AI	Artificial Intelligence
ARRS	Additional Roles Reimbursement Scheme
ASC	Adult Social Care
ATAIN	Avoiding term admissions into neonatal units
BFI	Baby Friendly Initiative
BSL	British Sign Language
CCGs	Clinical Commissioning Groups
CDCs	Community Diagnostic Centres
CDOP	Child Death Overview Process
CEOs	Chief Executive Officers
CFOs	Chief Finance Officers
CNST	Clinical Negligence Scheme for Trusts
CPCS	Community Pharmacy Consultation Scheme
CT	Computed Tomography Sc
CQC	Care Quality Commission
CVD	Cardiovascular Disease
CYP	Children and Young People
DMA	Digital Maturity Assessment
DMVS	Defence Medical Welfare Service
EDGs	Ethnic Diverse Groups
EHIA	Equality and Health Inequality Impact Assessment
ELF	End of Life, Frailty and Long-Term Conditions
e-RS	Electronics Self-Referral System
FMBUs	Free Standing Midwifery Birth Units
FPA	Full Prospective Access
FTE	Full Time Equivalent
GMC	General Medical Council
GP	General Practice / General Practitioner

HFMA	Healthcare Financial Management Association
HWBs	Health and Wellbeing Boards
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICPS	Integrated Care Partnership Strategy
ICS	Integrated Care System
IPH	Improving Population Health
ISDN	Integrated Stroke Delivery Network
JCRUP	Joint Capital Resource Use Plans
JFP	Joint Forward Plan
JSNA	Joint Strategic Needs Assessment
LDA	Learning Disabilities and Autism
LEV	Low Emission Vehicle
LIFT	Local Improvement Finance Trust
LMNS	Local Maternity and Neonatal System
LTCs	Long-Term Conditions
LTWP	Long Term Workforce Plan
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
METIP	Multi-Professional Educational and Training Investment Plans
MGP	Modern General Practice
MH	Mental Health
MNVP	Maternity and Neonatal Voices Partnership
NETS	National Education and Training Survey
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
OD	Organisational Development
OPE	One Public Estate
PCARP	Primary Care Access Recovery Plan
PCNs	Primary Care Networks
PCN DES	Primary Care Network Contract Directed Enhanced Service

PFI	Private Finance Initiative
PHM	Population Health Management
PPN	Procurement Policy Note
PSIRF	Patient Safety Incident Response Framework
QHB	Queen's Hospital Burton
QIA	Quality Impact Assessment
QSOF	Quality and Safety Oversight Forum
SBL	Saving Babies' Lives
SLAIP	System-Level Access Improvement Plan
SMS	short message service
SMOAG	System Maternity Oversight and Assurance Group
SQG	Strategic Quality Group
SSoT	Staffordshire and Stoke-on-Trent
SSHERPa	Staffordshire and Shropshire Health and Care Research Partnership
SIs	Serious Incidents
TCI	The Consultation Institute
UEC	Urgent and Emergency Care
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust
UHNM	University Hospitals of North Midlands
ULEV	Ultra-Low Emissions Vehicles
UNICEF	United Nations International Children's Emergency Fund
UTCs	Urgent Treatment Centres
VCSE	Voluntary, Community and Social Enterprise
VAWG	Violences against women and girls
WTE	Whole Time Equivalent
ZEV	Zero Emissions Vehicles

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:	**21 March 2024**						
Title:	**ICS Data and Intelligence Strategy and Implementation**						
Presenting Officer:	Paul Brown and Chris Ibell						
Author(s):	Colin Fynn, Head of Intelligence and Analytics						
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**	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:	ICS Data and Intelligence Strategy						

(1) Purpose of the Paper:

The purpose of the paper is to outline the ICS Data and Intelligence Strategy and the next steps to delivery and implementation.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
ICB Finance and Performance Committee (D,S)	03/10/2023
Digital Collaboration Forum (D,S)	14/12/2023

(3) Implications:

Legal or Regulatory	Implementation of this strategy supports the commitment outlined in the Staffordshire and Stoke-on-Trent Joint Forward Plan 2023 – 2028 and as set out in national guidance to realise the potential of data and intelligence to transform the way in which we operate to better serve our communities'.
CQC or Patient Safety	N/A
Financial (CFO-assured)	N/A
Sustainability	N/A
Workforce or Training	The strategy outlines objectives to develop technical skills through an OD training and development programme and a data centric culture and workforce.
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*, 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:

Our strategy sets out the vision of where we want our data, business intelligence infrastructure and capability to be in order to support delivery of the ambitions set out in our Integrated Care Strategy and Joint Forward Plan.

For us to start realising the benefits of operating as a system we need to effectively use our combined data and intelligence to enhance the care of the service user, improve the efficiencies of the system, predict, and create interventions for Population Health Management and innovate new ways of improving health and care. Utilising data means effective data-management, appropriate data sharing governance, robust digital infrastructure, digital skills pathways, and a shared operational framework.

The data and intelligence strategy sets out the national and local drivers for change, the goals and benefits of implementing the strategy and how we have worked with system partners to develop the strategy. The five main local goals and benefits of delivering the strategy cover:
1. Creating a data centric culture and workforce
2. A unified data warehouse
3. Governance and information governance processes
4. Intuitive reporting and Insight
5. A virtual ICS-wide intelligence function

We have followed an iterative development process to continuously collate feedback and refine our ambitions to ensure the strategy represents and is accepted by leaders across the ICS. The ICB has co-ordinated engagement with the wider NHS Intelligence Community throughout development of this strategy. We have undertaken direct engagement with stakeholders and NHS England Regional Leads.

As it progresses through delivery and implementation the strategy will be supported by a range of discussion papers to ensure that work across the digital, intelligence and population health management work programmes of the ICS do not sit in isolation of each other.

We are not recommending a 'big bang' approach, as there is simply too much to do for that to work instead, a pragmatic, incremental approach will be developed. Therefore, the next steps for the strategy

will be to move to delivery through a Programme Manager supported by the Digital Team. A time-phased delivery and transformation plan will be developed within the first two quarters of 2024/25, connecting with all the key stakeholders across the system/providers/region to support the design and delivery of key workstreams. A detailed roadmap outlining milestones, deliverables, dependencies, and timelines to track progress will be developed.

(7) Recommendations to Board / Committee:

The ICB Board members are asked to approve the implementation of the ICS Data & Intelligence Strategy.

Staffordshire and Stoke-on-Trent Integrated Care System

Staffordshire and Stoke-on-Trent Integrated Care System

Data and Intelligence Strategy

March 2024

CONTENTS

Introduction

The Health and Care Act 2022 created a statutory basis for Integrated Care Systems (ICSs) by creating an Integrated Care Partnership (ICP) and an NHS Integrated Care Board (ICB) for each ICS in July 2022.

The purpose of ICSs is to bring partner organisations together to:

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

The Staffordshire and Stoke-on-Trent ICS brings together a range of partners who are responsible for planning and delivering health and care and for improving the lives of people who live and work in our area. The ICP is made up of partners, including local authorities, the police, the voluntary, community and social enterprise (VCSE) sector, and representatives from the ICB. The ICB is a Statutory Body with the general function of arranging for the provision of services for the purposes of the health service.

For us to start realising the benefits of operating as a system we need to effectively use our combined data to enhance the care of the service user, improve the efficiencies of the system, predict, and create interventions for Population Health Management and research and innovate new ways of improving health and care. Utilising data means effective data-management, appropriate data sharing governance, robust digital infrastructure, digital skills pathways, and a shared operational framework.

This will enable us to meet our ICS Vision of

"making Staffordshire, Stoke-on-Trent the healthiest place to live and work."

Why do we need this strategy and what is our vision?

Decision-making for personalised medicine, predictive population health management and efficient care eco-systems need to be data-driven and evidence-based. We need to be able to provide a deep understanding of our population's current health and predictive health and to be able to seek comparison against other population health and social care systems to drive continual care improvements. This will require a digital 21st century business intelligence infrastructure and capability.

The insight required from Business Intelligence and Analyst teams to support clinicians and decision makers to make informed choices that directly improve care, demonstrates why we need outstanding intelligence and analysis, particularly at the point of health and social care delivery.

Our strategy sets out where we want our data, business intelligence infrastructure and capability to be in order to support delivery of the ambitions set out in our ICP Strategy and Joint Forward Plan, and how we are meeting all national legislative requirements now and in the next 5 years.

The strategy sets out our high-level approach to developing a system-wide approach to data and intelligence. The strategy will be underpinned by a time-phased delivery and transformation plan, setting out more detailed specific initiatives, and projects including proposed timelines, resource allocation, responsibilities, and milestones to track progress.

The Vision is to Provide, Deliver, Enhance and Enable

by 'maximising the value we have from our collective intelligence professionals, supported by a data driven infrastructure accessible and maintained by all system partners. Delivering enhanced health intelligence to improve clinical delivery, care through population health management and research.'

National and Local Drivers for Change

National Drivers

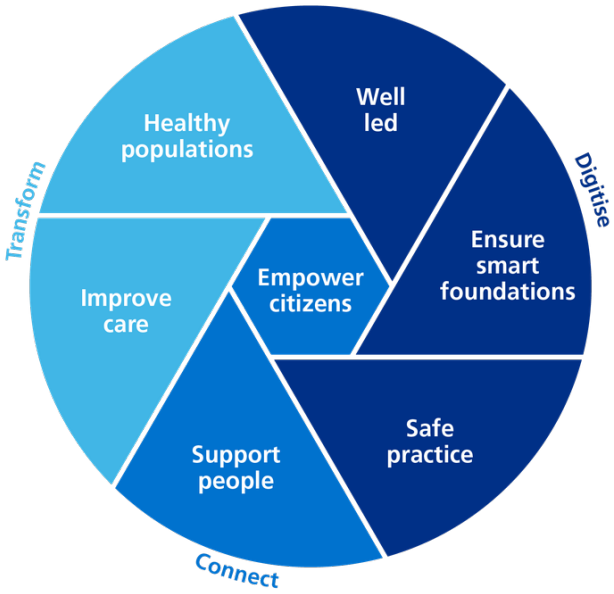
The Hewitt review, published in 2023, proposes greater autonomy to enable Integrated Care Systems (ICSs) to better prevent ill health and improve NHS productivity and care, matched by renewed accountability. In particular

- effective data-sharing approaches across multiple partners, with linked data sets enabling proactive population health management, significantly improved outcomes for population groups and substantial reductions in demand for emergency and specialist services.
- the rapidly growing use of smart data analytics tools, to provide the 'single version of the truth' that is an essential part of aligning all partners, locally and nationally, around the same purpose and goals.
- the skills needed to deliver data and digital transformation through a professional and highly skilled workforce at the system and provider level.
- the health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence.
- opportunities to use digital technologies for example to move to real time data dashboards.

National planning guidance and priorities specific to the Joint Forward Plan guidance and supporting materials outline the national ambitions around the implementation of a population health management (PHM) approach. This includes

- plans for integrated, person-level linked data across health, care and increasingly wider partners and clear and safe access controls through cross system information governance arrangements.
- plans for the development of a virtual ICS-wide intelligence function underpinned by a single analytical platform which can carry out advanced data and analytical techniques for example, offering data and analytics capability that aligns and docks into the national federated data platform.
- releasing analysts time for insight drive work through use of technology for routine tasks?
- ensuring that ICS and locality based decision-making forums have access to timely population health insight and analytical support.
- support the analytical workforce to develop sophisticated analytical capability including the emergence of national work to establish analytics and Data Science as a professional discipline.

National policy through the 'What Good Looks Like' framework published in 2021 also reinforced the digital and data focus. Clear guidance is provided, along with the impetus for health and care leaders to connect and transform services safely, securely and sustainably through the increased use of digital, data and intelligence for the efficient and effective delivery of health and care services. The diagram below outlines the seven success measures of what good looks like.



The new Federated Data Platform (FDP) will mean that every Hospital Trust and Integrated Care System (ICS) will have their own platform, which can connect and collaborate with other data platforms as a "federation" making it easier for health and care organisations to work together. Although the first stage of implementation is focused on NHS acute trusts, work will begin at the same time to build a close partnership between NHS England, the FDP developers, and appropriate colleagues from ICSs, local government and the provider sector including primary care, community and mental health, adult social care providers and VCFSE providers.

Nationally it is recognised that overall adult social care data as a sector is not as well progressed. While it has come a long way in improving the data collected and used, there is still much more to do. 'Care data matters: a roadmap for better data for adult social care' sets out the government's roadmap for improving how we collect, share and analyse data in adult social care in England.

Local Drivers

The COVID-19 pandemic has demonstrated the importance of the ability to draw upon the right intelligence at the right time. This encompassed a multi-disciplinary approach with analytical teams working seamlessly with digital and information technology, information governance, finance, people/workforce, service redesign, quality improvement, clinical, and public health and other local authority teams. This would not have been possible without intelligence and analytical collaboration between the NHS, local authorities and wider system partners. We are committed to building on existing ways of working and the approach used during the pandemic to better use our analytical resource, data and insights for maximum impact.

Across the ICS, there is significant interest in using data and insight for a range of purposes. While there is a culture that indicates leaders are keen to use data and intelligence to inform decisions, we need to ensure that we collectively have the capacity and capability to meet the growing need for evidence-based decision making. We need to support our teams to articulate data requirements and to be able to interpret data to drive data-informed decisions and shift focus from reactive reporting to forward looking, predictive / proactive reporting.

The ICS has significant digital ambitions, and the supporting infrastructure and intelligence are a crucial element in supporting the delivery of the Digital Strategy.

As a system we are broadly defined as low (2/5) on the national digital maturity assessment scoring for 2022/23. The results are in line with our understanding as to the extent of our system digital maturity to date and reflects that we have particular improvements to be made across key dimensions of the What Good Looks Like Framework (Empowering Citizens and Population Health Analytics & Intelligence).
Digital leads are developing a system plan in partnership with the People function for digital skills development across the wider workforce focused through membership of the Skills Development Network and sharing of training and resource capability across our system.

There are complexities in data sharing and information governance and Data Services for Commissioners Regional Offices (DSCRO) requirements around handling identifiable personal and confidential information for commissioning purposes. We need to resolve some of these challenges to maximise our insights and access to a range of data but recognising the legal requirements, particularly for the ICB where except for a handful of very specific exceptions commissioners are not able to receive identifiable data. Also, BI teams often do not have a clear and comprehensive view of existing data sharing agreements, which acts as a barrier to expanding inter-organisation data sharing.

There are several BI tools and underlying data warehouse infrastructures across our organisations and a consistent approach is required.

A Data Warehouse is a key component of our capability and is a critical enabler to our success. At present there are separate data sources, infrastructure and reporting systems between the ICB and providers, and these remain largely unlinked to wider system partners (e.g., local authorities, community and voluntary sector organisations). The exception, at the time of writing, being the One Health and Care (OHC) shared care record. OHC is used solely as a capability to support direct care, versus being used for analytics and secondary use.

It is imperative that ICS data and information assets can be freely accessed, leveraged and manipulated by all system partners. There is opportunity to consolidate data warehousing needs across the system. At present each organisation has a data warehouse solution, with the primary purpose of serving the requirements of that organisation.

The ICB has a data warehouse environment provided by NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) supporting the traditional commissioning data sets provided nationally and go some way in providing the performance and assurance measures for the SSOT population . There is very limited access to Primary Care data for secondary use.

OHC receives direct submissions from some Hospitals, Health and Social Care providers and Primary Care data. Access to OHC data is currently limited to direct patient care. A section 251 application is in process for legal basis of secondary usage. Until this time specific use case documentation is drawn to provide the governance of secondary usage.

The ICS has also procured a Population Health Management solution through a third party, OPTUM. This will serve as another repository of data received from Secondary Care, MLCSU, Primary Care, Social Care and beyond, with both data and analytical capability for all system partners. This solution is due to be realised in early 2024/2025.

In time, through partnership working, there are significant opportunities for the ICS to consolidate data warehousing and accessibility, reducing cost financially and environmentally while increasing the system capabilities of Population Health Management at both a clinical and strategic level.

The BI tools through which we utilise to access the data are equally important, particularly given that the most common tool in some BI teams is Microsoft Excel. There are pockets of excellence in reporting and analytics teams adopting visualisation tools such as PowerBI, and analyst communities show a consistent appetite to adopt these and upskill given sufficient opportunity to do so. Self-service reporting in the ICB is also limited and tools such as Aristotle are not widely used, limited by the need for additional login credentials.

Goals and Benefits

The goals and benefits of delivering the strategy are outlined in this section. They will be used to set clear and measurable objectives and targets towards the achievement of our vision. To meet legislative requirements and national and local drivers, these steps are proposed to put data-driven decisions at the centre of the transformation of health and care services.

Goal

a) Develop a standard framework and career development pathway for all analytical staff within the ICS including apprenticeship and graduate pathways aligning with National frameworks.

b) Standardised job descriptions and grades across the ICS organisations.

c) Develop technical skills through a formal development programme (Power BI, SQL, R or Python)

d) Maximise the value we have from our collective intelligence professionals through sharing skills and knowledge.

e) Engagement of academic partners to identify opportunities for graduates as well as wider opportunities to foster talent such as apprenticeships shared data science capability, Data Scientist Development Programme

f) Recognise analytics as a profession through registration with organisations such as the Association of professional healthcare analysts (APHA, BCS, FEDIP)

g) Identify formal and informal learning and development opportunities for data and non-data roles.

h) Use existing resources and training across the system and regionally to support development e.g., MDSN training programmes, regional analytical network, and capacity.

i) Utilise 3rd party supplier training e.g., Microsoft, Multiverse

j) Wider work force focus on digital and data skills and development of specialist and clinical champions.

k) Data literacy training and awareness for the non-analytical workforce, to encourage effective adoption of new tools and availability of insights to make decisions as intelligent customers

Benefits

- Workforce can access and coordinate the data they need for patients and direct patient care.
- Customers can see the reports, via simplifying where they go for the various tools (Power BI, Aristotle).
- Customers can use the data tools with training support to help them find, access and use the tools and products built by the analytical teams.
- Workforce can make decisions as intelligent customers and be enabled to ask structured questions about data to support transforming care and delivering
- More people with data science skills working in our ICS via partnership with universities, apprenticeship and training schemes, support for professional bodies,
- Extended workforce with graduates, apprentices and trainees working in our teams; future proofing the next generation of our NHS workforce.
- Clear progression routes using national career frameworks and professional membership.

Goal

A data warehouse capability that will:

a) Hold national, local and reference datasets which is accessible to all partners and stakeholders. (ICB, UHNM, MPFT, NSCHC, SCC, SOTCC – future Adult Social Care, Fire, Police, Voluntary)
b) Present real-time, consistent population-centric data in an accessible format.
c) Have health and social care data pseudonymised by a common key and linked. Wider determinants data, such as fuel poverty expands this view.
d) Store retrospective reports to be used by leads on a self-service basis through web, desktop, and mobile platforms.
e) Provide a singular version of activities recognised by all Partners to drive system transformation and decision making.
f) Utilise the FDP as it is commissioned, with all parts of the health and care system involved in its development.
g) Have accessible, understandable, and up to date data catalogues giving partners sight of system data assets.
h) Be built around an agreed approach to the role of the DSCRO.
i) Have role-based access, multi-factor authentication and other privacy enhancing technologies ensuring data is shared securely.
j) Have the capability to store and process Internet of Things (IoT), deliver Artificial Intelligence (AI) and Machine Learning (ML)
k) Be configured for a storage and consumption model to enable downsizing and upsizing depending on the future development of National Data Platforms.
l) Enhance transfer of data and interoperability of systems through National standards i.e., FHIR, DICOM
m) Gradually be developed to contain data encompassing all parts of health and social care delivery from clinical data at startup to include Finance, Estates, Patient Feedback etc. (See Appendix 1.)

Benefits

- Providers maintain controllers of their patient data within a Unified Data Warehouse
- Only the appropriate data is stored within the Unified DW reducing Information Governance overhead.
- A shared place where GP, Acute, and other clinical data is linked, with some linkage to social care and other provider data supporting ICS goals.
- Decreased administration for data sharing with a shared data service, data infrastructure and reporting tools in place between partners.
- Customers can find and access the data reporting environment on a self service basis.
- Reduced the burden of assurance reporting across the system, both internally and externally i.e., NHSE
- Links in place with the national FDP.
- Potential to develop real-time / near time dashboards e.g., system wide bed management.
- Reduce the risk of return in investment by being flexible and scalable using a Cloud Data Warehouse environment.
- Take advantage of developing data tools within a Cloud Data Warehouse environment e.g., AI, ML, IoT processing

Goal

a) We maintain and build on the Public Trust as custodians of their data. We will be transparent in the use and that use is ethical and for the public good.
b) We will comply with all Government mandatory or recommend Information Governance principles.
c) Apply FAIR principles to Data usage; Findable, Accessible, Interoperable, Reusable
d) Ensure we continue to respect patients' privacy, while creating a safe space for addressing the questions needed for non-patient care questions.
e) Submitting and sharing provider-based datasets into the ICS Data Warehouse
f) Establish information governance processes and documentation which will support data sharing for use of data for research and innovation, direct care, population health management, care planning and secondary use, including GP clinical system data.
g) An information governance work programme to include the broadening of linked datasets available including those outside of health and care such as education and housing.
h) A collaborative and integrated approach to data sharing through clear data policies and data sharing agreements.
i) Data sharing documentation which supports direct care and secondary usage, particularly GP data

Benefits

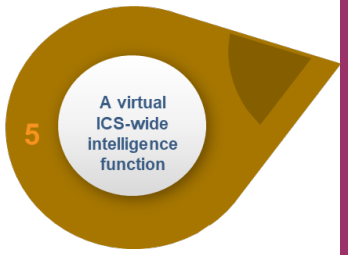
- Appropriate data governance and processes for different uses of data
- Providers maintain controllers of their data simplifying the Information Governance process within the ICS Data Warehouse.
- Data is readily available to identify the challenge of increasing demand including wider data such as education and housing.
- We can work across partners to promote healthy lifestyles and identify patients at risk earlier.
- Top-down strategic commitments on data sharing across all key stakeholders.
- Data is used lawfully and with respect so that the public can be reassured on how their data is used and Caldicott Principles
- Partnership networks with IG Teams who are proactive and able to jointly solve IG obstacles while shaping data sharing initiatives.

Goal

a) Maximisation of the automation potential of Power BI particularly for routine reporting
b) To agree and adopt greater utilisation of visualisation tools such as Microsoft Power BI and further develop skills such as SQL, R or Python
c) Supporting Operational Planning and Monitoring, and the ICB governance to demonstrate delivery.
d) Development of a locally maintained population health management tool accessible to all partners which will enable a data driven system decision making environment, tackling patient inequalities, drive prioritisation, exploring scenario and forecast modelling and root cause analysis.
e) Develop local understanding of Artificial Intelligence (AI) and Machine Learning (ML) toolsets and the benefits that can be employed to aid patient outcomes.
f) Data Quality process improvements and tools shared across the ICS providers to progress ICS wide data quality improvements.
g) Support providers in the ongoing addition and implementation of SNOMED and ICD-10 coding

Benefits

- Improved productivity capability for Analysts to develop predictive / proactive reporting.
- Analysts have clear direction on the tools and methods to use – using open, code first approaches, making improvements in use of data science practice i.e., R & python for reproducible analytics.
- Data is used effectively both in direct patient care for coordination and supporting clinicians in near real-time analysis, in performance, flow, inequalities and outcomes for patients.
- Live data can be made available to patients, their care givers, and the ICS population through tools like SharePoint.
- Aligns with and maintains industry standards and developments combined with the Data Warehouse.



Goal

a) A virtual ICS-wide intelligence function
b) ICS Analytical capacity is increased using automation of reports and dashboards via BI Tooling i.e., Power Bi
c) Analytical capacity, skills and capability reviewed annually, ensuring upskilling, analytics/insight focused intelligence teams supporting recruitment and retention.
d) System agreement on how the virtual team should work together and what their remit is e.g., providing bespoke expertise or training and leading on particular data requirements for system wide projects.
e) Reduce regional reporting activity at provider level thereby enabling productivity opportunities for providers to support ICS analytics.
f) Provider analysts continue to be embedded within the provider infrastructure to maintain tacit system knowledge.
g) Provider analytical capacity led and guided by the provider requirements.
h) ICS analytical capacity led and guided by ICB requirements.
i) Work at regional level to realise benefits on generating insight led, coordinated requests – particularly for finding variation, inequalities (with MDSN, and NHS England).

Benefits

- A collaborative and multi-organisational team comprising of analysts and other insight specialists from all constituent parts of the ICS, serving the strategic goals and projects of the ICP as required.
- A clear understanding of capacity, capability, and contractual obligations of ICB and provider analysts across the system.
- Recognition of the existing skills, knowledge and talent of analysts within our partner organisations,
- Analysts can support the development of key questions and have the data and tools they need to provide insight at regional, system, place and neighbourhood level.
- Collaborating with regional partners, MDSN, NHS England Region and National teams, universities, and other partners, to best develop data and insight to support cross region problems and support insight at scale.

Engagement

We have followed an iterative development process to continuously collate feedback and refine the output to ensure the strategy represents and is accepted by leaders across the ICS. The ICB has co-ordinated engagement with the wider NHS Intelligence Community throughout development of this strategy. We have undertaken direct engagement with stakeholders across key sectors of the ICS and NHS England Regional Leads. As the strategy is implemented, ongoing engagement will continue with all identified stakeholders.

Conclusion

To deliver our strategy successfully, we will need to change our ways of working to realise the benefits of being unified as a system, by exploiting and building upon existing best practice approaches and work.

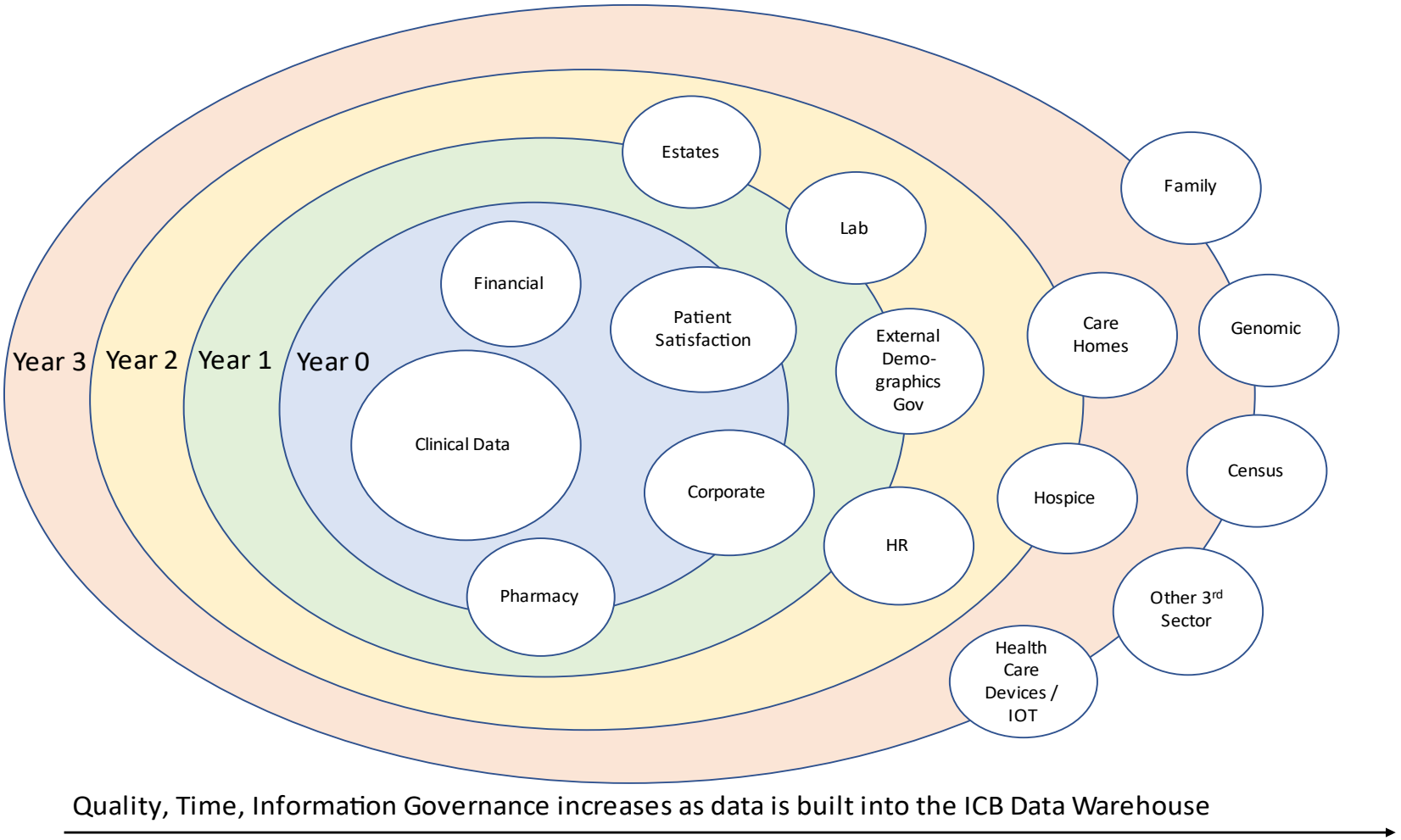
The strategy will be supported by a range of discussion papers to ensure that work across the digital and intelligence work programmes of the ICS do not sit in isolation of each other. Proposals around Data Warehousing (DW) to deliver reporting, analytics, Population Health Management (PHM) and Research and how this would align with the One Health and Care Shared Care Record and the national Federated Data Platform initiative.

We are not recommending a ‘big bang’ approach, as there is simply too much to do for that to work. Instead, a pragmatic, incremental approach will be developed. We will continue to engage on both the ambition and delivery expectations for our ICS as we move through to delivery and implementation, including the risks and dependencies we will need to manage.

We must consider that the providers are themselves legal entities with National Statutory reporting requirements and ongoing data processing, data quality and data management responsibilities. The strategy seeks to build on the successes of our respective providers’ digital and data strategies with a focus on where, collectively, the ICS can accelerate our intelligence approach and support health and care provision across our system.

Appendix 1

Shared Data priorities for developing the Data Warehouse environment.



Appendix 2

Glossary of Terms		
AI	Artificial Intelligence	The NHS AI Lab - NHS Transformation Directorate (england.nhs.uk)
APHA	Association of Professional Healthcare Analysts	AphA Home - AphA - Association of Professional Healthcare Analysts (aphanalysts.org)
BCS	British Computer Society	BCS, The Chartered Institute for IT | BCS
Caldicott		The Caldicott Principles - GOV.UK (www.gov.uk)
DICOM	Digital Imaging and Communications in Medicine	Digital Imaging and Communications in Medicine - NHS Data Standards Directory - digital-imaging-and-communications-in-medicine-dicom
DSCRO	Data Services for Commissioners Regional Offices	Data Services for Commissioners Regional Offices (DSCROs) - NHS Digital
FDP	Federated Data Platform	NHS England » Federated data platform (FDP) – frequently asked questions
FEDIP	Federation Informatics Professionals	Health And Care Informatics | The Federation for Informatics Professionals (fedip.org)
FHIR	Fast Healthcare Interoperability Resources	FHIR (Fast Healthcare Interoperability Resources) - NHS Digital
ICD-10 (11)	International Statistical Classification of Diseases and Related Health Problems	NHS Classifications ICD-10 - TRUD (digital.nhs.uk)
IoT	Internet of Things	What is the internet of things? | IBM
ML	Machine Learning	What is Machine Learning? | IBM
Power Bi	Microsoft Power Bi	Data Visualisation | Microsoft Power BI
Pyphon	Pyphon Programming Language	Welcome to Python.org
R		R: The R Project for Statistical Computing (r-project.org)
SNOMED	Systemized Nomenclature of Medicine	SNOMED CT - NHS Digital
SQL	Structured Query Language	What is SQL? - Structured Query Language (SQL) Explained - AWS (amazon.com)

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:	**21 March 2024**					
Title:	**Quality and Safety Report**					
Presenting Officer:	Heather Johnstone, Chief Nursing and Therapies Officer					
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 March 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.	14/02/2024
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 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 February 2023. 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:

- Board Assurance Framework and Risk Register
- All Age Continuing Care
- Local Maternity and Neonatal System
- Health Inequalities
- Safeguarding Adults and Children
- Working with People and Communities
- Quality Impact Assessment
- Continuous Quality Improvement
- Quality Dashboard
- West Midlands Ambulance University NHS Foundation Trust

(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.
- Ratify the decisions of the Quality and Safety Committee with regards to: (i) Quality Impact Assessment Policy update.

Appendix A: Quality and Safety Report – Detail March 2024

1. Board Assurance Framework (BAF) and Risk Register

1.1 The Quality and Safety Committee (QSC) is responsible for overseeing BAF risks BAF3: Proactive and Needs Based Community Services, BAF4: Reducing Health Inequalities and BAF5: High Quality, Safe Care Outcomes. QSC members considered and discussed these risks and agreed that (i) the Risk Scores and Assurance Assessments are an accurate reflection of the position, and (ii) the actions identified are sufficient to either reduce the risk score towards target or to provide additional assurance.

1.2 QSC received the risk register for assurance. Six new risks were added; Paediatric Audiology, Patient Safety Incident Response Framework, Learning Disability and Autistic people Review Performance, Wheelchair Service, Neonatal Workforce and Contractual Notice to CSU served risk to workforce stability. Further, following a discussion at QSC it was agreed that a further new risk should be added regarding the lack of local provision of Surgical Termination of Pregnancy services and subsequent impact on service users. No residual risk scores were changed, and no risks were closed.

2 All Age Continuing Care (AACC)

2.1 The QSC received a summary of progress to transform AACC to a more personalised, sustainable, quality and safety driven service. Updates included the Care Assurance Process being established in June 2023, the Continuing Healthcare (CHC) System Collaborative established in October 2023, the Eligibility Assurance Process established mid-October 2023, and strengthening of the AACC governance structure.

2.2 Since implementing the Eligibility Assurance Process, attended by system partners, there has been a 57% reduction in eligibility due to the appropriate application of the CHC Framework. In addition, alternative pathways, for example the delirium pathway, are being developed to improve experience, safety, and effectiveness for individuals.

2.3 In 2023/24 Quarter 3 (October to December 2023), the ICS achieved two NHS England key performance indicators (80% of Decision Support Tools (DSTs) completed within 28 days and <15% of DSTs completed in acute settings) at 87% and 0% respectively. This is an improvement upon previous quarters; 2023/24 Quarter 1 82% and 3%, Quarter 2 76% and 1% respectively.

3 Local Maternity and Neonatal System (LMNS)

3.1 The System Maternity Oversight and Assurance Group continues to meet. Good progress has been made in response to CQC improvement actions, including reducing vacancies and training compliance. Induction of Labour breaches have reduced following the re-opening of the Transitional Care Unit at Royal Stoke University Hospital, resulting in increased bed capacity and the ability to admit women the night before. The assurance process has been revised to support focussed discussions with University Hospital of North Midlands NHS Trust (UHNM) midwives at the Quality and Safety Overview Forum meeting.

3.2 The Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) bundle was developed using implementation science and quality improvement methods to support easy adoption and dissemination. PERIPrem has achieved life changing, sustainable improvements to the way vulnerable babies are cared for and accelerated the perinatal working culture and innovation. UHNM has advertised for staff to support the implementation, following an NHS England financial allocation, and regular updates will be presented to the Neonatal Improvement and Mortality Group.

4. Health Inequalities

4.1 A workshop was held on 30th January 2024, to support the co-production of an ICS Health Inequalities Strategy. The workshop included partners with a broad spectrum of organisations and interests across health, care and the voluntary, community or social enterprise sector to identify existing inequalities and opportunities to work together to address them through an Inequalities Strategy. The discussion focused on the importance of people and putting them at the centre of all we do and recognised that there are lots of islands of excellence within the system. The local authority Directors of Public Health and the ICB Senior Responsible Officer will drive this agenda forward as a triumvirate. Feedback from the workshop has been positive, particularly about the co-production approach and the breadth and depth of partners involved.

5. Safeguarding Adults and Children

5.1 The All-Age Safeguarding Provider Collaborative was refreshed in January 2024 and the ICB's Associate Director of Safeguarding appointed to lead the work. The governance arrangements have been reviewed and the Health Safeguarding Strategic Oversight Group has been established. This group will be responsible for monitoring safeguarding activity across the ICS and highlight any escalations/risks within the system. One of the benefits of system working across the health safeguarding economy is the ability to provide mutual aid.

5.2 The number of Initial and Review Health Assessments completed within agreed timescales remains significantly below compliance. UHNM have agreed funding to recruit a locum consultant for 3 months, to support with additional capacity. Further, an agreement has been reached with Midlands Partnership University NHS Foundation Trust (MPFT) to provide short term funding to address the current backlog, and to enable current cost pressure posts to be substantiated therefore bringing closer alignment between capacity and current demand. Senior ICB Colleagues are working through an internal governance approval to focus a short and long-term Multi-Disciplinary Team approach to managing the associated risks.

6. Working with People and Communities

6.1 The ICB's approach to engagement is shaped by the Working with People and Communities Strategy and the core principals of engagement that were developed with the public. Overseen by the People and Communities Assembly, engagement activities held with patients, the public, partners, and staff include:

- Communications and Engagement Plan developed for the Improving Population Health portfolio, including identification of key stakeholders and stakeholder mapping.
- Supported engagement being undertaken by Staffordshire County Council to shape a new Community Strategy and Stoke-on-Trent City Council's engagement to shape a new Special Educational Needs and Disabilities Strategy.
- Working with families and carers of people with learning disabilities and autism to develop information resources for the Dynamic Support Register – one video aimed at professionals, one aimed at the public and a bespoke campaign to support awareness of breast cancer screening.

7. Quality Impact Assessment

7.1 The ICB's QIA Policy has been strengthened following stakeholder feedback and work continues to be undertaken to socialise the policy including 'lunch and learn' sessions which receive positive feedback. This is also referred to in 10.1 below.

7.2 Following discussions at QIA Panels (Gateway 2) three escalations have occurred where there have been concerns about the ICB meeting its statutory duties, and/or the need to strengthen the monitoring of the impacts of decision-making; escalations have taken place to the Health and Care Senate and Finance and Performance Committee for further discussions. To support the QSC to understand the impact and risks identified through the QIA process a heat map, grouped by Portfolio, has been produced.

8. Continuous Quality Improvement (QI)

8.1 ICS partners continue to work together to share practice and collaborate on areas linked to the NHS IMPACT (Improving Patient Care Together) framework and embedding a culture of continuous improvement. The ICS Quality Improvement Network continues to be well received with an average of 75 people attending the most recent events on Co-production in QI and Environment Sustainability and QI (Stakeholder Analysis), with a 22% growth in membership from last quarter. The Network, system collaboration, has been recognised and praised by the Clinical Director of the National Improvement Team as an example of best practice and was showcased at Midlands Leading for Improvement Workshop on 29th February 2024. Partners from the ICS are also part of a National Peer Support programme led by the Health Foundation and NHS Confederation.

9. Quality Dashboard

9.1 QSC received the quality dashboard 2023/24 month 9 (December 2023) for information. The quality dashboard focuses on traditional measures of quality routinely reported as part of the committee's business cycle. Following the launch of the ICB's Quality Strategy (November 2023) and adoption of Patient Safety Incident Response Framework and portfolios, the dashboard will evolve over the coming months to reflect

current system intelligence focusing on system-based approaches to learning, outcomes and health inequalities which complement our Quality Strategy and cover the breadth of the systems portfolios.

10. West Midlands Ambulance Service University NHS Foundation Trust (WMAS)

10.1 The Care Quality Commission (CQC) has rated WMAS good overall following an inspection in August and October 2023. The inspection looked at two core services: the urgent and emergency care (UEC) service and the emergency operations centre (EOC) service, as well as how well-led the trust was overall. Following the inspection, the UEC service overall rating has changed from outstanding to good and the EOC service overall rating has improved from good to outstanding. As a result, WMAS' overall, as well as effective/responsive/well-led domains, rating changed from outstanding to good. WMAS continue to be rated outstanding for being caring. The CQC said that "Staff treated patients with compassion and kindness, respected their privacy, and took account of their individual needs."

10. Decisions by Quality and Safety Committee for Ratification

10.1 Quality Impact Assessment Policy

10.1.1 Members of the QSC approved the updated ICB's Quality Impact Assessment Policy. The policy was updated following engagement with ICB staff who fulfilled the role of QIA Author, Portfolio Director, Quality Buddy, and Safeguarding Lead since March 2023. Updates include: (i) QIA Panel role, responsibilities and purpose updated to reflect intended strengthening of QIA and focus on National Quality Board shared single view of quality. (ii) Explanation of essential information (completeness) outlined explicitly within policy. (iii) System partnership working (health) principles outlined.

NHS
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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 14th February 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Board Assurance Framework	The Q3 BAF was received by the Committee for discussion. BAF 3: Risk score remains at 20 with one additional action added to develop a plan to implement locality partnerships. The Committee considered the Quarter 3 Risk Scores and Assurance Assessments to be an accurate reflection of the position	
Risk Register	The Committee received the Risk Report, for discussion and assurance. The Committee approved new risks 1236, 1238, 1241, 1239, 1242 and 1247. The committee also noted confidential risk 1177 which had been redacted.	
Working with People and Communities	The report provided an update on the work being undertaken to engage and communicate with people and communities across Staffordshire and Stoke-on-Trent.	
Quality Impact Assessment (QIA) Policy	The committee approved the QIA Policy which had been updated following engagement with ICB staff.	
Quality Impact Assessment (QIA) Update Report	The report provided an overview of the QIA work programme and the actions being taken to ensure the ICB fulfils its statutory duty. • Strengthening of the QIA Policy • Production of a heat map grouped by portfolio to support the Quality & Safety Committee in understanding the impact and risks identified through the QIA process.	The Committee asked for a further update on the revised Termination of Pregnancy pathway to be provided at its next meeting.
WMAS Clinical Quality Review Group (CQRG) Terms of Reference	The Black Country ICB as Lead Commissioner for WMAS in the West Midlands had asked for associate commissioners to seek approval of the WMAS CQRG Terms of Reference. The committee approved the	

	Terms of Reference.	
Health Inequalities	The report outlined the approach to co-production of an ICS Health Inequalities Strategy for the Staffordshire and Stoke-on-Trent ICS, highlighted key themes and set out the next steps in the development of the final strategy.	
Local Maternity & Neonatal System (LMNS)	The report provided an update on maternity and neonatal services in Staffordshire and Stoke-on-Trent. This included an overarching update on key areas of responsibility for the LMNS as well as specific activities from local providers of maternity and neonatal services. The Committee received good levels of assurance around the work and were delighted to see a number of key areas of improvement.	
Safeguarding Adults & Children Report	The committee received the Safeguarding Adults and Children report, key themes included: • Changes in governance arrangements regarding the Safeguarding Provider Collaborative • Challenges regarding the number of children and young people waiting for health care assessments which is reflected on the ICB risk register.	
All Age Continuing Care	The report provided an update on the following areas: • System collaborative • Progress to date • National/local metrics • Quality, Safety & Experience updates • Activity data • Efficiency The quality and safety committee received the paper for assurance. And agreed to add a new AACC risk to the Integrated Care Board Risk Register.	
Continuous Quality Improvement (CQI)	The report outlined the progress made to date within the CQI Sub-Group. This included: • ICS partners working together to share and collaborate on areas linked to the NHS Impact framework. • Co-production of system wide QI training. • Attendance at the System Planning event to offer support and feedback on how QI methodology can support system priorities for 2024/25.	
System Quality Group	The report provided an overview of the System Quality Group (SQG) meetings held on the 1st of December 2023 and 2nd of February 2024 with partners from across health, social care, and the wider ICS in attendance. The SQG approved the Standard Operating Procedure for Management of LeDeR Reviews. Members were advised that there is currently a backlog of LeDeR reviews as a result of the current provider of these reviews being unable to reduce the backlog. Clinical staff within the Chief Nurse's team	

	have undertaken training with a view to getting this backlog reduced pending agreement on a long-term solution to this work.	
Quality Strategy Delivery Plan	A verbal update was provided on the Quality Strategy Delivery Plan. The final delivery plan will be presented at the April Committee.	
Quality Oversight Dashboard	The Quality Dashboard 2023/24 was presented as at Month 9 (December 2023) for information. Following the launch of the ICB's Quality Strategy and adoption of the Patient Safety Incident Response Framework, it is intended for the dashboard to evolve reflecting current system intelligence and focussing on a system-based approach.	
Committee Assessment Report	The committee noted and received the report which informed on the outcomes of the Committee Effectiveness Survey carried out in January 2024. The outcomes will be presented at the March Quality & Safety Committee Deep Dive Session for further discussion.	

Risk Review and Assurance Summary

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

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:	**21 March 2024**						
Title:	**Report to the ICB Board on Performance and Finance**						
Presenting Officer:	Paul Brown – Chief Finance Officer						
Author(s):	Colin Fynn – Head of Intelligence and Analytics Matt Shields – Head of System Finance						
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**	NO *If Y, are those signed off by and date:* Click or tap here to enter text.					
Appendices:	Performance and Finance Report						

(1) Purpose of the Paper:
The purpose of this paper is to provide a summary of performance and finance report 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 (D)	28/02/2024
System Finance and Performance Committee (S)	05/03/2024

(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. A headline 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. Escalations presented and considered at SFPC, along with exception reporting against our One Collective Aim and 4 system priorities at programme and performance level.
3. An overview on finance at month 9 which is forecasting a year end deficit of £91m in line with the plan agreed with NHSE.
4. An overview of delivery of £120.7m of efficiency as of December 2023, 90% of plan.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

1. Note the headlines, escalation and exceptions highlighted
2. Note the year-to-date deficit position and efficiency delivery.

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Finance and Performance Report

ICB Board 21st March 2024

Prepared by the Transformation Delivery Unit and

ICB Finance & Intelligence Team

Overview

The report was presented at the Finance and Performance Committee (F&PC) on 5th March 2024.

This report contains:

1. An executive summary outlining key headlines and escalations.
2. A placemat that demonstrates at a high-level key metrics and deliverables within the 2023/24 operating plan.
3. Exception reporting against our One Collective Aim and 4 system priorities.
4. A finance summary including a month 10 position
5. An update on efficiency delivery.

Headline Summary

Ctrl and click on any underlined text for further detail.

Headlines	Points to note
One Collective Aim	• WMAS data for January indicates a 2.4% decrease in Category 2 incidents over the previous month, which equates to 6 incidents fewer per day. This is 8% up on the same period last year and the 3-month average is reporting 3.57% higher than last year. Breathing problems account for the largest reduction over the previous month but there were also reductions in patients being found unconscious and the where no value was recorded. Category 3 incidents rose 3.8% on the previous month and reported 43.7% up on the same period last year, matched by increases in all other categories other than Category 5. Fall related incidents as well as Mental Health and Concerns for Welfare all reported increases over the previous month.
Urgent and Emergency Care (UEC)	• 4hr Emergency Department (ED) performance at University Hospital of North Midlands (UHNM) has seen a marginal fall over the previous month primarily due to reductions in performance at County Hospital due to load sharing, and Type 3 sites reporting increased breaches. Performance is also identical to that of the same period last year and continues to report below plan for 23/24. 12hr Performance reported above 10% (10.7%) for the first time since the same period last year (10.4%) as discharge flow placed pressure on the system. Category 2 Response continued to be pressured throughout January and into February with the week ending 11th February seeing a time of 1hr 1min.
Tackle Backlogs (Planned Care)	• Eliminating 104+ and 78+ week waiters (ww) remains a system focus; two patients remains in the 104ww category at ICB level in December. The most recent UHNM data (as at w/e 04/02) reports three 104ww and 133 78+ ww. UHNM have exceeded monthly targets in 52+ ww (at ICB level in December). 65ww at UHNM have increased this month, mainly in the 65–80-week segment. From UHNM's most recent data (as at w/e 04/02) 65ww are decreasing week on week.
Diagnostics	• Diagnostic performance against the 7-core test plan (of 78.5% of patients to be seen in <6 weeks in December) was 76.0%, the eighth consecutive month below the plan. The activity count decreased in all [7] tests, by 5,295, the greatest decrease in Ultrasound (of 2,163). Of the seven tests, the plan was exceeded in MRI only.
Cancer	• The number of patients whose treatment started after 62 days (at UHNM in month) is above plan in November and in January's provisional data. • The ICB 28-day faster diagnosis pathway saw 70.8% of patients told within 28 days (across all providers), below the plan of 75.2% in M9 and below the national standard of 75%. The percentage of Lower GI referrals with a FIT result has exceeded the plan (of 79.1%) by 2.1% The number of referrals and the number with a FIT test (this month) have both increased.
General Practice (GP)/Primary Care	• GP appointments for December 2023 fell short of the monthly plan by 8,156 appointments (1.72%). However, remains well above plan overall for 2023- 24. • CPCS (Community Pharmacist Consultation Service) referrals from General Practice continues to exceed the overall YTD target by 490 [referrals] (April 23 to January 24). • ARRS FTE and budget utilisation continues to increase month on month.
Prevention and Health Inequalities	• The national objective to increase the percentage of appropriate patients on lipid lowering therapies; the national target of 60% has not been met in November 2023 with 53.5% achieved.
Children and Young People (CYP)	• Reduce emergency admissions for Long Term Conditions (LTC), including diabetes, epilepsy and asthma in the under 18-year-old population. In December, emergency admission rates in the under 18-year-old population, were below the equivalent period in 2019/20 for all three conditions. • Year to Date (YTD) rates of diabetes and asthma admissions remained below the equivalent period in 2019/20, whilst the rate of epilepsy admissions was slightly raised (70.1 v 72.9).
Mental Health and Learning Disabilities	• Inappropriate adult acute Out of Area Placement (OAP) bed days are over the plan of zero by 185 this year, to November. A local PICU options appraisal is being developed to go through ICB governance in Q4. • Autism assessment waits for CYP increased by two weeks at Midlands Partnership Foundation Trust (MPFT) (from 24 to 26 weeks) and by two weeks at North Staffordshire Combined Healthcare Trust (NSCHT) (from 35 to 37 weeks). The 26 week median wait in December is double the plan of a 13 week median wait at MPFT and 17 weeks above the median plan of 20 weeks at NCSHT. • Access to NHS Talking Therapies dropped in December. Q3 performance was 13% below the planned target and Year to date (YTD) performance is 36% below the [YTD] trajectory.

Escalation Summary

Headlines	Escalation detail
One Collective Aim	• Work ongoing to expand on Call Before Convey data as it is currently insufficient to assess the impact of the services. Tier 2 regional support focused on a 4-week audit that looks at ambulance conveyances to site which will include the services patients have tried to access and suggestions of alternative services which will inform priority focus areas for 24/25 UEC improvement plan.
Urgent and Emergency Care (UEC)	• Redirection of patients into Enhanced Primary Care offer within ED continuing with 26.6% increase in activity over December, and February on track to report similar volumes. • Continuous conscious decision to use non-admitted capacity to support ambulance handover, consequently impacting non-admitted performance and to be expected, County Hospital stretched to accept intelligent conveyances and outliers to support RSUH site – resulting in a drop performance – this was anticipated. • Klynveld Peat Marwick Goerdeler (KPMG) onsite for 8 weeks to support with Simple & Timely discharges and ward standard work - daily exec sponsored driver meetings and particular focussed work on 5 worst performing medical wards. • Internal rapid handover protocol (risk stratification across Trust) to commence 09/02/2024. • Detailed review undertaken of Ambulance service provision to identify any structural issues within the system, utilising Summary Acute Provider Indicator Table (SAPIT), Get It Right First Time (GIRFT) and West Midlands Ambulance Service (WMAS) data.
Planned Care	• The underlying 78ww position is improving, however UHNM are currently forecasting 131 78ww breaches in February and 39 at the end of March 2024 (as at w/e 4th February, from the UHNM weekly forecast). • UHNM are achieving the Patient Initiated Follow Up (PIFU) target, but this is not resulting in a reduction in follow-ups to the national target. Analysis of new to follow up ratio's (December 22/23 compared to December 23/24) shows 20 specialities (of 58, 34.5%) having a greater first to follow-up ratio and 38 with a reduction (65.5%).
Efficiency Programme	• We continue to report an in-year deficit position of £91.4m.

Ctrl and click on any underlined text for further detail.

Overview of key underpinning deliverables

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 Disability 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

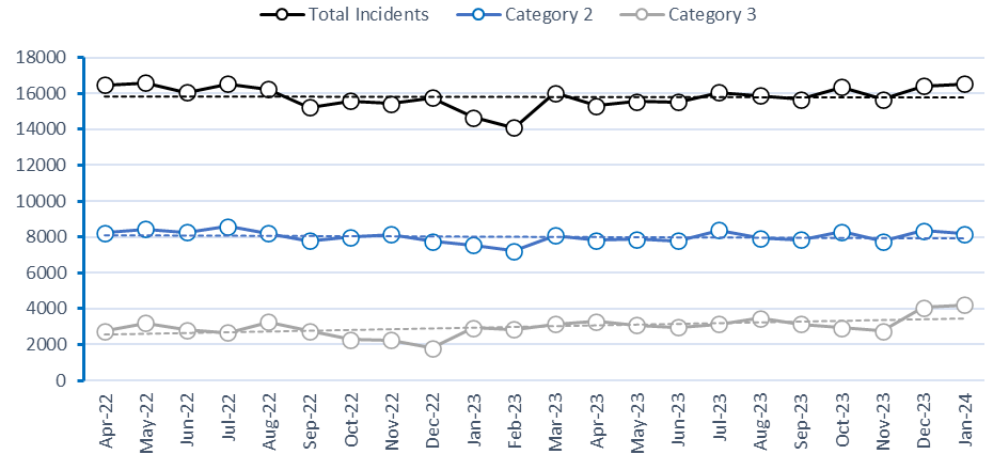
TRAFFIC LIGHT KEY:

- 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

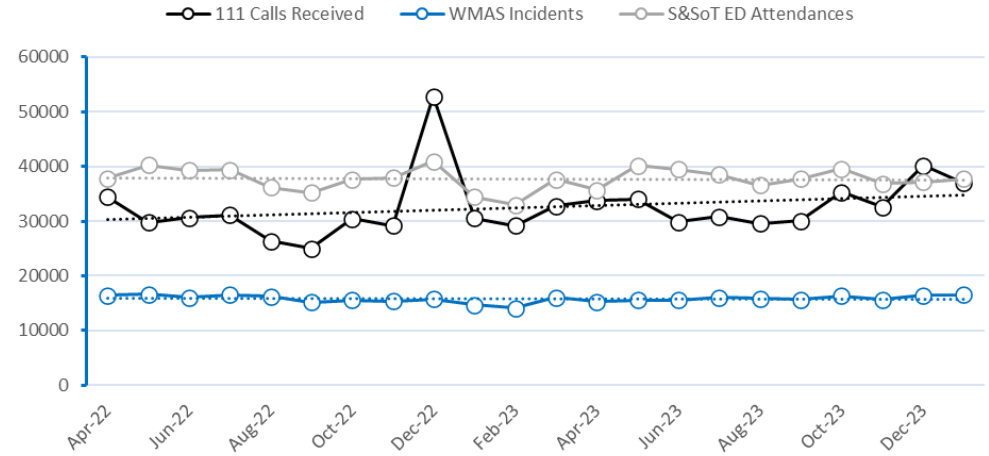
Exception reporting against our One Collective Aim

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 data for January indicates a 2.4% decrease in Category 2 incidents over the previous month, which equates to 6 incidents fewer per day. This is 8% up on the same period last year and the 3-month average is reporting 3.57% higher than last year. Breathing problems account for the largest reduction over the previous month but there were also reductions in patients being found unconscious and the where no value was recorded. • Category 3 incidents rose 3.8% on the previous month and reported 43.7% up on the same period last year, matched by increases in all other categories other than Category 5. Fall related incidents as well as Mental Health and Concerns for Welfare all reported increases over the previous month. • Emergency Department (ED) Attendances increased by 2.8% on the previous month and were up 8.8% on the same period last years as both Type 1 and Minor Injury Units reported increased attendance within the UHNM footprint. • The total number of 111 calls during January 2024 fell by 8% on the previous month but were 21% higher when compared to the same period in 2022/23, primarily due to the differing timelines of the flu season and other respiratory infections. • UHNM are in segment 3 of the NHS Oversight Framework with 5 exit criteria in place in relation to UEC with challenged performance in Ambulance Handover Delays and > 12-hour waits undergoing continual monitoring to gauge progress. • Monitoring against contractually agreed trajectories for Category 2 Response times continues with the latest 4-week average of 57m 58s significantly above the 30-minute target, placing us 10th out of 11 in the Midlands region, and 37th out of 42 nationally.

West Midlands Ambulance Service Total Incident, Category 2 and Category 3 incidents graph for Staffordshire and Stoke-on-Trent ICB



NHS111 calls received, WMAS incidents and Emergency Department Attendances graph for Staffordshire and Stoke-on-Trent ICB providers



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

Exception reporting against 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**	• In hospital - Systems for capturing ambulance handover delays across all areas are disjointed, requiring significant workaround. Review to be undertaken. Prioritisation matrix for ambulance handover to be piloted w/c 12th Feb 2024 – RFS to be used. • Critical Incident - Learning from incident (29/01/2024) to be shared at learning event on 22/02/2024 • Emergency Department - Additional operational leadership capacity over next 2 months to build sustainability that will support delivery of operational improvement plan. • Escalation process for ED waits >48hrs in place with Gold Director escalation level. Whilst low numbers, recognition of challenges for MH patients which will be addressed through immediate focus plan. • Medical outliers de-escalated, down to 10 in surgery and 2 in network to enable elective capacity. • Weekly long length of stay reviews underway to address increased stays over 21 days, we are now 11/11 regional for concern. Initial focus was on > 30 days. Numbers reducing, longest LoS down to 104 days from 276 (excluding paediatric and rehab). • Discharges - Trust 'manual' for discharge to educate and standardise processes. SAFER/R2G dashboards for each ward to enable focused support • Surge Plan Summary - System reduction of structural bed deficit, but LoS has increased resulting in a continued position of 30-60 Discharge to assess (DTAs) daily. Midlands Partnership Foundation Trust (MPFT) stood up 30 spot purchase Discharge to assessment (D2A) beds, all Acute planned capacity remains open, and additional 3 beds open via Orthopaedic ward.
2. Tackle Backlog (Planned Care) **Backlog reduction**	• Follow-up attendances are at a lower level of activity than planned this month but remains above the 19/20 baseline. Achieving the national target of a 25% reduction is challenging and remains the focus of outpatient transformation schemes. • 65+ week waits at UHNM were 1,116 in December, above the plan of 750 - impacted by Industrial Action (IA). • 78+ week waits; 99 at UHNM with IA in December. A total of 131 are forecast for the end of February and 39 are forecast at the end of March (latest forecast reported w/e 04/02). • 104+ week waits: Two at UHNM in December's monthly data. UHNM forecast (with Industrial Action) for there to be one 104+ ww at the end of February and zero at the end of March (latest forecast w/e 04/02). • Diagnostic activity was below plan in November (across the 7 core tests) by 9.4%. MRI was the only tests to exceed the plan. The percentage of patients seen in <6 weeks (at 76.0%) decreased (from November) and was below the monthly plan (of 78.5%). • The latest UHNM position (w/e 04/02 weekly recovery pack) reports the [Cancer] 62-day backlog has decreased to 335, below their revised trajectory of 342. • The 104-day Cancer backlog at UHNM (w/e 04/02 weekly recovery pack) has decreased across January and early February to 84; this total remains below the revised trajectory (of approximately 110 for this period). • The 28-day faster diagnosis standard (FDS) was below plan and below the National Standard of 75% in December, at both UHNM (69.7%) and across the ICB (70.8% for all Providers).

Exception reporting against 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 for December 2023 fell short of the monthly plan by 8,156 appointments (1.72%). However, remains well above plan overall for 2023- 24. • The December 2023 Did Not Attend (DNA) rate was 4.8% - a increase of 0.1% from November, 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 (data excludes 31st January due to the move to Pharmacy First).The overall YTD target is being exceeded by 490 referrals (April 23 to January 24). • Winter programme - extension agreed for schemes originally due to end on 31st March to include two weeks into April to support the Easter surge period. • The Scheduled Units of Dental Activity (UDAs) decreased in December 2023, remaining below the contracted number. A delay to the ability to rebase UDAs is an issue in terms of timeframes to lever change to dentistry provision. The ICB is impacted by corporate contract UDAs. Nationally contract changes to allow unilateral re-basing of UDAs within the contract term have been proposed however there will be a delay to the implementation of the changes as the regulatory changes required to enact this have not yet gone through parliament. A delay to the ability to rebase UDAs is an issue in terms of timeframes to lever change to dentistry provision. • Additional Roles Reimbursement Scheme (ARRS) stands at 493.6 Full Time Equivalent (FTE) for December and remains below plan however the FTE continues to increase month-on-month as PCNs continue to deliver their revised plans.
4. Complex Individuals **Improving access to high quality and cost-effective care for people with complex needs, which requires multi-agency management.**	Mental health: • Access to Children and Young People (CYP) community mental health services has dropped by over 1,000 contacts (rolling 12-months) so far this year, from 14,735 in April to 13,440 in December. North Staffordshire Combined Healthcare NHS Trust (NSCHT) identified an issue with their submissions and plan to resubmit the data for the current financial year. • The Dementia diagnosis rate at 72.2% in December, continues to exceed the national target of 66.7%. • Access to NHS Talking Therapies dropped in December. Q3 performance was 13% below the planned target and Year to date (YTD) performance is 36% below the [YTD] trajectory. • The number of people with Severe Mental Illness (SMI) having an annual physical health check in Q3 was 27% below the Q3 plan target of 6,092 (a shortfall of 1,637 patients). No further update as the Q3 position was reported last month. The quality of reporting is adversely impacted by the data collection process and we are working with relevant colleagues to improve. Learning Disabilities & Autism: • Patients with Learning Disabilities and Autism (LD&A) with an Annual Health Check (AHC): the January position is 57.7%, which is below the expected trajectory of 60.4%, however the LD register has been inflated by the inclusion of additional codes (up from 6,159 in December to 6,565) which is being queried with the national team.

Finance Summary

Following the H2 planning process completed in late November and early December, a revised control total of £91.4m deficit was agreed by NHS England. As a result, the system has been allowed to move its forecast outturn to reflect this deficit. In addition, we are reporting the additional forecasted costs of industrial action which sat outside of the H2 assumptions, which amounts to £1.2m. As a result, the forecast deficit as at month 10 was £92.6m. This is in line with the revised control total.

All organisations are increasingly confident of delivering their risk adjusted forecast and managing the residual risks. On this basis, as a system, we still believe that a deficit of £91.4m is our most likely position. We will endeavour to improve upon this, but it is in line with the recovery plan with the addition of non-recurrent mitigations expected in months 11 and 12.

The position includes risks around the fixed and variable aspects of Elective Recovery Fund (ERF), and we hold firm on our assumptions and reject bills related to overperformance associated to UEC, (non-elective long stay (NELS) and A&E attendances) amounting to £8.1m. These bills have been disputed on the basis the claim is outside the contracting guidance regarding the fixed element of the contract being based on provider cost base. Finally, forecast does not include any provision for band 2/3 retrospective payments as reported in prior months.

At month 10, at a system level we are reporting a year-to-date deficit position of £90.4m, which is a £69.5m adverse variance against the £20.8m deficit plan (Month 9 –year to date deficit £83.3m; variance to plan £64.2m). The year-to-date variance to plan sits within the ICB (£67.2m) and UHNM (£2.9m) with NSCHT and MPFT slightly better than plan. The main drivers behind this variance remain consistent with prior months, being:

- CHC and prescribing costs being over and above the inflationary assumptions used within the system plan submission (£49.0m)
- Slippage on efficiency programmes within the plan (£4.1m)
- Retention of escalation beds longer than initially planned due to the ongoing UEC demands within the system (£7.0m)
- Other adjustments including allocation clawback (£9.4m)

Our capital plan remains overcommitted as expected, although mitigations have brought the overcommitment down significantly, we have an overspend regarding Project Star which are known to region and pressure in International Financial Reporting Standard (IFRS)16 which we are managing as a system.

Month 10 Position

The general themes driving our financial position are CHC inflation & volume challenges, inflation in excess of plan in primary care prescribing and efficiency under-delivery. There are internal plans being developed and work ongoing to review the CHC challenges the system continues to face. Strong emphasis to close the efficiency gap remains, see the following slide.

	Month 10			Month 9		
System		£m			£m	
	Plan	YTD	Variance	Plan	YTD	Variance
Income	3,681.4	3,720.7	39.3	3,312.2	3,341.9	29.7
Pay	(1,000.8)	(991.9)	9.0	(899.3)	(888.3)	11.0
Non Pay	(518.7)	(576.9)	(58.1)	(466.5)	(516.4)	(49.9)
Non Operating Items (exc gains on disposal)	(23.9)	(16.4)	7.5	(21.5)	(14.7)	6.8
ICB/CCG Expenditure	(2,159.8)	(2,225.9)	(66.2)	(1,944.0)	(2,005.7)	(61.7)
Total	(21.8)	(90.4)	(68.5)	(19.1)	(83.3)	(64.2)
			-1.8%			-1.9%

	Month 10			Month 9		
ICB		£m			£m	
	Plan	YTD	Variance	Plan	YTD	Variance
Allocation	2,136.8	2,136.8	(58.1)	1,922.1	1,922.1	(49.9)
Expenditure	(2,159.8)	(2,225.9)	0.0	(1,944.0)	(2,005.7)	0.0
TOTAL ICB Surplus/(Deficit)	(22.9)	(89.1)	(66.2)	(21.8)	(83.5)	(61.7)
			-3.1%			-3.2%

	Month 10			Month 9		
UHNM		£m			£m	
	Plan	YTD	Variance	Plan	YTD	Variance
Income	886.9	926.8	39.9	797.9	830.5	32.6
Pay	(546.5)	(551.6)	(5.1)	(490.7)	(494.1)	(3.4)
Non-Pay	(316.3)	(357.8)	(41.5)	(284.5)	(320.6)	(36.1)
Non Operating Items (exc gains on disposal)	(23.3)	(19.5)	3.7	(20.9)	(17.5)	3.5
TOTAL Provider Surplus/(Deficit)	0.8	(2.1)	(2.9)	1.8	(1.7)	(3.5)
			-0.3%			-0.4%

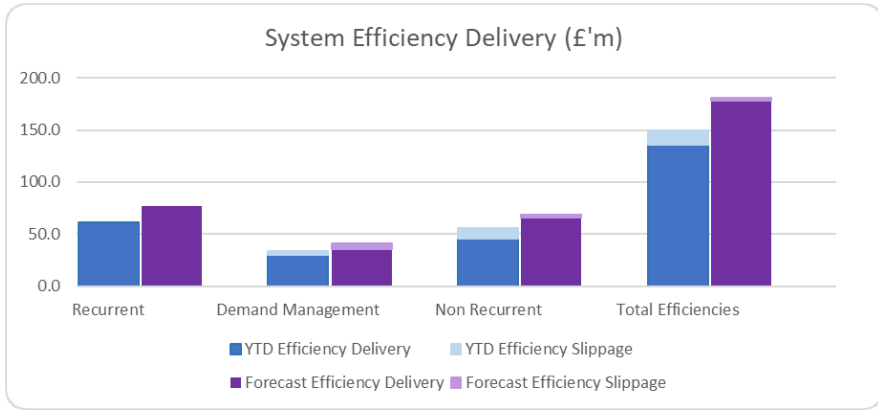
	Month 10			Month 9		
MPFT		£m			£m	
	Plan	YTD	Variance	Plan	YTD	Variance
Income	519.6	523.3	3.7	467.9	469.6	1.8
Pay	(376.2)	(362.9)	13.3	(338.3)	(324.5)	13.8
Non-Pay	(145.4)	(164.5)	(19.1)	(130.6)	(147.5)	(16.9)
Non Operating Items (exc gains on disposal)	2.3	4.4	2.1	2.0	3.9	1.9
TOTAL Provider Surplus/(Deficit)	0.3	0.3	0.0	1.0	1.5	0.5
			0.0%			0.1%

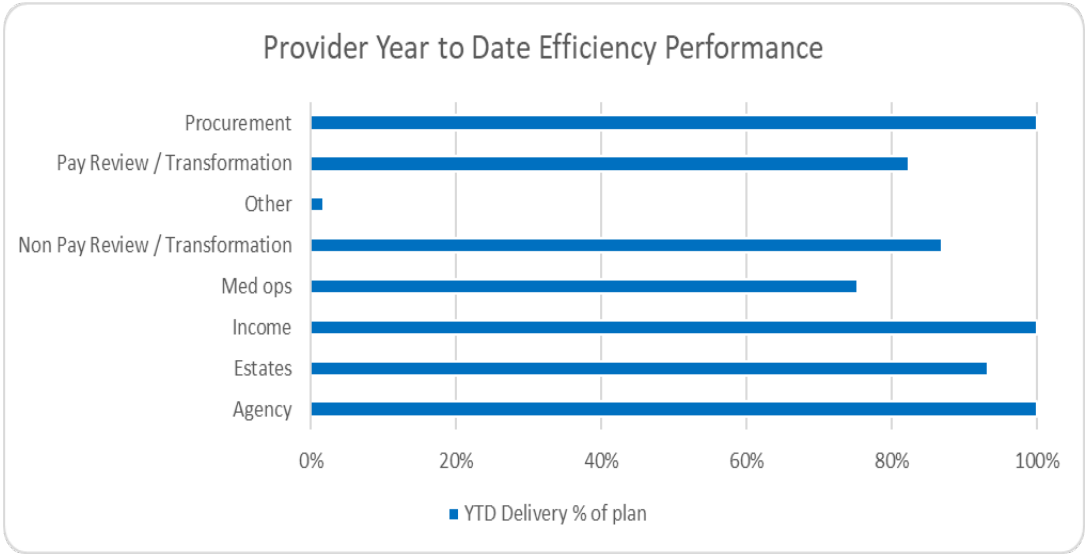
	Month 10			Month 9		
NSCHT		£m			£m	
	Plan	YTD	Variance	Plan	YTD	Variance
Income	138.1	133.8	(4.3)	124.3	119.6	(4.7)
Pay	(78.1)	(77.4)	0.7	(70.3)	(69.7)	0.6
Non-Pay	(57.0)	(54.6)	2.4	(51.4)	(48.3)	3.0
Non Operating Items (exc gains on disposal)	(2.9)	(1.3)	1.7	(2.6)	(1.2)	1.5
TOTAL Provider Surplus/(Deficit)	(0.0)	0.5	0.5	(0.0)	0.4	0.4
			-0.4%			-0.4%

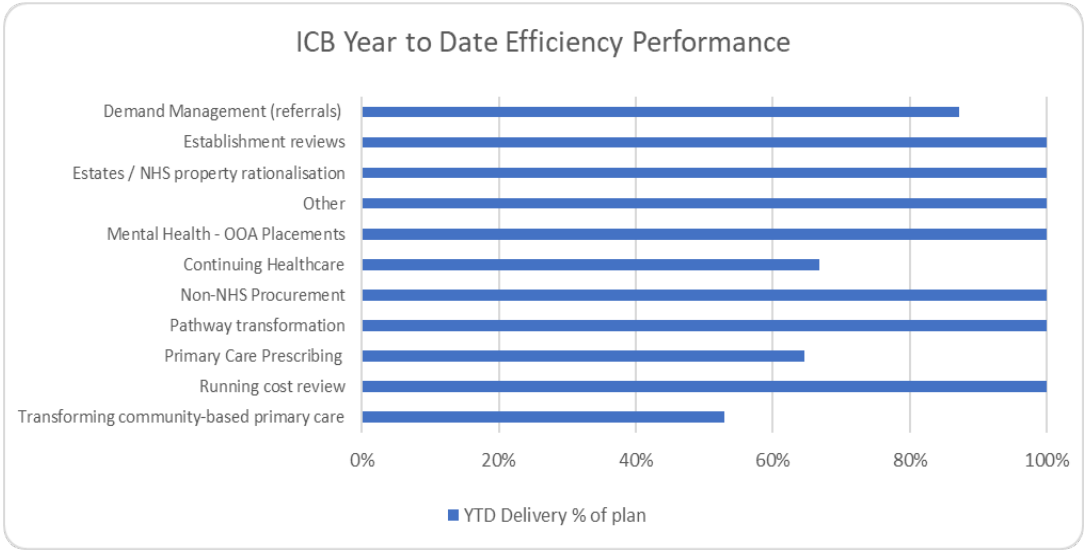
Efficiency Delivery

- The system has delivered £136.0m of efficiency as of January 2024, 91% of plan. Forecasts project the system to reduce to £2.4m behind their total efficiency plan by year end, and there remains a level of risk within this forecast due to the size of the efficiency target within the plan.

- Key challenges remain to deliver recurrent efficiency within the current environment. We are currently forecasting a to hit planned level of recurrent schemes at year end. All organisations have been ramping up assurance of FYE delivery into 2023/24 and the previously identified actions continue.







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:	5 March 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
System Recovery Programme 2024/25	Building on last month's paper setting out the themes following the System Executive event held on 24 January, this paper set out the System financial position, the key messages from the 27 February flash high level submission, the next steps and progress around the 6 System Collaboratives and next steps for discussion on the financial position. Following submission of the first high level operational plan flash submission to NHSE on 27 February, a further flash submission was requested on 29 February to improve the position around March 2025 A&E 4 Hour Performance from 76% to 77%, September 2024 trajectory on 65ww from 4572 to 995 and 2024/25 Value Weighted Activity percentage from 97.4% to 100.5%. We can expect significant challenge and further conversations with regulators on the financial position, activity and workforce submissions. The next more detailed submission is due on 21 March following a meeting with NHSE on 14 March.	FPC requested that the Recovery Programme be discussed at a confidential Board meeting in March. The 6 System Collaboratives for recovery which will lead out c19 projects have been agreed and the SROs identified. It is essential that sufficient capacity is aligned with the recovery programme to support delivery at pace. During March, SROs will work up their programmes and projects and the plan will be presented for agreement to the Finance and Performance Committee meeting on 2 April, to the System Executive event on 15 April and the Public Board meeting on 18 April.
System Recovery Programme 2023/24	The paper provided an update on performance against the overarching metrics for the System Recovery Programme and escalations. We are currently determining which projects will continue into 2024/25 and whether they will be aligned to one of the 6 System Collaboratives.	The escalation regarding the DPIA has now been resolved so the CHC 1:1 review programme can now be progressed.
Integrated System	The Committee noted the Month 9	FPC asked for further detail on

Performance and Programmes Highlight Report	performance position against the key metrics in the Operating Plan. The Committee received escalations from 6 Portfolios, including an urgent escalation on the ongoing risk regarding Acute Care at Home; addressing this needs to be a key focus of the 2024/25 planning round.	'One Collective Aim' performance, given Category 2 and 3 incidents are above the equivalent period in 2023 (same month and 3-month average). Monitoring 'Access to Children and Young People community mental health services' continues to be impacted by data issues which are being investigated by NSCHT and MPUFT.
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 noting that despite progress being made, the rate of improvement has been significantly hampered by industrial action. The report also provided details on the long-waiters who receive elective care outside of the Staffordshire and Stoke-on-Trent System. The Committee noted: • The good progress made in respect of 65ww breaches with an improvement of c1,700 patients since 14 January. • For the 78ww cohort, UHNM continue to work well with Nuffield but this has resulted in a number of patients being transferred late on the treatment pathway and therefore Nuffield are incurring long wait breaches. The transfer of patients to Nuffield still presents the best chance of them being treated at the earliest opportunity. UHNM have also started to work more closely with Ramsay following the offer of support to help with the backlog of long waits. • A revised route to zero by the end of March for the 78ww cohort has been drafted and discussed with NHSE. The current plan includes risks for two specialties for which a plan continues to be developed including exploration of mutual aid. • UHNM continue to focus on resolutions for challenged specialties.	Three patients have breached 104ww at the end of January at UHNM, 2 due to capacity and 1 is a paediatric spinal patient. There is a forecasted position of 2 breaches at the end of February, 1 due to capacity and 1 is an adult spinal patient. Additionally, there was 1 breach at the end of January who is outside of the System, who is also forecasted to breach at the end of February. A Route Cause Analysis is conducted for every breach.

System Finance Month 10 Report	At Month 10, we are reporting a year-to-date deficit position of £90.4m which is a £69.5m adverse variance against the £20.8m deficit plan. Our capital plan remains overcommitted as expected. Although mitigations have brought the over-commitment down significantly, we have an overspend regarding Project Star (Region are aware) and pressure in respect of IFRS16.	A further £1.2m of potential cost of industrial action for Q4 is expected to be funded so a deficit of £91.4m is still believed to be our most likely position. The position includes risks around the fixed and variable aspects of ERF but does not include any provision for Band 2/3 retrospective payments which could have a significant impact.
System Surge Winter Plan Update	The report provided an assessment against the plan, the mitigations and escalated risks. The Committee noted the following escalations: • Rapid Social Care scheme impacts are unclear, with limited referrals and usage to date • Golden Park EoL beds remain underutilised, touchpoints are in place to maximise use • Decision made not to proceed with mobilisation of Golden Park Step up beds in order to protect AC@H capacity as the workforce remains fragile • An additional 15 Spot Purchase beds have been opened at Golden Park to support system pressures, post the recent Critical Incident.	
System Transformation and Service Change Update	The paper provided the monthly overview of the clinical areas included within the System Transformation and Service Change Programme and the latest version of the monthly service change return to NHSE. Key updates for the Committee focused on UTCs, maternity and the Cannock Transformation Programme.	Regarding the Cannock Transformation Programme, the Committee noted that meetings have taken place with RWT during February and a formal written statement outlining their strategy for elective care provision in Cannock is expected in March.
Quarterly Green Plan Update	The report provided an overview of progress against the Staffordshire and Stoke-on-Trent Green Delivery Plan and the System Ambitions. It contained a summary highlight report, updates from provider trusts and existing working groups (Medicines, Solar Panels, Procurement and Digital) outlining recent achievements, upcoming key tasks or events, issues and risks for discussion at System level.	The Committee welcomed the inclusion of highlight reports in the paper and was pleased to note the progress of the programmes.
System Risk Register	There are 27 risks on the System Risk Register of which 16 are high scoring (12 and above) and there are	The Committee was pleased to note that the external audit of the 2022/23 MHIS by Grant

	9 medium risks and 2 low risks. The Committee approved: • The reduction in risk score and closure of risk 1183: Mental Health Investment Standard (MHIS) 2022/2023 • The reduction in risk score from 12 to 9 for Risk: 1170: Totally PLC Sustainability • The reduction in risk score from 12 to 8 for Risk 1224: NHSE timelines for NHS 111 Integration Non-Delivery The Committee has good sight of the top risks for finance, performance and transformation.	Thornton has been concluded with an unmodified opinion.
Feedback letter from Staffordshire and Stoke-on-Trent Quarterly System Review (QSRM) Meeting	The Committee received the letter from NHSE following the QSRM on 19 January 2024. The Committee noted that for the 5 actions outlined for the ICB/ICS to lead on, 4 are in progress and 1 is complete.	
PART B		
Risk Register	There are 11 risks on the ICB Risk Register of which 6 are high scoring (12 and above) and there are 4 medium risks and one low risk. The Committee approved the reduction in risk score from 12 to 8 for Risk 1224: NHSE timelines for NHS 111 Integration Non-Delivery as the Business Case has been approved and recruitment is underway.	
ICB Efficiency 2023/24 Performance and 2024/25 Targets	The paper reported on the achievement to date against the 2023/24 efficiency plan. The Committee took assurance from the remedial actions taken by the organisation against the plan with a year-end forecast variance of (£2.3m) against a previously reported (£30.0m) prior to implementation of the recovery plan. One of the actions agreed by CFOs to mitigate the 2024/25 deficit is to set all organisations an internal efficiency ask of 3.44%. For the ICB, the 3.44% is applied to the total cost base excluding the IFP payments to the in-system providers. Therefore, the target for the 2024/25 ICB efficiency programme will be £57.3m and the paper detailed how this has been split across the organisation. The Committee approved the ICB	The Committee noted that due to the level of financial deficit across the Staffordshire and Stoke-on-Trent ICS, the target is subject to increase if there is regulatory action.

	base efficiency target of 3.44% of cost base and the application of targets to portfolios.	
ICB Finance Report (Month 10)	The paper reported an ICB year-to-date deficit position of £89.1m against a planned deficit of £22.9m, creating an adverse variance to plan of £66.2m. As previously reported, the ICB continues to be confident in delivering the £91.4m deficit forecast but was managing a gap of (£3.2m) to achieve this target. During January, this gap has fully closed due to early indications of medicines management price reduction schemes delivering ahead of plan and the impact of winter activity increase on prescribing not being as significant as originally anticipated. The Committee approved the ICB's Month 10 forecast position of a £91.4m deficit.	
Medicines Optimisation Update	The paper detailed the achievements of the 2023/24 Medicines Optimisation Service Level (MO SLA) with General Practice and presented the plan and business case for 2024/25. The Committee approved the business case for the 2024/25 MO SLA which plans to delivery £8.8m gross savings with a maximum investment of £3.4m, giving a return on investment of 159%. The Committee approved a policy (which has been through Clinical Senate) relating to drug use in patients with severe active rheumatoid arthritis noting that this will enable specialist clinicians to provide greater options for treatment to patients and would be cost saving or cost neutral on treatment costs.	The Committee was pleased to note that the 2023/24 MO SLA is forecast to deliver between £4.2m - £6m cost savings in prescribing (range is dependent on the level of achievement which will be finalised when Q4 prescribing data is available); this has been achieved with an investment of £1.1m.
Delegation of Specialised Services from NHSE to ICBs	The paper provided an update on the delegation of Specialised Services to the ICB from April 2024. The report contained three appendices detailing the nature, scope and operation of the commissioning arrangements and financial risk pooling arrangements if delegation is supported by the Board: 1. Specialised MOU and Collaboration Agreement Final Draft	The Board to consider the Delegation Agreement. If delegation is supported, FPC recommends that signature is delegated to Chair / CEO to allow time for the ICB to have visibility on the decisions of the 11 other ICBs in the Region.

	2. Operating Framework 3. Midlands Specialised Delegation Programme	
Wheelchair Contract	The paper set out the current position of the contract, backlog and continued escalating risk. Following the procurement for the wheelchair service in 2022/23, the new provider reported an increase in the total number of patients on the open caseload and a hidden backlog following transfer from the previous provider. During 2023/24, the backlog has continued to increase month on month, with the total number waiting over 18 weeks at Month 10 reported to be 929, with 41 service users waiting over 52 weeks. The ICB is receiving an increased number of complaints in relation to long waits and a Section 42 Safeguarding Enquiry has identified 'harm'.	FPC noted the action approved by the ICB Executive to mitigate the quality and safety risks to patients and financial and reputational risks to the ICB.
Primary Care Forum Report	In order to have governance oversight, the Committee received a summary report of the meeting that took place on 19 February. This reported on the discussions on Primary Care finances, General Practice and Pharmacy, Optometry & Dental (POD).	
ICB 2024/25 Interim Budget	The paper provided information on the draft plan submission and requested approval for the budget for 2024/25, recognising that this is indicative and subject to change in line with the submission of the final plan at the end of April 2024. The ICB financial plan was informally submitted alongside the System level plan on 27 February 2024 and the ICB element contributed a £48.6m deficit to the £179.0m ICS deficit. As the financial plan does not live within allocated resources, we expect the position to be heavily challenged by NHSE and there to be a requirement for the System to operate within a more stringent control environment.	Board to ratify decision of FPC to approve the provisional budget based on the submitted financial plan of a £48.6m deficit and for Purchase Orders to be raised aligned to the draft budgets set out within the paper.
ICB Procurement Operations Group Highlight Report	The paper reported the key activities being co-ordinated by the Procurement Operations Group and in particular the actions being taken to ensure the ICB is able to implement the new Provider Selection Regime regulations. The Committee approved:	

	• An urgent caretaker contract award in respect of Gordon Street – GP Services The Committee noted: • An urgent caretaker contract award in respect of Termination of Pregnancy • 9 x Direct Award Process C contracts and 2 contract modifications	

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:	21 March 2024					
Title:	**2024/25 Operational Planning Update**					
Presenting Officer:	Paul Brown – Chief Finance Officer					
Author(s):	Vicki Inch – Associate Director of Planning and Intelligence					
Document Type:	Business Plan	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:	2024/25 Operational Planning Update					

(1) Purpose of the Paper:
The attached update provides the board with a summary of progress to date on 2024/25 operational planning.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
System Performance Group (D)	28/02/2024
System Finance and Performance Committee (S)	05/03/2024

(3) Implications:	
Legal or Regulatory	None directly arising based on the content of this report.
CQC or Patient Safety	None directly arising based on the content of this report.
Financial (CFO-assured)	Finance implications are outlined in the body of the report.
Sustainability	None directly arising based on the content of this report.
Workforce or Training	Workforce implications are outlined in the body of the report.
Equality & Diversity	None directly arising based on the content of this report.
Due Regard: Inequalities	None directly arising based on the content of this report.

Due Regard: wider effect	None directly arising based on the content of this report.

(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?		☐	☐	☒	

(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:

On 27th February we submitted our first operational plan flash submission to NHS England (NHSE), which focused on operational performance measures for urgent and elective care, the overall NHS system financial position and headline data around workforce. The position submitted is summarised in the report attached.

Operational plan submission guidance, technical and narrative have been published by NHSE.
At the time of writing this update the national planning guidance had not been published. The next operational plan submission is 21st March 2024. Regional assurance will take place post 21st March.

Since the 24th January system event we have progressed our recovery plan through discussion across a wide range of system leaders. System Directors of Strategy have set out the approach to defining our plans. We have agreed the 6 system collaboratives for recovery, identified SRO's and started to scope the outcomes and projects to deliver the outcomes.

(7) Recommendations to Board / Committee:

1. Note the operational plan flash submission
2. Note the timeline for our first operational plan submission
3. Note the progress made around the recovery plan
4. Note the wider high level planning timeline

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

2024/25 Operational Planning Update

21st March 2024

Overview

- On 27th February we submitted our first operational plan flash submission to NHS England (NHSE), which focused on operational performance measures for urgent and elective care, the overall NHS system financial position and headline data around workforce. The position submitted is summarised on slides 4 and 5.
- At the time of writing the national planning guidance had not been published.
- The next operational plan submission is 21st March 2024 with regional and national assurance taking place following submission.
- We can expect some significant challenge as at this stage we do not meet all the operational standards required and still have a level of expenditure growth which is driving a deficit plan.
- The need for an operational and financial recovery plan are well understood and intended to address the gap that we knew that we would have.
- Following the 24th January system event we have progressed our recovery plan through discussion across a wide range of system leaders. System Directors of Strategy have set out the approach to defining our plans.
- We have agreed the 6 system collaboratives for recovery, identified Senior Responsible Officers (SRO's) and started to scope the outcomes and projects to deliver the outcomes.

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What we have done so far and next steps

2024/25 Operational Planning Flash Submissions and System Collaboratives Progress

27 February Flash Submission Key Messages

The purpose of the flash submission is to provide an early view of the key metrics for the 2024/25 planning round.

Activity/Performance - Forecasts submitted are for University Hospitals of North Midlands (UHNM) only at this stage. The Value Weighted Activity UHNM figure of 97.4% represents a roll forward of current core activity. It does not include maintaining all the extra activity being delivered via the Elective Recovery Fund or otherwise, or any productivity opportunities. The system is committed working to reaching a clear date for eradicating 65 week waits. Performance standards (4 hour, and Cancer 62 day performance) are subject to further work through the planning process.

All department A&E 4-hour performance (E.M.13)			Elective 65w waits (E.B.20)			Value Weighted Activity growth (%)		Cancer - 62 day performance (E.B.35)			G&A Beds (E.M.30)	
Recent actuals Dec-23	All department A&E performance Mar-24 (%)	All department A&E performance Mar-25 (%)	Recent actuals Nov-23	Sep-24 waits	Month at which 65w waits are zero	Recent actuals Apr to Sep-23	Value Weighted Activity - including diverted pathways 2024/25 full year (% of 2019/20 baseline)	Recent actuals Nov-23	62 day performance Mar-24 (%)	62 day performance Mar-25 (%)	Recent actuals Jan-24	Available G&A Beds Annual mean
64.2%	*76.0%*	*76.0%*	*2,018*	*4572*	*NA*	*101.4%*	*97.4%*	*63.4%*	*50.0%*	*83.0%*	*1,388*	*1388*

Workforce (WF) – Although the increases are modest, the workforce plan to increase the workforce is at odds with the financial situation. Establishment is planned to increase from 24,243 whole time equivalents (wte) (Mar-24) to 24,358 wte (Mar-25) by +115 wte (+0.5%. The overall total workforce is planned to increase from 23,890 wte (Mar-24) to 24,205 wte (Mar-25) by 315 wte (+1.3%)

- Staff Composition (Total WF Mar-24 to Mar-25):
- Substantive: +433 wte (+2.0%
- Bank: -94 wte
- Agency: -24 wte

27 February Flash Submission Key Messages continued

Finance

- We came into the planning round with an underlying deficit of £240m. To this we added cost pressures and an assessment of underfunded inflation of £40m, leading to a savings requirement of £280m.
- We agreed on a cash-releasing cost improvement programme (CIP) of 3.44% which has contributed a net c£100m and led to a gap of £179m. This is the financial gap that we have alerted the centre to in the 'flash' return submitted on 27 February.
- This gap is likely to leave the system in the worst quartile. The headline CIP will also be an outlier as most systems are aiming at 4% or more.
- We need to reflect the demand management activity avoided as a count against the efficiency target, this equates to £5m growth avoided. This is a legitimate count and reflects what we have done in previous years. In terms of the narrative to the centre, this 3.44% CIP on turnover, plus the activity avoided component, equates to 6% efficiency of RRL.
- The movement from the expected system deficit in 2023/24 of £91m to this projection of £179m illustrates that the system's financial health is deteriorating.
- It is clear that the current savings programme is inadequate and that we need to do more. This was why we undertook the work that we did on a system savings programme, and highlights how crucial that is to our financial future.

System Collaboratives Progress

- The following slide outlines the progress made to date, through the leadership of the System Directors of Strategy, to give clarity to the system recovery programmes and projects.
- We have agreed 6 system collaboratives areas for recovery which will lead out circa 19 projects.
- We have identified SROs and started to scope the outcomes and projects to deliver the outcomes.

1. Throughout March SROs will work up their programmes and projects
2. Over March and April further conversations with the Integrated Care System Senior Leadership team about the emerging shape of the plan.
3. System Performance Group to discuss and agree a deliverable plan on 27th March and then this signed off at System Finance and Performance Committee on 2nd April.
4. System recovery plan to be agreed at system planning session on 15th April.

1. Opportunities

To include (but not exclusive to)

- Ideas from 24th January
- Current live projects (including recovery plan)
- Portfolio and Enabling Functions Priorities and Delivery Plans
- National guidance
- Strategies

2. Alignment

Operational Plan 2024 – 2025 (priorities)

ICP Strategy

Joint Forward Plan

2a. Assessment by SRO/project team

Ongoing assessment of projects as they progress

Examples include

Does it

- Address health inequalities?
- Improve clinical outcomes
- Reduce activity into Secondary care?
- Improve Productivity?
- Reduce service costs?

Underpinned by

- Quality Impact assessments (IA)
- Equality IA
- Financial IA
- Sustainability IA
- Statutory Dependencies

3. Designation

- Recovery 2024-25
  - 1 Continuing Health Care
  - 2 Children & Young People
  - 3 Demand Management >65s
  - 4 Corporate, Back Office & Estates
  - 5 Medicines & clinical value
  - 6 Contracts
- Transformation 2024-28
  - System-wide transformation plan
- Business as usual (BAU)
  - Statutory Responsibilities & targets
  - CIP @ 3.44%

4. Delivery

- System Collaboratives
- Portfolios, Provider Collaboratives
- ICB, Providers & PCNs

Workforce, Digital, Intelligence, Quality

Long list of opportunities identified by system leads

Align & short list against the 5 system Op plan priorities 24/25 & 2 key aims

Demonstrate that achieves an outcome

Designated into Recovery 2024-2025 Transformation and Business as Usual

Local Planning Timeline – Key Dates (as at 13th March)

Key:

Documents and submissions

- **NHSE facing** Activity, Finance and Workforce Submissions (**green**) including technical and narrative templates
- **Local** Ops plan for 2024/25
- **Local Recovery** Plan (6 system collaboratives)

First and second drafts of documents outputs

Final versions of documents

ICB/ ICS level meetings

First draft NHSE submission

Final version NHSE submission

w/c 11 March

11 March
Draft **AFW** returns

11 March
ICB Board papers due

14 March
AFW Task & Finish Meeting
First review of progress of submission

15 March
Final **AFW technical** and **Narrative plan** templates

w/c 18 March

19 March
Exec to Exec discussion
AFW technical and **Narrative plan** submission (ICB to provider)

20 March
CFOs, HRDs and COOs
Review of technical operational plan **AFW technical** and **Narrative plan**

21 March
NHSE Submission Deadline
1st Full
AFW technical and **Narrative plan**

21 March
ICB Board
(Draft ops planning update)

w/c 25 March

27 March
SPG
NHSE submissions and local **recovery** programmes (6 system collabs)

April 2024

2 April
SFPC
Progress update on **NHSE submissions** and local **recovery plan**

15 April
System Workshop 5 – Focus on **recovery** 6 system collaboratives

18 April
AFW Task and Finish Group Meeting
technical and **narrative**

24 April
SPG
Receive Draft **local Ops Plan** and progress on **NHSE submissions**

25th April
AFW Task and Finish Group
AFW technical and **Narrative plan** templates

26 April
Final **AFW technical** and **Narrative plan** templates

29 April
Directors of Strategy - meeting in place if discussion required

Date TBC
Exec to Exec discussion of final **NHSE submissions**

May 2024

Date TBC
System discussion
Final **NHSE** facing submission

2 May
NHSE Submission Deadline
Final Full
AFW and supporting narrative

7 May
SFPC – Receive **Final Local Ops Plan**

The timeline does not include the detail of developing the recovery plan (6 system collaboratives programmes)

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 14

Report to:	**Integrated Care Board**						
Date:	**21 March 2024**						
Title:	**2024/25 ICB Interim Budget**						
Presenting Officer:	Paul Brown, Chief Finance Officer						
Author(s):	Jacqui Charlesworth, Director of Operational Finance/ Ian Ashton, Head of Financial Management & Planning						
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:* Paul Brown, CFO. 14th March 2024					
Appendices:	Click or tap here to enter text.						

(1) Purpose of the Paper:

The purpose of this paper is:
- To seek ratification of the ICB Statutory Body Interim Budget for the 2024/25 financial year by the Integrated Care Board following approval and recommendation from the Finance & Performance Committee in line with Standing Financial Instructions (SFIs).
- To seek approval by the Board to raise purchase orders aligned to the draft budget to enable timely payment to providers/suppliers.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Finance & Performance Committee (A)	05/03/2024
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:

Legal or Regulatory	Failure of the ICB to achieve its statutory financial duty to remain within its resource limit
CQC or Patient Safety	None specifically identified pertaining to this report
Financial (CFO-assured)	Risks to delivery of the plan signed off by the ICB Board have been identified in the report
Sustainability	Delivery of the financial plan and effective implementation of the recovery plan are key to supporting the longer term plan for financial sustainability

Workforce or Training	None specifically identified pertaining to this report
Equality & Diversity	None specifically identified pertaining to this report
Due Regard: Inequalities	None specifically identified pertaining to this report
Due Regard: wider effect	None specifically identified pertaining to this report

(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:

As with every financial year, it is vital that the ICB has agreed budgets in place prior to the commencement of that year to ensure that the management team is operating within the Standing Financial Instructions (SFIs).

NHSE issued the draft planning guidance inclusive of allocations on the 16th February 2024, as such, we are confident to recommend an interim budget to the Integrated Care Board so the organisation can fulfil the ICB's statutory duty of having a budget in place from the 1st April 2024.

NHSE guidance states that "the achievement of financial balance, while maintaining the quality of healthcare provision, is a legal requirement for all systems. The organisations within each system have a duty to co-operate in the delivery of system objectives. Further, when a system overspends against its allocation for the year, spending must be restricted elsewhere to make sure that overall the NHS remains within its spending limits".

As a result of the proposed (£179.0m) deficit system financial plan in 2024/25 of which the ICB contributed (£48.6m), it is a statutory duty to break even that we are not meeting therefore we do not have the authority to spend more than the allocation, however at this stage we require approval so that spending can continue in April.

Following the formal draft submission on the 22nd March it is expected that NHSE will require the system to operate within a more stringent control environment. We fully expect the level of deficit to be heavily challenged by external stakeholders and further regulatory action has commenced and therefore this initial budget is subject to change.

System provider contracts have been set following the IFPS methodology and principles which have

been established for a number of years. The system agreed on an interim basis to redistribute the underlying deficit equally across the system during the planning process. Please note, this is not permanent and subject to change.

Internal efficiency target is set at 3.44%/£57.3m of the ICB's cost base following the agreement by system CFOs, a 5.3% efficiency of controllable expenditure. The principles and draft targets have been signed off by budget managers and approved by the Finance & Performance Committee. This efficiency target will in specific areas be subject to a further stretch target following further regulatory action.

As well as informing the Board of the draft plan submission to NHSE on the 22nd March, this paper also seeks Integrated Care Board ratification to the budget for 2024/25 following approval and recommendation by the Finance and Performance Committee, recognising that this is indicative and subject to change in line with the submission of the final plan at the end of April 2024.

(7) Recommendations to Board / Committee:

The Finance and Performance Committee is asked to:

- Approve – the provisional budget to be set based on the submitted financial plan of a (£48.6m) deficit, recognising that this is subject to change following enhanced regulatory scrutiny following the 22nd March submission.
- Approve – Purchase orders to be raised aligned to the draft budgets set out within this paper.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire & Stoke-on-Trent ICB
Integrated Care Board

ICB Interim Budget

Finance & Performance Committee – 5th March 2024

Integrated Care Board – 21st March 2024

Executive Summary

- The purpose of this paper is:
  - To seek ratification of the ICB Statutory Body Interim Budget for the 2024/25 financial year by the Integrated Care Board following approval and recommendation from the Finance & Performance Committee in line with Standing Financial Instructions (SFIs).
  - To seek approval by the Board to raise purchase orders aligned to the draft budget to enable timely payment to providers/suppliers.

- As with every financial year, it is vital that the ICB has agreed budgets in place prior to the commencement of that year to ensure that the management team is operating within the Standing Financial Instructions (SFIs).
- NHSE issued the draft planning guidance inclusive of allocations on the 16th February 2024, as such, we are confident to recommend an interim budget to the Integrated Care Board so the organisation can fulfil the ICB's statutory duty of having a budget in place from the 1st April 2024.
- NHSE guidance states that "the achievement of financial balance, while maintaining the quality of healthcare provision, is a legal requirement for all systems. The organisations within each system have a duty to co-operate in the delivery of system objectives. Further, when a system overspends against its allocation for the year, spending must be restricted elsewhere to make sure that overall the NHS remains within its spending limits".
- As a result of the proposed (£179.0m) deficit system financial plan in 2024/25 of which the ICB contributed (£48.6m), it is a statutory duty to break even that we are not meeting therefore we do not have the authority to spend more than the allocation, however at this stage we require approval so that spending can continue in April.
- Following the formal draft submission on the 22nd March it is expected that NHSE will require the system to operate within a more stringent control environment. We fully expect the level of deficit to be heavily challenged by external stakeholders and further regulatory action has commenced and therefore this initial budget is subject to change.
- System provider contracts have been set following the IFPS methodology and principles which have been established for a number of years. The system agreed on an interim basis to redistribute the underlying deficit equally across the system during the planning process. Please note, this is not permanent and subject to change.
- Internal efficiency target is set at 3.44%/£57.3m of the ICB's cost base following the agreement by system CFOs, a 5.3% efficiency of controllable expenditure. The principles and draft targets have been signed off by budget managers and approved by the Finance & Performance Committee. This efficiency target will in specific areas be subject to a further stretch target following further regulatory action.
- As well as informing the Board of the draft plan submission to NHSE on the 22nd March, this paper also seeks Integrated Care Board ratification to the budget for 2024/25 following approval and recommendation by the Finance and Performance Committee, recognising that this is indicative and subject to change in line with the submission of the final plan at the end of April 2024.

- **Recommendations:**
  - Approve – the provisional budget to be set based on the submitted financial plan of a (£48.6m) deficit, recognising that this is subject to change following enhanced regulatory scrutiny following the 22nd March submission.
  - Approve – Purchase orders to be raised aligned to the draft budgets set out within this paper.

2024/25 Draft Interim Budget

The below proposed interim budget has been reached following an extensive process set out, approved and monitored by the Finance & Performance Committee.

Key assumptions underpinning the budget:

- The financial plan is set following the national NHS guidance released on the 16th February 2024
- The start point of an underlying (£167.9m) deficit is based on the organisation's recurrent budget which has been monitored throughout the year, challenged by Finance & Performance Committee and fully signed off by budget holders
- System partner contracts have been modelled based on the IFPS contract arrangement. Note, the deficit has been re-aligned during the planning process on an interim basis.
- Internal efficiency has been targeted at 3.44%/£57.3m of cost base
- The ICB is committed to achieving the Mental Health Investment Standard

	2023/24 FoT			2024/25 Recurrent								2024/25 NR			
Financial Plan (ICB)	**Month 9 Forecast**	**NR Items**	**2024/25 Opening ULP**	**Inflation**	**Growth**	**Cost Pressures**	**Investments**	**Efficiency**	**Convergence**	**Other**	**Draft Recurrent Plan**	**NR Cost Pressures**	**NR Investments**	**NR Other**	**Draft Recurrent Plan**
	£000's			**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Revenue Resource Allocation	2,560,586	-120,847	**2,439,739**	46,111	38,383	0	26,557	0	-24,524	0	**2,526,266**	-1,349	93,055	0	**2,617,972**
Expenditure															
UHNM	-624,821	38,067	**-586,754**	-10,067	-9,657	0	-6,184	0	5,764	49,226	**-557,671**	343	-32,286	0	**-589,615**
MPFT	-319,783	-3,022	**-322,805**	-5,311	-5,094	0	-336	0	3,041	26,891	**-303,613**	-2,305	-12,052	0	**-317,970**
NSCHT (Exc TCP/P86)	-132,438	44,320	**-88,119**	-1,425	-1,369	0	-102	0	817	7,493	**-82,705**	49	-9,079	-44,080	**-135,815**
Acute	-564,168	14,287	**-549,881**	-10,296	-11,944	0	-4,887	16,667	0	0	**-560,341**	-143	-29,841	14,400	**-575,925**
Mental Health	-71,518	-35,191	**-106,709**	-1,729	0	0	-6,315	3,454	0	2,423	**-108,876**	0	-4,873	44,080	**-69,669**
Better Care Fund	-39,941	-3,569	**-43,510**	-2,463	0	0	-4,689	0	0	0	**-50,661**	0	0	0	**-50,661**
Community	-48,796	-1,298	**-50,093**	-820	0	0	-941	400	0	0	**-51,454**	-210	0	0	**-51,664**
Prescribing	-237,363	-3,869	**-241,232**	-8,443	-6,561	0	0	13,608	0	0	**-242,628**	0	0	0	**-242,628**
Primary Care Other	-39,899	6,315	**-33,583**	-642	0	0	250	1,691	0	0	**-32,284**	0	-2,795	0	**-35,079**
Primary Care Co-Commissioning	-213,026	-2,948	**-215,974**	-4,103	0	0	-956	1,315	0	0	**-219,718**	224	0	0	**-219,494**
Pharm, Optum & Dental (POD)	-101,158	-6,217	**-107,375**	-2,040	0	0	0	0	0	0	**-109,415**	0	-2,038	0	**-111,453**
Cont Care & FNC	-242,758	22,673	**-220,085**	-17,607	0	0	0	12,623	0	0	**-225,069**	0	0	0	**-225,069**
Other Programme Services	-16,315	-2,283	**-18,598**	-343	0	0	-846	0	0	0	**-19,787**	1,514	-205	0	**-18,478**
Reserves	20,616	-23,182	**-2,566**	-47	0	-7,825	0	3,273	0	1,495	**-5,670**	0	-299	0	**-5,968**
Sub-total	**-2,631,366**	**44,083**	**-2,587,283**	**-65,337**	**-34,625**	**-7,825**	**-25,006**	**53,032**	**9,623**	**87,528**	**-2,569,893**	**-528**	**-93,468**	**14,400**	**-2,649,489**
Corporate / Running Costs	-20,620	298	**-20,322**	-456	0	0	-583	4,269	0	0	**-17,091**	0	0	0	**-17,091**
Total Expenditure	**-2,651,986**	**44,381**	**-2,607,605**	**-65,792**	**-34,625**	**-7,825**	**-25,589**	**57,301**	**9,623**	**87,528**	**-2,586,984**	**-528**	**-93,468**	**14,400**	**-2,666,580**
Total In-Year Surplus / (Deficit)	**-91,400**	**-76,466**	**-167,866**	**-19,681**	**3,758**	**-7,825**	**968**	**57,301**	**-14,902**	**87,528**	**-60,718**	**-1,877**	**-412**	**14,400**	**-48,608**

The recovery plan and next steps within the overall planning context

1. Opportunities

To include (but not exclusive to)

- Ideas from 24th January
- Current live projects (including recovery plan)
- Portfolio and Enabling Functions Priorities and Delivery Plans
- National guidance
- Strategies

2. Alignment

Operational Plan 2024 – 2025 (priorities)

ICP Strategy

Joint Forward Plan

2a. Assessment by SRO/project team

Ongoing assessment of projects as they progress

Examples include

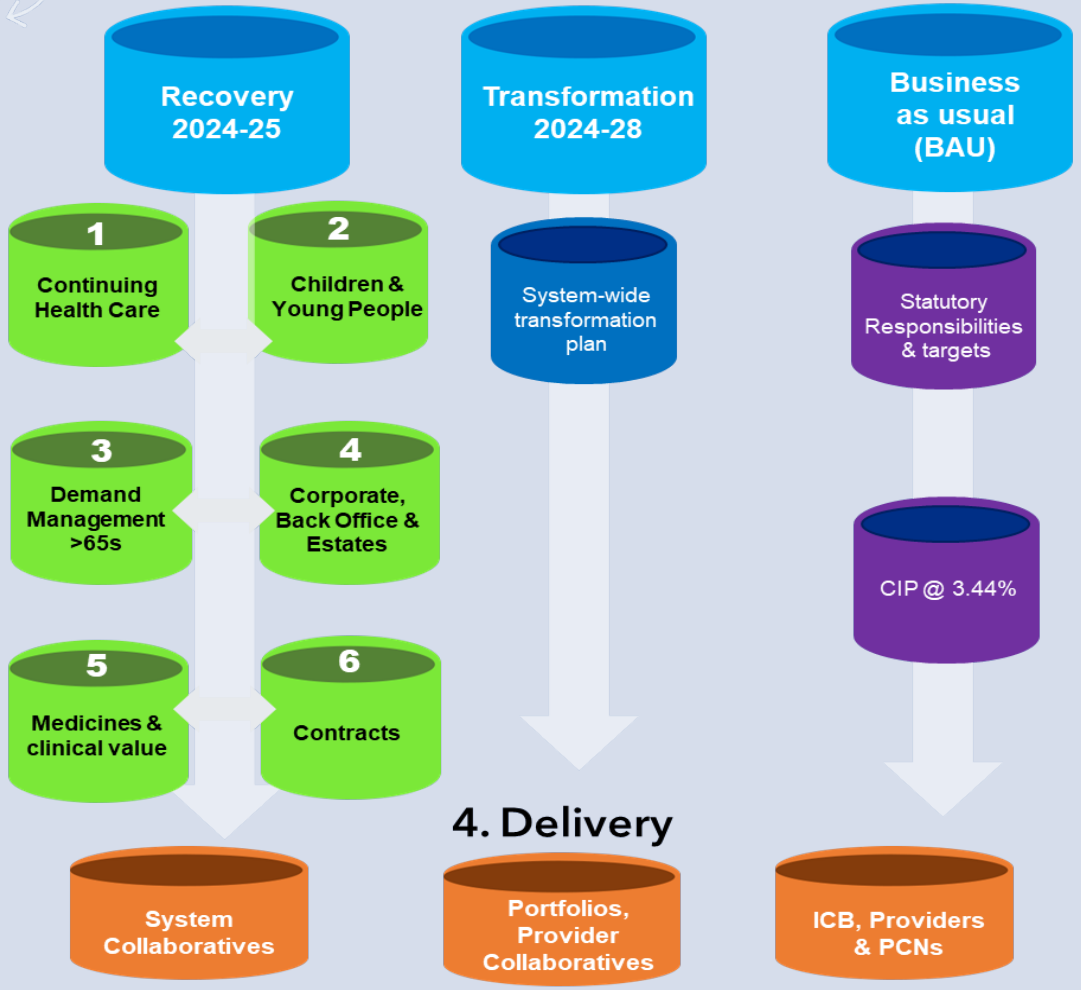
Does it

- Address health inequalities?
- Improve clinical outcomes
- Reduce activity into Secondary care?
- Improve Productivity?
- Reduce service costs?

Underpinned by

- Quality Impact assessments (IA)
- Equality IA
- Financial IA
- Sustainability IA
- Statutory Dependencies

3. Designation



Long list of opportunities identified by system leads

Align & short list against the 5 system Op plan priorities 24/25 & 2 key aims

Demonstrate that achieves an outcome

Designated into Recovery 2024-2025 Transformation and Business as Usual

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 15

Report to:	**Integrated Care Board**					
Date:	**21 March 2024**					
Title:	**People Culture and Inclusion Assurance Report**					
Presenting Officer:	Mish Irvine, Chief People Officer ICB					
Author(s):	Gemma Treanor, Head of ICS People Function Helen Conway, ICS Strategic Workforce Planning 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**	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:	People Culture and Inclusion Assurance Report					

(1) Purpose of the Paper:
The purpose of this paper is to provide 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).

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
People Culture and Inclusion Committee	13/03/2024
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	Delivery of Local people Plan, Joint Forward Plan and Long term Workforce Plan. NHSE workforce controls and reporting. ICB statutory duty for education and training
CQC or Patient Safety	NHSE reporting and assurance on workforce planning and metrics
Financial (CFO-assured)	External funding supports delivery of schemes including NHSE, ICB, being monitored and reported. Specific challenges in relation to agency, operating plan and workforce affordability in line with financial envelope.
Sustainability	Across all programmes. Specific activity linked to Green/Sustainability plans
Workforce or Training	Across all programmes – detailed in report
Equality & Diversity	Across all programmes – detailed in report

Due Regard: Inequalities	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers
Due Regard: wider effect	Population health and health inequalities links to all programme activities, strengthening our community engagement and offers

(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 report outlines the current position regarding workforce within SSOT.

Over the past 12 months, in line with the workforce plan, there has been a growth in substantive workforce in our System which has had a positive impact on care quality, morale and use of temporary high cost workforce. The National Long Term Workforce plan outlines a significant increase in workforce numbers required in 15 years to ensure safe staffing levels. However the financial challenge our System is in will require us to consider carefully the workforce models that are implemented to ensure maximum productivity is achieved by flexible teams doing tasks that are appropriate to their competency level. We must continue to innovate and create new roles to support the skill mix which draw on our wider community by being inclusive and retain our valuable existing highly skilled workforce.

The following areas are detailed in the report:
- Current workforce position
- Operational Workforce Plan
- People risks
- People Programme priorities
- People, Culture and Inclusion Programme delivery

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to: Note the workforce position, risks and mitigations in place to address.

Staffordshire and Stoke-on-Trent Integrated Care System

ICS People Culture & Inclusion Performance and Assurance Report

SSOT ICB Board in Public

March 2024

Executive summary for ICB Board

This report will outline:

- An executive summary outlining key headlines and escalations in relation to People, Culture and Inclusion
- Current workforce metrics, position and controls
- Operational Planning
- Risks /challenges and mitigation
- People Programme delivery

Executive Summary:

- This report outlines the current position regarding workforce within SSOT. Over the past 12 months, in line with the workforce plan, there has been a growth in substantive workforce in our System which has had a positive impact on care quality, morale and use of temporary high cost workforce. The National Long Term Workforce plan outlines a significant increase in workforce numbers required in 15 years to ensure safe staffing levels. However the financial challenge our System is in will require us to consider carefully the workforce models that are implemented to ensure maximum productivity is achieved by flexible teams doing tasks that are appropriate to their competency level. We must continue to innovate and create new roles to support the skill mix which draw on our wider community by being inclusive and retain our valuable existing highly skilled workforce.
- The following areas are highlighted:
- Current workforce position - Substantive and Bank workforce increases have been sustained, this along with enhanced workforce controls, is starting to have a positive impact on agency usage (3.2% of pay spend), vacancy levels, but also key workforce indicators including improvements in sickness and turnover.
- Operational Workforce Plan – A supporting delivery plan has been developed to support the delivery of the workforce plan. A high level plan (SSoT level) was submitted to NHSE national planning on 27th Feb 24, with a medium level plan (organisational and staff group) was submitted to NHSE region on 4th March 24. Work is underway to further develop and refine the workforce plans in preparation for the 1st granular plan submission to NHSE on 21st Mar 24, ahead of what is expected to be the final plan submission, 2nd May 24.
- People risks have been robustly reviewed and reflect the current risks across the partner organisations. The top risks to the system are: Agency usage and spend; Employee Wellbeing/Retention; and Ability to meet demand and Long Term Workforce Plan growth with financial deficit, workforce controls, supply, future pipeline, and availability of registrants.
- Overall People Programme priorities have been agreed for 2024/25 to support the achievement of the system priorities and recovery with particular focus on reducing spend, increasing reform and creating efficiencies
- People, Culture and Inclusion Programme delivery is overall on track, with actions in place to address those areas challenged (e.g. agency reduction, WRES/WDES standards and Staff Psychological and Wellbeing Hub funding).

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce position and controls

Staffordshire & Stoke-on-Trent NHS: January 2024

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Workforce

Total Workforce
24,043 WTE
Currently +1,632wte (Feb23)

Substantive
21,880 WTE
Currently +1,472wte (Feb23)

Bank
1,656 WTE
Currently +312wte (Jun23)

Agency
506 WTE
Currently -243wte (Jun23)

Temporary Workforce
9.0%
Currently -1.3% (Mar23)

Agency Spend
£3.4M (3.2%)
Currently -£1.6M (Jun23)

Vacancies
2,376 wte (9.8%)
Currently -778wte (Apr23)

Joiners
330 wte
Currently +119wte (Mar23)

Leavers
153 wte
Currently -56wte (Sep23)

12 Month Rolling KPI's (%)

9.3% Turnover Rate
Currently -2.1% (Feb23)

5.1% Sickness Absence Rate
Currently -0.6% (Feb23)

93.1% Mandatory Training
Currently +0.2% (Feb23)

Other Health and Care Workforce

SSOT ICB Workforce
277 WTE

Primary Care Workforce
2,872 WTE

Social Care Workforce
20,000 WTE

Dentistry Workforce
610 Headcount

Current Workforce Position – January 2024

Staffordshire and Stoke-on-Trent Integrated Care System

1) Total Workforce (WTE) – 24M	2) Substantive WF (WTE) – 24M	3) Bank Workforce (WTE) – 24M	4) Agency WF (WTE)– 24M	5) Vacancies (WTE) – 24M
Staff in Post (Total Workforce wte) Jan 24: **24,043** Jan 23: **22,175** 12M Change: **+1,868** FYTD Change: **+1,587**	**Staff in Post (substantive wte)** Jan 24: **21,880** Jan 23: **20,352** 12M Change: **+1,528** FYTD Change: **+1,202**	**Bank Usage (% of total staff)** Jan 24: **6.9%** Jan 23: **5.9%** 12M Change: **+0.9%** FYTD Change: **+0.9%**	**Agency Spend (% of total pay spend)** Jan 24: **3.2%** Jan 23: **3.6%** 12M Change: **-0.4%** FYTD Change: **-1.0%**	**Vacancy (%)** Jan 24: **9.8%** Jan 23: **12.2%** 12M Change: **-2.4%** FYTD Change: **-3.2%**

Staff in Post & Ops Plan

- Total workforce is currently above operating plan by +322 wte, this applies for substantive and bank, but positively below plan for agency.
- **However total workforce remains below the budgeted establishment (Mar-24) by -214 wte**
- Winter plan adjustments have been reflected from Nov-23.

Staff in Post & Ops Plan

- Total workforce is currently above operating plan by +322 wte, this applies for substantive and bank, but positively below plan for agency.
- **However total workforce remains below the budgeted establishment (Mar-24) by -214 wte**
- Winter plan adjustments have been reflected from Nov-23.

Bank Usage

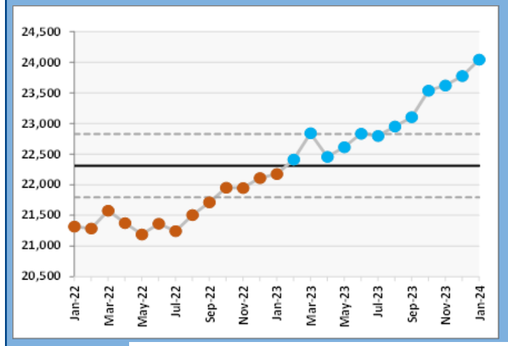
- SSoT to reduce reliance on agency.
- Bank workforce is currently above plan by +207 wte predominantly in Registered Nursing and Support to Clinical.
- System wide agreement in place for enhanced bank rates are in place following review of efficacy of this approach in FY22-23.

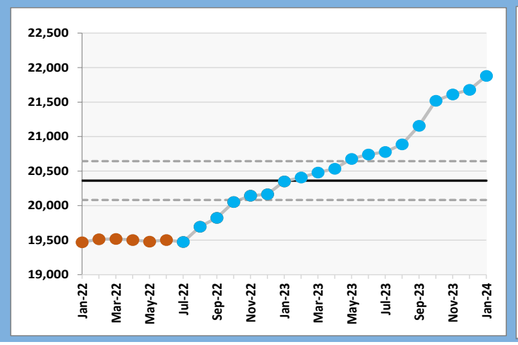
Agency Workforce

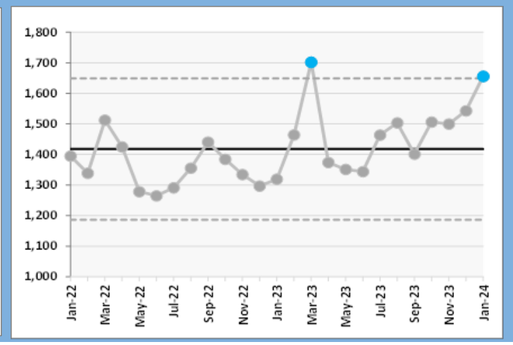
- Agency spend as of Jan-24 is currently 0.5% below 3.7% target (agency of total pay spend).
- Areas of sustained use relate to medical and registered nursing.
- Work is underway to respond to the PWC recommendations and assurance of progress will be obtained by a level of attainment (LoA) approach.

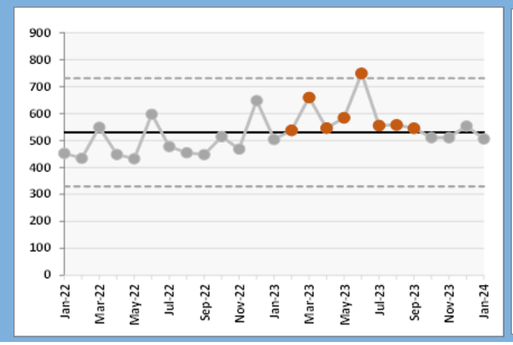
Vacancy

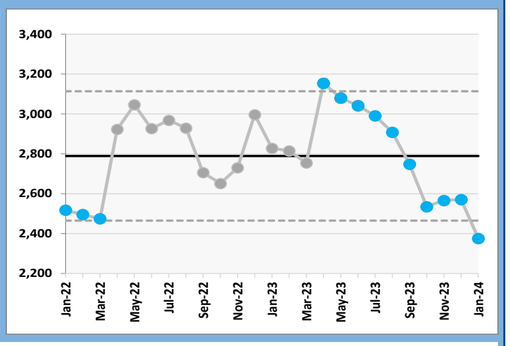
- Our vacancy position has periodically improved since the highest 12m position which was in Apr-23 (currently 778 wte lower).
- Supporting interventions are in place, including a vacancy management process for all non-clinical corporate roles across the system.











KPI

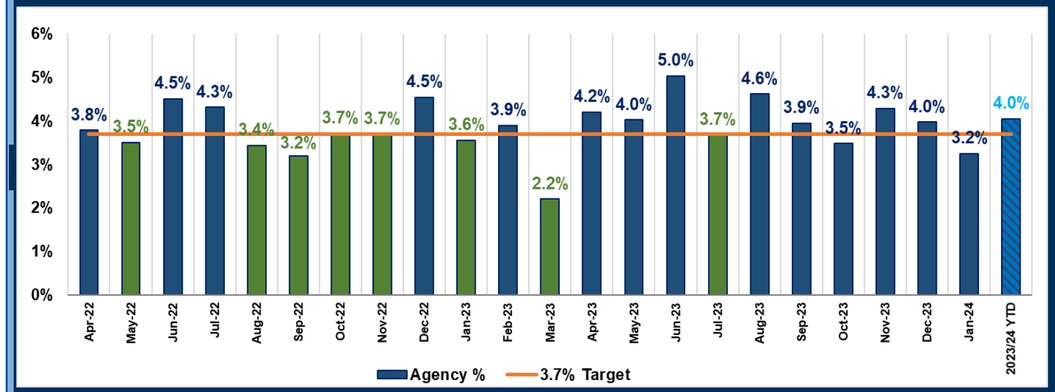
- **Turnover** levels continue to improve. Significant activity is underway at system level to continually address the levers that impact retention.
- **Sickness** is an improved position. A health and wellbeing committee has commenced to understand the key issues and develop structured improvement in these areas. Oversight of sickness in the remaining period of Q4 will remain critical.

Workforce Controls

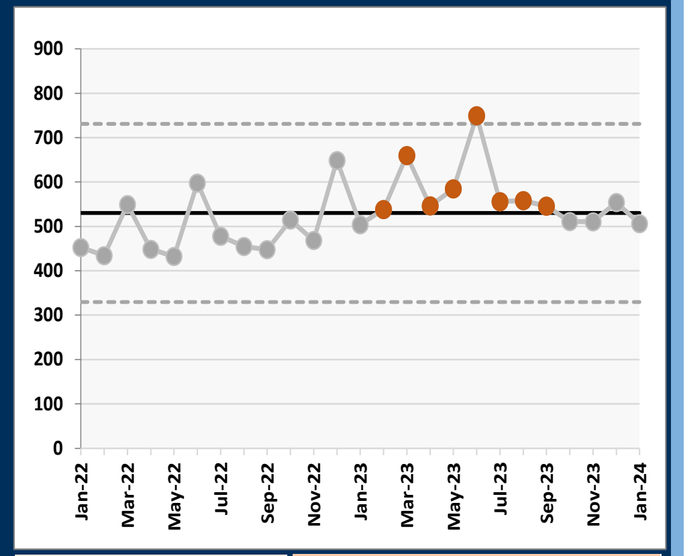
Staffordshire and Stoke-on-Trent Integrated Care System

PWC Report Findings – Opportunity for Enhancement	High	Medium	Low
External / agency controls and authorisation processes	6	9	0
Internal temporary staff controls and authorisation processes	0	10	4
Pay Controls	0	4	0
Temporary Staffing Governance	0	10	1
Temporary Staffing Governance and External / agency controls and authorisation processes	0	4	0
Vacancy Control	0	19	0

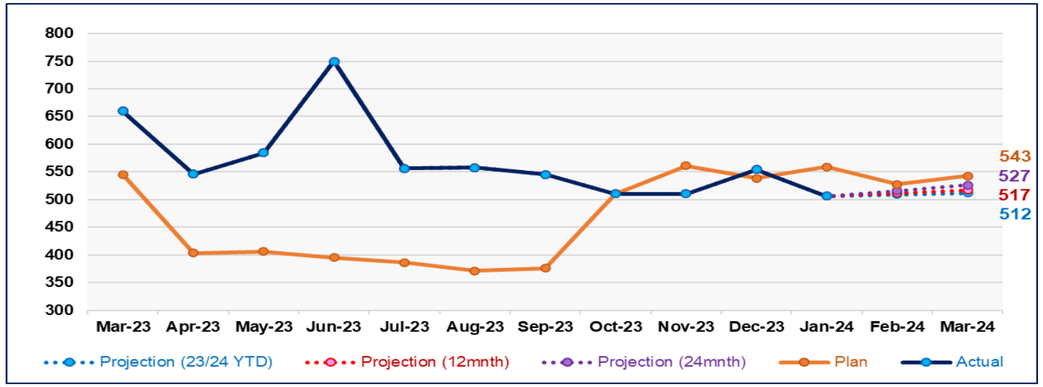
Agency Spend: % of Agency Spend of Total Workforce Paybill



Agency Trend (SPC)



Plan vs Actual vs Forecast (WTE)



Jan 24 WTE (Month Change)	
506 (- 48)	
Feb 23 to Jan 24 Change (WTE)	
- 32 / - 6.0%	
Jan 24: Difference from Plan	
- 53 WTE	

Staff Group: Actual / Variance from Plan	
Registered Nursing:	220 (+ 124)
Registered ST&T:	68 (+ 15)
Support to Clinical Staff:	92 (+ 30)
Infrastructure Support:	24 (- 13)
Medical & Dental:	101 (+ 7)

- Following introduction of additional workforce controls and review undertaken by PWC, NHS Trusts and ICB have strengthened their internal systems.
- This includes agency and bank usage and spend, recruitment and vacancy scrutiny processes.
- Vacancy scrutiny panels are in place internally within NHS Trusts and the ICB, supported by robust vacancy control systems and panels with Executives.
- Assurance is provided centrally via weekly returns to ICB and NHSE, reporting current position and progress.
- The ICS People Function works with partners via several programme approaches to address any deterioration in position, focus on shared challenges and implement solutions to improve the position.
- System Executives continue to monitor and work collaboratively to ensure appropriate scrutiny is in place, system-wide solutions explored to gain efficiencies, with quality and safety paramount.
- System is working with providers to oversee PWC Grip and Control recommended improvements and has developed a LoA approach to assess position.

Staffordshire and Stoke-on-Trent Integrated Care System

Operational Planning

Operational Plan

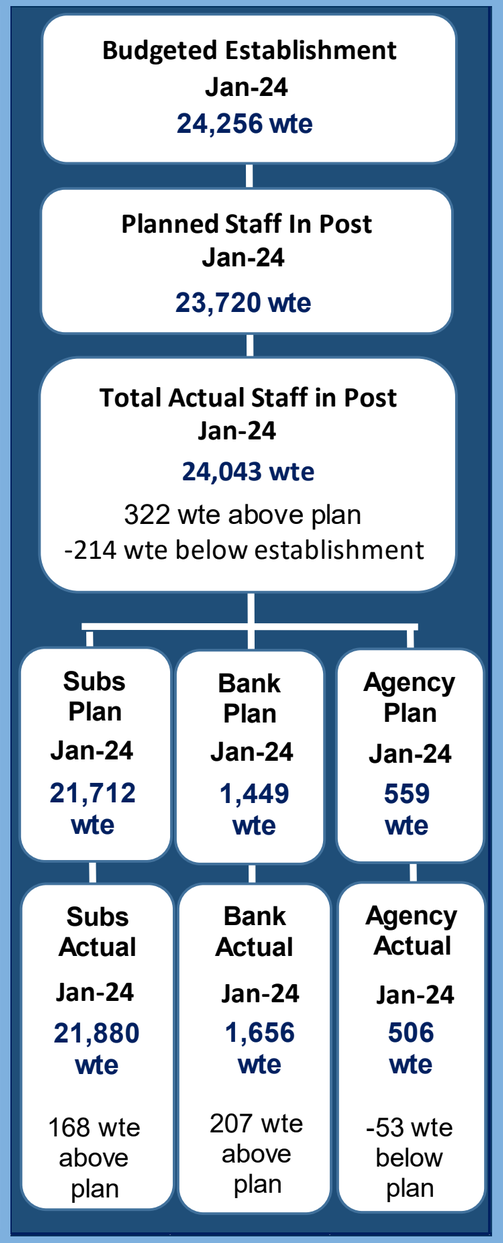
Staffordshire and Stoke-on-Trent Integrated Care System

Operational Plan FY23-24

- Operational workforce plan was adjusted in Dec-23 to reflect a revised operating plan position for the period Nov-23 to Mar-24.
- The workforce plan position to the left, incorporates the revised plan position.

Position to Plan:

- Total workforce levels as at Jan-24 equated to 24,043 wte, which is currently +322 wte (+1.4%) above the operational workforce plan of which:
  - Substantive levels are currently +168 wte above the plan
  - Bank levels are currently +207 wte above the plan
  - Agency is currently -53 wte below plan, which is positive.



Operational Plan FY24-25

- Operational planning round for FY24-25 is currently underway
- There is currently an absence of Strategic Operational Planning Guidance which was understood to be in a position to release after the government budget announcements.
- In terms of process system is working closely with providers to develop the operational workforce plan, which in terms of content remains relatively unchanged from FY23-24, which is helpful from a continuity and consistency basis.
- The operating workforce plan comprises of the following elements:
  - NHS Provider Return – all providers to complete a FY24-25 planned staff in post position, which includes:
    - Opening and closing establishment
    - Monthly planned staff in post (substantive, bank and agency)
    - Supply bridge – how any change (additionality/increases) will be delivered
    - Workforce KPI's – sickness and turnover
  - Hosted staff
  - Primary Care workforce plan
  - MH workforce plan, including:
    - NHS MH Providers
    - NHS Non-MH Providers
    - Non NHS MH Providers
- To date we have completed a high level return (27th Feb) to national NHSE and a medium level return (4th March) to NHSE Midlands. The workforce plan currently details modest growth. At the time of writing this content, work towards the 21st March deadline in providing a granular plan to NHSE, with a final submission expected for 2nd May. For this reason it is deemed premature to share details of the workforce plan whilst this is being worked up through, the operational planning process.

Staffordshire and Stoke-on-Trent Integrated Care System

Workforce challenges, risks and mitigation

Solving the workforce conundrum

Workforce challenges and forces

- £240m Deficit- Significant Workforce Financial Savings 24/25
- Maintain Positive Workforce Experience & Wellbeing
- Long Term Workforce Plan approx. 6000 for SSOT
- Limited resource for training & development
- Grip & Control

Sustainable, affordable and healthy workforce

To deliver the financial savings and meet the demands of the population now and in the future, we will need:

Activities and solutions

- Further develop workforce collaboration as a system
- Work smarter, with less financial resource
- Improve wellbeing of our people
- Skill mix with unregistered roles
- Continue to build the future pipeline

Risks, challenges and mitigation

The Risks and Challenge

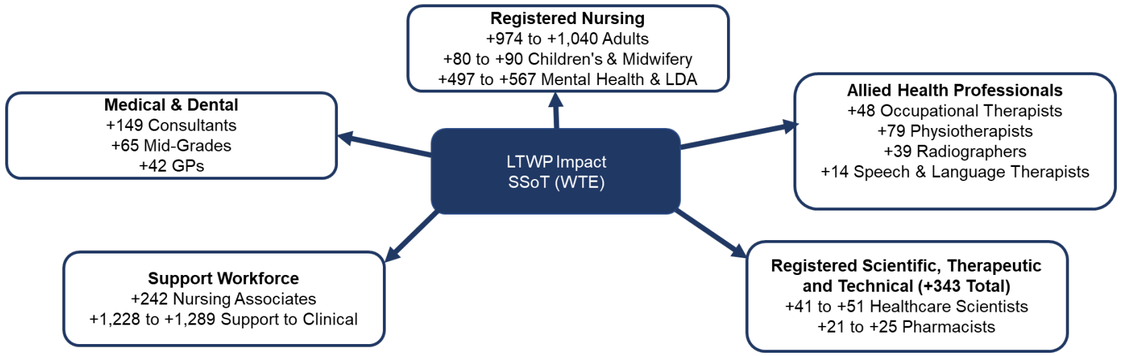
Following a deep dive into risks at the January 24 Committee, the following risks are identified on the People Culture and Inclusion Risk Register:

- Agency usage and spend
- Ability to deliver the Local People Plan programmes, People Operating Model and Long Term Workforce Plan
- Employee Health Wellbeing and Retention
- Ability to meet demand and Long Term Workforce Plan growth with financial deficit, workforce controls, supply, future pipeline, and availability of registrants'
- Industrial Action

Mitigating actions to reduce the impact of the risks is outlined in the People Programme Priorities, activities and programme delivery.

Long Term Workforce Plan (LTWP)

- Based on the NHSE long term workforce plan (LTWP) (June 2023) which models the expected workforce increases, when applying proportionately to Staffordshire and Stoke-on-Trent (SSoT), equates to potential increases between 5,200 to 6,800 whole time equivalent (wte) (increase of between 22.8% to 30.1%).

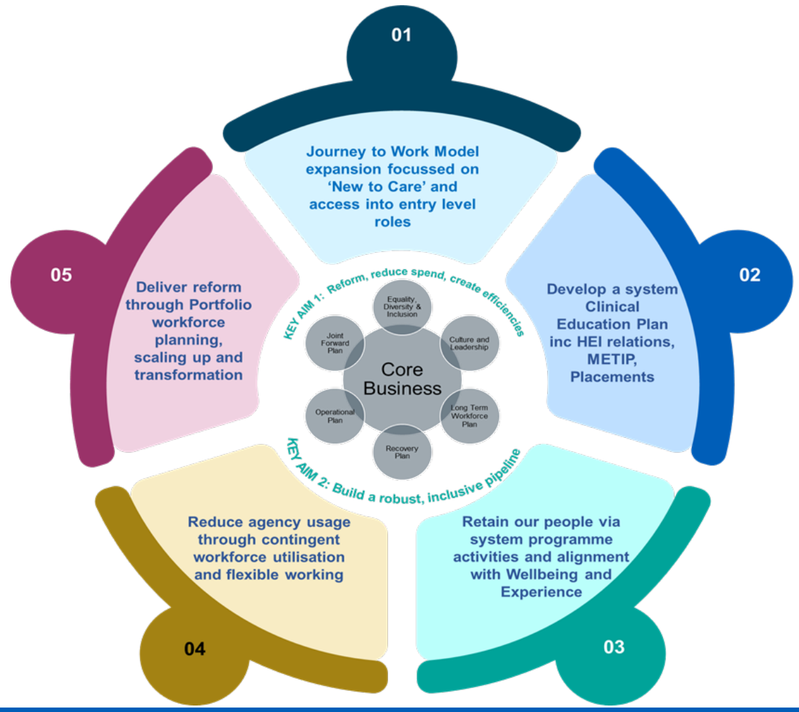


NHSE LTWP Priorities:

1) Productivity, 2) Improving access routes, i.e. apprenticeships, 3) Retention, 4) Medical expansion & reform, 5) Clinical expansion and reform (non-medical).

FY24-25 People Programme Priorities

- The current challenge necessitates a shift in focus for the Integrated Care System (ICS) People function to support the achievement of the system priorities and recovery in 2024/25.
- The key principles / aims of the 2024/25 approach will be to:
  - Reduce spend, increase reform, create efficiencies
  - Focus on collaboration and scaling; transformation, productivity, helping our local population access and entry level routes into health and care careers, securing our future pipeline; clinical and professional engagement.
  - Deliver specific projects aligned to National and Local priorities; undertaking reactive and future planning activities which create a sustainable workforce.



Staffordshire and Stoke-on-Trent Integrated Care System

People Culture and Inclusion Programme delivery

ICS People, Culture and Inclusion Programme Delivery

- Progress within programmes against agreed targets and metrics is reported via People Collaborative Board and People Culture and Inclusion Committee
- Below highlights from Jan – Feb 2024 position. Amber ratings = Inclusive recruitment programme is new; Agency reduction subject to ongoing review and actions to reduce; Digital People Plan delivery delayed due to competing demands; WRES/WDES – further improvements required to meet standards and workforce to be representative with parity across the system; Psychological Wellbeing Hub subject to business case to extend service beyond Sept 24.
- The 2023/24 Annual report is currently being prepared to captured programme achievements, year-end position and 2024/25 programme delivery.

Workforce supply – resourcing and retention	Workforce transformation and future pipeline	Equality, diversity and inclusion (EDI)	Employee experience, health and wellbeing	System culture and collaboration	Leadership and talent
• ICS People Hub inc Social Care and Admin Hubs • Reserves inc NHSE Pilot • Contingent Workforce Deployment • Redeployment • Retention Programme • New to Care Academy – access to jobs, outreach into communities • Inclusive Recruitment • Resourcing diagnostics: focus on shortage occupation, agency reduction	• Portfolio and profession workforce planning and transformation • Programme delivery e.g. Surge Plan, Recovery Plan, People Services at Scale • NHSE Workforce Development and Education funding – including Multi-professional Education and Training Investment Plan (METIP) • Education, Training and Development inc Clinical Placement Project • Widening participation – including J2W, ICS Apprenticeships, National T-Levels Pilot • Educational Engagement (in partnership with CYP) • ICS Strategy – Digital, Green	• Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) • Staff networks • Differently-abled buddy scheme • Inclusion School • EDI training and development – including New Futures, Comfortable Being Uncomfortable with Race and Difference • WRES Champions • Reciprocal Mentoring • #InclusiveHR Scheme	• Employee Experience & Wellbeing insights • Employee Wellbeing & Wellbeing Strategy • Staff Psychological Wellbeing Hub • Wellbeing resources and events • Occupational Health Provision	• PCN OD programme • System OD Plan	• High Potential Scheme • Coaching and Mentoring Pool • Exec and Senior Leader development – including System Connects, Alumni • Scope for Growth pilot

RAG Key:

On Track

Some elements behind schedule but mitigations in place

Significantly behind schedule

Complete

New programme

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Julie Houlder, Non Executive Director (Vice Chair)
Executive Lead:	Mish Irvine, Chief People Officer
Date:	Wednesday 13th March 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Remembering Paul Draycott, CPO NSHCT	The Committee began the meeting by formally acknowledging the passing of Paul Draycott, Chief People Officer at NSCHT. The Chair shared Paul's biography and led tributes from the Committee. It was noted that NSCHT colleagues are planning a formal tribute later this year and members were encouraged to visit the book of condolences.	
Staff Story	The Committee heard from ICS Outreach and Inclusive Recruitment Manager, Ruth Beard, and Betsalot Kiflay. Ruth provided an overview of the schemes her team leads on in working with system and wider partners to support people from seldom heard communities into health and care careers. Betsalot shared her experience and support gained via the Traineeship programme initially upon arriving in the country as a young refugee and how she has been part of the ICS rotational health and care apprenticeship programme. She shared that the schemes have helped her gain skills and qualifications. Betsalot also shared her positive experience of her Apprenticeship which has helped her to 'earn and learn'. She is currently working with the team to explore her next steps and is considering a career nursing. The Committee commended the work of the team in supporting people from seldom heard communities. The Committee also thanked Betsalot for sharing her health and care career journey and encouraged her to pursue her passion for nursing.	
People Culture and Inclusion Programme Assurance	Members received a high level summary of the People Culture and Inclusion Programme activities and assurance regarding delivery and progress. The Committee was assured that the programmes were on track and being monitored via the People Collaborative Board. Committee members welcomed the new style of	

	reporting and that this would be included in the ICB Board Assurance reporting going forward.	
People Metrics and Workforce Controls	The Committee was provided a summary of the workforce position and metrics for January 2024 (included in the people Assurance report to ICB Board). The committee noted the positive yet challenging position regarding the vacancy and staff in post position, improvement in agency spend, turnover and sickness rates. A discussion took place regarding the reporting of Social Care workforce information and the commitment to include this in reporting. The PWC report and workforce controls were highlighted, and assurance provided regarding levels of attainment in implementing the recommendations. Work is ongoing with providers to improve the position and work collectively to address key areas. The Committee were assured that the workforce position, metrics and controls are being monitored robustly and collaborative working continues with partner organisations and ICB leads.	
People Culture and Inclusion Risks	The Committee received an overview of the current People risks - with permission sought to close three risks and introduce one new risk. Members noted that the deep dive conducted in January and work outside the committee with partners provided robust assurance regarding management of risks. The Committee requested additional work be undertaken to review the 'Care Home and Home Care workforce capacity' risk.	Referral to People Collaborative Board to review Care Home and Home Care Workforce Risk.
Strategic People, Culture and Inclusion Update	Committee members received an update regarding the strategic people context as follows: - NHSE Regional Inclusive Leadership and Accountability Conference – members received an update regarding the recent event which was attended by NHS organisation representatives. Those in attendance reflected on the important messages and key note speeches highlighting the progress still to be made in inclusive leadership, accountability and action being taken to tackle racism. Members committed to further work on this collectively. - ICB Board People Deep Dive – members were updated on the deep dive session for People in February and welcomed the support and commitment for the people agenda from the ICB Board. - Forward planning for the May Committee Development session was discussed and	Referral to ICB Board and People Collaborative Board regarding Inclusive Leadership and Accountability

	members welcomed the event to discuss and plan the future of the Committee as senior leaders collectively.	
Strategy and Planning	2024/25 System Priorities Members were provided an update regarding the event held in January, the identified system priorities and methodology developed to determine and deliver the agreed priorities by system partners. The Committee welcomed the update and acknowledged the challenges associated with determining the priorities and developing programmes which deliver the transformational changes required to support system recovery and improve the financial position. Members recognised the impact of and on the workforce, and the importance of maintaining quality and safety. Operational Plan 2024/25 (included in People Assurance report) The Committee was provided an update on the FY24-25 operational planning round and progress to date, which included: 1) Operational Planning approach, 2) High level planning submission for NHS providers. Members were provided information on key milestones, the bridge exercise and advised that the plan is under ongoing development with further iterations of the plan to be shared as and when available. The Committee acknowledged the recent submission, timescales and further iterations of the plan expected. Members acknowledged the challenges associated with developing the plan against the financial position, and thanked partners for their continued efforts in developing the agreed system plan.	
People, Culture and Inclusion Programme focus	Too Hot to Handle Report The Committee were provided a summary of the report which highlights experiences of NHS staff who raised concerns about racism in their workplaces. Too Hot to Handle? (brap.org.uk) The Committee acknowledged the report, its findings and committed to taking further action in line with the evidence in a way that will create greater impact in how racial discrimination is addressed across our Partner organisations.	ICB Board acknowledgement of report and commitment Referral to People Collaborative Board agenda Item April Agreement to include EDI as standing PCI Committee agenda item

Risk Review and Assurance Summary
The following points were highlighted by the Committee: • Inclusive Leadership and Accountability and the 'Too Hot To Handle' report – require commitment from PCI members and the ICB Board to drive forward recommendations and

collective actions.

- Ongoing delivery of People, Culture and Inclusion programme activities in line with system and financial context
- Risks associated with delivering Operational Plans and the workforce position with the financial context
- Assurance received regarding management of People Risks with clear actions and mitigation agreed

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Enclosure No: 16

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee (Part B)
Chair:	Mish Irvine, Chief People Officer (Interim)
Executive Lead:	Tracey Shewan, Director of Corporate Governance
Date:	Wednesday 13th March 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Freedom To Speak Up (FTSU) Report	Committee members received a Freedom to Speak Up Report that detailed key activities that the FTSU Guardians have undertaken since August 2023 to date. Committed members noted the report and it was agreed the report and self-assessment be shared with the Board.	
2023 Public Sector Equality Duties (PSED) Annual Report	Committee members received a 2023 Public Sector Equality Duties (PSED) Annual Report, which had also been presented to the ICB Executive Team last week. This report will enable the ICB to evidence compliance with its (PSED) and will be presented to the Board. The Committee approved the report.	
2023 Workforce Diversity Profile Report	Committee members received a 2023 Workforce Diversity Profile Report. The report forms part of the reporting duties set out within the Equality Acts, Public Sector Equality Duties, that the ICB is required to produce and publish equality information. The Committee approved the report.	
Quarter 3 2023-2024 Workforce Report	The Committee received the Quarter 3 2023-2024 Workforce Report containing the following data; • Staff In Post • Staff by Pay Band • Leavers and Turnover • Sickness Absence • Mandatory and Statutory Training The Committee noted the report.	
ICB 2023 NHS Staff Survey Summary Slides	The committee received the ICB 2023 NHS Staff Survey Summary Slides. The Committee noted the slides.	

HR Policies	The committee received and approved the following HR Policies that were due for review; • Apprenticeship Policy • Career Break Policy • Grievance and Disciplinary Policy • Training and Development Policy • Staff Volunteering Policy • Work Experience Policy	

Risk Review and Assurance Summary

Staffordshire and Stoke-on-Trent Integrated Care System

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure No: 17

Report to:	**Integrated Care Board**					
Date:	**21 March 2024**					
Title:	**ICB Constitution Changes required by NHS England**					
Presenting Officer:	Tracey Shewan					
Author(s):	Tracey Revill / Paul Winter					
Document Type:	Other	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:	NHSE's required amendments Briefing Note					

(1) Purpose of the Paper:
NHSE have made some amendments to their guidance for a Model ICB Constitution. These mandatory changes are detailed in the attached paper.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Execs and NEDs Meetings	01/02/2024
Click or tap here to enter text.	Click or tap to enter a date.

(3) Implications:	
Legal or Regulatory	The ICB is legally required to have a Constitution; and is required to update it as guidance suggests. The Constitution sets out Terms of Reference for the ICB Board.
CQC or Patient Safety	Reviewed and not considered applicable.
Financial (CFO-assured)	There is no financial impact.
Sustainability	Reviewed and not considered applicable.
Workforce or Training	All staff are to familiarise themselves with the Constitution.
Equality & Diversity	For all regardless of ethnicity / gender etc.
Due Regard: Inequalities	Reviewed and not considered applicable.
Due Regard: wider effect	Reviewed and not considered applicable.

(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:

NHSE has asked ICBs to make amendments to their Constitutions at the next opportunity. These are set out in the attached supporting document. The Board are asked to review and agree to these amendments for changes to our Constitution; and to note the suggested process for confirming their approval by NHSE.

(7) Recommendations to Board / Committee:

The Board are asked to Approve that:

(a) ALL the mandated NHSE changes are made forthwith to the Staffordshire & Stoke-on-Trent ICB Constitution, as outlined in Section 2.3 of the Briefing Note;

(b) A letter from the ICB Chair is then sent, alongside the updated Constitution (enacting the above), to the NHS Regional Director.

Amendments to ICB Constitutions

(1) Introduction

1.1 Under national policy, ICB Constitutions can only be amended with the approval of NHS England (NHSE). NHSE have recently identified a number of relatively minor legal, procedural or technical changes that supersede their May 2022 Statutory Guidance to CCGs on the preparation of ICB Constitutions.

1.2 To enable the changes to be made in line with national requirements, NHSE have recently re-issued their 'Model Constitution' template and accompanying guidance. The template is pre-populated with the necessary changes that an ICB must make.

(2) Action Required of ICBs

2.1 The ask is that where an ICB has not already made the amendments to their Constitution required in Section 2.3, that they are to do so at their next available opportunity. The Board is asked to note that these particular changes are nationally generated by the Centre; rather than being locally self-selected by our ICB.

2.2 NHSE Constitution Change Policy normally requires notifying any proposed changes to our Region first, seeking their approval (before they can legally be made effective). This time, a return letter from ICB Chairs confirming the changes are made is required. Alongside an updated Constitution, for NHSE Region cross-checking.

2.3 The following sets out NHSE's amendments that are required by all 42 ICBs:

- Making one of the Non-Executive Members[1] but not the Audit Committee Chair, also the Deputy Chair of the Board. *(This is not intended to be a new appointment; rather to ensure that if the Chair is unavailable, for a short or sustained period, it is clear who will chair Board meetings. They would not become the Chair as that is an appointment of the Secretary of State. Local quoracy rules should allow the Board to meet without the Chair).*
- Ensuring that the Chair's period of office is expressed clearly as a maximum, rather than a fixed term, recognising that Interim Chair appointments (approved by the Secretary of State) may be necessary.
- Confirming that a proposal for the Chair or a Non-Executive to serve on the Board for **longer than six years** will be subject to rigorous review to ensure their ongoing independence, and they will not serve as a Board Member for **longer than nine years in total** (consistent with the 'Code of Governance' for NHS Providers[2]).
- Updating all sections and references to Procurement Rules, in order to take account of the January 2024 introduction of the new Provider Selection Regime.
- Removing all clauses referring to the Establishment of ICBs.

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[1] Technically, this Health & Care Act provided nomenclature must be in the Constitution. While it is in the main so expressed in ours, local custom & practice has historically referred to these as 'Non-Executive Directors' or 'NEDs'. We should consider sticking to the integrity of the Act's formal designations. Especially as Statutory Guidance now requires:

"NHSE and the Model Constitution use the [term] to identify different types of 'Ordinary Member' and these terms must not be departed from in ICB Constitutions."

[2] NHSE Regional Directors will make arrangements with ICB Chairs so there is not a large wave of ICB Chairs or of Non-Executive Members stepping down at the same time. Maximum periods in post for Partner and "Other" Board Members may be set locally by the ICB.

- A small number of cross-reference changes to other post-July 2022 legislation as made.

2.4 In addition, certain sections of NHSE guidance are updated to support ICBs to ensure:

- They are compliant with the Statutory Duty under the Act to keep under review the skills, knowledge and experience of the Board.[3]
- Their Conflicts of Interest Policy takes account of the introduction of the Provider Selection Regime and early NHSE-ICB findings on the management of Conflicts of Interest.
- They recognise the options related to the flexibility to delegate ICB functions to, or jointly exercise them with, certain other Public Bodies.[4]
- Portfolios of Board Members give Board-level leadership on specific issues as has been articulated in that guidance.[5]

(3) Recommendations to the Board:

3.1 The Board are asked **to Approve that**:

(a) ALL the mandated NHSE changes are made forthwith to the Staffordshire & Stoke-on-Trent ICB Constitution, as outlined in Section 2.3;

(b) A letter from the ICB Chair is sent alongside the updated Constitution document (enacting the above) to NHS Regional Director.

[3] Ministers made a commitment to Parliament that NHSE would issue guidance to ICBs on complying with this duty. The updates to this guidance meet that commitment.

[4] NHSE Statutory Guidance provides further explanation, including on accountability and imposes a number of restrictions on ICB functions that cannot be delegated, or makes their delegation subject to certain / specific conditions.

[5] The ICB Chair + Non-Executive Members may hold roles with other health & care organisations outside the ICS but must ensure that their commitments allow them to fulfil their ICB duties. NHSE expects to issue appointments guidance soon, to use in assessing whether proposed additional appointments for a Trust or ICB Chair should be considered appropriate.

Enclosure No: 18

Report to:	**Integrated Care Board**					
Date:	**21 March 2024**					
Title:	**Freedom to Speak Up (FTSU) Report**					
Presenting Officer:	Tracey Shewan, Director of Corporate Governance					
Author(s):	Shabana Mahmood, Medicines Optimisation Pharmacist and Tracey Revill, Interim Deputy Head of Governance					
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:	FOI Report					

(1) Purpose of the Paper:
The ICB is committed to creating a culture in which Freedom to Speak Up is business as usual. The purpose of this paper is to provide the Board with an update of contacts received during August 2023 to 4th March 2024 and the work undertaken to date.

(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.

(3) Implications:	
Legal or Regulatory	There is a requirement for the ICB to provide channels for staff to raise any concerns they have in relation to the organisation, their roles and impact on patient services.
CQC or Patient Safety	FTSU is at the forefront of safety for all staff and patients.
Financial (CFO-assured)	No financial impact, roles are voluntary.
Sustainability	This will be reviewed on an on-going basis.
Workforce or Training	FTSU training has been rolled out as part of mandatory training for all staff.
Equality & Diversity	FTSU is inclusive for all with no discrimination.

Due Regard: Inequalities	There are no inequalities identified.
Due Regard: wider effect	There are no wider effects identified.

(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	☐	☐	☒	Not applicable in relation to this report.
	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:

The FTSU report details the key activities that the Guardians have undertaken during August 2023 to date. Attached to this report is a copy of the workplan which sets out core activities to be undertaken during the coming year.

The Guardians have regular catch-up meetings with the Chief Executive, Director of Governance, Non-Executive Director and also link in with HR. A three year strategy is being developed which will be presented to Execs, the People, Culture and Inclusion Committee and the Board when finalised.

The report also sets out the numbers of contacts the Guardian have received, along with outcomes.

(7) Recommendations to Board / Committee:

No actions are required for this paper, the paper is presented for information.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

ICB Freedom to Speak Up (FTSU) Update

1.0 Background

1.1 In August 2023 Shabana Mahmood and Tracey Revill were appointed as Guardians for the ICB. Since their appointment in August 2023, the ICB Freedom to Speak Up Guardians have been actively involved in the development of a culture so that staff feel confident and safe to speak up.

2.0 Key activities

2.1 Have included the following:

- Regular meetings with the Executive lead for Freedom to Speak up (FTSU) and the Chief Executive Officer, to obtain senior leadership support for all FTSU activities and to ensure clear, regular communication to drive forward the FTSU agenda.

- Highlighting the importance of and commitment to speaking up through communication with staff at a team brief session, participation in Freedom to Speak up month in October 2023 and regular communications to staff during speak up month through staff bulletins.

- Making it easier for staff to speak up, through recently introduced FTSU drop-in sessions that will take place every 6 months, sessions will be held alternatively between virtual and face-to-face in Stafford Hub.

- Production of a workplan to detail core activities that will be undertaken during the year. A copy of this workplan can be seen in Appendix A.

- A three-year ICB organisational strategy is currently being developed to provide the overarching background, vision and delivery plan for FTSU for the next three years. The guardians are working with the Executive Lead for FTSU, the Non-Executive Director for FTSU and the Chief Executive Officer to design and develop this strategy.

3.0 Additional Information

3.1 NHSE have recently advised that ICBs should provide a way for GP practices to have access to FTSU, as such, Tracey Revill has also been appointed as Guardian for GP practices in Staffordshire and Stoke-on-Trent. Practices in the North and East also have FTSU provided via the Federation, However, this role sits alongside that so practices have a choice.

3.2 Comms have been sent out to practices advising them of this route to raise any concerns they may have.

3.3 Tracey Revill has also taken up the role of Guardian on an interim basis for Shropshire, Telford and Wrekin ICB. The role commenced on the 1st February to the 30th April 2024, as they are currently undergoing a management of change.

4.0 Caseload ~ ICB

4.1 The ICB receives limited numbers of cases. There has been a total of three cases since August 2023 to 4th March 2024, two of which have been closed and one is an open case that has been escalated for investigation.

4.2 All cases had an element of worker wellbeing. All individuals reporting concerns were provided with details of occupational support that they could access if needed. One of the cases also involved a report of inappropriate attitudes.

4.3 In one of the cases HR had reviewed processes and provided feedback. In another of the cases action was taken in the form of information provided to staff.

5.0 Caseload ~ GP Practices

5.1 Two practices have been in contact with the Guardian, from one practice there was five contacts, there is a range of concerns that have been brought to the Guardian. These concerns were put into process with the Primary Care team dealing with contractual elements.

5.2 With regard to the other concerns, staff were advised to raise these via their HR advisors and performance concerns can be raised with NHSE, CQC, LMC or GMC. Staff were advised of the role of Guardian and would continue to support them if required.

5.3 From the other practice there were two contacts and again the same advice was provided as above.

APPENDIX A

FTSU workplan from December 2023

- Dealing with cases as they arise, supporting staff through the process, being available for staff to contact when needed
- Work towards understanding barriers to speaking up
- Liaising with staff networks to ask them for feedback on barriers to speaking up
- Ask SEG for information from their teams on barriers to speaking up
- Utilise an anonymous method for capturing feedback on barriers during a team brief such as via menti.com or Microsoft forms
- Analysis of information on barriers to speaking up
- Develop a strategy to address the barriers
- Analysis of Staff Survey results to understand issues that affect staff
- Continued work towards previous Staff Survey results action plan as part of action plan working group
- Review of all organisational policies to ensure they align with our updated FTSU policy
- Quarterly drop-in sessions for staff, alternated between face to face at hub and virtual sessions
- FTSU Guardians will attend team meetings across the organisation when requested by individual teams
- Attendance at PCI committee meetings
- Develop FTSU ICB strategy and system strategy
- Develop FTSU annual comms plan
- To remain updated with any developments/discussions at local, regional and national level
- Support interview processes as panel member when requested
- Attendance at ICS Governance and Risk Group meetings
- Inductions for new starters
- FTSU Guardians attend Staff Engagement meetings to keep up to date with topics of discussion
- Develop plan, presentation and communications for annual FTSU month every October using/adapting national information
- People, culture and inclusion board sub-committee reports - every 6 months
- Discussions with Executive lead for Speaking Up (monthly) and Chief Executive Officer (quarterly) on themes and any other items

Enclosure No: 19

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Tracey Shewan/Paul Brown
Date:	4th March 2024

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Procurement Policy	The Chair provided an update on the outcome of a separate meeting to consider a revised Procurement policy which reflects the new Provider Regime.	Board are asked to note that the Audit Committee approved the policy by Chairs Book procedure.
EPRR Annual Assurance	The annual EPRR report was reported to the committee. It was noted that the latest assessment demonstrates substantial compliance and that adequate resources are in place to meet roles and responsibilities. Priorities for the coming year were also agreed will.	The report is recommended for approval by Board and demonstrates the considerable work to improve and maintain EPRR arrangements.
Risk Management	The Committee received the latest BAF and Corporate Risk Register, the latter distinguishing between system and ICB risks. All risks have been seen and scrutinised by each committee and proposed changes to the rating of risks discussed and agreed.	The 2024/25 is the subject of a Development Session today. The committee felt that it will be important to ensure that the refreshed BAF risks reflect the risks to delivery of agreed strategic priorities in both the short and longer term and are described to reflect risks to delivery and not issues reported in the performance report.
Finance	Progress in the delivery of the **2023/24 Accounts** was discussed. No issues were highlighted. **Single Tender waivers** were scrutinised. A revised **Debt Management Policy** was approved, noting minor narrative changes. The committee also considered proposed changes to the **Scheme of Delegation,** specifically in relation to The Remuneration Committee.	An additional separate meeting with a single Final Accounts agenda item will take place in in April 2024. The Board are asked to note that the Scheme of Financial Delegation is recommended to Board subject to some further discussion about the practical

	Various useful Sector Updates were included in the report from External Audit and consideration is being given as to how these are more fully reported to Board along with the actions being taken to respond.	application of delegated levels to the Remuneration Committee and changes to reporting outcomes of this Committee's decisions to Board. Grant Thornton presented the outcome of their independent review of the **Mental Health Investment Standard**, noting positive assurance with no significant areas for improvement.
Counter Fraud	RSM presented their latest update report and progress in delivering each element of their plan including a detailed update on active cases. In addition, their **Workplan for 24/25** was considered and agreed. Their proactive work will include Fit and Proper Person and Conflicts of Interest requirements and working with Internal Audit on Personal Health Budgets.	
Internal Audit	RSM presented their progress report noting all actions due for implementation having been completed. There were two reports received. **Data Quality** The review received **substantial assurance** observing rigour in the way that data is collected for inclusion in the Performance Report and a good level of challenge and oversight. A draft **Continuing Healthcare Report** was received with recommendations to strengthen arrangements. These recommendations have been well received and support the work of the Recovery System Collaborative.	The **Continuing Healthcare** Report was considered in draft as many of the actions did not include implementation dates. The report is therefore being circulated more widely internally and with System Partners. Once completed this will be circulated to the committee in advance of the next scheduled Audit Committee but actions will then be monitored within the Internal Audit Progress Report A positive draft **2023/24 Internal Audit Opinion** was received noting an adequate and effective framework for risk management, governance and internal control ….with further enhancements to the framework…..to ensure that it remains effective.
Governance	**Freedom of Information-** The Board can take assurance around the process for receiving and responding to FOI requests. The committee received a presentation setting out the outcome of the recent **Governance Review** and an outline of the actions being taken forward at a Development Session of the Board.	There will be a further session at the March meeting of the Board to ensure a clear understanding of the actions being taken forward from the Governance Review and the current progress. Going forward progress will be formally monitored by the Audit Committee. The ICB have received a letter from NHSE noting the outcome of the review and the actions being taken.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee. In particular, the Committee approved the amendments to the Scheme of Delegation and Debt Management subject to further discussions regarding the practical application of delegations to the Remuneration Committee.