NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 16 March 2023
2.00pm-4.00pm
Newcastle Room, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

[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 • Quoracy • Conflicts of Interest	Chair	Enc. 01 Verbal Enc. 02	S	2.00pm	1-5
2.	Minutes of the Meeting held on 19 January 2023 and Matters Arising	Chair	Enc. 03	A		6-18
3.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		19
4.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	2.05pm	
5.	Sarah's Social Care Story	AB	Enc. 05	I	2.10pm	20-28
	Strategic and System Development					
6.	ICB Chair and Chief Executive Update	DP/PA	Enc. 06	D/I	2.25pm	29-36
7.	ICP Strategy and Joint Forward Plan Update	PEJ	Enc. 07	A	2.35pm	37-45
8.	2023/24 Operating Plan Update	PB	Enc. 08	A	2.45pm	46-59
9.	NHSE Delegations	CB	Enc. 09	A	2.55pm	60-163
10.	Stoke-on-Trent Joint Commissioning Strategy for SEND	CB	Enc. 10	A	3.05pm	164-194
11.	Mental Health & Wellbeing Strategy	CB	Enc. 11	A	3.10pm	195-212
	System Oversight and Governance					
12.	Board Assurance Framework	SY	Enc. 12	S	3.15pm	213-217
13.	Risk Register	SY	Enc. 13	S	3.20pm	218-230
14.	Quality and Safety Report	HJ	Enc. 14	S	3.25pm	231-238
15.	System Finance and Performance Report	PB/PSm	Enc. 15	S	3.35pm	239-253
	Committee Assurance Reports					
16.	Quality & Safety Committee – February & March 2023	JS	Enc. 16	S	3..45pm	254-258
17.	Finance and Performance Committee – February & March 2023	MN	Enc. 17	S		259-265
18.	Audit Committee	JH	Enc. 18	S		266-268
19.	People, Culture and Inclusion Committee	SL	Enc. 19	S		269-271

	Any other Business					
20.	**Items notified in advance to the Chair**	All		D	3.50pm	
21.	**Questions from the floor relating to the discussions at the meeting**	Chair			3.55pm	
22.	**Meeting effectiveness**	Chair				
23.	**Close**	Chair			4.00pm	
24.	**Date and Time of Next Meeting** 20 April 2023 at 2.00pm in public					

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
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Integrated Care Board

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2022-2023
INTEGRATED CARE BOARD (ICB)
AS AT 09 MARCH 2023

Key
Declaration completed for financial year 2022/2023
Declaration for financial year 2022/2023 to be submitted

Note: **Key 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*
10th October 2022	Dr	Buki	Adeyemo	Mental Health Provers' Partner Member and Interim 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.
19th October 2022	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 (2019 - present) 4. North Staffordshire Local Medical Committee Member (2009 - ongoing) 5. Director Loomer Medical Ltd Medical Care Consultancy and Residential Care Home (2011 - ongoing) 6. Director North Staffordshire GP Federation (2019 - ongoing) 7. Director Austin Ben Ltd Domiciliary Care Services (2015 - ongoing) 8. CVD Prevention Clinical Lead NHS England, West Midlands (2022 - ongoing) 9. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. Accurx Ltd Pilot site for digital services (ongoing) 3. Redmoor Healthcare Digital Health Consultant (adhoc consultant) (ongoing)	1. Newcastle Rugby Union Club Juniors u11 Coach (ongoing)	1. Spouse is a principal partner of Loomer Road Surgery (ongoing) 2. Spouse is director of Loomer Medical Ltd (ongoing) 3. Brother is principal GP in Stoke on Trent (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. Redmoor Healthcare - no longer claiming expenses or speaker fees from them.
1st July 2022	Mr	Peter	Axon	Interim Chief Executive Officer	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Interim CEO, NHS Staffordshire & Stoke-on-Trent ICB until November 2022. Substantive role - CEO, North Staffordshire Combined Healthcare NHS Trust (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) interest recorded on the Conflicts Register.
17th August 2022	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	1. Chair of the Management Board of MERIT Pupil Referral Unit, Willeton Street, Bucknall, Stoke-on-Trent, ST2 9JA (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 July 2022	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 2019)	Nothing to declare	Nothing to declare	(h) recorded on conflicts register.
20th October 2022	Ms	Tracy	Bullock	Acute Care Partner Member and Chief Executive	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.
1st July 2022	Ms	Alexandra (Alex)	Brett	Chief People Officer	Midlands Partnership NHS Foundation Trust/ Staffordshire & SoT ICS	Nothing to declare	1. Chief People Officer for MPFT and member of the People Committee for the STW ICS (ongoing)	Nothing to declare	Nothing to declare	(h) recorded on ICB conflicts register.
4th October 2022	Mr	Neil	Carr OBE	Community Services Partner Member and CEO of MPFT	Midlands Partnership 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.	
1st July 2022	Dr	Paul	Edmondson-Jones	Chief Medical 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 July 2022	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
4th October 2022	Dr	Paddy	Hannigan	Clinical Director (Strategic Portfolio Lead)	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) 2. Works occasional Extended Access sessions for GP First Ltd (ongoing) 3. Practice is a member of Stafford Town Primary Care Network (ongoing)	Nothing to declare	Nothing to declare	1. Practice is a member in GP First Ltd (GP Federation) (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.
21st June 2022	Mr	John	Henderson	Local Authority Partner Member and Chief Executive Staffordshire County Council	Staffordshire County Council	1. Chief Executive Staffordshire County Council - 2015 - date. No direct financial relationship with the ICS, but SCC commissions services from NHS providers who are members of the ICS. (May 2015 - 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.

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*
9th January 2023	Mrs	Julie	Houlder	NED/Chair of Audit Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Owner/Director - Elevate Coaching Ltd (October 2016 - ongoing) 2. Associate - Charis Consultancy (January 2019 - ongoing)	1. Chair of Audit and Assurance-Derbyshire Community Health Trust (October 2018 - ongoing) 2. Non-Executive Director/Chair of Audit/Vice Chair - George Elliot NHS Trust (May 2016 - ongoing) 3. Chair Sir Josiah Mason Trust (2014 - ongoing) 4. Director/Chair of Finance and Performance - Windsor Academy Trust (January 2019 - ongoing) 5. Chair of Derby Community Health Trust (January 2023 - 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 ICB conflicts register
1st July 2022	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
1st July 2022	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 Heartlands Hospital (ongoing) 2. Step-sister employed by MPFT as a nurse (ongoing) 3. Brother-in law works as an Occupational Health Nurse for Team Prevent at UHNM (ongoing) 4. Daughter is marketing executive for Voyage Care (LD and community service provider in Staffordshire) (August 2020 - ongoing) 5. Daughter-in-law volunteers as a maternity champion as part of the maternity transformation	(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 July 2022	Mr	Shokat	Lal	NED / Chair of People Culture and OD Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	Nothing to declare	No action required
1st July 2022	Ms	Megan	Nurse	NED/Chair of Finance and Performance Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Independent Mental Health Act Panel member, MPFT. (May 2016 - ongoing) 2. NED at Brighter Futures Housing Association (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
1st January 2023	Mr	David	Pearson	ICB Non-Executive Chair	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Elected Councillor for Bagnall Parish Staffordshire Moorland (2005 - 30th June 2022) Retiring from this post 30th June 2022	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	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.
1st July 2022	Mrs	Tracey	Shewan	Director of Communications and Corporate Services	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	Nothing to declare	Nothing to declare	1. Husband in NHS Liaison for Shropshire, Staffordshire and Cheshire Blood Bikes (ongoing) 2. Sibling is a registered nurse with MPFT (ongoing) 3. Daughter has commenced a student paramedic at West Midlands Ambulance Service (WMAS) (February 2021 - ongoing)	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
1st July 2022	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 July 2022	Mrs	Josie	Spencer	NED / Chair of Quality and Safety Committee	Staffordshire and Stoke-on-Trent Integrated Care Board	1. Managing Director Josie Spencer Consultancy (November 2021 - ongoing)	Nothing to declare	1. Chief Executive Coventry and Rugby GP Alliance (May 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) interest recorded on the conflicts register
1st July 2022	Mr	Prem	Singh	Chair - Staffordshire and Stoke on Trent ICB	Staffordshire and Stoke-on-Trent Integrated Care Board	Nothing to declare	1. Chair of Derbyshire Community Health Services NHS Foundation Trust (November 2013 - ongoing) 2. Independent Coach (October 2021 - ongoing)	Nothing to declare	1. Spouse holds position of Chief Executive at Rotherham, Doncaster and South Humber NHS Foundation Trust (June 2015 - 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 July 2022	Mrs	Sally	Young	Director of Corporate Governance	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)

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2.00pm-4.30pm
Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford ST18 0BF

Members:	Quoracy	01/07/22	18/08/22	20/09/22	17/11/22	19/01/23	16/03/23
Prem Singh (PS) Chair, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓		
David Pearson (DP) Chair, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	
Peter Axon (PA) Interim 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		✓	✓	✓	✓	✓	
Sally Young (SY) Director of Corporate Services, 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		✓	✓	✓	✓	✓	
Heather Johnstone (HJ) Interim 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		✓	✓	✓	✓	✓	
Shokat Lal (SL) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✖	✓	✓	✖	✓	
Josephine Spencer (JS) Non-Executive Director, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✓	
Jon Rouse (JR) City Director, City of Stoke-on-Trent Council		✖	✓	✓	✖	✓	
John Henderson (JH) Chief Executive, Staffordshire County Council		✓	✖	✓	✖	✓	
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire & Stoke-on-Trent Integrated Care Board		✓	✓	✓	✓	✓	
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		✖	✓	✖	✖	✓	
Neil Carr (NC) Chief Executive, Midlands Partnership NHS Foundation Trust		✖	✓	✓	✖	✓	
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✖	✓	✓	✖	✓	
Simon Fogell (SF), Stoke-on-Trent Healthwatch						✓	
Baz Tameez (BT), Staffordshire Healthwatch						✓	
Present:							
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire & Stoke-on-Trent ICB		✓	✓	✓	✓	✖	
Helen Ashley (HA) Director of Strategy and Transformation/Deputy Chief Executive, University Hospital of North Midlands NHS Trust		✓	✖	✓	✓	✖	
Chris Sands (CS) Chief Financial Officer, Midlands Partnership NHS Foundation Trust		✖	✖	✖	✓	✓	
Eric Gardiner (EG) Chief Finance Officer, North Staffordshire Combined Healthcare NHS Trust						✓	
Gill Hackett (GH) Executive Assistant, Staffordshire & Stoke-on-Trent ICB					✓	✓	

		Action
1.	**Welcome and Introductions**	
	DP welcomed attendees to the ICB Board meeting. DP advised that this was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting. DP advised that the Leadership Compact document was included in the Board papers as a reminder that meetings should be conducted in accordance with the agreed principles. It was noted that the meeting was quorate.	
2.	**Apologies**	
	Apologies were received from Buki Adeyemo (Eric Gardiner attending), Paul Winter and Neil Carr (Chris Sands attending).	
3.	**Conflicts of Interest**	
	Members confirmed there were no conflicts of interest in relation to items on the Agenda other than those listed on the register. JHo declared that she had been made Chair of Derby Community Health Trust from 1 January 2023. With regard to Item 7 on the agenda, MPFT was involved in the decision for the contract for Mental Health Services and therefore MN, AB and CI were conflicted.	
4.	**Minutes of the Meeting Held on 17 November 2022**	
	The minutes of the meeting held on 17 November 2022 were **AGREED** as an accurate record of the meeting and were therefore **APPROVED**.	
5.	**Action Log**	
	Actions were noted on the actions log.	
6.	**Questions submitted by members of the public in advance of the meeting**	
	Questions submitted by Ian Syme and answer by heather Johnstone: - (i) What actions have been implemented to reduce induction of labour backlog and how is this being quantified and quality managed. *There is a significant quality improvement project underway. An improvement working group has been established with workstreams to lead on specific areas of improvement. LMNS and NHSE are supporting this. Improvements have been made which are now becoming more consistent. Each day IOLs are triaged and prioritised and risk assessed to ensure safety. Any delays trigger escalation internally and safety calls are made to the women. The LMNS team are notified by UHNM on a daily basis of that day's IOL backlog and can request further information if numbers begin to increase or further information is required* (ii) When is it likely that the Free-Standing Midwife led units at Lichfield and Stafford will re-open and the Intermittent Home Births service fully re-instated	

	The FMBUs remain temporarily closed following Covid but primarily due to staffing numbers as it's essential that the main units are safely staffed first. Both providers are in the process of active recruitment to address short falls in their staffing levels against the birth rate plus expected levels in order to maintain staff staffing ratios and the main sites and community midwifery teams. They continue to offer choice of midwife led and obstetric led births on the main sites. We have asked both UHNM and UHDB to provide a business case for their plans re the future of the FMBUs but it worth noting that there is to be a national review of FMBUs including safety and staffing and no date for this has yet been confirmed. (iii) When is it expected ie by what date that the escalation of Maternity issues WILL be managed as part of the System Control Centres as per para 'Local Maternity and Neonatal System (LMNS) enclosure 15 Quality and Safety Report in today's Board papers. *The final amendment to the escalation plans and associated documents are being reviewed at the steering group on 31st January after which, subject to approval, they will be presented to the Regional Quality Board on 7th February for final sign off. Implementation of the escalation policy will follow shortly after final approval.* A copy of the question would be sent directly to Mr Syme for completeness.	
7.	**Compassionate Communities**	
	Paul Edmondson-Jones, Chief Medical Officer, introduced the Compassionate Communities Network. The network included individuals from across the Health, Care and Voluntary sector and aimed to promote a more positive approach to death, dying and loss by connecting people to services that can support them. The network was currently working with the Cannock community, but their hope was to expand the network and develop compassionate communities across South West Staffordshire. Tina Wigfall presented the Compassionate Communities together with Mark Cardwell from MPFT Care Group and Michelle Williams from Support Staffordshire. In 2021-22 the South West Place Based Partnership Group allocated funding (via Support Staffordshire) for individuals drawn from a range of organisations including Voluntary and Community Sector, District and County Councils, NHS, local Churches etc. to undertake Compassionate Communities training. 'Compassionate Communities…..build compassion as a major value in life, manifesting in the way we treat each other and the world around us. Compassionate Communities is built on a combined ethos of a Public Health Approach to Palliative and End of Life Care and Community Development (1) A compassionate city is a community that recognizes that care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone's responsibility'' (2) Following the training a Compassionate Communities network was formed - this has continued to meet to progress the actions detailed below (initially focused on Cannock Chase area)–local mapping etc. is supported by the Support Staffordshire Communities Officer – Healthy Communities Southwest. JH commented that he especially liked the network's approach to finding and sharing resources that already existed and allowed the communities to volunteer in ways that they felt best served their community. JHo commented that this was a great example of bringing together communities and would like this model to be considered for other projects where possible.	

	DP thanked the team for their presentation and stated that it would be nice to hear the how the network develops going forward.	
8.	**ICB Chair and Chief Executive Officer Report**	
	DP advised that the Operating Planning guidance and the Joint Forward Plan had been published on 23 December operating plan guidance issued. There were three key objectives around recovering core services and productivity, make progress in delivering the Long-Term Plan and continue transforming the NHS for the future. DP highlighted that, despite the system pressures, there had been considerable activity delivered across the system as shown in table 3.2 of the report. He thanked all the teams and staff across the system over the last month for their intensive on call support arrangements put on during this period. PA referred to the recent industrial action and assured the Board that the ICC had been developed to control the system and each strike had bespoke action plans developed. PA advised that they were taking a bold approach to Planning for 2023/24 with a focus on a small number of key schemes and challenges across the system. He added that a number of Executives across the system would be coming together on 13 February to discuss that plan. PA referred to the winter pressures and the significant stress that the system had recently experienced. He advised that there would be a 'lessons learnt' session in early March to review what had work well and what had not work well. This would enable them to evaluate and understand their situation as a system. JHo commented that it seemed a clear way forward on lessons learned. She asked if they were collecting the right data in the right way for the session in March. PA responded that they had data in every area across the ICS. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
9.	**Inpatient Mental Health Services**	
	DP gave a short summary for the Board. In August the board had received the pre-consultation business case for in-patient mental services formerly provided at the George Bryan centre in Tamworth. The board agreed that the PCBC could progress to the NHS Assurance stage. He explained that the presentation today would take them through the stages that had happened since August and there were key recommendations for the board to consider. The Board needed to take into consideration the ICB statutory duty to involve and consult with the public. As a newly formed Board, the ICB executive team and non-exec directors have undertaken training in relation to the legal duties involved. He asked that the Board listen to the presentation, take into consideration the information provided within the documents shared and use that information in their decision making. PEJ spoke to the presentation on finding a long-term solution for the inpatient mental health services previously provided at the George Bryan Centre.	

Following informal feedback from NHSE, amendments were made to the Pre-Consultation Business Case which included:

- Focus on the strategic view, national and local, of mental health services
- Strengthened the narrative around governance arrangements for community care
- Expanded on responses to West Midlands Clinical Senate recommendations
- Capacity modelling for community services narrative expanded
- Increased evidence for mitigation of travel impact
- Expanded information relating to the wider community offer (hub and spoke model)
- Obtained letters of support from partner organisations

PEJ confirmed that the amendments were signed off by the ICS Finance & Performance Committee.

Following NHSE Stage 2 Assurance panel on 30th November 2022, NHSE were assured that the proposals met the five tests for service change and other good practice tests and were content for the ICB to proceed to consultation.

PEJ advised that two proposals were considered: -

- Provide 18 beds at St Georges - patients who needed inpatient treatment admitted to St George's Hospital in Stafford
- Provide beds at George Bryon centre – provide a ward with 18 beds

He added that both proposals included the enhanced community provision, meaning more people could be cared for in the community, supporting long-term wellbeing and independence.

Each proposal was reviewed in detail by the technical group, who discussed clinical safety. The recognition of limited numbers of specialist staff and no psychiatric intensive care at a standalone site and the potential destabilisation of workforce at St George's Hospital if standalone site established. Centralisation of the bed base provides sustainability in terms of staffing, as it is easier to recruit and keep staff at a bigger, specialist hospital. It was also better for patient care and outcomes because of the range of therapies and interventions available.

PEJ ran through the intentions for public consultation:-

1. To build on previous involvement activity since 2019, to identify the long-term solution for inpatient mental health services in south east Staffordshire
2. To understand if there is any new or additional information that should be taken into consideration ahead of decision-making
3. To ensure everyone who wants to is able to participate in the involvement activity, and that they have the opportunity to provide their views
4. To understand if there is any positive or negative impact we need to plan for, if we decide to go ahead with this proposal
5. To understand if there are alternative suggestions which have not already been considered ahead of decision-making

It was recommended to the Board that a public consultation was launched on the making permanent the 18 beds at St George's hospital and they proposed to launch the 6-week public consultation on or before 9 February 2023.

JHo referred to the fifth aim around alternatives and asked what would be the expectation about what level of detail would be required. CB responded that it did not

	need to be particularly detailed. He added that the legal advice set out the process to get to that point and they would need to be open to alternatives.
	
	JR stated that in terms of their unitary board role I would be supporting the recommendation, but I just want to reserve the city council's position in terms of being able to put in a response to the consultation as a consultant.
	
	The Staffordshire and Stoke-on-Trent Integrated Care Board: -
	• Formally **APPROVED**
	  • Pre-Consultation Business Case and appendices
	  • Communication and Involvement Plan
	  • Consultation Document (including consultation questionnaire)
	• **APPROVED** the recommendation to proceed to public consultation on the single viable proposal to make permanent the 18 beds at St George's Hospital, Stafford, supported by enhanced community provision.
	• **APPROVED** that the consultation period to be 6 weeks	

10.	**NHSE Delegation Update**	
	CB explained that, as initially set out in NHS Operational Planning Guidance, the decision had been taken to delegate some of NHS England's (NHSE) Direct Commissioning functions to ICBs, on behalf of ICSs, as soon as operationally feasible. From the 1st of April 2023, ICBs would additionally receive delegation responsibilities for the remaining three Primary Care professions (Pharmacy, Optometry, Dentistry: a.k.a. "POD"). To sit alongside the already-delegated duties for Primary Medical Services (General Practice), as delegated from July 2022. Some of NHSE's Specialised Commissioning duties would be delegated to ICBs from 1 April 2024. The 2023/24 financial year would see much closer joint working between NHSE and ICBs in preparation for full Joint Commissioning from this point. He added that the plan was for further areas of Direct Commissioning duties and responsibilities to follow in the future. Functions to be retained by NHSE nationally would include: • Responsibility for some Specialised Services that needed to be centrally commissioned • Identifying national priorities, setting outcomes and developing national contracts or contractual frameworks • Maintaining national policies and guidance that would support ICBs to be effective in their delegated functions • Delivering support services Giving ICB/ICSs responsibility for Direct Commissioning was a key enabler for integrating care and improving population health. It would give the flexibility to join up key pathways of care, leading to better outcomes/experiences for patients, less bureaucracy and duplication for clinicians/other staff. CB advised that they were proposing to hold a non-executive workshop during February that was purely focused on the governance proposal so that they could hear the views of our non-executive community in more detail. JHo welcomed the Non-Executive involvement in the proposed workshop as it was a complicated situation. She added that she would like to see clarity on the operational management, delivery and the assurance around accountability. MN raised a concern that they needed to ensure that their content could influence the shape of surgery within our system and making sure they got that balance right. SY confirmed that most of the detail in the paper had been taken from the national team	

	and was currently being worked on to include the local element and she was pleased for the proposal of a workshop to discuss this. PEJ welcome the proposal as it would give the ICB influence and suggested that they would probably need a clinical point of contact for this. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** Paper in readiness for a suite of formal governance documentation to follow in March for Board approval	
11.	**ICS Development**	
	SY explained that the paper provided the Board with an update to the Integrated Care Board on the continued development of the Integrated Care System, following establishment on the 1 July 2022 and the progress made over the last six months, that had been overseen by the ICS Development Group. The paper described the background into the establishment of the ICS Development Group; the main purpose of the group was to support the ICS in the ambition to develop and deliver against the first-year development plan. Through self-assessment against the ICS design principles using the System Development Tool (SDPT) to understand the main system development gaps, using the agreed development priorities for 2022/23 and to ensure that they accelerated and embedded system working. She added that the individual development workstreams undertook a self-assessment against the design features in the SDPT, during 2021-22, July 2022 and the last assessment was taken in October, results were being reported this month. The ICS System Development Group was established as a time limited group with a view to review the purpose, principles, and responsibilities in quarter one of 2023/24. ICS Development needed be a system wide approach, the emergence of the portfolios leadership arrangements was an opportunity to bring system partners together to describe the system ambition. PA added that the key point was the interdependencies that were linked across the programmes and the benefit was to understand those points. PA emphasised that they had leads in a number of areas leading on a number of programmes and there was clear oversight on the development of the portfolios. JHo agreed that linking was important and added that they needed to be careful that they did not over complicate. They also needed to be clear about measuring effectiveness and not just the design. PA agreed that they needed to keep it simple and that 2023/24 was an opportunity to go beyond the design and to start to use the provider collaboratives. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
12.	**VSCE and MOU**	
	SY gave a brief introduction to the paper. TS stated that in accordance with national requirements and local ambitions, a Staffordshire and Stoke-on-Trent VCSE Alliance is to be developed by April 2023	

	The VCSE Alliance and the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) had developed a Memorandum of Understanding (MoU) setting out their future relationship. The ICB received funding to help support the development of an Alliance, a further non-recurrent £10k has just been approved by NHSE to support further development of this work. This funding is ringfenced to the MoU VCSE Alliance work and would be passed through to the VCSE sector from the ICB. As the Alliance developed under the previous three 'Place' arrangements, the forums continued on this footprint, this worked for the VCSE sector and in terms of mutuality it would be for the VCSE Alliance and ICB to review as necessary; however, they did not want to disrupt the good relationships and activity that had already commenced. The MoU was discussed at Quality and Safety Committee in November which recommended the ICB approved and signed the agreement. PB confirmed that the spend was a small amount of money in the sector and he was dedicated to increasing the proportion of money for the voluntary sector. SL asked if they had considered whether the alliance should have a place on the board itself. SY responded that it had not been originally discussed when the board was established but it could be something that could be reviewed. JS fully supported the paper and confirmed that it had been through the Q&S committee. The Staffordshire and Stoke-on-Trent Integrated Care Board **APPROVED** and **SUPPORTED** the signing of the MoU agreement to create the Alliance.	
13.	**Board Assurance Framework (BAF) - Summary**	
	SY explained that the Board Assurance Framework had been developed in the line with the quadruple aims and the ICB's strategic objectives. The BAF had development sessions with colleagues in the wider system as well as the ICB NEDs. The Head of Governance has also met with each of the execs to review their objectives and formulate the associated BAF risks. She added that the BAF was a dynamic, ever evolving document and would continue to be developed throughout the remainder of 2022/23 and beyond. The BAF was discussed at the Audit Committee on the 9 January 2023 and following agreement at the ICB Board in December, it was agreed that the cycle for the BAF and risk register was as follows: • Board to receive a highlight report on the BAF on the basis that the lead committee is reviewing monthly and the BAF was reviewed monthly by the chief executives. • Each lead committee of the Board would receive their BAF risk monthly to review with a full BAF being presented to the committee quarterly for oversight/ triangulation. The Interim Head of Governance was meeting with colleagues from UHNM, (who had been helping with the development of the BAF and had been a great support), on 12 January 2023 to review the BAF after which, the BAF would distributed to all executives for their Q3 update. As the BAF had been developed late in the financial year, for this financial year executives would be required to complete the Q4 update at the end of March to close off the financial year.	

	Going forward the BAF would be updated for each quarter with the Q1 being updated at the end of June 2023 with the report for the quarter being presented at Board in July 2023. SY advised that work continued in refining risk definitions and the committees responsible for scrutiny of risks. This was in the context of the emerging review of governance below Board and its' Committees. A Meeting was taking place with system partners regarding how system risks will be reported across the system. As there have been no further updates to the BAF since last submitted to the Board in December the following overview remains current, but the Board can be assured that the BAF will be updated in the timescales detailed above. The board could receive further assurance that the Committees received and reviewed the BAF risk for which they were the lead committee. SY added that there was also a "Directorate Issues log" which was reviewed monthly and issues could be escalated to the risk register as necessary. JHo gave assurance around the process and the work put into it. The Staffordshire and Stoke-on-Trent Integrated Care Board **RECEIVED** assurance on the report.	
14.	**System Finance and Performance Report**	
	PB gave an overview of the System Financial position: • They continued to flag a risk of £12m to the achievement of this plan, however as a system we continue to strive to deliver breakeven for 2022/23. • Nationally, it was understood that many ICBs were struggling to get to a break-even, and if the ICB were to achieve this, they would be in a minority. • Following on from the financial strategy that system CFOs had worked up collaboratively with system colleagues, finance leads are continuing to ensure that the financial approach is fully integrated with other system strategies. They were now reflecting on the details of the national planning guidance and the allocations to understand the impact on the Staffordshire and Stoke on Trent system, with a first cut of the financial projections for 2023/24 due at the end of January. PSm gave an overview of the Operational Performance: • Extended and severe winter pressure across all parts of the system were experienced throughout December, particularly over the festive period. Those pressures contributed to continued high levels of ambulance handover delays and dictated that the system declared a Critical Incident on Thursday 29 December 2022. • Additional and sustained increases in inpatients with Covid, Flu and RSV have placed additional pressure onto the bed base and compounded patient flow issues. • Preliminary figures for December showed a significant increase in ambulance handover delays (>30 minutes) at Royal Stoke. Focus remained on front door opportunities, maximising flexibility of hospital capacity and maximising flow out of the hospital. • Preliminary figures for December showed a marked increase in NHS111 call volumes during the month when compared to previous years. • Medically Fit For Discharge (MFFD) numbers increased significantly through November and December, pre-Christmas levels of MFFD were around 150 patients, but with improved discharges this reduced to circa 100 patients. • Meeting constitutional targets around 4-hour performance and 12-hour trolley breaches continued to also be a challenge for all their main providers.	

	• The number of patients waiting >78 weeks and >104 weeks has decreased during October, however >52 week waits continued to rise. • Performance against the 28 day waits (faster diagnosis standard (FDS) in October is 60.4%, remaining below the 75% standard. • Mental Health was not included in this report as no new data had been published nationally. This is due to ongoing alignment being undertaken by NHSE to get ICB level breakdowns into datasets. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
15.	**System Operating Plan Update**	
	PB explained that the report was presented to summarise the national planning guidance published on 23 December 2022 and described to the Board the timetable and next steps in the creation of a system plan that focused on a smaller number of priorities. He advised that the final plan was due to be submitted at the end of March together with the draft Joint Forward Plan (5-year plan) on the same date. PB added that the report was for information at this time, then in March or April the Board would be asked to approve the final version of the Operating Plan for the year and the Joint Forward Plan. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the Planning update.	
16.	**Winter Plan Update**	
	PSm gave an update to the Board regarding all aspects of urgent and emergency care across the system this winter. He advised that the winter had seen unprecedented levels of pressure, felt across the entire system. The System Winter Plan, System Escalation Plan and System Ambulance Handover plan were working concurrently and in conjunction to ensure that all system partners take the appropriate action to mitigate risks to patient safety and patient care to the fullest extent. The winter plan was approved in November – reported some of the pressures seeing:- PSm highlighted the pressures experienced during December which were workforce, demand and supply. As a result of those pressures, they remain in the national oversight framework. They also had to take difficult decisions on elective care, utilise capacity of the corridors which was not ideal. For January the situation had improved with flu and covid levels reduced. During February, the system would mobilise a de-escalation plan, subject to demand and capacity modelling. In March, a lessons learnt and reflections event will be held with all system partners to ensure the richness of what has been learnt through the 2022/23 Winter was reflected in planning going forward. The surge planning process for 2023/24 would begin in April 2023.	

	HJ acknowledged that they had really needed to work together to make sure that they maintained an appropriate focus on patients given the significant pressures that the extraordinary pressure that the system's been on to date. She stated that it had been a very different year this year from a quality and safety oversight point of view and they have had to think differently about how they worked and alongside colleagues from other directorates. Her focus had been on looking at outcomes for patients with a particular focus on harm and reducing harm. For incidents involving the ambulance services HJ assured the Board that they Worked closely with WMAS and confirmed that the providers did significant work in terms of monitoring outcomes of patients. She added that harm reviews would feature at the event on 13 February. DP asked if there was a way of picking up issues immediately with the SI process. HJ confirmed that there was and they had well established working relationships with providers and would have telephone conversation with them. They also had other activity such as physical visits. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** and **RECEIVED** System Winter update for assurance.	
17.	**Quality and Safety Report**	
	HJ stated that there had been no Quality Committee meeting in January and most what was in the exception report had been spoken about earlier in the meeting. However, she referred to the **Independent Hospitals - Ivetsey Bank** (formally Huntercombe) and stated that further media reports had been published nationally with allegations of poor quality of care and safeguarding issues at Ivetsey Bank (formally known as Huntercombe Stafford) and Taplow Manor in Oxford. National Management of the issues continued, led by NHSE with robust oversight of current care from the Provider Collaboratives in both areas who have commissioning responsibilities delegated to them by NHSE. HJ reassured colleagues that the Quality Team continued to work closely to support the provider collaborative on these issues. **Safeguarding Adults** HJ advised that the Adult Safeguarding Board scoped a Safeguarding Adult Review referral on 9 December and made a recommendation for a S44 (4) discretionary referral relating to an individual with a Learning Disability who passed away in another area in 2017 but whose death had been subject to a LeDeR style review by NHSE due to historic allegations of significant sexual abuse by an individual in a position of trust. There was currently a S44 (1) statutory Safeguarding Adult Review following a serious assault in a nursing home. The Safeguarding team are currently reviewing protocols for patients with cognitive impairment displaying disinhibited behaviours, which was an early recommendation from the on-going independent review. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the contents of the report.	
18.	**Assurance Reports from Committees of the Board**	
	<u>Finance and Performance Committee</u>	

	MN presented the December and January Committee reports which were taken as read. In January the committee approved the extension of the NFL contract with Vocare for 12 months; <u>Audit Committee</u> JHo stated that the Board could take assurance regarding the reports provided and the discussions which took place at the committee and specifically recommended the proposed policies. No questions were raised <u>People, Culture and Inclusion Committee</u> SL raised the point on workforce data where they had a real challenge around four months ago in terms of being able to have a single line of sight in terms of what the data was and there had been some really good work done by AB and the team and all the provider organisations in terms of bringing that data together and now they had a real rich picture around what was going on across the whole system and what the workforce challenges were. He thanked everyone for their contributions and were now in a really good place to address some of those Recruitment and Retention issues. <u>Quality and Safety Committee</u> JS presented the report which was taken as read. No questions were raised. The Staffordshire and Stoke-on-Trent Integrated Care Board **NOTED** the Committee Assurance Reports.	
19.	**Any Other Business/Close**	
	No other business	
20.	**Questions from the floor relating to the discussions at the meeting**	
	No questions were received from the floor. Questions received online: - **Chris Pincher** **MP Tamworth** *First well done to all frontline and non-frontline teams for their efforts over winter.* *What deliberations have the MPFT reached on the Midlands Clinical Senate's 4 recommendations about the business case for mental health services and the George Bryan Centre in Tamworth? In particular, the concern raised about the distance some patients and families might need to travel should in-patient services be consolidated in Stafford. What is the specific remediation proposed?* *As a rider, what specific plans does the Trust have to ensure on-site mental health service support is available to Tamworth residents in Tamworth itself, given any closure of the GBC ipso facto means a diminution for local services which local people and I cannot support?* DP confirmed that the questions from Chris Pincher would be taken to MPFT for a response. **Questions from Ian Syme**	

	First can I wish you all the best for 2023 and my questions below are made in the full knowledge of the incessant extreme pressures on the totality of Care Delivery and Care Services. ***Mental Health**:* *Mention is made in Finance & Performance Report that MH Data is not available as its subject to NHS Digital working with NHSE re national alignment of Data. Has the ICB/ICS had any indication when this data will be aligned and thus MH Data can be reported on by the ICB.* CB confirmed there was a disruption in the transition from CC to some Mental Health Data group NHS digital that has now been amended and rectified data is flowing. **NHS 111:** *I appreciate that a Region wide NHS 111 service is being rolled out and in the interim the ICB have entered into a short term 12 months contract with its present NHS 111 provider VOCARE.* *The Finance Committee Report quantifies this as a " £831000" cost pressure in comparison to present cost of the NHS 111 VOCARE contract.* *How is what is in effect a 13% price hike for the NHS 111 service delivered locally by VOCARE justifiable?* PB stated that they had looked at that and it was driven by NHS111 and confirmed they had built that pressure into their financial plans. **Winter Plan:** *There is a significant Capacity deficit from plan eg Planned Impact to Anticipated Impact (Impact re stocktake January 2023 Table1). This is initially quantified as a 71-bed deficit (I realise that it's not just beds but workforce needed to deliver) and even with the highest escalation 14 bed deficit.* *How will the system manage delivery of a safe non-elective service, which of itself has been consistently under extreme pressure for over 18months now, within the ICB given the above identified deficits?* PSm confirmed that they are bed equivalent gap. Moving forward it was is about the annualised approach to surge planning and a confirmation for winter money going forward. There was an opportunity to learn from what we have done and what has worked well for future areas of surge. CB confirmed that the consultation was due to be launched on 9 February 2023.	
21.	**Meeting Effectiveness**	
	The Chair confirmed that the meeting followed the compact and closed the meeting at 4.00pm	
22.	**Date and of Next Meeting**	
	16 March 2023 at 2.00pm	

DATE	ITEM	AGENDA ITEM	ACTION	ACTION OWNER	UPDATE	DUE DATE
22/09/2022	12	Healthier Ageing And Frailty Strategy Implementation Update	A workshop to be held to establish actions and priorities and the results presented to the Board in spring 2023.	NC	Date of workshop held on 28 February 2023 - results will be published in due course.	**20/04/2023**

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**Sarah's Social Care Staff Story**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Mish Irvine		Megan Page

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	N

	Action Required (select):									
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**	✓

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Video shared at SSOT ICS People Programme Board	14/12/22	D/I

Purpose of the Paper (Key Points + Executive Summary):
Sarah is a Deputy Care Manager for Home Instead in Stoke-on-Trent. Sarah shares her journey from working in retail for 22 years to realising her passion for social care and starting with Home Instead to progressing along the Professional Care Pathway to Deputy Care Manager. Sarah shares her experience of working in social care to date and her career highlights. The system has been working with Home Instead and wanted to share Sarah's story to showcase the flexibility, support and opportunities the social care sector has to offer. Colleagues via SSOT ICS People Programme Board have agreed there is a lot we can learn from Sarah's story in regards to our recruitment supply pools, supporting passionate individuals to stay and progress in the sector and how we can share stories like Sarah's further and wider.

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/A*	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
N/A*

Implications:	
Legal and/or Risk	**N/A***
CQC/Regulator	**N/A***
Patient Safety	**N/A***
Financial – if yes, they have been assured by the CFO	**N/A***
Sustainability	**N/A***
Workforce / Training	**N/A***

**** Reviewed and noted as not applicable.***

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **Not required.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **Not required.**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N/A**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **This is a staff story being shared for awareness, discussion and information.**		

3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	

Recommendations / Action Required:

The Integrated Care Board is asked to:
Listen to Sarah's story and experience and encourage Trusts and partner organisations to support the systems Journey to Work pathway (attached poster and supporting information). The ICS People Function have been and are working with social care colleagues to ensure a strong link to the Social Care Strategy and use system initiatives to encourage local people to consider a career in care.

Alex Brett, Chief People Officer, Staffordshire and Stoke-on-Trent ICB, contributed the following for the Future Social Care Workforce Strategy; "I am incredibly proud of everything our ICS and Social Care partnership has achieved for Staffordshire and Stoke-on-Trent's current and future workforce in recent years; and that partnership continues to go from strength to strength in the establishment of 'One Workforce'.
Together we have; won the HPMA Capsticks Award for Innovation for our 'New2Care' campaign supporting a new pipeline of staff into home care and care home roles, created an interactive Social Care Virtual Work Experience Programme for our local students showcasing the hardworking staff from independent providers, Local Authorities and NHS organisations, arranged placements for our rotational Level 2 and 3 Health Care Support Worker Apprentices in local care homes to broaden their skillset and share learning across the system and supported social care staff shortages through People Hub deployment.
Through our continued collaboration I'm confident we'll create new and innovative opportunities for our future workforce and therefore provide the very best care for our local population."

We wish to continue building on this momentum and hope Journey to Work will be a crucial factor.

Staffordshire and Stoke-on-Trent Integrated Care System

Journey to Work

Health and Care Careers in Staffordshire and Stoke-on-Trent

Introduction

In Staffordshire and Stoke-on-Trent the Health and Social Care sector is a growth area for employment. With endless opportunities and over 350+ careers to choose from we want to demonstrate through the Journey to Work pathway that there is a job, career and route into health and care for all.

The ICS People Function have created and developed the pathway with health and social care organisations; to bring as many opportunities as possible into one concept to make it easy for anyone looking to start, change or progress their career.

How it works

Journey to Work will help to facilitate a career journey through a variety of routes either hosted or co-ordinated via the ICS People Function or via referral and signposting to partner organisations. Whether an individual is;

- **Leaving education** and ready to take their first step into the world of work
- Has **never worked in care** or the sector and would like to find a job
- Looking for a **career change**
- Working in health and care already and looking for **progression and development**

We want to improve employment outcomes for local people and show there is an entry point and career for all.

People will be supported by various ICS People Function Teams depending on the area of interest. Examples:

- A retired individual interested in **ad hoc clinical or non-clinical work**, would be referred to Deployment and Resourcing for information on the People Hub.
- Someone currently working in the system who would like a **career change** would be referred to the Retention Team.
- If someone is a **refugee** being supported by an organisation such as The Amity Hub, our Outreach Advisors would work with them to discuss suitable routes into health and care. E.g. an employability course or apprenticeship

- If a young person is interested in an **apprenticeship**, they would be referred to the ICS Apprenticeship Pathway or would be signposted to the relevant organisation hosting an apprenticeship in their area of interest.

Partnership Involvement

Journey to Work is a collaborative scheme, made up of offers from Health and Social Care organisations across the system. The scheme is dependent on partners working together to offer opportunities to new and existing staff.

The concept and infographic has been shaped by feedback from partners at our Widening Participation Group, Schools Engagement Task and Finish Group and various Boards.

Infographic

Following feedback from our partners this is the second infographic concept, focusing on the services and areas individuals may be interested in. We previously displayed entry routes, but discussions highlighted that people may not know how they want to get into a career in health and care, but will likely have an area in mind which they're interested in.

The infographic demonstrates the numerous clinical and non-clinical areas of health and care, with visuals representing a journey along a pathway. Images describe the many roles associated with these areas.

Regarding content, we engaged Outreach colleagues who provided feedback that the infographic should use simple and easy to understand language and avoid being text heavy; which has been applied to the visual.

The infographic will be supported by an interactive Journey to Work webpage which will house the associated information for people to read in more detail. The Journey to Work landing page will utilise links to existing webpages on the ICS Careers and Education area and how to get in contact with the appropriate team.

Associated Projects & Schemes

- ICS Apprenticeship Pathway / Organisation specific apprenticeships
- ICS Virtual Work Experience Programmes
- Pre-Employment courses
- Observerships
- Student opportunities (partnerships with local universities)
- Entry level roles
- People Hub / Organisational Banks

- ICS Reservist schemes (Registered professionals / Social Care / Corporate)
- Homecare workers
- Companion volunteers
- Outreach opportunities

Scale & Spread

Journey to Work has endless potential to expand and develop with the number of partners and educational, career and job opportunities involved.

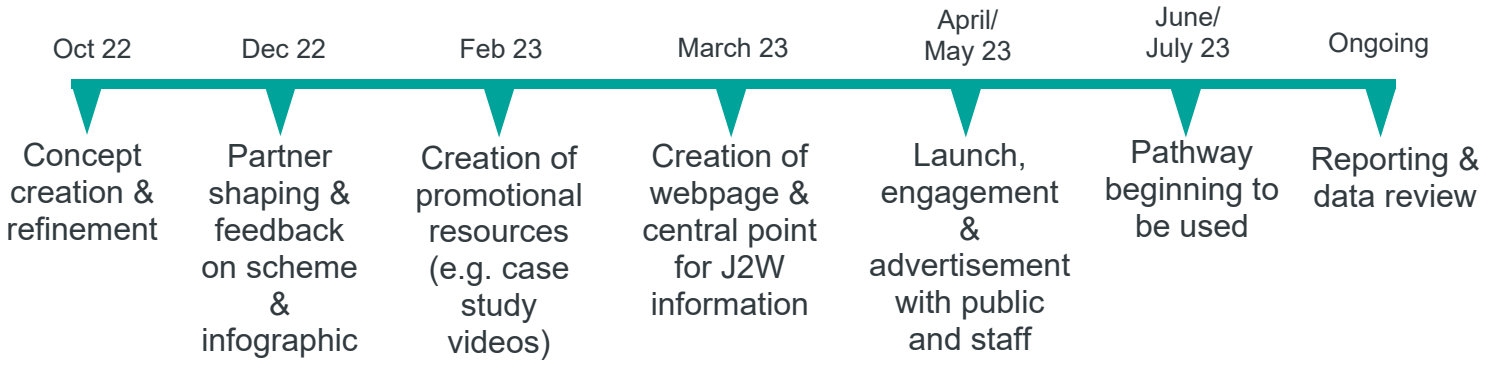
The model and learning from this scheme could be replicated in other areas nationally.

We are currently in the process of developing our Journey to Work webpage which will house detailed information and be a point of reference for the general public, existing staff and partner organisations; as well as outside of the system for organisations that may be interested in applying the Journey to Work scheme in their area.

Tracking

We want to follow and support any individual that participates in one of our educational or work opportunities; in order to support them at every stage of their journey and to report and evaluate Journey to Work data. However we know it is difficult to follow someone from start to finish of their career. We're currently looking at ways to mitigate this.

Timeline



Staffordshire and Stoke-on-Trent Integrated Care System

JOURNEY TO WORK

Looking for a new career? Not sure where to start?

Maternity

Facilities & Estates

Administration

Hospital

Social Care

General Practice Services

Mental Health

Community Care

Whether...

- **You're in education**
- **You've never worked in care**
- **Or you're looking for a career change**

Start building your future in Health & Care today!

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For more information visit us at staffsstokeics.org.uk or email icspeopleprojects@mpft.nhs.uk

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**06**

Title:	**Chair and Chief Executive Officer Report**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
David Pearson, ICB Chair and Peter Axon, ICB Interim Chief Executive Officer		Peter Axon, ICB Interim Chief Executive Officer

Clinical Reviewer:	**Clinical Sign-off Required Y/N**

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**		**Information-I**	✓

Is the [Committee]/[Board] being asked to make a decision/approve this item? N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
• N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	A/D/S/I

Purpose of the Paper (Key Points + Executive Summary):
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 & General Update** **2. Finance** **3. Planning and performance** **4. Quality and safety** **5. COVID-19** **6. Transformation**

Is there a potential/actual Conflict of Interest?	N
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/A*	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
N/A*

Implications:	
Legal and/or Risk	N/A*
CQC/Regulator	N/A*
Patient Safety	N/A*
Financial – if yes, they have been assured by the CFO	N/A*
Sustainability	N/A*
Workforce / Training	N/A*

** **Reviewed and noted as not applicable.***

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The Board will need to consider this statutory duty and how we reduce these.**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken.** • **Condition 2 & action taken.**		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • **Stage 1** • **Stage 2**	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • **Note the updates in the report.**			

1.0 System and general update

1.1 Investment in NHS mental health urgent and emergency care infrastructure

Over £5.5million funding has been secured to support mental health urgent and emergency care services in Staffordshire and Stoke-on-Trent. The allocation is part of a £150 million capital investment programme, which the Government is providing via NHS England over the next two years.

The investment is broadly split into £7 million of funding for the centralised procurement of up to 90 specialist mental health ambulances and £143 million of funding towards schemes that are providing new and improved mental health urgent and emergency care services. The latter is supporting a range of types of projects, all of which will contribute towards addressing pressures in the current system – benefiting both policing and the NHS.

Within the Staffordshire and Stoke-on-Trent ICS, funding has been allocated for the following projects:

- Crisis assessment centre at St. Georges Hospital in Stafford; funding allocated: £3,150,000**.** This scheme is one of a few that is relevant to health-based places of safety and section 136 suites, which are of particular interest to police forces in England.
- **Crisis café, location not yet identified; funding allocated: £821,000.**
- Project Chrysalis, a new mental health inpatient ward at Harplands Hospital in Stoke-on-Trent; funding allocated: £1,564,000.

To date NHS England have allocated around three quarters of the total capital funding available. Work is ongoing to finalise allocations for the remaining funding.

1.2 Industrial Action

All updates provided at the point of report submission (09/03/2023)

Junior Doctors: System partners are drawing up plans ahead of the Junior Doctor strikes due to take place on 13, 14 and 15 March. The industrial action will take the form of a full national walk out, which will impact on all trusts and primary care providers across Staffordshire and Stoke-on-Trent (SSOT).

The British Medical Association (BMA), the British Dental Association (BDA) and the Hospital Consultants Specialists Association (HCSA), have aligned action and announced that their Junior Doctor members will strike from 06:59am on 13 March until the morning of 16 March. During that time, Junior Doctors who choose to strike will not cover emergency rotas.

Across SSOT, Specialty and Specialist (SAS) Doctors and Consultants, nurses and Allied Health Professionals (AHP) are being asked to work differently to ensure patient safety.

Although System partners are collaborating to ensure a common approach, individual trusts are in the process of drawing up detailed operational plans and agreeing locally how staff will be remunerated during this period; local Acting Down Policies will be utilised where necessary. Where SAS and Consultant staff will be required to take TOIL (time off in lieu) for additional hours worked, in line with such Acting Down agreements, there is a risk associated with the potential impact on elective procedures. However, the expectation is that non elective care will not be impacted due to the reorganisation of staffing.

The ICB have brought partners together to gain an overview of plans and to discuss potential mutual aid support between organisations. A System wide Incident Control Centre (ICC) will be

in operation during the entirety of the industrial action. This will link closely with the System Workforce Cell to monitor any workforce gaps and respond to urgent requests for mutual aid support from partners, as well as for additional staffing from the People Hub.

Nurses: The outcome of talks between the Government and the RCN is still awaited.

Ambulance Workers: All three unions, Unison, GMB and Unite, have currently suspended scheduled strike action whilst entering pay talks with the Government.

2.0 Finance

As a system we are striving to breakeven for 2022/23 and although there is a risk to achieving this plan, the risk has now reduced from £12m to £6m.

Building on the financial strategy that system Chief Financial Officers worked up collaboratively with system colleagues, finance leads are continuing to ensure that the financial approach is fully integrated with other system strategies. Reflecting on the details of the national planning guidance and the allocations, to understand the impact on the Staffordshire and Stoke-on-Trent system, initial assessments show this to be very challenging. A first cut of the financial projections for 2023/24 was submitted on the 23 February.

3.0 Planning and performance

3.1 Elective care

Elective Waits (104 and 78 week): University Hospitals of North Midlands NHS Trust (UHNM) remain under tier 2 reporting with NHSE. Over recent days and weeks the forecast indicating the number of patients waiting at 31st March in both time categories has deteriorated. This appears to be due to patient choice and complexity of presentation. Work is ongoing to minimise the number of waits at 31st March which include mitigations such as seeking mutual aid from other providers. NHSE has also supported the Trust with additional funding to support waiting list initiatives over weekends.

Cancer performance: Significant improvements have been seen in waiting times and performance for cancer and although UHNM continues to remain in tier 2 reporting for cancer, NHSE have indicated that continued progress will result in UHNM being removed from tier 2.

Diagnostics: As reported last month, cancer diagnostic times have improved. The ICB has taken steps to implement a faecal immunochemical test (FIT) negative pathway to support appropriate 2 week wait referrals. The system wide teams continue to develop plans for 2023/24 to ensure there is a complaint submission to NHSE by the deadline.

3.2 Urgent Care

Operations:

- 111 has performed well throughout January and February. There have been requirements to go into national contingency a couple of times, however this has been planned due to maintenance work. Supporting the West Midlands transfer of 111 services to a new provider has been managed well and without detriment to patients.
- Emergency Departments have continued to experience long ambulance waits, however the time lost has halved in January compared to December. Ambulance response times have also improved significantly for Category 2 patients and a slight improvement for

Category 1 patients has also been observed. Handover times have been managed well during Industrial Action. There has also been a notable reduction in 12-hour breaches.

- High levels of bed occupancy continue. The Acute trusts have experienced several infection prevention control (IPC) issues including increases in Covid-19 inpatient numbers and Norovirus at Royal Stoke University Hospital. This has led to several restricted wards and has delayed patient flow further. These ICP challenges have slowly reduced throughout February and March.
- Complex discharges have been sustained with approximately 30-35 leaving each day from the University Hospitals of North Midlands NHS Trust site. However, due to acuity, Simple & Timely discharges have been low, and this has impacted on Length of Stay (LoS) data. The Complex discharges at weekends have been positive which shows good discharge planning from our community provider.
- Provider of Last Resort (POLR) across both the County Council and City Council footprints has continued to improve and is sustained well below 300 hours, at times dropping below 200, dependent on demand.

Delivery:

- **The new governance structure, sitting under and reporting into the UEC Board, is now fully established and all groups have met at least once, with the System Delivery group meeting weekly.**
- **Work continues on the seven system high impact programme areas.**
- **The UEC portfolio is also working to prepare for the 2023/24 winter season with demand and supply forecasting and a clear set of actions to close known capacity gaps.**

3.3 Key figures for our population:

	Oct-22	Nov-22	Dec-22	Jan-23
* **111 calls received**	30,438	29,161	52,748	30,580
Percentage of 111 calls abandoned	3.6%	3.4%	35.0%	8.3%
A&E and Walk in Centres Attendances (UHNM)	20,366	20,562	22,180	18,739
A&E and Walk in Centres Attendances (other providers)	17,270	17,335	18,805	15,942
Non elective admissions (UHNM)	6,360	6,791	7,038	7,232
Non elective admissions (other providers)	5,489	5,681	5,389	5,551

	Elective and Day Case Spells (UHNM)	6,465	6,853	5,955	7,319
	Elective and Day Case Spells (other providers)	7,460	8,148	6,693	8,008
	Outpatient procedures (UHNM)	4,341	5,118	3,848	4,215
	Outpatient procedures (other providers)	6,981	7,380	6,408	7,653
	GP Appointments (all)	571,228	556,735	469,981	520,189
**	**Physical Health Community Contacts (attended)**	132,190	141,355	121,165	
**	**Mental Health Community Contacts (attended)**	40,020	46,995	36,615	

**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 one month behind the other datasets*

Other datasets also subject to change - latest months are often refreshed and can therefore change

4.0 Quality and safety

4.1 LeDeR – Health Passport Campaign

On 27th February 2023, the Health Passport campaign went live across social media. This is one of the key actions from our LeDeR reviews and arose during COVID-19 when individuals with Learning Disabilities were becoming unwell and conveyed to acute settings without their usual support and those who knew them best.

The Health Passport is pre-populated with the individual's preferences and includes subjects such as communication, medications, carer details as well as favourite food, pastimes, and usual strategies employed for managing anxiety, etc. The campaign is supported by an animation which raises awareness of the Health Passport and a suite of documents including easy read leaflets, posters and flyers.

The campaign has been launched in collaboration with MLCSU and a full evaluation will take place after April 2023. Access can be found to on-line resources can be found here https://staffsstokeics.org.uk/your-health-and-care/learning-disability/health-passport/

4.2 Patient Safety Incident Response Framework (PSIRF)

Agreement has been reached in the system regarding the PRISF training for investigators and those with oversight as required by the framework. This training will be provided by the same provider for all NHS providers and the ICB Quality team to ensure consistency.

It has been agreed that the ICB will source and facilitate the training for everyone. The training provider being used is one who are also providing the required training for other ICBs in the region, again strengthening consistency.

4.3 Independent Senior Advocate

The Ockenden report includes an Immediate and Essential Action (EIA) that, 'Maternity services must ensure that women and their families are listened to with their voices heard', and specifically that:

Trusts must create an independent senior advocate role which reports to both the Trust and the Local Maternity Systems (LMS) boards, and

The independent senior advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

Staffordshire and Stoke-on-Trent ICB have been successful in becoming part of this exciting pilot and are currently recruiting to the post.

5.0 COVID-19

The COVID-19 booster vaccination offer, for both first boosters and autumn 2022 boosters, ended on 12 February 2023. Over 390,000 residents of Staffordshire and Stoke-on-Trent received their autumn 2022 booster dose. Primary courses of the COVID-19 vaccine continue to be available through Primary Care Networks (PCN) and community pharmacies in addition to walk-in clinics run by the Targeted Vaccination Team.

NHS England have announced that the spring 2023 booster campaign will offer all older age care home residents, those 75 years or over, and immunosuppressed individuals aged 5 years and over, a booster dose from early April. Work is currently ongoing to confirm local plans for the delivery of this phase of the programme.

6.0 Transformation

The public consultation to find a long-term solution for inpatient mental health services in southeast Staffordshire is over half-way through. The consultation is open until Thursday 23 March; more details are available on the ICB website.

7.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

David Pearson, ICB Chair

Peter Axon, Interim ICB Chief Executive Officer

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**ICP Strategy and Joint Forward Plan Update**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Edmondson-Jones	Yes	Leanda Adams-Collett

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Dr Lorna Clarson	Yes

	Action Required (select):								
Ratification-R		**Approval -A**	✓	**Discussion - D**	✓	**Assurance - S**	✓	**Information-I**	✓

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Integrated Care Partnership	06/03/2023	A

Purpose of the Paper (Key Points + Executive Summary):
To provide the Integrated Care Board with an appraisal of progress in developing an Integrated Care Partnership Strategy for Staffordshire and Stoke-on-Trent. To seek support for the continued development of the Integrated Care Partnership Strategy for Staffordshire and Stoke-on-Trent, in particular of the 5P's approach and ambitions across the life course, as well as the creation of an Integrated Health and Care Outcomes Framework for the short-medium and medium-long term.

Is there a potential/actual Conflict of Interest?	**~~Y~~/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/A	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
N/A

Implications:	
Legal and/or Risk	N/A*

Implications:	
CQC/Regulator	N/A*
Patient Safety	N/A*
Financial – if yes, they have been assured by the CFO	N/A*
Sustainability	N/A*
Workforce / Training	N/A*

* ***Reviewed and noted as not applicable.***

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**Y**	Continued engagement ongoing
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

Recommendations / Action Required:
The Integrated Care Board is asked to: • Acknowledge the progress that has been made in developing an Integrated Care Partnership Strategy for Staffordshire and Stoke-on-Trent. • Actively support the continued development of the Integrated Care Partnership Strategy for Staffordshire and Stoke-on-Trent, in particular of the 5P's approach and ambitions across the life course, as well as the creation of an Integrated Health and Care Outcomes Framework for the short-medium and medium-long term.

Integrated Care Partnership Strategy

Developing our priorities together

Background

One Strategy for Health and Care

Setting the overall strategy for integration across the Staffordshire and Stoke-on-Trent Integrated Care System for the long-term through one strategy for the system:

- National NHS requirement for a single integrated strategy – by March 2023
- 5-year strategy focusing on long-term priorities that will tackle longstanding challenges, reduce inequalities and deliver better care
- Aligned with the local Health and Wellbeing Boards' strategies
- A collaborative approach to developing the strategy
- One strategy, with the engine room for delivery at a local level

The Strategy Brief

- National requirement but (more importantly) locally owned
- Sets out the ambition, vision and approach for the ICP over the next 5 years and beyond
- Co-produced and owned by the Integrated Care Partnership and local communities
- Describes how the health, care and wellbeing needs of the local population are to be met
- Builds upon local knowledge and strategies to ensure we are greater than the sum of our parts
- Addresses how we will work towards increased integration of health, social care and other services
- Underpinned by a population health management approach outlining how the ICP will sustainably deliver more joined-up, preventative, and person-centred care for the whole population

Progress Update

A Phased Approach to Strategy Development

Phase 1 up to December 2022 - Completed

- What is the evidence telling us about our population needs
- What does good look like: existing good practice, research evidence, innovation, engagement, PHM programme
- What could this look like for Staffordshire & Stoke-on-Trent: our vision, approach and ambition

- Publish 'Initial' Strategy (Integrated Care Partnership - Staffordshire and Stoke-on-Trent, ICS (staffsstokeics.org.uk)

Phase 2 up to March 2023 – In Progress

- Involvement and engagement from system wider stakeholders: webinars, meetings, discussion groups, surveys
- Writing the Strategy: co-production approach
- Agreement of and commitment to the ICP Strategy
- Publish Final Strategy by 31 March 2023 (on track to deliver)

Engagement Update

- Programme of engagement events based on requests from community groups
- Stakeholder briefing, including link to online survey has been developed and shared
- Website amended to make the ICP strategy and survey more visible
- Website also now includes the stakeholder brief and a link to the survey
- Developed assets to share the ICP strategy survey via social media channels
- Signposted people to the engagement/survey as we attend the events for Inpatient Mental Health Services consultation
- Planned 'open-invite' online event(s) to which we have invited the public to attend

The Strategy

Why we need to change

National Mandate

- Health and Social Care Act 2022 gives new statutory powers to Integrated Care Boards and Partnerships

Local challenges/opportunities

- We have an increasingly older population. People are living longer but spending more years living with increasingly complex health and care needs
- Demand on services is growing due to a number of factors
- The impact of COVID-19 on health and care is still with us and we have a growing backlog with longer waiting times for some services
- Access to health and care varies and people experience fragmented care between services, making it difficult for some people to access and effectively navigate care.
- The health and social care workforce is in crisis as we try to recover from COVID-19 and provide increasing levels of care whilst managing staff shortages
- Some people and communities experience difficulty in accessing the things they need to live healthier lives like housing, secure employment and the services they need to stay well
- Our financial position is improving, but we have a significant deficit we need to balance

Addressing our population health and care needs

- We have existing joint strategic needs assessments that identify our populations health and wellbeing needs at Place:
    - Staffordshire Joint Strategic Needs Assessment
    - Stoke-on-Trent Joint Strategic Needs Assessment
- We will not replicate these but have reviewed where our population health outcomes can be improved to bring in alignment with national average across the Integrated Care System population to identify priorities
- Going forward the ICP Strategy approach will be underpinned by population health management, alongside community engagement and the best research evidence to ensure decision making is informed by the needs of our population

Staffordshire and Stok-on-Trent Communities – what we already know

The Staffordshire and Stoke-on-Trent (SSOT) ICP covers an area of just over 2,700 km2 in central England with a population of 1.13million according to the 2021 Census, 258,000 people live in Stoke-on-Trent and 876,00 people live in Staffordshire.

Staffordshire has a slightly older population compared to England, whilst Stoke-on-Trent has younger population compared to England with differences in demographic, social and economic factors between the two local authorities impacting on the levels of health and social care need from the population.

The Staffordshire and Stoke-on-Trent ICS area includes:

- 7 Integrated Care System Portfolios
- Upper Tier Local Authorities
- 8 District & Borough Councils
- 25 Primary Care Networks with 143 GP Practices
- 2 Acute Hospital, 2 Mental Health, 1 Community Health Trusts

These organisations, plus many Voluntary, Community and Social Enterprise organisations, other public and private sector partners, serve the needs of the population of Staffordshire and Stoke-on-Trent.

Staffordshire has a much higher proportion (25%) of its residents living in rural areas, although most of its population (75%) still live in areas that are classed as urban. In contrast, almost all (99.7%) of the population in Stoke-on-Trent live in areas that are classed as urban.

Like England the overall population in SSOT is estimated to increase from 1.13 million in 2018 to 1.2 million by 2035. This represents a population increase of 6%.

The older population is estimated to see the biggest increase: the population aged 65+ is estimated to grow by 25% by 2035

In our ICS we also see stark social inequality with More than half (53%) of the population in Stoke-on-Trent live in the most deprived 20% areas in England. Less than one tenth (7.4%) of the population in Staffordshire live in the most deprived live in the most deprived 20% areas in England but areas of high deprivation exist within urban areas in Staffordshire.

In our ICS Population, 91% of people identify as being White British. The next most common minority ethnic group is the population identifying as "Asian, Asian British or Asian Welsh", representing 4.8% of the ICB-population but we see higher levels of ethnicity in our urban areas like Stoke-on-Trent and Burton Upon Trent.

What we are hearing from our communities

Current high level strategic issues/priorities we hear in the Press and in discussion with residents and stakeholders

- Long waits for ambulances, delayed handovers & corridor care
- Crowded Emergency Departments with long waits
- Long waits for elective care, planned operations & cancer care
- Difficulty accessing primary care and/or seeing your GP
- Difficult to arrange social care and/or community services

Existing shared strategic priorities by ICP Partners

Documented in the NHS Long Term Plan, Staffordshire Health and Wellbeing Strategy 2022-27, Staffordshire County Council Strategic Plan 2022-26, Stoke-on-Trent Health and Wellbeing Strategy 2021-25 and the Stoke-on-Trent City Council Strategic Plan, Vision and Objectives 2020-24:

- Improving health in pregnancy and infancy (priority focus on reducing infant mortality)
- Mental Health across the life course
- Learning disability and autism
- Reducing drug and alcohol harm
- Addressing obesity across the life course
- Prevention and early intervention (LTC & Cancer)
- Improved prevention and management of LTC
- Reducing health inequalities
- Healthy ageing
- Personalised care
- Improved employment
- Digital transformation

Inclusion Health Groups

Strong focus on Health Inequalities in the Strategy: Inclusion Health Groups can be socially excluded and experience multiple overlapping risk factors in our population resulting in health inequalities

Engagement to understand challenges: Identified in Health & Wellbeing Strategies, national strategies and having a legal duty to ensure equitable opportunity to benefit from health and care services

Design targeted health and care interventions: Using a population health management approach and community engagement to understand the health and wellbeing needs of these groups to inform the development of integrated approaches to improving health & wellbeing

Suggested Groups:

- Learning disability and autism
- Women from ethnic minority communities and/or experiencing poverty
- Individuals, households and communities at risk of serious violence
- Informal carers
- Military Veterans
- Asylum Seekers and Vulnerable Migrants
- Our older population (prioritising those vulnerable or socially isolated)
- The population experiencing homelessness
- Others as identified by PHM programme at Place and PCN/Neighbourhood

Next Steps

Transforming our approach

Acknowledge the challenges BUT focus on the strengths and assets of the ICP, people and communities as we integrate health and care.

The 5 Ps of the Strategic Approach

Prevention & Inequalities: We will… offer equal opportunity to access and benefit from preventative services, use personalised care to prevent progression of illness and make tackling health inequalities core business to the work of the Integrated Care System

Productivity: We will… adopt a intelligence led continuous quality improvement approach across the work of our Integrated Care System. Innovation in use of digital technology, our workforce and models of care will be crucial to how we make best use of the resources we have.

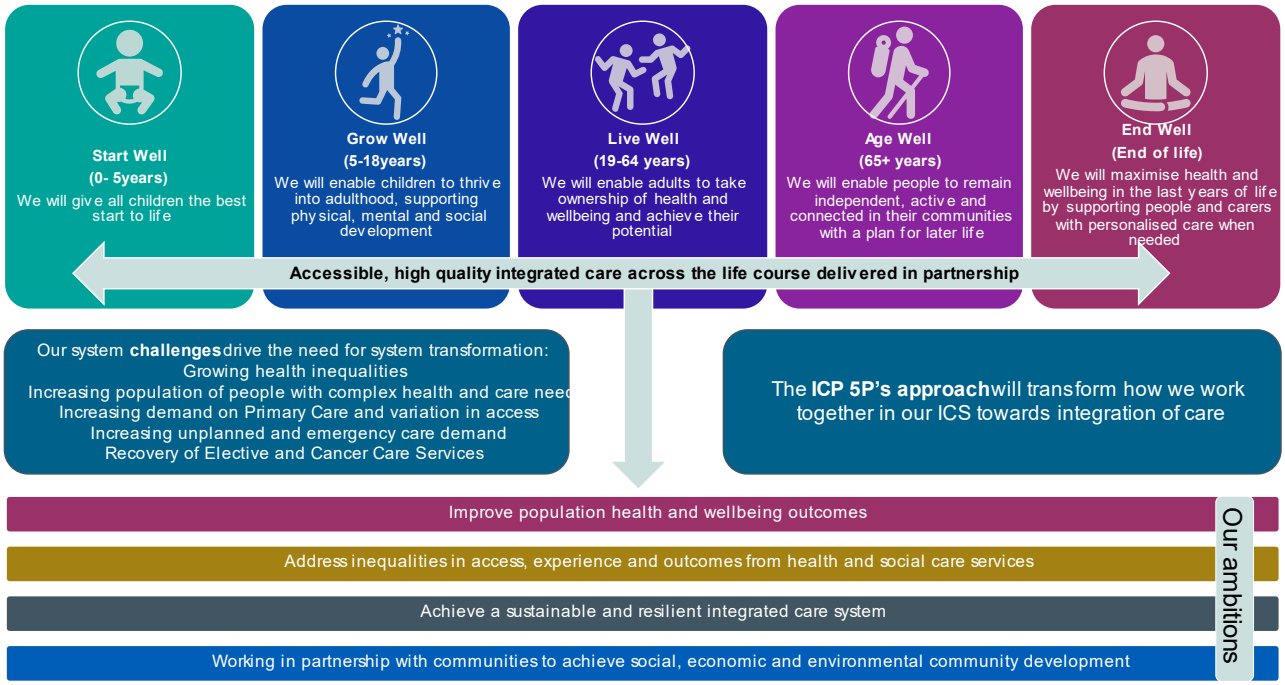
Personalised Care: We will… work with people as equal partners to deliver co-ordinated care centred on individual's physical, mental and social needs. We will empower people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life

Personal Responsibility: We will… work with people and communities to enable them to meet their health and wellbeing needs independently in the community. If people need care we will use personalised care and shared decision making to empower them to take ownership and manage their health and wellbeing as an active partner.

People & Communities: We will… adopt a strengths based approach in how we work with people and communities to develop community networks and resources offering health & wellbeing, social, education and welfare support, recognising the value that the partnership can bring in improving the wider determinants of health.

Underpinned by Population Health Management: We will… offer equal opportunity to access and benefit from preventative services, use personalised care to prevent progression of illness and make tackling health inequalities core business to the work of the Integrated Care System.

Integrated Care Partnership Strategy Ambition



Integrated Health and Care Outcomes Framework

	Start Well (0- 5years)	Grow Well (5-18years)	Live Well (19-64 years)	Age Well (65+ years)	End Well (End of life)
We will	We will give all children the best start to life	We will enable children to thrive into adulthood, supporting physical, mental and social development	We will enable adults to take ownership of health and wellbeing and achieve their potential	We will enable people to remain independent, active and connected in their communities with a plan for later life	We will maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed
Short to Medium	Reduce infant mortality	Improve mental health and wellbeing in CYP and families with equitable access to CAMHS	Improve access to secure employment and housing for vulnerable people in our communities	Increase the number of people living active, connected and independent lives in the community	Offer personalised, high quality end of life care for people and carers to improve reported quality of life at the end of life
Medium to Long	Ensure all children achieve good development during early life and are ready for school	Improve educational attainment and aspiration through integrated support for those who need it across all ages	Increase prevention of premature mortality from Cardiovascular Disease, Respiratory Disease, Alcohol Harm and Suicide in our ICS population	Reduce preventable emergency hospital admissions in the older population	Reduce emergency hospital admissions at the end of life

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**08**

Title:	**Draft planning submission, local system plan and joint forward plan update**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Brown Chief Financial Officer Chris Bird Chief Transformation Officer	Yes	Finance, Planning and Intelligence Directorate

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	No

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**	✓	**Information-I**	✓

History of the paper – where has this paper been presented		
	Date	A/D/S/I

Purpose of the Paper (Key Points + Executive Summary):

The purpose of this report is to provide an update to the board on the draft planning submission activity ambitions for 2023/24, development of the broader system plan for 2023/24 and Joint Forward plan (JFP) next steps.

Key Points

The draft planning submission is an NHSE facing submission primarily focused around recovering core services and productivity for activity in urgent care, planned care, cancer and diagnostics.

- At ICB level draft activity and performance plans indicate that there are currently four areas of non-compliance with national recovery ambitions. All our acute providers contribute to the non-compliance in one or more metrics.
  - Cost weighted activity (target 103%) draft plan 102.8%
  - Elective Recovery Fund (ERF) total activity 91%.
  - Reduction of 52 week waits
  - Elimination of 65 week waits

- University Hospital of North Midlands are indicating one area of non-compliance (65 week waits).
- Work will continue on the plan by ICB portfolio leads and providers up to final submission to address gaps or areas of non-compliance with national ambitions.

The final version of the broader system plan, which includes national and local ambitions for the population during 2023/24, will be finalised by end of March 2023.

The work already started to co-produce and consult on the JFP will continue up to the final version to be published in June 2023.

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
• Non-compliance with national recovery ambitions.

Implications:	
Legal and/or Risk	N/A
CQC/Regulator	N/A
Patient Safety	N/A
Financial – if yes, they have been assured by the CFO	N/A
Sustainability	N/A
Workforce / Training	**N/A**

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a)		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		

2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes, please give date(s) • Stage 1 • Stage 2	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g., service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened; We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients? The approach to planning for 2023/24 has been developed with system partners.	**Yes**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: • Discuss and note the contents of the Planning update.			

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Planning Update

Update to the Board on

Draft planning submission, local system plan and Joint Forward Plan

Introduction

The system is required to agree three planning documents, all due to be published at about the same time:

- A plan for the financial year 2023/24 (plan reflecting local and national priorities)
- A five year 'Joint Forward Plan'
- A Strategy

This paper describes the work on our plans for 2023/24 and beyond.

The approach was developed and discussed at an event on 13th February 2023 when CEOs and System Leaders from across the ICS came together to set the strategic direction for the 2023/24 planning round and agree organisational and individual contributions to that.

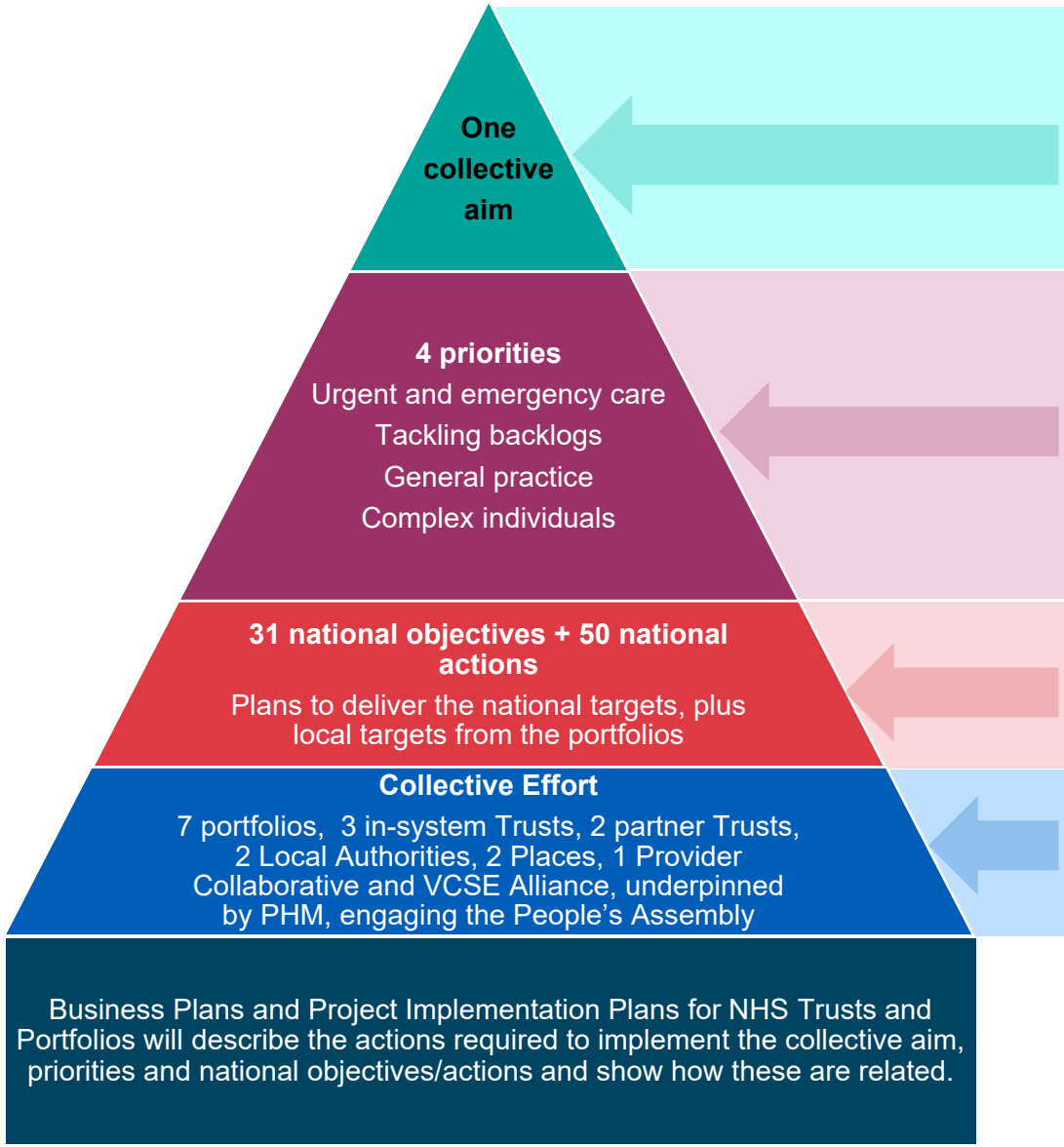
System Integrated Planning Session

At the event on 13th February there was a huge amount of agreement, and the sense was that the leadership shared a similar vision for the year ahead. Some of the common themes from the presentations which impact across all system partners and professional groups were:

- Workforce – retention, well-being, culture and innovative use of workforce.
- Seamless interfaces between organisations and teams
- A singular plan for urgent care – from primary care through to discharge
- Challenges presented by the finite supply of social care and the need to use this for maximum benefit
- A high priority focus on children and ensuring a healthy transition to adulthood
- Continuity of care in the management of long-term conditions
- Parity between mental and physical health and between primary and secondary care provision
- Delivering the required investment into the key priorities of workforce, digital and estate to design and deliver care fit for the 21st Century

The session discussed a way of connecting services and portfolios through a system approach to prioritisation. This approach, and some more detail on the planning process, are shown in the following slides.

The system plan for 2023/24 on a page



As a system we serve the 1.2 million people who live in Staffordshire and Stoke-on-Trent. We have a collective aim to improve health outcomes and provide the best health and social care services for our population. Our key metric for 2023/24 reflects our ambition to provide better and more compassionate care in the community and avoid hospital admissions where possible for elderly and frail people, especially at the end of life. This is to **reduce the number of Category 2 and 3 Ambulance calls.** This will also reduce ambulance call wait times and hospital bed occupancy. We chose this metric because all parts of the system can contribute to reducing the number of people calling an ambulance, for example GPs, community NHS services, the voluntary sector, and acute trusts through the way they manage people whilst in hospital and avoid readmission.

We provide a wide range of important services to our population. In 2023/24 we will bring these together to address four priorities:

- **Urgent and emergency care:** with a focus on prevention ad avoiding hospital admissions, as well as improving management of people in hospital and facilitating appropriate and timely discharge.
- **Backlogs:** reducing queues and wait times for elective care, cancer, mental health, learning disability and autism services, and NHS dentistry; reducing variation and ensuring equity of access for our whole population.
- **General practice:** ensuring that residents have appropriate, timely and equitable access to services. Ensuring that general practice is contributing to our collective aim through holistic management of elderly and frail people.
- **Complex individuals:** improving access to high quality and cost effective care for people with complex needs who require multi-agency management.

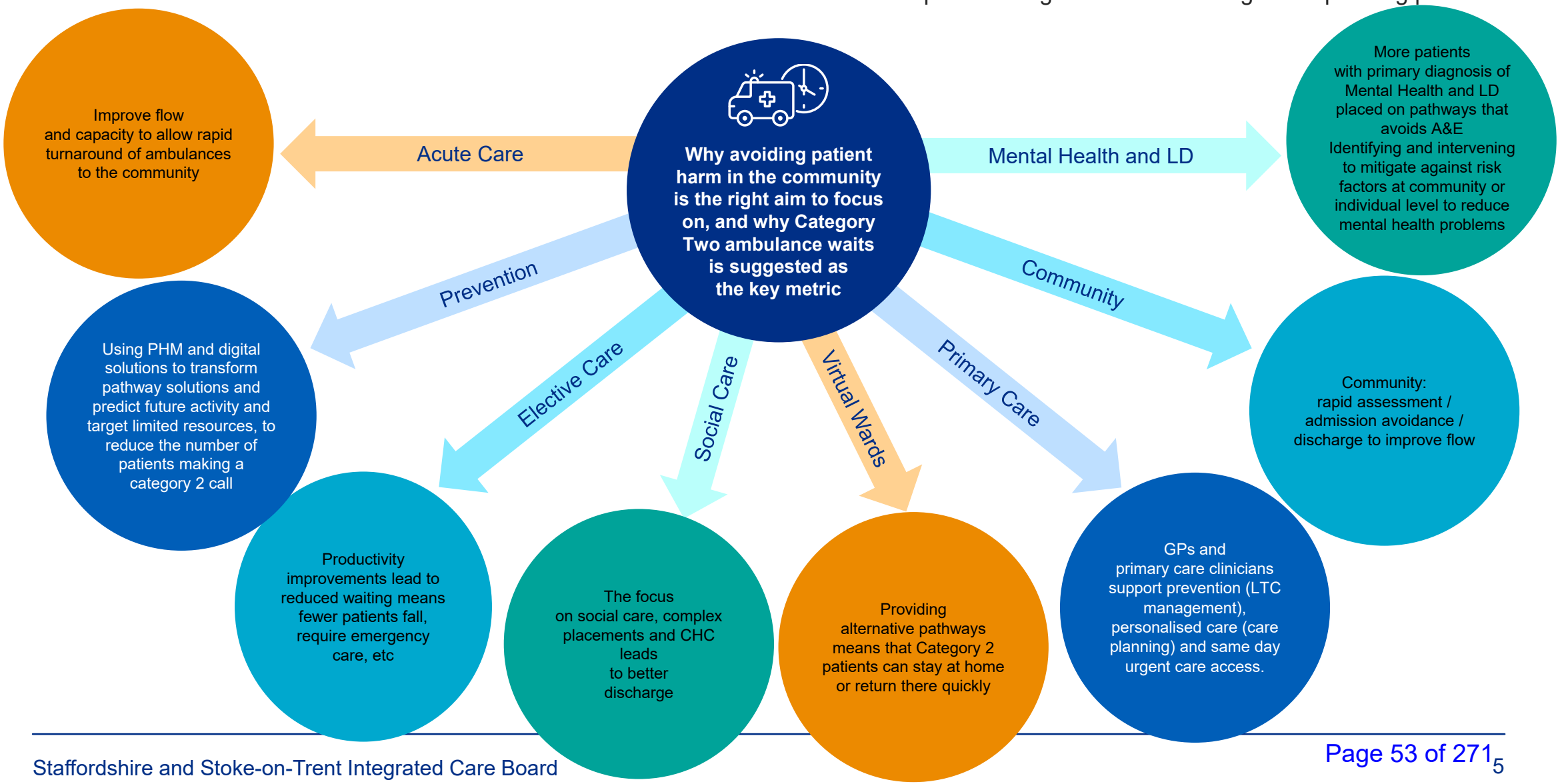
Includes other important tasks mandated by the NHS nationally, plus any other locally agreed targets. Plans will show the golden thread connecting these to the collective aim and priorities..

- Using the '5 Ps' explained in the Integrated Care Strategy, underpinned by Population Health Management to drive evidence based decision making.
- A people plan to recruit, retain and empower staff
- Clinical leadership by Health and Care Senate
- Digital solutions driving transformation
- Collective ownership of the Staffordshire and Stoke-on-Trent pound

Context for the Approach Suggested

We need a target that everyone can contribute to. This will have a few effects:

- It will clearly enhance the chance of achieving that one thing
- It will lead to a greater sense of common purpose – The Janitor and JFK effect
- It will enable the development of a golden thread through the operating plan

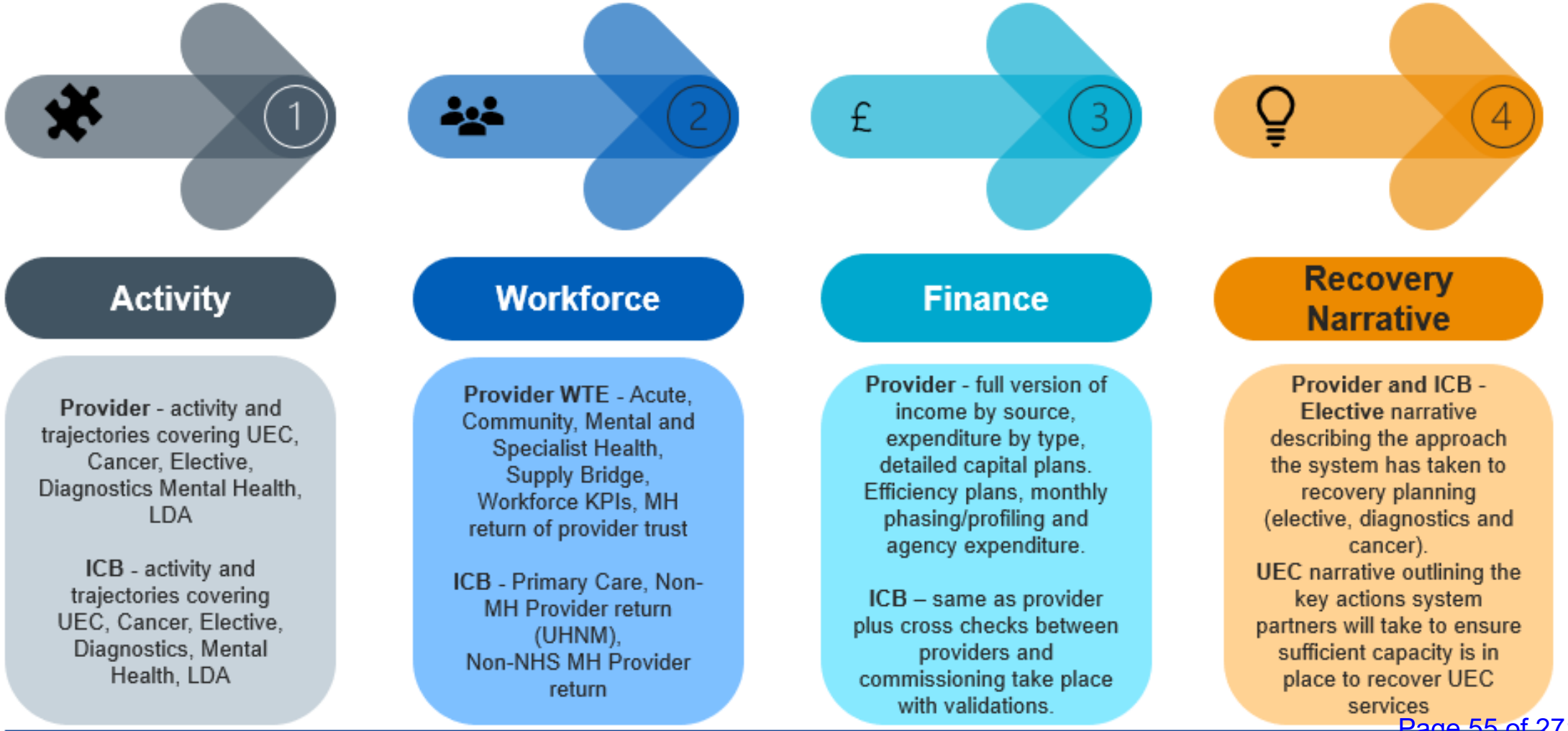


Development of system plans for 2023/24

- The plan for the financial year 2023/24 will focus on local and national priorities.
- This comprises of
  - a set of NHSE facing submissions and templates focused primarily on recovery
  - a one year local plan which reflects the wider range of our ambitions and work locally, across the delivery and enabling portfolios and providers. These are based around what has been outlined at a high level in the previous slides.
- The final version of the local plan runs along the same timeline as the NHSE submissions and is the first year of the five year 'Joint Forward Plan'. There will be a strategic narrative from portfolio/provider/place SRO's underpinned by a more detailed set of deliverables outlining the when, how, who delivery will take place through.

Draft NHSE Facing Submissions

- The draft plans which support the NHSE facing submissions and templates were submitted on 23rd February with final submission due on 30th March. These are as outlined in the diagram below.



Recovery Ambitions Key Messages

- NHSE facing submissions are primarily focused around recovering core services and productivity for activity in urgent care, planned care, cancer and diagnostics.
- The key messages against those are outlined below at ICB level and for UHNM.
- The ICB areas of non-compliance areas are contributed to by all our main acute providers (UHNM, UHDB and RWT).

ICB Position

- ✗ **Cost Weighted Activity** (103%) – 102.8%
- ✗ **ERF total activity** – 99.1%
- ✓ **Diagnostics activity** – 115%
- ✗ **52 week** wait reduce - not compliant
- ✗ **65 weeks** elimination – not compliant
- ✓ **Diagnostics** 95% within 6 weeks by March 2025 - compliant
- ✓ Cancer 28 day FDS 75% - compliant (78.76%)

UHNM Position

- ✓ **Cost Weighted Activity** – trust reports compliant 103%
- ✓ **52 weeks** reduce - compliant
- ✗ **65 weeks** elimination – not compliant (1,392)
- ✓ **Cancer 62 days**, reduce – compliant
- ✓ **Cancer 28 day** FDS 75% - compliant (79.98%)
- ✓ **A&E 4 hour minimum** 76% - compliant (76.4% in March 2024)
- ✓ **General & Acute Bed occupancy maximum** 92% - compliant (91.16%)

The Joint Forward Plan (JFP) (5 year plan)

- Guidance is looser and does not set out specific objectives tasks and actions across priorities.
- The guidance states specific statutory requirements that plans must meet.
- The JFP should be used to develop a shared delivery plan for the ICP strategy.
- ICBs and their partner trusts must consult with those for whom the ICB has core responsibility and anyone else they consider appropriate.
- ICBs and their partner trusts must involve relevant Health and Wellbeing Boards (HWBs) in preparing the JFP. This includes sharing a draft with and consulting relevant HWB's on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy.
- The national long term plan is to be re-issued later this year, meaning that the JFP will an iterative document.

The Joint Forward Plan (JFP) (5 year plan)

What have we done so far?

- Briefings to Health and Wellbeing boards (HWB) and ICB committees.
- Received and provided feedback on a set of draft deliverables from Portfolios and Providers.
- First thoughts around “straw man” document structure.

What do we need to do/continue?

- Discuss with the HWBs the approach to a statement of their final opinion on the JFP.
- Continue to co-produce the content with Portfolios and Providers.
- Define the final approach for consultation based around that already developed for the ICP strategy.
- Ongoing engagement and development of the JFP through system Directors of Strategy and local authority leads by the Chief Transformation Officer.

Next Steps

- Work will continue by ICB portfolio leads and providers on the NHSE facing submission, up to 30th March, to address areas of non-compliance with national ambitions
- In particular the work of the Activity, Finance & Workforce task and finish group will be focusing on the outputs of the NHSE triangulation tool up to final submission.
- NHSE regional feedback is expected on draft plans between 8th and 10th March, following a national meeting on 28th February.
- Final submission of NHSE facing plans and templates - 30th March.
- Final version of local system plan which includes our broader local ambitions for the population during 2023/24 – 31st March.
- Development of the Joint Forward Plan outlining ambitions over a five year period will continue – 30th March draft and 30th June Final.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**09**

Title:	**Delegation of NHS England Direct Commissioned Services**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Chris Bird, Chief Transformation Officer	Y	Chris Bird, Chief Transformation Officer

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
n/a	No

	Action Required (select):								
Ratification-R		**Approval -A**	✓	**Discussion - D**		**Assurance - S**		**Information-I**	

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/~~N~~			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Yes. The proposals reflect national NHS policy.			
Within SOFD Y/N	N/a	**Decision's Value / SOFD Limit**	N/a

History of the paper – where has this paper been presented		
	Date	A/D/S/I
SSoT Integrated Care Board – precursor paper	19.01.23	D
SSoT ICB NED Workshop – information sharing session	16.02.23	I
SSoT Audit Committee	06.03.23	I
SSoT Finance & Performance Committee	07.03.23	I
SSoT Quality & Safety Committee	08.03.23	I

Purpose of the Paper (Key Points + Executive Summary):

The Health & Care Act 2022 set an ambition to reconnect fragmented pathways of care by giving ICBs delegated responsibility for some aspects of services currently commissioned by NHS England.

This national policy is recognised as a key enabler for integrating care and improving population health. It gives the flexibility to join up key pathways of care, leading to better outcomes / experiences for patients, less bureaucracy and duplication for clinicians and other staff.

From the 1st of April 2023, ICBs will receive delegated responsibility for Primary Pharmacy and Optometry services as well as Primary and Secondary Dental Services (POD). These delegations will complement the already-delegated duties for Primary Medical Services (General Practice).

NHS England's Specialised Commissioning duties have been assessed through a national clinically-led process and categorised into those services which are suitable for delegation to ICB and those that should remain nationally commissioned.

During 2023/24, NHS England will retain responsibility for specialised commissioning but there will be much closer working with ICBs in preparation for delegation from April 2024.

The ICBs in the Midlands have worked together to develop arrangements to jointly commission POD on an East and West footprint. The governance arrangements are set out in this report together with the detailed agreements necessary to establish the proposed operating model.

These arrangements will enable close and collaborative working between NHS England and the ICBs in the West Midlands in respect of specialised commissioning as well as a partnership approach to the coordination and delivery of delegated POD services across the ICBs in the West Midlands. This multi-ICB approach has been developed with consideration to the future delegation of other NHSE commissioning functions that will also be delivered on a regional or sub-regional basis.

There will be a continued focus throughout 2023/24 to fully assess all aspects of the delegated services and embed the new responsibilities into the ICBs own governance arrangements.

Is there a potential/actual Conflict of Interest?	**~~Y~~/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
N/a	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
The ICBs Pre-Delegation Assurance Framework submitted in November 2022 identified risks relating to finance and workforce as being key areas for further review. The report updates on the progress since that time and the current position regarding risks as well as how these will be further reviewed and monitored post-delegation.

Implications:	
Legal and/or Risk	Delegation and Joint Working Arrangements are permissible under S.65Z5/6 of the Health and Care Act 2022. Risks have been identified and assessed through a Pre-Delegation Assurance Framework
CQC/Regulator	The delegated services are regulated services and established CQC arrangements will continue to apply
Patient Safety	The ICB will assume responsibility for all relevant patient safety duties under these delegations
Financial – if yes, they have been assured by the CFO	A Financial Risk Share Agreement has been developed to mitigate exposure to financial risk at individual ICB level

Sustainability	The NHS commitment to achieving net carbon zero by 2045 will apply to these services
Workforce / Training	NHS England staff supporting the delegated services are currently subject to a consultation exercise with a proposal to TUPE transfer to Birmingham & Solihull ICB as the host ICB with effect 1st July 2023

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? The delegation of these services complements the statutory duties of the ICB by enabling the ability to reconnect whole pathways of care across our population		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) The delegation of these services has been supported through an Integration Programme Board and has passed a Stage 2 Checkpoint Assessment which considers the impact of the proposals against the five tests of service change set out in national guidance. The ICB has completed a Pre-Delegation Assurance Framework assessment which has identified some areas which would benefit from continued active monitoring post-delegation. This will be coordinated through a 'Delegated Commissioning Group' chaired by the Chief Transformation Officer and will retain a specific focus on all aspects of delegated services throughout 2023/24.		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	N	N/a
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	N	N/a
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
3c.	***Please provide detail as to these considerations:***		

	• Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients As these delegations reflect national policy there has not been any engagement activity to date. However, post delegation there is a recognised need to communicate and publicise the changes so that stakeholders and the public are aware of the extended role and responsibility of the ICB	N	N/a
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	N	N/a

Recommendations / Action Required:

The Integrated Care Board is asked to:

Formally approve:

- Tier 1 Part A Joint Working Agreement – ICB/NHS E West Midlands re Specialised Commissioning
- Tier 1 Part B Joint Working Agreement – ICBs West Midlands re Pharmacy, Optometry and Dentistry

To ratify the national Delegation Agreement

To delegate final signature of the national Delegation Agreement to the ICB Chief Executive by 31st March 2023 with a supporting letter to NHS England outlining the need for sustained focus via the Phase 1 process outlined in this report

To note the supporting reference material to establish the operating model (document can be accessed through the links below)

- Primary Care Risk Share Framework **https://staffsstoke.icb.nhs.uk/~documents/route%3A/download/824/**
- Tier 2 Midlands ICBs POD Joint Commissioning Group **https://staffsstoke.icb.nhs.uk/~documents/route%3A/download/825/**
- Operating framework of the Office of the West Midlands **https://staffsstoke.icb.nhs.uk/~documents/route%3A/download/823/**

Delegation of NHS England Directly Commissioned Services

Purpose of Report

This report builds on the briefing document presented to the ICB Board at their meeting on 16th January 2023 together with general updates to ICB Boards since the inception of the ICB in July 2022.

The report sets out the national policy to delegate some aspects of services currently directly commissioned by NHS England to ICBs. The report also describes the operating model established on a regional and sub-regional basis and present the associated documents that require approval for the delegation to be enacted.

Background

The Health & Care Act 2022 set an ambition to reconnect fragmented pathways of care by giving ICBs delegated responsibility for some aspects of services currently commissioned by NHS England (NHSE).

This national policy is recognised as a key enabler for integrating care and improving population health. It gives the flexibility to join up key pathways of care, leading to better outcomes / experiences for patients, less bureaucracy and duplication for clinicians and other staff.

From April 2023, NHSE will commence the formal delegation of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services to Integrated Care Boards (ICBs) via the national Delegation Agreement.

These services have a collective budget of c£100m and include:

- 242 Pharmacies
- 79 Optometrists
- 134 Dentists and 4 Secondary Care Dental Contracts

In the following year, from April 2024 NHSE will delegate a sub-set of specialised services to ICBs, the services in scope of the delegation have been identified through a national clinically-led process to determine which services are suitable for delegation and which will need to be retained by NHSE. These services have a collective budget of c£250m with approximately 51% of that spend delivered in the ICB and 49% delivered through neighbouring health economies. NHSE and ICBs will work closely throughout 2023/24 to jointly plan services and enable a smooth transition of commissioning arrangements.

NHSE will retain overall accountability for all services at all times to the Secretary of State and will maintain national oversight as well as continued responsibility for setting standards, developing service specifications and negotiating nationally agreed contracts.

ICBs will become operationally responsible and liable the planning, performance, finance and quality & improvement of services.

Operating Model

The planning footprints of the East Midlands, West Midlands and Midlands are the continued basis for multi-ICB planning and decision making where it makes strategic sense to ensure continuity, access to expertise and economies of scale.

A Host ICB has been identified to provide, oversight, leadership, and support for the support teams who will TUPE transfer from NHSE. These teams will work for and on behalf of, each ICB within the planning footprint. This will be supported by a formal hosting agreement between the ICBs and for specialised services, between the ICBs and NHSE.

The Host will not make commissioning decisions on behalf of other ICBs or NHSE. All decisions will be made through the Joint Committees and their sub-groups with reference to ICBs own corporate governance arrangements as appropriate.

The Primary Care Pharmacy, Optometry and Dentistry (POD) workforce will be hosted on an East and a West footprint. The Host ICBs have been approved by the ICB CEOs and subject to ICB Board approval are as follows:

- East Midlands = Nottingham & Nottinghamshire ICB
- West Midlands = Birmingham & Solihull ICB

It is further proposed that for the West Midlands ICBs, Herefordshire & Worcestershire ICB provide strategic leadership to the POD services to distribute leadership across the multi-ICB arrangement.

Subject to consultation, teams supporting PODs, Primary Medical Service support and complaints will transfer to the Host ICB on 1st July 2023. This will be on a multi-disciplinary basis; including commissioning finance and clinical reviewers, but with specialised healthcare Public Health team members aligned or embedded to teams, not transferred.

The Specialised Services joint ICB and NHSE teams will be hosted by one Midlands ICB on behalf of all 11 ICBs and NHSE. Subject to ICB Board approval, this will be Birmingham & Solihull ICB. This will be supported by a formal Hosting Agreement between the ICBs and NHSE – this hosting agreement will be shared with the Board during Quarter 1 of 2023/24.

Governance Framework

A Governance Framework is included at Appendix One, setting out the coordinated arrangements for how the Operating Model described above is envisaged to work in practice.

In summary:

Tier 1 Joint Committee

This committee will be responsible for overseeing and decision making of the following:

- PART A – Joint NHSE/ICB joint planning of specialised services
- PART B – Joint ICB commissioning and oversight of POD services and any other collaborative commissioning arrangements agreed by the ICBs.

This will cover all aspects of commissioning including finance, performance and quality and the core membership will include NHSE (Part A only) and all ICB CEOs

Tier 2 groups and Tier 3 sub-groups

These groups will have delegated authority from the Joint committee around specific services. Tier 2 Groups will be constituted with all ICB Directors of Primary Care (or equivalent) plus other professional representation nominated from across the ICBs (e.g. one finance lead, one quality lead etc). Tier 3 operational groups will be led by Hosted Teams supported by ICB Senior Managers and representatives from the relevant professions.

In order for this operating model to be established a range of governance documentation has been developed:

- Tier 1 Part A Joint Working Agreement (included for approval)
- Tier 1 Part B Joint Working Agreement (included for approval)
- Tier 2 POD Joint Committee Terms of Reference (included as reference material)
- Tier 3 Operational Groups Terms of Reference (not included)
- Primary Care Risk Share Framework (included as reference material)

The documents have all been co-produced with the ICB Directors of Governance/or Chief Finance Officers with NHSE.

A nationally produced Delegation Agreement will set out the overall agreement between individual ICBs and NHSE to enable the continued to commissioning of Primary Medical Services (delegated to ICBs since 1st July 2022) and take on POD services from April 2023.

A near-final draft version of this document is attached and it is recommended the ICB Board review and support this Agreement on an in-principle basis and delegate final signature to the ICB Chief Executive in order to accommodate final version of this document being published and signed by 31st March 2023.

A final document regarding the hosting agreement between the West Midlands ICBs and Birmingham and Solihull ICB as the host for the staff transferring over from NHSE in July 2023 remains in development and will be finalized during the first quarter of 2023/24.

The Office of the West Midlands

The CEOs of the six West Midlands ICBs have previously agreed to formally establish an 'Office of the West Midlands' to work on their behalf. The Office will initially have two key roles:

- To commission POD and Specialised Services as delegated by NHSE on behalf of the six ICBs. This will involve the Office setting up an 'Integrated Staff Hub' hosted by Birmingham & Solihull ICB to employ the staff / teams being transferred from NHSE

- To agree a programme of work / set of priority areas for ICBs to work at scale for the benefit of West Midlands patients. It is envisaged that individual workstreams will be shared across ICB CEOs to ensure distributive leadership.

The proposed operating framework of the Office of the West Midlands is included within the reference material accompanying this report.

Due Diligence

The ICB has worked together with NHSE and the other ICBs in the Midlands region to complete as much due diligence has has been possible to support the national policy ambitions. The ICBs own Pre-Delegation Assurance Framework submission in November 2022 identified workforce and finance as two areas for further review. There has been positive movement since that time although some issues would benefit from additional focus.

- Finance

  The ICB allocations for POD services has become much clearer and will total approximately £100m. However, a combination of changes in national finance rules for dentistry and pressure on pharmacy budgets does create a degree of uncertainty. To mitigate this, a Financial Risk Share Agreement has been developed across the West Midlands Finance Teams and this will offer more confidence that the ICBs will not be exposed to adverse financial pressure during 2023/24.

- Workforce

  There is increasing confidence that the NHSE teams supporting the delegated services will, subject to consultation, will transfer to the Host ICB and arrangements have been put in place, via the Office of the West Midlands, for continued management, support and supervision of those teams. Further clarity is required on exact scale and nature of the teams that will transfer once the consultation process has concluded.

  Primary Dental Services have experienced workforce challenges for a sustained period of time and this presents a current issue in relation to access to NHS dentistry for some parts of our population. These challenges relate, to an extent, to the provisions of the national dental contract which forms part of the NHSE retained accountabilities and is not delegated to ICBs.

- Quality

  Primary and Secondary Dental Services are regulated by the CQC and will continue to be so post-delegation. Primary Pharmacy and Optometry are not required to register with the CQC on the grounds that effective alternative regulation is in place via, for instance, the General Pharmaceutical Council.

  There are known risks regarding the quality of some services but these are not considered to be material at this time. The key area of focus from a quality perspective will continue to be access to NHS dentistry.

Next steps

As the ICB takes on the delegated responsibility for these services, further work will be required throughout the first half of 2023/24 to complete a full stocktake of the services and the risks/issues associated with each, the mitigations that may already be in place and their effectiveness together with any new controls and assurances that may be required.

The ICB has already established a ‘NHSE Delegated Services Group’ led by the Chief Transformation Officer which seeks to bring a coordinated and cohesive approach to the transition of the delegated services. This will continue to meet throughout 2023/24 and will be the forum through which the stocktake above is completed and transition to new arrangements delivered.

This will include establishing SSoT ICB governance arrangements including how regional & sub-governance arrangements are translated to internal ICB oversight via ICB committees.

The ICB will continue to engage positively and proactively with colleagues in NHSE and ICBs across the Midlands to support the delegation of specialized commissioning from April 2024. This will include direct engagement with colleagues in NHS partners who hold specialized commissioning contracts in our ICS.

Recommendation

The ICB Board is asked to :

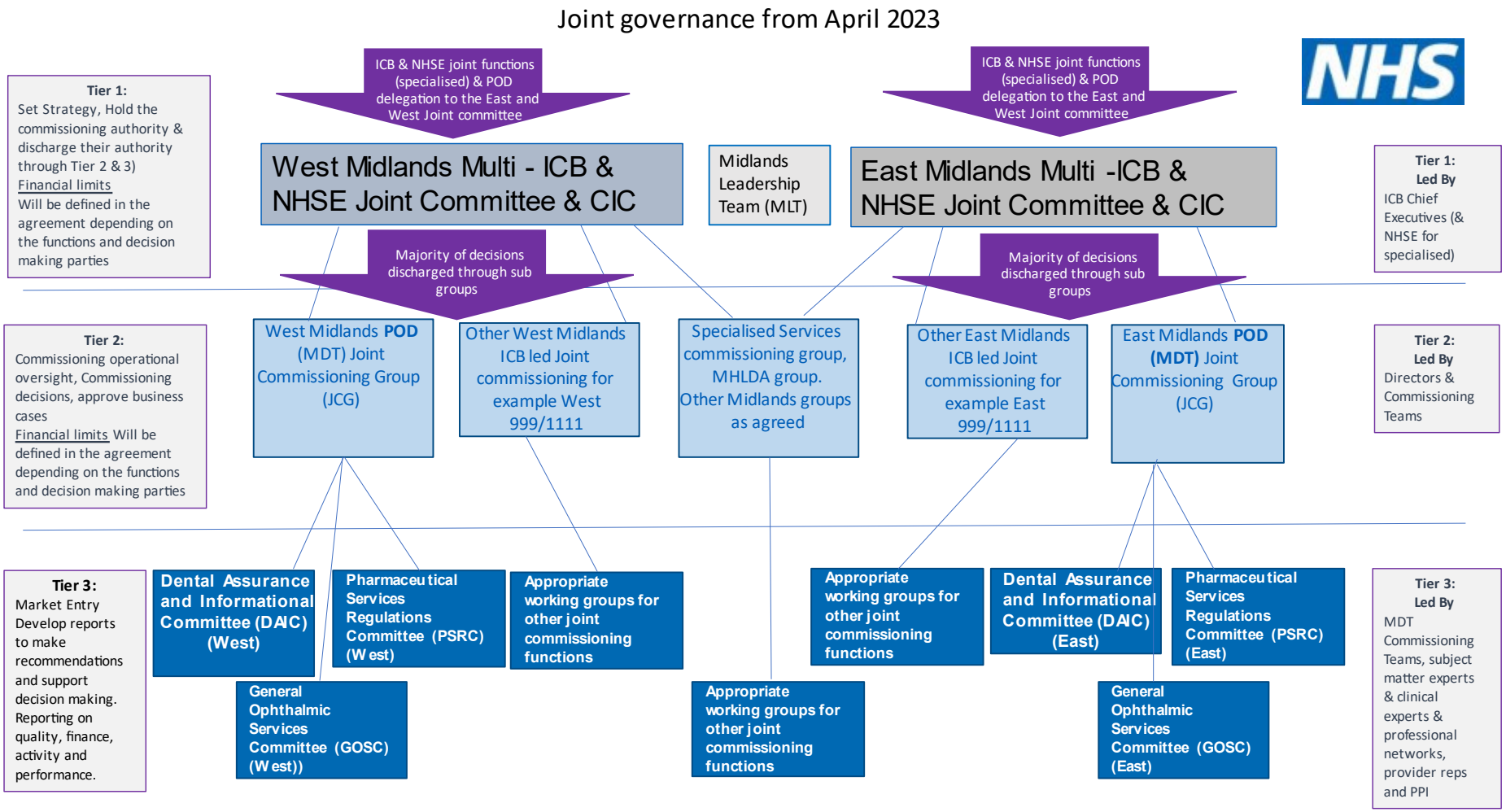
- Formally approve:
  - Tier 1 Part A Joint Working Agreement – ICB/NHS E West Midlands re Specialised Commissioning
  - Tier 1 Part B Joint Working Agreement – ICBs West Midlands re Pharmacy, Optometry and Dentistry

- To ratify the national Delegation Agreement

- To delegate final signature of the national Delegation Agreement to the ICB Chief Executive by 31st March 2023 with a supporting letter to NHS England outlining the need for sustained focus via the Phase 1 process outlined in this report

- To note the supporting reference material to establish the operating model
  - Primary Care Risk Share Framework
  - Tier 2 Midlands ICBs POD Joint Commissioning Group
  - Operating framework of the Office of the West Midlands

Appendix 1: Midlands Governance Framework 23/24



DATED: 2022

Delegation Agreement in respect of:

[Delete as applicable]

(i) Primary Medical Services

(ii) Primary Dental Services and Prescribed Dental Services

(iii) Primary Ophthalmic Services

(iv) Pharmaceutical Services and Local Pharmaceutical Services

between:

NHS England

-and-

NHS [Insert Name] Integrated Care Board

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Delegation Agreement for Primary Care & Dental 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	**[Insert Name]**
Area	**[Insert Area of the ICB as defined in its Constitution]**
Date of Agreement	**[Date]**
Effective Date of Delegation	**[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	**[Insert details of name of manager of this Agreement for NHS England]**
NHS England Email Address for Notices	**[Insert Address]**

The following parts of Schedule 2 are included in this Agreement[1]:

Schedule 2A – Primary Medical Services	**Yes**
Schedule 2B – Primary Dental Services and Prescribed Dental Services	**Primary Dental Services: [Yes/No]** **Prescribed Dental Services: [Yes/No]**
Schedule 2C – Primary Ophthalmic Services	**[Yes/No]**
Schedule 2D – Pharmaceutical Services and Local Pharmaceutical Services	**[Yes/No]**

1.2 This Agreement comprises:

1.2.1 the Particulars (clause 1);

1.2.2 the Terms and Conditions (clauses 2 to **Error! Reference source not found.**); and

1.2.3 the Schedules.

[1] This table must be completed to indicate which services are included in the Delegation.

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **NHS [Insert name] Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

(for and on behalf of NHS [Insert name] 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 Particulars and Terms and Conditions (clauses 1 to **Error! Reference source not found.**);

2.2.2 SCHEDULE 1 to SCHEDULE 6, SCHEDULE 8 and SCHEDULE 9 to this Agreement; and

2.2.3 SCHEDULE 7 (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 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 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.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and 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 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its 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;

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

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

5.1.7 act in a timely manner;

5.1.8 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

5.1.9 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 the people of the Area, as further described in this Agreement ("**the Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB in such of the following Schedules as have been marked as included within this Agreement:

6.2.1 Schedule 2A: Primary medical services;

6.2.2 Schedule 2B: Primary dental services and prescribed dental services;

6.2.3 Schedule 2C: Primary ophthalmic services;

6.2.4 Schedule 2D: Pharmaceutical services and local pharmaceutical services.

6.3 The Delegation has effect from the Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Primary Care Contracts or Arrangements and Prescribed Dental Services Contracts in place at the Effective Date of Delegation to the ICB for the purposes of determining the scope of the Delegated Functions. The Delegated Functions must be exercised both in respect of the relevant Primary Care Contract or Arrangement or Prescribed Dental Services Contract and any related matters concerning the Primary Care Provider that is a party to that Primary Care Contract or Arrangement, or provider of Prescribed Dental Services that is party to that Prescribed Dental Services Contract.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, any new Primary Care Contract or Arrangement entered into in respect of premises in the Area shall be managed by the ICB in accordance with the provisions of this Agreement as if it had been allocated to the ICB in accordance with clause 6.4.

6.6 NHS England may by Contractual Notice add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 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.

6.8 The ICB is not authorised by this Agreement to take any step or make any decision in respect of Primary Care Services or Prescribed Dental Services beyond the scope of the Delegated Functions.

6.9 NHS England may, at its discretion, substitute its own decision for any decision which the ICB purports to make that is outside the scope of the Delegated Functions. This will take the form of NHS England considering the issue and decision purportedly made by the ICB and then making its own decision. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision. In any event such a decision by NHS England shall not extend to those actions or decisions that are of themselves not capable of being delegated by NHS England to the ICB.

6.10 The terms of clause 6.9 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 agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement;

7.1.2 any Contractual Notices, including without limitation any Standing Financial Instructions;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

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

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at SCHEDULE 9 or otherwise referred to in this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

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

7.5 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 sections 65Z5 and 75 of the NHS Act.

7.6 The ICB must develop an operational scheme 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 of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

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

8. PERFORMANCE OF THE RESERVED FUNCTIONS

8.1 NHS England will exercise the Primary Care Functions and functions in respect of Prescribed Dental Services, other than the Delegated Functions, including but not limited to those set out in SCHEDULE 3 to this Agreement ("the Reserved Functions").

8.2 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 25 *(Variations)* of this Agreement.

8.3 NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 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.

8.5 The Parties acknowledge that, as from the date of this Agreement, the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.5.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 9.14 to 9.17; and

8.5.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 9.18 to 9.21.

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. FINANCE

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the NHS England central finance team's operational process (as such process is updated from time to time) for the reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 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.

9.3 Subject to clause 9.4, the ICB may use:

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

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

9.4 The ICB's expenditure on the Delegated Functions must be no less than that necessary to:

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

9.4.2 meet all liabilities arising under or in connection with all Primary Care Contracts and Arrangements allocated to the ICB in accordance with clauses 6.4 to 6.6;

9.4.3 meet all liabilities arising under or in connection with all Prescribed Dental Services Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions; and

9.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 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:

9.5.1 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 Primary Care Contracts or Arrangements or otherwise;

9.5.2 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;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 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 and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under clauses 9.14 to 9.23 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, 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.

9.6 NHS England acknowledges that the intention of paragraph 9.5 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.

9.7 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.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 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;

9.8.2 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 without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 SCHEDULE 5 (Financial Provisions and Decision Making Limits) sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in SCHEDULE 5 (*Financial Provisions and Decision Making Limits)* sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions.

9.10 NHS England may issue Mandated Guidance in respect of the use of funds for the purposes of the Delegated Functions.

Payment and Transfer

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

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

9.12.1 the terms and conditions of this Agreement;

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

9.12.3 any Capital Investment Guidance;

9.12.4 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); and

9.12.5 the HM Treasury guidance *Managing Public Money* (dated July 2013 and found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf).

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide 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.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

9.14 The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

9.15 The Parties further acknowledge that:

9.15.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

9.15.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in clauses 9.14 to 9.17 shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

9.16 Without prejudice to clause 9.15 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

9.16.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

9.16.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

9.16.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

9.17 NHS England may, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

9.18 The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

9.19 The Parties further acknowledge that:

9.19.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

9.19.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 9 *(Finance)* shall be construed as a divestment or delegation of the Section 7A Functions.

9.20 The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

9.20.1 the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

9.20.2 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

9.21 NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

9.22 NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

9.23 If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

9.23.1 provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 9.14 to 9.17) and the Section 7A Functions (clauses 9.18 to 9.21) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

9.23.2 such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Pooled Funds

9.24 The ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

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

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

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

9.24.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.25 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.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 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.

10.2 The provisions of this clause 10 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

10.3 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.

10.4 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

10.5 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.

11. FURTHER ARRANGEMENTS

11.1 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 sections 65Z5 and 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under sections 65Z5 and 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

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

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

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements;

without the prior written approval of NHS England.

11.6 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.

11.7 The terms of this clause 11 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.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described at SCHEDULE 6 and such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING

12.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

12.2 SCHEDULE 8 makes further provision about deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.3.

13. BREACH

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

13.1.1 exercise its rights under this Agreement; and/or

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

13.2 Without prejudice to clause 13.1, 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):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.9;

13.2.3 revoke the Delegation and terminate this Agreement in accordance with clause 25.7 *(Termination)* below;

13.2.4 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.5 exercise its rights under common law.

13.3 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 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or 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 considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

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

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

14. ESCALATION RIGHTS

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

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

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) 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).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 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 15.3).

15.2 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.

15.3 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 and, 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 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

15.4 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 s65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 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.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause **Error! Reference source not found.**16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

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

16.3.2 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;

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

16.3.4 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/or

16.3.5 at the request of NHS England, take such action 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.

16.4 Subject to clauses 16.3 and 16.5 and SCHEDULE 5 (Financial Provisions and Decision Making Limits) 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

16.5 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. In such cases:

16.5.1 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 16.5.3 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

16.5.2 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

16.5.3 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 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 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 9.5.3 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 9.5.3. 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 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of 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.

17.2 The ICB must respond to any information governance breach in accordance with IG 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.

17.3 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.

17.4 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"**).

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

17.5.1 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;

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

17.5.3 subject only to clause 16 *(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.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 SCHEDULE 4 makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

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

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

19.1 The ICB must and 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.

19.2 Without prejudice to the general obligations set out in clause 19.1, 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.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

20.2 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:

20.2.1 to revoke the Delegation; and

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

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

20.3 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).

20.4 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, the counter-fraud arrangements put in place by the ICB.

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

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

20.6.2 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.

20.7 On the request of NHS England or the 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 5 Operational Days following the date of the request, access to:

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

20.7.2 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.

21. CONFIDENTIAL INFORMATION OF THE PARTIES

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

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

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

21.2.2 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

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

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

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 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 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

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

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

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

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

21.4.3 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.

21.5 This clause 21 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.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 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 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. INTELLECTUAL PROPERTY

22.1 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.

22.2 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.

22.3 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 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.

23. NOTICES

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 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.

24. DISPUTES

24.1 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.

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

24.2.1 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;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) 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

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) 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 Solve. 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 Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) 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) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 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.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

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

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) 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.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

25.8 The Parties acknowledge that this Agreement is likely to require variation to take effect from 1 April 2023 as initial delegation arrangements are developed further. Accordingly, both Parties agree to engage constructively with a view to agreeing any such variation proposal in line with the provisions of this clause 25. In particular, the Parties agree to act reasonably and with the understanding that a single variation proposal will need to be accepted by all ICBs to ensure consistency across all delegation arrangements.

26. TERMINATION

26.1 The ICB may:

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

26.1.2 terminate this Agreement;

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

26.1.3 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 intention to terminate this Agreement; and

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner;

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.

26.2 NHS England may revoke the Delegation at the end of 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 26.4 will apply.

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

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

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

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

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

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

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 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

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively 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.

27. CONSEQUENCE OF TERMINATION

27.1 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.

27.2 Subject to clause 27.4, 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:

27.2.1 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 those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

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

27.3 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:

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

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

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

27.3.3 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.

27.4 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.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, 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.

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

28.2.1 Clause 9 (Finance);

28.2.2 Clause 12 (Staffing);

28.2.3 Clause 15 (Liability and Indemnity);

28.2.4 Clause 16 (Claims and Litigation);

28.2.5 Clause 17 (Data Protection, Freedom of Information and Transparency);

28.2.6 Clause 24 (Disputes);

28.2.7 Clause 26 (Termination);

28.2.8 SCHEDULE 4 (Further Information Governance and Sharing Provisions).

29. COSTS

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

30. SEVERABILITY

30.1 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.

31. **GENERAL**

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

31.2 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.

31.3 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:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act;
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
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;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
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 (a) 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 (b) 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;

Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
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;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
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 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 Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the 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 paragraph 9.2;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;

Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;
EIR	means the Environmental Information Regulations 2004;
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
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;
HSCA	means the Health and Social Care Act 2012;

ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
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;
IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit ;
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);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means 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 Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support

	national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means - a contract entered into pursuant to section 134 of the NHS Act; or - a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in SCHEDULE 7 *(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/about/board-meetings/committees/coi/ ;
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 from time to time, in accordance with clause 7.2**;**
Need to Know	has the meaning set out in paragraph 6.2 of SCHEDULE 4 (*Further Information Governance and Sharing Provisions)*;
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 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
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 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;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
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;
Personal Data Agreement	means the agreement governing Information Law issues completed further to SCHEDULE 4 (Further *Information Governance and Sharing Provisions)*;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means: (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services;
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;

PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt, services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means: (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision

	of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means: (i) a PMS Agreement; (ii) a GMS Contract; (iii) an APMS Contract; and (iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];
Primary Medical Services Provider	means a natural or legal person who holds a Primary Medical Services Contract;
Primary Ophthalmic Services	means primary ophthalmic services provided under arrangements made pursuant to Part 6 of the NHS Act, and in accordance with a Primary Ophthalmic Services Contract;
Primary Ophthalmic Services Contract	means: (i) a General Ophthalmic Services Contract; and (ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Primary Ophthalmic Services Provider	means a natural or legal person who holds a Primary Ophthalmic Services Contract;
Principles of Best Practice	means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
Prohibited Act	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;
QOF	means the quality and outcomes framework;
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) NICE; (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 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 the functions which are reserved to NHS England (and are therefore not delegated to the ICB under the Delegation) and as set out in detail in clause 8 and SCHEDULE 3 (Reserved Functions) of this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in clause 9.19.1;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
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 4 *(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;
Staffing Model	means the employment model as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;

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 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

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

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

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

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (Finance) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

3. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

5. Enhanced Services

5.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

5.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

5.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

5.4 When commissioning newly designed Enhanced Services the ICB must:

5.4.1 consider the needs of the local population in the Area;

5.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

5.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

5.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

5.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

5.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

5.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

6. Design of Local Incentive Schemes

6.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

6.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

6.2.1 consider the needs of the local population in the Area;

6.2.2 develop the specifications and templates for the Local Incentive Scheme;

6.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

6.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

6.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

6.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

6.3 The ICB must be able to:

6.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

6.3.2 support ongoing national reporting requirements (where applicable); and

6.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf) .

6.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

6.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

6.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

7. Making Decisions on Discretionary Payments or Support

7.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

7.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

8. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

8.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

8.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

8.3 For the purposes of paragraph 2.15, urgent care means the provision of primary medical services on an urgent basis.

9. Transparency and freedom of information

9.1 The ICB must:

9.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

9.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

10. Planning the Provider Landscape

10.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

10.1.1 establishing new Primary Medical Services Providers in the Area;

10.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

10.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

10.1.4 closure of practices and branch surgeries;

10.1.5 dispersing the patient lists of Primary Medical Services Providers; and

10.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

10.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 16 (Procurement and New Contracts) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

10.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

10.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

10.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

11. Primary Care Networks

11.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

11.1.1 maintain or establish identified Network Areas to support the local population in the Area;

11.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

11.1.3 ensure that each PCN has at all times an accountable Clinical Director;

11.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

11.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

12. Approving Primary Medical Services Provider Mergers and Closures

12.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

12.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

12.3 Prior to making any decision in accordance with this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

12.4 In making any decisions pursuant to this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 16 *(Procurement and New Contracts)*, below, where applicable.

13. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

13.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

13.2 In accordance with paragraph 13.1 above, the ICB must:

13.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

13.2.2 ensure that any risks identified are managed and escalated where necessary;

13.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

13.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

13.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

14. Premises Costs Directions Functions

14.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

14.2 In particular, but without limiting paragraph 14.1, the ICB shall make decisions concerning:

14.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

14.2.2 revisions to existing payments being made under the Premises Costs Directions.

14.3 The ICB must comply with any decision-making limits set out in Schedule 5 (Financial Provisions and Decision Making Limits) when taking decisions in relation to the Premises Costs Directions Functions.

14.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

14.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

14.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

14.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

14.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

14.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

14.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

14.8.3 seeking the resolution of premises disputes in a timely manner.

15. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

16. Procurement and New Contracts

16.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

16.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

16.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

16.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

16.4.1 made in the best interest of patients, taxpayers and the population;

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

16.4.3 made transparently; and

16.4.4 compliant with the rules of the regime as set out in NHS England guidance.

16.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

16.5.1 improve outcomes for patients;

16.5.2 reduce inequalities in the population; and

16.5.3 provide value for money.

17. Complaints

17.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

18. Commissioning ancillary support services

18.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

18.1.1 collection and disposal of clinical waste;

18.1.2 provision of translation and interpretation services;

18.1.3 occupational health services for performers registered on the Performers List.

18.2 The arrangements for the provision of ancillary services to Primary Medical Services Providers are described in Schedule 7 (Local Terms).

19. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

20. Workforce

20.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

20.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

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

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

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

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: General Obligations – Prescribed Dental Services (applicable only if Prescribed Dental Services are included in the Particulars)

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services.

1.2 For the purposes of Paragraph 2.1 of this Part 1B of Schedule 2B *(Dental Care Services)*, the term "Population" refers to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

1.3 Community Dental Services are a form of Prescribed Dental Services. However, they may be governed by the terms of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

1.3.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission any new PDS Agreement for such services), those contracts must be managed in accordance with the relevant provisions of Part 1A of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part only. The provisions of this Part 1B of Schedule 2B also apply, with the exception of paragraphs 2.5.2 and 2.5.3; and

1.3.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 1B of Schedule 2B apply in full.

2. General Obligations

2.1 NHS England may, by Contractual Notice, designate the ICB as the body responsible for commissioning Prescribed Dental Services for its Population and allocate Prescribed Dental Contracts to the ICB in accordance with clause 6.4 of this Agreement.

2.2 Each Contractual Notice referred to in paragraph 2.1 above will set out, in relation to each Prescribed Dental Services Contract, which rights, obligations and duties under that Presecribed Dental Services Contract are to be delegated to the ICB and which are to be retained by NHS England.

2.3 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders.

2.4 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 subject to paragraph 1.3.1 of this Part 1B, use the current NHS Standard Contract published by NHS England from time to time; and

2.5.3 subject to paragraph 1.3.1 of this Part 1B, pay for the Services in accordance with the National Tariff or the NHS Payment Scheme (each as defined in the Health and Social Care Act 2012) as applicable from time to time.

Part 2: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 2 of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under a GDS Contract, PDS Agreement and Personal Dental Services Plus Agreement procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 10 (Procurement and New Contracts), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

9.1 On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

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

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The arrangements for the provision of ancillary services to Primary Dental Services Providers are described in Schedule 7 (Local Terms).

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services

and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure

that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

3. Introduction

3.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Ophthalmic Services Contract Management

4.1 The ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

4.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Maintaining the Performers List

6.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

7. Finance

7.1 Further requirements in respect of finance will be specified in Mandated Guidance.

8. Workforce

8.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

8.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

9. Integrating optometry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

10. Complaints

10.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

11. Commissioning ancillary support services

11.1 The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme
LPS Chemist	has the meaning give to that term by the Pharmaceutical Regulations
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations

Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1.1. preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1.1. lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.1.2. lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.1.3. lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.2. managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.3. managing and determining applications by persons included in a Pharmaceutical List;

2.1.4. responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.5. overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.5.1. their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.5.2. relevant Conditions of Inclusion; and

2.1.5.3. requirements of the Community Pharmacy Contractual Framework.

2.1.6. exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.7. exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.8. communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.8.1. pandemic; and

2.1.8.2. a serious risk or potentially a serious risk to human health[7];

2.1.9. communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.10. performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.11. performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.12. making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.13. overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.14. exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.15. determining LPS matters[10] in respect of LPS Schemes;

2.1.16. determining Rurality Decisions and other rurality matters[11];

2.1.17. determining Dispensing Doctor Decisions[12];

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[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations

2.1.18. preparing and maintaining Dispensing Doctor Lists[13];

2.1.19. making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.20. making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.21. supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.22. consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.23. responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.24. responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.25. recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.26. bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.27. making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.28. recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liasing with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.29. commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.30. making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.31. undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2. Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1. the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1. Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2. a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

2.2.1.3. a Dispensing Doctor List (together the "Relevant Lists"); and

[13] Regulation 46 of the Pharmaceutical Regulations
[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.2. the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3. Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1. NHS England shall by Contractual Notice designate:

2.3.1.1. the ICB;

2.3.1.2. another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3. NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2. the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3. the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 3.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:
   3.1. Paragraph 3.1.1 (maintaining Pharmaceutical Lists)
   3.2. Paragraph 3.1.2 (managing applications for inclusion)
   3.3. Paragraph 3.1.3 (managing applications from those included in a list)
   3.4. Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)
   3.5. Paragraph 3.1.10 (Fitness to Practise)
   3.6. Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)
   3.7. Paragraph 3.1.25 (recovery of overpayments)

   with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

   7.1. all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

   7.2. any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

   8.1. responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

   8.2. where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under clause 9.20.

Integration

9. In respect of integrated working, the ICB must:

   9.1.1. take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

   9.1.2. work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

   9.1.3. work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).

13. **Finance**

    13.1. Further requirements in respect of finance will be specified in Mandated Guidance.

14. **Workforce**

    14.1. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This SCHEDULE 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.

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

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with SCHEDULE 2 (Delegated Functions) Part 1 paragraphs 7.1 and 7.2 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 In accordance with clause 9.18, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with clauses 9.20 and 9.21, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 In accordance with clause 9.14**Error! Reference source not found.**, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with clauses 9.16 and 9.17, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions)* and the Personal Data Agreement at the Annex is to set 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 4 *(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' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel 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 Personal Data Agreement is 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

1.3.5.1. Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2. Dental Services Providers and their personnel;

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' personnel; 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 ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement annexed to this Schedule.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of Primary Care Services and Primary Dental Services.

4. Lawful basis for Sharing

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the Personal Data Agreement annexed to this Schedule.

5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the Personal Data Agreement annexed to this Schedule.

6. Restrictions on use of the Shared Information

6.1. 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.

6.2. 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 Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3. Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor the Personal Data Agreement annexed to this Schedule should be taken

to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written 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.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

7.1. 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:

7.1.1. amendment of internal guidance to improve awareness and understanding among personnel;

7.1.2. 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;

7.1.3. ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

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

7.2. 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.

7.3. Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment 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.

7.4. Further provision in relation to specific data flows is included in the Personal Data Agreement annexed to this Schedule.

8. Governance: personnel

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

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

8.3. Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel 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 Information Law requirements, or causes damage to or loss of the Relevant Information.

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

8.5. Each Party shall ensure that:

8.5.1. only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2. 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. These access controls are set out in the Personal Data Agreement annexed to this Schedule; and

8.5.3. specific limitations on the personnel who may have access to the Information are set out in the Personal Data Agreement annexed to this Schedule.

9. Governance: Protection of Personal Data

9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate 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/Special Category Personal Data.

9.3. 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. If either Party:

9.3.1. becomes aware of 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

9.3.2. becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate 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 Information Law.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Special Category Personal Data) only 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;

9.4.2. process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5. Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised

or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1. 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

9.5.2. 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 regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6. In particular, each Party shall:

9.6.1. ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2. 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;

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

9.6.4. permit the 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

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

9.7. Each Party shall adhere to the specific requirements as to information security set out in the Personal Data Agreement.

9.8. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9. The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2. 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 / gcsx) email.

10.3. 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 / data is identified.

10.4. Any other special measures relating to security of transfer are specified in the Personal Data Agreement annexed to this Schedule.

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

10.6. The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1. 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.

11.2. Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1. The 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.

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

12.3. If either 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 under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. 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.

12.5. Any special retention periods are set out in the Personal Data Agreement annexed to this Schedule.

12.6. Each Party 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.

12.7. 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.

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

12.9. 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.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2. Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

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

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1. 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. Details of the single points of contact shall be set out in the Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the Personal Data Agreement annexed to this Agreement.

Annex

Template Personal Data Agreement

Data flow subject matter: [Description]
Data flow duration: *The duration of the delegation arrangement* **[OR Insert alternative period]**
Nature and purpose of processing: *Described in the Delegation Agreement at Schedule 4 paragraph 2.1 above*

Description of information flow and Single Points of Contact for parties involved

Originating Data Controller	[Insert:]			
Contact details for Single Point of Contact for Originating Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**
Recipient Data Controller	[Insert:]			
Contact details for Single Point of Contact of Recipient Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**

Description of information to be shared

Comprehensive description of Relevant Information to be shared – including the type(s) of personal data to be shared and categories of personal data	[Insert:]
Anonymised / not information about individual persons	**Yes / No**
Strongly pseudonymised	**Yes / No**

Weakly pseudonymised	**Yes / No**
Person -identifiable data	**Yes / No**
Justification for the level of identifiability required	[Insert or N/A:]

Legal basis for disclosure and use

GDPR Article 6 Legitimising Condition/s	[Insert or N/A:]	
GDPR Article 9 Exemption/s	[Insert or N/A:]	
Confidentiality	**Explicit consent**	Yes / No [If yes, how documented?:]
	Implied Consent	Yes / No [If yes, how have you implied consent?:]
	Statutory required/permitted disclosure	[Insert statutory basis:]
	Public interest disclosure	[Insert how the public interest favours use/disclosure of the information:]
	Other legal basis	[Insert:]
s. 13Z3 / 14Z61 NHS Act 2006 justification	**S. 13Z3 condition(s) to permit disclosure**	[Insert:]
	S. 14Z23 condition(s) to permit disclosure	[Insert:]
Other specific legal considerations		

Restrictions on use of information

[Insert:]

Governance arrangements

Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken	[Insert:]
Access controls on use of information	[Insert:]
Specific limitations on Personnel who may access information	[Insert:]
Other specific security requirements (transmission)	[Insert:]
Other specific security requirements (general)	[Insert:]
Specific requirements as to ensuring quality of information	[Insert:]
Specific requirements for retention and destruction of information	[Insert:]
Specific monitoring and review arrangements	[Insert:]

SCHEDULE 5

Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability)*.		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

2.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

2.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

2.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

2.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

3. Primary Ophthalmic Services

3.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

3.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

3.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

3.1.3 GOS complaints. Administration of the annual GOS complains survey.

3.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

3.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

4 **Pharmaceutical Services and Local Pharmaceutical Services**

4.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

4.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

4.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

4.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

5 Support Services directed by DHSC

5.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

5.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

5.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

5.1.3 Clinical advisory support;

5.1.4 Administration functions;

5.1.5 Assurance services - performance and contract management of primary care providers;

5.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

5.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

[*Note – Local terms may only be agreed between the ICB and NHS England on an exceptional basis and must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:*

- *details of any pooled funds of NHS England and the ICB;*
- *resourcing arrangements between NHS England and the ICB;*
- *details of ancillary services provided to Primary Care Providers such as clinical waste;*
- *details of any particular services that the Assigned Staff will provide to the ICB under SCHEDULE 8**Error! Reference source not found.**; and*
- *Staffing arrangements.*

If there are no Local Terms, state "None" in this SCHEDULE 7.]

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note:
This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

1. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

2. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

   2.1 faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

   2.2 perform all duties assigned to them pursuant to this Schedule 8.

3. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

4. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

   4.1 by reason of industrial action;

4.2 as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

4.3 in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

4.4 if making the NHS England Staff available would breach or contravene any Law;

4.5 as a result of the cessation of employment of any individual NHS England Staff; and/or

4.6 at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

1. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

2. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

3. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

1. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

2. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

1. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

2. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

1. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

2. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

1. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.

Primary Ophthalmic Services

- Policy Book for Eye Health.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.
- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*

Workforce

- Guidance on the Employment Commitment.

Other 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.
- IG 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.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**10**

Title:	**Stoke-on-Trent Joint Commissioning Strategy for children and young people with Special Educational Needs and Disabilities (SEND) 2023 - 2028**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Chris Bird, Chief Transformation Officer	Y	Denise Dyke – Senior Strategic Manager, CYP Portfolio

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Dr Waheed Abbasi ICB Clinical Lead Mental Health	No

	Action Required (select):									
Ratification-R		**Approval -A**	✓	**Discussion - D**		**Assurance - S**		**Information-I**		

Is the Committee being asked to make a decision/approve this item? Yes *(although there is no finance attached to the item)*			
Is the decision to be taken within Committee's delegated powers & financial limits?			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Stoke-on-Trent Inclusion Partnership Board	14/12/2022	I
ICS Children and Young Peoples Board	18/01/2023	I
Staffordshire and Stoke-on-Trent Health and Care Senate	09/02/2023	A
Stoke-on-Trent Executive Board for SEND and Inclusion	16/02/2023	A
SSOT ICB Quality and Safety Committee	08/03/2023	A

Purpose of the Paper (Key Points + Executive Summary):

- The Stoke-on-Trent Joint Commissioning Strategy for children and young people (CYP) with special educational needs and disabilities (SEND) is a high-level strategic document that sets out our vision and intentions for improving children's lives in Stoke-on-Trent over the next 5 years. With implementation starting in Spring 2023.
- Stoke-on-Trent City Council and Staffordshire and Stoke-on-Trent ICB work jointly through the Stoke-on-Trent Inclusion Partnership Board and share a common vision that CYP with SEND, and social, emotional, and mental health, living in Stoke-on-Trent will have the opportunity to be the best that they can be, live their best life and be as aspirational as they want to be. One way in which this vision can be achieved is through joint commissioning of services.
- The Joint Commissioning Strategy for SEND, identifies a set of shared principles and priorities that will set a road map for all joint planning and commissioning decisions. This has been informed by current data and intelligence on service provision as well as feedback from our communities.
- This strategy development is in-line with the requirements of the SEND Code of practice:0-25 years where local authorities and clinical commissioning groups (now Integrated Care Board) must make joint commissioning arrangements for education, health, and care provision for CYP with SEND. In addition, the NHS Long Term Plan Implementation Plan (2019 –24) highlights the need for a shift towards localised integrated care in response to health inequalities across prevention and treatment spectrum.
- The development of the strategy has been directed by the Stoke-on-Trent Inclusion Partnership Board (now known as the Executive Board for SEND and Inclusion) and they will have the overall oversight and accountability. The Stoke-on-Trent SEND Delivery Group will have responsibility and oversight of managing improvements in services, systems and processes that are detailed in the Strategy.
- Ten priorities have been identified:
    1. Understanding our SEND population need and current/future service demand and capacity
    2. Meeting the needs of our neurodiverse population
    3. Developing a joint graduated approach that meets the speech, language and communication needs of our SEND population
    4. Improving access to therapy and integrated equipment provision.
    5. Nursing provision for CYP with SEND
    6. Improve communication between agencies, professionals, CYP and families
    7. Ensuring the workforce is skilled, knowledgeable and feels supported and equipped to support CYP with SEND
    8. CYP with SEND are supported with their social and emotional mental health
    9. Improve the early identification of SEND needs, in early years, as well as intervening when issues start to arise
    10. Make improvements in the attainment of CYP with SEND
- The Strategy was presented at and well received by the ICS CYP Board in January 2023. Feedback suggested that the section on engagement and co-production should be amended to reflect that there is a 'toolbox 'of methods that can used for engagement and participation with parents and children. This has been taken on board and changes made.
- The Strategy was presented at the Staffordshire & Stoke-on-Trent Health & Care Senate in February 2023, where the Senate recommended its approval for ratification at the ICB Board meeting in March 2023.
- The Strategy was presented at the Stoke-on-Trent Executive Board for SEND and Inclusion in February 2023, where it was agreed that a tenth priority around attainment in CYP with SEND should be included. This has been taken on board and changes made.

- The Strategy was presented at the Staffordshire & Stoke-on-Trent ICB Quality & Safety Committee in March 2023, where the Committee recommended its approval at the ICB Board meeting in March 2023.
- Next Steps:
    a. An accompanying action plan is currently in development and will be reviewed annually (there is a Council for Disabled Children/RISE workshop planned for 10th March to assist with its development).
    b. The Strategy to be presented at Stoke-on-Trent City Council Cabinet 28th March 2023.
    c. Launch Strategy – April 2023

Is there a potential/actual Conflict of Interest?	**No**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
No conflicts identified	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
None specifically identified pertaining to this report.

Implications:	
Legal and/or Risk	None
CQC/Regulator	None
Patient Safety	None
Financial – if yes, they have been assured by the CFO	No financial implications. The Strategy outlines at a high level what our joint commissioning principles and priorities are to meet the needs of our SEND population in Stoke-on-Trent.
Sustainability	None
Workforce / Training	None

Key Requirements:	
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? *Quality and Equality Impact assessments have been completed.* *This Strategy is all about improving how we jointly commission services for CYP with SEND and their families and carers, some of our most vulnerable people in society. So that there is* • *the right care, at the right time in the right place* • *improved early identification of needs and so that early support can be accessed and provided to prevent any escalations and ensue a graduated approach*

	• *positive outcomes for CYP across all education, health, and social care services* • *an educated workforce on SEND to ensure equal access to services* *SEND cuts across many of the services and cohorts of people where we see the largest inequalities. For example, children and young people with SEND do not achieve the same educational, health and social outcomes as other children. Also, when looking at adult data, the average the age at death for people with a learning disability is 23 years younger for men and 27 years younger for women than the wider population (Learning disability mortality review 2020).* *If we can get positive outcomes for children and young people and ensure that they can be the best that they can be, live their best life and be as aspirational as they want to be, this will help to reduce the health inequalities that are currently seen.*		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality, and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) *Benefits of joint commissioning include improving quality and efficiencies of services as well as looking at data and intelligence as a whole system rather than in silos. By involving all agencies (health education and social care) and parents/carers allows to understand the wider impact on this population of any decisions that are made.* *It also ensures that we meet the statutory SEND code of practice: 0 to 25 years Guidance on the special educational needs and disability (SEND) system for children and young people aged 0 to 25*		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group? Quality colleagues have been consulted and in their decision was that this Strategy does not fit the criteria for a QIA. If there are any changes in commissioning that occurs as a result, then a Quality Impact Assessment will be completed. (The QIA criteria are commissioning, decommissioning or service redesign)	**No**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes, please give date(s) • Stage 1 - approved • Stage 2 – not required	**Yes**	**Dec 2022**
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? N/A		

3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? *Vulnerable groups (such as CYP with SEND, parents, and carers of CYP with SEND) have been targeted for engagement in the development of this strategy.* • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g., service improvements). *There was no negative feedback from our engagement on the Strategy.* • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened; We Did'?) *There has been no re-shaping of services. This is a high-level strategic document.* • Explain any 'objective justification' considerations, if applicable. *Not applicable*		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients? • Pegis Parent Group Session via Zoom (September 2022) • Various engagement with Midlands Partnership NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust • Face-to-face session with young people at Strathmore College (September 2022) • On-line Survey in October 2022 • Members of the Stoke-on-Trent SEND Steering Group have contributed to the contents of the Strategy (included representation from social care, education, and health) • The RISE Programme (funded by the Department of Education) and the Council for Disabled Children facilitated a workshop on 7th September 2022. This was to support leaders in Stoke-on-Trent to develop content for a local Joint Commissioning Strategy. This was attended by a range of stakeholders, from education, health, social care, and parents. • On-line Survey in January 2023 • Face to face parent/carer engagement session, Hazel Trees (January 2023) • Face to face parent/carer engagement session, Water Mill Special School (January 2023) • Profession/provider online engagement session (January 2023)		
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**No**	
Recommendations / Action Required:			
The ICB Board is asked to: • **Approve** the Stoke-on-Trent Joint Commissioning Strategy for children and young people with SEND 2023-2028			

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

City of Stoke-on-Trent

Joint Commissioning Strategy for children and young people with Special Educational Needs and Disabilities 2023 - 2028







CONTENTS

INTRODUCTION

As a partnership between Stoke-on-Trent City Council and the Integrated Care Board it is important that we understand the challenges and issues facing the local area in order to effectively support residents and to enable the joint commissioning of **the right support at the right time, delivered by the right people**. Not only does this statement support this strategy but also feeds into the key wider local outcomes identified in the "To be the best I can be" priorities and outcomes have been developed by children, young people and families.

We aim to provide the best opportunities for every child in our city, inclusive of those with Special Educational Needs and Disabilities (SEND) and we know that there is a lot of good practice happening across the City of Stoke-on-Trent. However, the global COVID pandemic and the subsequent economic challenges has meant significant disruption and immense pressure for children and young people.

For some families these have lessened resilience, increased poverty, and increased mental health difficulties across the population. For some children and young people with SEND and their families the impact will have delayed access to learning, access to social support and health provision. Services are also operating with increasing local need and amid significant challenges. Therefore, our ability to develop and adapt provision in line with demand will be essential to meet the outcomes of our children and young people in the future.

We have got improvements to make to ensure that in Stoke-on-Trent, joint commissioning can take centre stage so that we work more closely and creatively with communities to understand need, shape the best possible co-produced solutions with our families and meet ambition and hope.

What this Strategy does:
Identifies a set of shared principles and priorities that will set a road map for all joint planning and commissioning decisions for SEND. This has been informed by local data, Explore education statistics (external link) and feedback from our communities and is in line with the requirements of the SEND Code of practice:0-25 years.

Working in Partnership:
Stoke-on-Trent City Council and the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) will work in partnership, which will be set out within this Joint Commissioning Strategy for SEND. We will co-produce with parents, carers, children and young people, the voluntary sector, service providers, professionals and other stakeholders to ensure inclusion plays a part of every service that is to be jointly commissioned or accessed across communities. We will directly address priority areas that matter most to children, young people and their families.

We are committed to Joint Commissioning:
This Strategy, which is part of a suite of strategies that have a link to children and young people with SEND (see Appendix 1) sets out our current arrangements and the ambitious plans we have to improve. We need to maximise the same opportunities for all our children, young people and families and we will align joint commissioning activities with all actions identified through other strategies and legislation. This will ensure individual needs are recognised and support has a personalised focus.

As a partnership we have reflected upon what children and young people, parents and carers have told us and with this feedback has helped to shape our Joint Commissioning Strategy for children and young people with Special Educational Needs and Disabilities;

Parents tell us that .....

Families who we support are not familiar with the language and processes of commissioning

Parents will only see what impact joint commissioning has when they can see improved changes to the services they access

They want to.....

See improved joint working to improve services

Be allowed to be parents and not a professional

OUR VISION

“Children and young people with special educational needs, disabilities and social, emotional and mental health, living in Stoke-on-Trent will have the opportunity to be the best that they can be, live their best life and be as aspirational as they want to be’

OUR VISION FOR CHILDREN AND YOUNG PEOPLE WITH SEND IN STOKE-ON-TRENT

This Strategy will provide a roadmap on how collectively we will jointly commission and work towards this vision, ensuring high quality, joined up services across education, health and social care. We will build upon our strengths, working closely with our community to understand and listen to what matters most to them, to ensure that we are able to meet the needs of young people with SEND and their families.

As a partnership, The City Council, the ICB and other key stakeholders on our Inclusion Partnership Board share a common vision that this Joint Commissioning Strategy combines the overarching vision and road map to jointly design, develop and deliver better services for SEND.

We need to remove barriers to opportunity, to improve equality of access to services and to provide care and support to enable children to enjoy and achieve life to the maximum of their potential. Joint commissioning is just one element of how the vision can be achieved and we must do this through the best use of our available resources, planning and commissioning wisely to achieve the greatest impact.

In addition to this vision within Stoke-on-Trent "Pots of Positivity" have been developed with children and families as part of the Room to Grow and the Inclusion Strategy to ensure a joined up consistent approach within the City. These outcome statements will be the centre of all decisions that involve and impact children, young people with SEND and their families including joint commissioning.

Pots of Positivity

Outcome	What this means for children and young people
Live Well	I want to feel valued and part of a community and be respected by the people I meet.
Good Education	I want to have a good quality education that is meaningful to me.
Preparing for Adulthood	I want to feel confident about growing up and look forward to being as independent as I can be.
Employment Opportunities	I want to have opportunities for work experience, apprentices and the chance to have a job I enjoy.
Be Healthy	I want to be physically, mentally and emotionally healthy as I can be.
Skilled Workforce for support	I want the people who support me to have the right skills and knowledge and for them to work together to help me be the most I can be.

PRINCIPLES AND VALUES

During the life of this Strategy and on this journey to where we want to be as a partnership these are the principles and values that will underpin how we jointly commission and how we will work.

Put children, families, and young people at the heart of everything that we do by using participative and co-production methods.

Continuously monitor and review services for children and young people with SEND to ensure they are of high quality and achieving the outcomes required

We commission together, examining our priorities, look at opportunities to align work jointly or joint commission where we are buying the same or similar provision.

Focusing on an outcomes-based approach for commissioning, will allow us to deliver effective, integrated, and person-centred support, and build services that are holistically focused on the person rather than around organisations.

We will ensure that the foundations of joint commissioning are strong and well led. We will enhance and improve those relationships that we already have in place and where they don't exist create new ones.

We will commission wisely by considering quality as well a cost and will forward plan to ensure we are commissioning at the right time. We will use a graduated approach to ensure we have the right care, in the right place, at the right time.

WHAT WE KNOW ABOUT SEND IN STOKE-ON-TRENT

A Joint Strategic Needs Assessment (JSNA) is a review of the current and future education, health and social care needs of a defined community. Demographics and statistics enable us to understand the local population and the support already in place and support needed for the future in order to improve outcomes for all. We can also compare how we are doing nationally and regionally.

The full report can be accessed at
Data directory - Joint strategic needs assessment | Stoke-on-Trent (external link)

Our City has a large population of children and young people.

The child population makes up over

24%

of the current population,
over 18 percent being between 0-15 years

As of January 2022

18.9%

of the school population in Stoke-on-Trent have an Education Health and Care Plan (EHCP) or Special education needs (SEN) support. This is higher than the national average of 16.5%*.

The number of children in primary and secondary school most likely to have support for SEN.

Primary
13%
compared to the national average of **17.7%**

Secondary
13.8%
compared to the national average of **11.9%**

122 pupils in year 12,13 and 14 have SEN support or an EHCP.

Amongst all school-age children with an EHCP in Stoke-on-Trent, most are educated in:

LA Mainstream 681 **LA Special School 908** **Independent Schools 157**

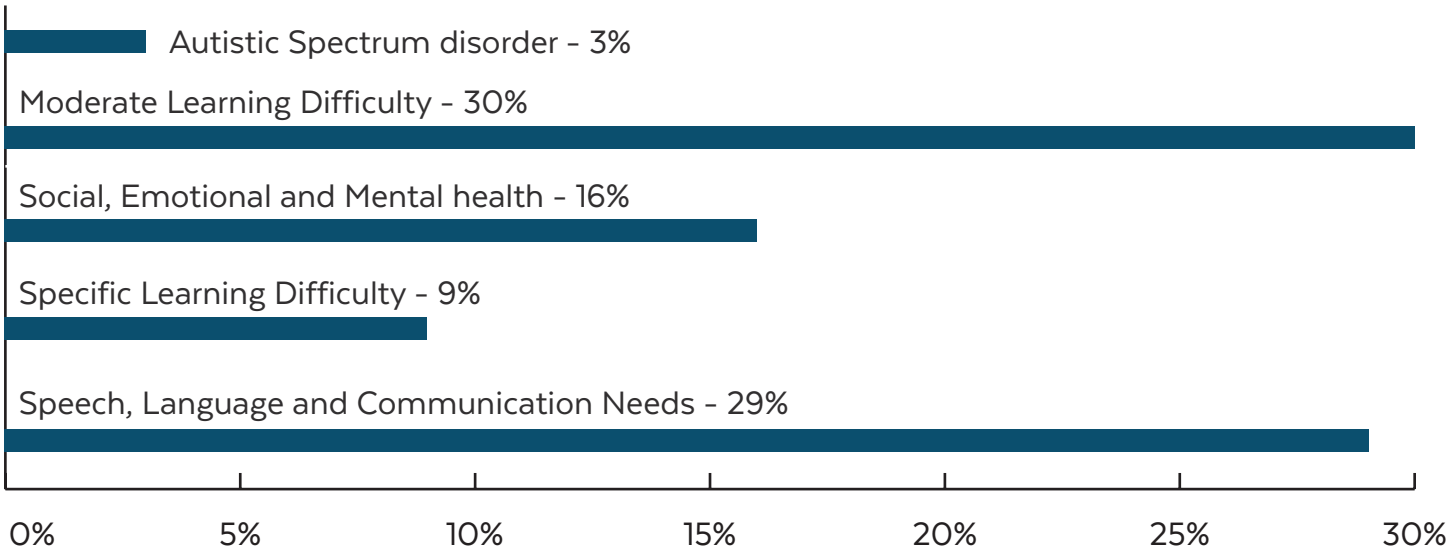
*Totals include state funded nursery, primary, secondary and special schools, Non-maintained schools, pupil referral units and independent schools.

SEN support and EHC Plan data in Stoke-on-Trent

ECHP and SEN Support 2021/22	Stoke-on-Trent	England
EHCP	1,746	355,566
SEN Support	6,058	1,128,843
Total SEN Support and EHCP population	7,804	1,485,409
Total school population	41,244	9,000,031
Percentage	**18.9%**	**16.5%**

Data published in 16 June 2022
Source: Academic Year 2021/22 Special educational needs in England publication.
Special educational needs in England, Academic Year 2021/22 – Explore education statistics – GOV.UK (external link)

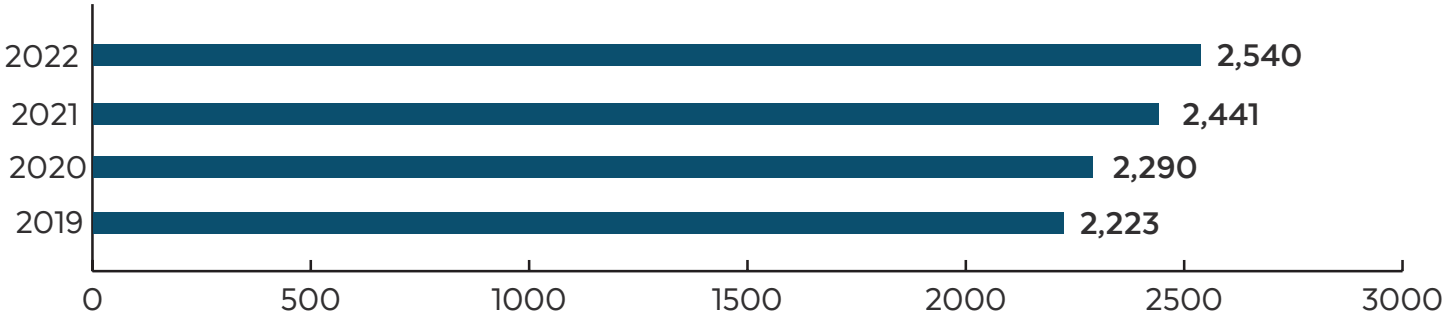
The most common primary needs of SEND (SEN support and EHCP) in Stoke-on-Trent



Percentages based on a SEN Support and EHCP population of **7,804**

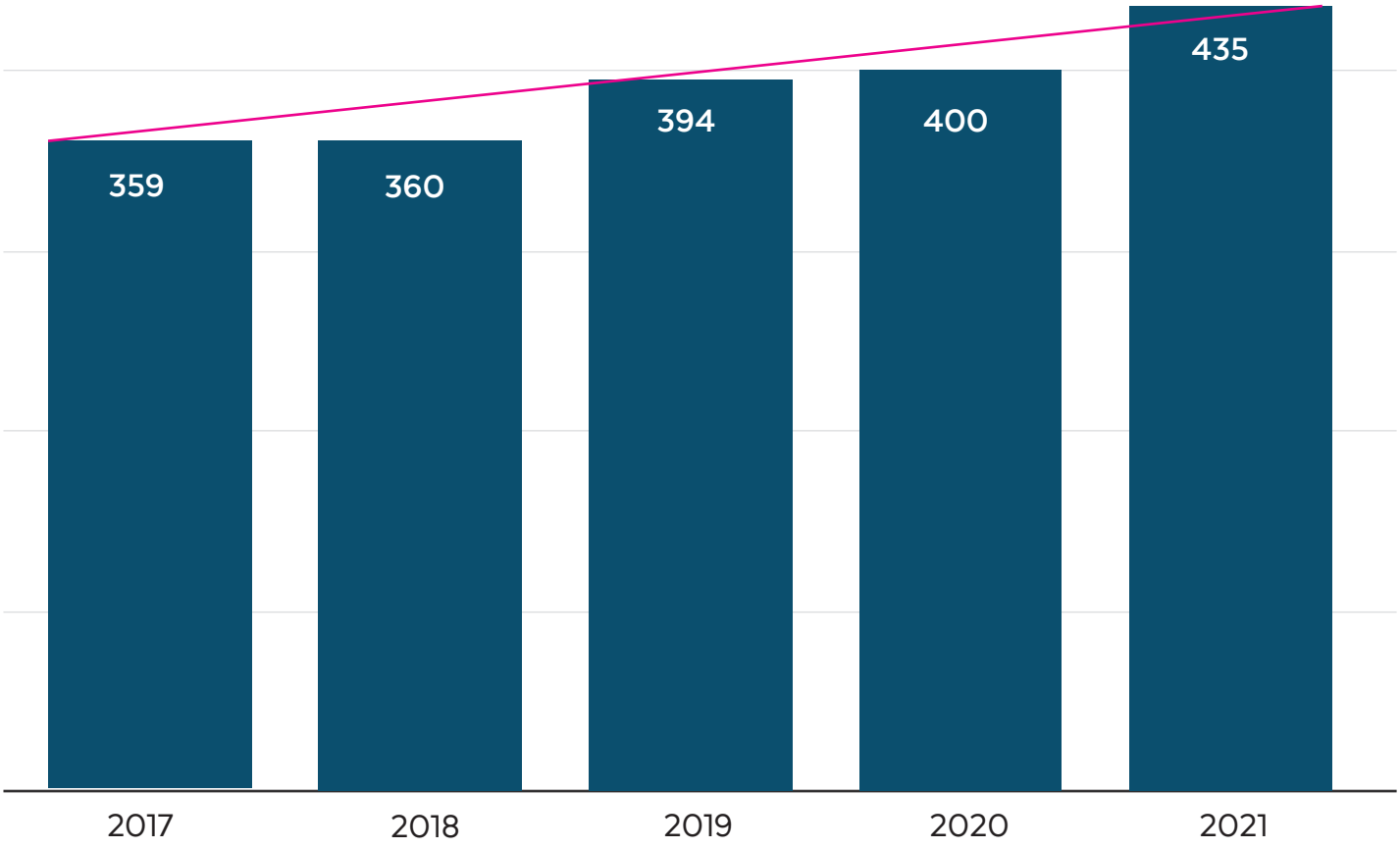
Data published in 16 June 2022
Source: Academic Year 2021/22 Special educational needs in England publication
Special educational needs in England, Academic Year 2021/22 – Explore education statistics – GOV.UK (external link)

Number of EHCPs in Stoke-on-Trent



Data published: 12 May 2022
Source: Reporting Year 2022 Education, health and care plans (SEN2 Data).
Education, health and care plans, Reporting Year 2022 - Explore education statistics (external link)

Initial EHCP requests



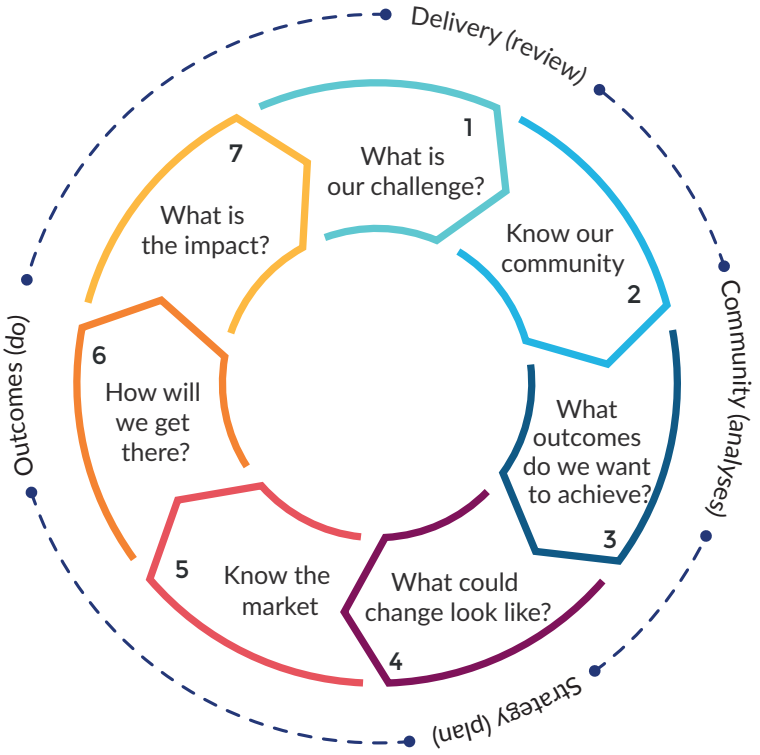
Data published: 12 May 2022
Source: Reporting Year 2022 Education, health and care plans (SEN2 Data).
Education, health and care plans, Reporting Year 2022 - Explore education statistics - (external link)

WHAT IS JOINT COMMISSIONING AND WHY IT IS IMPORTANT

Commissioning is a way of understanding need, planning a response to meet this need and reviewing the effectiveness of action taken. It is often viewed as a cycle and is commonly described as having 4 stages which are described in more detail below.

The Commissioning Wheel

How are decisions about changes to services made



- What do Stoke-on-Trent City Council and the Integrated Care Board need to do differently and what money do we have jointly to spend?
- What is our understanding about the people who use the services and are more services needed in the future?
- What needs to change for Stoke-on-Trent City Council and The Integrated Care Board?
- What is our joint vision for the future?
- Which stakeholders or Partners provide these types of services?
- What does good look like and how will our plan to change services look like?
- How do we check if our plans are working?

Joint Commissioning is a whole system approach to the planning and delivering of services. This approach to commissioning should be done at the strategic, service or individual level and supports better outcomes by meeting the needs of our children, young people and their families in a more joined-up way.

Families benefit when services communicate well and work cohesively together. This ensures that children's needs are usually identified early and that provision is effective in meeting those needs. The effective working relationships between services are productive, so they ensure that identified needs in the local area are appropriately prioritised.

Effective joint commissioning for SEND generates efficiencies and value for money and enable partners to:

- Agree local priorities – linking with and informing the Children and Young People's Strategic Plan.
- Have a shared understanding of the range and effectiveness of current service provision across public, private and voluntary/community sectors.
- Achieve a shared understanding of the current gaps or duplication in service provision, including areas that need to be developed in order to meet local needs.
- Bring together a variety of commissioning expertise and professionals' experts all working to achieve common outcomes
- Speak to children and their families and other stakeholders with a single voice.
- Improve our ability to forecast and respond to the needs of the local area, so we can improve planning and commissioning of our local SEND services.
- Have a joined or aligned contractual and performance processes for all commissioned services to ensure better outcomes and the inclusiveness of SEND services.
- Ensure that the resources and funding available within the area can make the most difference.

ENGAGEMENT AND CO-PRODUCTION

Effective and meaningful participation and co-production is critical to the success of this strategy and improving experiences of services and pathways and by extension improving outcomes. Working with children and young people and their families will be at the core of our joint commissioning activities across education, social care and health.

The City Council and ICB are committed to listening and responding to the voice of the child and their families/carers. We shall gather regular feedback about the services we provide and commission in order to improve them.

There are several methods or tools that can be considered for effective participation and engagement. These are broadly based on two models the 'Rogers Harts Ladder of Children's Participation[1] and the 'National Co-production Advisory Group's Ladder of Participation[2]'. In any engagement we carry out, we shall use the most appropriate method and strive and aspire to use that approach.

As well as having engaged on this Strategy, we shall engage and co-produce the accompanying Action Plan, prioritising actions according to feedback, evidence and needs analysis.

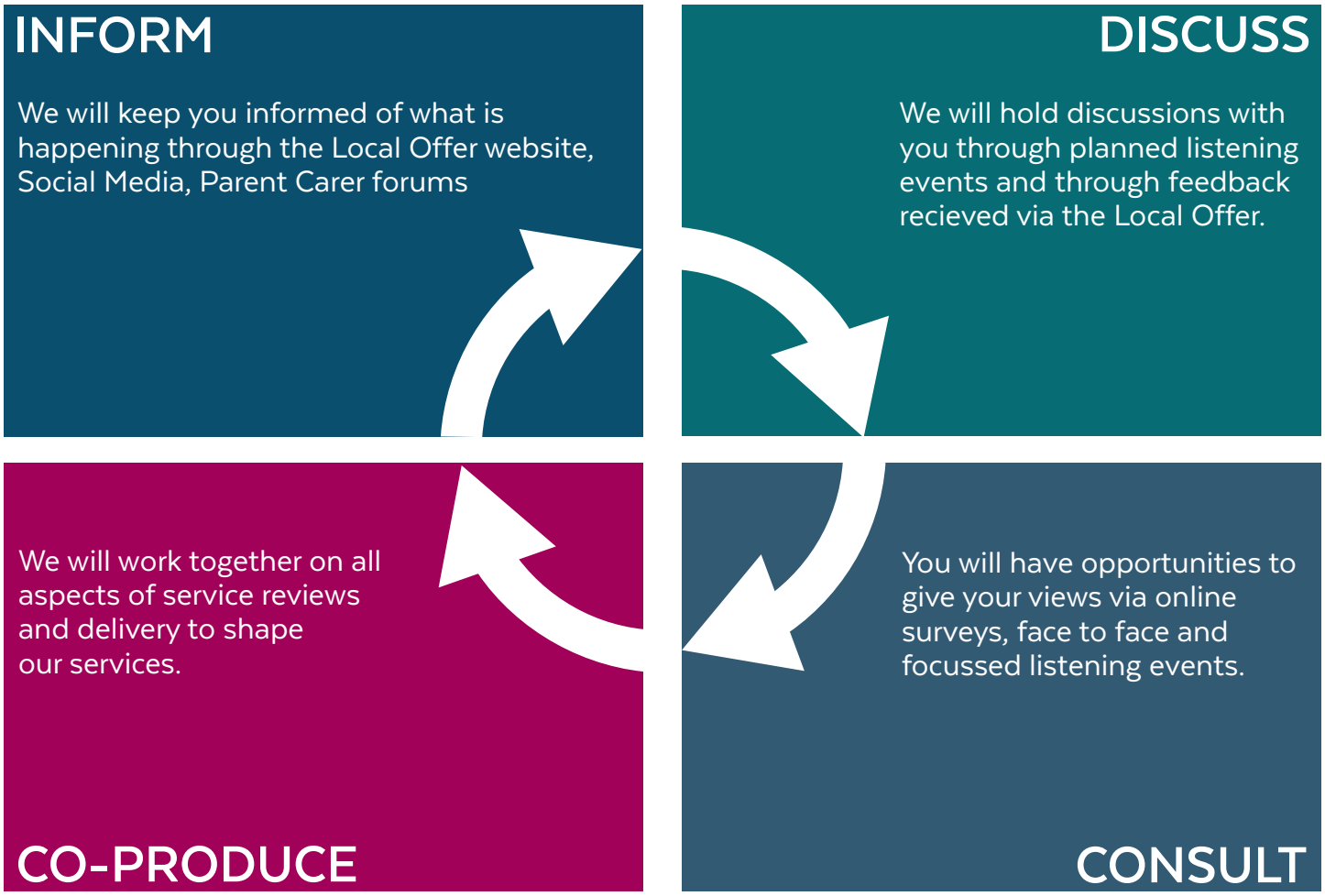
Cycle of Co-production

Where we do co-produce, the approach that is used shall be based on Stoke-on-Trent Five Pillars of Wisdom, that has been developed by the City Council. This along with People Supporting People (Co-production for SEND) shall be the basis of our co-production and the broader engagement and participation for all aspects of Joint Commissioning in SEND.

[1]Hart, Roger A. (1992). Children's Participation: From tokenism to citizenship, Innocenti Essay, no. 4, International Child Development Centre, Florence

[2]Ladder of Coproduction | TLAP | social care (thinklocalactpersonal.org.uk)

Engagement and Participation Cycle



Who we will Co-produce with

1) Co-production with Community Partnerships (Widening Networks)

2) Co-production with Stakeholders (Improving Services)

3) Co-production with local partners (Sharing Outcomes and Shared Responsibility)

4) Co-production with Our Children and Young People (Getting Involved)

5) Co-production with Parents and Carers or Responsible Adults (Using a voice)

WHAT YOU SAID

Commissioning through a different lense

In order to better understand how as partners we see joint commissioning through different lenses, we have undertaken a number of engagement events, one to one sessions and on-line surveys with children and young people, parents, carers, partners and stakeholders.

This feedback has influenced our priorities for the "Joint Commissioning Strategy".

What you said;

Hearing the voice of children and young people:

"No one talks to each other when discussing my needs and wishes "

"I want to access a school that is close to me that meets all my needs "

Listening to parents and carers:

"Better communication between services."

"Local schools who can meet the needs of CYP"

"Waiting lists are too long."

"Parents want to be listened too."

"Better early years support and intervention is needed."

"The system needs to work together. "

"Support following diagnosis for families, young people and children."

Communicating with Professionals:

A graduated approach to ensure the correct level of support at the right time, that all professionals understand.

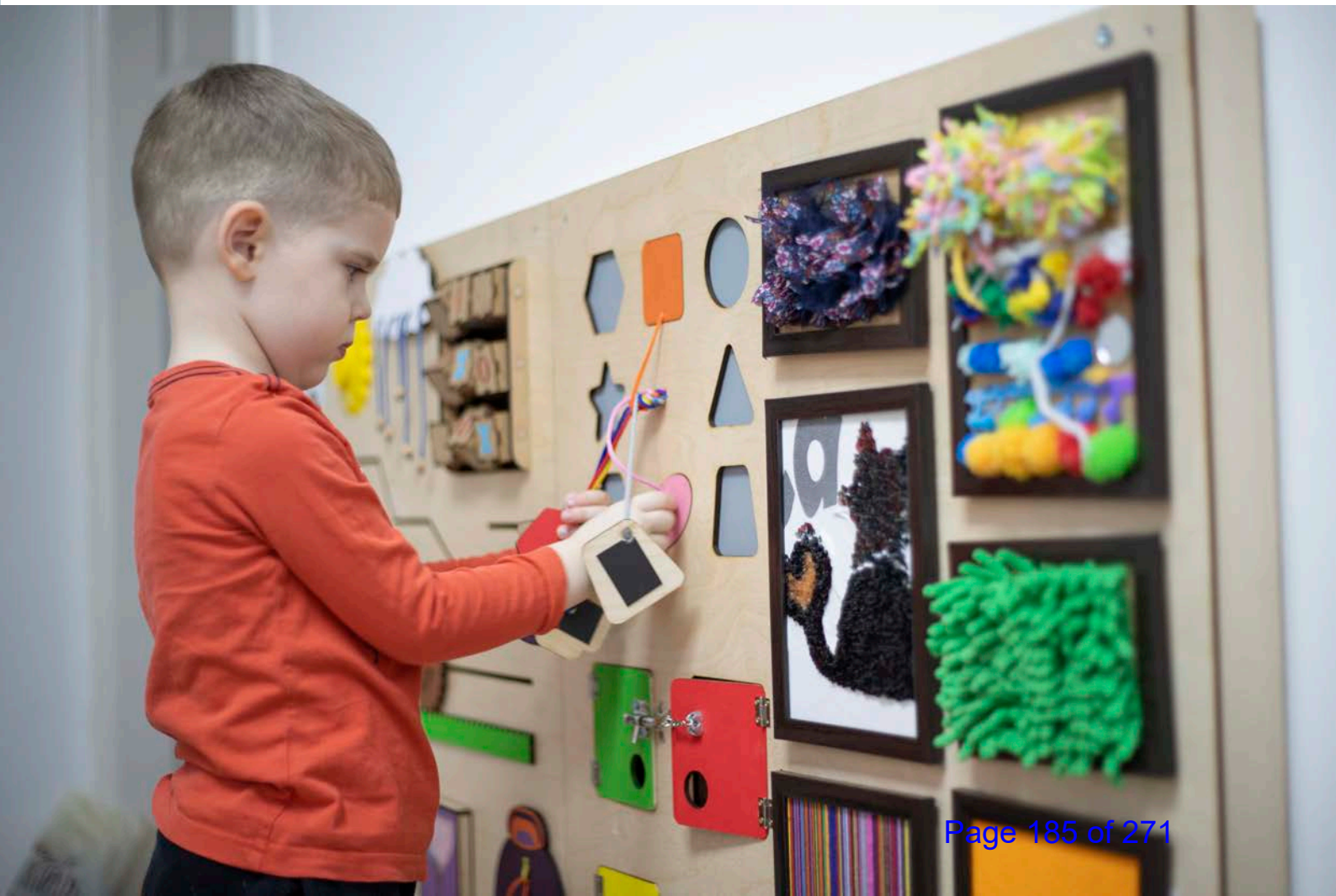
Workforce development programme.

Pathways between LA and health that are seamless

There is a large gap in supporting sensory needs. A position statement would be helpful.

Lack of community-based support

Better training needs to be in place to recognise additional needs



OUR COMMISSIONING PRIORITIES

This section details our Joint Commissioning priorities and key areas for improvement over the lifespan of this strategy (2023-2028). It is worth noting that these are not all the priorities for SEND in the city but specifically for better joint commissioning.

These have been developed through conversations with children, young people, parents, carers, stakeholders and partners through a number of engagement events, one to one sessions and surveys.

Priority 1

Understanding our SEND population need and current/ future service demand and capacity

Why?

- To identify where the graduated approach is working well and where improvements are required
- To ensure that the relevant services are supporting where necessary and there is no duplication.
- Good data can support and drive improvements and ensure that resources are utilised where there is the most need
- To encourage 'right service at right time'
- So that children and young people feel confident that we understand them.
- So there is a shared understanding across partners

Priority 2

Meeting the needs of our neurodiverse population.

Why?

- Early intervention is necessary in order to ensure the right support is given to parents and also the educational environments.
- Parents and carers tell us the waiting times for Autism Spectrum Disorder (ASD) is too long.
- Professionals tell us that there is an increase in referrals, but this does not always translate in an increase in diagnosis rates
- The data tells us that there is a gap between the numbers we see with ASD and what we would expect to see.
- To ensure that children and young people are getting the provision and support for their SEND need.
- To limit the distress to children and young people and their families.
- Current services are based on diagnosis rather than presenting need.

Priority 3

Developing a joint graduated approach that meets the speech, language and communication needs of our SEND population

Why?

- We need to improve early intervention as staff are not always aware of the support that can be put into place at an early stage.
- Individuals that require a more structured, targeted support programme need to be identified better.
- Professionals tell us that partners commission individual services, uninventively creating silos of provision.
- Data tells us that speech, language and communication is one of the top 3 the primary needs of children with SEND across the City.
- To ensure that children and young people are getting the provision and support for their SEND need.

Priority 4

Improving access to therapy and integrated equipment provision.

Why?

- We need improve early intervention as staff are not always aware of the support that can be put into place at an early stage.
- Individuals that require a more structured, targeted support programme need to be identified better.
- Professionals tell us that partners commission individual services, unintentionally creating silos of provision.
- Professionals tell us that the process for obtaining and maintaining equipment to support in education is fragmented.
- Clear policy and process around equipment that is shared between social care, health and education.

Priority 5

Nursing provision for children and young people with SEND

Why?

- To ensure children and young people can attend school safely and have their health needs met.
- So that parents and professionals have a shared understand of each partners statutory obligation to delegate and deliver.
- So that there is joint working for the most complex children to ensure clear information and assessment outcomes are shared.
- Professionals tell us that partners commission individual services, unintentionally creating silos of provision.
- To ensure that the delivery is child centred.

Priority 6

Improve communication between agencies, professionals, children and young people and families

Why?

- Parents tell us that communication between professionals is disjointed
- Poor communication can escalate matters unnecessarily that can lead to disputes resolution, mediation and tribunals processes.
- To ensure that information is shared in a timely manner between professionals and families.

Priority 7

Ensuring the workforce is skilled, knowledgeable and feels supported and equipped to support children and young people with SEND.

Why?

- Parents tell us that that joint decision processes are not always clear.
- Professionals tell us that EHCP processes need to be streamlined.
- As a system we need to retain our skilled staff and ensure they feel valued and are making a difference.

Priority 8

Children and young people with SEND are supported with their social and emotional mental health

Why?

- Parents are concerned about the impact COVID 19 has on children and young people mental health.
- Parents and carers have told us that navigating the SEND system has a negative impact on parent's mental health.
- There are pockets are good practice within the City and this needs to be replicated wider.
- Data tells us that social and emotional mental health is one of the top 3 primary needs of children with SEND across the City.

Priority 9

Improve the early identification of SEND needs, in early years, as well as intervening when issues start to arise

Why?

- A consistent offer between all educational settings is required across all ages.
- If a timely response is given, needs can be meet not escalated further.
- Professionals tell us that referrals have increased since COVID 19, especially in early years services.
- Parents and carers tell us that getting early help makes a big difference.

Priority 10

Make improvements in the attainment of children and young people with SEND

Why?

- There is a gap in the number of children and young people with SEND reaching the expected standards in reading, writing and maths, compared to their peers
- The impact of the COVID-19 pandemic has negatively affected the attainment gap
- Raising attainment leads to the improving life chances of our children and young people and provides the opportunity for them to be the as aspirational as they want to be

HOW WE WILL MONITOR PROGRESS

Next Steps

As part of our first steps in achieving positive outcomes for our SEND population, a co-produced Action Plan will be developed, that starts to take a more practical approach in how this can be delivered. There will be specific actions detailed that we would take over the life span of this Strategy

The Action Plan shall be based on the initial data analysis, engagement and feedback that we have obtained from a range of stakeholders in the development of this Strategy. Over time the detail of the Action Plan will continue to be co-produced and developed in partnership with key stakeholders across the system. The Action Plan will be refreshed annually.

It is imperative that we measure how successful we are in making progress against our commissioning priorities. We will identify key indicators linked to each of the priorities and pots of positivity outcomes. This will reflect and measure the impact our joint commissioning decisions have on the lives of the individual children, young people, and their families.

Governance

Good governance enables organisations to build a sustainable and better future for all of us. It adds value, is open, transparent, and ethical. Good governance focuses on achieving the best outcomes for our children and young people by helping to address any of issues, challenges and obstacles (operational or otherwise) to progress. There are clear and established governance arrangements across both the City Council and ICB that will monitor the progress of this Strategy and its Action Plan.

While the Executive Board for SEND and Inclusion in the City, will have the overall oversight and accountability to ensure WHAT WE WILL DO is carried out, it is the SEND delivery group that will have responsibility, oversight and manage improvements in services, systems and processes that are detailed in the Strategy and Action Plan.

Quarterly updates will be provided from the SEND delivery group to the Executive Board SEND and Inclusion so that progress can be measured, and achievement highlighted. This will also provide the vehicle for when there are risks or underperformance that are required to be escalated. The Executive Board for SEND and Inclusion will in turn report to the Health and Wellbeing Board and the ICB Quality & Safety Group.

In time, workstreams, will be put in place to support the priorities identified in the Strategy and that align with the detail and emerging need within the Action Plan. In addition, we will put in place mechanisms by which we can regularly review whether the changes that are happening are having a positive affect for children, young people, families, schools and other professionals across the SEND system.

APPENDIX 1 – LINKED STRATEGIES

Room to Grow Children and young people Strategy 2020 – 2024
Policies, procedures and strategies directory - Room to Grow Children and young people Strategy 2020 - 2024 | Stoke-on-Trent

Inclusion Strategy for children and young people with Special Education Needs and Disabilities 2021 – 2024
Policies, procedures and strategies directory - Inclusion Strategy for children and young people with Special Education Needs and Disabilities 2021 - 2024 | Stoke-on-Trent

Early Help and Prevention Strategy
Policies, procedures and strategies directory - Early Help and Prevention Strategy | Stoke-on-Trent

Children's Commissioning Strategy
Policies, procedures and strategies directory - Children's Commissioning Strategy | Stoke-on-Trent

Children and young people's mental health and emotional wellbeing strategy
Policies, procedures and strategies directory - Children and young people's mental health and emotional wellbeing strategy | Stoke-on-Trent

APPENDIX 2 – GLOSSARY

Glossary of Terms

Accountability
Governance that is in place to ensure that responsibility is being taken for implementation.

Autistic Spectrum Disorder
Autism spectrum disorders (ASD) are a diverse group of conditions. They are characterised by some degree of difficulty with social interaction and communication. Other characteristics are atypical patterns of activities and behaviours, such as difficulty with transition from one activity to another, a focus on details and unusual reactions to sensations.

Co-production
The term 'co-production' refers to a way of working where the people who use services (in this case children and young people with SEND, their parents, carers and service providers all work together to create a service that works for them all).

Education Health and Care Plan
A legal document that set out the education, health and care need of a child or young person. It is for children or young people who have a disability and or special educational needs that cannot be met by support that is usually available in school or college

Governance
Corporate governance is the structure of rules, practices, and processes used to direct and manage organisations.

Mainstream Schools
In a mainstream school a child with Special Educational Needs or a Disability (SEND) would be supported in following the National Curriculum alongside peers without SEND. All state maintained educational settings including nurseries, schools and colleges have a legal obligation to support children and young people with Special Educational Needs and disabilities (SEND).

Outcomes
The outcome of an activity, process, or situation is the situation that exists at the end of it.

Pathways
A Pathway is interconnected navigated support, a number of professionals can support an individual to meet their support needs.

Speech, Language and Communication Need
Speech, language and communication needs (SLCN) is an umbrella term. Children with SLCN may have difficulty with many aspects of communication. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say and using language socially.

Special Education Needs and Disabilities
A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support.

Special Educational Needs and Disability Code of Practice
The Special Educational Needs and Disability (SEND) Code of Practice provides statutory guidance on the SEND system for children and young people aged 0 to 25.

Neurodiverse
Neurodiverse or neurodiversity is the idea that some people's brains are 'wired' differently and that these differences are simply variations of the human brain. This means that there are different ways in how a person's brain processes information. It often used as an umbrella term to describe conditions such as Autism Spectrum Disorders, Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia, Dyscalculia and Dyspraxia.

Occupational Therapy
Therapy that aims to develop skills and improve a child or young person's ability to engage with day to day activities, including education, play, and personal care, which in turn develops, their long-term independence.

Acronyms

ADHD - Attention Deficit Hyperactivity Disorder
ASC - Autism spectrum disorders
CYP - Children and young people
EHCP - Education Health and Care Plan
ICB - Intergraded Care Board
JSNA - Joint Strategic Needs Assessment
LA - Local Authority
SEND - Special educational needs and disability
SEN - Special educational needs
SLCN - Speech language and communication needs

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**11**

Title:	**Mental Health & Wellbeing Strategy**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Chris Bird	Y	Sarah Evans – CYP Strategic Improvement Lead

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Waheed Abbasi	Y

	Action Required (select):									
Ratification-R		**Approval -A**	✓	**Discussion - D**		**Assurance - S**		**Information-I**		

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
Y			
Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Clinical Senate	08.02.22	D/I
Mental Health Programme Board	05.01.23	D/I
Finance & Performance Committee	07.02.23	A

Purpose of the Paper (Key Points + Executive Summary):

The existing Mental Health Strategy "Mental Health is Everybody's Business", went live in 2014 and is joint between Staffordshire County Council, Staffordshire and Stoke on Trent Clinical Commissioning Groups (now known as the ICB (Integrated Care Board)) and Stoke City Council.

During December 2020, the Staffordshire Health and Wellbeing Board approved a recommendation for a joint approach, by Staffordshire County Council and the then Staffordshire CCGs to co-ordinate, contribute and develop a new Staffordshire Joint Mental Health Strategy to replace the existing strategy 'Mental Health is Everybody's Business'. It should be noted that Stoke-on-Trent City Council are not party to the development of this new joint Strategy; a separate strategy is under development via the City Council.

To inform the development of the strategy across Staffordshire a period of meaningful engagement took place in partnership with people with lived experience their families and carers, as well as a range of organisations across the public sector, private sector, and the voluntary and community sector.

The revised and updated strategy takes into account a range of national changes, the impact of the Covid-19 pandemic and compliments the existing strategies and work programmes to address mental ill-health and wellbeing.

To address and help to improve the mental health and mental wellbeing of people across Staffordshire six key outcomes were identified from the engagement activities. These outcomes are the key focus of the strategy and will aspire to ensure: -

1. Everyone can look after their own mental well-being and find support in their communities when they need.
2. People have access to services when needed.
3. A timely response to crises.
4. There is equal access to support to improve mental well-being and services to manage mental health problems.
5. People with severe mental health problems are supported to live in the community and have good quality, integrated care.
6. More integrated, good quality services for young people that focus on achieving independence in adulthood.

Next Steps:

- Staffordshire County Council Cabinet approval – March 2023
- Launch Strategy – April 2023
- Development of delivery plan – April - June 2023

Following approval of the Strategy at the Staffordshire & Stoke-on-Trent ICB Finance & Performance Committee on the 7th March 2023, the ICB Board members are asked to:

- **Ratify** the new joint Staffordshire Mental Health and Wellbeing Strategy
- **Note** that work will continue to develop the delivery plan to sit alongside the strategy

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None identified	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
No risks identified

Implications:	
Legal and/or Risk	None
CQC/Regulator	Providers of Mental Health services are CQC registered.
Patient Safety	N/A
Financial – if yes, they have been assured by the CFO	No financial implications identified as a direct result of the implementation of the strategy, compliments existing programmes of work including the Mental Health Investment Standards.
Sustainability	Strategy aims to improve outcomes for mental health and wellbeing over the next 5yrs.
Workforce / Training	N/A

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? The Strategy takes into account national policy changes and related local strategies to improve mental health and well-being and mental health services. Whilst mental health problems are far from equal this strategy will look to address the differences in people's health and ensure equal access to support to improve mental well-being and services to manage mental health problems.		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) Through the development of the strategy, it is recognised that inequalities span much wider that just health; this can involve differences in life expectancy, access to care, quality and experience of care, behavioural risks to health and the wider determinants of health including the quality of housing. This Strategy is a joint strategy with Staffordshire County Council which looks to address all aspects to ensure that our statutory duty is met.		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected) **Not required - the Mental Health & Wellbeing Strategy is a joint strategy led by Staffordshire County Council.**		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **The Mental Health & Wellbeing Strategy is a joint strategy led by Staffordshire County Council. The Strategy does not propose any changes to services for service users or conditions for staff.**		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements)		

<table>
<tr><td></td><td colspan="3">

- What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?)
- Explain any 'objective justification' considerations, if applicable

</td></tr>
<tr><td>4.</td><td>

Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients

- Public Survey - open for 6weeks from 01.10.21 – 12.11.21; promoted via:

Promotion action	Date
Staffordshire County Council website	07/10/2021
The Knot	07/10/2021
Staffordshire Parish Councils Association (SPCA) newsletter	07/10/2021
Communities Together network email	07/10/2021
District Strategic Managers contacts	07/10/2021
Internal Health and Social Care and Public Health teams informed	07/10/2021
Burton and District Mind newsletter	08/10/2021
Staffordshire Joint Autism Implementation Group	08/10/2021
South Staffs District Council communications	08/10/2021
MH social inclusion and recovery providers and Shared Lives provider	14/10/2021
Advocacy provider(s) and networks	14/10/2021
The Knot	15/10/2021
Staffordshire County Council Public Health team contacts	15/10/2021
Staffordshire Libraries news feeds	15/10/2021
Virtual background created by Comms to promote the survey	15/10/2021
Yammer	17/10/2021
Richard Harling news	17/10/2021
Gov. Delivery My Staffs newsletter	01/11/2021
Staffordshire County Council social media	10/11/2021

- Stakeholder interviews and focus group feedback
- Workforce Survey – open for 2weeks from 01.11.21 – 12.11.21
- Service User Groups – Service User Carer Council ran by NSCHT (North Staffordshire Combined Healthcare NHS Trust) and Staffordshire Autism Joint Implementation Group (SAJIG) were attended

</td><td>Y</td><td></td></tr>
<tr><td>5.</td><td>Has a Data Privacy Impact Assessment been completed?

DPIA is not required for this workstream.</td><td>N</td><td></td></tr>
<tr><td colspan="4">Recommendations / Action Required:</td></tr>
<tr><td colspan="4">

The Integrated Care Board is asked to:

- **Ratify** the new joint Staffordshire Mental Health and Wellbeing Strategy
- **Note** that work will continue to develop the delivery plan to sit alongside the strategy

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Good Mental Health

In Staffordshire

2023 - 2028

Staffordshire County Council

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Introduction

Good mental health is one of the priorities of Staffordshire's Health and Well-being Strategy.

This Strategy will help to achieve our ambition to build strong and resilient communities and individuals who are in control of their own mental well-being.

In this Strategy when we refer to 'mental well-being' we mean a feeling of control, confidence, and resilience; when we refer to 'mental health' we mean the absence of mental health problems that impair a person's ability to engage in many day-to-day activities.

The Strategy will aim to help everyone improve and maintain their mental well-being, help those who have short periods with problems to regain their mental health and well-being, and help people of all ages with severe long term mental health problems to live productive and fulfilling lives.

The Strategy takes into account recent national policy changes, the impact of the Covid pandemic on people's mental health, and related local strategies and plans to improve mental health and well-being and mental health services.

The Strategy has been co-produced by the County Council and NHS with other partners, the public, mental health professionals, and the people who use these services and their carers.

We would like to thank everyone involved in the production of the strategy, and we look forward to working with you to achieve our outcomes.

Cllr Julia Jessel

Cabinet Member for Health and Care, Staffordshire County Council

Dr Richard Harling MBE

Director of Health and Care, Staffordshire County Council

Dr Waheed Abbasi

Clinical Professional Leadership, Strategic Clinical Lead, Staffordshire and Stoke-on-Trent Integrated Care Board

Chris Bird

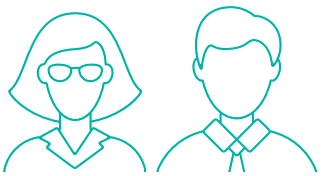
Chief Transformation Officer, Staffordshire and Stoke-on-Trent Integrated Care Board

Mental health in Staffordshire

Mental health problems affect many people

ONE IN FOUR PEOPLE
experience mental health problems in their lifetime; at any one time

ONE PERSON IN SIX
is experiencing a mental health problem.



AROUND 20% OF WORKING AGE ADULTS
have mental health problems.

AROUND ONE IN FOUR CHILDREN AGED 11-12
have an emotional well-being issue;

FOR 5-16-YEAR-OLDS, ONE IN 10
have a diagnosed mental health condition.

Mental health problems represent the **LARGEST SINGLE CAUSE OF DISABILITY IN THE UK;**

the cost to the economy is estimated at **£119 BILLION A YEAR.**

HALF OF ADULTS
with long-term mental health problems experienced their **FIRST SYMPTOMS BEFORE THE AGE OF 14;**

75% BY THEIR MID-20S.

AROUND 10-15% OF MOTHERS
have mild to moderate depression during pregnancy;

3% HAVE SEVERE DEPRESSION.

Outcomes

The Strategy will aim to achieve six outcomes

1 Everyone can look after their own mental well-being and find support in their communities when they need it

This will include

- Raising awareness of measures that everyone can take to improve and maintain their mental well-being, including promotion of the Five Ways to Wellbeing (and other approaches with strong evidence).
- More social interaction and initiatives that tackle loneliness and isolation.
- More physical activity, linking to Better Health Staffordshire whole system approach.
- Creating neighbourhoods, workplaces and schools that are more conducive to good mental health.
- A stronger focus on encouraging and supporting communities to support each other and themselves.
- Ensuring people understand where to go for support with mental health problems and can self-refer to services to get help at the earliest opportunity.
- Increasing access to mental health support in schools.
- Improving access to psychological therapies.
- Strengthening mental health literacy across the population to increase resilience and skills in self-management of mental health problems.

2 People have access to services when needed

This will include

- Improving access for children and young people to emotional health and well-being support to help prevent more serious mental health problems.
- Improving access for children and young people to mental health services.
- Ensuring mental health liaison services are available in all general hospitals.
- Ensuring care is personalised to people's individual needs, and mental health professionals work in partnership with people to provide choices about their care and treatment, and to reach shared decisions.
- Ensuring access for women and their partners to specialist perinatal mental health services.
- Ensuring people receive timely access to the assessments, interventions, support, and treatments that they need.

3 A timely response to crises

This will include

- A system-wide approach to reduce and prevent suicide, self-harm, and reduced unsafe social media use, reducing suicides to below the national rate by 2025.
- Expanding services for people of all ages experiencing a mental health crisis and making it easier and quicker to receive crisis care, around the clock, 365 days a year, including through NHS 111.
- When a person requires care and treatment that can only be provided in a mental health inpatient setting and cannot be provided in the community, ensuring they receive prompt access to the best hospital provision available for their needs.

4 There is equal access to support to improve mental well-being and services to manage mental health problems

This will include

- People identified from certain groups within the wider population who may have more difficulties accessing support, and those from areas with poor transportation links will have access to online and mobile services such as psychological therapies.
- We will have better data and insight about the mental health needs of different groups within our population.
- Children that are care experienced can access support for their mental health and well-being.
- Ensure that people are not prevented from accessing or receiving good quality mental health care simply because of a disability, diagnostic label, or another protected characteristic.

5 People with severe mental health problems are supported to live in the community and have good quality, integrated care

This will include

- Increasing the numbers of adults who are living in their own homes.
- Increasing the numbers of adults who receive Individual Placement Support into paid employment.
- A stronger focus from key public sector organisations ("anchor organisations") to create employment, training, and volunteering opportunities.
- Ensuring care is joined up across the health and care system - services work in a cohesive way with partner organisations, so that people are supported to stay well and can further their recovery.
- Offering a range of community support, including step down care and supported living options, which meet different levels of needs with providers of care consistently promoting people's independence and quality of life.
- People with severe mental health problems benefit from new models of integrated primary and community care.

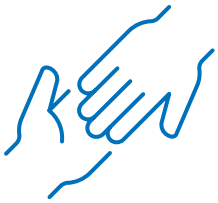
6 More integrated, good quality services for young people that focus on achieving independence in adulthood

This will include

- The early identification of mental health problems in children and young people.
- Improved maternal and paternal mental health.
- Young people with mental health problems will have a well-planned and joined up transition, so they can thrive and become independent in adulthood.
- Young people have settled care arrangements that meet their mental health needs and allow them to continue their education.

Our approach

To achieve these outcomes, we will:



Help people to help themselves

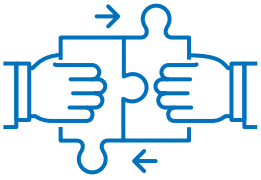
by offering good information about how to maintain their physical and mental well-being and where to go for support.

Minimise medicalisation

by strengthening people's personal resilience and helping them develop lifelong skills for good mental health.

Promote independence

by offering support and services to people as close to home as possible and the least restrictive care options



Build and use community capacity

to support people with mental health problems.

Co-produce support and services,

working with individuals and communities.

Encourage and enable our workforce

to learn and grow, develop their skills and maintain their own mental well-being.

Embrace technologies

to improve people's mental well-being, access to services and quality of care.

Related documents

Appendix 1

Recent national policy changes.

Appendix 2

Related local strategies and plans.

Appendix 3

Summary mental health joint strategic needs assessment and NHS performance data.

Appendix 4

Mental health problems and ideas for this Strategy raised by the public, staff of mental health services, and the people who use these services and their carers.

Appendix 1 Achieving Good Mental Health in Staffordshire Strategy 2023-2028

National Changes

There are a number of national policy and legislative changes that will impact on mental health and wellbeing in Staffordshire.

- The 2019 the National Health Service (NHS) Long Term Plan NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk).

- White Paper 'Reforming the Mental Health Act' (2021) in response to an independent review Reforming the Mental Health Act - GOV.UK (www.gov.uk)

- Government White paper 'People at the Heart of Care: Adult Social Care Reform White Paper' (2021). People at the Heart of Care: adult social care reform - GOV.UK (www.gov.uk)

- The Liberty Protection Safeguards (LPS) Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS) - GOV.UK (www.gov.uk)

Appendix 2 Achieving Good Mental Health in Staffordshire Strategy 2023-2028

Related local strategies and plans:

- Staffs and Stoke on Trent Mental Health Implementation Plan 2019 – 2024

- NHS Community Mental Health Framework Transformation (CMHT)

- Staffs Joint Health and Wellbeing Strategy 'Health is everyone's business' 2022-2027

- Staffs and Stoke on Trent approach to children's and young people's mental health 'Starting well, living well, supporting well' 2018 -2023

- Staffs Public Health Delivery Plan 'Resilience Through Health' 2021 – 2026

- Staffs and Stoke Suicide Prevention Partnership Plan 2022 – 2024

- All Together for Carers: A Carer's Strategy for Staffordshire 2019 - 2023

Appendix 3 Achieving Good Mental Health in Staffordshire Strategy 2023-2028

Summary Joint Strategic Needs Assessment

*Infographics

Adults

Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £119 billion a year – roughly the cost of the entire NHS. (Centre for Mental Health https://www.centreformentalhealth.org.uk/news/centre-mental-health-calls-government-set-budget-wellbeing-cost-mental-ill-health-england-reaches-ps119-billion)

In Staffordshire there were 1 in 3 (33%) emergency hospital admissions for adults with a mental health diagnosis in 2020/21 – lower than national. East Staffordshire and Tamworth have the highest admission rates and are statistically higher than the national average. Tamworth also having higher than average GP recorded depression.

Staffordshire has the 5th highest rate among similar authorities of emergency admissions for intentional self-harm (all ages). Newcastle, Stafford and Cannock are Chase among the highest district areas in the West Midlands.

There are nearly 95 suicides in Staffordshire each year, with rates of suicide rising to 12.2 per 100,000 (2018-20) and higher than national (10.4 per 100,000). Three quarters of deaths from suicides in Staffordshire are males, yet the suicide rate in females is increasing and higher than the national average. Those aged 30-59 are overrepresented in suicides, with 57% of suicides coming from 44% of the Staffordshire population.

GP recorded depression is 12% in Staffordshire adults and continues to increase, a trend that has doubled since 2012/13 and is higher than the national average.

In Staffordshire there are lower levels of GP recorded severe mental illness, however over half of Staffordshire's districts have higher than

average GP recorded depression Stafford, Staffordshire Moorlands, Tamworth, Cannock Chase and Newcastle have the highest figures.

The above information is from the JSNA Living Well in Staffordshire [Mental health in adults - Staffordshire Observatory]

Children and Young People

Annual Staffordshire CAMHS referrals reported by Staffordshire's local trusts have increased year-on-year from around 6,400 in 2015/16 to 10,500 in 2019/20

Mental health referrals (age 0-18) increasing for all Staffordshire CCGs - all of which are now above pre-pandemic levels.

Mental health is a top concern (24%) among Staffordshire's young people (aged 11-18, Make Your Mark Survey 2020). It is also the most common factor in Children's Social Care assessments – half of assessments cited this as a factor (2020/21).

Overall mental health hospital admissions in children (85.5 per 100,000) remains similar to national. However, there were 695 self-harm admissions to hospital in 2019/20 (age 10-24).

Rates also rising since 2017 and higher than national - up to 493 per 100,000 in 2019/20, from 425 per 100,000 in 2017/18. More recent unpublished data does show a fall in admissions, similar to national, however this likely to be attributed to the impact of COVID-19.

Local survey research also verifies that COVID-19 has had a significant impact on children's mental health - 61% of under 35's were worried about their mental wellbeing, compared to 25% aged 65+ (Staffordshire COVID-19 Resident Survey).

All of the above information are from the JSNA Growing Well in Staffordshire [Mental health in children - Staffordshire Observatory]

Appendix 4 Achieving Good Mental Health in Staffordshire Strategy 2023-2028

Summary of the mental health issues and ideas for this Strategy, raised by the public, staff of mental health services, and the people who use these services and their carers.

In preparation for the development of this strategy, engagement was conducted with the public, stakeholders, partners, front line staff in mental health and social care services, the people who use mental health services, and their family and carers. The feedback identified areas for further improvement that the strategy aims to address to help improve the mental health and mental wellbeing of people in Staffordshire. A summary of the feedback is shown below:

3.1 When stakeholders were asked what should be addressed to improve mental health and wellbeing in Staffordshire, they said:

1. Developing a better understanding and knowledge of what services and support are available in health and care, including from the voluntary and community sector.
2. Building community capacity and better integration with voluntary sector organisations.
3. Better communication with partners and the public on how to access the right information and support for them.
4. Training and education for front line staff and partners who work with vulnerable groups, and for the children in schools and the public on how to build resilience and stay well.
5. Building effective partnerships, better multi agency working and opportunities to pool resources and work collaboratively.
6. A focus on prevention, early intervention, and upstream actions.
7. Ensuring there is robust and up to date data and evidence to direct resources efficiently.
8. Ensuring 'experts by experience' are central in shaping and continuously improving support.

9. Taking a personalised approach and using a social recovery model where the individual has control over their support choices and has the information to make informed decisions.

3.2 When people who access support were asked what would make the biggest difference to them, they said:

1. Being able to find support services and information easily.
2. Being clear about what different services offer, what to expect, and understanding which support was right for them.
3. More support to address emotional wellbeing and lower level mental health to prevent crisis situations.
4. Support and services that are tailored to their needs and provide support for wider issues that were contributing towards poor mental health.
5. Professionals working together and sharing information so people can move between different services more easily.

1.3 Feedback from the strategy engagement found that people are not sure where to go for support or what is available. Only 14% felt confident seeking support from online forums, and 10% stated they would seek support from a local charity or voluntary group. Whilst Staffordshire does have some really good alternatives to the NHS, there are improvements to be made in promoting such support, so people can potentially access advice and support earlier, helping to prevent more significant mental health problems later on.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**12**

Title:	**Board Assurance Framework - Highlight Report**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Sally Young, Director of Corporate Governance	Y	Jane Chapman, Heath of Governance

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Not applicable	No

	Action Required (select):									
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**	✓	**Information-I**	

Is the [Committee]/[Board] being asked to make a decision/approve this item?	**No**		
Is the decision to be taken within Committee delegated powers & financial limits?			
There are no direct financial implications			
Within SOFD Y/N	Y	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Audit Committee	06/03/2023	D
Highlight Report to F&P	07/03/2023	A
Q&S Committee	08/03/2023	A

Purpose of the Paper (Key Points + Executive Summary):

The paper presented is the full BAF for Quarter 3, there has not been any major changes to the BAF since the last report and risk owners will be updating the BAF for Q4 at the end of March and will provide a detailed update which will include how and if, the actions set against the risks have been achieved or not and whether the risk tolerances set were achievable. The Q4 BAF will be presented to the Board at the April 2023 meeting for the 22/23 closedown of the BAF.

Feedback from Audit Committee:

The BAF was discussed at Audit Committee on the 6th March 2023 noted the following two points:

- The committee did not support the reduction of BAF risk 3 and 6.

- Risks relating to the POD delegations should be part of the BAF for 2023/24.

In relation to the two risks highlighted for the reduction in risk score, the committee did not feel that there was justification in decreasing the scores and the committee did not support this reduction.

Two of the BAF Risks are:
• BAF Risk three which maps to the Strategic Objective, Better Quality for all Patients and Service Users, and has reduced its current score from 16 to 12 and is on track to achieve its target score of 9 by the end of March 2023.

• BAF Risk six, which maps to Reducing Inequalities, and has reduced its current score from total 20 to 15 but is unlikely to achieve its target score of 4 by the end of March 2023.

Audit members queried who the responsible committee for BAF risk 6 was and it was confirmed that the Quality and Safety Committee has oversight of this risk.

The committee asked about the creation of BAF risks for 2023/24 and if these would link in with the ICS Strategy, the five-year plan and the annual plan linked back to the strategic objectives in the BAF. SY advised the committee that a BAF workshop with execs is being held on the 14th March to look at the closedown of the 22/23 BAF risks and potential strategic objectives for 2023/24. The output from this will be shared with non-exec directors and be reported on to the April ICB Board. Audit Committee asked for execs to consider risks regarding the POD delegations.

Feedback from Finance and Performance Committee

SY provided an updated on the BAF and the process for closing down the 2022/23 BAF and developing the strategic objectives for the 2023/24 BAF, she also advised the committee of the feedback received from Audit Committee the previous day and this was accepted.

Feedback from Quality and Safety Committee

SY provided an updated on the BAF and the process for closing down the 2022/23 BAF and developing the strategic objectives for the 2023/24 BAF, she also advised the committee of the feedback received from Audit Committee the previous day and this was accepted.

SY set out the concerns related to where health inequalities sat and reiterated the discussion held at the previous Quality and Safety Committee where the Committee felt it should sit with Quality and Safety. The Committee supported this approach.

Feedback from People, Culture and Inclusion Committee

The Head of the ICS People Programme presented the BAF and the risk register, she also explained how she has been working with the governance team and thanked them for the support given. The Audit Committee Chair felt very reassured by the presentation and could see that this was coming together well.

Summary of additional items

The planning for the workshop with execs has been supported by the Governance and Risk Group. Claire Cotton, Company Secretary from UHNM, will be presenting part of the agenda and we are grateful for this support from our provider colleagues.

The Company Secretary from UHNM will also be presenting to the NHS Northwest Company Secretaries Network and ICB Leads meeting on the 15th March 2023, along with the Director of Corporate Governance and the Associate Director of Corporate Governance. The presentation will set out the learning and benefits of working together on the BAF and risk register as well as wider governance issues with system colleagues.

The draft BAF for 2023/2024 will be presented to the Board for approval in April 2023.

Is there a potential/actual Conflict of Interest?	**No**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
No action required.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
The aligned risks are identified in the paper

Implications:	
Legal and/or Risk	Completion of the BAF is a key component of the ICB's Risk Management Strategy
CQC/Regulator	There are no implications for CQQ or other regulators
Patient Safety	Progress on patient safety is Strategic Objective 2.
Financial – if yes, they have been assured by the CFO	There are no financial implications resulting from this paper
Sustainability	There are no sustainability implications resulting from this paper
Workforce / Training	There are no workforce training implications resulting from this paper

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The paper provides assurance on progress on the Strategic Objectives set by the Board which includes quality & safety standards and improved equality for our population**		
1b.	How can the author best assure the Board that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **the paper is not for decision making so this is not applicable**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**No**	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**No**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **This paper will not result in any direct changes to services**		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients **This paper will not result in any direct changes to services**	**No**	
5.	Has a Data Privacy Impact Assessment been completed? **This paper does not use PID**	**No**	

Recommendations / Action Required:

The ICB Board is asked to:

- **Receive** the Board Assurance Framework for **discussion and assurance.**
- **Consider** the Audit Committee's recommendation not to support the reduction of the scores for BAF risk 3 and 6
- **Confirm** that Health Inequalities sits under the remit of the Quality and Safety Committee

Staffordshire and Stoke-on-Trent Integrated Care Board

2. Summary Board Assurance Framework (BAF)

No.	Risk Title	Q1			Q2			Q3			Q4			Target			Target Date	Change	Impact on Objectives			
		L	C	S	L	C	S	L	C	S	L	C	S	L	C	S			S01	S02	S03	S04
BAF 1	Commissioning improved outcomes				3	4	12	3	4	12							31/03/2023	→	✓	✓	✓	✓
BAF 2	Delivery of Winter Plan				4	5	20	4	5	20				3	4	12	31/03/2023	→	✓	✓	✓	
BAF 3	Improving Quality				4	4	16	3	4	12				3	3	9	31/03/23	↓	✓	✓	✓	✓
BAF 4	Workforce				4	5	20	4	5	20				4	4	16	31/03/23	→	✓	✓	✓	
BAF 5	Finance				5	4	20	5	4	20				4	3	12	31/03/23	→	✓			
BAF 6	Health Inequalities				4	5	20	3	5	15				2	2	4	31/03/23	↓	✓	✓	✓	✓

Risk reduction to BAF Risk 3, from 16 to 12 and BAF Risk 6 from 20 to 15, are not supported by the Audit Committee the Board are asked to consider this.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**13**

Title:	**Corporate Risk Register**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Sally Young Director of Corporate Governance	Y	Tracey Revill, Interim Deputy Head of Governance Andrea Brown, Governance Officer

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	No

	Action Required (select):										
Ratification-R		**Approval -A**		**Discussion - D**		**Assurance - S**	✓	**Information-I**	

Is the Finance and Performance Committee being asked to make a decision/approve this item?
No

Is the decision to be taken within Finance and Performance Committee delegated powers & financial limits? No decision to be made

- Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits

Within SOFD Y/N	N/A	**Decision's Value / SOFD Limit**	N/A

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Executive Weekly Meeting	Jan 2023	D
Audit Committee	06/03/2023	D
Finance risks went to Finance and Performance Committee	07/03/2023	D
Quality risks went to Quality and Safety Committee	08/03/2023	D
People, Culture & Inclusion Committee	08/03/2023	D

Purpose of the Paper (Key Points + Executive Summary):

The Governance team are working with colleagues and partners across the system to align the risk register. Risk owners are required to review the risks to identify where there is any possible cross-over between committees, to determine if any of the risks should be reviewed by another committee.

For each committee, the Executive Directors have been asked to consider what their top three risks are, this may not necessarily be determined by risk score, as a high scoring risk could be being managed sufficiently. The top risks should be determined by mitigations in place needing to be more robust or risks that are not on track despite mitigations in place. These are considered the "worry risks".

Audit Committee

The Audit Committee met on the 6th March and discussed the risk register at length, there was a view from members that it should be at each committee's discretion as to which risks fall under the top three concerns and not sit with the Executive Directors. Audit Committee members wanted to see a more robust risk report with more clarity on the risks in the future. The team will focus on developing the report.

Currently the Finance and Performance team and Quality and Safety team have identified their top three risks and these are detailed below:

Finance and Performance Committee

Finance

Risk 001; Sustainable break-even financial position – current risk score; **16**.
The underlying financial position ('ULP') has been refreshed and will be updated again following the finalisation of the draft plan that was submitted 23 February. As noted in the last update the underlying pressure has increased from c.£140m to £210m deficit due to increased CHC costs, delivery of recurring efficiency and excess inflation pressures. Confirm and challenge of each organisation's plans were held on 8th February. Any risks to deliver break even in 2023/24 have clearly been set out in the submission to region.

No change to risk score due to balance of risk in plan.

ICB

Risk 113; *CHC Cost Pressure – current risk score* **20.**
CHC cost increases in 2022/23 have been managed in year however this new risk arises due to the extra cost pressure expected in 2023/24. The Local Authority are assuming a cost pressure of 10% which compares to NHSE funded increase of 5.5%. Other areas in the healthcare market are being considered to increase capacity as part of the Chief Transformation Officer's review of CHC and agreeing budgets and plans for 2023/34.

ICS

Risk 003; *Capital planning – current risk score* **12**.
Capital plans from providers reviewed for CFO meeting as part of planning process. As previously noted, there has been a meeting and correspondence with the Region and they are looking to support the ICS with brokerage from across the central Region. NHSE recognise the risk however, no agreed mitigations currently identified therefore no change to risk score.

The above risks are considered the top three risks due to finance and financial planning being volatile. These form part of the ICB's statutory obligations to achieve break-even and are considered critical risks.

Performance

Risk 098; *Winter Plan Workforce / Staffing – current risk score* **25** (Urgent Care - CDO)
The System Workforce plan remains in place to try and mitigate workforce issues and ensure adequate staffing for the winter period and beyond. Recruitment has seen progress and concerted recruitment activities continue. However latest information shows that 190 WTE of a planned total of 342 WTE has

been appointed to – leaving a significant staffing gap when assessed against requirements identified via the winter planning process.

Engagement with system partners has been strong and collaborative approaches have been utilised to ensure equitability, however recruitment remains a challenge and this has a significant impact upon mobilisation of additional "surge" capacity across the system.

A coordinated approach via weekly Steering Groups, MDT forums and an agreed System Escalation plan have been utilised to mitigate these pressures and to ensure that workforce priorities are considered on a system wide basis rather than in isolation.

Risk 111; *Ambulance Handover Delays – current risk score* **25**
Ambulance handover delays have improved which has reduced pressure on the category 2 and 3 calls outstanding. Handover delays remain a system priority to ensure that the number of delays are reduced further, this is subject to regional and national scrutiny and monitoring. However, the processes put into place across the system to mitigate and manage these issues remain operational and continued focus is required to ensure that delays continue to reduce. Mitigation via daily System escalation calls and Task and Finish groups will ensure enhanced oversight remains and that any emergent issues are addressed as swiftly as possible.

Risk 112; *Industrial Action – current risk score* **16.**
The system has worked collaboratively to manage and mitigate the impact on industrial action during the winter period to date. The System Control Centre (SCC) has been operational since the end of November and remains crucial in mitigating impact of proposed/planned and enacted periods of industrial action across all facets of the system. The SCC is key to overseeing agreed system actions and preparedness. Daily system COO calls remain in place, escalation actions have been defined during previous periods of industrial action and are accepted across all system partners. The System Winter Steering Group and appropriate sub-groups retain oversight of preparedness planning, contingency arrangements and decision making. The UEC Ops team ensures oversight and links to regional/national teams to ensure joined up approach to planning, reporting and monitoring actions.

Transformation
The following three risks have been identified as those with the highest concern:
Risk 113 CHC Cost pressure; Due to the scale and nature of the challenge being so significant, it needs urgent remedy.

Risk 073; Transfer of Primary Care PODs to the ICB; The national policy requires delegation to take effect from the 1st April 2023, but it is likely to be the summer 2023 by the time we have been able to fully assess the level of risk included within the delegated services.

Risk around Prescribing; There is an overspend which is driven by national arrangements and has limited influence at system level, with the ICB bearing the risk. This risk has recently been identified and will be added to the risk register.

Quality and Safety Committee
Risk: 114; *Children and Young People Placements for Complex Behaviour – current risk score* ***16***

Risk 115; *Looked After Children Initial Health Assessment/Review Health Assessment (IHA/RHA) Compliance (regulatory) – current risk score* ***16***

Risk 108; *Ivetsey Bank (independent hospital) – current risk score* **16**

The above risks have been identified as the top three risks due to the mitigations in place which have not ensured that all the risk has been mitigated against.

People, Culture & Inclusion Committee
The Chief People Officer identified the following three risks as being of the greatest concern. The selection was endorsed by the P,C&I Committee and it was noted by the Chair of the Audit Committee that there was a clear correlation between the work of the committee and the Risk Register, and it reflected the discussions held in the committee. There was evidence of a good working relationship and understanding of risks between Governance and the People functions.

Risk 094 ~ Staff sickness, wellbeing and burnout current score 12
Risk 095 ~ Vacancies and workforce growth required; supply and availability of Registrants current score 12
Risk 096 ~ Industrial Action current score 16

Should Board members wish to see the Issues Log and closed risks these can be found at:

MASTER ICB Risk Register .xlsx

The risk register has been through vigorous review and the register has been updated to reflect the following changes:

The ICB Board have oversight of 28 high risks on the register (12 and above).

The following changes have been made:

New Risks:

Risk No:	***Description:***	***Risk Rating:***
115	*Looked After Children Initial Health Assessment/Review Health Assessment (IHA/RHA) Compliance (regulatory)*	***16***

Increase in Risk scores:

Risk No:	***Description:***	***Risk Rating:***
082	*Agency Usage and Spend* *Risk score **increased** from **12** to **16**. (See note below).*	***16***
085	*Care Home and Home Care Workforce Capacity* *Risk score **increased** from **12** to **16**. (See note below).*	***16***
086	*Supporting workforce modelling for Joint Forward Plan, Portfolios and Transformation* *Risk score **increased** from **12** to **16**. (See note below).*	***16***
094	*Staff Sickness, wellbeing and burnout* *Risk score **increased** from **12** to **16**. (See note below).*	***16***
095	*Vacancies and workforce growth required; Supply and availability of Registrants* *Risk score **increased** from **12** to **16**. (See note below).*	***16***
097	*Cost of Living Impact* *Risk score **increased** from **12** to **16**.*	***16***

108	*Invetsey Bank (Independent Hospital)* *Risk score increased from **12** to **16**.* *Score increased due to further concerns raised by other health professionals.*	***16***
083	*Ageing Workforce* *Risk score **increased** from **9** to **12.** (See note below).*	***12***

***Note**:* Risks, 082, 085, 086, 094, 095, 097, and 083 have been increased following a review of the risks at the People, Culture and Inclusion Committee. Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.

Risk 108 was increased following the raising of additional concerns at the Independent Hospital

Decrease in Risk scores:

Risk No:	***Description:***	***Risk Rating:***
074	*Medical Examiner role* *Legal requirement for the implementation of Medical Examiners in the community is now April 2023The regional and local MEs came together for a combined event with the SSOT H&C Senate to discuss implementation. Recruitment has taken place and pilot sites have been identified. The main risk to implementation is data sharing between Primary Care and MEs, a regional solution to this is being progressed by the ME regional lead. Work is continuing across the ICS to ensure that all systems and processes are in place by April 2023.* *Risk reduced from **12** to **9*** As this risk has been reduced to 9 this is not presented on the accompanying risk register.	***9***

Risks proposed for closure (highlighted on the register):

Risk No:	***Description:***	***Risk Rating:***
101	*System Care Home Resilience* *We now have IPC offset capacity for D2A (managed by MPFT) to support restrictions if required for Covid, Norovirus, Flu etc so the risk associated to hospital discharge is mitigated and can be closed.* This risk was also presented at the Audit Committee on Monday 6th March 2023, members raised concerns around the risk being closed with a risk score of 16 and did not support the closure. Members requested that the risk is reviewed by the Chief Medical Officer. The risk was reviewed by the CMO who reduced the score to 4 and was discussed at the Q&SC. The Q&S Committee	***4***

	accepted the recommendation to close 101, as it relates specifically to capacity issues during the Covid outbreak. However, the Q&S Committee have supported the opening of a more generalised risk relating to Care Home Capacity being raised	

Full details of all the above risks can be found in the accompanying risk register.

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
Members declare any conflicts at the start of the meeting and are also presented on a Conflicts of Interest Register for the meeting members.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks as detailed on the attached risk register.

Implications:	
Legal and/or Risk	Presentation of the Risk Register is a key source of assurance to the Committee
CQC/Regulator	Reviewed and considered not applicable.
Patient Safety	The Risk Register if a key tool for identifying patient safety risk and recording the mitigations put is place
Financial – if yes, they have been assured by the CFO	The CFO is sighted on all the financial risks and any potential financial implications.
Sustainability	Reviewed and considered not applicable.
Workforce / Training	Governance team provide on-going training in risk management and the use of the risk register

Key Requirements:			
1a.	How can the author best assure the Committee that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? **The ICB Board is asked to review the risk register for discussion and recommendations.**		
1b.	How can the author best assure the Committee that the decision put before it meets our new statutory duty to have regard to the wider effects of our decisions in relation to health & wellbeing, quality and efficiency? (If the paper is 'for information' / for awareness-raising, not for decision, please put n/a) **N/A**		
		Y/N	**Date**
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N/A**	

2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N/A**	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **N/A**		
3c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail*** ***There have been 1:1 discussion between Directors and the governance team regarding the risks and their management.***	**Yes**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	
Recommendations / Action Required:			
The ICB Board is asked to: • **Receive** the Risk Register for **discussion** and **assurance** of the risks highlighted.			

LIKELIHOOD of Occurrence	Most Likely CONSEQUENCE				
	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic
1= Rare	1	2	3	4	5
2= Unlikely	2	4	6	8	10
3= Likely	3	6	9	12	15
4= Highly Likely	4	8	12	16	20
5= Certain	5	10	15	20	25

Key:

Inherent Score ~ this is the score at the time of risk being added to the register
Residual Score ~ this is the score of the risk after monthly update
Target Score ~ this is the score you aim to bring the risk down to for closure

12 and above - High risk
5 - 10 Medium risk
1 - 4 Low risk

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

SO1	Strategic Objective 1 - Better Health & Wellbeing for the Whole Population
SO2	Strategic Objective 2 - Better Quality for all Patients and Service Users
SO3	Strategic Objective 3 - Sustainable services for the taxpayer
SO4	Strategic Objective 4 - A reduction in health inequalities

A Risk is an event that has not yet happened, but may do
An Issue relates to an event that has already occurred

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
RISK REGISTER

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
098	**Winter Plan Workforce/Staffing**	Finance & Performance Committee	If we fail to improve on the current vacancy rates, or experience increased staff sickness	Then there may be an acute impact upon the system during the winter period.	Resulting in workforce constraints dictating that the system is forced to prioritise urgent services - with a negative impact upon non-urgent and elective services.	**22/02/2023**	The System Workforce plan remains in place to try and mitigate workforce issues and ensure adequate staffing for the winter period and beyond. System agreement re an Enhanced Bank Rate of pay across all system partner organisations for RNs and HCAs has facilitated some improvements. Additional funding, approved by F&PC and System CFOs has been utilised to prioritise recruitment initiatives. Engagement with system partners and neighbouring systems to ensure collaborative approach to align wherever possible has been in place and has led to a joined up approach. A coordinated approach via weekly Steering Groups and an Escalation plan utilised to ensure workforce pressures/priorities are considered on a system wide basis rather than in isolation Recruitment challenges remain.	**01/12/2022**	**25 (5x5)**	**25 (5x5)**	**4 (2x2)**	**Static**	Phil Smith	**2, 4**	Mish Irvine/Tom Bailey	Delivery	Urgent Care
111	**Ambulance Handover Delays**	Finance & Performance Committee	If Continued delays to ambulance handovers are incurred, and sustained or levels increased	Then there will be significant pressures placed onto ED, ambulance crews and the wider UEC system	Resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time & associative issues	**01/02/2023**	**07/02/2023 -** The Finance and Performance Committee discussed this risk and agreed that the slight improvement in January was artificially driven by strikes and not a true reflection of the improvement in flow. The Committee therefore, agreed and requested that the risk should **remain** at **25.** **01/02/2023** - Ambulance handover delays have improved which has reduced on the category 2 and 3 calls outstanding. It remains a system priority to ensure the delays are reduced further. Given the current performance it is recommended that the risk score is reduced from 25 to 20 (5 impact, 4 likelihood).		**25 (5x5)**	**25 (5x5)**	**8 (2x4)**	**Static**	Phil Smith	**2**	Ashleigh Shatford	Delivery	Urgent Care
048	**Digital Cyber Security**	Audit Committee	If the ICB/ICS systems suffer a cyber attack	Then it could lead to the loss of IT systems and/or unauthorised access to data	Resulting in reputational damage to the Staffordshire and Stoke-on-Trent NHS Healthcare providers, GP Practices and Local Authorities.	**07/02/2023**	Procurement for a 24x7 security operations centre is ongoing. The planned approach is for a SOC capability for the whole ICS footprint, which includes local authorities, potentially ambulance services, Primary Care, UHNM, MPFT and NSCHT. Plans are progressing positively and would provide a standard level of cyber protection across the ICS. Mandatory cyber awareness training has also been put in place in MPFT and therefore included in their DSP Toolkit return – this approach has been shared with other system partners. A Cisco firewall has recently been deployed via the S&SHIS and strengthens our cyber capability for remote workers across the S&SHIS partners. The aim is to bring a common approach to cybersecurity for all partners. Following review of the risk the Director has advised this risk should have been put on the register with an **inherent** score of **20**, after the system SOC is in place this would reduce to 12, score to currently remain at **20**.	**/ /**	**20 (4x5)**	**20 (4x5)**	**8 (4x2)**	**Static**	Chris Ibell	**1, 2, 3**	Sally Deacon	Digital	
113	**CHC cost pressure**	Finance & Performance Committee	If the volume, acuity and price pressure in the CHC market leads to costs being greater than NHSE funded levels of inflation	Then budgets may be exceeded	Resulting in cost pressure to the ICB financial position in 2023/24, a potential deficit for that year and detrimental impact on the ICB's financial sustainability	**10/02/2023**	Local authority are assuming a cost increase of 10% which compares to the NHSE funded increase of 5.5%. Other areas in the healthcare market are being considered to increase capacity as part of the Chief Transformation Officer's review of CHC and agreeing budgets and plans for 2023/24.	**31-Mar-24**	**20 (5x4)**	**20 (5x4)**	**12 (4x3)**	**Static**	Paul Brown	**5**	Pamela Rodgers	Finance	Frailty and Long Term Conditions

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
001	**Underlying deficits from 2023/24**	Finance & Performance Committee	If the system saving schemes do not deliver the financial strategy	Then the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position (i.e. a financial deficit from 2023/24), in line with the operating and planning framework.	Resulting in additional cost pressure, historic deficits being repaid. regulator intervention and reputational damage	**27/02/2023**	The underlying financial position ('ULP') has been refreshed and will be updated again following the finalisation of the draft plan that was submitted 23 February which shows a deficit of £123m for the ICS for 23/24. Underlying pressure increased from c. £140m to £205m deficit due to increased CHC costs, delivery of recurring efficiency and excess inflation pressures. Confirm and challenge of each organisation's plans were held on 8th February. Any risks to deliver the plan in 2023/24 have clearly been set out in the submission to region. No change to risk score due to balance of risk in plan. Monthly reporting to committees and Board is consistent with the plan submitted in June (see No 54 on issues log for updated financial position)	**31/03/2023**	**16 (4x4)**	**16 (4x4)**	**9 (3x3)**	**Static**	Paul Brown	**5**	Helen Dempsey	Finance	
077	**Implementation of the Fuller Report**	Finance & Performance Committee	If the implementation of the Fuller report does not address the known primary care workforce issues	Then health services may not be able to cope with the demand or meet the recommendations in the Fuller Report.	Resulting in demand and capacity issues which will impact on access and poorer patient outcomes and experiences.	**27/02/2023**	•General practice strategy in final draft before being signed off via ICB board in March 2023. The core of the strategy is the implementation of the 4 building blocks of Fuller. •The commitment in the strategy is to have a workforce strategy in place by 2024 •The first Primary Care Workforce Implementation Group (WIG) is taking place on 14th March with key stakeholders internally and externally supporting the primary care workforce agenda. This is a strategic group looking at the full workforce programme across all general practice staffing from training right through to retirement aligned to outputs of the Fuller Stocktake. •Further ongoing recruitment and retention initiatives taking place through the ICB, Staffordshire Training Hub, 2 x workforce clinical champions and wider ICS People Function. All strands will be brought together as part of the PC WIG.	**31/03/2023**	**16 (4x4)**	**16 (4x4)**	**8 (2x 4)**	**Static**	Chris Bird	**3, 4**	Sarah Jeffery	Transformation	Primary Care
082	**Agency Usage & Spend**	People, Culture & Inclusion Committee	If the national mandate on reducing agency spend is introduced with a target reduction from £34m to £25m in SSOT	Then the system's ability to attract/recruit/retain staff, to hard to fill positions will be negatively impacted leading to varying demand in bank, BAU and 'day job' priority for members, under-utilisation of system People Hub	Resulting in vacant posts, continued reliance on agency, move back to pre-Covid silo working, duplication of work, system benefits and efficiencies not realised	**03/02/2023**	Introduction of system-wide metrics to provide oversight and collaborative working to address. Provider level actions in place to tackle internally. System agreement on Escalated winter bank rates. Successful implementation of People Hub and Reservist Model, moving towards system contingent workforce utilised prior to agency bookings. **Residual risk score increased from 12 to 16.** At the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**20 (4x5)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	**3, 4, 5**	Mish Irvine / Gemma Treanor	People, Culture & Inclusion	People Programme
085	**Care Home and Home Care Workforce Capacity**	People, Culture & Inclusion Committee	If Care Home and Home Care existing and future workforce supply remains unstable, unable to mobilise workforce to support the PIRT, lack of demand and capacity modelling, infection control and outbreaks,	Then there will continue to be significant gaps in the Care Home and Home Care workforce	Resulting in an inability to operate Care Home and Home care services effectively and safely, wider system impacts on hospital admissions and discharge, stretching existing workforce, leaver rates, impacts on workforce health and wellbeing.	**03/02/2023**	Care and Nursing home and Home Care Commissioners and providers mobilising system response. PIRT model still in operation. Deployment of workforce into Care Home and Home Care services from People Hub/ Reserves. Various reserve models and recruitment campaigns in place to support e.g. New to Care. **Residual risk score increased from 12 to 16.** At the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**16 (4x4)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	**3, 4**	Mish Irvine / Gemma Treanor	People, Culture & Inclusion	People Programme
086	**Supporting workforce modelling for Joint Forward Plan, Portfolios and Transformation**	People, Culture & Inclusion Committee	If a lack of clarity around Joint Forward Plan, Portfolios and Transformation Plan workforce requirements exists	Then there is an inability to effectively workforce plan and understand the workforce requirements for existing and future service delivery.	Resulting in lack of clarity on current and future workforce models, skills mix, education/course requirements and future pipeline.	**03/02/2023**	Operating, Restoration & Recovery Plans in place. Workforce elements included to support plans. Engagement with workforce and clinical leads of Portfolios to establish links to support workforce modelling. **Residual risk score increased from 12 to 16.** At the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**16 (4x4)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	**4**	Mish Irvine / Gemma Treanor	People, Culture & Inclusion	People Programme

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
094	**Staff sickness, wellbeing and burnout**	People, Culture & Inclusion Committee	If staff continue to work under the pressures experienced during the Pandemic	Then it could impact on future well being & retention Stress/Anxiety/ Depression and MSK reasons for absence remain prevalent, impact of additional pressures on services and workforce	Resulting in increased sickness and absence, impact on health and wellbeing of the workforce, links to turnover	**03/02/2023**	A range of Health and Wellbeing initiatives and schemes in place for all staff across the system. Staff Psychological and Wellbeing Hub available to all, with resources and materials to access for support. Retention Programme activities ongoing at provider and system level to improve experience and turnover. This risk also includes risk 084 which has been closed as it has been separated out. **Residual risk score increased from 12 to 16.** at the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**20 (4x5)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	4	Gemma Treanor	People, Culture & Inclusion	People Programme
095	**Vacancies and Workforce growth required; Supply and availability of Registrants**	People, Culture & Inclusion Committee	If we are unable to fill the number of vacancies across all groups, deliver the growth required to deliver the operational plan and winter schemes and meet the national workforce models. design new/adapt courses and placements to meet the immediate and future needs	Then we will not deliver the availability of workforce to support service delivery: Restoration and Recovery Plans; Winter Plans; BAU service delivery; Transforming care models and pathways; different skills, competencies and roles required to support different ways of delivering care	Resulting in an impact on service delivery, workforce burn out and turnover; reduction in productivity; gap in existing workforce skills and competencies, creation of new roles and requirement to train and recruit.	**03/02/2023**	Short term solutions in place through system partnership working and redeployments. ICS People programme focus on supporting system workforce supply, ongoing system People Hub support and Reservist model. Trust and System Recruitment Campaigns ongoing. Strategic workforce planning aligned to demand modelling within clinical and operational input to ensure the right skill mix in place. Work closely with programme managers and clinical leads in the design of new care models and pathways to determine the workforce requirements and implications. Designing and delivering solutions to address the gap including new roles, integrated roles, rotational apprenticeships. Work in partnership with Digital workstream in introducing new technologies and supporting the workforce. Work with HEIs/HEE to review courses and placements. This risk also includes the workforce element from risk 084 which has been closed as it has been separated out. Risk 087 has also been merged into this risk. **Risk score increased from 12 to 16.**		**20 (4x5)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	**1, 2, 3, 4**	Gemma Treanor	People, Culture & Inclusion	People Programme
096	**Industrial Action Strike**	People, Culture & Inclusion Committee	If the union ballots support Industrial Action	Then there will be workforce action which could impact across the system	Resulting in reduced staffing levels, additional pressures on service delivery and temporary suspension of services	**03/02/2023**	National pay negotiations ongoing. Working to national position and advice. Locally: regular discussion with Staff side, communication and engagement with the workforce, contingent workforce models in place, emergency preparedness processes developed including Workforce Cell and system deployment.		**20 (4x5)**	**16 (4x4)**	**4 (2x2)**	**Static**	Alex Brett	**4**	Gemma Treanor	People, Culture & Inclusion	People Programme
097	**Cost of Living impact**	People, Culture & Inclusion Committee	If the cost of living, fuel and energy price rises with subsequent impact on workforce and the population.	Then the population and workforce will struggle to manage financially	Resulting in a detrimental impact on health and wellbeing, increased turnover and inability to attract people to health and care careers over higher paid private sector jobs.	**03/02/2023**	National pay negotiations ongoing. System financial wellbeing resources available, Trust and organisation level support in place to help individuals facing hardship. **Residual risk score increased from 12 to 16.** At the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**20 (4x5)**	**16 (4x4)**	**4 (2x2)**	**Increased**	Alex Brett	**4, 6**	Gemma Treanor	People, Culture & Inclusion	People Programme
101	**System Care Homes Resilience**	Quality & Safety Committee	If the resilience of Care Homes continues to result in operational issues and they continue to apply differing interpretation and operationalisation of Covid guidance - resulting in some CHs restricting or precluding new admissions and/or re-admissions.	Then Care Homes will have limited/reduced capacity for patient admissions .	Resulting in an impact upon patient flow.	**06/03/2023 22/02/2023**	This risk was reviewed by the Audit Committee on the 6th March 2023 and members requested that this was reviewed by the CMO due to the risk being closed with a risk score of 16. At the request of the Audit Committee this risk has not been closed. The risk dates back to 2020 and was initially logged via the discharge cell due to the lack of capacity across care homes to support hospital discharge as a result of Covid. We now have IPC off set capacity for D2A (managed by MPFT) to support restrictions if required for Covid, norovirus, flu etc so the risk associated to hospital discharge is mitigated and can be **closed**.	**01/12/2022**	**16 (4x4)**	**16 (4x4)**	**4 (2x2)**	**Static**	Dr Paul Edmondson-Jones	**3,4**	Natalie Cotton / LAs	Delivery	Urgent Care

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
108	**Ivetsey Bank (Independent Hospital)**	Quality & Safety Committee	If assurance is not obtained that children are safe from harm in Ivetsey Bank in Stafford	Children may be harmed by restrictive practices and psychological harm	Resulting in significant harm	**23/02/2023**	NHSE Specialised Commissioners working with Birmingham Women's and Children Hospital as the Provider Collaborative are leading on the response to the media findings and publicly shared story's. To date these are related to historical stays at the hospital but all current patients have been reviewed by a case officer. CQC visited in Sept 22 and hospital remains in special measures but is now rated RI - Action being developed supported by all stakeholders Quality Team fulfilling functional commissioner role and supporting the above as well as attending all relevant meetings to maintain an oversight on risk and improvement plan. Reviewed 10-1-23 situation continues to be managed by NHSE and Provider Collaborative with close monitoring and daily sitreps as well as admission limitations/review so risk likelihood reviewed Reviewed 14/2/23 further significant complaint from a family and issues similar to that reported in press earlier - Provider collaborative investigating Reviewed 23-2-23 as further concerns raised by other health professional - urgent review meeting planned with provider collaborative. **Given nature risk likelihood increased from 12 to 16.**	**30/01/2023**	**16 4x4**	**16 (4x4)**	**8 (4x2)**	**Increased**	Heather Johnstone	**3**	Cath Marsland	Ambulance	CYP & Maternity
112	**Industrial Action**	Finance & Performance Committee	If Industrial action continues, with further days/periods of staff walk-outs	Then there will be periods of additional pressure placed upon the system due to staffing cover and contingency arrangements	Resulting in increased instances of patient harm, increased system capacity issues, compromised staffing ratios and the need for enhanced contingency measures	**17/01/2023**	System Control Centre operational and overseeing system actions and preparedness Daily system COO calls in place, escalation actions defined during previous periods of industrial action. System Winter Steering Group oversight of preparedness planning, contingency arrangements and decision making. UEC Ops team oversight and link to regional/national teams to ensure joined up approach to planning, reporting and monitoring actions.		**16 (4x4)**	**16 (4x4)**		**Static**	Phil Smith	**2, 4**	Kate Farrow	Ops & Delivery	Urgent Care
114	**Children and Young People placements for complex behaviour**	Quality & Safety Committee	If there is no appropriate inpatient facility children and young people will need to be admitted to an inappropriate setting.	Then children and young people may not be able access inpatient services which meet their needs either locally or nationally	Resulting in potential placement within an environment which is not commissioned to meet their needs which could result in risk for the individual and others, alongside inappropriate clinical management leading to deterioration of condition/behaviours	**23/02/2023**	Mitigations: MDT professional response in place on an individual case basis Rapid review commenced - lessons learnt/feedback will be developed into a system agreed action plan Review 23-2-23 significant criticism for system regarding provision for one child now in national media		**20 (5x4)**	**16 (4x4)**	**8 (2x4)**	**Static**	Heather Johnstone/ Chris Bird	**1,2,3,4**	Cath Marsland/ Gemma Smith	Nursing & Therapies Directorate	CYP
115	**New Looked After Children Initial Health Assessment/ Review Health Assessment (IHA/RHA) Compliance (regulatory)**	Quality & Safety Committee	If there is an increase in demand for IHA then consequent RHA for looked after children, due to an increasing number of Looked after Children some of which is associated with the increasing numbers of unaccompanied asylum-seeking children (UASC). It is important to note that UASC children are routinely given a double appointment to enable and support the delivery of a quality assessment. This is having further impact on the demand.	Then there will be continued decline in compliance for Looked After Children having their Initial and Review Health Assessments (IHA/RHA) within the statutory time scales. The target for IHA is 85% reviewed within agreed timescales: Dec was 58.5% but Jan is 13% For RHA the target is 85% and Dec was 23.8% with Jan at 13.3%	Resulting in looked after children not receiving their assessments in line with Statutory Timeframes which can result in missed opportunities and/or delayed appropriate intervention for health needs and consequent risk.	**22/02/2023**	Mitigations: * UHNM and MPFT have added this risk to their internal risk register and it is now added to ICB Risk Register with planned meetings to agree actions in place. Recruitment of 3.0 wte additional fixed term staff and engaging bank staff by MPFT to support the demand. With the backlog waiting time is decreasing slowly. * MPFT have shared intention to submit a further business case to with regards to the need for more staff in response to the increased numbers of LAC. * Reviews for adoption and care leavers continue to be prioritised. * UASC currently receive a double appointment to enable and support delivery of a quality of assessment. * Recruitment to LAC Designate Nurse in ICB - Appointed. Plan to contact employer to consider opportunity to release new employee earlier. * System Task and Finish Group to be established to understand challenge and agree further mitigations. Breakdown of Staffs and Stoke figures requested.		**20 4x5**	**16 4x4**	**8 4x2**	**New**	Heather Johnstone/ Chris Bird	**3,4,6**	Claire Underwood	Nursing & Therapies Directorate	CYP & Safeguarding
073	**Transfer of Primary Care PODs to ICB**	ICB Board	If the ICB does not receive sufficient resource from NHSE when the PODs are transferred	Then the ICB may not have sufficient capacity or technical skills, corporate memory &/or adequate finances to support additional role	Resulting in failure to optimally commission the new services and additional cost pressures	**27/02/2023**	* Transition plan in place – phase 1 BAU from 1/4/23 (finance, governance, quality, communications, Secondary care dental) and phase 2 (digital, complaints and workforce from July 2023) * Operational framework re. contracts and other workstreams (what happens, how) in development * ICB delegation meeting now in place covering PODs and specialised commissioning to bring together all workstream leads to ensure alignment and highlighting of risks * Delegation agreement to come to ICBs in March for review and sign off	**30/06/2023**	**15 (3x5)**	**15 (3x5)**	**6 (2x3)**	**Static**	Chris Bird	**1**	Tracey Cox	Transformation	Primary Care

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
003	**Capital Regime**	Finance & Performance Committee	If MPFT are unable to utilise their cash reserves for the development of Community Hubs	Then there is a risk of delay as capital resources identified for future years are inadequate for the plan that includes BAU, the community hubs, car park scheme at UHNM; and dormitories at Combined Healthcare	Resulting in Community Hub capital investment not being made, a potential judicial review and reputational impact.	**27/02/2023**	Capital plans from providers reviewed for CFO meeting as part of planning process and a five year plan has been submitted. Meeting held 19 October with Regional Capital Team to discuss the capital limit requirements for the DMBC over the next three years following the ICS letter to Region. The Region are looking to support the ICS with brokerage from across the central Region. NHSE recognise the risk however no agreed mitigations currently identified therefore no change to risk score.	**31/03/2023**	**12 (4x3)**	**12 (4x3)**	**6 (3x2)**	**Static**	Paul Brown	**5**	Helen Dempsey	Finance	
032	**Maternity and Neonatal workforce**	Quality & Safety Committee	If Providers don't recruit to all of their clinical vacancies and develop a robust retention strategy	Then there will be an impact on the implementation of safety initiatives and the transformation agenda	Resulting in poor outcomes for birthing people and their babies	**23/02/2023**	Risk reviewed by LMNS team. agreed that this is a risk because clinical vacancies are impacting on operational pressures and thus impacting on availability of senior staff to attend transformation meetings and engage with transformation initiatives. workforce gaps discussed at LMNS programme board and QSOF. Newly qualified midwives are now in post but still in supernumerary status so positive impact on rosters not yet felt. 29/11/22: Risk reviewed at Quality and safety forum and agreed that this specific risk still exists. each maternity provider is carrying a residual 15-20 clinical midwifery vacancies which will increase over the coming year until the next Student cohort qualify. Universities have increased training places in order to meet the demand but these qualified staff won't be available until 2024 Risk reviewed on 9/1/2023 at LMNS board with further discussion on 11/01/2023 with maternity SRO. agreed risk score is static. Risk reviewed by LMNS team, LMNS Board cancelled 06/02/2023 due to industrial action. All providers continue to report operational pressures. UHNM report OPEL 3 for the majority of days via the sitrep report. Recruitment day for UHNM arranged for March 2023. Risk score remains unchanged.	**31/03/2024**	**16 (4x4)**	**12 (4x3)**	**6 (3x2)**	**Static**	Heather Johnstone	**1, 5**	Alison Budd	Nursing & Therapies Directorate	CYP & Maternity
059	**Confidential Risk - Cannock**	Quality & Safety Committee	If the two Practices currently at Cannock Hospital cannot extend their contract with RWH or find alternative accommodation	Then there is a risk to service continuity in Cannock Town Centre	Resulting in reduced services and poor patient outcomes	**27/02/2023**	We continue to work to the timeline of September 2023 for movement to take place. Contact with practices is ongoing with schedule of accommodation confirmed so design phases are progressing. Further engagement has been productive with Local Authority colleagues in Cannock Council with two further car parks being offered for the site of the temporary building which will not impact revenue opportunities for LA and also offer strong strategic fit for the life of the temporary building and what services could look like post this phase, for example integrated neighbourhood teams. The ICB team continue to stay connected with RWT and have updated on progress to date. RWT estates team are supporting with procurement options for the temporary building as they have an established framework which can reduce procurement timelines, reduce need for ICB resource, ensure good governance, challenge value for money. Cannock Transformation programme which supports the varied issues in Cannock such as the provision of services since MIU stood down, Cannock practices relocation and then the longer term strategic options for long term sustainability and service provision for Cannock population.	**31/03/2022**	**16 (4x4)**	**12 (4x3)**	**1 (1x1)**	**Static**	Chris Bird	**1, 3, 6**	Andy Hadley	Transformation	Primary Care
083	**Ageing Workforce**	People, Culture & Inclusion Committee	If the ageing workforce and existing & future pension changes across all sectors leads to a loss of skills & experience and inability to attract/recruit/retain future workforce	Then there may be increased early & normal retirement,	Resulting in gaps in supply, hard to fill posts vacant, loss of experience and skills, health & wellbeing of older workforce	**03/02/2023**	Risk reviewed and no change to mitigations. Collaborative working at a system level on retention and retirement, in addition to organisational level schemes. Future workforce pipeline schemes at org and system level including apprenticeships, rotational, graduate schemes. Continued collaboration with HEIs, HEEs. Successful implementation of People Hub, moving towards system contingent workforce. **Residual risk score increased from 9 to 12.** at the request of the People, Culture and Inclusion Commiottee, Members agreed that the risks are particularly significant at present in view of the strike action, ongoing impacts of winter, increased cases of Covid and Flu within the local population and workforce, and the ongoing challenges around attracting and recruiting skills and registered professionals. The risks have a significant impact on the delivery of the People objectives, delivery of the People Plan, delivery of services across the system and align to the risks provider organisations are facing.		**16 (4x4)**	**12 (4x3)**	**4 (2x2)**	**Increased**	Alex Brett	4	Mish Irvine / Gemma Treanor	People, Culture & Inclusion	People Programme

Risk No.	Risk Title	Lead Committee	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Link to BAF Risk	Action Owner	Directorate	Portfolio
089	**Inductions of labour**	Quality & Safety Committee	If Provider improvement interventions to the induction of labour pathway are not put in place and sustained	Then the daily backlog of inductions of labour will continue to require reactive management , system oversight and response	Resulting in potential physical and / or emotional harm for birthing people and their babies: Poor experience - fear of not knowing, anxiety and worry an impact on other areas of the service e.g. new bookings being delayed	**23/02/2023**	This is monitored via the daily provider sit rep and supported through system escalation as required. An induction OPEL framework is being developed led by System exec Nurse. Any incidents are being monitored through UHNM Quality governance process. Induction of labour improvement group has been established in partnership with UHNM, the LMNS and the regional NHSE perinatal team. this risk has been agreed at LMNS programme board and QSOF. Improvement workstream is established in UHNM and includes the LMNS and NHSE regional team 29/11/22: risk reviewed and LMNS quality and safety forum on 28/11/22 and all agreed that this specific risk remained. The improvement group coordinated by UHNM is now established and making some progress but this is not yet embedded and sustained. Quality and safety forum discussed the risk score and agreed that the likelihood remains the same. Risk reviewed at LMNS board on 9/1/23 with further discussion with SRO on 11/01/2023 - significant improvement in the IOL pathway made but yet to be embedded. risk score therefore remains static. Risk reviewed by LMNS Team, LMNS Board cancelled 06/02/2023 due to industrial action. Continued peaks noted in women awaiting induction via the OPEL sitrep, therefore risk to remain the same. Task and finish meeting continues. Delay with progressing the baseline audit. Regional support continues.	**31/03/2023**	**12 (3x4)**	**12 (3x4)**	**6 (2x3**	**static**	Heather Johnstone	**3**	Alison Budd	Nursing & Therapies Directorate	CYP & Maternity
090	**High levels of Covid and viral illnesses**	Quality & Safety Committee	If the system experiences high levels of Covid & other viral illnesses	Then there may be high demand for health and social care services coupled with staff sickness	Resulting in (1) demands overwhelming hospital and community services including PC (2) excess deaths (3) financial pressures (4)staffing gaps in ICB and system		Currently the number of Covid patients in UHNM is less than one third of the level experienced in late October and early November (this is used as the best barometer available at present of community covid activity in the absence of robust community recording) and, while flu and RSV levels are up slightly on previous years they are not causing significant pressure. The Vaccination programme is underway for staff and community with good response to date. There is a robust winter plan in place that has been agreed with all partners. Finance are maintaining a clear record of covid expenditure and all organisations have robust business continuity plans in place. The picture can and could change quite rapidly and hospital rates and vaccination data are monitored daily and weekly respectively.	**31.03.2022**	**16 (4x4)**	**12 (4x3)**	**9 (3x3)**	**Static**	Paul Edmondson-Jones / Phil Smith / Heather Johnstone	**1, 2, 4, 5**	TBC	All	
102	**UHDB Winter Plan**	Finance & Performance Committee	If UHDB are currently utilising all their surge capacity and have an outstanding 110 bed deficit.	Then there could be an impact on Staffordshire capacity if the Burton site and UHDB footprint demand outstrips capacity.	Resulting in a negative impact on the Staffordshire Winter Plan.	**22/02/2023**	UHDB mitigation plans developed to mitigate winter pressures. UHDB remain active members of the system MDT and associative groups and continue to update. Daily work with the UEC ops team to ensure system is sighted on pressures and can provide early warning. Surge beds are available at the Burton site and will continue to be used throughout winter. D2A capacity at Philip Ward (Sor Robert Peel Comm. Hospital site) has been operational during Winter and has demonstrated positive impacts. Assessing continuation of the service post March.	**01/12/2022**	**16 (4x4)**	**12 (3x4)**	**4 (2x2)**	**Static**	Phil Smith	**2**	Debbie Pook	Delivery	Urgent Care
105	**Virtual Wards**	Finance & Performance Committee	If we are unable to recruit a sufficient workforce to staff the additional Virtual beds by December due to workforce challenges, including recruitment to VW roles and sustainability of the number and capacity of clinical leads needed to manage remote care and virtual wards.	Then we will not be able to roll out the planned number of Virtual beds.	Resulting in a significant gap in the winter capacity plan.	**22/02/2023**	ICS workforce lead involvement with VW Steering Group. Development of Clinical Leads and Remote Care recruitment and retention plans continues. VW roll-out did not realise acute bed equivalent impacts as originally planned. VWs forms a significant aspect of the UEC Recovery Plan submission, with a trajectory for opening additional capacity documented within. System partners continue to work collaboratively to try and address recruitment issues to ensure that VWs deliver as intended/planned in 2023/24.		**15 (3x5)**	**12 (3x4)**	**4 (2x2)**	**Static**	Phil Smith	**2, 4**	Sarah Piggot	Delivery	Urgent Care
106	**D2A Capacity**	Finance & Performance Committee	If the on-going challenges with flow from D2A capacity, due to capacity issues in the domiciliary care and care home markets, persist.	Then there will be reduced D2A capacity.	Resulting in a significant gap in the winter capacity plan.	**22/02/2023**	LA plans/arrangements in place for developing domiciliary care and care home market capacity so as to improve flow from D2A enacted throughout winter. D2A beds have functioned as intended and delivered capacity throughout winter. POLR has greatly reduced across the system, post targeted intervention via Winter monies.		**15 (3x5)**	**12 (3x4)**	**4 (2x2)**	**Static**	Phil Smith	**2, 4**	Jenny Collier	Delivery	Urgent Care

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**14**

Title:	**Quality and Safety Report**

Meeting Date:	16 March 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Heather Johnstone – Chief Nursing and Therapies Officer	Y	Cath Marsland - Associate Director of Quality and Patient Safety Lee George - Associate Director of Quality Assurance and Improvement Karen McGowan - Associate Director of Nursing and Quality Claire Underwood – Associate Director for Safeguarding Alison Budd – Lead Midwife for the Local Maternity and Neonatal System Sally Bestwick – Lead Nurse for Infection Prevention and Control

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
N/A	N

Action Required (select):									
Ratification-R		**Approval-A**		**Discussion-D**		**Assurance-S**	✓	**Information-I**	

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
N/A			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
This paper is a combination of those corresponding papers presented and discussed at the System Quality Group	08/03/2023	S

Purpose of the Paper (Key Points + Executive Summary):
This paper is intended to provide assurance to the ICB in relation to the key quality matters. These include: Routine updates from subgroups including System Quality Group, Continuous Quality Improvement, the Local Maternity and Neonatal System Board and the Quality Impact Assessment Subgroup. Updates provided under the system headings of Acute, Community and Emergency Services, Mental Health and Learning Disabilities, Primary Care and Other Stakeholders, i.e. NHSE, HEE and Healthwatch. Current System Quality Matters include: • Infection Prevention and Control • Local Maternity and Neonatal System (LMNS) • Safeguarding • SEND • CHC Deep Dive • Delegated Commissioning – Pharmacy, Optometry and Dentistry (PODs) Quality Assurance and Improvement of ICB and ICS developments include a focus on discharge practices following a discussion at the System Quality Group. The refreshed Freedom to Speak Up policy was presented to the Quality and Safety Committee and approved subject to agreed amendments. The Terms of Reference (ToRs) for the Health Economy Infection Prevention and Control Group were approved by the Quality Safety Committee

Is there a potential/actual Conflict of Interest?	Y/N
Outline any potential Conflict of Interest and recommend how this might be mitigated	
No conflicts of interest were identified.	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
Risks aligned to these areas of work are submitted as a separate agenda item and discussed fully at the Quality Safety Committee

Implications:	
Legal and/or Risk	Risks identified and discussed within the agenda of QSC
CQC/Regulator	Discussed as appropriate and against the relevant organisation, as appropriate
Patient Safety	All key areas in response to system assurance for patient safety have been identified within the report
Financial – if yes, they have been assured by the CFO	Potential financial implications on the quality of services across the system due to restoration and recovery
Sustainability	N/A
Workforce / Training	Many current quality issues relate to workforce matters including areas where gaps in workforce present ongoing challenges.

Key Requirements:		Y/N	Date
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	N	

1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2		
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	N	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	N	

Recommendations / Action Required:

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, quality improvement and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.
- To ratify the approval of the revised Freedom to Speak Up Policy

Quality and Safety Report to the Integrated Care Board – March 2023

1. Introduction

The purpose of this report is to provide assurance to the Integrated Care Board regarding quality matters whilst also providing a summary of the discussions and emerging issues raised at the key quality forums throughout March 2023.

2. Quality Risks on the Register

Quality and Safety Committee approved the closure of risk 101 - System Care Homes Resilience, given the risk reflected issues related to capacity and the management of IPC issues within a care home environment during Covid. Assurance was received by the committee that there are well established Infection, Prevention and Control (IPC) processes now embedded along with additional bed capacity procured which can be stood up in the event that discharge flow is affected and that relevant outstanding IPC matters are addressed in risks 90 and 91.

3. Updates from across the ICS

Acute Services

UHNM are awaiting feedback from their response to a s29a, following a CQC visit to the Emergency Department in January 2023. The Trust have spoken with CQC who have indicated that there is currently a significant backlog and therefore no confirmed timeframe for the release of the report.

Healthwatch Staffordshire recently undertook an 'Enter and View' visit at County Hospital. The feedback from the visit was positive with some key recommendations particularly around discharge to care homes provided.

Discussions have also taken place between NHSE and UHNMs Deputy Chief Nurse recognising that prisoners should be afforded the same consideration when planning discharge. NHSE representatives have been invited to meet with the Matrons across both hospital sites to place a spotlight upon these specific issues and agree actions to reduce inequity.

The Quality and Safety Committee received a comprehensive overview of Your Next Patient and Corridor Care. Both are considered in "extremis" actions which have been put into place to balance the continued patient safety risks within the community as a result of ambulance handover delays. 'Your Next Patient', is based upon the Bristol model, which sees 2 patients an hour being discharged during daytime hours from the Emergency Department to designated wards to receive care prior to ward discharges being completed. A comprehensive risk assessment and clinical review is undertaken prior to implementing the actions at site level, aligned to the system agreed triggers.

Emergency Services

WMAS reported an improving position with their response times which reflects a reduction in handover delays in February.

A new simulation suite has been established at the WMAS hub in Sandwell, which will enhance the training offered to WMAS staff. The state-of-the-art facility has a number of sophisticated mannequins which will support '*hands on*' training across a variety of scenarios, including

resuscitation training. It is expected to be the most extensive modern simulation centre in the country.

In line with the recent announcements regarding additional ambulances and dedicated mental health response vehicles, WMAS outlined their plans to increase their fleet size as part of their ongoing replacement programme, whilst procuring the vehicles have indicated that the additional ambulances have been identified as part of the Urgent and Emergency Care strategy, however there are no additional staff to man them.

Mental Health and Learning Disabilities

Project Chrysalis is a programme in NSCHT, aimed at eradicating dormitories and will be implemented in April 2023 and may cause some disruption to patients.

NSCHT are keen to promote their Wellbeing College which is now in its 3rd term. A prospectus has been produced and available for staff, the public and service users and recognised as a good opportunity to listen to those with lived experience of mental health.

System partners were thanked for the collaborative working displayed in managing children and young people with challenging behaviours.

MPFT are awaiting feedback from a draft action plan submitted to CQC following a visit in December 2022 to look at safe management of care on the wards, and the subsequent issuing of a 29a notice. A meeting is planned with the new CQC inspector on the 15th of March 2023 and a meeting to be diarised with the ICB.

Community Services

The 2022 Community Mental Health survey results showed that MPFT performed well against benchmarking; in the highest 20% of trusts surveyed and in the mid 60% range for areas except one which the Trust are addressing. NSCHT results were below those expected with a project group established to address the findings.

Primary Care

Face to face appointments were raised as a query at the February SQG. Data released for November 2022 shows that compared to 2019 there has been a rise in primary care appointment activity with a smaller proportion of appointments undertaken face to face recognising patient choice to use telephone or video consultations.

Other stakeholders

NHSE provided an update on prison healthcare which includes plans to mobilise an eighth prison contract. There is also a re-procurement for the West Midlands sexual health referral service and a pilot to mainstream the specialist care unit at Stafford, currently a national resource which only provides reablement and end of life care for those with sexual offences.

Health Education England (HEE) have produced a Midwifery Safe Learning Environment Charter through collaboration with 636 midwives and 12 Education Providers, which is due to be published in July 2023.

4. ICB Updates

Infection Prevention and Control

Covid19 continues to present a challenge, influenced by community rates of infection. The IPC teams across the system respond in line with local guidance to minimise the impact on services while maintaining safe care. Weekly IPC Lead meetings support a system wide approach and shared learning including Local Authority colleagues who have oversight of adult social care settings.

Due to low numbers of Monkeypox (Mpox), national epidemiological reporting will no longer be published. As of 19th of December 2022, 131 cases were confirmed or highly probable in the West Midlands, which remained unchanged since September 2022.

Group A Streptococcal infections saw an increase nationally during Q3, with increased demand on services across the system. Although cases are reported to have slowed in children, there is an increase in incidence amongst older adults.

The Terms of Reference (ToRs) for the Health Economy Infection Prevention and Control Group were presented to the Quality and Safety Committee for approval. No issues or concerns were raised, and the ToRs were approved in line with delegated responsibility.

Maternity and Neonatal Services

The Local Maternity and Neonatal System (LMNS) Board continues to monitor all aspects of maternity quality and safety, including services provided out of area.

Workforce challenges remain an issue affecting the ability to provide safe maternity staffing in line with Ockenden recommendations and risks are mitigated by moving staff to areas of greatest need, primarily the consultant units on the delivery suites. However, the freestanding midwife led units in Lichfield and Stafford remain closed for births and home births are intermittently suspended in line with local escalation levels. Recruitment events are planned as well as a drive for international recruitment.

The high number of women who require their labour inducing (IOL) and subsequent backlog continues to impact on capacity within Maternity services. An Improvement project is in progress in collaboration with UHNM, LMNS and NHSEI with the aim to develop an IOL pathway that promotes choice and positive experiences for women and families, whilst developing a service that meets operational demands to reduce the need for escalation for mutual aid.

The ICB Chief Nursing and Therapies Officer, has led work to standardise the escalation criteria for maternity and to enable regional agreement on actions to support improvements in maternity access. Monitoring is via daily COO calls, as necessary and daily sitreps.

A CQC visit to UHNM maternity unit commenced on 7th of March and is planned to continue for 3 days.

A Maternity and Neonatal Single Delivery Plan from NHS England is expected in the next couple of months. There is an expectation it will pull together all the existing maternity and neonatal goals and aims.

Safeguarding

The Safeguarding Team continue to monitor and support all aspects of Safeguarding of adults and children within the Integrated Care System. Safeguarding training compliance amongst staff

across the ICS has seen a decline. A more detailed report is to be presented to future QSC meetings.

Plans are underway to establish a Provider Collaborative for safeguarding to ensure best use of safeguarding resources, initially in health. Phase two of the Provider Collaborative commenced on the 27th of February 2023 and will provide the opportunity to develop improved and robust governance for safeguarding across the system, aligned to key priorities and programmes of work. Oversight and assurance of the provider collaborative and associated work will remain the responsibility of the ICB.

Staffordshire & Stoke-on-Trent has seen an increasing number of asylum seekers and a subsequent rise in safeguarding referrals. There is a Migrant Health Cell Collaborative workstream which is overseeing the support to asylum seekers.

Increasingly, the safeguarding team are involved in reactive and urgent case discussions regarding complex children and young people who present to urgent and emergency care services and admitted to inappropriate settings. The ICS is committed to identifying solutions to support, ensure safety is not compromised and manage the risk.

January 2023 saw an increase in Section 42 enquiries, this has led to a backlog of allocations. In response to this a triage process has been temporarily put in place and protective measures are dealt with as a priority. This work and demand will be considered as part of the earlier mentioned Provider Collaborative work.

SEND

A re-inspection of Staffordshire SEND services in February 2022 resulted in the requirement for an APP (Accelerated Project Plan). A 12-month review meeting with NHSE and the Department for Education, is planned for the 20th of April 2023. An inspection of Stoke-on-Trent SEND services is still awaited and expected imminently. There is significant work to collate evidence and the governance strengthened with a new three-tiered process which includes an Executive Board, a Strategic Board and a SEND Delivery Group.

SEND Joint Commissioning is progressing with ongoing work on a Joint Commissioning Strategy, supported by the Council for Disabled Children (CDC) and presented to the Quality and Safety Committee on 8th of March 2023. An action plan has been developed which will be used to monitor performance and will be re-presented to relevant ICB forums.

Continuing Healthcare (CHC) Deep Dive

The Quality and Safety Committee received a CHC deep dive presentation demonstrating challenges, both in demand and financially. Additional actions to support the CHC programme include further work to understand the reasons behind the increase in costs, including the processes for transacting CHC and also ideas to stimulate the market, which includes working with MPFT and NSCHT.

The ICB is reviewing 190 of the highest costed packages of care, associated protocols and processes, starting week commencing 6th of March 2033.

Delegated Commissioning – Pharmacy, Optometry and Dentistry (PODs)

A presentation was received on delegated commissioning. The services to be delegated to ICBs include primary pharmacy, primary optometry and primary and secondary dentistry, subject to agreement to transfer. Going forward some specialised services will also transfer. The governance

arrangements will change as arrangements are put in place to sub-contract with others ICBs and to develop a delegated agreement with NHSE and the other 11 ICBs in the midlands.

The ICB Nursing and Therapies Directorate are engaging with the CQC to understand the work programme and look at the role of the ICB and how the teams can work together to share data.

Freedom to Speak up Policy

The new Freedom to Speak Up policy was presented to the Quality and Safety Committee and approved subject to some amendments.

5. Other System Quality Matters by exception:

Industrial Action (IA)

The recent Industrial Action by physiotherapists resulted in a significant amount of work for UHNM. 95% of physiotherapists were involved but the impact on patient care was minimal with no incidents reported. Plans were produced in response to the anticipated IA by nurses in early March which was subsequently stepped down pending further discussions. Plans will continue to be implemented as necessary and in response to the imminent Junior Doctors' IA which will require support from all partners.

Quality Improvement

Significant Quality Improvement activity continues across the system. Over the coming months the programme will focus on timely discharges and include pathway 1 and 2 discharges (D2A) to minimise the impact of long stays on patients and to support the drive for improvements in system flow.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**15**

Title:	**Finance and Performance Update**

Meeting Date:	16 March 2023

Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Paul Brown Chief Financial Officer	Yes	Finance, Planning and Intelligence Directorate

Clinical Reviewer:	Clinical Sign-off Required Y/N
N/A	**No**

Action Required (select):									
Ratification-R		**Approval-A**		**Discussion-D**		**Assurance-S**	✓	**Information-I**	✓

Is the [Committee]/[Board] being asked to make a decision/approve this item? Y/N			
Is the decision to be taken within [Committee]/[Board] delegated powers & financial limits?			
No			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	**A/D/S/I**
Finance and performance committee	07/03/23	D/S/I

Purpose of the Paper (Key Points + Executive Summary):

The purpose of this report is to provide detail on

- the current financial performance of the ICB
- risk adjusted outturn
- progression on our developing financial strategy.
- performance against key targets and levels of activity.

Key points on finance

- The net risk to break-even has reduced due to £6m as a result of the receipt of further non-recurrent income and growing confidence in the delivery of the year end position. It is understood that nationally many ICBs are struggling to achieve break-even.
- Pressures remain in both Continuing Health Care and primary care prescribing however mitigations have been identified.

Key points on performance

- The pressure in **Urgent and Emergency Care** reduced in January to more normal levels for the time of year, and the System in now back in line with the assumptions made in the Winter Plan. Significant improvements have been made with hours lost due to ambulance handover delays and the number of category 2 calls outstanding.
- It has been confirmed that the target to eliminate **78+ week** waits by the end of March 2023 will not be achieved. As at 19th February 1,144 ICB patients were waiting more than 78 weeks.
- Performance against the **Cancer 28 Day Faster Diagnosis Standard** in December increased to 65.1% - below the 75% standard but increasing for the third consecutive month.
- The number of **GP appointments** continues to be above plan - 100.9% of the plan year to date. **GP FTE** increased by 6.5% on November – the increase is due in part to a higher number of ST2 trainees starting in December. Compared to December 2019, GP FTE is 2.9% higher.

Is there a potential/actual Conflict of Interest?	**Y/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
None	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):

- BAF Strategic Aim '(3C) (**Risk 961**) - Support the delivery of system financial balance by 2025/26'. (BAF submissions being reviewed by ICB Board and are subject to change)
- **Risk 001** - Underlying deficits from 2023/24: If the system saving schemes do not deliver the financial strategy, the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position, in line with the operating and planning framework.
- **Risk 068** – Finance: there is a risk that the ICB does not achieve break even in the current period 2022/23, resulting in additional cost pressures in 23/24.
- **Risk 111** – If continued delays to ambulance handovers are incurred and sustained, or levels increased there will be significant pressures placed onto ED, ambulance crews and the wider UEC system resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time and associative issues.

Implications:	
Legal and/or Risk	Monitoring performance is a statutory duty of the ICB.
CQC/Regulator	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Patient Safety	Where non-delivery of activity indicates an adverse impact on patient safety this is investigated by the ICB Quality Team.
Financial – if yes, they have been assured by the CFO	The report provides a headline summary of finance and the financial strategy developed by the CFO with system partners.
Sustainability	N/A
Workforce / Training	The finance strategy is realistic about workforce availability and suggests a focus on retention of the people we have and replacing high agency use with substantive.

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**N**	
1b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		

1c	Were there any conditions? If yes, please state details and the actions in taken in response: • Condition 1 & action taken. • Condition 2 & action taken.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • Stage 2	**N**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		
2c.	***Please provide detail as to these considerations:*** • Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those? • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) • Explain any 'objective justification' considerations, if applicable		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**N/A**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N/A**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: **Note the contents of the Finance & Performance report.**			

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Report to the ICB Board on Finance and Performance

ICB Board Meeting – 16 March 2023

Executive Summary

The purpose of this report is to summarise the **key financial and operational performance issues for the ICB Board**.

Headlines

Finance

- The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) agreed a plan to break even over the financial year after flagging a number of risks. Net risk has reduced due to £6m as a result of the receipt of further non-recurrent income and growing confidence in the delivery of the year end position. It is essential to note that pressures still increase in both CHC and primary care prescribing however mitigations have been identified. A number of these mitigations utilise budgetary underspends, including non-recurrent underspends from allocations, and we continue to work under the assumption these will not be clawed back centrally.
- Nationally we understand that many ICBs are struggling to get to a break-even, and if we were to achieve this we believe that we would be in a minority. Our relatively strong position is down to a culture of transparency and collective working between all system partners, and a huge amount of hard work by our operational and clinical colleagues who are mainly managing within their budget.
- Whilst work is still being done to deliver balance in 2022/23, we have now reflected on the details of the national planning guidance and the allocations to understand the impact on the Staffordshire and Stoke on Trent system, with the draft financial plans submitted for 2023/24 on the 23rd of February. Work will continue with system partners and the regional team for the final submission on 30th March. Following on from the financial strategy that system CFOs have worked up collaboratively with system colleagues, finance leads are continuing to ensure that the financial approach is fully integrated with other system strategies.

Operational Performance by Exception – *please note that the below summary contains updated Urgent Care and RTT positions for February using the latest available operational information.*

- The pressure in **Urgent and Emergency Care** reduced in January to more normal levels for the time of year. The System in now back on track in line with the assumptions made in the Winter Plan and pressure is being managed. Acute hospitals saw a decrease from the exceptionally high numbers of patients with flu and Covid-19, however this still represents a point of significant pressure. Significant improvements have been made with hours lost due to ambulance handover delays and subsequently the impact of category 2 calls outstanding.
- It has been confirmed that the target to eliminate **78+ week** waits by the end of March 2023 will not be achieved. As at 19th February 1,144 ICB patients were waiting more than 78 weeks.
- **104+** week waits have also increased; 65 patients were waiting over 104 weeks as at 19 February compared to 44 at the end of December.
- Diagnostic activity decreased by 11.0% in December compared to November. Year to date 81.3% of 2019/20 activity is being delivered. The year end forecast is at 82.9% - a shortfall of 78,321 tests.
- Performance against the **Cancer 28 Day Faster Diagnosis Standard** in December increased to 65.1% - below the 75% standard again but increasing from November's 62.7%. Lower GI and skin pathway transformation is underway with performance improving in December for our patients across all providers and at UHNM.
- **Primary care:** The number of GP appointments is 100.9% of the plan year to date. GP FTE increased by 6.5% on November – the monthly FTE a year to date high; this is due in part to a higher number of ST2 trainees starting in December. Compared to December 2019, GP FTE is 2.9% higher.
- **Mental Health**: Inappropriate out of area bed days (for patients with acute mental health conditions) at ICB level is 133.3% above the plan as at Q2; this equates to 160 bed days compared to a plan of 120. The current demand exceeds the bed base available due to high levels of patient acuity and a limited number of female beds.

Supplementary information

Financial Position – Year to date

The general themes driving our financial position remain constant as previous months. These include: workforce vacancies, offset by CHC price & volume challenges and efficiency under-delivery. We continue to operate with a more favourable run rate position than expected due to a continuation of non recurrent favourable items falling into the position. Strong emphasis to close the efficiency gap remains, see following slide.

The deterioration in the YTD position was mostly driven by the increased costs relating to CHC and prescribing within the ICB position. This is an issue out of our control and something affecting regions across the country.

System	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	3,284.6	3,325.9	41.3	2,954.2	2,992.9	38.7
Pay	(879.9)	(890.0)	(10.1)	(789.8)	(799.8)	(10.0)
Non Pay	(495.7)	(528.6)	(32.9)	(445.3)	(474.7)	(29.4)
Non Operating Items (exc gains on disposal)	(26.4)	(24.2)	2.2	(23.7)	(22.3)	1.4
ICB/CCG Expenditure	(1,879.0)	(1,880.6)	(1.6)	(1,689.3)	(1,685.5)	3.8
Total	3.7	2.5	(1.2)	6.1	10.6	4.5
			0.0%			0.2%

ICB	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Allocation	1,879.0	1,879.0	0.0	1,689.3	1,689.3	0.0
Expenditure	(1,879.0)	(1,880.6)	(1.6)	(1,689.3)	(1,685.5)	3.8
TOTAL ICB Surplus/(Deficit)	(0.0)	(1.6)	(1.6)	0.0	3.8	3.8
			-0.1%			0.2%

UHNM	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	811.3	838.1	26.8	730.1	753.4	23.3
Pay	(482.6)	(487.2)	(4.5)	(432.7)	(437.5)	(4.8)
Non-Pay	(305.3)	(329.8)	(24.5)	(274.7)	(296.3)	(21.6)
Non Operating Items (exc gains on disposal)	(21.5)	(20.8)	0.7	(19.3)	(19.0)	0.3
TOTAL Provider Surplus/(Deficit)	1.9	0.3	(1.6)	3.3	0.6	(2.7)
			-0.2%			-0.4%

MPFT	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	470.9	479.4	8.5	423.8	434.4	10.6
Pay	(329.3)	(330.6)	(1.4)	(295.9)	(297.5)	(1.6)
Non-Pay	(137.6)	(144.5)	(6.9)	(123.1)	(130.1)	(7.0)
Non Operating Items (exc gains on disposal)	(2.2)	(0.7)	1.6	(2.0)	(0.8)	1.2
TOTAL Provider Surplus/(Deficit)	1.9	3.7	1.8	2.9	6.1	3.2
			0.4%			0.7%

NSCHT	Month 10 £m Plan	Month 10 £m YTD	Month 10 £m Variance	Month 9 £m Plan	Month 9 £m YTD	Month 9 £m Variance
Income	123.4	129.4	6.0	111.1	115.8	4.8
Pay	(68.0)	(72.2)	(4.2)	(61.2)	(64.8)	(3.6)
Non-Pay	(52.8)	(54.3)	(1.5)	(47.5)	(48.4)	(0.8)
Non Operating Items (exc gains on disposal)	(2.7)	(2.7)	(0.0)	(2.4)	(2.5)	(0.1)
TOTAL Provider Surplus/(Deficit)	(0.1)	0.2	0.3	(0.1)	0.2	0.3
			0.2%			0.2%

Urgent Care – Ambulance delays

	Indicator	Target	Period / Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	YTD to current month	Change on previous period	Y/E (Actual/FOT)	YTD monthly trend
Ambulance	Ambulance handovers @ UHNM (all Patients at UHNM)		Handover delays of over 60 minutes	1,400	874	1,495	1,561	1,022	1,376	1,717	1,567	1,606	1,003	13,621	▼	16,345	
			Variance to 19/20	1,390	857	1,442	1,472	992	1,342	1,656	1,506	1,301	923				
			Handover delays of over 30 minutes	2,398	1,969	2,439	2,496	2,101	2,273	2,566	2,374	2,368	1,935	22,919	▼	27,503	
			Variance to 19/20	2,080	1,540	1,828	1,348	1,445	1,586	1,689	1,471	802	775				
			Handover delays of over 15 minutes	3,558	3,824	3,778	3,653	3,659	3,518	3,636	3,629	3,507	3,629	36,391	▲	43,669	
			Variance to 19/20	1,360	1,299	1,057	367	861	607	386	277	-428	85				
	Response Standards (WMAS - all responses) Times in hh:mm:ss	00:07:00	Category 1 mean	00:09:25	00:08:32	00:08:58	00:09:08	00:08:54	00:08:59	00:09:29	00:09:39	00:10:17	00:08:53	00:09:18	▼		
			Time variance to 19/20	00:02:17	00:01:22	00:01:46	00:01:51	00:01:43	00:01:26	00:01:53	00:02:14	00:02:32	00:01:27				
		00:18:00	Category 2 mean	01:28:01	00:40:26	01:01:39	01:11:07	00:43:06	00:59:23	01:35:19	01:05:13	02:25:40	00:34:07	01:11:32	▼		
			Time variance to 19/20	01:14:55	00:27:47	00:47:48	00:56:59	00:29:32	00:45:42	01:20:52	00:49:39	02:08:47	00:21:04				
	Time Lost		Hours lost in total (Handover)	3,800	2,264	3,572	4,116	2,728	3,178	4,532	3,921	4,839	2,498	35,448	▼		

Ambulance Activity

The data on this slide is for the West Midlands Ambulance Service (WMAS) and, in terms, of response performance, reflects the services responses across their area of operation. The 'Time Lost' line is the total time WMAS lost to Handovers.

- Call volumes for WMAS during January reduced by 40% from the peak experienced during December 2023, falling to a level not seen since April 2021.
- Category 2 Response waits, after the first week of the New Year, reduced significantly and have continued at low levels into February with no current sign of previous post-lull surges.
- January saw a decrease in 60 minute + handover delays. At site level there was a decrease of 36% (on December) at Royal Stoke though almost 17% more conveyances, whilst County Hospital recorded a reduction in 60+ minute handover delays of 56% following December's surge from almost similar numbers of conveyances.
- At Burton Hospital there was a slight increase in EMAS conveyances during January, to 26.8%, from 24% [of ambulance arrivals] in December.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Urgent Care - Performance against NHS Constitutional Standards

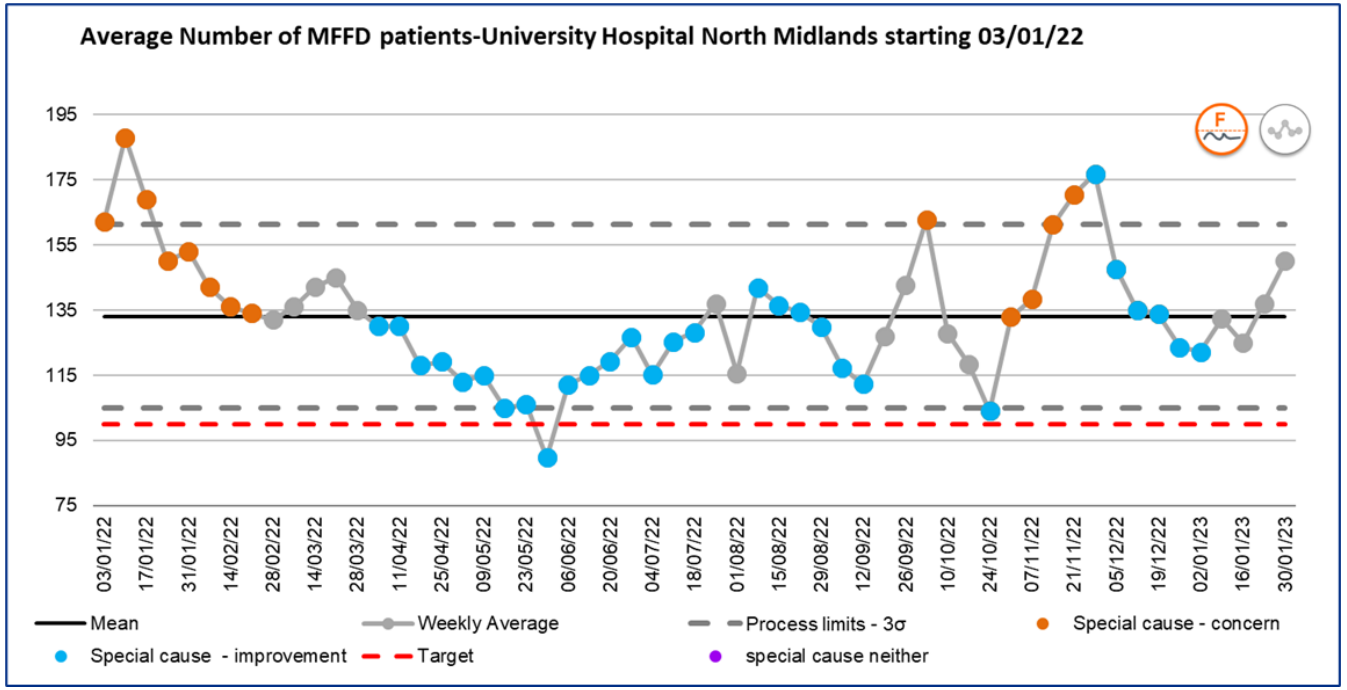
	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD	Change on previous period	Trend
A&E 4 Hour Performance (% seen in <4 hours)	University Hospitals North Midlands	95%	62.9%	62.8%	62.3%	63.4%	64.9%	66.0%	64.0%	62.9%	55.2%	62.6%	▼	
	University Hospitals Derby & Burton	95%	62.0%	64.2%	61.7%	62.4%	63.0%	62.5%	61.0%	61.3%	55.9%	61.5%	▼	
	The Royal Wolverhampton	95%	76.8%	79.5%	78.9%	80.4%	80.5%	79.3%	79.1%	73.5%	70.1%	77.4%	▼	
	University Hospitals Birmingham	95%	54.7%	54.6%	53.2%	49.8%	52.7%	52.1%	52.1%	51.1%	49.9%	52.3%	▼	
	The Dudley Group	95%	80.3%	74.7%	74.0%	75.6%	75.9%	75.0%	74.8%	72.5%	68.4%	74.5%	▼	
	Walsall Healthcare	95%	73.9%	72.3%	72.5%	72.4%	73.9%	74.5%	70.6%	72.8%	69.7%	72.4%	▼	

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD	Change on previous period	Trend
A&E 12 Hour Trolley Breaches	University Hospitals North Midlands	0	878	390	555	665	346	695	1028	947	1289	6793	▲	
	University Hospitals Derby & Burton	0	432	388	256	333	348	394	785	323	872	4131	▲	
	The Royal Wolverhampton	0	30	20	30	194	130	100	208	84	487	1283	▲	
	University Hospitals Birmingham	0	271	211	552	749	525	775	1384	1233	1830	7530	▲	
	The Dudley Group	0	31	79	49	67	90	95	129	20	67	627	▲	
	Walsall Healthcare	0	6	10	1	35	13	14	63	91	259	492	▲	

- Constitutional targets around 4 hour performance and 12 hour trolley breaches continue to be a challenge.
- Performance against both targets dropped in December, as a result of the extreme pressure and demand seen over the festive period. Urgent and Emergency Care demand has reduced to levels more typically seen at this time of year in January, so it is expected that January performance will improve on December.

Date Source: Performance data published by NHSE.
Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission, data published by NHSE. This is normal process.

Urgent Care – Medically Fit For Discharge



SPC analysis of key areas of focus at UHNM. Data period: 26th September to 12th February 2023

- Medically Fit For Discharge (MFFD) numbers stabilised at lower levels through January having reduced though December. Early figures for February indicate a period of higher numbers.
- Average weekly MFFD for RSUH has fluctuated through January and currently stands at 107 as of the 12th February, still above the target (of below 90).
- The latest values remain within the process limits and at the final point of record were above the mean and trending upwards.

Planned care

- The total RTT waiting list in December was 67% more than the 19/20 volume (or 59,874 patients).
- **28 day waits (faster cancer diagnosis standard (FDS)** performance for December is 65.1%, the third consecutive increase yet remaining below the 75% standard. Some further improvement is expected in January based on provider positions, with UHNM reporting their January position as 67.4%.

	2019/20									2022/23									YTD 1920 v YTD 2223				Y/E (Actual/FOT)		
Indicator	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	19/20	22/23	% Var	Trend	19/20	22/23	Below 19/20?
RTT - admitted, completed	5,423	5,794	5,427	6,076	5,440	5,599	6,247	5,818	5,100	4,143	5,107	5,004	4,801	4,766	4,775	5,173	5,510	4,358	50,924	43,637	-14%		66,046	58,183	Yes
RTT non-admitted, completed	21,951	23,159	21,735	24,049	21,320	22,606	25,314	23,282	20,641	19,410	22,194	20,723	20,294	22,400	22,067	22,722	24,728	19,707	204,057	194,245	-5%		268,666	258,993	Yes
Incomplete Pathway - Total Waiting List	85,296	86,968	87,398	89,266	90,289	89,986	89,297	89,788	88,771	144,518	146,503	148,018	150,901	150,307	150,584	150,849	149,380	148,645	88,771	148,645	67%		88,982	152,413	No
Incomplete Pathway - 52+ Weeks	0	1	1	0	0	1	0	0	0	8,415	8,550	8,498	8,920	8,926	9,164	9,246	9,287	9,559	0	9,559			11	9,946	No
Incomplete Pathway - 78+ Weeks	0	0	0	0	0	0	0	0	0	2,041	1,828	1,488	1,420	1,351	1,368	1,296	1,284	1,494	0	1,494			0	1,011	No
Incomplete Pathway - 104+ Weeks	0	0	0	0	0	0	0	0	0	445	235	64	59	85	69	41	37	44	0	44			0	0	No
GP and other (non-GP) referrals first consultant-led outpatients3	35,448	36,394	34,198	37,420	33,230	33,854	36,836	35,056	30,255	34,894	38,797	36,348	36,202	37,130	35,793	38,173	38,551	32,337	312,691	328,225	5%		406,751	437,633	No
Cancer 28 days FDS - Total Patients Diagnosed	1,510	1,945	1,858	2,015	2,723	3,102	3,527	3,382	3,322	4,564	5,017	4,653	5,139	5,487	5,600	5,380	6,004	4,571	23,384	46,415	98%		33,199	61,887	No
Cancer 31 day Treatments	539	524	523	591	526	560	614	563	529	550	546	615	586	625	635	547	609	545	4,969	5,258	6%		6,672	7,011	No

Updated RTT position as at 12 February (data is weekly)

- 52+ week waits: 9,132 across all providers, of which 4,817 are at UHNM and 348 at the Independent Sector providers. The ICB and UHNM totals are a decrease on the position as of the previous week, the ICB total decreasing by 123. Decreases are driven by the 65+ wait band. Independent Sector Provider (ISP) 52+ week waits have increased by 14 on the previous week. 52+ week waits at UHNM remain on an upward trajectory but across January and February weekly growth has reduced.
- 65+ week waits: 3,501 across all providers, of which 2,014 are at UHNM and 73 at the Independent Sector Providers. Each total a decrease on the previous week since the start of January. At UHNM 65+ week waits have declined for the last 3 consecutive weeks.
- 78+ week waits: 1,228 across all providers, of which 773 are at UHNM and 19 at the Independent sector providers. The volume in the Independent Sector is focused at Nuffield Health North Staffordshire, where 26 have now waited 78+ weeks. The ICB total remains on a downward trend; weekly decreases across February have helped to drive this.
  - The forecast at UHNM (trust-wide) is for 704 patients to be waiting >78 weeks at the end of February. 8 patients are forecast be waiting >78 weeks at the end of February at our ISPs. Please note this data is not a final position and will change.
- 104+ week waits: 64 across all providers, of which 62 are at UHNM, 1 at UHB and 1 at another NHS Provider. A small decrease of 4 on the previous week.
- UHNM forecasts 8 patients to be waiting >104 weeks by the end of March, all due to complex pathways..

Date Source: SUS and Performance data published by NHSE. Time Period: Note the data is subject to a 2 month 'lag' for Provider re-submission data published by NHSE. This is normal process.
Y/E Actual/FOT: When year end actual position is yet available, estimated FOT is used: RTT waiting list FOTs are calculated using linear regression; Other metrics are derived by applying the current YTD monthly average to the entire financial year.

Planned care and Cancer – Month 9

Indicator	2019/20 Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	2022/23 Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 1920 v YTD 2223 19/20	22/23	% Var	Trend	Y/E (Actual/FOT) 19/20	22/23	Below 19/20?
Elective Ordinary Spells	1,537	1,770	1,663	1,751	1,613	1,577	1,829	1,739	1,445	1,213	1,410	1,441	1,331	1,317	1,399	1,454	1,548	1,444	14,924	12,557	-16%		19,137	16,743	Yes
Day cases	12,887	13,222	12,309	13,665	12,486	12,763	13,753	13,321	12,050	10,844	12,466	12,207	12,073	12,318	12,285	12,773	13,503	11,761	116,456	110,230	-5%		152,523	146,973	Yes
Outpatient procedures (Cons Led)	13,708	14,216	13,744	15,297	13,588	14,194	15,246	14,193	12,611	10,411	12,200	11,169	11,219	11,778	11,996	11,288	12,488	10,142	126,797	102,691	-19%		164,216	136,921	Yes
Outpatient first attendances without a procedure (Cons Led)	26,313	27,224	25,683	28,824	24,826	27,192	29,681	27,507	24,620	23,166	27,884	26,687	25,552	26,693	27,974	29,460	31,852	24,862	241,870	244,130	1%		317,277	325,507	No
Outpatient follow-up attendances without a procedure (Cons Led)	43,191	45,665	42,944	48,318	42,218	45,885	50,110	46,857	39,981	38,223	44,412	41,593	38,851	41,800	42,424	45,348	48,709	37,745	405,169	379,105	-6%		535,884	505,473	Yes
Diagnostic Tests (Specific 7 Tests)	37,950	39,669	39,235	40,563	37,767	37,914	40,824	39,753	36,898	29,625	32,536	30,406	31,850	32170	32103	32818	33641	29944	350,573	285,093	-19%		458,445	380,124	Yes

Elective Activity

- Year to date, elective ordinary spells, day cases and outpatient procedures remain below the volume in 2019/20
- In month, elective ordinary spells, day cases and outpatient procedures in December 2020 are below December 2019 levels
- Outpatient first attendances have exceeded 2019/20 activity levels by 1% year to date.
- Outpatient follow-up attendances have decreased by 6% year to date. The national target is to reduce follow-up attends by a minimum of 25% against 2019/20 activity.

Diagnostics

- Diagnostic activity decreased by 11.0% in December compared to November, and year to date is 19% below activity levels at this point in 2019/20.

*Note: The current Year End FOT is set to be **below** the 19/20 FOT for the above indicators (with the exception of outpatient follow-up attendances). This indicates that activity must increase for Elective Ordinary Spells, Day Cases, Outpatient and Diagnostics if the 2019/20 volume [target] is to be met.*

Primary Care Summary

Indicator	Currency	Q1			Q2			Q3			YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22				
Appointments in General Practice	Count	423,294	484,394	448,258	455,173	470,805	501,940	571,228	556,735	469,981	4,381,808	5,875,116	▼	
	% to Plan	99.4%	114.6%	93.5%	98.8%	108.5%	93.3%	100.3%	99.6%	103.1%	100.9%	103.2%	▲	
	% to 19/20	99.6%	111.1%	108.8%	97.5%	116.4%	105.1%	104.9%	116.3%	112.7%	107.9%	109.3%	▼	

Appointments in General Practice:

- Appointment activity in December was 3.1% above the plan (equating to 14,090 appointments), and remains above that delivered in 2019/20, for the fifth consecutive month.
- Year to date the ICB is delivering 100.9% of the plan (39,995 more appointments).
- Overall activity in December is lower due to bank holidays and reduced demand for routine appointments.

Indicator	Targets / Variance	Q1			Q2			Q3			Q4	YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23				
Total number of social prescribing referrals (cumulative)	*Cumulative target Q1: 3365, Q2: 6730, Q3: 11,780, Q4 16830*	3,103			6,692			9,991			12,120	12,120	13,611	▲	
Learning Disabilities annual health checks (quarterly targets) cumulative data	*Targets: Q1 12.29%, Q2 31.0%, Q3: 49.8%, Q4: 75%*	12.0%			29.4%			50.0%			59.0%	59.0%		n/a Cumulative	
Antimicrobial resistance: total prescribing of antibiotics in primary care	0.871	0.989	1.003	1.008	1.013	1.019	1.013	1.013	1.024			1.024	1.038	▲	
	Variance to 19/20 (rate)	-0.063	-0.046	-0.037	-0.033	-0.027	-0.034	-0.032	-0.019			-0.019		▲	

Y/E Actual/FOT: Estimated by applying linear regression

- **Social Prescribing referrals** (cumulative): Q3 is below target (by 1,789 referrals).
- **LD Annual Health Checks** (cumulative) : Q3 is 0.2% above the 49.8% quarterly target (end of year minimum target of 75%).
- **Antimicrobial Resistance:** the rate increased in November and remains above the target set for our ICB, an adverse position. Performance is likely to be impacted in December, based on support being provided for the asylum seeker population and a very high increase in prescribing of antibiotics due to Strep A. Year end FOT indicates that this target will not be met.
- Although the trend looks unfavourable, the overall level of prescribing of antimicrobial drugs currently is less than for the same period during 2019/20 (pre-covid year has been chosen as an appropriate period for comparison).

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			Q4	YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23				
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days - ICB level	Count	15			160							175	1,050	▲	
	% to Plan	8.3%			133.3%							175.0%	291.7%	▲	
	% to 19/20 (count)	12.5%			65.3%							145.8%		▲	
	Provider wide actual - NSCHT*	0	0	0	25	40	55	20	0			140	420	▼	
	Provider wide actual - MPFT*	85	260	235	305	345	270	275	225			2000	3,000	▼	
Total access to IAPT services	Count	6,025			5,935			2,020	2,800			16,780	31,009	▲	
	% to Plan	75.5%			70.9%							75.9%	91.6%	▼	
	% to 19/20 (count)	116.4%			110.4%			70.0%	97.1%			118.9%		▲	
Estimated diagnosis rate for people with dementia	Count	10,157			10,476			10,586				10,586	11,075	▼	
	% to Plan (numerator)	102.8%			105.2%			105.8%				105.8%	109.8%	▲	
The proportion of CYP with ED (**routine** cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <4 weeks	78.3%			77.8%			80.0%				80.0%	75.0%	▲	
	Variation to plan (rate)	-0.5%			0.5%			-6.2%				-6.2%	-19.9%	▼	
	Variation to 19/20 (rate)	-13.9%			-13.7%			-14.4%				-14.4%		▼	
	Variance to National Target (95%)	-16.7%			-17.2%			-15.0%				-15.0%		▲	
The proportion of CYP with ED (**urgent** cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Percentage <1 week	91.7%			98.1%			97.9%				97.9%	100.6%	▼	
	Variation to plan (rate)	8.3%			13.9%			7.9%				7.9%	0.6%	▼	
	Variation to 19/20 (rate)	-0.6%			-1.9%			-2.1%				-2.1%		▼	
	Variance to National Target (95%)	-3.3%			3.1%			2.9%				2.9%		▼	

Metrics by Exception

- Out of Area bed days (at ICB level) remain above plan in Q2, by 133.3% - 160 bed days to a plan of 120. Current demand exceeds the bed base available due to high levels of patient acuity and a limited number of female beds.
  - **note that Provider data includes all patients not just SSoT and is rounded by NHSE to the nearest 5 and must be used as an indicative guide only.*
- Access to IAPT Services is at 70.9% of plan in Q2, 5,935 contacts against a plan of 8,367. Activity in November (2,800 contacts) is a marked increase on 2,020 in October.
- The estimated diagnosis rate for people with dementia is above the plan in Q3 .
- The national target for CYP eating disorder services for routine cases has not been met again (80.% seen within 4 weeks against the target of 95%), however improvements are noted.
- The national target for CYP eating disorder services for urgent cases was exceeded again in Q3 (97.9% seen within 1 week against the target of 95%).

Data Source: Performance data published by NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.
Note re. CYP eating disorders (ED) data; the source is the initial cut of the data direct from NHSE/D and remains consistent (as a source) across the financial year. This may not match the published data as that is often subject to change and has a time lag.

Mental Health Summary

Indicator	Currency	Q1			Q2			Q3			YTD	Y/E (Actual/FOT)	Change on previous period	Trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22				
People with severe mental illness receiving a full annual physical health check and follow up interventions	Count	3,697			3,801			3,976			3,976	4,104	▲	
	% to Plan	112.4%			102.5%			87.5%			87.5%	73.8%	▼	
	% to 19/20 (count)	141.1%			149.1%			149.6%			149.6%	152.7%	▲	
Women Accessing Specialist Community Perinatal Mental Health Services	Count	305			450			520			520	681	▲	
	% to Plan	85.4%			83.6%			71.1%			71.1%	76.0%	▼	
	% to 21/22 (count)	95.3%			97.8%			89.7%			89.7%	96.6%	▼	
Access to Individual Placement and Support Services	Count	345			460			550			550	733	▲	
	% to Plan	156.6%			104.4%			83.2%			83.2%	83.2%	▼	
	% to 19/20 (count)	328.6%			270.6%			224.5%			224.5%	225.6%	▼	
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Count	10,560			11,040			10,895			10,895	11,507	▼	
	% to Plan	93.9%			97.7%			96.0%			96.0%	100.0%	▼	
	% to 21/22 (count)	102.5%			111.6%			106.7%			106.7%	110.3%	▼	
Access to Children and Young People's Mental Health Services	Count	14,885			14,945			14,785			14,785	15,268	▼	
	% to Plan	75.2%			74.8%			72.9%			72.9%	75.5%	▼	
	% to 21/22 (count)	121.9%			114.4%			107.9%			107.9%	105.4%	▼	

Metrics by Exception

- Severe Mental Illness (SMI) annual health checks – The year end forecast remains well below the plan, impacted by Q3 where activity fell to 87.5% of the planned value. However activity is considerably higher than 19/20 levels. A range of actions have been put in place to restore activity levels.
- Perinatal Access – Decrease in activity in Q3 as referrals reduced and DNAs increased around December - this is a consistent seasonal pattern. Additionally the service has been affected by staff sickness. At current activity levels the plan is forecast not to be met at year end.
- Access to Individual Placement and Support Services is, in Q3, delivering below the plan – a marked decline on Q2, although activity continues to exceed 2019/20 levels.
- Overall Access to Core Community Mental Health Services (for Adults and Older Adults with Severe Mental Illnesses) is below plan in Q3 but well above 2021/22 levels.
- Access to Children and Young People's Mental Health Services is forecasted to be below plan YTD as activity declined in Q3. Activity is at 72.9% of plan.

Notes:

- *(*) Where metrics do not have a FOT they either do not have a plan or they are a combination of monthly data and quarterly plans therefore it is not possible to generate a linear forecast*
- *Overall Access to Core Community Mental Health Services for Adults and Older adults with Severe Mental Illnesses and Access to Children and Young People's Mental Health Services continue to be impacted by the move to ICBs. NHS Digital are working on getting the data for August and September into next month's publication of the MHSDS.*
- *Published First Episode Psychosis treatment data is currently withheld because the data has yet to be released by NHS Digital in a usable format (being only available at Sub-ICB level and rounded to the nearest 5/ suppressed where values fall below 5).*

Data Source: Performance data published by NHSE. Time Period: Note that Mental Health data is updated in different intervals to performance and activity data. This data is presented from the most recent [data] available.

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Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 8th February 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Board Assurance framework (BAF)	The Committee received the full BAF for Quarter 3, which had been updated by the BAF Risk Owners. Risk three maps to the Strategic Objective, Better Quality for all Patients and Service Users, which is overseen by the Quality & Safety Committee. Risk three has been reduced from a total of 16 to 9 and remains on track to deliver the target score of 9 by the end of Q4, with no additional actions required.	
Risk Register	The quality team have identified the top three risks: **Risk 032;** Maternity and Neonatal Workforce – current risk score 12 Risk has been reviewed by the LMNS team, due to the risk being clinical vacancies which are impacting on operational pressures. Newly qualified midwives are now in post but the impact of this has not yet been realised. **Risk 089;** Inductions of labour – current risk score 12 This is being monitored daily via the provider sit rep and is supported through system escalation as required. An improvement work stream has been established in UNHM and includes the LMNS and NHSE. This risk has recently been reviewed by LMNS Board where it was recognised there had been significant improvement in the IOL pathway, however the changes were yet to be embedded. **Risk 108**; Ivetsey Bank (independent hospital) – current risk score 12	In relation to Risk 108 there were further concerns re CAMH's pathways and the transition of Looked After Children to adult services. Futher work was requested to be brought back to the committee in March.
Assisted Conception Patient & Public Involvement Plan	The Committee reviewed the draft involvement plan and questionnaire and to advised on any additional information or questions should be included.	

	Approved the documentation for the launch of the involvement exercise	
NHS Continuing Healthcare (CHC) Fast Track Referral Process	The Committee approved the proposal to continue with the use of the Transfer of Care (ToC) for Fast Track referrals with the caveat that this position is reviewed in six months rather than the proposed annual review.	
Update on Ambulance Delays and Serious Incidents	A verbal update as given. Assurance was given in regard to a closer working with WMAS when reviewing serious incidents.	
Quality Impact Assessment (QIA)	The Committee received the update report and approved the QIA Policy	
Local Maternity & Neonatal System	The paper updated the Committee on the current challenges, risks, and issues in Maternity and Neonatal services in Staffordshire and Stoke-on-Trent LMNS. It highlighted the risks, mitigations, and any gaps in assurance Overall the position has improved at UHNM, which is pleasing to see but must be sustained. There were still issues to be addressed at UHDB. The Committee was assured that the ongoing issues are being managed by the Trusts and supported by the ICB team	
Continuous Quality Improvement	The Committee received and noted the updates demonstrating the work being undertaken within the CQI Sub-Group.	It was suggested that a discussion take place at Board in relation to how to best develop a collective and shared understanding of CQI
System Quality Group (SQG)	SQG met in February 2023 with partners from across the health, social care, and wider ICS in attendance. Intelligence, identification of opportunities for improvement and concerns/risks to quality are discussed to enable on going improvement in quality of care and services across Staffordshire and Stoke-on-Trent. The Committee ratified the terms of reference for the Patient Safety Incident Response Framework (PSIRF) System Implementation Group.	
Staffordshire Safeguarding Children's Board Annual Report 2021-22G)	The Committee received the Staffordshire Safeguarding Children Board Annual Report 2021/2022 for information	
Staffordshire & Stoke-on-Trent Adult Safeguarding Partnership Board Annual Report 2021 – 2022	The Committee received the report for information	

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

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Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 8th March 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Board Assurance framework (BAF)	The Committee received the BAF highlight report. There had been no formal changes to the BAF risk scores.	
Risk Register	The Committee receive the Risk Register for discussion and assurance. After some discussion, the Committee approved the closure of the risk 101 "System Care Home Resilience" as this was related to COVID outbreaks and IPC measures. It was highlighted that this longstanding risk has been replaced with two relating to the current challenges regarding IPC which are risks 90 and 91..	.
NHS Continuing Healthcare (CHC) Deep Dive	The Committee received the report, discussed the actions already taking place and supported the further recommended actions.	
Delegated Commissioning – Pharmacy, Optometry and Dentistry (PODs)	The Committee received the report which had also been to the Audit Committee and Finance and Performance this month. The Committee supported the recommendations to accept delegated responsibility as outlined in the paper in line with national policy. However, it requested further discussions about the risks and issues as they emerged.	
Stoke-on-Trent Joint Commissioning Strategy for children and young people with Special Educational Needs and Disabilities (SEND) 2023 - 2028	The Committee reviewed the Stoke-on-Trent Joint Commissioning Strategy for Children and young people with SEND 2023-2028 and approved the strategy for ratification at the ICB Board meeting in March 2023.	
Freedom to Speak Up Policy (FTSU)	The Committee received and approved the FTSU policy with some minor amendments. However, there was significant discussion about the appropriateness of a Director as FTSU Guardian and the role of the Independent NED's. The Director of	

	Corporate Governance outlined discussions held with HR and the Champion about whether there should be an additional Guardian to enable choice and agreed to facilities further conversations to agree an appropriate way forward. Further work is underway regarding the delegations of Primary Care to the ICB.	
Your Next Patient	The deep dive provided the background to the Your Next Patient initiative at University Hospitals of North Midlands. The paper provided information and assurance in relation to the associated risk assessment and standard operating procedure.	
Local Maternity & Neonatal System	The paper updated the Committee on the current challenges, risks, and issues in Maternity and Neonatal services in Staffordshire and Stoke-on-Trent LMNS. It highlighted the risks, mitigations, and any gaps in assurance Significant work is ongoing and are discussed in more detail in the Board Quality and Safety Exception Report. It was agreed that the Committee would like to see more focus on the voices of patients and families in relation to maternity services. This work will feature more prominently in future reports The Committee gained assurance that the ongoing issues are being managed by the Trusts supported by the ICB team	
Safeguarding Quality and Safety Exception Report	This paper provided detail and assurance to the Committee in relation to the key system quality and safety matters with regards to Safeguarding Adults and Children for Staffordshire and Stoke on Trent for the period of September 2022 – February 2023. The ongoing recruitment to the vacancies in the team were noted as an area of concern that was being addressed.	
Stoke-on-Trent Safeguarding Children Partnership – Annual Report 2021/2022	The Committee received Stoke-on-Trent Safeguarding Children Partnership Annual Report 2021/2022 for information	
Infection Prevention and Control (IPC) update report	The Committee received the update report for assurance.	
Health Economy Infection Prevention &Control Group, Terms of Reference	The Committee approved the terms of reference.	
System Quality Group (SQG)	SQG met in March 2023 with partners from across the health, social care, and wider ICS in attendance. Intelligence, identification of opportunities for improvement and concerns/risks to quality are discussed to enable on going improvement in quality of care and services across Staffordshire and Stoke-on-Trent. The Committee received the report for assurance.	

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

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	7 February 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register and BAF	The Committee was asked to receive the Risk Register for assurance, note the inclusion of one new risk and changes in risk scores. They were also asked to approve the closure of 6 risks. The Q3 BAF was received for assurance.	A discussion took place on the top risks to be highlighted to the Committee, the link to partner organisations' Risk Registers and whether ICB and System risks need to report separately. Executives are examining this and will discuss this further with NEDs. The proposal to reduce the ambulance handover delay score from 25 to 20 was discussed and the Committee agreed that the score should remain at 25.
Performance Report	The Committee received detailed data reports including months 7 and 8 data focusing on Primary Care, Urgent and Emergency Care, Mental Health, Electives and Cancer. Information on performance against NHS Constitutional Standards was included in the papers.	The Committee discussed the importance of building on the demand and capacity work to help with the delivery of the elective programme and requested that the interventions being undertaken to reduce future bed gap be included in the performance reports.
ICS Finance Report	The report provided details of the current financial performance of the System, risk adjusted outturn and progression on the development of the financial strategy. There continue to be uncertainties around staff absence, Covid prevalence, excess inflationary pressures and the continuing growth in activity, acuity and package prices within CHC. Prescribing in Primary Care is deteriorating related to inflation issues in price and no cheaper generic stock being available.	Formal reporting of an ICS breakeven forecast, the current projection of risk against the breakeven target and the actions being taken to mitigate the remaining £12m risk.

System Savings PIPs 22/23 Progress Update	The Committee noted the contents of the report, in particular Long-Term Conditions, and the plans being developed to help this progress. The appendix to the report summarised the project type for each of the schemes e.g. cost saving, cost avoidance etc.	A Q3 review of all PIP metrics will be presented to the March 2023 Committee meeting.
Adult social care key issues	The Directors of Public Health from Staffordshire County Council and the City of Stoke-on-Trent presented the paper. Key challenges and opportunities were highlighted including working in a more coordinated way for complex patients.	
Planning Round Overview	The report summarised the national planning guidance published on 23 December 2022 and the approach and progress of the development of the 2023/24 Operational Plan and Five Year Joint Forward Plan (JFP).	
Workforce Update	The paper provided a deep dive into delivery of the operational and workforce plans for 2022/23 and the planning in place for 2023/24 including the interventions which will be required to provide ongoing support to the delivery of the workforce plan.	The Committee discussed the actions being put into place to achieve better productivity e.g. digital solutions and having the right staff doing the right tasks in the various organisations.
Digital Update	The 11 key System digital initiatives for the next 3 years were presented. The Committee recognised the importance of digital work in the delivery of some of the transformation programmes and the workforce productivity piece as there was potential in terms of technology and skills development.	
System Transformation and Service Change Update	The Committee received the monthly overview of the clinical areas included within the System Transformation and Service Change Programme and specifically an update on the relocation of the 2 GP Practices and MIU in Cannock.	The Primary Care Team continue to work with the Local Authority to find appropriate accommodation in Cannock for each of the services and work is also taking place with wider partners on the long term vision for the regeneration of Cannock town centre.
ICB Month 9 Financial Position	The Month 9 report set out the year to date and forecast outturn position.	The Committee noted the forecast of a break even risk adjusted position with a “most likely” forecast being a (£6.3m) deficit and was assured of the ongoing approach to identifying mitigations to achieve a breakeven

2023/24 Financial Planning Update		position. The challenges in achieving this were the fluctuation in prescribing affecting the position and increased CHC costs. The Committee noted that in terms of statutory duties, we are achieving the Mental Health Investment Standard (MHIS), our running cost targets and meeting the Better Payment Practice targets.
2023/24 Financial Planning Update	The report set out the financial challenge the ICB faces during 2023/24 and the steps the ICB has agreed to address the current position. The Committee discussed the construct of the Intelligence Fixed Payment System (IFPS) and the role of all partners in managing the System deficit for 2023/24.	ICB is seeking a 5% efficiency target on the controllable spend which will be very challenging. The targets for CHC and prescribing are significant and around £10m each. The Committee discussed the management of CHC packages and requested a report on the work regarding market sustainability be presented to a future Committee meeting.
ICB Procurement Operations Group Report	The monthly update contained a section on governance regarding the ICB Financial Scheme of delegation and an overview of the current procurement programme. Single Tender Waiver for the Complex Case Panel Funding was approved. Update on the current programme of procurements.	The Committee approved the communication to staff on the Scheme of Delegation to provide clarity for approval routes.
Continuing Healthcare Deep Dive	Detailed report on the factors impacting on the NHS CHC. The actions being taken in response to the volume increase and number of high cost packages were discussed, including: • A review of high cost packages • Collaborative work with the Local Authorities • Conversations with Providers around market stimulation regarding the supply of care home beds • Further examination of the service provided by the CSU	Deep dive provided assurance regarding understanding the issues driving the rise in costs of CHC. Further updates will be provided regarding how the ICB will improve management controls over CHC in light of benchmarking and areas of concern highlighted in the report and work to develop the care home market in Staffordshire and Stoke-on-Trent.
Consultancy - Interim Director of Urgent Care	The paper provided an update on the engagement of interim capacity in respect of Urgent and Emergency Care (UEC).	
Midlands and Lancashire Commissioning Support Unit – 2023/24 Service	This was an update to the paper presented to the Committee in January 2023 on the joint service review of the Midlands	The Committee noted the additional information in the report and was assured of the process that has been run to date and that will continue to

Review Updates	and Lancashire Support Unit (MLCSU) main contract and the associated services.	develop as more information becomes available from the back office workstream programme.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions which took place at the Committee. Assurance provided on work to understand drivers of CHC overperformance. Further assurance required on effectiveness of CHC management controls.

Staffordshire and Stoke-on-Trent Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	7 March 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register and BAF	The highlight report informed the Committee that there had been no formal changes to the BAF risk scores and no exception reports had been received. A high level outline of the process for closing down the 2022-23 BAF and developing the 2023-24 BAF was presented. The Committee was asked to receive the Risk Register for assurance, note the changes in risk scores and approve the closure of 2 risks. The committee has good sight of the top risks for finance, performance and transformation.	
System Planning Update Joint Forward Plan	The Committee discussed the draft planning submission activity ambitions, the finance storyboard and development of the broader system plan for 2023/24. Committee approved the 'triangle' narrative, with the collective goal to reduce incidence of harm in the community and accompanying metric. The paper provided a summary of the next steps on the Joint Forward Plan.	Draft financial submission shows a system deficit of £123m which includes significant risk and an efficiency programme of £112m (5.1% of influenceable spend). Board to note 4 areas of non-compliance with national recovery ambitions: Cost weighted activity Elective Recovery Fund Reduction of 52 week waits Elimination of 65 week waits Board to note non-compliant capital plan.
Performance Report	The Committee received detailed data reports including	Performance against 78 and 104 week waits present a challenge to

	month 9 data focusing on Primary Care, Urgent and Emergency Care, Mental Health, Electives, Diagnostics and Cancer. Information on performance against NHS Constitutional Standards was included in the papers.	the system.
ICS Finance Report	The report provided details of the current financial performance of the System, risk adjusted outturn and progression on the development of the financial strategy. Capital is forecast to achieve plan but medium-term challenges remain.	ICS breakeven forecast with actions taken to mitigate £6m risk. The mitigations are likely to be non-recurrent leading to a significant challenge in 2023/24. Risks in relation to junior doctors' strike highlighted.
System Savings PIPs 22/23 Progress Update	Q3 PIP performance review outlined areas of success and challenge to date. Work is underway with Portfolio Directors to determine what a productivity and efficiency strategy looks like for each Portfolio in 2023/24.	Fundamental review of PIP governance and process requested to sit alongside review of future PIP programme.
Staffordshire Mental Health & Wellbeing Strategy	The Committee was asked to review the new joint Staffordshire Mental Health and Wellbeing Strategy and approve the strategy for ratification at the March ICB Board. A separate strategy is being developed with the City of Stoke-on-Trent.	Strategy approved to go forward to Board.
System Transformation and Service Change Update	Key points to note were: • The launch of public consultation on 9 February for Inpatient mental health services previously provided at the George Bryan Centre • Progress against Cannock transformation programme • Amendment to timeline for submission of Community Diagnostic Centre business case to NHSE • Alignment of transformation programmes to Portfolios	Positive engagement with Cannock Chase Council regarding a potential site for 2 GP surgeries, the urgent care offer and the mobile MRI unit, with a temporary modular building delivered by the September deadline. Council Members also agreed to consider the longer term joined up strategic options for integrated services in Cannock.
General Practice Five Year Strategy	Strategy sets out the direction of travel for general practice for the next five years. Strategy will be further refined prior to submission to Board.	
Capital Update/Estates	Capital Investment Group	23/24 target is yet to be determined,

Update	update, outlining progress against the main capital schemes and estate priorities for 2023/24. • Successful bids in frontline digitisation and Greener Decarbonisation • PDC monies received for mental health dormitories Estates rationalisation hopes to achieve £997k in 2023/24. Project extended to include MPFT and NSCHT to reduce duplication in community and primary care assets.	however, given the financial challenges within the system a provider collaborative approach is preferred. Any movement of clinical services that involve direct patient care would be subject to equality and quality impact assessment
ICB Month 10 Financial Position	Committee was assured of the ongoing approach to identifying mitigations to achieve a breakeven position.	Forecast of breakeven is a risk adjusted position with a 'most likely' forecast of £3.8m deficit.
2023/24 ICB Financial Plan and Initial Budget Setting Proposal	Initial budget based on the draft financial plan of a £85.0m deficit was approved. The Committee was assured of the next steps the ICB is taking to deliver this challenging financial plan and further mitigate the deficit position. CHC action plan will come to April Committee.	ICB breakeven forecast position for 2022/23 is heavily supported by non-recurring mitigations which means our exit position is an underlying £136m deficit. As a result of a 2% efficiency programme (5.0% against influenceable expenditure), the ICB is planning to reduce the underlying expenditure by 3.6% in year one of the financial strategy.
Delegated Commissioning – Pharmacy, Optometry and Dentistry (PODs)	Delegation is national policy. Risks and opportunities outlined. Dentistry considered to be highest risk, specifically: patient access; workforce; complex payment system and quality. Further work will take place in 2023/24 to fully understand risk and service provision in SSoT, and shape services going forward. Governance arrangements locally not yet fully developed.	Approval to go forward to Board. Committee recommended if the ICB Board approve the delegations, they should write to NHSE setting out that whilst the Board approved the decision, there was a lack of clarity available at the time about the risks and issues the ICB would be taking on.
Adult Attention Deficit (Hyperactivity) Disorder (ADHD) Services – Single Tender Waivers	The Committee approved two Single Tender Waivers (STW) for two independent providers providing Adult Attention Deficit (Hyperactivity) Disorder (ADHD) assessments as the amounts exceed the delegated authority of the CFO.	A paper on a proposed pathway redesign will be presented to April meeting.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussions which took place at the Committee. Significant risk highlighted regarding deliverability of the draft financial submission and activity targets, and POD delegation.

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Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Sally Young/Paul Brown
Date:	6th March 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Management	In its' role of providing assurance to the Board regarding the robustness of risk management arrangements, the Committee reviewed both the BAF and the latest Risk Register. Significant progress is being made in refining these documents. Both reports demonstrated review of risks by Finance and Performance and Quality and Safety Committees. The timing of Committee dates has meant that the People and Culture Committee did not meet until after Audit Committee, although the Audit Chair can confirm that there was robust consideration at the meeting on 8th March. Audit Committee challenged the proposed reduction of BAF Risk 6 relating to the reduction of Health Inequalities solely on the progress being made to develop strategy and engagement. The Committee also asked for greater clarity in the covering report regarding the reasons for the proposed closure of risks	Further work ongoing to: -develop the 2023/24 strategic priorities and BAF Risks -align system risks -review the rating of BAF Risk 6 which is likely to roll forward into 2023/24 -consider the process for the sub-Committee review of risks to ensure that there is a focus on transformation -amend the covering report to provide greater clarity regarding the closure of risks
Finance	In accordance with the agreed Procurement Policy, it was agreed to extend the contract with the CSU.	This contract will be subject to ongoing review
Internal Audit **- Reports** **- 2022/23 Draft Internal Audit Opinion** **-2023/24 Internal Audit Plan**	The Progress report from RSM was discussed and particularly to understand the tracking of recommendations where extensions have been requested. Three reports were received. These were: -**Continuing Health Care and Personal Health Budgets** (Partial Assurance). There was significant discussion on this report which focused on specific areas of concern which had	Detailed work has been requested on Continuing Health Care and Personal Health Budgets by the Finance and Performance Committee which will ensure added scrutiny to these significant budgets.

	been highlighted to RSM. Assurance was received around the actions being taken to strengthen these arrangements in the context of a key member of staff leaving the organisation. -**ICS Cyber Security Risk Assessment** (Reasonable assurance). MPFT, NSCHT and the ICB have a shared service group for the purpose of providing information, communication and technology services. RSM noted several controls in place to protect information and made recommendations to further improve control. **People Hub mobilisation and onboarding-**(Reasonable assurance). MPFT host this service for the system and RSM undertook an audit to provide assurance. RSM noted a considered framework of control and made recommendations to further improve arrangements **2022/23 Draft Head of Internal Audit Opinion-**The Committee were pleased to receive the draft opinion demonstrating adequate and effective frameworks of Internal Control, Risk Management and Governance arrangements within the ICB. **2023/24 Internal Audit Plan**- The committee considered and agreed the plan which includes a balance of audits to give assurance around financial controls, data quality, service quality, risk and governance.	Follow up Audits will take place to ensure that recommendations are implemented on these audit recommendations and those relating to the Cyber Security Risk Assessment. It is suggested that the People and Culture Committee receive and note the People Hub Report
External Audit	The Committee received an update on the current position regarding audit of the first quarter of 2022/23 CCG Accounts and the 2022/23 ICB Accounts	Both External Audit and internal Audit Teams are working closely together within tight timescales to ensure that submission dates are achieved.
Counter Fraud	RSM presented their latest update report and progress in delivering each element of their plan including a detailed update on active cases.	
Governance -Annual Reporting guidance -Freedom of Information -Information Governance	The Committee received an update on the process and timescales for producing the 2022/23 Annual Report .~~and~~ The Committee welcomed the report from the Information Governance Group and the latest Freedom of Information report.	-The Chair stated that the Annual Report should showcase the achievements of the ICB. The Committee received confirmation that trend information will be included in future FOI Reports.
Financial Governance	The Committee received and discussed Losses and Compensations and Single Action Tenders which the committee	

	was assured -have been scrutinised internally.	

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee and specifically recommend the proposed policies.

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Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal, Non Executive Director
Executive Lead:	Alex Brett, Chief People Officer
Date:	Wednesday 8th March 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	A story based on the Journey to Work Programme was presented. Committee members heard from Edward who has additional needs and has completed work experience with Sodexo at UHNM. Committee members welcomed the story and welcomed the opportunity this gave to Edward.	
Strategic People, Culture and Inclusion Update	AB highlighted the recent meeting with system partners around key priorities and focus for the upcoming year, and the discussions that were held at the ICP meeting held on Monday 6th March. Committee members acknowledged the headline messages released by the national team around running cost reductions for 24/25 and 25/26,the impact this may have had on staff and the work that will be required going forward to achieve this. The Committee noted the Junior Doctors strike taking place next week, from 13th March for 72 hours, this will be really challenging. There is a lot of planning taking place through the EPRR functions with a system wide oversight. The BMA are also proposing to ballot consultants on a potential strike action in the coming weeks. AB shared the ICS People Culture and Inclusion Operating Model and proposed revised governance structure. The committee welcomed the refresh and recognised the need to align with overall ICB governance and committees.	
People, Culture and Inclusion Metrics and Programme Assurance	People metrics were discussed and it was acknowledged that the system position remains challenged. Committee members noted the positive news around the increase in the number of substantive workers and the reduction in bank and agency usage. Committee members were assured by the high quality	

	of information provided for the meeting and the wealth of data that is shared. Assured on delivery of PCI programmes.	
People, Culture and Inclusion Risk Register and BAF	Risks noted and discussed by the Committee. Members were assured that the risks are being managed and addressed within organisations and collectively at system level through People Plan delivery. Committee members supported the way the risks had been presented to the meeting including making those classed as the top three, easily accessible and clear.	
People, Culture and Inclusion Draft Cycle of Business	Committee members noted the draft cycle of business	
People, Culture and Inclusion Annual Report	Committee members were assured by the work being done in relation to the Annual Report and agreed it really highlights and showcases all the progress that has been delivered to date.	Final report will be shared at the ICB Board.
Portfolio / Profession/ provider spotlight - Volunteer workforce focus	Sandra Payne and Charlotte Bennett provided a comprehensive update around the huge amount of work being done within the volunteer sector. The update included discussions around the Healthy Communities Alliance and the aims of the ICP Volunteer Managers Network. Members were keen to ensure that volunteers are recognised as part of the Staffordshire and Stoke-on-Trent system as they are an integral part to everything we are doing.	Further work required across Population Health and Inequalities Portfolio and volunteer workforce to be considered at board.
Equality Diversity and Inclusion	Committee members received an update on the EDI programme including work being done around inclusion schools, race equality code and workforce equality metrics and standards. The Committee noted that Roger Kline has committed to working with the system over the next 12 months as a critical friend.	
Staff Experience / Looking After Our People - Retention Programme update - Health and Wellbeing	The ICS retention programme highlights were presented to the committee with a summary of Phase 1 and Phase 2 activities. The phase 1 evaluation was also included in the information provided to colleagues. Work is ongoing around the retention strategy which will include key outcomes and measurables. PD confirmed that following the discussion at the January meeting around the Staff Psychological Health and Wellbeing Hub, a review has taken place around the costings of the Hub for the last two years and he was pleased to confirm that following this we are able to continue to fund the Hub until the end of March	

	2024. During this next year this will allow time to look at the service, the challenges and consider what we continue to carry forward.	
Workforce Transformation and Future Supply	Committee members received an update around workforce transformation including the national education planning discussion forum with HEE, METIP and the Joint Forward Plan. Locally, it has been agreed that the Chief Nursing Officer from UHNM will lead on the ICS education and development worsktream. A summit is scheduled for 2nd October.	
Workforce Planning	Committee members noted the progress made to date around workforce planning and the development of the Operating Plan due for final submission on 30th March 2023	Operating Plan submission will be shared with ICB Board

Risk Review and Assurance Summary
The People Culture and Inclusion Committee noted the significant challenges in workforce supply, achieving the workforce growth and the Agency reduction target. The Committee is assured that the action and solutions are in place to address the challenges, and continue to be developed in collaboration with system partners.