NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

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

Thursday 19 January 2023
2.00pm-4.30pm
Stafford 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	1-3
2.	Minutes of the Meeting held on 17 November 2022 and Matters Arising	Chair	Enc. 03	A	2.05pm	4-13
3.	Action Log Progress Updates on Actions	Chair	Enc. 04	D		14-15
4.	Questions submitted by members of the public in advance of the meeting	Chair	Verbal	D	2.10pm	
5.	Compassionate Communities	SY/TS	Enc. 05	I	2.15pm	16-22
	Strategic and System Development					
6.	ICB Chair and Chief Executive Update	DP/PA	Enc. 06	D/I	2.30pm	23-35
7.	Inpatient Mental Health Services (George Bryan Centre)	PEJ/CB	Enc. 07	A	2.40pm	36-40
8.	NHSE Delegation Update	CB	Enc. 08	D	3.00pm	41-49
9.	ICS Development	SY/KO	Enc. 09	D	3.05pm	50-69
10.	VSCE and MOU	SY	Enc. 10	D	3.15pm	70-84
	System Oversight and Governance					
11.	Board Assurance Framework - Summary	SY	Enc. 11	S	3.25pm	85-89
12.	System Finance and Performance Report	PB	Enc. 12	S	3.30pm	90-104
13.	System Operating Plan Update	PB	Enc. 13	S	3.35pm	105-113
14.	Winter Plan Update	PSm	Enc. 14	S	3.40pm	114-126
15.	Quality and Safety Exception Report	HJ	Enc. 15	S	3.50pm	127-131
	Committee Assurance Reports					
16.	Finance and Performance Committee	MN	Enc. 16	S	4.00pm	132-139
17.	Audit Committee	JH	Enc. 17	S	4.05pm	140-141
18.	People, Culture and Inclusion Committee	SL	Enc. 18	S	4.10pm	142-144
19.	Quality & Safety Committee	JS	Enc. 19	S	4.15pm	145-147
	Any other Business					
20.	**Items notified in advance to the Chair**	All		D	4.20pm	

21.	**Questions from the floor relating to the discussions at the meeting**	Chair				
22.	**Meeting effectiveness**	Chair				
23.	**Close**	Chair			4.30pm	
24.	**Date and Time of Next Meeting** 16 March 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**.

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD
CONFLICTS OF INTEREST REGISTER 2022-2023
INTEGRATED CARE BOARD (ICB)
AS AT 11 JANUARY 2023

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

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

Date of Declaration	Title	Forename	Surname	Role	Organisation/Directorate	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
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	MPFT	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. Non-Executive Director /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 July 2022	Mr	David	Pearson	NED / Chair of Remuneration Committee	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)

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board Meeting
IN PUBLIC

17 November 2022
12.45pm-2.30pm

Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford, ST18 0BF

Members:	**01/07/22**	**18/08/22**	**22/09/22**	**17/11/22**
Prem Singh (PS) Chair, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Peter Axon (PA) Interim Chief Executive Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Paul Brown (PB) Chief Finance Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	x	✓	✓
Phil Smith (PSm) Chief Delivery Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Sally Young (SY) Director of Corporate Services, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	x	✓
Alex Brett (AB) Chief People Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Chris Ibell (CI) Chief Digital Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Heather Johnstone (HJ) Interim Chief Nursing and Therapies Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓	✓
Dr Paul Edmondson-Jones (PE-J) Chief Medical Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓	✓
Chris Bird (CB) Interim Chief Transformation Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	x
David Pearson (DP) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Julie Houlder (JHo) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Megan Nurse (MN) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Shokat Lal (SL) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	x	✓	✓	x
Josephine Spencer (JS) Non-Executive Director, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Jon Rouse (JR), City Director, City of Stoke-on-Trent	x	x	✓	x
John Henderson (JH) Chief Executive, Staffordshire County Council	✓	x	✓	x
Dr Paddy Hannigan (PH) Primary Care Partner Member, Staffordshire and Stoke-on-Trent Integrated Care Board		✓	✓	✓
Dr Jack Aw (JA) Primary Care Partner Member, Staffordshire and Stoke-on-Trent Integrated Care Board		✓	Via Teams	✓
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands	x	✓	x	x
Neil Carr (NC) Chief Executive, Midlands Partnership NHS Foundation Trust		✓	✓	x
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓	✓	x

In Attendance:	01/07/22	18/08/22	22/09/22	17/11/22
Helen Ashley (HA) Director of Strategy and Transformation /Deputy Chief Executive, University Hospitals of North Midlands NHS Trust	✓		✓	✓
Chris Sands (CS) Chief Financial officer, Midlands Partnership NHS Foundation Trust				✓
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓
Debbie Everden (DE) Executive Assistant, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓	✓	✓

		Action
1.	**Welcome and Apologies**	
	PS welcomed attendees to the ICB Board meeting. PS 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. PS 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. The meeting was quorate. Apologies were received from Buki Adeyemo, John Henderson, Jon Rouse, Chris Bird, Shokat Lal, Tracey Shewan, Neil Carr (Chris Sands attending) and Tracy Bullock (Helen Ashley attending).	
2.	**Conflicts of Interest Register**	
	No additional conflicts of interest were declared. The Integrated Care Board: • Noted the Conflicts of Interest Register.	
3.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 22 September 2022 were approved.	
4.	**Action Log**	
	The action log was updated.	
5.	**Questions submitted by members of the public in advance of the meeting**	
	No questions had been submitted from the public in advance of the meeting.	
6.	**Staffordshire and Stoke-on-Trent Staff Story**	
	AB presented the paper which provided details of the System wide apprenticeship scheme and Adil's experience. We are working with the YMCA who support with our work as an anchor employer. AB commented that the scheme is ground-breaking in its approach with placements taking place across the whole System and aimed to attract people new to caring or people who traditionally may not be able to access the scheme via a registered route. AB advised that support for Adil is provided by Stoke-on-Trent College to enable him to get his Maths and English qualifications. The film of Adil's experience of the apprenticeship scheme was shown.	

	Regarding being an anchor organisation, PS commented that it would be beneficial for the Board to receive a report on the areas we want to invest in collectively in the future and on progress. One of the aims of the ICS was for the NHS to provide a socio-economic contribution to employment, sustainability and procuring from businesses at a local level. JHo advised that at the People, Culture and Inclusion Committee meeting last week, there had been many initiatives reported where we are making a difference and it had been agreed to present this information at a future Board meeting. She commented that the Providers also have apprenticeship schemes and where there are opportunities to work together further should be examined. AB advised that this work is taking place and commented that this scheme was unique as apprentices rotate around the System and it had been nominated for the National Apprenticeship Scheme of the Year. She welcomed the opportunity to report further to the Board. JA commented that a lot of funding was directed to apprenticeships at a more senior level and as a System we should look at opportunities for younger people and join up transitional rotational training. AB agreed and advised TB had contacted her regarding T-Level placements and this was being taken forward. PE-J commented that one of the strands in the developing Integrated Care Partnership (ICP) strategy was examining what might happen at the different levels and picking out themes. JA asked about the engagement with the 2 local higher education institutes. He advised that senior physiotherapy apprentices have had to travel out of the area due to a lack of funding and resources locally and some have had to withdraw from their courses as a result. PS commented that a deep dive could take place at an ICP meeting on anchor institutions and this should include the universities. PS commented that the health and social care budget for Staffordshire and Stoke-on-Trent is c£3.5bn and if we moved just 10% from global national procurement to local businesses that would make a huge impact on the local economy. The Integrated Care Board: • Listened to Adil's story and experience • Committed to continuing to support the apprenticeship scheme via vacancies and placement opportunities.	**SL/AB**
7.	**ICB Chair and Chief Executive Update**	
	PS advised that Amanda Pritchard, NHSE Chief Executive, had visited this morning. A meeting had taken place at UHNM with Chief Executives of NHS organisations, other ICB colleagues and JH and JR from the Local Authorities. She had commented on the high standard of the briefing pack she had received and the strong alignment between what was in the briefing and the discussions that took place. PS commented that having all the Chief Executives present at the meeting demonstrated the commitment to collaborative working. PS commented that Amanda had praised the work taking place to prevent people coming into hospital, particularly the use of the Community Rapid Intervention Service (CRIS), and also the discharge strategy and the sharing of risk across the System. He advised that she then went to A&E and theatres at UHNM and then to Harplands to discuss mental health. PS advised that the Health Service Journal (HSJ) awards were taking place that evening; every Trust in the System had been nominated and we had been shortlisted for ICS of the year. PS advised that the revised Constitution had received NHSE approval and NC and JA were now Partner Members of the Board representing community physical health and Primary Care respectively.	

	PS congratulated SL on his appointment as Chief Executive of Sandwell Council. PS advised that DE was taking up a role in the Finance, Performance and Intelligence Directorate so this was her last meeting supporting the Board. PS commented that this was his final Board meeting in public before his retirement in December. He said that it had been a pleasure to chair the wider partnership Board and undertake the development work on how the System would work together. He was proud to have worked with all Board members and was impressed by their leadership. PA presented the paper and regarding industrial action, he advised that the ballot result meant that one Trust would be affected. He advised that other unions were undertaking the process of balloting their members. He advised that as a System, we are undertaking a thorough process to assess the risk of industrial action but there are other possible risks such as floods and winter challenges and the System was evaluating the likelihood and actions needed if one or all these risks occurred. PA advised that the ICB structure was being published today. This was orientated around the portfolios. The 3 emerging elements for the work of the System are the portfolios, provider collaboratives and place and PA advised that work would take place on the evolution of the portfolios and these were key in driving the strategy through to delivery. PA commented that the fiscal arrangements for the NHS from 1 April were awaited following the government's Autumn Statement. PA commented that he was pleased with the progress around planned care and work carried out by UHNM to bring down the number of long waits. He commented that Urgent and Emergency Care (UEC) is very pressurised and we are undertaking work to ensure we are pro-active when there are any spikes in demand. DP asked about the engagement with Staff Side organisations regarding the industrial action and PA advised that regular meetings take place with representatives of all organisations to discuss their respective positions and look for common ground. AB advised that each organisation is working closely with their Staff Side and trade unions representatives. Preparations for industrial action and business continuity are taking place and Staff Side would be involved. The Social Partnership Forum representative attends the System People Committee which provides a further link. JHo asked if the ballots were just for industrial action or whether other actions could be taken. AB advised that this depended on the union; the RCN have voted for industrial action and we will receive a letter advising of the date this will take place and outlining the action. PS referred to section 3.6 in the paper and commented that future reports should highlight what we are delivering and have some metrics providing a comparison with previous years. PA agreed and commented that GP appointment numbers are above pre-Covid levels and we have over delivered against the plan for electives. The Integrated Care Board: • Noted the updates in the report.	**PA**
8.	**Winter Plan**	
	PSm advised that the whole System had been involved in developing the Winter Plan. This had been presented to the Provider Trust Boards and the Local Authority equivalent forums. He advised that a summary paper was included in the pack and this contained a link to the whole plan. PSm commented that it was difficult to predict the demand over winter but we had taken a prudent approach and assumptions had been made that there would be severe flu, further waves of Covid, and an increase in UEC general demand. We have included the maintenance and protection of the elective recovery programme and cancer services in the plan.	

	PSm advised that the plan was divided into 3 areas, capacity, escalation and workforce and he outlined the details for each section. PSm commented that we have a solid theoretical plan for winter but this now needed turning into a pragmatic, realistic, practical plan that takes account of any industrial action and the other pressures expected during winter. A Winter Steering Group will meet weekly to act as the re-calibrating mechanism to respond to the pressures and examine the workforce challenges and decide what capacity should be employed where. PSm advised that there is a national expectation that we establish a System Control Centre from 1 December to provide an immediate tactical response to respond to emerging pressures and prevent escalation. PSm commented that the winter period would be very challenging but what the System had demonstrated through the development of the plan is a compassionate, collaborative leadership approach and this needed to continue during winter. DP advised that the plan had been presented to the Quality and Safety Committee and had been received positively. He was aware that there were ongoing discussions taking place with the voluntary sector regarding their involvement. MN advised that the Winter Plan had been presented to the Finance and Performance Committee and the escalation plan was particularly welcomed as it demonstrated a more pro-active approach. The Integrated Care Board: • Ratified the decision of the Finance and Performance Committee and approved the System Winter Plan • Thanked PSm for his work on the System Winter Plan.	
9.	**ICS Oversight Framework**	
	PB presented the paper and advised that the approach had been discussed at the Board meeting in September and further discussions had taken place with Non-Executive Directors, the Senior Leadership Team and at the System Performance Group and Finance and Performance Committee. PB advised that 4 guiding principles had been developed as detailed in the paper. These principles had been developed into a compact. PA commented that the ICS was a new construct and this framework was an important part of that journey; he thanked PB for his work. JHo asked if this had been presented to all partner Boards to enable further understanding. PB agreed that it was important and would action this. HA commented that this could become more challenging when the concept is further understood as it was outside the formal constructs of Providers and previous lines of accountability. PA commented that this could be taken to the Provider Collaborative Board to assist further with the understanding of the concept. PS praised the work due to the complex nature of the accountabilities and commented that achievements are made when working collectively. Agreeing a compact means more chance of success and ensures alignment. The Integrated Care Board: • Endorsed the proposed guiding principles and the compact for System oversight.	**PB**
10.	**Finance and Performance Update**	

	PB presented the paper and advised for the current financial year we are forecasting a break even position for the System. He acknowledged the work carried out by the Trusts particularly UHNM and advised that the Chief Finance Officers (CFOs) are working together in a transparent way to identify opportunities. He commented that through the financial strategy we want to do things that are better for patients and gave an example of a patient receiving out of area long term care who had been brought back to Staffordshire. This resulted in better patient care and a financial saving of £0.5m. PB advised that achieving a break even position for 2 consecutive years would result in the CCGs' historic debt of £300m being written off. For 2023-24, PB advised that the CFOs have been working on a financial strategy and this work would continue over the next few weeks. He commented that we are awaiting the details of the government's Autumn Statement but it would be a very challenging year not least because we have received a large amount of non-recurrent funds to support this year. PB advised that collectively we have been able to reduce the amount of activity going into the acute sector and productivity improvement was the route to achieving the System's objectives; activity has reduced but costs have increased and there are complexities around Covid which have led to a fall in productivity. He advised that it was key to work with the HR Directors to link the Financial Strategy and Workforce Plan and also with the operational and clinical teams on the capacity and delivering clinical improvement as well as financial savings. MN thanked PB and the System CFOs for their work enabling us to get to the point where we may breakeven. JHo asked if work had started on different allocations for provider collaboratives and place. PB advised that for efficiencies this could be broken down into cash and activity. Providers are being asked to deliver the 2% cash out and the portfolios will lead the work on activity and manage the pathways. JA commented that there are challenges regarding culture, where the activity occurs, where the savings are realised and the governance surrounding this. PSm presented the ambulance handover delay report and an update on the actions being taken. He advised that Royal Stoke remains significantly challenged in terms of ambulance handover delays and is one of 12 sites nationally receiving support to make improvements. PSm commented that ambulance handover delays are a symptom of capacity and flow challenges across the whole system and, therefore, a whole system response was needed to address them. A weekly Task and Finish Group is in place and this is attended by all partners including the ambulance service and an improvement plan is in place. PSm highlighted the key action areas and the progress detailed in the paper. The Integrated Care Board: • Noted the contents of the Finance and Performance Report and the Staffordshire and Stoke-on-Trent ICB financial strategy.	
11.	**Quality and Safety Update Report**	
	HJ presented the report and advised that it contained information on the development of systems and processes for quality, assurance and improvement across the ICB.	

	She commented that there have been high profile publications in the last few weeks including the East Kent Report and details of this would be contained in future reports being presented to the Board. HJ advised that maternity and neo-natal services locally remain a concern mainly due to workforce challenges and, therefore, the Free Standing Midwife Unit at Stafford remains closed. She advised that the System is working collectively to monitor and drive improvements on the issues regarding labour inductions. HJ highlighted the section of the report providing details on The Woodhouse and Ivetsey Bank and advised that the report providing an overview of the governance arrangements for System oversight of the quality and safety of mental health, learning disability and autism in-patient services had been positively received by the Quality and Safety Committee. The Integrated Care Board: • Received the report and was 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.	
12.	**Assurance Reports from Committees of the Board**	
	<u>Finance and Performance Committee</u> MN presented the October and November Committee reports which were taken as read. No questions were raised. <u>Audit Committee</u> JHo presented the report and highlighted the recommendation from the Committee on the amendments to the Scheme of Financial Delegation as detailed in the appendix to the report. She advised that the levels had been discussed in detail together with the Procurement Policy and the Committee was happy to recommend the proposed levels of delegation to the Finance and Performance Committee. PS asked about some the limits referenced in the document and JHo advised that there were checks and balances in place. PB confirmed this and advised the Finance and Performance Committee was attended by Non-Executive Directors. <u>People, Culture and Inclusion Committee</u> JHo presented the report which was taken as read. No questions were raised. <u>Quality and Safety Committee</u> DP presented the report which was taken as read. No questions were raised. The Integrated Care Board: • Approved the amendments to the Scheme of Financial Delegation • Noted the Committee Assurance Reports.	
13.	**Questions from the floor relating to the discussions at the meeting**	
	Questions were received from Ian Syme as follows: <u>It's reported that there are sudden financial deficits appearing amongst providers etc. in ICBs nationally. How do deficits in adjoining ICBs impact on services for individuals in Staffordshire and Stoke-on-Trent ICB given a considerable amount of service is provided to local individuals by NHS Trusts based in adjoining ICBs?</u> PB advised that there is no direct impact on us. We pay the Systems who are caring for Staffordshire and Stoke-on-Trent patients in their hospitals through an agreed contract. However, if that hospital experiences financial challenges then this may have an impact on the care they are able to provide. PB commented that if our Local Authorities experience financial challenges then this could have more of an impact i.e. if they are unable to provide social care then this could lead to patients being in hospital for longer than needed.	

	HJ advised that regarding quality and safety, we work very closely with all our out of area Providers and their lead ICB to ensure that the standards we expect are maintained. As per enclosure 10 Quality and Safety para 3.3 Induction of Labour (highlighted in September ICB papers). (i)What actions have been implemented to reduce Induction of Labour backlog? (ii) When is it likely that the free standing midwife led units in Lichfield and Stafford will re-open and the intermittent home births service fully re-instated? HJ advised that this had been covered in her earlier report.	
14.	**Meeting Effectiveness**	
	PS reminded Board members of the Leadership Compact and Members agreed that the meeting had been conducted according these principles.	
15.	**Any other Business**	
	DP reminded Members that this was PS's last meeting in public before his retirement. He acknowledged his energy and passion and commented that he had established strong foundations to allow the System to continue develop.	
16.	**Date and time of next meeting**	
	19 January 2023 at 2.00pm.	

Integrated Care Board - Action Plan

Date	Item	Agenda Item	Action	Action Owner	Update	Due Date	RAG
18.08.22	5.	Inpatient Mental Health Services previously provided at the George Bryan Centre/Questions from members of the public	The MPFT transport policy and the mapping work to be completed and included as part of the submission to NHSE. Transformation Team to present to a future meeting of the Board following assurance meeting with NHSE.	NC PE-J	15.09.22 MPFT have shared the travel document and this has been submitted to NHSE ahead of the assurance process. **Action closed.** Travel analysis and mapping is part of the technical impact assessment work undertaken and included in the business case appendices. The mapping has been refined for inclusion in the formal involvement documentation submitted to NHSE. NHSE Assurance meeting will take place 21 September 2022 and the team will present back once the report from NHSE is received.	By submission date of 21 September Provisional date of October 2022. 22.09.22 A positive meeting with NHSE has taken place ahead of the formal assurance panel. A report will be presented to the November Board meeting. 17.11.22 Awaiting confirmation of NHSE meeting date. An update will be presented to the December Board meeting with a further report presented to the Board meeting in public in	

						January.	
22.09.22	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		April 2023	
17.11.22	6.	Staffordshire and Stoke-on-Trent Staff Story	A report from the People, Culture and Inclusion Committee on the apprentice scheme and other initiatives to be presented to a future Board meeting.	SL/AB			
17.11.22	7.	ICB Chair and Chief Executive Update	Future reports to highlight what we are delivering and have some metrics providing a comparison with previous years.	PA			
17.11.22	9.	ICS Oversight Framework	The paper to be presented to the Provider Collaborative Board.	PB	On the agenda for the Provider Collaborative Board meeting on 19.12.22	**Action closed.**	

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**05**

Title:	**Compassionate communities Network**

Meeting Date:	19 January 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Paul Edmondson-Jones		Christina Wigfall

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
N/A		

Purpose of the Paper (Key Points + Executive Summary):
Purpose of the paper is: To share with the ICB Board the work and approach of the South West Compassionate Communities Network. In 21-22 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 South West.

Current areas of work:

- Treasure mapping the community resources in Cannock that will be shared in a meaningful format across the communities identified, to promote groups making connections that would add value to their ambition.
- Engaging identified groups as above to ascertain how embedded death dying and loss is in their work and identifying any gaps and making links to fill those gaps.
- Developing a communication approach to engage communities and community groups in Cannock and to inform the wider system of our work
- Planning a celebration event at some time in the future as work progresses.
- Undertaking a self-assessment to guide the work of the network both in achieving 'Charter status' for Cannock and informing an ongoing plan of work to continue to develop as a Compassionate Community.
- Using the experience of focussing on the communities of Cannock to inform the wider development and expansion of the network to develop compassionate Communities across South West Staffordshire

References

(1) https://compassionate-communitiesuk.co.uk/

(2) The Compassionate City Charter, Copyright Allan Kellehear, Compassionate Communities UK https://compassionate-communitiesuk.co.uk/wp-content/uploads/2021/12/The-Compassionate-City-Charter.pdf

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

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
none

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	Dependent on organisational priorities to some extent.
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?		
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/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?		
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 Local organisations have been contacted and offered the opportunity to feedback on the approach.Event held 16 December 2022 included evaluation and feedback opportunities.	**Y**	
5.	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 content of this paper.			

Staffordshire and Stoke-on-Trent Integrated Care System

South West Staffordshire Compassionate Communities Network

Describing who we are, what our Common Purpose is, and how we will achieve it.

November 2022

Introduction

The South West Staffordshire Place Based Partnership group invested in 'Compassionate Communities Training' for a diverse cohort of individuals delivered over 'Zoom' by Julian Abell from Compassionate Communities UK. The course ran six, 1.5 hrs sessions from 8th March 2022 to 6th April 2022 and as part of the last session there was a call to establish an ongoing group to progress the development of 'Compassionate City' in South West Staffordshire.
'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'. https://compassionate-communitiesuk.co.uk/

Initially co-facilitators were identified to establish regular Compassionate Communities network meetings that members of the cohort signed up to voluntarily and these meetings are ongoing every three weeks for a duration of 1.5 hours

Common Purpose

'As a Network of individuals from across the Health and Care System including the wider Voluntary Community Sector, we aim to promote a more positive approach to death, dying and loss across our communities initially focussing on the communities of Communities within the Cannock Chase District and then broadening out across the other communities within the geography of South West Staffordshire.'

'Compassionate Communities that recognise that all natural cycles of sickness and health, birth and death, and love and loss happen daily within the orbits of its institutions and regular activities. 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. Compassionate Cities are communities that publicly encourage, facilitate, supports and celebrates care for one another during life's most testing moments and experiences, especially those pertaining to life-threatening and life-limiting illness, chronic disability, frail ageing and dementia, grief and bereavement, and the trials and burdens of long term care'. *The Compassionate City Charter, Copyright Allan Kellehear, Compassionate Communities UK https://compassionate-communitiesuk.co.uk/wp-content/uploads/2021/12/The-Compassionate-City-Charter.pdf*

Reporting Arrangements

Each member will have their own expectation from their host organisation as to how to feedback the work of the network and influence ongoing developments, as the network and group membership is not formally constituted within the emerging ICS structures, but progress is reported to the South West Staffordshire Healthy Communities Group and South West Place Based Partnership Group.

Membership

Initial Membership of the network was through self-selection from the cohort of trainees who attended 'Compassionate City' training in March/April 2022. However, the group is

seeking to broaden its membership to ensure wider community representation as work progresses

Areas of Work

- Treasure mapping the community resources in Cannock that will be shared in a meaningful format across the communities identified, to promote groups making connections that would add value to their ambition.
- Engaging identified groups as above to ascertain how embedded death dying and loss is in their work and identifying any gaps and making links to fill those gaps.
- Developing a communication approach to engage communities and community groups in Cannock and to inform the wider system of our work
- Planning a celebration event at some time in the future as work progresses.
- Undertaking a self-assessment to guide the work of the network both in achieving 'Charter status' for Cannock and informing an ongoing plan of work to continue to develop as a Compassionate Community.
- Using the experience of focussing on the communities of Cannock to inform the wider development and expansion of the network to develop compassionate Communities across South West Staffordshire

Compassionate City Charter

The Compassionate Communities Charter identifies 13 social changes to a 'cities' key institutions and activities. This includes schools, workplaces, places of worship and hospices amongst others.

The-Compassionate-City-Charter.pdf

Review of the network

Review and reflections are an ongoing part of the standing agenda at each meeting, but formal review will be undertaken 6 monthly with the next review planned as part of the self-assessment exercise to be undertaken in February 2023.

Tina Wigfall Christina.Wigfall@staffsstoke.icb.nhs.uk
Mark Cardwell Mark.cardwell@mpft.nhs.uk

Network co-facilitators

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:	19 January 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
David Pearson, Interim 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**

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

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

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**		
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***		
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***		
Recommendations / Action Required:			
The Integrated Care Board is asked to: • **Note the updates in the report.**			

1.0 System and general update

1.1 Industrial Action Update

Trade unions representing some NHS staff are in dispute with the Government over the 2022/23 pay award. As a result, we have seen industrial action in December and January by members of the Royal College of Nursing (RCN), GMB and Unite (ambulance) and UNISON (ambulance).

Strikes by both ambulance and nursing staff have had impacts across the system for the days of action and as trade unions continue to ballot members, further strikes are anticipated for up to six months, and potentially longer.

Preparedness for RCN Industrial Action is led on an organisation-by-organisation basis with support through the ICB EPRR, UEC and People Hub functions as required. Derogation discussions continue at a national and local level with unions to agree services to be maintained to ensure patient safety during strike action. A national list of derogations is publicly available and for more information on the industrial action, please see appendix 1 on page 10.

2.0 Finance

We continue to flag a £12m risk to delivery of our financial plan however, as a system, we are striving to breakeven for 2022/23. Nationally, we understand that many ICBs are in a similar position and if we were to achieve this, we believe we would be in a minority.

Building on the financial strategy that has been worked up collaboratively with system partners, finance leads are ensuring the system's financial approach is fully integrated with other strategies. We are now reflecting on the details of the national planning guidance and the allocations to understand the impact on Staffordshire and Stoke on Trent, with a first cut of the financial projections for 2023/24 due at the end of January.

3.0 Planning and performance

The 2023/24 priorities and operational planning guidance (one year plan) and Joint Forward Plan guidance were published by NHS England on 23 December 2022.

There are three high level national priorities to be delivered within financial allocations for the one-year plan, underpinned by 31 objectives and a set of required actions. These are:

1) **Recovering core services and productivity – including improving patient safety, outcomes and experience, reducing elective wait times and cancer backlogs and making it easier to access primary care services.**

2) **Make progress in delivering the Long-Term Plan (LTP) key ambitions – to improve mental health services, services for people with a learning disability and/or autism, prevention and management of long-term conditions.**

3) **Continue transforming the NHS for the future** – ensuring sustainability of the workforce and driving greater digital connectivity.

The Joint Forward Plan (JFP) guidance does not set out specific objectives, tasks, and actions across priorities, which is a change to previous 5-year plan guidance but sets out a flexible framework to build on existing system and place strategies and plans. Additional supporting guidance has yet to be published by NHSE including contracting guidance, contract values and activity baselines

The ICB is currently working with system partners to understand the implications at organisational and system level and to develop plans to meet the national objectives and local priorities. System plans will be triangulated across activity, workforce, and finance, and signed off by the ICB and partner trust and foundation trust (FT) boards before the end of March 2023.

We are also in the process of ensuring that our established Portfolio arrangements are at the heart of our delivery plan for 2023/24.

ICBs and their partner trusts have a duty to prepare a first JFP by 1 April 2023 with the final version to be published and shared with NHS England, the Integrated Care Partnership and Health and Well-being Boards (HWBs) by 30 June 2023. It is expected that there will be consultation on the draft plan, but it is recognised that consultation on further iterations may continue after March, prior to the plan being finalised in time for publication in June.

3.1 Performance

Key messages in December were:

- **Primary care:** A continued focus on workforce recruitment and retention plans and work to support general practice resilience and access through winter. Learning Disability Annual Health Checks: Q1 and Q2 remain below the specific quarterly target. Q3 data (for October and November) is provided for information however the quarterly figure is predicted to meet the Q3 target (of 49.7%).
- **Ambulance Handover Plan:** Overall hours lost, and ambulance handover delays decreased in November. Category 2 Response waits continued to be a point of pressure and risk for the ICB through December, with significant waits experienced at the 8pm time.
- **Mental Health:** Mental Health is not included in this month's report as no new data has been published nationally due to ongoing alignment being undertaken by NHSE to get the ICB level breakdowns into the datasets.
- **Cancer:** 28 Day Faster Diagnosis Standard: Performance against national target (in October) is 60.4%, remaining below the 75% standard but increasing from September's 53.8%. The system aims to prioritise implementation of Tier 2 national guidance received. This indicator was newly introduced in 21/22 operational planning. Systems is expected initially to meet the target of 75% from Q3 2021/22.
- **78+ week waits:** The elimination of 78ww by the end of March remains a challenging target however mutual aid from the ISP and constant dialog between University Hospitals of North Midlands NHS Trust (UHNM) and Nuffield is providing assurance that this will be achieved. At UHNM across the last 6 weeks 78+ week waits have increased slightly from 629 w/e 06/11 to 656 w/e 11/12.
- **104+ week waits:** At UHNM, 104+ week waits have increased slightly across the last 6 weeks, from 38 w/e 06/11 to 42 w/e 11/12.
- **Diagnostics:** Recovery plans are in place for the top 5 contributors, the biggest pressure in non-obstetric ultrasound. An outsourced provider has been procured to support this. Year to date, 75.2% of 19/20 Diagnostic activity (across the 7 tests) is being delivered.

3.2 Key figures for our population:

	September	October	November
Number of attendances at A&E and Walk in Centres	35,115	36, 823	37, 004
Number of episodes of planned care (elective and day case)	13,874	14,376	16,694
Number of outpatient procedures	11,919	11,249	12,057
Number of people seen by GPs	475,404	534,693	526,795
Number of emergency admissions via A&E	6,168	6,390	6,490
Number of Physical Health community contacts	125,883	125,883	136,160
Number of Mental Health community contacts	N/A*	40,020	33,755
Number of 111 calls received	25,040	30,438	29,161

*Data for September 2022 is currently unavailable due to NHS Digital working on reshaping the dataset post ICB establishment.

3.3 Urgent and emergency care and System Winter Plan

Extended and severe winter pressure across all parts of the system were experienced throughout December, particularly over the festive period. These pressures contributed to continued high levels of ambulance handover delays and dictated that the system declared a Critical Incident on Thursday 29 December.

Whilst the official NHS 111 figures are yet to be released, provisional figures for December showed a marked increase in call volumes when compared to previous years. This was particularly prevalent over the festive period. Latest data shows abandonment rates remained

above the national 3% threshold but still below the locally contracted 5% level. We continue to have a lower-than-average call abandonment rate against national position.

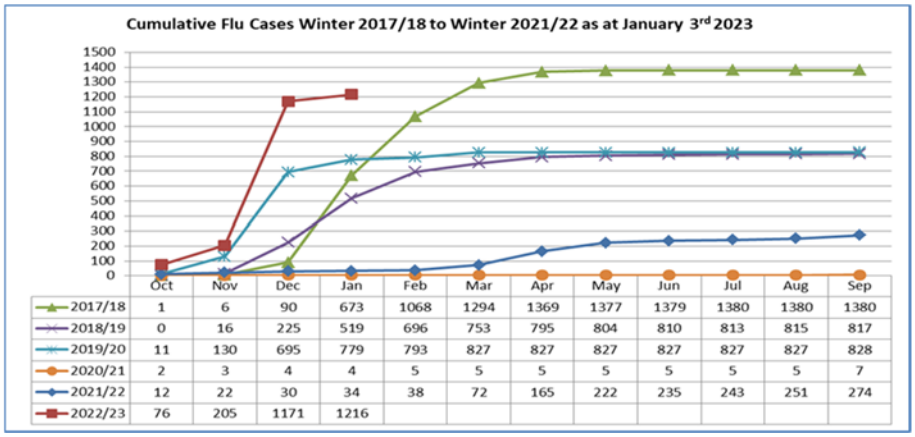
Continuing under national direction for ambulance handover delays, the Ambulance Task and Finish group is reporting weekly on the position at Royal Stoke University Hospital. Preliminary figures for December show a significant increase in ambulance handover delays (in excess of 30 minutes) at Royal Stoke over the festive period linked to severe system pressures. Focus remains on front door opportunities, maximising flexibility of hospital capacity and maximising flow out of the hospital. Your Next Patient continues to operate and special focus is being given to ensure that the flow of patients out of the Emergency Department (ED) in a timely manner to aid the situation. Additional winter surge actions have been put into action to attempt to mitigate the severe pressures in the system and a de-brief has been undertaken to review the festive period to ensure that learning and improvements are facilitated.

Pressures within the ED were constant through December and included a day which surpassed the previously identified date of the highest individual attendance counts in recent years (402), reaching a total of 419 Type 01 attendances on 5 December (full data is awaited). The impact of the high volumes was felt through a reduction in the proportion of patients being seen for assessment within 15 minutes, down from 55.3% in November to around 48% in December (as per latest available figures).

High levels of bed occupancy continue to be experienced with sustained use of escalation beds across the system, as all partners continue to implement additional capacity schemes where possible. Staffing levels remain a high risk for operationalising the additional planned capacity and increased staff sickness has been reported during December.

Additional and sustained increases in inpatients with Covid, Flu and RSV have placed additional pressure onto the bed base and compounded patient flow issues, with significant infection prevention and control (IPC) measures required to try and manage infection and spread of these illnesses. For reference, there was a 68% increase in the number of inpatients with Covid during the two-week period from 16 December – 30 December. During this time there was also a 136% increase in the number of inpatients with flu and a 55% increase in the number of inpatients with RSV.

The data in the graph below indicates the scale of pressure that the system faced during December when compared to previous years. A key contributing factor to system acute challenges during that period.



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2017/18	1	6	90	673	1068	1294	1369	1377	1379	1380	1380	1380
2018/19	0	16	225	519	696	753	795	804	810	813	815	817
2019/20	11	130	695	779	793	827	827	827	827	827	827	828
2020/21	2	3	4	4	5	5	5	5	5	5	5	7
2021/22	12	22	30	34	38	72	165	222	235	243	251	274
2022/23	76	205	1171	1216								

Provisional Medically Fit for Discharge (MFFD) figures for December show a fluctuating picture of criteria to reside, pre-Christmas levels of MFFD were around 150 patients, but with improved

discharges this reduced to circa 100 patients, with fewer patients waiting over two days for discharge from MFFD status.

Provider of Last Resort (POLR) increased over the festive period as has been the case in previous years. However, post the New Year bank holiday POLR has begun to reduce once more. Generally, POLR in the North continues to reduce in line with the planned trajectory and is currently on track for achieving eradication by the end of February. Achievement of this is highly dependent upon sourcing and bringing on-line the additional capacity indicated in the plan.

The System Winter Steering Group remains live and has overall oversight of the Winter Plan to recalibrate, assess and action as required. Not all capacity planned in December was delivered due to workforce constraints; the workforce risk remains significantly high. Continual monitoring and action will be ongoing throughout winter. System Escalation Plan discussions continue, with system partners adopting the Escalation Plan during times of extreme pressure and agreed actions in place to mitigate risks.

The System Control Centre (SCC) went live on 1 December and is being staffed by the ICB. The SCC gives oversight of operational pressures and is supporting the system (alongside intelligent data) to understand current demand to make informed decisions alongside around flexibility of the winter plan. The SCC role during the festive period was imperative to collaborative system working and managing the extreme system pressures experienced. A thorough de-brief is underway to ensure that system actions are reviewed, and learning is embedded immediately and for future management.

4.0 Quality and safety

4.1 Impact of Current System Pressures

The nursing and quality teams, with oversight from the Quality and Safety Committee, are working with provider colleagues to monitor the impact of the increase in wait times for urgent care and treatment, including ambulance responses and delays in off-loading patients on arrival at hospital. From this monitoring, opportunities to learn and improve will be identified. There will be a focus on quality improvement as well as assurance, which will be collectively owned and managed across the system.

4.2 Clinical upskilling pilot

Following the successful bid for funds, this programme continued in December 2022 with a group of ICB non-practicing clinical staff. When there is less pressure on the system, these staff will continue their upskilling by shadowing on their chosen ward areas. In general, there are an increasing number of staff who are supporting the system by making themselves available for shifts.

5.0 COVID-19

5.1 Latest figures

- **385,025 autumn boosters given since 5 September 2022**
- **Continued availability of Autumn Booster until mid-February 2023**
- **Currently no plans by the Joint Committee on Vaccination and Immunisation (JCVI) to widen eligible cohorts or enact any surge planning**

5.2 Activity

This month, we are hosting two engagement events with partners, including Citizens Advice and Warm and Well, where vaccinations will be available. Several clinics for homeless people at well-used centres and shelters are planned and Spotify and DAX ads, and a paid for social media advertising campaign, launched on 9 January. The out-of-home advertising campaign aimed at Black African, Black Caribbean, Black British communities, and pregnant women, that has been running since November, will continue until the end of January.

5.3 Site hibernations

We have been reviewing our COVID-19 vaccination sites with a view to temporarily 'hibernating' some of them between January and March – as there will be less demand for vaccination. Several of our GP practice clinics will be amongst those hibernating so that they can focus their capacity on their usual practice activity.

Many community pharmacies will continue to offer the COVID-19 vaccination, alongside our mobile vaccination teams who will hold clinics across the Staffordshire and Stoke-on-Trent area. Many of our COVID-19 vaccination sites are now also offering flu vaccination.

6.0 Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

David Pearson, Interim ICB Chair

Peter Axon, Interim ICB Chief Executive Officer

Appendix 1
NHS Industrial Action

January 2023

Executive Summary

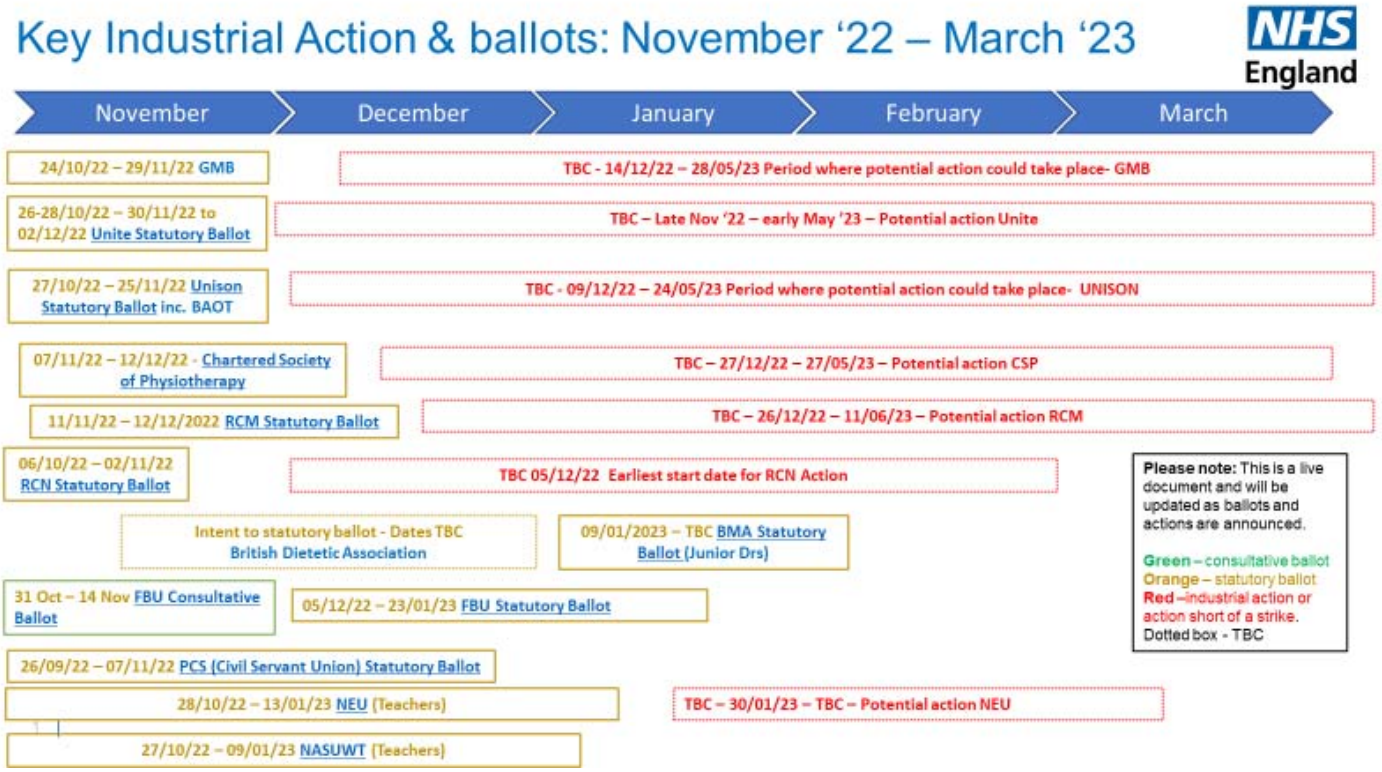
Trade unions representing some NHS staff are in dispute with the Government over the 2022/23 pay award.

In addition to the Royal College of Nursing (RCN) strike action on 15 and 20 December, and GMB and Unite (ambulance staff) strike action on 21 December, members of the GMB and UNISON (ambulance staff) are striking on 11 January, members of the Royal College of Nursing are striking on 18 and 19 January, and members of UNISON (ambulance staff) are striking on 23 January.

Ambulance service industrial action will have impacts across the system for the days of action. The RCN action on 18 and 19 January impact Midlands Partnership NHS Foundation Trust, and Midlands and Lancashire Commissioning Support Unit, directly, and will have wider impacts across the system. As trade unions continue to ballot their members, further strike action dates are anticipated for up to six months, and potentially ongoing depending upon ballot mandates.

Preparedness for RCN Industrial Action is led on an organisation-by-organisation basis with support through the ICB EPRR, UEC and People Hub functions as required.

Derogation discussions continue at a national and local level with unions to agree services to be maintained to ensure patient safety during strike action. A national list of derogations is publicly available.



Ambulance Service Industrial Action Integrated Care System Coordination

NHSE instructed the following measures were to be enacted across Integrated Care Systems (ICS) to mitigate the IA action:

1. Ensure measures are in place to enable all ambulances to handover patients no later than 15 minutes after arrival.
2. Free up maximum bed capacity by safely discharging patients, working closely with system partners, in advance of industrial action.
3. Confirm system-level operational plans for the days of ambulance industrial action with NHS England regional teams by 16:00 Monday 19 December to allow for any additional support to be considered and arranged. These plans must include how Emergency Departments will ensure the release of all ambulances within 15 minutes

ICS partners worked together to ensure robust planning was completed to provide assurance that:

- Patient safety is at the heart and centre of all planning
- Provide business services as usual across the NHS as far as practically possible, ensuring a full provision of services available
- Ensure effective communications in line with NHSE England mandates
- Ensure the risks associated with IA where possible are mitigated and highlighted across the system
- Identify a battle rhythm across the system and escalation process for system partners,
- Outline each ICS partners additional actions across SSOT to support patient safety of the population and continuation of services

The ICS industrial action plan remains live and is updated during daily system calls to reflect organisational and agreed system actions, and following Regional Incident Management Team

meetings between NHSE, ICBs, and Ambulance Services as necessary. ICS partners are briefed regularly on the outcomes of these meetings through the EPRR function.

ICS Roles and Responsibilities

- **NHS Trusts -** will work with ICB/ICS locally to undertake a risk assessment of the impact of industrial action and complete a mitigation plan to maintain critical service.
- **Integrated Care Boards (ICBs) -** will work with NHSE to ensure their local system is assured and prepared for potential industrial action. They will provide daily situational reporting via the NHSE Regional Operations Centres.
- **ICB Chief Delivery Officer (CDO) -** to act as the executive level responsible for system resilience and preparedness for NHS industrial action events 22-23, and to take strategic command of the system in the response to Industrial action events
- **ICS System Call -** to act as the system tactical level for assurance, coordination and response to incidents, and impacts from industrial action
- **ICB System Control Centre/Urgent Care Operations Team -** to ensure system oversight, information gathering and escalation to system partners or where required regional escalation routes for Industrial Action affecting SSOT.
- **ICB Emergency Preparedness Resilience and Response (EPRR) Strategic Lead -** to ensure EPRR processes are followed and embedded within Industrial Action planning.

Preparedness and Response

In advance of January's ambulance strike industrial action, the following actions have been set out by NHSE, and are observed within the organisation specific actions within the ICS industrial action plan:

- Any prospective elective cancelations made from 4 January through to 22 January are agreed with ICBs and NHSE regional team in the first instance.
- Between 10-13th January ICS's have Strategic, Tactical and Operational (Gold, Silver and Bronze), meetings stood up throughout the period at regular intervals.
- Providers have Senior level leadership in place including senior/executive leadership visible throughout the IA period,
- Suitably trained and experienced in UEC/ Ambulance operations,
- Additional Medical/Consultants in ED and senior decision makers leading discharge processes
- On the 10 - 12 January that there are no Ambulance Handover delays >15mins (national standard),
- Discharge Profiles for Tuesday 10 and Wednesday 11 January are designed to maximise flow, with an emphasis on pre 10am and pre 12pm discharge – confirmation of agreed discharge numbers planned for S&T and complex as part of the system plan,
- Plans for MADE events to be held in support of the day of action,
- Pharmacy teams are resourced to support the processes of early and timely discharge,
- Additional resource has been planned and in place across all community partners to support the flow of activity away from Ambulance Services and EDs and into the community,
- How additional resource will be deployed to support safe discharge from Community Hospitals/Beds and Mental Health beds, enabling rapid flow from acute partners.

Partners have established robust actions within the ICS industrial action plan which can be made available as needed for information.

Learning from December 2022 Industrial Action

System partners engaged with a hot debrief process to capture initial learning following ambulance service industrial action on 21 December 2022, summarised below:

- Risks were mitigated by the ICB System Control Centre (SCC) and EPRR function as far as reasonably practical
- Actions and plans were monitored by the SCC enabling clear escalation routes and unblocking of arising risks and issues
- Existing governance structures utilised, with standing system calls used as gold command for robust risk identification and decision making
- ICB Clinical leads and additional acute support in medicine supported triage and expedited discharge pathways
- Clear command and control structures established with visible clinical leadership
- Additional capacity created and bolstered to ensure patient safety
- Level 4 actions utilised to support discharge and flow
- Timely and staggered discharges possible with transport support
- UCCC triage bolstered by additional MPFT staffing
- Enhanced falls response from CRIS
- Clear communications with providers
- Additional discharges enabled prior to strike action to increase capacity

Some learning was identified for future planning, which has been included within industrial action plans ahead of action on 11, 18, 19 and 23 January:

- Further work to understand integrated work and success of actions undertaken on 21 December
- Extension of senior decision maker operating hours to support flow into the evening pre- and post-industrial action periods at UHNM
- Review of strategic and tactical roles
- Utilisation of space available to support discharges
- Further work to identify improved mechanisms for cross-border working and collaboration to support UHDB
- Direct escalation route for CRIS into WMAS 999 where required
- Improved junior medic cover at NSCHT
- Review of staffing and rota, including bank and reserve workforce

Ongoing Learning and Preparedness

As with industrial action undertaken on 21 December 2022, a continual review process is in place to identify lessons and recommendations against the live ICS industrial action plan, in anticipation of planned and unconfirmed future dates of action.

The ICB will continue to support planning for RCN industrial action in addition to the steps outlined above for ambulance service industrial action on an ongoing basis as future dates are announced.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**07**

Title:	**Pre-consultation business case - Inpatient Mental Health Services previously provided at the George Bryan Centre**

Meeting Date:	19 January 2023

Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Chris Bird, Chief Transformation Officer, ICB Dr Paul Edmondson-Jones, Chief Medical Officer, ICB	Y	Helen Slater, Associate Director of Transformation, ICB Nicola Bromage, Head of Strategic Commissioning, ICB Tracey Shewan, Director of Communications and Corporate Services, ICB

Clinical Reviewer:	Clinical Sign-off Required Y/N
Dr Abid Khan, Medical Director, MPFT Lisa Agell, Operations Director Unplanned Care & Mental Health, MPFT Dr Paul Edmondson-Jones, Chief Medical Officer, ICB	Y

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

Is the Board being asked to make a decision/approve this item? Y			
Is the decision to be taken within Board 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	**Decision's Value / SOFD Limit**	Not applicable

History of the paper – where has this paper been presented		
The proposal and updates throughout the programme have been considered by:	**Date**	**A/D/S/I**
ICS Mental Health Programme Board	23/06/22	R/A
MPFT Major Transaction Committee	28/06/22	R
MPFT Trust Board	30/06/22	R
Staffordshire Health and Care Overview and Scrutiny Committee	01/08/22	I/D
SSoT ICB Board	18/08/22	R/A

SSoT ICB Finance and Performance Committee	01/11/22	I/D
NHSE Stage 2 Assurance Panel	30/11/22	S
SSoT ICB Quality and Safety Committee	14/12/22	I/D
SSoT ICB Finance and Performance Committee	03/01/23	A/D

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

This paper provides the Board with the Pre-Consultation Business Case (PCBC) for inpatient mental health services previously provided at the George Bryan Centre.

In August 2022 the Integrated Care Board received the business case and associated documents which set out the process undertaken to develop the long-term proposals for in-patient mental health services that were previously provided at the George Bryan Centre in Tamworth. The Board was assured by the process undertaken and agreed for the business case to progress to NHS England (NHSE) for the Stage 2 Assurance meeting.

An informal assurance meeting was convened with NHSE on 21st September 2022 with the formal assurance meeting being held on 30th November 2022 where ICB and MPFT colleagues presented the following evidence:

- The Pre-Consultation Business Case and appendices.
- The Clinical Senate Report – this is also available publicly on the West Midlands Clinical Senate website https://midlandssenates.nhs.uk/
- The consultation plan and associated documents – this included the Communications & Involvement Plan approved by ICB Quality & Safety Committee on 9th November 2022 and the draft Consultation Document approved by ICB Quality & Safety Committee on 14th December 2022.
- Confirmation of capital funding requirements - There are no direct capital costs arising from the proposal outlined within the PCBC. Transition and transaction costs are sourced from within existing allocations with no additional funding requirements.
- Inclusion of the legal advice the ICB received from our legal advisors, Mills & Reeve, in relation to the single viable proposal outlined in the PCBC, the business case details the process by which the viable option was identified.

Following the regional assurance panel on the 30th November 2022 and through subsequent discussions, NHSE have confirmed they are assured that the proposals meet the five tests for service change as well as other good practice tests and are content for the ICB to proceed to consultation.

Based on recommendations from NHSE a series of amendments have been made to the business case submitted to ICB Board in August 2022. Most notably setting the ICB strategic direction for mental health services and sustainability of the clinical model/workforce. The PCBC has been informed by extensive patient, public, staff and stakeholder engagement, which is set out in detail in the accompanying business case. The business case has been through a governance process that has included approval by MPFT Board, approval from the West Midlands Clinical Senate and has been approved by NHSE Stage 2 Assurance panel. The Staffordshire Health Overview and Scrutiny Committee have received regularly updated on the process that has been followed and are assured. The activity undertaken as described in the business case meets the key legal requirements when proposing service change.

In 2019 two proposals were identified. These were (1) to Centralise inpatient beds at St George's Hospital and (2) Provide beds at George Bryan Centre site. Due to the strong evidence that older adults (especially those who need dementia care) should be cared for in their usual place of residence, it was not recommended to reinstate the 12 older adult (dementia) beds. It is recommended that the enhanced community service is continued and would best support these patients in their usual place of residence. This enhanced community service would be in place for both proposals.

In autumn 2021, following a pause in the options appraisal process due to COVID-19, the programme team undertook additional sense check involvement activity. This included an online survey and two online events. The objective of this activity was to understand if there were any new considerations. No additional proposals were identified at this stage.

A Technical Group was held in December 2021, which considered feedback from the sense-check involvement activity, alongside the clinical model, activity and workforce data. This was reviewed by a group, including clinicians, staff and Healthwatch representatives. The group identified that there were no new proposals to be considered at this stage. The technical group of experts was asked to consider whether the proposals remained viable and realistic.

The group discussed advantages and disadvantages of both proposals, including meeting the needs of patients, travel impacts, workforce requirements in the context of the national model for mental health services. Reflecting that lower-level needs are now supported in the community; it was recognised that the needs of patients currently being cared for as inpatients at St George's Hospital are greater than could be admitted to a standalone site. This is because there are limited numbers of specialist staff and no psychiatric intensive care available when the patient needs additional support. This, alongside the ability to maintain a high level of care during periods of staff absences, increased ability to manage crises and the need to transfer unwell patients, led the group to recommend there is one viable proposal, which is to make permanent the current clinical model of 18 beds at St George's Hospital, Stafford, supported by enhanced community provision.

Based upon the involvement activity to date, it is recommended that the ICB undertake a 6-week public consultation. The aims of this will be:

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

The communication and involvement plan outlines the process for consultation and the methods used to seek involvement, this includes an online questionnaire, two structured online events and four drop in roadshows.

Our recommendation to the Board is:

1. To formally approve:
   - Pre-Consultation Business Case and appendices
   - Communication and Involvement Plan
   - Consultation Document (including consultation questionnaire)
2. To approve 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.
3. To approve a consultation period of 6 weeks.

Enclosed documents include:

- Pre-Consultation Business Case and appendices
- Communications and Involvement plan
- Consultation document, including questionnaire

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

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

Implications:	
Legal and/or Risk	The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services and influence ICB decisions at the level of participation they choose as set out in the NHS Act (2006). As part of the Public Sector Equality Duty as contained in section 149 of the Equality Act 2010, decision-makers need to adhere to the Brown Principles to demonstrate their due regard to the aims set out in the general equality duties. The Board must have due regard to the need to: • Eliminate discrimination • Advance equality of opportunity • Foster good relations between different people when carrying out their activities. To 'have due regard' means that in making decisions and in its other day-to-day activities a body subject to the duty must consciously consider the need to do the things set out in the general equality duty. We will consult the Local Authority Health Overview & Scrutiny Committee when the ICB is considering any proposal for: • A substantial development of the health service in the area, or • A substantial variation in the provision of a service. This is underpinned by S244 of the NHS Act 2006 and explained further by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The ICB has a legal duty under the Equality Act (2010) to promote equality through the services we commission and establish processes to hear the voices of local people irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. Planning, assuring and delivering service change for patients (PADs) is a key NHS guidance to consider. The guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports ICSs to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.
CQC/Regulator	None
Patient Safety	Full details of the implications are outlined within the business case

Financial – if yes, they have been assured by the CFO	
Sustainability	
Workforce / Training	

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	**Y**	27.04.22
1b.	What was the outcome from the System QIA Panel? **Approved** at QIA panel with two amendments		
1c	Were there any conditions? If yes, please state details and the actions in taken in response: • **Condition 1 & action taken** To add in information on the impact of social isolation and mitigations -including activities that will wrap around people in their homes/ communities. This information has been added to the QIA and the business case. • **Condition 2 & action taken** To add in the impact on staff mileage protection expiring and mitigations. This information has been added to the QIA and the business case.		
2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 • **Stage 2 approved**	**Y**	22.03.22 and updated 07.11.22
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? Protected groups were not specifically targeted, but recruitment activity for this programme included a range of community groups and organisations which are known for including or could include identified protected characteristics within their membership or networks throughout the involvement activity from 2019 to date. Stakeholders included voluntary organisations, service providers, local councils, support groups and religious organisations. Participants to surveys, workshops and the reference group were asked to complete Protected Characteristic profiling questions, with a mid-point review of the involvement activity identifying any geographical areas or groups with lower response rates than expected or representative of the population. In such cases, remedial activity was undertaken to encourage participation to ensure we heard as representative a voice as possible during the involvement activity. Another group - not recognised with protected characteristic status through the		

	Equality Act 2010 - was carers. All of the involvement activity - the survey and events, and reference group - were advertised widely and carers, a protected group we were keen to seek views, from participated throughout. • Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements) The main impact raised during the involvement activity relates to the potential additional travel for patients and carers, if a person requires admission to an inpatient bed. • What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?) MPFT are developing a travel policy, which will be available on their website, which will provide details of support available. • Explain any 'objective justification' considerations, if applicable • N/A		
3.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients ***Please provide detail***	**Y**	2019 - ongoing
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	

Recommendations / Action Required:

The Integrated Care Board is asked to:

1. Formally approve:
   - Pre-Consultation Business Case and appendices
   - Communication and Involvement Plan
   - Consultation Document (including consultation questionnaire)

2. Approve 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.

3. Approve a consultation period of 6 weeks.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**08**

Title:	**Board Update Paper on NHS England Delegations to ICBs**

Meeting Date:	19 January 2023

Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Chris Bird, Chief Transformation Officer	YES	Paul Winter, Associate Director of Governance // Jo Melling, Senior Programme Director, NHSE

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 Board being asked to make a decision/approve this item? NO			
Is the decision to be taken within Board delegated powers & financial limits?			
Paper is not for decision today – for awareness and initial discussion purposes. Approval decisions will be taken at the March Board, prior to April 1st commencement.			
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**
First Discussion today	-	-

Purpose of the Paper (Key Points + Executive Summary):
As initially set out in NHS Operational Planning Guidance, the decision has been taken to delegate some of NHS England's Direct Commissioning functions to ICBs, on behalf of ICSs, as soon as operationally feasible. From the 1st of April 2023, ICBs will 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 NHS England's Specialised Commissioning duties will be delegated to ICBs from April 1st 2024. The 2023/24 financial year will see much closer joint working between NHSE and ICBs in preparation for full Joint Commissioning from this point.

The plan is for further areas of Direct Commissioning duties and responsibilities to follow in the future. Functions to be retained by NHS England nationally will include:

- Responsibility for some Specialised Services that need to be centrally commissioned
- Identifying national priorities, setting outcomes and developing national contracts or contractual frameworks
- Maintaining national policies and guidance that will support ICBs to be effective in their delegated functions
- Delivering support services

Giving ICB / ICSs responsibility for Direct Commissioning is 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 / other staff.

Is there a potential/actual Conflict of Interest?	**NO**
Outline any potential Conflict of Interest and recommend how this might be mitigated	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
The proposals to delegate additional commissioning functions, duties and responsibilities has a direct or indirect impact upon all corporate Risks, Issues and Strategic Objectives in the BAF – not just those already pertaining to Primary Care – as this is the ICB assuming direct, formal responsibility for commissioning and arranging for additional healthcare services that each of these existing matters and wider ICB Statutory Duties already refer to.

Implications:	
Legal and/or Risk	Delegation and Joint Working under S.65Z5/6 of the 2022 Health & Care Act
CQC/Regulator	These are all regulated services, so existing CQC interfaces apply
Patient Safety	The ICB is assuming responsibility for all Quality & Safety statutory duties
Financial – if yes, they have been assured by the CFO	The ICB is assuming responsibility for all Financial statutory duties; and through a new Financial Risk Share process will work jointly with other ICBs
Sustainability	These services all fall under existing Greener NHS programme strategies
Workforce / Training	Most NHSE staff will transfer to 'Hosted Teams' (led by 2 ICBs, East & West Midlands): all ICB staff will need to appreciate the additional duties the delegations will place upon their day-to-day operational duties; and make the relevant operational links with their Hosted Team

Key Requirements:		**Y/N**	**Date**
1a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group? ("No" as NHSE would be expected to produce the initial assessment; although the ultimate liability for post-delegation EQIAs will transfer to ICBs)	**NO**	
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~~.		
Key Requirements:		**Y/N**	**Date**

2a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • ~~Stage 1~~ • ~~Stage 2~~	**NO**	
2b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? ("No" as NHSE would be expected to produce the initial assessment; although the ultimate liability for post-delegation QIAs will transfer to ICBs)		
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***	**NO**	
4.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail*** (NHSE have produced an initial DPIA for data-sharing personal data relating to commissioned services ready to transfer the duties to ICBs and enable lawful, safe access to relevant data for those areas where liability for post-delegation DPIAs will transfer to ICBs)	**YES**	**Nov-22**

Recommendations / Action Required:
The Integrated Care Board is asked to: **NOTE** the appended Discussion Paper in readiness for a suite of formal governance documentation to follow in March for Board approval

ICB Briefing - The Delegation of NHS England (NHSE) Functions to ICBs

Overview

1.1 By delegating some NHSE commissioning functions to ICBs, the aim is to break down barriers and join up fragmentated pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it. The services that will be delegated to ICBs are:

- Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1st April 2023
- Complaints functions associated with these Services
- Specified Specialised Services (Acute & Pharmacy) April 2024

1.2 Delegation of these services is national policy. In all cases, the responsibility and liability for the planning, performance, finance, quality and improvement will move from NHSE to ICBs upon delegation. The ICB will be responsible for any claims (negligence, fraud, recklessness, or breach of the Delegation). However, in all cases NHSE remains accountable to Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.

1.3 ICBs and NHSE have worked together to co-produce the approach to delegation in order to achieve the safest and most effective approach, given the challenges facing the NHS at this time. We do need to be clearly focussed on our operational accountabilities alongside this important work to ensure we deliver for our populations.

Planning Footprints and Hosting

2.1 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 in order to meet the 'Quadruple Aim' objectives.

2.2 As a basis for joint planning for delegated and devolved functions, ICB CEOs and NHSE Executives have worked on the principle of pragmatic strategic planning ensuring that skills are retained and that specialised resources are shared between ICBs and between ICBs / NHSE, where appropriate.

2.3 Whilst all decisions will be through formal Joint Working arrangements (committees or groups), ensuring equal and equitable decision-making for each individual ICB, with no one ICB having primacy over another, the hosting of the workforce requires one ICB to provide this function on behalf of the other ICBs (and, for specialised services, NHSE).

2.4 The Host ICB will provide, oversight, leadership, and support for the workforce. The workforce will work for and on behalf of, each ICB within the planning footprint (East/West or Midlands). This will be supported by a formal hosting agreement between the ICBs and, for specialised services, between the ICBs and NHSE.

2.5 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.

2.6 Recognising that authority does not rest with one individual or individual ICB a model of 'Distributed Leadership' will be adopted to implement shared vision / values and continue the ICB and regional commitment to collaboration and building a strong learning culture.

2.7 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

2.8 The Distributed Leadership model of strategic leadership for Primary Care POD will be through Herefordshire & Worcestershire ICB for the West; Nottingham & Nottinghamshire ICB for the East.

2.9 The Complaints Workforce that aligns to Primary Care will also transfer to the Hosts. However, there is recognition that there are still some national policy agreements and operating model challenges to be resolved, informed by national policy discussions.

2.10 Services will be delegated from 1st April 2024; however, it is planned that, subject to consultation, workforce transfers for POD, Primary Medical Service support and complaints staff will transfer on 1st July 2023. This will be on a multi-disciplinary basis; also including commissioning finance and clinical reviewers, but with specialised healthcare Public Health team members aligned or embedded to teams, not transferred.

2.11 The Specialised Services joint ICB and NHSE workforce 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.

2.12 Further discussions are ongoing regarding the Distributed Leadership model for specialised services, which will be resolved in advance of formation of formal joint working arrangements and delegation.

2.13 A Governance Framework is illustrated as Appendix One, setting out the agreed co-ordination arrangements for the delegated and devolved functions; which will be undertaken through the following Joint Working (committee or group) forums.

[Note: the Terms of Reference for each of these forums will form part of a suite of Governance Framework documents for each ICB Board to sign off locally before April 1st 2023, as noted in the "Next Steps" section below].

(a) The current East Midlands and West Midlands Collaborative Commissioning Boards will transition into formal Joint Committees, operating at 'Tier One' – with a quarterly 'Committee-in-Common', where both East and West Midlands Committees will come together as 11 ICBs for decisions that require a whole Midlands planning footprint. The Joint Committee's membership will be comprised of each ICB's CEO (and Chair if so desired) and NHSE Directors;

(b) For Primary Care POD, two East Midlands and West Midlands Joint Commissioning Groups, operating at 'Tier Two' and led by ICB Directors (NHSE will not be members), will be formed in shadow by March 2023, to be fully operational from 1st April 2023;

(c) The Joint Commissioning Groups supported in turn by three "Tier 3 Pillar Groups", one each for Pharmacy, Optometry & Dentistry, taking often highly-regulated, pertinent to each Primary Care profession decisions. To be led by ICBs, who may assign operational leads as members to each Pillar Group, if so desired, to work alongside the Hosted Teams in taking the day-to-day transactional / operational commissioning decisions. (Again, NHSE will not be members).

2.14 The model of Distributed Leadership will continue through into the POD Joint Commissioning Groups. To ensure sufficient clinical and financial expertise into the groups, one POD ICB(S) Finance Lead and one POD ICB(S) Quality Lead – nominated as Lead ICB rep by the 5 or 6 ICBs comprising the East or West Joint Commissioning Groups – will also form the core membership of the Joint Commissioning Groups.

2.15 These will sit alongside the *de minimus* requirement of each ICB's Director of Primary Care (or equivalent) being each ICB's standing representative. It is envisaged this person will also be acting as the ICB's "Authorised Officer", as set out within ICB-to-ICB and ICB-to-NHSE Joint Working Agreements.

Further Delegated Functions

3.1 *Immunisation and Vaccination Services* – subject to confirmation of the national policy position, it is expected these will be delegated to ICBs from April 2024. NHSE are currently integrating the Covid programme with the Vaccination Team and separating Vaccination / Immunisation and Screening functions. NHSE will work with ICBs throughout 2023/24 to develop the operating model ready for delegation.

3.2 *Screening Services* – given the strategic, infrastructure and digital development work needed to underpin safe, effective / equitable delegation of these, and their complex end-to-end nature, this is unlikely to be possible or desirable within the same timeframe.

The West Midlands Office – overview

4.1 On 9th December 2022 the CEOs of the six West Midlands ICBs agreed to formally establish an 'Office of the West Midlands' to work on their behalf. The Office will initially have two key roles:

(1) 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 (BSol), to employ the staff / teams being transferred from NHSE - as previously noted in sections 2.7 & 2.11:

- The first phase of this will involve the POD Team being transferred from April 2023. BSol will provide employment to the Team and corporate support only, with the expertise & leadership on POD provided by Hereford & Worcester ICB (see section 2.8 above). This will ensure wider leadership and involvement across ICBs; and H&W will be the key link for all ICBs and for the region for this function;
- Secondly, it has been agreed that for Specialised Commissioning, the Midlands-wide team will be hosted and employed through BSol from April 2024. (More work on the arrangements and leadership will take place over the next few months.)

(2) To agree a programme of work / set of priority areas for ICBs to work at scale for the benefit of West Midlands patients[1]. This will again be led by different ICBs to ensure distributive leadership.

[1] This would involve commissioning a set of agreed functions / services at West Midlands level (through shared leadership, joint decision-making), and provide a vehicle for future delegated services from NHSE. It would help identify shared priorities / goals through a clear work programme owned by ICBs together via BSol as Host ICB using the distributive leadership model to co-ordinate expertise across a range of functions / teams from each ICB, and provide a single coherent voice for the West Midlands, where appropriate, sharing learning and supporting improvement across all ICBs.

Next Steps

5.1 The next, immediate steps to support NHSE to ICB delegation are:

(i) Finalising the draft Governance Framework documentation – a pack for each ICB / its Board, setting out the formal NHSE to ICB Delegation & NHSE to ICB / ICB to ICB Joint Working Agreements, Terms of Reference for joint forums, Memorandum of Understanding between ICBs / Host ICB etc – due for completion early Q4 22/23;

(ii) We will be asking the Board to approve the delegation and the above pack of documentation at their meeting in March 2023;

(iii) We use the Q4 prep period to progress our internal, pan-Directorate “Task & Finish Group” to set out our internal ICB arrangements in response. Enabling how we both support preparation for formal delegation and effectively co-ordinate our internal governance arrangements. (For example forging the necessary robust links between West Midlands sub-regional and internal SSOT ICB decision-making arrangements: e.g. F&P committee, Quality & Safety committee etc. Thereby ensuring that the full range of internal / stakeholder colleagues are actively involved in engaging on key issues like forming the essential, operational day-to-day Hosted Team interactions. All the above to be formally supported by our own, principal ICB governance frameworks like the Schemes of Reservation & Delegation and Financial Delegation).

NHS
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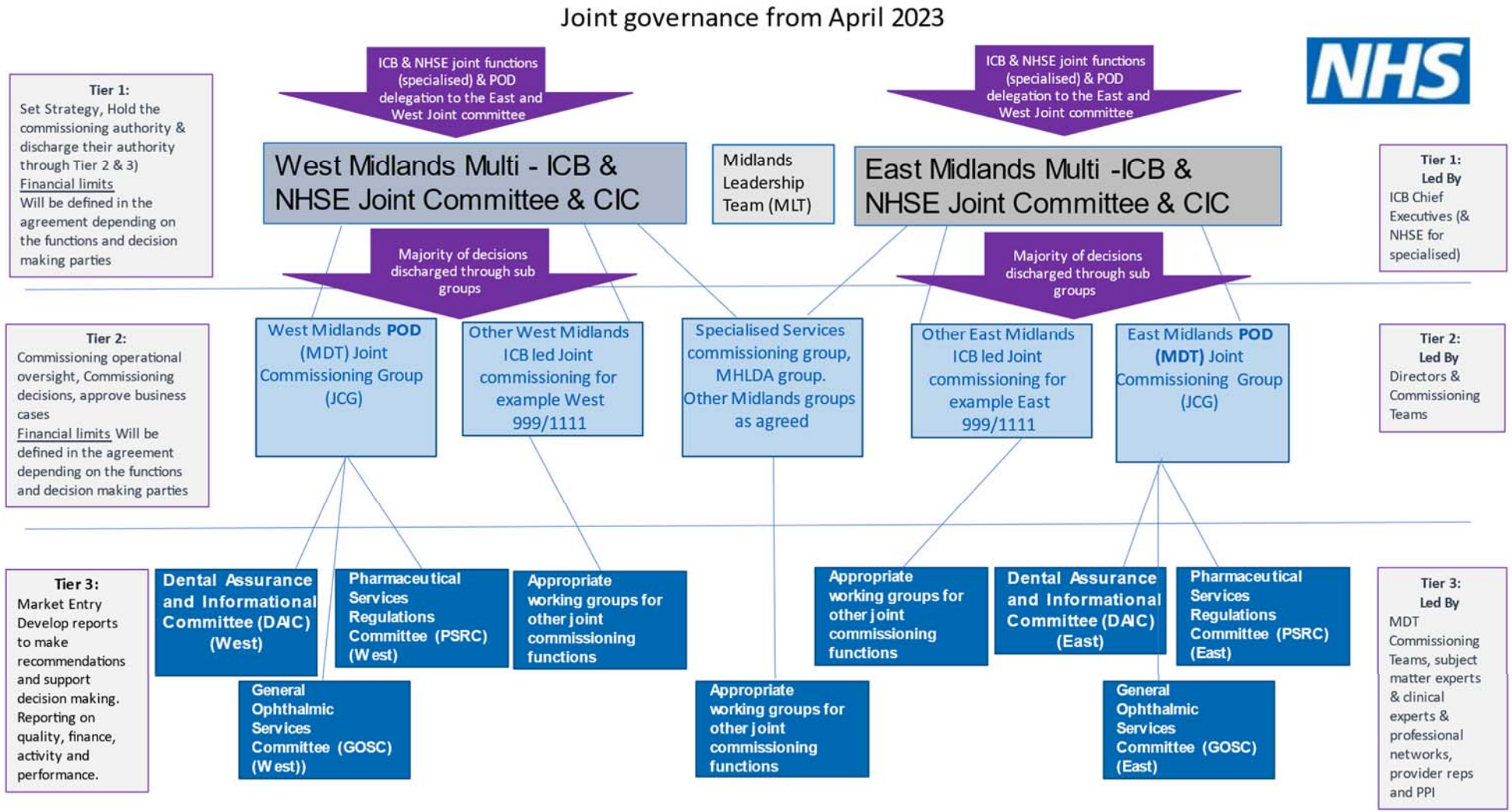
Integrated Care Board

Appendix One – the Governance Framework



NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**09**

Title:	**ICS Development Group – 6 months progress update**

Meeting Date:	19 January 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Peter Axon Sally Young	Y	Kirsten Owen Sally Young

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
	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?			
• Author to check with Finance to determine if the decision is within Scheme of Financial Delegation (SOFD) approved limits			
Within SOFD Y/N		**Decision's Value / SOFD Limit**	

History of the paper – where has this paper been presented		
	Date	A/D/S/I
The ICS Development Group met to discuss the key achievements and priorities to date across the workstreams.	12/01/2023	D

Purpose of the Paper (Key Points + Executive Summary):
This paper provides the Integrated Care Board with an update to the Integrated Care Board on the continued development of the Integrated Care System, following establishment on the 1st July 2022 and the progress made over the last six months, that has been overseen by the ICS Development Group. The paper describes the background into the establishment of the ICS Development Group; the main purpose of the group which is to support the ICS in the ambition to develop and deliver against our first-year development plan. Through our self-assessment against the ICS design principles using the

System Development Tool (SDPT) to understand our main system development gaps, using the agreed development priorities for 2022/23 and ensure that we accelerate and embed system working.

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 are being this is 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 needs be a system wide approach, the emergence of the portfolios leadership arrangements is an ideal opportunity to bring system partners together to describe the system ambition.

Is there a potential/actual Conflict of Interest?	**~~Y~~/N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
There are no conflicts of interest with the paper or recommendations	

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
There are no risks relating to this paper or recommendations

Implications:	
Legal and/or Risk	The on-going development of the ICB and the ICS is critical for the system if we are to deliver our priorities.
CQC/Regulator	Reviewed and deemed not applicable
Patient Safety	Reviewed and deemed not applicable
Financial – if yes, they have been assured by the CFO	Reviewed and deemed not applicable
Sustainability	Reviewed and deemed not applicable
Workforce / Training	As part of the development of the ICB and ICS it is important we develop our workforce.

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? **Reducing Inequalities is key to developing the ICB and ICS.**		
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 applicable		
		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		
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? **This is a paper for information about the ongoing development of the ICS and ICB.**		
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 establishment of the ICS development group
- To note the progress of the ICS development workstreams
  To note that the CEO will work with Senior Leadership Team agree next steps

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Staffordshire and Stoke-on-Trent ICS Development Group – 6 months progress

Introduction

This paper is to provide an update to the Integrated Care Board on the continued development of the Integrated Care System, following establishment on the 1st July 2022, and the progress made over the last six months, that has been overseen by the ICS Development Group.

Background

During the 2021/22 the Staffordshire and Stoke on Trent Health and Social Care system embarked on their transition to become an Integrated Care System with an Integrated Care Board from the 1st July 2022. This transition was informed by national guidance and was formalised by the passing of the 2022 Health and Care Act.

To support systems in this transition NHS England published the System Development Progression Tool (SDPT) that had been designed to sit alongside the ICS Design Framework, other guidance documents that were issued and was intended to support system planning and development throughout 2021/22.

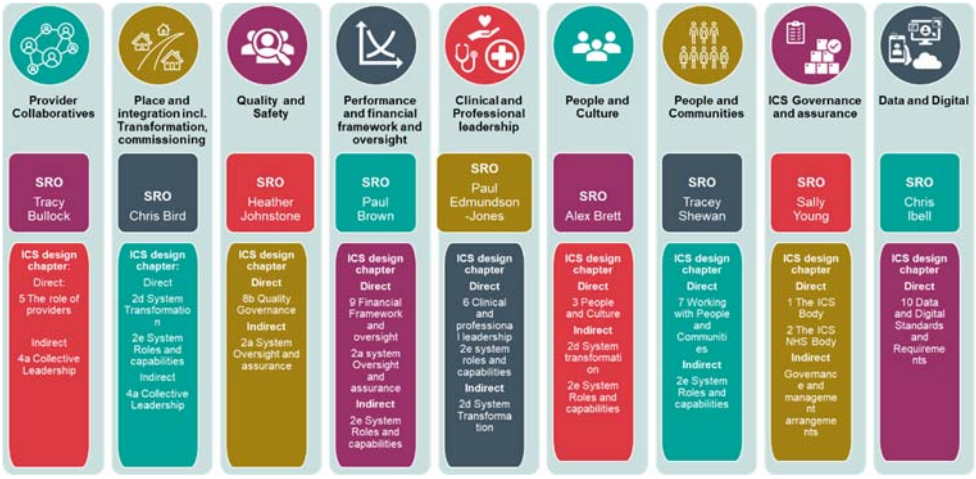
The SSOT ICS Transition Steering Group, adopted the use of the SDPT to identify development priorities, alongside the Readiness to Operate Statements to help broaden thinking outside of the initial areas of focused to become established in July 2022.

Information

The establishment of the ICS and ICB was the conclusion of the transition period however, it was agreed that this should not be the end of the development journey of either the ICS or the ICB, being established was seen as the beginning rather than the end. It was agreed that the ICS Transition Steering Group would morph into the ICS Development Group (ICSDG) that would focus and support the development of the newly established system towards becoming an advanced ICS.

The SDPT was intended to inform development priorities by enabling systems to understand where their main development gaps are and through identifying common system development themes. The ICSDG agreed to continue to use the tool in order to set workstream development priorities for the remainder of 2022/23, along with a refresh of the ICS workstreams.

The refreshed ICS development workstreams were largely aligned with the ICS design framework chapters:



The main purpose of the ICSDG was to support the ICS in the ambition to develop and deliver against our first-year development plan. Through our self-assessment against the ICS design principles, we identified our main system development gaps, agreed the development priorities for 2022/23 and ensure that we accelerate and embed system working.

The ICS development group has agreed a set of principles:

- To support the development journey of Staffordshire and Stoke-on-Trent ICS from establishment to a thriving Integrated Care System by April 2023
- The ICS development work plan for continue improvement and stretch will informed by both the ICS design framework, other national Health and Care guidance documents and our system ambition.
- Work with system partners, to build strong and robust relationships
- To ensure the interdependencies between workstreams is understood and support coordination of the collective effort
- To be informative, supportive, provide constructive challenge and help to problem solve to drive development forward and maintain good progress

The responsibilities of the group were to provide senior executive leadership, strategic direction, and steer in the ongoing development of the Integrated Care System from its establishment in July 2022. They account to the ICB Board and ICS Partnership Board periodically throughout the year on the system review against the progression toolkit.

Progress

The SDPT provides three levels to assess system progress and established priorities to address the gaps identified by determining for each feature the extent to which they can demonstrate:

- **Significant progress**: the ICS can demonstrate sound progress in incorporating the respective ICS Design Feature into its system working arrangements
- **Some progress:** the ICS can demonstrate some progress in incorporating respective ICS Design Feature into its system working arrangements but has gaps
- **Lots to do:** the ICS can demonstrate little progress currently in incorporating respective ICS Design Feature into its system working arrangements

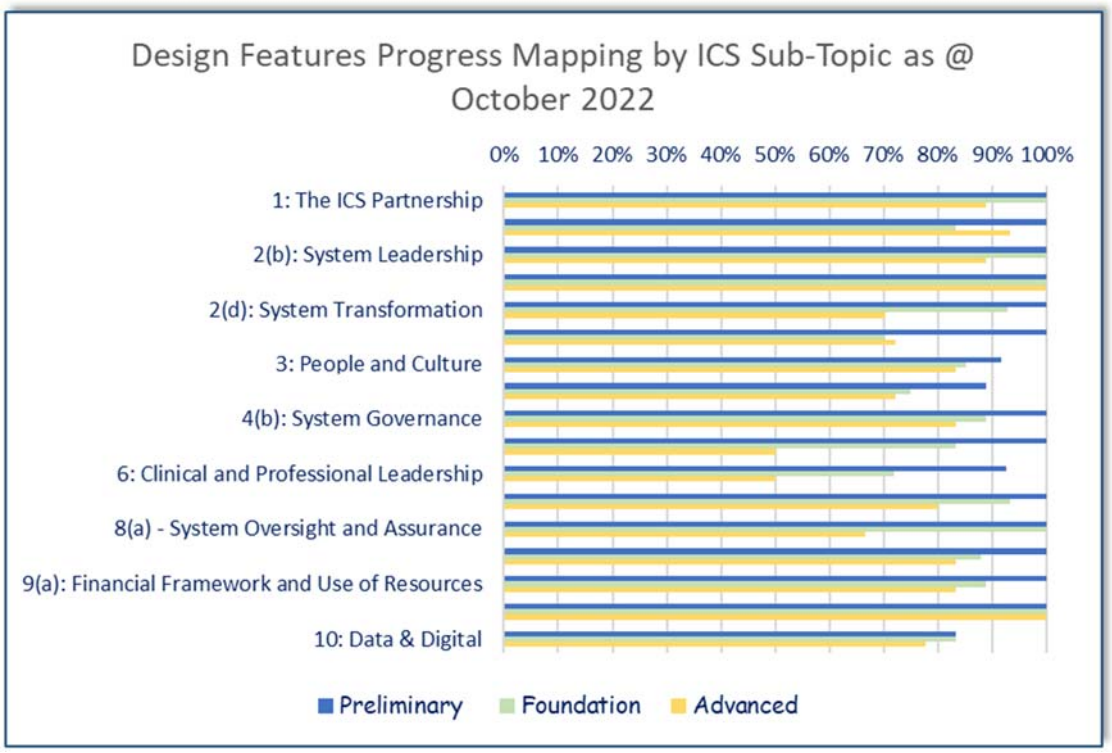
The tool has been divided in to three levels of maturity:

- **preliminary** features assume the old pre 2022 legislative framework,
- **foundation** features assume the 2022 legislative framework,
- **advance** the ambition of the NHS Acct 2022.

The SDPT is a living document, it represents good practice as articulated by systems themselves and is not a statement of NHSE policy. It is intended as a development tool and is not an expression of requirements on systems – nor is it to be used as a performance tool.

As described above the each of the individual workstreams has undertaken a self-assessment against the design features in the SDPT, during 2021-22, July 2022 and the last assessment was in October, results are being this is being reported this month.

The graph below shows the combined results of this assessment under the main design feature headings, please see appendix 1 for the full SDPT



In terms of movement between the July 2022 and the October 2022 self-assessments, in **preliminary** there has been an increase of 3% from 94% to 97%. There are three areas that still showing as some progress rather than significant progress these are:

- **Transformation leadership:** at the time of the assessment the ICB was going through the management of change, and it is expected that this will move to significant progress on the next assessment.
- **People and Culture:** this is largely focused on the talent management section of the assessment and whilst there is progress the workstream lead felt that there is still more to do from a system perspective.
- **Collective Leadership:** this largely focused on the Place based arrangements and again progress is being made, and at the time the assessment in October there were further workshops being held with the local authorities around place-based arrangements, this is being address through the place based workstream.

For maturity level status of **Foundation** this had increased by 10% from 78% to 88% mainly linked to the points above although with a couple of other areas, with the areas of Population Health Management, Talent Management and Clinical and Professional Leadership assessing as still lots to do; these are being addressed by the workstream leads and we would expect these will have moved significantly in our next assessment. In the Advanced maturity level this had also seen in increase of 10% from 69% to 79%.

There will be a further self-assessment undertaken in the next month and this will be report in March 2023.

Next Steps

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 needs to be a system wide approach, the emergence of the portfolios leadership arrangements is an ideal opportunity to bring system partners together to describe the system ambition. The CEO will discuss the ICS development with the ICS Senior Leadership Team and ask them to describe the

future state of Staffordshire and Stoke-on-Trent ICS and what needs to be different to deliver our ambition

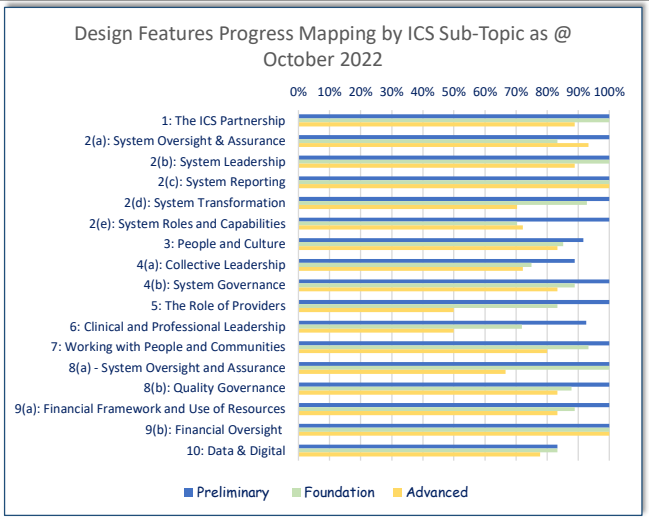
Recommendation

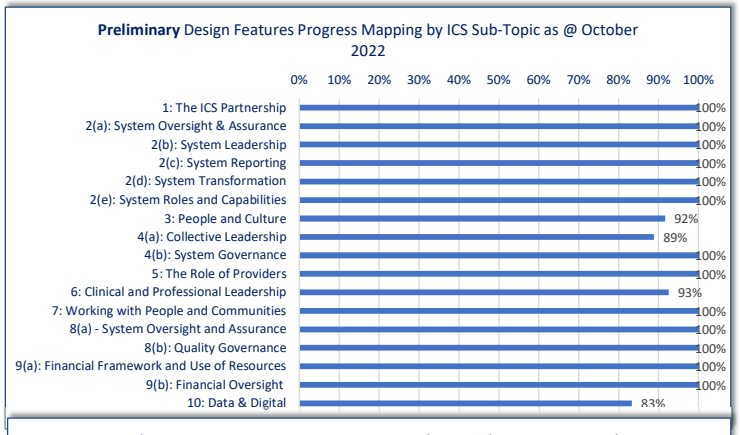
The Integrated Care Board is asked to

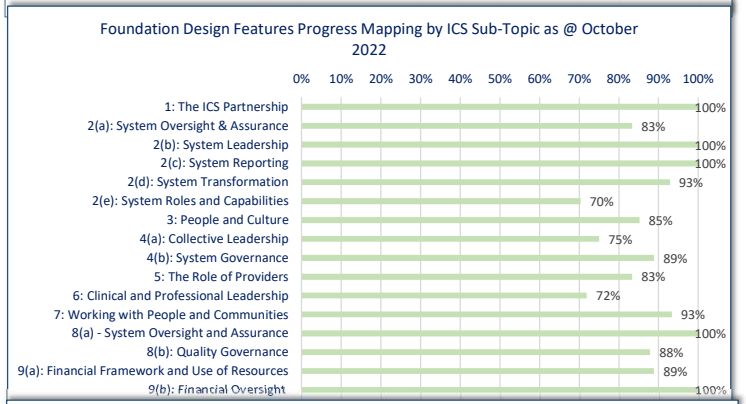
- Note the establishment of the ICS development group
- To note the progress of the ICS development workstreams
- To note that the CEO will work with Senior Leadership Team

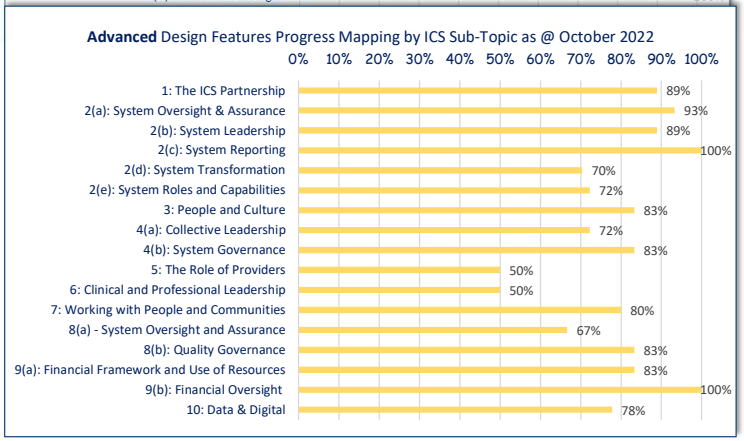
ICS Progress Mapping Diagnostic - By Design Framework Sub-Topic

ICS Sub-Topic	Preliminary	Foundation	Advanced
1: The ICS Partnership	100%	100%	89%
2(a): System Oversight & Assurance	100%	83%	93%
2(b): System Leadership	100%	100%	89%
2(c): System Reporting	100%	100%	100%
2(d): System Transformation	100%	93%	70%
2(e): System Roles and Capabilities	100%	70%	72%
3: People and Culture	92%	85%	83%
4(a): Collective Leadership	89%	75%	72%
4(b): System Governance	100%	89%	83%
5: The Role of Providers	100%	83%	50%
6: Clinical and Professional Leadership	93%	72%	50%
7: Working with People and Communities	100%	93%	80%
8(a) - System Oversight and Assurance	100%	100%	67%
8(b): Quality Governance	100%	88%	83%
9(a): Financial Framework and Use of Resources	100%	89%	83%
9(b): Financial Oversight	100%	100%	100%
10: Data & Digital	83%	83%	78%



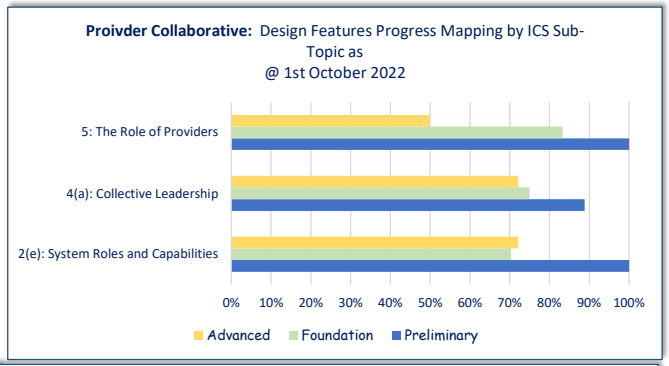


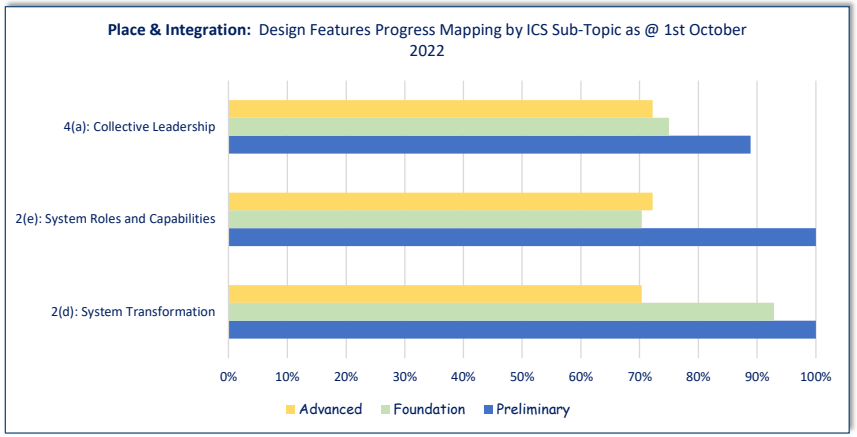


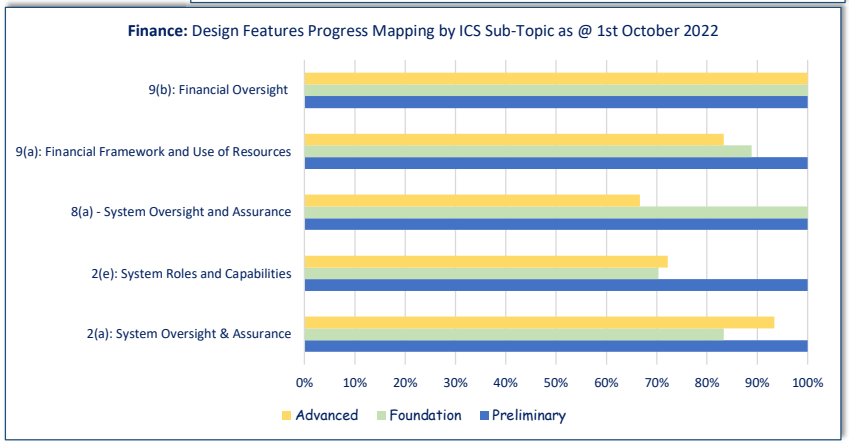


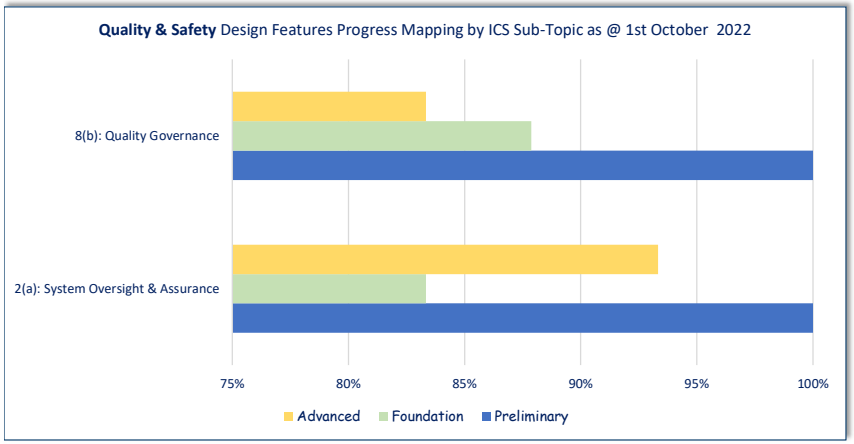
ICS Progress Mapping Diagnostic - By Design Framework Sub-Topic

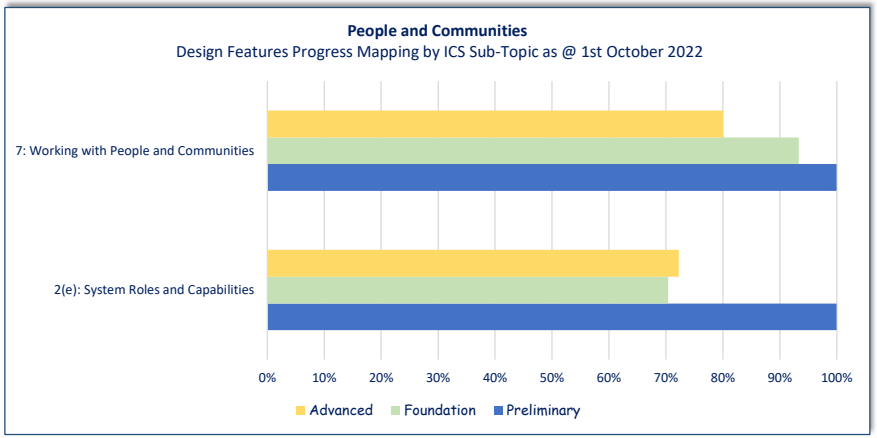
ICS Sub-Topic	Preliminary	Foundation	Advanced
1: The ICS Partnership	100%	100%	89%
2(a): System Oversight & Assurance	100%	83%	93%
2(b): System Leadership	100%	100%	89%
2(c): System Reporting	100%	100%	100%
2(d): System Transformation	100%	93%	70%
2(e): System Roles and Capabilities	100%	70%	72%
3: People and Culture	92%	85%	83%
4(a): Collective Leadership	89%	75%	72%
4(b): System Governance	100%	89%	83%
5: The Role of Providers	100%	83%	50%
6: Clinical and Professional Leadership	93%	72%	50%
7: Working with People and Communities	100%	93%	80%
8(a) - System Oversight and Assurance	100%	100%	67%
8(b): Quality Governance	100%	88%	83%
9(a): Financial Framework and Use of Resources	100%	89%	83%
9(b): Financial Oversight	100%	100%	100%
10: Data & Digital	83%	83%	78%

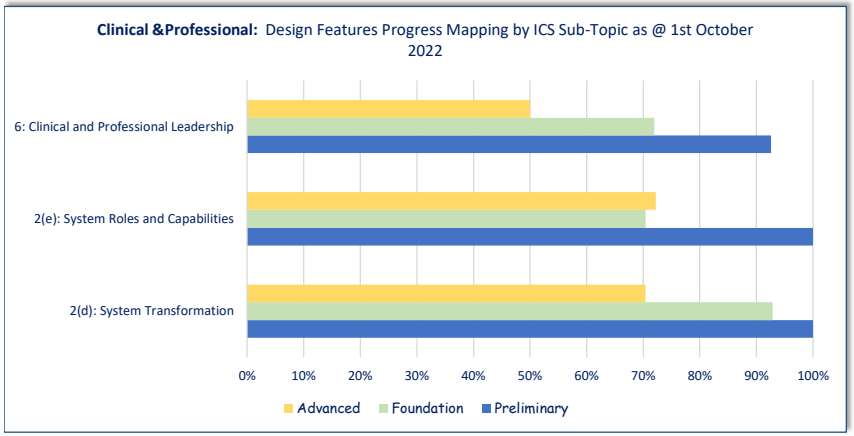








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6: Clinical and Professional Leadership
2(e): System Roles and Capabilities
2(d): System Transformation
0%
10%
20%
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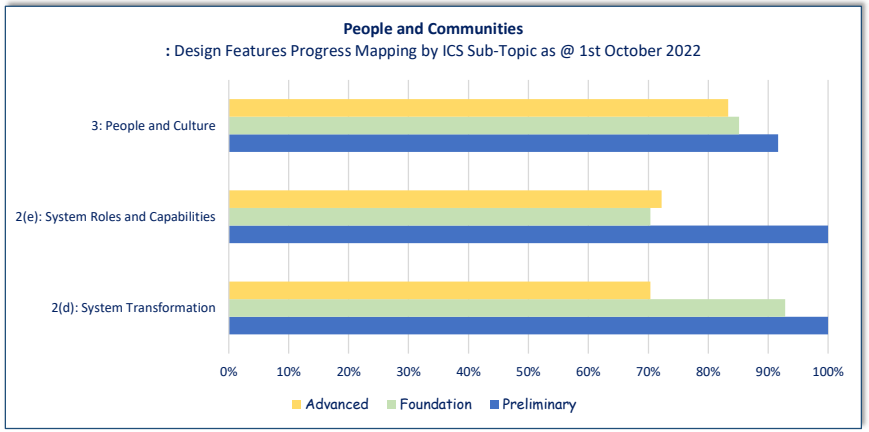
40%
50%
60%
70%
80%
90%
100%
Advanced
Foundation
Preliminary


People and Communities
: Design Features Progress Mapping by ICS Sub-Topic as @ 1st October 2022
3: People and Culture
2(e): System Roles and Capabilities
2(d): System Transformation
0%
10%
20%
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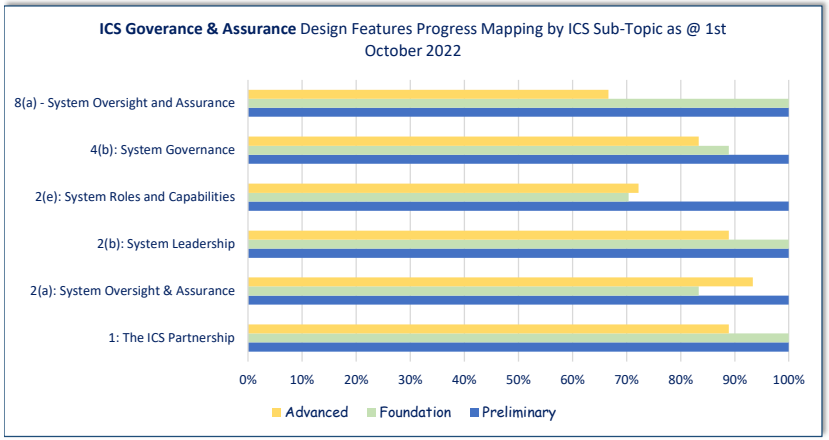
ICS Goverance & Assurance Design Features Progress Mapping by ICS Sub-Topic as @ 1st October 2022
8(a) - System Oversight and Assurance
4(b): System Governance
2(e): System Roles and Capabilities
2(b): System Leadership
2(a): System Oversight & Assurance
1: The ICS Partnership
0%
10%
20%
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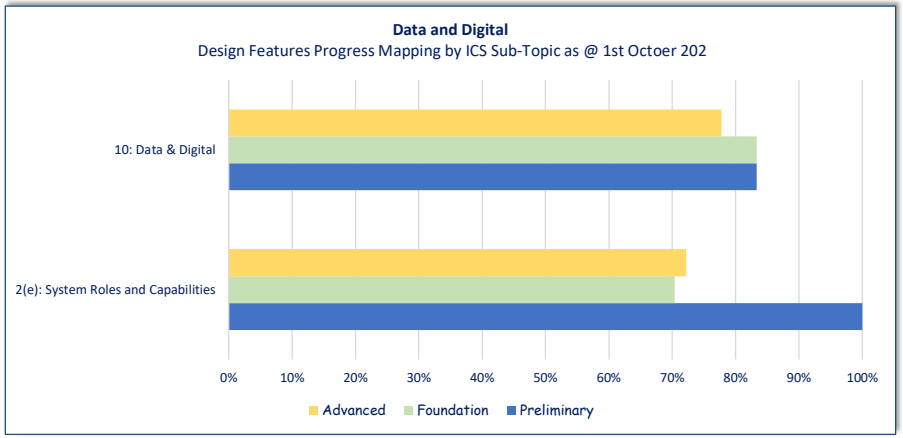
Advanced
Foundation
Preliminary


Data and Digital
Design Features Progress Mapping by ICS Sub-Topic as @ 1st Octoer 202
10: Data & Digital
2(e): System Roles and Capabilities
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Advanced
Foundation
Preliminary

Preliminary Design Features for Designation as an Integrated Care System

ICS Topic	#	ICS Design Features	Workstream area	Jun 22 Self-Assessment	Oct 22 Self-Assessment
Chapter 1: The ICS Partnership					
Collective system culture	1.1	ICS membership is well defined and appropriately inclusive at all three ICS levels (i.e. system, place and neighbourhood)	ICB Governance / Assurance	Significant progress	Significant progress
	1.2	ICS partners are clear on the mission, benefits and added value of them working collaboratively as an ICS, and at each of the three ICS levels (i.e. system, place and neighbourhood) and within the provider collaboratives	ICB Governance / Assurance	Significant progress	Significant progress
	1.3	ICS partners are clear on, and content with, the nature, shape and functionality of the ICS governance and delivery arrangements	ICB Governance / Assurance	Significant progress	Significant progress
	1.4	ICS partners bring a range of perspectives to bear, leading to better decision-making and ensuring that patients' and staff's needs are properly accounted for	ICB Governance / Assurance	Significant progress	Significant progress
Chapter 2: The ICS NHS Body					
ICS Sub-topic 2(a): System Oversight & Assurance					
System oversight and assurance	2.1	The ICS assures performance against all four elements of ICS' core purpose (improving outcomes, tackling inequalities, enhancing productivity and supporting social and economic development)	ICB Governance / Assurance	Significant progress	Significant progress
	2.2	ICS partners understand the need for collective management and ownership of system challenges, be they qualitative or financial in nature, and are ready to adopt collaborative approaches to resolving issues that arise across the ICS	ICB Governance / Assurance	Significant progress	Significant progress
ICS Sub-topic 2(b): System Leadership					
Collective leadership at system level within the ICS	2.3	The ICS has established fit-for-purpose leadership arrangements across the ICS. This includes a core ICS leadership team and a non-executive chair appointed in line with NHSEI guidance	ICB Governance / Assurance	Significant progress	Significant progress
	2.4	ICS partners clearly accept the remit and leadership role of the ICS core leadership team and co-operate effectively to enable it to discharge its duties	ICB Governance / Assurance	Significant progress	Significant progress
ICS Sub-topic 2(c): System Reporting					
System reporting	2.5	The ICS recognises the need to report regularly on the outcomes of its system performance assurance activities in line with NHSE's oversight arrangements for 2021/22. It has processes under development for reporting such system performance to various bodies including NHSEI, local health and wellbeing boards and ICS partners	ICB Governance / Assurance	Significant progress	Significant progress
ICS Sub-topic 2(d): System Transformation					
Service transformation	2.6	The ICS has developed and activated local **service transformation** programmes that address:		Significant progress	Significant progress
		• Local population health needs including the population's experience and aspirations for health and care	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• COVID-19 recovery	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• NHS Long Term Plan service priorities	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
	2.7	Progress of all service transformation programmes is monitored regularly, and an account of progress is made periodically to the ICS Board (and/or to other relevant system boards, as appropriate)	Place, intergation Transformation and Commissioning	Some progress	Significant progress
Enablers to accerlate system transformation	2.8	The ICS has developed and activated **system enablement** programmes designed to reduce, or to remove altogether, several of the major barriers that are preventing system partners from working together more effectively	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
ICS Sub-topic 2(e): System Roles and Capabilities					
Collective system **roles** and capabilities	2.9	For collective system roles, the ICS has either already clearly defined, or has programmes in train to rapidly clarify, which component of the ICS apparatus should discharge which system role, and at which of the three levels (i.e. system, place or neighbourhood)	ICB Governance / Assurance	Significant progress	Significant progress
Specialist system **roles** and capabilities - **population health management**	2.10	The ICS has a clear plan for developing comprehensive, leading edge population health management capabilities in a co-ordinated and harmonised way, at system and place levels, and in such a way that such capabilities are easily accessible to the ICS's PCNs and provider collaboratives. This includes a linked data set (by September 2021) that can be analysed to provide actionable insight into at risk population groups to support providers and PCN MDTs to design new proactive and integrated care models which improve health outcomes and prevent future ill-health, demand and hospitalisation. *This is further described in the PHM maturity matrix*	Clinical and professional	Significant progress	Significant progress
Specialist system **roles** and capabilities - **commissioning**	2.11	The ICS has established, and is now implementing, a commissioning redesign and development programme		Significant progress	Significant progress
	2.12	The ICS's commissioning redesign and development programme incorporates:	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• Clear and committed programme leadership	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• Clear and achievable work plans, key milestones and timetable	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• Such work plans include a review of NHS commissioning functions to determine how such functions can be optimally organised across the ICS	Place, intergation Transformation and Commissioning	Some progress	Significant progress
		• Effective stakeholder engagement and involvement	People and communities	Significant progress	Significant progress
		• Clear and timely collective decision-making processes, including organisational and ICS Board sign-off arrangements	Place, intergation Transformation and Commissioning	Some progress	Some progress
		• Capable and sufficient resources	Place, intergation Transformation and Commissioning	Some progress	Some progress
		• Effective, inclusive and timely communications activities, notably with staff directly impacted by any changes being considered	People and communities	Significant progress	Significant progress
		• Appropriate collaborating between health commissioners and local government	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• Appropriate arrangements to account for progress and performance to the ICS Board, to place partnerships and to the statutory boards of ICS partners, as appropriate	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
Specialist system **roles** and capabilities – s**ystem partnerships and engagement**	2.13	The ICS has an **organisational design and development** programme that focuses on strengthening collaborative working across all partners and promotes dialogue with democratic and community representatives	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
	2.14	The ICS's organisational design and development programmes involve (amongst other things):		Significant progress	Significant progress
		• Optimising how the ICS governance and management arrangements operate and interplay at system, place, neighbourhood and provider collaborative levels	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
		• Developing clear inclusive language to express the system vision and narrative	Place, intergation Transformation and Commissioning	Significant progress	Significant progress
Chapter 3: People and culture					
People delivery infrastructure	3.1	The ICS has established a System People Board and a leadership model and associated resources have been identified and mobilised	People and culture	Significant progress	Significant progress
	3.2	The ICS has established arrangements to account for progress both in delivering the NHS People Plan and People Promise, and in establishing the ICS people function to the NHS People Plan to the ICS Board, to place partnerships and to the statutory boards of ICS partners, as appropriate	People and culture	Significant progress	Significant progress
	3.3	The ICS has a clear understanding of the key workforce challenges that prevail across and within the ICS	People and culture	Significant progress	Significant progress
	3.4	A system-wide people and workforce design and development programme has been defined and key priorities and timelines identified. This work programme is under way	People and culture	Significant progress	Significant progress
Talent management and development	3.5	There are clear approaches to talent management which include annaul career converastions, unbias recruitment process and identification of talent pools. This is underpinned by consistently understood definitions of potential, talent and readiness criteria	People and culture	Some progress	Significant progress
	3.6	Recruitment and onboarding processes are inclusive and values based, aligned to organisational objectives	People and culture	Significant progress	Significant progress
	3.7	Inclusive talent management is recognised as a strategic priority which is reflected in ICS people plans and with collective accountability embedded within the ICS	People and culture	Some progress	Some progress
	3.8	Organisations routinely collect talent data and have initiated the development of cross-boundary talent data sharing principles. This includes collecting and measuring data around diversity and associated benefits	People and culture	Some progress	Some progress

Chapter 4: Governance and Management Arrangements					
ICS Sub-topic 4(a): Collective Leadership					
Collective leadership at place and at neighbourhood level within the ICS	4.1	Where place and neighbourhood level leadership arrangements are made, individual place partnerships and PCNs within the ICS are part of the ICS leadership platform	Place, intergation Transformation and Commissioning	Some progress	Some progress
	4.2	The NHS, local government and other local partners have agreed the configuration, size and boundaries of the ICS's places	Place, intergation Transformation and Commissioning	Some progress	Significant progress
Collective leadership within provider collaboratives within the ICS	4.3	The ICS leadership platform brings together Trust leadership provider collaboration lead arrangements for hospital systems, ambulance services and acute mental health systems	Provider Collaborative	Significant progress	Significant progress
ICS Sub-topic 4(b): System Governance					
System governance and collective decision-making	4.4	There are appropriate system arrangements for decision making which include all partners in the system	ICB Governance / Assurance	Significant progress	Significant progress
	4.5	The ICS has system-wide governance arrangements (including a system partnership forum with NHS, Local Government and other partners) to enable a collective model of responsibility and decision-making between system partners	ICB Governance / Assurance	Some progress	Significant progress
	4.6	The ICS has introduced arrangements that engage the VCSE sector across the ICS and in collaborative activities, and is working with them to establish a formal agreement for embedding the VCSE sector in system-level governrance and decision-making arrangements	People and communities	Significant progress	Significant progress
ICS Design Framework Chapter 5: The role of providers					
Provided Collaboratives	5.1	The ICS has a good understanding of existing collaborations working within and across their systems, and the goals of each one	Provider Collaborative	Significant progress	Significant progress
Provided Collaboratives	5.2	ICS leaders have worked with their system providers (and potentially other ICSs and their providers) to identify opportunities for delivering benefits of scale, including reducing unwarranted variation and inequalities across places and building greater resilience in services, for example, through mutual support for quality improvement or workforce management	Provider Collaborative	Significant progress	Significant progress
Provided Collaboratives	5.3	Building on existing collaborations where possible, providers have started to work together, putting in place a shared vision and governance arrangements to support collective decision-making	Provider Collaborative	Significant progress	Significant progress
Chapter 6: Clinical and Professional Leadership					
Clinical and professional leaders from diverse backgrounds are integrated into system decision-making, supported with a flow of communications and opportunities for	6.1	ICS and designate ICB leaders have agreed an initial local framework and associated development plan for clinical and care professional leadership with partners across the ICS, as described in the published clinical and care professional leadership guidance	Clinical and professional	Significant progress	Significant progress
	6.2	There are named, multi-disciplinary clinical and care professional leads from all sectors of the system identified with agreed communication channels between those leads and the rest of the system, ensuring that all clinical and care professionals are engaged and involved, even if not in a formal role.	Clinical and professional	Significant progress	Significant progress
	6.3	System leaders are developing a plan that will progress the system on to 'Foundation' stage	Clinical and professional	Significant progress	Significant progress
Culture that embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a	6.4	The system encourages collaborative working and innovation and models those behaviours	Clinical and professional	Significant progress	Significant progress
	6.5	System leaders listen and respond purposefully when barriers to collaboration are identified	Clinical and professional	Significant progress	Significant progress
	6.6	All service redesign takes place with effective, demonstrable coproduction with people who use services including feedback mechanisms to report the impact that coproduction has made	Clinical and professional	Lots to do	Some progress
	6.7	System leaders are developing a plan that will progress the system on to 'Foundation' stage	Clinical and professional	Significant progress	Significant progress
Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate	6.8	Planned allocation of resource/back-fill to cover clinical and care professionals' time plus project support/analytical support is built into budgets on a recurring basis, and process for accessing this resource established	Clinical and professional	Significant progress	Significant progress
	6.9	Agreed arrangements across the system to support clinical and care professionals' involvement in key decisions made by the ICS	Clinical and professional	Significant progress	Significant progress
	6.10	System leaders are developing a plan that will progress the system on to 'Foundation' stage	Clinical and professional	Significant progress	Significant progress
Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders and provides training and development	6.11	System and place leaders have agreed a plan for dedicated leadership development support that will be available to clinical and non-clinical professionals across the system	Clinical and professional	Some progress	Some progress
	6.12	There is an allocated budget for system and place based clinical and care professional leadership development	Clinical and professional	Significant progress	Significant progress
	6.13	Human Resources policies and processes reflect the skills and capabilities required for system leadership and support the identification of development needs at all levels of the system, including ensuring opportunities for clinicians and non-clinicians to learn together are available and communicated widely	People and culture	Some progress	Some progress
	6.14	System leaders are developing a plan that will progress the system on to 'Foundation' stage	Clinical and professional	Significant progress	Significant progress
Transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline	6.15	Opportunities are widely and proactively shared across the system and organisational boundaries to a wide range of clinical and care professionals	Clinical and professional	Significant progress	Significant progress
	6.16	Proactive steps taken to ensure fair process and equity of opportunity e.g. blind shortlisting/representative and diverse panels	Clinical and professional	Significant progress	Significant progress
	6.17	System and place leaders have an agreed plan including timescales to reach key milestones that demonstrates how they will ensure the clinical and care professional leadership of the system reflects the demographics of the population they serve	Clinical and professional	Some progress	Some progress
	6.18	System leaders are developing a plan that will progress the system on to 'Foundation' stage	People and culture	Significant progress	Significant progress
Chapter 7: Working with People and Communities					
Community engagement & involvement	7.1	The ICS has developed and tested its vision with the communities it serves. This vision is expressed in plain and inclusive language and has been shared extensively across and within ICS communities	People and communities	Significant progress	Significant progress
	7.2	The ICS is developing a system-wide strategy for engaging with people and communities	People and communities	Significant progress	Significant progress
	7.3	The ICS recognises the need for a system-wide approach to collating and sharing service user and carer intelligence which links to quality governance, decision-making and planning/commissioning and is working with partners to get this in place	People and communities	Significant progress	Significant progress
System partnerships	7.4	The ICS recognises the need for the ICB constitution to include principles and arrangements for how it will work with people and communities	People and communities	Significant progress	Significant progress
	7.5	There is close dialogue with democratic and community representatives to ensure each is able to exercise significant influence on collaborative activities	People and communities	Significant progress	Significant progress
Chapter 8: Accountability and Oversight					
ICS Sub-topic 8(a):System Oversight and Assurance					
System accountability	8.1	The Integrated Care Board, together with local authorities recognises the need for it to account for its leadership and oversight of health and care activities that are designed to improve the health of the local population, to deliver services that achieve local and national quality standards and that can be afforded within the financial funds allocated. It has processes under development to enable an effective and timely account of its performance to ICS partners, local health and wellbeing boards, NHSEI and its citizens	ICB Governance / Assurance	Significant progress	Significant progress
ICS Sub-topic 8(b): Quality Governance					
Quality oversight arrangements	8.2	The ICS recognises that, within its core purpose, it has a duty to deliver high-quality care and outcomes. This includes providing assurance of system performance and driving quality improvement across the ICS	Quality oversight	Significant progress	Significant progress
	8.3	ICS partners understand the need for collective management and ownership of system quality challenges and a collaborative approach to resolving issues (as per existing National Quality Board guidance)	Quality oversight	Significant progress	Significant progress
	8.4	The ICS recognises the need, from 1st July 2022, to report regularly on the outcomes of its system performance assurance duties, including delivery of quality	Quality oversight	Significant progress	Significant progress
	8.5	ICS partners are developing reporting and oversight mechanisms that will enable the Integrated Care Board to oversee outcome and service quality performance across the ICS from 1st July 2022, to ICS partners, local health and wellbeing boards, NHSEI, its citizens (as per existing National Quality Board guidance)	Quality oversight	Significant progress	Significant progress
Quality Improvement	8.6	The ICS recognises the need to have clear quality planning & improvement objectives in place, which reflect population health needs and what matters to people using services	Quality oversight	Significant progress	Significant progress
	8.7	The ICS understands the importance of using resources effectively to drive quality improvement, sustainably and also flexibly across different areas of the workforce	Quality oversight	Significant progress	Significant progress
Chapter 9: Financial Allocations and Funding Flows					
ICS Sub-topic 9(a): Financial Framework and Use of Resources					
Collective acceptance and management of whole population capitation risk by ICS partners	9.1	The ICS acknowledges and manages the risks associated with its ICS partners providing the whole of ICS population with (NHS-funded) care	Financial Framework and oversight and Performance	Significant progress	Significant progress
System driven	9.2	ICS partners understand that, from 1st July 2022, the ICS will determine how national NHS funding allocated to the ICS is spent year-on-year	Financial Framework and oversight and Performance	Significant progress	Significant progress

funding, risk and incentive allocations	9.3	ICS partners are developing detailed proposals that will enable them to effectively allocate such funding fairly, and to accept and manage whole population financial risk that arises for the whole of the ICS from 1st July 2022	Financial Framework and oversight and Performance	Significant progress	Significant progress
ICS Sub-topic 9(b) - Financial Oversight					
Financial oversight arrangements	9.4	ICS partners are developing reporting and oversight mechanisms that will enable the Board of the Integrated Care Board to oversee consolidated financial performance, in respect of NHS spend, across the ICS from 1st July 2022	Financial Framework and oversight and Performance	Significant progress	Significant progress
Chapter 10: Data and Digital Standards and Requirements					
Digital transformation	10.1	The ICS has an overarching plan for data and digital transformation of services, including shared care records as a priority to enable service transformation programmes	Data and Digital	Some progress	Some progress
Shared Care Record	10.2	The ICS has developed and activated plans to design and implement a full **shared care record**, allowing the safe flow of patient data between care settings, and the aggregation of data for to improve population health	Data and Digital	Significant progress	Significant progress

Significant progress
Some progress
Lots to do

Foundation Design Features for Integrated Care System Development

ICS Topic	#	ICS Design Features	Workstream area	Jun 22 Self-Assessment	Oct 22 Self-Assessment
ICS Design Framework Chapter 1: The ICS Partnership					
Collective system culture	1.1	ICS partners have clear collaboration and decision-making arrangements across the system to agree and deliver local strategic and operational priorities across different functional areas, in line with the principle of "subsidiarity"	ICB Governance / Assurance	Significant progress	Significant progress
	1.2	ICS partners understand the importance of equality and diversity and have plans for creating a compassionate and inclusive culture across all organisations in the system	ICB Governance / Assurance	Significant progress	Significant progress
ICS Design Framework Chapter 2: The ICS NHS Body					
ICS Sub-topic 2(a): System Oversight & Assurance					
System oversight and assurance	2.1	ICS partners are clear on, and content with, how mutual accountability operates within the ICS at each of its levels including system, place and neighbourhood	ICB Governance / Assurance	Some progress	Some progress
	2.2	The ICS accounts effectively and in a timely manner for its leadership and oversight of health and care activities within the ICS boundaries to its ICS partners, its local health and wellbeing boards, NHSEI and its citizens in line with its oversight MoU agreed with NHSEI	ICB Governance / Assurance	Some progress	Significant progress
ICS Sub-topic 2(b): System Leadership					
Collective leadership at system level within the ICS	2.3	The Integrated Care Board's core leadership team:	ICB Governance / Assurance	Significant progress	Significant progress
		• Has a well-defined and documented remit and clear, time-bound goals to achieve	ICB Governance / Assurance	Some progress	Significant progress
		• Has clear functions to discharge and appropriate powers have been delegated to enable success	ICB Governance / Assurance	Significant progress	Significant progress
		• Has been appointed by a fair and transparent process and is substantively complete	ICB Governance / Assurance	Significant progress	Significant progress
		• Is credible and demonstrably capable	ICB Governance / Assurance	Significant progress	Significant progress
		• Has sufficient capacity and resource to discharge its duties	ICB Governance / Assurance	Significant progress	Significant progress
		• Includes clinical and professional leaders	ICB Governance / Assurance	Some progress	Significant progress
	2.4	The ICS has established an ICS NHS Board that brings together NHS Trusts/FTs, Primary Care and Local Authorities to foster collective leadership, mutual accountability and enable joined up decision making - this should draw on appropriate input and contribution from place leadership and provider collaboratives	ICB Governance / Assurance	Some progress	Significant progress
	2.5	The ICS NHS Board has introduced arrangements that engage the wider non-executive community across the ICS in and on collaborative activities, and in helping them identify and proactively manage the interplay between system and organisational responsibilities within the system	ICB Governance / Assurance	Some progress	Significant progress
ICS Sub-topic 2(c): System Reporting					
System reporting	2.6	The ICS reports regularly on the outcomes of its system performance assurance duties both internally, to the NHS ICS Board and the Partnership Forum, and externally to NHSEI, local health and wellbeing boards and ICS partners	Financial Framework and oversight and Performance	Significant progress	Significant progress
	2.7	The ICS NHS Board has defined when and how it should escalate performance issues and risks for regional scrutiny, support and intervention in line with oversight MoU agreed with NHS England	ICB Governance / Assurance	Some progress	Significant progress
ICS Sub-topic 2(d): System Transformation					
Service transformation	2.8	The ICS has a comprehensive and specific set of programmes up and running (including all national service improvement priorities) to achieve **service transformation** goals for all ICS service priorities	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.9	The ICS has a comprehensive and specific set of programmes up and running to **recover** from the adverse effects of COVID-19, aligned to ICS service priorities	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.10	The ICS has assigned responsibilities for designing and delivering its service transformation programmes to partners working at an appropriate scale (or working across an appropriate footprint) that is practicable and as close as possible to the patient/service user	Place, integration Transformation and Commissioning	Some progress	Some progress
	2.11	The ICS has defined, tested and activated processes designed to co-ordinate and harmonise its service transformation programmes as they are implemented at the various scales and footprints of the ICS	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.12	The ICS has an agreed system approach to seeking and updating insights into community experience of and aspirations for health and care, including for communities that are affected by health inequalities	Place, integration Transformation and Commissioning	Some progress	Some progress
	2.13	All service transformation programmes have suitable and sufficient resources, including funded budgets, and are supported by the right capacity and capabilities	Place, integration Transformation and Commissioning	Some progress	Significant progress
Enablers to accerlate system transformation	2.14	The ICS has a comprehensive and specific set of programmes up and running designed to reduce, or to remove altogether, the major barriers that are preventing system partners from working together more effectively in pursuit of defined ICS priorities	Place, integration Transformation and Commissioning	Significant progress	Significant progress
	2.15	The ICS has assigned responsibilities for delivering its system enabler transformation programmes at an appropriate scale (or working across an appropriate footprint) that is practicable and as close as possible to the patient/service user	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.16	The ICS has defined, tested and activated processes designed to co-ordinate and harmonise its system enabler transformation programmes as they are implemented at the various levels of the ICS	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.17	All system enabler transformation programmes have suitable and sufficient resources, including funded budgets, and are supported by the right capacity and capabilities	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.18	The ICS has well-established plans, that are progressing to time, designed to develop and embed comprehensive, leading-edge **population health management** capabilities, at both system and place levels	Clinical and professional	Significant progress	Significant progress
	2.19	The ICS has well-established and appropriately resourced system people plans, integrated with wider ICS activity and financial plans, developed in line with national priorities, that are progressing to time, designed to grow, develop, retain and support the **health and care workforce** across the ICS to deliver high quality health and care services	Place, integration Transformation and Commissioning	Significant progress	Significant progress
	2.20	The ICS has well-established plans, that are progressing to time, designed to achieve a step-improvement in the quality of the **estate** from which health and care services are being delivered within the ICS. A clear division of responsibilities for achieving and overseeing agreed estates development goals has been established between the ICS Board, the ICS's place-partnerships and ICS partners	Place, integration Transformation and Commissioning	Significant progress	Significant progress
	2.21	The ICS has well-established plans, that are progressing to time, designed to achieve a step-improvement in the quality of the **equipment and technology** available to ICS partners to support the delivery of high quality health and care services. A clear division of responsibilities for achieving and overseeing agreed equipment and technology development goals has been established between the ICS Board, the ICS's place-partnerships and ICS partners	Place, integration Transformation and Commissioning	Some progress	Some progress
ICS Sub-topic 2(e): System Roles and Capabilities					
		The ICS has clearly defined which system roles can be more successfully discharged by acting collectively. Key functions to be located at the system level include:			Some progress

Collective system **roles** and capabilities	2.22	• System stewardship to constructively challenge local health and well-being leaders to set higher collective ambitions than any single ICS partner, acting alone, is able to do	ICB Governance / Assurance	Some progress	Some progress
		• Partnering development to nurture and deepen relationships between ICS partners	ICB Governance / Assurance	Significant progress	Significant progress
		• System-wide clinical network development to address key clinical challenges prevalent across the ICS	Clinical and professional	Lots to do	Significant progress
		• Facilitation and incentivisation of system working approaches through, amongst other things, learning, communications and development activities	ICB Governance / Assurance	Some progress	Significant progress
		• Oversight of the ICS's compliance with (NHS) standards and of improving the health and well-being outcomes of the local population	ICB Governance / Assurance	Lots to do	Some progress
		• Facilitation and encouragement of collective involvement of all ICS partners in system level performance assurance	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Establishing a 'one workforce' approach to planning, developing, growing and supporting the whole ICS workforce	People and culture	Some progress	Significant progress
		• Operationalisation of mechanisms that enable the ICS's services users, its clinicians and its citizens to become involved in priority-setting, in associated decision-making and in holding the ICS to account for both the outcomes and value for money achieved	People and communities	Some progress	Significant progress
	2.23	Where a system role is to be discharged collectively, appropriate powers have been invested in the ICS leadership by ICS partners to enable this to be achieved.	ICB Governance / Assurance	Some progress	Some progress
Specialist system **roles** and capabilities - **population health management**	2.24	The ICS has a well-established **population health management** development programme in place. Through this programme, the ICS has set itself ambitious goals for developing and embedding leading edge population health capabilities at system and at place levels which support a preventative population risk based approach to service redesign	Clinical and professional	Some progress	Significant progress
	2.25	The ICS has **joined up its health and social care patient and workforce data** (with plans to integrate data from wider system partners on social determinants) and established a **cross system intelligence function across places which is providing timely actionable and predictive insight** into population health risk and future demand which enables PCNs and provider collaboratives to develop proactive and integrated models of care and dynamic workforce planning through collaborative working (as described in the PHM maturity matrix). This intelligence function should draw on analytical capacity across system partners to provide cross-system population health insights and should be supported by robust governance into ICS decision makers. The function should sustain a PHM platform to provide automatable insights to clinical, operational and strategic decision makers.	Clinical and professional	Lots to do	Some progress
	2.26	The ICS has put in place **clear leadership** for population health management at system and place with defined governance arrangements which bring together multidisciplinary teams across place based partners with intelligence teams to design new care models for population groups experiencing greatest health inequity (as described in the PHM maturity matrix)	Clinical and professional	Some progress	Some progress
	2.27	The ICS is beginning to design **population based payment and contractual models** for these at risk groups, predicated on a clear understanding of future need and risk, which traverse organisational boundaries to incentivise proactive and holistic support, collaborative workforce models and a community asset based approach (as described in the PHM maturity matrix)	Clinical and professional	Lots to do	Lots to do
Specialist system **roles** and capabilities - **commissioning**	2.28	The ICS's **commissioning** redesign and development programme has resulted in NHS commissioning being re-purposed and re-organised with the goal of achieving highly co-ordinated commissioning of health and well-being outcomes, and associated services, across the NHS and local authorities, at system level and at place level (as described in the PHM maturity matrix)	Place, integration Transformation and Commissioning	Some progress	Significant progress
Specialist system **roles** and capabilities – **system partnerships and engagement**	2.29	The ICS's governance and OD programme is inclusive of all partners including local government, VCSE, social care, clinicians and residents/patients and where appropriate resources their engagement (as described in the PHM maturity matrix)	ICB Governance / Assurance	Significant progress	Some progress
	2.30	The ICS maintains an effective **organisational design and development** programme capability, which is deployable rapidly and effectively to meet new ICS organisational development challenges as they arise (as described in the PHM maturity matrix)	ICB Governance / Assurance	Some progress	Some progress
ICS Design Framework Chapter 3: People and culture					
People delivery infrastructure	3.1	The ICS has strong local people and workforce leadership, with Board level accountability for people across the breadth of the system. People and workforce are prioritised within ICS strategic plans	People and culture	Significant progress	Significant progress
	3.2	A system-wide ICS People Plan has been developed and is being delivered by the ICS. This Plan describes how the ICS will deliver the people priorities set out in the NHS People Plan and annual planning guidance, as well as its own local people priorities	People and culture	Significant progress	Significant progress
	3.3	An ICS People Board has been established to oversee the implementation of the ICS People Plan and other local people priorities. The ICS People Board has appropriate powers vested in it that enable it to carry out the functions assigned to it and it includes appropriate clinical, professional and staff representation. The People Board reports directly to the ICS Board	People and culture	Significant progress	Significant progress
	3.4	The ICS has assessed its current maturity to deliver a full people function in line with the ICS people function guidance, and has plans with key milestones to develop its capacity and capability to deliver this, as part of wider ICS development plans	People and culture	Significant progress	Significant progress
Talent management and development	3.5	Organisations have a clear transparent inclusive talent management strategy which is incorporated into People Plans and linked to strategic priorities and objectives. This strategy describes the benefits and value of diversity	People and culture	Some progress	Some progress
	3.6	The system has a clear approach to using data to identify and mitigate issues relating to talent management	People and culture	Lots to do	Lots to do
	3.7	The ICS actively engages with talent by shaping apprenticeships, development initiatives, mentoring schemes and career transition conversations to support individuals' ability to maximise their potential and the ICS to deliver its objectives	People and culture	Significant progress	Significant progress
	3.8	There are named organisational Board members responsible for inclusive talent management, with priorities written into strategic/delivery plans, job descriptions and objectives and explicitly role modelled	People and culture	Significant progress	Significant progress
	3.9	Quantitative and qualitative talent data is routinely shared across the ICS to inform best practice and support specific inclusive talent management interventions	People and culture	Some progress	Some progress
ICS Design Framework Chapter 4: Governance and Management Arrangements					
ICS Sub-topic 4(a): Collective Leadership					
Collective leadership at place and at neighbourhood level within the ICS	4.1	The NHS, local government and other local partners have agreed the ICS responsibilities and functions to be carried out at place level	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.2	The NHS, local government and other local partners have agreed the planned governance model for place including: • Membership • Place-level decision-making arrangements, including any joint arrangements for statutory decision-making functions between the NHS and local government • Leadership roles, for convening the place-based partnership, as well as any individuals responsible for delegated functions • Representation on, and reporting relationships with, the ICP and ICB	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.3	Each place partnership core leadership team has a well-defined remit, clear functions to discharge and appropriate powers and sufficient resources to achieve its goals in a timely way and includes appropriate clinical and professional leadership	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.4	Each place system partner clearly accepts the remit and authority of its respective place partnership core leadership team and cooperates effectively in enabling it to discharge its duties	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.5	Each neighbourhood core leadership team has a well-defined remit, clear functions to discharge and appropriate powers and sufficient resources to achieve its goals in a timely way and includes appropriate clinical and professional leadership	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.6	Each neighbourhood system member clearly accepts the remit and authority of its respective neighbourhood leadership team and cooperates effectively in enabling it to discharge its duties	Place, integration Transformation and Commissioning	Some progress	Some progress
Collective leadership within provider collaboratives within the ICS	4.7	Each provider collaborative core leadership team has a well-defined remit, clear functions to discharge and appropriate powers and sufficient resources to achieve its goals in a timely way and includes appropriate clinical and professional leadership	Provider Collaborative	Some progress	Some progress
	4.8	All members of the ICS's provider collaboratives clearly accept the remit and authority of their respective provider collaborative core leadership teams, and cooperate effectively in enabling these leadership teams to discharge their duties	Provider Collaborative	Some progress	Significant progress
ICS Sub-topic 4(b): System Governance					
	4.9	The ICS has confirmed configuration, size and boundaries, which should reflect meaningful communities and scale for the responsibilities of the place partners	ICB Governance / Assurance	Significant progress	Significant progress

System governance and collective decision-making	4.10	The ICS has established a partnership forum that brings together local partners including the local authorities and the NHS	ICB Governance / Assurance	Significant progress	Significant progress
	4.11	The Integrated Care Board and local authorities have defined the role, terms of office and accountabilities of, and have jointly selected a Partnership chair	ICB Governance / Assurance	Significant progress	Significant progress
	4.12	The ICS is testing and developing its formal arrangements to systematically engage the VCSE sector in system-level governance and decision-making across the ICS	ICB Governance / Assurance	Some progress	Some progress
ICS Design Framework Chapter 5: The role of providers					
Provider Collaboratives	5.1	The ICS has supported and ensured all trusts that provide acute and mental health services are part of one or more provider collaborative and community, ambulance and other providers are part of collaboratives where this makes sense to deliver benefits	Provider Collaborative	Significant progress	Significant progress
Provider Collaboratives	5.2	ICS leaders, trusts and system partners, with support from NHS England regions, have identified and agreed the objectives for each provider collaborative, aligned with ICS priorities, and have established appropriate membership and governance and programmes of delivery with clear plans for provider collaboratives to achieve these	Provider Collaborative	Some progress	Some progress
ICS Design Framework Chapter 6: Clinical and Professional Leadership					
Clinical and professional leaders from diverse backgrounds are integrated into system decision-making, supported with a flow of communications and opportunities for dialogue	6.1	ICS and designate ICB leaders have agreed an initial local framework and associated development plan for clinical and care professional leadership with partners across the ICS, as described in the published clinical and care professional leadership guidance	Clinical and professional	Significant progress	Significant progress
	6.2	System leads are able to flexibly coordinate input from cross-system clinical and care professionals, into system programme teams within an identified governance framework that supports the right team, built around the right system task	Clinical and professional	Some progress	Significant progress
	6.3	System leaders are developing a plan that will progress the system on to 'Advanced' stage	Clinical and professional	Some progress	Significant progress
Culture that embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities	6.4	Partners across the system recognise and confirm a culture of psychological safety that facilitates collaboration and sharing of ideas across organisational and professional boundaries to inform more integrated and responsive services	Clinical and professional	Some progress	Some progress
	6.5	Forums for cross organisational integrated working are in place and attendance to such forums are practically supported	Clinical and professional	Significant progress	Significant progress
	6.6	Citizens, patients and carers are involved in all key decisions affecting service delivery and the system can demonstrate how it is supporting citizens, patients and carers to input and the impact this is having	Clinical and professional	Lots to do	Lots to do
	6.7	System leaders are developing a plan that will progress the system on to 'Advanced' stage	Clinical and professional	Some progress	Some progress
Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work	6.8	Clinical and care professional leaders are connected to data and digital enablers to support their understanding of population and system need and enable them to carry out their leadership roles	Clinical and professional	Some progress	Some progress
	6.9	Clinical and care professionals are supported through appropriate governance and sufficient protected time (to be determined locally on a case by case basis) to perform their leadership duties and input into decision making processes	Clinical and professional	Significant progress	Significant progress
	6.10	Clinical and care professionals have the opportunity to attend forums and meetings that are relevant to their work	Clinical and professional	Significant progress	Significant progress
	6.11	System leaders are developing a plan that will progress the system on to 'Advanced' stage	Clinical and professional	Some progress	Some progress
Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and	6.12	All existing system leaders have identified learning needs regarding system leadership skills and behaviours built into Personal Development Plans	Clinical and professional	Lots to do	Lots to do
	6.13	System-facilitated leadership development offer for current and aspiring leaders is available alongside confirmed organisational approval to ensure prioritisation	Clinical and professional	Lots to do	Lots to do
	6.14	System leadership development offer is well promoted across the system and easily identifiable for future leaders to find and be able to discuss with line managers	Clinical and professional	Lots to do	Lots to do
	6.15	System leaders are developing a plan that will progress the system on to 'Advanced' stage	Clinical and professional	Some progress	Some progress
Transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function	6.16	Agreement across system constituent organisations, of behaviours and skill-set expected of system leaders (built into job descriptions and adverts) that is not reliant on clinical speciality or discipline	Clinical and professional	Significant progress	Significant progress
	6.17	All leaders across the system have gone through a competitive process against agreed system leadership person specification. Process is open, transparent, inclusive and properly documented	Clinical and professional	Significant progress	Significant progress
	6.18	System leaders agree a plan to proactively identify and develop future system leaders and build a talent pool from which to create a diverse multi-professional pipeline for succession planning	Clinical and professional	Lots to do	Lots to do
	6.19	System leaders are developing a plan that will progress the system on to 'Advanced' stage	Clinical and professional	Some progress	Some progress
ICS Design Framework Chapter 7: Working with People and Communities					
Community engagement & involvement	7.1	The ICS has developed and tested its vision with the communities it serves and ICS leaders provide clear and regular updates on the ICS's plans to achieve its vision and on progress made in implementing these plans	People and communities	Some progress	Some progress
	7.2	The ICSs has a system-wide strategy in place for engaging with people and communities with shared system approaches to 2-way engagement	People and communities	Some progress	Significant progress
	7.3	Some system-wide approaches are in place to collating and sharing service user and carer intelligence which links to quality governance, decision-making and planning/commissioning,	People and communities	Some progress	Significant progress
System partnerships	7.4	The ICB constitution includes principles and arrangements for how the ICB will work with people and communities	People and communities	Significant progress	Significant progress
	7.5	ICS leaders maintain a regular and constructive dialogue with democratic and community representatives to ensure each is able to exercise significant influence on collaborative activities	People and communities	Significant progress	Significant progress
ICS Design Framework Chapter 8: Accountability and Oversight					
ICS Sub-topic 8(a): System Oversight & Assurance					
System oversight and assurance	8.1	The ICS has a clear understanding of its duty to deliver high-quality care and outcomes, which improve population health outcomes and are delivered within the ICS's financial means year in, year out	ICB Governance / Assurance	Significant progress	Significant progress
	8.2	The Integrated Care Board is set up and populated so that it can properly discharge its system performance assurance duties effectively and timeously. This includes participating in wider cross systems quality intelligence sharing and reporting	ICB Governance / Assurance	Significant progress	Significant progress
	8.3	The ICS has a clearly defined reporting relationship between the ICS and regulatory bodies, as well as the circumstances in which, and how, and ICS-led intervention in respect of system performance is merited and / or judged necessary. National guidance on implementing this will be provided during 2021/22	ICB Governance / Assurance	Some progress	Significant progress
ICS Sub-topic 8(b): Quality Governance					
Quality oversight arrangements	8.4	The ICS recognises its duty to assure system performance and drive quality improvement across the ICS. The Integrated Care Board has established mechanisms to enable it to discharge its duties in respect of health outcomes and service quality	Quality oversight	Significant progress	Significant progress
	8.5	Quality oversight and reporting arrangements are in place within the ICS, including an ICS-level group to share intelligence on learning, issues and risks, and an agreed approach to identifying and addressing risks, including involvement of Regional NHSEI and wider partners when required - national guidance on implementing this will be provided during 2021/22 building on existing National Quality Board guidance	Quality oversight	Significant progress	Significant progress
	8.6	There is clarity on the roles, responsibilities and accountabilities of system partners on quality, with work underway to address any areas of uncertainty	Quality oversight	Significant progress	Significant progress
	8.7	There is a defined way for the ICS to engage and share intelligence on quality across the system, including with regulators. A System Quality Group (updated QSG) is set up to identify and manage quality risks, and share opportunities for improvement and learning	Quality oversight	Significant progress	Significant progress
	8.8	There is a defined process for escalating quality concerns to regional teams and regulators, which links to regional quality oversight arrangements formally (Quality Surveillance Group (QSG) / Joint Strategic Oversight Group (JSOG))	Quality oversight	Significant progress	Significant progress
	8.9	Routine oversight of quality performance takes place at place level, with governance and systems in place to support this (based on the principle of subsidiarity)	Quality oversight	Some progress	Some progress
	8.10	The ICS recognises its responsibilities relating to the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles	Quality oversight	Significant progress	Significant progress
Quality Improvement	8.11	The ICS is developing a clear vision and credible strategy to deliver high quality, sustainable care across the system and through place-based partnerships. This is based on recognition that improvement in quality can often be achieved within the current level of resources, and that "quality" and "resource use" must be viewed together	Quality oversight	Significant progress	Significant progress
	8.12	The ICS has quality improvement priorities, which are based on what matters to people using services and population health needs and has engaged with other systems, regional and national teams as relevant to address those	Quality oversight	Some progress	Some progress

Quality improvement	8.13	The ICS is developing plans for how it will draw on intelligence to improve understanding of quality and inform quality improvement, including how it will develop capability and capacity in the methodologies used	Quality oversight	Some progress	Some progress
	8.14	The ICS understands what data is collected on quality at different levels and is working to agree some key quality indicators. Common or consistent improvement methodologies are being used to address some pressing or complex challenges	Quality oversight	Some progress	Some progress
ICS Design Framework Chapter 9: Financial Allocations and Funding Flows					
ICS Sub-topic 9(a): Financial Framework and Use of Resources					
Collective acceptance and management of whole population capitation risk by ICS partners	9.1	The ICS has a clear picture of:			Some progress
		• All (NHS and non-NHS) funding inflows into the ICS	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Current (NHS and non-NHS) funding allocations to ICS partners	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Current and recurrent financial imbalances (positive or negative) between (NHS and non-NHS) funding flows and costs	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Contract payment mechanisms and the allocation of financial risk and reward between ICS partners that these mechanisms apply	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• The fitness-for-purpose of existing collective financial risk management and financial governance apparatus within the ICS, at both system and place levels	Financial Framework and oversight and Performance	Significant progress	Significant progress
	9.2	The ICS has defined, tested and activated reporting processes, controls, interventions and governance arrangements designed to enable ICS partners to collectively accept and manage whole population capitation risk	Financial Framework and oversight and Performance	Some progress	Significant progress
System driven funding, risk and incentive allocations	9.3	The ICS has set goals that are designed to enable it to:	Financial Framework and oversight and Performance	Some progress	Significant progress
		• Introduce fair and transparent mechanisms to enable the ICS to allocate financial resources, and risks, to place partnerships and/or ICS service delivery partners	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Establish contingency arrangements to manage unforeseen or unmanageable financial risks	Financial Framework and oversight and Performance	Some progress	Some progress
		• Introduce fit-for-purpose, collective financial management and reporting processes, and associated oversight apparatus	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Determine and operationalise a proportionate intervention regime, setting out the circumstances in which an ICS intervention, resulting from financial challenge, is merited and/or necessary	Financial Framework and oversight and Performance	Some progress	Significant progress
ICS Sub-Topic 9(b) - Financial Oversight					
Financial oversight arrangements	9.4	The Integrated Care Board has established reporting and oversight mechanisms that enable it to effectively oversee consolidated financial performance, in respect of NHS spend, across the ICS	Financial Framework and oversight and Performance	Significant progress	Significant progress
	9.5	The Integrated Care Board has defined the circumstances in which it brokers discussions with partners to agree how they can support individual trusts to resolve their financial difficulties. The nature of such interventions has been defined and its efficacy road-tested	Financial Framework and oversight and Performance	Some progress	Significant progress
ICS Design Framework Chapter 10: Data and Digital Standards and Requirements					
Digital transformation	10.1	The ICS's digital and data plans inform and support service and system transformation plans. These plans should be developed in line with the What Good Looks Like Framework being published by NHSX in Q2 of this year	Data and Digital	Some progress	Some progress
Shared care record	10.2	The ICS has reached the implementation phase of establishing a **full shared care record**, that is accessible across the ICS, including the ability for analysts across ICS partners to use this data for population health analysis	Data and Digital	Significant progress	Significant progress

Significant progress
Some progress
Lots to do

Advanced Design Features for a Thriving Integrated Care System

ICS Topic	#	ICS Design Features	Workstream area	Jun 22 Self-Assessment	Oct 22 Self-Assessment
ICS Design Framework Chapter 1: ICS Partnership					
Collective system culture	1.1	ICS partners work together, effectively and cooperatively, even in circumstances that have proven to be testing for one or more individual ICS partners	ICB Governance / Assurance	Significant progress	Significant progress
	1.2	ICS partners are able to introduce constructive challenge in pursuit of improved collective working, or in mitigating risks that threaten system performance, in the confident knowledge that such challenges will be addressed seriously	ICB Governance / Assurance	Some progress	Significant progress
	1.3	ICS partners are demonstrably creating a compassionate and inclusive culture across all organisations in the system, including driving a focus on equality and diversity	ICB Governance / Assurance	Some progress	Some progress
ICS Design Framework Chapter 2: ICS NHS Body					
ICS Sub-topic 2(a): System Oversight & Assurance					
System oversight and assurance	2.1	The ICS NHS Board is set up and populated so it can properly discharge its system oversight and performance assurance duties effectively and in a timely manner. This includes participating in wider cross systems quality intelligence sharing and reporting and the establishment of appropriate governance structures within place-based partnerships	ICB Governance / Assurance	Some progress	Some progress
	2.2	The ICS has a clearly defined reporting relationship between the ICS and regulatory bodies, as well as the circumstances in which, and how, and ICS-led intervention in respect of system performance is merited and/or judged necessary, in line with oversight MoU agreed with NHS England	ICB Governance / Assurance	Some progress	Significant progress
	2.3	The ICS NHS Board discharges its system oversight and performance assurance and quality governance duties effectively. The Board has set up and maintains appropriate sub-committees that focus effectively on system assurance and quality improvement (including appropriate forums within place-based partnerships)	Financial Framework and oversight and Performance	Significant progress	Significant progress
	2.4	The Integrated Care Board and all NHS Trusts receive timely reports that comprehensively summarise system performance and which identify matters where ICS intervention either to improve, or recover or to escalate, is merited. Each Board has access to robust "check and challenge" capacity, drawing on the skills and expertise of independent expertise. Mechanisms are in place to engage wider partners on quality oversight and improvement. National guidance on implementing this will be provided during 2021/22	Financial Framework and oversight and Performance	Some progress	Significant progress
	2.5	The Integrated Care Board works effectively with NHS providers, escalating system performance and quality issues and risks for ICS scrutiny, support and intervention when appropriate	Financial Framework and oversight and Performance	Some progress	Significant progress
ICS Sub-topic 2(b): System Leadership					
Collective leadership at system level within the ICS	2.6	The Integrated Care Board's core leadership team conducts its business effectively and accounts for its performance regularly and transparently to the Board of the Integrated Care Board, the Integrated Care Partnership and to democratic and community representatives	ICB Governance / Assurance	Some progress	Significant progress
	2.7	The Integrated Care Board's core leadership team is well-established and its membership is coherent and appropriately inclusive. The Integrated Care Board has effective and efficient collective decision-making arrangements in place	ICB Governance / Assurance	Significant progress	Significant progress
	2.8	The ICS has well-established processes for resilience planning and taking collective action in response to crises or emergencies. As a category 1 responder, the Integrated Care Board will lead EPRR locally	ICB Governance / Assurance	Some progress	Some progress
ICS Sub-topic 2(c): System Reporting					
System reporting	2.9	The ICS reports regularly on the outcomes of its system performance assurance duties both internally, to the Integrated Care Board and the Integrated Care Partnership, and externally to NHSE, local health and wellbeing boards and ICS partners	Financial Framework and oversight and Performance	Some progress	Significant progress
	2.10	The ICS liaises effectively with regulatory bodies and, as appropriate, escalates performance issues and risks for regional scrutiny, support and intervention	ICB Governance / Assurance	Some progress	Significant progress
ICS Sub-topic 2(d): System Transformation					
Services transformation	2.11	The ICS maintains, and regularly updates, its overarching plan that identifies key **service transformation** priorities, along with programmes of work that identify first order milestones, resource requirements, communications, budget, risk management and any resource or funding gaps	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.12	Each service transformation programme has well-established:			Some progress
		• Governance mechanisms (such as Programme Board/Steering Group with underpinning Terms of Reference)	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Clear leadership (especially clinical and professional leadership), drawing in specialist expertise, as appropriate	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• 12-month (refreshable) work plans, timetable and key milestones	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Suitable resource capacity and capability (including programme management)	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Funded budgets	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Stakeholder engagement and communications activities	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.13	All programmes co-design services and tackle system priorities in partnership with service users, carers and the full range of health and care professionals including local government, VCSE, and social care and are systematically informed by data on experience and inequalities	Place, integration Transformation and Commissioning	Some progress	Some progress
Enablers to accerlate system transformation	2.14	The ICS maintains, and regularly updates, its overarching masterplan that identifies key **system enablement** transformation priorities, along with programmes of work that identify 1st order milestones, resource requirements, communications, budget, risk management and any resource or funding gaps	Place, integration Transformation and Commissioning	Some progress	Some progress
	2.15	Each system enabler transformation programme has well-established:			Some progress
		• Governance mechanisms (such as Programme Board/Steering Group with underpinning Terms of Reference)	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Clear leadership (especially clinical and professional leadership), drawing in specialist expertise, as appropriate	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• 12-month (refreshable) work plans, timetable and key milestones	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Suitable resource capacity and capability (including programme management)	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Funded budgets	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Inclusive stakeholder engagement and communications activities	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.16	**Population health management** is fully embedded in the ICS and plays a pivotal role in assessing population health need, predicting and managing health and care demand, planning health and care capacity on a system-wide basis and enabling system-wide approaches to service delivery for health and care services	Clinical and professional	Lots to do	Lots to do
	2.17	The ICS has achieved ambitious goals in supporting and growing its **health and care workforce** including, amongst other things:			Significant progress
		• Developing, supporting and creating a sense of belonging and identity for the whole ICS workforce, through a 'one workforce' approach across the health and care sector, including local government, the third sector, volunteers and informal carers	People and culture	Some progress	Significant progress
		• Looking after the ICS workforce, keeping them safe, healthy and well, both physically and psychologically	People and culture	Significant progress	Significant progress
		• Enabling and encouraging the ICS workforce to operate in new ways across the ICS, including through the adoption of new roles and skills, technology and digital innovation, collaborative employment arrangements and flexible careers	People and culture	Significant progress	Significant progress
		• Future-proofing the ICS workforce through collaborative arrangements to grow, develop and retain people	People and culture	Significant progress	Significant progress
		• Developing system leadership skills that support changes in behaviour and skills required to work most effectively across the ICS	People and culture	Significant progress	Significant progress
		• Ensuring that talent is identified, nurtured and developed, wherever it is located amongst ICS partners	People and culture	Significant progress	Significant progress
		• Creating opportunities for health and care employment and careers for local people, contributing to a vibrant local labour market and local economic growth	People and culture	Significant progress	Significant progress
		The ICS has achieved ambitious goals to improve the quality of its **estates** including, amongst other things:	Financial Framework and oversight and Performance	Some progress	Some progress
		• Improving the condition and functionality of health and care premises	Financial Framework and oversight and Performance	Some progress	Some progress

	2.18	• Achieving greater efficiency of the ICS estate by increasing utilisation and by making sizeable reductions in unoccupied space, estates running costs and energy consumption	Financial Framework and oversight and Performance	Some progress	Some progress
		• Achieving sizeable reductions in the ICS's carbon footprint by, amongst other things, increasing the proportion of energy generated from renewable sources	Financial Framework and oversight and Performance	Some progress	Some progress
		• Operating fair, transparent and high quality processes for assembling, assessing, prioritising and supporting investment proposals that progress the ICS's estates development goals, especially where discretionary NHS capital is being sought	Financial Framework and oversight and Performance	Some progress	Some progress
	2.19	The ICS has achieved ambitious goals to improve the quality of the **equipment** and **technology** available to ICS partners including, amongst other things:			Some progress
		• Increasing the quantity and quality of digitally-enabled care being delivered within the ICS, within and across service provider boundaries (especially for complex care and for the treatment of co-morbidities) and for self-care	Data and Digital	Some progress	Some progress
		• Improving the technological and digital platforms available for clinical support service such as medical physics, diagnostics, and laboratory services	Data and Digital	Some progress	Some progress
		• Increasing access to digitally-enabled service, such as *Digital-First* primary care and outpatients, including access to fit-for-purpose broadband	Data and Digital	Some progress	Some progress
		• Increasing access to assistive technology, telehealth and wearables	Data and Digital	Some progress	Some progress
		• Successfully mitigating any adverse impacts of increased digitisation and technology penetration on health inequalities across the ICS	Data and Digital	Some progress	Some progress
ICS Sub-topic 2(e): System Roles and Capabilities					
Collective system **roles** and capabilities	2.20	The ICS's system capabilities have been established across, and are aligned with, the distinct priorities of the ICS's collaborative mission, including:			Some progress
		• Transformation of services and system enablers	Place, integration Transformation and Commissioning	Some progress	Significant progress
		• Assurance of system performance across the NHS Triple Aim	ICB Governance / Assurance	Some progress	Some progress
	2.21	All system roles being discharged collectively are operating effectively and efficiently. Where the success of a system role can only be achieved by being discharged at more than one level of the ICS (i.e. at system, place, neighbourhood and/or provider collaborative levels), the interplay between those different levels is well-understood and effectively co-ordinated within and across the ICS	ICB Governance / Assurance	Some progress	Some progress
	2.22	The ICS's system capabilities (i.e. leadership and governance, strategies and plans, delivery mechanisms) are fit for purpose. They enable the ICS to fulfil its full range of development, programme management, transformation and assurance activities, wherever they surface (i.e. at the system, place or neighbourhood levels or in system collaboratives)	ICB Governance / Assurance	Some progress	Some progress
	2.23	At all levels of the ICS (i.e. system, place, neighbourhood or provider collaborative) the ICS's system capabilities now enable it to:		Some progress	Some progress
		• Create and communicate an inspiring and inclusive vision of the health and well-being status to which ICS partners, the people they employ and local citizens can realistically aspire	ICB Governance / Assurance	Some progress	Some progress
		• Update and deliver its system people plan in line with its system development plan and with national priorities and guidance, including the NHS People Plan 2020/21, the NHS People Promise and guidance on NHS recovery	People and culture	Significant progress	Significant progress
		• Take and implement demonstrably fair decisions, collectively and transparently	ICB Governance / Assurance	Some progress	Some progress
		• Identify and deploy effective leadership, both dedicated and distributed, to achieve the ICS's vision	ICB Governance / Assurance	Some progress	Some progress
		• Identify and prioritise first order goals for the ICS	ICB Governance / Assurance	Some progress	Some progress
		• Assemble and deploy an effective blend of specialist and programme resource, drawn in the main from ICS partners, to plan, organise and deliver key work programmes that meet first order ICS goals	ICB Governance / Assurance	Some progress	Some progress
		• Nurture, develop and support collaborative relationships between ICS partners	ICB Governance / Assurance	Some progress	Some progress
		• Design, incentivise and operate pooled risk and mutual aid mechanisms		Significant progress	Significant progress
		• Exercise collective grip on operational, qualitative and financial performance across the ICS and, where appropriate, to intervene to improve, recover and/or escalate where required	Financial Framework and oversight and Performance	Some progress	Significant progress
		• Undertake workforce planning alongside activity and financial planning, ensuring system plans are appropriately resourced, and ensuring the workforce across the ICS meets population needs	People and culture	Significant progress	Significant progress
		• Oversee the work of the ICS effectively	ICB Governance / Assurance	Some progress	Significant progress
		• Provide robust assurance that the ICS's vision is being progressed, its first order transformation goals are being achieved and its "business as usual" activities are being conducted effectively and efficiently	ICB Governance / Assurance	Some progress	Some progress
		• Communicate the successes and challenges of the ICS to key stakeholders and to provide an honest account of the ICS's performance to ICS partners, to local Health & Well-Being Boards, to NHSEI and to the public	People and communities	Some progress	Significant progress
	2.24	The ICS has a robust approach to identifying and examining significant challenges being faced by ICS partners (either individually or collectively), and of designing and implementing collective solutions (e.g. by way of mutual aid or introducing/scaling innovation) that address those challenges expeditiously	Place, integration Transformation and Commissioning	Some progress	Significant progress
	2.25	The ICS demonstrates considerable agility in sourcing and deploying new or supplementary capabilities as new or changing priorities arise	People and culture	Lots to do	Significant progress
Specialist system **roles** and capabilities - **population health management**	2.26	The ICS's population health management capabilities, underpinned by joined up data driven from the integrated care record and strong federated analytical intelligence capability with dedicated analytical resource from place-based and provider partners, which also draws in expertise from local authorities, VCSE and other insight-driven teams in the ICS. This should be enabling the ICS in:			Lots to do
		• Assessing current and future population health need across the system to determine resource deployment across places and providers, including:	Clinical and professional	Lots to do	Lots to do
		✓ Actuarially assessing and monitoring the ongoing health and well-being status of the local population, future health risks, demand and financial risk	Clinical and professional	Lots to do	Lots to do
		✓ Comparing current and predicted health status of the local population with achievable health and well-being outcomes and performance standards for populations of similar size, demography and epidemiology to understand mitigated scenarios	Clinical and professional	Lots to do	Lots to do
		✓ Using such population health intelligence to inform and influence service delivery strategy, resource deployment and capacity planning at system and place level	Clinical and professional	Lots to do	Lots to do
		• Predicting and managing health and care demand across segmented and stratified population groups within places, including:	Clinical and professional	Lots to do	Lots to do
		✓ Completing predictive risk modelling of the local population and understanding population groups experiencing greatest health inequity and bio-psycho-social drivers of risk	Clinical and professional	Lots to do	Lots to do
		✓ Using such modelling to identify citizens with prevailing health and care needs that require short-medium term holistic interventions or ongoing support	Clinical and professional	Lots to do	Lots to do
		✓ Using evidence based interventions - nationally and internationally - to identify impactable models of care to improve outcomes, experience and mitigate financial risk	Clinical and professional	Lots to do	Lots to do
		• Designing, incentivising and delivering proactive and integrated health and care capacity within places including:	Clinical and professional	Lots to do	Lots to do
		✓ Designing and deploying consistent whole-person care models for at risk groups through place based multidisciplinary teams	Clinical and professional	Lots to do	Lots to do
		✓ Making use of service-user tracking, patient activation outcomes, experience and utilisation measurement tools to enable ICS partners to monitor, understand and influence how interventions impact on required outcomes and how workflow presents itself to build the future evidence base and continually learn	Clinical and professional	Lots to do	Lots to do
		✓ Defining, framing, agreeing and applying incentives (and sanctions) to the way that actors in the system (be they citizens, family carers, volunteers, care professionals, individual clinicians or ICS partners) operate, so that behaviour aligns with population health goals	Clinical and professional	Lots to do	Lots to do
		✓ Planning future workflow and in determining and signalling how the current disposition of capacity (workforce, estates, community assets etc.) across the ICS needs to change to improve health and well-being	Clinical and professional	Lots to do	Lots to do
		✓ Codifying incentives, outcomes, workforce arrangements through population based alliance agreements across vertically and horizontally integrated providers	Clinical and professional	Lots to do	Lots to do
Specialist system **roles** and capabilities - **commissioning**	2.27	The ICS's commissioning activities are working effectively and efficiently at all levels of the ICS that they operate (i.e. system place and neighbourhood)	Place, integration Transformation and Commissioning	Some progress	Some progress
	2.28	The ICS's commissioning activities have led demonstrably to better co-ordinated health and care planning, a clearer focus on, and achievement of, health and well-being outcomes, and higher quality health and care services, across both the NHS and local authority spend, at system level and at place level	Place, integration Transformation and Commissioning	Some progress	Some progress
Specialist system **roles** and capabilities – **system partnerships and engagement**	2.29	Leaders from all partners regularly highlight system progress and challenges and celebrate achievements	ICB Governance / Assurance	Some progress	Significant progress
	2.30	There is proactive and systematic dialogue about health and care priorities with democratic and community representatives	ICB Governance / Assurance	Some progress	Some progress
	2.31	OD programmes develop and deploy capabilities from a range of partners into governance and service transformation priorities development challenges, such that all partners are supported to enable engagement with governance and decision-making	ICB Governance / Assurance	Some progress	Some progress

ICS Design Framework Chapter 3: People and culture					
People delivery and infrastructure	3.1	The ICB has agreed and established leadership and governance arrangements for delivering its people function, working in collaboration with partners in the ICP to support the one workforce	People and culture	Significant progress	Significant progress
	3.2	The ICS NHS Board continues to provide oversight of delivery of the ICS's People Plan and other local people and workforce actions in line with emerging local and national people priorities	People and culture	Significant progress	Significant progress
	3.3	The ICS has established processes to undertake medium to long-term planning of the system's 'one workforce' in an integrated way across workforce, finance and activity – factoring in future workforce demand, changes in skills and ways of working, service transformation and care delivery requirements	People and culture	Some progress	Significant progress
Talent management and development	3.4	The ICS has an inclusive talent management strategy, linked to strategic priorities and objectives. This strategy is understood by all and delivery of it is seen as everybody's responsibility	People and culture	Some progress	Some progress
	3.5	Data and lived experience are actively used to close the gap on inequalities and address retention issues	People and culture	Some progress	Some progress
	3.6	Talent information is used to design ICS-wide interventions and support mobility through ICS-wide succession planning and engaging staff in talent development opportunities	People and culture	Some progress	Some progress
	3.7	Collective decision making takes into account national perspectives and encompasses organisational, ICS, regional and national landscapes	People and culture	Significant progress	Significant progress
	3.8	Insight and learning from talent data is shared across the ICS to inform inclusive talent management interventions, collective responses and agree best practice	People and culture	Some progress	Some progress
ICS Design Framework Chapter 4: Governance and Management Arrangements					
ICS Sub-topic 4(a): Collective Leadership					
Collective leadership at place and at neighbourhood level within the ICS	4.1	Place partnership forums have been established in such a way that each is coherent and appropriately inclusive, in the light of the particular health and well-being features of each place. Each is operating effective, collective decision-making arrangements, involving, as appropriate, constituent local authorities	Place, integration Transformation and Commissioning	Lots to do	Some progress
	4.2	Each of the ICS's place partnership core leadership teams conducts its business effectively and accounts for its performance regularly and transparently including to the Integrated Care Board and the Integrated Care Partnership	Place, integration Transformation and Commissioning	Lots to do	Some progress
	4.3	Neighbourhood based decision-making forums have been established in such a way that each is coherent and appropriately inclusive, in the light of the particular health and well-being features of each neighbourhood. Each is operating effective, collective decision-making arrangements, involving, as appropriate, a broad range of primary care professionals	Place, integration Transformation and Commissioning	Some progress	Some progress
	4.4	Each of the ICS's neighbourhood leadership teams conducts its business effectively and accounts for its performance regularly and transparently	Place, integration Transformation and Commissioning	Some progress	Some progress
Collective leadership within provider collaboratives within the ICS	4.5	Provider collaborative decision-making forums have been established in such a way that each is coherent and appropriately inclusive, in the light of clinical and care focus and membership. Each is operating effective, collective decision-making arrangements	Provider Collaborative	Some progress	Significant progress
	4.6	Each provider collaborative core leadership team conducts its business effectively and accounts for its performance regularly and transparently to the Integrated Care Board and the Integrated Care Partnership	Provider Collaborative	Some progress	Some progress
ICS Sub-topic 4(b): System Governance					
System governance and collective decision-making	4.7	ICS Partnership-wide governance arrangements enable a collective model of responsibility and decision-making between system partners, with systematic arrangements to have the voice of public, patients and the voluntary sector represented	ICB Governance / Assurance	Some progress	Significant progress
System governance and collective decision-making	4.8	The ICS has VCSE alliance arrangements in place to reflect the diversity of sector and the VCSE is engaged in governance and decision-making arrangements at system and place including the Integrated Care Partnership and place arrangements	ICB Governance / Assurance	Significant progress	Some progress
ICS Design Framework Chapter 5: The role of providers					
Provided Collaboratives	5.1	Provider collaboratives have agreed a set of programmes that are delivered on behalf of collaborative members, and their system and are driven by population health management approaches and well informed by people and communities	Provider Collaborative	Some progress	Some progress
Provider Collaboratives	5.2	Provider collaboratives enable effective peer support and mutual accountability that holds members to account to ensure delivery of agreed objectives and mandated standards, through agreed systems, processes and ways of working; for example, open-book approaches to finance, data sharing and performance, to overcoming organisational siloes and maximising capacity	Provider Collaborative	Lots to do	Lots to do
Provider Collaboratives	5.3	Provider collaboratives work in a joined up way, with clinical networks, clinical support networks, cancer alliances and clinical leaders to develop strategies, agree proposals and implement resulting change	Provider Collaborative	Some progress	Some progress
Provider Collaboratives	5.4	Provider collaboratives define and share (definitions of) best practice and a common quality improvement methodology that leads to service change that improves health outcomes and reduces unwarranted variation	Provider Collaborative	Some progress	Lots to do
ICS Design Framework Chapter 6: Clinical and Professional Leadership					
Clinical and professional leaders from diverse backgrounds are integrated into system decision-making, supported with a flow of communications and opportunities for dialogue	6.1	Clinical and care professionals are fully integrated into all system decision-making supported by robust governance structures with clear, documented lines of sight from and to the wider clinical and care communities	Clinical and professional	Some progress	Some progress
	6.2	System leaders have clear communication channels across the different layers of the system including a feedback loop to ensure experience at Place and Neighbourhood is able to influence wider system thinking and priorities	Clinical and professional	Some progress	Some progress
	6.3	The system's approach to distributed leadership is well communicated and understood across system partners and clinical and care professionals including health, social care, local government and the voluntary sector, know how to influence and raise constructive challenge where required	Clinical and professional	Some progress	Some progress
Culture that embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities	6.4	System leaders have created a culture of shared learning, collaboration and innovation, working alongside patients and local communities	Clinical and professional	Lots to do	Lots to do
	6.5	There are clear opportunities for shared learning at neighbourhood and place, which are shared across the system to facilitate innovation, supported by system strategy	Clinical and professional	Lots to do	Lots to do
	6.6	System thinking with place and communities at the heart, is the norm and coproduction is at the heart of system transformation arrangements, processes and culture	Clinical and professional	Lots to do	Lots to do
	6.7	Patients and public are supported to build their knowledge, skills and confidence to work alongside clinical and care leaders to shape integrated services across the health and care system. System leaders advocate for this approach and promote the benefits and impact of genuine coproduction	Clinical and professional	Lots to do	Lots to do
Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry	6.8	Clinical and care professional leaders have sufficient time away from clinical work to effectively lead in their area of the system and across the system, supported by backfill where necessary as well as the infrastructure and permission	Clinical and professional	Significant progress	Significant progress
	6.9	System leaders ensure that clinical and care professional forums and meetings are established where necessary and that the attendees are released to participate	Clinical and professional	Significant progress	Significant progress
	6.10	Clinical and care professionals have access to the necessary digital, data, PMO and administrative support and to subject matter expert colleagues such as analysts, finance etc, in order to inform clinical and care decision making	Clinical and professional	Lots to do	Lots to do
Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders and providers	6.11	System leaders ensure there is a dedicated leadership development offer for all clinical and care professional leaders at all levels of the system, which enables them to learn and develop alongside non-clinical leaders	Clinical and professional	Lots to do	Lots to do
	6.12	System leaders ensure that leadership skills development programmes are fit for purpose looking to the future of ICSs and the knowledge and skills required for system leadership	Clinical and professional	Lots to do	Lots to do
	6.13	There is a strong and effective offer at place with a proactive recruitment process that enables future leaders to be identified to take up the offer	Clinical and professional	Lots to do	Lots to do
Transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based	6.14	System and place leaders have adopted a transparent approach to identifying, recruiting and creating a diverse multi-professional pipeline for clinical and care professional leaders which reflects the community served and promotes equity of opportunity	Clinical and professional	Lots to do	Lots to do
	6.15	There are mechanisms in place to identify and develop potential system leaders earlier, which are flexible enough to identify future leaders who may currently be in roles not traditionally associated with leadership	Clinical and professional	Lots to do	Lots to do
	6.16	Except in circumstances where there is a statutory obligation to specify the discipline needed for the position – i.e. Director of Nursing – job descriptions are professionally agnostic and recruitment processes and outcomes demonstrate an openness to a wide range of clinical and care leaders for system roles. This is demonstrable by the range of disciplines constituting the system, place and neighbourhood leadership teams	Clinical and professional	Some progress	Some progress
ICS Design Framework Chapter 7: Working with People and Communities					
Community engagement & involvement	7.1	The ICS has continues to iterate and re-validate its vision with the communities it serves. ICS leaders provide clear and regular updates on the ICS's plans to achieve its vision and on progress made in implementing these plans	People and communities	Some progress	Some progress
	7.2	The ICS is working with partners including Healthwatch and the VCSE to refresh its system-wide strategy for engaging with people and communities	People and communities	Significant progress	Some progress
	7.3	There is a systematic and documented approach to collating and sharing service user and carer intelligence which links to quality governance, decision-making and planning/commissioning	People and communities	Some progress	Some progress
System partnerships	7.4	The ICB constitution includes principles and arrangements for how the ICB will work with people and communities which have been designed with community engagement partners	People and communities	Significant progress	Significant progress
	7.5	ICS leaders maintain a regular and constructive dialogue with democratic and community representatives to ensure each is able to exercise significant influence on collaborative activities. Leaders from all ICS partners highlight system progress and challenges and celebrate achievements	People and communities	Some progress	Significant progress
ICS Design Framework Chapter 8: Accountability and Oversight					
ICS Sub-topic 8(a): System Oversight & Assurance					
System accountability	8.1	The Integrated Care Board and the Integrated Care Partnership (and, as relevant, partnership forums governing places, neighbourhoods and provider collaboratives) discharge their external accountability obligations in an effective and timely way	ICB Governance / Assurance	Some progress	Some progress

ICS Sub-topic 8(b): Quality Governance					
Quality oversight arrangements	8.2	The ICS recognises its duty to assure system performance and drive quality improvement across the ICS. Quality oversight arrangements are functioning well. Quality intelligence on learning, issues and risks is being shared, and risks are being identified and acted upon promptly. Routine oversight of quality takes place effectively at place level (based on the principle of subsidiarity)	Quality oversight	Some progress	Some progress
	8.3	The Integrated Care Board discharges its system performance assurance and quality oversight duties effectively. All system partners are clear on their roles, responsibilities and accountabilities within the ICS on quality, including management of risks; and work collectively and effectively to deliver improvement and address risks/ issues	Quality oversight	Significant progress	Significant progress
	8.4	Place-based quality oversight arrangements are functioning well. Quality intelligence on learning, issues and risks is being shared, and risks are being identified and acted upon promptly. This includes risks identified through patient safety incident reporting and investigation. Quality concerns are escalated appropriately, formally linking to regional quality oversight arrangements (Quality Surveillance Group (QSG) / Joint Strategic Oversight Group (JSOG)). This aligns with NQB and NHSEI guidance, which will be updated further in 2021/22	Quality oversight	Some progress	Significant progress
	8.5	Information-sharing, governance and escalation process functions well, meaning that the ICS Board and place partnership forums (as appropriate), discharge their quality oversight duties effectively. The Integrated Care Board reports the result of system performance to ICS partners, local Health and Wellbeing Boards, to NHSEI and citizens	Quality oversight	Some progress	Significant progress
	8.6	The Integrated Care Board and relevant governance committees receive timely reports that comprehensively summarise system performance and which identify matters where ICS intervention either to improve, or recover or to escalate, is merited. The Board has access to robust "check and challenge" capacity, drawing on the skills and expertise of independent expertise	Quality oversight	Some progress	Significant progress
	8.7	A defined approach is agreed in the ICS for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles	Quality oversight	Significant progress	Significant progress
Quality Improvement	8.8	System partners work together to deliver the vision and strategy for high quality, sustainable care, which leads to improved population health outcomes and reduced inequalities. Resource use is seen as an important element of delivering high quality care, and there is early evidence of improved quality being achieved without additional resourcing	Quality oversight	Some progress	Significant progress
	8.9	System partners work together to share learning and drive improvement and innovation. Organisations within the ICS routinely turn to a common or consistent improvement methodology to address the most pressing or complex challenges, which achieved results	Quality oversight	Some progress	Some progress
	8.10	Agreed key quality indicators are triangulated with professional insight and reported at ICS Board-level to inform decision-making and ensure identification and management of risks and issues, including variation and inequalities. Quality is monitored dynamically to enable identification of emerging considerations. Analysis focuses on trajectories, changes in variation, reviews of quality across provider collaboratives, performance against other ICSs and regions (benchmarking) and inequalities. E.g. use of Statistical Process Control and Making Data Count methodologies	Quality oversight	Some progress	Some progress
	8.11	The ICS has quality improvement priorities, which are delivered collectively and reviewed and refreshed regularly	Quality oversight	Some progress	Some progress
	8.12	Consistent metrics and QI methods are used by ICS partners to drive ICS quality improvement objectives	Quality oversight	Some progress	Some progress
	8.13	The whole ICS workforce (including health and care staff, the VCSE and informal carers) and the ICS's collective resources are used optimally across the ICS to drive quality improvement and deliver new models of care and ways of working	People and culture	Some progress	Some progress
ICS Design Framework Chapter 9: Financial Allocations and Funding Flows					
ICS Sub-topic 9(a): Financial Framework and Use of Resources					
Collective acceptance of whole population capitation risk by ICS	9.1	Systems have committed to work together to deliver system financial balance, year in, year out	Financial Framework and oversight and Performance	Significant progress	Significant progress
System driven funding, risk and incentive allocations	9.2	The ICS has succeeded in:	Financial Framework and oversight and Performance	Some progress	Some progress
		• Introducing fair and transparent mechanisms that enable the ICS to allocate financial resources, and risks, to place partnerships and/or ICS service delivery partners	Financial Framework and oversight and Performance	Some progress	Significant progress
		• Establishing contingency arrangements that effectively manage unforeseen or unmanageable financial risks	Financial Framework and oversight and Performance	Some progress	Some progress
		• Introducing fit-for-purpose, collective financial management and reporting processes, and associated oversight apparatus	Financial Framework and oversight and Performance	Significant progress	Significant progress
		• Establishing a proportionate intervention regime, in which, where necessary and appropriate, the Integrated Care Board, individual governing bodies and the regulators operate and cooperate transparently and effectively to address financial challenges in line with oversight MoU agreed with NHS England	Financial Framework and oversight and Performance	Some progress	Significant progress
IF Topic 9(b) - Financial Oversight					
Financial oversight arrangements	9.3	The Integrated Care Board operates sound reporting and oversight mechanisms that enable it to effectively oversee consolidated financial performance, in respect of NHS spend, across the ICS	Financial Framework and oversight and Performance	Significant progress	Significant progress
	9.4	The Integrated Care Board brokers discussions with partners to agree how they can support individual trusts to resolve their financial difficulties. ICS partners acknowledge that such interventions complement and support institutional efforts to address financial challenges	Financial Framework and oversight and Performance	Significant progress	Significant progress
ICS Design Framework Chapter 10: Data and Digital Standards and Requirements					
Digital transformation	10.1	The ICS's digital and data capabilities underpin all of the ICS's significant service and system transformation plans, in line with guidance set out in the "What Good Looks Like" Framework	Data and Digital	Some progress	Some progress
	10.2	The ICS has a named SRO with the accountability for digital and data, with the appropriate expertise that has clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services	Data and Digital	Significant progress	Significant progress
Shared care record	10.3	The ICS has now fully operationalised its **shared care record**. This is accessible across the ICS and functionality includes, amongst other things:	Data and Digital	Some progress	Some progress
		• Real-time support for clinical decision-making, including transfers of care and effective shared care planning	Data and Digital	Some progress	
		• Proactive support to enable effective population health management and anticipatory care, identifying individuals within the population at greater risk	Data and Digital	Some progress	
		• Support for self-care and patient activation, via citizen-facing access and viewing of the care record	Data and Digital	Some progress	
		• "Near" real-time data to support commissioning and service & pathway management of the local health and well-being system, accessible at system, place and neighbourhood levels	Data and Digital	Some progress	

Significant progress
Some progress
Lots to do

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**10**

Title:	**Voluntary Community Social Enterprise Sector**

Meeting Date:	19 January 20223

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Sally Young	Y	Tracey Shewan

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

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

History of the paper – where has this paper been presented		
Quality and Safety Committee	9.11.22	Approved

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

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) have now developed a Memorandum of Understanding (MoU) setting out our 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 will be passed through to the VCSE sector from the ICB.

As the Alliance developed under the previous three 'Place' arrangements, the forums continue on this footprint, this works for the VCSE sector and in terms of mutuality it will be for the VCSE Alliance and ICB to review as is necessary; however, we do not want to disrupt the good relationships and activity that has already commenced.

The MoU was discussed at Quality and Safety Committee in November,and recommended the ICB approves and signs the agreement.

The Staffordshire and Stoke-on-Trent Integrated Care Board are asked to approve and support the signing of the MoU agreement to create the Alliance.

Is there a potential/actual Conflict of Interest?	**N**
Outline any potential Conflict of Interest and recommend how this might be mitigated	
Not as part of the MoU; however we will continue to review this as procurements of services that impact on the VCSE sector are reviewed. There is a resolution process as part of the MoU.	

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

Implications:	
Legal and/or Risk	Reviewed and deemed not applicable
CQC/Regulator	Reviewed and deemed not applicable
Patient Safety	Reviewed and deemed not applicable
Financial – if yes, they have been assured by the CFO	The ICB needs to look at the structure of funding to the VCSE sector in the future.
Sustainability	Reviewed and deemed not applicable
Workforce / Training	Reviewed and deemed not applicable

***** *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? By having a formal agreement with the VCSE sector it will enhance the working relationships with the sector who contribute to much of the work to address inequalities across Staffordshire and Stoke-on-Trent.		
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 VCSE MoU Alliance will build on relationships across the system and there are opportunities for them to provide services to support health and wellbeing of our citizens.		
		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? The MoU is an agreement between two parties, which is based on inclusion.		
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 ***Engagement has taken place with the VCSE sector in order that we can develop the MoU and the Alliance. There was a stakeholder workshop held by NHSE for all stakeholders on 11th May 2022.***	**Y**	
5.	Has a Data Privacy Impact Assessment been completed? ***Please provide detail***	**N**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: Agree to approve and sign the MoU to create the VCSE Alliance.			

Staffordshire and Stoke-on-Trent VCSE Healthy Communities Alliance

Memorandum of Understanding

This document is a written understanding between the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and the Staffordshire and Stoke-on-Trent VCSE Healthy Communities Alliance and sets out how they will co-operate.

Ratification date: ** 2022
Date of review: TBD

Introduction

This Memorandum of Understanding (MoU) sets out why the parties wish to work in partnership on shared ambitions and the shared values governing the way in which they will work together. The MoU formalises the partnership and shows the willingness of both parties to work together. The MoU details the accountability and governance arrangements and provides clarity on each of the partner's commitments.

Partner Definitions

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

As of the 1st July 2022 Integrated Care Systems (ICS's) brought together NHS, local authority and voluntary sector bodies to take on responsibility for the resources and health of an area or "system". England is formally divided into 42 area-based ICSs. An ICS is responsible for planning and funding health and care services in the area they cover.

Each ICS is led by an NHS Integrated Care Board (ICB), (locally NHS Staffordshire and Stoke-on-Trent Integrated Care Board), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy.

What is the Staffordshire and Stoke-on-Trent VCSE Healthy Communities Alliance?

The VCSE Healthy Communities Alliance (hereafter termed 'the Alliance') is the recognised governance structure through which the Staffordshire and Stoke-on Trent Integrated Care System (ICS), including the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) shall engage, consult and empower VCSE organisations and networks to be involved in our health and care system on an ongoing basis.

The Alliance has an overarching aim to increase health equity of Staffordshire and Stoke-on-Trent communities through community-based approaches, and to support the health and care agenda in its broadest sense.

The Alliance brings together VCSE organisations to engage with statutory health and care organisations so that they can:

- Have a strong collective voice for the role of the VCSE sector.
- Inform, engage, consult, and empower one another in relevant health & care structures, relationships, policy and practice.
- Bring VCSE sector knowledge, skills, and expertise to address health inequalities.
- Increase the role and influence of the VCSE sector in ICS strategic thinking and decision making.

- Network with one another, develop contacts, share information and best practice.
- Develop working relationships between organisations and across sectors.

The Alliance shall provide the recognised legitimate means of both mandating and supporting individuals to act on its behalf, as Representatives, in attending and voicing VCSE perspectives and insight at ICS, ICB and ICP Boards.

The Alliance is made up of both place-based and thematic forums with cross sector membership of each. The forums are supported by a system-level Co-ordination Group which acts as the point of coordination and wherever possible seeks subsidiarity to the local Forums. The system-level Co-ordination Group acts as the primary point of contact for the ICB and ICP through a VCSE Healthy Communities Assurance Group.

The VCSE Healthy Communities Alliance structure is captured in Appendix 1.

The Alliance will support the ICB to deliver its aims:
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Shared Values

The following shared values and associated behaviours which underpin the partnership between the Alliance and the ICB were coproduced with representation across all ICS partners. These reflect and support the Leadership Compact.

- ### Trust

The Alliance and the ICB recognise the importance of trust and will enable a safe space, open conversations, and continual nurturing to foster long term collaborative relationships that are sustained over time.

The Alliance and ICB recognises that trust is dependent on other values and is intrinsic to equity, transparency, and honesty.

The Alliance and ICB will enable a culture of trust through decision making based on good rationale and the recognition that organisations in the Alliance are working from a position of good faith.

The Alliance and ICB recognises collaboration will change ways of working and trust will be demonstrated by a willingness to work across sectors and through enabling the VCSE sector to be involved strategically at the very early stages and at the genesis of ideas.

- Equitable

The Alliance and ICB will support all members to have a voice and provide a contribution and will enable a culture where time is taken to actively listen to and understand the different perspectives represented.

The Alliance and ICB will respect each other's views and will provide systems that are fair to all organisations recognising that valuable contributions can be made from all organisations.

The Alliance and ICB will design and review its processes to ensure equitable opportunities and proportionate performance management of VCSE sector led services.

The Alliance and ICB will work to identify areas where support is required to make systems more inclusive to the VCSE sector.

- Inclusive

The Alliance and ICB will create an inclusive approach to the coproduction of services with a collective purpose and through shared endeavour.

The Alliance and ICB will build inclusivity and engagement into commissioning ensuring the knowledge of the VCSE sector and the communities they work with are built into commissioning processes.

The Alliance and ICB will act as the mechanism and space for the different perspectives to be captured, allowing for cross fertilisation across the networks structures and sectors.

- Transparent

The Alliance and ICB recognise that transparency is intrinsically linked to both trust and collaboration and will enable a safe space ensuring all partners are open and honest with each other and understand what can (or cannot) be achieved.

The Alliance and ICB's collaboration will remove hidden agendas and foster a common understanding of strategy and objectives.

The Alliance and ICB communications will be open, honest and in simple and plain language to ensure all parties have a clear understanding. Partners will seek to agree decisions by consensus but recognises that there may be times when a decision doesn't meet all needs and in these instances the rationale will be communicated effectively.

The Alliance and ICB will enable transparent VCSE sector representation through clearly defined roles, expectations and purpose allowing effective feedback to wider stakeholders.

- Purposeful

The Alliance and ICB will have a collective approach, focused on delivery and practical outcomes.

The Alliance and ICB will be solution focused and flexible, involving the right people around the table with specific experience or knowledge.

The Alliance and ICB will ensure a clearly defined, common purpose and shared vision for the VCSE sector role in the wider integrated care system.

- Collaborative

The Alliance and ICB recognises collaboration benefits all partners and beneficiaries and will create a culture and systems to ensure effective cross sector collaboration whilst enabling VCSE sector organisations to work collaboratively.

The Alliance and ICB will enable shared understanding of each sector's activity, drivers, perspective, governance, and regulations and will celebrate the shared values and recognise the differences and interdependencies.

The Alliance and ICB recognise the need to build relationships to enable barriers to be removed, data to be shared for collaboration to be successful over the longer term.

- Person and community focused

The Alliance and ICB are committed to ensuring that the people and communities we support are at the heart of all decision making.

The Alliance and ICB will enable the VCSE sector's knowledge, expertise and passion for Staffordshire and Stoke-on-Trent's communities to be heard ensuring representation of all perspectives and removing barriers.

The Alliance and ICB is committed to support and develop a sustainable VCSE sector through longer term strategies, planning and funding to enable organisations rooted in local communities to deliver targeted and effective support and empower local people and communities to improve their health and wellbeing.

Integrated Care Board Commitments

The Integrated Care Board has made the following commitments in order to support the development of the Alliance and to effectively embed the Alliance in the Integrated Care System architecture.

- To recognise the role of the Alliance within system level governance and decision-making.
- To adopt a Memorandum of Understanding between the ICB and the Alliance.
- To nominate a named Executive Director (Sally Young – Director of Corporate Governance) with responsibility for leading engagement with the Alliance.

- To nominate a named Non-Executive Director (David Pearson - Non-Executive Chair of Remuneration Committee) with responsibility for assuring appropriate engagement with the Alliance.
- To undertake a review of the resourcing required for the Alliance during 2022-2023 to ensure NHSE pump-priming investment is capitalised upon.
- To ensure meaningful VCSE sector representation on ICB Portfolios and Enabling Programmes.
- To reinforce and champion membership of the VCSE Healthy Communities Alliance to all VCSE sector contacts through ICB and ICP members.

Key Priorities

There are four key priority areas on which the ICB and the Alliance agree to focus their initial collaborative work. Each will be progressed through an agreed ICS portfolio or enabling programme and the VCSE Healthy Communities Assurance Group will provide assurance and tackle barriers where required.

- Commissioning & Procurement
  Embedding sustainable and proportionate commissioning and procurement processes through ongoing dialogue and a commitment to ensuring VCSE organisations are included in the co-production of solutions. Through ICB portfolios, Provider Collaboratives and relevant channels partners commit to ensuring VCSE organisations are not excluded by overly complex processes and requirements.
- Communications and Engagement
  Embedding the **Working with People and Communities Strategy** through the Communications and Engagement System Group.
- Prevention and Social Prescribing
  Championing the role of community-based prevention support and the social prescribing ecosystem through the **Population Health, Prevention and Health Inequalities** portfolio.
- Volunteering
  Championing locally led, empowering volunteering processes as part of the **People Plan** via the **ICS People, Inclusion and Culture Board**.

Partnership

This MoU has been drafted between the Staffordshire and Stoke-on-Trent Integrated Care Board and the Staffordshire and Stoke-on-Trent VCSE Healthy Communities Alliance and is signed by The ICB Chair and Chief Executive Officer (CEO) and the VCSE Health Communities Alliance Chair and Vice-Chair.

This partnership has been established to recognise the role of the VCSE sector and contribution it can make across the ICS functions whilst acknowledging their independence.

It is an equal partnership for the mutual benefit of all partners, all of which have a vested interest in maintaining, developing, and enabling the partnership.

Commencement Date and Term

The Parties will work collaboratively as part of an ongoing arrangement. The Partnership will be reviewed annually, starting 12 months after the agreement is signed. This review will identify any changes to the landscape, confirm continuation and update shared objectives.

The initial timeframe for partnership activities will be five years, commencing [point of time here].

Activities will be regularly reviewed to ensure that they are being delivered as agreed, and that they are having the intended impact.

This MoU will be revised or updated as and when deemed necessary.

Resolving Disputes

Both parties are committed to working together to solve difficulties positively through raising concerns early and in as amicable way as possible. Both parties have the right to raise concerns and recognises there can be a perceived power imbalance between the VCSE and public sectors and that this should not prevent VCSE organisations feeling able to raise concerns, challenges, or complaints without fear of reprisal.

The Resolution Procedure is captured in Appendix 2

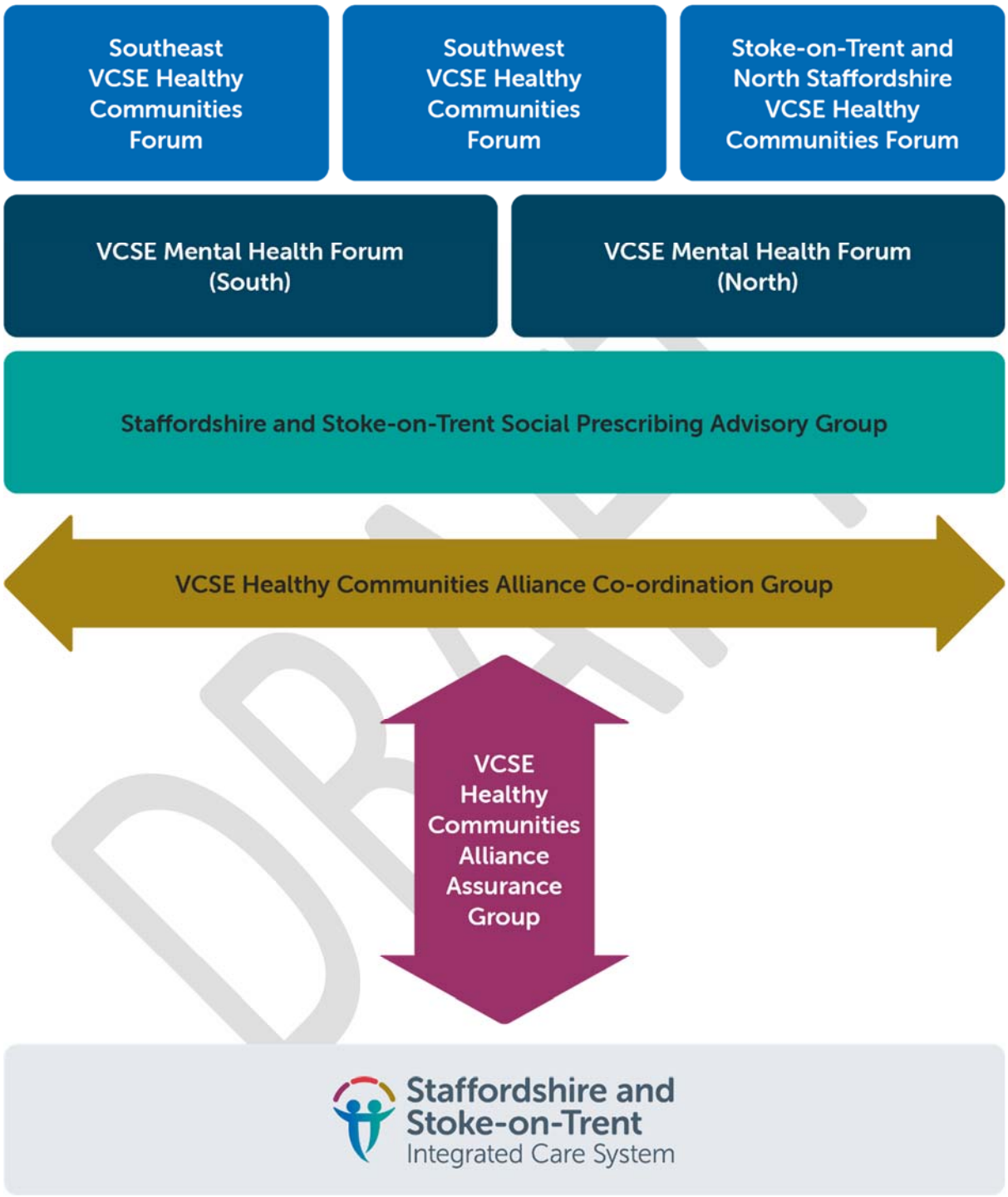
The Memorandum of Understanding (MoU)

The Staffordshire and Stoke-on-Trent Integrated Care Board supports the principles and priorities set out in this MoU and is committed to working collaboratively with the VCSE Healthy Communities Alliance to achieve this.

Signature	Signature
……	……
Name	Name
……	……
Organisation	Organisation
……	……
Position in organisation	Position in organisation
……	……
Date	Date
……	……

The Staffordshire and Stoke-on-Trent VCSE Healthy Communities Alliance supports the principles and priorities set out in this MoU and is committed to working collaboratively with the Integrated Care Board to achieve this.

Appendix 1 The VCSE Healthy Communities Alliance Structure



Appendix 2 Resolution Procedure

This Resolution Procedure gives a framework for settling disputes that are more complex and may need mediation or an objective view to find a resolution. It aims to provide a way for lessons to be learnt and for similar disputes to be avoided in the future as well as ensuring positive working relationships are maintained. It is not intended to decide a winner or a loser, but instead to find a positive way forward which maintains and improves the working relationship. While we encourage disputes to be resolved through this process, it's also important to recognise that other means, including legal redress, are always an option to either party.

The process

Any complaints regarding compliance with this agreement are monitored and recorded, so partners know if the resolution process and our contribution have been useful. Furthermore, we can use this information to help us review our effectiveness and will ensure all personal details remain confidential.

- Stage One - Informal

If an organisation has any difficulty in its relationship with another, it should first try to resolve this through discussion. There is always support available for such discussions through the VCSE Alliance Co-ordination Group.

- Stage Two - Formal

If an organisation can't find a solution informally, they can contact the VCSE Alliance Co-ordination Group for further support. The issue should be put into writing stating what the problem is, how the issue has been dealt with by the parties so far, why the issue has not been resolved and what would be a good outcome. The statement will be logged, and a panel drawn up from within the VCSE Alliance and the ICB, containing members who are objective, and have no links with either organisation. They will discuss the problem with both sides and attempt to find a solution. This should happen within six weeks of initial contact being made.

- Stage Three - Additional

If the formal process hasn't found a solution, the panel will support both organisations in seeking further mediation through alternative means. Organisations are free to follow other procedures and find support from elsewhere at any stage of the process.

If an organisation is unhappy about the result of a complaint the Health and Social Care Ombudsmen can be contacted. They can decide whether there are any grounds for investigation.

https://www.lgo.org.uk/adult-social-care/complaints-about-health-and-social-care#:~:text=The%20Health%20Service%20Ombudsman%20investigates,can%20investigate%20these%20issues%20together.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**11**

Title:	**Highlight Report for the Board Assurance Framework (BAF)**

Meeting Date:	19 January 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Sally Young, Director of Corporate Governance	Y	Tracey Revill, Interim Head of Governance

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
Q2 BAF presented to Audit Committee	09/01/2023	D
Q2 BAF presented to Finance and Performance (F&P)	03/01/2023	D
Q2 BAF presented to Single Leadership Team (SLT)	08/12/2022	D
Q2 BAF presented to Execs	14/11/2022	D

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

The Board Assurance Framework has been developed in the line with the Quadruple aims and the ICB's strategic objectives. The BAF has 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 execs to review their objectives and formulate the associated BAF risks.

The BAF is a dynamic, ever evolving document and will continue to be developed throughout the remainder of 2022/23 and beyond.

The BAF was discussed at the Audit Committee on the 9th January 2023 and following agreement at the ICB Board in December it has been agreed that the cycle for the BAF and risk register is as follows:

- Board to receive a highlight report on the BAF on the basis that the lead committee is reviewing monthly and the BAF is reviewed monthly by the chief executives.
- Each lead committee of the Board will 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 is meeting with colleagues from UHNM, (who have been helping with the development of the BAF and have been a great support), on the 12th January 2023 to review the BAF after which, the BAF will distributed to all executives for their Q3 update. As the BAF has been developed late in the financial year, for this financial year executives will be required to complete the Q4 update at the end of March to close off the financial year.

Going forward the BAF will 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.

Feedback from Finance and Performance Committee (F&P)

Feedback has been received from the Finance and Performance Committee. The committee focused on a new ambulance risk and Mark Docherty from WMAS asked to ensure a "read across" to the WMAS risk register. It is noted that further work will take place with WMAS to ensure there is symmetry between SSoT and WMAS in relation to this risk.

Further clarity is requested on BAF Risk 1 Commissioning intentions and BAF Risk 2 Inadequate Winter capacity.

The F&P Chair requested that the rationale be clarified in relation to their top three risks:

001 sustainable break-even financial position.

003 capital planning.

068 2023/34 break-even financial position.

As risk 098 Winter Plan Workforce has the highest residual score at 20 and is not included.

Feedback from Audit Committee

The Audit Committee ensured their understanding of the process and agreed their oversight role in providing assurance to the Board.

Work continues in refining risk definitions and the committees responsible for scrutiny of risks. This is in the context of the emerging review of governance below Board and its' Committees. A Meeting is 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:

BAF Risk 1 – Commissioning intentions are challenging and there is a high volume of commissioned services which require review within a short timeframe. The risk impacts all four strategic objectives. Overall risk rating is 12 at Q2, with actions to deliver on track.

BAF Risk 2 – Inadequate winter capacity to maintain system flow, winter is expected to be significantly challenging across the system, with the plan being developed as a system plant with full partner ownership. The risk impacts on strategic objectives SO1, SO2 and SO3. Overall risk rating is 20 at Q2, with one to deliver and two actions to deliver at risk.

BAF Risk 3 – Maintaining a competent nursing, midwifery and social care workforce, all areas are progressing, but workforce remains a challenge across the system. Maternity Induction Labour continues to be an area of concern, UHNM are reviewing the management of these. This risk impacts on all four strategic objectives. Overall risk rating is 16 at Q2, with actions to deliver currently at risk.

BAF Risk 4 – Insufficient workforce, the risks to the delivery of the strategic People objectives are being managed through the People, Culture and Inclusion Committee, with the ICS People Function working with partners to explore and implement innovative approaches and solutions to workforce supply. This risk impacts on all four strategic objectives. Overall risk rating is 20, with actions to deliver on track.

BAF Risk 5 – Unable to achieve statutory financial duties, the system financial strategy has been finalised and approved by CFOs. Monthly reporting remains consistent with the plan submitted in June. The system Run rate suggests a deficit of c.£40m with £20m non-recurrent mitigations. This

risk impacts on strategic objective SO3. Overall risk rating at Q2 is 20, with four actions to deliver on track and one at risk.

BAF Risk 6 – Reducing Health Inequalities, this impacts on all four strategic objectives. The responsible committee for this risk is to be confirmed by the lead Director. Risk score trajectory has been completed for both Q2 and Q3, the risk is expected to reduce in Q3 from 20 to 15. This risk impacts on all strategic objectives. Overall risk rating at Q2 is 20, with actions to deliver on track.

The board can receive further assurance that the Committees receive and review the BAF risk for which they are the lead committee.

There is also a "Directorate Issues log" which is reviewed monthly and issues can be escalated to the risk register as necessary.

Access to the BAF, risk register and issues log can be requested via the governance team if required.

Is there a potential/actual Conflict of Interest?	**NO**
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 risk register links to all risks and strategic objectives.

Implications:	
• Legal and/or Risk	Presentation of the BAF is a key source of assurance to the Board
• CQC/Regulator	Reviewed & considered not applicable
• Patient Safety	The BAF is a key tool for identifying patient safety risk and recording the mitigations put in place
• Financial – if yes, they have been assured by the CFO	CFO is sighted on all risks and any financial implications that may arise.
• Sustainability	Reviewed & considered not applicable
• Workforce / Training	Governance team provide on-going training in risk management and support executives with the BAF

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 BAF is an important assurance mechanism to demonstrate whether the ICB 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) **The updates in the BAF should provide this assurance.**		
		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 ***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:

- Receive assurance on the Board Assurance Framework.
- If any Board members wish to see the full BAF during the intervening time, please contact the governance team governance@staffsstoke.icb.nhs.uk

Staffordshire and Stoke-on-Trent Integrated Care Board

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										31/03/2023		✓	✓	✓	✓
BAF 2	Delivery of Winter Plan				4	5	20							3	4	12	31/12/22	→	✓	✓	✓	
BAF 3	Improving Quality				4	4	16							3	3	9	31/03/23	→	✓	✓	✓	✓
BAF 4	Workforce				4	5	20							4	4	16	31/03/23	→	✓	✓	✓	
BAF 5	Finance				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	↓	✓	✓	✓	✓

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**12**

Title:	**Finance and Performance Update**

Meeting Date:	19 January 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**
	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
Finance and performance committee	03/01/2023	D

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

The purpose of this report is to summarise the key financial and operational performance issues for the ICB Board.

Medically fit for discharge figures are included in the report based on feedback from the Board. Finalisation of Children and Young People metrics is progressing well with a plan for those to be included in the next performance report for the ICB Finance and Performance Committee to then flow up through to the ICB Board report.

In relation to the feedback around inclusion of social care/LA metrics, work is ongoing with our local authority partners to agree the most appropriate information to include. This will support a stronger alignment with LA reports.

Finance Overview

- We continue 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 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.

- 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. We are 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.

Operational Performance Overview

- Extended and severe winter pressure across all parts of the system were experienced throughout December, particularly over the festive period. These 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 show a significant increase in ambulance handover delays (>30 minutes) at Royal Stoke. Focus remains 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 NHS 111 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 continues to also be a challenge at all our main providers.
- The number of patients waiting >78 weeks and >104 weeks has decreased during October, however >52 week waits continue to rise.
- Performance against the 28 day waits (faster diagnosis standard (FDS) in October is 60.4%, remaining below the 75% standard.
- Mental Health is not included in this report as no new data has been published nationally. This is due to ongoing alignment being undertaken by NHSE to get ICB level breakdowns into datasets.

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):

- **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 103 –** Performance: Ambulance handover delays at RSUH are significant and of national concern. In an attempt to support the issue, the winter plan proposals may be brought forward. The risk is that the capacity is open ahead of need and there become limited options at time of super surge need.
- **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:			
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 ***Please provide detail***	**N/A**	
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 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 – 19 January 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. We continue 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. A detailed year-end forecast is being developed across the system and next month we will be taking a view as to whether we will continue to forecast break-even.
- 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, planning guidance has recently been issued for 2023/24. We are 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. 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 an updated Urgent Care position for December using the latest available operational information.*

- Preliminary figures for December show a significant increase in ambulance handover delays (>30 minutes) at Royal Stoke. Focus remains 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 NHS 111 call volumes during the month when compared to previous years. Abandonment rate remained above the national 3% threshold but still below the locally contracted 5% level. We continue to have a lower than average call abandonment rate against national position.
- 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 continues to also be a challenge at all our main providers.
- The number of patients waiting >78 weeks and >104 weeks has decreased during October, however >52 week waits continue to rise. Independent Sector capacity and mutual aid is in place to enable reduction in long waiters, particularly 78 week waits. Weekly updates, reporting and meetings with NHSE are in place.
- Performance against the 28 day waits (faster diagnosis standard (FDS) national target (in October) is 60.4%, remaining below the 75% standard but increasing from September's 53.8%. The system aims to prioritise implementation of Tier 2 national guidance received.
- In primary care it is anticipated that the learning disability annual health checks performance will meet the Q3 target (of 49.7%).
- Antimicrobial Resistance prescribing remains above the target set for our ICB. Year end FOT indicates that this target will not be met and has been impacted by Strep A and support being provided to the asylum seeker population.
- Mental Health is not included in this report as no new data has been published nationally. This is due to ongoing alignment being undertaken by NHSE to get ICB level breakdowns into datasets.

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.

- The improvement in the YTD position was mostly driven by the release of the 'non clawback' element of the H1 ERF allocation and a plan phasing review of the health inequalities & ageing well SDF underspent investments. Offset by, higher workforce costs at UHNM due to urgent care pressures and front loading of the winter plan.

	Month 8			Month 7		
System		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	2,625.7	2,660.8	35.1	2,299.6	2,328.3	28.7
Pay	(700.6)	(709.3)	(8.7)	(612.1)	(618.0)	(5.9)
Non Pay	(395.4)	(421.3)	(25.9)	(345.9)	(371.5)	(25.7)
Non Operating Items (exc gains on disposal)	(21.1)	(20.2)	0.9	(18.5)	(18.0)	0.5
ICB/CCG Expenditure	(1,501.2)	(1,492.9)	8.3	(1,315.2)	(1,308.1)	7.2
Total	7.4	17.2	9.8	8.0	12.8	4.8
			0.4%			0.2%

	Month 8			Month 7		
ICB		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Allocation	1,501.2	1,501.2	0.0	1,315.2	1,315.2	0.0
Expenditure	(1,501.2)	(1,492.9)	8.3	(1,315.2)	(1,308.1)	7.2
TOTAL ICB Surplus/(Deficit)	0.0	8.3	8.3	0.0	7.2	7.2
			0.6%			0.5%

	Month 8			Month 7		
UHNM		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	649.0	669.1	20.1	568.0	583.6	15.6
Pay	(383.4)	(387.4)	(3.9)	(334.7)	(337.4)	(2.7)
Non-Pay	(244.6)	(262.1)	(17.5)	(213.9)	(229.1)	(15.3)
Non Operating Items (exc gains on disposal)	(17.2)	(17.0)	0.1	(15.0)	(15.1)	(0.0)
TOTAL Provider Surplus/(Deficit)	3.8	2.6	(1.2)	4.3	2.0	(2.4)
			-0.2%			-0.4%

	Month 8			Month 7		
MPFT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	376.7	387.7	10.9	330.1	338.8	8.7
Pay	(262.7)	(264.3)	(1.6)	(229.7)	(230.6)	(0.9)
Non-Pay	(108.6)	(116.3)	(7.7)	(95.0)	(101.1)	(6.1)
Non Operating Items (exc gains on disposal)	(1.8)	(0.9)	0.8	(1.6)	(0.9)	0.6
TOTAL Provider Surplus/(Deficit)	3.7	6.1	2.4	3.8	6.2	2.4
			0.6%			0.7%

	Month 8			Month 7		
NSCHT		£m			£m	
	Plan	**YTD**	**Variance**	**Plan**	**YTD**	**Variance**
Income	98.7	102.9	4.1	86.4	90.7	4.3
Pay	(54.5)	(57.6)	(3.1)	(47.7)	(50.0)	(2.3)
Non-Pay	(42.3)	(42.9)	(0.6)	(37.0)	(41.3)	(4.3)
Non Operating Items (exc gains on disposal)	(2.1)	(2.2)	(0.1)	(1.9)	(2.0)	(0.1)
TOTAL Provider Surplus/(Deficit)	(0.1)	0.2	0.3	(0.2)	(2.6)	(2.4)
			0.3%			-2.7%

Urgent Care – Ambulance delays

- During November waiting times decreased slightly for all of the time-based metrics for West Midlands Ambulance Service (WMAS) compared to October, although they remain consistent with overall averages for the last few months.
    - November recorded a reduction of 4% on October's >60 minutes Handover Delays at Royal Stoke through 8% more conveyances
    - County Hospital reversed the previous 2 months of increases reporting a 70% reduction through 9% fewer conveyances.
- Call volumes for WMAS and EMAS reduced during November, WMAS still reported the 2nd highest number of calls received in month since January 2019.
    - At Burton Hospital, 25% of ambulance arrivals were by EMAS since 11th October 2022.
- Category 2 Response Waits *(a serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport)* continue to be a point of risk and pressure into December with significant waits experienced at the 8pm time.
- Provisional numbers for December indicate the pressure at 8pm continued, with 69 patients waiting on the 6th December.
- The reduction in Category 3 Response Waits experienced at the end of October was temporary with higher numbers reporting almost daily through November.

	Indicator	Target	Period / Description	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	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	11,012	▼	16,518	
			Variance to 19/20	1,390	857	1,442	1,472	992	1,342	1,656	1,506				
			Handover delays of over 30 minutes	2,398	1,969	2,439	2,496	2,101	2,273	2,566	2374	18,616	▼	27,924	
			Variance to 19/20	2,080	1,540	1,828	1,348	1,445	1,586	1,689	1,471				
			Handover delays of over 15 minutes	3,558	3,824	3,778	3,653	3,659	3,518	3,636	3629	29,255	▼	43,883	
			Variance to 19/20	1,360	1,299	1,057	367	861	607	386	277				
	Response Standards (WMAS - all responses)	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	00:08:32	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	00:01:07				
		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	00:47:56	01:05:38	▼		
			Time variance to 19/20	01:14:54	00:27:47	00:47:48	00:56:59	00:29:32	00:45:42	01:20:52	00:32:22				
	Time Lost		Hours lost in total (Handover)	3,800	2,264	3,572	4,116	2,728	3,178	4,532	3921	28,111	▼		
			% variance to 19/20												

Urgent Care - Performance against NHS Constitutional Standards

- Constitutional targets around 4 hour performance and 12 hour trolley breaches continue to be a challenge. Performance against both targets decreased at all our main providers. This remains a consistent regional and national picture. JB(SIO

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-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%	63.7%	▼	
	University Hospitals Derby & Burton	95%	62.0%	64.2%	61.7%	62.4%	63.0%	62.5%	61.0%	62.4%	▼	
	The Royal Wolverhampton	95%	76.8%	79.5%	78.9%	80.4%	80.5%	79.3%	79.1%	79.2%	▼	
	University Hospitals Birmingham	95%	54.7%	54.6%	53.2%	49.8%	52.7%	52.1%	52.1%	52.8%	⇨	
	The Dudley Group	95%	80.3%	74.7%	74.0%	75.6%	75.9%	75.0%	74.8%	75.8%	▼	
	Walsall Healthcare	95%	73.9%	72.3%	72.5%	72.4%	73.9%	74.5%	70.6%	72.8%	▼	

	Provider	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-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	4557	▲	
	University Hospitals Derby & Burton	0	432	388	256	333	348	394	785	2936	▲	
	The Royal Wolverhampton	0	30	20	30	194	130	100	208	712	▲	
	University Hospitals Birmingham	0	271	211	552	749	525	775	1384	4467	▲	
	The Dudley Group	0	31	79	49	67	90	95	129	540	▲	
	Walsall Healthcare	0	6	10	1	35	13	14	63	142	▲	

Slide 6

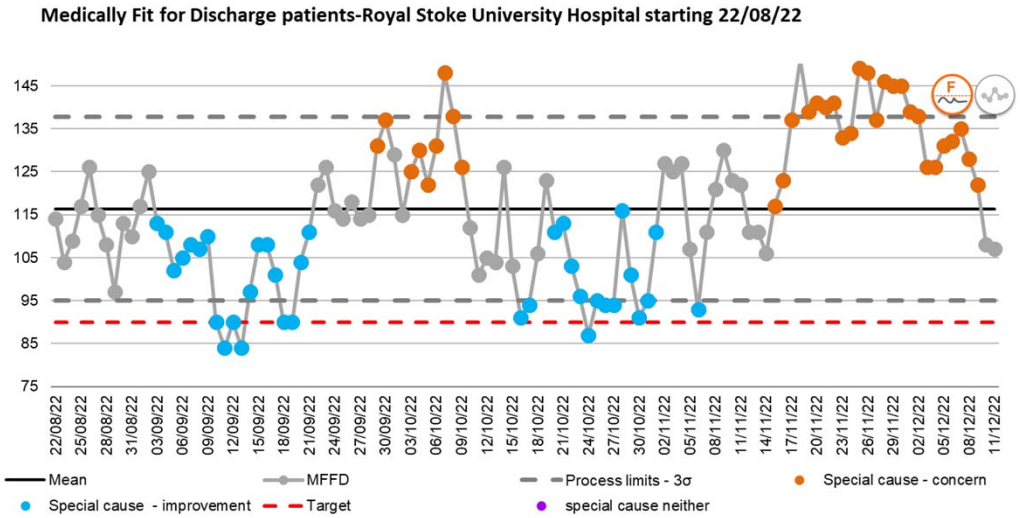
JB(SI0 Is this statement still true?
Jenny Branford (QNC) SSOT ICB, 2023-01-04T16:04:16.706

VH(SI0 0 As far as I am aware - check with RA
Victoria Hawley (QNC) SSOT ICB, 2023-01-04T16:34:52.428

Urgent Care – Medically Fit For Discharge

SPC analysis of key areas of focus at UHNM.

- Medically Fit For Discharge (MFFD) numbers increased significantly through the middle of November. This increase was seen at both sites of UHNM.
- This results in restricted capacity through delayed discharge and arrangement of packages of care.
- Provisional data for December has shown the start of a reduction. Pre-Christmas levels of MFFD were around 150 patients, but with improved discharges this reduced to circa 100 patients, with fewer patients waiting over two days for discharge from MFFD status.
- Provider of Last Resort (POLR) increased over the festive period as has been the case in previous years. However post the New Year bank holiday POLR has begun to reduce once more.



Data period: 22nd August to 11th December 2022

- Revised discharge targets for the system are in effect and are reviewed as part of the daily system calls.

Planned care – Month 7

- **52+ week waits:** 9,939 across the ICB (all providers), of which 4,789 are at UHNM and 430 reported at the Independent Sector providers. This is an increase on the position as of 4th December 2022. Across the last 6 weeks at UHNM, 52+ week waits have **increased** week on week, from 4,412 w/e 06/11 to 4,789 w/e 11/12.
- **78+ week waits:** 1,456 across the ICB (all providers), of which 656 are at UHNM and 121 reported at the Independent Sector providers (compared to 19 w/e 04/12); this increase at ISP is focused at Nuffield Health North Staffordshire, where 99 have now waited 78+. There is no immediate cause for concern due to forecasting eliminating the 78ww by the end of March.
- **104+ week waits:** 55 across the ICB (all providers), of which 42 are at UHNM, 4 at UHB and 14 reported at the Independent Sector provider (all 104 week waits at Nuffield Health North Staffordshire). At UHNM, 104+ week waits have **increased** slightly across the last 6 weeks, from 38 w/e 06/11 to 42 w/e 11/12.
- **GP referrals** into acute services (YTD) for outpatient appointments are above pre-pandemic levels by 4%.
- **28 day waits (faster cancer diagnosis standard (FDS)** performance for October is 60.4%, increasing from September's 53.8%, yet remaining below the 75% standard. This is due in part to a decrease in the number of patients receiving a diagnosis (down by 224 on September).

	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	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-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	4,143	5,107	5,004	4,801	4,766	4,775	5,173	40,006	33,769	-16%		66,046	57,890	Yes
RTT non-admitted, completed	21,951	23,159	21,735	24,049	21,320	22,606	25,314	19,410	22,194	20,723	20,294	22,400	22,067	22,722	160,134	149,810	-6%		268,666	256,817	Yes
Incomplete Pathway - Total Waiting List	85,296	86,968	87,398	89,266	90,289	89,986	89,297	144,518	146,503	148,018	150,901	150,307	150,584	150,849	89,297	150,849	69%		88,982	157,224	No
Incomplete Pathway - 52+ Weeks	0	1	1	0	0	1	0	8,415	8,550	8,498	8,920	8,926	9,164	9,246	0	9,246			11	10,002	No
Incomplete Pathway - 78+ Weeks	0	0	0	0	0	0	0	2,041	1,828	1,488	1,420	1,351	1,368	1,296	0	1,296			0	601	No
Incomplete Pathway - 104+ Weeks	0	0	0	0	0	0	0	445	235	64	59	85	69	41	0	41			0	0	No
GP and other (non-GP) referrals first consultant-led outpatients	35,448	36,394	34,198	37,420	33,230	33,854	36,836	34,894	38,797	36,348	36,202	37,130	35,793	38,173	247,380	257,337	4%		406,751	441,149	No
Cancer 28 days FDS - Total Patients Diagnosed	1,510	1,945	1,858	2,015	2,723	3,102	3,527	4,564	5,017	4,653	5,139	5,487	5,600	5,380	16,680	35,840	115%		33,199	61,440	No
Cancer 31 day Treatments	539	524	523	591	526	560	614	521	534	602	564	608	631	547	3,877	4,007	3%		6,672	6,869	No

Planned care and Cancer – Month 7

Elective Activity

- Elective Ordinary Spells, Day Cases and Outpatient Procedures remain below the volume in 2019/20 – both year to date and in-month.
- Outpatient first attendances are below 2019/20 activity levels (6% lower in October 2022 compared to October 2019).
- Outpatient follow-up attendances have reduced by 2% year to date. The national target is to reduce follow-up attends by a minimum of 25% against 2019/20 activity.

Diagnostics

- Diagnostic performance against the national ambition to be above 19/20 activity levels has not been met during October. Activity has increased by 2.2% compared to September.
- In October, 65.5% of patients were seen within 6 weeks against the constitutional target of 95%, this is a 1.8% increase on September.

	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	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	19/20	22/23	% Var	Trend	19/20	22/23	Below 19/20?
Elective Ordinary Spells	1,537	1,770	1,663	1,751	1,613	1,577	1,829	1,213	1,409	1,441	1,331	1,317	1,400	1,511	11,740	9,622	-18%		19,137	16,495	Yes
Day cases	12,887	13,222	12,309	13,665	12,486	12,763	13,753	10,843	12,465	12,208	12,074	12,317	12,281	12,865	91,085	85,053	-7%		152,523	145,805	Yes
Outpatient procedures (Cons Led)	13,708	14,216	13,744	15,297	13,588	14,194	15,246	10,411	12,200	11,170	11,221	11,777	11,993	11,249	99,993	80,021	-20%		164,216	137,179	Yes
Outpatient first attendances without a procedure (Cons Led)	26,313	27,224	25,683	28,824	24,826	27,192	29,681	23,165	27,881	26,686	25,548	26,638	27,956	28,002	189,743	185,876	-2%		317,277	318,645	No
Outpatient follow-up attendances without a procedure (Cons Le	43,191	45,665	42,944	48,318	42,218	45,885	50,110	38,222	44,412	41,588	38,846	41,744	42,347	41,773	318,331	288,932	-9%		535,884	495,312	Yes
Diagnostic Tests (Specific 7 Tests)	37,950	39,669	39,235	40,563	37,767	37,914	40,824	29,625	32,536	30,406	31,850	32170	32103	32815	273,922	221,505	-19%		458,445	379,723	Yes

*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 – ICB Level Summary

Performance against Plan

- **Appointments in General Practice**: Appointment activity for October 2022 was 0.3% above the plan, equating to 1,615 appointments.
- Year to Date the ICB is delivering 103% of the plan (25,085 appointments). This has been revised applying historic performance

	Indicator	Currency	Q1 Apr-22	Q1 May-22	Q1 Jun-22	Q2 Jul-22	Q2 Aug-22	Q2 Sep-22	Q3 Oct-22	YTD	Y/E (Actual/FOT)	Change on previous period	Trend
	Appointments in General Practice	Count	423,294	484,394	448,258	455,173	470,805	501,940	571,228	3,355,092	5,865,416	▲	
		% variance to plan	99.4%	114.6%	93.5%	98.8%	108.5%	93.3%	100.3%	100.8%	103.0%	▲	
		% variance to 19/20	-0.4%	11.1%	8.8%	-2.5%	16.4%	5.1%	4.9%	5.9%	9.1%	▼	

Data Source: *Appointment in General Practice – Appointments in General Practice data collection (NHS Digital).*
Time Period: 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 calculated using the 3 year cumulative average

Performance against Target

- **Social Prescribing referrals** (cumulative): October performance is provided for information as this is a quarterly target.
- **LD Annual Health Checks** (cumulative) : Q1 and Q2 remain below the quarterly targets. October and November figures show that Q3 is on track to meet the target of 49.7%. A baseline against historical (pre-covid) performance will be reflected in the M8 report.
- **Antimicrobial Resistance:** the rate decreased in September (latest data) but remains above the target set for our ICB. Performance is likely to be impacted for November and 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.

Indicator	Target	Q1 Apr-22	Q1 May-22	Q1 Jun-22	Q2 Jul-22	Q2 Aug-22	Q2 Sep-22	Q3 Oct-22	Q3 Nov-22	YTD	Y/E (Actual/FOT)	Change on previous period	Trend
Total number of social prescribing referrals (cumulative)	*Cumulative target Q1: 3365, Q2: 6730, Q3: 11,780*	3,121			6,714			7,726		7,726	13,872	▲	
Learning Disabilities annual health checks (quarterly targets) cumulative data	*Q1 Target 12.29%, Q2 Target 31.0%*	12.0%			29.4%			35.4%	44.0%	44.0%	59.5%	▲	
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	1.050	▼	

Data Sources*: Social Prescribing Referrals – Local Extract for IIF Reporting (accessed via Aristotle). Performance against target data taken from the ICB Dashboard. Time Period: 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: Estimated by applying linear regression*

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**13**

Title:	**One-year operational plan and joint forward plan (JFP) national guidance summary**

Meeting Date:	19 January 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**
	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
Executive Weekly Meeting	9/1/2023	D

Purpose of the Paper (Key Points + Executive Summary):
The purpose of this report is to summarise the national planning guidance published on 23rd December 2022 and to describe to the Board the timetable and next steps in the creation of a system plan that focusses on a smaller number of priorities. This report is for information at this time, then in March or April the Board will be asked to approve the final version of the operating plan for the year and the Joint Forward Plan.

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):
• N/A, guidance summary paper.

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

Summary of 2023/24 National Operational Planning and Joint Forward Plan Guidance

Introduction

- This paper is to introduce the approach and timetable for the creation of a system plan for 2023/24.
- Ahead of the publication of national guidance, the system has been doing a lot to prepare ourselves for the planning round for 2023/24. For example, the System Performance Group is a meeting of system partners where leaders are working together to build greater collective understanding and to oversee system work to address our performance challenges; and the System Finance & Performance Committee is exercising the assurance of performance and plans, which is deepening partner understanding of the challenges across the portfolios and services.
- Also, system CFOs have developed a system financial strategy that has been shared with the Board, and is being used to frame this work on the system plan for 2023/24.
- Feedback from colleagues has been consistent – all are seeking greater focus in the 2023/24 plan. Colleagues have commented that we have too many priorities, and consequently we struggle to prioritise people and resources. The plan for the current year was a sound collective effort, but was essentially a consolidation of partner plans. Looking ahead to 2023/24, we aspire to a unifying plan, that direct focus to the issues that are the most pressing ones for our residents, patients and staff. It needs to describe the plan for 2023/24 that will be a step forward towards the ICP strategy that is being developed and agreed.
- This paper summarises the guidance which was received on 23rd December 2022. It describes the timescale we are following. And it introduces the approach we are taking to identifying the key priorities that we well centre the plan around.

2023/24 priorities and operational planning guidance (One year Plan)

- The 2023/24 national priorities and operational planning guidance describes:

3 high level national priorities

31 national objectives

50 national actions

Recovering core services and productivity

31 key actions to improve patient safety, outcomes and experience it is imperative that we:

- Improve ambulance response and A&E waiting times
- Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- Make it easier for people to access primary care services, particularly general practice.

Make progress in delivering the Long Term Plan (LTP) key ambitions

8 key actions

- Our core commitments to improve mental health services and services for people with a learning disability and autistic people
- Prevention
- Effective management of long term conditions.

Continue transforming the NHS for the future

11 key actions

- Put the workforce on a sustainable footing for the long term
- Level up digital infrastructure and drive greater digital connectivity.

- The link to view the full guidance document can be found here: NHS England » 2023/24 priorities and operational planning guidance
- A range of guidance is yet to be published eg contracting guidance, general practice recovery plan.

Guidance on developing the joint forward plan (JFP) (5 year plan)

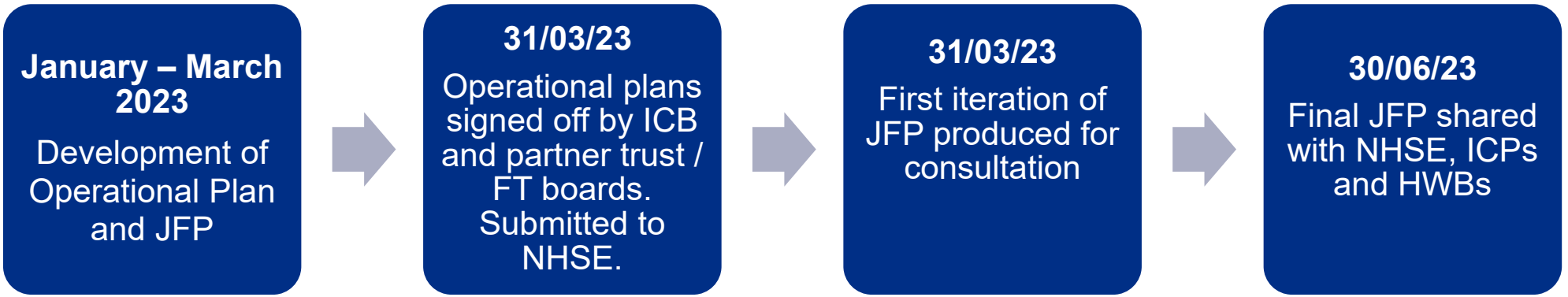
- Guidance is more loose and at this stage does not set out specific objectives tasks and actions across priorities. This is a change to the previous 5 year plan guidance.
- The guidance sets out a flexible framework for JFPs to build on existing system and place strategies and plans.
- The guidance states specific statutory requirements that plans must meet.
- Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured.
- Systems should use the JFP to develop a shared delivery plan for the integrated care strategy.
- As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.
- Further additional guidance is to be released 12th January 2023.
- The national long term plan is to be re-issued later this year, meaning that the 5 year plan will need to be an iterative document.

Finance

- The Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25. The settlement remains as per the spending review and allows for inflation to be fully funded.
- Core ICB capital allocations for 2022/23 to 2024/25 have been published: allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.
- At a national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity. Average cash allocation growth is 3.2%, which is broadly equal to the 2023/24 inflation factor.
- We have been set an aggregate target to bring costs down agency costs to 3.7% of the pay-bill. There are differential targets for ICBs, but we start in a relatively strong position and so expect a lower target for improvement.
- ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.
- A number of resources have been added to baselines, consequently the System Development Fund (SDF) has been squeezed, although mental health funding is retained.
- There is strong instruction to adopt Aligned Performance & Incentive contracts, where all services have a fixed value (block), apart from Elective Care (including Best Practice Tariff). Non NHS contracts are on pure cost and volume (no change).

National Timescales and Next Steps

- Key dates are as follows:



- The process is an opportunity for us to create a unifying plan that generates a greater sense of joint purpose, with a smaller number of key priorities and metrics that we can all focus on.
- To grasp this opportunity, we have agreed on an all-system session on 13th February where the exec teams will come together. We are seeking to agree about 4 system priorities that we will all agree to focus on, and then we will centre the plan around the delivery of those priorities through the delivery of agreed metrics.
- We will share the emerging thinking at the next Board.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:
Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**14**

Title:	**Staffordshire & Stoke-on-Trent ICB System Winter Update**

Meeting Date:	19 January 2023

Executive Lead(s):	**Exec Sign-Off Y/N**	**Author(s):**
Phil Smith/Heather Johnstone	Y	Tom Bailey, Ashleigh Shatford, Cath Marsland

Clinical Reviewer:	**Clinical Sign-off Required Y/N**
Dr Steve Fawcett, Heather Johnstone	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

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

This paper provides an update to ICB Board regarding all aspects of urgent and emergency care across the system this winter.

Included within the report are sections relating to:

- Stocktake of planned vs actual
- Review and reforecast
- Ambulance Handover Plan
- Quality and Safety update
- Next steps

To date, this winter has seen unprecedented levels of pressure, felt across the entire system. The System Winter Plan, System Escalation Plan and System Ambulance Handover plan are working concurrently and in conjunction to ensure that all system partners take appropriate action to mitigate risks to patient safety and patient care to the fullest extent.

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

Summary of risks relating to the proposal (inc. Ref. No. of risk it aligns to on Risk Register):
There are a number of risks associated with the winter plan and UEC. These are being routinely reviewed by the System Winter Steering Group, System UEC Board and System Winter MDT meetings and are uploaded on to the corporate risk register. Workforce and ambulance handover delays remain to have the highest risk score at 25 respectively.

Implications:	
Legal and/or Risk	System-wide risk relating to non-delivery of Winter Plan
CQC/Regulator	All providers are CQC registered.
Patient Safety	Quality involvement throughout development of plan and within Winter Steering Group, Winter MDT and UEC Board forums – Quality & Safety Committee updates and oversight.
Financial – if yes, they have been assured by the CFO	Spend commitments approved by CFO in advance – linked to Winter Plan initiatives and schemes. Additional funding received from NHSE with appropriate assurance and reporting mechanism in place (via Board Assurance Framework). CFO membership of Steering Group and wider finance team membership of supporting winter forums.
Sustainability	Risks relating to de-escalation and ensuring NHSE funded schemes are stood down in timely fashion added to Risk Register.
Workforce / Training	Workforce risks managed via System Workforce plan & escalated via Risk Register.

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?	**Y**	**22/11/ 2022**
2b.	What was the outcome from the System QIA Panel? **Approved**		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: • N/A		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) • Stage 1 complete • Stage 2 complete	**Y**	
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 ***Winter plan presented to Trust Public Boards, ICB Public Board and other forums for NED and public engagement. Communications plan in place to proactively engage with patients and public regarding initiatives and contingency planning.***	**Y**	
5.	Has a Data Privacy Impact Assessment been completed?	**Y**	
Recommendations / Action Required:			
The Integrated Care Board is asked to: **Receive the System Winter update for assurance.**			

1. Introduction

The Staffordshire and Stoke-on-Trent ICS Winter Plan was developed, and is reviewed, amended and updated, in partnership with all constituent organisational partners within the ICS.

This includes; University Hospital North Midlands (UHNM) Midlands Partnership Foundation Trust (MPFT), North Staffordshire Combined Healthcare Trust (NSCHT), Staffordshire County Council, Stoke-on-Trent City Council and University Hospitals of Derby and Burton (UHDB). The Royal Wolverhampton Trust (RWT) have been sighted on all aspects of the System Winter Plan and development discussions have been held with the Deputy Chief Operating Officer and other colleagues to ensure awareness and collaboration on key aspects. Engagement with provider partners that serve the ICS population but sit within other ICSs has been carried out to ensure a joined-up approach and to factor in relevant considerations from partner organisations.

The Winter Plan was presented to the ICB Board in November (post review and scrutiny and Finance and Performance Committee, Quality and Safety Committee and all system partner public board meetings) for approval. The plan was approved and has been implemented in accordance with the principles and timelines outlined in the original document.

Within the Winter Steering Group (and other related forums, such as the System Winter Plan MDT meeting), clinical, finance, patient safety and communications partners remain integral, involved and sighted at all stages to ensure a holistic system approach to assessment and review of the plan and to ensure that all actions and interventions are prioritised to ensure maximum impact.

Those schemes funded by NHSE winter monies are subject to assurance reporting via the monthly UEC Board Assurance Framework (BAF) return, both in terms of spend and delivery. The UEC BAF has now been expanded to incorporate wider action planning linked to all facets of UEC and additional priority areas (for example Primary Care and Cancer standards).

The three component parts of the Winter Plan are:

System Capacity Plan

Capturing plans put into place to increase capacity within the system through the winter period by deploying targeted initiatives and schemes to increase system bed capacity or to provide an equivalent impact.

System Escalation Plan

Designed to provide system resilience during times of increased demand and pressure, learning from previous experience as the system has become rapidly stressed leading to the development of unmitigated risks.

The Escalation Plan seeks to address issues in light of the increased levels of demand which has contributed to systems pressures, including ambulance handover delays, workforce challenges and increased clinical risk.

The escalation plan contains agreed parameters and triggers dictating enhanced action considered to be OPEL level 4+ actions, the need for all partner organisations to be sighted on risk along the entire patient pathway and agreed escalation actions to minimise and mitigate risk by sharing risk across the system.

System Workforce Plan

The System Workforce Plan is led by the ICS People Function and aims to support delivery of the Winter Plan, including the additional winter capacity schemes across the system.

The Workforce plan is updated to provide information on additional workforce numbers required to support each scheme, actions being taken to recruit/supply this additional workforce (including provider and system level activities), workforce risks and mitigations.

The Winter Plan is a 'live' document and is under constant review to ensure that all activities and decisions are made to enhance the system response during the winter period.

A Risk Register is in operation to ensure that all Risks are assessed holistically and addressed via system-wide action. The Winter Plan Risk Register feeds into the ICS Corporate Risk Register and is updated weekly, via the Winter Plan System MDT and Steering Group forums.

2. Stocktake of Plan vs Actual

Whilst the ICS developed a robust Winter Plan, the position in Staffordshire and Stoke on Trent remains challenged with high levels of pressure that echo national reports. Cumulative factors contributed to the system declaring a Critical Incident on Thursday 29th December, which remains ongoing at the time of submission (11th January 2023).

Through the System Winter Steering Group and System MDT, the ICS has continuously evaluated the live position of the urgent care system against the expected plan to understand the root causes of pressure. There are three key components which are understood to have exacerbated pressure beyond plan:

a) Workforce
b) Demand
c) Supply

During December, the system implemented capacity beyond that planned (super surge) and delivered capacity through escalated OPEL Level 4+ actions as per the System Escalation Plan. Further detail is provided at section 3.

a. Workforce

The ICS Winter Plan has remained transparent in identifying and monitoring the risk that there is not the workforce capacity required to deliver the plan. This has been mitigated against the System Workforce Plan, however, despite robust campaigns and schemes aimed to support recruitment and retention, there remains a lack of workforce able to deliver the capacity required.

For context, the overall sickness levels of core capacity ranged from 4% – 10.3% in December 2022 across the Health Economy, and vacancy rates have ranged between 8% – 24% across staffing groups.

Within the Winter Plan, to deliver all capacity a requirement for 342.59 WTE was needed (this figure does not include primary care capacity), to date only 134.08 WTE staff have been appointed, this represents 39% of the capacity required.

It is important to note, that with high rates of absence; provision and efficiency of capacity available will be compromised as staffing ratios are stretched.

b. Demand

Demand profiles are multifaceted with key factors being numbers requiring care and a change in the demand profile expected.

When evaluating the demand experienced vs that predicted there has been an increase in patients presenting to ED as well as an increase in those requiring admission to an inpatient bed. Overall, attendances through November and December at RSUH were 650 higher than those forecast (this equates

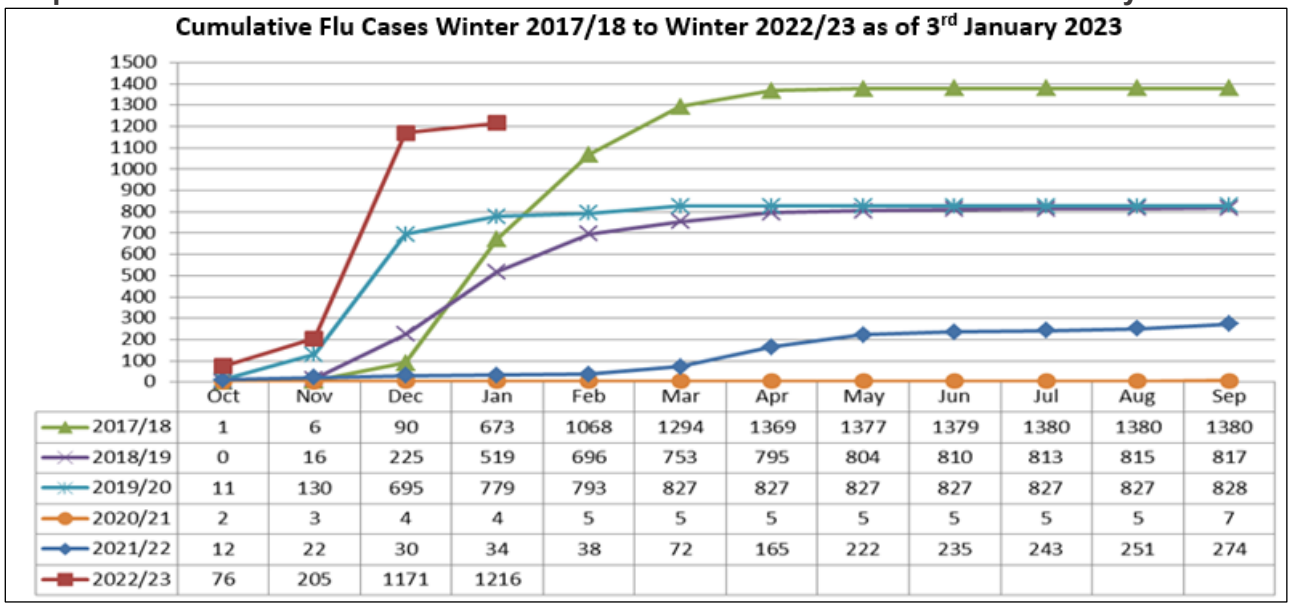
to an increase vs. plan of 3.3%). This picture has been replicated across County Hospital and Queen's Hospital Burton with prolonged periods of increased demand in ED.

Pressure within emergency departments has been constant throughout winter to date and include a day that surpassed the previously identified date for the highest number of attendances, whereby over 420 individual attendances were recorded at Royal Stoke hospital.

Compounding the increased levels of demand has been the variance in the demand profile vs that predicted, there have been significant increases in the number of inpatients with seasonal infectious diseases. Sustained increases in inpatients with Covid, Flu and RSV have placed additional pressure onto the bed base and exasperated patient flow issues, with significant infection prevention and control (IPC) measures required to try and manage infection and spread of these illnesses.

The System Winter Plan demand was modelled utilising the flu predictions from 2017/18, where the system experienced high numbers of patients with flu which subsequently resulted in significant pressure; up until now this year was considered our worst flu year in terms of volumes. The difference from 2017/18 is that the pressure of the flu season currently being experienced started far sooner than previously experienced. The peak capacity across the system was planned to be delivered in January as per previous years, however the pressures started to build early November and was hitting previously seen peak levels in December as demonstrated below, which the system was not prepared for.

Graph 1: Cumulative Flu Cases Winter 2017/18 to Winter 2022/23 as of 3rd January 2023



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2017/18	1	6	90	673	1068	1294	1369	1377	1379	1380	1380	1380
2018/19	0	16	225	519	696	753	795	804	810	813	815	817
2019/20	11	130	695	779	793	827	827	827	827	827	827	828
2020/21	2	3	4	4	5	5	5	5	5	5	5	7
2021/22	12	22	30	34	38	72	165	222	235	243	251	274
2022/23	76	205	1171	1216								

For reference, there was a 68% increase in the number of inpatients with Covid during the two-week period from December 16th – December 30th. During this time period there was also a 136% increase in the number of inpatients with flu and a 55% increase in the number of inpatients with RSV.

Further factors contributing to a change in the predicted demand profile are:

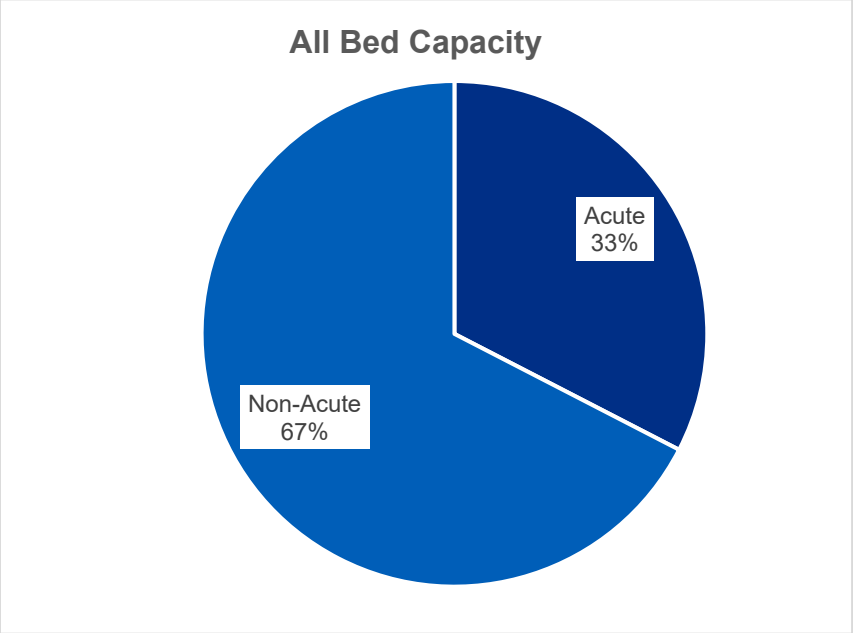
- Unforeseen Strep A attendances at ED, within primary care and via calls to 111 and 999. A Strep A outbreak was not foreseen during the modelling stage of the plan,
- Those patients attending or conveyed to hospital have been observed as being of a higher acuity, requiring greater medical support and for a longer period, and
- Periods of industrial action have also impacted notably upon the system, with further action planned throughout January requiring mitigation and enhanced action at a time when the system is already at a significantly pressured state.

c. Supply

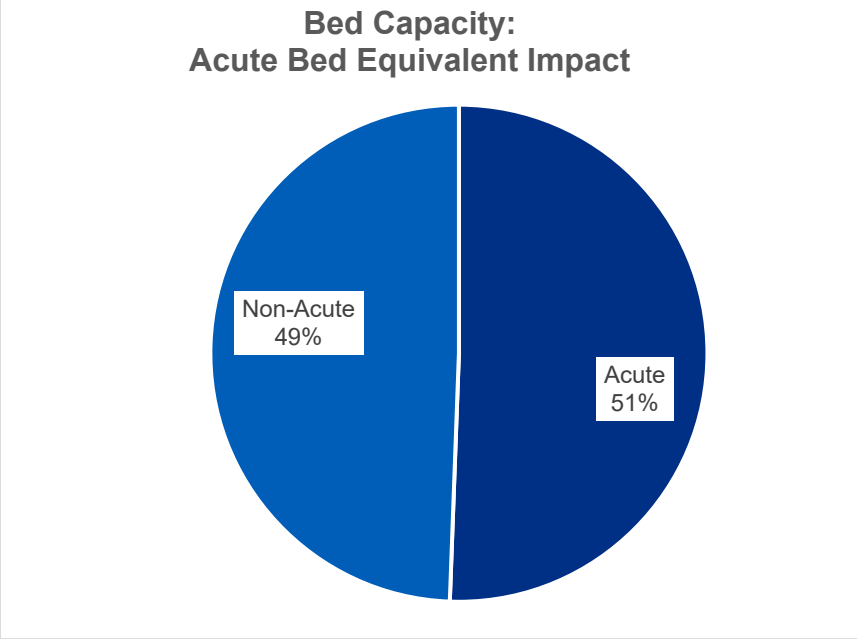
During the modelling phase it was identified that a number of acute beds were required during the peak surge period; it is worth noting the emphasis on acute beds. As to be expected, not all additional capacity can be delivered through the acute setting due to logistical issues and estate constraint. In addition, this year, the system made a commitment where at all possible elective capacity would remain to ensure our patients received the planned care they needed as part of the elective recovery backlog.
If a non-acute bed is provided as additional capacity, it does not represent the equivalent of an acute bed given several factors including patient need, staffing, environment. Therefore, when modelling is undertaken, we build in assumptions to calculate an equivalent acute impact.

In its rawest sense, actual acute capacity accounts for 33% of the surge capacity planned.

Graph 2:



Graph 3. Equivalent bed capacity



3. System Winter Plan – review and reforecast

Whilst assessing the current actual vs predicted, the system is remodelling forecast positions for the remainder of the winter period. The stocktake is designed to assess and evaluate the impact of the winter plan schemes/initiatives versus plan and to recalibrate and evaluate resource utilisation and impact.

The latest stocktake position (for January 2023) is included below in Table 1:

Table 1.

January Winter Plan Initiative	**Planned Impact**	**Anticipated Impact**
Virtual Wards	30	18
System Frailty Decision Unit MDT	14	7
Ward 7 Escalation beds	14	14
Ward 123 Escalation beds	25	25
D2A spot purchase	26	26
Cheadle D2A beds	17	17
Therapy Enhanced Discharge	5	0
Provider Of Last Resort (POLR) Capacity	13	13
UHNM Non-elective improvement programme	13	0
Ward 80/81 Escalation Beds	34	0
TOTAL	**191**	**120**
Super Surge Capacity		
AMU		6
Bradwell Hall		4
WD75		10
WD7 annex		7
St Giles		2
Total + super surge		**149**
Escalated actions		
Your Next Patient cohorting		8
Corridor care		15
Boarding at Haywood		5
Total + super surge + escalated actions		**177**

NOTE: escalated actions do not constitute sustainable inpatient capacity and are actions taken only at extremis and through level4+ actions.

As is illustrated, several of the Winter Plan schemes have not delivered the equivalent bed impacts anticipated. Each scheme/initiative has been reviewed to understand the reasons behind this and these can be mainly attributed to recruitment and workforce, with some logistical issues.

To mitigate the loss of this anticipated capacity, further schemes have been developed collaboratively to seek to increase capacity as rapidly as possible. These are documented above and include schemes that are designed to embed for a longer period (such as hospice bed capacity at St Giles) and those which are strictly implemented as winter surge escalated actions (specifically corridor care and AMU boarding). These actions are time limited and implemented only in times of extreme and concerted system pressure.

In addition to those additional bed capacity schemes contained within the stocktake table, system partners have also mobilised further actions above plan:

- Acute Respiratory Infection (ARI) capacity within primary care, specifically targeted to paediatric patients and those at greatest risk.
- Increased primary care capacity in support of 111
- Increased Enhanced primary care provision within ED
- Increased capacity within Primary Care
- System MDT discharge teams to expedite discharges (acute and community) via in-reach assessment
- Accelerating the Continuing Healthcare (CHC) process to discharge patients sooner – alongside work with care homes to accept patients sooner
- Increased capacity within Track and Triage service
- Increased Non-Emergency Patient Transport provision
- Increased discharge to assess capacity

The System Bed Modelling tool has been used extensively to underpin the assumptions within the Winter Plan and also to calibrate capacity so that it is implemented at times of greatest need.

The Bed Model forecasts that the greatest need for acute bed capacity is during the month of January, whereby "excess demand" (a combination of increased UEC activity combined with increased covid/flu impact and factors impacting patient flow – such as increased length of stay) peaks at a demand level of 170 additional acute beds.

This forecast figure is calculated assuming 'worst case' scenarios from underpinning data (utilising 2017/18 flu levels, consistent Covid-19 impacts, etc.) and forms the basis of all contingency planning across the system.

In response, the system Winter Plan capacity impacts were designed to deliver an additional 191 equivalent acute bed impact (this is captured in Table 1 above), however this capacity has not been fully delivered due to reasons described above.

Work is ongoing to adjust the parameters within the bed model to take into account the increased levels of flu and Covid-19 observed so far this winter as well as the increased UEC demand across the system to ensure that proactive assessment of winter plan capacity is undertaken and that additional capacity can be implemented, where possible, to mitigate the severe pressures currently being experienced. The model is intended to be a 'live' tool allowing system leads to amend inputs and parameters to reflect observed activity trends and other impacting factors.

4. Ambulance Handover Delays

As documented, Royal Stoke University Hospital is one of 12 sites to be under national direction due to the number of ambulance handover delays. A weekly Task and Finish group chaired by the ICB CEO oversees the Ambulance Handover improvement plan ensuring all partners are implementing priority actions.

National data shows a direct link between available acute beds and ambulance handover delays. Nationally "General and Acute" available beds have been reducing since late 2021. A small increase in acute hospital "occupancy" has a large impact on handover delays.

Various factors impact upon acute hospital occupancy but boil down to two key factors: demand and supply.

Demand – this is both absolute numbers through ED and the needs on average that group have. This includes health and social care needs.

Supply – available urgent and emergency care resources including - beds, workforce, community capacity and discharge capacity. How effective the resources are being used and the flow is also a supply factor.

Additional factors linked to demand, including the acuity of attending patients and demand for social care provision heavily impact upon the ambulance handover position.

Factors impacting upon supply, such as hospital bed occupancy, delayed discharges, unmet demand for patients requiring community provision and workforce limitations, are also prevalent across the system and impact upon the position.

To address these issues, the Ambulance Handover Task and Finish Group reports weekly on the position at RSUH both internally and to national and regional NHSE leads.

Key actions linked to the demand and supply factors include:

- Demand – minimising A&E attendances
- Supply – maximising patient flow out of the hospital
- Supply – maximising flexibility of available hospital capacity

Underpinning these actions is a system-wide, collaborative approach: ensuring joint ownership of the issue across health and social care, a balanced clinical risk across system partner organisations, data and target driven actions and a relentless focus.

Prior to the recent period of extreme system pressure, notable improvements had been observed, reflected in nationally reported data. However recent pressures have led to a direct increase in handover delays as is present in the latest available data.

Preliminary figures for December show a significant increase in ambulance handover delays (more than 30 minutes) at Royal Stoke over the festive period linked to the severe system pressures experienced. This pressure was not isolated to Royal Stoke. For context, hours lost through ambulance handover delays in the last week of November compared to that in December increased by 121% nationally.

System focus remains on front door opportunities, maximising flexibility of hospital capacity and maximising flow out of the hospital. Actions relate to estates work at RSUH to expand the Emergency Department, bringing online additional winter capacity and utilisation of the national Winter Discharge fund to expedite patient flow.

In addition, Your Next Patient continues to operate and special focus is being given to ensure that the flow of patients out of the Emergency Department (ED) in a timely manner is prioritised in order to aid the situation. Additional winter surge actions have been put into action to attempt to mitigate the severe pressures in the system and a de-brief has been undertaken to review the festive period to ensure that learning and improvements are facilitated.

The ambulance handover plan is inextricably linked to the winter plan, however, to ensure complete focus on the priority actions to address the handover delays, there remains and will continue to remain two separate focused groups.

5. Quality and Safety

The continued national challenge of handover delays at Emergency Departments has meant that WMAS are having to keep patients waiting for long periods for an ambulance response.

Consequently, there is an increase in the number of Serious Incidents being reported and investigated. WMAS have reported several Serious Incidents which initially do appear to be related to delays for Staffordshire and Stoke on Trent over the last month and these are under investigation by WMAS.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Black Country ICB

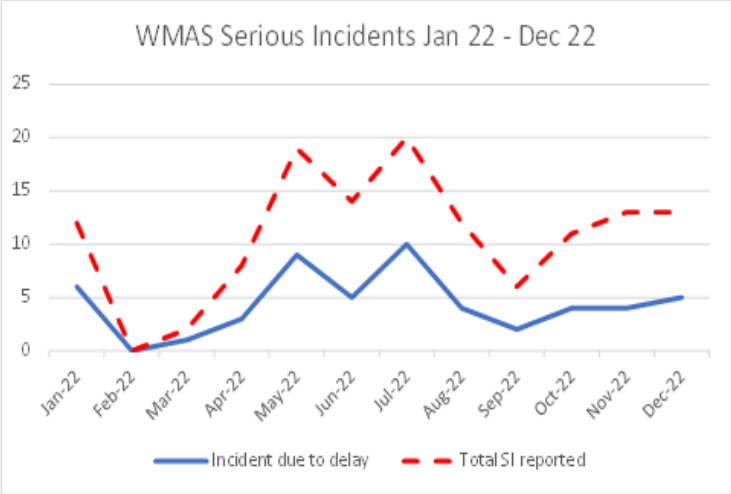
Are the lead commissioners for the West Midlands Ambulance Service and the SSOT ICB work closely with them as associate commissioners. We are advised, in a timely manner, of all WMAS Serious Incidents related to patients with a SSOT General Practitioner. The individual investigations and any thematic reviews are also reviewed by the Quality Team and feedback given on findings to WMAS. SSOT quality staff also attend the Clinical Quality Review Group (CQRM) for WMAS hosted by the Black Country ICB alongside other associate commissioners which includes monthly reviews of all patient safety incidents across the whole of the West Midlands.

Serious Incident (SI) management

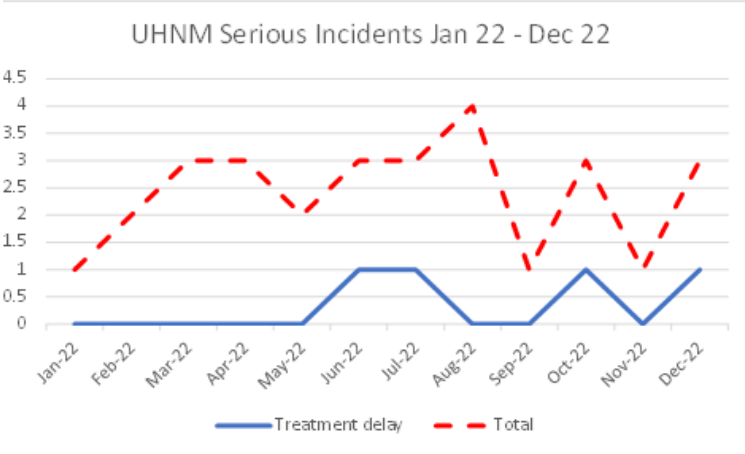
Both UHNM and WMAS report all incidents of patient harm, and this includes those that meet the criteria to be deemed a Serious Incident under the current NHS Serious Incident Framework. Serious Incidents are managed and reviewed as per the framework and the importance for learning and a clear Duty of Candour are monitored by the Quality Team. This includes Serious Incidents for SSOT residents and can be in regard to varying issues and incidents, related not only to delays.

UHNM Serious Incidents are reported directly to SSOT Quality Team via the national reporting system, and these will include any incidents related to ambulance holds causing serious harm or care on the corridor causing serious harm. As with WMAS, Serious Incidents are managed as per the Serious Incident Framework.

Graph 4 1 WMAS SI for SSOT Residents



Graph 5 2 UHNM Serious Incidents



Recognition of all harm caused by ambulance handover delays and corridor care

Normal management of incidents (outside of Serious Incidents) for both UHNM and WMAS has always included the reporting of all harm and all near miss incidents. These are reviewed, and thematic analysis is undertaken with further investigation as always required.

The current pressures have led to discussion about the identification of possible harm very specifically due to handover delays or corridor care which does not meet SI criteria (either moderate or low harm).

Black Country ICB Quality Team has given assurances that these incidents are managed across the whole region via monthly quality meetings and themes and mitigating actions are discussed and monitored at these meetings. WMAS are also to review the possibility of producing very specific SSOT incident reports related to these issues with the development of the new incident reporting system.

UHNM have always had a process for the monitoring and management of all levels of incident however have acknowledged that it would be beneficial to be able to review those very specific harms caused by the ambulance holds and also corridor care.

UHNM now have a weekly report regarding harm caused by delays or corridor nursing that includes all levels of harm and near miss incidents in order to develop robust analysis of the risks action effectiveness and any further required mitigations. This report will be shared with the ICB on a weekly basis for review and discussion.

UHNM Quality Team already undertake harm reviews, monthly, of a percentage of those patients who waited over 12 hrs to admission and those patients cared for, for long periods, in ambulances. These not only look at harm they also consider quality of care and comfort for patients. These are shared regularly with the ICB Quality team and mitigating actions are reviewed with any themes and recurrence discussed and actioned as appropriate.

Potential Impact

It may not be identified immediately that the delays in handing over patients/ambulance arrival to the home have caused harm and as all incidents are reviewed as per a standardised process if it is identified that the issue relates back to those elements of the patient journey this will be captured in order to ensure that a clear picture of harm is recognised and required actions can be developed to reduce the harms occurring; for example pressure ulcers.

Quality Team oversight

- The ICB quality Team receive and review all Serious Incidents and subsequently the completed investigation report and action plan. Monthly SI meetings take place to understand and identify themes where a deep dive review may be required.
- Monthly Quality meetings take place attended by quality leads for all providers and these include discussion and review of incident reporting for themes trends and harm in all areas of the organisations.
- Quality visits have taken place for ambulance holds and the ED and a further visit is planned in relation to the introduction of monitored corridor care.
- UHNM Harm review reports for the Emergency Department are shared at a specific review meeting where findings actions and themes are discussed.
- A senior representative of the Quality team attends and engages with all ICB Urgent Care planning and delivery meetings to ensure quality oversight of decisions and plans.

6. Summary and Next Steps

The System Winter Plan will continue to be evaluated and evolved according to need as we move through the winter period. The Winter Planning process has been closely aligned to the System Ambulance Handover plan and associative workstreams and will remain as a concurrent process to ensure synergies and coalescence with other system priorities.

To ensure appropriate review, oversight, scrutiny and management throughout the winter period, the weekly System Winter Plan Steering Group will continue to re-evaluate schemes and utilisation of resources across the system, taking proactive decisions regarding the deployment of resource to mitigate winter pressures and other events/incidents.

The Winter Plan will remain a ‘live’ document and be recalibrated as required to try to ensure that the ICS addresses winter pressures in a robust, compassionate and holistic means, prioritising patient care and access and minimising risks to patient safety and system staff and resources.

During February, the system will 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 is reflected in planning going forward. The surge planning process for 2023/24 will begin in April 2023.

7. Recommendation

The Integrated Care Board is asked to: receive the System Winter update for Assurance.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	**15**

Title:	**Quality and Safety – Exception Report**

Meeting Date:	19 January 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 Alison Budd – Lead Midwife for the Local Maternity and Neonatal System

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
		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 on an exceptional basis. These include: • Independent Hospitals • Ambulance Handover Delays • Safeguarding Adults • Local Maternity and Neonatal Service (LMNS)

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 are collated from all partners and presented and discussed at Quality and Safety Committee (QSC). Please note there was no meeting for January 2023.

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:			
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 report relates to key quality assurance, quality improvement and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.		
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**	
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:

Members of the Integrated Care Board are asked to:

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.

Members are asked to receive this report and seek clarification and further action as appropriate.

Quality and Safety Exception Report to the Integrated Care Board – January 2023

Current System Quality Matters by exception:

Independent Hospitals - **Ivetsey Bank** (formally Huntercombe)

Further media reports have 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 continues, 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. The Quality Team continue to work closely to support the provider collaborative on these issues

Ambulance Service ED waits and delayed dispatch

The continued national challenge of handover delays at Emergency Departments has meant that patients are waiting for long periods for an ambulance response. Consequently, there has been an increase in the number of serious incidents being reported and investigated. WMAS have reported several Serious Incidents which initially do appear to be related to delays for Staffordshire and Stoke on Trent over the last month and these are under investigation by WMAS.

Ambulance handover delays remain a significant challenge across the system leading to a critical incident being declared at both UHDB and UHNM due to increased pressures.

UHNM have, in response to this, instigated a process for bringing the patients in off the ambulance to avoid waits and caring for them in corridor areas. This is being reviewed daily and the balance of risks discussed daily by senior management across the system.

The response to industrial action taken by Paramedics on the 21st December 2022 was led nationally by NHSE with full engagement of all partners across the system and debriefs are occurring to ensure lessons are learned effectively. As a consequence of the enacted robust system actions, ambulance delays were reduced significantly in preparation for the industrial action. A second day of action planned for the 28th December 2022 was cancelled by the unions however a further day of action is planned for the 11th and 23rd January 2023 and preparations are underway, again led by NHSE.

The ICB is working closely with UHNM, WMAS and The Black Country ICB as lead Commissioner on how to ensure quality impact is recognised and any harms are reviewed and reduced including Serious Incidents as per the National Serious Incident Framework. This is included in the Winter Update paper included in today's papers.

Safeguarding Adults

The Adult Safeguarding Board scoped a Safeguarding Adult Review referral on 9th 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 has 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 is 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 is an early recommendation from the on-going independent review.

Local Maternity and Neonatal System (LMNS)

High numbers of inductions of labour (IOL) and a subsequent backlog remain an issue across the system although the position has been noted to reduce recently. The UHNM improvement collaborative continues to make steady sustainable progress on reducing the delays.

The regional OPEL escalation working group, led by our Chief Nursing and Therapies Officer, are developing escalation protocols and a daily maternity and neonatal sitrep which is currently being piloted Monday – Friday. Once fully completed and rolled out across the region, the escalation of maternity issues will be managed as part of the work of the System Control Centres and daily escalation calls which should result in increased awareness of maternity service status by all system partners.

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:	3rd January, 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Risk Register	The committee received the F&P risk register and ICB BAF. Discussion focused on a new ambulance risk and need to ensure there was a read across to the WMAS risk register, and the three highest risks identified for the committee.	Further work will take place with West Midlands Ambulance Service (WMAS) to ensure there is symmetry between the Staffordshire and Stoke-on-Trent (SSoT) system and WMAS regarding risk. Board is asked to note risk 111 Ambulance Handover Delays, which has a residual risk score of 25. Further work will take place to clarify the rationale behind the three highest risks identified for the Committee: 001 sustainable break-even financial position; 003 capital planning; 068 2023/34 break-even financial position. Risk 098 Winter Plan Workforce has the highest residual risk score (20). Further clarity requested on BAF Risk 1 Commissioning Intentions and BAF Risk 2 Inadequate Winter Capacity.
Performance Report	Key areas of risk highlighted to committee at month 7 and 8, supplemented by most recent data where available. Discussion focused on urgent and emergency care and current pressures including ambulance handovers, Impact on Discharge (IPC) and difficulty in identifying patients for discharge. System critical incident declared on 29/12/22. Additional capacity	Board is asked to note the extremely pressurised situation in urgent and emergency care and the impact this is likely to have on elective care. Finance and Performance Committee (FPC) is concerned at the continued decline in the number of GP full time equivalents and SSoT ranking in the lowest performing quartile nationally. Further assurance requested regarding actions and

	opened and community task force established.	mitigants.
PWC Bed Modelling Report	Update on progress of bed modelling work and initial outputs, with a specific focus on the impact of winter plan schemes and the outturn position relating to bed provision on the 'worst day' expected in January 2023.	FPC took assurance from this detailed work and welcomed the improved understanding of current excess capacity/demand, the acuity of the patients and projections for the next five years. FPC noted that more work is taking place to include social care in the model. Board to note the findings that more fundamental transformation is required to manage the bed pressure growth in the next five years.
Planned Care Activity Update	Report on action being taken to address the financial risk to the system of not delivering the 104% Elective Recovery Fund (ERF) for 2023/24. In 22/23, SSoT Cost Weighted Average is at 95% against plan of 99.6%. Target is 104%, but system is one of the highest performers in the Midlands.	FPC took assurance from work underway to understand the baseline position and address 23/24 ERF performance. Elective Recovery Board taking forward discussions with (University Hospitals Derby and Burton on Trent) UHDB and (Royal Wolverhampton Trust) RWT to understand plans for 23/24 and their impact on SSoT ICS.
Finance Report	Delivery of breakeven challenging but remains possible. £12m risk position mitigants are likely to be non-recurrent, creating additional pressure in 23/24. Capital forecast to achieve plan however medium-term challenges remain. Assurance taken from detailed reporting to committee, including the work of System Performance Group and deep dives into areas of concern.	Net risks have improved, moving from £15m to £12m in month 8. Board to note: - £13m forecast shortfall of recurrent efficiency schemes placing additional pressure on 2023/24; - medium term challenges in the capital programme; - continuing growth in activity, acuity and package prices within continuing care; - new emerging risk on price inflation in relation to primary care prescribing.
PIPS and System Savings	High Intensity Users moved to become a provider collaborative initiative. Committee discussed the 5 PIPs linked to the Frailty Strategy submitted for review and noted that there were still significant gaps in the information provided. FPC requested further information regarding level of cash releasing savings for each PIP.	Board to note further work required to deliver good quality Project Implementation Plans (PIPs) in relation to 14 of the 29 system PIPs.

Adult Social Care Discharge Fund	FPC noted schemes that have been co-produced across the system as part of the Discharge Funds bid, submitted on 16th December.	Joint Commissioning Board will retain oversight of Discharge Fund delivery, while the Winter Steering Group will receive fortnightly reports.
System Performance Group (SPG) Update	Committee took assurance from SPG work to examine our productivity performance; progress against plan regarding Virtual Wards; and a Deep Dive into Learning Disability and Autism.	SPG to undertake further work to agree specific measures we can take as a system to achieve productivity improvements. Virtual Wards: current performance significantly below plan. Digital solution now agreed which will drive forward performance. Ambition for impact in 23/24.
ICP Strategy and Joint Forward Plan	Update on national planning expectations and progress in SSoT.	Board to take assurance from FPC discussion on progress towards production of 23/24 Financial Strategy and broad involvement across the system.
Inpatient Mental Health Services previously provided at George Bryan Centre	FPC received update on the development and assurance process for the pre-consultation business case, in particular the key changes to the business case following the regional assurance panel in November and future timeline.	FPC noted the high-level feedback following the NHSE Assurance Panel and changes to the business case. Business Case to be taken to Board in January for consideration.
PART B		
ICB finance report – month 8	'Most likely' forecast position has improved to a deficit of £3m following agreement from system partners for £4.2m system held mitigation to be reported within ICB. Formal forecast full year position as breakeven. Focus continues to be on reducing continuing health care expenditure run rate and inflationary pressures in primary care prescribing.	Board to be aware of ongoing risk to breakeven position and significant concern for 23/24 regarding continuing healthcare overperformance. Deep dive on CHC to go to SPG in February and onto FPC.
Procurement Update	Discussion around procurement progress since October and request to reverse prior agreement for Increasing Capacity Framework option for specific services due to concern regarding value for money. Committee asked SPG to review	Board to note reversal of previous decision to award gynae and minor hand surgery contracts via Increasing Capacity Framework due to discovery that the ICF does not offer value for money. FPC requested SPG to review a cost pressure of £340k for Direct Award of

	contracting process for 23/24, and cost pressure of £340k for securing ongoing provision of minor hand surgery and gynae services via Direct Award.	these services.
NHS 111 Contract	Committee reviewed contract negotiations with current provider for NHS 111 and approved contract extension for a 12 month period ending 31/3/24. FPC given prior approval for the ICB to join a regional procurement of 111 services from 1/4/24. This contract extension will maintain 111 services pending the regional contract.	Board to note FPC approval of extension to NHS 111 contract with Vocare for a 12 month period at a value of £7.037m, which represents a cost pressure of £0.831m against the current budget. The negotiation and contract extension has had significant clinical involvement.
Treatment of Historic CCG Deficits	Committee noted the aggregated cumulative financial position of the six SSoT CCGs as a deficit of £298.72m, and NHSE guidance which states that this historic deficit will be written off if the SSoT system and ICB achieve a break-even financial position in 2022/23 and 2023/24.	
Medicines Optimisation (MO) Report	Deep dive requested by FPC. 95% of practices have signed up to the MO Service Level Agreement. SLA has generated cost savings of £2.4m, 36% of the 2-year target. Underperformance due to inadequate capacity and capability at practice and ICB level. Forecast out-turn is £1.6m above budget (est £208m). Cost pressures due to price inflation of category M drugs. However, year to date growth in prescribing expenditure is third lowest in NHSE Midlands region.	Board to note forecast out-turn of £1.6m above budget due to drug pricing. Further work required to deliver SLA at Practice and ICB level to meet 2-year target.
East Staffordshire Community Services	FPC discussed report referred from December Board.	FPC confirmed its support for the recommendations and referred to Board for approval.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee. Individual risks outlined in summary report.

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:	6th December, 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
PART A		
Risk Register	Risk register was discussed, and the improvements made to the quality of information and presentation of the register were welcomed. F&P's five high risks were discussed; however performance risks were not included in the report. The highest risks are discussed by the committee monthly.	Further work is required to ensure all risks relating to the remit of the F&PC are presented to the committee.
System Dashboard	The developing System Dashboard was discussed, and work to create a visual representation of performance at portfolio level welcomed. Further refinement is required around quality measures and contextual information.	Considerable work has taken place to develop an 'at a glance' Dashboard, and further refinement will take place following discussion at FPC.
Performance Report	Key areas of risk highlighted to committee. Board to note: risks for urgent care and ambulance handover delays remain challenging. Community Rapid Intervention Service (CRIS) are working closely with WMAS. Mental Health: high levels of patient acuity and demand for limited number of female only beds. Elective: 52ww increased across the ICB. Cancer: most challenged pathways are Lower GI and skin, with both areas the focus of the Improving Together Project.	Board to note key risks outlined in monthly performance report.

Finance Report	System continues to forecast breakeven position, and net risk reported to Region has reduced from £21m to £15m. Much of reduction due to non-recurrent headroom and some underspends. Non-delivery of recurrent efficiencies creates risk into 23/24. FPC commended the work of individual Trusts and the System Performance Group in achieving the current financial position.	Board to note net risk of £15m and challenging position regarding the level of recurrent efficiency savings.
Capital Plan	System capital plan report requested by FPC.	FPC reviewed risks to delivery of in-year capital programme and more challenging position in relation to medium term capital programme.
Financial Strategy	Discussion on connection between Financial Strategy and Workforce Strategy. All system Executive discussion planned for February ’23.	
System Performance Group Update	Assurance received regarding progress of Digital Strategy; Virtual Wards; and supporting system projects.	
Outwards Village Project	FPC advised that although this was an excellent scheme, there is no capital funding available in Derbyshire or SSoT at present, so it will remain on hold. This creates an issue for 2 GP practices who require new premises.	Board to note requirement for new premises for 2 GP practices in Burton, and work being taken forward by Estates Workstream to develop options.
Community Diagnostics Centre Position Statement	UHNM advised on development of a business case for a community diagnostic centre (CDC) in Stoke-on-Trent. Capital will need to be fully met by NHSE. Revenue funding remains a risk.	
Inpatient Mental Health Services formerly delivered from George Bryan Centre	FPC advised on a positive meeting with NHSE and the work done to improve and strengthen the business case.	

Adult Social Care Discharge Funds	New funding for adult social care discharge has been made available. ICB is working with the local authorities to develop plans aligned with the Winter Plan.	Agreed that FPC Chair will have delegated authority to approve submission to NHSE by 16th December.
PART B		
ICB Finance Report	Confirmation that H1 EFR is not subject to clawback. Outturn forecast of breakeven, with risks of £7.5m. Continuing healthcare is running at 20% inflationary pressure, with 5% planned. CHC run rate is continuing to accelerate. External company will carry out a review of CHC systems, processes, and high-cost packages. Inflationary pressures in primary care prescribing.	Board should take assurance on ICB approach to identifying mitigations to achieve a breakeven position.
Procurement Update Wheelchair Procurement Report	Update on the progress of procurement projects. Procurement Operations Group has been established and is developing an ICB Procurement Policy. FPC advised of the output from a procurement approach agreed at August ICB.	Under the scheme of delegation, FPC accepted the Evaluation Panel's recommendations that a 3-year contract with AJM Healthcare should be awarded at a value of £7.4m.
ICB Budget Setting	ICB budget setting methodology and timetable agreed.	
Cannock GP Practice Relocation / Cannock MIU	Discussion regarding need to relocate 2 Cannock GP practices and difficulties in finding suitable space. Short term solution identified with revenue pressure of £115,000 per annum longer term option still to be designed. Current risk level of 12 on ICB Risk Register.	Board to note difficulty in finding suitable sites for permanent GP practice relocation in Cannock, and recommendation for system partners to collaborate in considering the public sector estate and future need.
East Staffordshire Community Services Business Case	Discussion on future of community services in East Staffordshire and external legal advice on options available to promote collaboration while ensuring compliance with public contractual regulations.	FPC supported the proposal for taking forward the procurement of East Staffordshire Community Services. Decision referred to Confidential Board.

Risk Review and Assurance Summary
The Board can take assurance regarding the reports provided and the discussion which took place at the committee. Individual risks outlined in summary report.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Sally Young/Paul Brown
Date:	9th January 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Management	The ICB agreed its approach to risk monitoring arrangements at its December 2022 meeting. The Audit Committee ensured their understanding of the process and agreed their oversight role in providing assurance to the Board.	Work continues in refining risk definitions and the committees responsible for scrutiny of risks. This is in the context of the emerging review of governance below Board and its' Committees. A Meeting is taking place with system partners regarding how system risks will be reported across the system
Finance/Policies -Procurement -Cash and Treasury Management -Budgetary Control -Annual Accounts Timetable	The Committee were assured by the changes to the Procurement Policy to ensure that best value will be achieved through procurement arrangements. Both Cash and Treasury Management and Budgetary Control Policies were approved, and the Committee received and acknowledged the timetable for producing the Annual Accounts.	The Board can take assurance from the discussion at the Committee and the training that is planned to embed the refreshed policies
Internal Audit **-**Financial Sustainability -Data Quality	The Progress report from RSM was discussed and two reports were received which were advisory in nature. These were a review of the self-assessment of Financial Sustainability arrangements and Data Quality. Both reports included recommendations for improvements which will be monitored by the Committee.	RSM are producing a summary of the results of the Financial Sustainability self- assessments undertaken by all Provider Trusts which will be shared with the Committee in due course to identify learning and best practice.
External Audit	The Sector update was received and the current position regarding audit of the first quarter CCG Accounts	The audit of CCG Accounts for Quarter 1 2022/23 is progressing. It was noted however that resource is becoming constrained for both GT and the Finance Team.
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	No guidance has yet been received regarding the Annual Report process for the ICB. The Committee welcomed the report from the Information Governance Group	The Committee asked if consideration could be given to trend information within the FOI Report.
Financial Governance -Hospitality -Losses and Special payments -Waivers for Single Action Tenders	The Committee received and discussed the latest FOI Report, Losses and Compensations and the 10 Single Action Tenders which have been scrutinised by Internal Audit.	

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. The Committee also agreed that it would undertake a review of the effectiveness of the Committee using the HFMA Checklist.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal
Executive Lead:	Alex Brett
Date:	Wednesday 11th January 2023

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Staff Story	A story from a Social Care member of staff was shared. Sarah works for Home Instead and told her inspirational story of how she had a total career change after 22 years in the retail sector and moved into care.	Story to be shared with next ICB Board
Strategic People, Culture and Inclusion Update	The current difficulties in the urgent care system were noted and the impact of this on staff in particular with the ongoing strike actions. Two more are expected next week and the Committee were assured around the work being done to prepare for these. An update was provided around the Hewitt review and the work being done in relation to this. Committee members were assured that despite the short deadlines given, all have been met to date and the organogram supplied to NHS England can be found on the website.	
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.	
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 agreed to review some of the risk register scores as a score of 12 seemed low and a score of 16 may be more appropriate.	
People, Culture and	Committee members were assured by the work being done in relation to the Annual Report and agreed it	Final report will be shared at the ICB

Inclusion Annual Report	really highlights and showcases all the progress that has been delivered to date.	Board.
Workforce Transformation and Future Supply	Committee members had a lengthy discussion about the impact of reserve roles and were pleased to note the scheme was a Winner for Innovation at the HPMA Awards. Committee members were assured by the ongoing work around the educational engagement programme working alongside primary and secondary schools, colleges and universities. Members were also provided an update on the appointment of an SRO for the Education, Training and Development workstream (UHNM CNO, Ann-Marie Riley) and the proposed plans to take this important agenda forward across the system	
Workforce Planning	Committee members noted the possible dates for the submission of the Operating Plan, a draft is expected on the 23rd February with final submission on the 30th March 2023. Work is ongoing with further technical guidance expected this week.	Operating Plan submission will be shared with ICB Board
Staff Experience / Looking After Our People Retention Programme update Staff Psychological Wellbeing Hub and Wellbeing Week	The ICS retention programme highlights were presented to the committee with a summary of Phase 1 and Phase 2 activities. Committee members were assured that the arrangements for the wellbeing week were progressing well with a number of key speakers already lined up. Committee members were provided with a summary of how successful the Psychological Wellbeing Hub has been for staff with over 800 referrals into the system. Funding has been reduced by NHS England and an options appraisal is being worked through for how the Hub can operate going forward.	Phase 1 evaluation to be presented at the March meeting. Funding for the Psychological Wellbeing Hub to be flagged to the ICB Board as a risk.
Culture and Leadership	Committee members noted the format and agenda was linked to the People Plan domains. OD leads are currently working on our approach to leadership development and this piece of work will be brought back to a future committee meeting.	
Equality, Diversity and Inclusion	Committee members received a comprehensive update on the Equality Diversity and Inclusion work that is ongoing across the system and welcomed the degree of information shared requesting that updates are shared with the Committee on a regular basis.	

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

Committee members were concerned by the reduction in funding for the Staff Psychological Wellbeing Hub and wished to flag this as an issue to ICB Board members. The Hub has seen a significant amount of referrals from staff and is key to some of our priorities such as retention.

NHS
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 14 December 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register	A discussion was held outlining the oversight of the Risk Register at Committee level. It was agreed to receive the full risk register quarterly and the Committee specific risks at every meeting. This needs Board approval as does the approach the approach to the BAF which will be considered at the private board meeting on the December 15th 2022.	
Voluntary Community Social Enterprise Sector Memorandum of Understanding	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 is already in place and the ICB with the VCSE Alliance have now developed a Memorandum of Understanding (MoU) setting out our future relationship.	The Committee supported the recommendation to the ICB Board that the MoU is signed.
Inpatient Mental Health Services Draft Consultation Document & Questionnaire	The Committee was asked to review the draft consultation document and questionnaire and to advise if any additional information or questions should be included. It was noted that the draft consultation document and questionnaire are live documents and will be updated as the programme progresses.	The Committee approved the documentation and recommended it to ICB for sign off.
Infection Prevention & Control (IPC)	The Committee received HCAI (Healthcare Associated Infections) data attributed to Staffordshire and Stoke-on-Trent CCGs. UKHSA advise the mandatory surveillance team strategy to reflect the move to	

	ICB's and will continue to support CCG codes until April 2023. Regional collaborative work is underway to support HCAI reductions with several task and finish groups in place. ICB IPC teams across services have continued to respond to the ongoing Covid-19 pandemic during the initial half of 2022/23, adapting to rapid guidance changes to ensure safety of patients and staff. The more recent Monkeypox outbreak demonstrated the importance of collaborative working, with teams responding to needs for advice and support across the system. The Committee received the report for assurance.	
Safeguarding Adults & Children	The Safeguarding report outlined key points of activity providing assurance that the safeguarding system across Staffordshire and Stoke-on-Trent is focussed on keeping children and adults with care and support needs safe from harm through transparent sharing of information, robust systems and processes including: • access to policies • work plans • audit findings • collaborative working. The Committee received and approved the Safeguarding Children & Young People Report and the Adult Safeguarding Report for Staffordshire & Stoke-on-Trent.	
Maternity & Neonatal Services	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	
System Quality Group (SQG)	SQG met in December 2022 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. There was extensive discussion in several key areas, but no new risks were identified. However, there were some concerns raised about the "your next patient model" the committee asked for a deep dive review of this issue be scheduled for its February or March meeting.	
ICB Grant Renewals – Quality Assurance	This paper described the programme in place for managing grants and any quality concerns regarding the proposed extensions. There are no reported quality concerns related to group of services outlined in the paper. The Committee was assured of the existing quality monitoring programme and transfer into a portfolio matrix approach. The Committee noted the proposed review of the Quality Assurance Framework with the intention to build upon the existing systematic quality assurance structure that will evolve to support both provider and system-based improvements and accountability	

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