

Thursday 22 September 2022 13.00-16.30

**Newcastle Suite, Stafford Education and Enterprise
Park, Weston Road, Stafford, Staffordshire, 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	Prem Singh Prem Singh	Verbal Enc. 01 Enc. 02	 S	13.00 	 3 4-5
2.	Minutes of the Meetings held on 1 July 2022 and 18 August 2022 and Matters Arising Action Log Progress Updates on Actions	Prem Singh Prem Singh	Enc. 03 Enc. 04	A D	13.05 	6-16 17-19
3.	Questions submitted by members of the public in advance of the meeting	Prem Singh		D	13.10	
4.	Staffordshire and Stoke-on-Trent Resident Story	Chris Bird	Enc. 05	D	13.15	20-23
	Strategic and System Development					
5.	BAF and Risk Register	Peter Axon	Enc. 06	A	13.30	24-59
6.	Clinical Policy Alignment	Paul Edmondson-Jones	Enc. 07	A	13.45	60-93
7.	ICB Chair and Chief Executive Update	Prem Singh/ Peter Axon	Enc. 08	D	14.05	94-102
8.	Delegation of Services from NHS England to ICB Boards	Peter Axon	Enc. 09	D	14.20	103-116
9.	Memorandum of Understanding	Peter Axon	Enc. 10	S	14.30	117-147
10.	Healthier Ageing And Frailty Strategy Implementation Update	Neil Carr	Enc. 11	D	14.40	148-151
	Break 14.55-15.05					

11.	ICS Oversight Framework	Paul Brown	Enc. 12	D	15.00	152-188
System Oversight and Governance						
12.	• System Performance and Finance Report	Paul Brown	Enc. 13	S	15.15	189-198
	• Quality and Safety Update Report	Heather Johnstone	Enc. 14	S	15.35	199-206
	• Organisational Development Programme	Peter Axon/ Alex Brett	Enc. 15	D	15.45	207-218
Assurance Reports from Committees of the Board						
13.	• Finance and Performance Committee Report	Megan Nurse	Enc. 16	A	16.00	219-220
	• Audit Committee Report	Julie Houlder	Enc. 17	A	16.05	221-222
	• People, Culture and Inclusion Committee Report	Shokat Lal	Enc. 18	A	16.10	223-236
	• Safety and Quality Committee Report	Josie Spencer	Enc. 19	A	16.15	237-239
Any other Business						
14.	Items notified in advance to the Chair	All		D	16.20	
15.	Questions from the floor relating to the discussions at the meeting	Prem Singh				
16.	Meeting effectiveness	Prem Singh				
17.	Close	Prem Singh			16.30	
18.	Date and Time of Next Meeting 17 November at 14.00.					

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 13 SEPTEMBER 2022

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

Note: Key relates to date of declaration

Date of Declaration	Title	Forename	Surname	Role	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken to mitigate identified conflicts of interest
3rd August 2022	Dr	Buki	Adeyemo	Interim Chief Executive	None	1. Membership of WRES - Strategic Advisory Group (ongoing) 2. CQC Reviewer (ongoing)	1. Board of Governors University of Wolverhampton (ongoing)	None	(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 August 2022	Mr	Jack	Aw	ICB Partner Member with a Primary Care Perspective	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. Redmoor Healthcare Digital Health Consultant (adhoc consultant) (ongoing) 10. Clinical Advisor Cegedim Healthcare Solutions (2021 - ongoing)	1. North Staffordshire GP VTS Trainer (2007 - ongoing) 2. Accurx Ltd Pilot site for digital services (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.
22nd June 2022	Mr	Peter	Axon	Interim Chief Executive Officer	1. Interim CEO, NHS Staffordshire & Stoke-on-Trent ICB until November 2022. Substantive role - CEO, North Staffordshire Combined Healthcare NHS Trust (ongoing)	None	None	None	(h) recorded on CCG conflicts register.
17th August 2022	Mr	Chris	Bird	Chief Transformation Officer	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, Willetton Street, Bucknall, Stoke-on-Trent, ST2 9JA (ongoing)	None	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
6th April 2022	Mr	Paul	Brown	Chief Finance Officer	None	1. Previously an equity partner and shareholder with RSM, the internal auditors to the ICB. I have no on-going financial interests in the company (January 2014- March 2017) 2. Previously a non-equity partner in health management consultancy Carnall Farrar. I have no on-going financial interests in the company (March 2017-November 2018)	None	None	(h) recorded on conflicts register.
21st June 2022	Ms	Tracy	Bullock	Chief Executive	None	1. Lay Member of Keele University Governing Council (November 2019 - November 2023)	None	None	(h) recorded on conflicts register.
15th June 2022	Ms	Alexandra	Brett	Chief People Officer	None	1. Chief People Officer for MPFT and member of the People Committee for the STW ICS (ongoing)	None	None	(h) recorded on ICB conflicts register.
4th August 2022	Mr	Neil	Carr OBE	Chief Executive Officer	1. CEO of MPFT (ongoing)	1. Member of ST&W ICB (ongoing)	1. Fellow of RCN (ongoing) 2. Doctor of University of Staffordshire (ongoing) 3. Doctor of Science Keele University (Honorary) (ongoing)	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on conflicts register.
6th June 2022	Dr	Paul	Edmondson-Jones, MBE	Chief Medical Officer	None	None	None	None	None required.
31st May 2022	Mrs	Debbie	Everden	Executive Assistant	None	None	None	None	None required.
6th April 2022	Dr	Paddy	Hannigan	Chair and GP	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)	None	None	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.

Date of Declaration	Title	Forename	Surname	Role	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken <i>to mitigate identified conflicts of interest</i>
21st June 2022	Mr	John	Henderson	Non-Executive Director	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)	None	None	None	(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.
15th June 2022	Ms	Julie	Houlder	NED/Chair of Audit Committee	1. Owner/Director - Elevate Coaching Ltd (October 2016 - ongoing) 2. Associate - Charis Consultancy (January 2019 - ongoing) 3. Director/Chair of Finance and Performance - Windsor Academy Trust (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)	None	None	(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
6th June 2022	Mr	Chris	Ibell	Chief Digital Officer	None	None	None	None	None required
7th June 2022	Mrs	Heather	Johnstone	Interim Chief Nursing and Therapies Officer	None	1. Visiting Fellow at Staffordshire University (March 2019 - March 2025)	None	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. Daugher 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 programme (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.
8th June 2022	Mr	Shokat	Lal	NED/Chair of People Culture and OD Committee	None	None	None	None required	
21st June 2022	Ms	Megan	Nurse	NED/Chair of Finance and Performance Committee	1. Independent Mental Health Act Panel member, MPFT. (May 2016 - ongoing)	None	None	None	(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
16th June 2022	Mr	David	Pearson	NED/ Chair of Remuneration Committee	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)	None	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.
21st June 2022	Mr	Jon	Rouse	City Director	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)	None	None	None	(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.
5th July 2022	Mrs	Tracey	Shewan	Director of Communications and Corporate Services	None	None	None	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 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.
14th June 2022	Mr	Phil	Smith	Chief Delivery Officer	None	None	None	None	None required
6th June 2022	Ms	Josephine	Spencer	NED/Chair of Quality and Safety Committee	1. Managing Director Josie Spencer Consultancy (November 2021 - ongoing)	None	1. Interim Chief Executive Coventry and Rugby GP Alliance (May 2022 - November 2022)	None	(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 ICB Conflicts Register
7th June 2022	Mr	Prem	Singh	Chair	None	1. Chair of Derbyshire Community Health Services NHS Foundation Trust (November 2013 - ongoing) 2. Independent Coach (October 2021 - ongoing)	None	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	Ms	Sally	Young	Corporate Governance Director	None	None	None	None	None 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)

Integrated Care Board Meeting

IN PUBLIC

1 July 2022

2.00pm-4.00pm

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

Members:	01/07/22
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	✓
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 (via Teams)	✓
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	✓
Chris Bird (CB) Interim Chief Transformation Officer, Staffordshire and Stoke-on-Trent Integrated Care Board	✓
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	✓
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
John Henderson (JH) Chief Executive, Staffordshire County Council	✓
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands	x
In Attendance:	
Helen Ashley (HA) Deputy Chief Executive Officer, University Hospitals of North Midlands	✓
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire and Stoke-on-Trent Integrated Care Board	✓
Tracey Shewan (TS) Director of Communications, Staffordshire and Stoke-on-Trent Integrated Care Board	✓
Jenny Fullard (JF) Communications and Engagement Service Partner, NHS Midlands and Lancashire Commissioning Support Unit	✓
Mish Irvine (MI) ICS Associate Director of People	✓
Debbie Everden (DE) Executive Assistant, Staffordshire and Stoke-on-Trent Integrated Care Board	✓
Kay Steele (KS) Executive Assistant, Staffordshire and Stoke-on-Trent Integrated Care Board	✓

		Action
1.	Welcome and Apologies	
	<p>PS welcomed attendees to the inaugural Board meeting of the Staffordshire and Stoke-on-Trent ICB (Integrated Care Board) and thanked members of the public for attending.</p> <p>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.</p> <p>The meeting was quorate.</p> <p>Apologies were received from Shokat Lal, Paul Edmondson-Jones, Heather Johnstone, Jon Rouse and Tracy Bullock (Helen Ashley attending).</p>	
2.	Conflicts of Interest Register	
	<p>PS thanked all Board members for completing the Declarations of Interest Forms.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> Noted the Conflicts of Interest Register. 	
3.	Minutes of the Previous Meeting	
	The minutes of the meeting held on 21 April 2022 were approved.	
4.	Action Log	
	The action log was updated.	
5.	Questions Submitted by Members of the Public	
	<p>The following question was received from Andrew Millward: With regard to Item 8 on the agenda. In regard to administrative costs, are those for the new ICB, in comparison with the outgoing CCGs, the same, higher or lower? What are the actual figures concerned, please?</p> <p>PB advised that these will remain the same; we are required to have a cap on running costs and this is £21.6m. The ICB is currently working through the structure for the organisation and he confirmed that there would be no increase in overhead costs.</p>	
6.	Staffordshire and Stoke-on-Trent Staff Story	
	<p>PS advised that we start with a resident or staff story an important reminder of why we are here and to keep us grounded and connected with our residents and staff. As a learning system, there are also really important lessons to be taken and spread.</p> <p>AB introduced a video showing the story of Phillip Irlam's experience of working in the People Hub.</p> <p>MI advised that a collaborative approach had been taken to the running of the People Hub and there were many individuals like Phillip who have benefited.</p> <p>MI advised that Phillip had decided to concentrate on a career in mental health as he had experience of caring for a family member with mental health issues. It was important to reach out to communities and give people the opportunity to work in health and social care.</p> <p>DP commented that the video was very powerful and requested that this was made available on the website and more widely to inspire others.</p> <p>JHo questioned how the Hub was working with schools on career opportunities and MI advised that virtual work experience takes place for children from 5 years old. The next aim was for older children to then have physical work experience.</p>	MI/TB

	<p>MN questioned how we are contacting people in later life and MI advised that we have an outreach worker linking with refugees and other groups. There are also external campaigns which offer opportunities. People are trained for a short intensive period and then work for us flexibly in the reserves. In partnership with the Local Authorities, the Reserve Model has been nominated for an award but further involvement from all partners was needed.</p> <p>AB commented that the pandemic had meant partnerships had been built with the voluntary sector and the ICB People Function would continue to connect more widely. JH agreed and commented that during the pandemic, Staffordshire County Council had worked with the voluntary sector to train people to work in care homes and incorporating volunteers into the wider system was very important.</p> <p>JS commented that it would be beneficial to capture stories from colleagues who started their careers as volunteers and share these to encourage others.</p> <p>PS commented that Phillip's story was inspirational and the opportunities available through the People Hub and working with volunteers and our citizens was at the heart of being an ICS (Integrated Care System).</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • Thanked MI for the presentation and asked for their thanks to be passed on to Phillip • Noted the Staffordshire and Stoke-on-Trent Workforce Staff Story. 	AB/TS
7.	ICB Chair and Chief Executive Update	
	<p>PS commented that as this was the inaugural meeting it would be useful to remember that the core purposes of the ICS/ICB were:</p> <ul style="list-style-type: none"> • To improve outcomes for health and care for our population • To tackle inequalities • To examine how we can work together to become more efficient and have better productivity • For the NHS to be tasked as a collective to step up the contributions to the socio-economic development of Staffordshire and Stoke-on-Trent <p>PS advised that work had taken place in the ICS Partnership Board to produce the following that we would adhere to as a system:</p> <ul style="list-style-type: none"> • We will work together to ensure that children in Staffordshire and Stoke-on-Trent have the best start in life and have the right skills, health and capabilities to start school • We will work tirelessly together to improve the healthy years of our population • When citizens need help and our care we will join forces with our partners to ensure we are responsive and the care is integrated <p>PS advised that the 42 ICSs nationwide have gone through a rigorous assessment process and positive feedback has been received from NHSE on our transition process. We now have agreement for there to be 2 place based partnerships rather than 3 although further work needs to be carried out on this. All the Board appointments have been made and the Constitution approved. PS advised that the CCGs' staff have today migrated over to the ICB and he welcomed them all.</p> <p>PS advised that he would confirm the priorities of the ICB with the NHSE Regional Director but his initial objectives were to achieve traction on the benefits of integrated working, embed the governance and operating model, develop Provider Collaborative arrangements and Place, improve efficiencies, ensure there is system oversight on delivery and performance and set the right culture through the OD programme.</p> <p>PA thanked colleagues specifically involved in the transition process, all CCG staff and the CCG Executives. He welcomed Phil Smith and Chris Bird who were newly appointed to the ICB Executive Team.</p>	

	<p>PA advised that work is taking place on a system strategy and it was important for the ICS to have direction and key priorities. Seven portfolios had been identified and it was important to ensure that these are appropriately resourced to ensure the operating plan is effective. He acknowledged the challenges for Urgent and Emergency Care and the elective backlog and it was a key priority to have the resources in place to deal with these.</p> <p>JHo commented that when we develop the priorities we need to consider the cost of living challenges and the impact on health and wellbeing.</p> <p>PS commented that Covid had impacted on waiting lists and it would take time to resolve this; he apologised to patients who are on waiting lists and advised that we would do everything necessary to tackle the backlogs.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> Noted the Chair and Chief Executive Update. 	
8.	Delegation of Services from NHS England to ICB Boards	
	<p>PA advised that we now have delegated authority for GMS (General Medical Services) contracts and future contracts regarding specialist commissioning services would be delegated in the future.</p> <p>PA advised that a lot of work has taken place with NHSE regarding the delegation process.</p> <p>PS advised that this was a national programme and the delegation of the services has to correlate with the delegation of the staff who have the expertise to work on these contracts.</p> <p>PA commented that one of the 7 priorities was Primary Care services which was part of GMS and this demonstrated the importance of these services.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> Noted the contents of the paper Approved the approach and way forward detailed in the paper Noted that in order to achieve the April 2023 delegation requirement, applications are required to be submitted by each ICB by mid-September 2022 for Primary Care Pharmacy, Optometry & Dental services. Each ICB is required to sign off an Operating and Workforce model in advance of the September 2022 assurance process. A further paper would be presented to the Board before the mid-September deadline. 	
9.	Working with People and Communities Strategy 2022 - 2023	
	<p>DP advised that the Board had received regular updates as the strategy has been developed and expressed thanks to colleagues who had worked on this. He advised that the strategy would be refined further particularly as the ICP begins to mature.</p> <p>TS presented the slides and advised that the ICP has a statutory responsibility to develop the strategy.</p> <p>JS advised that the strategy had been presented to the Quality and Safety Committee which has provider members and was very well received.</p> <p>PA thanked colleagues for their work on the strategy and commented that we should use the mechanisms that the Local Authorities have in place to engage with the public.</p> <p>HA advised that this gave the opportunity to engage more broadly with our population as UHNM have historically just engaged with a small group of patient representatives and not had a broader perspective.</p> <p>JH advised that this provided an opportunity to achieve synergy between the voluntary sector who support the NHS and the broader voluntary sector. He commented that during the pandemic, there was an increase in neighbourliness and the work of small community groups and there shouldn't be too much governance and assurance which would stifle this. He</p>	

	<p>commented that there was a real opportunity for prevention work and keeping people healthier for longer.</p> <p>PS commented that it was important to learn from the collaborative work during the pandemic, to draw on the expertise of the voluntary sector and empower local communities.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • Endorsed the strategy and supported the working through of the next steps • Agreed to review the strategy in March 2023. 	
10.	System Performance and Finance Report	
	<p>PB presented slides highlighting the work carried out on the Operating Plan for the year and the mechanisms for delivery.</p> <p>PB advised that for elective recovery, we have mainly been able to deliver the plan. HA advised that during the pandemic, patients were having to wait longer for cancer diagnosis, outpatient appointments, diagnostics, surgery or treatment. We have been working on restoring the capacity we had in previous years and that this is expanded to pre-Covid levels. Workforce capacity has been the biggest challenge in restoring this capacity and we are continuing the work to recruit and retain staff. HA advised that a further challenge was keeping patients who are waiting in optimum health and work was taking place with UHDB and RWT for support.</p> <p>PB presented further slides and advised that a balanced financial plan had been submitted although there were some risks which were detailed in the paper.</p> <p>PB presented slides on the performance against constitutional targets. We were not achieving these but improvements are being made. PSm advised that regarding Urgent Care, the most significant challenge was ambulance handover delays. May was a better period following the implementation of new initiatives but in June there have again been challenges to patient flow largely linked to rising Covid levels. A system approach is taking place; we have an excellent Community Rapid Intervention Service (CRIS) which is currently only 50% utilised which allows patients not requiring acute help to be treated at home. Work is taking place with the acute hospital to ensure efficiency of patient flow and we are also ensuring patients who are medically fit to be discharged leave the hospital in a timely way and have community care.</p> <p>PSm advised that he was leading the formation of the system winter plan and it was important to protect the elective care capacity.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • Discussed and approved the Local System Delivery Plan and the next steps being taken • Noted the submission of the balanced financial plan • Noted the additional income/resource allocation and key assumptions made in moving from the deficit plan of £28.6m on 28 April to the balanced plan on 20 June • Noted the risks identified and the actions being taken to address those risks in the financial plan • Noted the deficit financial position reported at Month 2 (May 2022) • Noted the ongoing actions to clarify and mitigate the Month 2 financial position • Discussed and noted the contents contained within the Performance Update. 	
11.	Quality and Safety Update Report	
	<p>LT presented the report and advised that she would update on the position regarding the Independent Hospitals for people with Learning Disabilities and Autism.</p> <p>The John Munroe Group had experienced financial difficulties and advised that they would be closing their hospital. We worked with them on the transfer of patients.</p>	

	<p>LT advised that re-configuration was taking place at the Woodhouse Independent Hospital but they will have to continue to report to the CQC following the recent inspection.</p> <p>LT advised that regarding ambulance delays, a patient specialist is working on a new system harms review.</p> <p>JS advised that a workshop was taking place to reshape the Quality Committee and examine the way its meetings operate in the future.</p> <p>DP requested a further update on the Woodhouse Independent Hospital at a future meeting and following the publication of the CQC report.</p> <p>PA commented that we undertake good due diligence from a clinical and quality perspective and visit and monitor patients. However, as there can be instability, we need to have an oversight of the finances and we could utilise the mechanisms that Staffordshire County Council have for this. He commented that we also need to undertake a strategic piece of work and examine the mitigations.</p> <p>LT advised that meetings take place to ensure the hospitals have adequate staffing levels, examine safety issues and any incidents that have occurred.</p> <p>JH advised that there are nearly 700 care providers in Staffordshire of which 250 are care or nursing homes. Staffordshire County Council has a dedicated team to maintain quality and the viability of the homes. A small specialist team works with care homes experiencing issues with viability to assist with finances, infection control or staffing levels.</p> <p>PS commended the work on Quality Impact Assessments and Equality Impact Assessments.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • Noted the Quality and Safety Update Report • Was assured in relation to key quality and safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System. 	HJ
12.	ICS People Plan and Annual Report	
	<p>AB presented the Interim People Plan and advised that this was aligned to the national People Plan and the 10 domains of the ICB People Function. She commended the work of partners and advised that the aspiration was to work as one workforce.</p> <p>AB advised that there are significant workforce challenges; there are issues regarding health and wellbeing following the pandemic and staff are also experiencing financial hardship.</p> <p>AB advised that work is taking place on retention of staff and workforce planning for the ICB is key. She commented that digital capabilities had enabled us to develop at pace for online training and this was highlighted in the staff story.</p> <p>AB advised that one of the key responsibilities was working with communities and with health, social care and education providers to attract people to come and work with us.</p> <p>AB advised that work had taken place on developing our leadership and culture and the national review of leadership within the NHS will be a key focus.</p> <p>It would be examined how we can deliver at scale and working with partners to deliver collectively is the only solution to the workforce challenges.</p> <p>AB commented that staff health and wellbeing was key and we need to look after people in our services.</p> <p>AB commended partners for the work on the Annual Report and particularly the Health and Wellbeing Hub, EDI networks, People Hub and Reserve Model and the High Potential Scheme which is being nominated for a national award. AB advised that during the pandemic</p>	

	<p>we have been able to flex and work across all providers and this has now been embedded into business as usual.</p> <p>PS commented that there were significant workforce challenges but the work of the ICB People Function is commended by NHSE during regional quarterly reviews and the excellent work is recognised nationally.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • Approved the ICS People Plan • Noted the Annual Report of the ICS People Culture and Inclusion Committee. 	
13.	Any Other Business	
	No matters were raised.	
14.	Questions from the floor relating to the discussions at the meeting	
	<p>Andrew Millward requested clarification on the following in the ICB Chair and Chief Executive Update: “In April 2023 these duties will increase when the ICBs become responsible for primary care services (GP services, pharmacy, dentistry and optometry) and also some specialised commissioning”.</p> <p>PA advised that GP services transfer over on 1 July 2022 and the specialised commissioning, pharmacy, dentistry and optometry services transfer in April 2023.</p> <p>David Leah, Healthcare Manager for Pfizer wished to make the Board aware that NHSE have purchased a large stock of anti-virals and the aim of these is to keep Covid patients out of hospital.</p> <p>HA advised that we have a Staffordshire Covid Medicines Delivery Unit to provide anti-virals for vulnerable patients who test positive.</p>	
15.	Meeting Effectiveness	
	PS reminded Board members of the Leadership Compact and Members agreed that the meeting had been conducted according to these principles.	
16.	Date and time of next meeting	
	To be confirmed.	

**Integrated Care Board Meeting
IN PUBLIC
18 August 2022
1.30pm-2.00pm
Via Microsoft Teams**

Members:	01/07/22	18/08/22
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	✓	✓
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	✓	✓
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	✓
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
John Henderson (JH) Chief Executive, Staffordshire County Council	✓	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		✓
Tracy Bullock (TB) Chief Executive, University Hospitals of North Midlands	x	✓
Neil Carr (NC) Chief Executive, Midlands Partnership NHS Foundation Trust		✓
Dr Buki Adeyemo (BA) Interim Chief Executive, North Staffordshire Combined Healthcare NHS Trust		✓
In Attendance:		
Peter Tomlin (PT) Interim Director Adult Social Services, City of Stoke-on-Trent		✓
Steve Grange (SG) Executive Director of Strategy and Strategic Transformation / Deputy CEO, Midlands Partnership NHS Foundation Trust		✓
Helen Slater (HS) Head of Transformation, Staffordshire and Stoke-on-Trent Integrated Care Board		✓

Lisa Agell-Argiles (LA) Operations Director – Unplanned Care and Mental Health, Midlands Partnership NHS Foundation Trust		✓
Paul Winter (PW) Deputy Director of Corporate Governance, Compliance & Data Protection, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓
Tracey Shewan (TS) Director of Communications, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓
Jenny Fullard (JF) Communications and Engagement Service Partner, NHS Midlands and Lancashire Commissioning Support Unit	✓	✓
Harpeet Bangar (HB) NHS Midlands and Lancashire Commissioning Support Unit		✓
Ruth Shepherd (RS) NHS Midlands and Lancashire Commissioning Support Unit		✓
Richard Caddy (RC) NHS Midlands and Lancashire Commissioning Support Unit		✓
Debbie Everden (DE) Executive Assistant, Staffordshire and Stoke-on-Trent Integrated Care Board	✓	✓

		Action
1.	Welcome and Apologies	
	<p>PS welcomed attendees to the extra-ordinary meeting taking place as part of the process for the development of the Business Case for the inpatient Mental Health Services previously provided at the George Bryan Centre.</p> <p>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.</p> <p>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.</p> <p>The meeting was quorate.</p> <p>Apologies were received from John Henderson, Paul Brown and Jon Rouse (Peter Tomlin attending).</p>	
2.	Conflicts of Interest Register	
	<p>MN, AB, CI and NC declared an interest as they were members of the Midlands Partnership NHS Foundation Trust (MPFT) Board that took the decision to approve the Business Case.</p> <p>They would not take part in any discussions on the item.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> Noted the Conflicts of Interest Register and the additional conflicts of interest declared. 	
3.	Inpatient Mental Health Services previously provided at the George Bryan Centre	
	<p>P-EJ presented slides and advised these contained the key essential information required for the Board's decision; no new material was contained in the presentation.</p> <p>He advised that there were colleagues attending the meeting who could assist with any questions.</p> <p>PE-J advised that:</p> <ul style="list-style-type: none"> The final responsibility for service transformation is held by the Integrated Care Board (ICB) The clinical model outlined in the Business Case had informed the appraisal process The presentation of the Business Case was a further step in the assurance process 	

	<ul style="list-style-type: none"> Although the Business Case had been through the governance process at MPFT, no decision has been made as there are a number of steps left in the process before the ICB can consider a decision. <p>DP commented that he felt assured that a detailed process had been followed and that there was a clearly articulated clinical case for change built upon best practice.</p> <p>JHo commented that the Business Case had been developed over a long period of time and questioned how this would be presented in the context of the ICS priorities as the process continues.</p> <p>PE-J advised that this would now be taken up as part of the Integrated Care System's Mental Health Portfolio. It was in line with the national model for Mental Health Services.</p> <p>BA advised that the Business Case had been presented to and supported at the Mental Health programme Board.</p> <p>HJ advised that the Business Case had been through a comprehensive Quality Impact Assessment by Executives and Lay Members at MPFT and at the former CCGs.</p> <p>When reviewing the timeline, PE-J advised that the Decision Making Business Case would be developed in Winter 2022 – Spring 2023.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> Was assured by the process undertaken by MPFT in developing the Business Case and proposals to date Unanimously approved that the Business Case be passed into the NHS England assurance process. 	
4.	Any Other Business	
	No matters were raised.	
5.	Questions from the floor relating to the discussions at the meeting	
	<p>Councillor Rosey Claymore, Tamworth Borough Council, commented that the residents of Tamworth were disappointed that there was only one option being considered and the main issue for service users and their carers was travel. At the Overview and Scrutiny Committee (OSC) meeting on 1 August, it was agreed that MPFT would produce a clear transport policy for the service users and this hadn't yet been received. At the OSC meeting it was also agreed that a mapping exercise would be completed on the travel required. She stated that the Tamworth Health and Wellbeing Committee were not in favour of the proposal as they felt it disadvantaged their residents.</p> <p>PS confirmed that the OSC had requested that a transport policy be agreed and that digital solutions were also examined.</p> <p>PE-J confirmed that MPFT were undertaking the revisions to the transport policy and the mapping work was taking place; these would be available in the next 7-10 days.</p> <p>Councillor Daniel Maycock, Tamworth Borough Council, advised that he is a service user. He questioned how NHSE could examine the Business Case without the transport policy being in place. He highlighted the difficulties for Tamworth residents travelling to Stafford by public transport and commented that more emphasis should be placed on travel. He commented that face to face contact was more beneficial for service users than digital appointments.</p> <p>The ICB Board gave an undertaking that the transport logistics and the use of digital appointments would be worked through by MPFT. PS advised that key officers of MPFT, including the Chief Executive, were at the meeting so were aware of the commitment. PS advised that the further work would be presented to the ICB Board before any consideration of the final Business Case.</p>	NC/MPFT Executives

	PE-J advised that the tentative timeline for the Business Case to be considered by NHSE was the end of September and the transport policy would be included as part of that submission.	
6.	Date and time of next meeting	
	22 September 2022 at 1pm. Newcastle Suite, Stafford Education and Enterprise Park, Weston Road, Stafford, Staffordshire, ST18 0BF.	

Integrated Care Board - Action Plan

Date	Item	Agenda Item	Action	Action Owner	Update	Due Date	RAG
16.12.21	12.	System Performance and Finance Report	A balance scorecard to be included in future Performance Reports.	PB	<p>Scorecard being updated for the ICB. <u>22.06.22</u> The system performance dash Board is being designed and developed. The report is starting with urgent care, where the range of metrics that are reviewed has already been agreed. It is being developed in line with the 8 portfolios which are being discussed and we expect to be agreed by the end of June 2022. <u>01.07.22</u> PB advised that work was taking place on the scorecard. The SROs for each of the portfolios will develop the metrics to be used to monitor performance and present the information for the dashboard. Deep dives will take place on a rotational basis. <u>23.08.22</u> The approach to the development of the dashboard with the emerging portfolios was agreed at the System Performance Group at its meeting in July. The areas of focus are being agreed through deep dives into the portfolios over the coming months, and the outputs will be scrutinised by the System Finance and Performance Committee and then reported to the Board. Action closed.</p>	01.07.22 On-going over next 3 months	
01.07.22	6.	Staffordshire and Stoke-on-Trent Staff Story	The staff story video to be published on the website.	MI/TS	<p><u>25.08.22</u> Story published on the website. Action closed.</p>		
01.07.22	6.	Staffordshire and Stoke-on-Trent Staff Story	Stories of colleagues who started their careers as volunteers to be captured	AB/TS	<p><u>23.08.22</u> The Communications Team will publish the stories as they are</p>		

			and published.		received, and we will promote volunteering into employment as part of our workforce campaigns. Action closed.		
01.07.22	11.	Quality and Safety Update Report	A further update on the Woodhouse Independent Hospital to be presented at a future meeting and following the publication of the CQC report.	HJ	<u>23.08.22</u> Since the date of the last meeting CQC have published their report and rated the Woodhouse Inadequate and placed into special measures. The full report can be found here The WoodHouse Independent Hospital - Care Quality Commission (cqc.org.uk) Since that date the group who own the Woodhouse have announced their plans to temporarily close the unit to undertake some redesign work. As a result, the ICB team are working with placing commissioners up and down the UK to ensure the safe movement of their patients to alternative units. There is currently just 1 Staffordshire and Stoke on Trent patients at the unit, this individual has been at the unit for a long time. There are no further placements planned at this stage. Monitoring of progress regarding moving all patients will be reported via ICB quality meetings and any significant matters escalated to Board. Action closed.		
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	<u>15.09.22</u> 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	By submission date of 21 September Provisional date of October 2022.	

					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.		
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REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	05
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Title:	Staying Well: Presentation of Service
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Chris Bird Chief Transformation Officer		Claire Taylor, Commissioning Manager South West Locality

Clinical Reviewer:	Clinical Sign-off Required Y/N
Dr Gary Free	No

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

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

Purpose of the Paper (Key Points + Executive Summary):
<p>Frailty and care of older people remain a key challenge across the NHS especially with rapidly changing demographics and patterns of illness. There is recognition that many parts of the health and care system fail to sufficiently improve the quality of life of older people and there are unacceptable variations in health inequalities. Much more needs to be done to delay the onset of frailty and slow down its progression.</p> <p>We know that care of older people can be streamlined to make it more collaborative, integrated and patient-centred and that such an approach will benefit the population; and improve the efficiencies and outcomes within the NHS.</p> <p>Staying Well is a transformational approach to integrated care for people who are at risk of frailty.</p>

The aim is to proactively manage the deterioration of frailty by taking a preventative approach and help individuals to stay well, live well, and age well¹. The service covers the whole of South Staffordshire.

People who are referred to the service have been identified (currently through GP referral – although may be initiated by a range of professionals including social prescribers, clinicians, pharmacists and voluntary sector organisations), as those with mild to moderate frailty. One of the Staying Well Facilitators will then visit the person at home and carry out a holistic assessment looking at general health, medications, social support, cognition/memory, mood, mobility, functional performance and functional independence.

There is also an opportunity for those who need additional assessment and support to attend a Staying Well Hub in the community where they can access a range of professionals in one place.

Staying Well support individuals to understand and manage their own health and wellbeing, promote healthy living and behaviours, signpost and onward referrals are also made. Links into local communities are also made to reduce isolation.

The multi-disciplinary team includes nurses, registered mental health nurses, occupational therapists and occupational therapy assistants. The team continues to develop and will shortly include dedicated pharmacist support. Staying Well work closely with Community Connectors and Social Prescribers to link people to their local communities.

Following the assessment, personalised plans are provided and monitored, and followed up by the Staying Well Facilitator at six weeks and six months following the initial assessment. Evidence suggests that by delivering a preventative approach to healthcare, enabling individuals to manage their own health, and through early intervention successful aging will be increased within the community.

Is there a potential/actual Conflict of Interest?

N

Outline any potential Conflict of Interest and recommend how this might be mitigated

None known

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

N/A

Implications:

Legal and/or Risk	N/A
CQC/Regulator	N/A
Patient Safety	Consent has been obtained from any patients involved in the presentation.
Financial – if yes, they have been assured by the CFO	N/A
Sustainability	N/A
Workforce / Training	N/A

Key Requirements:

¹ Staffordshire and Stoke-on-Trent Healthy Ageing and Managing Frailty in Older Age Strategy - September 2021

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? This paper is for awareness-raising and not decision however the paper will explore how the Staying Well Service hope to reduce inequalities and ensure equal access.		
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?	Y	25.03.19
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected) The QIA was completed and approved at the commencement of the service		
2c.	Were there any conditions? If yes, please state details and the actions in taken in response: <ul style="list-style-type: none">Condition 1 & action taken.Condition 2 & action taken. Any conditions identified were addressed and approved.		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none">Stage 1Stage 2	Y N/R	20/08/20
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: <ul style="list-style-type: none">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 Staying Well have engaged with stakeholders and attended and engaged with GP/PCN clinical boards. The service regularly engages	Y	See narrative

	in PDSA service evaluation review cycle with stakeholders. A bi-weekly operational delivery meeting takes place attended by MPFT Staying Well service and ICB colleagues. Staying Well Service and CCG/ICB have been working collaboratively together as providers and commissioners to deliver shared outcomes that focuses on the delivery to patients.		
5.	<p>Has a Data Privacy Impact Assessment been completed?</p> <p><i>Please provide detail</i></p> <p>The CCG was not required to complete a DPIA. However, the ICB manage the submission of Data Sharing Agreements (DSA) from GP practices. The Staying Well Service (MPFT) have completed all necessary DPIA/ IG requirements as the lead organisation. Referrals can only be processed for practices that have completed DSA.</p>	Y	See Narrative
Recommendations / Action Required:			
<p>The Integrated Care Board is asked to note the content of the presentation and the work that is being undertaken by the Staying Well Service.</p>			



**06
REPORT TO:**

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	06a
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Title:	Risk Management Strategy
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Meeting Date:	22 nd September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Sally Young	Y	Jane Chapman

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

Action Required (select):							
Ratification-R	<input checked="" type="checkbox"/>	Approval -A	<input type="checkbox"/>	Discussion - D	<input type="checkbox"/>	Assurance - S	Information-I

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Governance Network	July 2022	D
Audit Committee	Sept 2022	A
Internal Auditors	Sept 2022	D

Purpose of the Paper (Key Points + Executive Summary):
<p>The Risk Management Strategy, used by the CCGs, has been reviewed and updated to ensure that the strategy is fit for the ICB's purpose. The Strategy outlines the development of the ICB's Risk Culture and the processes in place to manage risk across the organisation.</p> <p>The document contains simple definitions and examples of the common terms and concepts used in risk management, to enable staff across the organisation to use the document to support their understanding of risk.</p> <p>The key changes to the document are</p> <ul style="list-style-type: none"> • Update of the definition of risk to the ISO 31000 standard that links risk to delivery of the organisation's objectives • High Level strategic risks (i.e. those scoring 16+) will be presented as part of the BAF report on a quarterly basis to the ICB Board. • All risks will be presented on the Risk Register to the relevant ICB Board sub-committee on a quarterly basis.

- The Executives and their Teams will continue to update and review the risks monthly
- Introduction of Issues Logs, to be managed by Directors/Portfolio Leads
- Outlines the co-ordination role of the Risk Group which has representatives from Directorates and ICS Partner organisations.
- Issues Logs will be presented to the Portfolio Leads monthly.

Once approved, the Governance Team will be responsible for building the risk culture through communicating the changes and delivering training/coaching. By instilling a culture where we have a shared understanding of risks we can help focus attention to the areas of greatest risk and ensure most effort is directed to where they will have the greatest impact.

The Strategy has been discussed and approved by the Audit Committee, who are responsible for oversight of the ICB's Systems of Internal Control (Risk Strategy and Risk Management).

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):

All risks will be managed by the proposals within the Risk Management Strategy

Implications:

Legal and/or Risk	The document describes how the organisation will recognise, record and managed risk
CQC/Regulator	N/A
Patient Safety	Risk management is a critical tool for the maintenance of Patient Safety
Financial – if yes, they have been assured by the CFO	N/A
Sustainability	N/A
Workforce / Training	The document can be used to underpin training on Risk Management.

Key Requirements:

1a.	<p>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?</p> <p>The ICB will recognise risks related to it's statutory duties within the register, including the duty to reduce inequalities. The application of the Risk Management Strategy will ensure that the Committees and Board are informed of any risks to delivery of that duty.</p>
1b.	<p>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)</p> <p>The Risk Management Strategy reflects risks to the delivery of Strategic Objectives, set by the Board, which include improving health outcomes, quality, use of resources and reducing inequalities.</p>

		No	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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> Stage 1 Stage 2 	No	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? The ratification of the Risk Management Strategy does not propose any changes to services for service users or conditions for Staff.		
3c.	Please provide detail as to these considerations: <ul style="list-style-type: none"> 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 The Draft Risk Management Strategy has been shared with Governance professionals and Company Secretaries across the Integrated Care Partnership to ensure they build alignment	Yes	
5.	Has a Data Privacy Impact Assessment been completed? Please provide detail The agreement of the Risk Management Strategy will not lead to the holding of personal data by any organisation.	No	
Recommendations / Action Required:			
The Integrated Care Board is asked to: Ratify the Risk Management Strategy			

Draft

Risk Management Strategy

Version 2.7

Name of Strategy	Risk Management Strategy
Committee approving Strategy	Audit Committee
Ratified by	
Date of Ratification	

VERSION CONTROL			
Version	Description of amendments	Date	Author / Amended by
1.0	New Strategy	Sept 2019	Paul Winter
1.1	Updated to include ✓ Presentation of Risk Register & BAF to Exec Directors monthly	Oct 2019	Paul Winter
2.0	Revised for ICB <ul style="list-style-type: none"> Identifies ICB & ICS risks and role of the ICS Governance & Risk Group Recognises role of the Board in setting risk tolerance levels 	May 2022	Jane Chapman
2.1	<i>Feedback from Chair of the Audit Committee</i> <ul style="list-style-type: none"> Identifies the difference between risks and issues Highlights the role of the Audit Committee in the management of risk 	July 2022	Julie Houlder Jane Chapman
2.2	Description of three tiered approach to risk management	July 2022	Jane Chapman
2.3	Addition of deep dive investigations for assurance of strategic objectives or risks	Aug 2022	Jane Chapman
2.4	Added case studies and examples	Aug 2022	Jane Chapman
2.5	Proof Read & Accessibility Check	Aug 2022	Paul Winter
2.6	Added section on BAF & role of Director of Corporate Governance	Aug 2022	Sally Young
2.7	Increased score for strategic risks to 16	Sept 2022	Audit Committee

Introduction and Common Definitions of Risks and Issues

RISKS are generally defined as the combination of the **Likelihood** (probability) of an event and its **Consequences**. Within a business environment, a Risk is the “*effect of uncertainty on objectives*”. [ISO 31000¹]. Which means that a Risk is an event that has not happened yet, but may. The language used to define or describe a Risk is always set in the Future Tense: e.g. if this happens, then this will be impacted.

In all areas of business, there is the potential for Risk events and consequences that constitute either opportunities for benefit to the organisation (the upside), or threats to its success (the downside).

In the quality management and safety field, it is generally recognised that consequences are mostly negative. So therefore the management of clinical quality and/or safety risks will need to be more focused upon prevention and mitigation of harm to patients, staff or the organisation.

“The focus of good Risk Management is the identification and treatment of risk. Its objective is to add maximum value to all the activities of the organisation. It marshals the understanding of the potential upside and downside of all those factors which can affect the organisation. It increases the probability of success, and reduces both the probability of failure and the uncertainty of achieving the organisation’s overall objectives.” (Institute for Risk Management, 2002)

**Risks are part of everyday life
e.g. there is a risk to health from crossing the road.**

“Risk Management” is about being concerned with both the positive and the negative aspects of risk. This is a continuous and developing process that covers all parts of the business, from developing strategies through to implementing those. Effective Risk Management requires not just effective policy implementation, but robust programme management too.

**We could choose to avoid crossing the road, but this would make life difficult.
So better alternatives are to:**

- **Reduce the likelihood of an accident by crossing at recognised crossings.**
- **Reduce the impact of an accident by limiting the speed vehicles can travel at.**

They are both good strategies but are more valuable if everyone adheres to them.

ISSUES are obstacles or challenges that have already happened and need to be managed as part of day-to-day operational processes or plans. The language used to define or describe an Issue is always set in the Present Tense: e.g. this problem has arisen, how should we deal with it?

¹ ISO 31000:2018 is a family of standards relating to Risk Management codified by the International Organisation for Standardisation. It provides principles and generic guidelines on managing risks faced by organisations. It seeks to provide a universally-recognised paradigm for practitioners and companies to replace the myriad existing standards, methodologies etc that differ between industries, subject matters and countries. The recommendations provided in ISO 31000 can be customised to any organisation / its context.

Issues may result as a consequence from failure to mitigate risks sufficiently. Or can be part of the environment. Issues are not recorded in a Risk Register. Although may be recorded on separate Issues Logs, which use a similar format / layout as a Risk Register; to ensure consistency of purpose and approach).

**A lack of street lighting is known to contribute to poor road safety.
This is an Issue that needs to be managed.**

While each risk is managed in isolation, by the risk owner, we use the Board Assurance Framework to develop our overarching approach to risk within the ICB.

The *Board assurance framework (BAF)* is a tool used by the Board to identify the level of risk it is willing to take in the pursuit of improvement and by the organisation to demonstrate to the Board sources of assurance and how they are tested and develop proportionality in reporting.

The BAF brings together all the relevant information about risks to the Board's strategic objectives. The BAF should set out:

- the organisation's strategic objectives
- the risks to achieving these
- the controls in place to minimise the likelihood or effect of those risks materialising
- the assurances the board needs to be confident that the controls are operating effectively.

As part of developing the BAF the Board needs to agree its

- *Risk appetite* - is the level of risk that the organisation is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.
- *Risk tolerance* - is the predetermined upper level of risk that can be assigned to an objective. This might be set as an overall risk rating or might specifically relate to an upper 'impact' or upper 'likelihood' rating which, if reached, must be mitigated at all costs.

If we do not know what our organisation's collective appetite for risk is, and the reasons for it, this may lead to erratic or inopportune risk-taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach, which may stifle growth and development.

To ensure we get it right from the outset, we need to methodically address all risks surrounding our business activities and integrate these into our new Integrated Care Board (ICB) **Risk Culture**.

What do we mean by a “Risk Culture”?

An effective Risk Culture describes the Values, Beliefs, Knowledge and Understanding about risk and is a shared, common purpose by the organisation’s leadership and employees. Effective frameworks, processes and standards alone won’t create a Risk Culture. To reliably manage risk and deliver strategic objectives, we also need to understand the behavioural element as to why individuals, teams and organisations operate in the ways they do; and how this affects Risk Management.

An effective Risk Culture is one that enables and rewards individuals and groups for taking the right risks, in an informed manner. A successful Risk Culture includes the following:

- ☑ A distinct and consistent tone from the top in respect of risk taking and avoidance, along with consideration of this by all levels
- ☑ A commitment to ethical principles and considering wider stakeholder positions in decision-making
- ☑ A common acceptance of the importance of continuous Risk Management, including clear accountability for and ownership of specific risks or risk areas
- ☑ Transparent and timely risk information flow up and down the organisation, with bad news rapidly communicated and without fear of blame
- ☑ Encouragement of risk reporting and whistleblowing, and actively seeking to learn from mistakes or near misses
- ☑ No process or activity is too large, complex or obscure for risks to be readily understood
- ☑ Appropriate behaviours are encouraged and inappropriate behaviours challenged
- ☑ Risk Management skills and knowledge are valued, encouraged and developed, supported by a corporate Risk Management function for technical training and timely provision of advice
- ☑ There is sufficient diversity of perspectives, values and beliefs covered, in order to ensure that the status quo is consistently and rigorously challenged
- ☑ Alignment of Risk Culture with employee engagement and OD programmes to ensure that staff are supported and focused on the task in hand

Every organisation has a Risk Culture. The key question is whether that culture is effectively supporting or undermining the longer-term success of the organisation, in terms of assisting or hampering delivery of its agreed corporate (strategic) objectives.

For example, organisations with inappropriate cultures will inadvertently find themselves allowing activities that are at odds with its stated objectives, policies and procedures. Where at worst, people are probably operating completely outside these. Problems with ineffective Risk Culture are the root cause of nearly all organisational scandals or collapses.

Our Vision for a Risk Culture

Getting it right will provide the appropriate ‘Internal Control’ mechanisms, checks and balances to provide assurances and confidence to the ICB’s Board and Audit Committee. As

well as patients, partners and stakeholders that we are acting with probity and less likely to be derailed by unexpected risk. An effective Risk Culture enables us to assure all that we are operating in accordance with the law and our statutory duties.

Our approach will avoid being overly bureaucratic and procedural, but will nonetheless be robust and proportionate to the level of risk facing the wider Staffordshire and Stoke-on-Trent Integrated Care System (ICS). Included in this, it is understood that system risks, especially where these have a direct bearing on the ICB, as the Statutory Body, also need to be reflected on our Risk Register.

Our solution will be systematic but will not look to expend effort on non-value adding processes. Nor will it overload the Risk Register with multiple issues that are not directly linked to delivery of our strategic objectives. The recognition of and speedy reaction to risk will be crucial to this.

Roles and Responsibilities

Development of our Risk Culture will be led by the Board, its Audit Committee and the Senior Management Team. This is because they are ultimately responsible for determining our approach to risk, while carrying out their various leadership and assurance roles.

These roles also include oversight of the effectiveness of organisational systems and controls. Identifying the level of risk they are willing to tolerate ('Risk Appetite'), as well as instilling the Risk Culture. They will ensure that corporate strategy is cascaded into everyone's objectives, and by assigning risk responsibilities throughout the organisation. However, every employee has a role in identifying and minimising risks and must play a full and active role in helping to manage those risks.

All activities of ICB are aligned to its four Strategic Objectives, managed by the ICB Board. The Board is therefore responsible for the oversight of all risks. Assurance is achieved in through a three-tiered approach:

Strategic Risks	The highest-level risks (i.e. those which score 16 and above) that are directly overseen by the ICB Board as part of their Board Assurance Framework: BAF, which is at Appendix 3
Operational Risks (ICB Directorate / ICS Portfolio)	The medium-to-low level risks (i.e. those scoring under 16) and are overseen by ICB Board Committees: the 'Board Assurance Committees' responsible for providing assurance to the Board
Corporate Issues	The Issues (non-risks) managed by Directors and their Teams responsible for providing assurance to the Board that their day-to-day activities are being discharged effectively

[A 'Process Map' (diagram) explaining the roles noted below is provided after the various categories (1) to (7) as described]

(1) Integrated Care Board (ICB):

- ✓ Has overall responsibility for the effectiveness of the ICB's Risk Management system and processes;
- ✓ Must ensure they seek independent assurances from its Audit Committee, Internal Audit and any other suitably qualified persons that systems and processes are robust and effective;
- ✓ They should also routinely ask themselves the types of questions included as Appendix One, in relation to development of our Risk Culture. (These are recommended by the Institute of Risk Management as core questions for any Board that is responsible for leading a Risk Culture).

(2) Audit Committee:

- ✓ The Audit Committee has lead responsibility for oversight of the ICB's Systems of Internal Control (Risk Strategy and Risk Management);
- ✓ The Audit Committee are responsible for the regular review of the Risk Strategy and will receive updates of all risks at every meeting undertaking their role.

(3) Other Board Assurance Committees:

- ✓ These will act under delegated authority from the Board for additional, operational responsibility of managing the Risk Register pertinent to their roles and responsibilities outlined in their Board-approved Terms of Reference;
- ✓ The relevant risks will be assigned to the relevant committee – e.g. Quality & Safety Committee will be responsible for clinical risk; and Finance & Performance and People, Culture & Inclusion will be responsible for non-clinical risk. Place-based Boards will receive operational clinical or non-clinical risks pertinent to their area;
- ✓ All committee meetings will include risk as a standing agenda item at the start of their meeting, at least quarterly; and agenda items would ordinarily only be agreed where they can show how they will manage / mitigate the risks associated with that subject matter and in relation to strategic objectives;
- ✓ At the end of each meeting, members and attendees will be asked if any further risks have been identified during the course of proceedings, and how satisfactorily the meeting has mitigated their existing risks.

(4) ICB Governance Team:

- ✓ Will act as the bridge between ICB, its committees, partners and ICB staff in managing day-to-day ICB risk activities;
- ✓ The Team will hold operational responsibility for co-ordinating the Risk Register, liaising with all Directorates, Risk Owners and Lead Directors (or deputies) in updating and processing their Risk Register responsibilities;
- ✓ The Team will provide Risk Owners with dedicated support and advice on managing their assigned risks, including training & development programmes where required;

- ✓ Risk training will be given to all staff and ICB Board by the Governance Team. Our Internal Auditor will also provide additional training where required in line with this strategy document's key principles.

(5) Integrated Care System (ICS) Governance Network & Risk Group

The Group consists of Governance representatives from each ICS membership organisation and representatives from ICB Directorate Risk Owners.

- ✓ This Group is established to review risks on the ICB's BAF and Risk Register, to provide assurance to ICB and each of the established partner organisations, that risks are being monitored, recorded and managed, in a way that is optimal for the system;
- ✓ The Group will review the ICB's BAF and Risk Register, which will then progress through the ICB governance reporting structure:
 - All risks go to the appropriate committee at least quarterly
 - All risks go to the Board and Audit Committee at least quarterly
- ✓ The Group may also identify risks in the ICB and partner organisations that impact or have the potential to impact on one or more partners or the whole system;
- ✓ The Group will ensure that each partner organisation co-ordinates local management of the risk to achieve optimal system-wide outcomes;
- ✓ Under a collective 'System Risk Appetite', the Group will ensure that a consistent approach to the scoring of shared risks is taken, allowing for the fact that the likelihood or impact may differ between individual organisations;
- ✓ Provide initial triage of new risks to identify whether they sit on the Strategic or Operational Risk Register;
- ✓ Ensure the ICB Risk Strategy is current, and procedures consistently followed by:
 - Ensuring risks are being regularly reviewed by Risk Owners
 - Reviewing all newly-identified risks, ensuring each is clearly described
 - Reviewing proposed risk closures by ensuring risk has been reduced or eliminated
 - Discussing any changes to risk scores since the previous meeting
 - Providing challenge to risk descriptions, scores and updates
 - Ensuring risks are scored consistently with the Scoring Matrix
 - Reviewing risk mitigation / action plans and outcomes, where appropriate
 - Ensuring financial and resource implications / impacts are properly represented
 - Ensuring each risk has a nominated Risk Owner and Executive Lead
 - Ensuring each risk is correctly aligned to one of the Board Committees
 - Ensuring all risks 16+ are appropriately represented in the Strategic Risk Register
 - Supporting our Risk Culture in respect of promotion and enabling
- ✓ The Group will also agree and oversee a programme of 'deep-dives' covering our strategic objectives, receiving reports from Leads to establish levels of assurance and identify where further actions should be presented to Board or Audit Committee.

(6) ICB Chief Executive Officer (CEO):

- ✓ Has overall accountability for Risk Management on behalf of the ICB;
- ✓ The CEO will make and sign off an informed (annual) Governance Statement within the ICB's Annual Report, on behalf of the ICB that provides public assurance that:
 - Risks that impact on the achievement of objectives are being effectively managed
 - The ICB is managing risk appropriately

(7) Director of Corporate Governance

- ✓ Executive lead for Risk Management
- ✓ Through the Governance Network is leading a system approach to risk management

(8) The ICB Executive:

- ✓ Are responsible for ensuring that their teams update risks on a regular basis (monthly);
- ✓ They will regularly review the Risk Register and BAF matters that sit within their Directorate and/or Portfolio (monthly);
- ✓ The Executive Team will receive regular Risk Register and BAF reports for review, discussion and executive oversight to support the ICB's other meeting arrangements.

(9) All Other ICB Staff:

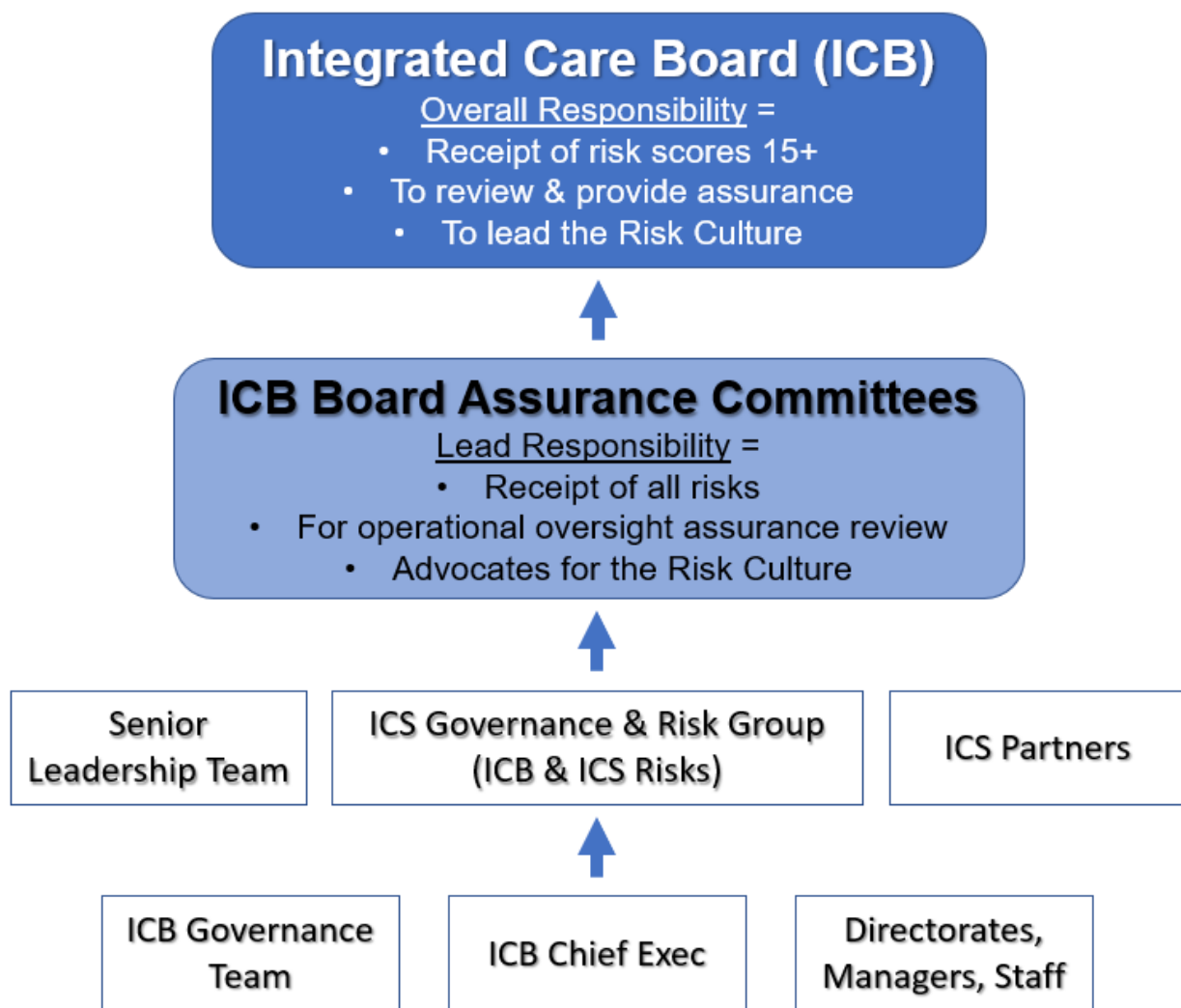
- ✓ Have responsibility for providing assurance to ICB that Risk Management is relevant to their goals and objectives; and that strategic objectives are understood and maintained at all levels within the ICB;
- ✓ Risk Owners will individually be assigned risks identified through the ICB Risk Management Framework – Directorate Team meetings will review their Directorate's risks, with Risk Owners each framing the discussions at these meetings accordingly;
- ✓ Each Executive will share / cascade their annual objectives throughout their Teams, managers and staff to ensure all personal objectives align well to strategic objectives (and risks assigned) to that Directorate;
- ✓ Other responsibilities for managers and staff will be as follows:

MANAGER RESPONSIBILITIES

STAFF RESPONSIBILITIES

<ul style="list-style-type: none"> • Implement ICB policy within their area and ensuring that staff understand / apply these: e.g. Budget Holders need to manage financial risks by adhering to Budgetary Control Policy • Support the Governance Team to develop / maintain Risk Registers, and their staff to develop / maintain Issues Logs • Support the management of risk action plans • Conduct local risk assessments by identifying, quantifying and managing risks • Promote awareness of the Risk Culture in their area and ensure their staff recognise that Risk Management is essential: e.g. day-to-day active reporting and delivery • Identify training needs, including their own, and ensuring that staff undertake this where identified • Support the effective and efficient use of ICB's Risk Management systems 	<ul style="list-style-type: none"> • Be familiar with, understand and adhere to ICB risk policy & procedure requirements • Be aware of risks and issues associated with their role and take reasonable measures to minimise them • Report all incidents or near misses in line with the Incident Reporting Procedure • Participate in Risk Assessment work relevant to their role • Take responsibility for a risk or an issue until it is resolved or transferred to / accepted by someone under whose remit it lies • Initiate action to stop any practice considered to be unsafe, regardless of seniority / profession of the person undertaking the practice • Attending any mandatory or statutory training as defined in ICB training programmes
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- ✓ Issues (or other areas of concern) facing a Directorate are captured effectively on their Issues Logs; and to manage / mitigate these by deploying the relevant (operational) management process within their Directorate, Portfolio or Team structure;
- ✓ The intention behind these is to uphold the principal Risk Strategy aim of keeping the Risk Register aligned to strategic objective matters, but to enable a Directorate to manage their "day job" issues in the same way as it does for the Risk Register role as outlined.



The Risk Management Process

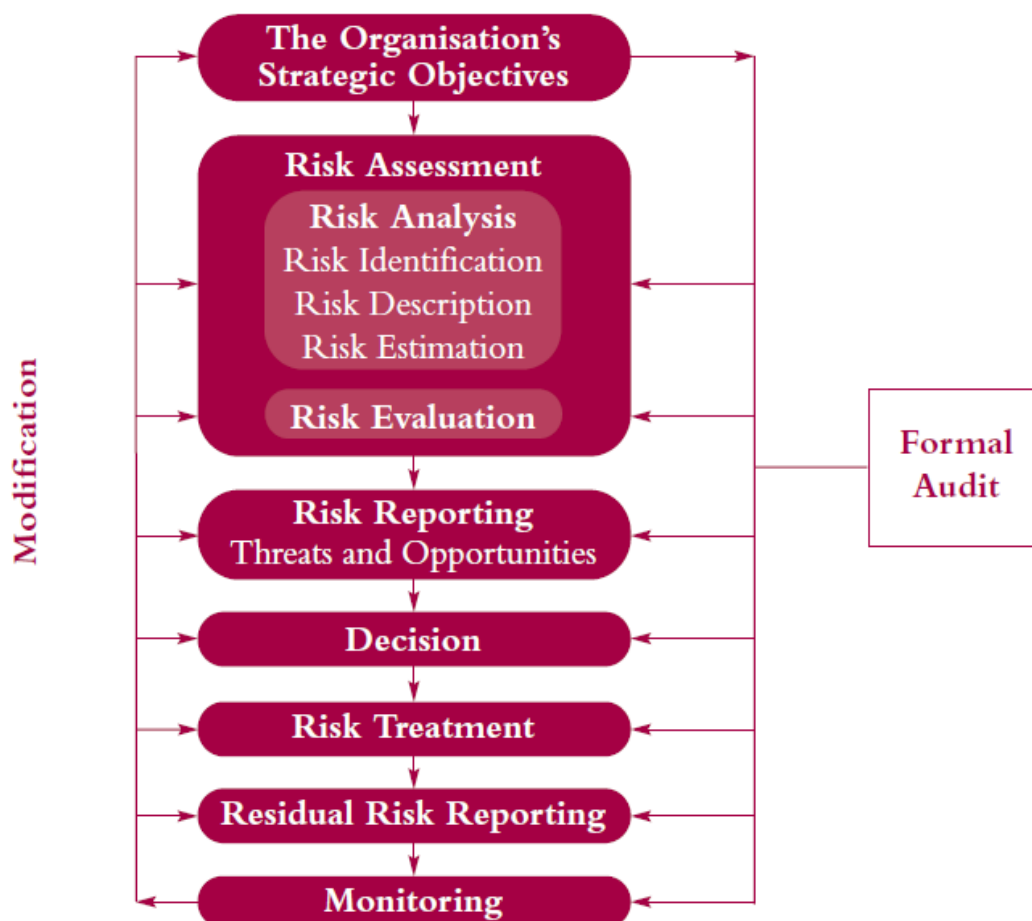
It is essential that our process protects and adds value to the organisation / our stakeholders and supports the delivery of our corporate objectives by:

- ☑ Providing a framework to enable ICB business to take place in a consistent and controlled manner
- ☑ Improving corporate and local (Directorate) decision making, planning and prioritisation through the comprehensive and structured understanding of our business activity, including taking advantage of any opportunities or mitigating any threats associated with this
- ☑ Contributing to more efficient use and allocation of capital and resources
- ☑ Protecting and enhancing our corporate assets, image and reputation
- ☑ Developing and supporting our staff and our organisational knowledge / intellectual property
- ☑ Optimising operational efficiency and effectiveness



The Risk Register will be developed for all clinical and non-clinical risks; and will link into the ICB's Board Assurance Framework. The process will be as described on the following two pages:

The Risk Management Process (from the Institute of Risk Management's "Risk Management Standard", 2002)



(1) Risk Analysis & Risk Identification:

This will be done methodically by ensuring that all significant business activities are identified and all risks flowing from these defined by the Lead Directorate.

(2) Risk Description:

All risks are recorded and reported in a structured format, using the standardised Risk Assessment / Risk Register approach outlined.

(3) Risk Estimation (Risk Scoring):

All identified risks will be scored using the standard "5x5" (Australia & New Zealand) Risk Assessment Matrix outlined in Table One.

(4) Risk Evaluation & Risk Treatment:

This technique will be used by responsible Board Assurance Committees and Single Leadership Team to make decisions about the significance of the risks reported to them, in order to ascertain whether each specific risk should be accepted or treated in a particular way according to the ICB and System's 'Risk Appetite' (risk treatment / handling) options.

(5) Risk & Residual Risk Reporting / Monitoring:

All risks will be reported to and monitored by the nominated Lead Committee, Risk Group and Board as per their defined roles & responsibilities (as set by their Terms of Reference).

All risks will be classed on the Risk Register according to scores derived from assessing the *Likelihood* of its occurrence, as against the *Consequence* of it occurring.

Scores will be created for each risk – the *Inherent Score* (at first identification); the *Residual Score* (after it has been treated) and a Target Score (which when reached indicates likely risk closure, as the proposed mitigating actions have controlled the risk to acceptable levels).

These in turn determine the overall Risk Status established by Table One below – i.e. a score from 1-4 will be a Low Risk; a score between 5-10 will be a Medium Risk; and a score between 12-25 will be a High Risk.

(6) Risk Description

This will determine how the risk is initially assessed by the individual manager or staff member and will also form the basis of the actual Risk Register reporting structure too. So as to ensure the accurate transfer of the risk from its identification phase into the evaluation and reporting phases. Table Two describes how this works and uses a real-life example to illustrate how it should be completed by Risk Owners.

Table One – RISK SCORING MATRIX

LIKELIHOOD of Occurrence	Most Likely CONSEQUENCE				
	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic
1= Rare	1	2	3	4	5
2= Unlikely	2	4	6	8	10
3= Likely	3	6	9	12	15
4= Highly Likely	4	8	12	16	20
5= Certain	5	10	15	20	25

Likelihood is ascertained through determining the frequency / probability of occurrence:

- *Rare – not expected to occur for years / occurs only in exceptional circumstance (<1% chance)*
- *Unlikely – at least annually / unlikely to occur (1-5% chance)*
- *Possible – at least monthly / reasonable chance of occurring (6-20% chance)*
- *Highly Likely – at least weekly / likely to occur (21-50% chance)*
- *Certain – at least daily / more likely to occur than not (>50% chance)*

Consequence is set by determining the level of severity using the core ‘Risk Domain’ factors set out in Appendix Two:

- *Insignificant – barely noticeable, minimal loss / damage / duration, unsatisfactory service*
- *Minor – short-term impact, locally-resolvable issue, low level loss or damage*
- *Moderate – longer term impact, issue needs formal resolution, medium level loss or damage*
- *Major – far more serious impact (regional level), long duration, medium-high loss or damage*
- *Catastrophic – significant impact (national level), effect, duration, loss and damage*

Table Two – RISK DESCRIPTION (also to include Risk Owner & ICB Directorate)

	Definition	Example
Risk Name	Subject Matter / Topic + Risk Reference (local ID)	Cancer 62-Day Constitution Standard

Scope of Risk	Qualitative description of the events involved; their size, type, number & dependencies	Delivery is under threat. A number of breaches are potentially avoidable, but with no harm indicated to patients. Long waits are increasing causing Regulator intervention.
Nature of Risk	<p>Strategic: long-term strategic objectives; internal or external factors (e.g. political, legal, reputational risk)</p> <p>Operational: from delivering the business day-to-day</p> <p>Financial: effective management & control of finances</p> <p>Clinical: quality & safety of services commissioned</p> <p>Knowledge: effective management & control of ICB resources (e.g. intellectual property, business continuity, technology, loss of key staff)</p> <p>Compliance: health & safety, environmental, data protection, employment practice, statutory & regulatory matters</p>	<p>Operational (non-delivery of a Constitution Standard that could improve in-year further to application of the proposed risk treatment / control mechanisms outlined below)</p> <p>Clinical (potential for breached patients to have suffered harm + poorer patient experience of care received)</p> <p>Compliance (non-delivery of a Constitution Standard & breach of ICB Regulations)</p>
Stakeholders	Stakeholders and their expectations	<ul style="list-style-type: none"> - Boards of affected ICS organisations (re. assurance) - NHS England (re. Constitution & System Oversight) - Patients (re. Constitution standard + rights to access)
Risk Score	Likelihood times Consequence scores: inherent + residual	Scores = 3x4 (12) Inherent / 2x3 (6) Residual
Risk Tolerance / Appetite	Loss potential & financial impact of risk // Objective(s) for risk control // Desired level of performance – the “Target Risk Score”	Value = opportunity cost loss. No significant loss of budget expected // Risk Appetite objective = MANAGE RISK // Target Risk Score = 4
Risk Treatment & Control	The primary means by which the risk is managed, inc. confidence levels of existing control and identification of protocols for monitoring & review	<ul style="list-style-type: none"> - ICB-Provider Remedial Action Plan + contract meetings - Finance & Performance / Quality Committee ownership
Improvement Actions	Other potential recommendations to reduce risk	<ul style="list-style-type: none"> - ICB / NHSE assurance process - ICB Cancer Strategy & RightCare opportunities

(7) Risk Treatment

Risk Owners, ICS Governance & Risk Group and Lead Committees will all develop / recommend a range of options for mitigating the risk, assessing those and then preparing and implementing action plans. The highest-rated risks should be addressed as a matter of urgency. Selecting the most appropriate option will require balancing the costs of implementing each activity against the benefits derived. In general, the cost of managing the risks needs to be commensurate with the benefits obtained. Depending on the type and nature of the risk, the following options are available:

Avoid:

This means deciding not to proceed with the activity that introduced the unacceptable risk, or choosing an alternative more acceptable activity that meets business objectives, or choosing an alternative less risky approach or process.

Reduce / Manage:

This means implementing a strategy that is designed to reduce the likelihood or consequence of the risk to an acceptable level, where elimination is considered to be excessive in terms of time or expense. Action can be taken to reduce / manage the identified risk to within acceptable risk tolerances. Control procedures need to be established and monitored. For significant or principal risks these actions must be agreed by the Board.

Share or Transfer:

This means implementing a strategy that shares or transfers the risk to another party or parties, such as outsourcing the management of physical assets, developing contracts with service providers or insuring against the risk. The third-party accepting the risk should be aware of and agree to accept this obligation.

Accept (then close):

This means making an informed decision that the risk rating is at an acceptable level or that the cost of the treatment outweighs the benefit. These should apply to insignificant or minor risks that can be accepted as requiring no further action, mainly where the risk is regarded as one that the ICB can legitimately bear and is often merely part of “doing business”. This option may also be relevant in situations where a residual risk remains after other treatment options have been put in place. No further action is taken to treat the risk; however, ongoing monitoring is recommended (e.g. carrying out an annual review to ensure the level of underlying risk has not changed).

A range of treatments may be available for each risk and these options are not necessarily mutually exclusive or appropriate in all circumstances. Selection of the most appropriate approach should be developed in consultation with all relevant decision-makers, stakeholders, Risk Owners and the Governance Team.

Appendix One: Institute of Risk Management Risk Culture Questions for the Board

Corporate Governance requires that Boards understand and address their Risk Culture. They have a responsibility to set, communicate and enforce a culture that consistently influences,

directs and aligns the strategic objectives with its Risk Management Framework and processes. This starts with the behaviours, attitudes and culture of the Board / Leadership, and then reaches down through the organisation. The Board and Leadership need to ask:

- *What is our current Risk Culture and how do we improve Risk Management within that?*
- *How do we want to change that culture, moving from where we are, to where we want to be?*
- *What tone do we set from the top? Are we providing consistent, coherent, sustained and visible leadership in terms of how we expect our people to behave and respond when dealing with risk?*
- *How do we establish sufficiently clear accountabilities for those managing risks and hold them to account for these?*
- *What risks does our current corporate culture create for the organisation, and what Risk Culture is needed to ensure achievement of our corporate goals? Can people talk openly without fear of consequences or being ignored?*
- *How do we acknowledge and live our stated corporate values when addressing and resolving risk dilemmas? Do we regularly discuss issues in these terms and has it influenced our decisions?*
- *How do our structure, processes and systems support or detract from the development of our desired Risk Culture?*
- *How do we actively seek out information on risk events and near misses (both ours and others) and ensure key lessons are learnt? Do we have sufficient humility to look at ourselves from stakeholders' perspectives and not just assume we're getting it right?*
- *How do we respond to whistle-blowers and others raising genuine concerns? When was the last time this happened?*
- *How do we reward and encourage appropriate risk taking behaviours and challenge unbalanced risk behaviours (either overly risk averse or risk seeing)?*
- *How do we satisfy ourselves that new starters will quickly absorb our desired cultural values and that established staff continue to demonstrate attitudes / behaviours consistent with our expectations?*
- *How do we support learning and development associated with raising awareness and competence in managing risk at all levels? What training have we as a board and leaders had in risk?*

Appendix Two: *the core 'Risk Domain' Consequence Factors*

Scoring Factor	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic
Impact on Patient, Staff or Public Safety (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment // No time off work	Minor injury or illness, requiring minor intervention // Requiring time off work for >3 days // Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention // Requiring time off work for 4-14 days // Increase in length of hospital stay by 4-15 days // RIDDOR or agency reportable incident // An event which impacts on a small No. patients	Major injuries, or long-term incapacity + disability (loss of limb) / Time off work >14d	Incident leading to death // Multiple permanent injuries or irreversible health effects // An event which impacts on a large number of patients
Quality / Complaints / Audit	Peripheral element of treatment or service suboptimal // Informal complaint or inquiry	Overall treatment or service sub-optimal // Formal complaint - local resolution // Single failure to meet internal standards // Minor implications for patient safety if unresolved	Service has significantly reduced effectiveness // Formal complaint - local resolution (with potential to go to independent review) // Repeated failure to meet internal standards // Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved // Multiple complaints - independent review // Critical report	Totally unacceptable level or quality of Service // Inquest or Ombudsman inquiry // Gross failure of patient safety if findings not acted on // Gross failure to meet national standards
Scoring Factor	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic

HR / OD / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff // Unsafe staffing level or competence (>1 day) // Low staff morale // Poor staff attendance for stat & mand or key professional training	Uncertain delivery of key objective / service due to lack of staff // Unsafe staffing level or competence (>5 days) // Loss of key staff // Very low staff morale // Significant numbers of staff not attending stat & mand or key professional training	Non-delivery of key objective / service due to lack of staff // Ongoing unsafe staffing levels or competence // Loss of several key staff // No staff attending stat & mand or key professional training on an ongoing basis
Statutory Duty / Regulatory / Inspections	No or minimal impact or breach of guidance / statutory duty	Material breach of statutory legislation	Single material breach in statutory duty // Challenging external recommendations // Improvement Notice	Multiple material breaches in statutory duty // Critical report // Prohibition Notice	Multiple material breaches in statutory duty with high likelihood of enforcement action // Complete systems change required // Severely critical report // Prosecution
Adverse Publicity / Reputation	Rumours with potential for public concern	Local media coverage // Short-term reduction in public confidence // Elements of public expectation not being met	Local media coverage // Long-term reduction in public confidence	National media coverage for <3 days with services well below reasonable public expectation	National media coverage for >3 days with service well below reasonable public expectation // MP concerned (questions in the House) // Total loss of public confidence
Scoring Factor	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic

Business Objectives (Corporate & Strategic) / Programmes & Projects	Insignificant cost increase / Schedule slippage	<5% over project budget // Schedule slippage	5-10% over project budget // Schedule slippage	10-25% over project budget // Schedule slippage // Key Objectives not met	Incident leading to >25% over project budget // Schedule slippage // Key objectives not met
Financial (including Claims)	Small loss // Risk of claim remote	Loss of 0.1-0.25% of budget // Claim less than £10k	Loss of 0.25-0.5% of budget // Claim between £10k-£100k	Uncertain delivery of key objective // Loss of 0.5-1.0% of budget // Claim(s) between £100k-£1m // Failing to pay suppliers on time	Non-delivery of key objective // Loss of >1% of budget // Claim(s) in excess of £1m // Loss of contract
Service / Business Interruption (Business Continuity - EPRR)	Loss / interruption of >1 hour	Loss / interruption of >8 hours	Loss / interruption of >1 day	Loss / interruption of >1 week	Permanent loss of service or facility
Environmental Impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Appendix Three: ICB Strategic Objectives 2022-23 (agreed by ICB 18.08.22)

REF	Principle Objective	Lead Director	Date of Initial Assessment
SO1	Strategic Objective 1 – Better Health & Wellbeing for the Whole Population	Chief Medical Officer	
SO2	Strategic Objective 2 – Better Quality for all Patients and Service Users	Chief Nursing and Therapies Officer	
SO3	Strategic Objective 3 – Sustainable services for the taxpayer	Chief Financial Officer	
SO4	Strategic Objective 4 – A reduction in health inequalities	Chief Medical Officer	

Appendix Four: System (ICB) Risk Appetite

Example for review and amendment by the Integrated Care Board

1. INTRODUCTION

The following Risk Appetite Statement makes clear the Board's expectations in relation to the category of risks they expect management to identify and the level of such risk that is acceptable. If the organisation's collective appetite for risk is unknown, it may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate.

The statement is based on the premise that the lower the Risk Appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put into place to manage the risk.

The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls. Risk Appetite will therefore be set at one of the following levels:

LEVELS OF RISK APPETITE	
Avoid Risk Score Tolerance 0	We are not prepared to accept any risk.
Minimal Risk Score Tolerance 1 – 3	We accept that risks will not be able to be eliminated, therefore these should be reduced to the lowest levels, with ultra-safe delivery options, recognising that these may have little or no potential for reward / return.
Cautious Risk Score Tolerance 4 – 6	We are willing to accept some low levels of risk, while maintaining overall performance of safe delivery options, recognising that these may have restricted potential for reward / return.
Open Risk Score Tolerance 8 – 12	We are willing to accept all potential delivery options, recognising that these may provide an acceptable level of reward.
Seek Risk Score Tolerance 15 – 25	We are eager to be innovative, choosing options with the potential to offer higher business rewards.

2. CATEGORIES OF RISK

Risks at an operational level will be considered under the following categories:

- Quality – Safety, Effectiveness & Experience
- Regulation and Compliance
- Reputation
- Workforce
- Infrastructure (Estates & IM&T)
- Finance and Efficiency
- Partnerships / Collaboration

- Innovation

3. APPETITE FOR RISKS THAT MAY IMPACT UPON QUALITY

OUR STATEMENT ON QUALITY

Patient safety is our number one priority. While we aim to find a balance in our approach to achieve the best value for money in order to achieve financial sustainability for the future, we will not hesitate to spend money and apply resources to situations that present unacceptable risks to the safety of our patients.

We will protect patients from harm, giving them treatment that provides the best possible outcomes and make sure that they have a good experience of the treatment and care we provide. We have a moderate appetite to risks that may have an impact on any aspect of safety.

We will collect useful information on quality and share this information quickly with the people who are best placed to improve care. We will empower our staff to get things done and will be constantly vigilant in keeping quality standards high. We will take every opportunity to compare ourselves with other providers so that we continue to strive for excellence.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	Cautious	Mod 4 - Mod 6
Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	Open	High 8 – High 12
Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	Open	High 8 – High 12

4. APPETITE FOR RISKS THAT MAY IMPACT UPON REGULATION AND COMPLIANCE

OUR STATEMENT ON REGULATION AND COMPLIANCE

We provide services within a highly regulated environment that must meet high levels of compliance expectations from a large number of regulatory sources. We will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against pragmatic operational imperatives.

Non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the organisation, has the potential for harm and legal consequences and therefore the organisation has a moderate appetite in relation to those risks.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Statutory Regulation and Requirements (e.g. ICO, CQC, HSE, Professional Regulatory Bodies such as GMC / NMC, external certifications such as JAG and ISO).	Cautious	Mod 4 – Mod 6
National Guidance and Best Practice (e.g. NICE, GIRFT)	Open	High 8 – High 12

5. APPETITE FOR RISKS THAT MAY IMPACT UPON REPUTATION

OUR STATEMENT ON REPUTATION

We accept that a level of reputational risk is inherent in all of our activities which include the effect of factors such as regulatory intervention; employee conduct, human resource practices, legal, licensing, policy decisions; fiscal responsibility and information security. Negative perceptions by patients, staff and other stakeholders may jeopardise our credibility and impede the achievement of delivering our strategic objectives.

We expect high standards of conduct, ethics and professionalism to be maintained at all times and we have a moderate appetite for risks that could cause reputational damage to the Trust or a loss in public confidence in our ability to deliver a quality service.

We will accept a significant level of risk to our reputation (where for instance we may spend above planned levels) in protecting and improving the safety of our patients, as this is the Board's highest priority.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	Cautious	Mod 4 – Mod 6
Risk as a result of protecting and improving the safety of patients	Seek	Ext 15 – Ext 25

6. APPETITE FOR RISKS THAT MAY IMPACT UPON WORKFORCE

OUR STATEMENT ON WORKFORCE

We believe that patient outcomes, safety and the quality of care we provide is influenced by the experiences and engagement of staff and the support they receive from colleagues and the organisation more widely. We will endeavour to ensure that the right numbers of properly qualified staff are in the right place at the right time.

As our greatest area of expenditure we expect that staff potential and performance is efficiently maximised while balancing this against opportunities for professional development, flexible working practices and the implementation of national agreements regarding terms and conditions. We have a moderate risk appetite for compliance risks relating to staff recruitment and the controls applied while in work.

We have high risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure that the organisation remains as an employer of choice.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities / Diversity, that ensure staff are recruited fairly and competent to deliver)	Cautious	Mod 4 - Mod 6
Employment practice	Cautious	Mod 4 - Mod 6
Staff retention (e.g. attractiveness of Trust as an employer of choice)	Open	High 8 – High 12

7. APPETITE FOR RISKS THAT MAY IMPACT UPON INFRASTRUCTURE

OUR STATEMENT ON INFRASTRUCTURE

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a moderate appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance.

IM&T plays an ever increasing role in supporting staff to deliver high quality services to patients. IM&T must support core organisation functions with sufficient capability, capacity, resilience and security from internal and external threats. The organisation relies on an increasingly mobile and technologically dependent workforce to carry out its core functions; we therefore expect that full business continuity plans are in place should services become unavailable.

We will collect GDPR-acceptable information to help us deliver services and improve their quality, ensuring that only those who have a legitimate purpose are given access to this data. We have a low risk appetite for IM&T risks relating to security, control of assets, business continuity and data.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Estates infrastructure	Cautious	Mod 4 – Mod 6
Security (e.g. access and permissions to systems and networks)	Cautious	Mod 4 – Mod 6

Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	Cautious	Mod 4 – Mod 6
Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	Cautious	Mod 4 – Mod 6
Data (e.g. integrity, availability, confidentiality and security, unintended release)	Cautious	Mod 4 – Mod 6

8. APPETITE FOR RISKS THAT MAY IMPACT UPON FINANCE AND EFFICIENCY

OUR STATEMENT ON FINANCE AND EFFICIENCY		
<p>To achieve the best value for money and to ensure our future financial sustainability we expect appropriate stewardship over our financial resources. This means that decisions regarding the pursuit of our strategic objectives must be balanced against the expectations of our regulators in meeting our financial plans / statutory duties.</p> <p>We expect robust internal controls to be maintained which ensure compliance with applicable government and accounting standards. We will not tolerate risks that may lead to financial losses from fraud and negligent conduct as this represents a corporate failure to safeguard public resources.</p>		
Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Value for money & sustainability (inc. cost saving)	Cautious	Mod 4 – Mod 6
Standing Financial Instructions (SFIs) and financial control	Cautious	Mod 4 – Mod 6
Fraud and negligent conduct	Minimal	Low 1 – Low 3
Contracting	Seek	Ext 15 – Ext 25

9. APPETITE FOR RISKS THAT MAY IMPACT UPON PARTNERSHIPS / COLLABORATION

OUR STATEMENT ON PARTNERSHIPS & COLLABORATION

We are committed to collaborating with our stakeholder organisations to bring value and opportunities across current and future services, through system-wide partnerships. We have a high risk appetite in developing partnerships with organisations who are responsible and have similar values, maintaining the required level of compliance with our statutory duties.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Partnerships	Open	High 8 – High 12

10. APPETITE FOR RISKS THAT MAY IMPACT UPON INNOVATION

OUR STATEMENT ON INNOVATION

We have a significant appetite to pursue innovation in the delivery of services and challenge current working practices. The potential rewards in pursuing new solutions that may improve quality and provide business efficiencies must be balanced against the safety and wellbeing of our patients and staff.

We have a significant appetite to pursue innovation and challenge current working practices in support of the use of systems and technology developments, as well as new service design within the services it manages. We will therefore pursue options where innovation can provide higher rewards (despite greater inherent risks), but only where quality and compliance are not affected.

Although we cannot control or predict external factors that may affect our financial resources, we have a duty to protect cost saving through efficiencies and innovation. We are therefore willing to accept a high level of risk in pursuit of such activities but we expect prudent decisions to be made to mitigate the financial impact while providing optimal value for money.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	Seek	Ext 15 – Ext 25
Financial Innovation (e.g. new ways of working, new products, new and realigned services)	Open	High 8 – High 12



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	06b
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Title:	Risk Register – 16+
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Meeting Date:	22 nd September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Sally Young, Director of Corporate Governance	Y	Tracey Revill

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

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

History of the paper – where has this paper been presented		
	Date	A/D/S/I
All Risks presented to Execs monthly	31/08/2022	D
All Risks presented Audit Committee	05/09/2022	D

Purpose of the Paper (Key Points + Executive Summary):
<p>As outlined in the Draft Risk Management Strategy the Risk Register presents the ICB Board with all the current risks scoring 16 and above.</p> <p>The Register has been constructed from the c.70 risks received by the ICB on the 1st July 2022. Using the approach outlined in the Draft Risk Management Strategy we have introduced more robust definitions of Risks and Issues, which has led to a number of reclassifications. The Governance team has worked with Directors to review all the risks and where appropriate close them or move them an issues log.</p> <p>Following the review, the following changes have been made</p> <ul style="list-style-type: none"> • 18 risks have been closed – of those closed about half related to the development of the ICB and half because the mitigations reduced the risk to the target score • 24 have been moved to the Issues Log. • 7 redrafted/replaced with a new risk

There is a total of eight risks scoring 16 and above on the attached register:

- Two risks scoring 20
- Six risks scoring 16

There are five new risks which have been added to the register; which are

- 072 related to the wheelchair procurement.
- 077 related to recommendations publish in the Fuller Report
- 078 related to delays in agreeing the governance arrangements for the ICB, and
- 079 related to the lack of a governance route for approval of commissioning decisions
- 080 related to patient harm due to increased waiting times

Of the five new risks added only 077 and 080 score 16 and these are detailed on the attached register.

Risk 048 has been reviewed and has been increased from 16 (4x4) to 20 (4x5).

All risks scoring below 16, closed risks and the issues log can be viewed on request.

Example of rationale for closing a previously high scoring risk

There had been a long-standing risk on the CCG risk register which identified a risk of poor performance that may lead to patients coming to harm. The risk was scored between 16-20 depending on recent A&E performance.

However, given that the A&E targets hadn't been met for some years the performance element of the risk was known and documented. This is an issue that was being managed through the UCB.

The risk to patients coming to harm has been mitigated through a range of actions led by the Quality team. The Quality team also monitored SUI and carried out harm reviews and found little evidence of patients coming to harm. Therefore, the level of risk to patients is low and within tolerance.

This risk has therefore been closed and the A&E performance has been added to the Issues log.

The risks are unevenly spread across the strategic objectives with more risks related to strategic objective 2 patient safety and quality and strategic objective use of resources. At present there are no risks or issues identified related to strategic objective 4 reducing inequalities.

However, it is anticipated that additional risks and issues will be identified as the Portfolio work is progressed.

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 risk register links to all risks and strategic objectives.

Implications:

Legal and/or Risk	Presentation of the Risk Register is a key source of assurance to the Board
CQC/Regulator	N/A
Patient Safety	The Risk Register 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	N/A
Sustainability	N/A
Workforce / Training	Governance team provide on-going training in risk management and the use of the risk register

Key Requirements:

1a.	How can the author best assure the 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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> 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: <ul style="list-style-type: none">• 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 the Risk Register for discussion and assurance			

LIKELIHOOD of Occurrence	Most Likely CONSEQUENCE				
	1= Insignificant	2= Minor	3= Moderate	4= Major	5= Catastrophic
	1= Rare	2	3	4	5
	2= Unlikely	4	6	8	10
	3= Likely	6	9	12	15
	4= Highly Likely	8	12	16	20
	5= Certain	10	15	20	25

12 and above - High risk
5 - 10 Medium risk
1 - 4 Low risk

Key: Inherent Score ~ this is the score at the time of risk being added to the register
Residual Score ~ this is the score of the risk after monthly update
Target Score ~ this is the score you aim to bring the risk down to for closure

S01	Strategic Objective 1 - Better Health & Wellbeing for the Whole Population
S02	Strategic Objective 2 - Better Quality for all Patients and Service Users
S03	Strategic Objective 3 - Sustainable services for the taxpayer
S04	Strategic Objective 4 - A reduction in health inequalities

A Risk is an event that has not yet happened, but may do
An Issue relates to an event that has already occurred

STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD

RISK REGISTER

ICB BOARD

Risk No.	Risk Detail	Risk Type	Strategic Objective Code	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Action Owner	Directorate	Portfolio	ICB or System wide risk
048	DIGITAL CYBER SECURITY: The Staffordshire wide network is made up of core components, namely: 1. N3/Health and Social Care Network (HSCN) link which gives access to clinical systems. 2. Internet links. 3. Wide area network / local network (SSHIS central links and individual practice links). All of these components are at risk of cyber attack or environmental impacts, such as links being impacted by local building work. There is also a risk that overarching infrastructure we use and this impacts our links as has been seen during October/November by 4 outages. There is advanced monitoring across our networks that demonstrate the network is being hacked and our defence systems continue to stop these attacks and manage them effectively. The risk exists and is heightened following the WannaCry incident in 2017.	Clinical Compliance	SO3	12.09.2022	SSHIS continue to manage the network and cyber security controls in place, including the new Security Operations Centre team, are working effectively with quick responses to the increased NHS Digital directives and alerts from CareCert process. SSHIS SOC Team continues to be highly effective and discussions to potentially expand service across the system to further support system resilience in this area is positive for our LHE. An increase in recent Ransomware activity including NHS suppliers like Advanced, increases the likelihood of this risk and therefore the score should be increased from 16 to 20 whilst these national investigations continue. The root cause is yet to be fully confirmed and therefore we should be very aware to the risk and suggest this scoring reflects that and how our IT partner is treating this - changed to 20 on SSHIS risk register on 17 August.	/ /	16 (4x4)	20 (4x5)	8 (4x2)	Increasing	Chris Ibell	Andy Hadley	Digital		System
068	Break even risk for 2022/23: the break even plan for the ICB (and system) contains risks of £87m for the ICS and unidentified mitigation of £21m and as such might mean that the ICB does not achieve break even.	Organisation Operational Compliance Reputational	SO3	02.08.2022	Q1 of the plan relates to the CCGs and will be adjusted to break even by a national allocation transfer. System CFO meeting discussing orgnaisation position and assumptions to achieve plan. No change to risk score.	31/03/2023	20 (4x5)	20 (4x5)	4 (2x2)	Static	Paul Brown	Jacqui Charlesworth	Finance		System
001	Underlying deficits: Without the delivery of robust system saving schemes, the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position, in line with the operating and planning framework. This risks a deficit in 23/24.	Organisation Operational Compliance Reputational	SO3	02.08.2022	System CFOs submitted revised Annual Plans on 20th June 2022 at break even for 2022/23. There are risks to deliver break even that have clearly been set out in the submission to region. No change to risk score due to balance of risk in plan.	31/03/2023	16 (4x4)	16 (4x4)	9 (3x3)	Static	Paul Brown	Nigel Mander	Finance		System

Risk No.	Risk Detail	Risk Type	Strategic Objective Code	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score	Trend	Risk Owner	Action Owner	Directorate	Portfolio	ICB or System wide risk
014	MATERNITY TRANSFORMATION PROGRAMME (MTP) - The system is unlikely to deliver the requirements of the MTP due to delays resulting from Covid-19.	Organisation Reputational Operational Clinical	SO2	05.09.2022	Risk reviewed with ICB Head of Governance and agreed to review with LMNS team in light of the revised national timescales - scheduled for 7/9/22.	30/09/2022	16 (4x4)	16 (4x4)	4 (2x2)	Static	Heather Johnstone	Alison Budd	Nursing And Quality Maternity Transformation	CYP & Maternity	System
032	There is a risk that the gaps in maternity and neonatal workforce due to vacancies and retention will impact on the implementation of safety initiatives and the transformation agenda	Operational	SO2	05.09.2022	risk reviewed with ICB Head of Governance. Agreed to review with the LMNS team and consider whether an issue - scheduled to review on 7/9/22.	31/03/2023	16 (4x4)	16 (4x4)	6 (3x2)	Static	Heather Johnstone	Alison Budd	Nursing And Quality Maternity Transformation	CYP & Maternity	System
050	Maternity Services unable to deliver Continuity of Carer trajectories for the NHS Long Term Plan , of continuity of carer for the default model of care for the majority of women by March 2023 and may not be achieved due to insufficient staffing levels within Provider Trust. This impacts on delivery of IAF 125c - choices in maternity services. Impacts on delivery of LMS work streams for service reconfiguration & workforce. Impacts on delivery of Better Births and the NHS Long Term Plan. Impacts on the delivery of the contractual SDIP between the ICBG's and the provider (UHNM).	Compliance Safety Clinical	SO2	05/09/2022	Risk reviewed with ICB Head of Governance and agreed to review with LMNS team in light of the revised national timescales - scheduled for 7/9/22.	31/03/2023	12 (4x3)	16 (4x4)	9 (3x3)	Static	Heather Johnstone	Alison Budd	Nursing And Quality Maternity Transformation	CYP & Maternity	System
077	There is a risk that the implementation of the Fuller Report does not address the known workforce issues in primary care.	Operational Financial	SO1	02.09.2022	Local stocktake undertaken in response to the recommendations published in the Fuller Stocktake Report. The ICB are already progressing well against many of the recommendations, for example: 1. A Primary Care Collaborative comprising 25 PCNs has been established and are meeting on monthly basis. 2. Enablers such as organisational development support and data sharing agreements are in place across the PCNs and work on the PCN Estates Plan has commenced. 3. Taking the Fuller recommendations forward as shared actions across all partners and are in the process of creating a development plan which will support the sustainability and evolution of primary care.	31/03/2023	16 (4x4)	16 (4x4)	8 (2x 4)	New	Chris Bird	Tracey Cox	Transformation	Primary Care	ICS
080	There is a risk patient harm is likely due to increased waiting times for surgery and cancer surgery	Operational Reputational Clinical safety compliance	SO2	01.09.2022	UHNM undertaking harm reviews for patients on waiting lists and list performance management reviewed monthly. Improvement plans with trajectories in place across all specialities. Improvement seen in 103 day targets, outsourcing surgery where relevant and possible.	01/04/2023	16 (4x4)	16 (4x4)	8 (2x 4)	New	Heather Johnstone	Cath Marsland	Nursing and Quality		ICB



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	07
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Title:	Clinical Policy Alignment (formerly Difficult Decisions)
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Dr Paul Edmondson-Jones <i>Chief Medical Officer</i>	Y	Gina Gill <i>Senior IFR/Improvement Manager</i> Helen Slater <i>Head of Transformation</i>

Clinical Reviewer:	Clinical Sign-off Required Y/N
Dr Paul Edmondson-Jones <i>Chief Medical Officer</i>	Y

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

History of the paper – where has this paper been presented		
	Date	A/D/S/I
Executive Weekly Meeting	22/08/2022	D
Finance and Performance Committee	06/09/2022	A/D/S
System Quality and Safety Committee (scheduled)	14/09/2022	S

Purpose of the Paper (Key Points + Executive Summary):
<p>The programme was launched in January 2020 and aims to harmonise the eligibility criteria for five areas across Staffordshire and Stoke-on-Trent. These are;</p> <ul style="list-style-type: none"> • Assisted Conception • Hearing Loss in Adults • Male and Female Sterilisation • Breast Augmentation and Reconstruction • Removal of excess skin following significant weight loss

The Commissioning teams have previously reviewed policies and procedures to identify differences in eligibility criteria and ensure any eligibility criteria is in line with recommendations from the former CCGs Clinical Priorities Advisory Group (further detail on the role of the group can be found in section 2 of the main report).

The differences were collated and reviewed on a line by-line basis with clinical leads. A large proportion of amendments were not expected to have a material impact on patient access, referral processes or treatment pathways therefore these were approved in line with the former CCGs governance process and implemented either within the Excluded and Restricted Procedures policy or within separate commissioning policies.

For the areas identified above the former CCGs noted that further work was required to understand any potential impact on patients prior to aligning these policies and therefore it was agreed that public, patient, and stakeholder involvement would be undertaken to shape proposals that will inform the future commissioning policy in line with the Integrated Care Board's Duty to Involve.

This has included public surveys and face to face involvement events prior to the COVID-19 pandemic for interested parties to share their views.

During the options appraisal process the former CCGs held several internal technical events to develop and review the proposals. Clinical leads, Quality leads, Public Health specialists and Locality leads were involved in these events supporting the wider project team with the evaluation. The former CCGs also held two virtual public events to review and score the proposals.

The Midlands and Lancashire Commissioning Support Unit (MLCSU) has reviewed the involvement activities and sought advice from the Consultation Institute (tCI) who is satisfied that the involvement work and the process undertaken so far is transparent and robust.

Quality and Equality impact assessments have been completed for each of the proposals. These recognised the positive impact of aligning criteria across the county. Where any negative impact was noted, adequate mitigations were identified and all assessments were approved. Further detail on the individual impact assessments can be found in Appendices A-E of the main report.

No material workforce impact was highlighted during the options appraisal process or within the quality and equality impact assessments

On completion of the options appraisal process, the Women's Health Strategy was published which has indicated that a review of fertility provision across the UK will be undertaken. As a result, the proposal for this area is to separate assisted conception from the wider policy alignment programme and develop an aligned assisted conception policy for approval and implementation whilst the ICB awaits further directives following the national review of service provision (Further detail can be found in Appendix A of the main report).

This paper was presented to the Finance and Performance Committee on 06 September 2022. The committee was assured that a robust process had been taken through the work programme and approved the recommendations within the paper.

This report provides an update on the work completed to date and the recommended proposals including the impacts and financial implications identified for discussion and approval by the Board. The Integrated Care Board is asked to:

- BE ASSURED that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.
- CONSIDER the financial consequences and the risks relating to the recommendations
- APPROVE the recommendation to decouple assisted conception from the wider policy alignment programme and develop an interim aligned assisted conception policy.
- APPROVE the recommendations for the four other clinical areas.

Is there a potential/actual Conflict of Interest?	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):

Implications:	
Legal and/or Risk	Potential legal challenge if clinical prioritisation process is not followed
CQC/Regulator	None
Patient Safety	None
Financial – if yes, they have been assured by the CFO	Financial implications approved by the Finance and Performance Committee on 06 September 2022
Sustainability	None
Workforce / Training	None

Key Requirements:	
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services?

	<p>The recommendations have been developed following a robust options appraisal process. Further detail can be found in section 3 of the main report.</p> <p>Quality and Equality Impact assessments have been completed for each recommendation. Further detail can be found in Appendices A-E of the main report for further detail on the impact assessments for each clinical intervention.</p>		
1b.	<p>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)</p> <p>In line with the ICBs Policy on the Prioritisation of Healthcare resources, all clinical interventions have been reviewed through the ICBs Clinical Priorities Advisory Group which takes into consideration the latest clinical evidence. Further detail can be found in section 2 of the main report.</p> <p>Feedback received through the involvement process was taken into consideration when developing the recommendations for approval. Further detail can be found in section 3 of the main report.</p>		
		Y/N	Date
2a.	<p>Has a Quality Impact Assessment been presented to the System QIA Sub-group?</p> <p>A QIA for each clinical indication was presented to the QIA panel.</p> <p>To note, the QIA for assisted conception was placed on hold following publication of the Women's Health Strategy due to the revised recommendation to develop an interim aligned assisted conception policy. Should this recommendation be approved, a revised QIA will be completed for the interim aligned policy once it has been developed (see timelines in Appendix A).</p>	Y	29 June 2022
2b.	<p>What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)</p> <p>Approved</p>		
2c.	<p>Were there any conditions? If yes, please state details and the actions in taken in response:</p> <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. <p>n/a</p>		
3a.	<p>Has an Equality Impact Assessment been completed? If yes please give date(s)</p> <p>A Stage 1 EIA for each clinical indication was submitted and subsequently approved;</p> <p>Breast Augmentation and Reconstruction</p> <p>Female Sterilisation</p> <p>Hearing Loss in adults</p>	Y	20 July 2022

	<p>Body Contouring Procedures</p> <p>Abdominoplasty/Apronectomy procedures</p> <p>The EIA for assisted conception was placed on hold following publication of the Women's Health Strategy due to the revised recommendation to develop an interim aligned assisted conception policy. Should this recommendation be approved, a revised EIA will be undertaken on the interim aligned policy once it has been developed (See timelines in Appendix A).</p>		01 Aug 2022
3b.	<p>If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?</p> <p>n/a</p>		
3c.	<p>Please provide detail as to these considerations:</p> <ul style="list-style-type: none"> 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.	<p>Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients</p> <p><i>Detail of involvement activities can be found in section 3 of the main report.</i></p> <p><i>This has included face to face events prior to the pandemic and internal technical events and virtual public events post pandemic as part of the options appraisal process.</i></p> <p><i>Report of findings can be found here Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)</i></p>	Y	Jan 2020 – March 2022
5.	<p>Has a Data Privacy Impact Assessment been completed?</p> <p><i>Not required for this programme</i></p>		
Recommendations / Action Required:			
<p>The Integrated Care Board is asked to:</p> <ul style="list-style-type: none"> BE ASSURED that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders. CONSIDER the financial consequences and the risks relating to the recommendations APPROVE the recommendation to decouple assisted conception from the wider policy alignment programme and develop an interim aligned assisted conception policy. APPROVE the recommendations for the four other clinical areas. 			

Clinical Policy Alignment (formerly known as Difficult Decisions)

September 2022

1. Executive Summary

- 1.1. The programme was launched in January 2020 and aims to harmonise the eligibility criteria for five areas across Staffordshire and Stoke-on-Trent. These are:
 - 1.1.1. Assisted Conception
 - 1.1.2. Hearing Loss in Adults
 - 1.1.3. Male and Female Sterilisation
 - 1.1.4. Breast Augmentation and Reconstruction
 - 1.1.5. Removal of excess skin following significant weight loss
- 1.2. The Commissioning teams have previously reviewed policies and procedures to identify differences in eligibility criteria and ensure any eligibility criteria is in line with recommendations from the former CCGs Clinical Priorities Advisory Group (further detail on the role of the group can be found in section 2).
- 1.3. The differences were collated and reviewed on a line by-line basis with clinical leads. A large proportion of amendments were not expected to have a material impact on patient access, referral processes or treatment pathways therefore these were approved in line with the former CCGs governance process and implemented either within the Excluded and Restricted Procedures policy or within separate commissioning policies.
- 1.4. For the areas identified in section 1.1, the former CCGs noted that further work was required to understand any potential impact on patients prior to aligning these policies and therefore it was agreed that public, patient, and stakeholder involvement would be undertaken to shape proposals that will inform the future commissioning policy in line with the Integrated Care Board's Duty to Involve¹.
- 1.5. This has included public surveys and face to face involvement events prior to the COVID-19 pandemic for interested parties to share their views.

¹ 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.

The public sector Equality Duty (2011) means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It also requires that public bodies have due regard to the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between different people when carrying out their activities

- 1.6. During the options appraisal process the former CCGs held several internal technical events to develop and review the proposals. Clinical leads, Quality leads, Public Health specialists and locality leads were involved in these events supporting the wider project team with the evaluation. The former CCGs also held two virtual public events to review and score the proposals.
- 1.7. The Midlands and Lancashire Commissioning Support Unit (MLCSU) has reviewed the involvement activities and sought advice from the Consultation Institute (tCI) who were satisfied that the involvement work and the process undertaken so far is transparent and robust.
- 1.8. A quality impact assessment (QIA) was completed for each of the proposals. The panel recognised the positive impact of aligning criteria and eliminating variation across the county. The panel noted the potential mental health impact on some patients if they are no longer able to access certain procedures however adequate mitigations were identified and all assessments were approved by the QIA panel on 29 June 2022. Further detail on the individual impact assessments can be found in Appendices A-E.
- 1.9. An equality impact assessment (EIA) was completed for each of the proposals. The assessments recognised the positive impact of aligning criteria across the county. Where any negative impact was noted, adequate mitigations were identified and all assessments were approved. Further detail on the individual impact assessments can be found in Appendices A-E.
- 1.10. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments.
- 1.11. On completion of the options appraisal process, the Women's Health Strategy was published which has indicated that a review of fertility provision across the UK will be undertaken. As a result, the proposal for this area is to separate assisted conception from the wider policy alignment programme and develop an aligned assisted conception policy for approval and implementation whilst the ICB awaits further directives following the national review of service provision (Further detail can be found in Appendix A).
- 1.12. This paper was presented to the Finance and Performance Committee on 06 September 2022. The committee was assured that a robust process had been taken through the work programme and approved the recommendations within the paper.
- 1.13. This report provides an update on the work completed to date and the recommended proposals including the impacts and financial implication identified for discussion and approval by the Board. The ICB Board is asked to:
- BE ASSURED that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.

- CONSIDER the financial consequences and the risks relating to the recommendations
- APPROVE the recommendation to decouple assisted conception from the wider clinical policy alignment programme and develop an interim aligned assisted conception policy.
- APPROVE the recommendations for the four other clinical areas.

2. Background and context

- 2.1. Introducing excluded or restricted criteria for any intervention are difficult decisions to make, which is why the ICB has a clinically led prioritisation process.
- 2.2. Inevitably, as some interventions/services score below the threshold for investment, difficult decisions have to be made; however, using a clinically led prioritisation process based on review of available scientific evidence of effectiveness ensures that where interventions are excluded from commissioning or, where they are prohibitively expensive or in limited supply, restrictive criteria are used to ensure that these interventions are reserved for those most likely to benefit.
- 2.3. The Integrated Care Board has a process for prioritising the use of the resources available to commission healthcare across Staffordshire and Stoke-on-Trent. This is set out in the Policy on the Prioritisation of Healthcare Resources².
- 2.4. The ICB has a group known as the Clinical Priorities Advisory Group (CPAG), which is a subcommittee of the Finance and Performance Committee. The membership consists of Clinicians, Medicines Optimisations Representatives and Consultant(s) in Public Health (the full terms of reference can be found in the Policy on the Prioritisation of Healthcare Resources). The group considers interventions and services which are referred from the commissioning team. This may be because there is a recognised unmet need and the ICB wishes to identify the best interventions to invest in or, as is the reason in this case, because there is a view that services need to be reviewed.
- 2.5. CPAG undertakes the ranking of healthcare interventions using a scoring system of criteria based on the Portsmouth Scorecard. Interventions are scored by the group against eight criteria that include:
 - Strength and quality of evidence - how well does this treatment or service work?
 - Magnitude of health improvement benefit for the patient group or population - to what extent does this intervention increase the health gain or life expectancy for the patients/population? Appraise outcome measures e.g. improvement in functionality or of clinical markers for the condition, Quality of Life (QoL), increase in health expectancy

² The Policy on the Prioritisation of Healthcare Resources can be found on the ICB webpage [Contents](https://www.icb.nhs.uk/Contents) ([icb.nhs.uk](https://www.icb.nhs.uk))

- Does the intervention prevent a condition or detect a condition which is not yet known (i.e. screening)?
- Supporting people with existing conditions - Does this intervention prevent or reduce complications in people with ongoing conditions?
- How cost effective is the intervention – how much health gain compared to the cost?
- Does it address health inequalities?
- Does it deliver national and/or local requirements/targets?

2.6. CPAG does not make decisions on whether a service should or should not be commissioned. The group makes recommendations which are reviewed by the commissioning teams and taken to the ICB Board meeting for discussion and approval.

2.7. As the policy explains there is a threshold score, and interventions scoring below the threshold will not be considered by the ICB for new investment and where already commissioned, current eligibility criteria will be subject to review.

2.8. This is particularly important given the ICB's challenged financial position and the need to balance the services that are commissioned against their statutory responsibilities to ensure that they operate within their defined budgets and achieve financial balance.

2.9. In 2019, the former six Staffordshire and Stoke-on-Trent CCGs reviewed eligibility criteria for a range of interventions/procedures with the overarching aim of aligning criteria where there were differences across the CCGs and to review any outstanding recommendations from the CCGs CPAG. A timeline of key dates is provided in Table 1 below.

2.9.1. Table 1: Timeline of key dates

Milestone	Date
Six separate CCGs came together under a single management structure. We began to review policies and procedures.	July 2018
Differences in policies for procedures discovered that meant patients received different levels of access depending on where they lived ('postcode lottery').	July - December 2018
Development of case for change – including possible solutions for making policies the same across Staffordshire and Stoke-on-Trent in five clinical areas.	March 2019
Patient and public involvement about views or experiences of the five procedures. This feedback was used when developing our proposals.	January - March 2020
Programme paused due to COVID-19 pandemic.	March 2020
Involvement findings from start of 2020 published.	November 2020

Involvement conversation restarted – to sense check if anything had changed due to the impact of COVID-19. Patients, public and other stakeholders were surveyed.	September 2021
Two internal technical events with clinicians, which produced a revised number of proposals.	Oct - Dec 2021
Further involvement events to confirm the desirable criteria ('impact on overall health and wellbeing' and 'clinical benefit') and their weighting; and to score proposals against desirable criteria.	March 2022
Third technical event to review the outcomes of the involvement phase. This was used to move to a final set of proposals.	May 2022
EIAs and QIAs finalised for each proposal to support governance process.	May 2022 – July 2022
Present recommendations to Finance and Performance meeting (6 September).	September 2022
Present recommendations to Quality and Safety Committee (14 September).	September 2022
Present recommendations to ICB board meeting (22 September).	September 2022
Present recommendations to Health and Overview and Scrutiny Committees.	October / November 2022

3. Summary of the process

- 3.1. The Commissioning teams have previously reviewed policies and procedures to identify differences in eligibility criteria and ensure any eligibility criteria is in line with recommendations from the former CCGs Clinical Priorities Advisory Group (further detail on the role of the group can be found in section 2).
- 3.2. The differences were collated and reviewed on a line by-line basis with clinical leads. A large proportion of amendments were not expected to have a material impact on patient access, referral processes or treatment pathways therefore these were approved in line with the former CCGs governance process and implemented either within the Excluded and Restricted Procedures policy or within separate commissioning policies.
- 3.3. For the areas identified in section 1.1 the former CCGs noted that further work was required to understand any potential impact on patients prior to aligning these policies and therefore it was agreed that public, patient, and stakeholder involvement would be undertaken to shape proposals that will inform the future commissioning policy in line with the Integrated Care Board's Duty to Involve (see executive summary).
- 3.4. In January 2020 the former Staffordshire and Stoke-on-Trent CCGs began the involvement and options appraisal process for this programme of work. An overview of the phases is detailed below:
 - 3.4.1. *Phase 1* - Winter 2019/2020 Listening exercise

- 3.4.2. *Phase 2a* - Autumn 2021 Public involvement refresh/sense check
 - 3.4.3. *Phase 2b* - Winter 2021 Development of proposals
 - 3.4.4. *Phase 2c* - Winter 2021/Spring 2022 Options appraisal
 - 3.4.5. *Phase 3* - Summer 2022 Governance process
- 3.5. **Phase 1** - This took place in January 2019 to March 2020 the objective was to understand service users and patient views and experiences of the interventions under consideration.
- 3.5.1. The feedback came back via survey and at seven deliberative events that were held in the localities. These were structured as an interactive event - '*be a commissioner*' workshops. These allowed the former CCGs to understand how patients felt services should be prioritised.
 - 3.5.2. Two additional events were held at the request of organisations representing people who were suffering from hearing loss. The feedback from these events was considered when developing the proposals.
 - 3.5.3. The report of findings can be found here [Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board \(icb.nhs.uk\)](https://www.icb.nhs.uk/difficult-decisions)
 - 3.5.4. Plans for further involvement were placed on hold when all local health services focused on supporting the efforts to manage the COVID-19 pandemic. Notification was sent to all stakeholders explaining the rationale for pausing the involvement.
- 3.6. **Phase 2a** - COVID-19 saw a change in the way the NHS delivers services and sees patients and it was felt that this may have affected the way that our patient population feel about the services.
- 3.6.1. A survey was shared to understand if any new feedback needed to be considered since the pandemic. Feedback was gathered via online and paper surveys; emails were sent to participants and community groups were contacted via social media.
 - 3.6.2. The feedback was included with the feedback from the listening exercise to develop the proposals.
 - 3.6.3. The report of findings can be found here [Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board \(icb.nhs.uk\)](https://www.icb.nhs.uk/difficult-decisions)
- 3.7. **Phase 2b** – Autumn 2021 to winter 2022 – Involvement to develop potential solutions for each of the clinical areas. Clinicians, Quality Leads and Locality Leads were involved with developing and evaluating the potential solutions. This included reviewing the clinical evidence base, taking the involvement feedback into consideration and oversight of finance and activity.
- 3.7.1. In October 2021, the former CCGs convened a technical event, with clinicians, project managers and the executive leads to develop and critique each of the proposals.
 - 3.7.2. A second technical event was held on 14th December 2021 to confirm the proposals for each of the interventions.
- 3.8. **Phase 2c** - Spring 2022 – Involvement to evaluate the potential solutions for each of the clinical areas.

- 3.8.1. Interested stakeholders, patients, members of the public were invited to an interactive workshop to understand the updated desirable criteria and confirm the weighting that should be applied to that criterion.
- 3.8.2. During a second workshop the public, patients and wider stakeholders worked together to evaluate each of the proposals against the desirable criteria through a scoring process.
- 3.8.3. The report of findings can be found here [Difficult decisions - Staffordshire and Stoke-on-Trent, Integrated Care Board \(icb.nhs.uk\)](https://icb.nhs.uk/difficult-decisions-staffordshire-and-stoke-on-trent)

3.9. **Phase 3** – Spring 2022 – Receive the report of findings from the workshops and determine any further involvement that is required.

- 3.9.1. A third technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.
- 3.9.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.
- 3.9.3. Following discussion at the technical group, a number of proposals were removed from the shortlist and there is now one proposal per clinical area. These are summarised in section 4.

3.10. The Midlands and Lancashire Commissioning Support Unit (MLCSU) has reviewed the involvement activities and sought advice from the Consultation Institute (tCI) who is satisfied that the involvement work and the process undertaken so far is transparent and robust.

3.11. Both quality and equality impact assessments have been completed for each of the proposals. These recognised the positive impact of aligning criteria across the country. Where any negative impact was noted, adequate mitigations were identified and all assessments were approved. Further detail on the individual impact assessments can be found in Appendices A-E.

3.12. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

4. Summary of proposals

4.1. The proposals for each of the interventions has now been refined and consist of one proposal for each clinical intervention.

4.2. Table 2 outlines the proposals and the impact on each of the geographical areas across Staffordshire and Stoke-on-Trent.

4.2.1. *Table 2: Proposals for the interventions*

Procedure / Proposal	Impact
Removal of excess skin following significant weight loss:	<ul style="list-style-type: none"> A reduced offer for Stoke-on-Trent, South East Staffordshire and Seisdon

<p><i>Abdominoplasty / apronectomy and body contouring will not be commissioned.</i></p>	<p>Peninsular, Cannock Chase, Stafford and Surrounds, and East Staffordshire geographical areas where abdominoplasty/apronectomy is currently commissioned against criteria</p> <ul style="list-style-type: none"> • A reduced offer within Stoke-on-Trent where body contouring is currently commissioned against criteria.
<p>Breast augmentation and reconstruction: <i>Will be routinely funded following mastectomies carried out due to suspected or proven cancer OR following double mastectomies for cancer prevention in high-risk cases.</i></p>	<ul style="list-style-type: none"> • An improvement on the policy within South East Staffordshire and Seisdon Peninsular, Cannock Chase, Stafford and Surrounds, and East Staffordshire where post-mastectomy reconstruction is only offered in the affected breast. • A reduced offer within North Staffordshire and Stoke-on-Trent where reconstruction due to burns is currently offered as well as for post-mastectomy. • A reduced offer in Stoke-on-Trent where breast augmentation for developmental failure and significant asymmetry is currently commissioned against criteria.
<p>Hearing loss in adults: <i>To commission hearing aids with no eligibility criteria.</i></p>	<ul style="list-style-type: none"> • Removal of current restrictions for mild hearing loss in North Staffordshire.
<p>Male and female sterilisation: <i>Female sterilisation will be routinely funded for contraception when unable to tolerate other contraceptives OR absolute clinical contraindication to pregnancy. No amendment to male sterilisation is proposed.</i></p>	<ul style="list-style-type: none"> • Equal impact across Staffordshire and Stoke-on-Trent as currently no criteria in place. Potential reduction in activity. • Note: Vasectomies (male sterilisation) in an acute setting will not be undertaken unless there is a clear clinical indication.
<p>Assisted conception: <i>Develop an interim aligned policy</i></p>	<ul style="list-style-type: none"> • Following the publication of the women's health strategy on 20 July 2022, the recommendation is to develop an aligned commissioning policy whilst the ICB awaits further guidance. Impact unknown at this stage.

4.3. Further detail on each of the clinical areas is provided below in Appendices A-E.

4.4. As demonstrated within the above table, there are financial implications within the proposals; some result in a financial benefit and others will have a cost impact. Further detail is included in section 5 below.

5. Financial and activity implications

5.1. A review of previous activity was undertaken to understand the financial implications of the recommended proposals.

5.2. Overall, there is an expected cost impact for the ICB of £77,175 related solely to the levelling up of digital hearing aids provision within North Staffordshire.

5.3. Table 3 below provides an outline of the financial implications for proposals that impact on acute activity. Due to the nature of block contracts, it is unlikely material costs could be removed from the system providers. For an indication of scale PbR proxy of activity is provided. The gain for the system is that there will be an element of elective capacity that may be utilised for alternative elective activity.

5.3.1. *Table 3: Financial Implications – Acute activity*

	17/18 activity	17/18 total costs	18/19 activity	18/19 total costs	19/20 activity	19/20 total costs
Abdominoplasty	-8	£16,478	-9	-£20,165	-13	-28,494
Body Contouring	0	0	-4	-£3,450	0	0
Breast Augmentation and Reconstruction	-11	£28,146	-11	-£27,753	-20	-£64,290

5.4. For breast reconstruction/augmentation, activity was included for any procedure undertaken without a cancer diagnosis within Stoke-on-Trent as this is the potential activity that would no longer be funded under the recommended proposal.

5.5. To note, there may be coding errors and cancer diagnoses not recorded therefore the activity reduction for breast augmentation and reconstruction is an indication only.

5.6. Table 4 below provides an outline of the financial implications for the hearing loss in adults proposal.

5.6.1. *Table 4: financial implications – hearing loss in adults*

	Feb 2021 – Jan 2022 activity	Feb 2021 – Jan 2022 costs
Hearing Loss	343	+£77,175

5.7. The cost impact identified for hearing loss is based on the number of patients who did not qualify for hearing aids following assessment during the period February 2021 - January 2022 within North Staffordshire (data received through provider reports).

5.8. No impact is identified within Stoke-on-Trent, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds as these areas currently commission hearing aids in line with the recommended proposal.

5.9. Table 5 below provides an outline of female sterilisations that are undertaken for contraceptive purposes.

5.9.1. Table 5: Female sterilisations activity

17/18 Activity	17/18 Total Costs	18/19 Activity	18/19 Total Costs	19/20 Activity	19/20 Total Costs
119	£132,318	159	£169,053	122	£136,442

5.10. The introduction of eligibility criteria for female sterilisations may reduce activity however the level of reduction cannot be quantified from the data that is available.

5.11. To note, there may be coding errors and diagnoses not recorded therefore the above is an indication only of current activity relating to female sterilisations undertaken for contraceptive purposes. This also does not provide an indication of whether these patients would meet the criteria within the recommended proposal.

5.12. Due to the publication of the Women's Health Strategy and the potential for further guidance on assisted conception services, the proposal is to develop an aligned commissioning policy within this area. The financial implications are currently unknown within this area but will be presented to the Board once the policy has been developed for approval.

5.13. As outlined above, the greatest impact is due to the removal of the commissioning policy within North Staffordshire which is not offset by any opportunity identified within the other clinical areas.

6. Recommendations

6.1. The ICB Board is asked to:

6.1.1. BE ASSURED that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including the requirement for involvement with relevant stakeholders.

- 6.1.2. CONSIDER the financial consequences and the risks relating to the recommendations
- 6.1.3. APPROVE the recommendation to decouple assisted conception from the wider policy alignment programme and develop an interim aligned assisted conception policy.
- 6.1.4. APPROVE the recommendations for the four other clinical areas.

7. Next Steps

- 7.1. Following approval of the recommendations by the ICB Board, the programme findings will be presented to the Staffordshire and Stoke-on-Trent Health and Care Overview and Scrutiny Committees to provide an update on the programme and seek advice on whether further additional involvement activity is required.
- 7.2. If no further involvement is required, the next steps for each clinical area is outlined in Table 6 below.

7.2.1. Table 6: Next steps by clinical area

Clinical Area	Indicative next steps
Assisted Conception	Develop an interim aligned commissioning policy. Timelines specific to this area is included in Appendix A, table A3
Hearing Loss in Adults	Removal of North Staffordshire hearing aid policy. Implementation following 1 month notice to providers.
Male and Female sterilisation	Eligibility criteria to be included within the ICB excluded and restricted procedures policy. Implementation following 1 month notice to providers.
Breast augmentation and Reconstruction	Eligibility criteria to be included within the ICB excluded and restricted procedures policy. Implementation following 1 month notice to providers.
Removal of excess skin following significant weight loss	Eligibility criteria to be included within the ICB excluded and restricted procedures policy. Implementation following 1 month notice to providers.

Appendix A: Assisted Conception

1. Rationale for review

- 1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to elective treatments/procedures depending on where they live. Table A1 below provides a high-level summary of the differences in policy.

1.1.1. Table A1: Differences in assisted conception services eligibility criteria

	North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Number of cycles	1 cycle consisting of 1 fresh embryo transfer only	1 Cycle and 1 fresh OR frozen embryo transfer	2 Cycles to include one fresh transfer and up to 3 frozen transfers per cycle
Age	Women aged 23-35 Male under 55	Women aged 23-39 No upper age limit for men	Women aged 23-39 No upper age limit for men
IUI	IUI Commissioned	IUI Not commissioned	IUI Not Commissioned
Investigations	Investigations not commissioned if patients do not meet eligibility criteria for IVF	No restrictions on investigations	No restrictions on investigations
Minimum ovarian reserve	No Criteria	It is proposed that a threshold of AMH >3 will be applied to all women 35 years or over for access to IVF treatment.	No Criteria
Donor Eggs	Not funded	Donor eggs commissioned if Premature ovarian failure, Gonadal dysgenesis including Turner syndrome, Bilateral oophorectomy, Ovarian failure following chemotherapy or radiotherapy	Not funded

1.2. Assisted conception was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

1.3. While the number of patients accessing assisted conception services is relatively low, we know that infertility is an area of considerable concern to the people affected. Table A2 below provides previous years activity.

1.3.1. Table A2: Assisted conception activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Activity (cycles)	216	169
Total cost	£875,952	£710,162

1.4. Assisted conception services are provided by specialist fertility providers with set fees per cycles which may include ovulation stimulation, egg retrieval, fertilisation and embryo transfer dependent on the individuals' clinical requirements.

1.5. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. Respondents raised concerns about the lack of access to treatment and the cost of self-funding.

2.2. The negative impact of infertility and unsuccessful treatment on patients' mental health, wellbeing and relationships were also highlighted.

2.3. Respondents tended to be in support of funding this service, but there were also suggestions to restrict the number of cycles (e.g. two or three) and who is eligible (e.g. prioritise those without children).

2.4. The Royal British Legion highlighted that Armed Forces couples' entitlement to three rounds of IVF should not be diminished.

3. Women's Health Strategy

3.1. Whilst developing the proposals for assisted conception services, the Women's Health Strategy was published which has indicated that a review of fertility provision across the UK will be undertaken

3.2. The strategy does not give an indication of whether ICBs will be expected to implement mandated access criteria however it is clear that the intention is to review geographic variation, address inequities of provision and remove any non-clinical

criteria that is currently in place (for example, that people must not have children from previous relationships)

- 3.3. The strategy does not provide an estimated timeline for any policy mandates however a review of current NICE guidance has been initiated with expected publication in 2024.
- 3.4. In light of the publication of the strategy, a meeting was convened to consider the impact of this on the proposals for assisted conception and whether this should be separated from the wider clinical policy alignment programme whilst awaiting further guidance.
- 3.5. The meeting was chaired by the Chief Medical Officer and included the following attendees:
 - 3.5.1. ICB Clinical Lead Partnerships and Engagement
 - 3.5.2. ICB Medical Director
 - 3.5.3. Head of Transformation
 - 3.5.4. Director of Communications and Corporate Services
 - 3.5.5. Director of Corporate Governance
 - 3.5.6. Senior IFR/Improvement Lead
 - 3.5.7. IFR/Commissioning Support Manager
- 3.6. The meeting agreed that the ICB could not continue with proposals to reduce to zero cycles of IVF at this time and assisted conception should be separated from the wider clinical policy alignment programme.
- 3.7. The meeting highlighted that assisted conception policies are currently not aligned and this would need to be addressed to ensure there is a single policy across the ICB whilst waiting for further guidance.
- 3.8. The meeting recognised that, due to the differences in current policies, an aligned policy would inevitably result in levelling down in some areas of provision and a levelling up in other areas of provision.

4. Recommended Proposal

- 4.1. Separate assisted conception from the wider clinical policy alignment programme and pause further work on proposals until further guidance is released.
- 4.2. Instruct the Chief Medical Officer to ensure that an interim aligned assisted conception policy is developed for implementation whilst the ICB awaits further directives following the national review of service provision.
- 4.3. Should the proposal to develop an aligned policy be approved, Table A3 below outlines the process that will be undertaken with indicative timescales.

4.3.1. Table A3: Assisted Conception policy alignment

Activity	Date
Clinical and technical working group(s) to review policy differences and recommend aligned criteria	September – October 2022
Draft aligned policy	October – November 2022
Complete quality and equality impact assessments	December 2022 – January 2023
Present aligned policy to F&P for approval	February 2023
Present aligned policy to ICB Board meeting for approval	February 2023
Present policy to Staffordshire and Stok-on-Trent HOSCs	March 2023
1 month notice of policy change to providers	April 2023
Policy implementation (if further public involvement is not required)	May 2023

4.4. To note, these are indicative timelines that may change if further public involvement is required.

Appendix B: Hearing Loss in Adults

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to this intervention depending on where they live. Table B1 below outlines the policy differences.

1.1.1. Table B1: Difference in hearing aid eligibility criteria.

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula, Stafford and Surrounds and Stoke-on-Trent
Not routinely funded for patients diagnosed with 'mild' hearing loss, unless the patient: <ul style="list-style-type: none">• is aged under 18 or has had hearing loss since childhood• has a confirmed diagnosis of dementia, a learning disability, an auditory processing disorder or a severe multiple sensory disability• has tinnitus• has sudden onset hearing loss• has multiple severe physical disabilities.	Commissioned for all patients with a hearing loss greater than 25 decibels (diagnosed through an audiogram or by an audiologist).

1.2. Hearing aids for mild hearing loss was reviewed by the former CCGs CPAG. This did not score below the threshold but in line with current commissioning margins in the policy, the recommendation was to commission with criteria. This means that if the ICB did not currently commission this, the implementation would include clinical eligibility criteria.

1.3. We know people have different communication needs and that their hearing loss may not affect them in the same way as it affects someone else

1.4. The NICE guidance is clear – communication difficulties should not be judged by measuring only hearing thresholds (such as an audiogram)

1.5. Around 1 in 6 adults in England have some form of hearing loss, and as the number of older people increases, demand for hearing aids is expected to rise. Table B2 below shows previous years activity.

1.5.1. Table B2: Hearing aid activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Activity (hearing aid fittings)	13,502	12,400
Total cost	£3,412,847	£3,621,722

1.6. Hearing aids services are provided by community and acute providers through any qualified provider contracts with set tariffs which may include initial assessment, fitting, six-week review, aftercare and annual review.

1.7. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. The key themes raised tended to be in support of funding hearing aids for all patients.

2.2. Respondents noted the importance of hearing aids in improving hearing, patients' social life, wellbeing and quality of life including the potential of untreated hearing loss resulting in adverse patient outcomes.

2.3. The need to improve follow-up care, such as access to batteries and checking patients are using their aids, was also highlighted.

2.4. Respondents also raised concerns over the lack of access to hearing aids.

3. Recommendations from the technical group

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to commission this intervention with eligibility criteria.

3.4. The group stated that assessing the benefit of hearing aids in individuals is difficult to predict via a functional impact assessment in order to determine eligibility and the most effective way to assess benefit is once hearing aids are fitted and patients are supported to use them.

3.5. In addition, the group noted that the recommended functional impact assessment (HHIE-s) is a subjective tool that may be applied inconsistently and create inequalities amongst those who may benefit from hearing aids.

- 3.6. Whilst the group recognised the recommendation from CPAG to implement eligibility criteria, the consensus of the group was that the points noted above were sufficient to remove the proposal to commission in line with the CPAG recommendation and allow assessment of benefit to be undertaken during patients 6-week review following initial assessment and fitting of hearing aid(s)
- 3.7. The recommended proposal from the technical group is to commission hearing aids with no eligibility criteria and remove the current restrictions within North Staffordshire.

4. Impact assessments

- 4.1. A quality impact assessment (QIA) has been completed for the recommended proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.
- 4.2. An Equality impact assessment has been completed for recommended proposal which was approved on 20 July 2022.
- 4.3. Both assessments noted that the proposal improves access for patients with mild hearing loss within North Staffordshire. The proposal would also remove current inequities in access and improve patient experience.
- 4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix C: Male and Female Sterilisation

1. *Rationale for review*

- 1.1. There are no restrictions currently in place for these procedures other than the requirement to only undertake male sterilisations (vasectomies) within an acute setting if there is a clear clinical indication for doing so.
- 1.2. Male and Female sterilisation for contraceptive purposes was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.
- 1.3. There are various forms of contraceptive available to patients, both surgical and non-surgical methods and it is estimated that in the UK 75% of women aged 16-49 use some form of contraceptive. Table C1 below provides previous years activity for sterilisation procedures.

1.3.1. Table C1: Male and Female sterilisation activity across Staffordshire and Stoke-on-Trent

	2018/19	2019/20
Female Sterilisation activity	370	354
Total Cost	£608,031	£693,433
Male sterilisation activity	1360	1309
Total cost	£294,976	£330,433

- 1.4. Female sterilisations are elective inpatient procedures undertaken by acute providers within block contracts. A small number of male sterilisations are undertaken in an acute setting but only where there is a clinical indication that means these cannot be undertaken within a community setting.
- 1.5. Male sterilisations are predominantly undertaken within a primary care or community setting with specialist clinicians through a service level agreement.
- 1.6. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. *Themes from involvement activities*

- 2.1. Respondents commented that these procedures should be available to anyone who wishes to be sterilised.
- 2.2. Respondents noted that not offering these procedures may have a financial impact on the NHS in the long-term e.g. maternity care and terminations.
- 2.3. Respondents also stated that there may be potential adverse impact of pregnancy on patients and this needs to be taken into consideration.

3. *Recommendations from the technical group*

- 3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.
- 3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.
- 3.3. The group considered the proposal to not commission these procedures for contraceptive purposes. As previously noted, sterilisations undertaken for medical purposes such as ectopic pregnancy were not within scope of discussions as this was outside of the CPAG review.
- 3.4. Under this proposal, patients are likely to access long-acting reversible contraceptives as an alternative. This will convert one off procedures into a requirement for ongoing and long-term GP appointments. This equates to an additional 5,661 appointments within year one and as the case load grows there is a potential for up to 34,846 appointments by year 5 resulting in a significant impact on Primary Care workforce and capacity.
- 3.5. It was also noted that as this removes a significant proportion of community vasectomy activity, providers may not be able to maintain their competency standards and this could lead to the cessation of these services.
- 3.6. In addition to the workforce impact the group also noted this proposal may create an inequity of choice for males who do not have an alternative choice of long-term contraception.
- 3.7. The group also discussed the proposal to introduce eligibility criteria for male and female sterilisations where patients may access these interventions if the female has an absolute contraindication to pregnancy or cannot tolerate other forms of long-acting reversible contraception.
- 3.8. The group recognised that whilst this proposal reduced the workforce impact when compared to the previous proposal, there may still be a large cohort of patients transferring to long-acting reversible contraceptives that impacts primary care capacity and potentially destabilises community-based vasectomy services.
- 3.9. The group also stated that this does not address the inequity impact and may create further inequities due to the proposal requiring patients to be in a relationship in order to access this intervention (i.e. vasectomies would only be undertaken if the patient's partner cannot tolerate alternative long-acting reversible contraceptives or has an absolute contraindication to pregnancy.)
- 3.10. Whilst the group recognised the recommendation from CPAG to implement eligibility criteria, the consensus of the group was that the points noted above were

sufficient to remove previous proposals from the shortlist and an alternative proposal was discussed.

- 3.11. The recommended proposal from the technical group is to apply eligibility criteria to female sterilisations only. This ensures females can access sterilisation where there is no viable alternative whilst ensuring patients are fully counselled on their alternatives prior to undergoing invasive surgery. This also minimises the workforce impact and ensures equity of choice for males.

4. Impact assessments

- 4.1. A quality impact assessment (QIA) has been completed for the recommended proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.
- 4.2. An Equality impact assessment has been completed for the recommended proposal which was approved on 20 July 2022.
- 4.3. Both assessments noted the significant reduction in workforce and equity impact within this proposal. It was recognised that this proposal ensures invasive female sterilisations are only undertaken following full exploration of alternative methods of contraception and consideration of the risks associated with invasive surgery.
- 4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix D: Breast augmentation and Reconstruction

1. Rationale for review

1.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to this intervention depending on where they live. Table D1 below outlines the policy differences.

1.1.1. Table D1: Difference in eligibility criteria for breast augmentation and reconstruction.

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Commissioned following mastectomy, post burns or asymmetry following prophylactic bilateral mastectomy for cancer prevention in high-risk cases.	Not routinely commissioned for small breasts, congenital absence of breast or breast asymmetry. This procedure will ONLY be routinely commissioned in the following circumstances: - As reconstructive surgery following mastectomy for either suspected or proven malignancy *Treatment of the unaffected breast following cancer surgery shall not be routinely commissioned	Will be routinely funded under the following circumstances: - Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry (congenital amastia) OR - Significant degree of asymmetry of breast shape and/or volume at least a difference of 2 cup sizes as a result of: Previous mastectomy or excision breast surgery for cancer/lumpectomy or following prophylactic bilateral mastectomy for cancer prevention in high risk cases OR Trauma to the breast – post burns. Breast asymmetry, endocrine abnormalities, developmental asymmetry The following criteria must be met for surgery to be routinely funded:

		- Patient must have a BMI within the range of 18kg/m2 to 25kg/m2 AND - Minimum age for surgery is 18 of age and evidence that pubertal growth of breasts has ceased
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1.2. Breast Reconstruction and Augmentation for cancer and non-cancer indications was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

1.3. Although the number of people affected by a potential change in policy is relatively low, we know that this is an area of considerable concern to those people who are affected by it.

1.4. Breast cancer is diagnosed in approximately 55,000 patients in the UK every year. The incidence of breast cancer in western Europe is 89.7 per 100,000 women. Table D2 below provides previous years activity

1.4.1. Table D2: Breast reconstruction and augmentation activity across Staffordshire and Stoke-on-Trent

	2017/18	2018/19	2019/20
Activity	171	173	158
Total cost	£518,734	£540,674	£516,020

1.5. Within Stoke-on-Trent it is estimated that on average across the 3 years, 14 of the 30 procedures undertaken were for non- cancer indications.

1.6. Breast Augmentations and Reconstructions are elective inpatient procedures undertaken by acute providers within block contracts.

1.7. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity.

2. Themes from involvement activities

2.1. Service users highlighted the impact of the procedure on reducing discomfort and improving quality of life.

2.2. Key themes raised were that reconstructive surgery should be available for breast cancer or breast surgery patients. However, respondents were clear that the procedure should not be funded for cosmetic reasons.

2.3. The impact of this procedure on patient wellbeing, quality of life and relationships was also highlighted.

3. *Recommendations from the technical group*

3.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.

3.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.

3.3. The group considered the proposal to not routinely commission this intervention for any indication.

3.4. The group stated that this would have a significant impact on cancer patients as this proposal removes access to all post mastectomy breast reconstructions and could be seen as a disruption to the cancer pathway.

3.5. The group also stated that removing post cancer breast reconstructions would create inequity as other post cancer prosthetics are commissioned e.g. testicular prosthesis.

3.6. Non cancer indications for breast augmentation such as congenital absence of breast and significant asymmetry was discussed as these procedures are currently offered within Stoke-on-Trent.

3.7. Whilst the group recognised the potential mental health impact for those affected if this access is removed, it was noted that Stoke-on-Trent is currently an outlier with this criterion and no adverse impacts have been noted within the other geographical areas who currently do not offer breast reconstruction and augmentation for non-cancer indications.

3.8. Within North Staffordshire and Stoke-on-Trent breast reconstruction is offered post burns but not for other types of trauma. The group agreed that it was inequitable to offer treatment for one type of trauma and not others but there was insufficient evidence to consider expanding the criteria to all types of traumas. The group did however note that in the case of significant trauma, this would be addressed within an emergency setting immediately following the trauma. The group also noted that no adverse impacts have been identified within the south of the country where this procedure is not offered post-burns.

3.9. Whilst the group recognised the recommendation from CPAG to not commission the procedures for any indication the consensus of the group was that the points noted

above were sufficient to commission the intervention for cancer related indications but remove proposals relating to non-cancer indications.

- 3.10. The recommended proposal from the technical group is to commission breast reconstruction/augmentation following mastectomy following mastectomies carried out due to suspected or proven cancer OR following double mastectomies for cancer prevention in high-risk cases

4. Impact assessments

- 4.1. A quality impact assessment (QIA) has been completed for the recommended proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.
- 4.2. An Equality impact assessment has been completed for recommended proposal which was approved on 20 July 2022.
- 4.3. Both assessments noted the potential mental health impact on patients who were not able to access this procedure however it was recognised that there are mental health services in place to support these patients. Emphasis was placed on the importance of good communication when amending policy to confirm what is commissioned and ensure patient expectations are not raised during their clinical pathway. It was also noted signposting to relevant support services is essential where adverse impacts on mental health are identified.
- 4.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments

Appendix E: Removal of excess skin following significant weight loss

5. Rationale for review

5.1. There are different policies in place across Staffordshire and Stoke-on-Trent meaning patients have varying access to these procedures depending on where they live. Tables E1 and E2 below outlines the policy differences.

5.1.1. Table E1: Difference in eligibility criteria for abdominoplasty/apronectomy procedures

North Staffordshire	Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Not routinely commissioned	<p>This procedure will ONLY be routinely commissioned in the following circumstances:</p> <ul style="list-style-type: none"> - Weight loss of at least 10 points on BMI AND - An abdominoplasty /apronectomy has not already been performed AND - Presence of a large abdominal fold hanging below the level of the mons pubis AND - Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment with anti-fungal and other topical skin products for a minimum period of one year or disability resulting in severe restrictions in activities of daily living AND - The patients current BMI must be between 18kg/m² and 25kg/m² AND - The patients weight must have been stable and within this range for a minimum of 1 year as measured and formally recorded by an NHS service 	<p>Will be considered providing that ALL of the following criteria are met:</p> <ul style="list-style-type: none"> - Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment for a minimum period of one year or disability resulting in severe restrictions in activities of daily living AND - The patients BMI before weight loss must have been no less than 40kg/m² AND - The patients current BMI must be between 18kg/m² and 25kg/m² and has been within this range for a minimum of 1 year as measured and recorded by the NHS. If this is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.

	<p>OR</p> <p>- If this weight range is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and significant functional disturbance is also evident and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.</p>	<p>AND</p> <p>- The patient's weight must have been stable and within this range for a minimum of 1 year as measured and recorded by the NHS AND</p> <p>- An abdominoplasty/apronectomy has not already been performed</p>
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5.1.2. Table E2: Difference in eligibility criteria for body contouring procedures

North Staffordshire, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds	Stoke-on-Trent
Not routine commissioned	Will be commissioned where the criteria for abdominoplasty/apronectomy is met

5.2. Procedures to remove excess skin was reviewed by the former CCGs CPAG where it scored below the threshold for commissioning. This means that if the ICB did not currently commission this, it would not be recommended for investment.

5.3. While the number of patients receiving these surgeries is relatively low, obesity rates are rising, so demand for treatments like these is expected to rise. Table E3 below provides previous years activity.

5.3.1. Table E3: Excess skin removal activity across Staffordshire and Stoke-on-Trent

	2017/18	2018/19	2019/20
Activity	8	13	13
Total cost	£16,478	£23,615	£28,494

5.4. Surgeries to remove excess skin are elective inpatient procedures undertaken by acute providers within block contracts.

5.5. Total activity and spend for 2018/19 and 2019/20 is included in the table above. Data for 2020/21 and 2021/22 has been excluded for evaluation purposes as COVID-19 led to restrictions in appointments that artificially suppressed activity

6. Themes from involvement activities

- 6.1. There were mixed views on whether the removal of excess skin should be funded. Respondents stated that the excess skin does impact on patients' health and wellbeing such as sores, itching and may impact on patients' mental health.
- 6.2. Respondents commented that removal of excess skin should be funded to support patients who have made significant lifestyle changes.
- 6.3. Respondents also stated that restricting access to this procedure may discourage patients from losing weight. This, along with adverse impact in patients from not funding the treatment, may cost the NHS in the long-term.

7. Recommendations from the technical group

- 7.1. A technical event was held on 17 May 2022 to share the feedback from the deliberative events and provide an update on any quality and equality impacts identified.
- 7.2. The group were asked to review the proposals in light of the information presented and provide input on whether any of the proposals may need amending or removing from the short-list.
- 7.3. The group considered the proposal to not routinely commission these interventions.
- 7.4. Whilst the group recognised the potential mental health impact for those affected if this access is removed, patients would continue to access commissioned mental health services as required.
- 7.5. For some patients, there can be a functional impact of the excess skin, for example sores, rashes and potentially infections however the group noted conservative management would continue to be offered to support patients to manage their symptoms.
- 7.6. The group also noted that activity is minimal and no adverse impacts have been identified in areas where these procedures are not currently commissioned.
- 7.7. Following discussions the group agreed there was sufficient evidence to adopt the CPAG recommendation and remove proposals to commission these interventions.
- 7.8. The recommended proposal from the technical group is to not routinely commission abdominoplasty/apronectomy and body contouring procedures.

8. Impact assessments

- 8.1. A quality impact assessment (QIA) has been completed for the recommended proposal. The assessment was presented to the QIA panel on 29 June 2022 and approved.

- 8.2. Equality impact assessments have been completed for the recommended proposals for both abdominoplasty/apronectomy and body contouring procedures and these were approved on 01 August 2022.
- 8.3. Both assessments noted the potential mental health impact on patients who were not able to access this procedure however it was recognised that there are mental health services in place to support these patients. Emphasis was placed on the importance of good communication when amending policy to confirm what is commissioned and ensure patient expectations are not raised during their clinical pathway. It was also noted signposting to relevant support services is essential where adverse impacts on mental health are identified.
- 8.4. No material workforce impact was highlighted during the options appraisal process or within either the quality or equality impact assessments



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	08
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Title:	Chair and Chief Executive Officer Report
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Prem Singh, ICB Chair and Peter Axon, ICB Interim Chief Executive Officer	Y	Imogen Crouch-Hyde Communications and Engagement Manager, MLCSU

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

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

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

Purpose of the Paper (Key Points + Executive Summary):
<p>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.</p> <p>Specifically, the paper details a high-level summary of the following areas:</p> <ol style="list-style-type: none"> 1. System & General Update 2. Finance 3. Planning and performance 4. ICP strategy update 5. Quality and safety 6. Urgent and Emergency Care demand 7. Transformation

Is there a potential/actual Conflict of Interest?	N
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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):
This report covers a range of risks on the Risk Register.

Implications:	
Legal and/or Risk	The report outlines key updates from the Chair and CEO.
CQC/Regulator	N/A
Patient Safety	The report sets out pressures relating to maternity services and quality which will be detailed in the Quality report.
Financial – if yes, they have been assured by the CFO	The report provides a headline summary of finance, further detail will be in the finance report.
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? 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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> • 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.	<p><i>Please provide detail as to these considerations:</i></p> <ul style="list-style-type: none"> • 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 <i>Please provide detail</i>	N	
5.	Has a Data Privacy Impact Assessment been completed? <i>Please provide detail</i>		
Recommendations / Action Required:			
The Integrated Care Board is asked to: <ul style="list-style-type: none"> • Note the updates in the report. 			

Introduction

We are deeply saddened by the passing of Her Majesty, Queen Elizabeth II. On behalf of the NHS Staffordshire and Stoke-on-Trent Integrated Care Board and the wider system, we express our deepest condolences and our thoughts are with the Royal Family at this very sad time.

1.0 System & General Update

1.1 National Priorities

Following last week's announcement that Liz Truss has succeeded Boris Johnson as Prime Minister and announced the appointment of the new Cabinet, the new Secretary of State for Health and Social Care, Therese Coffey, laid out the four priorities for the NHS that the government see as being key over coming weeks and months. These being ambulance waiting times, backlogs, care and Primary Care services (including dental services).

Our work in all four areas is described in this update and also throughout the documentation presented within the Board pack. Our emerging 7 Delivery Portfolios clearly align with these four ambitions and we will ensure that through their development, we will focus on delivery of each priority.

1.2 System Progress

Our Quarterly System Review meeting with regional NHSE colleagues took place on 8 September. A number of positive steps were discussed including but not limited to progress with our system operating model, the work done to develop our prevention portfolio and the substantial efforts made to reduce elective waiting lists. Challenges relating to our People Agenda were noted as were the difficulties that were being faced within certain diagnostics services. These challenges all present with the backdrop of winter being just around the corner and the likely difficulties that this will bring to all parts of the NHS and Social Care. We describe later in this paper the work that is taking place to prepare us for the winter period.

1.3 Constitution Update

As Board members will be aware, we recently embarked on a process of consulting on changes to the Board Constitution. Stakeholders have been asked their views on the proposed amendments. The ICB formally agreed these changes to the Board composition at the private Board meeting held in August, with agreement that the views and progress would be brought to the open Board session in September.

The ICB recently formally wrote out to all key stakeholders on the proposed changes, these included Staffordshire and Stoke-on-Trent Local Authorities, University Hospital of North Staffordshire, North Staffordshire Combined Health Care Trust, Midlands Partnership Foundation Trust, along with VAST and Support Staffordshire.

There was broad support for the proposed changes however, there were some views regarding the increase of NHS representation on the Board and that the change was being sought so early on in the Board establishment which was felt unnecessary.

Our approach to seeking the view on our proposed changes with the public and patients was via an online survey with our patient panel and via our engagement and involvement team.

The results again were largely supportive of the changes, with views expressing:

- This would be brilliant, it brings more expertise to the panel, which can only be a positive move
- It seems that it can only be beneficial to have representatives from a wider range of services
- Anything that will improve communication and deliver better services overall is the way forward
- The proposed change should broaden the depth of experience available to the Board.

The main basis of the concerns was around the size of the Board and the cost of the additional members:

- The bigger the committee the more time is wasted, and nothing gets done
- Full disclosure of conflicts of interest is required
- Are the additional people new salaried positions that will require extra funding?

Therefore, given the broad support received for the proposed changes, and noting the consensus reached in the August Board meeting, our formal application and the amended Constitution will shortly be forwarded to NHS England for them to consider.

In line with NHS England's published timetable the ICB should be informed of the outcome within four weeks of the application, and we will update the Board in due course.

1.4 Bank Holiday Operations

ICS wide Health Services on the 19 September will, wherever possible, operate in line with normal Bank Holiday operating arrangements. To ensure that the burden on emergency services is minimised, we would ask that where appropriate the public utilise out of hospital urgent care services such as NHS 111.

1.5 Foster Friendly Network

Along with other ICSs and SSOT NHS organisations, the ICB is signing up to be part of the Foster Friendly Network and become a Foster Friendly employer with a dedicated employer policy. This supports the recent work that Stoke-on-Trent City Council have been undertaking with all the major employers in the area and it's a brilliant way to support foster carer employees and benefit local children in need of foster families.

The Foster Friendly Policies are very similar in content and are being ratified through internal processes. For the ICB, I am pleased to say that the Executive Team have ratified the policy and it was shared with the Staff Engagement Group on 8 September; we are now seeking ratification through the national Foster Friendly Network process. The final policy will be available to all staff and uploaded to IAN in due course.

<https://www.thefosteringnetwork.org.uk/get-involved/championing-fostering/fostering-friendly>

2.0 Finance

In total, across the NHS and Upper Tier Local Authorities, we spend £3.5bn on health and social care for our 1.2 million residents with £3.0bn spent on health services. We have a strong collaborative working relationship across all system partners, speaking with one voice and viewed as a model system. We have a balanced plan for 2022/23. The system has a number of challenges to address with an underlying deficit of £135m, we're jointly signed up to tackle this by transformation and in turn treat all our patients, at the right time, in the right setting.

3.0 Planning and performance

Following submission of the 2022/23 Staffordshire and Stoke-on-Trent Operating Plan, the system has continued to monitor activity versus plan performance. Meeting the national ambitions and delivery of the plan continues to be challenging due to a number of system pressures linked to workforce, demand and acuity. The system is focused on ensuring disruptions to the Elective Care Recovery Plan are kept to a minimum as we work through the system pressures and actions within the Urgent and Elective Care Programme.

In 2022/23 Integrated Care Partnerships (ICPs) will develop their first Integrated Care Strategy and the ICB and its partner Trusts/FTs will develop the first 5 Year Joint Forward Plan (JFP), both of which will build on the system's priorities. The draft Joint Forward Planning Guidance was published on 23 August 2022 and work is underway to develop the delivery approach.

The first Portfolio Deep Dive Report was presented in August focussing on Primary Care and the schedule for the next 12 months of reporting has been finalised. It is intended that the ICB will receive a rolling programme of Portfolio Deep Dives from later this year.

4.0 ICP Strategy Update

At the first meeting of the Integrated Care Partnership on Wednesday 17 August 2022 it was noted that Dr Paul Edmondson-Jones, ICB Chief Medical Officer, will co-ordinate the ICP Strategy working with the Directors of Public Health/Strategy/Social Care and other partners. The Strategy will need to address the core purposes of the ICS, build on existing priorities for the ICS and set out the vision for the next 5 years. There will need to be full engagement with the Health and Wellbeing Boards as well as all the ICS partners and wider stakeholders. Work started in early September 2022 and an update will be provided to the November ICP meeting so that we can submit a suitable draft Strategy to NHSE by December 2022. The final strategy will be signed off in March 2023. The ICP strategy will include an Outcomes Framework that aims to explain what success looks like and how this will improve the health and wellbeing of staff and residents.

5.0 Quality and Safety

A more detailed report from the Quality and Safety Committee is presented further in the agenda. Key highlights include:

5.1 The Woodhouse Hospital (Elysium Healthcare)

Due to the challenges of managing a service which had made clear its intention to reconfigure but gave no specific date, the decision was made to write to Elysium Healthcare Board to request a date when their service will cease to provide care for the remaining patients, allowing the company to reconfigure and move forward. Elysium's response recognised the ICB's concerns about patient safety and advised that they have written to every placing commissioner independently serving notice, meaning all parties now can manage and work to expected discharge dates. They have agreed that all patients will move by 19 September 2022 and due to the complexities of 5 patients, there will be an extension to 9 November 2022 for these patients only.

5.2 Maternity

In August 2022 the Board was informed of pressures with delays in induction of labour at UHNM as well as regionally and nationally. Following the local response, NHSE have asked the

Staffordshire and Stoke-on-Trent ICB Chief Nursing and Therapies Officer to lead a piece of work and to chair the Midlands Regional System Leader Escalation and Maternity Opel Project Steering Group which covers 11 ICSs. There has been successful system working in Cheshire and Merseyside ICS, who presented to the group on 2 September 2022. However, it is recognised their providers are within one ICB, whereas the Midlands providers are not, creating further challenges. There has been good representation from across the Midlands to the meetings, demonstrating their commitment to being solution focused. This work will continue until the project findings are implemented across the region.

5.3 Quality and Safety Committee

There has been two workshops held to consider the final implementation of the National Quality Board Guidance to ensure we have both an ICB Quality and Safety Committee (QSC) and a System Quality Group (SQG). Other items discussed were Place Quality Arrangements and the system Quality Impact Assessment (QIA) arrangements going forward.

5.4 Quality Impact Assessment (QIA)

A paper was presented to Quality and Safety Committee providing an overview of the QIA work to date and proposed next steps. The interim arrangements have been agreed whereby the Quality Committee Non-Executive Director, the Chief Nursing and Therapies Officer and Chief Medical Officer will review quality impact assessments and this approach will continue monthly until December 2022. A workshop is planned for October 2022 to progress the development of the final ICB QIA policy and procedures.

5.5 Patient Safety Specialists

Preparation for a workshop for all providers to launch a pilot Harm Review process, which is consistent across the system is underway based upon the MPFT pilot earlier in the year. The workshop will involve patient safety specialists and relevant clinicians from the three large NHS providers.

5.6 Patient Safety Incident Response Framework (PSIRF)

PSIRF is replacing the current Serious Incident (SI) framework and is due to be implemented by September 2023. Guidance documents and templates were released in August 2022 and are currently being reviewed by the ICB quality team prior to implementation.

6.0 Urgent and emergency care demand

6.1 111

Call volumes for NHS 111 continue to be above the pre-pandemic level. Given the sustained increase, there has been a pressure on call volumes particularly with call abandonment rate. This has seen significant improvement in-year with July showing Staffordshire to have one of the lowest call abandonment rates nationally. Our local contract has built in an increase of call handlers in anticipation of the call volumes not decreasing to pre-pandemic levels.

6.2 Ambulance activity

Royal Stoke

Royal Stoke has been identified as one of ten sites nationally to have National direction for ambulance handover delays.

Reducing handover delays were reported through the end of July and into August. This reduction was abruptly halted by 11 days of extreme pressure on the system beginning in the 2nd week of the month. Reduction schemes were put in place and resultant waits reduced through the remainder of the month. August saw a reduction of 35% on July handover delays at Royal Stoke through approx. 5% more conveyances. County Hospital recorded a 3% decrease in handover delays arising from an increase in arrivals of over 11%.

Category 2 Response Waits rose through the opening weeks of August reaching a high point on the 15th of the month before drastically reducing throughout the remainder of the month. The average response time for July category 2s was 2hr 1min across the West Midlands region, significantly higher than the 18min target.

Category 3 Response Waits having reduced through the end of July into August increased in line with those for Category 2 during the middle of the month before reducing in the 2nd half of the month.

As part of a national programme to improve performance in this area, we are working with nine other systems / providers to define key actions that will improve ambulance hand over delays during and beyond October. Next month the Board will receive an update regarding this work.

6.3 ED activity

UHNM

Reductions in Average Time to Initial Assessment at Royal Stoke through August saw it repeatedly achieve compliance with the 15 minute threshold. Changes to pathway management through the 2nd half of August led to significant reductions in the Average Time in Department for both those waiting to be admitted and those awaiting discharge.

Burton

Burton Hospital routinely reported Average Time to Initial Assessment below the 15 minute threshold throughout August and into September. Average Time in Department for both those waiting to be admitted and those awaiting discharge were within tolerance of the thresholds, and occasionally were reported as below.

6.4 Bed Occupancy

Royal Stoke

Bed Occupancy stabilised at a high level through the beginning of August. However, it has begun to fluctuate through the second half of the month and into September. It remains consistently above the target occupancy rate of 92%.

County

Bed occupancy at County Hospital continued to see periods of full occupancy through the beginning of the month, however, a significant reduction took place at the beginning of the second half of the month.

Burton

Bed occupancy has continued to remain high throughout August with a few days of respite through the third week of the month. Provisional figures for September show continuing periods of high occupancy with little expectation of change.

6.5 Medically Fit For Discharge (MFFD)

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Having risen through July the number of MFFD patients at Royal Stoke reduced during the first week of August before returning to an upward trend through the second week. Numbers began reducing after the mid-point of the month and continued the downward movement through the remainder of the month and into September. County Hospital reported numbers within their normal range through August and into September.

7.0 Transformation

Transformation update for Inpatient Mental Health Services in South East Staffordshire formerly provided at the George Bryan Centre: The programme to identify the long-term solution for the inpatient mental health services previously provided by the George Bryan Centre is progressing following the last ICB Board meeting. The NHSE Assurance process has begun, and we are waiting for the imminent publication of the West Midlands Clinical Senate report. We anticipate a further update will be given to the ICB Board in late autumn, which will help inform a decision whether further involvement activity is needed. We will continue to keep people informed as we progress through this programme of work.

Summary of recommendations and actions from this report

ICB Board members are asked to note these updates.

Prem Singh, ICS and ICB Chair designate

Peter Axon, Interim ICS and ICB Chief Executive Officer



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

Enclosure:	09			
Title:	Delegation of Services from NHS England to ICB Boards			
Meeting Date:	22 nd September 2022			
Executive Lead(s):	Exec Sign-Off Y/N	Author(s):		
Peter Axon, Interim Chief Executive Officer	Y	Paul Maubach c/o NHS England Paul Winter c/o SSOT ICB		
Clinical Reviewer:	Clinical Sign-off Required Y/N			
n/a	No			
Action Required (select):				
Ratification-R	Approval -A	Discussion - D <input checked="" type="checkbox"/>	Assurance - S	Information-I
History of the paper – where has this paper been presented				
	Date	A/D/S/I		
Initial Stocktake Paper presented to August ICB Board	Aug-22	D		
Purpose of the Paper (Key Points + Executive Summary):				
<p>The attached Discussion Paper sets out 1 the proposals for the initial joint committee arrangements between the six West Midlands ICBs; who will take on the delegation of all Primary Care and some Specialised Services from NHSE from April 2023.</p> <p>There are a number of areas where it will either be beneficial, or necessary, for the six ICBs to collaborate and make joint decisions. It is the intention for this committee to provide this mechanism.</p> <p>The proposal is to enable the six ICBs to put in place an initial arrangement with immediate effect. At the inception of the ICBs, but anticipated that these arrangements will develop and be reviewed / revised by ICBs together over time as circumstances and opportunities evolve.</p> <p>The proposed Terms of Reference (TOR) for the Committee is included as annex one to the attached Discussion Paper. A proposed initial Commissioning Framework against which the committee will operate and delegated activities will be conducted, is enclosed as annex two.</p>				
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):
No ICB or System Risks currently identified, as the proposed working arrangement is still draft and supporting processes are currently in development across the Region. However should any risks or issues be identified as part of wider NHSE-ICB “Task & Finish Groups”, these will be added as required onto the Corporate Risk Register.

Implications:	
Legal and/or Risk	Delegation from NHSE is guided by the Health & Care Act 2022
CQC/Regulator	n/a
Patient Safety	n/a
Financial – if yes, they have been assured by the CFO	Financial Issues are being managed via an NHSE-ICB Finance Workstream as part of the development / establishment process
Sustainability	n/a
Workforce / Training	Workforce requirements are being managed via an NHSE-ICB HR Workstream as part of the development / establishment process

Key Requirements:			
1a.	<p><i>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?</i></p> <p>Because the pan-Region Joint Commissioning arrangements are envisaged as effective from April 2023, ensuring that the statutory accountabilities and duties of both NHSE as delegator and ICBs as delegates will continue to be progressed in the coming months to ensure we meet this duty prior to any April 2023 Joint Committee establishment.</p>		
1b.	<p><i>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)</i></p> <p>The safe transfer of delegated activities from NHSE to ICBs will be covered off by the eventual NHSE to ICB and ICB to Joint Committee Delegation Agreements.</p>		
		Y/N	Date
2a.	Has a Quality Impact Assessment been presented to the System QIA Sub-group?	NO	
2b.	What was the outcome from the System QIA Panel? (Approved / Approved with Conditions / Rejected)		
2c.	<p>Were there any conditions? If yes, please state details and the actions in taken in response:</p> <p>Condition 1 & action taken.</p> <p>Condition 2 & action taken.</p>		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s): Stage 1 / Stage 2	NO	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?		

3c.	<p><i>Please provide detail as to these considerations:</i></p> <p>Which if any of the nine Protected Groups were targeted for engagement and feedback to the ICB, and why those?</p> <p>Summarise any disaggregated feedback from local Protected Group reps about any negative impacts arising / recommendations (e.g. service improvements)</p> <p>What mitigation / re-shaping of services resulted for people from local Protected Groups (along the lines of 'You Said: We Listened, We Did'?)</p> <p>Explain any 'objective justification' considerations, if applicable</p>		
4.	<p>Has Engagement activity taken place with Stakeholders / Communities / Public and Patients</p> <p><i>Please provide detail</i></p>	n/a	n/a
5.	<p>Has a Data Privacy Impact Assessment been completed?</p> <p><i>Please provide detail</i></p>	n/a	n/a
Recommendations / Action Required:			
<p>The Integrated Care Board is asked to:</p> <p>(1) Approve the TOR and to confirm the expectation that the TOR will be reviewed as delegation arrangements progress through into 2023/24;</p> <p>(2) To note the commissioning framework and to confirm (as part of the TOR for the committee) that it is for the committee to determine the most appropriate arrangements for each activity and/or function</p>			

Paper Title:
ICB Joint Committee Arrangements

1. Purpose:

- 1.1 This paper sets out the proposals for the initial joint committee arrangements between the six West Midlands ICBs.
- 1.2 There are a number of areas where it will either be beneficial, or necessary, for the six ICBs to collaborate and make joint decisions. It is the intention for this committee to provide this mechanism.
- 1.3 This proposal is to enable the six ICBs to put in place an initial arrangement with immediate effect, at the inception of the ICBs but it is anticipated that these arrangements will develop and be reviewed and revised by the ICBs together over time as circumstances and opportunities evolve.
- 1.4 The proposed Terms of Reference for the Committee is included as annex one.
- 1.5 The proposed initial commissioning framework against which the committee will operate and delegated activities will be conducted, is enclosed as annex two.

2. Key Principles for joint working:

- 2.1 The ICBs start from a shared principle of subsidiarity – so that joint arrangements will only be put in place where there is a clear demonstration of the added value that is being derived from the joint arrangement.
- 2.2 Consequently, the ICBs will expect to undertake a SWOT analysis comparing the pros and cons of undertaking functions on a West Midlands basis vs retaining those functions within their respective ICBs as a prerequisite.
- 2.3 The joint arrangements will be expected to support the delivery of the NHS constitution, the triple aim, as well as the four purposes of the ICBs, namely:
 - 2.3.1 improving health outcomes;
 - 2.3.2 improving health inequalities;
 - 2.3.3 improving clinical effectiveness and/or value for money;
 - 2.3.4 supporting the wider economic impact of the ICBs.
- 2.4 Any joint functions overseen by the joint committee will be organised in such a way that it both:
 - 2.4.1 enables the delivery of expert capabilities at scale which would otherwise not be possible for the ICBs individually to undertake individually;

- 2.4.2 operates efficiently and effectively;
- 2.4.3 uses the best possible available (clinically led) intelligence to inform decision-making;
- 2.4.4 Is mindful of the ICBs public accountabilities and public opinion;
- 2.4.5 has clear governance and lines of accountability back to the ICBs (and to NHSEI for delegated functions).

3. Potential areas of joint working:

- 3.1.1 The ICBs will be expected to take on the delegation of all primary care from NHSEI from April 2023. So there needs to be a mechanism for joint decision-making on both any areas of these services where the ICBs may decide to commissioning jointly; but also particularly in the coordination and oversight of any joint functions that are needed to discharge the ICBs' responsibilities in these areas. The delegation agreement between NHSEI and the ICBs specifically states that: *'The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies...'* and that *'The ICB must develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions.'*
- 3.2 The ICBs will also be expected to take on the delegation of some specialised services (likely from April 2023). So similarly there needs to be a mechanism in place both for the joint commissioning, and in the joint oversight, of shared support functions to enable the commissioning of these services.
- 3.3 The ICBs therefore need a shared mechanism in place in order to coordinate the joint preparation for these delegation arrangements.
- 3.4 The ICBs' are inheriting from their predecessor CCGs existing joint commissioning arrangements for 111/999 services which can therefore be incorporated into this new arrangement.
- 3.5 There are pre-existing cross-ICS collaborative arrangements in place which would most likely benefit from being repositioned to be aligned to this new joint ICB collaboration. So that there are clear lines of responsibility and accountability for such arrangements and to provide a clear mechanism for them to be reviewed (eg: joint clinical networks and alliances).
- 3.6 The ICB CEOs have begun to identify in joint discussions some areas which may benefit from shared collaborative efforts in the future and so a joint committee arrangement has the potential to provide any joint future oversight of such work. The areas that have been identified (in addition to primary care and specialised services delegation) are as follows:
 - 3.6.1 Liaison with the West Midlands Combined Authority;
 - 3.6.2 Review of future CSU arrangements / contract renewal / efficiency opportunities;

- 3.6.3 Shared arrangements for building intelligence capabilities and analysis – maximising the benefits of the existing Decision Support Network, working with East Midlands ICBs
 - 3.6.4 Mutual aid on elective and cancer recovery and waiting lists, collaboration between systems;
 - 3.6.5 Urgent and Emergency Care: looking at the interface with 111/999 arrangements, ambulance handover delays and the strategy on where people go/ conveyancing/ capacity distribution;
 - 3.6.6 Provider productivity and provider collaboration arrangements – sharing intelligence, capabilities and oversight;
 - 3.6.7 Workforce strategy: engagement on the HEE changes and new ways of working, standardising approaches across ICBs where appropriate;
 - 3.6.8 Overall oversight of creating a new relationship with NHSEI on performance functions, transfer of functions, NHSEI/ICS collaboration.
- 3.7 There may also be opportunities in the future to receive NHSEI support / capacity / or bid proposals; or to work in partnership with other agencies (such as the West Midlands Combined Authority); which would require the ICBs to have collaborative arrangements in place (and which otherwise either would not be possible or available at an individual ICB level). This joint committee can therefore provide the mechanism for coordinating any such joint arrangements where this is mutually beneficial to the ICBs.
- 3.8 Most of these activities are areas which are either work-in-progress or which require further work to be done to clarify both existing and potential best-fit future arrangements. A joint committee will provide the mechanism to enable the ICBs to both oversee, set objectives for, and review this work together.

4. Terms of reference

- 4.1 Annex one sets out the proposed initial terms of reference for the joint committee.
- 4.2 The Joint Committee is a joint committee of the six ICBs (not of the six ICSs) and is therefore equally accountable to the six ICB Boards. As such the committee will report all decisions, actions and progress to the six ICBs.
- 4.3 The TOR of the joint committee is intended to be delegation-light at this stage, setting a direction of intent that can be built upon over time and as the new delegation requirements from NHSEI develop. Therefore, it should be noted that the TOR will need to be updated and reviewed on a regular basis initially – particularly once NHSEI have confirmed precisely how they expected the delegation of their services to be conducted and which services might be delegated.
- 4.4 The committee is intended to be an executive committee. However joint meetings will be held with ICB chairs when appropriate (potentially 3 times

per year) to review strategic priorities and overall development of the ICB collaboration agenda.

- 4.5 Further consideration will also need to be given as to how this joint committee engages with and/or incorporates involvement of NHSEI (from a commissioning and development capacity) and other partners.

5. Commissioning Framework

- 5.1 There are a number of ways in which the activities that are overseen by the joint committee can be conducted. Annex two sets out the possible options and how governance and accountability arrangements would work in each instance.
- 5.2 It is proposed that whilst the ICB will determine the activities and functions that are delegated to the joint committee; it should be for the joint committee to determine the most appropriate arrangements for each activities/function.
- 5.3 It is also important to be clear that, by virtue of this being a joint committee, all of the ICBs will need to agree the same delegation of functions and services

6. ICB Decisions

- 6.1 The ICB is asked to **approve** the TOR and **to confirm** the expectation that the TOR will be reviewed as delegation arrangements progress through into 2023/24.
- 6.2 The ICB is asked to note the commissioning framework and to confirm (as part of the TOR for the committee) that it is for the committee to determine the most appropriate arrangements for each activity and/or function.

Annex one

West Midlands ICBs Joint Committee Terms of Reference

1. Joint Signatories:

1.1 This is the terms of reference for the Joint Committee between:

- Birmingham and Solihull ICB
- Coventry and Warwickshire ICB
- Herefordshire and Worcestershire ICB
- Staffordshire and Stoke-on-Trent ICB
- Shropshire, Telford and Wrekin ICB
- The Black Country ICB

1.2 Consequently the joint committee has responsibility for the functions delegated to it from the six ICBs covering the population of the six ICBs.

2. Delegated functions and activities:

The joint committee has delegated authority from the ICB for the following:

1.1 Preparation for the future joint collaborative arrangements with the other ICBs to support the delegation from NHSEI of primary care commissioning in accordance with section 13V and/or section 65Z6 of the NHS Act. This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and subsequently approved by the ICBs.

1.2 Preparation for the future joint collaborative arrangements to enable the delegation from NHSEI of specialised services commissioning (also in accordance with section 13V and/or section 65Z6 of the NHS Act). This is with the expectation that the committee subsequently provides the joint governance oversight for such arrangements once they have been determined and subsequently approved by the ICBs, recognising that there will also still be an accountability for these arrangements back to NHSEI.

1.3 Oversight and co-ordination of the commissioning arrangements for the six ICBs in respect of 111 and 999 services and any associated shared commissioning functions.

1.4 Oversight and co-ordination of shared collaborative arrangements that may be determined by the ICBs (such as the co-ordination of clinical networks). This will include the production of proposals by the committee for approval by the ICBs for the appropriate alignment of accountabilities for any shared activities through the joint committee to the ICBs.

- 1.5 Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.
- 1.6 Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs.
- 1.7 Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs.

3. Accountability

- 3.1 The Joint committee is accountable to the six ICB Boards.
- 3.2 Consequently, and to assist with public accountability, the minutes of the joint committee, which will include a record of all actions and decisions taken by the committee, will be reported to the ICB public board meetings

4. Membership and quoracy

- 4.1 The joint committee will include the following members:
 - The six ICB CEOs
 - Consideration may be given to other members being in attendance at the committee. For example:
 - The Senior Manager for the West Midlands ICB CEOs office
 - NHSEI commissioning representative;
 - East Midlands provider collaborative representative;
 - East Midlands public health representative
 - Finance and Clinical representatives from the ICBs
- 4.2 If an ICB CEO cannot attend then they will send a representative with full authority to act on their behalf.
- 4.2 For decisions that are made in relation to section 1.5 then quoracy is not required as members are contributing based on their own limits of delegation.
- 4.3 Similarly for recommendations / and or proposals that are being submitted for approval by the ICBs, quoracy is not required.
- 4.4 For decisions in relation to the collective delegation of functions and/or services then all ICB CEOs (or their designated representative) would need to be in attendance for the decision to be quorate. All decisions will also need to be made in accordance with the delegation agreement between NHSEI and the ICBs where this is appropriate.

4.5 The meeting will be chaired by one of the ICB CEOs – to be determined by the committee.

5. Frequency of meetings

5.1 The committee will meet when and as often as determined necessary by its membership (most likely on a monthly basis).

Annex Two

Joint Commissioning Framework

1. Joint Principles

- 1.1 The ICBs start from a shared principle of subsidiarity – so that joint arrangements will only be put in place where there is a clear demonstration of the added value that is being derived from the joint arrangement.
- 1.2 The joint arrangements will be expected to support the delivery of the NHS constitution, the triple aim, as well as the four purposes of the ICBs, namely:
 - 1.2.1 improving health outcomes;
 - 1.2.2 improving health inequalities;
 - 1.2.3 improving clinical effectiveness and/or value for money;
 - 1.2.4 supporting the wider economic impact of the ICBs.
- 1.2 Any joint functions overseen by the joint committee will be organised in such a way that it both:
 - 1.3.1 enables the delivery of expert capabilities at scale which would otherwise not be possible for the ICBs individually to undertake individually;
 - 1.3.2 operates efficiently and effectively;
 - 1.3.3 Uses the best possible available (clinically led) intelligence to inform decision-making;
 - 1.3.4 Is mindful of the ICBs public accountabilities and public opinion;
 - 1.3.5 has clear governance and lines of accountability back to the ICBs (and to NHSEI for delegated functions).

2. Commissioning arrangements

- 2.1 When considering the joint commissioning arrangements you need to consider both the joint commissioning governance arrangements as well as the joint operational delivery arrangements.
 - 2.1.1 The former covers how the ICBs make joint decisions and conduct joint performance and assurance arrangements on the services that they are commissioning together.
 - 2.1.2 The latter covers the means by which the ICBs conduct the functions and activities that enables the commissioning to take place.
- 2.2 It is important not to confuse these two sets of arrangements. For example it would be possible for different ICBs to take the lead (in governance terms) for different services; but for the operational functions that support these arrangements to be hosted by one ICB.

- 2.3 When planning to take on new services and/or functions the joint committee will need to undertake an options appraisal to determine the most appropriate model to use.

3. Joint Commissioning Governance options:

3.1 Lead Commissioner Model

- 3.1.1 In this arrangement one ICB (or potentially NHSEI for specialised services) hosts the commissioning of the service(s) and therefore takes responsibility for the commissioning of those service(s) on behalf of the other members.
- 3.1.2 This includes providing the sub-governance arrangements (such as quality assurance, financial and contractual management oversight). Ordinarily such sub-governance arrangements would be incorporated into the lead commissioner's committees, such as quality and assurance committee and finance and performance committee. Through these arrangements the lead commissioner is then able to take full responsibility for the commissioning of the service(s).
- 3.1.3 The relevant outputs from the lead commissioner's assurance processes would be reported to the ICB joint committee by the lead commissioner. This then provides the mechanism to enable clear lines of accountability from the lead commissioner to the six ICBs.
- 3.1.4 Note: it would be possible for different services to be led by different ICBs (eg: primary care arrangements by one ICB; specialised services by another; 111/999 by another) or for all to be led by one.
- 3.1.5 Such an arrangement would normally work well for the commissioning of a specific service from a single provider (such as 111/999).
- 3.1.6 Such an arrangement would normally be best supported by either a host provider or contracted provider model (see below).

3.2 Shared Commissioning Model

- 3.2.1 In this arrangement the six ICBs jointly share the responsibility for the commissioning of the service(s) so no individual ICB is leading on behalf of the others.
- 3.2.2 To enable this arrangement to work then there would need to be jointly organised sub-governance arrangements (such as joint quality assurance processed and joint financial management processes) which reports into the joint committee. This would therefore require the establishment of relevant joint working groups through which these joint processes would be conducted. These joint arrangements would be in place solely for the oversight of the shared services (ie: they stand apart from any other governance arrangements in the ICBs).
- 3.2.3 The relevant outputs from the joint working groups would report in to the joint committee.
- 3.2.4 Such an arrangement would normally work well for activities that do not require substantial/complex oversight and/or are delivering shared

functions as opposed to delivering front-line services (such as oversight of shared clinical networks).

3.3 Network Commissioning Model

- 3.3.1 In this arrangement the six ICBs take a distributed leadership and governance approach to the commissioning of a service. So ICBs will make collective decisions on how a service is to be commissioned but then each ICB oversees the arrangements in their own system.
- 3.3.2 The sub-governance arrangements (such as quality assurance, financial and contractual management oversight) are undertaken by each ICB for their own local system. Note this may include acting on behalf of other ICBs where they are associates to the main ICB's contract.
- 3.3.3 The outputs, where relevant would be reported back by each ICB to the joint committee.
- 3.3.4 Such an arrangement would normally work well where you might want to make a joint policy decision but then enact it separately; or where you want to take the same approach to a service but it is provided by multiple organisations (ie: in several ICSs) so it makes sense for the oversight to be incorporated into each ICB's existing arrangements rather than undertaken separately.

4. Joint operational delivery arrangements:

4.1 Hosted Model

- 4.1.1 In this arrangement the lead ICB take full responsibility for the function. Therefore the host ICB is accountable to the joint committee for all of the outputs and performance of this function.
- 4.1.2 This would include the employment of staff and the organisation of financial arrangements.
- 4.1.3 Consequently the staff would be working in accordance with the host ICB's HR policies and procedures; similarly the financial arrangements would follow the host ICBs SOs and SFIs.

4.2 Hosted (subcontracted) model

- 4.2.1 In this instance the hosted model includes the host ICB subcontracting the functions from a 3rd party (such as a CSU). In this instance the host ICB retains responsibility for the function, manages the CSU contract and reports to the joint committee accordingly.

4.3 Shared model

- 4.3.1 In this arrangement the ICBs establish a shared resource/team that works to support shared arrangements across the ICBs.
- 4.3.2 You would still need there to be a single employer for the staff who are working in this shared team (and as such the team works in accordance with the host employers HR policies and procedures.

- 4.3.3 However the team (usually through a lead manager) would be held jointly responsible equally by all 6 ICBs, through the joint committee for the activities of the team working on behalf of all 6 ICBs.

4.4 Shared (subcontracted) model

- 4.4.1 It would similarly be possible for the shared model to be subcontracted from a 3rd party. In this instance the 6 ICBs would all agree the terms of the 3rd party contract (through the joint committee) and each ICB would be a joint contract-holder with the 3rd party.

4.5 Distributed model

- 4.5.1 In this arrangement the ICBs each take responsibility for the function in their own organisation but there is a collaborative arrangement whereby those functions work together for mutual benefit.
- 4.5.2 Each ICB employs their own staff working to their own HR policies, financial SOs and SFIs.
- 4.5.3 Each ICB makes a commitment to the others for their own individual contribution that they make to the collective effort.

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

Enclosure:	10
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Title:	ICB Memorandum of Understanding with NHS England
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Peter Axon Sally Young	Y	Sally Young Kirsten Owen

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

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

History of the paper – where has this paper been presented		
	Date	A/D/S/I
ICB meeting in private	18/08/2022	A
Single Leadership Team (SLT)	01/09/2022	D

Purpose of the Paper (Key Points + Executive Summary):
<p>This paper is to update the Board on the progress of finalising the ICB Memorandum of understanding (MOU) with NHS England (NHSE) and present the final version of the MOU the Board.</p> <p>Previous discussions have taken place at the August ICB meeting in Private and with the SLT. A number of versions have been shared SLT during the development.</p> <p>As Integrated Care Boards (ICBs) became statutory bodies from July 2022, NHS England regions and ICBs are required to refresh the oversight arrangements supporting their relationship and describe how they will underpin their working arrangements in the first year. This document is developmental in nature.</p> <p>The attached MOU will be formally signed by the ICB Chair and Chief Executive Officer and the Regional Director, and arrangements will commence from the 1st October 2022.</p>

However, the ICB will continue to work with NHSE and system partners to clarify a few areas and it is likely that the next formal iteration of the MOU will be developed during quarter three with a view to have it agreed by the end of that quarter.

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):

NA

Implications:

Legal and/or Risk NA

CQC/Regulator NA

Patient Safety NA

Financial – if yes, they have been assured by the CFO NA

Sustainability NA

Workforce / Training NA

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?

NA

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)

NA

Y/N

Date

2a. Has a Quality Impact Assessment been presented to the System QIA Sub-group?

NA

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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 MOU has been shared with all system partners both informally and formally via the ICS Senior Leadership Team	Y	
5.	Has a Data Privacy Impact Assessment been completed? Please provide detail	NS	
Recommendations / Action Required:			
The Integrated Care Board is asked to: <ul style="list-style-type: none"> Receive the agreed October 2022 NHS England Memorandum of understanding with Staffordshire and Stoke-on-Trent ICB. 			

ICB Memorandum of Understanding with NHS England

Purpose

This paper is to update the Board on the progress of finalising the ICB Memorandum of Understanding (MOU) with NHS England (NHSE) and present the latest version of the MOU the Board.

Background

As Integrated Care Boards (ICBs) became statutory bodies from July 2022, NHS England regions and ICBs were required to refresh the oversight arrangements supporting their relationship and describe how they will underpin their working arrangements in the first year.

Information

Using the nationally issued MOU template, we have been working with NHSE and as a system to describe our emerging oversight arrangements. The latest iteration has been agreed with NHSE Regional Director and with our ICB Executive, this was shared with the ICS Senior Leadership Team on 1st September. This document is developmental in nature.

Whilst there is large scale agreement with the MOU there are several areas which will need more clarity and further discussion as a system and with NHSE. The MOU is described as an iterative document and as the ICS develops our MOU will need to change to reflex this.

Next steps

The attached MOU will be formally signed by the ICB Chair and Chief Executive Officer and the Regional Director, and arrangements will commence from the 1st October 2022.

The ICB will continue to work with system partners and NHSE to clarify a few areas and it is likely that the next formal iteration of the MOU will be developed during quarter three with a view to have this agreed by the end of that quarter.

Recommendation

The Board is asked to:

- Receive the current iteration (October 2022) NHS England Memorandum of understanding with Staffordshire and Stoke-on-Trent ICB.

Memorandum of Understanding Staffordshire and Stoke-on-Trent Integrated Care Board and NHS England

Staffordshire and Stoke-on-Trent ICB
01/10/2022

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Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

The four key aims of an ICS are to:

- improve quality of services and 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.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

ICSs are led by both an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). The ICP is a statutory committee bringing together all system partners to produce the ICSs integrated care strategy. The focus of this MOU is with the ICB as the statutory body with responsibility for NHS functions and budgets.

Purpose of this agreement

This MOU is between the [Staffordshire and Stoke-on-Trent](#) Integrated Care Board, and [NHS Midlands](#) region, on behalf of NHS England. It is effective as of 1st October 2022. It sets out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

This MOU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either party. NHSE will continue to exercise its statutory role

and powers in relation to regulatory action under legislation, including to address individual organisational issues in line with the principles set out in this MOU. The accountabilities of individual NHS organisations also remain unchanged.

In particular, it is noted that:









- this MOU does not delegate functions from NHSE to the ICB or vice versa
- NHSE's oversight delegated functions will take place in accordance with the delegation agreement.
- the MOU does not mean that functions are being exercised jointly by NHSE and the ICB within the meaning of section 65Z5 of the NHS Act 2006 (joint working and delegation arrangements) and
- references to meetings held jointly do not mean that a joint committee has been set up between NHSE and the ICB.

It is acknowledged that the MOU represents a new way of working and there will be a period of transition and bedding in required, and an associated regular review process.

Ways of working

Staffordshire and Stoke-on-Trent ICS Partners Leadership Compact

The Staffordshire and Stoke-on-Trent Leadership compact (below) was developed and shared with Partners in August 2021. It focuses on the behaviours and approach that is expected all partners to demonstrate and adhere to when working in and across our system. It focuses on trust, respect, courage, kindness and compassion, openness and honesty, looking forward, leading by example and system first.

 Trust <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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.

Midlands Leadership Behaviours to support 'Whole System' Working in the Midlands

To deliver the best for our people and our patients, we are committed to the following leadership behaviours across the Midlands.



Rules of engagement to support 'Whole System' Working in the Midlands

The following principles will inform how the ICB and NHSE will work together:

1. **First among equals whilst respecting the respective responsibilities and accountabilities.** Ways of working will be non-hierarchical and jointly owned whilst respecting that statutory roles and responsibilities of different parts of the system will still need to be carried out. Despite respective NHSE/ICB roles there are common challenges that affect us all which will require collaborative leadership to resolve.
2. **No decision about me without me.** Structures for regional decisions relating to development and improvement will include systems as part of a whole system approach. This is to ensure that decisions around regional support are informed by the knowledge, skills and experience of those leading and delivering the strategic change/operational improvement.
3. **No surprises.** Arrangements will be transitional and will need to evolve as together we build confidence and trust. Early notice of information and concerns, be open and willing to share intelligence using agreed data sources to avoid different views.
4. **No bypassing.** There will be agreed, channels of communication between the organisations, the ICB and NHSE ensuring that duplication is minimised and that the

region and system role is not undermined. There should be no bypassing system or regional leadership. NHSE's primary relationship will be with national directorates and ICBs whereas ICB primary relationships will be with place, organisations and local government.

5. **ICB Oversight will be NHSE Led with oversight of NHS organisations led by the ICB - where we need to deviate from this it will be with ICB involvement.** ICBs are accountable for the oversight of NHS performance whilst NHSE remains statutorily responsible. NHSE will work with and through ICBs to discharge this function however where there is a need to respond quickly to unexpected issues or where formal regulatory action is required this will be responsibility of NHSE. In all cases NHSE decisions will include the involvement of the ICB and good relationships and communication should ensure that NHSE is sighted on local issues.
6. **Midlands and NHSE ways of working will be clearly outlined to clarify responsibilities and to avoid undermining or duplicating the role of an ICB.** Jointly agreed arrangements will be set out for Midlands System Leadership. Individual ICB/NHSE ways of working will be outlined in MOUs which are to confirm roles and responsibilities for any NHSE functions discharged or delegated by NHSE and reviewed/updated regularly as arrangements evolve. These will articulate the 'step in rights for NHSE' where required.
7. **Continue to address unwarranted variation whilst upholding the principle of subsidiarity and local flexibility.** Some things will need to be done once for consistency and or where there are benefits to economies of scale. The overriding principle however should be one of decisions being taken as locally as possible to ensure we are meeting the need of populations served.
8. **Together we will strive for excellence and harness the talent we have to improve health and care outcomes, quality and access to care and reduce health inequalities.** Where things go well we will lock in the learning and strive to do better. When things go wrong, we will seek to understand why and learn from our mistakes.
9. **Collaboration.** All ICBs are expected to work together and with NHSE to support effective and timely delivery of care to patients and communities, and performance improvement against regional priorities. We recognise that collaborating and supporting beyond system or organisational boundaries can create additional challenges and risks locally and we will work together to quickly resolve any barriers and ensure that the positive impact of effective collaborative behaviour is duly recognised and celebrated.

System priorities and deliverables

The Staffordshire and Stoke-on-Trent System Delivery Plan has been produced for 2022-2023 to ensure that the system is aligned, and are collectively clear about who is doing what, when and how we will be able to assess success. The ICS has 8 priorities that it will be working to:

1. Improving Outcome in population health and health inequality
2. Improving delivery of elective Care Services
3. Improving Cancer and outcomes in Cancer Care
4. Delivering improvements in CYP services and maternity care
5. Improving UEC and delivering more care at home
6. Promoting healthy aging and managing frailty
7. Delivering more services through primary care to support system transformation
8. Growing and improving mental health services

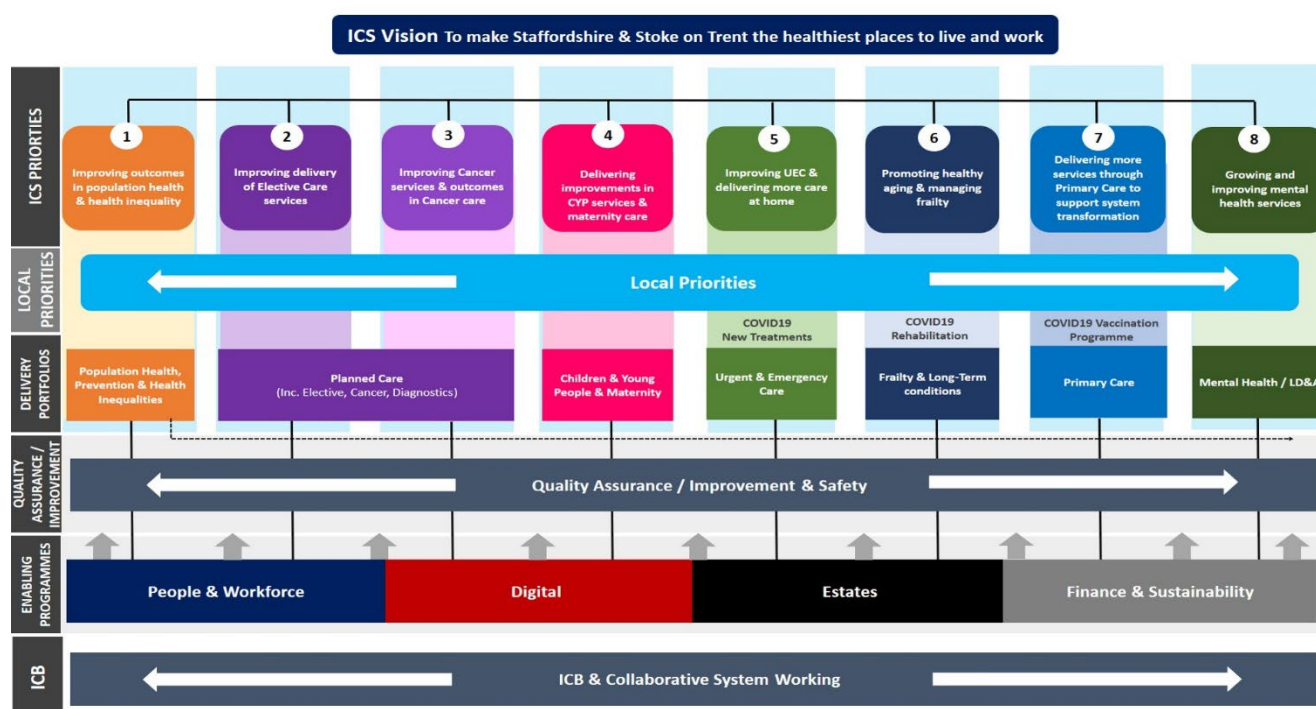
The establishment of the ICB has provided an opportunity to revisit our programme and delivery structure and make this simple and streamlined. The ICB is establishing a revised portfolio structure, which focuses on delivery of the 8 priorities.

The purpose of each portfolio is to:

- Work with partners and stakeholder to developing the strategy in the area to meet the system priorities (co-produced at a system level based on evidence)
- Deliver objectives in the area (national and local) in conjunction with the Delivery Director
- Task and finish of transformation needed to deliver the above (these can be short, medium, or long term) including establishing appropriate MDTs which draw in capacity and capability from other portfolios or subject matter experts for example quality or finance – in conjunction with the Transformation Director
- Provide assurance to the ICB CFO and system on the items above
- Support transformation within other portfolios for example the digital portfolio will support work on LTCs through new remote monitoring technologies

Each Portfolio will work to a standard agenda which will be the process for reporting and monitoring their contribution to ICB delivery of its fundamental purposes. The portfolio agenda will include:

- Items of strategic significance / horizon scanning;
- A performance dashboard (which will include key SOF metrics)
- An overview of programme and project delivery for their area – this will include all relevant system savings projects



Our joint commitment to 3 key priority areas for 2022/23

1. Delivering a Greener NHS:

As a Midlands team we are committed to address the climate emergency, which is also a health emergency. Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.

All ICS's and Providers have Green Plans in place, and NHSE will provide appropriate expertise, investment and focus to enable us to deliver as a region. Sustainability should be implicit in all considerations and decisions made and geared towards delivery of the NHS's net zero targets.

2. Reducing health inequalities:

We will work together to support tackling Health Inequalities in outcomes, experience and access.

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individual that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

There are unfair and avoidable differences in access to and experience of NHS services by different population groups. Additionally, there are healthcare inequities that could be addressed through the provision of needs based, person centred services and systems.

The Health and Care Act 2022 introduces a range of obligations on NHS bodies in relation to action on health inequalities. These new obligations are summarised in Annex A.

3. Supporting our People:

Staff are at the centre of our collective ambition for greater integration and better care and ICBs have a central role to play in delivering the vision for our 'one workforce'.

As NHS leaders and organisations we will work together to deliver 10 outcomes-based functions with our partners in the ICB to make the local area a better place to live and work for their people and we will work together and through the local People Board to meet the following core objectives:

- i. Supporting the health and wellbeing of all staff
- ii. Growing the workforce for the future and enabling adequate workforce supply
- iii. Supporting inclusion and belonging for all, and creating a great experience for staff
- iv. Valuing and supporting leadership at all levels, and lifelong learning
- v. Leading workforce transformation and new ways of working
- vi. Educating, training and developing people, and managing talent
- vii. Driving and supporting broader social and economic development
- viii. Transforming people services and supporting the people profession
- ix. Leading coordinated workforce planning using analysis and intelligence
- x. Supporting system design and development.

Partnership and place arrangements

Staffordshire and Stoke-on-Trent ICS has a population of 1.1million, in total across the NHS and upper tier local authorities, the spend is £3.1 billion on health and social care, the spend on health services is £2.7billion.

With the ICB now fully established, the development of Place working arrangements can gain momentum. Although the strategy and statutory responsibilities will sit at a systemwide level (ICB/ICP), the real engine room for delivery will be at a Place level. In line with the national White Paper, the shadow Board agreed that in Staffordshire and Stoke-on-Trent activity would be delegated to two Places (geographical areas), aligned with the footprints of the upper tier local authorities. This will better support integration between health, care and the voluntary sector and ensure that services are designed based on local needs and local insight.

Our places are aligned to the two upper tier local authorities' boundaries of Staffordshire and Stoke-on-Trent:

Staffordshire	Stoke-on-Trent
In 2017 Staffordshire resident population was approximately 870,800 in 369,000 households, with a population density of 332 persons per square kilometre.	In 2021 Stoke-on-Trent population was approximately 246,400 in 103,500 households, with a population density of 1,248 persons per square kilometre.
The geographical are of Staffordshire is a total of 2,620km ² .	The geographical are of Stoke-on-Trent is a total of 197.35km ² .

There are 18 PCNs within the Staffordshire Place footprint, with a total of 110 practices.	There are 7 PCNs within Stoke-on-Trent Place footprint, with a total of 33 practices.
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The Place boards will identify the local priorities, using local data and networks. These Place boards will then be given delegated authority and budgets to support delivery of national and local priorities and delivery of the overarching system strategy that will be developed by March 2023.

During 2022/23, shadow arrangements will be established in order to transition delegation as agreed with partners.

A Provider Collaborative Board has been established to facilitate greater discussion and reduce competition between NHS providers, ultimately focused on delivering improved care for local people.

The new provider collaborative will focus on how NHS providers can support the integration agenda, supporting service redesign, making greater use of our People and budgets and sharing insight. This Board will report on progress into the ICB and ICP.

The priorities for the Provider Collaborative are Medicines Optimisation (Shared Care), Obesity, Back Office Functions, Frailty, MSK (Hip and Knee), Eye Health, Gastro/colorectal and Green Sustainability.

Collaboration across ICBs:

- In order for an ICB to effectively discharge its functions it will need to collaborate with other ICBs both within the region and across regional boundaries.
- NHSE/ICB ways of working will need to evolve to take account of collaborations and agreed governance including the emerging offices of the East/West Midland ICBs. This MOU will be updated to take account of those arrangements when they are clear both in terms of the governance and the activity.
- For some commissioning activity, the preference is to collaborate across East and West Midlands footprint. During 2022/23 we plan to develop the existing East and West Collaborative Commissioning Boards into formal committees / decision making bodies. This work is being led by NHSE Commissioning Directorate and the Chief Executives from the eleven Midlands ICBs.
- Some commissioning functions will be retained by NHSE and these responsibilities will also be recognised within the developing collaborative arrangements noted above.
- The ICBs have formally been delegated responsibility for Primary Medical services. NHSE will operate the support services GMAST under a separate MOU arrangement until all the other Primary Care Services - Pharmacy, Optometry and Dental are formally delegated in April 23.
- NHSE will need to engage directly with providers on specialised and directly commissioned contract arrangements and procurements, but the ICB(s) will be involved as appropriate.

- NHSE Specialised Commissioners have a relationship with mental health provider collaboratives through the NHS Standard form contract, retaining strategic commissioning and oversight and assurance functions. Multi-ICB involvement and oversight will be on an East/West Midlands basis through collaboration and agreed governance as above.
- Responsibility for complaints will be delegated to ICBs at the same time as functions are delegated but the regional complaints functions will continue to transact pending confirmation of national policy and local implementation.
- Mutual aid arrangements to support the region to meet its elective recovery plans will continue during 2022/23. Where mutual aid is provided between providers and systems, NHSE will recognise and support where an ICB has provided this capacity, including taking into account any consequential impact on the local delivery of financial and operational performance targets.

Single point of contact:

- The Regional Operations Centre (ROC) will become the single source of access in and out of the NHSE Midlands region for formal and / or routine communications, cascades, commissions and data requests from Regional and National teams. There will be a transitional period to confirm the scope of what is covered by the ROC, and embed the new arrangements.
- SPOC address@ ICS_SPOC@staffsstoke.icb.nhs.uk

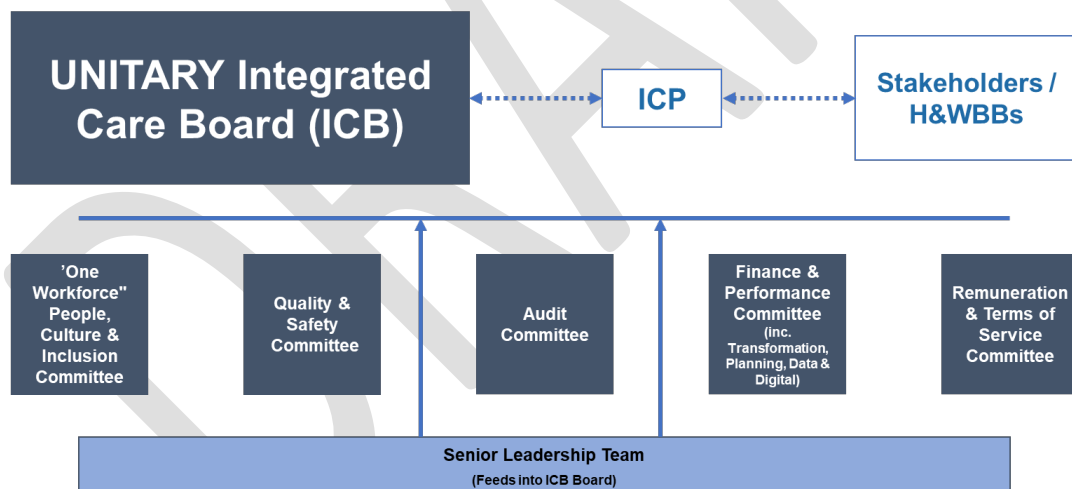
Governance and oversight

The Integrated Care Board (the Board or ICB) must ensure it can effectively discharge its full range of statutory functions and duties. This includes establishing committees of the ICB, to support the Board and exercise any delegated functions, to help effective discharging of their range of functions. The ICB has five ICB committees:

- Finance and Performance
- Quality and Safety Committee
- Audit Committee
- One Workforce, People, Culture, and inclusion committee
- Remuneration and Terms of Service Committee

The Committees are established to contribute to overall delivery of ICB objectives by providing oversight and assurance to the Board on the delivery of the core committee purposes as described in their terms of reference which can be found in the ICB Governance Handbook found on our [ICB website](#).

Integrated Care Board – Committees Governance: Board Assurance (part 1)



Finance and Performance Committee: assures the ICB that the financial governance arrangements are in line with the National Health Service Act 2006, as amended by Health and Care Act 2022, supports the effective management of resources within the system financial envelope; this includes how the ICB will work with NHSE to deliver and report against the system financial plan

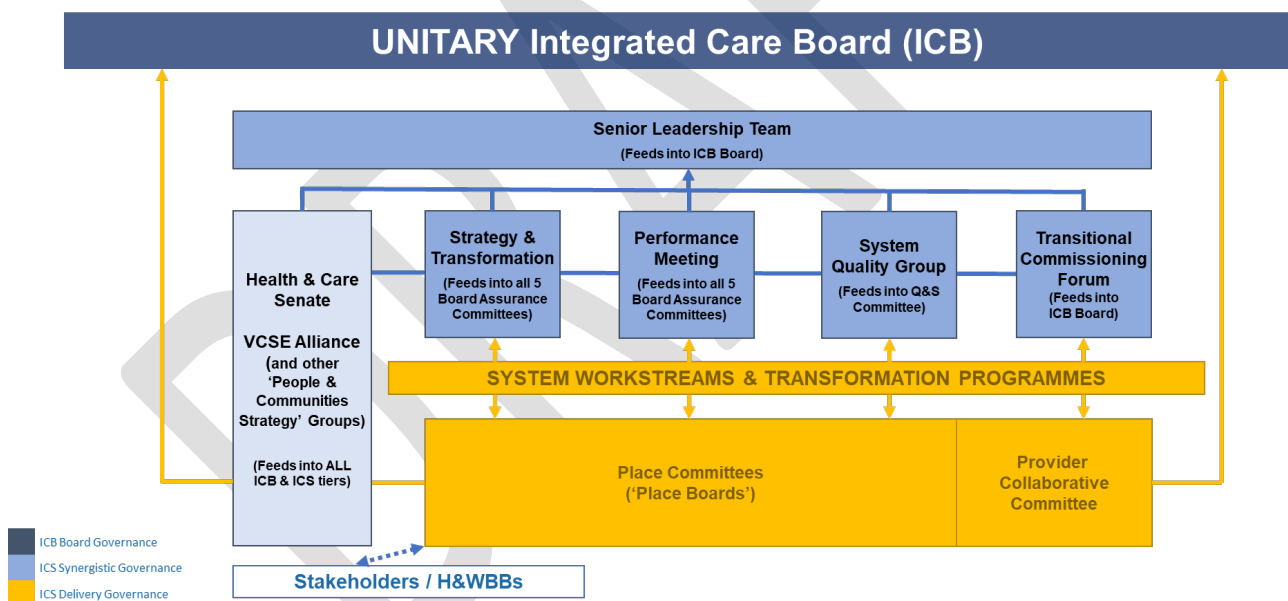
Quality and Safety Committee: assures the ICB that quality assurance and improvement and all associated governance processes enable the proactive identification, monitoring and escalation of quality issues and concerns. This includes cross-system quality governance as set out in the National Quality Board's (NQB) shared commitment to quality. NHSE are

members of the Quality and Safety Committee. The System Quality Group is a sub group of the Quality and Safety Committee and has been established to meet the NQB's specific requirements for a quality governance and intelligence sharing mechanism where system partners work together on key quality matters. All partners, including NHSE, are included in the membership.

One Workforce, People, Culture, and inclusion committee: assures the ICB and Regional People Board of the delivery of the ICS People Plan, the Long-Term Plan workforce priorities and the People, Culture and Inclusion strategic objectives. It provides a platform for Organisations, PCNs and ICS workstreams to escalate strategic people, culture and inclusion risks, and debate mitigation proposals

Place boards will be given delegated authority and budgets to support delivery of national and local priorities and delivery of the overarching system strategy that will be developed by March 2023. During 2022/23, shadow arrangements will be established in order to transition delegation as agreed with partners.

Integrated Care Board – Broader ICS Governance Committees (part 2)



ICB Senior Leadership Team (SLT) is established by the ICB as a Management Group as part of the boarder ICS synergistic governance. It is an executive committee of the Board, acting as its “governance forum”, the members of the committee are the ICB CEO and the CEOs from each NHS system providers and two from the Local Authorities, and NHSE Senior Lead – to attend one meeting per month. This group formalise the predecessor ICS Exec Forum and is most-senior system management decision-making forum to support / assist the various ICB decision-making committees. It is established as a collegiate, co-ordinating forum that contributes to overall delivery of ICB objectives by providing oversight and assurance to the Board, it provides initial CEO oversight of collective performance and

delivery (non-assurance view: that being a core function of F&P Committee), including acting in support of NHSE's System Oversight Framework (SOF regime).

There are several system management groups that sit below the ICB Senior Leadership Team and ICB Board Committees these manage the specific performance oversight and more details on these groups is on Annex B.

Oversight Arrangements with NHSE

Core objectives

- The Midlands oversight model recognises that effective system governance and oversight arrangements should underpin regional oversight and assurance processes.
- Systems will take a joint and leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden.
- Oversight arrangements should reflect a balanced approach across the six oversight themes in the NHS oversight framework, including leadership and culture at organisation and system level.
- NHS Midlands role in system-level oversight arrangements will reflect both the performance and relative development of an ICS.
- The oversight process for providers will be led by the ICB and follow an ongoing cycle of monitoring performance and capability against the six themes; identifying the scale and nature of support needs; and coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.
- Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

All systems

- ***Quarterly System Review Meeting*** led by NHS Midlands RD.
Purpose: formal accountability mechanism for region to assess and assure system performance, what support is required and gather evidence for any change to provider or system segmentation.
- ***Regional and sub-regional boards*** include system SROs / professional leads.
Purpose: mutual oversight and accountability for regional position and agreement of specific support and intervention to address underperformance.

N.B. specific pan-regional oversight arrangements will be discussed and agreed where oversight is required for services which across ICS boundaries. For example, for ambulance providers.

Most systems

- ***System oversight and assurance structures to include specific system: NHSE: provider oversight and assurance meetings.***

Purpose: to discharge respective responsibilities for enhanced or intensive oversight and support. For example, to oversee elective and cancer recovery, quality and financial improvement actions or monitoring progress against provider undertakings.

These should be agreed on a case-by-case basis between NHSE and the system and arranged to minimise the administrative and regulatory burden on challenged organisations.

Where NHSE is part of system governance meetings, it should be clear in what capacity this is i.e. a critical friend support and / or to support mutual accountability.

Where NHSE is not part of system governance meetings, the ICB will be responsible for notifying NHSE on any new issues or concerns relevant to statutory duties on a timely basis.

- ***System review / oversight and assurance***

Purpose: review performance challenges within the system (which are driving the SOF ratings for the system and organisations), progress made and the effectiveness of interventions and support.

The NHS Oversight Framework 2022-23 outlines the segmentation approach and key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains.

At this present time the Staffordshire and Stoke on Trent system is in NHS Oversight Framework (NOF) (previously known as SOF) segment 3, with areas of heightened concern for the following:

Area of Concern	Issue identified	Enhanced oversight
Financial position	System underlying financial deficit	Regular NHSE meetings with system DOFs, escalation meetings as required
Elective care – long waits	High volume of waits >78 weeks, with weighted average activity planned below 104% ambition	Tier 2 – regionally led oversight with national support – weekly meetings to oversee recovery
Elective care – cancer backlog	High (and growing) 62d backlog	Tier 2 - regionally led oversight with national support - weekly meetings to oversee recovery
Urgent and emergency care	Ambulance handover times and >12 hour waits	One of 10 nationally identified Trusts (UHNM) and systems with National and regional oversight and scrutiny

With regards to the respective Trusts there are specific areas of concerns driving the respective NOF ratings.

Trust	NOF Segmentation	Rationale	Enhanced Oversight
Midlands Partnership Foundation Trust	2	Key role that the Trust has in addressing the underlying system financial deficit and in delivering sustainable improvements to the Urgent and Emergency Care pathway.	N/A
North Staffordshire Combined Healthcare NHS Trust	2	Key role that the Trust has in addressing the underlying system financial deficit and in delivering sustainable improvements to the Urgent and Emergency Care pathway.	N/A
University Hospitals of North Midlands	3	<p>Mandated support due to concerns relating to:</p> <ul style="list-style-type: none"> • CQC's assessment of the Trust as 'Requires Improvement' overall and well led* • The need for sustainable improvements in UEC performance • Elective and cancer recovery, including the need to address backlogs and long waits • The Trust's contribution to the underlying system financial deficit 	<ul style="list-style-type: none"> • Regular NHSE meetings with system DOFs, escalation meetings as required • Tier 2 – regionally led oversight with national support – weekly meetings to oversee recovery • One of 10 nationally identified Trusts (UHNM) and systems with National and regional oversight and scrutiny

- It is noted that the CQC rating for UHNM in the well led domain changed from 'requires improvement' to 'good' in December 21, though the overall rating remains as 'requires improvement'

Whilst the individual NOF segmentation ratings are noted the system will continue to work together on the issues through the arrangements set out in this MOU, with oversight of areas of concern escalated through the ICB Senior Leadership Team (SLT) Meetings, with NHSE representation.

Within the system one provider is NOF3. NHSE has a mandated role in oversight of SOF3 providers and enhanced oversight is described as above. Further discussions and development to take place in relation to how the NOF oversight will be managed in conjunction with NHSE.

The ICB Senior Leadership Team (SLT) will be utilised in place of a formal System Review Meeting (SRM) and will allow NHSE and the ICB to focus on system areas of challenge/escalation and development areas for the system, NHSE will be invited to attend once a month.

Additionally, as outlined above, and in Annex B, there are a number of ICB 'groups' where NHSE is invited to attend for the purpose of gaining assurance, including the "Senior Leadership Teams (SLT) meeting", which is chaired by the Chief Executive of the ICB.

Roles and responsibilities in performance improvement

The ICB have developed an ICS Performance Framework – Discussion Paper. The paper recognises that one of the ICB's main roles will be to oversee the performance of the system and to provide assurance to NHS England (NHSE). The ICB would like to enact this role in a new and different way. It seeks to explore with partners from across the ICS how system performance management should work going forward both in principle and in practice. The new approach will only work if all partners are on board and buy into it, and so partner views and approval are critical.

The approach will be based on strong collaborative working across partners to monitor performance collectively, hold each other to account, identify problems, and act together. The system will only be as strong as the sum of its parts.

NHSE and the ICB are committed to working together effectively to support performance improvement locally and across the region, and in accordance with the respective roles and responsibilities outlined below.

System

- ICBs will take a leadership role in driving improvement across the system, including ensuring that a quality improvement methodology underpins the approach within the ICS.
- ICBs will co-ordinate NHS support interventions within their system, where appropriate, working in partnership with NHSE, including to jointly review the impact of interventions.
- Systems are responsible for ensuring that the system develops, monitors and oversees plans to meet the agreed 'exit criteria' for systems and organisations receiving mandated support.
- Common exit criteria:
 - Realistic and ambitious recovery/improvement plan developed
 - Key trajectories being delivered
 - The system has the capacity and capability to deliver the key requirements agreed with NHSE
 - The system is proactively taking relevant actions to ensure that deliverables are maintained.

Region

- Regional support will focus on learning and improvement by:
 - Working with the local system to develop capability and capacity

- Bringing systems together and/or with experts/peers to share learning and facilitate the adoption of best practice and innovation
- Embedding colleagues within the system to provide solution focused support, that supports problem solving and sharing of best practice
- Supporting peer review e.g. of service quality, the model of care, the governance or the approach to quality assurance or improvement etc.
- Regional support will be tailored according to SOF segmentation level.
- Clinical Professional Leadership (CPL) to be a critical element of leadership to quality and clinical transformation agenda, working with regional leads on system quality groups, supported by quality leads meetings to review progress against improvement plans/quality metrics/SI thematic reviews/learning.
- Support will also be provided via Clinical Network Infrastructure and we will agree the approach and interfaces with system leadership.
- Support and facilitation to mediate or intervene where there is conflict or a difference of opinion within the ICB or between ICBs.
- Manage the interface and accountability of the region with the national team.
- Conduct the annual performance assessment of the ICB in each financial year and publish a summary of its findings.

System & Region

- Regular engagement between NHS Midlands SMEs / professional leads and system counterparts to:
 - Support individuals in their respective roles
 - Understand the current position
 - Assess what support and input would be helpful
 - Contribute to the development and implementation of improvement actions.
- NHSE will work with systems to identify quality, financial and operational improvement and transformation actions; and design bespoke support as and when mandated, required or requested. This will be linked to SOF and for all domains as necessary.
- NHSE relationship leads will work with systems on oversight infrastructure to provide support/critical friend input into forums such as boards for UEC, elective and cancer.
- NHSE and systems will collaborate through regional forum, such as the finance leadership group.
- Where new concerns are identified, rapid risk and review (or escalation) meetings will be used as a consistent approach to understand issues, agree actions and outcomes required. To include what further support is required, future monitoring and co-ordination arrangements.

Overarching approach to risks and escalation

The approach to the escalation of issues within the ICB or by NHSE with the ICB or provider is dependent on the segmentation of the ICB, current levels of oversight, as well as the specific metrics and qualitative factors.

The 2022/23 NHS Oversight Framework outlines the segmentation approach and key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains. Included in Annex C are some key qualitative indicators, which will influence NHSE's judgement regarding escalation levels and interventions, however, the new framework should be referred to in full for guidance on segmentation and metrics.

For individual providers, NHSE and the ICB will together discuss segmentation and any support required. However, NHSE will be responsible for making the final segmentation decision and taking any necessary formal enforcement action. Where there is a deterioration in segment NHSE and the ICB will agree exit criteria which will need to be met to exit mandated support and move to a lower segment.

Annex D outlines the varying degrees of oversight, assurance and improvement associated with different escalation levels. This does not match the segmentation approach in the oversight framework but does follow the logic model in the national guidance Quality Risk Response and Escalation in Integrated Care Systems and is a helpful tool support escalation.

NHSE Performance and Improvement and support

Oversight arrangements linked to specific support and segmentation are outlined in the in "Governance and Oversight" section. The specific NHSE improvement support in place which links to the segmentation is reiterated below:

Segment 3 (SSOT ICB and UHNM)

Enhanced oversight and support are in place for Staffordshire and Stoke on Trent ICB and University Hospitals of North Midlands for Financial deficit, Elective recovery, Cancer and Ambulance handover delays. The enhanced oversight through regional and national meetings is outlined in the 'Governance and Oversight' section.

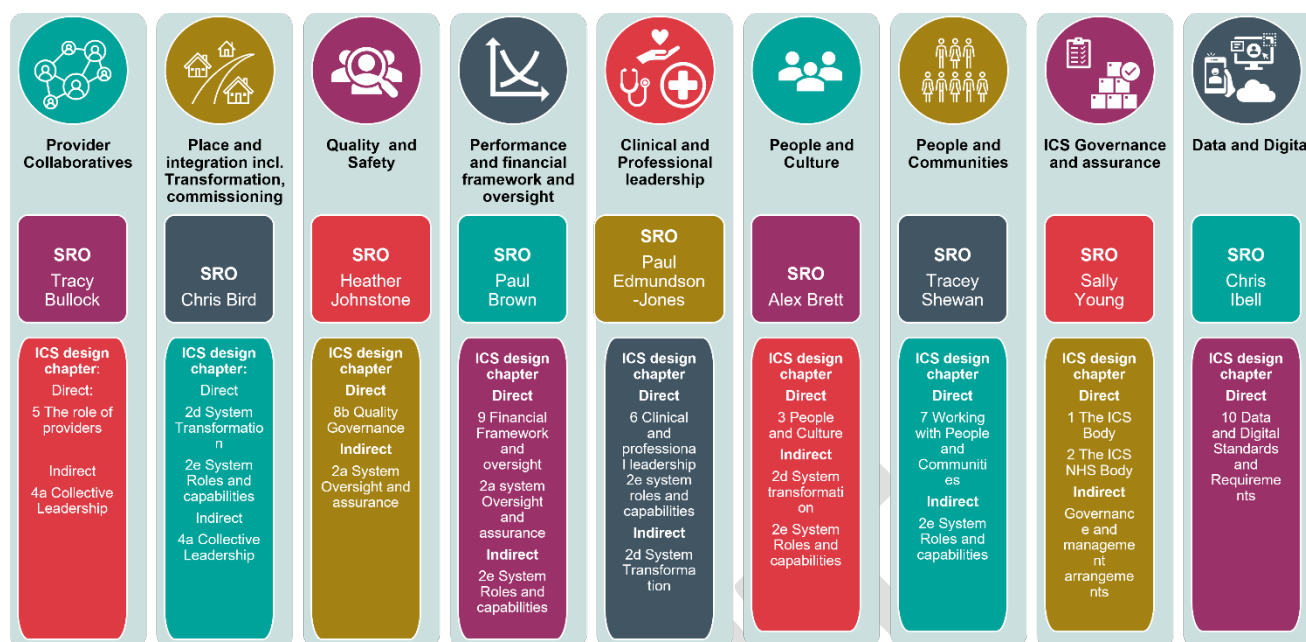
ICS development

Staffordshire and Stoke-on-Trent ICS have established an ICS development group to continue the ICS transitional journey from an established ICS on the 1st July 2022, to an advance Integrated Care System during 2022/23 and into 2023/24.

The Development group will be responsible for producing the refreshed system development plan, including the system priorities for each of the nine workstreams and responding to the national policy development.

The systems nine workstreams are aligned to the ICS development framework and build on the previous ICS transitional workstreams.

Classification: Official



- Systems will continue to produce a system development plan (SDP) which will evolve in response to system priorities and national policy development.
- NHSE will provide an allocation of funding (figure TBC) for system development and system participation in the co-design of policy related to the long-term ambition and vision for ICSs.
- NHSE will continue to broker regional and national support in relation to needs identified in system development plans.
- NHSE will work collaboratively with systems to support the interpretation and implementation of national policy and share learning and good practice in relation to ICS development.

Delegated Commissioning:

Work is underway on the completing the PDAF (pre-delegation assessment framework), the safe delegation checklist which includes the criteria of transformation, governance. Workforce and finance. The assessment will determine how the PODs integrate with the ICBs.

Each area is being RAG rated where we are now versus where we will be 1/4/23. We attended a workshop with all other ICB's in the west midlands to go through the template and assess where we are.

The PDAF is now in draft form, and we are on schedule to deliver the timelines outline below, there will be an options appraisal with other west midlands ICBs regarding the workforce implications to deliver the functions.

Primary Care Risks and Mitigations:

	Risks	Mitigations
1	Workforce capacity: delivering on 11 strategic objectives including procurement and service redesign and the additional workload necessary to service 11 ICB committee will create competing pressures for the team to deliver the function. This in turn could mean that the speed of change sought by ICBs will not be possible	Collaboration agreement between the system in the West and West that sets out: <ul style="list-style-type: none"> • Expectations of the team and how they service the ICS within their resource • How systems agree an annual work plan for the team that meets their join objectives within the existing resource • Oversight group to agree and manage the work programme/plans and staff resources and support upskilling of existing ICS primary care teams
2	NHSE reserve function: the size and make up of this team is yet undetermined whilst further information guidance is sought. There is a risk that the expectations of this team and the need for POD subject matter experts could mean that the delegated team could be depleted	The regional team are committed to maximising the capacity within the delegated function. The design of the reserve team will be undertaken jointly and transparently with solutions found if there are competing requirements for specialist staff
3	Finance: commissioning budgets will be delegated to ICBs, however currently this is managed as one budget across the region. The delegation to 11 systems loses the current risk share arrangements were by fluctuations could create budget pressure. In addition, due to COVID, analysis of the last three years will provide difficult	A financial transitional group for Primary Care has been setup involving all 11 systems to provide detailed information to enable due diligence process for sae transfer of budgets. Within this is a consideration of financial risk sharing will be considered
4	Transition: risk that one or more systems will not sign the operating model or the proposed workforce model and also do not agree to a	Co-design the workforce model with clear risks and benefits and develop through joint workshops

	common scheme of delegation for the clinical subcommittee and collaboration agreements for the system within the East and West Midlands	This approach will continue through a governance group to agree common approach to committees and scheme of delegation
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DRAFT

Reviewing, amending, and monitoring of the MOU

This MOU relates to an ongoing relationship between the ICB and NHSE and will be formally reviewed and renewed on an annual basis. The ICB and NHSE also agree to review the agreement every 3 months to assess whether it is still accurate and fit for purpose, as an output of the Quarterly System Review Meeting and taking account of any changes in SOF segmentation.

Changes to the MOU required outside of the proposed review period can occur at any time, if agreed by both parties.

Signatures

The ICB and NHSE, as represented by the below officers, agree to honour the aspirations and commitments made in this MOU.

Peter Axon, SSOT Interim ICB Chief Executive

Fran Steele, NHSE Midlands Director of Strategy and Transformation

[insert effective date]

Annex A: Obligations on Health Inequalities

New ICB obligations on health inequalities

- A new duty on health inequalities for ICBs: 'Each integrated care board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services**.'
- A new **quality of service** duty on ICBs which includes addressing health inequalities.
- A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.
- Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting, publishing certain reports and plans, annual reports and forward planning**.
- In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

New requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

- NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.
- NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed

Annex B: Oversight arrangements

The following sets out the oversight arrangements:

Name of meeting	Frequency	Lead	NHSE attendance	Purpose of NHSE involvement*
Statutory / Regulatory				
QSRM	Quarterly	NHSE - Regional Director	ESMs	Regulatory/ Statutory
ICP	Quarterly	Chair ICB HWB Chairs LA	x	
ICB	Bi – Monthly	Chair ICB	S&T	
HWB x 2	Monthly	HWB Chairs LA	x	
Health and care senate x2	Monthly	Elected Member LA	x	
Senior Leadership Meeting	Fortnightly	ICB CEO	S&T - Monthly	Assurance/ Oversight
Audit Committee	Monthly	ICB NEM	x	
Remuneration & Terms of Service Committee	Monthly During recruitment of Chair CEO	ICB NEM	x	
Finance and Performance Committee	Monthly	ICB NEM	x	
Our Workforce, people, culture and inclusion committee	Bi monthly	ICB NEM	x	
Quality and Safety committee	Monthly	CB NEM	x	
Functional				
Finance meetings	Monthly/ as required	ICB DoF	Finance	Assurance / Oversight
Management Finance and Performance Oversight Group	Monthly	ICB DoF	S&T	Assurance / Oversight
Planned Care Board (including Cancer, Diagnostics and Elective)	Monthly	UHNM DoST	S&T/SME	Info gathering/ Support
ICS Urgent and Emergency Care Delivery	Monthly	ICB CEO	S&T/Urgent Care	Info gathering/ Support
Elective and Cancer recovery	Weekly	NHSE – Regional Director of Performance	P&I, S&T	Oversight / Assurance
COO Call	Daily	ICB	S&T/Urgent Care	Info gathering / Support
Strategy and Transformation Group	Monthly	ICB CTO	S&T	Oversight / Assurance

Annex C: Key factors in NHSE escalation and intervention decisions

System Oversight Framework

The 2022/23 System Oversight Framework outlines the key metrics which will be considered by NHSE to assess performance of the system and providers against 6 key domains.

Key qualitative factors

which will influence NHSE's judgement regarding segmentation decisions and if regulatory intervention is required (as a last resort):

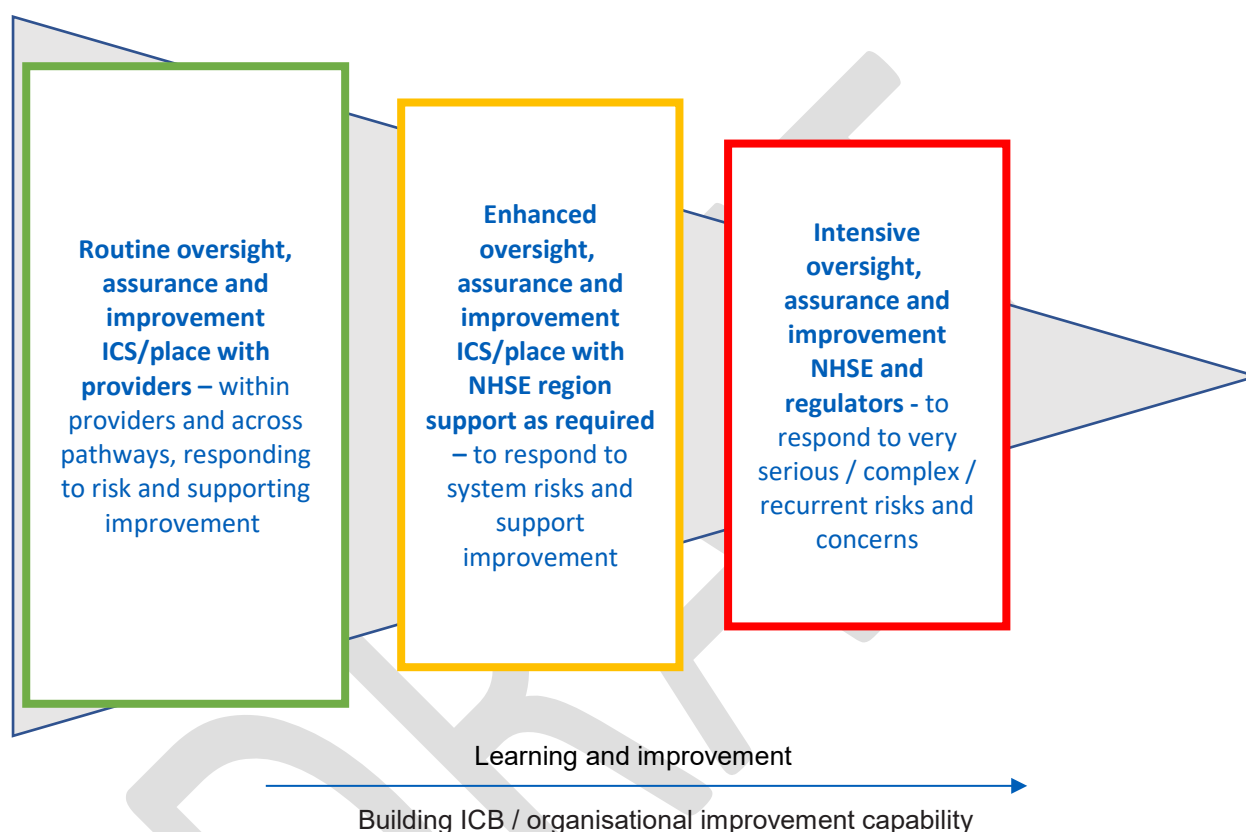
- Lack of assurance that the issue/ concern is being addressed or managed in a timely and effective manner by the ICB
- System tensions or conflicts of interest, e.g. a whistleblowing report about an ICB exec lead
- Poor engagement with regional teams
- Lack of effective system collaboration to drive improvements
- Lack of robust governance and oversight arrangements within the ICS or within a provider
- Material concerns regarding the structure, leadership, and culture of an ICB
- Evidence that the ICB or a provider lacks the capacity and capability to effectively address the issue

Instances where NHSE might by-pass the system

- Evidence of a conflict of interest
- A need to act rapidly to protect patients or staff (but we would notify the ICB at the earliest opportunity).
- Evidence of a failure of system governance to identify the issue
- Whistleblowing issues raised with NHSE

Annex D: Escalation approach

Annex D outlines the varying degrees of oversight, assurance and improvement associated with different escalation levels. This does not match the segmentation approach in the oversight framework but does follow the logic model in the national guidance Quality Risk Response and Escalation in Integrated Care Systems and is a helpful tool support escalation.



The different escalation levels are as follows:

- Routine oversight, assurance and improvement:
 - Day-to-day activity when there are no risks or minor risks which are being addressed effectively
 - Includes standard monitoring and reporting, due diligence and contract management.
- Enhanced oversight, assurance and improvement:
 - Undertaken when there are system risks that are serious, complex and/ or recurrent and require action/ improvement plans and support.
- Intensive oversight, assurance and improvement:
 - When there are very serious, complex or recurrent risks, which require intensive support, including mandated support from NHS England for recovery and improvement.

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

Enclosure:	11
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Title:	Healthier Ageing And Frailty Strategy Implementation Update
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Meeting Date:	22.9.2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Neil Carr	Y	Prof Zafar Iqbal

Clinical Reviewer:	Clinical Sign-off Required Y/N
Prof Zafar Iqbal and Dr Amit Arora	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
Variations of this presentation has have been presented at the Senate and the ICS Executive	21.07.2022	

Purpose of the Paper (Key Points + Executive Summary):
<p>Healthier ageing and frailty is a key cornerstone of the ICS transformation programme. Frailty management is not only a measure of our societal barometer, if left unaddressed it can also result in poor urgent and emergency care performance, queues in hospitals and GP surgeries, long waits for ambulances, delays in elective care, cancer treatments and operations. It can also result in increased social care demand, poor patient outcomes, poor financial balance as well as loss of public confidence in the system and poor staff morale.</p> <p>An ICS Healthier Ageing and Frailty strategy was published in 2021 and based on an in depth epidemiological analysis, an evidence review and extensive clinical and stakeholder engagement. The team has been working across Staffordshire and Stoke on Trent and spanning various organisations including health and social care; with insights from multiple presentations and discussions at various stakeholder workshops, Clinical Senate, HWBBs and various executive fora.</p>

The presentation at the ICS Board will outline the ambitions and an update on progress in the key priority areas :

- Healthy ageing and prevention
- Mild Frailty and digital approaches
- Moderate frailty outcomes and service reviews
- Severe Frailty
- Falls Prevention
- Evaluation of CRIS services
- Other Priorities e.g. dementia

This agenda is closely linked with other transformation priorities such as:

- Prevention
- End Of Life
- Urgent Care
- Long Term Conditions
- Mental Health
- Elective Care
- Social Care

Discussion will focus on the next steps and how delivery could be strengthened through clarifying the management and clinical support, stronger integration with other transformation priorities, the application of Population Health Management techniques and maximising use of digital technology.

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

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

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

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? There are significant health inequalities in the health outcomes for older people. The Health and Wellbeing Boards are leading on this agenda.		
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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> Stage 1 Stage 2 	n	
3b.	If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion? Not relevant at this stage		
3c.	Please provide detail as to these considerations: <ul style="list-style-type: none"> 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 Extensive engagement with stakeholders in the development of the strategy		

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

5.	Has a Data Privacy Impact Assessment been completed? <i>Please provide detail</i>	n	
Recommendations / Action Required:			
The Integrated Care Board is asked to: Note and discuss the presentation.			

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

Enclosure:	12
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Title:	ICS Oversight Framework
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Paul Brown, Chief Finance Officer	Y	Helen Dempsey, Director of Planning

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

Action Required (select):							
Ratification-R		Approval -A		Discussion - D	x	Assurance - S	

History of the paper – where has this paper been presented		
	Date	A/D/S/I
System Performance Group	31.08.22	D
Senior Leadership Team	01.09.22	D
Finance and Performance Committee	06.09.22	D

Purpose of the Paper (Key Points + Executive Summary):
<p>On 1 July 2022 the Integrated Care Board (ICB) was established. The ICB is a new institution with a new role and although it is taking on many of the duties of the previous CCGs' Governing Bodies, the ICB is clearly intended to represent something different to a CCG, with new ways of working.</p> <p>One of the ICB's main roles will be to oversee the quality and performance of the system and to provide assurance to NHS England (NHSE). The ICB would like to enact this role in a new and different way. It would like to explore with partners from across the ICS how system oversight should work going forward both in principle and in practice. Therefore this position paper presents a starter for ten on what a new approach could look like.</p> <p>The thinking outlined in the paper was discussed with system CEOs, the System Performance Group and the ICB Finance & Performance Committee (F&PC). The discussion held at the F&PC is referenced in the update by the Committee Chair. It is not proposed to repeat that full discussion at the Board, but we are keen to hear from colleagues who have not had the opportunity to voice an opinion. The intention is that the comments will be built into a final output that describes the approach to performance management in the system, which will be scrutinised by the F&PC in October and then brought back to the ICB Board later in October for approval.</p>

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):
<p>Strategic Objective 3 – Sustainable services for the taxpayer</p> <p>The draft ICB Board Assurance Framework and related risks are being discussed at an ICB development session.</p> <p>Risk 103: Underlying deficits from 2023/24: Without the delivery of robust system saving schemes, there is a risk that the system, its providers and consequently the ICB will be unable to deliver a financially sustainable position (i.e. a financial deficit from 2023/24), in line with the operating and planning framework.</p>

Implications:	
Legal and/or Risk	Yes risk of not delivering sustainable services for the taxpayer
CQC/Regulator	The regulator has delegated the performance management of the ICS to the ICB and will hold the ICB to account
Patient Safety	None
Financial – if yes, they have been assured by the CFO	Achievement of financial plans
Sustainability	Yes relating to use of resources
Workforce / Training	None

Key Requirements:			
1a.	How can the author best assure the Board that the decision put before it meets our statutory duty to reduce inequalities by ensuring equal access to services and the maximising of outcomes achieved by those services? Inequalities will be considered as part of the performance management process that is agreed upon, following this work.		
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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 paper has been discussed with system partners in the Leadership Group, at the System Performance Group and the ICB F&PC.	Yes	
5.	Has a Data Privacy Impact Assessment been completed? Please provide detail	No	
Recommendations / Action Required:			
The Integrated Care Board is asked to: <ul style="list-style-type: none"> Note and discuss the contents of the paper 			

Developing an ICS Oversight Framework – Discussion Paper

July 2022



Contents

- 1 Purpose of this paper
- 2 The role of the ICB
- 3 Culture, behaviours and approach
- 4 The mechanics
- 5 Changing the mindset
- 6 Scenarios for discussion
- 7 Conclusion and next steps

Purpose of this paper



Purpose of this paper

On 1st July 2022 the Integrated Care Board (ICB) was established. The ICB is a new institution with a new role and although it is taking on many of the duties of the previous CCG Governing Bodies, the ICB is clearly intended to represent something different to a CCG, with new ways of working.

One of the ICB's main roles will be to oversee the quality and performance of the system and to provide assurance to NHS England/Improvement (NHSE/I).

The ICB would like to enact this role in a new and different way.

It would like to explore with partners from across the ICS how system oversight should work going forward both in principle and in practice.

Therefore this position paper presents a starter for ten on what a new approach could look like. There are questions posed throughout.

Any views and comments on these questions and the content within the paper would be much appreciated so the ICB can evolve the approach by working closely with the system.

The new approach will only work if all partners are on board and buy into it, and so partner views and approval are critical.

The role of the ICB



The role of the ICB

It is important as a starting point that everyone within the ICS understands the role of the ICB in this context so that there are no misunderstandings.

In June 2022, the NHS System Oversight Framework 2022/23 was published to support ICBs and NHS England (NHSE) to work together and develop locally tailored approaches to oversight whilst reinforcing system-led delivery of integrated care.

Specifically, this framework outlines that from July 2022, ICBs are responsible for oversight of NHS services within their Integrated Care System (ICS), including:

- leading the oversight of individual providers on delivery against the NHS Oversight Framework;
- identifying the scale and nature of support needs, and
- co-ordinating support activity (and where necessary, formal intervention).

Further, this framework is based around a set of high-level oversight metrics at both an ICB and Trust level. A suite of 99 performance metrics has been developed to support the monitoring of ICB and Trust performance.

Of these metrics, only 62 indicators are currently being reported on and will be used by NHSE to indicate potential issues and prompt further investigation of support needs. The remaining 37 are still in development.

Please note that the Oversight Framework sits alongside the annual planning and contracting guidance.

<https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378-NHS-Oversight-Framework-22-23-v1.2.pdf>

The role of the ICB

The table below provides a helpful summary of the assurance processes both for the ICB itself and for individual organisations and partnerships within the ICS. It makes clear that NHSE will lead assurance of the ICB. The ICB will lead assurance of individual organisations.

Assurance of the ICB		Assurance of individual organisations and partnerships
Scope	<ul style="list-style-type: none">• Current performance and service quality including onward trajectories and historical performance trend• Delivery against key local priorities• Current support arrangements• Extent to which system partners are working effectively together	<ul style="list-style-type: none">• Oversight of and support to:<ul style="list-style-type: none">○ Individual organisations○ Collaboratives that span multiple places○ Place-based partnerships• By exception – scope determined by specific issues identified between NHSE regional team/ICB leadership
Roles and participation	Led by NHS England regional team with: <ul style="list-style-type: none">• ICB leadership team• Senior leaders from system providers/organisations	Led by ICB with: <ul style="list-style-type: none">• Senior leaders from relevant providers/collaboratives• NHS England (where appropriate)
Frequency of review meetings	<ul style="list-style-type: none">• At least quarterly• Regional team will engage more frequently where there are material concerns• Annual meeting linked to ICB assessment process	Agreed between the ICB and partner organisation, and set out within the MOU

<https://www.england.nhs.uk/wp-content/uploads/2022/05/B1378ii-nhs-oversight-metrics-for-22-23.pdf>

The role of the ICB


The previous slides make clear that the ICB will lead assurance of the system.

However, the ICB has another key role: leading the system to improve outcomes and reduce health inequalities.

This can only be achieved by working in partnership together as a whole system.

There is an interesting tension here. Undertaking regulation and assurance to fulfil the ICB's statutory duties in the traditional NHS manner could damage the relationships between organisations that are so critical to improving outcomes and reducing health inequalities.

Therefore the ICB believes a new approach to these duties is required.



Question: Do partners agree that a new approach to assurance and oversight is required?

Culture, behaviours and approach



A new approach?

The ICB would like to co-produce a new approach to assurance and oversight with the system and would like the views of the system on this.

The approach would be based on strong collaborative working across partners to understand the needs of the system and put the system priorities first. Partners would monitor quality and performance collectively, hold each other to account, identify problems, and act together. The system will only be as strong as the sum of its parts. It requires the right collaborative behaviours, and the systems and processes to support those behaviours.

This will demonstrate to NHSE that the ICS can be trusted to manage and resolve its own issues.

Initial guiding principles would be as follows:

Further embed a
system culture of
openness,
transparency and
trust

ICB acts as enabler
and facilitator

The whole system
manages
performance
collectively

Delegation where
possible

These principles have been developed to support the system's overall Leadership Compact values and have been colour coded accordingly. The Leadership Compact has been provided on the next two slides as a reminder. It is hoped that the system can find a way to stress the Compact at system meetings and check that it has been observed.

Question: What do you think of these principles as a starter for ten?
What changes would you make?
Are the Leadership Compact values key?

The 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

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' point of view and **empathise** with their position
- We will respect and uphold **collective decisions** made

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

Kindness & 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**

The Leadership Compact

Openness & 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

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 willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution**

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

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 & 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

A new compact for oversight?

Question: Is a compact required? If so, what changes would you make to the below?

Should this compact apply to providers within the system only, or should it apply to providers who sit outside but are important contributors to performance?

One idea that has been suggested is that the ICB and providers agree to a compact for oversight and assurance specifically, which outlines their responsibilities to one another, and supports the overall Leadership Compact. If this is seen as a good idea, a starter for ten has been drafted below for comment. The ICB believes that if the system can operate in line with the commitments below, the likelihood of intervention is much reduced. The Compact can of course be reviewed over time and evolve and be adjusted as required.

Principle	The ICB commits to:	All partners and providers commit to:
Further embed a system culture of openness, transparency and trust	<p>The ICB will trust providers to raise issues where required.</p> <p>The ICB will not ask questions (unless data or intelligence indicates an issue).</p> <p>The ICB will not use any information provided by any provider against them.</p>	<p>Providers will raise risks and issues with the ICB as soon as they occur.</p> <p>Providers will share all relevant data and information with the whole system.</p> <p>Providers will actively and consistently engage with the ICB and its Committees.</p>
ICB acts as enabler and facilitator	<p>The ICB will try to resolve problems by bringing partners together.</p> <p>The ICB will not get involved in operational management as long as providers are open and share information.</p> <p>If things are not going right, the ICB will intervene.</p>	<p>Providers will put the system first, collaborate and work together to solve problems.</p> <p>All partners will do what they say they will, and do their utmost to deliver solutions.</p> <p>Partners will work with the ICB if things are not going right and the ICB has to intervene.</p>
The whole system manages performance collectively	<p>The ICB will not hold individual organisations accountable for issues. The ICB will hold all partners as well as the ICB itself accountable.</p> <p>The ICB will provide constructive and appropriate challenge to the system and will not tolerate poor behaviour.</p> <p>The ICB will always invite providers to oversight meetings with NHSE and present a collective front.</p>	<p>Providers will take accountability for delivery collectively. If one organisation fails, all are accountable. If one provider is struggling, all providers will work together to find a solution.</p> <p>Providers will provide constructive and appropriate challenge to each other and not tolerate poor behaviour.</p> <p>Providers will always attend oversight meetings with NHSE and present a collective front.</p>
Delegation where possible	The ICB will encourage Places and Provider Collaboratives to take on duties around performance management.	Partners and providers commit to helping Place and Provider Collaborative to mature.

The mechanics



The mechanics: Developing an oversight framework

In this section of the paper some thinking is provided on the following aspects of how an oversight framework could operate. Please note some of this may have been circulated in previous papers, but it was felt useful to recap in this paper.

1. The Portfolios (which will be at the heart of the new framework)
2. Reporting, Roles and Responsibilities
3. Accountability
4. What an intervention might look like
5. What a good metric looks like

Some key features of the new approach could include:

- Streamlined performance reports to avoid time-consuming burdensome paperwork, which have previously made it difficult to identify the key issues that need to be addressed.
- Using only seven key Portfolios rather than a much larger number of programmes will be beneficial and will structure performance discussions away from organisational discussions
- The framework ought to be solution-focused and easy to navigate.
- One dashboard which can be remastered very easily/quickly for different audiences with metrics using qualitative and quantitative measures.
- Full datasets stored in one place for all partners in the system with easy to access would be valuable.

Portfolios – at the heart of the framework

Historically, the system has had a myriad of Committees, Boards and Programmes which have emerged over time. The establishment of the ICS has provided the opportunity to revisit the programme and delivery structure and make this simple and streamlined.

A proposal to establish a small number of Portfolios was approved at the Integrated Care Board on 1st July. Portfolio Management is a way of strategically aligning all projects and programmes to the goals of the system. The primary aim is to balance the implementation of change initiatives and the maintenance of business as usual, whilst optimising a return on investment.

These 7 Portfolios are set out on page 17 (note Planned Care and Cancer will be managed as a single Portfolio).

The next step is to allocate key roles and responsibilities to each Portfolio and a proposal for what this should include is set out on slide 18.

To date, the Chief Executive sponsor roles have been agreed and these are set out on slide 19.

The Portfolios are not simply about delivering the system savings agenda, they are the system's way of bringing delivery and local transformation together

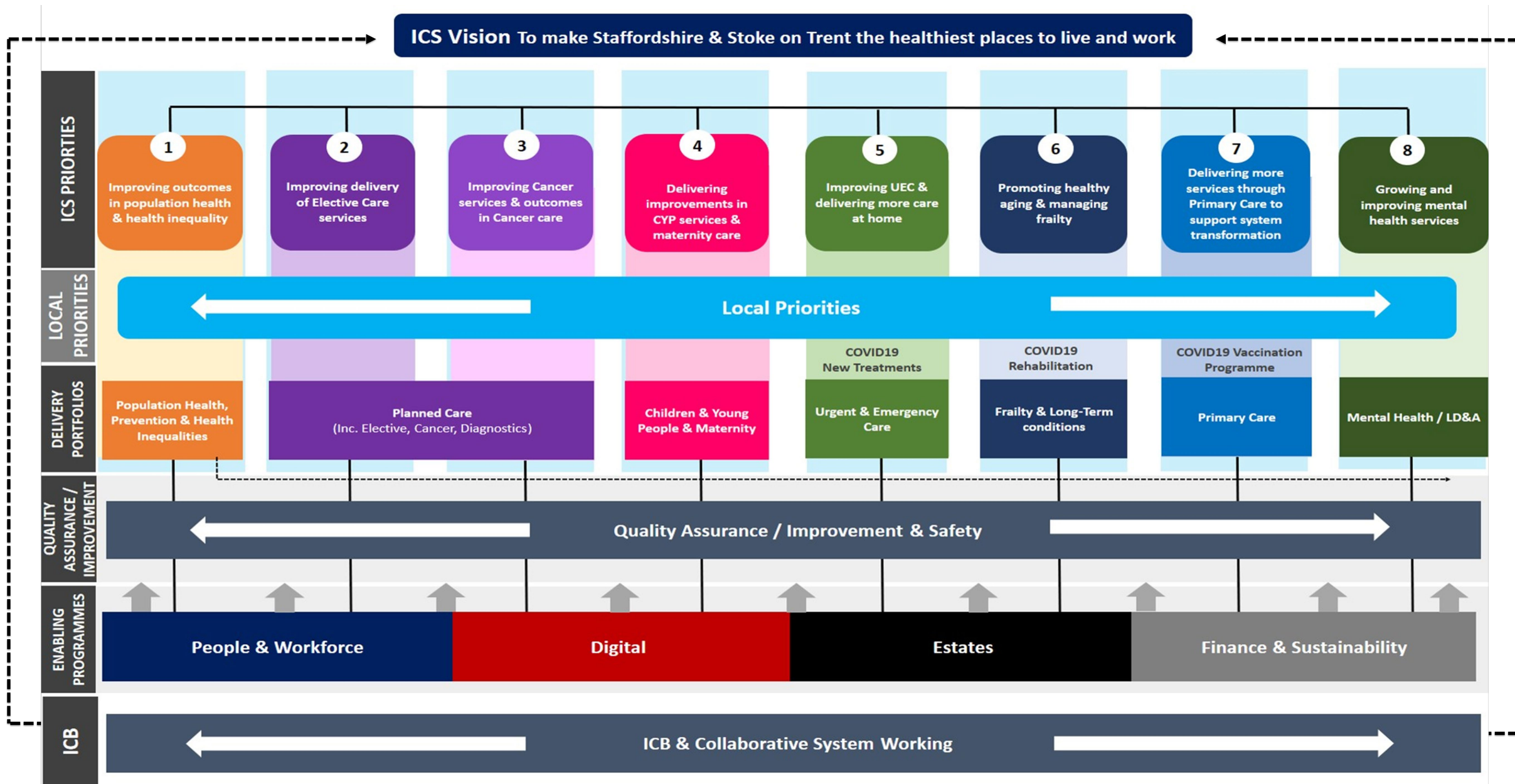
Key to the success of the portfolios will be the establishment of multi-organisation and multi-disciplinary teams who work together with a common aim of delivering both the local operating plan and deliverables but also working on the longer term transformation goals

The enabling functions e.g. digital, estates, workforce will support all of the portfolios. There will also be a communications lead who will advise/support with any engagement or consultation requirements and a Governance advisor if needed.

In addition, quality, finance, planning, PMO (TDU) and analytical resource will also be aligned to the portfolios and regarded as core to the MDTs.

All of this resource will adopt an “organisationally agnostic” approach in terms of bringing in their knowledge and have a key role in reaching out to relevant colleagues within each of the organisations within the system, and also to key partners who sit within other ICSs.

The approved Portfolio structure



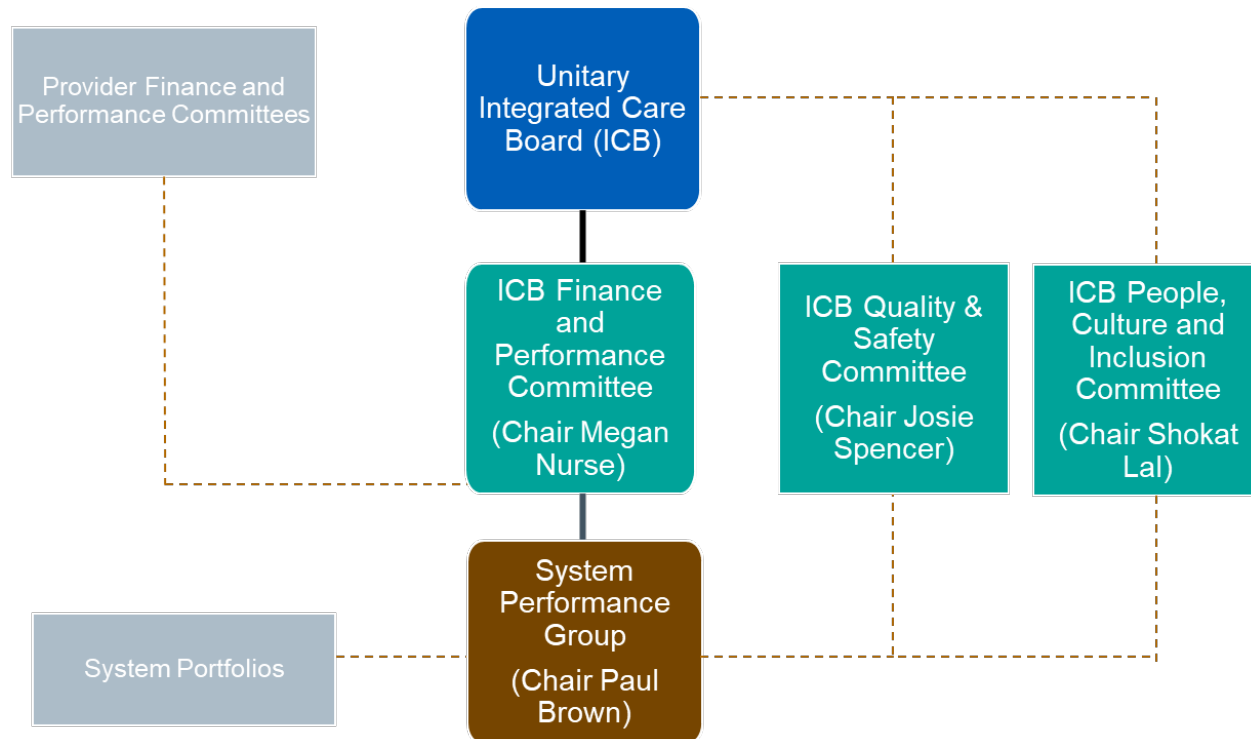
Role	Responsibilities
Chief Executive (CEO) Sponsor	<ul style="list-style-type: none"> Each Portfolio will have a Chief Executive sponsor chosen from the existing CEOs in the Staffordshire and Stoke Integrated Care System (ICS). They will chair the Portfolio meeting and ensure that the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) is sighted on any significant areas of risk and escalation.
Senior Responsible Officer (SRO)	<ul style="list-style-type: none"> The SRO will be an Executive role within the system. They will be responsible for the management of the Portfolio. This includes setting the strategy and communicating the vision and priorities of the Portfolio. They will provide regular updates to the ICB's Finance & Performance Committee and Provider Collaborative Board as appropriate.
Clinical Director	<ul style="list-style-type: none"> Each Portfolio will have Clinical Director who will chair the meeting in the CEO's absence. They will be the subject matter expert linking into the Health and Care Senate and will be responsible for clinical engagement and buy in. Together with the SRO, they will be jointly responsible for the delivery of the portfolio plan and transformation of the services within it. They will systematically assure that patients views and needs are driving the decision making process.
Portfolio Director (senior management lead)	<ul style="list-style-type: none"> Each Portfolio will have a senior management lead who will focus on delivery. They will be the day-to-day contact point for the SRO and the delivery team (which will be developed using CCG and system resource). They will have a key role in making sure that the Portfolio is sufficiently resourced. They will work with the SRO and TDU lead to construct a monthly highlight report for the ICB's Finance & Performance Committee and Provider Collaborative Board as appropriate.
Business Intelligence Lead	<ul style="list-style-type: none"> Each Portfolio will have a nominated BI Lead to co-ordinate existing and future data requirements, be that from a Population Health Management (PHM) or activity perspective. They will make sure that each Portfolio has a robust performance dashboard.
Planning Lead	<ul style="list-style-type: none"> Each Portfolio will have a nominated planning lead who will support in areas such as the national and local planning requirements, co-ordination of portfolio input in to the quarterly system review meetings and embedding of the system oversight framework. They will co-ordinate the regular deep dives of performance in each portfolio and support horizon scanning.
Finance Lead	<ul style="list-style-type: none"> Each portfolio will have a nominated finance lead who will provide financial advice and insight. This will including and supporting financial modelling and evaluation and helping understand the financial implications at a system level. They will work close with the BI lead in providing insight such as through the use of relevant benchmarking data.
TDU Lead	<ul style="list-style-type: none"> Each Portfolio will have a nominated TDU Lead who will have a key role in mapping the interdependencies across the various portfolios. They will also support the delivery and reporting of all programme / project activity using a standardised approach.
Enabling Functions	<ul style="list-style-type: none"> Representation from enabling functions such as digital, workforce, estates, quality, governance and communications / engagement. They will provide 2-way communications between the Portfolios and the Enabling Functions Programme, which is expected to wrap around all 7 Portfolios.
Programme and Project Leads	<ul style="list-style-type: none"> Each Portfolio will include a range of Programme and Project Managers from various organisations within the system who will be driving forward the transformational change. They will be invited to attend the Portfolio meetings either as part of the deep dive process or when projects are at significant risk of non-delivery.

Portfolio	CEO Sponsor	SRO	Clinical Director	Portfolio Full Time Director	ICB Exec Lead (For alignment purposes)
Prevention	Dave Haywood South Staffordshire District Council	Paul Edmondson-Jones (ICB)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Paul Edmondson-Jones
Planned Care & Cancer	Tracy Bullock UHNM	Helen Ashley (UHNM)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Phil Smith
UEC	John Henderson Staffordshire County Council	TBC	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Phil Smith
Primary Care	Peter Axon Stoke-on-Trent and Staffordshire ICB	Dr Paddy Hannigan (Primary Care)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Chris Bird
LTC / Frailty	Neil Carr Midlands Partnership NHS FT	Steve Grange (MPFT)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Chris Bird
Childrens & Maternity	Jon Rouse Stoke-on-Trent City Council	Heather Johnstone (ICB)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Heather Johnstone
Mental Health & LD	Buki Adeyemo Combined Healthcare	Ben Richards (Combined)	To be determined through Clinical and Professional Leadership Structure appointment process	To be appointed by Portfolio Leaders	Chris Bird

Reporting

Question: Does primarily running the approach through Portfolios work? How would you change and improve this method?

The diagram below illustrates how the Portfolios will report into the system so that the system receives assurance and can take action if required. Please note this is a simplified version. Portfolios may be required to report to other ICB Committees. Underneath the ICB Committees are a range of other sub-groups. In summary:



- The Portfolio monitors quality and performance against a dashboard and using local intelligence, providing regular reports to System Performance Group.
- System Performance Group reviews reports, considers any issues for action and deploys a problem solving approach, reporting to ICB Finance and Performance Committee (and other Committees as required).
- ICB Finance and Performance Committee Chair provides assurance to ICB and reports by exception on areas of concern (the other Committees do the same for their areas).

This demonstrates that the ICB has three main sources of information:

- It will see the overall system scorecard with overall metrics;
- It will receive exception reports from the ICB Committees, and
- It will build an informal network of information sharing and two-way communication.

The Provider Collaborative and Places will not be given performance management duties at this time. However, when these have grown in maturity, decisions will need to be made on what future oversight role each part of the system has.

Roles and Responsibilities

Question: Would you make any changes to the below? Are you confident that a combination of Portfolios and the ICB can pick up individual organisation oversight too?

The diagram below summarises roles and responsibilities at each level of the system (excluding Places and Provider Collaborative at the moment).

Portfolio

- Undertake regular monitoring of performance within its remit using a dashboard and qualitative intelligence
- Review performance of both individual organisations and collective system performance (always using the principle of collective accountability)
- Reporting regularly to System Performance Group
- If a problem arises, analyse the root causes and develop a plan to resolve the issue, reporting by exception to the ICB Finance and Performance Committee

System Performance Group

- Regular monitoring of performance
- If intelligence emerges of an issue, investigate with the Portfolio
- If Portfolio brings a problem or issue, hold a discussion on how the systemwide executives can support and give the Portfolio what it needs to fix the problem
- Reporting by exception to the ICB Finance and Performance Committee (and other Committees as required)

ICB Committees

- Receive regular reports from the Portfolios; undertake deep dives if not assured
- Review system dashboard; undertake deep dives if not assured
- Take a holistic view of individual organisations
- If a problem arises, adopt a problem-solving mindset and support the Portfolio with addressing the problem
- Report specific issues by exception to the ICB

The ICB

- Receives regular reports from Committees and receives exception reports as required
- Take holistic view of risks across the whole system and individual organisations
- If a problem arises, adopt a problem-solving mindset and seek to put in place conditions for success
- As a last resort, adopt a regulatory approach
- Liaise with NHSE in conjunction with system leaders

Accountability

Question: Will this kind of approach work – what changes would you make to the below?

Being clear on accountability and where it sits will be important to a high functioning oversight framework.

The ICB will be accountable for:

- Specific ICB elements: e.g., its own staff and control total, the quality of primary care and the delivery of systemwide digital programmes.
- Specific system elements on behalf of the system: e.g. system control total and system performance and quality

Where the ICB is accountable on behalf of the system, the ICB and partners and providers will operate on the basis of collective accountability.

This means that all parties have equal and shared responsibility for delivery. If one part of the system fails, all are accountable.

Trust and transparency will therefore be key, particularly in the sharing of data, and informing other partners of a problem when it arises. If these principles are not maintained, it is more likely that interventions will be required to establish clarity.

Collective accountability will be driven by the Portfolios, which will bring organisations together to monitor performance, be accountable collectively for that performance, and solve problems as they arise. Portfolios will be held to account for delivery by the ICB and its Committees.

The collective accountability will also be driven by the ICB's approach to working with NHSE. All ICB meetings with NHSE will include representation from across the system to demonstrate the shared accountability.

Individual organisations also retain their individual accountabilities and the ICB Finance and Performance Committee and ICB itself will take a view of individual organisations in line with the System Oversight Framework. However, the ICB will look to take a collective approach to accountability wherever possible through the Portfolios, unless issues are very specifically related to individual organisations who have breached their duties.

What does an intervention look like?

Question: Will the approach defined below work?

It is clear that when problems arise with performance, some form of intervention will be required. However, the ICB would like to see interventions look very different as part of the new approach.

Therefore the ICB will coordinate and facilitate, but not mandate, interventions if at all possible.

Partners will solve problems, review causes, look at processes and controls, and develop interventions together. This will first happen through the Portfolios but will also happen at higher levels within the system too (e.g. System Performance and Programmes Team, ICB Finance and Performance Committee, ICB itself).

Partners will use peer support, review and mutual aid. Partners will make joint decisions on how to solve problems and then ensure that all joint decisions made are implemented by holding each other to account.

Partners are able to challenge each other on why certain things have not happened. When challenging each other, an alternative should be provided to help resolve the problem.

The ICB will facilitate these problem solving and monitoring processes and will report back to NHSE on progress with system leaders in the room.

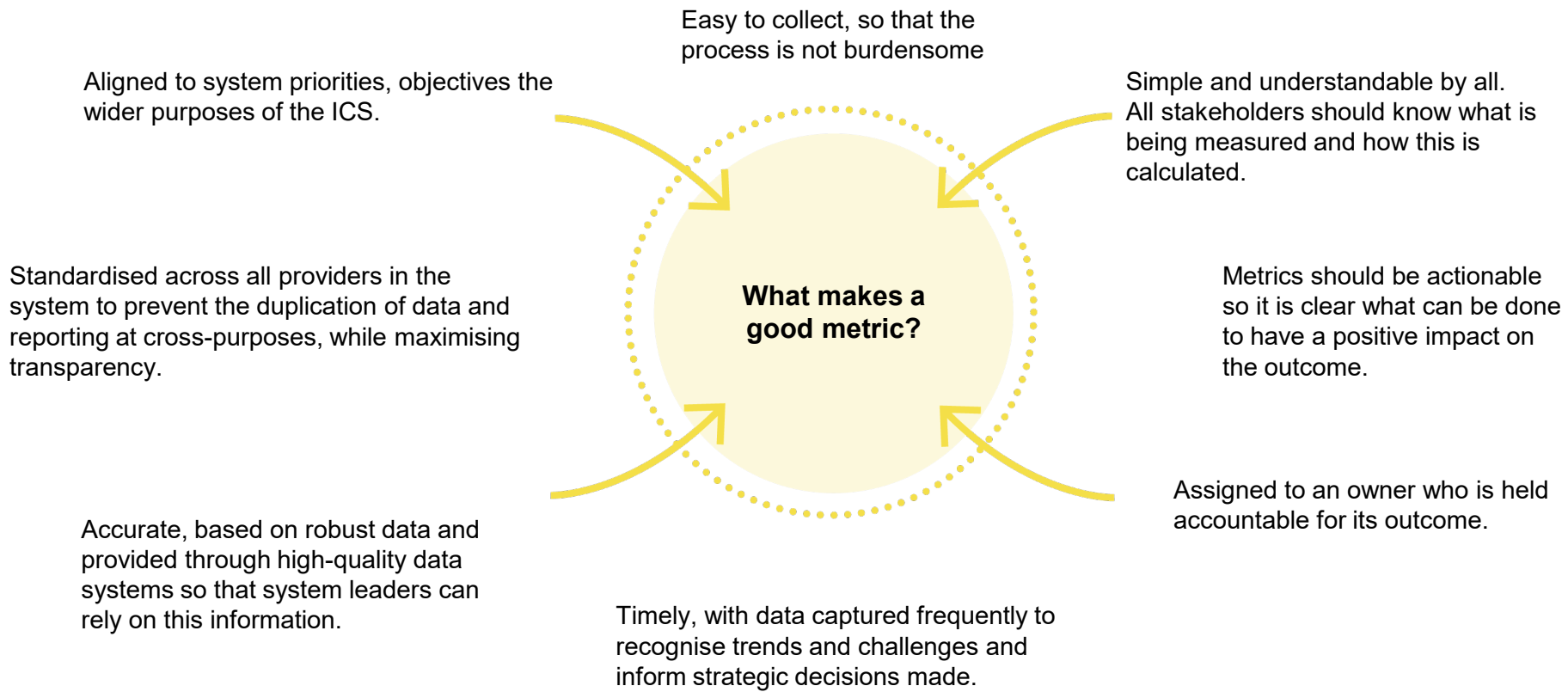
This requires strong culture, relationships and behaviours. Everyone accepting mutual accountability and providing robust, respectful challenge will be key.

As a matter of last resort, the ICB will take a more regulatory approach and intervene.

All of the above also applies to the ICB's oversight of individual organisations. Interventions will be based on mutual aid and action. However, if all else fails, the ICB may be required to take a more regulatory approach to individual organisations.

What a good metric looks like

The diagram below provides some thoughts on what a good metric looks like.



Changing the mindset



Changing the mindset

A great deal of what is in this paper represents cultural change for the organisations within the Staffordshire and Stoke-on-Trent system.

If a new approach along these lines is adopted, it represents a significant change from historic NHS practice.

In this context, it may be difficult for all organisations to let go of historic ways of working and some of the damage this may have caused to relationships in the past.

The ICB would like this to feel like a new start and would therefore propose two things:

An amnesty: is a discussion required about past issues, with an agreement to let past behaviours and issues go, in order to build trust?

A discussion on how some ICB staff members can most usefully be deployed to support the system rather than commission providers

Question: Would either of these ideas be helpful? If so, how could they be implemented? If not, are there other things that could be done to signal that this is a new start and convince everyone that it will be different this time?

Scenario for discussion as a system



Introduction: scenarios

Much of the content provided on the previous pages of this paper is theoretical in nature.

We thought it may be useful to consider how the concepts outlined in this paper would play out in practice.

Therefore there are two simple scenarios outlined on the following pages.

There are then some questions outlined.

Any thoughts on how the principles outlined in this paper would be applied in practice in these scenarios would be much appreciated.

Some initial thoughts have been provided if they are helpful, but please feel free to ignore or disagree.

Scenario 1

Urgent and Emergency Care:

In 2023 sustained pressure in urgent and emergency care has emerged across primary care, community services, mental health, acute services and social care.

The symptoms of this include increasing attendances and admissions, delays in ambulance handovers, and continuing difficulties with discharge arrangements.

The regulator is becoming involved and has tasked the ICB CEO with supporting the system to agree a shared ambition to reduce the immediate pressures, improve operational delivery and define and deliver longer-term transformation.

Scenario 1 questions

Urgent and Emergency Care: Key Questions

- In 2023, when the ICB CEO receives the call from the regulator, where does he/she go to first?
- What structures will be required?
- Where does accountability sit?
- How will the Urgent Care Board, Places and Provider Collaborative operate and behave?
- How will the ICB operate and behave?

Scenario 1 – thoughts on approach

Here are some thoughts on how the ICB might respond in this scenario if adopting the new approach:

- The CEO might first look to the ICB Director of Delivery and the ICB Director of Delivery would likely seek intelligence from the Portfolio Lead.
- The Portfolio Lead would look at the root cause of the problem and understand what change was required to solve the problem.
- The ICB and other system leaders would have to try and ensure the Portfolio is set up for success and has the right tools and conditions.
- Sharing accountability is important: the Portfolio Lead would work with all organisations to produce a shared response. All organisations would be responsible for this and all would have to contribute to developing the solution.
- Accountability would therefore sit at the level of the Portfolio with the organisations sitting on the Portfolio Board / Committee. The ICB would be accountable jointly for ensuring the solution is implemented and supporting the Portfolio to deliver the solution.
- The data and information is important to reduce surprises. The more information available in one place, the better. There should be full data sets in one location, i.e. a dashboard which covers activity, performance, quality and patient experience rather than more disaggregated intelligence. A holistic set of data is critical.
- In some senses one could question whether anything will be different as the result of this new approach given that this kind of scenario is faced all the time currently. The hope is that the collective commitment of partners to do things differently, with incentives to act and tackle the problems, will result in action.

Scenario 2

It's 2024. The ICB is two years into a ten year contract with the Place Based Partnership in a specific place within the system to improve population outcomes for the population group of children and young people.

The ICB is told that a range of intelligence has been received around the declining quality in the provision of CAMHS services in the Place. Local MPs are now beginning to notice. The ICB must consider how to proceed.

- What is the role of the ICB in this situation?
- What is the role of NHSE / I?
- What is the role of the Place Based Partnership?
- How could this situation have been prevented – what should have been the roles of the ICB and Place Based Partnership and individual organisations?
- Based on these roles and functions, where does accountability sit?
- What will the ICB do about this issue? How will it behave?

Conclusion and next steps



Conclusion and next steps

This paper is only intended as a starter for ten and not intended to be considered for approval.

It is intended to start a conversation with the system about how oversight and assurance are undertaken moving forward.

When it has been discussed with partners, providers, and at the ICB Finance and Performance Committee, all comments received can be brought together and a new version produced accordingly.

The new version can then be iterated and co-produced until the ICB and the wider system partners are all happy with the final text.

It should also be noted that the paper only represents the start of a process of establishing the ways of working for the system. Further work is required in areas including decision making and governance.

For example, given the shared nature of accountability described here, further work may be required on a decision making framework if quality or performance issues lead to proposals to transform services. Would resulting decisions be made by the system in one of the system groups or committees, or by individual Trust Boards? Clarity on these points will be important.

Similarly, does the enabling and facilitating role laid out here imply a different approach to governance – perhaps based more on informal networks and decision making by consensus and using delegated authority, rather than formal decision making? This may offer the potential to streamline or slim down the governance.

Further work is required in these areas.



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	13
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Title:	Finance and Performance Update
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Meeting Date:	22 nd September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Paul Brown Chief Financial Officer	Yes	Finance, Planning and Intelligence Directorate

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

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

History of the paper – where has this paper been presented		
	Date	A/D/S/I
System performance group	31/8/2022	
Finance and performance committee	6/9/2022	D

Purpose of the Paper (Key Points + Executive Summary):
<p>System performance has been scrutinised by the ICB Finance and Performance Committee (F&PC). The report of the Committee chair is included in the Board pack. This paper is a summary of the material that was presented and discussed at the F&PC.</p> <p>The purpose of this report is to summarise the key financial and operational performance issues for the ICB Board.</p> <p>The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) agreed to a plan to break even over the financial year after flagging a number of risks. Given the uncertainties around staff absence, covid prevalence, excess inflationary pressures and the growth in activity, acuity and package prices within Continuing Health Care (CHC), we are flagging that breakeven will be extremely challenging and we have estimated a gap of £20m. We are working to review mitigating actions to reduce the £20m risk flagged, albeit these will likely be non-recurring, leaving the system with a substantial challenge for 2023/24.</p>

In addition to the focus on in-year financial control, attention is turning to addressing the underlying deficit and we have started work on the financial strategy that we will adopt for 2023/24. The early thinking is shared in the attached report.

The ICS continues to experience a number of system pressures impacting on the Urgent and Emergency Care (UEC) pathway. Ambulance handover delays remain a challenge and an area of focus to support maintaining lower numbers and reducing delays.

During the summer strong progress has been made in terms of addressing waiting time backlogs, and the focus is now on continuing this momentum and protecting elective activity during the winter months. In June 2022 all elective points of delivery (PODs) remain below 2019/20 activity levels. To date 86% of pre-pandemic elective activity has been delivered (ordinary spells and day cases), however waiting times across the ICB have continue to reduce for those waiting 78 and 104 weeks.

Cancer faster diagnosis 28-day standard performance for June is 59.2%, remaining below the 75% standard. Providers are seeing an increase in the number of cancer referrals. Improvement to cancer waiting times is currently a top priority for the planned care portfolio.

Diagnostic waiting times and activity have remained challenging, similarly to elective, being impacted by COVID and workforce issues. Current levels of activity within all tests remain below pre-pandemic levels. Year to date 79.2% of 2019/20 activity is being delivered, across all tests, with 67% of patients being seen within 6 weeks of referral versus the 95% target (June 2022).

As part of the development of the ICB we are streamlining our reporting into a balanced scorecard approach with much more focus on the risks and the actions being taken to address these risks. At this point there is further work to do to finalise the new approach and therefore this report focusses on three key areas:

- Financial performance at the system level
- Key urgent care performance targets
- Planned care and cancer performance

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):

Systems are required to deliver on the 2022/23 operational planning ambitions set out in the planning guidance. Failure to meet these requirements would pose a risk to the ICB in meeting its four core purposes;

- a) improve outcomes in population health and healthcare
- b) tackle inequalities in outcomes, experience and access
- c) enhance productivity and value for money
- d) help the NHS support broader social and economic development

Implications:

Legal and/or Risk	Monitoring performance is a statutory duty of the ICB as stated in their respective constitutions.
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	
Sustainability	
Workforce / Training	

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? N/A		
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: <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	Has an Equality Impact Assessment been completed? If yes please give date(s) <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 		

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

4.	Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients <i>Please provide detail</i>	N	
5.	Has a Data Privacy Impact Assessment been completed? <i>Please provide detail</i>	N	
Recommendations / Action Required:			
The Integrated Care Board is asked to: Discuss and note the contents contained within the attached report.			

Report to the ICB Board on Finance and Performance

ICB Board Meeting – 22 September 2022



Executive Summary

The purpose of this report is to summarise the **key financial and operational performance issues for the ICB Board**. Finance and performance is assured through detailed reporting at the System Finance and Performance Committee (F&PC) which meets monthly and reports to the ICB Board on its assurance activities. The F&PC focusses on the actions being taken to address the risk and seeks assurances directly from the individual ICB Partner Organisations.

As part of the development of the ICB we are streamlining our reporting into a balanced scorecard approach with much more focus on the risks and the actions being taken to address these risks. At this point there is further work to do to finalise the new approach and therefore this report focusses on three key areas:

- Financial performance at the system level
- Key urgent care performance targets
- Planned care and cancer performance

Headlines as at the end of August 2022

- The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) agreed to a plan to break even over the financial year after flagging a number of risks. Given the uncertainties around staff absence, covid prevalence, excess inflationary pressures and the growth in activity, acuity and package prices within Continuing Health Care (CHC), we are **flagging that breakeven will be extremely challenging** and we have estimated a gap of £20m. We are working to review mitigating actions to reduce the £20m risk flagged, albeit these will likely be non recurring, leaving the system with a substantial challenge for 2023/24.
 - In addition to the focus on in-year financial control, attention is turning to **addressing the underlying deficit** and we have started work on the financial strategy that we will adopt for 2023/24. The early thinking is shared in this pack.
 - The ICS continues to experience a number of system pressures impacting on the Urgent and Emergency Care (UEC) pathway. Ambulance handover delays **remain a challenge** and an area of focus to support maintaining lower numbers and reducing delays.
 - During the summer strong progress has been made in terms of addressing waiting time backlogs, and the focus is now on continuing this momentum and protecting elective activity during the winter months. Waiting times across the ICB have continued to reduce for those waiting 78 and 104 weeks.
 - All elective points of delivery (PODs) remain below 2019/20 activity levels. **To date 86% of pre-pandemic elective activity has been delivered** (ordinary spells and day cases).
 - **28 day waits (cancer faster diagnosis standard) performance for June is 59.2%**, remaining below the 75% standard. Providers are seeing an increase in the number of cancer referrals. Improvement to cancer waiting times is currently a top priority for the planned care team.
 - **Diagnostic Waiting Times and activity have remained challenging**, similarly to elective, being impacted by COVID and workforce issues. Current levels of activity within all tests remain below pre-pandemic levels, with 67% of patients being seen within 6 weeks of referral versus the 95% target (June 2022). Year to date 79.2% of 2019/20 activity is being delivered, across all tests.
-

Financial Position

- Ledger outages have impacted our ability to report a full month 4 position. These issues are not limited to the NHS in Staffordshire and Stoke on Trent. We are confident however that the year to date position reported is materially correct.
- As shown opposite, at a system level we are reporting a relatively small deficit (£1m) against the plan (just 0.1% variance).
- However this is partly mitigated by the ICB position as due to the requirement to account for three months as 6 CCGs, all available non recurrent flexibilities have been fed into the position and are netting down some of the in-year pressures. These pressures relate to the Continuing Health Care budgets, partially offset by underspends on Primary Care and Prescribing.
- The system efficiency target is 4.2%, historically a very challenging target. We have delivered 85% of the year to date target which is a positive performance, nevertheless the full year effect of the shortfall would amount to £20m.
- There are financial pressures in the providers due to a number of factors, the key ones being:
 - Covid19 costs continue at c£1m per month without budgetary cover from June 22 onwards
 - Shortfalls in the delivery of cash releasing efficiency savings
 - Inflationary pressures above the 28th April plan

We currently face a £20m deficit against the system plan. However we are continuing to work to mitigate this and we remain focussed on the delivery of a balanced position, if at all possible.

System	Plan	£'m YTD	Variance
Income	1,284.8	1,286.2	1.4
Pay	(349.3)	(343.0)	6.3
Non Pay	(197.5)	(206.9)	(9.4)
Non Operating Items (exc gains on disposal)	(10.5)	(10.3)	0.3
ICB/CCG Expenditure	(721.7)	(722.8)	(1.4)
Total	5.6	3.1	(2.8)
			-0.2%

UHNM	Plan	YTD	Variance
Income	324.6	324.9	0.3
Pay	(190.9)	(186.7)	4.3
Non-Pay	(122.0)	(129.3)	(7.3)
Non Operating Items (exc gains on disposal)	(8.6)	(8.4)	0.2
TOTAL Provider Surplus/(Deficit)	3.1	0.4	(2.6)
			-0.8%

MPFT	Plan	YTD	Variance
Income	189.1	188.3	(0.7)
Pay	(131.0)	(128.5)	2.6
Non-Pay	(54.4)	(54.1)	0.3
Non Operating Items (exc gains on disposal)	(0.9)	(0.7)	0.2
TOTAL Provider Surplus/(Deficit)	2.7	5.0	2.3
			1.2%

NSCHT	Plan	YTD	Variance
Income	49.4	51.2	1.8
Pay	(27.4)	(27.9)	(0.5)
Non-Pay	(21.2)	(23.5)	(2.3)
Non Operating Items (exc gains on disposal)	(1.1)	(1.1)	(0.1)
TOTAL Provider Surplus/(Deficit)	(0.2)	(1.3)	(1.1)
			-2.1%

ICB	Plan	YTD	Variance
Allocation	721.7	721.7	0.0
Expenditure	(721.7)	(722.8)	(1.0)
TOTAL ICB Surplus/(Deficit)	0.0	(1.0)	(1.0)
			-0.1%

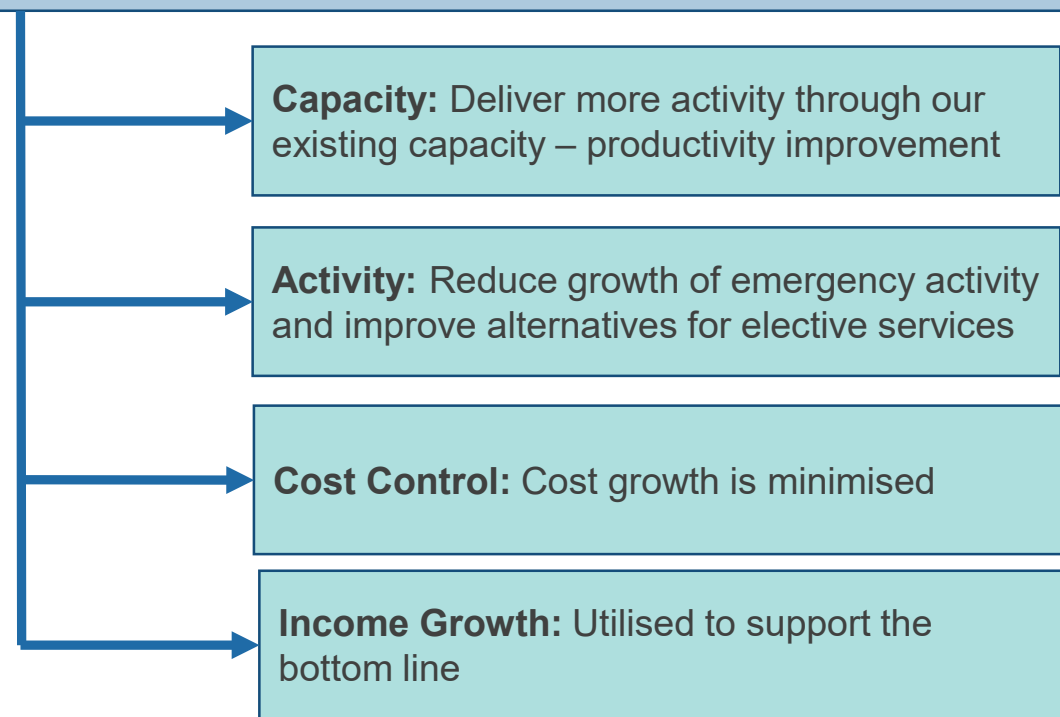
Addressing the system's financial challenge

- We are already focusing in on 2023/34 where the challenge is very significant. We start the next planning period with an underlying deficit of c£135m.

The Financial Strategy - Evolution not Revolution

What = Eliminate our underlying deficit through the release of growth to the bottom line and contain costs within the current financial envelope.

How = System works to avoid activity growth and to ensure that the right patients are treated at the right time, within the right setting.



Milestone	Owner	Deadline
Financial Modelling	Deputy CFOs	Complete
CFO internal timeframe for ratification / deliverability	CFOs	23 rd September 2022
System Executive discussion on emerging financial strategy and Joint Forward Plan	CFOs	28 th September 2022
SPG asked to support the financial strategy. System COOs / Strategy Directors tasked to work on transformation.	System	26 th October 2022
Test strategy & organisational LTFM affordability against 2023/24 allocations	CFOs	Likely to be around Christmas
Apply strategy to contracts (outside system) and detailed budget setting	CFOs	Jan 23 to March 23
Agree 23/24 Operating Plan and Budget	System	End March 23

System performance – focus on planned care

- The system has achieved a significant reduction in the numbers of patients waiting more than 104 weeks for elective care. The number of patients waiting this long spiked during the Covid period, but is now down to 62 people. We are also making in-roads into those waiting for more than 78 weeks.
- The table below compares current performance with activity from before the pandemic. Overall, elective activity is below 2019/20 activity levels, whilst GP referrals for outpatient appointments are above pre-pandemic levels.
- During the course of Quarter 1 the total number of patients waiting has continued to grow, to 147,735 as at the end June 2022. The system's priority is to reduce the longest waiters first, with appropriate clinical prioritisation.
- 28 day waits (faster cancer diagnosis standard) performance for June is 59.2%, remaining below the 75% standard. This is a priority that the elective care team are focussing on at the moment.
- Diagnostic performance against the national ambition has not been met during June. YTD only 79.2% of 19/20 activity is being delivered, across all tests. 67% of patients are being seen within 6 weeks of referral versus the 95% target. We are planning investment into diagnostic facilities to increase capacity.

Indicator	2019/20			2022/23			YTD 1920 v YTD 2223		
	Apr-19	May-19	Jun-19	Apr-22	May-22	Jun-22	19/20	22/23	% Var
Elective Ordinary Spells	1,537	1,770	1,663	1,216	1,411	1,464	4,970	4,091	-18%
Day cases	12,887	13,222	12,309	10,850	12,475	12,198	38,418	35,523	-8%
Outpatient procedures (Cons Led)	13,708	14,216	13,744	8,991	10,471	9,645	41,668	29,107	-30%
Outpatient first attendances without a procedure (Cons Led)	26,313	27,224	25,683	22,911	27,580	26,015	79,220	76,506	-3%
Outpatient follow-up attendances without a procedure (Cons Led)	43,191	45,665	42,944	37,750	43,770	40,035	131,800	121,555	-8%
RTT - admitted, completed	5,423	5,794	5,427	4,143	5,107	4,985	16,644	14,235	-14%
RTT non-admitted, completed	21,951	23,159	21,735	19,410	22,194	20,684	66,845	62,288	-7%
Incomplete Pathway - Total Waiting List	85,296	86,968	87,398	144,518	146,503	147,735	87,398	147,735	69%
Incomplete Pathway - 52+ Weeks	0	1	1	8,415	8,550	8,459	1	8,459	
Incomplete Pathway - 78+ Weeks	0	0	0	2,041	1,828	1,480	0	1,480	
Incomplete Pathway - 104+ Weeks	0	0	0	445	235	62	0	62	
GP and other (non-GP) referrals first consultant-led outpatients	35,448	36,394	34,198	34,894	38,797	36,348	106,040	110,039	4%
Cancer 62 days Waits - Patients over 62 Days	77	67	82	139	167	193	82	193	135%
Cancer 28 days FDS - Total Patients Diagnosed	1,510	1,945	1,858	4,564	5,017	4,653	5,313	14,234	168%
Cancer Treatment Starts (31 Days Pathway)	539	524	523	521	534	602	1,586	1,657	4%
Diagnostic Tests (Specific 7 Tests)	37,950	39,669	39,235	29,625	32,536	30,387	116,854	92,548	-21%

System performance – focus on urgent care

- Ambulance handover delays remain significantly high at acute sites with delays over 60 minutes during June rising up to 1,069 at University Hospital of North Midlands. Royal Stoke University Hospital (RSUH) is one of 10 sites receiving support from the National NHS England (NHSE) team to reduce delays. The ICS continues to maximise access to all non-Emergency Department (ED) pathways through a single access route which incorporates community pathways, including Urgent Community Response and Acute Respiratory illness, for all patients to support the reduction of ambulance handover delays.
- A&E 4-hour target performance remains challenging for all acute providers locally and nationally. There have been a high number of 12-hour trolley breaches across the system post-winter.
- A series of additional and extraordinary actions have been developed and deployed to support pressures. This includes a series of rapid improvement weeks, focus upon increasing the level of WMAS referrals directly to Community Rapid Intervention Service (CRIS), increased capacity for Virtual Wards and NHS 111 enhanced clinical validation.

Accident & Emergency - Provider	Target	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance	22/23 YTD	Apr 22	May 22	Jun 22	Rolling 12 Months Trend / Performance
		UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST					THE ROYAL WOLVERHAMPTON NHS TRUST					THE DUDLEY GROUP NHS FOUNDATION TRUST				
A&E 4 Hour Target	95%	62.65%	62.91%	62.79%	62.27%		78.42%	76.77%	79.50%	78.91%		76.34%	80.34%	74.71%	74.03%	
12 hour trolley breaches	0	1,823	878	390	555		80	30	20	30		159	31	79	49	
		UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST					UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST					WALSALL HEALTHCARE NHS TRUST				
A&E 4 Hour Target	95%	62.63%	61.97%	64.18%	61.68%		54.18%	54.75%	54.63%	53.17%		72.87%	73.92%	72.30%	72.48%	
12 hour trolley breaches	0	1,076	432	388	256		1,034	271	211	552		17	6	10	1	



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	14
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Title:	Quality and Safety – Update Report
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Meeting Date:	22 nd September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Heather Johnstone – Chief Nursing and Therapies Officer		Nursing and Quality Heads of Service

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

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

History of the paper – where has this paper been presented		
	Date	A/D/S/I
This paper is a combination of those corresponding papers presented and discussed the at Quality & Safety Committee	14/09/22	S

Purpose of the Paper (Key Points + Executive Summary):
<p>This paper is intended to provide assurance to the ICB in relation to the key quality matters. These include:</p> <ul style="list-style-type: none"> • Updates from the Quality Workshops held in July and August 2022 • Updates from the Subgroups: <ul style="list-style-type: none"> • Continuous Quality Improvement. • Maternity and Neonatal Services. • Quality Impact Assessment including the approval of the Interim ICB Quality Impact Assessment Subgroup Terms of Reference. • Patient Safety Specialist including the approval of the Patient Safety Specialist Network Terms of Reference. • Infection Prevention Control. • Adult and Children's Safeguarding.

- Current System Quality Matters
 - Patient Safety Incident Response Framework
- Clinical Policy Alignment

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 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 the meeting.

Implications:	
Legal and/or Risk	Risks identified and discussed within the agenda
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?		
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.	<p>Were there any conditions? If yes, please state details and the actions in taken in response:</p> <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	<p>Has an Equality Impact Assessment been completed? If yes please give date(s)</p> <ul style="list-style-type: none"> Stage 1 Stage 2 	N	
3b.	<p>If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?</p>		
3c.	<p>Please provide detail as to these considerations:</p> <ul style="list-style-type: none"> 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.	<p>Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients</p> <p>Please provide detail</p>	N	
5.	<p>Has a Data Privacy Impact Assessment been completed?</p> <p>Please provide detail</p>	N	
Recommendations / Action Required:			
<p>The Integrated Care Board is asked to:</p> <p>Be assured in relation to key quality and safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System and ratify the decisions made by the committee under delegated authority.</p> <p>Ratify the decisions of the System Quality and Safety Committee as follows:</p> <ul style="list-style-type: none"> Quality and Safety Committee – APPROVE Terms of Reference System Quality Group – APPROVE Terms of Reference Interim QIA Subgroup - APPROVE Terms of Reference System Patient Safety Specialist Network - APPROVE Terms of Reference <p>Members are asked to receive this report and seek clarification and further action as appropriate.</p>			

Quality and Safety Committee (QSC) report to the Integrated Care Board – September 2022

1. Introduction

The Quality and Safety Committee (QSC) was established in shadow form in July 2021 and has met monthly since that date. The QSC is currently being revised to ensure the ICB fulfil the requirements of the most recent National Quality Board guidance in respect of quality assurance and improvement in an Integrated Care System (ICS).

This report is intended to summarise the key discussion points from the September 2022 meeting, to highlight any additional relevant emerging quality matters and to provide assurance to the ICB that quality is being monitored and improved in partnership across the system.

2. Update from Quality Workshops

There have been two workshops held to consider the final implementation of the National Quality Board Guidance to ensure we have both an ICB Quality and Safety Committee (QSC) and a System Quality Group (SQG). Other items discussed were Place Quality Arrangements and the system Quality Impact Assessment (QIA) arrangements going forward. Further to both workshops, subsequent actions have been taken, supporting progress in both areas.

Using National Quality Board (NQB) Guidance, Terms of Reference (ToRs) for both the QSC and SQG have been produced and discussed at the QSC. Both ToRs were agreed in principle with further discussions with the Local Authorities to confirm membership of the relevant meetings.

3. Sub-Group Updates

3.1. Continuous Quality Improvement (CQI)

The Continuous Quality Improvement Subgroup continues to meet monthly, and preparations are being made for the Quality Improvement Network, originally scheduled for the 15th September 2022 but postponed following the period of mourning for the Queen, and the launch of the ICS CQI Webpage in October 2022. QSC members were provided with updates across several ongoing projects including complex hospital discharge, falls redesign and mapping planned care to best practice. A special interest group from membership including two PCN Clinical Directors explored how Quality Improvement could be further embedded in Primary Care. Actions have been agreed and progress is being monitored.

3.2. Maternity and Neonatal Services

The Local Maternity and Neonatal System (LMNS) Board continues to monitor all aspects of maternity quality and safety, including services provided out of area and the findings from all such cases which are incorporated into the work of the LMNS Board.

Workforce challenges continue to impact on the ability to provide safe maternity staffing in line with Ockenden recommendations. The risks associated with this are mitigated by moving staff to areas of greatest need, primarily the consultant units on the delivery suites. This impacts on several areas:

- Inability to provide intrapartum care at both freestanding midwife led units; Samuel Johnson Hospital, Lichfield and County Hospital, Stafford. This continues to be monitored

via the Transformation Programme Board, NHS England and overview and scrutiny panels. Both providers are due to update the LMNS this month with timescales for reinstating.

- The ability to consistently provide home birth services, which have been suspended intermittently in line with escalation policies. Our Maternity and Neonatal Voices Partnership (MNVP) are gathering feedback from families and working with Trusts to ensure good communication.
- A backlog of antenatal first booking appointments at the University Hospital North Midlands NHS Trust (UHNM). Further analysis of which is being undertaken through the maternity Quality & Safety Oversight Forum (QSOF) to understand the extent and impact of this.
- Providing timely inductions of labour at UHNM – there has been a backlog of overdue inductions and action is being taken to address and closely monitor this. An improvement group has been established internally with additional support from the LMNS team and NHS England.
- Attendance at LMNS Board and Neonatal improvement group is also affected with no attendance by UHNM senior team at this month's LMNS Board meeting. This has limited the ability of the team to obtain full assurance this month and there is work underway to explore this further in partnership with the Trust team.

Due to ongoing pressures relating to delays in inductions of labour at UHNM as well as regionally and nationally NHSE have asked the Staffordshire and Stoke-on-Trent ICB Chief Nursing and Therapies Officer to lead a piece of work and to chair the Midlands Regional System Leader Escalation and Maternity Operational Pressures Escalation Level Project Steering Group which covers 11 ICSs. This approach is being modelled on successful system working in Cheshire and Merseyside ICS, who presented to the group on 2nd September 2022. However, it is recognised their providers are within one ICB, whereas the Midlands providers are not, creating further challenges. There has been good representation from across the midlands to the meetings, demonstrating their commitment to being solution focused. This work will continue until the project findings are implemented across the region. Due to the current pressures this escalation system has been tested over the past couple of days and learning will be fed into the development process.

3.3. Quality Impact Assessment (QIA)

A paper was presented to the QSC providing an overview of the QIA work to date and next steps. The Committee were advised that following agreement at ICB Executives on the 8th August 2022, an interim ICB QIA arrangement has been put in place to support the approval of ICB QIAs. The QSC approved the Interim QIA Subgroup's Terms of Reference which will be a subgroup of the ICB's Quality & Safety Committee. Interim QIA Subgroup meetings have been scheduled monthly for the period of August to December 2022. Work is underway, including a workshop in October 2022, to co-produce a new ICB QIA Policy and process. Meetings with system partners to discuss a system-wide approach to QIAs that supports collaboration and reduces duplication but retains individual organisations governance processes will be reconvened following the agreement of the new ICB approach.

3.4. Patient Safety Specialists (PSS)

The QSC approved the System Patient Safety Specialist Network's Terms of Reference which will be a subgroup of the System Quality Group. Preparation is underway for a workshop for all providers to launch a pilot Harm Review process which is consistent across the system based upon MPFT pilot earlier in the year.

3.5. Infection Prevention and Control (IPC)

Data for the first quarter of 2022/23 when compared to the same period of last year indicates increases in MRSA Bacteraemia, Clostridium difficile (*C. diff*) infection and all gram-negative blood stream infections with the exception of Pseudomonas. This reflects National epidemiological reports which note increases in MRSA, *C. diff* and all gram-negative blood stream infections coinciding with increased rates of Covid-19 which is under further investigation and analysis. Regionally work is underway supported by NHSE IPC leads to work on specific pathways influencing Healthcare associated infections (HCAI) including a *C. diff* Collaboration. Task and finish groups have been established aiming to share learning and use a common approach to refocus and reduce the incidence of HCAI.

The IPC services continue to respond to the Covid-19 pandemic and associated guidance as the region emerges from the Omicron wave. IPC leads continue to meet weekly to ensure a system wide approach in response to changes in national and regional guidance. Information is shared with colleagues across Local Authorities and health systems.

The recent Monkeypox outbreak has again highlighted the importance of system wide working to develop appropriate recognition of cases, treatment and management including screening, contact tracing and vaccination as required in line with requirements. Cases continue to rise nationally and locally, although appear to be slowing at the time of reporting.

3.6. Adult and Children's Safeguarding

3.6.1 Safeguarding Children and Young People

Stoke-on-Trent Local Authority children's services are still being scrutinised and supported by appointed external commissioners by way of a Children's Improvement Board and plan to improve their OFSTED inspection rating where all areas were deemed inadequate. Collaboration meetings between the Local Authority, Police and Health are being undertaken weekly to ensure an integrated approach. This has been agreed and adapted locally to ensure standardised assessment, governance, recognised good practice and streamlined processes.

During the pandemic the Joint Targeted Area Inspection (JTAI) schedule was stepped down. However, it is now expected that Staffordshire and Stoke-on-Trent will be inspected within the next 6 months. Full details of the inspection can be found on [www.gov.uk](https://www.gov.uk/government/news/new-frameworks-for-joint-targeted-area-inspection-jtais) - 'New frameworks for joint targeted area inspection (JTAs)'.
(Note: The original text contains a typo 'JTAs' which has been corrected to 'JTAs' based on the context and the link provided.)

There are two thematic Child Safeguarding Practice Reviews (CSPR) awaiting publication, highlighting learning around intra familial child sexual abuse in Staffordshire and infants under 1 year subject to infant head trauma across Staffordshire and Stoke-on-Trent. Learning from these reviews has been shared with frontline practitioners and included in the GP professional forums.

3.6.2 Adult Safeguarding

Within the independent care sector there are several care homes and domiciliary care agencies being monitored through the Quality and Safeguarding Information Sharing Meeting (QSISM) with 3 nursing homes and 1 care agency in the large-scale enquiry process.

One statutory Safeguarding Adult Review (SAR) has been published this quarter with one new SAR referral being scoped. There are a total of 15 Domestic Homicide Reviews open across the county in various stages of the process.

The consultation on the guidance for the Liberty Protection Safeguards (LPS) has closed. The LPS process, once in place, will make the ICB a responsible body for fully funded patients and some of the Deprivation of Liberty Safeguards (DoLS) cases currently held by the Local Authorities will become the ICB responsibility. Stoke-on-Trent Local Authority has reported a backlog of DoLS authorisations, but assurances have been given that there is an action plan where these will be addressed and all high risk cases have been seen.

4. Current System Quality Matters

4.1. Ramsay Healthcare UK – Care Quality Commission (CQC)

Throughout August 2022, the CQC conducted unannounced inspections of Rowley Hospital and Beacon Park which are operated by Ramsay Healthcare UK. The CQC have shared site visit feedback letters with Ramsay Healthcare UK, which are overall positive. The Well Led discussion has since taken place and the inspection is ongoing. This will be reported in due course.

4.2. The Woodhouse

Due to the challenges of managing a service which had made clear its intention to reconfigure but gave no specific date, the decision was made to write to Elysium Healthcare board to request a date when their service will cease to provide care for the remaining patients, allowing the company to reconfigure and move forward. Elysium's response recognised the ICB concerns about patient safety and advised that they have written to every placing commissioner independently serving notice, meaning all parties now can manage and work to expected discharge dates. They have agreed that all patients will move by 19th September 2022 and due to the complexities of 5 patients, there will be an extension to 9th November 2022 for these patients only. On the 14th September the Woodhouse advised members of the ICB team that they are moving away from providing Learning Disability Services in line with the Transforming Care Agenda.

The Woodhouse will therefore be renamed as Moorlands Neurological Centre and will provide a Neurobehavioral hospital service. Further detail is awaited and any relevant updates will be provided in a future report.

5. Patient Safety Incident Response Framework (PSIRF)

Guidance documents and templates to support this mandatory requirement, which will replace the current Serious Incident process by September 2023, were published in August 2022 and are currently being reviewed by the ICB quality team with summaries for all are being developed.

6. Clinical Policy Alignment

Prior to the Clinical Policy Alignment paper being received at Board for decision, the QSC received a paper outlining the process used to harmonise the eligibility criteria for five clinical procedures across Staffordshire and Stoke-on-Trent; Assisted Conception, Hearing Loss in Adults, Male and Female Sterilisation, Breast Augmentation and Reconstruction, Removal of excess skin following significant weight loss. The paper outlined the programme of work including Clinical Priorities Advisory Group reviewing best practice and statutory processes, clinical and stakeholder engagement. Members of the QSC were assured that the process undertaken was robust and support the recommendations made in the associated report.



REPORT TO:

Staffordshire and Stoke-on-Trent Integrated Care Board

Enclosure:	15
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Title:	ICB Board Development Programme
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Meeting Date:	22 September 2022
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Executive Lead(s):	Exec Sign-Off Y/N	Author(s):
Prem Singh, ICB Chair and Peter Axon, Interim ICB CEO	Y	Alex Brett, Chief People Officer

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

Action Required (select):							
Ratification-R	Approval -A	<input checked="" type="checkbox"/>	Discussion - D	<input type="checkbox"/>	Assurance - S	Information-I	<input type="checkbox"/>

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

Purpose of the Paper (Key Points + Executive Summary):
<p>This paper sets out an outline proposal for ICB board development using the National Leadership Academy programme. A provider will need to be commissioned to deliver the programme. The Leadership Academy are providing £20,000 to support the costs.</p> <p>Staffordshire and Stoke-on-Trent ICB was formed on 1 July 2022 as a statutory organisation and is now developing and evolving its functions and structures.</p> <p>Leading this fundamental shift towards statutory ICS development requires a system organisational development approach, at all levels of subsidiarity. However, the ICB will play a pivotal role in governing effectively to build patient, citizen and communities' confidence that their wellbeing, health and care is in safe hands.</p> <p>This is also at a time of unprecedented time of pandemic recovery when the ICS will face historically unrivalled challenges.</p> <p>It is proposed the ICB as it evolves and develops takes time, as it should, to consider its development in the round to ensure it is effective. We know that there is a strong link between leadership and</p>

performance which is well demonstrated in the evidence, leading to good organisational climate which in turn can lead to high performing cultures.

Compassionate and Inclusive cultures underpin effective Boards and our behaviours form a key pillar of any effective Board development. Our Leadership Compact outlines how we want to operate collectively and individually with our teams and respective organisations that make up the ICS/B.

Our proposed Board Development Programme builds on the national framework for effective Boards but will as ever develop and respond to the changing climate and our own priorities. Subject to sign off at the ICB a delivery partner will be sourced to commence the programme in the New Year.

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	Our ICB is committed to build a strong culture, which may not happen without a robust Leadership Development Programme in place.
CQC/Regulator	CQC will review the ICB and look at how well led we are.
Patient Safety	N/A
Financial – if yes, they have been assured by the CFO	Funding to support the Board programme on an ongoing basis; non-recurrent funding secured to contribute £20k
Sustainability	Without robust leadership development during a period when the ICB Chair retires, there is real risk that the sustainability of the ICB could flounder.
Workforce / Training	Leadership Development of the Board is key to developing the ICB.

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)		
		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.	<p>Were there any conditions? If yes, please state details and the actions in taken in response:</p> <ul style="list-style-type: none"> Condition 1 & action taken. Condition 2 & action taken. 		
3a.	<p>Has an Equality Impact Assessment been completed? If yes please give date(s)</p> <ul style="list-style-type: none"> Stage 1 Stage 2 	N	
3b.	<p>If an Equality Impact & Risk Assessment has not been completed what is the rationale for non-completion?</p>		
3c.	<p><i>Please provide detail as to these considerations:</i></p> <ul style="list-style-type: none"> 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.	<p>Has Engagement activity taken place with Stakeholders / Practices / Communities / Public and Patients</p> <p><i>Please provide detail</i></p>	N	
5.	<p>Has a Data Privacy Impact Assessment been completed?</p> <p><i>Please provide detail</i></p>	N	
Recommendations / Action Required:			
<p>The Integrated Care Board is asked to:</p> <ul style="list-style-type: none"> Approve the ICB Board Development Proposal Note the proposal to source a delivery Partner 			

A photograph of three people in a meeting room, all wearing face masks. A woman with curly hair in the foreground is looking towards the right. Two other people are seated behind her. The room has large windows and modern office furniture. A blue geometric graphic is in the top right corner, and a yellow square is in the bottom right corner.

ICS Board Development



ICS Board Development

Leading this fundamental shift towards statutory ICS development requires a systems organisational development approach, at all levels of subsidiarity, however, the ICB and ICP, will play a pivotal role in governing effectively to build patient, citizen and communities confidence that their wellbeing, health and care is in safe hands.



This is also at a time of unprecedented time of pandemic, recovery and unmet/pent up need, when the ICS will face historically unrivalled challenges.

Role of Board

Three key roles, underpinned by three building blocks that enable boards to exercise their role



Board Effectiveness

Five important clusters of activity that enable boards to improve their effectiveness.



Well-Led

The 2021/22 System Metrics Oversight Framework proposes the development of a system (ICS) quality of leadership indicator. National Leadership Competencies (Appendix 1) will also underpin NHS Board level roles (and are transferable to wider public sector)



ICB Board Development Proposal

A co-production approach will enable tailored options that reflect local need, however, a high level approach will encompass:

- Table top review of evidence of evolving Board performance and effectiveness
- Observation of Board performance
- Conduct interviews with key staff
- Board self-assessment of performance
- Identify and agree gaps/areas for development in Board function
- Match to support offer and build Board Development Programme
- Identify requirement for external/specialist input to Board Development Programme

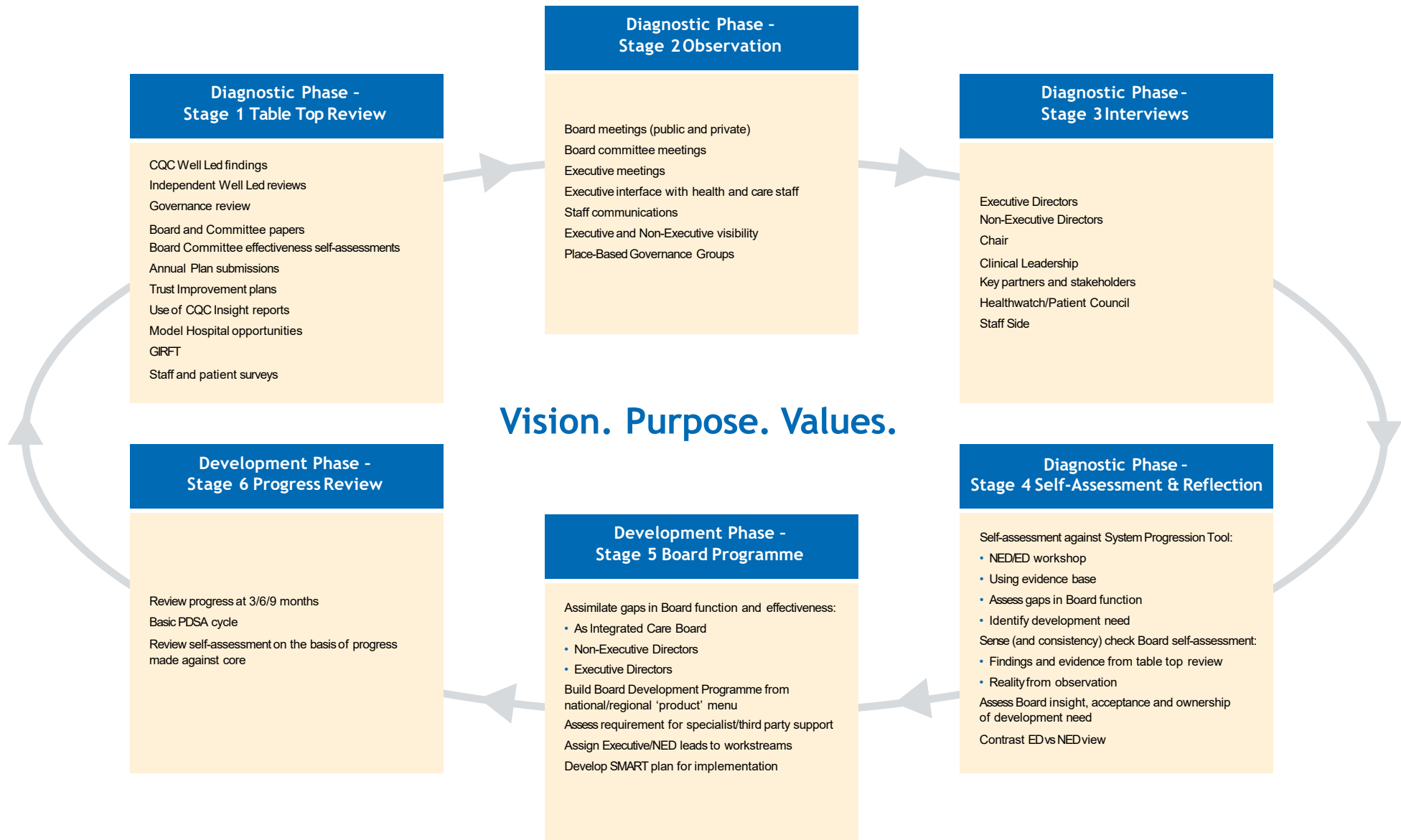


The Leadership Academy have provided some funding, including support to source/contract external/specialist facilitation. Expected outcomes include:

- Progression against System Development Tool indicating evolving maturity
- Outstanding performance (or movement towards) system quality of leadership indicator
- Leadership competencies and behaviours that reflect Our Leadership Compact and in turn the NHS Our Leadership Way



ICB Board Development Approach





Our Leadership Compact and Competencies



Our Leadership Compact.....

and how we will operate in Staffordshire and Stoke-on-Trent ICB

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**.



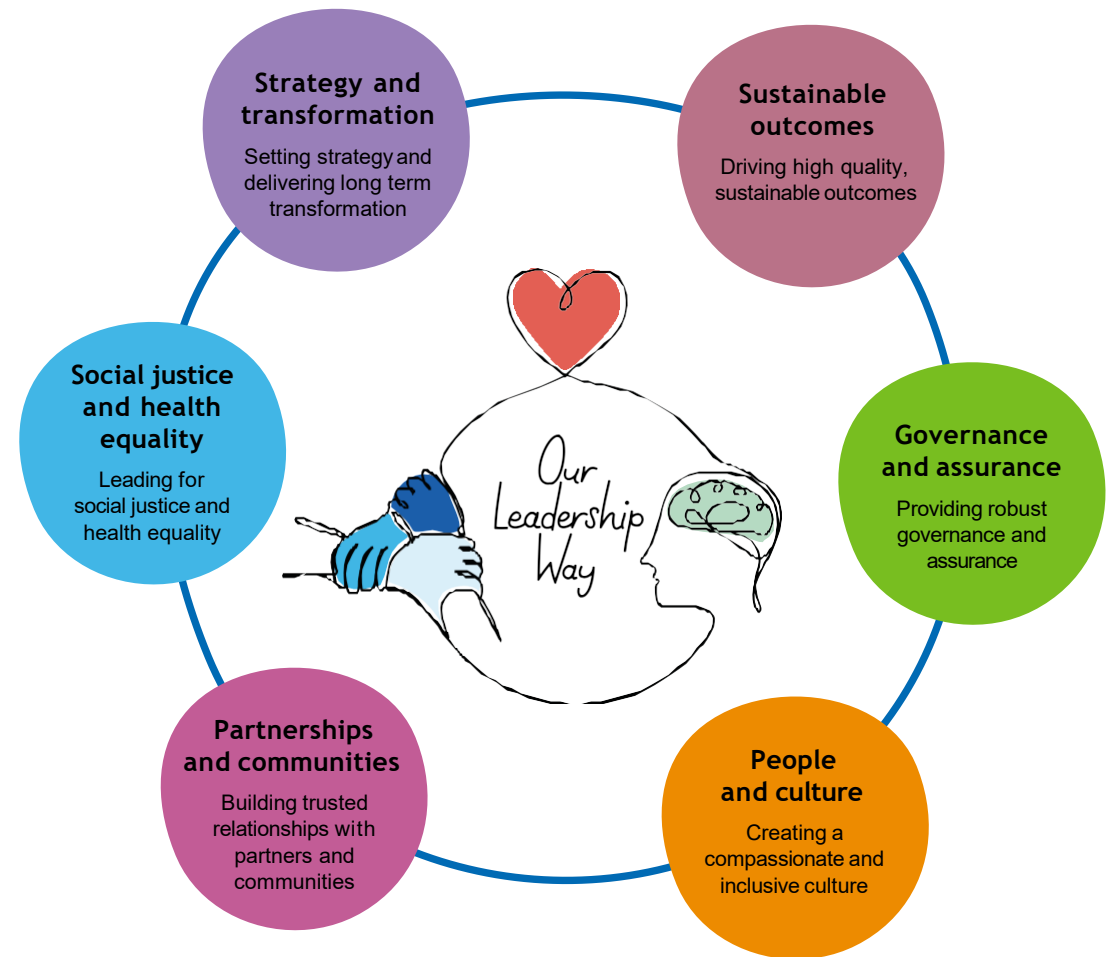
Leadership Competencies

The framework sets out the key competencies associated with the role of an NHS board member in the context of the principles and values detailed in the [NHS Constitution](#).

It has been developed taking into consideration comprehensive feedback received from a wide range of internal and external stakeholders, as well as taking account of the [NHS Long Term Plan](#), [People Plan](#) and ICS transformation.

The framework will support the recruitment and appraisal of NHS board members, underpin the Fit and Proper Person Test (FPPT) 'fitness' attestation, and help to identify potential support and development interventions.

The diagram on the right shows the six key competency domains around which the framework has been built. These inform a series of detailed behavioural descriptors which are, in turn, reflected in model job descriptions.



Alignment of the NHS Leadership Competencies with Our Leadership Way and Our NHS People Promise

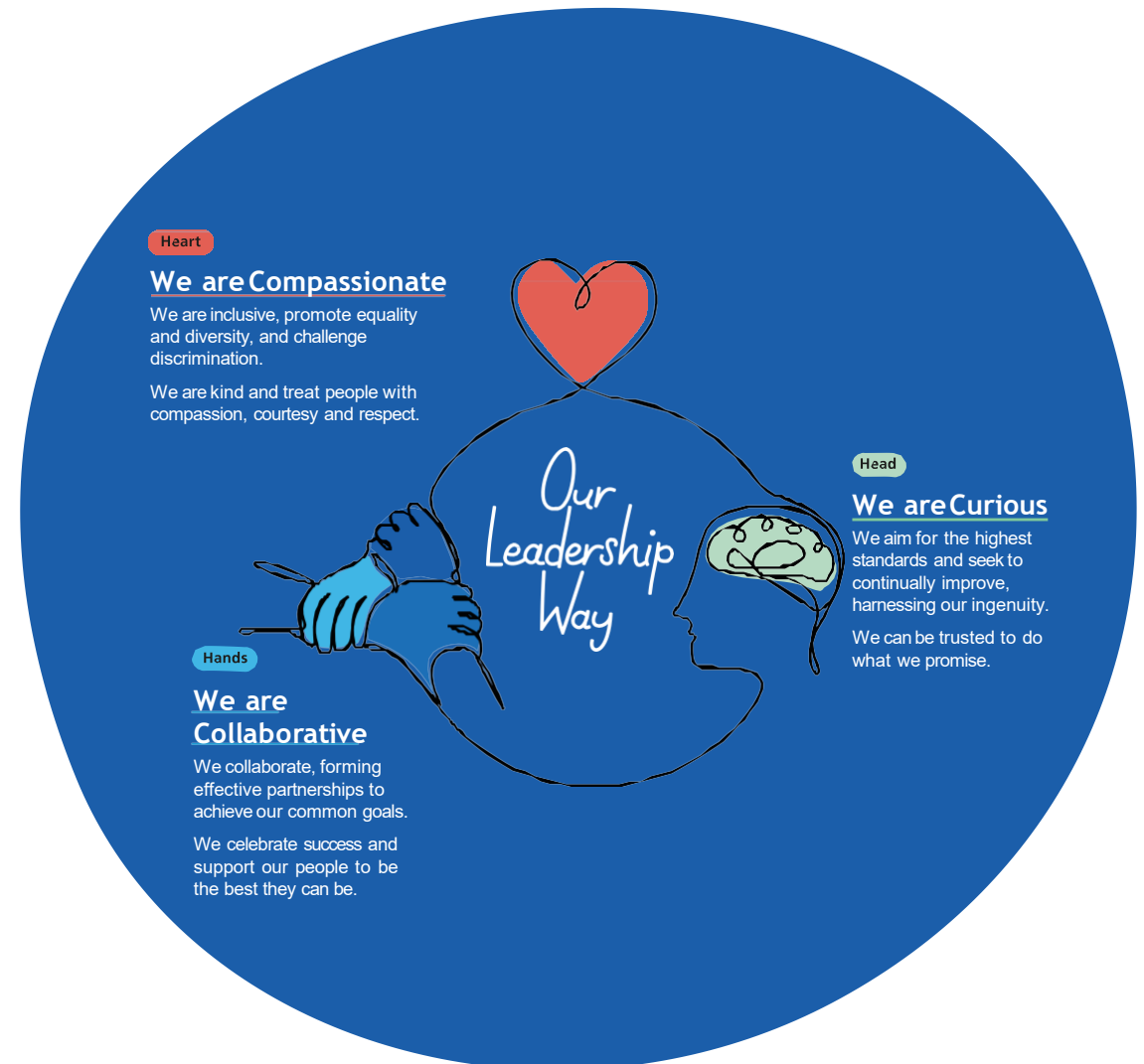
Leaders set the tone for their organisation, team culture and performance.

We have worked with 3,000 NHS leaders to describe what we do when we operate at our best.

Our Leadership Way is a simple way of describing the behaviours we expect every leader to practice every day.

This will anchor the NHS Leadership Competency Framework which is focused on defining the skills, knowledge and behaviours required for our boards and directors to perform effectively.

Our NHS People Promise – the promise we must all make to each other to work together to improve the experience of working in the NHS for everyone – is woven into the NHS Leadership Competency Framework.



Board Committee Summary and Escalation Report

Report of:	Finance and Performance Committee
Chair:	Megan Nurse
Executive Lead:	Paul Brown
Date:	6 th September 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Performance Report	The Committee received detailed ICB level data reports focusing on elective recovery, urgent care and wider metrics where activity vs plan is off track. Planned care performance has improved. Cancer and Diagnostics require further focus. National support is being provided to assist with reducing ambulance handover delays.	Future reports to provide additional information on system actions to recover performance and likely impact. Winter planning report to October F&P. Quality Committee will focus on impact on quality and safety.
Finance Report	Detailed reports and discussion regarding the financial position across the system and wider partners. Outturn deficit risk of £20m flagged, driven by continuing covid19 costs; inflationary pressures above plan; recurrent efficiency shortfall. Focus on 2023/24 planning.	Continued commitment to deliver year end breakeven position if possible, however net risks after mitigations suggest most likely outturn deficit of £20m. Deep dive into CHC activity / costs underway; static workforce numbers, sickness / vacancy levels and sharp rise in agency costs in June are being addressed by the People Committee; deep dive into system capital programme to future F&P.
Portfolio Deep Dive – Primary Care	Overview of Primary Care KPI delivery and Operating Plan; Fuller Review position statement and plans; Pharmacy, Optometry and Dental overview and risks. Significant programme of work underway – further focus required on integration of Primary Care into delivery of the rest of the system and the role of Primary Care in driving reduction in health inequalities.	Primary Care Strategy in development, with draft anticipated by December 2022. Primary Care Dashboard being developed. Risks around delegation of POD include workforce capacity and budgetary pressures. Mitigations in place.

Transformation Update	Discussion around system transformation programme.	Integrated community hubs in North Staffordshire and Stoke on Trent to be included in programme.
Intelligent Fixed Payment System	Committee approved the principles of the IFPS contract and proposed approach to the management of investments and system risks. Report to be discussed individually by each system partner.	Report to progress to Board.
System Performance Management Framework	Positive discussion around proposals presented in the paper.	Paper to be discussed at other system groups before final Framework adopted by Board.
System Oversight Framework	Committee supported ratings proposed for each system provider.	

Risk Review and Assurance Summary

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

Board Committee Summary and Escalation Report

Report of:	Audit Committee
Chair:	Julie Houlder
Executive Lead:	Sally Young/Paul Brown
Date:	5 th September 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Audit Committee terms of reference	The committee reviewed changes made since 1 st July 2022 to ensure quoracy. The recommendation for all Chairs of Committees to be members except the Chair of People and Culture was agreed. In practice attendance will be the Chair and the Chair of Finance and Performance (Vice-Chair) unless the Committee is not quorate.	The Board to note changes in membership and practical working arrangements.
Risk Management arrangements	The committee received a presentation on risk management arrangements, a verbal update on the production of the Board Assurance Framework and the latest Risk Register reviewed within the organisation. Significant work has been undertaken in this area and the Board can take assurance from the progress made. In particular, the work done to distinguish between risks and issues, the working arrangements which are emerging within the system and the creation of a BAF which reflects agreed system priorities	Further work is being undertaken to improve risk definition, form of reporting and consistent rating. The Committee recommended that the Board receive the presentation seen by Audit Committee setting out refreshed risk management arrangements.
Unaudited CCG Accounts for quarter 1 2022/23 and process for producing associated Annual reports and update from External Audit	Unaudited Accounts were presented to the Committee which demonstrated compliance with the key metrics. If these accounts are formally audited alongside the ICB accounts in June 2023, the reduced materiality threshold and the elapsed time poses a risk to the impact on the ICB accounts and	Grant Thornton is taking steps to create capacity to audit the CCG Q1 2022/23 Accounts ahead of the ICB accounts.

	<p>External Audit are being asked to audit the CCG Accounts earlier. The associated Annual Reports are being produced within the agreed timescales for submission. Grant Thornton confirmed that their 2021/22 Value for Money work has concluded and there are no matters of concern to be addressed.</p>	
Internal Audit update	<p>A Progress report from RSM was discussed and some changes to the phasing of the Internal Audit Plan were agreed. Four Internal Audit Reports were discussed. A review of Data Protection Security and a benchmarking review of the ICB website were advisory and no recommendations of high priority were highlighted. Some improvements were recommended which are being actioned. The Operational Planning Review was given a rating of Significant Assurance and Medicines Management Reasonable Assurance with comments and recommendations again being actioned.</p>	
Counter Fraud Update	<p>RSM presented their latest update report and progress in delivering each element of their plan. The CCG compliance with the National fraud Authority has resulted in an overall rating of green and an Action Plan has been created. There are four investigations ongoing and one case has been closed. A separate briefing was provided regarding these investigations. The report included emerging risks and fraud alerts.</p>	<p>Board will be provided with a separate briefing regarding the ongoing fraud investigations. It was agreed that the Team Briefings will be used to advise staff of the latest fraud alerts particularly around mandate fraud.</p>

Risk Review and Assurance Summary

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

Board Committee Summary and Escalation Report

Report of:	People, Culture and Inclusion Committee
Chair:	Shokat Lal
Executive Lead:	Alex Brett
Date:	25.07.2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
People Culture and Inclusion Governance	Inaugural Committee meeting under the new ICB governance. Terms of Reference and membership reviewed. Recognition that the Committee is in transition from previous format and membership.	Agreement to review TOR and format of the Committee following transition (6 months)
One Workforce – People Metrics	<p>People Metrics discussed - turnover, vacancies and recent Covid sickness spike.</p> <p>Committee acknowledged a significant improvement in solutions to address the workforce challenges, however the metrics are still a concern.</p>	<p>Partners agreed to work together where appropriate and possible to develop workforce solutions which address the challenges.</p> <p>Specific projects & actions in progress within the People and OD, Leadership And Inclusion Programmes including Retention, Recruitment, Health and Wellbeing and Staff Psychological wellbeing hub.</p> <p>To be discussed and addressed via People Culture and Inclusion Programme Boards.</p>
People Plan Engagement approach	Committee discussed the approach to communicating the ICS People Plan to the whole system workforce; engaging and involving them in the development of the 'One Workforce' approach.	Task and Finish group to be set up, interdependencies with other Boards and Committees at system and organisational level.

People Programme Delivery	All projects on track and being monitored. Progress highlighted in the attached assurance report.	No action or escalation required.
OD, Leadership, Inclusion and HWB Programme Delivery	All projects on track and being monitored. Progress highlighted in the attached assurance report.	No action or escalation required.
Staff Story	<p>Story of an ICS health and Care Reserve, their journey onto our People Hub via the vaccination programme and pathway into a mental health career.</p> <p>https://youtu.be/msbdjxOdmzk</p>	No action or escalation.

Risk Review and Assurance Summary	

Staffordshire and Stoke on Trent ICS

People Culture and Inclusion Committee

Programme Assurance Report June 2022

System Workforce Challenges & Mobilisation		RAG rating : ●			
Current system workforce pressures and risks		Mitigation and Actions			
<ul style="list-style-type: none">Acute: A&E, Maternity are experiencing significant pressures due to increases in demand and staff sicknessCommunity hospital: discharge and minor injuries affected by staff sickness and capacity in the communityCare Home and Domiciliary Care capacity, and increased wider service demandCovid admissions and covid related staff absences have increased and are being monitored closelyLong term impact of C-19 on all staff – Omicron, burn out and recovery <p>Anticipated pressures associated with heat wave and Commonwealth Games</p>		<ul style="list-style-type: none">Partnership working across the system and sectorsBi-weekly Workforce planning and resourcing meetings with workforce planning and recruitment leads.Mutual aid and staff mobilisation requests to system partners for critical gapsReservist model mobilisation inc CCG and corporate staff, as well as studentsIncrease workforce available and supply through system and org level campaigns inc external recruitment, volunteer engagement, workforce and scenario planningPlanning for future emergencies / surge in train, Phase 2 SSOT Reservist Model proposal with system leads for consideration			
Summary of Staff Mobilisation Requests		Staffordshire and Stoke on Trent People Hub – Activity and pipeline			
<ul style="list-style-type: none">MPFT HomefirstStoke CC HomecareUHNM Maternity ServicesUHNM Discharge LoungeKey2Care supported livingSchool immunisation programmeUHNM Heart Failure team – nursing and adminAHP referral unitEast Staffs PCN Admin hub			TOTAL	Ready to deploy	Of which currently in active assignment
		Overall Total - ready to be deployed /in active assignment	994	994	82 (in the previous month)
		Awaiting interviews	20		
		Undergoing pre-employment checks / training in progress	33		

Staffordshire and Stoke on Trent ICS

People Culture and Inclusion Committee

Programme Assurance Report June 2022

People Programme Activity	RAG rating : ●
Key Activity Highlights	
<p>Workforce Planning and Transformation</p> <ul style="list-style-type: none"> Continuing to work with system partners and workforce planning leads on the response to ongoing operational pressures 2022-23 system operating plan resubmitted on 20th June; subsequent bridging activity request from region/national to explain historic substantive and agency growth from Month 9 2019 to Mar 22 and forecasted growth currently being undertaken with providers Maternity and Neonatal workforce planning support continues with specific focus currently on: <ul style="list-style-type: none"> Neonatal STAR Workshop – upskilling and new roles; quarterly updates on progress against the project plan to be provided to LMNS Board. The workshop was also featured as an example of good practice at the WPI Community of Practice Network on 6th July 2022. Scoping exercise with HEE to explore Midwifery apprenticeship provision from HEIs, which will feed into a system wide career pathway Supporting Trusts with the development of their staffing models in response to Birthrate+, Continuity of Carer and Ockenden Establishing a working workforce group to focus on all of the above, as well as other potential workforce initiatives; attendees will include the ICS People Function, HEE, Providers and HEIs Cancer workforce planning support continues with specific focus currently on: <ul style="list-style-type: none"> Supporting the ICB to agree initial workforce priorities across the Cancer pathway Development of Community Diagnostic Centres and associated project plans Appointed a 12m fixed-term Band 7 Cancer Project Manager (funded by HEE) who will commence in post in September Urgent Care – Currently refreshing workforce baseline in UEC across providers to understand current workforce profile and identify needs moving forwards Supporting the development of the ICS Virtual Ward Pathway and associated workforce plans Mental Health Plan – Final return and narrative submitted on 23rd June. No major changes to draft in numerical return. Review session with NHSEI on 29th July Joined the Learning Disability and Autism Partnership (LDAP) Board and the LDA Steering Group to support the development of the associated workforce workstream Ongoing support to the Vaccination programme with work commencing on planning for the Autumn programme Continue to support the Staffordshire Training Hub to develop their training, OD and clinical placement offer to Primary Care services Working with system partners on the ICS Digital and Green Strategies to ensure alignment to the ICS People Plan and partner activities <p>Workforce Resourcing and Deployment</p>	

Staffordshire and Stoke on Trent ICS

People Culture and Inclusion Committee

Programme Assurance Report June 2022

- The People Hub continues to on-board and deploy staff into a number of areas across the system, focusing on care workers and registered professionals. Targeted retention and pastoral activities continue to ensure supply for vaccination programme and surge.
- Throughout June, the People Hub responded to staffing shortages across the Home care and Care Homes sectors with ongoing recruitment campaigns to appoint 'New to Care' workers on behalf of Local Authorities, as well as 'Care Reserve' contingent workforce for the system. The Programme has been nominated for a National HPMA award and shortlisted. Continued work with the National team on the Health and Care Reservist
- Continued system wide recruitment activity taking place at venues across Staffordshire and Stoke-on-Trent including Stoke Pride – New2 Health and Care, representation from all NHS Trusts, local authorities and private providers. Aim to increase diversity of our workforce.
- Linking in with Job Centres across the County to support individuals wishing to return to work and to promote entry-level opportunities
- Live recruitment campaign to support recruitment of 'new to care' home care support workers to MPFT's Home First service, utilising NHSE funding. Successful appointment to the roles and training has commenced with the first cohort.
- Currently 5 employees on the Redeployment register and actively being managed by the service. Savings made to date: approx. £4,341,729 million and 227 people redeployed.
- ICS Retention programme continues with targeted support to hotspots areas including Mental Health, Pathology and Dietetics. Working with Primary Care GP Recruitment and Retention leads to plan the Primary Care offer. Development of system wide resources in progress, including Flexible working, preceptorship and retirement

Development and Widening Participation

- Reboot of the Education, Training and Development Group and activity commenced in June, with the inaugural meeting focussing on Social Care. The next workshops will focus on Nursing, AHP and Pharmacy. Projects already identified to progress and link with other activities e.g. Clinical Placements, Schools and Colleges engagement
- Clinical Placement project kick off meeting took place with Nursing leads to commence scoping of the project and support required. Next step is to advertise the project lead role and extend the group to include all professional groups.
- There are currently three system wide rotational HCSW apprenticeship programmes in place.
 1. Cohort 1 are coming towards the end of their level 3 programmes, one apprentice has already secured a permanent Health Care position, one is continuing into higher education and the two remaining apprentices are being offered guaranteed Health Care Support Workers Interviews;
 2. Cohort 2 apprentices have now all successfully completed their Level 2 programme, with 4 out of the 6 progressing on to Level 3;
 3. Cohort 3 have just completed their second spoke placements and are now half way through their level 2 programmes.
- A system wide bid has been submitted to HEE this week for level 3 rotational Pharmacy Apprenticeship, this is a rotational programme which will encompass both primary and secondary care placements. A task and finish group are working on the design and recruitment of the programme.
- An Apprentice Lead has been recruited to the team, part of their remit will be to undertake an evaluation of the system wide apprenticeship programmes.

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- The Apprenticeship Levy portal closed on 3 July 2022, with 5 requests totalling £88,500, the requests are being sent to system partners to be reviewed.
- The ICS Virtual Work Experience for Primary Care went live in May 2022, 123 students enrolled, with 78% of students fully completing the programme. The Acute programme will be launching in September 2022 and the Social Care in October 2022. A Digital programme will follow along with on demand and bite size career sessions.
- The ICS Outreach Adviser is currently supporting 12 individuals on a 1-2-1 basis into employment. A Dentistry career session has been organised for young people at the Amity Hub. A Journey to work programme for seldom heard communities is being devised, which includes a Traineeship programme. Successful candidates will be given the opportunity to join an apprenticeship programme or offered a guaranteed interview for vacancies within health or social care.
- Commenced design and development of an ICS Journey to Work concept – outlining the various pathways and entry points into Health and Care to our population.
- Health and Care Careers pilot project commenced – identified 5 primary, middle and secondary Schools to build an engagement plan, resources and promotion offer.
- Working with the system partners and Careers and enterprise Hub

People Programme Risks

The risk register is reviewed by the People Programme Board regularly. No risks requiring escalation to the People, Culture and Inclusion Board

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OD, Leadership, Inclusion and Staff HWB Programme Activity

RAG rating :



Key Activity Highlights

INCLUSION UPDATE

- **Spring Inclusion School** held May 2021 with an audience of approx 160 participants from across the system and beyond. The session, led by John Amaechi OBE, received high acclaim and a score of 9.7 out of 10 in our feedback. Further Inclusion School sessions in development.
- **Comfortable Being Uncomfortable with Race and Difference** sessions continue to be rolled out / available on request. Approximately 300 system attendances to date.
- **New Futures / Stepping Up:** The core programme for New Futures concluded on 13 May. The final day included attendance by senior leaders from across the system. Participant groups presented their journey to this senior audience. Candidates are now progressing their additional development opportunities, including utilisation of the Strengths Deployment Inventory (SDI) work personality profile and access to a series of coaching meetings. A briefing on the Scope 4 Growth (S4G) career conversations tool is being arranged. Access to this tool and places will also be made available to the Stepping Up Alumni. A full Stepping Up (Stepping up and New Futures cohorts combined) alumni event is in planning for the Autumn.
- **Equality Delivery System** is progressing. We are in the process of finalising report contents and stakeholder consultation for the 2021 EDS (period 2020-21) ready for publication, and work has commenced on the 2021-22 version (for publication by end March 2023). The 2020-21 process is part of a Test phase in support of NHS England and NHS Improvement (NHSEI) and the 2021-22 process is part of the national pilot of the proposed new format. The new (test and pilot) process focusses on a joined-up system approach, reviewing related services across the ICS, with an emphasis on shared learning and growth. Services being reviewed are Learning Disabilities services and Interpretation and Translation services. In future years, 3 services will be reviewed.
- **NSCHT Pilot of Differently Abled Buddy Scheme** a great success. The scheme, initially funded through the WDES Innovation Fund, seeks to offer buddying support to new colleagues with a disability, neurodifference or long term health condition (or existing colleagues with a recently diagnosed disability, neurodifference or long term condition) from someone with a similar condition. The scheme has been highly praised by initial participants (buddies and buddied) and has been extended for a further 3 month period. All participants said they were more likely to declare their disability and that they found the scheme helpful; all but one said that the scheme helped them feel welcome within the

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organisation (the other response remaining neutral). The majority also said that the scheme had positively influenced their decision to stay with the organisation (two responses neutral). Wider application of the scheme across the system is now being considered.

- **System celebrates Stoke Pride:** the ICS took part in Stoke Pride on Saturday 18th June. The event was a colourful celebration of inclusion and representatives from across the system enjoyed engaging with the local community to share details of our organisations and our approach to inclusion. We also took part in the Pride March for the first time. Pronoun badges were given out and were a huge hit with all visiting our stall. The system Psychological Wellbeing Hub additionally represented the system for the first time.

LEADERSHIP/COACHING UPDATE

- **Coaching collaborative** current focus is on development and growth of internal talent pool. Currently developing 1-3 year vision for coaching & mentoring partnership, will share once in draft. SSOT Partnership Case Study, to articulate shared learning and benefits, delivered at 16th June WMEmployers.
- **NHS Leadership Academy and SSOT High Potential Scheme** graduation event for Cohort 1 took place on 7th July with excellent attendance from system partners including as part of the buddy model for Cohort 2 working with Shropshire, Telford and Wrekin. Applications open for Cohort 2, with roadshows taking place across both systems (so far 59 attended). Continue to recruit to supportive roles: assessors, coaches, mentors. Continue to work closely with the National Leadership Academy to shape assessment process and training.



STAFF HEALTH AND WELLBEING UPDATE

- Develop a **financial resilience toolkit** for colleagues to support and direct to resources, tips and tools for managing personal finances.
- Continue to **collate and share system wide resources** to promote to colleagues.

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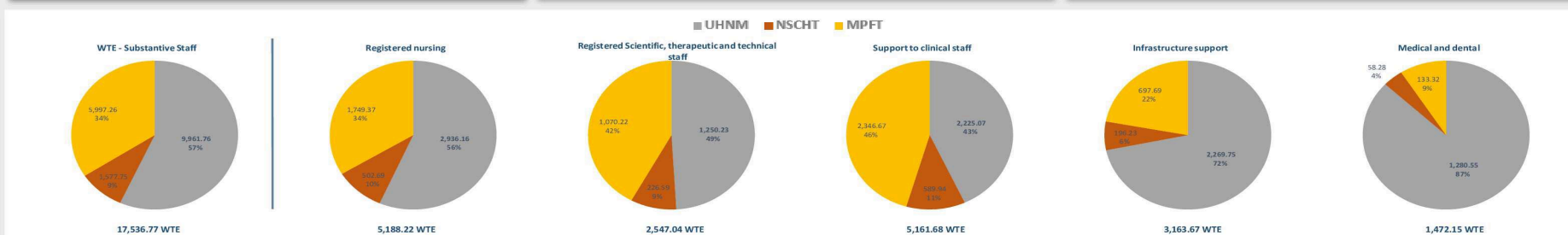
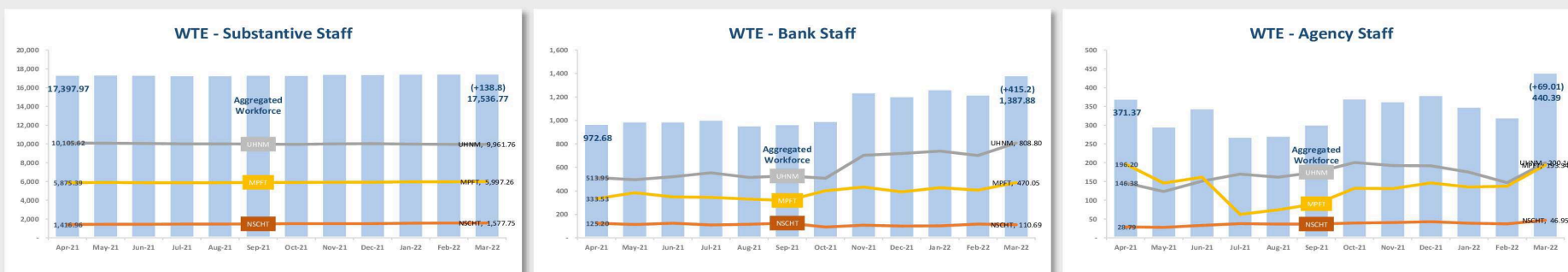
- **Be Well Midlands** big conversation findings are now available and being shared at system level and through the regional steering group. Triangulation with other key sources of information including the workforce / population health profile will provide a needs assessment to progress into phase 2 for action.
- **The staff psychological wellbeing hub** has now received more than 550 referrals. A wellbeing workshop programme has been released for July including focus on Financial Wellbeing, Self-Care and Supporting Carers. Twitter activity to promote engagement, workshops and campaigns has increased. Commissioning of dedicated resource from IAPT to ensure timely access to support and in the process of being commissioned. Extended opening hours to be piloted and evaluated.

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Staffordshire & Stoke-on-Trent Provider Aggregated Workforce Information

Reporting Period: Apr21 To Mar22



All Trusts are reporting 100% for jobs advertised as flexible.

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Reporting Period: Apr21 To Mar22

TOGETHER WE'RE BETTER
 Transforming health and care for
 Staffordshire & Stoke-on-Trent

Turnover
 Rate
11.12%

Sickness
 Absence Rate
5.72%

Mandatory Training
 Compliance
93.21%

AfC Appraisal
 Rate
81.61%

Medical
 Appraisal Rate
91.09%

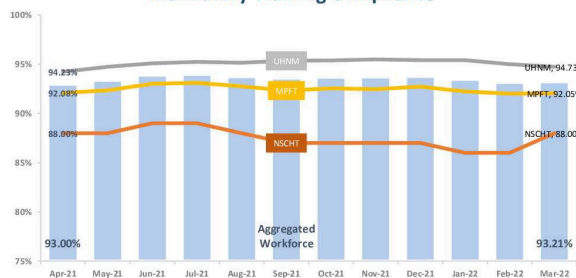
Turnover Rate - Rolling 12 Month



Sickness Absence Rate - Rolling 12 Month



Mandatory Training Compliance



AfC Staff Appraisal Rate



Medical Staff Appraisal Rate



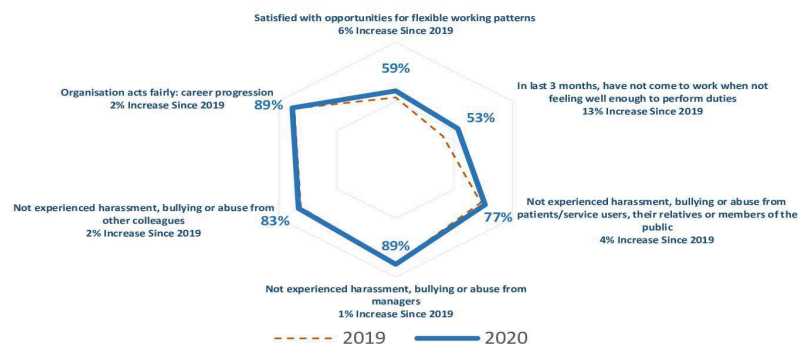
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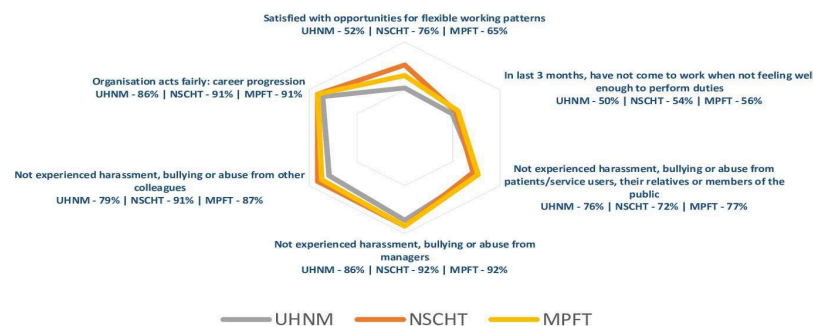
Staffordshire & Stoke-on-Trent Provider Aggregated Workforce Information



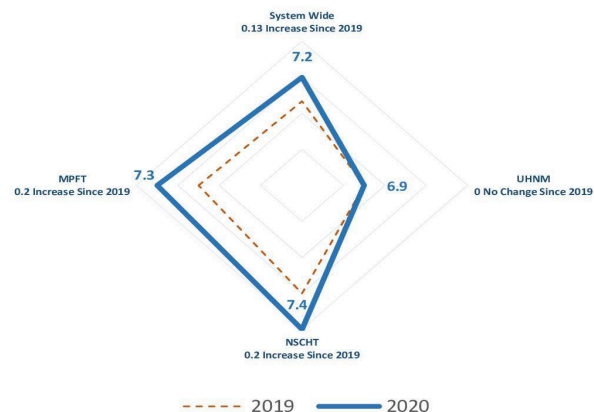
Looking after our people 2020
(UHNM, NSCHT & MPFT)



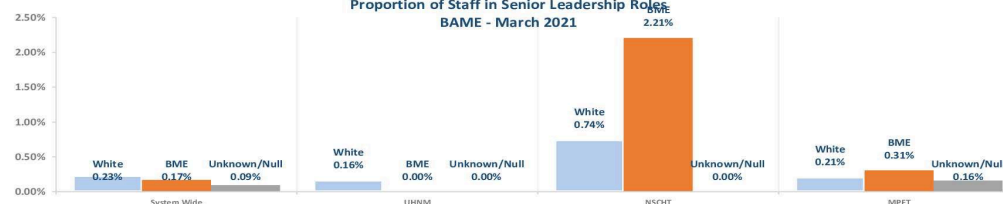
Looking after our people 2020 By Trust



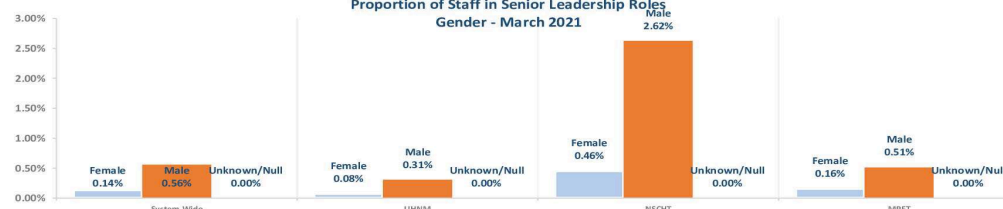
Positive experience of engagement 2020
(UHNM, NSCHT & MPFT)



Proportion of Staff in Senior Leadership Roles BAME - March 2021



Proportion of Staff in Senior Leadership Roles Gender - March 2021



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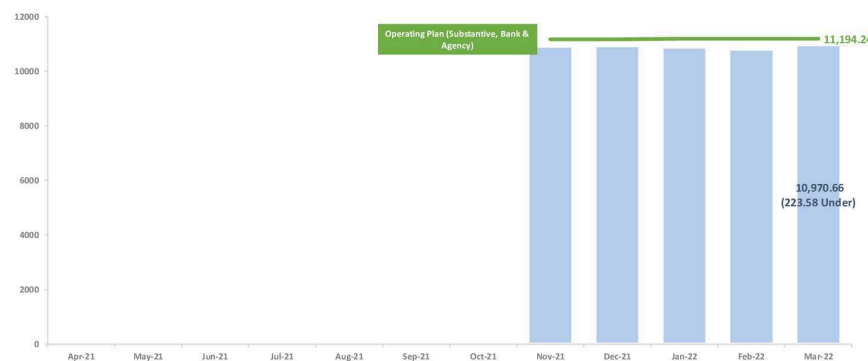
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Staffordshire & Stoke-on-Trent Provider Aggregated Workforce Information

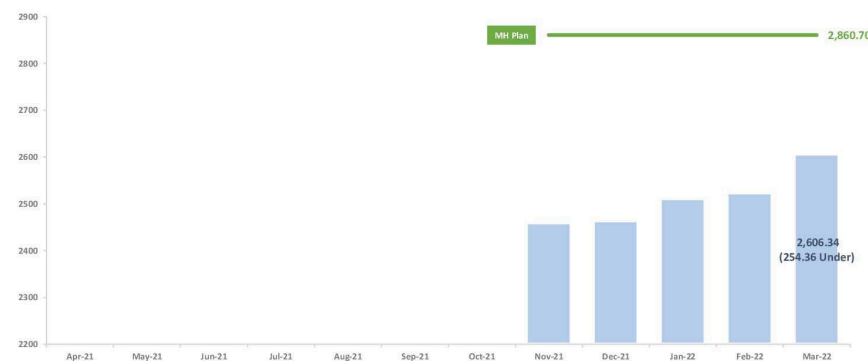
Reporting Period: Apr21 To Mar22



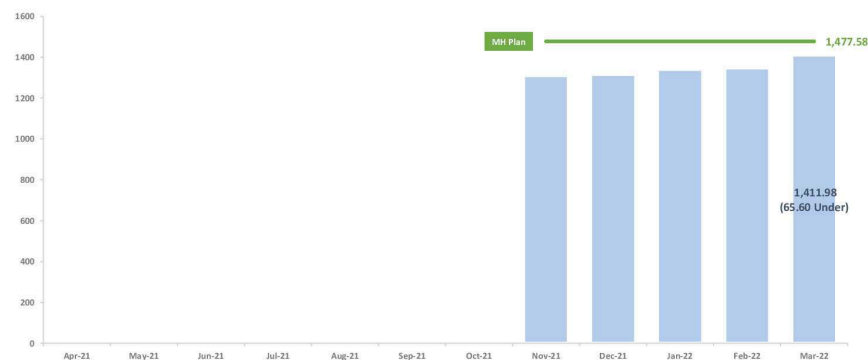
UHNM - Staffing VS Operating Plan - WTE



NSCHT & MPFT (Staffordshire) - MH Staff In Post VS MH Plan - WTE



NSCHT - MH Staff In Post VS MH Plan - WTE



MPFT - Staffordshire MH Staff In Post VS MH Plan - WTE

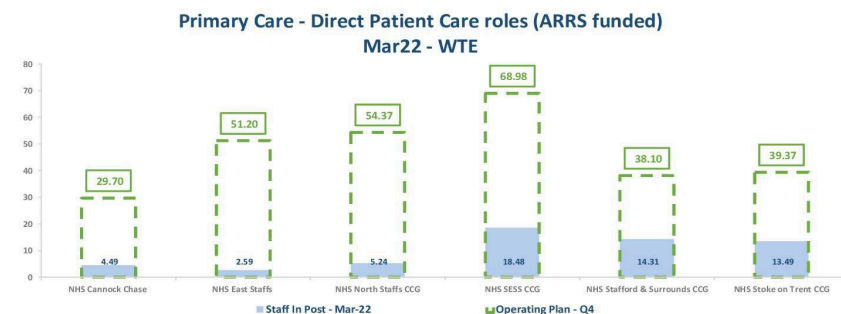
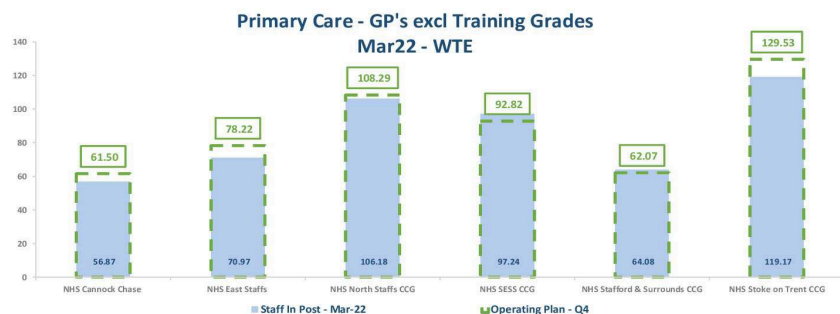
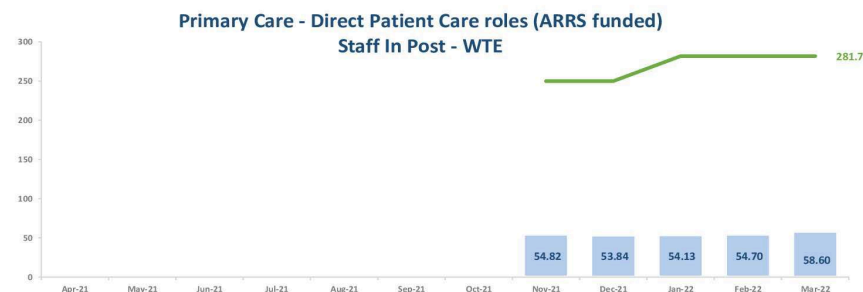


Staffordshire and Stoke on Trent ICS People Culture and Inclusion Committee

Programme Assurance Report June 2022

Staffordshire & Stoke-on-Trent Primary Care Workforce Information

Reporting Period: Apr21 To Mar22



Board Committee Summary and Escalation Report

Report of:	System Quality & Safety Committee
Chair:	Josie Spencer
Executive Lead:	Heather Johnstone
Date:	Wednesday 14 September 2022

Key Discussion Topics	Summary of Assurance	Action including referral to other committees and escalation to Board
Risk Register	<p>The current highest risks were related to Maternity Services. Detail of which was further discussed in the Maternity & Neonatal Services report</p> <p>In addition, there is a risk patient harm is likely due to increased waiting times for surgery and cancer surgery - work on harm reviews is taking place across the system.</p> <p>Ongoing actions to mitigate risk at present in place and no serious harm reported to date.</p> <p>Current highest scoring issues are:</p> <ul style="list-style-type: none"> • Pressures in ED Departments with interdependencies across ambulance services and MFFD delays and Home First delays • Staffing ratio concerns across all providers • Lack of home care provision due to staffing challenges in Domiciliary care • Delayed Hospital Discharges with interdependencies across system: home first and MFFD delays <p>All issues have collective and organisational actions in place to mitigate risk</p>	The Committee reviewed all risks and issues and confirmed scores.
Quality and Safety	The System Quality & Safety	Further discussion needs to take

Committee Terms of Reference	Committee approved the terms of reference in principle although not all partners had identified named individuals as their members yet. There is also an ongoing discussion about provider Non-Executive membership that has yet to be concluded.	place with the Director of Public Health for Staffordshire re their membership of the Committee/sub groups.
System Quality Group Terms of Reference	The System Quality & Safety Committee approved the terms of reference subject to resolving the matter regarding local authority representatives in the respective meetings.	
Clinical Policy alignment	The System Quality and Safety Committee were assured that a robust process has been taken through the work programme and that all relevant best practice and statutory processes have been applied including clinical engagement and the requirement for involvement with relevant stakeholders	<p>The recommendations are being presented to ICB board meeting 22nd September 2022.</p> <p>The recommendations are to be presented to the Health and Overview and Scrutiny Committee. October / November 2022</p>
Patient Safety Incident Response Framework Launch and ICS responsibilities	<p>The committee agreed the following:</p> <ul style="list-style-type: none"> • The ICB Lead for implementation (HJ Executive Owner) • The ICB Implementation membership • The date for membership recommendations for System PSIRF Implementation Group • The reporting requirements for ICB Implementation Group 	
<p>Sub-Group Updates</p> <ul style="list-style-type: none"> • Continuous Quality Improvement • Maternity & Neonatal Services • Quality Impact Assessment • Patient Safety Specialist Network • Infection Prevention & Control • Safeguarding Children & Adults 	<p>The Committee received updates from its subgroups the majority of which gave full assurance. The exception was: Maternity & Neonatal Services where limited assurance was available due to a number of ongoing issues which are being managed by the Trusts and supported by the ICB team.</p> <p>Terms of reference were approved for the Interim Quality Impact Assessment Sub- Group and the Patient Safety Specialist Group</p>	Further detail to be given in the Quality and Safety Report at ICB on the 22 nd September 2022 by Heather Johnstone Chief Nursing & Therapies Officer
Current System Quality	Verbal updates were given from	

Matters	all partners present. There was an underlying theme around workforce pressures. The Committee was given assurance by members that these issues were be tackled at a system level through both the Chief Nursing Officers meeting and by the System People Culture and Organisational Development Committee.	
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Risk Review and Assurance Summary

Aside from the limited assurance re Maternity Services the Board can take assurance regarding the reports provided and the discussion which took place at the committee.