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NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

# Annual Report and Accounts

## 2022/23






# Contents

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# Welcome

## A statement from the Chief Executive Officer

I would like to welcome you to our first annual report from Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) at the end of a year of transition, change and challenge.

As an ICB, we lead the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) and have responsibility for NHS functions and budgets. We were officially established as a statutory organisation on 1 July 2022, against a backdrop of post-COVID-19 backlogs and ongoing workforce pressures. However, through collaboration with our system partners, we are continuing to work hard to address them.

Staffordshire and Stoke-on-Trent ICS brings together all the main partners – local government, the voluntary, community, faith and social enterprise sectors, social care providers and the NHS with a common purpose to improve the health and wellbeing of our population of around 1.13 million people.

The reason that ICBs and ICSs have been created is both simple and logical. It is about mutuality and taking a multi-agency approach to our collective challenges and not just pushing problems from one part of the “system” to another.

Since the foundation of the NHS in 1948, we have taken a step backwards for the first time, witnessing a reduction in life expectancy and an increase in unhealthy life years.

That is the reason we need to renew our relationship with the public, working increasingly to take a preventative approach to healthcare, and being more active at community level.

We know from elsewhere that you can produce better outcomes by working across ICS partners by becoming hyper-local and working at neighbourhood level. This not only works by tackling social problems like anti-social behaviour but can also have an impact on health.

We also need to get better at using data more effectively. We know we can use data and artificial intelligence (AI) where a crisis can happen. If you can predict it, you stand a much better chance of mitigating the impact.

Locally, for instance, we have carried out a trial to look at how existing patient data could be used to predict those most likely to attend A&E or need hospital care in the near future and intervene with targeted clinical coaching to reduce their dependence on A&E and GP services.

One qualified success from greater joint working has been our overall hospital discharge performance this winter. The winter plan worked well with the notable exception of a short period centred on New Year’s Eve when we were hit by a perfect storm of an earlier and harder onset of flu admissions than modelling suggested, a sharp rise in COVID-19 cases, and scares about strep A and scarlet fever. The local picture was reflected nationally.

Since then, however discharge delays have performed far better overall and there has been much less ambulance delay, bringing performance in-line with planning. This has been down to planning, concerted co-operation across the system and new initiatives such as a falls recovery service operated by the Fire Service which, while only a trial, undoubtedly reduced admissions.

We know that the thing that concerns most of our patients are not strategic but very much operational – when am I going to get my operation, and why does it take so long to get a GP appointment.

COVID-19 did leave us with record backlogs but our provider colleagues are making steady progress. We have now eliminated 65-week waits, and are making good advances dealing with people who have been waiting for 52 weeks and over.

Issues concerning primary care, and more specifically access, never seem to be out of the media, either nationally or locally. However, while acknowledging there are issues, the fact is that primary care is seeing more patients now than before the pandemic, with around 5.8 million appointments across Staffordshire and Stoke-on-Trent in the last year – an increase of 11% compared to pre-COVID, with 47% same-day appointments.

We published our General Practice Five Year Forward Strategy setting out positive changes we intend to take shape across our primary care networks. This aims to ensure patients have good access to high-quality, sustainable and resilient general practice, reducing inequalities and variability.

> *Our focus will be on urgent same day access, personalised care for people with complex needs and managing long-term conditions, prevention which has to take an increasingly high priority, and developing integrated community teams bringing together primary, secondary and care colleagues. As part of the ICS, we have a unique opportunity to transform the way health and social care services are designed and delivered in Staffordshire and Stoke-on-Trent. Working with partners, we want to change and improve our services to ensure they address inequalities and better support individuals, families and communities now and in the future.*

Working with people and communities, we want to have a better understanding of the local population, including the wider determinants that influence their health and wellbeing and use our collective strength to tackle the health and care challenges that local residents face.

Our Working with People and Communities Strategy will support our new approach to engaging the population, which will be based on the principles that we co-designed with groups and members of the public. Our People and Communities Assembly will advise on how we can reach those who are often furthest away from health and care services and together we can strive to put the voices of our communities at the heart of our decision making.

Finally, I would like to thank everyone involved in the NHS Staffordshire and Stoke-on-Trent clinical commissioning groups that preceded the ICB. They started out as six different organisations but over the decade of their existence worked increasingly collaboratively under a single management team. This really helped to start to tackle health inequalities, harmonise commissioning policies, and lay the groundwork for the ICB to build upon.

Peter Axon

Chief Executive Officer

Staffordshire and Stoke-on-Trent ICB

29 June 2023

# Chair's Report

## Welcome to this Annual Report highlighting the work of our Integrated Care Board during 2022/23. As the NHS enters its 75th year I am proud that despite the increasing challenges we face, our NHS remains true to its heritage and foundations set all those decades ago.

Formally established on 1 July 2022, Staffordshire and Stoke-on-Trent Integrated Care System is a partnership that brings together local government, the NHS, social care providers, voluntary, community, faith and social enterprise organisations, and other partners to improve the lives of people who live and work in our region.

To support this ambition, the Integrated Care Board is the statutory organisation responsible for bringing NHS and other partners together to plan and deliver integrated health and social care services, and is accountable for the finances and performance of our local NHS as a whole.

We exist to achieve the quadruple aims of:

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- advancing productivity and value-for-money
- helping the NHS to support broader social and economic development.

We will build on platform of engaging stakeholders, partners and local communities to develop our Integrated Strategy and Five Year Forward Plan.

We are a young organisation – still forming and maturing, and building capability and capacity.

And we are starting at a difficult period in history, with the world still recovering from a pandemic and facing a cost-of-living crisis.

But we are determined to make the best use of resources and to turn up the dial on prevention work, respect place-based decision making, and providing care and support at the most local level – the neighbourhoods where people live.

Our sense of purpose is clear, and we are proud to be a partnership harnessing collective effort with a single plan for the first time.

We are committed to increasing the influence that people have to shape the services they use. Our work is divided into seven portfolios that will look, in granular detail, at how we achieve our four main goals.

David Pearson MBE

Chair

Staffordshire and Stoke-on-Trent ICB

30 June 2023

# Our story

## Staffordshire and Stoke-on-Trent Integrated Care Board was established on 1 July 2022 by the Health Care Act (2022). The Act established the statutory framework to support greater collaboration and partnership working to integrate services for patients.

Key to the effectiveness of the ICB is to work with the wider Integrated Care Partnership (ICP), which is made up of health and care organisations, including primary care, acute providers, mental health providers, community care services and local authorities. These bodies have come together to plan and deliver joined-up services for our community and improve the health of people who live in Staffordshire and Stoke-on-Trent.

The area covered by the ICB is the county of Staffordshire, including the city of Stoke-on-Trent. We are responsible for the health and care of 1.13 million people who live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles.

We are aligned with two upper tier local authorities (UTLAs): Staffordshire County Council and Stoke-on-Trent City Council; and eight local authority districts (LADs) and borough councils: Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth.

## Purpose and activities of the organisation

To deliver a joined-up approach to care, on behalf of the Integrated Care Partnership (ICP), the ICB developed the Integrated Care Partnership Strategy to improve the health and wealth, happiness and wellbeing of our local population. The principles have been established and have already been approved by the ICP, which has representation from all the system partners.

Completed on 31 March 2023, the ICP Strategy addresses the concerns raised by both our partners and our local population, who have told us what needs to change:

- Demand on services, risking them becoming overwhelmed
- COVID-19, which is still with us, leading to a growing backlog for services
- Longer waiting times
- Services are fragmented, with multiple organisations involved
- Our workforce is weary and there are national shortages across key specialities
- Our financial position is improving but we have a significant deficit that we need to balance
- Some of our communities can face barriers to accessing services.

Local communities have identified the following high-level issues:

- Long waits for ambulances, delayed handover and corridor care
- Crowded emergency departments with long waits
- Difficulty accessing primary care and/or seeing a GP
- Difficult to arrange social care and/or community services.

## Our objectives and strategies

Given what we know about our population's health and care needs and the feedback from residents, the Integrated Care Partnership Strategy will:

- address the national requirement but – more importantly – be locally owned
- set out the ambition, vision, and approach for the ICP over the next five years and beyond
- be co-produced and owned by the ICP and local communities
- demonstrate how the health, care and wellbeing needs of the local population are to be met

- build upon local knowledge and strategies to ensure we are greater than the sum of our parts
- show how we will work towards increased integration of health, social care and other services
- be underpinned by a population health approach outlining how the ICP will sustainably deliver more joined-up, preventative and person-centred care for the whole population.

## Our challenges and opportunities

Our services are generally safe and well-led, thanks to our incredible staff. However, we are not complacent and there are many challenges and opportunities that will affect our ability to continue to deliver high-quality care in future.

We have an **ageing population**. We have seen life expectancies increase but people are not always living longer in good health. On average, people spend between 16 and 25 years living with one or more long-term conditions before they pass away, while more people are living with complex health and care needs. People in our most deprived areas live with poor health for 12 years more than those living in less deprived communities.

**Demand** for our health and care services has increased across primary care, community health services, social care and within the voluntary sector. This has been made worse by the **COVID-19 pandemic**.

Services are still recovering from disruption caused by the pandemic, with huge efforts ongoing to reduce people waiting for treatment and care. Despite the best efforts of our hospital teams, there remains a backlog for diagnostic, elective care and cancer services, while community, mental health, social and primary care services are also managing longer waiting lists. The impact on people's health has not been equal, with some people experiencing long COVID-19 and other harm to their physical and mental health. The full impact of COVID-19 remains to be seen.

People across Staffordshire and Stoke-on-Trent experience **fragmented care** because of avoidable and unfair differences in the types of services that are available in different areas.

Some communities also experience **social exclusion** – this is where people struggle to access support with things like housing, secure employment, or health and care services. These problems are usually linked to other difficulties such as poverty, violence or complex trauma, and need special care.

There is a health and social care **workforce crisis** which is heavily impacting the wellbeing of staff and the sustainability of services. This needs to be addressed to ensure high-quality care can continue to be delivered at all levels.

**Finances** are a challenge, with health and care organisations being asked to do more with no additional funding. NHS finances are improving but there is a significant financial deficit that must be balanced in future years without impacting the quality of our services.

Strong partnership across our system is the best way to address the issues we face, and the Staffordshire and Stoke-on-Trent Integrated Care Strategy focuses on long-term priorities to prevent ill health, reduce inequalities, and deliver better health and care services for our population.

## Our vision

***The vision for Staffordshire and Stoke-on-Trent ICS Board is:*** *"to make Staffordshire and Stoke-on-Trent the healthiest place to live and work."*

For local people, this means:

- Reduce the demand for health and care services
- Enable us to improve the quality of our services
- Relieve pressure on our staff
- Enable us to work within our budgets.

System partners recognise that no one organisation working in isolation can solve the demand pressures that the system is currently facing. Stark health inequality challenges remain across the system and there is an urgent need to improve outcomes for our population while living within our collective resources.

The NHS Long Term Plan (2019) set out key ambitions for the next 10 years and the main commitments are making sure everyone gets the best start in life, delivering world-class care for major health problems, and supporting our population to age well.

The ICB operates within the wider Integrated Care System, and as such is signed up to the ICS vision and purpose.

## Staffordshire and Stoke-on-Trent Integrated Care System

The ICS has worked to agree a single purpose for our population:

- If you live in Staffordshire or Stoke-on-Trent, your child will have the best possible start in life and will start school ready to learn
- Through local services, we will help you live independently and stay well for longer
- When you need help, you will receive joined-up timely and accessible care, which will be the best that we can provide.

With the broad and inclusive membership of the Integrated Care Partnership, we can address wider factors that influence health, care and social needs. We will deliver this by using smaller, integrated 'place' working that will follow our shared approach but have the flexibility to meet the specific needs of different populations in Staffordshire and Stoke-on-Trent.

Close partnerships across the NHS, local authorities, the voluntary, community, faith and social enterprise sector (VCFSE), Healthwatch, hospices, universities and wider public sector organisations are crucial to our approach. This will enable greater influence and action to achieve significant impacts on health and wellbeing.

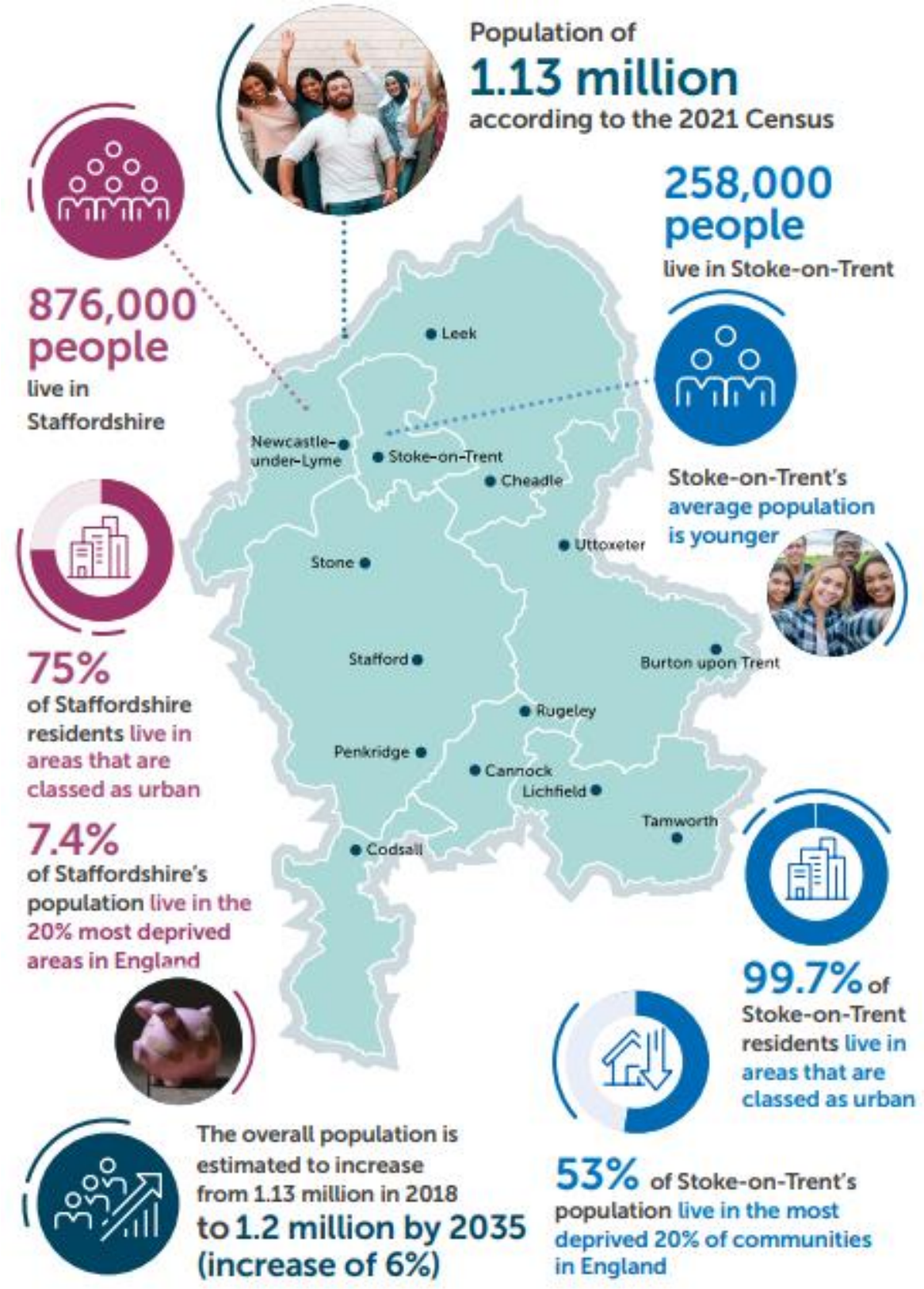
### Staffordshire and Stoke-on-Trent ICS partners

- Seven Integrated Care System portfolios
- Two upper tier local authorities
- Eight district and borough councils
- 25 primary care networks
- 143 GP practices
- Two acute hospital trusts
- Two mental health trusts
- One community health trust.

We thank and acknowledge the support of all ICS partners in coming together to improve the health and wellbeing of our local population and making Staffordshire and Stoke-on-Trent the healthiest places to live and work.

# Our population

Staffordshire and Stoke-on-Trent is a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation.



Other characteristics of our system include:

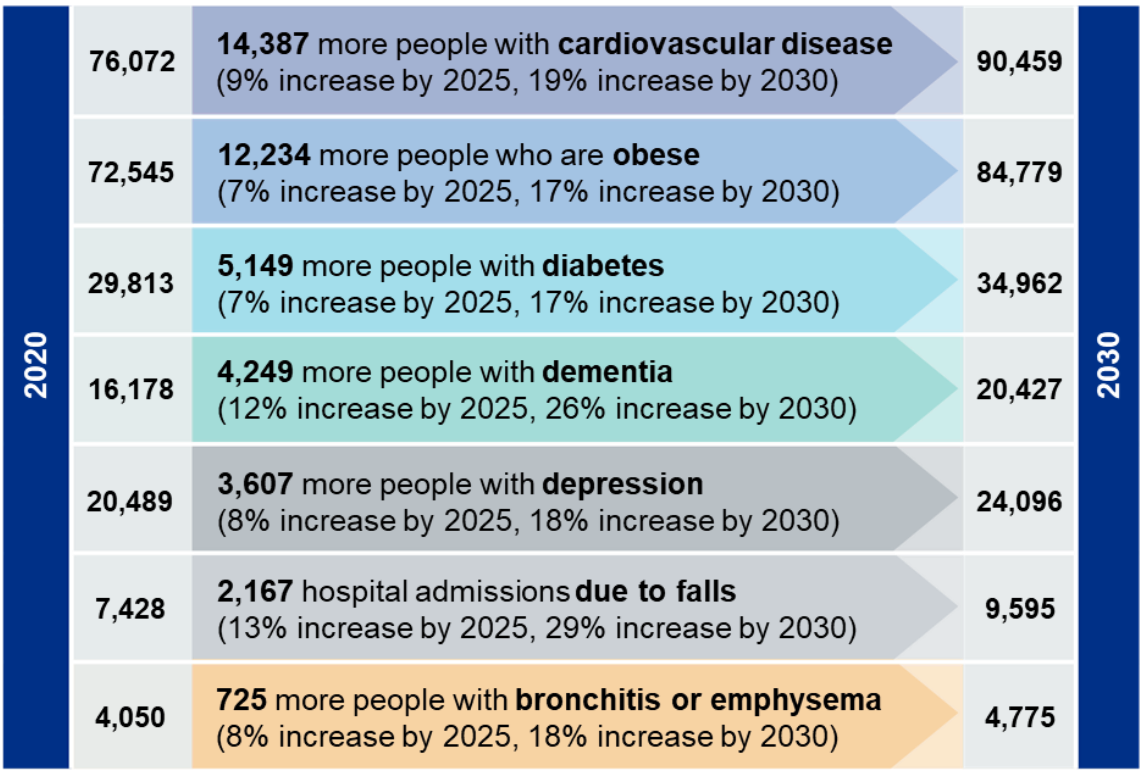
- Staffordshire has a much higher proportion (25%) of its residents living in rural areas, although most of its population (75%) still lives in areas that are classed as urban. In contrast, almost all (99.7%) of the population of Stoke-on-Trent live in areas that are classed as urban
- Similar to the percentage increase for England, the overall population of Staffordshire and Stoke-on-Trent is estimated to increase from 1.13 million in 2018 to 1.2 million by 2035
- The older population is estimated to see the biggest increase – the population aged 65+ is estimated to grow by 25% by 2035
- Our local population experiences stark social inequality with more than half (53%) of the population of Stoke-on-Trent living in the most deprived 20% of areas in England, while less than one tenth (7.4%) of the population of Staffordshire live in the most deprived 20% of areas of England. However, we do know that high deprivation areas exist within the urban areas of Staffordshire
- In our local population, 92% of people identify as being White British. The next most common ethnic group is the population identifying as Asian, Asian British or Asian Welsh, representing 4.8% of the population. The higher levels of ethnic minorities are concentrated in urban areas like Stoke-on-Trent and Burton upon Trent
- More people have diabetes, strokes or heart disease than the national average, and obesity is also significantly worse than the national average
- The number of people with long-term conditions is increasing, with more than half of over-65s having two or more long-term conditions. The diagram below shows the levels of common long-term conditions in 2020 and how this is expected to grow by 2030 if the current trends persist
- People in Stoke-on-Trent have a lower life expectancy than in other parts of the country. More people under the age of 75 die from cancer than the national average
- Deprived and ethnic minority communities are at a greater risk of exposure to COVID-19 and are more likely to have poorer outcomes due to existing poor health and adverse lifestyle factors. The control measures that have been implemented during the pandemic such as lockdown, social distancing and changes to routine care have resulted in disproportionately worse economic, social and health impacts on disadvantaged populations.

Services are delivered to our population through primary care networks (PCNs), which are made up of GP practices working together with a range of local providers, including those across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

As the ICB, we are the delegated commissioner of general medical services, which means we are responsible for managing the national General Medical Services (GMS) / Personal Medical Services (PMS) contracts with the 143 GP practices in our system. The GP practices are listed on our website:

Practices in Staffordshire and Stoke-on-Trent (staffstokeics.org.uk)

## Long-term condition projections in people aged 65+ in Staffordshire and Stoke-on-Trent




*POPPI v15.0 17 November 2020. www.poppi.org.uk. Data sources: Institute of Public Care (IPC) and ONS. Crown copyright 2020.*

We also commission healthcare and work with other providers, including:

- Acute trusts including University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and The Royal Wolverhampton NHS Trust (RWT)
- Mental health trusts, including Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- NHS community trusts, including UHDB and MPFT
- Vocare (urgent care services)
- West Midlands Ambulance Service University NHS Foundation Trust (WMAS)
- For the south and east of Staffordshire, there are patients treated at a number of trusts in Derbyshire and the Black Country and West Birmingham
- NHS elective services provided to the local population by non-NHS providers
- Voluntary, community, faith and social enterprise (VCFSE) partners
- A diverse market of nursing, residential home and domiciliary care providers.

We are working closely with our partners and providers to prevent poor health, improve wellbeing and involve and empower our population.

# Performance Report

This overview provides information about Staffordshire and Stoke-on-Trent ICB including its purpose, the key risks to the achievement of its objectives and how it has performed during the year. This overview is designed to provide you with enough information to understand a bit more about our organisation, our purpose, the key risks, and challenges to the achievement of our objectives and how we have performed in the period from our inception on 1 July 2022 to the end of the financial year on 31 March 2023.

## Performance overview

As a statutory body, we recognise the importance of providing assurance to our stakeholders and the public so that they have confidence in our ability to plan and deliver safe, high-quality and sustainable services within the resources that we have available.

Integrated care boards (ICBs) were established from 1 July 2022. Their general statutory function is being responsible for the performance and oversight of the NHS services in their integrated care system (ICS).

Our performance as an ICB is assessed against a wide range of indicators that reflect whether we are delivering the standards set out in the NHS Constitution and the NHS Oversight Framework (NHSOF), and whether health outcomes are improving for our local population.

The Finance and Performance Committee monitors performance within Staffordshire and Stoke-on-Trent ICB. The committee meets monthly to provide assurance to the ICB Unitary Board in relation to performance. The Committee is chaired by an ICB non-executive director and membership is made up of partners from across the system with an emphasis on collaborative working to manage resources, performance and delivery, to change the way health and care is delivered for the better.

## Oversight and assessment

ICBs play a major role in achieving good health outcomes for their local population. NHS England oversees them through an annual performance assessment process.

This is underpinned by the NHS Oversight Framework (NHSOF), which includes a set of performance indicators that monitor how well an individual ICB is tackling these health issues, and identify areas where support may be required.

ICBs are assessed against five main national themes that reflect the ambitions of the NHS Long Term Plan:

- Quality of care, access and outcomes
- Preventing ill-health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability.

A sixth theme – local strategic priorities – reflects the ICB's contribution to the wider ambitions and priorities of its ICS.

To inform oversight arrangements and support, NHS England regional teams assess and allocate ICBs to one of four 'segments'.

Further information on the NHSOF is available on NHS England's website.

In the second quarter of 2022/23, NHS England completed an assessment review of the ICB. **Staffordshire and Stoke-on-Trent ICB were categorised as segment 3 – enhanced support and oversight by NHS England.** This was based on the categorisation of our three main providers and driven by performance against elective recovery and cancer targets, ambulance handover delays, and a challenging financial plan.

## Performance appraisal

The national operational planning guidance for 2022/23 published by NHS England (NHSE) consolidated the focus on restoring services and recovering elective activity. It set out clear ambitions around recovery, specifically for elective care, diagnostics and cancer. In addition to the operational planning guidance, a range of recovery ambitions were outlined in the national Delivery Plan for tackling the COVID-19 backlog of elective care.

The ICS developed plans to significantly increase elective and diagnostic activity to above pre-COVID levels, while eliminating long waits for treatment and improving performance against cancer waiting times standards. We were also asked to expand capacity in primary and community care and improve mental health services and services for people with a learning disability and/or autism.

Delivery on these ambitions depended on us doing things differently, accelerating partnership working and increasing our capacity and resilience. It required us to expand our use of digital technologies to deliver patient care.

We have made progress in recovering our performance during 2022/23, against an ongoing high level of COVID-19 infection, patient acuity, capacity constraints in social care, and workforce availability.

We have seen exceptional levels of demand in emergency departments and GP practices at peak points throughout the year, in particular during December. High levels of demand also remain in community and mental health services. The NHS and social care continue to experience difficulties in recruiting and retaining staff along with high levels of staff sickness, and from January 2023 have been affected by ongoing industrial action affecting hospital and ambulance services.

We have tried to maintain and improve on our elective plan delivery. However, there have been periods where elective work has been unavoidably delayed because of staffing and capacity problems. Capacity in outpatient, diagnostic and theatre services has been impacted by the increase in COVID-19 and other respiratory illnesses. There have been higher than normal staff absences along with an increase in demand from GP referrals – in particular, clinically urgent referrals.

Social care remains consistently under pressure, experiencing similar pressures to the NHS services with severe workforce challenges which have reduced capacity in the market and across the county.

Overall we have had a successful year and have achieved many of the targets we were set. However, not all targets were achieved – in particular delivery of elective activity over and above 2019/20 levels and reduce waiting times in line with national ambitions.

This performance appraisal should be read in the context of ongoing recovery of urgent and emergency care (UEC) and increased mental health demand – plus the recovery of elective activity and work to reduce the waiting list backlogs.

Despite the ongoing pressures, there have been some positives to note:

- We have made progress in **reducing the backlogs of patients waiting 62 days** or more for cancer treatment
- We have seen improvements across **primary care – specifically face-to-face GP appointments** – where Staffordshire and Stoke-on-Trent is the second-highest performing ICB in the region
- **Mental health services and services for people with learning disabilities and autism** are areas where strong performance has been noted.

# Highlights and challenges during this period

## Development of the ICB

As a newly formed statutory body, we have worked hard to ensure that our structures are effective and enable our staff to be fully focused on delivering for our population. We are proud of how well the Board and its five committees have carried out their duties. We owe thanks to colleagues in our partner organisations, who now sit on our Board and many of our committees.

We would also like to thank our staff who oversaw the closure of the six Clinical Commissioning Groups and ensured that all responsibilities were smoothly transferred to the ICB. This was a huge task, with complex risks but thanks to the work of staff across all parts of our organisation this has been fully delivered.

During the period of change, all statutory functions were fully delivered.

## Health Service Journal nomination

In August 2022, Staffordshire and Stoke-on-Trent ICS was shortlisted for the prestigious national **HSJ Award for Integrated Care System of the Year**. The award recognises the progress within a system towards delivering fully integrated services. Although we didn't go on to win the award, the shortlisted nomination is evidence that we are working together in a joined-up way to make real change in the way health and care is delivered.

## Continued impact of COVID-19

While we have been fortunate that the number of people contracting COVID-19 has reduced, we must remember that it has not gone away. Our providers are continuing to treat patients with COVID-19 but are also losing capacity, owing to the measures in place to prevent infection spreading and because of staff testing positive and therefore unavailable for work.

## Winter pressures

Winter has been very difficult for the NHS across England, with high levels of demand for ambulances and A&E – and our system was no exception. In December 2022, we experienced some of the longest delays for ambulances and emergency department waiting times in the country at UHNM. The system came together to manage the demand and minimise harm to patients. The demand eased in the new year, and we were able to deliver services in line with our Winter Plan.

## Performance against targets

We have seen improvement in performance in primary care, with the number of GP appointments on plan and the Annual Health Check target for the third quarter of 2022/23 being met.

Unfortunately, urgent care performance remains below target for all aspects of care from ambulance performance, A&E waits and delayed discharges. These results reflect the pressures seen in both health and social care.

In planned care, the system has made some reductions in the number of patients experiencing long waits for operations and achieved the target that no-one should wait more than 104 weeks for an operation or procedure by July 2022. We were not able to achieve the target that no patients should wait more than 78 weeks by the end of November 2022.

In mental health, the current demand for inpatient beds has exceeded the capacity – resulting in above planned levels of inappropriate out-of-area bed days for patients with acute mental health conditions. The current demand exceeds the bed base available due to high levels of patient acuity and a limited number of female beds.

For cancer waiting times, the positive impact of the tele-dermatology pilot and the lower GI hub is being seen in two-week-wait performance. The 62-day performance has improved on the screening and upgrade pathways but the standard pathway sees worsening performance, and 104-day waits have decreased month-on-month from June 2022.

## Financial climate

The financial outlook for 2023/24 and beyond is very challenging given the levels of inflation and the increasing demands for healthcare. The focus of the system is to work collaboratively, to make the local Staffordshire and Stoke-on-Trent pound go as far as possible. This is a collective effort with local authorities as we are keen to ensure that residents of our system get the best possible health and social care when they need it, and that the boundaries between health and social care do not impinge on that ambition.

While it is going to be challenging to maintain our track record of three consecutive financial years where we have achieved a break-even position, we have the strongest chance possible given the strength of those relationships.

## Key issues and risks

The Board Assurance Framework (BAF) is our primary document for identifying strategic risks and action plans to mitigate them. The BAF was agreed by the ICB in December 2022. There were six risks identified that could impact on delivery of the strategic objectives. The BAF also identifies the Board's level of tolerance for each risk.

The full BAF is presented to every Audit Committee, who maintain oversight of the Risk Management Process and bring the relevant risks to the responsible committee for discussion. The full BAF is presented to the Board with the Committee's report forming part of the assurance that the risks are being optimally managed when presented to the ICB Board.

The first table below sets out the strategic risks and the following table summarises the quarterly progress.

### Risks and their impact on strategic objectives

| BAF risk | Cause (likelihood) | Event | Effect (consequences) |
|---|---|---|---|
| **1. Commissioning intentions** | If the ICB approach to commissioning is uncoordinated | Then services will not be commissioned which meet the health needs of our local population | Resulting in poor health outcomes, lack of value for money and gaps in service provision |
| **2. Inadequate winter capacity to maintain system flow** | If demand exceeds expected levels or capacity is reduced | Then the demand for urgent care will overwhelm all parts of the health and social care system | Resulting in poor patient experience and outcomes, low staff morale, increased regulatory intervention and inefficiencies |
| **3. Better quality for all patients and service users** | If we cannot maintain a competent nursing, midwifery and social care workforce | Then we will be unable to deliver sufficient and safe levels of services | Resulting in bed reductions and safety issues in wards, maternity units and care homes |
| **4. Insufficient workforce** | If we are unable to address the current national shortfall of staff in health and social care in Staffordshire | Then there is a risk of increased vacancy rates in key services | Resulting in insufficient capacity to deliver current services, transformation and the Winter Plan and further increase staff sickness and burnout |
| **5. Unable to achieve statutory financial difficulties** | If financial pressures are not controlled | Then we will not achieve a break-even position in 2022/23 and 2023/24 | Resulting in cuts to services and reputational damage |

| | | | |
|---|---|---|---|
| **6. Reducing health inequalities** | If we are unable to work together as an integrated care system across organisation and sector boundaries | Then we will have less (or no) impact on reducing health inequalities in the population of Staffordshire and Stoke-on-Trent | Resulting in sustained or increased health inequalities, worsening health and wellbeing of the population, potentially increased cost of health and care and worsened quality of service experienced |

The table below summarises the progress toward the targets set by the Board.

## Summary of BAF risk scores

The ICB Board Assurance Framework Report identifies good practice that should be carried over into 2023/24. There is much to celebrate, and it should be noted that not all ICBs have developed a BAF in their first year.

In addition, the BAF development has been recognised as a good example of system working which the Risk and Governance Group have presented to the North West ICBs and will be developed by the Good Governance Institute as a case study on the subject of system risk, for the Healthcare Financial Management Association (HFMA).

The full BAF for Quarter 4 Report, has been updated by all risk owners for the final quarter of the 2022/23 financial year, including issues that led to any gaps between the target and final score.

There are six BAF risks, which have been organised within the four Strategic Objectives, agreed by the Board. While the ICB can be satisfied that good progress has been made towards developing an effective BAF and that it has been delivered through a system approach, these lessons learnt will be taken forward into our approach for the 2022/23 BAF.

| BAF risk | Q2 L | Q2 C | Q2 S | Q3 L | Q3 C | Q3 S | Q4 L | Q4 C | Q4 S | Target L | Target C | Target S | Target date | Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Improved outcomes** | 3 | 4 | **12** | 3 | 4 | **12** | 3 | 2 | **6** | 3 | 2 | **6** | 31/03/23 | ↓ |
| **2. Delivery of Winter Plan** | 4 | 5 | **20** | 4 | 5 | **20** | 3 | 4 | **15** | 3 | 4 | **12** | 31/03/23 | ↓ |
| **3. Improving quality** | 4 | 4 | **16** | 3 | 4 | **16** | 3 | 4 | **16** | 3 | 3 | **9** | 31/03/23 | → |
| **4. Workforce** | 4 | 5 | **20** | 4 | 5 | **20** | 4 | 5 | **20** | 4 | 4 | **16** | 31/03/23 | → |
| **5. Finance** | 5 | 4 | **20** | 5 | 4 | **20** | 2 | 4 | **8** | 4 | 3 | **12** | 31/03/23 | ↓ |
| **6. Health inequalities** | 4 | 5 | **20** | 4 | 5 | **20** | 4 | 5 | **20** | 2 | 2 | **4** | 31/03/23 | → |

The BAF is supported by an organisational Risk Register which captures operational risks. The Register is presented to the Board and committees for assurance.

Details of the risks and their mitigations can be found in the Governance Statement.

# Performance analysis

Staffordshire and Stoke-on-Trent ICB has several acute providers, listed in 'Our population' earlier in this report. Collectively, these providers determine our ability to deliver services for our population and to meet national standards and other locally determined targets.

This report highlights those providers relevant to the area.

## Urgent and emergency care (UEC)

Urgent and emergency care covers acute hospital emergency departments (ED), NHS 111, ambulance services, community urgent response services and hospital discharge services. Acute hospital providers are monitored on two key constitutional standards however we recognise that the responsibility of these metrics is system wide:

- 95% of patients attending A&E to be admitted, discharged or transferred to another facility within four hours of arrival in the department
- 0 patients waiting on trolleys in the emergency department for 12 hours or more.

Our main acute hospital provider is the University Hospitals of North Midlands NHS Trust (UHNM). Our population also use services at surrounding hospitals in Burton, Wolverhampton, Birmingham, Dudley and Walsall. Performance against the target to see 95% of patients within four hours ranged between 52% and 77%. Further information on how these providers are performing against the above national targets can be found in their own annual reports.

Our approach to planning for increased demand over winter was to establish whole system partnership working and shared ownership from the outset. The ICS Leadership Compact was adapted for UEC and tested throughout the winter planning process. The Winter Plan was written with all our main providers and the local authorities to ensure there was one robust plan that supported our patients and our workforce.

The Winter Plan was presented, reviewed and approved by all system partner trust public boards or equivalent forum and had three key areas:

- The **System Capacity Plan** detailed all the additional capacity the system could stand up, including a phased plan of when
- The **System Workforce Plan** demonstrated how system partners would work together to support recruitment and retention to promote all services having equal staffing
- The **System Escalation Plan** remains pivotal to ensure acceptable and agreed levels of clinical risk prior to onset of winter.

The System Winter Plan delivered enhancements to a number of schemes, including expansion of the Community Rapid Intervention Service (CRIS) to include a two-hour Urgent Community Response service, Community Falls Response services and expansion of our virtual wards offer.

The System Winter Plan is overseen via the supporting System Winter Multidisciplinary Team (MDT) forums, with senior attendance from all ICS partner organisations. The System Winter Plan remains operational and is monitored and reported monthly via the UEC Board.

The System Winter Plan is a live document, which is updated and adjusted to take into account fluctuating demand, seasonal illnesses and workforce availability.

Urgent and Emergency Care saw unprecedented demand over the winter. This was the first winter with no social restrictions since the start of the pandemic and as a result flu peaked earlier and faster than any previous winters. This contributed to the pressures seen with high levels of ambulance handover delays and long waits for patients in emergency departments.

Our modelling assumed worst case flu demand by predicting 2017/18 levels, which saw a peak late January which was the usual trend.

However, in December 2022 demand peaked earlier and higher than predicted and coincided with a surge in COVID-19 and respiratory syncytial virus (RSV), and an unexpected rise in cases of strep A and scarlet fever. This placed further pressure onto the inpatient wards and affected patient flow, with significant infection prevention and control (IPC) measures required to try and manage infection and spread of these illnesses.

On 29 December 2022 a System Critical incident was stood up due to the increase in demand, and ran until 5 January 2023.

The System Escalation Plan was enacted over Christmas and new year, with extra capacity being made available to expedite patient flow. The focus remains on maintaining flexibility of hospital capacity and maximising flow out of the hospital throughout the year.

Aside from the peak in demand during this period, patient flow has been maintained across UEC and partners across the ICS have continued to work collaboratively.

## Ambulance and NHS 111 performance

Across the country, ambulance handover delays have reached critical levels over the last year. This led to considerable delays for patients waiting in the community – especially for our Category 2 and 3 patients. This has been the result of several factors: a peak in flu demand that was outside of the patterns previously observed, levels of demand coming through emergency departments, unexpected rise of strep A and scarlet fever over winter, staffing shortages across all of health and social care, and difficulties discharging medically well patients.

During December, our main ambulance provider West Midlands Ambulance Service (WMAS) recorded the second highest volume of calls ever received, and East Midlands Ambulance Service (EMAS) recorded their highest.

The UEC system worked collaboratively to develop a plan to address **ambulance handover delays**. Significant improvements in delays have been made from early 2023:

- The number of ambulance handover delays over 60 minutes from WMAS ambulances to UHNM emergency department reduced to a monthly average of 814 in the fourth quarter (January to March 2023), from 1,630 in the third quarter (October to December 2022)
- Response times for Category 2 patients reduced significantly (from an average of 1 hours 40 minutes in the third quarter to 30 minutes in the fourth quarter.

Tackling ambulance handover delays remain a priority, although we saw a significant improvement in the last quarter of 2022/23 due to the following:

- Weekly Ambulance Handover Delay Task and Finish group, chaired by ICB CEO Peter Axon, has been in place to assess weekly performance and agree system priority focused actions
- The Ambulance Handover Plan and System Winter Plan has delivered key actions:
    - The rate at which patients who are medically fit for discharge have been discharged has been sustained as a result of additional funding
    - Improved flow through our main provider (UHNM), reduced overcrowding in emergency departments, and reduced number of walk-ins
- The Ambulance Handover Plan has been used to assign actions in order to maintain flow throughout the UEC pathway. Lack of flow will inevitably create a bottleneck in pressure.

**NHS 111** has recovered well from the busy period over Christmas and the impact of strep A and scarlet fever. The percentage of calls to NHS 111 which were abandoned reduced from 19.0% in the third quarter to 9.5% in the fourth quarter. While this is higher than the national target and has room for improvement, Staffordshire and Stoke-on-Trent has had a lower abandonment rate than many other areas. In addition, a higher proportion of our calls get access to a medical professional which helps support decision making and signposting.

The NHS and the local system are emerging from the pressures of a hugely challenging winter period, compounded by early peaks in infectious disease and the effects of ongoing industrial action. ED performance forms a cornerstone of the System UEC Recovery Plan and will be subject to targeted and ongoing improvement work with system partners as part of recovery planning in to 2023/24.

## Elective care

Elective care refers to planned surgery and treatment, in inpatient and outpatient settings. It also includes diagnostic tests such as X-rays and endoscopy.

The national ambitions set out in the NHS planning guidance 2022/23 were to:

- Recover elective activity (planned overnight and day-case hospital stays and outpatient appointments)
- Reduce waiting times by delivering an additional 4% more activity than was delivered in 2019/20 (pre-pandemic)
- Eliminate waiting times of 104 weeks or more from referral to treatment by 30 September 2022
- Eliminate waits of 78 weeks or more by 31 March 2023.

The guidance also asked systems to develop plans to support an overall reduction in 52-week waits where possible, in line with the ambition to eliminate them by March 2025 – except where patients choose to wait longer or in specific specialties.

Elective recovery continues to be challenging for all providers locally and nationally. Our providers have worked hard to improve elective capacity and reduce waits. But pressures on health and care services have continued to make it difficult to achieve our objectives. In 2022/23, 94.6% of 2019/20 activity was delivered – a shortfall of 9.4% on the target of 104%.

High demand for urgent and emergency care led to wards and theatres being used for emergency cases. COVID-19 has also continued to affect capacity, resulting in the postponement of some elective surgery and outpatient consultations, and staff being absent because of sickness and isolation needs.

These factors, along with staffing pressures, have meant that some of our patients had to wait significantly longer for treatment. This has meant that our acute providers have not met the waiting time standards this year.

The following table shows the performance for Staffordshire and Stoke-on-Trent over 2022/23. At year-end, the number of 104-week waits had reduced to 57, and the number of 78-week waits had reduced to 618. The numbers of 52-week waits have increased slightly over the year – from 8,498 at the end of the first quarter to 8,648 at the end of the fourth quarter.

Our main acute providers are using additional capacity from independent sector providers and mutual aid of other NHS trusts to enable reduction in long waits, particularly 78-week waits. We recognise that there is a lack of capacity across the region to treat these patients – many of whom have more complex health needs.

Number of Staffordshire and Stoke-on-Trent patients waiting more than 52, 78 and 104 weeks from referral to treatment

| 2022/23 | Number of patients waiting more than 52 weeks | Number of patients waiting more than 78 weeks | Number of patients waiting more than 104 weeks |
|---|---|---|---|
| Quarter 1 – end | 8,498 | 1,488 | 64 |
| Quarter 2 – end | 9,164 | 1,368 | 69 |
| Quarter 3 – end | 9,559 | 1,494 | 44 |
| Quarter 4 – end | 8,648 | 618 | 57 |
| **Year end** | **8,648** | **618** | **57** |

## Outpatients

In 2022/23, the number of first outpatient attendances increased across the ICS, exceeding 2019/20 activity levels by 7%, which met and exceeded the national ambition of 4%.

Systems were also asked to speed up progress towards a more personalised approach to follow-up care in hospitals or clinics. The target was to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, going further where possible.

In Staffordshire and Stoke-on-Trent, outpatient follow-up attendances increased very slightly by 0.4%, meaning this ambition was not met.

## Diagnostics

To meet the national ambition for recovery in diagnostic activity, systems were asked to increase diagnostic activity to a minimum of 120% of pre-pandemic (2019/20) levels. This was in addition to the constitutional standard for 95% of patients to receive a diagnostic test within six weeks of referral.

The seven main diagnostic tests include non-obstetric ultrasound, endoscopy, Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) scans, and echocardiography (ECG). Levels of activity across these tests have remained stable throughout the year. As with other elective activity, staffing pressures have affected capacity, and 87.7% of 2019/20 activity was delivered across the seven tests.

In 2022/23, 65.4% of patients received their diagnostic test within six weeks of referral, compared to the target of 95%. This figure has been steady across the year.

The system is looking to secure a robust service across Staffordshire and Stoke-on-Trent with additional capacity planned for 2023/24. There are plans for two **Community Diagnostic Centres (CDCs)** to open in Cannock Chase and Tamworth during 2023/24. We anticipate seeing the impact of additional capacity at these two sites in 2023/24. There are plans for a third CDC to be opened in Stoke-on-Trent during 2024/25.

# Cancer

The national ambitions set out in the NHS planning guidance 2022/23 were to:

- Ensure cancer treatment levels are fully recovered
- Reduce the number of patients waiting 62 days or more for a confirmed diagnosis and start of treatment to that seen in February 2020
- Ensure 75% of patients with suspected cancer receive a diagnosis within 28 days. This is known as the faster diagnosis standard.

In addition, the NHS Constitution states that:

- In 93% of urgent referrals where cancer is suspected, patients should be seen within two weeks of referral
- 96% of patients diagnosed with cancer should start treatment within 31 days of decision to treat.

Although cancer services were largely protected from the worst impacts of the pandemic, the service has been affected by overall pressures on diagnostic capacity, and by some patients delaying seeking advice from their GP. This has meant that waiting times for both cancer diagnosis and treatment have been longer compared to before the pandemic.

Cancer performance has seen sustained improvement during the latter half of 2022/23. This is largely due to developments in diagnostics and treatment focussed on the pathways under greatest pressure both locally and nationally – colorectal, skin and urology.

- Roll-out of **faecal immunochemical testing (FIT)** carried out prior to referral. Patients with a negative test but ongoing symptoms are referred into the most appropriate non-cancer service. Where FIT is in use, the typical waiting time for first outpatient appointment has been reduced from about three weeks to just over one week
- **Teledermatology** – patients with skin lesions where cancer may be suspected have a set of high-quality photographs taken in the community where are then assessed by a doctor prior to referral. Patients are having their first appointment

in seven to 10 days and two to three weeks earlier than prior to introduction of teledermatology

- For **urology**, particularly prostate cancer, recent initiatives include patients going straight to MRI scan and also the introduction of an improved biopsy technique which can be done using local anaesthetic.

One of the main purposes of the 28-day Faster Diagnosis Standard is to ensure that as many patients as possible receive their diagnosis within four weeks of referral. There has been a focus to ensure that as many patients as possible referred with suspected cancer go straight to having a diagnostic test such as a scan without needing to have an additional outpatient appointment.

The positive impact of these initiatives is being seen in performance against national targets. Their effectiveness is reviewed monthly, and all metrics to date indicate that they are effectively supporting the cancer diagnostics pathway.

The table below outlines performance against these targets. Although the ambitions have not yet been met, improvements can be seen throughout the year in two-week, 31-day and 28-day targets.

There are a number of initiatives ongoing to further increase capacity. It is predicted that the improvements in 28-day performance will continue to be seen, and improvements in 62-day performance will start to be seen from the start of 2023/24.

Percentage of Staffordshire and Stoke-on-Trent patients achieving the key national cancer waiting time standards

| 2022/23 | 2 weeks referral to appointment (Target: 93%) | 31-day first definitive treatment (Target: 96%) | 28-day faster diagnosis standard (Target: 75%) |
|---|---|---|---|
| Quarter 1 – end | 58.2% | 85.0% | 61.6% |
| Quarter 2 – end | 58.8% | 85.9% | 57.0% |
| Quarter 3 – end | 83.4% | 87.0% | 62.6% |
| Quarter 4 – end | 90.5% | 87.8% | 69.1% |
| **Year to date** | **72.7%** | **86.4%** | **62.5%** |

## Mental health

At the beginning of the year, the NHS Long Term Plan renewed the NHS commitment to pursue the most ambitious transformation of mental health care England has ever known. Much has already been achieved for mental health across Staffordshire and Stoke-on-Trent.

**The ICS has operated a comprehensive mental health programme that has delivered many improvements.** It has received extremely positive feedback both regionally and nationally for coordination and performance throughout 2022/23.

As an ICS we aim to work in an integrated, collaborative way to ensure that mental health is given equal priority to physical health and that everyone receives the help and support they need closer to their home and family.

Our key ambitions are about enabling timely access to mental health services for our patients. The table below outlines the numbers of our patients who accessed community mental health services compared to our local ambition.

Number of Staffordshire and Stoke-on-Trent patients accessing community mental health services

| 2022/23 | Children and young people's mental health services (0-17) (Target: 14,405 over 12 months) | Core community mental health services for adults and older adults with severe mental illnesses (Target: 11,352 over 12 months) | NHS Talking Therapies (formerly Improving Access to Psychological Therapies) (Target: 33,843 for 2022/23) |
|---|---|---|---|
| Quarter 1 | 14,885 | 10,560 | 6,025 |
| Quarter 2 | 14,945 | 11,040 | 5,935 |
| Quarter 3 | 14,845 | 10,995 | 6,630 |
| Quarter 4 | 14,690 | 10,355 | 3,980 |
| **Year to date** | **14,690** | **10,355** | **22,570** |

- *Data for access to Children and Young People's Mental Health services is a rolling 12-month period.*
- *Data for access to Core Community Mental Health services is a rolling 12-month period.*
- *Data for access to NHS Talking Therapies is for months 1-11, as month 12 data was not available at the time of writing.*

The ICS is on track to achieve the access targets for children and young people and has been close to achieving the targets for adults with severe mental illnesses. Improving access to psychological therapies (IAPT) services have not achieved target levels – mainly due to a low number of referrals into the service. The ICS is taking measures to address this, by raising the profile of IAPT and promoting the service extensively across Staffordshire and Stoke-on-Trent. The service has been rebranded and renamed 'NHS Talking Therapies'. A mobile clinic will be provided to make access easier for patients who cannot easily travel.

**Dementia diagnosis rates** are recovering following the reduction in rates which occurred nationwide during COVID-19. The ICB currently has the top diagnosis rate (69.9%) within the 11 Midlands ICBs and is achieving the national target of 66.7%.

As with other services, staffing and capacity issues have affected patient access. Targeted recruitment is underway at our two core mental health providers – North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT). We are working with NHS and voluntary sector partners to look at creative ways to increase capacity and improve patient uptake of services.

Assurance is provided through the Staffordshire and Stoke-on-Trent ICS Mental Health, Learning Disability and Autism Portfolio Board.

## Learning disabilities and autism

The Staffordshire and Stoke-on-Trent population of people with a learning disability (LD) and/or autism is diverse in its needs. Inequality can take many forms and impacts on health and wellbeing – to which all organisations across the system need to respond.

The national ambitions set out in the NHS planning guidance 2022/23 and the NHS Long Term Plan were to:

- Increase the rate of annual health checks for people aged 14 and over on a GP Learning Disability Register (LD Register) towards the 75% ambition in 2023/24
- Continue to improve the accuracy of GP learning disability registers
- Reduce reliance on inpatient care for both adults and children with a learning disability and/or autism.

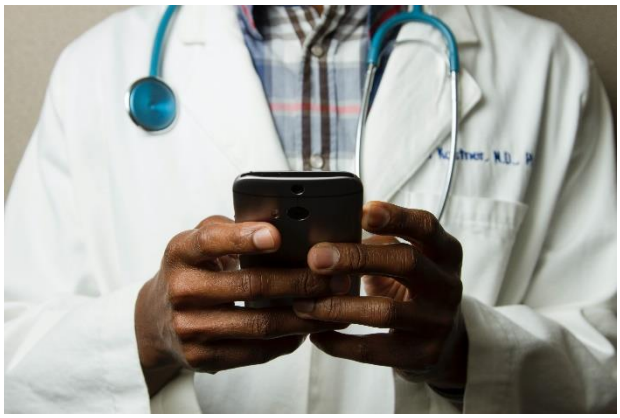
There are areas of strong performance in learning disabilities and autism services, which reflect our increased focus:

- The target to **deliver annual health checks to 75% of people aged 14 and over on a GP LD Register** was exceeded by more than 5%
- GP practices have increased **the number of people on the LD Register** during this financial year from 5,680 to 6,049 (+6.5%)
- The target to reduce **the number of patients with a learning disability and/or autism in an inpatient bed** was achieved for adults, but not achieved for children and young people (three additional patients above the limit set).

Number and percentage of people in Staffordshire and Stoke-on-Trent aged 14 and over on a GP LD Register who received an annual health check

| 2022/23 | Number of people on a GP LD Register who received an annual health check | Percentage (Target: 75%) |
|---|---|---|
| Quarter 1 | 706 | 12.0% |
| Quarter 2 | 1,775 | 29.4% |
| Quarter 3 | 3,017 | 50.0% |
| Quarter 4 | 4,884 | 80.7% |
| **Year to date** | **4,884** | **80.7%** |

Partners across the system have worked hard to raise the profile of learning disabilities and autism. They have developed a Joint Strategic Needs Assessment which was presented to the Staffordshire and Stoke-on-Trent Health and Wellbeing Boards in November and December 2022.



## Primary care

Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice and community pharmacy services.

The national ambitions for primary care set out in the NHS planning guidance 2022/23 were about improving timely access to primary care and transferring lower acuity care from both general practice and NHS 111. Systems were asked to:

- increase the number of appointments in general practice
- secure universal participation in the Community Pharmacist Consultation Service across general practice and community pharmacies.

Primary care has been impacted by the unforeseen increase in strep A and scarlet fever cases, which caused significant demand in the autumn. Despite this, more face-to-face appointments are being offered in Staffordshire and Stoke-on-Trent than nationally, and GP appointments have increased compared to pre-pandemic levels.

Number of GP appointments across Staffordshire and Stoke-on-Trent and percentage of appointments held face-to-face

| 2022/23 | Total number of appointments in general practice | Percentage of appointments held face-to-face |
|---|---|---|
| Quarter 1 | 1,355,946 | 66.6% |
| Quarter 2 | 1,427,918 | 70.6% |
| Quarter 3 | 1,597,944 | 74.7% |
| Quarter 4 | 1,563,770 | 74.3% |
| **Year to date** | **5,945,578** | **71.8%** |

GP appointments have increased by 3.6% this year compared to last year – a 10.6% increase on 2019/20. **Almost three quarters of GP appointments were held face-to-face in surgeries** – 71.8% compared to a national average the year-end national position of 70.1%.

**The Community Pharmacy Consultation Service offering same-day pharmacist advice or treatment has been successfully rolled out**, with 99.7% of community pharmacies signed up to the scheme and 128 GP practices using the service. The Staffordshire and Stoke-on-Trent service is the highest performing in the Midlands in usage and uptake.

The ICB has launched our General Practice Strategy for the next five years which was signed off by the ICB Board in March 2023. This is based on the recommendations in the Fuller Stocktake report to build integration, personalised and flexible care. Patients will have more choice over when, where and how they access their GP practice, with a range of workforce to meet their needs.

Our access programme focuses on patients having a positive experience of accessing general practice healthcare. As an ICB we will continue working with practices to make it easier for people to contact a GP practice and to ensure everyone who needs an appointment gets timely assessment and an appointment according to their clinical need.

A Primary Care Workforce Implementation Group will oversee the development of a workforce strategy by March 2024.

## Children and young people (CYP)

The NHS Long Term Plan sets out that over the next five and 10 years we need to concentrate our focus on children and young people – as their health and wellbeing will determine our future. However, we know that the health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life, and a healthy environment all significantly influence young people's health and life chances.

By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences, so working closely with local government and other public services across Staffordshire and Stoke-on-Trent will remain crucial. The good news is that these close working relationships continue to get stronger across the ICS.

Key priority areas now include:

- Reducing rates of infant mortality
- Increasing the number of children and young people achieving and sustaining a healthy weight
- Reducing hospital admissions for asthma, epilepsy and diabetes.

Many different services and portfolios will be involved in working towards these goals, including maternity, mental health, elective recovery for children and young people, urgent care, and population health management.

Although there has been a reduction in infant mortality rates in Stoke-on-Trent, the rate remains above the England average. 2018–20 data shows 3.9 per 1,000 in England, 6.5 per 1,000 in Stoke-on-Trent, and 5 per 1,000 in Staffordshire.

Rates of obesity continue to be above the England average across Staffordshire and Stoke-on-Trent:

| 2021/22 | England | Stoke-on-Trent | Staffordshire |
|---|---|---|---|
| **Reception** | 22.3% | 25.4% ↑ | 25.0% → |
| **Year 6** | 37.8% | 44.7% ↑ | 37.8% → |

We continue to experience an increase in demand for education, health and care plans, with the largest increase for those with social and emotional mental health difficulties. Compliance among NHS providers varies between 46% and 100%.

**System-wide task and finish groups have been set up to drive forward the actions needed to deliver the National Asthma Bundle.** These groups include Early and Accurate Diagnosis, Environmental Impacts, Clinical Effectiveness and Prevention, and Asthma Friendly Schools. The Asthma Friendly Schools pilot of 14 schools has begun and aims to improve the schools' approach for these children. The learning from this pilot will shape the programme that will be rolled out to further schools.

## Safeguarding children and young people

As an ICB we have a significant statutory and strategic role in protecting children and young people. This includes protection of CYP from maltreatment, preventing impairment of children's health and development, ensuring children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best outcomes (Working Together 2018). Health services (including the ICB) also have a duty under section 11 of the Children's Act (2004) to ensure they cooperate to safeguard and promote the welfare of children.

As a key statutory partner, we have discharged our duties by working with health providers and in partnership with the other key statutory partners – children's social care and the police. Both Staffordshire and Stoke-on-Trent Safeguarding Children Partnerships have completed the annual section 11 audit, incorporating the system's findings. The agencies' safeguarding processes and practice have achieved a grading of overall compliance, demonstrating effective leadership, safe practice and a clear focus on capturing the voice of the child.

Aspects of information sharing between the agencies were identified as an area for development, although minimum standards were met. Assurance measures have been developed, including the successful implementation of the Child Protection Information System (CP-IS) and the One Health and Care Record – enabling an integrated way of working and improved sharing of information across health and children's social care.

The tragic deaths of Arthur Labinjo-Hughes and Star Hobson prompted the National Panel Review in 2022. The Staffordshire Safeguarding Children Board and the Stoke-on-Trent Safeguarding Children Partnership have used the learning from these cases and local learning from Rapid Reviews and Child Safeguarding Practice Reviews (CSPR) to reflect on their key priorities. Neglect remains a key factor in child protection plans across Staffordshire and Stoke-on-Trent – for babies under the age of two, in particular. The Thematic Review of Under-1s published in 2023 shows a need for improvement in the early identification of risk for this group of children and for increased observation and intervention with families in need of parenting support.

The ICB Safeguarding team led on the roll-out of the ICON (Babies Cry You Can Cope) programme and awareness and training for parents, carers and practitioners across the system. Alongside this, the safer sleep programme for practitioners has been started, led by the Child Death Overview Process (CDOP) Nurse Practitioner. There are plans to offer improved access for parents and carers.

The number of child deaths due to suicide continue to be a concern. Our Safeguarding team was involved in a thematic review and took part in a region-wide review, where the key findings identified some learning in relation to local pathways and processes. These findings have been translated into meaningful actions driven by the ICS Children and Young People's Mental Health Improvement Board. The learning from reviews is shared with practitioners working across the system.

As an ICB, we are a proactive partner in the consultation for 'Stable Homes, Built on Love' Implementation Strategy. This sets out a system vision, which is to rebalance children's social care to provide more meaningful and effective early support, in preference to costly crisis intervention. We believe this will improve outcomes for children living in Staffordshire and Stoke-on-Trent.

There is a specific focus on children in care and care leavers – an area on which focus will be needed to improve these children's life chances and health outcomes.

The numbers of children entering the care system across Staffordshire and Stoke-on-Trent continue to grow. There are also increasing numbers of unaccompanied asylum-seeking children (UASC), which increases the demand for statutory Initial Health Assessments (IHA) for these children. Our Safeguarding team has been working in partnership with children's social care to address some of the inequalities for this vulnerable group of children and young people – working towards a safer and effective transition process into adult services and ensuring the earliest of interventions for those at risk of exploitation.

Access to free prescriptions and dental care has improved. The timeliness of the Initial Health Assessments and Review Health Assessments

needs further improvement, but the quality of assessments remains high. Short-term additional resource has led to improvement, as evidenced by routine quality assurance processes. We are working with providers on a sustainable plan for the future.

Our Safeguarding team continues to support and contribute towards Stoke-on-Trent City Council Children's Improvement Board plans – demonstrating multi-agency commitment to the collaborative partnership meetings.

As an ICB, we have demonstrated compliance with the requirements of the Safeguarding Accountability and Assurance Framework (SAAF) and we are regularly monitored against the requirements of the Safeguarding Commissioning Assurance Tool (SCAT). This provides assurance of secure safeguarding arrangements. Our Safeguarding team contributes to the Staffordshire Safeguarding Children Board (SSCB) and Stoke-on-Trent Safeguarding Children Partnership's annual reports. The Designated Professionals write the CSPR annual report for the SSCB and the annual report for the Staffordshire and Stoke-on-Trent Safeguarding Children Forum (SSSCF). Representation at both boards and associated scrutiny and assurance groups remains consistent. This means we contribute safeguarding expertise to the delivery of priorities and the business plans, driving improvements and quality.

As part of the wider system, the ICB Safeguarding team contributes to the delivery of the Serious Violence Duty (2023), which requires specified authorities to work together to reduce and prevent serious violence. Domestic abuse and child exploitation remain focused areas of improvement, and our Safeguarding team contributes to the strategic delivery of the Domestic Abuse Act (2022) and local Domestic Abuse Strategy. This helps to make sure that children are recognised as victims and that children who present as missing are safeguarded appropriately according to the local Child Exploitation Strategy and policies.

Multi Agency Safeguarding Hub (MASH) arrangements are going through changes. This means key statutory partners must work together to make sure there is clear oversight and accountability for changes in the information-sharing process. The ICB Safeguarding team remains integral to the decision-making processes in this workstream.

A programme of system work directed by the Chief Nursing and Therapies Officer for the ICB, led by the Associate Director for Safeguarding, is developing a Provider Collaborative for Safeguarding. On 27 February 2023, the Provider Collaborative Board was presented with phase one of the proposal and approved to move to stage two. This programme builds on the workstreams undertaken through the Safeguarding Health Forum. Using this Provider Collaborative approach will help us develop improved and robust governance for safeguarding across the system. It will also make the best use of the system's specialist safeguarding resource. Oversight and assurance of the Provider Collaborative will remain the responsibility of the ICB and will be carried out via the Safeguarding Strategic Health Forum, currently being established.

CYP safeguarding reports and strategies:

- Working Together to Safeguard Children 2018 (publishing.service.gov.uk)
- Child Protection in England - May 2022 (publishing.service.gov.uk)
- Children's social care 'Stable homes, built on love' consultation (publishing.service.gov.uk)
- Staffordshire Safeguarding Children Board - Annual Report 2021/22 - Staffordshire Safeguarding Children Board (staffsscb.org.uk)
- Stoke-on-Trent and Staffordshire Safeguarding Children Health Forum Annual Report 2021/22 (staffsstokeics.org.uk)

## Safeguarding vulnerable adults

The ICB holds statutory adult safeguarding duties and responsibilities detailed within the Care Act 2014 and is an active statutory partner of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB). The Designated Nurse for Safeguarding Vulnerable Adults is Vice Chair, Chair of the Executive Sub-committee and Vice Chair of the Safeguarding Adult Review sub-group.

Our Safeguarding team has supported the Board's strategic priorities, which include engagement and financial abuse. Activities this year have included:

- Producing short video briefings on key topics including advocacy in financial abuse enquiries and cuckooing
- Participating in important national research projects conducted by Keele University and a Research Fellow of King's College London
- Delivering four training events and supporting the question-and-answer panel
- Supporting the updating of the SSASPB website to make it more compliant with accessibility legislation and to refresh the content
- Working to produce a more accessible version of the SSASPB Annual Report
- Supporting the Adult Safeguarding week with several events arranged by connected partners, covering subjects including raising awareness of adult abuse (including specific types of abuse and neglect), how to report concerns, and an explanation and illustration of Safeguarding Adult Reviews
- Leading the first 'Safeguarding's Got Talent' practitioner event – bringing all system safeguarding teams together to present a complex multi-agency case they had led on. The event was well received and attended, and there are plans to make this an annual event
- Supporting the production of safeguarding newsletters which were distributed widely and covered a variety of topics. These included learning from Safeguarding Adult Reviews, how to make a referral to Stoke-on-Trent Multi-Agency Resolution Group, sepsis awareness, how to make a good SAR referral, and understanding Lasting Powers of Attorney.

The Board has agreed to continue with engagement as a strategic priority for 2022–25. It will focus in particular on how to better engage with adults with needs for care and support who have experienced abuse or neglect. In addition, the Board will start working on 'Effective Practice' which has been identified following recommendations from a recent Safeguarding Adult Review (SAR).

The Adult Safeguarding Roles and Competencies for Healthcare Staff intercollegiate document was published in August 2018 and is endorsed by NHS England and Improvement and the Royal Colleges. It guides professionals and the teams they work with to identify the competencies they need to make sure people receive personalised and culturally sensitive safeguarding support. The Adult Safeguarding team worked with NHS Providers to ensure action plans derived from this document have been delivered, and to demonstrate compliance. This is also fed into the audit activity of the Adult Safeguarding Board.

As an ICB we have a statutory duty to make sure practitioners are effectively applying the Mental Capacity Act (MCA) 2005. We created a system working group in preparation for the implementation of the MCA Amendment Act (2019). We have a duty to authorise the Liberty Protection Safeguards for health-funded care arrangements for people who lack capacity to consent to the arrangements, if the care gives rise to a deprivation of their liberty.

NHS services have a statutory duty under the Counter Terrorism and Security Act 2015 to ensure all staff have received training in relation to the PREVENT agenda. The ICB represents the health partnership at both the Staffordshire and Stoke-on-Trent PREVENT Boards and leads a Health PREVENT Forum for all partners to provide assurance, raise exceptions and ensure partners are sighted on the workings of both PREVENT Boards.

Our Safeguarding team plays a reactive role where there are failing independent sector care services. The team completes statutory S42 Safeguarding enquiries in relation to both Staffordshire and Stoke-on-Trent local authorities. The Senior Safeguarding Nurse

represents the ICB at the Quality and Safeguarding Information Sharing Meeting (QSISM). They work in collaboration with CQC, local authority, police and Healthwatch partners to ensure that independent sector services of concern are being scrutinised and supported to drive the necessary improvements.

The Designated Adult Nurse is a member of the NHS England and Improvement Safeguarding National Network. This is a clinical reference group which influences national policy and develops key partnership working at a national level. The group has had an active role in shaping the statutory guidance for the new Liberty Protection Safeguards and has enabled the sharing of best practice.

Local adult safeguarding report:

- Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Annual Report 2021/22

## Environmental matters

Staffordshire and Stoke-on-Trent ICB continue to recognise the impact of climate change on our communities and the importance of delivering health and care services in an environmentally sustainable way.

In September 2022, the Board approved a Memorandum of Understanding (MoU) with NHS England to set out their working relationship. This included a limited number of joint commitments including delivery of a Greener NHS.

This MoU commits the ICB, its partners and NHS England to work collaboratively to achieve the government ambitions for the NHS:

- an 80% reduction in the emissions we control directly by 2028-32 and net zero by 2040
- an 80% reduction in our entire emissions profile by 2036-39 and net zero by 2045.

As an ICB we have reduced the carbon footprint of the NHS by conducting as many meetings as possible over remote connections, limiting business miles to only those cases where face-to-face meetings were really necessary.

This agile approach to working helps to limit our physical estate footprint and the energy needed to heat and light buildings as well as other costs of occupation, such as waste management.

During 2022/23, the ICB's procurement of goods and services has been compliant with the government's Social Value Model including carbon net zero requirements.

As well as delivering measures to promote environmental sustainability for our own functions and services, the ICB leads in coordinating the efforts of partner organisations across the ICS, via the Staffordshire and Stoke-on-Trent Greener NHS Programme Board.

In 2022/23, progress has been made in a wide range of areas:

- Each partner organisation has a **designated Executive Lead** responsible for sustainability
- A **reduction in the use of medicines and medical supplies** to avoid atmospheric release of medical gases including the availability of dry powder inhalers where clinically appropriate
- The proportion of fleet and/or lease cars which are **zero or ultra-low emission vehicles** (ZEV or ULEV)
- A **reduction in the reliance on office paper**, and paper purchasing to be from recycled sources
- Energy purchased by trusts from sources backed by **renewable energy** guarantees
- Application of net zero hospital building standards
- Applications to the Public Sector Decarbonisation Scheme.

As we move towards 2023/24, we will be refreshing our Senior Responsible Officer arrangements to make sure we have sufficient focus on the continued delivery of our Green Action Plan.

# Quality assurance and improvement

The ICB has a systematic quality assurance and improvement structure. This ensures that we fulfil our statutory duties in respect of quality, and that concerns about performance and quality are escalated appropriately and openly. The structure incorporates the provider Clinical Quality Review Meetings (CQRM), the System Quality Group (SQG), and Quality and Safety Committee (QSC) which includes representatives from across the ICS as well as the Care Quality Commission, Healthwatch, Health Education England and NHS England. The SQG and QSC maintain strong links with the Health and Care Clinical Senate to ensure a strong clinical and care focus.

Since the ICB's inception, the emphasis has shifted from provider-based reporting to system-level, partnership working. Agreement on common risks and areas of concern are a core part of the quality approach. All members of the Quality and Safety Committee are expected to share accountability for the quality of services and for driving improvements.

System partners work collaboratively to identify early warning signs of emerging issues or impacts. When areas of concern are identified whether by routine monitoring, soft intelligence or other forms of feedback and review, the ICB's Nursing and Therapies directorate undertakes additional quality assurance activities. These include (but are not limited to) announced and unannounced visits (including visits on evenings and weekends), deep-dives into data, and focused reviews. If these highlight further areas of concern, or a lack of a plan to address identified concerns, the escalation process outlined in the National Quality Board guidance is followed.

The SQG provides a strategic forum at which partners from across health, social care and public health can join up around common priorities (linked to the ICP Strategy). The partners share insight and intelligence, identify opportunities for improvement and concerns/risks to quality, and develop system responses. This work enables ongoing improvement in the quality of care and services across the ICS.

The QSC was established by Staffordshire and Stoke-on-Trent ICB as a statutory sub-group of the ICB in accordance with its Constitution.

- The QSC will contribute to delivery of our quality objectives by providing oversight and assurance to the Board on the delivery of core purposes:
- Enabling system alignment on quality, and routinely sharing intelligence, insight and learning on quality matters across the ICS
- Identifying ICS quality concerns and risks, and opportunities for improvement and learning. This includes escalating to the ICB, local authorities' assurance (such as Safeguarding Assurance Boards) and regional NHS England teams as appropriate
- Discussing collective action needed to address risks and issues, which the system is responsible for delivering with support from partners
- Developing ICS responses and actions to enable improvement, mitigating risks (respecting statutory responsibilities), and demonstrating that these plans have had the desired effect. This includes commissioning other agencies or using ICS resources to deliver improvement programmes or solutions to the intelligence identified above – for example Academic Health Science Networks, Provider Collaboratives and clinical networks
- Testing new ideas, sharing learning and celebrating best practice.

The SQG is a sub-group of the QSC and supports the strategic priorities of the system regarding quality, including:

- Ensuring that quality is central to system planning, decision-making and delivery, and that there is a credible and focused strategy to improve quality across the ICS (integrated in the ICP Strategy)
- Ensuring that reducing inequalities is embedded in all discussions to improve quality
- Supporting a psychologically safe and healthy culture for quality management in the ICS, which is based on transparency,

open sharing of information and learning, and collective ownership of actions and issues
- Ensuring a shared view of risks to quality and a shared approach to measurement, learning and improvement. This includes supporting alignment and resolving system barriers to improvement
- Supporting place-based and Provider Collaborative engagement, intelligence and improvement for quality
- Providing quality oversight in relation to public health outcomes and the wider determinants of health, and taking appropriate action as required to reduce health inequalities
- Proactively challenging and reviewing delivery against the Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes – agreeing any action plans or recommendations as appropriate.

## Patient Safety Incident Response Framework

In response to the planned change in the way serious incidents are managed and reported, the ICB has launched a system-wide Patient Safety Incident Response Framework Implementation Group (PSIRF). Implementation of PSIRF is needed by September 2023. This is a time-limited working group with an estimated completion date of autumn 2023. The group provides a forum for all stakeholders to discuss challenges and successes, and to support each other in implementing the PSIRF.

In line with the PSIRF methodology, this working group is not an oversight, assurance, or compliance meeting. The purpose of the group is to enable all stakeholders to have 'insight' into the implementation of the PSIRF and provide a learning forum.

The group's key functions are to:

- Provide a supportive meeting for all stakeholders within the boundary of NHS Staffordshire and Stoke-on-Trent ICB
- Identify areas of good practice for consideration by all
- Identify potential areas of joint work – for example training, Patient Safety Partners
- Identify and record areas of system risk to the delivery of the PSIRF
- Provide assurance and/or escalate risks to achievement to the ICB System Quality Group of which this group is a sub-group.

## Patient Safety Specialists

The Patient Safety Specialists Requirements (2020) highlighted that patient safety specialists will be the lead patient safety experts in healthcare organisations. They will be 'captains of the team' and provide dynamic, senior leadership, visibility, and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems and have sufficient seniority to engage directly with their executive team.

The requirements document identifies the expected benefits of patient safety specialists collaborating in networks to share good practice and learn from each other. It also highlights that these specialists will be responsible for, and may directly lead or support, patient safety understanding and involvement and improvement activity. They will ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.

As an ICB, we have started a Patient Safety Specialist Network, to make sure there is a fully joined-up approach to patient safety across the whole system and all providers of health and social care. Partner Patient Safety Specialists across the system are members of this network. The aim is to lead and support improvement activity in line with the published guidance.

The network aims to move thinking beyond why things go wrong in healthcare (Safety I), to examining why things routinely go right and how that can be maximised (Safety II). The network prioritises patient safety by:

- Sharing all system and national safety learning
- Influencing executive and leadership teams, including having access at no notice to escalate immediate risks or issues

- Having an overview of and ability to influence and interact with all patient safety processes within the system
- Ensuring that patient safety is appropriately prioritised and considered in the work of the ICB
- Ensuing the embedding of shared learning and good practice.

This network provides the opportunity to discuss common issues, risks and challenges and support an integrated and standardised approach to improving safety. The network also provides an opportunity for communication with the national patient safety team and regions as appropriate.

## Continuous Quality Improvement (CQI)

To enable the system to provide outstanding quality services for all, our shared vision and underpinning quality framework include both quality assurance and continuous quality improvement. In line with the guidance set out by National Quality Board, our approach to CQI is focused on developing capacity and capability to practise quality improvement (QI), supporting the embedding of QI in all levels of change, nurturing a learning culture and sharing best practice.

Within the ICS, partners have worked collaboratively to develop a framework and a set of agreed principles. The delivery mechanisms for CQI at a system level include a CQI Sub-Group that focuses on the strategic development and deployment across the ICS, and a QI Network that is a joint ICS endeavour with Shropshire, Telford and Wrekin ICS. This network brings people together from both systems to connect, learn, share and improve.

As the system matures and CQI continues to grow, some areas will be further strengthened. These will include the development of an ICS CQI training offer, and the further embedding of CQI within Place, Provider Collaboratives and Portfolio programmes. A core principle at the heart of CQI is putting the people we serve at the centre of change. The ambition is that through the growth and further embedding of CQI across the system, we can also move towards system-wide co-production being our default approach to involvement within CQI and the ICS.

## Quality Impact Assessment (QIA)

The ICB is committed to ensuring that commissioning decisions, possible or actual business cases and any other significant plans and strategies are appropriately evaluated, that the potential impacts on the quality of services users are considered, and that any necessary mitigating actions are outlined. Our QIA Policy ensures that the impacts of decisions are reviewed against the National Quality Board's definition of quality and provides a governance process for us to deliver against the triple aim.

We undertook an exercise to update our QIA Policy, working with colleagues from across the ICB directorates including Clinical and Care Professional Leadership, Corporate Governance, Delivery, Medicines Optimisation, Nursing and Therapies, and Transformation. A series of workshops in October and November 2022 considered the ICB's statutory responsibility, and carried out a strengths, weaknesses, opportunities, and threat (SWOT) analysis of the former CCGs' approach and peer comparisons. The Quality and Safety Committee approved the updated QIA Policy in February 2023. The policy is available on our Intranet, News, QIA and Policies webpages. Training is available to staff.

## Infection Prevention and Control (IPC)

Services across Staffordshire and Stoke-on-Trent have continued to feel the impact of the COVID-19 pandemic, and infections such as monkeypox and strep A have been affecting our population and services. IPC teams have continued to provide support and advice across the system to ensure safe practice for the patients, staff and the wider population. They have renewed the focus on the wider healthcare associated infections (HCAI) while also dealing with the fluctuating demands of COVID-19.

The system has a well-established collaborative approach. This includes working alongside IPC colleagues at NHS England on guidance and initiatives agreed at a regional level, implementing system-wide actions with risk assessments supporting organisational variance, where required, and observance of particular areas of health and social care working practices.

COVID-19 numbers have fluctuated throughout the year and impacted on services.

Likewise, health and social care providers have managed subsequent outbreaks while continuing to support patient flow across the system. Numbers have reduced towards the end of 2022/23, with those affected less unwell and numbers of people requiring intensive care significantly reduced.

Early 2022/23 saw an outbreak of monkeypox which steadily reduced throughout the year. Across the West Midlands, no cases were reported after the second quarter of 2022/23 – demonstrating the importance of adopting a collaborative approach.

Rates of HCAIs showed an increase, alongside the incidence of COVID-19. MRSA bacteraemia currently remain at the same levels as in the previous year, while C.Difficile infection (CDI) rates are recognised regionally and nationally as having increased, reflecting the local picture.

IPC teams work alongside the regional IPC leads at NHS England to address these issues and are actively engaged in several workstreams to minimise the risks of HCAIs – all of which are discussed at the monthly ICS Health Economy IPC meeting.

HCAI data on the national system is still assigned to previous CCG footprints, with plans to attribute data to ICBs.

## Learning from the Lives and Deaths of those with a Learning Disability and Autism (LeDeR)

The LeDeR programme in Staffordshire and Stoke-on-Trent enjoys good engagement with all system partners to implement the learning from LeDeR reviews. In March 2021, a new LeDeR policy was published, setting out requirements for implementation by April 2022.

As a result, the ICB has established a governance process involving all ICS partners as follows:

- Robust contracting with South, Central and West Commissioning Support Unit (SCW CSU) to ensure all LeDeR reviews are produced independent of ICS system partners and aligned to national policy requirements
- High-standard ICB Quality Assurance of all reviews to ensure all relevant information and intelligence regarding the individual is captured and reflect the life and death of that person. An element of the programme was recently endorsed by NHS England following an audit of reviews across the region
- LeDeR Steering Group with attendance by all ICS partners and including the voice of an Expert by Experience. Key themes that arise from the national, regional and local reviews, as captured in the respective Annual Plans, are scrutinised to identify key areas of focus, including annual health checks, end of life, equity for those from ethnic diverse groups and a health passport. Providers provide updates on changes made in their own organisations in response to identified areas of good practice and areas for development
- A LeDeR Governance Panel has been established and is operating well as a direct consequence of a requirement in the national policy. All completed reviews are presented to the group and actions identified for system partners, including, in some instances, housing and the police. We are incredibly fortunate to have the support of a local charity, for those with direct experience of the loss of a child, who attend the group and support with chairing the meeting
- Reporting into the ICB Board via the Quality and Safety Committee and the Learning Disability and Autism Partnership (LDAP) Board, as well as updates to the Staffordshire and Stoke-on-Trent Adult Safeguarding Board (SSAPB).

During COVID-19, the learning disability (LD) community experienced significant challenges as a result of actions taken to reduce contact and minimise infections.

One particular example where a care home resident with LD required ambulance conveyance to an acute setting, alone and without the support of those who knew him best, resulted in the production of a **Staffordshire Health Passport**. This is a communication tool to aid those caring for

those with LD, and includes basic contact details as well as information to better understand their likes and dislikes, their usual ways of doing things and what certain behaviours are trying to convey – for example if the person is in pain.

The Health Passport was submitted and successfully shortlisted as a finalist at the **Nursing Times Awards** in October 2022 and is being adopted by other groups of individuals within the ICS as well as other regions.

## Maternity and neonatal

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 matters incorporated into the work of the LMNS Board.

Workforce challenges remain an issue, affecting the ability to provide safe maternity staffing in line with the recommendations from the Ockenden Report. Risks are mitigated by moving staff to areas of greatest need – primarily the consultant units on the delivery suites. The freestanding midwife-led units in Lichfield and Stafford remain closed for births, and home births are intermittently suspended in line with local escalation levels. A recruitment drive includes local events as well as international recruitment.

The MBRRACE-UK report about maternal and perinatal mortality shows worse outcomes for pregnant women from ethnic minority groups, with stark and widening social inequalities linked to poverty. Staffordshire and Stoke-on-Trent ICB's vision is to reduce inequalities and achieve the best in healthcare and wellbeing for everyone in the area.

We have developed an Equity and Equality action plan to improve equity for mothers and babies from ethnic minority groups and those living in the most deprived areas.

The final report of the Ockenden Review, published in March 2022, examined the care of 1,486 families who experienced adverse outcomes in Shrewsbury and Telford Hospital NHS Trust. It describes the damaging outcomes and experiences caused by poor care given to women and their babies in pregnancy, labour and birth.

An interim report in December 2020 had identified seven immediate and essential actions (IEAs), and a further 15 IEAs were identified in 2022. An action plan has been produced and overseen by the LMNS programme board. As a direct consequence of this work, Staffordshire and Stoke-on-Trent has been selected as a pilot site for an Independent Senior Advocate to provide support to families – particularly where there has been an adverse outcome.

Both UHNM and UHDB have reviewed their maternity and neonatal services against the Kirkup Report. The report reflected on services in East Kent and found unacceptable lack of compassion and kindness which affected women and their families who sought answers when things went wrong. Actions focus on organisational culture and clinical behaviours and oversight, with a specific requirement to listen to the voices of service users. Position statements for both organisations against the report have been reported into their respective Trust Boards.

An improvement project in collaboration with UHNM, LMNS and NHS England aims to develop an induction of labour (IOL) pathway that promotes choice and positive experiences for women and families. The pathways must also meet operational demands, to reduce the need for escalation for mutual aid when backlogs occur.

The ICB Chief Nursing and Therapies Officer has led work to standardise the escalation criteria for maternity and enable regional agreement on actions to support improvements in maternity access. Monitoring is via daily ICS Chief Operating Officer calls and daily sitreps.

# Engaging people and communities

Transitioning to a new way of working as an ICB within a system-wide partnership has given us a unique opportunity to fundamentally change the way we work to improve the quality of life and health of our diverse population.

Working together as an Integrated Care System, we are in a much stronger position to address health inequalities, acknowledge and support community-based developments, collaborate with the public to build social assets, and encourage people and communities to become active participants in shaping the services and issues that are important to them.

Our **Working with People and Communities Strategy** recognises and values the benefits of a community-focused approach and builds on established relationships and best practice already being delivered by partners and communities across Staffordshire and Stoke-on-Trent. It reflects how people have told us they would like to be engaged and will continue to support a collaborative way of working that places people and communities at the heart of what we do.

## Governance and assurance

Patient and public involvement in the ICB is governed by our Director of Corporate Governance but the principles that underpin our approach to engagement are woven into the fabric of our ICB governance structures, systems, processes, and procedures. We know that our staff are one of our biggest assets when it comes to supporting conversations with the community and championing the public voice through their individual roles and activities.

Assurance around working with people and communities is provided to the ICB Board via the Quality and Safety Committee. Our Non-Executive Chair is responsible for championing the public voice as well as promoting our work on health inequalities, public engagement, and insight. Development and delivery of our Working with People and Communities Strategy is overseen by our Director of Communications and Corporate Services, supported by the Communications and Engagement team.

Our People and Communities Assembly acts as a critical friend and advises us on our approach to involvement and engagement, including targeted engagement with seldom heard communities. One of our key principles in engagement is to not make assumptions about how best to involve people but to ask them and to build on what is already there, using existing knowledge, relationships, experience, and local assets.

The Assembly reports to the ICB Board through the Quality and Safety Committee and holds us to account on our statutory duty to engage. It also ensures we meet the requirements of the public sector equality duty to eliminate discrimination, advance equality of opportunity and foster good relations between different people.

We have strong relationships with the Staffordshire County Council and Stoke-on-Trent City Council scrutiny committees, and regular engagement and involvement enables a constructive and transparent process of scrutiny. There is a commitment to work in partnership with our local authority colleagues at system and local levels and to harness their knowledge of, and established relationships with, local residents.

Scrutiny is also provided by two Healthwatch organisations, who have a seat on the ICB Board and hold us to account on our approach to engagement. We have developed good, positive relationships with both organisations over a number of years and have commissioned Healthwatch to undertake independent engagement with the people and communities they represent.

Locally there are two Health and Wellbeing Boards (one for each council), and we are represented on both to support delivery of system-wide priorities. Regular engagement ensures that priorities being developed by the Integrated Care Partnership in its five-year strategy are aligned to the Joint Strategic Needs Assessment (JSNA) for Staffordshire and Stoke-on-Trent.

Robust governance arrangements are in place through a system-wide Communications and Engagement group, with representation from all partners, including NHS, the councils, police, fire, Healthwatch and the voluntary, community, faith and social enterprise (VCFSE) sector. Collaborative working enables us to develop a

consistent narrative around key messages. It also helps us identify examples of best practice, learning, and opportunities to make the best use of our resources.

### Collaboratively working with VCFSE partners

We recognise the valuable role that the voluntary, community, faith and social enterprise (VCFSE) sector plays in supporting the health and wellbeing of the population and in championing the public voice. This year we have established an equal partnership with the sector that formally recognises this role and the contribution it can make across the ICS functions, whilst acknowledging their independence.

The VCFSE Healthy Communities Alliance is the recognised governance structure through which we, and the wider ICS, have agreed to consult with VCFSE organisations and networks and involve them in our health and care system on an ongoing basis. The ICB has made a number of commitments that aim to support the development of the Alliance and to effectively embed it within the integrated care system architecture.

A Memorandum of Understanding, which was co-produced with our VCFSE partners, is in place to support collaboration with the Alliance, and robust links with community VCFSE forums support involvement with the sector and the communities they represent. It sets out why the parties wish to work in partnership on shared ambitions and the shared values governing the way in which they will work together.

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

The MoU formalises the partnership and shows the willingness of both parties to work together. It details the accountability and governance arrangements and provides clarity on each of the partner's commitments. This is further supported through monthly meetings, which take place between the ICB, Support Staffordshire and VAST.

### Commissioning and procurement

Embedding sustainable and proportionate commissioning and procurement processes through ongoing dialogue and a commitment to ensuring VCFSE organisations are included in the co-production of solutions. This means making sure that VCFSE organisations are not excluded by overly complex processes and requirements.

### Communications and engagement

Embedding the Working with People and Communities Strategy through the Communications and Engagement System Group.

### Prevention and social prescribing

Championing the role of community-based prevention support and the social prescribing ecosystem through the Population Health, Prevention and Health Inequalities portfolio.

### Volunteering

Championing locally led, empowering volunteering processes as part of the People Plan via the ICS People, Inclusion and Culture Board.

We are also working closely with Staffordshire Council of Voluntary Youth Services (SCVYS) to strengthen our engagement with children and young people. Working with children and young people, parents, carers and professionals, we are currently developing a co-production charter that will set out our local approach to working with children, young people and families.

## How our working with people and communities is being put into practice

Our Working with People and Communities Strategy is shaped by a core set of principles. These were co-produced through engagement with existing partners, patient forums, community groups and VCFSE sector organisations. The principles reflect how people have told us they would like to be engaged, and what would empower them to become active participants in their own health and wellbeing.

The principles, set out below, are aligned to those in the ICS guidance on working with

people and communities, and are fundamental to the work of the ICB:

- **Health and wellbeing are everyone's business** – engagement needs to be inclusive and accessible to all
- Put the public voice at the heart of decision-making
- **Don't make assumptions** – ask how best to engage
- Recognise the different needs of the population, especially those who could be excluded
- **Do it once and do it well** – shared intelligence between partners
- **Allow enough time to engage properly**, adapting the approach where necessary
- Be honest, open and transparent – authentic involvement
- **Clear communication that can be understood by** all – be clear on what you are asking and consider your audience
- **Commit to feedback** – explain what impact engagement has made in simple terms
- **Build on what is already there** – use existing knowledge, relationships, experience and local assets and channels, including the community and voluntary sector.

As the ICB matures, we are working to embed these principles throughout the organisation and are using them to shape our systems and processes. We are also working closely with partners, such as Provider Collaboratives and Primary Care Networks, to help develop emerging engagement structures at a system and local level, ensuring that they are accessible, effective and meaningful.

## People and Communities Assembly

Our People and Communities Assembly is the strategic forum that provides direction around the principles to **recognise the different needs of the population** and to ask **how best to engage rather than making assumptions**. It brings together a range of public and community representatives from across Staffordshire and Stoke-on-Trent as well as establishing links with community engagement leads and forums such as Healthwatch, VCFSE Alliance forums and Community Champions.

One of the core functions of the Assembly is to advise the ICB on our approach to engagement. This includes our plans for communicating, involving, and consulting with the public about designing pathways and services, service change proposals and decommissioning. It also includes reviewing the outcomes of public involvement and ensuring that we can demonstrate how our decision making has been influenced by the feedback we receive, using a 'You said, we did' approach.

For example, engagement to support development of the Integrated Care Partnership Strategy was shaped by early conversations with the Assembly and their knowledge of groups and forums to tap into. To date, this has led to community conversations with the VCFSE forums in the north, south and west as well as targeted engagement with groups supporting older people, carers and the deaf community. Each community conversation was tailored to the audience but based on a consistent set of key messages. Feedback from the engagement was also used to shape the initial draft of the Joint Forward Plan, which is currently being taken back to the public for further consultation ahead of the publication deadline.

The Assembly is not an engagement forum in itself but is designed to work with the ICB to share insight and learning from communities about how they would like to be engaged. It advises on how communication or engagement needs to be adapted for particular groups. It includes representatives from often excluded groups, such as the deaf community. These groups can not only recommend how to engage but also advise on existing groups or forums that would support conversations in and with the broader community.

Building on established networks and relationships, the Assembly aims to support a system-wide approach to working with people and communities, and to move away from 'tick box engagement' to genuine two-way conversations with partners and the public. One of its most valuable roles to date has been to raise awareness about engagement that is already taking place and to identify opportunities where channels or learning can be shared between partners.

Through the links that have been established, the ICB has been involved in engagement activities such as a Citizens' Inquiry to understand the barriers to communities accessing preventative services. We have also been involved in work led by the two local authorities on Community Champions. Feedback from the Citizen's Inquiry has been used to shape the ICP Strategy, particularly around exploring further how people and communities can be supported to live healthier lives, and their role in making Staffordshire and Stoke-on-Trent a healthier place to live and work. Intelligence from the public is also being used to shape the priorities that will be set out in the Joint Forward Plan.

## People's Panel

To build and maintain an ongoing relationship with people and communities, we are establishing a range of ways to communicate and engage with our partners and the public. For example, regular updates about the work of the ICB and our partners are promoted via a community stakeholder bulletin, reports to the Local Medical Councils and overview and scrutiny committees, our website, social media channels, and through mechanisms already in place with community and voluntary sector organisations.

Another regular channel, established in 2019, is our online People's Panel. This has approximately 1,000 members, who are broadly representative of our communities with digital access. The People's Panel is managed by a third-party organisation and is one route through which we are able to seek representative, robust views to support decision-making on service change/design, including formal consultation.

Since the People's Panel was formed, panel members have been regularly asked to share their views on topics or programmes of work by taking part in online surveys. Anonymised reports are then shared with the ICB or the ICS as appropriate to help shape the planning, development, or delivery of services.

Enhancing our People's Panel is integral to our Working with People and Communities Strategy. A separate strategy has been created to identify ways in which we can improve the panel and develop it as a system-wide tool for online engagement. The Strategy aims to support recruitment and retention of panellists, identify any demographic gaps and aid targeted recruitment to fill them. This year we aim to enhance the People's Panel by developing a sub-group of Ambassadors who could meet as focus groups to discuss service areas in more detail. They could also support recruitment by sharing their own reasons for joining the Panel in promotional materials.

Recognising that not everyone has access to digital communications, we commissioned our third-sector provider to undertake a research project to understand some of the barriers that prevent people from taking part in online surveys and to identify if there are any reasonable adjustments we could make to mitigate these. Targeted engagement was carried out with communities such as the homeless, gypsy, Roma and travellers, carers, people from ethnic communities and people with a sensory impairment.

It was clear from the research that the minority groups we spoke to are hugely different and cannot be treated as one. However, there were things they had in common and the principles of what they told us could be applied more broadly.

- People's lives and the factors that place them in a minority group are complex and difficult to understand without specialist experience and knowledge of that sector. Therefore, we need to work closely with partner organisations to conduct sensitive, bespoke engagement with groups as, for the most part, they cannot be 'slotted into' the existing People's Panel
- The challenges that some people face can be all-encompassing, which can lead to poor mental health, feelings of isolation and an inward focus. This means they are often less interested in the wider issues faced by health and social care services so engagement needs to be tailored and focused on subjects of importance to them, which may not always tie in with ICB priorities
- Areas of interest and relevance to these groups are diverse but with some common themes such as access to services, mental health and accessible communications. These subjects are not only complex but subjective to individual needs and therefore engagement would be better conducted qualitatively rather

than through a survey or at least through a hybrid approach, which could be completed using a variety of different techniques and the assistance of partner organisations
- For some groups, the standard quantitative 'tick-box' surveys represent a barrier to participation and could only be used to skim the surface. A deeper understanding is needed to gain the insights that could lead to positive change
- If surveys are to be used, they need to be short, of direct relevance to the group being targeted, in plain English and easy to understand and complete. Other practical adjustments could include having British Sign Language (BSL) translation videos embedded in the survey and the option for people to respond in BSL.

As part of our work plan for 2023/24, we will further develop our panel to allow involvement in a wider range of activities at both local and system level, including:

- **Developing and implementing a formal system to gather feedback** about how panel insights have been used in commissioning decisions to improve outcomes
- **Developing a coordinated programme of work in line with partners** (NHS trusts and primary care, councils, VCFSE and Healthwatch) and collating a forward view of projects and programmes of work
- Looking at cross-cutting themes such as digital inclusion and health inequalities, to align with our system portfolios and priorities.

## Equality and inclusion

COVID-19 reinforced the importance of understanding and tackling health inequalities and of working directly with communities to understand their needs, reliably identify potential barriers, and design solutions. In responding to the pandemic, we have identified seldom-heard groups who need a more targeted approach to communication and engagement. We have collaborated more with staff, local people and the VCFSE sector, and broadened our thinking, particularly towards digital engagement.

**During the pandemic, we established a Communities2gether forum to focus on the needs of seldom-heard groups.**
Representatives from equality and health inclusion groups come together to shape and develop resources that can be shared via their own communication channels to spread the key messages. Although initially the focus was on communications around COVID-19, and the vaccine in particular, the group is now being used to advise on a range of topics of community interest. The group continues to support our equality work around the COVID-19 vaccination, with community leaders being uniquely placed to work with some of our target groups.

Taking learning from the pandemic, we have continued to proactively reach out to groups who are often less represented in engagement activities, such as people with a learning disability, people whose first language is not English (including those who use BSL), and children and young people. We have also recruited representatives to our People and Communities Assembly, who are able to advise on our approach to engaging with some of the groups who are most often excluded.

We are active members of the VCFSE healthy communities' forums and regularly seek advice from community representatives to shape ICB plans and programmes of work. We have also commissioned Healthwatch and the VCFSE Alliance to undertake engagement on behalf of the ICB. This has included engagement with seldom-heard groups as part of our involvement for the transformation programme and working with people living in deprived communities to help shape our Working with People and Communities Strategy.

In 2022, DEAFvibe and ASSIST supported engagement with the deaf community to help shape a new service specification for an interpreter service in general practice. The two groups advised on the best approach for getting feedback from their members, and then BSL interpreters were commissioned to facilitate conversations in focus groups. A similar approach is being taken to the engagement around the Joint Forward Plan, with ICB leaders attending a facilitated discussion at a DEAFvibe

coffee morning to seek their views on local priorities.

Community Champions, hosted by the VCFSE sector, have been working with communities around the Core25PLUS5 priorities locally. Partners across the health and care system are developing a co-production charter for working with children and young people, with a specific focus on those with autism or special educational needs. Our stakeholder database identifies community groups aligned to the nine protected characteristics but can also be segmented by different demographics or more specific communities, such as those supporting particular conditions.

As an ICB we are committed to making our communications and engagement activities accessible, with reasonable adjustments being offered as standard for any meetings or public events. BSL interpreters support our People and Communities Assembly, and we now use a combination of Microsoft Teams and Zoom following feedback from our deaf representatives that Zoom better supports the use of BSL interpreters.

Communication campaigns include information translated into alternative languages and formats, including videos as well as printed materials and BSL. Videos posted on our YouTube channel include captions and our website is fully compliant with the public sector accessibility regulations.

To share learning across the health and care system, we are developing a series of 'how to' guides to include advice and guidance about engaging with different communities. Based on local intelligence, the guides aim to highlight examples of best practice and information about how groups have told us they would like to be engaged, as well as things to avoid.

The guides will signpost partners to useful groups and community champions who have supported engagement locally and are often better placed to support engagement at a grassroots level. They will continue to evolve as our knowledge of communities develops and will be shared with all our partners.

## Insight and data

Feedback from people about their experience of local services is a fundamental part of the quality and quality improvement process. It is also used to inform decision making and governance.

Many of our channels can capture this feedback informally – often anonymously – but this information can then be considered alongside feedback received through formal processes.

- **Patient Experience Reports** – provide an overview of key themes and trends of patient feedback relating to providers – including actions taken in response to concerns. Includes contacts to Patient Advice and Liaison Service (PALS), complaints and MP letters
- **Annual complaints analysis** – includes complaints that directly relate to commissioned services and those handled on behalf of external providers
- **Soft intelligence** – we have a central system that enables patients, the public and healthcare professionals to provide feedback on local services. All soft intelligence is clinically reviewed and taken to a monitoring group for assurance, review of themes and trends, or a multidisciplinary review
- **Learning Disabilities Mortality Review (LeDeR)** – a programme that undertakes a review of all deaths of individuals with learning disabilities aged four years and over. The aim is to improve the quality of health and social care service delivery for people with learning disabilities, reduce premature mortality and health inequalities, and influence practice at individual, operational and strategic levels.

Intelligence from local communities is also being used to shape our new approach to working with people and communities. This can be directly from activities undertaken by the ICB, such as the People and Communities Assembly or previous engagement but can include also insight from activities undertaken by partner organisations.

For example, the first phase in developing our Integrated Care Partnership Strategy was a desktop review across all partner organisations

to learn which themes and priorities had already been identified in engagement carried out over the previous two years. A summary of the information was used to shape a framework for the Strategy, which was subsequently taken out for further engagement with partners and the public.

During our engagement on the Working with People and Communities Strategy, a recurring theme from communities and the public was for partners to share intelligence between them to avoid unnecessary duplication and the risk of engagement fatigue. One of the Strategy's ambitions is to develop a system-wide observatory of local intelligence that would help partners to share information about communities, including inequalities, and to develop a greater understanding of the impact of inequalities on health and wellbeing.

## Meeting our statutory duty to involve the public

NHS commissioning organisations have a legal duty under the NHS Act 2006 to 'make arrangements' to ensure that people to whom services are being or may be provided and their carers/representatives are involved when commissioning services for NHS patients.

For ICBs, this duty is outlined in section 14Z45 of the NHS Act 2006 (and for NHS England the duty is outlined in section 13Q).

To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

- the planning of services
- the development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services
- decisions which, when implemented, would have such an impact.

In demonstrating how the system has discharged its duties to involve the public it is appropriate to recognise that the range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement and must equally consider applicable legislation and guidance, such as:

- NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006)
- The Health and Care Act 2022 extended the duty to carers and representatives of people receiving a service or who may do so. The extension of this duty is replicated in an equivalent duty on ICBs.

## How we have discharged our duty in relation to public involvement

The system-wide Transformation programme has been active since 2019, with the launch of a listening exercise with the public. Work paused in March 2020 to allow the system to respond to the COVID-19 pandemic and restarted in autumn 2021 with a listening exercise refresh.

Through involvement activity completed by the Together We're Better partnership and through Midlands Partnership NHS Foundation Trust (MPFT), commissioners and partners have provided opportunities for service users, carers and/or family members, staff, the voluntary sector, neighbouring health systems and other stakeholders to share their views about services under discussion, and to share their experiences (including views of what worked well and what could be improved).

Involvement activity has included digital surveys and events/workshops, with support available for anyone experiencing difficulties with digital access or requiring information in alternative languages or formats. Stakeholder mapping for these activities has including reviews to ensure views of people impacted or likely to be impacted are heard. This work has been overseen by the relevant project group for the service under consideration and Steering Groups, with oversight by Technical Groups (clinicians and managers) and a Reference Group (patients, carers, staff, and members of the public).

Since the lifting of COVID-19 restrictions, face-to-face activity has been reinstated to provide additional opportunities for people to join in involvement activities, as demonstrated with the public consultation for inpatient mental health services in south east Staffordshire.

- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ('the 2013 Regulations') made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel
- Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider.

The Staffordshire and Stoke-on-Trent system has worked closely with the Staffordshire County Council Health and Care Overview and Scrutiny Committee (OSC), which has membership from each of the county's borough and district councils, including elected members who have direct experience of health services. The system has also worked with the City of Stoke-on-Trent Council Adult Social Care, Health Integration and Wellbeing Overview and Scrutiny Committees. Members have been updated throughout the programme with representatives from the NHS attending regular meetings to answer questions and provide assurance about the process and progress of the programmes.

Involvement activity has been the subject of regular discussions with NHS England through both the West Midlands Clinical Senate and the NHS England Assurance Panel. There has also been oversight from internal governance processes in the Staffordshire and Stoke-on-Trent health system.

The Transformation programme engagement and involvement activity have also received oversight, advice, and guidance from The Consultation Institute to ensure public and patient engagement is strong and meets the legislative and guidance requirements.

## How the ICB has met the triple aim

Key requirements of ICBs, trusts and NHS England include that they:

- assess the need for public involvement and plan and carry out involvement activity
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions
- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports.

## Assessing the need for public involvement

The ICB commissions communications and engagement services from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). This includes place-based and at-scale service provision to support the system-wide Transformation programme as well as core business in the delivery of the Five Year Plan.

Communications, engagement, and involvement leads are actively involved in discussions about service change, supporting ICB managers to identify stakeholders and when and how involvement activity should be carried out. Involvement plans are developed, reviewed, and updated throughout the programme of activity to ensure that those affected, or likely to be affected, and those with an interest in the service under discussion, can join in the involvement activity. Assessment of the need for public involvement also forms part of the discussions with NHS England and NHS Improvement, in addition to internal governance discussions and reviews.

In planning and preparing for involvement activity, the system has carried out extensive stakeholder mapping to understand who stakeholders are, if and to what extent they would be impacted by any change to service provision, and any barriers which may exist to their participation in involvement activity.

**Current transformation programmes:**

- **Inpatient Mental Health Services**
- **Clinical Policy Alignment**
- **Maternity**
- **Community Diagnostics**
- **Urgent and Emergency Care**

## How involvement activity has informed decision-making

The system-wide Transformation programme has spanned several years, with individual service programmes progressing at different paces and with a range of engagement, involvement and consultation activities required. Involvement activity has been delivered in phases, with each phase including a period of analysis, reporting and consideration to inform decision-making, decision-making rationale and any additional activity required in later phases.

Involvement activity carried out in 2019 was supported by sense-check activity in 2021, resulting in – as applicable – the identification of options, options appraisals, proposal development and the drafting of a programme-specific business case.

Transformation programmes are supported through the development of detailed project plans which identify and set out the range of tasks and actions required of the individual programmes of work. Those project plans include clear timescales to ensure sufficient time has been allocated for the collection and collation of comments and information received through the range of involvement activities, as well as the analysis, reporting and consideration of that information.

The ICB has a transparent process to document how involvement activity has informed decision-making and the decision-making rationale. This includes updates and reports to internal and public-facing meetings facilitated by both the ICB and local partners such as the county council, or district and borough councils.

Most importantly, documentation of involvement activity includes:

- Reports of findings developed and reviewed internally as part of the decision-making process
- Presentation and consideration of the reports at public meetings of the ICB Board (and the combined CCGs Governing Body prior to the formation of the ICB)
- Discussion about the reports during public board meetings, including receiving questions from Board members and members of the public
- Publication of the reports of findings on our website.

When reports are published, we publicise this through stakeholder updates and briefings, and media releases.

## How we assure ourselves we are meeting our legal duty

Legislation, guidance, and advice about involving patients and public, including carers and representatives of people receiving a service or who may do so, are at the forefront of all ICB discussions about potential and actual involvement activity.

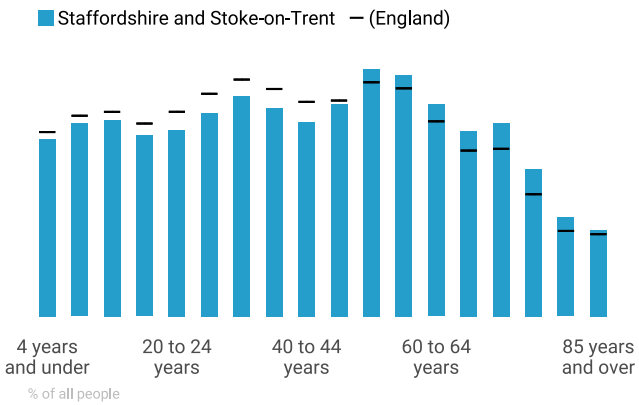
We have established a robust, regular schedule of internal meetings to monitor and measure the discharge of our duties, and we regularly attend external meetings facilitated by Integrated Care System partners (for example county, city, and district and borough councils) to demonstrate our compliance with our duties.

External oversight, monitoring and management are achieved through frequent and planned meetings and discussions with NHS England partners. We gain additional assurance that the processes and planned activity help us to meet our legal duties by having regular meetings and briefings with overview and scrutiny committees for the city and county councils, which include elected members from district and borough councils.

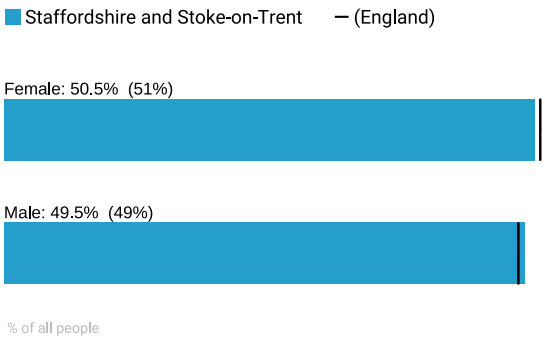
Annual reports set out how the ICB considers and meets its legislative duties when considering, planning, and delivering involvement activity to ensure patients and the public are provided with opportunities to join in discussions about potential and actual service change. All reports are published on our website.

# Reducing health inequality

## Population by five-year age group

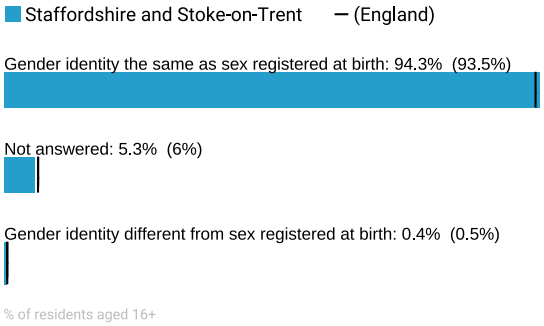



## Sex

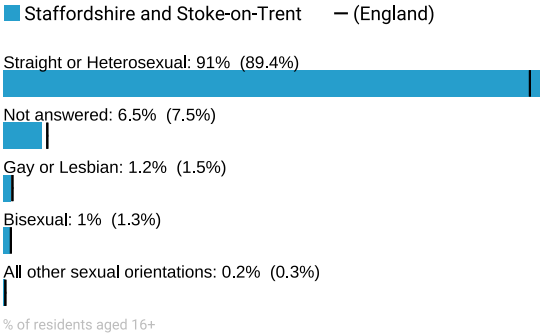



A total of 1.13 million people live in Staffordshire and Stoke-on-Trent ICB, according to the latest 2021 Census. The ICB has an older population compared to England, and there are slightly more women than men.

## Gender identity

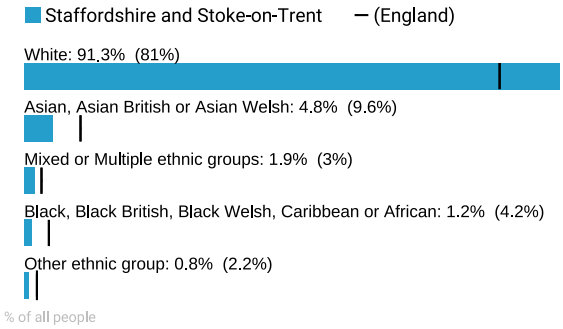



## Sexual orientation

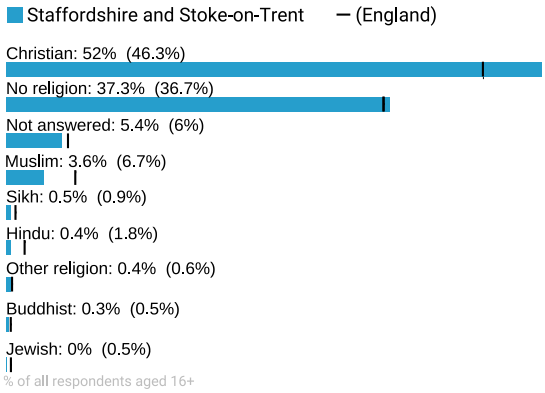



The proportion of the Staffordshire and Stoke-on-Trent ICB population who identify as straight or heterosexual is slightly higher than the national average. The ICB also has a slightly higher proportion of the population whose gender identity is the same as their sex registered at birth.

## Ethnic group




## Religion




Compared to England, a higher proportion of people in Staffordshire and Stoke-on-Trent ICB are White, and the region is less ethnically diverse. Just over half of the ICB population are Christian, which is a higher proportion than England. Over one-third of the ICB population have no religion, and the next most common religion is Islam. *Source for the above charts: Office for National Statistics – Census 2021*

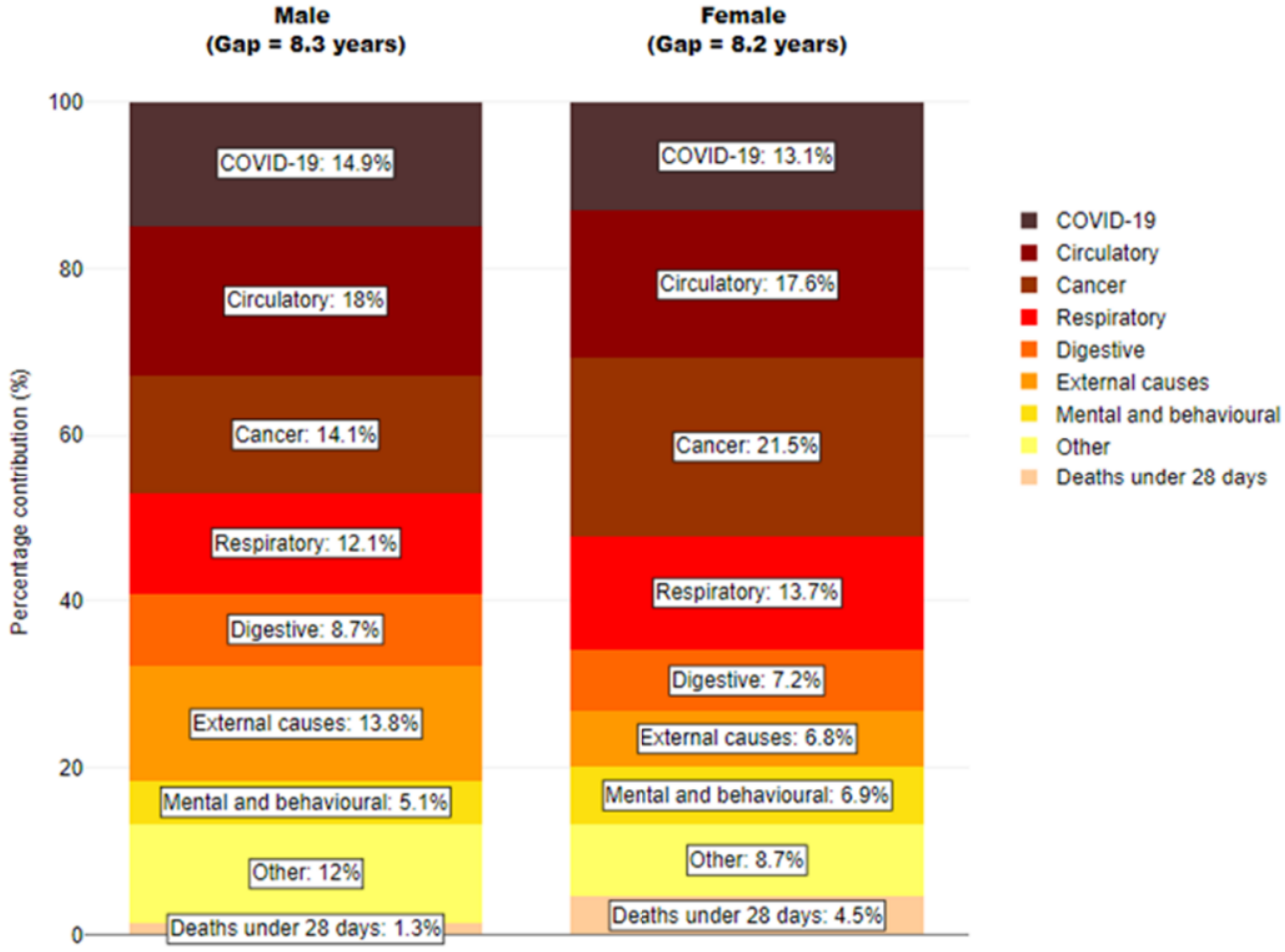
## Addressing health inequalities

A key area of focus for Staffordshire and Stoke-on-Trent ICB is to address health inequalities. It is a diverse area, with challenges including deprivation (more than half of the population of Stoke-on-Trent live in the 20% most deprived areas of England) and rurality (25% of Staffordshire residents live in rural areas). The above data (from the 2021 Census) provides a snapshot of some of our inclusion health groups, who can experience overlapping risk factors resulting in health inequalities.

During 2022/23, we have spent time understanding these challenges and how they affect our population and their health and wellbeing. We are beginning to take action to address inequalities – for the first time, in addition to our Joint Strategic Needs Assessments (JSNAs), we have undertaken needs assessments relating to residents living with learning disabilities and autism, and to women's health, and embedded a number of initiatives relating to the Core20Plus5 methodology which are described later.

However, we recognise that there is still more to do, and tackling health inequalities is a 'golden thread' that runs through our ICP Strategy, published on 31 March 2023. Our Operating Plan for 2023/24 builds on this by identifying clinical priorities based on the drivers of the gap in life expectancy between the most and least deprived areas of Staffordshire and Stoke-on-Trent – namely cardiovascular disease, respiratory disease and cancer.

### Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Staffordshire and Stoke-on-Trent by cause of death, 2020 to 2021



Staffordshire and Stoke-on-Trent ICB has a dedicated resource within the Chief Medical Officer's directorate for health inequalities. The programme has appointed Chief Executive Sponsors, Senior Responsible Officer, Clinical Director and Portfolio Director roles. The ICB has a committed Core20 Ambassador lead – Dr Lorna Clarson, Clinical Director for Health Inequalities.

We have been working on our health inequalities programme throughout the year, which uses the Core20PLUS approach:

- **Complete Care Communities Programme** – East Staffordshire Primary Care Network (Demonstrator Site) focusing on diabetes, both from a treatment and prevention perspective
- **Core20PLUS Connectors** – scoping of connectors already engaged with Support Staffordshire or voluntary, community, faith and social enterprise (VCFSE) member organisations. The emphasis is on geographical target areas agreed and development of bespoke hypertension training to be delivered to Core20 officers and community connectors
- **Health inequalities** – InHiP funding bid was successful. This is a joint initiative between secondary and primary care to identify and increase the use of asthma biologics, FeNO (fractional exhaled nitric oxide) a medical technology used to aid in the diagnosis of asthma and improve outcomes for Core20PLUS communities.

## Primary care

Primary care plays an essential role in preventing ill-health, tackling health inequalities, and managing long-term conditions. People in the most deprived areas of England develop multiple health conditions 10 years earlier than people in the least deprived areas. The incidence of multiple conditions is rising – without concerted, targeted responses in our most deprived communities, progress on inequalities in healthy life expectancy will continue to stall.

The Core20PLUS5 approach provides a focus for reducing healthcare inequalities across systems, identifying a target population comprising the most deprived 20% of the population of England (the 15 Core20) and other groups identified by data (plus groups), alongside five clinical priorities for action to reduce inequalities.

This needs to go alongside positive action in local communities – health coaches and social prescribing link workers provide a fantastic opportunity for neighbourhood teams to take a more active role in improving health, and where successfully incorporated into primary care, teams are transforming not just the lives of people and families they work with but also the culture and function of the clinical teams they work alongside. Where used most effectively, these roles can help form an effective bridge into local communities, building trust, connecting services, and galvanising the wealth of expertise in the VCFSE sector. We know that healthy life expectancy (a key measure of the quality-of-life years) locally is around 65 years, meaning men spend 16 years in poor health and women 19 years – this continues to put pressure on our health and care services.

### What are we achieving already?

- General practice has been taking a more active role in creating healthy communities and reducing the incidence of ill-health – by working with communities, more effective use of data, and through close working relationships with local authorities
- We have been educating general practice on the use of population health management (PHM) tools, to identify specific groups of patients to prioritise for specific services or interventions
- The ICB completed a 22-week National Population Health Management (PHM) pilot development programme
- Some practices are actively involved in the Stoke-on-Trent Community Lounges project – part of a new community-led support programme where the council is working alongside a network of partners, organisations, and local community groups as well as GPs, North Staffordshire Combined Healthcare NHS Trust, and Midlands Partnership NHS Foundation Trust. Stoke-on-Trent is one of the 20% most deprived districts in England, which makes projects like this even more critical in keeping people well

- Health and wellbeing coaches are embedded in several of the PCNs, and each PCN has a dedicated health inequalities lead
- Social prescribers are embedded into Primary Care teams delivering community-based support and co-producing personalised care plans with patients
- General practice has been working to identify their populations who experience inequality in health provision, to then develop a plan to implement which tackles the unmet needs. Long-term conditions have been a central focus of these plans, with a specific focus on reducing Type 2 diabetes and respiratory conditions, including the impact of long COVID
- We have used Core20PLUS5 approach and risk stratification in the ICB's Quality Improvement Framework (QIF) to support practices to address the backlog that the COVID pandemic created and to prioritise reviews for those most at risk.

### What else are we planning to do?

We will support general practice to identify further unmet needs in their population and develop a population health management approach to prevention for long-term conditions. Improved use of technology will enable them to do this. We will also continue to support the system with tacking health inequalities by building on the Core20PLUS5 approach to support the reduction of health inequalities experienced by adults, children, and young people.

### What else are we planning to do in personalised care?

We will provide proactive and personalised care with support from Integrated Care Teams which we will evolve this through our Primary Care Networks. The core of this is to have a shared ownership in improving the health and wellbeing of the population, using collaborative approaches and having built up trust and relationships between general practice and wider system partners and communities.

We will support reduction of inequalities by ensuring good data is available to analyse using appropriate risk tools, to help with early prediction of an individual's need for support. This will enable targeted activities to support the patient with their needs.

We will support patients to take a more active role in improving and managing their own health and be better informed about which professional is best able to help them by making the most of the expertise, capacity and potential of people, families, and communities in delivering better outcomes and experiences. We will further develop self-management to enable our population to develop the knowledge, skills, and confidence to manage their health and wellbeing through interventions such as health coaching, peer support and education.

## Public Sector Equality Duty

The ICB meets its 2010 Equality Act and Public Sector Equality Duties through the completion of a range of equality tools, documents, and instruments – primarily these are the NHS Equality Delivery System, Gender Pay Gap, Workforce Race Equality Standard, Race Equality Code, Workforce Disability Equality Standard, and Workforce Diversity Profile Report. These mechanisms produce actions which form the ICB's annual Action Plan. The equality mechanisms and Action Plan are reviewed and monitored through the ICB's governance process. Data is collated from a range of sources – for example staff electronic records, staff surveys, HR workforce and recruitment data and previously published reports. This allows the ICB to set and measure progress against benchmarked targets.

The Equality Health Inequality Impact Assessment process ensures that services, policies, and day to day functions give due regard to the Equality Act, Public Sector Equality Duty and other duties contained within the Act. The assessment process considers the NHS Core20PLUS5. This approach is designed to drive targeted action in health inequalities improvement to the most vulnerable sections of our communities who experience poorer health, access and/or outcomes compared to the population as a whole.

At an Integrated Care System level, the ICB works in partnership with NHS provider partners in delivering the Staffordshire and Stoke-on-Trent Workforce Race Equality Strategy and six high-level actions. Resulting actions and activity, performance, and progress is reviewed and

monitored by the Midlands NHS England Equality, Diversity and Inclusion (EDI) Subgroup. The ICB also works with the wider ICS in supporting and developing system-wide staff networks, Equality Diversity and Inclusion allied roles, positive action, and leadership/development initiatives.

## Vaccinations

COVID-19 and flu vaccinations have continued to be delivered by general practice (via Primary Care Networks), community pharmacies and NHS trusts throughout 2022/23.

**423,445 COVID-19 vaccinations** have been given this year by local vaccination sites for season booster campaigns in spring and autumn – together with continued access to evergreen primary care doses. The Staffordshire and Stoke-on-Trent system has achieved above the national average for all cohorts for all phases of the COVID-19 vaccination programme – one of only two systems in the Midlands region to achieve this.

To address and prevent inequalities in vaccine uptake across demographic and geographic populations, a Targeted Vaccination team has worked to improve access to COVID-19 vaccinations. Vaccination data is reviewed at the Vaccine Equalities group to identify areas of focus based on ethnicity or geographical data, and targeted clinics have been arranged where need is greatest. The Targeted Vaccination team held clinics at a variety of locations including large employer sites, religious or community centres, homeless shelters, and community lounges to provide vaccinations close to communities.

This has resulted in improved vaccination uptake rates for both primary courses and booster doses in the targeted communities. Children and young person vaccination teams have held dedicated clinics for under-18s and provided vaccinations in special schools to improve vaccination rates in these groups.

During the autumn, **432,655 seasonal flu doses** were administered in Staffordshire and Stoke-on-Trent. We were able to co-administer flu and COVID-19 vaccinations for the autumn campaign, which enabled individuals to get vaccinated for both at the same time. The COVID-19 Targeted Vaccination team were also able to offer flu vaccinations at their clinics from late 2022 to improve the vaccination rates in low uptake cohorts. The success of this will lead to improved healthcare provision in planned clinics.

## Asylum seekers

For asylum seekers living in Staffordshire and Stoke-on-Trent, the ICB has led on supporting all health requirements for these vulnerable individuals. Initial health checks have been undertaken for residents within contingency hotels prior to GP registration, and all subsequent health needs are managed equitably by the registered GP practice.

For those who are dispersed into other accommodation, services support all health needs and ongoing management of health issues. There is a continued focus to ensure that all vulnerable migrant individuals are identified on arrival and supported to ensure that their health needs are met in the short and longer term.

# Health and Wellbeing Strategy

## What is our Integrated Care Partnership Strategy?

Our Integrated Care Partnership (ICP) brings together senior leaders from the NHS, local authorities, police, Healthwatch and the voluntary sector. Working together is essential, as we know that no single organisation can solve the challenges we are facing.

> ***Paul Edmondson-Jones, Chief Medical Officer said:***
> *"The Integrated Care Partnership Strategy brings together partners from across health and care with wider stakeholders from police, fire, local authorities, and voluntary and community organisations who have a strong collective ambition to tackle health inequalities and deliver better outcomes for people and communities in Staffordshire and Stoke-on-Trent. Together, we are working across organisational boundaries to tackle the wider determinants of health – such as education, employment and housing – to make Staffordshire and Stoke-on-Trent the healthiest place to live and work."*

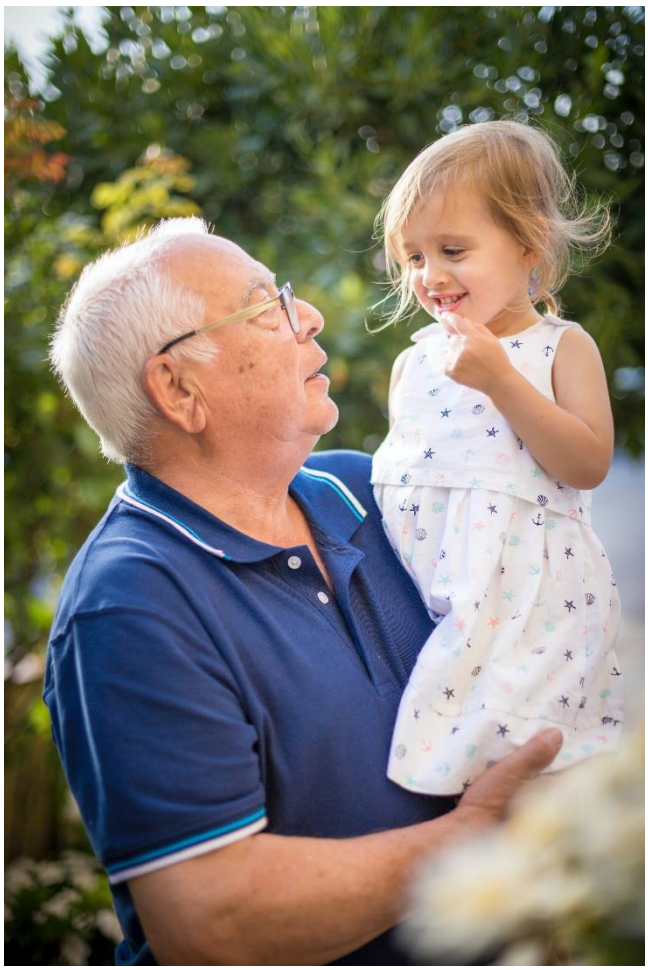
One of the ICP's first tasks was to develop an Integrated Care Strategy. The Strategy looks at the broad health and social care needs of our local people, and how we can meet them.

This is not just about treating sickness when it happens but about dealing with the causes of poor health. These can include unemployment, poverty, housing problems, and the wider environment – creating health inequalities among our population.

As an ICP, we want to make tackling health inequalities central to our approach. As one way of achieving this, we want to adopt an innovative 'Health in all Policies' approach when we are making any policy or strategy in the integrated care system. This would ensure that we consider health and health inequalities in all that we do. ICBs and local authorities are required to have regard to the ICP's Strategy when making decisions, commissioning and delivering services.

We also plan to work with the voluntary sector and communities to give people equal opportunity to benefit from early years support, education, good employment and good housing – particularly for those who experience social exclusion or live in our most deprived communities.

We face many challenges, including high demand for services, workforce shortages, and an increasingly older population, with many older people living with long-term health conditions. Finances are another challenge, with health and care organisations being asked to do more with no additional funding. We know it might take many years, or decades, to address some of these challenges, and that we need an ambitious strategy to underpin our work.



A key part of the Strategy is taking a 'life-course approach' to improving people's health and wellbeing outcomes.


## Key themes of the Strategy

The key themes are the five things we need to change if we are going to make a difference. We also call this the Five Ps approach – as shown in the diagram. Working with people and communities is at the heart of this. For example, one way to prevent ill health is to work with people in their communities to promote healthy decision making.

You can read more about our ICP Strategy in this strategy document or the public summary.

## Mental Health Investment Standard

Staffordshire and Stoke-on-Trent ICB considers that it has complied with the requirements of the Mental Health Investment Standard (MHIS) for 2022/23. The 2022/23 target spend was £210.22 million and actual spend was £213.72 million. Subject to audit, this shows an overachievement of £3.5 million.

## Going concern

We have assessed our status as a going concern. The ICB and our providers across the system have produced a Financial Strategy, in conjunction with our partners in the ICS. We are implementing this with the aim of returning the system to an underlying financial balance and therefore annual financial balance.

This is based on having established an ICB supported by two local Places, a Provider Collaborative and seven portfolios, which enables the system partners within the health economy to focus on delivering a collaborative transformation plan. This has been supported by strengthened system governance measures, including the establishment of a System Finance and Performance Committee chaired by a Non-Executive Director, supported by the System Performance Group. These governance arrangements are ensuring that decisions are made in the interest of all residents of the system, and that partners across the system are making good financial decisions.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Bill established integrated care boards across England, and abolished NHS clinical commissioning groups (CCGs). ICBs took on the commissioning functions and had transferred across to them all of the assets and liabilities of the CCGs from 1 July 2022.

A public sector body is assumed to be a going concern when it is expected to continue to provide a service, as evidenced by inclusion of financial provision for that service in published documents.

The ICB considers whether or not its services will continue to be provided in determining whether to use the concept of going concern in drawing up its financial statements. If services will continue to be provided, the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up as at 31 March 2023 on a going concern basis.

# Accountability Report

Peter Axon

Chief Executive Officer

Staffordshire and Stoke-on-Trent ICB

29 June 2023

## The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives
- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

# Corporate Governance Report

## The Corporate Governance Report seeks to explain the composition and organisation of the ICB's governance structures and how they support achievements.

From April 2013 until June 2022, the population's health was overseen by six clinical commissioning groups (Cannock Chase CCG, East Staffordshire CCG, North Staffordshire CCG, South-East Staffordshire and Seisdon Peninsula CCG, Stafford and Surrounds CCG and Stoke-on-Trent CCG). During the year leading up to the ICB becoming the statutory body, a significant amount of work was undertaken to ensure that there were sufficient structures and processes in place for the ICB to receive the functions from the CCGs and also deliver the additional responsibilities delegated to ICBs.

To oversee this huge piece of work, a Transition Group was formed to ensure due diligence was carried out to close the six CCGs and ensure their functions were smoothly transferred into the new organisation – the ICB. The workplan covered all aspects of the organisation's operations including the transfer of staff, constitutional, corporate and regulatory matters, quality governance, contracts and leases, asset management and financial due diligence. The Transition Group reported to the CCGs' Audit Committees which were held in common and had attendance from the ICB shadow Chair of Audit Committee.

In addition to taking on the delegated responsibilities of the CCGs, the Integrated Care Board has additional functions, such as:

- Co-ordinating the development and delivery of an ICP Strategy, leading the integration of the health and social care system
- Providing oversight and taking on some of the regulatory responsibilities for the health care system
- Leading the strategic transformation of the system.

The ICB was able to make appointments to key posts in 2021/22 so that there was a period of overlap between the CCG Governing Body and the shadow ICB Board.

This included the appointment of the ICB Chair, five Non-Executive Directors and an ICB Board of Executive Directors.

The Constitution, key policies and governance structures were developed during the shadow period and adopted by the ICB on 1 July 2022.

## The governance structure

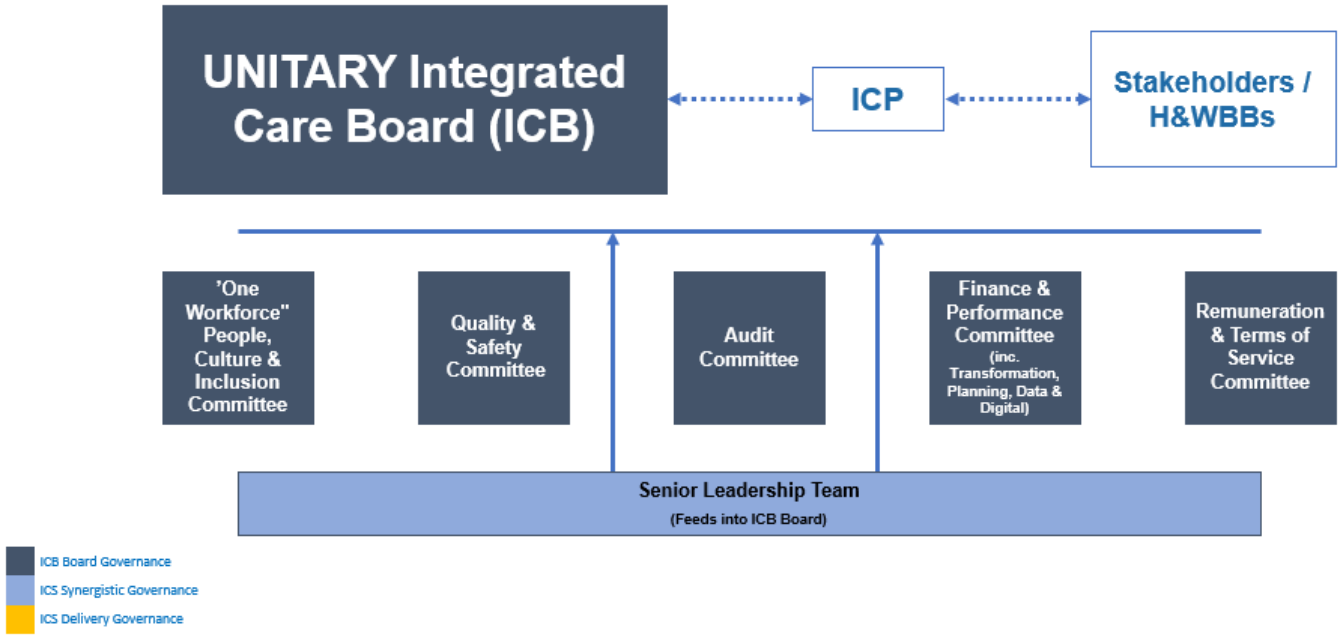
The ICB is a statutory NHS organisation whose Board discharges the following broad functions and makes associated decisions either directly or via its appointed committees:

- Prepare a five-year Forward Plan with partner NHS providers to set out how ICB functions will be delivered to meet the health needs of local people, having due regard to Integrated Care Strategy and Joint Local Health and Wellbeing Strategies
- Allocate resources across the system to deliver the Forward Plan via a Joint Capital Resource Use Plan, prepared with partner NHS providers
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities
- Establish governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, to ensure statutory duties are met – including preparing the ICB Constitution and related documents that describe how these arrangements operate
- Arrange for the provision of hospital and other health services in line with allocated resources across the ICS – including putting contracts and agreements in place to secure delivery of the Forward Plan by providers, supporting them working at scale / at place to lead major service transformation programmes

- Arrange for the provision of NHS Continuing Healthcare, Funded Nursing Care, Personal Health Budgets and Direct Payments for healthcare
- Arrange for the provision of Primary Medical Services (as delegated by NHS England)
- Manage Individual Funding Requests
- Lead system-wide implementation of the People Plan
- Lead system-wide action on Data and Digital
- Understand local priorities, deliver plans, monitor and address variation, and drive continuous improvement in performance and outcomes, using joined-up data and digital capabilities
- Ensure the NHS plays a full part in social and economic development and environmental sustainability
- Drive joint work on estates, procurement, supply chain and commercial strategies
- Plan for, respond to, and lead recovery from incidents (EPRR)
- Work with partners to safeguard vulnerable children, young people and adults
- Determine employees' terms and conditions and Board and committee members' remuneration and allowances
- Prepare an Annual Report and Accounts
- Maintain a Register of Interests and manage Conflicts of Interest.

The ICB has set up five committees through which it delegates its function and responsibilities. They are shown in the diagram below.

## ICB committees' governance – Board assurance



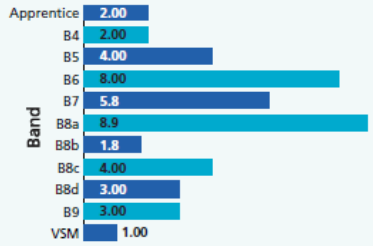
Our staff have been organised to work either on specific delivery portfolios or into Directorates that provide underpinning support across the organisation.

## ICB organisation diagram

## Finance Planning and Intelligence

**Paul Brown**
Chief Finance Officer

- Finance
- Planning
- PMO/TDU
- Contracts and Procurements
- Performance/Reporting Management
- SIRO

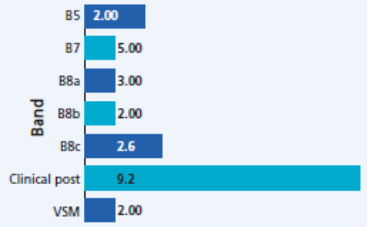



**WTE: 43.53 - £2,217,421**

## Medical and Professional Leadership

**Dr Paul Edmondson-Jones MBE**
Chief Medical Officer

- Clinical and Professional Leadership
- Public Health Screening, Vaccinations, Immunisations
- LTC and Frailty
- Population Health Management
- Prevention and Inequality
- Research and Innovation
- System Strategy
- CPAG/IFR




**WTE: 25.78 - £2,150,102**

## People Function

**Alex Brett**
Chief People Officer

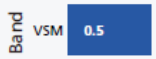
- HR
- OD
- Training and Development
- Recruitment
- Special Projects
- Inclusion
- Coaching


**WTE: 3.5 - £229,223**

## Digital

**Chris Ibell**
Chief Digital Officer

- Digital Transformation
- Solutions Architect
- IG




**WTE: 0.5 - £63,860**

## CSU support services:

- Primary Care Digital
- Data Quality Facilitation
- Registration Authority
- Funded Care
- Regional Capacity Management Team
- Communications
- Engagement
- Design/Media
- Information Governance
- Health and Safety
- Contract Management
- Procurement
- Business Intelligence
- Data Processing
- Human Resource Support
- Equality, Diversity and Inclusion
- Digital Leadership and Management Support
- Chief Technology Officer Support
- Digital Transformation Programme Delivery

## Composition of Integrated Care Board

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Mr Prem Singh | ICB Chair | | Dec 2022 |
| Mr David Pearson | Non-Executive Director and Interim Chair | | |
| Mrs Julie Houlder | Non-Executive Director | | |
| Mrs Josephine Spencer | Non-Executive Director | | |
| Mr Shokat Lal | Non-Executive Director | | |
| Ms Megan Nurse | Non-Executive Director | | |
| Mr Peter Axon | Interim Chief Executive Officer | | |
| Mrs Alex Brett | Chief People Officer | | |
| Mr Chris Ibell | Chief Digital Officer | | |
| Mrs Heather Johnstone | Interim Chief Nursing and Therapies Officer | | |
| Mr Paul Brown | Chief Finance Officer | | |
| Mrs Sally Young | Director of Corporate Governance | | |
| Dr Paul Edmondson-Jones | Chief Medical Officer | | |
| Mr Chris Bird | Interim Chief Transformation Officer | | |
| Mr Phil Smith | Chief Delivery Officer | | |
| Mr Jon Rouse | Stoke-on-Trent City Council, Partner Member | | |
| Mr Jack Aw | Primary Care, Partner Member | | |
| Mr Neil Carr | Physical Health MPFT, Partner Member | | |
| Dr Buki Adeyemo | Mental Health CHCT, Partner Member | | |
| Dr Paddy Hannigan | Primary Care, Partner Member | | |
| Mrs Tracey Bullock | UHNM, Partner Member | | |
| Mr John Henderson | Staffordshire County Council, Partner Member | | |

**Dates will only be included if there has been a change in-year.*

# Membership of the Board Committees

## Audit Committee

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Mrs Julie Houlder | Non-Executive Director and Audit Committee Chair | | |
| Ms Megan Nurse | Non-Executive Director and Audit Committee Vice Chair | | |
| Mr David Pearson** | Non-Executive Director and Interim Chair | | January 2023 |
| Mrs Josephine Spencer** | Non-Executive Director | | |

**Dates will only be included if there has been a change in-year*

*** While four Non-Executive Members of the Board will be members of the Audit Committee, the expectation is that the Chair of the Remuneration Committee and the Chair of the Quality Committee will not routinely attend the Audit Committee and will not be subject to the usual requirement to attend 70% of meetings.*

## Remuneration Committee

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Mr David Pearson | Non-Executive Director and Chair | | December 2022 |
| Mr Peter Axon | Chief Executive | | |
| Ms Megan Nurse | Non-Executive Director | | |
| Mrs Julie Houlder | Non-Executive Director | | |
| Mr Shokat Lal | Non-Executive Director and Chair | January 2023 | |
| Mrs Josephine Spencer | Non-Executive Director | | |
| Mrs Sally Young | Director of Corporate Governance | | |
| Mrs Alex Brett | Non-Executive Director | | |

**Dates will only be included if there has been a change in-year.*

## Quality and Safety Committee

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Mrs Josephine Spencer | Non-Executive Director and Chair | | |
| Mr David Pearson | Non-Executive Director | | Dec 2022 |
| Mrs Heather Johnstone | Chief Nursing and Therapies Officer | | |
| Dr Steve Fawcett | Clinical Director | | |
| Dr Rachel Gallyot | Clinical Director | | |
| Mrs Sarah Jeffery | Deputy Director of Primary Care | | |
| Dr Paul Edmondson-Jones | Chief Medical Officer | | |
| Mrs Lynn Tolley | Interim Nursing and Quality Director | | |
| Mrs Sally Young | Director of Corporate Governance | | |
| Mr Paul Winter | Deputy Director of Corporate Governance | | |
| Ms Liz Locket | Executive Director of Quality and Clinical Performance, MPFT | | |
| Mr Steven Martin | Associate Chief Nurse, MPFT | | |
| Mr Ian Turner | Deputy Chief Nurse, MPFT | | |
| Ms Donna Bird | Interim Chief Nurse, UHDB | | |
| Ms Ann Marie Rile | Chief Nurse, UHNM | | |
| Mr Scott Malton | Deputy Chief Nurse | | |
| Mr Kenny Laing | Executive Director Nursing and Quality, NSCHT | | |
| Ms Bridget Cameron | Assistant Director, Stoke-on-Trent City Council | | |
| Dr Richard Harling | Director Adult Social Care, Staffordshire County Council | | |
| Mr Andrew Jepps | Assistance Director Adult Social Care, Staffordshire County Council | | |
| Mr Simon Fogell | Chief Executive, Healthwatch | | |
| Ms Julie McCabe | Deputy Director Nursing and Quality, NHS England | | |
| Ms Cheryl Sheratt | Assistant Director of Nursing and Quality, NHS England | | |
| Mrs Karen Richardson | Hospitals, CQC | | |
| Ms Leanne Clews | Head of Quality and Commissioning, Health Education England | | |
| Ms Megan Nurse | Non-Executive Director | February 2023 | |

**Dates will only be included if there has been a change in-year*.

## Finance and Performance Committee

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Ms Megan Nurse | Non-Executive Director and Chair | | |
| Mrs Josephine Spencer | Non-Executive Director and Vice Chair | | |
| Mr Paul Brown | Chief Finance Officer | | |
| Mr Phil Smith | Chief Delivery Officer | | |
| Mr Chris Bird | Chief Transformation Officer | | |
| Mrs Sally Young | Director of Governance | | |
| Dr Paul Edmondson-Jones | Chief Medical Officer | | |
| Mrs Heather Johnstone | Chief Nursing and Therapies Officer | | |
| Mr Mark Oldham | Chief Finance Officer, UHNM | | |
| Mr Paul Bytheway | Chief Operating Officer, UHNM | | |
| Mr Chris Sands | Chief Finance Officer, MPFT | | |
| Mr Steve Grange | Director of Commercial Development, MPFT | | |
| Mr Eric Gardiner | Director of Finance and Performance, NSCHT | | |
| Ms Alison McCaul | Deputy Director of Finance, UHDB | | |
| Mr James Green | Interim Director of Finance, RWT | | |
| Mrs Lisa Healing | VCFSE Rep, VAST | | |
| Mr Alan Shakespeare | Strategic Finance BP, Staffordshire County Council | | |
| Mr Rob Salmon | County Treasurer, Staffordshire County Council | | |
| Mr Nick Edmonds | Director of Strategy, Stoke-on-Trent City Council | | |
| Mr Eric Talbot | Statutory and Financial Accounting, Stoke-on-Trent City Council | | |

**Dates will only be included if there has been a change in-year*.

## People, Culture and Inclusion Committee

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Mr Shokat Lal | Non-Executive Director and Chair | | |
| Mrs Julie Houlder | Non-Executive Director | | |
| Mrs Alex Brett | Chief People Officer, ICB | | |
| Mrs Sally Young | Director of Corporate Governance, ICB | | |
| Dr Paul Edmondson-Jones | Chief Medical Officer, ICB | | |
| Mrs Heather Johnstone | Chief Nursing and Therapies Officer, ICB | | |
| Ms Sarah Jeffrey | Deputy Director of Primary Care, ICB | | |
| Mrs Denise Baker | Derby University | | |
| Ms Charlotte Bennett | VAST | | |
| Ms Lisa Bridger | Staffordshire City Council | | |
| Ms Helen Conway | Staffordshire and Stoke-on-Trent ICP | | |
| Ms Rebecca Crowther | UHNM | | |
| Mr Paul Draycott | NSCHT | | |
| Mr Kaine Davidson | MPFT | | |
| Ms Ann Ewans | Staffordshire University | | |
| Ms Sarah Getley | Staffordshire County Council | | |
| Ms Sheena Gibson | Staffordshire Training Hub | | |
| Ms Jane Haire | UHNM | | |
| Mr Andrew Jepps | Staffordshire County Council | | |
| Mr Baz Kaur | NSCHT | | |
| Ms Rachel McKeown | MPFT | | |
| Mr Paul Meredith | Staffordshire Training Hub | | |

**Dates will only be included if there has been a change in-year*.

## Register of Interests

Details of company directorships and other significant interests held by members of the ICB that may conflict with their management responsibilities are available on our website, along with information on how these conflicts can be managed:

Our publications and policies (staffsstokeicb.nhs.uk)

## Personal data related incidents

Please see Governance Statement for more information.

## Modern Slavery Act

Staffordshire and Stoke-on-Trent ICB fully support the government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on our website.

## Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each ICB to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Staffordshire and Stoke-on-Trent ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each ICB shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Mr Peter Axon to be the Accountable Officer of Staffordshire and Stoke-on-Trent ICB. The responsibilities of an Accountable Officer are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury. These include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the ICB and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- safeguarding Staffordshire and Stoke-on-Trent ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Staffordshire and Stoke-on-Trent ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

29 June 2023

# Governance statement

## Staffordshire and Stoke-on-Trent ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

Staffordshire and Stoke-on-Trent ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 July 2022 and 31 March 2023, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Staffordshire and Stoke-on-Trent ICB's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in Staffordshire and Stoke-on-Trent ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that Staffordshire and Stoke-on-Trent ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within Staffordshire and Stoke-on-Trent ICB as set out in this governance statement.

## Governance arrangements and effectiveness

The main function of the governing body is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

This has been achieved by the following.

### Key features of the ICB's constitution for governance

The ICB promotes good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties. The principles of good governance are established in our Constitution.

The ICB will at all times observe these generally accepted principles in the way it conducts its business. These include:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business
- the Good Governance Standard for Public Services
- the standards of behaviour published by the Committee on Standards in Public Life (1995), known as the 'Nolan Principles'
- the seven key principles of the NHS Constitution
- the Equality Act 2010.

The ICB Board and Committees have continued to meet throughout the period from 1 July 2022 to 31 March 2023.

These consist of the following:

## Committees of the Integrated Care Board

- Audit Committee
- Remuneration and Terms of Service Committee
- Quality and Safety Committee
- Finance and Performance Committee
- People, Culture and Inclusion Committee.

Below is a short summary of the key decisions taken by the ICB Board and its committees. The full details of each of the above committees can be found on our website.

## Meetings of the Integrated Care Board

Our Integrated Care Board has met monthly during the final three quarters of 2022/23.

From July 2022 to March 2023, the ICB met nine times – six of the meetings were held in public, with an opportunity for the public to be present or join via live stream. In addition to listening to the debate, the public can submit questions to the Board. Each Public Board meeting aims to start with either a patient or staff story and four have been presented covering the journey into work, frailty, apprenticeships and social care. All meetings have been quorate.

Key actions of the Board include approving the adoption of the Leadership Compact, the organisation's policies and procedures, and the Working with People and Communities Strategy. The Board has also overseen the implementation of the Ageing and Frailty Strategy and have set the strategic objectives of the organisation.

## Audit Committee

The Committee contributes to overall delivery of ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB. The Committee has met four times in September, November, January and March. All of the meetings were quorate.

During this period, the Audit Committee has provided assurance to the Board on the following:

- Integrated governance, risk management and internal control
- Internal and external audit functions
- Other assurance functions
- Counter fraud
- Freedom to Speak Up
- Information Governance (IG)
- Financial reporting
- Conflicts of Interest (COI)
- Communications.

## Quality and Safety Committee

The Quality and Safety Committee provides assurance to the ICB that there is an effective system of quality governance and internal control that supports us to effectively deliver our strategic objectives and provide sustainable, high-quality care.

It also provides the ICB with assurance that we are delivering our functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

During 2022/23, the Committee met eight times and all the meetings were quorate. During this period the Committee provided assurance to the Board on the following:

- Provider quality
- Patient engagement
- Maternity services
- Special Educational Needs and Disabilities (SEND)
- Learning from Lives and Deaths of People with Learning Disability and Autism (LeDeR)
- Safeguarding
- Looked after Children
- Patient experience
- Quality Impact Assessments
- Serious Incident Report
- BAF and risk.

## Finance and Performance Committee

The Finance and Performance Committee advises and supports the Board in scrutinising and tracking the delivery of key financial and service priorities, outcomes and targets as specified in the ICS Strategic and Operational Plans.

The Committee is responsible for:

- Delivering the ICB annual plan including finance and performance
- Scrutinising system plans and performance to ensure that the system is addressing health inequalities.

It also works closely with the Quality Committee. The two committees between them consider financial and operational performance alongside the delivery of high-quality care and services. During 2022/23, the Committee met eight times and all the meetings were quorate. During this period, the Committee provided assurance to the Board on the following:

- System and ICB financial performance
- System performance
- BAF and risk
- Transformation
- Planning
- Winter Plan
- Savings plans
- Capital programme
- Procurement
- Continuing Healthcare.

## People, Culture and Inclusion Committee

The People, Culture and Inclusion Committee seeks to act in the best interest of citizens, patients, our people and the system as a whole. It looks for innovative solutions that address the cultural changes needed to build the workforce we want to have – one that befits a world-class health and care system which is recognised as being the best place to work.

During 2022/23, the Committee met four times in September, November, January and March and all the meetings were quorate. During this period, the Committee provided assurance to the Board on the following:

- Workforce planning
- Workforce transformation
- Culture and leadership
- BAF and risk
- Equality, diversity and inclusion
- Organisational development
- Training.

## The Remuneration Committee

The Remuneration Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors, excluding the Chair.

The Remuneration Committee met 11 times during 2022/23, and all meetings were quorate. The Committee has also:

- received regular reassurance around the progress of the implementation of the clinical and professional leadership model
- provided oversight to implications for staff for the transition from CCG to ICB
- provided oversight to any executive or non-executive director recruitment processes
- approved the implementation of the Fit and Proper Persons Policy.

# UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing on the Good Governance Institute Best Practice.

## Freedom to Speak Up

The ICB wishes to promote an open organisational culture where employees are not only aware of how to report but also have confidence in the reporting procedures. The protection of people who raise concerns from retaliation for reporting in good faith suspected acts of corruption and other wrongdoing is therefore integral to efforts to protect patients and staff and combat corruption, safeguard integrity, and enhance accountability.

To deliver this role, the ICB has appointed a lead Director as Freedom to Speak Up Guardian, a Freedom to Speak Up Champion and a lead non-executive Director to oversee the process and support staff. The Board receives high level information about all concerns raised by our staff and what we are doing to address them.

## Discharge of Statutory Functions

Staffordshire and Stoke-on-Trent ICB has reviewed all of the statutory duties and powers conferred on it by the NHS Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that as an ICB we are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

To ensure the ICB Board has the skills, knowledge and experience required to effectively carry out its functions, appointments were made in line with the HR Framework for Developing an Integrated Care Board; March 2022. All Board level appointments include a Fit and Proper Persons Test. Board members, including the Non-Elective Directors complete a Personal Development Programme (PDP), and the Chair's PDP is undertaken by a Senior Independent Non-Executive Director.

Following any change to Board Membership, the balance of skills and knowledge of the Board, as a whole, is reviewed to confirm that the Board continues to have sufficient skills and knowledge to deliver its duties or identify emerging gaps which will be addressed through recruitment or development.

The Board allocates time for Board development and additional briefings are scheduled with either internal leads or input from external leads such as Auditor-led sessions. During 2022/23, the Board development sessions have included Finance, Risk Appetite and Tolerance and Mental Health and Learning Disabilities.

## Risk management arrangements and effectiveness

The ICB reviewed its approach to managing risk and drafted a Risk Management Strategy based on best practice guidance issued by the National Audit Office. The Strategy was approved for adoption by the Audit Committee. There are two key changes from the predecessor organisation's approach:

- The Board identifies the level of risk tolerance that we are prepared to accept, which ensures that responses are proportionate
- The ICB has developed an issues log to record issues and mitigations which impact on delivery.

The ICB Risk Management Strategy demonstrates how the Board Assurance Framework, Risk Register and Issues Log complement each other in the management of risks at all levels of the organisation.

The Governance and Risk Network for the system has been fundamental to developing our new system-wide approach to risk management and implementing the Risk Management Strategy. We have worked closely with our system partners and have adopted best practices from these to develop a far more robust and effective set of processes. UHNM has shared their best practice with us and helped challenge us to improve our processes.

We have also been asked to present what we've done and how we've worked with our system partners to the North West Region and are also part of a case study being written by the Good Governance Institute.

With the assistance of Internal Auditors RSM, we implemented best practice in relation to our Board Assurance Framework (BAF) development. Senior executive leads reviewed their objectives, which were renewed and rewritten as 'SMART' objectives to deliver the Quadruple Aims set for ICB delivery.

The BAF and Risk Register are also presented to the Audit Committee in full, with risks scoring 12 or above being reported to the Board and associated committees responsible for their area of risk.

Our Internal Auditors then reviewed the arrangements formally and overall, found reasonable assurances with the re-modelled and re-aligned approach, which was positive. Full details of their audit opinion can be found in our 2022/23 Annual Report.

The administration of both the BAF and Risk Register is undertaken by the Governance team who continue to provide support on the completion of the registers.

We have auditor-assured and adequate risk management control frameworks, with clear reporting lines and regular review of the ICB's identified risks.

We have ensured that risk management has remained fully embedded in the ICB's core business activity (including interlinked areas such as undertaking Equality Impact Assessments with in-built risk assessment checks, or to support all incident reporting to be carried out openly).

RSM have identified a number of areas for improvement, with the ICB's Board Assurance Framework, relating to risk owners understanding of controls, assurances and risks and the way these are defined within the BAF, updating of action plans to reflect action progress, detailing the effects of action completion upon risks scores and ensuring cover sheets include sufficient justification of changes to risks.

Staffordshire and Stoke-on-Trent ICB Risk Management Strategy

## Capacity to handle risk

The ICB's Board is responsible for the organisation's systems for internal control, including risk management.

### Chief Executive Officer

The Chief Executive Officer has overall responsibility to ensure appropriate systems of internal control are in place for all aspects of governance, including financial and risk management as well as plans for dealing with emergencies that may impact on the ICB.

Day-to-day management of risk management processes is delegated to the Director of Corporate Governance.

### Executive Management Team

The role of the Executive Management Team is to have oversight of the BAF and the encompassing risk register for all risks. Executive directors are responsible for validating and managing risks within their designated remit of work.

### Audit Committee

The Audit Committee ensures that we maintain effective systems of integrated governance, risk management and internal control.

The Audit Committee reviews the risk register and BAF.

The sub-committees of the ICB are responsible for overseeing the risks relating to their workstreams. The Audit Committee has oversight of all risks.

### Risk owners

The risk owners ensure that their risks are continuously managed. They check that the risk register is updated on at least a monthly basis or as deemed appropriate by their executive director.

The directors are listed below.

| Executive leads | Area of work |
|---|---|
| Chief Finance Officer | Finance, Financial Governance, Senior Information Risk Owner |
| Chief Nursing and Therapies Officer | Quality, Safety, Safeguarding, Caldicott Guardian |
| Director of Corporate Governance | Corporate Governance, Communication and Engagement |
| Chief Transformation Officer | Primary Care and Medicines Optimisation, Mental Health, Continuing Healthcare |
| Chief Delivery Officer | Performance, Information, Planning and Strategy, as well as formal processes for ICC incident response |
| Chief People Officer | Human Resources, Organisational Development, Equalities |
| Chief Digital Officer | Digital and Cyber Security |

## Risk assessment

On 1 July 2022, 15 high-scoring risks (with a score of 15 or above) were transferred from the predecessor organisations into the ICB. At the end of March 2023, 18 high-scoring risks (with a score of 15 or above) were recorded on the Risk Register.

Details of the risks are set out below.

| Risk reference and description | Score |
|---|---|
| **098: Winter Plan workforce/staffing**<br>• If we fail to improve on the current vacancy rates, or experience increased staff sickness<br>• Then there may be an acute impact on the system during the winter period<br>• Resulting in workforce constraints dictating that the system is forced to prioritise urgent services – with a negative impact on non-urgent and elective services. | 25 (5x5) |
| **111: Ambulance handover delays**<br>• If continued delays to ambulance handovers are incurred, and sustained or levels increased<br>• Then there will be significant pressures placed on emergency departments, ambulance crews and the wider urgent and emergency care system<br>• Resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time and associated issues. | 25 (5x5) |
| **048: Digital cyber security**<br>• If the ICB/ICS systems suffer a cyber attack<br>• Then it could lead to the loss of IT systems and/or unauthorised access to data<br>• Resulting in reputational damage to the Staffordshire and Stoke-on-Trent NHS healthcare providers, GP practices and local authorities. | 20 (5x4) |
| **113: Continuing Healthcare (CHC) cost pressure**<br>• If the volume, acuity and price pressure in the CHC market leads to costs being greater than NHS England funded levels of inflation<br>• Then budgets may be exceeded<br>• Resulting in cost pressure to the ICB financial position in 2023/24, a potential deficit for that year and detrimental impact on the ICB's financial sustainability. | 20 (5x4) |

| | |
|---|---|
| **97: Cost of living impact**<br>• If the cost of living and fuel and energy prices rise with subsequent impact on workforce and the population<br>• Then the population and workforce will struggle to manage financially<br>• Resulting in a detrimental impact on health and wellbeing, increased turnover and inability to attract people to health and care careers over higher-paid private sector jobs. | 16 (4x4) |
| **001: Underlying deficits from 2023/24**<br>• If the system saving schemes do not deliver the Financial Strategy<br>• Then the system, its providers, and consequently the ICB will be unable to deliver a financially sustainable position (i.e. a financial deficit from 2023/24), in line with the operating and planning framework<br>• Resulting in additional cost pressure, historic deficits being repaid, regulator intervention and reputational damage. | 16 (4x4) |
| **095: Vacancies and workforce growth required; supply and availability of registrants**<br>• If we are unable to fill the number of vacancies across all groups, deliver the growth required to deliver the operational plan and winter schemes and meet the national workforce models, design new/adapt courses and placements to meet the immediate and future needs<br>• Then we will not deliver the availability of workforce to support service delivery: Restoration and Recovery Plans; Winter Plans; BAU service delivery; Transforming care models and pathways; different skills, competencies and roles required to support different ways of delivering care<br>• Resulting in an impact on service delivery, workforce burn out and turnover; reduction in productivity; gaps in existing workforce skills and competencies, creation of new roles and requirement to train and recruit. | 16 (4x4) |
| **085: Care home and home care workforce capacity**<br>• If care home and home care existing and future workforce supply remains unstable, unable to mobilise workforce to support the Provider Improvement and Response Team (PIRT), lack of demand and capacity modelling, infection control and outbreaks<br>• Then there will continue to be significant gaps in the care home and home care workforce<br>• Resulting in an inability to operate care home and home care services effectively and safely, wider system impacts on hospital admissions and discharge, stretching existing workforce, leaver rates, impacts on workforce health and wellbeing. | 16 (4x4) |
| **077: Implementation of the Fuller Report**<br>• If the implementation of the Fuller Report does not address the known primary care workforce issues<br>• Then health services may not be able to cope with the demand or meet the recommendations in the Fuller Report<br>• Resulting in demand and capacity issues which will impact on access and poorer patient outcomes and experiences. | 16 (4x4) |
| **112: Industrial action**<br>• If industrial action continues, with further days/periods of staff walk-outs<br>• Then there will be periods of additional pressure placed on the system due to staffing cover and contingency arrangements | 16 (4x4) |

| | |
|---|---|
| • Resulting in increased instances of patient harm, increased system capacity issues, compromised staffing ratios and the need for enhanced contingency measures. | |
| **094: Staff health, wellbeing and retention**<br>• If staff continue to work under the pressures experienced during the pandemic<br>• Then it could impact on future wellbeing and retention. Stress, anxiety, depression and MSK reasons for absence remain prevalent, impact of additional pressures on services and workforce<br>• Resulting in increased sickness and absence, impact on health and wellbeing of the workforce, links to turnover. | 16 (4x4) |
| **086: Supporting workforce modelling for Joint Forward Plan, Portfolios and Transformation**<br>• If a lack of clarity around Joint Forward Plan, Portfolios and Transformation Plan workforce requirements exists<br>• Then there is an inability to effectively workforce plan and understand the workforce requirements for existing and future service delivery<br>• Resulting in increased sickness and absence, impact on health and wellbeing of the workforce, links to turnover. There will also be continued decline in compliance for Looked After Children having their Initial and Review Health Assessments (IHA/RHA) within the statutory timescales. | 16 (4x4) |
| **115: Looked After Children – Initial and Review Health Assessments (IHA/RHA) compliance (regulatory)**<br>• If there is an increase in demand for IHA and consequent RHA for Looked After Children, this is due to an increasing number of Looked After Children – some of which is associated with the increasing numbers of unaccompanied asylum-seeking children (UASC)<br>• It is important to note that UASCs are routinely given a double appointment to enable and support the delivery of a quality assessment. This is having further impact on the demand. | 16 (4x4) |
| **114: Children and young people placements for complex behaviour**<br>• If there is no appropriate inpatient facility children and young people will need to be admitted to an inappropriate setting<br>• Then children and young people may not be able access inpatient services which meet their needs either locally or nationally<br>• Resulting in potential placement in an environment which is not commissioned to meet their needs, which could result in risk for the individual and others, alongside inappropriate clinical management leading to deterioration of condition/behaviours. | 16 (4x4) |
| **096: Industrial action**<br>• If the union ballots support industrial action<br>• Then there will be workforce action which could impact across the system<br>• Resulting in reduced staffing levels, additional pressures on service delivery and temporary suspension of services. | 16 (4x4) |
| **108: Independent hospital**<br>• If assurance is not obtained that children are safe from harm in an independent hospital in Stafford<br>• Then children may be harmed by restrictive practices and psychological harm<br>• Resulting in significant harm. | 16 (4x4) |

| | |
|---|---|
| **082: Agency usage and spend**<br>• If the national mandate on reducing agency spend is introduced with a target reduction from £34 million to £25 million in Staffordshire and Stoke-on-Trent<br>• Then the system's ability to attract/recruit/retain staff to hard-to-fill positions will be negatively impacted leading to varying demand in bank, business as usual and 'day job' priority for members, under-utilisation of system People Hub<br>• Resulting in vacant posts, continued reliance on agency, move back to pre-COVID silo working, duplication of work, system benefits and efficiencies not realised. | 16 (4x4) |
| **073: Transfer of PODs to ICB**<br>• If the ICB does not receive sufficient resource from NHS England when the PODs are transferred<br>• Then the ICB may not have sufficient capacity or technical skills, corporate memory and/or adequate finances to support this additional role<br>• Resulting in failure to optimally commission the new services and additional cost pressures. | 15 (3x5) |

# Other sources of assurance

## Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure we deliver our policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact if they are realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

## Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

The ICB's internal auditors have undertaken the Conflicts of Interest compliance check and have identified that all areas are rated as compliant. At the time of the compliance check, conflicts of interest and declarations of interest were under review by NHS England for ICBs.

There is no statutory guidance that states the ICBs should make or retain any conflicts or declarations of interests.

However, the ICB has carried on with conflicts and declarations of interest in accordance with the former CCG processes and procedures as it awaits any new guidance from NHS England and NHS CFA Government Functional Standard 013: Counter Fraud. The ICB continues to publish its Declarations of Interest Register on the ICB website.

# Data quality

The Board agrees that the data, information and intelligence brought to its attention and that of the Committees are fully acceptable and fit for purpose.

Data collection and reliability are kept under review and if issues are identified with the data the ICB would take steps to rectify the situation.

## Information Governance (IG)

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an IG Toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed processes and procedures in line with the IG Toolkit. We have ensured all staff undertake annual IG training and have implemented a staff IG Handbook to ensure staff are aware of their roles and responsibilities.

In past years, the Data Security and Protection Toolkit's (DSPT) final submission has been submitted at the end of March to align with end of year reporting.

However due to COVID-19, NHS Digital took the decision to move the final submission date to 30 June. It was later decided that this date would remain as the final submission date for all future DSPTs.

As we have not yet reached our final submission date, we are currently reporting 107 mandatory evidence assertions completed out of 113. With only five, we anticipate to achieve 'Standards Met' and final submission to be completed on 30 June 2023.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and we will establish a programme to fully embed an information risk culture throughout the organisation.

## Personal data-related incidents

There have not been any personal data breaches during the period 1 July 2022 to 31 March 2023.

## Freedom of Information (FOI) requests

We have received 338 FOI requests during the period 1 July 2022 to 31 March 2023, with no breaches. Our robust process in place for answering FOI requests and has ensured that we have not had any breaches in the last four years, with the majority of responses being provided well before the deadline.

## Subject Access Requests (SARs)

Again, we have kept the robust process developed by our predecessor organisation for Subject Access Requests. However, as an ICB we do not receive patient medical records or hospital notes, and so we cannot provide this information under Subject Access. Instead, these must be obtained from the relevant hospital trust or GP practice.

We are able to provide information relating to Continuing Healthcare (CHC) and Personal Health Budget (PHB) funding and/or Individual Funding Requests (IFR).

During the period 1 July 2022 to 31 March 2023, the ICB received 338 requests, 11 of which were in relation to CHC funding. The ICB did not receive any requests in relation to IFR.

## Business Critical Models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, we confirm that an appropriate framework and environment are in place to provide quality assurance of business critical analytics and modelling.

## Third party assurances

The ICB commissions its back-office support from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). Monthly performance reviews are scheduled with MLCSU.

MLCSU's Internal Audit support is provided by Deloitte. The ICB is awaiting the outcome of the MLCSU's Service Auditor Reports and will include any identified weaknesses in controls within the final submission.

## Control issues

No material issues requiring reporting beyond the underlying financial position were identified via the Month 9 Governance Statement return to NHS England.

The financial framework for 2023/24 is one of a population-based funding method. The system operating plan is still under development and due to be published at the end of July 2023. This plan will describe the system response to all operational requirements.

The accompanying financial plan is based on the latest system allocations and is currently showing that the system will have a financial deficit in 2023/24.

This financial forecast is under discussion with NHS England, and an agreed plan will be published as soon as agreements have been reached.

At the time of writing the external audit, opinion on the financial statements is expected to be unqualified – therefore, delivery of the standards expected of the Accountable Officer are not deemed to be at risk.

## Review of economy, efficiency and effectiveness of the use of resources

Financial planning and in-year performance monitoring are covered within the Performance Report section.

Central management costs are provided in the Financial Performance Targets note in the Accounts section. Our Governing Body in Common and the Finance and Performance Committee and Audit Committees meeting in Common have been kept fully abreast of the ICB's financial position and have provided both support and challenge as would be expected.

Business processes have been restructured to enable the Finance and Performance Committee to scrutinise and lead the financial agenda whilst adroitly separating the Committee into two parts, one to focus on the performance of the unitary entity that is the ICB and the second part concerning itself with the wider Integrated Care System.

## Delegation of functions

The key financial systems (general ledger, accounts payable, accounts receivable and payroll) are operated by Shared Business Support under contract to MLCSU. These systems undergo a separate regime of Internal Audit assessment which is provided by Deloitte. Their Service Auditor Reports are published twice a year, presented to the Audit Committee and reviewed by our external auditors in terms of informing the overall audit opinion.

## Counter fraud arrangements

The ICB has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake counter fraud work proportionate to identified risks. This service is provided by RSM. The ICB continues to ensure that a comprehensive counter fraud and anti-bribery culture exists through the ICB as detailed in the Counter Fraud and Bribery Policy and through the work undertaken by the LCFS. All policy and procedure is subject to review by the LCFS to ensure all our documentation is maintained in accordance with Service Condition 24 (SC24) of the NHS Standard Contract 2021/22 and the NHS Requirements to meet Government Functional Standard 013: Counter Fraud.

The Chief Finance Officer and Counter Fraud Champion work with the LCFS to support a proactive work plan to address identified risks.

During 2022/23, we have held fraud awareness campaigns and RSM have put on webinars for staff to attend which have focussed on raising awareness of the different types of fraud. Staff are also required to complete mandatory training for fraud awareness, there have also been briefing sessions as part of the Team Briefs.

## Gifts and hospitality

All ICB staff are required to declare any gifts and hospitality offered to them. Staffordshire and Stoke-on-Trent ICB Gifts and Hospitality Register.

# Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's Annual Governance Statement.

This section provides RSM's annual internal audit opinion for 2022/23 as at 6 March 2023.

For the nine months ended 31 March 2023, as at 6 March, the draft Head of Internal Audit Opinion for Staffordshire and Stoke-on-Trent ICB is as follows:

**The organisation has an adequate and effective framework for risk management, governance and internal control.**

**However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.**

The following audits have been undertaken during the nine-month period:

| Assignment | Opinion issues |
|---|---|
| Medicines Management | Reasonable Assurance |
| Procurement and Single Tender Waivers | Reasonable Assurance |
| Data Security Protection Toolkit | Advisory |
| Operational Plan | Substantial Assurance |
| Financial Feeder Systems – Balances | Substantial Assurance |
| Financial Sustainability | Agreed Upon Procedures |
| Key Financial Controls | Reasonable Assurance |
| Continuing Health Care and Personal Health Budgets | Partial Assurance |
| ICB Website – Benchmarking | Advisory |
| Data Quality – Referral to treatment 52+ and 104+ week waits | Advisory |
| Cyber Risk Assessment | Reasonable Assurance |
| Board Assurance Framework | Reasonable Assurance |
| Primary Care Commissioning – Additional Roles Reimbursement Scheme | Partial Assurance |
| ICB Governance Arrangements | Reasonable Assurance |
| Maternity Arrangements | In Progress |

# Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- If relevant, the Risk / Clinical Governance / Quality Committee
- Internal audit
- Other explicit review/assurance mechanisms.

## Conclusion

No significant internal control issues have been identified.

# Remuneration and Staff Report

## Remuneration Report

### Remuneration Committee

The ICB has a Remuneration and Terms of Service Committee in Common, which is a sub-committee of the Board. The Chair of the Remuneration Committee is an ICB Non-Executive Director and its members are the ICB Chair and the ICB Non-Executive Directors.

The purpose of the committee is to advise the Board about appropriate remuneration and terms of service for senior employees, on Very Senior Manager contracts, including:

- all aspects of salary
- provisions for other benefits, including pensions
- arrangements for termination of employment and other contractual terms
- discipline and dismissal of officer members of the Board.

The Director of Corporate Governance and the Chief People Officer, support the meeting with the Chair, the Chief Executive and other Executive Directors being asked to attend as appropriate.

#### Remuneration Committee members

| Name | Position | Date joining the committee* | Date leaving the committee* |
|---|---|---|---|
| Prem Singh | ICB Chair | 01/07/2022 | 31/12/2022 |
| David Pearson | ICB Non-Executive Director / ICB Chair | 01/07/2022 | |
| Shokat Lal | ICB Non-Executive Director | 01/07/2022 | |
| Josie Spencer | ICB Non-Executive Director | 01/07/2022 | |
| Julie Houlder | ICB Non-Executive Director | 01/07/2022 | |
| Megan Nurse | ICB Non-Executive Director | 01/07/2022 | |

Details of the Remuneration Committee can be found in the Annual Governance Statement.

### Percentage change in remuneration of highest paid director

Due to this Annual Report being the first since the creation of the Staffordshire and Stoke-on-Trent Integrated Care Board, no prior year comparators have been included.

### Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in Staffordshire and Stoke-on-Trent ICB in the reporting period 1 July 2022 to 31 March 2023 was £195,000 to £200,000.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| 2022/23 | 25th percentile | Median pay ratio | 75th percentile pay ratio |
|---|---|---|---|
| Total remuneration (£) | 33,706 | 48,526 | 77,199 |
| Salary component of total remuneration (£) | 33,706 | 48,526 | 77,199 |
| Pay ratio information | 5.86:1 | 4.07:1 | 2.56:1 |

*Note: Salary movement for all pay scales reflects incremental movement only. While this Annual Report covers the period 1 July 2022 to 31 March 2023, the figures above are annualised.*

During the reporting period 2022/23, 0 employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £9,405 to £181,500.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

## Policy on the remuneration of senior managers

The following posts were paid on the Very Senior Manager pay scale:

- Chief Executive Officer
- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing and Therapies Officer
- Chief Transformation Officer
- Chief Delivery Officer
- Chief People Officer
- Chief Digital Officer
- Director of Corporate Governance
- Agenda for Change – see next paragraph.

### Agenda for Change

All other staff except medical and dental staff are paid through the Agenda for Change pay structure.

Non-Executive Director remuneration was based on national guidance from the Department of Health and Social Care.

No senior managers have been paid/will be paid through a performance-related pay mechanism in 2022/23.

Everything relating to the remuneration and terms and conditions of Very Senior Managers is subject to approval by the Remuneration Committee.

## Remuneration of Very Senior Managers

A letter from the National Director for People from NHS England and Chief Executive NHS Improvement was received by the Remuneration Committee in October 2022 outlining a recommendation for a 3% pay rise for Very Senior Managers. This recommendation was adopted/approved by the ICB Remuneration Committee meeting of 20 October 2022.

# Senior manager remuneration (including salary and pension entitlements) (subject to audit)

## 1 July 2022 to 31 March 2023

| Name and Title | (a) Salary (bands of £5,000) £000 | (b) Expense payments (taxable) to nearest £100** £ | (c) Performance pay and bonuses (bands of £5,000) £000 | (d) Long-term performance pay and bonuses (bands of £5,000) £000 | (e) All pension-related benefits To the nearest £1,000 £000 | (f) TOTAL (a to e) (bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Prem Singh - ICB Chair | 30-35 | 0 | 0-0 | 0-0 | 0-0 | 30-35 |
| David Pearson - Interim ICB Chair | 15-20 | 0 | 0-0 | 0-0 | 0-0 | 15-20 |
| Peter Axon - Interim CEO | 145-150 | 0 | 0-0 | 0-0 | 267.5-270.0 | 410-415 |
| Dr Paul Edmondson-Jones - Chief Medical Officer | 120-125 | 0 | 0-0 | 0-0 | 32.5-35.0 | 155-160 |
| Phil Smith - Chief Delivery Officer | 95-100 | 0 | 0-0 | 0-0 | 57.5-60.0 | 150-155 |
| Paul Brown - Chief Finance Officer | 105-110 | 6,100 | 0-0 | 0-0 | 45.0-47.5 | 155-160 |
| Heather Johnstone - Chief Nursing and Therapies Officer | 95-100 | 0 | 0-0 | 0-0 | 42.5-45.0 | 140-145 |
| Chris Bird - Chief Transformation Officer | 90-95 | 0 | 0-0 | 0-0 | 115.0-117.5 | 205-210 |
| Alex Brett - Chief People Officer | 50-55 | 0 | 0-0 | 0-0 | 155.0-157.5 | 205-210 |
| Chris Ibell - Chief Digital Officer | 45-50 | 0 | 0-0 | 0-0 | 0-0 | 45-50 |
| Julie Houlder - NED, Chair of Audit Committee | 10-15 | 0 | 0-0 | 0-0 | 0-0 | 10-15 |
| Megan Nurse - NED, Chair of Finance and Performance Committee | 10-15 | 0 | 0-0 | 0-0 | 0-0 | 10-15 |
| Josie Spencer - NED, Chair of Quality and Safety Committee | 10-15 | 0 | 0-0 | 0-0 | 0-0 | 10-15 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Shokat Lal - NED, Chair of People, Culture and Inclusion Committee | 10-15 | 0 | 0-0 | 0-0 | 0-0 | 10-15 |
| David Pearson - NED, Chair of Remuneration Committee | 5-10 | 0 | 0-0 | 0-0 | 0-0 | 5-10 |

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

**Further information**

- Prem Singh - ICB Chair | Annual Salary £60k | Joined 1 July 2022, left the organisation 31 December 2022
- David Pearson - Interim ICB Chair | Annual Salary £60k | Appointed to the role as Interim Chair 1 January 2023
- Peter Axon - Interim CEO (seconded from North Staffordshire Combined NHS Trust at 1 WTE) | Annual Salary £195k | Joined 1 July 2022
- Dr Paul Edmondson-Jones - Chief Medical Officer | Annual Salary £154k | Joined 1 July 2022
- Phil Smith - Chief Delivery Officer | Annual Salary £128k | Joined 1 July 2022
- Paul Brown - Chief Finance Officer | Annual Salary £149k | Joined 1 July 2022
- Heather Johnstone - Chief Nursing and Therapies Officer | Annual Salary £127k | Joined 1 July 2022
- Chris Bird - Chief Transformation Officer (seconded from North Staffordshire Combined NHS Trust at 1 WTE) | Annual Salary £123k | Joined 1 July 2022
- Alex Brett - Chief People Officer (seconded from Midlands Partnership NHS Foundation Trust at 0.5 WTE) | Annual Salary £144k | Joined 1 July 2022
- Chris Ibell - Chief Digital Officer (seconded from Midlands Partnership NHS Foundation Trust at 0.5 WTE) | Annual Salary £123k | Joined 1 July 2022
- Julie Houlder - NED, Chair of Audit Committee | Annual Salary £18k | Joined 1 July 2022
- Megan Nurse - NED, Chair of Finance and Performance Committee | Annual Salary £16k | Joined 1 July 2022
- Josie Spencer - NED, Chair of Quality and Safety Committee | Annual Salary £16k | Joined 1 July 2022
- Shokat Lal - NED, Chair of People, Culture and Inclusion Committee | Annual Salary £16k | Joined 1 July 2022
- David Pearson - NED, Chair of Remuneration Committee | Annual Salary £16k | Joined 1 July 2022.

## Pension benefits (subject to audit)

| Name and Title | (a) Real increase in pension at pension age (bands of £2,500) £000 | (b) Real increase in pension lump sum at pension age (bands of £2,500) £000 | (c) Total accrued pension at pension age at 31/03/23 (bands of £5,000) £000 | (d) Lump sum at pension age related to accrued pension at 31/03/23 (bands of £5,000) £000 | (e) Cash Equivalent Transfer Value at 01/07/22 £000 | (f) Real Increase in Cash Equivalent Transfer Value £000 | (g) Cash Equivalent Transfer Value at 31/03/22 £000 | (h) Employers Contribution to partnership pension £000 |
|---|---|---|---|---|---|---|---|---|
| Peter Axon - Interim CEO | 12.5-15 | 25-27.5 | 65-70 | 125-130 | 869 | 211 | 1,106 | 0 |
| Dr Paul Edmondson-Jones - Chief Medical Officer | 0-2.5 | 0-0 | 0-5 | 0-0 | 0 | 0 | 0 | 0 |
| Phil Smith - Chief Delivery Officer | 2.5-5 | 0-0 | 15-20 | 0-0 | 135 | 26 | 174 | 0 |
| Paul Brown - Chief Finance Officer | 2.5-5 | 0-2.5 | 40-45 | 80-85 | 816 | 47 | 878 | 0 |
| Heather Johnstone - Chief Nursing and Therapies Officer | 2.5-5 | 2.5-5 | 40-45 | 80-85 | 791 | 52 | 856 | 0 |
| Chris Bird - Chief Transformation Officer | 5-7.5 | 0-0 | 50-55 | 0-0 | 581 | 81 | 679 | 0 |
| Alex Brett - Chief People Officer | 5-7.5 | 15-17.5 | 20-25 | 40-45 | 242 | 140 | 387 | 0 |

## Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

## Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

## Compensation on early retirement of for loss of office

No payments have been made in respect of compensation on early retirement. Payments paid or payable in respect of loss of office are summarised within the notes relating to Exit Packages.

## Payments to past directors

There were two payments made in relation to Exit Packages during 2022/23 and these were made to Marcus Warnes, CCG Accountable Officer and Cheryl Hardisty, CCG Executive Director of Commissioning and Operations.

The two proposed business cases were presented to and approved by the Remuneration Committee on 27 June 2022, these were then ratified by the Board on 1 July 2022. National approval was received on 6 July 2022. The final payment for Marcus Warnes was £160,000 and for Cheryl Hardisty was £93,333.

# Staff Report

## Number of senior managers

A senior manager is defined by NHS Business Services Authority as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS organisation.

For the purposes of this report, we believe those persons in Band 8a and above are senior managers.

### Senior staff analysis by Band (based on staffing at 31 March 2023)

| Pay Band | Headcount |
|---|---|
| Apprentice | 3 |
| Band 1 | 0 |
| Band 2 | 10 |
| Band 3 | 2 |
| Band 4 | 24 |
| Band 5 | 21 |
| Band 6 | 35 |
| Band 7 | 33 |
| Band 8 - Range A | 47 |
| Band 8 - Range B | 32 |
| Band 8 - Range C | 21 |
| Band 8 - Range D | 13 |
| Band 9 | 11 |
| Medical | 30 |
| Very Senior Manager (VSM) | 11 |
| Governing Body (off payroll)* | 12 |
| **Grand total** | **305** |

**Governing Body (off payroll) pertains to Governing Body members without a pay record in the ICB Electronic Staff Record (ESR) system.*

## Staff numbers and costs (subject to audit)

The table below shows the average number of people employed in 2022/23 in NHS Staffordshire and Stoke-on-Trent ICB.

| Average number of people employed 31/03/23 | Permanently employed | Other | Total |
|---|---|---|---|
| Administration and Estates | 188.61 | 4.65 | 193.26 |
| Medical and Dental | 9.85 | 0.46 | 10.31 |
| Nursing, Midwifery and Health Visiting Staff | 19.55 | 0.43 | 19.98 |
| Other | 2.19 | 0.51 | 2.70 |
| Scientific, Therapeutic and Technical Staff | 22.73 | 0.27 | 23.00 |
| **Total** | **242.94** | **6.32** | **249.26** |

The table below shows the associated staff costs for NHS Staffordshire and Stoke-on-Trent ICB:

| Staff costs 31/03/23 | Permanently employed £000 | Other £000 | Total £000 |
|---|---|---|---|
| Salaries and Wages | £10,455 | £681 | £11,136 |
| Social Security Costs | £1,102 | £0 | £1,102 |
| Employer Contributions to NHS Pension Scheme | £1,823 | £0 | £1,823 |
| Apprenticeship Levy | £36 | £0 | £36 |
| **Total** | **£13,416** | **£681** | **£14,097** |

## Staff composition

### Headcount by gender (based on staffing at 31 March 2023)

| Staff grouping | Female | Male | Unknown* | Totals |
|---|---|---|---|---|
| Governing body | 5 | 7 | 12 | **24** |
| Other senior management (Band 8C+) | 43 | 31 | 0 | **74** |
| All other employees | 176 | 31 | 0 | **207** |
| **Grand total** | **224** | **69** | **12** | **305** |

### Percentage by gender (based on staffing at 31 March 2023)

| Staff grouping | Female | Male | Unknown* |
|---|---|---|---|
| Governing body | 20.8% | 29.2% | 50.0% |
| Other senior management (Band 8C+) | 58.1% | 41.9% | 0.0% |
| All other employees | 85.0% | 15.0% | 0.0% |
| **Grand total** | **73.44%** | **22.62%** | **3.93%** |

**Named individuals categorised as 'Unknown' are:*

- *Alex Brett*
- *Baz Tameez*
- *Buki Adeyemo*
- *Chris Bird*
- *Chris Ibell*
- *Jack Aw*
- *John Henderson*
- *Jon Rouse*
- *Neil Carr*
- *Peter Axon*
- *Simon Fogell*
- *Tracy Bullock*

## Sickness absence data

| Staff sickness absence 2022 | 2022 number |
|---|---|
| Total days lost | 1,450.01 |
| Total staff years | 246.57 |
| Average working days lost | 5.88 |

The sickness absence data for the ICB in 2022 was whole time equivalent (WTE) days available of 55,477.78 and WTE days lost to sickness absence of 1,450.01. Average working days lost per employee was 5.88, which was managed through the Absence Management policy.

## Staff turnover percentages

| ICB staff turnover 2022/23 | 2022/23 number |
|---|---|
| Average FTE employed | 245.81 |
| Total FTE leavers | 26.33 |
| Turnover rate | 10.71% |

The ICB staff turnover rate for 2022/23 has been calculated by dividing the total full-time equivalent (FTE) leavers in-year by the average FTE staff in post during the year.

The ICB's total FTE leavers in year was 26.33. The ICB's average FTE staff in post during the year was 245.81. The ICB's staff turnover rate for the year was 10.71%.

## Staff policies

The ICB has continued to work with the Staff Engagement Group (SEG), Staff Networks and Support Groups, Staff Side Representatives and the General Purposes Group to align all HR policies. As part of the due diligence process for the transition of staff to the ICB on 1 July 2022, a review of all policies was undertaken to ensure they were fully aligned at the point of TUPE transfer (Transfer of Undertakings – Protection of Employment). The policies are used by managers and staff for consistency. All reviewed policies have an accompanying Equality Impact Assessment (EIA).

Our rolling programme of training for current staff and new starters on mandatory equality and diversity includes awareness of a range of issues impacting on people with disabilities. The ICB includes in their training programme an independent mandatory training for all staff on invisible disabilities and unconscious bias. We also ensure that any employee who needs training (either because they work with people with disabilities, or because they have acquired an impairment or medical condition) receives the necessary support through workplace risk assessments and health and wellbeing conversations.

Through unconscious bias training, all interview panel members must have attended the training, and each panel has a band-related equality question to ask all candidates.

Staff can easily access HR policies and documents by using the staff intranet, 'Information and News', known by staff as IAN.

## Trade Union Facility Time Reporting Requirements

We have regional representatives for the ICB in Staffordshire and Stoke-on-Trent. However, as we continue to work across the Staffordshire and Stoke-on-Trent system, we have utilised a system of local representative as well as continuing to engage and consult with regional representatives from various trade unions.

### Health and safety

Midlands and Lancashire Commissioning Support Unit (MLCSU) provides advice and support on all health and safety-related matters. In October 2021, the majority of ICB staff had a change of base to home and relevant display screen equipment (DSE) assessments are reviewed annually. Those staff who are still office-based continue to be supported by the Buildings Management team, where they are

based. The staff that continued to work in the office had additional safety precautions in place along with the appropriate personal protective equipment (PPE) and distancing guidance.

All staff are asked annually to undertake a DSE assessment for their home office set up, and this was sent to the HR team for inclusion in their personnel records. Staff were required to complete a risk assessment prior to visiting any of the offices for particular reasons, and for this to be signed off by their line manager within the national or local COVID-19 restrictions at the time. Changes in legislation mean that risk assessments are no longer required for each time a member of staff visits one of the officers however MLCSU's Health and Safety team continue to monitor any changes in government health and safety legislation and advise the ICB accordingly.

There were no health and safety-related incidents reported to the MLCSU Health and Safety Officer and no RIDDOR incidents.

# Other employee matters

## Agile working

Agile working is about what you do, and not where you do it. We have developed our agile working principles and framework to provide an opportunity to modernise our working practices – moving away from assumptions of traditional office working about where, when and how work should be done, to a culture of working wherever, whenever and however is most appropriate to get the work done.

It is not just about working hours, locations and workstyles – it is about being responsive and adaptive to service needs and advancements in technology. Agile working aims to provide greater flexibility, particularly in relation to the time and location our staff can work, subject to the requirements of the service and individual job.

The 'Back to the Future Programme' brought together and co-ordinated a broad range of changes around digital transformation, estates, corporate governance, human resources, wellbeing and organisational development. April 2022 saw the opening of the three designated 'hubs' for staff to use, utilising two existing office hubs and one new hub in Stafford. These are supported by the Agile Framework which continues to be monitored and developed to create a new work culture and approach to agile and hybrid working.

## Staff development days

Development days have occurred virtually throughout the year, embracing new technology and new ways of getting staff together to hear key messages and provide feedback from previous events. Some of the events were recorded through Microsoft Teams, so staff who may have missed the event could watch back. Several equality, diversity and inclusion related topics and themes have been presented and discussed during these sessions – some of which have influenced the wider equality agenda across the ICB.

Staff development days were held on:

- 27 April 2022
- 25 May 2022
- 28 June 2022
- 29 September 2022
- 17 January 2023
- 21 March 2023.

## Staff training

The commitment to organisational development by the Board remains strong and work will progress for 2023/24, with the release of the Training and Development catalogue. Over 218 courses have been approved during 2022/23, with 152 members of staff taking up the opportunity to develop their skills and knowledge. A broad range of training has been delivered, from nationally-recognised accreditation such as Prince 2 and Managing Successful Programmes, to ILM5 coaching and mentoring.

## Health and wellbeing support to staff

The ICB took part in the national NHS Staff Survey in 2022 with a response rate of 80% resulting in feedback via free text which will form the Action Plan working group with staff members.

The ICB HR lead has continued to ensure health and wellbeing is a priority for the culture of our workforce, ensuring that all staff are signposted to local and national services and support, apps and the system Psychological and Wellbeing Hub. The introduction of the Coaching Culture app with various support modules has also been launched.

Our job adverts state that all staff will receive a health and wellbeing conversation with their line manager, and staff are signposted to support via two Wellbeing Guardians.

A significant number of staff are also trained Mental Health First Aiders, and we have recently appointed volunteer staff, Change Ambassadors, Menopause Ambassadors, Diversity Champions and Domestic Abuse Ambassadors.

## Whistleblowing

For our corporate whistleblowing obligations, we have a dedicated policy in place. We have appointed Freedom to Speak Up Guardians, and all our staff are assured that they can speak up freely to raise any concerns they may have.

## Board Organisational Development session

The Board meet on a monthly basis and alternate between meetings held in public and meetings held virtually.

The Board has a full development programme in place for 2023/24 and this will be supported by Deloitte. The programme aims to consider:

- How the ICB can use principles of mutual accountability to oversee performance. This will explore the necessary conditions and behaviours to allow partners to challenge each other and gain assurance as a unitary Board
- The roles of each part of the system in overseeing performance (including the ICB, its members, and NHS England). This will include the processes and behaviours required in regular monitoring, gaining assurance, and escalating where required
- How the ICB can embed the ways of working identified in the Compact and cascade these out to the wider system, including using them in practical situations
- How the ICP Strategy and Joint Forward Plan are shared with the wider system and the necessary focus on delivery of these plans is obtained.

## Staff Engagement Group

The ICB has successfully maintained a formal Staff Engagement Group (SEG) while working virtually, which includes core members and various volunteers from all directorates. During 2022/23, the group have continued to support staff events, supported charity and health awareness days, initiated investment in Mental Health First Aiders refresher training and provide monthly feedback on key issues.

The group have supported the business cycle review of a significant number of aligned HR Policies and standing items have been introduced on the Equality, Diversity and Inclusion (EDI) and People Plan.

## Staff Survey

The Staff Survey ran between October and November 2022. Overall there was a response rate of 80%. The average response rate for similar organisations is 76%.

Feedback from the NHS Staff Survey has been reviewed by the ICB Executive Team and the Staff Engagement Group to form an action plan to recognise the achievements, investigate areas of concern and seek new opportunities of support for staff.

We will ensure that the action plan tracks progress towards the seven elements of the People Promise:

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

## Staff diversity and inclusion (best practice disclosures)

Throughout this reporting period 2022/23, the Integrated Care Board has met and reported on their equality statutory and mandated obligations, principally delivering on the Equality Acts, Public Sector Equality Duty (PSED) to address inequality and health inequalities. This continues to be a key focus for the ICB and the wider Staffordshire and Stoke-on-Trent Integrated Care System.

The ICB continue to advance and evidence EDI through a range of statutory and mandated instruments and mechanisms, along with good practice initiatives all of which are reported and published throughout the year on the ICB's

dedicated equality webpage. All resulting feedback and analysis from these activities are being considered and will form the ICB's 2023/24 Annual Equality Action Plan.

### ICB Equality Policy

The ICB has updated its Equality Policy to be more aligned to and reflective of its new functions and structure. The policy provides details of governance arrangements and accountability measures when developing services, policies or when carrying out our day-to-day functions and activities. The policy can be accessed from the ICB dedicated EDI webpage.

### ICB Equality Objectives 2022-25/Equality Delivery System

The ICB agreed to adopt the NHS Equality Delivery System 3 Domains and 11 outcomes as its 2022 – 2025 equality objectives. Domain 2 focuses on Workforce Wellbeing and Domain 3 on Organisational Leadership. The EDS is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010 and its associated duties.

ICB Staff Network members, mental health first aiders, diversity champions, ICB Staff Engagement Group representatives, ICS Staff Side representatives, and menopause and domestic abuse ambassadors participated in this year's EDS grading event. This year the ICB presented evidence in relation to Domain 2 where the ICB received an overall performance grading of 'Achieving'.

### Workforce diversity profile and recruitment reporting

We aim to employ a diverse workforce that is representative of our local communities, as we believe this will improve our decision making in the development of health and care services.

The ICB produced its first annual workforce diversity profile report, the data from this report which will be used as a baseline to measure the diversity of our staff across the full range of NHS pay grades and in future workforce planning.

Regarding recruitment, the ICB has also started to collate data around its recruitment activity. As this will be the first time the ICB has produced and published this information, no clear messaging, analysis or comparisons can be drawn from this first set of data. It will be used as a baseline for identifying any future trends where potential disparities between certain protected groups may exist during the recruitment process, where any such disparities might be mitigated or rationalised.

The report generated a range of actions which are incorporated into the ICB Annual Equality Action Plan.

### Gender Pay Gap (GPG)

The GPG requires comparison against two years consecutive data and reported one year in arrears. This has not applied to ICBs for 2022/23, as they were only established in July 2022.

The ICB will take a snapshot of data in for March 2023, for data relating to 2022 this will act as a baseline year. We will then be required to produce data on 2023 figures and report our gender pay gap before the reporting deadline of March 2024, comparing 2022 against 2023 figures.

### Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

The ICB has collated the WRES/WDES data for 2022/23 with any resulting actions forming part of the ICB's Annual Equality Action Plan. The WRES/WDES reports are due to be published in October 2023. This year the ICB adopted the Race Equality Code. There will be a focus on ensuring that WRES reporting reflects the RACE Equality Code actions and recommendations.

### Race Equality Code (REC)

In 2022 the ICB adopted the REC as part of our commitment to addressing race equality. The REC is an accredited leadership-focused programme, requiring two diagnostic assessments, an audit on existing processes and procedures which were completed during January and March 2023. The assessment process produced 31 short- to long-term actions. Actions include specific and meaningful race diversity targets, to address disparities in Board and Senior Leadership Team representation.

The code has been developed around 12 core principles focusing on three areas, Resources, Competency and Execution. The assessment process resulted in a total of 31 short- to longer-

term actions. The implementation of these actions will form a significant part of the ICB's Annual Equality Action Plan 2023/24.

The sessions were attended and positively received by the ICB leadership team, including ICB Board Chair, ICB CEO, Director of Corporate Governance, Chief People Officer, Non-Executive Director/Chair of the People, Culture and Organisational Development Committee, with support from the MLCSU EDI Team and Head of People, OD and Inclusion.

Other national equality reporting tools and mechanisms used to evidence compliance with the (PSED) include:

- NHS Accessible Information Standard
- Race Disparity Ratio
- Modern Day Slavery.

### Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

EHIIRAs are a well-established and embedded tool in the ICB. Using EHIIRAs helps ensure that services, policies and day-to-day functions are fair, accessible and inclusive. Through a process of questions and data analysis, EHIIRAs help to identify gaps and potential risks and highlight opportunities to improve staff and patient, access, experience and outcomes. EHIIRAs are evidence-based tools, requiring stakeholder engagement.

### ICB staff networks and support groups

During 2022/23, staff networks and support groups were active and provided a platform for staff to support, express and voice a range of experiences. Information and feedback from these network groups progress through the governance process with the aim of influencing ICB policies, procedures and day-to-day functions.

### Individual ICB-appointed roles allied to equality, diversity and inclusion

In addition to the staff support groups, the ICB has appointed several voluntary EDI-related ally/staff support roles. These roles have been taken up by staff across a range of pay bands including very senior managers. They also include Diversity champions, Menopause Ambassadors, Invisible Conditions Reps, Mental Health First Aiders, Wellbeing Guardian, Wellbeing Champions, Freedom to Speak Up Guardian, Freedom to Speak Up Champion, Domestic Abuse Ambassadors and Change Ambassadors.

### Staff Engagement and Involvement

Staff have access to and are informed through a range of activities, including:

- **Staff Team Brief:** via Microsoft Teams each Monday as usual. If an urgent communication is needed, we will arrange a special Team Brief
- **Staff Wednesday Wellbeing Message:** the vehicle for documents for structural change and key messages about process, policy and system updates
- **Friday Message:** a message directly from the Chief Executive Officer, Peter Axon. These are stored on the staff intranet Information and News (IAN)
- **Staff Time Out Sessions**: the main sessions are recorded but not if there are breakout rooms. Jamboard or an alternative is used to collate questions and answers, allowing people to ask their questions confidentially
- **Monthly equality awareness articles:** throughout the year the ICB provides and promotes equality awareness articles and significant dates which are distributed via several social platforms.

### Staff training and development

Throughout this reporting period, ICB staff have been invited to a wide range of voluntary and mandated equality-related training and awareness sessions.

As of February 2023, the compliance figure for ICB staff completing their mandatory Equality, Diversity and Human Rights training was 88.4%.

The ICB has mandated two new Equality Training programmes which all staff are required to attend. Unconscious Bias and Invisible Disability respectively.

ICB staff have also attended or had access to the following training (please note that this is not an exhaustive list):

- All new staff receive an Equality and Inclusion induction session

- One-to-one Equality Health Inequality Impact and Risk Assessment (EHIIRA) and U-Assure sessions
- Recruitment and selection training
- Diversity masterclass
- Healthy Ageing in Staffordshire workshop
- Population Health Management training.

### Integrated Care System activity

Most of the work this year has been influenced by national and regional directives as a result of several reports highlighting health inequalities within and between the different protected characteristic and other vulnerable communities in the population we serve.

The ICB has worked closely with its NHS provider partners in developing and delivering system-wide initiatives including:

- Staffordshire and Stoke-on-Trent Workforce Race Equality and Inclusion (WREI) Strategy
- System-wide staff networks
- ICS Inclusion School Programme
- ICS leadership and system-wide training programmes
- Development opportunities for ethnically diverse staff, for example The New Futures Programme and the High Potential Scheme aimed at staff with a protected characteristic who have historical experienced inequalities in development opportunities and career progression.

## Expenditure on consultancy

For the nine-month period ending 31 March 2023, expenditure on consultancy was £662k. Expenditure classified as consultancy relates to the provision to management of objective advice and assistance relating to strategy, structure, management, or operations of an organisation in pursuit of its purposes and objectives.

## Off-payroll engagements

A £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB did not have any highly paid off-payroll engagements during the period 1 July 2022 to 31 March 2023.

### Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2023, for more than £245 per day:

| Existing engagements | Number |
|---|---|
| Number of existing engagements as of 31 March 2023 | 0 |
| **Of which, the number that have existed:** | - |
| for less than one year at the time of reporting | 0 |
| for between one and two years at the time of reporting | 0 |
| for between two and three years at the time of reporting | 0 |
| for between three and four years at the time of reporting | 0 |
| for four or more years at the time of reporting | 0 |

## Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245 per day:

| Temporary off-payroll workers | Number |
|---|---|
| Number of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023 | 0 |
| **Of which:** | - |
| Number not subject to off-payroll legislation | 0 |
| Number subject to off-payroll legislation and determined as in-scope of IR35 | 0 |
| Number subject to off-payroll legislation and determined as out of scope of IR35 | 0 |
| Number of engagements reassessed for compliance or assurance purposes during the year | 0 |
| **Of which:** | - |
| Number of engagements that saw a change to IR35 status following review | 0 |

## Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

| Off-payroll engagements of board members / senior official engagements | Number |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or senior officials with significant financial responsibility”, during the financial year. This includes both on payroll and off-payroll engagements | 14 |

# Exit packages, including special (non-contractual) payments

## Table 1: Exit packages

| Exit package cost band (inc. any special payment element) | Number of compulsory redundancies (whole numbers only) | Cost of compulsory redundancies (£s) | Total number of exit packages (whole numbers only) | Total cost of exit packages (£s) |
|---|---|---|---|---|
| Less than £10,000 | 0 | 0 | 0 | 0 |
| £10,001 to £25,000 | 0 | 0 | 0 | 0 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 1 | 93,333 | 1 | 93,333 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 1 | 160,000 | 1 | 160,000 |
| >£200,000 | 0 | 0 | 0 | 0 |
| **Total** | **2** | **253,333** | **2** | **253,333** |

HM Treasury requires the disclosure of exit package information in the Annual Report and Accounts. When incurred, redundancy and other departure costs are paid in accordance with the provisions of the NHS Agenda for Change agreement. Where the ICB agrees early retirements, the additional costs are met by the ICB and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme.

## Table 2: Analysis of other departures

| Analysis of other departures | Agreements (number) | Total value of agreements (£000s) |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs | 0 | 0 |
| Contractual payments in lieu of notice* | 0 | 0 |
| Exit payments following employment tribunals or court orders | 0 | 0 |
| Non-contractual payments requiring HMT approval** | 0 | 0 |
| **Total** | **0** | **0** |

*Note: As a* single *exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in Table 1 which will be the number of individuals.*

**any non-contractual payments in lieu of notice are disclosed under 'non-contracted payments requiring HMT approval' below.*

***includes any non-contractual severance payment made following judicial mediation, and nil relating to non-contractual payments in lieu of notice.*

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that report.

# Parliamentary Accountability and Audit Report

## Staffordshire and Stoke-on-Trent ICB is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report between pages 5 – 24 of the Annual Accounts. An audit certificate and report is also included in this Annual Report between pages 1 – 6 of the following Independent Auditor's Report.

Peter Axon

Chief Executive Officer

Staffordshire and Stoke-on-Trent ICB

29 June 2023

# Independent auditor's report to the members of the Governing Body of NHS Staffordshire and Stoke-on-Trent Integrated Care Board

## Report on the audit of the financial statements

### Opinion on financial statements

We have audited the financial statements of NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the 'ICB') for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

### Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

### Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

### Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

### Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

### Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or

is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

### Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page 64, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries posted by senior officers

- year end accruals

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to prescribing accruals.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

## Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

### Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

### Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

### Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

## Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Staffordshire and Stoke-on-Trent Integrated Care Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we

have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

### Use of our report

This report is made solely to the members of the Governing Body of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

29 June 2023

31st March 2023

# NHS Staffordshire & Stoke-on-Trent Integrated Care Board

Accounts for the period

01/07/2022 to 31/03/2023

NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

# NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

## Accounts For The Period 1st July to 31st March 2023

Foreword to the accounts:

These accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted in HM Treasury's 'Financial Reporting Manual' (FReM), subject to any agreed divergences for the DHSC group, or through subordination to the Companies Act 2006.

ICBs were legally established on 1 July 2022, replacing clinical commissioning groups (or CCGs), taking on the NHS planning functions previously held by CCGs (as well as absorbing some planning roles from NHS England).

As this is the first set of financial statements and accompanying accounting notes of the ICB since its establishment, no prior year comparators have been included.

## Table of Contents

## Statement of Comprehensive Net Expenditure for the period ended 31st March 2023

| | Note | 1st July 2022 – 31st March 2023 £'000 |
|---|---|---|
| Income from sale of goods and services | 2 | (5,195) |
| **Total operating income** | | **(5,195)** |
| Staff costs | 4 | 14,097 |
| Purchase of goods and services | 5 | 1,771,548 |
| Depreciation and impairment charges | 5 | 220 |
| Provision expense | 5 | 1,711 |
| Other Operating Expenditure | 5 | 3,848 |
| **Total operating expenditure** | | **1,791,424** |
| **Net operating expenditure** | | **1,786,229** |
| Finance expense | 7 | 8 |
| **Net expenditure for the period** | | **1,786,237** |
| **Comprehensive expenditure for the period** | | **1,786,237** |

The notes on pages 5 to 24 form part of this statement

## Statement of Financial Position as at 31st March 2023

| | Note | 31st March 2023 £'000 | 1st July 2022 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Right-of-use assets | 9 | 936 | 1,155 |
| **Total non-current assets** | | **936** | **1,155** |
| **Current assets:** | | | |
| Trade and other receivables | 10 | 11,560 | 6,320 |
| Cash and cash equivalents | 11 | 1,031 | 8,466 |
| **Total current assets** | | **12,591** | **14,786** |
| **Total assets** | | **13,527** | **15,941** |
| **Current liabilities** | | | |
| Trade and other payables | 12 | (143,725) | (130,633) |
| Lease liabilities | 9 | (330) | (365) |
| Provisions | 13 | (4,544) | (3,429) |
| **Total current liabilities** | | **(148,599)** | **(134,427)** |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(135,072)** | **(118,486)** |
| **Non-current liabilities** | | | |
| Lease liabilities | 9 | (596) | (837) |
| **Total non-current liabilities** | | **(596)** | **(837)** |
| **Assets less Liabilities** | | **(135,668)** | **(119,323)** |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (135,668) | (119,323) |
| **Total taxpayers' equity:** | | **(135,668)** | **(119,323)** |

The notes on pages 5 to 24 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 29th June 2023 and signed on its behalf by:

Peter Axon

Interim Chief Accountable Officer

29th June 2023

## Statement of Changes In Taxpayers Equity for the period 1st July 2022 - 31st March 2023

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Balance at 01 July 2022** | - | - |
| **Changes in NHS Integrated Care Board taxpayers' equity for reporting period** | | |
| Transfers by absorption from other bodies | (119,902) | (119,902) |
| Net operating expenditure for the financial period | (1,786,237) | (1,786,237) |
| **Net recognised expenditure for the reporting period** | **(1,906,139)** | **(1,906,139)** |
| Net funding | 1,770,471 | 1,770,471 |
| **Balance at 31 March 2023** | **(135,668)** | **(135,668)** |

The notes on pages 5 to 24 form part of this statement

## Statement of Cash Flows for the period 1st July 2022 - 31st March 2023

| | Note | 1st July 2022 – 31st March 2023 £'000 |
|---|---|---|
| **Cash Flows from Operating Activities** | | |
| Movement due to transfer by Modified Absorption (receivables & payables) | | (124,892) |
| Net operating expenditure for the financial period | | (1,786,229) |
| Depreciation and amortisation | 5 | 220 |
| (Increase)/decrease in trade & other receivables | 17 | (11,560) |
| Increase/(decrease) in trade & other payables | 23 | 143,725 |
| Provisions utilised | 30 | (597) |
| Increase/(decrease) in provisions | 30 | 1,711 |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(1,777,622)** |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **-** |
| **Net Cash Inflow (Outflow) before Financing** | | **(1,777,622)** |
| **Cash Flows from Financing Activities** | | |
| Grant in Aid Funding Received | | 1,770,471 |
| Repayment of lease liabilities | | (284) |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **1,770,187** |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 20 | **(7,435)** |
| **Cash & Cash Equivalents at the Beginning of the Financial period** | | **-** |
| Movement due to transfer by Modified Absorption (cash) | | **8,466** |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial period** | | **1,031** |

The notes on pages 5 to 24 form part of this statement

## Notes to the financial statements

### Note 1. Accounting policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### Note 1.1 Going concern

These accounts have been prepared on a going concern basis.

The Health and Social Care Act 2022 allows for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When Clinical Commissioning Groups ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

### Note 1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### Note 1.3 Movement of assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the resulting gain or loss is recognised within reserves.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

## Notes to the financial statements (continued)

### Note 1.4 Joint Operations

The ICB has entered into a joint operation with both Staffordshire County Council and Stoke City Council, in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled in order to provide healthcare benefits to the people of its region and note 17 provides details of the income and expenditure.

The two separate joint operations are hosted by the Councils named above. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

### Note 1.5 Operating segments

Income and expenditure are analysed in the operating segments note and are reported in line with management information used within the ICB. Both internally and externally, management report the entity as one single operating segment, that being the commissioning of healthcare services.

### Note 1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England and is distinct from revenue. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

## Notes to the financial statements (continued)

### Note 1.7 Employee benefits

#### Note 1.7.1 Short term employee benefits

Salaries, wages, and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

#### Note 1.7.2 Retirement benefits costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

### Note 1.8 Other expenditure

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

### Note 1.9 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accrual's basis.

### Note 1.10 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

#### Note 1.10.1 The ICB as a lessee

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

## Notes to the financial statements (continued)

Lease payments included in the measurement of the lease liability comprise;

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use. Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

### Note 1.11 Cash

Cash relates to cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

## Notes to the financial statements (continued)

### Note 1.12 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

### Note 1.13 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

### Note 1.14 Contingent assets and liabilities

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

### Note 1.15 Financial assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.
-

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

### Note 1.15.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

## Notes to the financial statements (continued)

### Note 1.15.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

### Note 1.15.3 Financial assets at fair value through profit and loss

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

### Note 1.15.4 Impairments

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

### Note 1.16 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

### Note 1.16.1 Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

## Notes to the financial statements (continued)

### Note 1.16.2 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

### Note 1.17 Value added tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

### Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

### Note 1.20 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions.

### Note 1.20.1 Critical accounting judgements in applying accounting policies

Management has made no critical accounting judgements, apart from those involving estimations, in the process of applying the clinical ICB’s accounting policies.

### Note 1.20.2 Sources of estimation uncertainty

There are no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the ICB's financial statements. Estimations have been made in respect of a number of accruals; these accruals have been calculated based on the best available information when preparing the financial statements, and on historic experience, principally in respect of certain elements of GP prescribing and the Continuing Healthcare service.

### Note 1.21 Adoption of new standards

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. The financial impact to the ICB has not yet been assessed.

## Note 2. Other operating income

| | 1st July 2022 – 31st March 2023 Total £'000 |
|---|---|
| **Income from sale of goods and services (contracts)** | |
| Education, training and research | 1,953 |
| Non-patient care services to other bodies | 443 |
| Other Contract income | 2,799 |
| **Total Operating Income** | **5,195** |

## Note 3.1 Disaggregation of income - Income from sale of good and services (contracts)

| | Education, training and research £'000 | Non-patient care services to other bodies £'000 | Other Contract income £'000 |
|---|---|---|---|
| **Source of Revenue** | | | |
| NHS | 1,953 | 359 | 6 |
| Non NHS | - | 84 | 2,793 |
| **Total** | **1,953** | **443** | **2,799** |

| | Education, training and research £'000 | Non-patient care services to other bodies £'000 | Other Contract income £'000 |
|---|---|---|---|
| **Timing of Revenue** | | | |
| Point in time | 1,953 | 443 | 2,799 |
| Over time | - | - | - |
| **Total** | **1,953** | **443** | **2,799** |

## Note 3.2 Transaction price to remaining contract performance obligations

The ICB did not have any contract revenue during the reporting period expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

## Note 4. Employee benefits and staff numbers

### Note 4.1 Employee benefits

| | 1st July 2022 – 31st March 2023 | | |
|---|---|---|---|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| **Employee Benefits** | | | |
| Salaries and wages * | 10,455 | 681 | **11,136** |
| Social security costs | 1,102 | - | **1,102** |
| Employer Contributions to NHS Pension scheme | 1,823 | - | **1,823** |
| Apprenticeship Levy | 36 | - | **36** |
| **Total employee benefits expenditure** | **13,416** | **681** | **14,097** |

* Whilst the recent pay offer for Agenda for Change staff has not yet been accepted, proximity to the reporting date requires that we take a prudent approach and reflect the likely cost in this reporting period. The estimated cost to the organisation is £668k and has been accounted for within the table above.

### Note 4.2 Average number of people employed

| | 1st July 2022 – 31st March 2023 | | |
|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number |
| **Total** | 242.94 | 6.32 | **249.26** |

### Note 4.3 Exit packages agreed during the reporting period

| | 1st July 2022 – 31st March 2023 Compulsory redundancies | |
|---|---|---|
| | Number | £ |
| Less than £10,000 | - | - |
| £10,001 to £25,000 | - | - |
| £25,001 to £50,000 | - | - |
| £50,001 to £100,000 | 1 | 93,333 |
| £100,001 to £150,000 | - | - |
| £150,001 to £200,000 | 1 | 160,000 |
| **Total** | **2** | **253,333** |

The table above reports the number and value of exit packages agreed in the financial period. However, the expense associated with these departures have been recognised in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report.

## Note 4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

### Note 4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### Note 4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

## Note 5. Operating expenditure

| | 1st July 2022 – 31st March 2023 Total £'000 |
|---|---|
| **Purchase of goods and services** | |
| Services from other ICBs, CCGs and NHS England | 11,393 |
| Services from foundation trusts | 465,592 |
| Services from other NHS trusts | 659,918 |
| Services from Other WGA bodies | 2 |
| Purchase of healthcare from non-NHS bodies | 241,462 |
| Purchase of social care | 36,141 |
| Prescribing costs | 174,818 |
| General Ophthalmic services | 3,821 |
| GPMS/APMS and PCTMS | 159,132 |
| Supplies and services – clinical | 260 |
| Supplies and services – general | 1,308 |
| Consultancy services | 662 |
| Establishment | 4,434 |
| Transport | 6,965 |
| Premises | 3,736 |
| Audit fees * | 440 |
| Other non statutory audit expenditure | |
| · Internal audit services | 174 |
| · Other services | 90 |
| Other professional fees | 150 |
| Legal fees | 467 |
| Education, training and conferences | 583 |
| **Total Purchase of goods and services** | **1,771,548** |
| | |
| **Depreciation and impairment charges** | |
| Depreciation | 220 |
| **Total Depreciation and impairment charges** | **220** |
| | |
| **Provision expense** | |
| Provisions | 1,711 |
| **Total Provision expense** | **1,711** |
| | |
| **Other Operating Expenditure** | |
| Chair and Non Executive Members | 111 |
| Grants to Other bodies | 20 |
| Research and development (excluding staff costs) | 1,796 |
| Expected credit loss on receivables | 1,919 |
| Other expenditure | 2 |
| **Total Other Operating Expenditure** | **3,848** |
| | |
| **Total operating expenditure** | **1,777,327** |

* Audit fees are split between the ICB and CCG audit (£170k CCG – April 22 to Jun 22, £270k ICB – July 22 to March 23).

The auditor's liability for external audit work carried out throughout the period is limited to £2m.

## Note 6. Better payment practice code

| | 1st July 2022 – 31st March 2023 Number | 1st July 2022 – 31st March 2023 £'000 |
|---|---|---|
| **Non-NHS Payables** | | |
| Total Non-NHS Trade invoices paid in the period | 36,075 | 471,923 |
| Total Non-NHS Trade invoices paid within target | 35,630 | 465,174 |
| **Percentage of Non-NHS Trade invoices paid within target** | **98.77%** | **98.57%** |
| **NHS Payables** | | |
| Total NHS Trade invoices paid in the period | 1,242 | 1,146,927 |
| Total NHS Trade invoices paid within target | 1,223 | 1,146,243 |
| **Percentage of NHS Trade invoices paid within target** | **98.47%** | **99.94%** |

## Note 7. Finance Costs

| | 1st July 2022 – 31st March 2023 £'000 |
|---|---|
| Interest on lease liabilities | 8 |
| **Total finance cost** | **8** |

## Note 8. Net loss on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the resulting gain or loss is recognised within reserves.

| | 1st July 2022 – 31st March 2023 Total £'000 |
|---|---|
| Transfer of right of use assets | 1,155 |
| Transfer of cash and cash equivalents * | 8,466 |
| Transfer of receivables * | 28,585 |
| Transfer of payables * | (152,898) |
| Transfer of provisions | (3,429) |
| Transfer of right of use liabilities | (1,202) |
| Transfer of payables * | (579) |
| **Net loss on transfers by absorption** | **(119,902)** |

* When combined, these totals represent the transfer by modified absorption value of (£116,426) represented on the Statement of Cashflows as contributions to movements in working capital balances.

## Note 9. Leases

### Note 9.1 Right-of-use assets

| 2022-23 | Buildings excluding dwellings £'000 | 31st March 2023 £'000 |
|---|---|---|
| **Cost or valuation at 01 July 2022** | - | - |
| Transfer (to) from other public sector body by modified absorption | 1,229 | 1,229 |
| **Cost/Valuation at 31 March 2023** | **1,229** | **1,229** |
| **Depreciation 01 July 2022** | - | - |
| Transfer (to) from other public sector body by modified absorption | 73 | 73 |
| Charged during the year | 220 | 220 |
| **Depreciation at 31 March 2023** | **293** | **293** |
| **Net Book Value at 31 March 2023** | **936** | **936** |

### Note 9.2 Lease liabilities

| | 31st March 2023 £'000 |
|---|---|
| **Lease liabilities at 01 July 2022** | - |
| Interest expense relating to lease liabilities | (8) |
| Repayment of lease liabilities (including interest) | 284 |
| Other | (1,202) |
| **Lease liabilities at 31 March 2023** | **(926)** |

### Note 9.3 Lease liabilities - maturity analysis of undiscounted future lease payments

| | 31st March 2023 £'000 |
|---|---|
| Within one year | (330) |
| Between one and five years | (596) |
| After five years | - |
| **Balance at 31 March 2023** | **(926)** |

### Note 9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

| | 1st July 2022 – 31st March 2023 £'000 |
|---|---|
| Depreciation expense on right-of-use assets | 220 |
| Interest expense on lease liabilities | 8 |

## Note 9. Leases (continued)

### Note 9.5 Amounts recognised in Statement of Cash Flows

| | 1st July 2022 – 31st March 2023 £'000 |
|---|---|
| Total cash outflow on leases under IFRS 16 | 284 |

## Note 10. Receivables

### Note 10.1 Trade and other receivables

| | Current 31st March 2023 £'000 | Current 1st July 2022 £'000 |
|---|---|---|
| NHS receivables: Revenue | 777 | 2,220 |
| NHS prepayments | 119 | 460 |
| NHS accrued income | 495 | 279 |
| Non-NHS and Other WGA receivables: Revenue | 8,458 | 1,561 |
| Non-NHS and Other WGA prepayments | 786 | 1,376 |
| Non-NHS and Other WGA accrued income | 3,843 | 1,235 |
| Expected credit loss allowance-receivables | (3,157) | (1,239) |
| VAT | 237 | 426 |
| Other receivables and accruals | 1 | 2 |
| **Total trade and other receivables** | **11,560** | **6,320** |

As at 31 March 2023 there were no non-current trade and other receivables.

### Note 10.2 Receivables past their due dates but not impaired

| | 31st March 2023 | |
|---|---|---|
| | DHSC Group Bodies £'000 | Non DHSC Group Bodies £'000 |
| By up to three months | 68 | 4,080 |
| By three to six months | - | 1,214 |
| By more than six months | - | 13 |
| **Total** | **68** | **5,307** |

### Note 10.3 Loss allowance on asset classes

| | Trade and other receivables £'000 | Total £'000 |
|---|---|---|
| Lifetime expected credit losses on trade and other receivables - stage 3 | (3,157) | **(3,157)** |
| **Total** | **(3,157)** | **(3,157)** |

## Note 11. Cash and cash equivalents

| | 31st March 2023 £'000 |
|---|---|
| **Balance at 01 July 2022** | - |
| Transfer (to) from other public sector body under absorption | 8,466 |
| Net change in year | (7,435) |
| **Balance at 31 March 2023** | **1,031** |
| | |
| Made up of: | |
| Cash with the Government Banking Service | 1,031 |

## Note 12. Trade and other payables

| | Current 31st March 2023 £'000 | Current 1st July 2022 £'000 |
|---|---|---|
| NHS payables: Revenue | 6,281 | 1,748 |
| NHS accruals | 7,150 | 18,340 |
| NHS deferred income | - | 8 |
| Non-NHS and Other WGA payables: Revenue | 28,552 | 17,463 |
| Non-NHS and Other WGA accruals | 81,405 | 77,326 |
| Non-NHS and Other WGA deferred income | 9 | - |
| Social security costs | 201 | 220 |
| Tax | 197 | 230 |
| Other payables and accruals | 19,929 | 15,298 |
| **Total Trade & Other Payables** | **143,725** | **130,633** |

As at 31 March 2023 there were no non-current trade and other payables.

There are no liabilities included in the above for any person due in future years under arrangements to buy out the liability for early retirement over 5 years.

* Other payables include £1.635m outstanding pension contributions as at 31 March 2023.

## Note 13. Provisions

| | Current 31st March 2023 £'000 |
|---|---|
| Redundancy * | 343 |
| Continuing care | 1,160 |
| Other ** | 3,040 |
| **Total current and non-current** | **4,544** |

* Redundancy – this is associated with the impact of the Health and Social Care Bill of the 06 July 2021 for the establishment of Integrated Care Boards across England which abolished Clinical Commissioning Groups.

** Other – this is primarily related to GP premises rent reviews, covering any premises that have not been reviewed externally to ascertain their current market rental value within the last three years which would result in a future cash outflow for the entity.

## Note 13. Provisions (continued)

| | Redundancy £'000 | Legal Claims £'000 | Continuing Care £'000 | Other £'000 | Total £'000 |
|---|---|---|---|---|---|
| **Balance at 01 July 2022** | **-** | **-** | **-** | **-** | **-** |
| Transfer (to) from other public sector body under absorption | 536 | 250 | 901 | 1,742 | **3,429** |
| Arising during the year | 134 | - | 1,114 | 2,052 | **3,300** |
| Utilised during the year | (253) | (38) | (192) | (114) | **(597)** |
| Reversed unused | (74) | (212) | (663) | (639) | **(1,589)** |
| **Balance at 31 March 2023** | **343** | **-** | **1,160** | **3,040** | **4,544** |
| **Expected timing of cash flows:** | | | | | |
| Within one year | 343 | - | 1,160 | 3,040 | **4,544** |
| **Balance at 31 March 2023** | **343** | **-** | **1,160** | **3,040** | **4,544** |

## Note 14. Other financial commitments

The Staffordshire and Stoke-on-Trent ICB has entered into one non-cancellable contract (which is not a lease, private finance initiative contracts or other service concession arrangements) which expires as follows:

| | 31st March 2023 £'000 |
|---|---|
| In not more than one year | 1,169 |
| In more than one year but not more than five years | 5,854 |
| In more than five years | 8,195 |
| **Total** | **15,218** |

NHS Staffordshire and Stoke-on-Trent has a long term contractual arrangement running until 2037 with an Intermediate care provider in the local area which is the cause of the large commitments value identified above.

## Note 15. Financial instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

## Note 15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrate Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within organisations standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by internal auditors.

## Note 15.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

## Note 15.1.2 Credit risk

Because the majority of the organisation’s revenue comes parliamentary funding, it has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

## Note 15.1.3 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

## Note 15. Financial instruments (continued)

### Note 15.2 Financial assets

| | Financial Assets measured at amortised cost 31st March 2023 £'000 | Financial Assets measured at amortised cost 1st July 2022 £'000 |
|---|---|---|
| Trade and other receivables with NHSE bodies | 946 | 2,230 |
| Trade and other receivables with other DHSC group bodies | 4,061 | 1,424 |
| Trade and other receivables with external bodies | 8,567 | 1,641 |
| Cash and cash equivalents | 1,031 | 8,466 |
| **Total** | **14,606** | **13,761** |

### Note 15.3 Financial liabilities

| | Financial Liabilities measured at amortised cost 31st March 2023 £'000 | Financial Liabilities measured at amortised cost 1st July 2022 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 1,419 | 2,038 |
| Trade and other payables with other DHSC group bodies | 12,001 | 18,691 |
| Trade and other payables with external bodies | 130,824 | 110,647 |
| **Total** | **144,244** | **131,376** |

## Note 16 Operating segments

The ICB considers that it has only one operating segment: commissioning of healthcare services.

## Note 17. Joint operation

The joint operations of the ICB relate solely to pooled budget arrangements.

The ICB has entered into joint operations with both Staffordshire County Council and Stoke City Council. They are hosted by either the ICB or the councils named above. Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

The contributions made by NHS Staffordshire and Stoke-on-Trent ICB during the reporting period are as follows:

| Name of arrangement | Parties to the arrangement | Description of principal activities | Reporting Period Expenditure |
|---|---|---|---|
| | | | £'000 |
| Better Care Fund | Staffordshire County Council | Adult Social Care | 27,987 |
| Better Care Fund | Staffordshire County Council | Implementation of the Care Act | 1,740 |
| Better Care Fund | Staffordshire County Council | Carers Hub | 529 |
| Better Care Fund | Stoke City Council | Adult Social Care | 8,847 |
| | | | **39,104** |

## Note 18. Related parties

The DHSC is regarded as a related party. During the year the organisation has had a significant number of material transactions with entities for which the Department is regarded as the parent. These entities are listed below and represent organisations where we have had greater than 1% of expenditure (£17m):

- University Hospitals of North Midlands NHS Trust (Integrated Care System partner)
- Midlands Partnership NHS Foundation Trust (Integrated Care System partner)
- North Staffordshire Combined Healthcare NHS Trust (Integrated Care System partner)
- University Hospitals of Derby and Burton NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- University Hospitals Birmingham NHS Foundation Trust
- West Midlands Ambulance Service University NHS Foundation Trust
- Walsall Healthcare NHS Trust

## Note 19. Events after the reporting period

From April 2023, all Integrated Care Boards (ICBs) will have delegated responsibility of NHS England pharmaceutical, ophthalmic and dental (POD) functions giving ICBs responsibility for a broader range of functions. This will enable the ICB to design services and pathways of care that better meet local needs and priorities.

There are no other events after the reporting period that would impact the income, expenditure, assets or liabilities recorded within the financial statements for the reporting period.

## Note 20. Financial performance target

| | Target | Performance | Target Achieved |
|---|---|---|---|
| Revenue resource use does not exceed the amount specified in directions | 1,786,720 | 1,786,237 | Yes |
| Revenue administration resource use does not exceed the amount specified in directions | 17,811 | 17,223 | Yes |

## Note 21. Losses and special payments

Losses
The total number of losses and special payments cases, and the total value incurred, was as follows:

| | Total Number of Cases 1st July 2022 – 31st March 2023 Number | Total Value of Cases 1st July 2022 – 31st March 2023 £'000 |
|---|---|---|
| Fruitless payments | 1 | 3 |
| **Total** | **1** | **3** |

The fruitless payment relates to a payment which cannot be avoided as the recipient was entitled to it even though nothing of use will be received in return.

No expenses were incurred during the period which would be categorised as special payments.